

Luton's Joint Strategic Needs Assessment 2015

Foreword

We are delighted to present this 2015 Joint Strategic Needs Assessment (JSNA) for Luton. This is the third JSNA which has been undertaken in Luton and provides a comprehensive analysis of the current and future health and wellbeing needs of people in Luton. Its purpose is to provide the starting point for discussion and debate about the health and wellbeing of people in Luton and describe what can be done to inform our planning and commissioning decisions.

The analysis covers Luton's people and Luton as a place (our environment, transport, education, housing, culture and community involvement). We look at specific behaviours and the consequences of those, eg specific diseases and how we are responding to the needs of our residents, as well as looking at what our residents can offer (their assets).

The executive summary provides an overview of Luton, its population and key areas of focus for action (strategic recommendations) to improve the health and wellbeing of residents. Each chapter within the main report provides priorities for action, which gives the initial focus for the topic area. The JSNA will inform our health and wellbeing strategy and how we can work jointly to improve the health and wellbeing of those who live in Luton.

We would like to thank everyone who contributed to this report, both those who provided content and those who helped directly in the production.

Copies of the report are available from: www.luton.gov.uk/jsna

Signed



Councillor Simmons

Chair Health and Wellbeing Board



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Executive summary

1.1 Introduction

A Joint Strategic Needs Assessment (JSNA) is a way local authorities, the NHS and other public sector partners work together to understand the current and future health and wellbeing needs of the local population and to identify future priorities. Local authorities and clinical commissioning groups have an equal and explicit duty to prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) through Health and Wellbeing Boards.

The JSNA is not just about health and personal social care services - it is also about the wider aspects of health and wellbeing including poverty, employment, education, housing and the environment. The purpose of the JSNA is to use the information gathered to identify local priorities and support commissioning of services and interventions based on need. This helps us achieve better health and wellbeing outcomes and reduce health inequalities in Luton. As part of the development of the JSNA a system-wide overview was conducted of performance measured against nationally-reported indicators (Public Health¹ and Adult Social Care Outcomes Frameworks,² children and young people's health benchmarking tool,³ Commissioning for Value and Spend⁴ and Outcomes Tool for Local Authorities⁵) to provide strategic focus. Each outcome was RAG rated (red, amber, green¹) according to how much Luton differs from the mean of local authorities in England. These indicators are shown in table 1 below at the end of the executive summary and provide the impetus for the strategic recommendations. However this does not show where Luton is doing well or improving, which are shown in each chapter.

Voluntary and community sector (VCS) organisations have a vital role in addressing health and social care needs of communities and can represent the voice of the communities it serves, often marginalised, harder to hear views and experiences. VCS organisations can help inform, review, deliver and shape local support services.⁶ Local VCS priorities include:

- Children and young people: child and adolescent mental health services; drug and alcohol misuse.
- Disabled people: accessibility and quality of services; patient experience of joint health and social care services.
- General practices: accessibility; the patient experience.
- Hospital care: staff behaviour; communication; dignity and respect; inpatient experience – including the family and carers.

¹ indicators greater than 2 standard deviations (approximately 2.5% or 4 out of 152 local authorities) from the mean of local authorities and representing low performance or high spend are RAG rated **red**; indicators between 1 and 2 standard deviations (approximately 13.5% or 21 out of 152 local authorities) from the mean of local authorities and representing low performance or high spend are RAG rated **amber**; and otherwise an indicator is rated **green**.

- Mental health: early intervention and crisis management; integrated care for mental and physical wellbeing.
- Older people: reablement services; care in the home; care homes.

These issues identified are all covered in this JSNA with specific priorities for action being recommended.

There are stark inequalities in Luton, both within the town and between Luton and the rest of the country. Reducing these inequalities is the overarching priority of this JSNA. It is possible to narrow health inequalities if action is focused, systematic and large scale.^{7,8} Therefore action to reduce health inequalities needs to systematically take into account the health implications of decisions, policies and actions, seek synergies with other partners and aim to avoid harmful health impacts of decisions to improve population health and health equity⁹.

Both the NHS (Luton CCG) and the council have duties placed upon them to reduce health inequalities set out in the Equality Act (2010)¹⁰ and Health and Social Care Act (2012).¹¹

The Health and Wellbeing Board will provide governance on the implementation of the strategic recommendations and chapter priorities and will ensure there are appropriate governance, monitoring (including equality dimensions) and evaluation in the implementation of plans. These will in turn inform the agreement of future priorities.

1.2 Luton's people

Over the next 20 years there will be an estimated increase in the population by some 30,000 people with a large increase in the number of children and those above retirement age. Luton has a high population density and significant inward and outward migration. Between the 2001 and 2011 Census there was around 70% population mobility.

Luton is an ethnically diverse population with around 55% of the population from black and minority ethnic groups and 75% of school pupils from black and minority ethnic groups. Half of Luton's children do not speak English as their first language.

Luton has high levels of deprivation and relatively low levels of life expectancy (compared with England) and there is a large gap between least and most deprived areas within Luton (7.1 years for males and 5.3 years for females).

The major causes of deaths are: a high rate of infant deaths, circulatory disease, cancer, respiratory disease, and mental illness.

Cultural participation is low, with the engagement in arts, sport and physical activity low. One in three adults are inactive.

1.3 Luton as a place: to live, to work, to grow

Most of people's health and wellbeing can be explained to a large extent by differences in the social, economic and environmental circumstances of their lives that impact from before birth and throughout life.¹² Therefore having an environment that promotes health and wellbeing is essential if we want to improve the lives of our residents and reduce health inequalities.

1.3.1 What does this mean for Luton?

We want to:

- Create an environment that promotes health and wellbeing and reduces inequalities.

1.3.2 Strategic recommendations:

1. Increase provision of affordable, quality (including warm) housing to reduce homelessness, seasonal excess deaths and isolation.
2. Increase access to and connectivity of public and sustainable transport to improve air quality.
3. Maintain quality of and access to green infrastructure and increase street cleanliness.
4. Increase school readiness, KS1 and KS2 attainment (especially English and maths), skills and readiness for work, the continual development of our population and increase job opportunities.
5. Increase community engagement and pride through building on the benefits of Luton's diversity.
6. Increase involvement of people in the decisions that affect their health and wellbeing through coordination of community development activity.

1.4 Healthy start (0-19 years)

Getting a good start in life, building emotional resilience and getting maximum benefit from education are the most important markers for good health and wellbeing throughout life. Most brain cell development takes place by age three and how we care for infant's shapes their lives. Enabling children to achieve their full potential and be physically and emotionally healthy provides the cornerstone for a healthy, productive adulthood.

1.4.1 What does this mean for Luton?

We want to

- Support all children to realise their full potential through the coordination of early years support.

1.4.2 Strategic recommendations:

1. Give Luton's children a Flying Start and reduce infant deaths and neglect by improving the coordination of early years provision including midwifery, Family Nurse Partnership, health visiting, school nursing, children's centres, childcare provision and ensure a consistent evidenced-based core offer.
2. Safeguard children and young people from the risks of radicalisation, child sexual exploitation and gangs through a child-centred coordinated agency approach.

3. Reduce dental caries by reviewing and increasing the provision of oral health services.
4. Improve adolescent emotional resilience to improve long-term adult mental wellbeing through investing in prevention services.
5. Reduce childhood obesity by developing multi-agency/department approach to reduce obesity, and develop a specific offer for schools.
6. Reduce tobacco usage in young people, including focusing on illegal tobacco availability.

1.5 Adult wellbeing

Consolidating our good health and wellbeing from childhood into adulthood is important. The choices we make every day will go a long way to promoting adult wellbeing. It is important to stay healthy, physically, mentally and emotionally and learn how to deal with the issues and concerns that may face us. Doing so can go a long way toward ensuring good health later in life. Staying healthy commonly includes making good lifestyle choices and decisions, taking precautions to avoid accidental injuries, and following recommendations for preventative care.

1.5.1 What does this mean for Luton?

We want to:

- Improve physical and mental wellbeing by supporting adults to have a greater ability to manage their own lives and have stronger social relationships and improved care when they need it.

1.5.2 Strategic recommendations:

1. Increase the physical health for those diagnosed with a mental health problem, a disability and at risk black minority ethnic communities.
2. Increase access and provision of IAPT (Improving Access to Physiological Therapies) and social prescribing to improve mental wellbeing and reduce social isolation.
3. Reduce adult obesity by developing a multi-agency/department approach to reduce obesity, and increase the take up of physical activity (leisure and sporting) opportunities.
4. Improve access and completion of drug and alcohol treatment by changing to a recovery model to reduce substance misuse.
5. Improve sexual health (especially HIV late and chlamydia diagnosis) by reviewing the model to improve outcomes.
6. Increase primary care access and outcomes by reducing variation of care, especially for cardiovascular disease, cancer, diabetes and respiratory disease.

1.6 Ageing well (>65 years)

There will be a large increase in the population over retirement age in Luton over the next 20 years and our population has been increasing its life expectancy over the last decade. Ageing well is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age for both individuals and population groups. Having the right support, housing, transport, and easily accessible information about what's available for older people are just a few things which are key to helping older people live happy, healthy lives.

1.6.1 What does this mean for Luton?

We want to:

- Support older people to age well and continue to live independently by enabling them to have the information, opportunities and resilience to make choices about their lives.

1.6.2 Strategic recommendations:

1. Increase independence through a focus on prevention, early intervention and safeguarding.
2. Increase independence and reablement by better coordination of the falls prevention plan.
3. Improve support to carers to enable them to support and feel confident in supporting the people they care for.
4. Improve our responsiveness so that people can access the information and services they need in a timely manner in order to make informed decisions.
5. Reduce seasonal excess deaths by implementing a systematic approach to vulnerable older people.
6. Reduce social isolation and its consequences by bringing together different support initiatives across the borough.

Luton 2015 JSNA Strategic Recommendations

Healthy People

- Increasing population size, some 30,000 more over 20 years with high population density and turn-over (~70% between 2001 -2011 Census)
- Significant growth in the number of children and those above retirement age
- Ethnically diverse population (~ 55% BME, 75% BME school pupils, with 50% English not their first language)
- High levels of deprivation, low life expectancy (compared to England) and large gap between least and most deprived areas within Luton (7.1yr M, 5.3yr F)
- Low levels of culture, arts and sports/physical activity participation (~ 1 in 3 adults inactive)
- Major causes of deaths – high rate of infant deaths, circulatory disease, cancer, respiratory disease, mental illness

Healthy Place

Create an environment that promotes health and wellbeing, and reduces inequalities

1. Housing - ↑ provision, affordable, quality (warm) housing to ↓ homelessness, seasonal excess deaths and isolation
2. Transport - ↑ access to and connectivity of public and sustainable transport to ↑ air quality
3. Environment - ↑ quality and access to green infrastructure and ↑ street cleanliness
4. Employment - ↑ school readiness, KS1 and KS2 attainment (esp. English and maths), skills and readiness for work, the continual development of our population and ↑ job opportunities
5. Culture - ↑ community engagement and pride through building on the benefits of Luton's diversity
6. Involvement - ↑ people in the decisions that affect their health and wellbeing through coordination of community development activity

Healthy Start (0-19)

Support all children to realise their full potential through the coordination of early years support

1. Give Luton's children a Flying Start and ↓ infant deaths and neglect by ↑ coordination of early years provision including midwifery, FNP, health visiting, school nursing, children's centres, childcare provision and ensure a consistent evidenced-based core offer
2. Safeguard children and young people from the risks of radicalisation, child sexual exploitation and gangs through a child-centred coordinated agency approach
3. ↓ dental caries by reviewing and ↑ provision of oral health services
4. ↑ adolescent emotional resilience to ↑ long-term adult mental wellbeing through ↑ prevention services
5. ↓ childhood obesity by developing multi-agency/department approach to reduce obesity, and develop a specific offer for schools
6. ↓ tobacco usage in young people, including focusing on illegal tobacco availability

Adult wellbeing

Improve physical and mental wellbeing by supporting adults to have a greater ability to manage their own lives, stronger social relationships and improved care when they need it

1. ↑ the physical health for those with diagnosed MH, disabilities and at risk BME communities
2. ↑ access and provision of IAPT and social prescribing to ↑ mental wellbeing and ↓ social isolation
3. ↓ adult obesity by developing a multi-agency/department approach to reduce obesity, and ↑ take up of physical activity (leisure & sporting) opportunities
4. ↑ access and completion of drug and alcohol treatment by changing to a recovery model to ↓ substance misuse
5. ↑ sexual health (esp. HIV late and chlamydia diagnosis) by reviewing the model to ↑ outcomes
6. ↑ primary care access and outcomes by ↓ variation of care esp. for CVD, cancer, diabetes and respiratory disease

Ageing well (>65)

Support older people to age well and continue to live independently by enabling them to have the information, opportunities and resilience to make choices about their lives

1. ↑ independence through a focus on prevention, early intervention and safeguarding
2. ↑ independence and reablement by better coordination of the falls prevention plan
3. ↑ support to carers to enable them to support and feel confident in supporting the people they care for
4. ↑ responsiveness so that people can access the information and services they need in a timely manner to make informed decisions
5. ↓ seasonal excess deaths by implementing a systematic approach to vulnerable older people
6. ↓ reduce social isolation and its consequences by bringing together different support initiatives across the Borough

1.7 Relevant outcome framework indicators (where Luton's performance below average)

1.7.1 Luton as a place: to live, to work, and to grow relevant indicators.

Table 1: Red and amber indicators in PHOF

PHOF indicator*	Time Period	Sex	Age	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
					Value	Value	Value	Value	Value	Value	
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	Persons	6	High	64.1	69.9	70.8	69.1	65.8	67	69.1
1.15i - Statutory homelessness - homelessness acceptances	2013/14	Not applicable	Not applicable	Low	9.2	1.4	2.9	7.6	3.3	4.3	2.3
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	Persons	All ages	Low	12.6	1.6	5.3	1.8	0.6	19.8	2.6

Table 2: Red and amber indicators in SPOT.

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
Proportion of population aged 19-64 for males and 19-59 for females qualified to at least level 2 or higher	Outcome	2011	High	65%	70%	72%	65%	62%	74%	74%
Achievement of at least 78 points across the early years foundation stage with at least 6 in each of the scales in personal, social & emotional development & communication and language & literacy	Outcome	2011-12	High	55%	64%	63%	62%	58%	63%	63%

*Comparators for local authorities are: Slough; Hillingdon; Birmingham; Wolverhampton; Redbridge.

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
Number living in temporary accommodation per 1,000 households	Outcome	Mar-13	Low	11.3	2.2	4.8	2.2	0.5	19.9	3.7
Number accepted as being homeless and in priority need per 1,000 households	Outcome	Mar-13	Low	2.9	0.6	0.1	2.2	0.8	1.1	0.7
Progression by 2 levels in English between KS1 and KS2	Outcome	2012	High	86%	87%	91%	91%	90%	90%	90%
Progression by 2 levels in maths between KS1 and KS2	Outcome	2012	High	83%	84%	90%	89%	88%	88%	88%
Adult participation in sport and active recreation	Outcome	2011-12	High	15%	17%	18%	19%	22%	20%	22%
Improved street and environmental cleanliness - levels of detritus	Outcome	2009-10	High	3%	10%	27%	9%	5%	24%	11%
Residual household waste per household	Outcome	2011-12	Low	702.5	687.4	558.8	655.7	603	665.8	566.8
Percentage of municipal waste landfilled	Outcome	2011-12	Low	51%	6%	0%	5%	7%	0%	28%
Percentage of students achieving level 4 or above in reading test, writing TA and mathematics test at key stage 2	Outcome	2013	High	68%	74%	78%	73%	74%	78%	76%
Primary schools	Spend	2013/14	Low	£453.81	£275.90	£346.61	£444.43	£365.93	£439.05	£345.04
Other Strategic Functions	Spend	2013/14	Low	£118.59	£67.40	£86.45	£41.32	£54.92	£55.04	£53.69

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
TOTAL EDUCATION SERVICES	Spend	2013/14	Low	£1,023.20	£739.46	£675.60	£944.59	£874.78	£1,028.75	£762.09
Public transport: co-ordination	Spend	2013/14	Low	£23.87	£0.35	£1.18	£0.00	£0.19	£0.00	£0.94
Waste disposal	Spend	2013/14	Low	£49.88	£38.56	-£0.28	£30.51	£0.21	£3.09	£29.16

**Mean in the table above is the mean values of the estimates from the Local Authorities. It does not represent the mean value for England.

1.7.2 Healthy Start relevant indicators

Table 3: Red and amber indicators in PHOF.

PHOF indicator*	Time Period	Sex	Age	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
					Value	Value	Value	Value	Value	Value	Value
2.01 - Low birth weight of term babies	2012	Persons	>=37 weeks gestational age at birth	Low	5	4	2.9	3.9	3.2	4	2.8
4.02 - Tooth decay in children aged 5	2011/12	Persons	5 yrs	Low	1.6	1.7	1.5	1.2	1	1	0.9

Table 4: Red and amber children and young people's health benchmarking indicators.

Children and Young People's Health Benchmarking Tool indicator (not in PHOF)*	Time Period	Sex	Age	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
					Value	Value	Value	Value	Value	Value	Value
Child mortality rate	2010 - 12	Persons	1-17 yrs	Low	19.4	11.6	9.0	13.9	13.8	9.9	9.9
Family homelessness	2012/13	Persons	Not applicable	Low	5.7	1.9	0.5	7.3	2.8	3.1	3.1
Children killed or seriously injured in road traffic accidents	2010 - 12	Persons	<16 yrs	Low	32.0	17.8	18.5	32.5	33.0	15.3	15.3
Low birthweight of all babies	2012	Persons	All ages	Low	9.5	9.7	7.3	9.2	7.5	9.1	9.1
Obese children (10-11 years; based on child's postcode)	2012/13	Persons	10-11 yrs	Low	23.1	20.9	19.8	23.4	24.1	21.5	21.5

Children with one or more decayed, missing or filled teeth	2011/12	Persons	5 yrs	Low	38.7	38.0	38.2	32.7	28.2	27.0	27.0
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Table 5: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome or Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England	
			Value	Value	Value	Value	Value	Value	
% of patients aged 8 years and over diagnosed as having asthma from 1st April 2006 with measures of variability or reversibility (ASTHMA 08)	Outcome	2012/13	High	79.8	85.4	81.2	85.9	83.8	83.1

Table 6: Red and amber indicators in SPOT indicators.

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
Percentage of initial assessments for children's social care carried out within 7 working days of referral	Outcome	2010-11	High	45%	70%	75%	45%	76%	62%	66%
Percentage of core assessments for children's social care that were carried out within 35 working days of their commencement	Outcome	2010-11	High	63%	67%	86%	71%	89%	66%	76%
Children subject to a child protection plan for two years or more	Outcome	Mar-12	Low	8%	0%	4%	6%	0%	0%	4%
Children's social care: Youth justice	Spend	2013/14	Low	£9.42	£7.10	£4.67	£6.65	£7.89	£2.98	£4.90

**Mean in the table above is the mean values of the estimates from the Local Authorities. It does not represent the mean value for England.

† Comparators for CCG are: Slough CCG; Hillingdon CCG; Birmingham South and East CCG; Redbridge CCG.

1.7.3 Adult wellbeing relevant indicators

Table 7: Red and amber PHOF indicators.

PHOF indicator*	Time Period	Sex	Age	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
					Value	Value	Value	Value	Value	Value	Value
2.15ii - Successful completion of drug treatment - non-opiate users	2013	Persons	18-75 yrs	High	26.4	47.8	39.7	48.4	28.4	60.2	37.7
2.17 - Recorded diabetes	2012/13	Persons	17+ yrs	Low	7.2	7.8	6.4	7.6	7.7	7.5	6
2.20ii - Cancer screening coverage - cervical cancer	2014	Female	25-64 yrs	High	69.2	68.8	69	67.5	70.5	71.2	74.2
3.05ii - Incidence of TB	2010 - 12	Persons	All ages	Low	46.8	56.3	47.8	37.6	32.9	54.1	15.1
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Persons	<75 yrs	Low	110.4	106.3	78.3	101	98.4	76.8	78.2
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Male	<75 yrs	Low	150.6	137.2	113.6	143.1	137.2	107.2	109.5
4.04i - Under 75 mortality rate from all cardiovascular diseases	2011 - 13	Female	<75 yrs	Low	71.5	75.8	45.3	61.4	61.6	48.3	48.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Persons	<75 yrs	Low	79.4	71.7	49	69.3	62.9	47.9	50.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Male	<75 yrs	Low	113.7	103.4	76.4	106.1	96.6	72.3	76.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2011 - 13	Female	<75 yrs	Low	46.3	40.7	23.3	34.7	31.1	25.1	26.5

Table 8: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome spend or	Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
				Value	Value	Value	Value	Value	Value
Spend on primary care prescribing for breast cancer per 1,000 weighted population	Spend	2012/13	Low	£625	£388	£337	£329	£340	£418
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99	Outcome	2011 (2012)	High	66.7	69	68.9	69.8	68.8	69.5
% of people aged 60-69 who were screened for bowel cancer in the previous 30 months	Outcome	2013	High	50.8	41.1	49.4	47	52.3	58.8
% of colorectal cancers detected at an early stage (1 or 2)	Outcome	2012	High	26.9	14.6	34.3	32.7	41.6	37.2
Mortality from colorectal cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	Outcome	2009-11	Low	12.3	6.8	6.6	10.9	7.6	10.1
% of patients with CHD whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (CHD 06)	Outcome	2012/13	High	83.7	89.2	87.1	88	86.4	88.1
% of patients with CHD whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (CHD 08)	Outcome	2012/13	High	70.2	72.8	73.1	72.4	71.5	72.5
% of patients with hypertension whose last blood pressure reading (as measured within the last 9 months) is 150/90 or less (BP 05)	Outcome	2012/13	High	73.5	79.4	77.9	77.5	76.9	77.4
Spend on non-elective (emergency and other non-elective) admissions for CHD per 1000 population	Spend	2012/13	Low	£12,423	£11,230	£11,630	£4,170	£8,738	£7,916
Mortality from CHD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	Outcome	2009-11	Low	47.4	48.8	34	44.9	30.2	34.6
Mortality from acute myocardial infarction: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	Outcome	2009-11	Low	25.6	20.4	16	17.7	10.6	14

Table 9: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome spend or	Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
				Value	Value	Value	Value	Value	Value
% of patients with stroke or TIA whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (STROKE 06)	Outcome	2012/13	High	82.2	87.6	86.2	84.8	83.6	85.5
% of patients with a non-haemorrhagic stroke or TIA with a record that an anti-platelet agent or an anti-coagulant is being taken (STROKE 12)	Outcome	2012/13	High	86.5	91.4	88.8	89.8	90.2	90.5
% of patients with atrial fibrillation in whom the risk of stroke has been assessed using CHADS2 in the previous 15 months (AF 05)	Outcome	2012/13	High	93.1	96.2	94.8	95.6	94.9	94.9
Diabetes Prevalence (%)	Outcome	2012/13	Low	7.3	7.8	7.5	7.6	6.4	6
% of all diabetes patients having retinal screening in the previous 15 months (DM21)	Outcome	2012/13	High	78.3	87	85.7	78.3	87.9	84.8
Spend on primary care prescribing for diabetes per 1,000 weighted population	Spend	2012/13	Low	£15,565	£18,409	£16,354	£19,007	£15,164	£12,611
New cases of psychosis: estimated incidence per 100,000 aged 16-64	Outcome	2011	Low	35.4	32.2	33.2	38.3	28.8	24.2
Physical health checks for patients with Serious Mental Illness: summary score (average of the 6 physical health check indicators)	Outcome	2012/13	High	68.8	71.8	73.2	73.9	72.8	71.5
Mental health admissions to hospital: Rate per 100,000 population aged 18+	Outcome	2013/14 Q3	Low	124.9	48.3	38.6	75.1	59.8	70.2
% of new cases of depression in the previous year who had an assessment of severity using an assessment tool validated for use in primary care (DEP06)	Outcome	2012/13	High	69.3	80.6	71.8	77	77.2	79.8

Table 10: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome or spend	Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
				Value	Value	Value	Value	Value	Value
Completion of IAPT treatment: Rate completing treatment per 100,000 population aged 18+	Outcome	2013/14 Q4	High	107.9	236.6	63.5	315.8	236.3	242
% of people who are "moving to recovery" of those who have completed IAPT treatment	Outcome	2013/14 Q4	High	33.3	50	60.9	34.1	41.5	44.9
% of IAPT referrals with treatment outcome measured	Outcome	2013/14 Q4	High	72.7	100	96.3	95.8	99	96.6
% of people (over 45) who have hip osteoarthritis (total)	Outcome	2012/13	Low	11.4	11	10.5	11.2	10.6	10.9
% of people (over 45) who have hip osteoarthritis (severe)	Outcome	2012/13	Low	3.5	3.4	3	3.5	3.1	3.2
Spend on primary care prescribing for renal problems per 1,000 weighted population	Spend	2012/13	Low	£1,260	£649	£863	£814	£539	£662
% of patients on CKD register, whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less (CKD03)	Outcome	2012/13	High	65.1	75.6	71.4	71.4	71.7	71.6
% of patients on the chronic kidney disease register with hypertension and proteinuria who are treated with an ACE-I or ARB (CKD05)	Outcome	2012/13	High	70.7	83.7	78.6	76.3	82.7	78.5
% of patients on the CKD register with a record of a urine albumin creatinine ratio test in the preceding 15 months (CKD06)	Outcome	2012/13	High	75.1	83.7	70	81.5	82.4	78.8
% of people receiving dialysis undertaking dialysis at home	Outcome	2010-2012	High	9.2	25.4	22.2	14.3	5.4	18
Spend on elective and day-case admissions for renal problems per 1,000 population	Spend	2012/13	Low	£1,859	£1,717	£1,736	£1,387	£1,798	£1,433

Table 11: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome or spend	Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
				Value	Value	Value	Value	Value	Value
% of COPD patients with a record of FEV1 in the preceding 15 months (COPD 10)	Outcome	2012/13	High	71.1	82.1	79.4	78.9	81.7	77.9
% of COPD patients having had a review in the previous 15 months (COPD 13)	Outcome	2012/13	High	78.4	85.3	82.2	84.1	84	82.1
% of asthma patients who have had a review in the preceding 15 months (ASTHMA 09)	Outcome	2012/13	High	64.6	71.5	70.3	72.6	71.4	69.5
Mortality from asthma: all age directly age-standardised rates (DSR) per 100,000 European Standard Population	Outcome	2009-11	Low	1.8	2.7	1.7	1.3	1.6	1.2

The Commissioning for value indicator table compares Luton CCG with comparator areas CCG which are different from Local Authority comparator areas.

Table 12: Red and amber indicator in SPOT.

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
Adult participation in sport and active recreation	Outcome	2011-12	High	15%	17%	18%	19%	22%	20%	22%
Sexual health services - Contraception (prescribed functions)	Spend	2013/14	Low	£6.36	£0.76	£4.90	£2.92	£7.35	£0.14	£3.19
Substance misuse - Alcohol misuse - adults	Spend	2013/14	Low	£9.36	£0.56	£5.86	£10.32	£7.93	£0.57	£4.16

**Mean in the table above is the mean values of the estimates from the Local Authorities. It does not represent the mean value for England.

1.7.4 Ageing well in Luton relevant indicators

Table 13: Red and amber PHOF indicators.

PHOF indicator*	Time Period	Sex	Age	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
					Value	Value	Value	Value	Value	Value	Value
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	2012/13	Persons	65-79 yrs	Low	304.3	213.8	257.4	292	211.9	227.4	237.3
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	Persons	All ages	Low	21.6	14.1	20.1	15.6	19.7	13.2	16.5

Adult Social Care Outcomes Framework (ASCOF) 2013-14. All persons, all age.

Table 14: Red and amber ASCOF indicators.

ASCOF indicator*	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
		Value	Value	Value	Value	Value	Value	Value
1 B - Proportion of people who use services who have control over their daily life	High	70.7	72.3	72.3	69.7	77.6	87	76.8
3 A - Overall satisfaction of people who use services with their care and support	High	54.7	58	58.6	62.4	62.5	76.5	64.8
3 D1 - Proportion of people who use services who find it easy to find information about services	High	67.8	74.7	72.4	73.5	74.3	82.8	74.5

Table 15: Red and amber indicators in the commissioning for value data set.

Commissioning for value indicator†	Outcome or spend	Time Period	Good is	Luton CCG(06P)	Slough CCG(10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
				Value	Value	Value	Value	Value	Value
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99	Outcome	2011 (2012)	High	66.7	69	68.9	69.8	68.8	69.5
% of people aged 60-69 who were screened for bowel cancer in the previous 30 months	Outcome	2013	High	50.8	41.1	49.4	47	52.3	58.8
% of patients aged 75+ years with a fragility fracture scan who are currently treated with an appropriate bone-sparing agent (OST 03)	Outcome	2012/13	High	67.1	86.4	78.3	80.9	79.5	72.5

Table 16: Red and amber indicator in SPOT.

SPOT indicator (not in PHOF or ASCOF)*	Outcome or Spend	Time Period	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	Mean**
				Value	Value	Value	Value	Value	Value	
Achieving independence for older people through rehabilitation / intermediate care	Outcome	2012-13	High	74%	95%	88%	-	86%	82%	83%

**Mean in the table above is the mean values of the estimates from the Local Authorities. It does not represent the mean value for England.

2 Healthy people

2.1 People of Luton

2.1.1 Background

The health of the population of Luton tends to be slightly poorer than the England average. The poorer health outcomes are linked primarily to the levels of socioeconomic deprivation experienced by a significant segment of the population.

This section will describe the numbers and projected growth of the population; demographics (eg age, gender, and ethnicity); population movement in and out of the borough; deprivation and poverty; the health of the people in Luton using life expectancy as a measure; and information on causes of death in the borough.

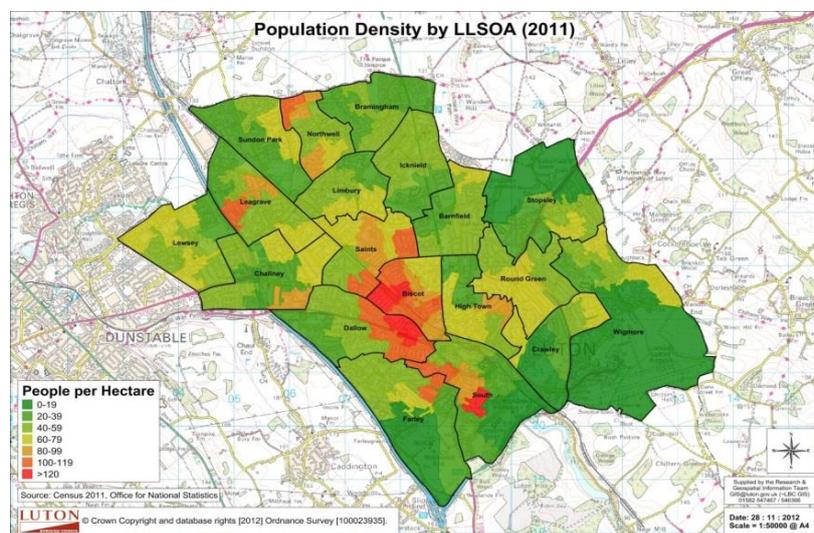
2.1.2 Demography of Luton

Population size

The latest (2013) Office for National Statistics (ONS) Mid-Year Population Estimate for Luton was 208,000.¹³ The council considers this to be an under-estimate and the population to be around 210,800 in 2013. The Council's figure draws upon local administrative data including the GP register and child benefit records. In recent years, there has been convergence between the ONS figures and those of the Council due, in the main, to improved accuracy of ONS data as a result of increased enumeration in the 2011 Census and the subsequent rebasing of population figures.

Figure 1 shows the most densely populated areas of Luton are in the centre of the town. With an area of 4336 hectares, the official (ONS) population figure translates into a population density of 48 people per hectare and the council estimate is 48.6 people per hectare. Both of these figures are greater than many London Boroughs.¹⁴

Figure 1: Luton population density



Population projections

Luton’s population is projected to grow significantly between 2011 and 2031, with the latest forecast projecting growth of 20% in the next 20 years.^b Key drivers for this are high levels of natural growth (more births than deaths) and international in-migration. Luton also has high population churn and Mayhew Harper Associates found that 70% of the population in Luton in 2010 was either not born or not living in Luton at the time of the 2001 Census.¹⁵

Table 17 shows a summary of population projections for Luton. Key changes over the next 20 years are the:

- Population of Luton is projected to increase by 41,500, a rise of 20%.
- School age population (5-15 year olds) is projected to increase by 7,100, a rise of 23%.
- Retired population is projected to increase by 11,400 people, a rise of 40%.
- Very elderly population is projected to increase by 2,550 people, a rise of 91%.

Table 17: Luton population projections by age from 2011 to 2031

Year	0-4	5-10	11-15	16-17	18-retired	retired-74	75-84	85+	Total
2011	17,600	17,050	13,350	5,450	123,550	16,900	8,600	2,800	205,300
2021	19,200	21,700	15,300	5,850	136,150	19,150	9,200	4,100	230,650
2031	18,950	20,850	16,650	7,250	143,350	23,350	11,000	5,350	246,800
2011-21 growth	9.1%	27.3%	14.6%	7.3%	10.2%	13.3%	7.0%	46.4%	12.3%
2011-31 growth	7.7%	22.3%	24.7%	33.0%	16.0%	38.2%	27.9%	91.1%	20.2%

Source: The council using POPGROUP software and a five year migration average. Components may not sum to totals due to rounding.

2.1.3 Ethnicity and migration

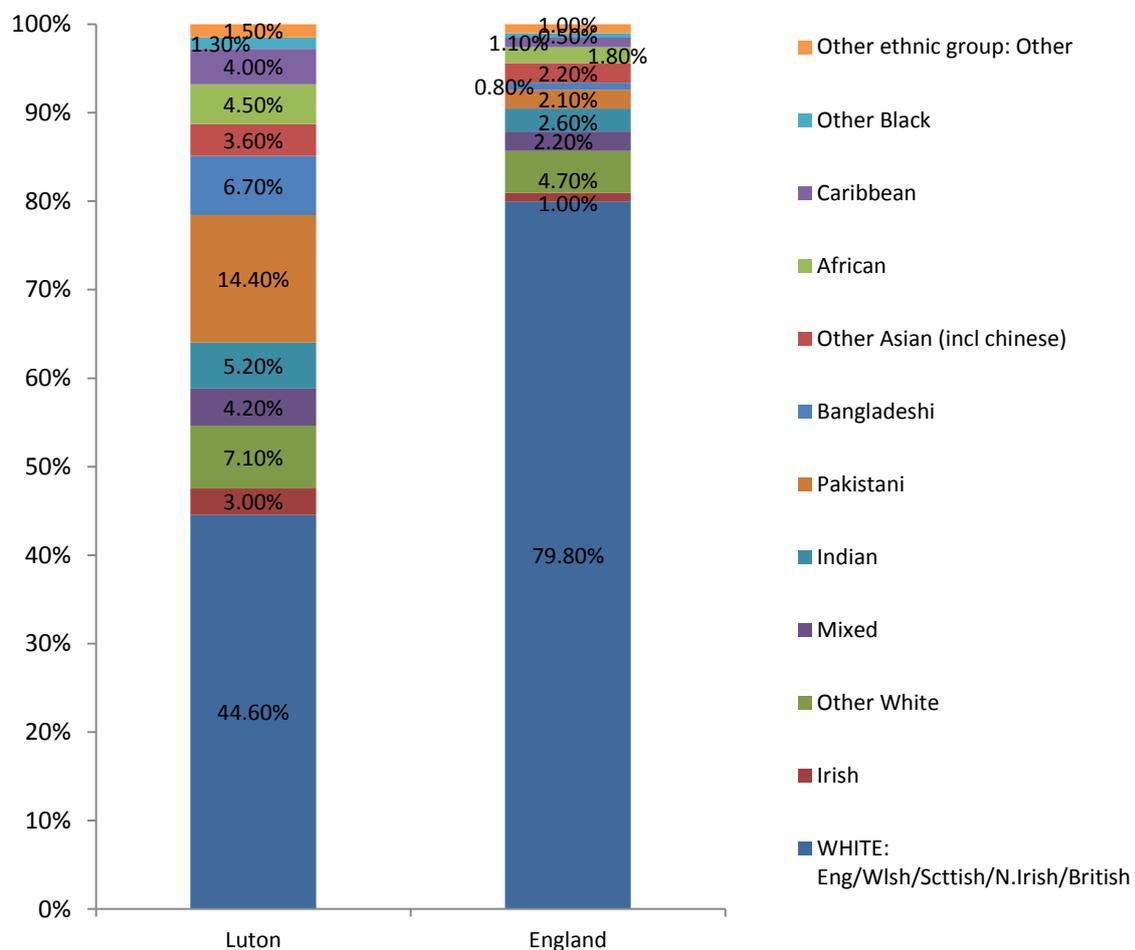
Figure 2 shows that Luton is ethnically diverse, with approximately 55% of the population being of Black and Minority Ethnic Origin (BME), all people who are not White British. The ethnic composition of Luton fits a model known as ‘super-diversity’ in which there is an increasing number of BME communities within the population each with its own needs and cultures. Luton has a long history of migration into the area both from elsewhere in the UK and overseas. There have been long-standing African-Caribbean, Bangladeshi, Indian, Irish and Pakistani communities in Luton as a result of international migration. More recently, the migration patterns have become more complex. In the mid-1990s, the opening of the University of Luton (now the University of Bedfordshire) caused a

^b 2014 The Council Population Projections are consistent with the Council’s Strategic Housing Market Assessment. These projections use a 5 year migration trend and local fertility and mortality rates in line with standard methodology.

rapid growth in the student population of the town. This growth has been sustained with an increase in numbers of overseas students.

In the mid-2000s, the expansion of the European Union led to a significant increase in migration from eastern European countries, particularly Poland and Lithuania. There has also been immigration from African countries such as the Congo, Ghana, Nigeria, Somalia and Zimbabwe. There is also a Turkish population in Luton. More recently, National Insurance Registration data has demonstrated further increases in international migration with Romanians moving to the town after the change in law allowing them the right to work in the UK at the beginning of 2014. Analyses of translation service data also highlighted the levels of diversity in the town by identifying over 120 languages or dialects being spoken by residents. This provides corroborating evidence of Luton being super-diverse.

Figure 2: Ethnic composition of Luton.



Source: 2011 Census, Office for National Statistics.

2.1.4 Deprivation

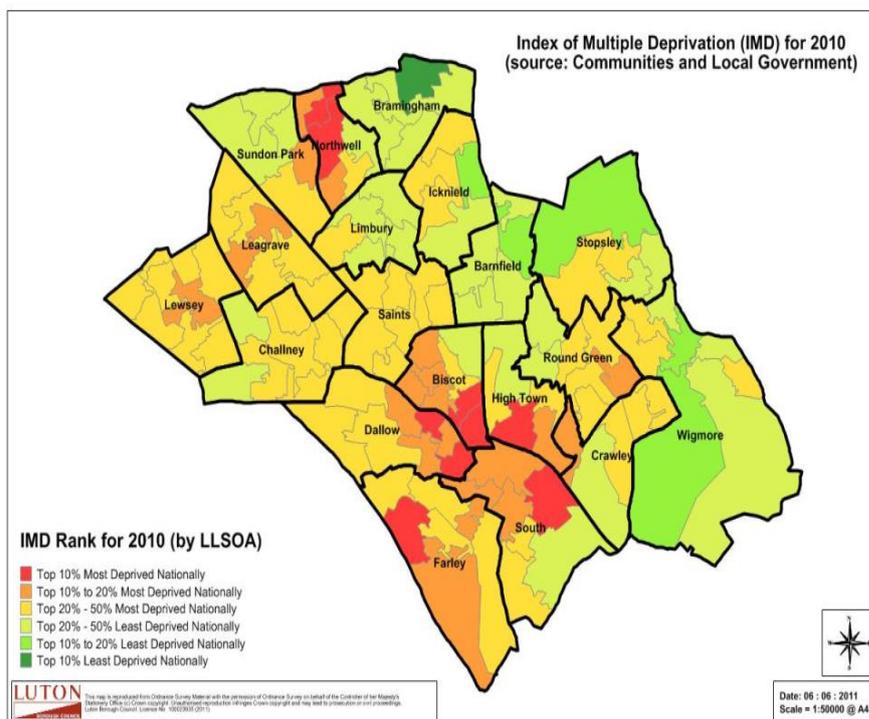
There is no single generally agreed definition of deprivation. Deprivation is a concept that overlaps, but is not synonymous with, poverty. Absolute poverty can be defined as the absence of the minimum resources for physical survival, whereas relative poverty relates this to the standards of living of a particular society at a specific time.

The Index of Multiple Deprivation 2010 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to each other according to their level of deprivation.

Luton is ranked as the 69th (out of 326) most deprived local authority area. In 2007 Luton was ranked as the 87th most deprived local authority area and in 2004 as the 101st (out of 357). This indicates that Luton is becoming relatively more deprived in comparison with the other local authorities of England.

Luton has nine Lower level Super Output Areas (LSOAs) in the top ten per cent most deprived areas in the country. Biscot, Dallow and Northwell wards have two LSOAs each in this category and Farley, High Town and South wards each have one LSOA falling in the most deprived 10% nationally (Figure 3).

Figure 3: Deprivation in Luton 2010.



2.1.5 Impact of family poverty and the welfare reform

The number of people in poverty in Luton has been affected by the impact of the economic recession, an increase in prices (particularly energy and food) and the government's programme of

welfare reform. In light of this, it can be expected that levels of poverty in the borough have increased from previous needs assessments conducted.

The Welfare Reform Act 2012 became law on 8 March 2012. The Act introduces a wide range of reforms to the benefits and tax credits system. Reforms are having the greatest impact on poorer households and on families with children. In contrast, pensioners' incomes have been protected. The Royal College of Psychiatrists has raised concerns about the impact of these changes on people with mental health issues and those with learning disabilities as these are among the most vulnerable members of society.¹⁶

A major research project is underway, within the Council to assess poverty levels in Luton including child poverty. There are evidenced concerns regarding the level of in-work poverty of both single people and families. The research will also look at the contribution welfare changes have made to poverty in Luton. The project is based around the concept of the "living wage" and sets out to assess the number of individuals and households (and their characteristics) below this wage level. This work is due for completion in 2015 and will feed into a Family Poverty Strategy and wider Anti-poverty Strategy.

Priorities for action:

Use the forthcoming Poverty Assessment to develop strategies and action plans to:

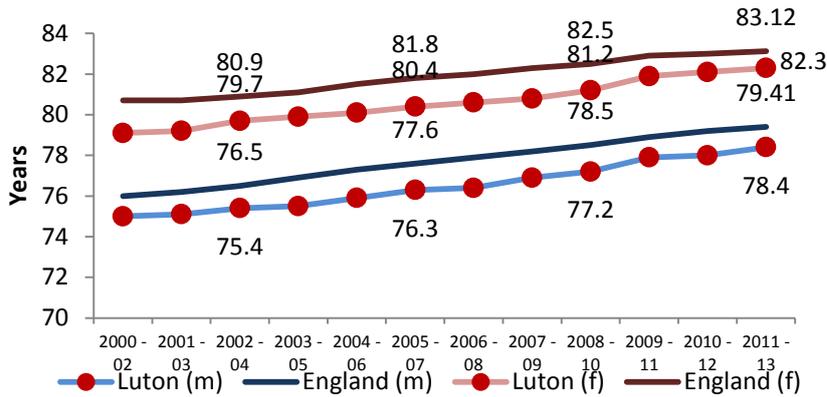
- Reduce poverty in the town.
- Mitigate against the immediate and long-term impacts of poverty.
- Mitigate against any negative impacts of the welfare reform programme.

2.1.6 Life expectancy

Life expectancy at birth is a way to estimate how long a newborn baby can expect on average, to live if they experienced the current age-specific mortality rates of an area throughout the remainder of their life. It is used as a summary indicator of health status in an area.¹

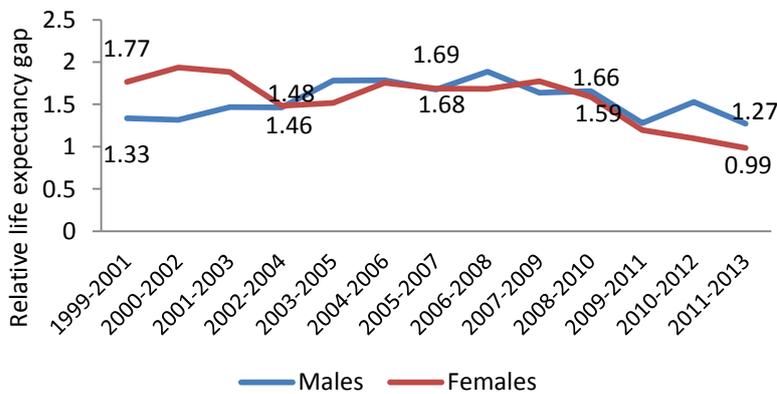
Life expectancy at birth in Luton for males is 78.4 years and 82.1 years for females. This is an increase for both on the previous year (77.9 and 81.9 years respectively). Although life expectancy in Luton has shown a steady increase (Figure 4), it is one year below that of England (79.4 years and 83.1 years respectively). Luton is ranked 276 and 275 out of 404 local areas for male and female life expectancy respectively. Trend data has shown that both male and female life expectancy in Luton has been rising and the gap in life expectancy (Figure 5) with females in England as a whole has narrowed (1.77% to 0.99%). However, the trend for males shows that the life expectancy gap between Luton and England has remained similar since the start of the 21st century.¹⁷

Figure 4: Life expectancy in Luton and England



Source: PHOF and Luton PHI

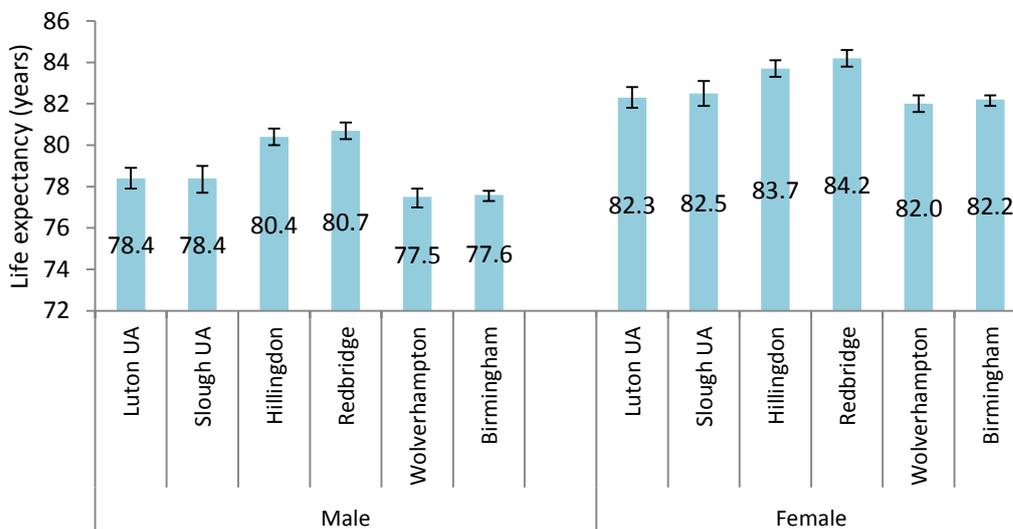
Figure 5: Relative life expectancy gap between Luton and England, 1999-01 to 2011-2013



Source: ONS and Luton PHI

Luton's life expectancy is similar to comparators for female life expectancy, and significantly higher than those in the West Midlands for male life expectancy as shown in Figure 6.

Figure 6: Life expectancy, males and females, Luton and comparator areas, 2011-13



Slope index of inequality This is a key high-level health inequality outcome that measures the difference in life expectancy between the most and least deprived deciles (or tenths) of the population over a three year pooled period.¹

The overall increase in life expectancy for both genders masks the inequalities that exist between areas within Luton. The slope index of inequality helps highlight the gap between the most and least deprived areas. Figures for 2011-13 show a gap of 6.6 years for females and 9.8 years for males, which compared with 2008-10 is a reduction for females but an increase for males (Figure 9).

Variation in life expectancy by Middle Layer Super Output Area (MSOA) within Luton for 2008-12 shows the inequalities in life expectancy across Luton (Figure 8 and Figure 7). Lower life expectancy is concentrated around the more deprived areas in Luton (see Figure 3) and differs for males and females as outlined below.¹

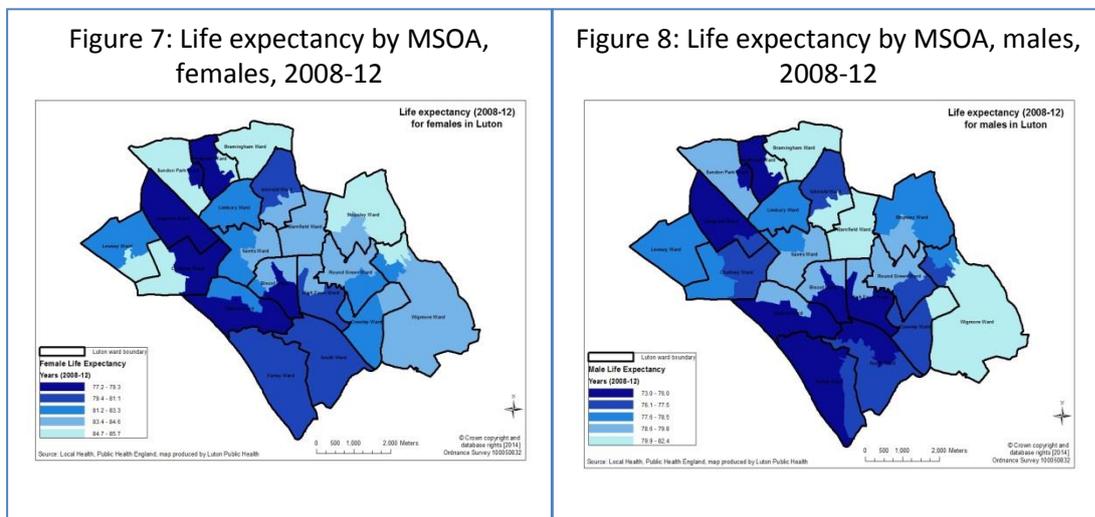
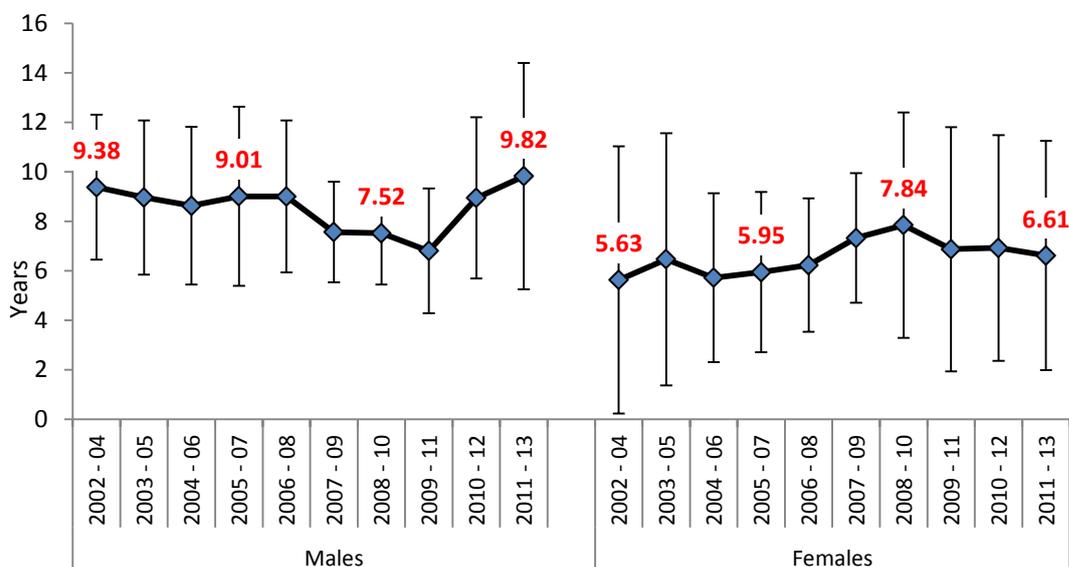


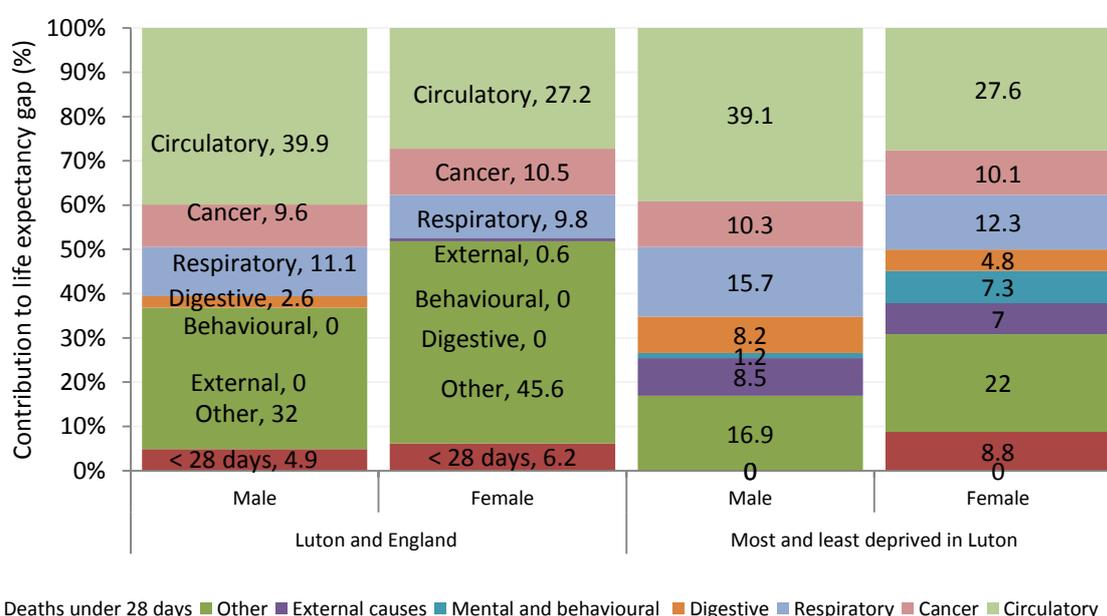
Figure 9: Slope index of inequality



The Public Health England (PHE) Segment Tool (2015) highlighted (Figure 10) that circulatory diseases contributed 40% to the gap between Luton and England in 2010-12 for males and 27% for females. CHD contributes the largest gap between Luton and England for both males and females. It contributes to the most life expectancy years gained if death rates were the same in Luton as they are in England, followed by other respiratory diseases, lung cancer and 'other'.

Circulatory disease also contributes to most of the inequality gap between the most and least deprived areas within Luton (as shown in Figure 10). For males and females CHD contributes to the largest proportion of this inequality gap followed by other circulatory diseases, pneumonia and lung cancer for males and deaths under 28 days, dementia, 'other' and lung cancer for females.

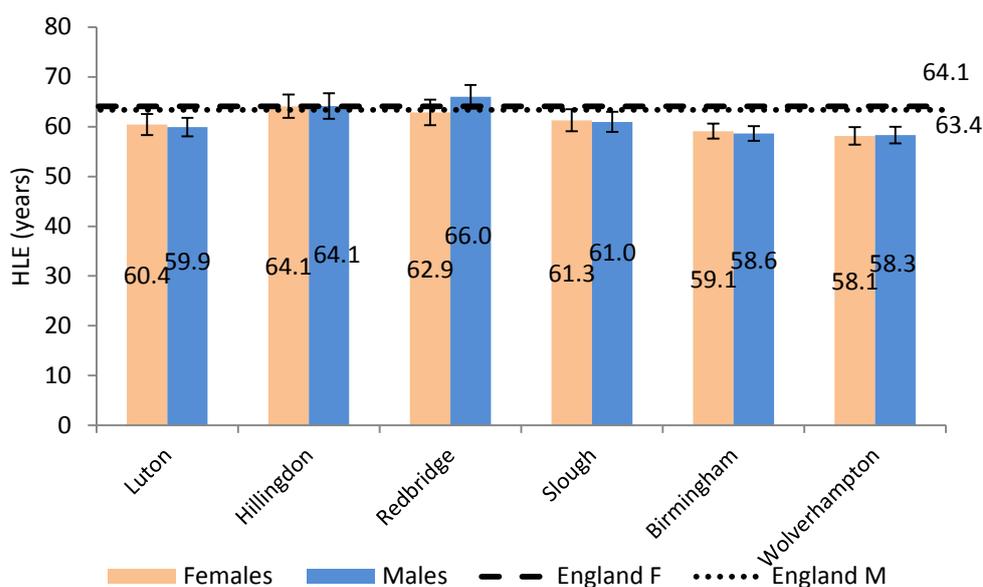
Figure 10: Breakdown of the life expectancy gap (2010-12)



Healthy life expectancy is an extremely important summary measure of mortality and morbidity. It is a measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.¹

Whereas life expectancy is an estimate of how many years a person might be expected to live, healthy life expectancy is an estimate of how many years they may live in good health (eg. without disabilities).¹⁸ Luton has a high proportion of years spent in disability compared with the national average for both males and females. Healthy Life Expectancy at birth is 59.9 years for males and 60.4 years for females - this is significantly lower than England (63.4 years for males and 64.1 years nationally for females) but similar to comparator areas (Figure 11). The male and female figure is 36th and 41st lowest of 150 local areas respectively. For males living in Luton, approximately 23.2% of their life is spent not in good health compared with 20.0% nationally. For females living in Luton 26.4% of their life is spent not in good health compared with 22.8% nationally.

Figure 11: Healthy life expectancy, 2010-12



Source: ONS and Luton Public Health Intelligence

2.1.7 Burden of disease/deaths

In 2013, local data showed there were approximately 1,327 deaths in Luton, compared with 1,451 in 2012 (a reduction of 9%). With 38% of the deaths (540) occurring in those aged under 75 years. The directly standardised all-age all-cause mortality rate for Luton was 1,039 per 100,000 population for 2010-13. The rate is significantly higher than England for both male and female mortality. In relation to Luton’s comparators the rate is similar to Wolverhampton, Birmingham, and Slough but significantly higher than Hillingdon and Redbridge.

Over the last 10 years Luton’s all-age all-cause mortality rate has reduced at a faster rate than England (29% compared to 20%) narrowing the inequality gap. Premature mortality (less than 75 years) in Luton has reduced at a similar rate to England (Figure 12). The rate was 895 for females and 1208 for males for the three year average 2011-13. Both are significantly higher than the rates for England.

Figure 13 shows the most common causes of death are circulatory (29.5%) followed by cancer (28.5%) and respiratory diseases (14.5%). The more detailed breakdown shows that coronary heart disease accounts for the highest proportion of deaths (16%). More information can be found in the long-term condition chapter (Section 10).

Figure 12: All-cause mortality, Luton and England, 2003-2013

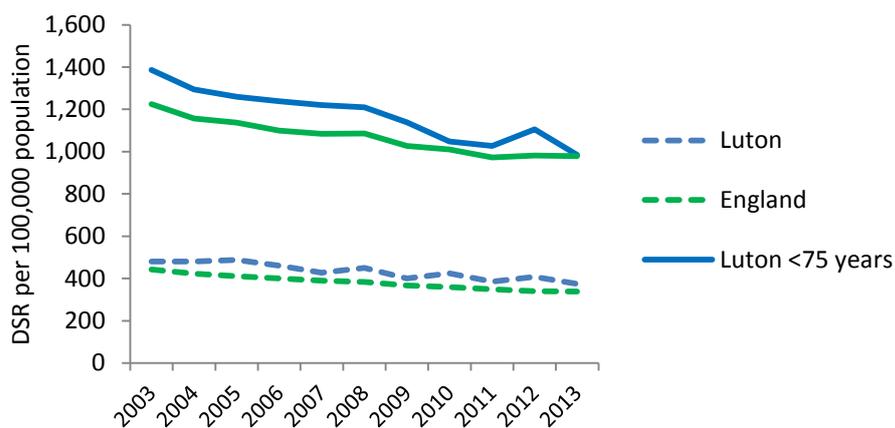
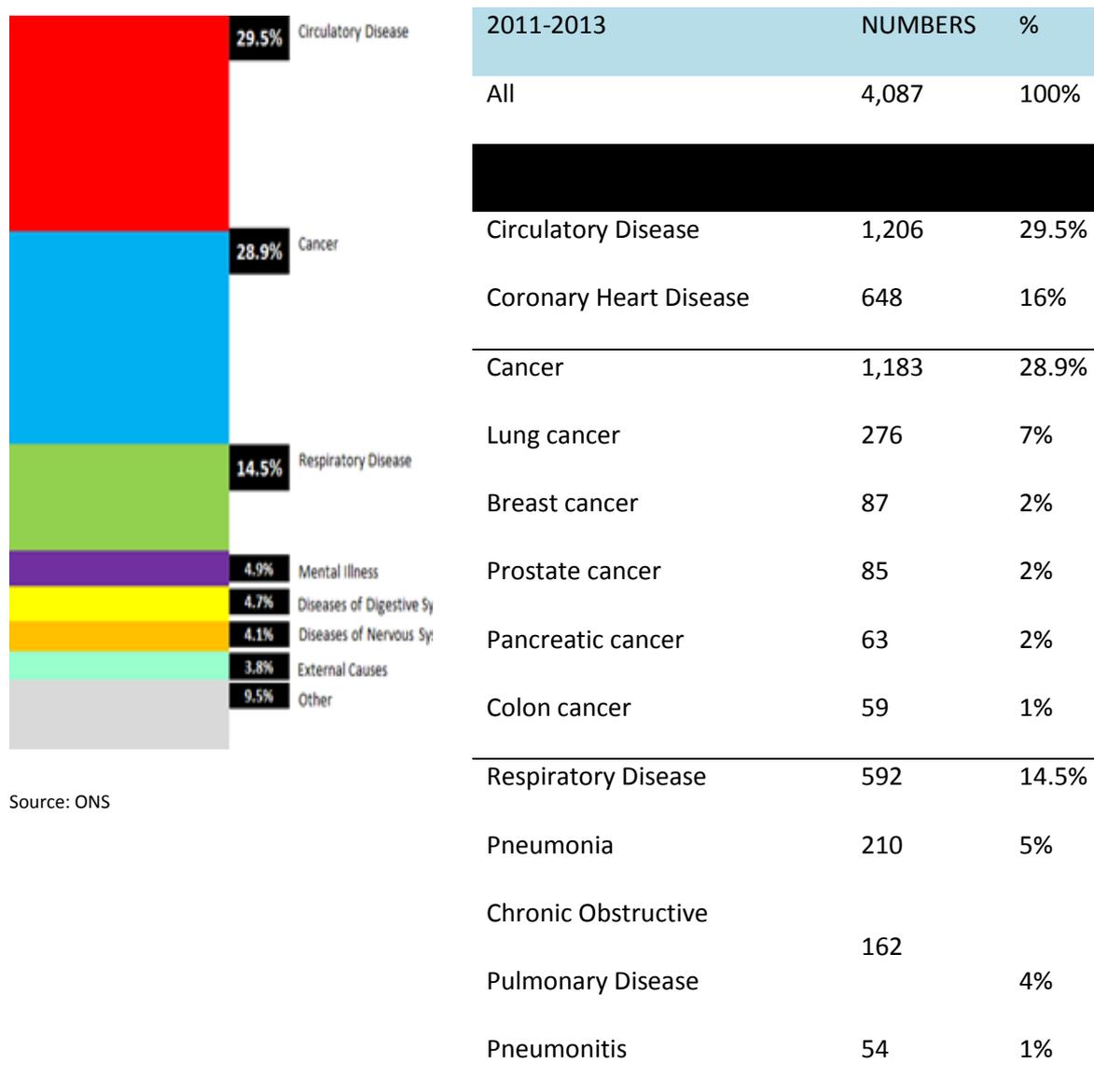


Figure 13: Most common causes of death, 2011-13



Source: ONS

3 Healthy place

Background

This section will describe Luton as a place and explore some of the wider determinants of health - including the:

- Quality of the local area (access to transport, availability of parks and green spaces, cultural services, and levels of pollution).
- The deprivation that exists within the town with a focus on child poverty and the impacts of recent national policies (including the welfare reform).
- Housing.
- Employment and crime (with a focus on domestic violence and gang crime).

Creating and developing healthy and sustainable places and communities is important to improve health and wellbeing. These can be created through:

- Active travel.
- Availability of green spaces.
- Food environment (factors affecting an individual or groups eating habits and patterns).
- Integration of planning, transport, housing, environmental and health systems to address social determinants of health in localities.
- Community regeneration to increase participation and reduce isolation.

Healthy Place
<ul style="list-style-type: none">• Air quality• Community cohesion and cultural assets• Economy and employability• Housing, overcrowding, fuel poverty, homelessness• Noise pollution• Parks and green spaces• Transport

3.1 Transport

3.1.1 Introduction

Transport involves the movement of people and goods by road, rail, water and air, playing an important role in contributing to the health and wellbeing of a community. It can promote health by enabling access to employment, education and training opportunities, shopping, recreational facilities, social support networks and health services. Those living in walkable neighbourhoods are more likely to know their neighbours, participate politically, trust others and be socially engaged.¹⁹ However, transport is a major source of air and noise pollution, traffic injuries and physical inactivity.¹²

Effective sustainable transport systems can help to provide alternatives to car usage and increased opportunities for more sustainable modes of travel (eg improved opportunities for walking, cycling and affordable public transport). Increasing the number of people who regularly walk or cycle can help achieve many of the key aims, from reducing air pollution and carbon emissions to addressing congestion and helping people live active, healthy lives.²⁰

3.1.2 Risk factors and vulnerable groups

The adverse health effects of transport fall disproportionately on the most vulnerable, generally

children in the 10% least deprived wards those living in poorer communities are often located in close proximity to major transport axes, such as railway stations or depots, main roads, busy junctions, airports and flight paths. These discourage active travel and active play and those living there experience more accidents.¹⁹

Children in the 10% most deprived wards in England are four times more likely to be hit by a car than.¹² Road deaths, especially among pedestrians and cyclists, are particularly high among children of parents classified as never having worked or as long-term unemployed.¹²

3.1.3 What is the evidence base

Nationally the Government has set out a range of policies and funding to encourage a reduction in car use,²¹ for example, the National Planning Policy Framework includes measures to improve physical activity, air quality and promoting sustainable transport,²² and can be used to develop local plans.

NICE guidance on walking and cycling provides a range of recommendations including developing a comprehensive network of local walking and cycling, addressing road danger (including perception), ensuring relevant policies and plans consider walking and cycling, and setting up walking/cycling programmes in the community and schools.²⁰

3.1.4 Local picture

Luton is located approximately 30 miles north of central London. The town has excellent transport links. Central London is 30 minutes away by train (from the town's three railway stations – Luton, Luton Parkway and Leagrave). There are also direct links to the south of the country (Brighton and Gatwick) and to the north (Bedford, Leicester, Derby, Nottingham and Sheffield); and through

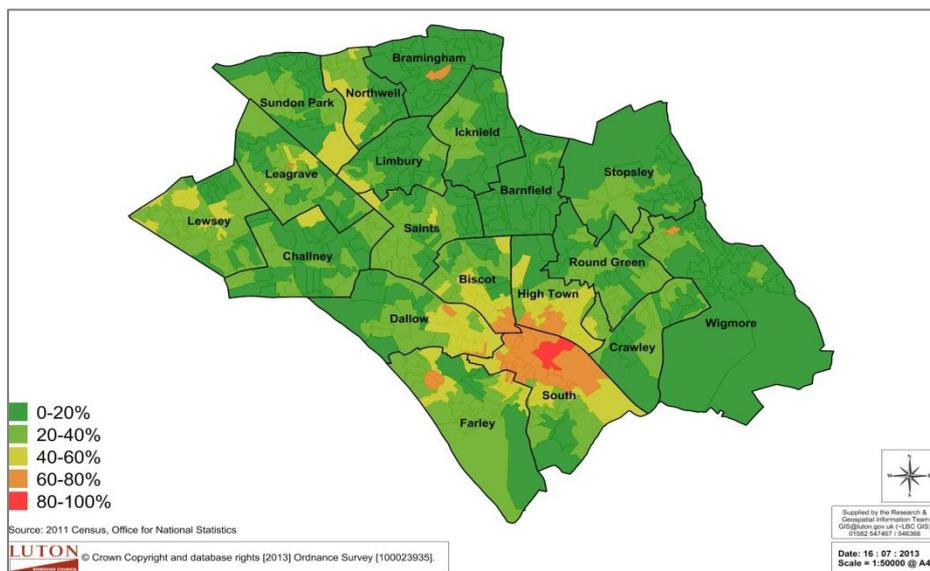
Eurostar connections at St Pancras International to destinations in Europe including Paris and Brussels.

Luton has its own international airport (London Luton Airport) that provides a range of scheduled and charter flights. Scheduled flights are to and from most European countries plus Israel, Morocco, United Arab Emirates and the United States.

A quarter (26%) of all journeys to and from schools in Luton are by private car.²³ Just over a quarter of children state that ‘stranger danger’, distance and parents are preventing children walking or cycling to school.²⁴ Almost a third (31%) of secondary school pupils preferred the car as their mode of travel.²⁴ However, 11% did have a desire to cycle to school.²⁴ In Luton on average 7.3 children per year were injured travelling to or from school between 2011 -2013 compared to an average of 12 per year in 2007-2009.²³

The 2011 census shows that almost two thirds of Luton residents in employment either drive a car or van to work (55%) or are a passenger (8.4%) compared, in combination, with 56% in statistical neighbours and 59% in England.¹⁴ 27.4% of Luton residents do not have access to a private car compared with 25.8% in England.¹⁴ Non-car ownership is higher than average in more deprived wards such as Biscot and Dallow (37.1%), High Town (42%) and South (53.2%).¹⁴ Figure 14 shows that a greater number of households with no car are within areas with higher rates of deprivation and in particular clustered around the town centre.

Figure 14: Percentage of households with no cars or vans, 2011

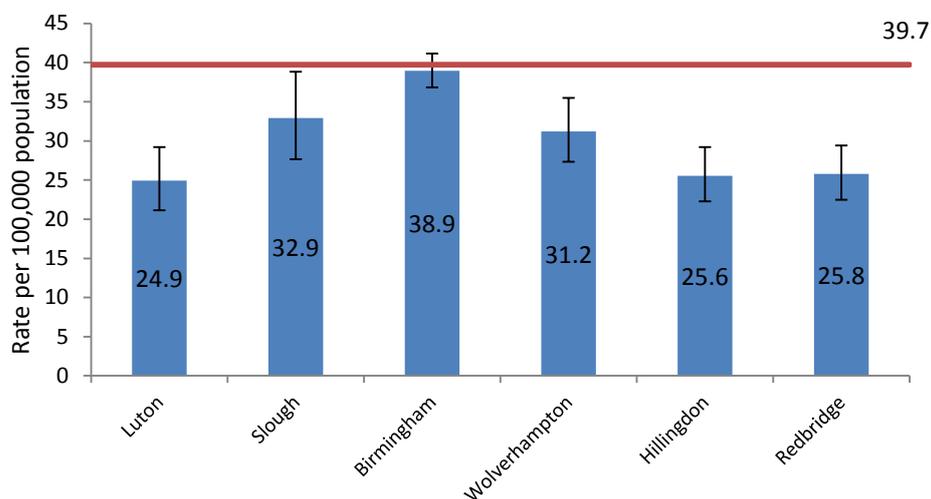


Accessing healthcare services can become a regular part of the lives of some older people, however, they can have problems accessing these services either due to mobility problems (which can prevent them using traditional public transport services) or for financial reasons (inability to afford the transport costs). The Social Exclusion Unit reported that 31% of people without a car have difficulty travelling to their local hospital, compared with 17% of people with a car.²⁵ Whilst the Luton and Dunstable Hospital is easier to access by bus from parts of Luton, it is more difficult to reach by bus from areas in the south and east of Luton.

Killed or seriously injured

Road safety is a key part for encouraging people to shift to active travel. The rate of people either killed or seriously injured on Luton's roads is significantly lower than the England average and lower than statistical neighbours (Figure 15).

Figure 15: Killed and seriously injured (KSI) casualties.



Source: PHOF and Luton PHI

Active travel refers to any form of transport that incorporates physical activity; the two main forms are walking and cycling.

The number of children cycling to school is increasing. The 2014 school census showed that 3.6% of primary school children and 2.6% of secondary school children cycled to school²³ (compared with 0.2% for primary schools and 1% for secondary schools in 2007)²⁴ and 48.4% of primary and 66.6% of secondary school, children walk to school.²³

The 2011 census showed that 12.6% of Luton residents in employment walked to work (compared with 9.1% in the East of England and 9.8% in England) and 1.3% cycle (compared with 3.4% in the East of England and 2.9% in England). A local survey showed that 75% of respondents walked as one of their three main forms of transport²⁶ and 83% of people surveyed in the GreenSTAT survey²⁷ normally travelled to parks and open spaces by foot, while 4% travelled by cycle.

Providing a network of specific routes for walking and cycling helps people increase their active travel as well as improving safety.²⁰ There are nearly 20 miles of on-road cycle lanes and more than 30 miles of off-road cycle tracks in Luton. National Cycle Network Route 6 (NCN6) runs through the town and there are also miles of bus lanes useable by cyclists and nearly 130 miles of roads where vehicle speeds are restricted to 20mph.

From 2004 to 2014, the number of pedestrians entering the town increased by 30% (6,968 to 9,098) between the hours of seven and twelvenoon²⁷ and 86% traffic signal junctions have pedestrian

facilities. There are 51 zebra crossings, 37 pelican/puffin crossing and 4 toucan crossings are all of which Disability Discrimination Act (DDA) compliant.²⁸

Public transport access and affordable travel provide ways of reducing car usage as well as helping individuals to achieve their recommended levels of daily physical activity. There are three railway stations in Luton (Leagrave, Luton Town and Luton Airport Parkway) which link Luton with London and parts of Surrey, Sussex and Kent as well as Bedford to the north. Intercity services north of Bedford connect London St Pancras and Luton to key centres in the East Midlands and South Yorkshire. The 2011 census showed that 7.3% of Luton residents in employment use a bus or coach to get to work (compared with 3.7% in the East of England and 7.3% in England) and 6.1% use the train (compared with 8.1% in the east of England and 9.1% in England). The use of Luton's three stations increased from about 7.04m passengers in 2009 to just over 7.8m in 2013, the greatest increase being at Leagrave (300,000) with Luton and Luton Airport Parkway about 250,000.²⁹

Surface access to London Luton Airport

Passenger throughput at London Luton Airport has increased from just over 8.75m passenger's year in 2010 to around 9.71m in 2013.³⁰ Over the same period the number of jobs at the airport and the surrounding area has increased from 8,200 to 8,400.³⁰ The Average Daily Flow (7 day/24 hours) on the approach roads to the airport has increased from about 14,100 vehicles per day in 2010 to just over 15,100 in 2013³⁰ (for air quality and transport issues please see Section 3.2).

In June 2014 a planning application to grow passenger throughput at the airport to 18m passengers a year by 2028 was approved by the Council. This level of growth is expected to increase employment on the wider airport campus by a further 5,000 jobs over the same period. In addition to the grade separation of M1 Junction 10a, other junctions around the airport and town are being improved to cater for the increase in traffic to and from the airport and other planned growth.

3.1.5 What is being done locally?

The Local Transport Plan makes explicit commitment to promote active travel, and the Rights of Way Improvement Plan has several projects that encourage walking.²⁰ Investment in new cycle routes, crossing facilities and cycle parking has increased and the Council is working with Sustrans to encourage residents and people coming into Luton to use cycles. Increasing investment in green travel is also a key action within the Luton Investment Framework.

The Council is home to school transport policy gives the entitlements for free home-to-school travel through distance to schools, special needs, and low income. There are 723 pupils entitled to free home to school transport for the 2014/15 school year.

The Council, in partnership with JobCentre Plus, operates Travel Aid which provides concessions for jobseekers, offering half price fares on some bus services and concessionary travel card passes for older people and residents with disabilities. There were 28,516 cards in issue on the grounds of pensionable age as of November 2014.

The Council regularly monitors how rail passengers travel to and from the three rail stations in Luton. The latest survey for Luton Station (February 2015) indicates that almost 2/3 of rail passengers walk, cycle, use the bus or a taxi to get to the station. Comparing this with previous

surveys indicates that between 2009 and 2015 there has been a 10% increase in people travelling by bus to Luton station compared with a reduction of both 9% for people walking and a 2% travelling by car (either driving or as a passenger).³¹

3.1.6 Perspective of the public/service users

Passenger surveys carried out in October 2013 and October 2014 asked for views about key attributes of the Busway services. The latest survey²¹ showed almost 90% of people felt bus journey times were excellent/good and more than 70% felt service frequency, passenger information and stop quality was excellent/good, a general increase since 2013.²²

3.1.7 Priorities

- Increase the use of sustainable travel (including walking and cycling) as the 'first choice' of transport.
- Increase accessibility of public transport in areas in the south and east of Luton and key facilities and employment sites.
- Engage schools and parents to overcome fears of cycling and walking.
- Maximise the national and regional accessibility of Luton's key facilities and employment opportunities in order to attract inward investment.

3.2 Air quality

3.2.1 Introduction

Air pollution is caused when chemicals and particles considered to be harmful to human health or ecosystems are released into the atmosphere. The main sources of pollution in the UK are the burning of fossil fuels, transport and industrial emissions, with some sources of pollution occurring naturally.

Exposure to outdoor air pollution is known to have a range of short and long-term health effects on human health, and those with pre-existing health conditions or diseases are likely to be at an increased risk.³² Air pollution can increase deaths and reduce life expectancy.³³

There are several different gases that can occur in ambient air and which have been identified as having health impacts. These include nitrogen dioxide (NO₂), sulphur dioxide (SO₂) and ground-level ozone (O₃). In addition, very small particles of dust can be inhaled and reach the inner airways and lungs. Breathing in polluted air is linked to respiratory illnesses including Chronic Obstructive Pulmonary Disease (COPD)³⁴ and asthma³⁵; cardiovascular disease³⁶; and neurological impairments.

3.2.2 Risk factors and vulnerable groups

All people who live, work or even just pass through Luton may be affected by poor air quality. The relationship between distribution of pollutant concentrations and areas of social deprivation is complex as it depends on the pollutant in question and differs in different cities and regions of the UK. However there is a general trend in the UK that those living in more deprived communities are exposed to higher levels of nitrogen dioxide (NO₂), particulate matter (PM₁₀) and sulphur dioxide (SO₂).³²

Children are particularly susceptible to the effects of pollution, as their lungs are not yet fully developed, and pollution may have an effect on lung growth and lung function.³⁷ Older people are also more vulnerable to the detrimental health effects of pollution, and those with pre-existing health conditions and diseases are also more at risk.³⁸ When levels of air pollutants are raised, adults with heart conditions and adults and children with lung conditions are at increased risk of becoming ill and needing treatment.³²

3.2.3 What is the evidence base?

The Air Quality Strategy for England, Scotland, Wales and Northern Ireland (2007) outlines policy measures to improve air quality on a national level, particularly where the objectives are being exceeded, and identifying areas where further work is needed.³⁹

3.2.4 Local picture

A recent report by Public Health England estimated that in Luton, 86 deaths were attributable to particulate air pollution per annum with 1,004 associated life-years lost.⁴⁰ Luton has a higher percentage of adult deaths (5.8%) related to long term exposure to air pollution than England (5.1%).¹ This compares with Wolverhampton at 5.3% and Birmingham at 5.7%.

The main source of air pollution in Luton is from road traffic particularly the M1 motorway and congested town centre streets.

3.2.5 What is being done locally?

Luton's air quality is continuously monitored for nitrogen dioxide and particulates at a roadside analyser in the town centre. In addition, nitrogen dioxide is being measured at an addition 32 sites across the borough. Reports detailing the level of pollutants found can be viewed from the Council's website. When pollutant concentrations exceed acceptable levels local authorities are required to declare Air Quality Management Areas (AQMAs) and work together with other stakeholders to reduce concentrations to below the objective level.⁴¹

There is currently one AQMA within Luton with elevated nitrogen dioxide as a result of traffic using the M1 motorway. The area covers 431 dwellings situated nearby. However, an area of the town centre has recently been identified as having elevated nitrogen dioxide and work is underway to declare a further AQMA in respect of this exceedance.

An Air Quality Action Plan (integrated with the Local Transport Plan) has been developed containing initiatives aimed at reducing relevant air pollutants to levels no higher than the corresponding objective levels in the Air Quality Regulations 2000.

Air quality monitoring is being undertaken by London Luton Airport Operations Limited within the airport boundary. Surface access targets for passengers and staff are set out in the Airport Surface Access strategy 2012-2017 to monitor the air quality around the airport. On the whole, air quality is rated as good.³⁵

3.2.6 Priorities

1. Review current air quality strategy for Luton and ensure there is a full range of actions to improve air quality.
2. Develop and expand actions to focus on the reduction of road traffic as the major source of air pollution in the town. Such actions include:
 - Changes to road layouts and junctions.
 - Encourage modal shift to more sustainable methods of transport.
 - Working towards more sustainable fleet of private hire and taxi vehicles.
 - Promotion of fuel efficient driving to businesses in the area.
 - Encourage the uptake of electric vehicles.
 - Promote the use of travel planning within schools and businesses.
3. Ensure all major developments, and any significant developments in areas of elevated air pollution, are required to produce an air quality assessment.

3.3 Noise pollution

3.3.1 Introduction

Noise is a sound, especially one that is loud or unpleasant or that causes disturbance.⁴² Exposure to excessive noise can cause serious harm to humans. It can interfere with people's daily activities at school, work, home and during leisure time. It can disturb sleep, cause cardiovascular and psychophysiological effects, reduce performance and provoke annoyance, responses and changes in social behaviour.⁴³

In the UK, about 30% of the population express dissatisfaction with their noise environment.⁴⁴

3.3.2 Risk factors and vulnerable groups

Social inequalities may be exacerbated as the most deprived areas are often located in close proximity to major transport axes, such as railway stations or depots, main roads, busy junctions, airports and flight paths. These areas are often at the highest risk from noise exposure as well as from air pollution.⁴⁵ Those in lower paid jobs are also most at risk of poor working environment and practices.⁴⁶

3.3.3 What is the evidence base?

Noise management is a complex issue and at times requires complex solutions.^{47,48} There are many ways of reducing noise and noise exposure and often a combination of methods works best.⁴⁹ These include:

- Environmental noise - which includes noise from transportation sources.
- Neighbour noise - which includes noise from inside and outside people's homes.
- Neighbourhood noise - which includes noise arising from within the community such as Industrial and entertainment premises, trade and business premises, construction sites and noise in the street.

The Noise Policy Statement for England (NPSE) "*aims to avoid significant adverse impacts on health and quality of life from environmental, neighbour and neighbourhood noise within the context of Government policy on sustainable development. It recognises the need to manage noise, for which Defra has the overall responsibility in England*".⁴⁸

The application of the NPSE should mean noise is properly taken into account in the appropriate time.⁵⁰

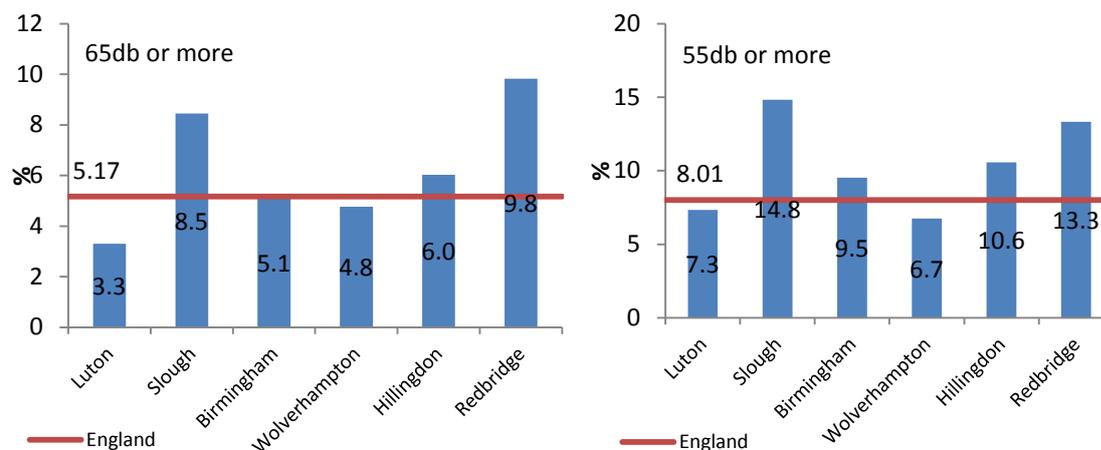
3.3.4 Local picture

Most urban noise in residential areas is traffic-related. Nightclubs, bars and parties are other sources of noise in more central areas. In non-industrial urban environments, opinion poll research conducted in 2003 found that environmental noise problems are worse in areas of high density housing, rented accommodation (both social and private sectors), areas of deprivation and areas which are highly urbanised,⁵¹ all of which have higher rates within Luton compared to the England average.

Luton is served by the M1 motorway, a railway line with three stations and a busy airport, which is due to increase from 12 million passengers per year to 18 million by 2031. Luton has a high population density of 48 people per hectare which is greater than many London boroughs.¹⁴

Strategic noise mapping¹ using national calculation methods and using data supplied by local authorities to model the percentage of the population exposed to road, rail and air transport noise of 65 and 55 dB between 07:00-23:00 shows that Luton is lower than the national average and most statistical neighbours (Figure 16 and Figure 17).

Figure 16: Proportion of population exposure to road, rail and air transport noise during daytime, 2011.



Source: PHE and Luton PHI

3.3.5 What is being done locally?

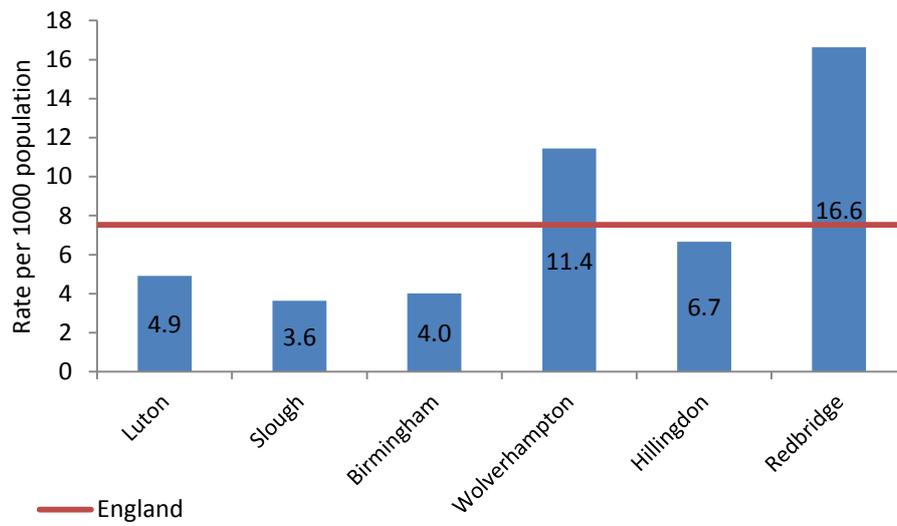
London Luton airport has various measures to control noise and it monitors noise closely to assess any trends in order to minimise the impact of its operations.⁵² There has been an impact assessment on the expansion plan that recommended no additional mitigating factors are required on the impact aircraft ground noise at existing properties or increased road traffic associated with the proposed development.⁵³

There is a range of advice sheets available on the council website⁵⁴ and guidance on reporting noise disturbances. The Council investigates complaints about noise and can take varying action dependent on the type and duration.

3.3.6 Perspective of the public/service users

The Luton Citizens Panel Survey 2012⁵⁵ reported that only 11% reported that noisy neighbours or loud parties were a very big or fairly big problem. This was down from 16% in 2008⁵⁶. Additionally the rate of complaints from Luton residents is below the England average (Figure 17).

Figure 17: The rate of complaints about noise, 2012/13



Source: PHE and Luton PHI

3.3.7 Priorities

1. Map noise complaints across the borough to provide a greater understanding of any noise hotspots affecting local residents, allowing for targeted local action.
2. Monitor measures in place ensure that the impact of noise as a result of airport expansion is mitigated.

3.4 Housing, overcrowding, fuel poverty, homelessness

3.4.1 Introduction

Home environments have an impact across the life course on health and wellbeing. Cold, damp and accident prone homes increase risks for respiratory and cardiovascular diseases, poor mental health and excess winter deaths.⁵⁷

Having a home which is safe and affordable is generally considered to be a basic need. Homelessness is one of the many challenges faced by the borough's residents and is inextricably linked to poverty including child poverty, worklessness and health inequalities.

Local and national population and household projections (see Healthy people) show that Luton's population is expected to grow by around 20% in the period 2011 to 2031, which equates to 17,800 new homes, meaning there will be increasing demand within the limited boundaries for housing across the borough.

3.4.2 Risk factors and vulnerable groups

There are a number of different housing conditions that may constitute a risk to health, primarily felt by those on lower incomes. These include homelessness (which includes rough sleeping and living in hostels and other temporary accommodation), overcrowding, insecurity of tenure, inappropriate housing (size, type), and housing in a poor physical condition.⁵⁸ Less affluent households are more exposed to and affected by inadequate housing conditions and associated risk factors.⁵⁹

Poverty rates for people living in social housing are double that of the population as a whole with only a third of tenants in full-time employment and fewer than half with any paid work.¹² Being in social housing as a child also increases the risk of multiple disadvantages in adulthood.¹²

BME households are much more likely to live in rented accommodation than their white counterparts; their households are larger but their homes are smaller.⁶⁰ Private housing of minority ethnic households is more likely to be in poor condition.⁶⁰

3.4.3 What is the evidence base?

NICE has recently produced guidance on how to reduce risk of death and ill-health associated with living in a cold home with a view to reducing excess winter deaths and morbidity associated with living in cold homes. The guidance addresses each of the common factors linking cold homes to winter deaths and illness including: fuel costs, appropriate ventilation, dressing appropriately and efficient heating and insulation. It includes recommendations to:

- Have a strategy.
- Ensure single point of contact.
- Provide tailored solutions.
- Identify and support those at risk.
- Provide training to a range of health and non-health staff.
- Promote awareness among practitioners and the public about how to keep warm.⁶¹

The Housing Health and Safety Rating System (HHSRS) provides an assessment tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings and this is used in Luton to tackle identified issues.⁶² The World Health Organisation is currently updating existing guidelines that focus on healthy housing. These guidelines cover an extensive range of categories that impact on health including: ambient air pollution, sanitation, home safety and disease vectors, pests and vermin.⁶³

In 2011, Crisis made a number of recommendations for improving services for homeless people, including that local Council's should:

- Provide meaningful advice and assistance to single homeless people.
- Improve access to mainstream and outreach healthcare services such as GP surgeries.
- Join physical and mental health services to provide a holistic approach to meeting the specific needs of homeless people.
- Increase the number and type of drug and alcohol treatments available.⁶⁴

A Government document also set out a joint approach through Making Every Contact Count to prevent homelessness. This aims to ensure that every local agency contact with vulnerable people and families has an impact on preventing homelessness.⁶⁵

3.4.4 Local picture

Housing

In the 2011 census, there were 74,293 households in Luton of which 60.2% were either owned outright or owner occupied, 15.7% were social rented and 22.7% private rented⁶⁶. The largest numbers of private rented households are located in Biscot, Dallow, High Town and South ward accounting for almost half of the private rented market in Luton⁶⁷.

Within Luton there is a continuing imbalance between supply and demand, with demand significantly outstripping supply. The most recent Strategic Housing Market Assessment (refresh 2014) concluded there is a shortfall of 890 units per year, with nearly 30% of this shortfall being affordable housing.⁶⁸ Nearly 9,000 people in housing need are on the Council's housing register and over 800 homeless families are living in temporary accommodation. Of these more than 120 are placed in expensive and unsuitable bed and breakfast accommodation.

The Strategic Housing Land Availability Assessment (SHLAA) indicates that Luton does not have sufficient land within its boundary to meet all its housing needs.⁶⁹ Research for the Local Plan demonstrates that Luton can only accommodate about 6,000 new houses, which will not meet the expected demand for homes from an increasing population (17,800 new homes by 2031). If the longer term housing requirements are not delivered, there is strong risk there will be:

- Increased population density.
- Increased overcrowding.
- Reduced employment opportunities (as land is used for housing).
- Reduced open space (as land is used for housing).
- Increased deprivation.

- Decreased employment opportunities.
- Increased poverty.
- Increased division of residents across Luton.
- Increase in community tensions.

This may lead to many of the existing socioeconomic issues being exacerbated, which in turn impacts on service delivery and health outcomes.

Overcrowding

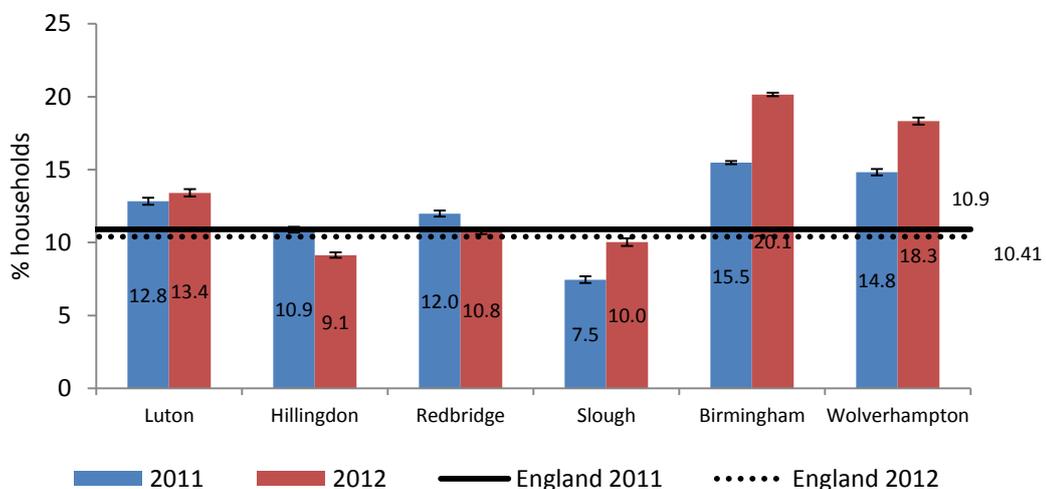
Luton’s Private Sector Housing Stock Condition Survey (2006) suggested that approximately 7.6% of all private sector households in Luton were overcrowded, with around 7.4% seriously overcrowded. A further breakdown of overcrowding by ward showed that Biscot and Dallow had the highest level of overcrowding with over 25% of households having a deficiency of 1 bedroom or more. Dallow ward had almost 10% of households with a bedroom deficiency of 2 or more. Saints and South wards were heavily overcrowded areas by 18% and 16% respectively.

Fuel poverty

There is compelling evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures and low temperatures are strongly linked to a range of negative health outcomes. Fuel poverty in England is measured by the Low income, high costs definition, which considers a household to be in fuel poverty if they have required fuel costs that are above average (the national median level) and were they to spend that amount they would be left with a residual income below the official poverty line.⁷⁰

The percentage of households experiencing fuel poverty increased from 12.8% in 2011 to 13.4% in 2012 in Luton. The inequality gap with England has widened as nationally a decrease in fuel poverty was seen. Luton’s rate is significantly higher than England and London and Slough comparators but significantly lower than those in the West Midlands (Figure 18).

Figure 18: Fuel poverty, 2012



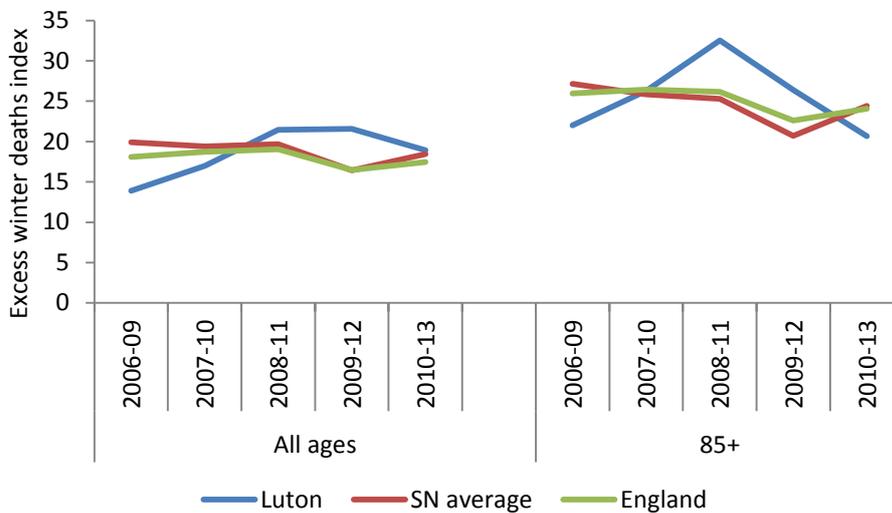
Source: PHOF and Luton PHI

Key determinants behind fuel poverty are energy efficiency of the property, cost of energy and household income.

There is estimated to be a 13.8% rise in deaths in Luton during the colder months of the year compared with the rest of the year.⁶⁷ Most of these deaths are due to circulatory and respiratory diseases with the majority occurring amongst the elderly population, and research has suggested that many excess winter deaths in England and Wales are preventable.¹

In Luton, excess winter deaths for all ages has increased (although not significantly) from a ratio (observed vs expected) of 13.9 in 2006-09 to 18.9 in 2010-13 which is just above the national average (17.4) but not significantly different. Excess winter deaths in those aged 85 years and over is lower in Luton than comparator areas (Figure 19).

Figure 19: Excess winter deaths Index (ratio of observed vs expected)



SN (Statistical Neighbours = Comparator Areas)

Source: PHOF and Luton PHI

Homelessness

Homelessness is associated with severe poverty and is a social determinant of health. Homelessness is associated with adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities.

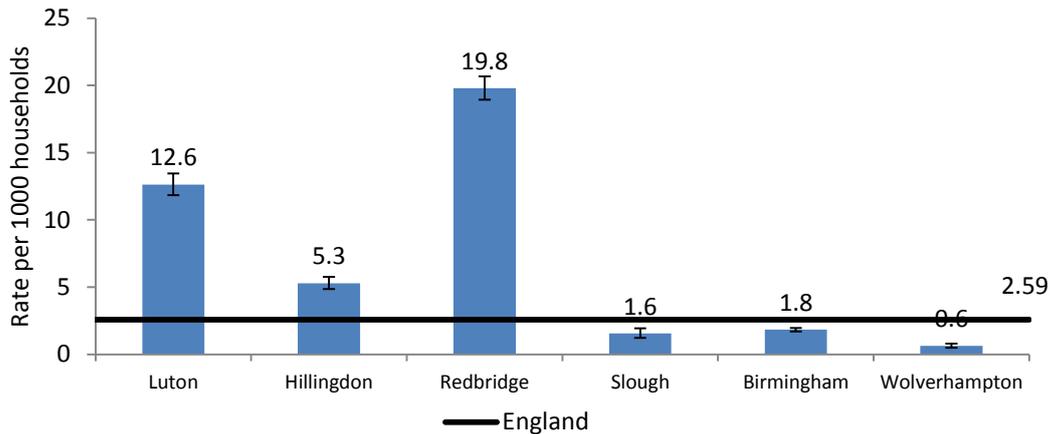
A recent report into the health of those that are homeless found:

- 41% of homeless people reported a long-term physical health problem (compared with 28% of the general population)
- 45% had been diagnosed with a mental health problem (compared with 25% of the general population)

- 36% had taken drugs in the past six months (compared with 5% of the general population).⁷¹

The rate of households who are statutory homeless and in temporary accommodation in Luton (12.6 per 1,000 households) is significantly higher than the England average (2.59) and significantly higher than most statistical neighbours, apart from Redbridge (Figure 20). The trend also shows an increase in the rate year on year, widening inequalities with England and statistical neighbours.

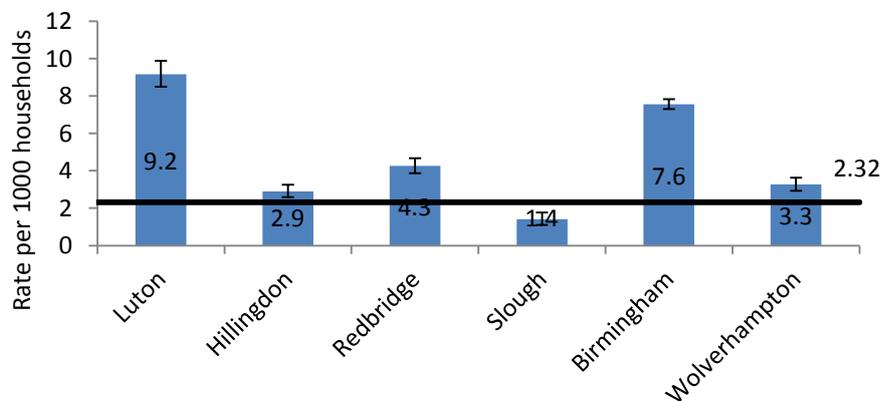
Figure 20: Households in temporary accommodation per 1,000 households (2013/14)



Source: PHOF and Luton PHI

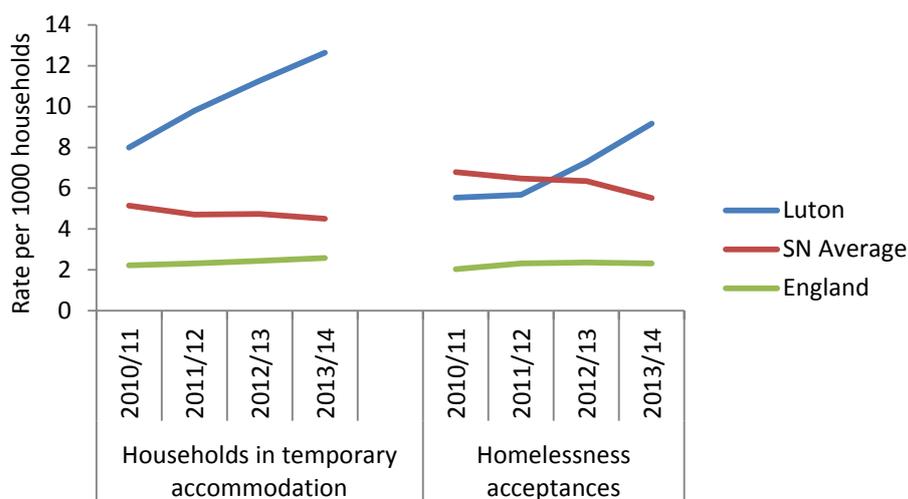
Figure 21 (number of homelessness acceptances per thousand households) demonstrates the number of households accepted as being owed a duty by their local authority under homelessness legislation as a result of being eligible for assistance, unintentionally homeless and in priority need. Households accepted as being homeless or in temporary accommodation may have greater public health needs than the population as a whole.¹ Luton's rate is significantly higher than the England average and significantly higher than all statistical neighbours. Figure 22 shows the rate of homelessness acceptances has been increasing in the last three years above the England and statistical neighbour average.

Figure 21: Homelessness acceptances per 1,000 households



Source: PHOF and Luton PHI

Figure 22: Households in temporary accommodation per 1,000 households (2010/11 to 2013/14)



Source: PHOF and Luton PHI. SN (Statistical Neighbours = Comparator Areas)

3.4.5 What is being done locally?

To combat this need, advice, options assessment and information on rights alongside greater attention to reasons for homelessness is being delivered across Luton. Homeless families in temporary housing are offered training on tenancy and financial management to avoid repeat homelessness.

The Council is rewriting the housing strategy (due for publication in late 2015), which has four main aims:

1. To provide more affordable housing.
2. Improve conditions and housing quality.
3. Reduce homelessness.
4. Establish the Council as a landlord of choice.

A Fuel Poverty Action Plan is also being developed. Other actions that have recently been taken include:

Housing

- Four new affordable homes for older people with a physical disability were built in 2013 and two further small sites have been identified to build a further seven units.
- Land has been released and funding secured to increase provision of new affordable housing.
- Empty properties have been brought back into use; for example, additional temporary housing has been secured from the private sector through conversions of former commercial buildings in the town centre.
- Grants are offered by the Council for adaptation of homes to better accommodate families with a person with disabilities.

- Luton's Home Improvement Agency (HIA) helps older and vulnerable people with grants, loans or day-to-day assistance, and Luton's Handyman scheme provides support for small improvements around the home.

Private rented sector

- The Council has introduced, and subsequently extended, a licensing scheme for private landlords to improve standards in multi occupied properties.
- Enforcement action has been taken by the Council against non-complying landlords to prevent sub-standard rooms being let.
- Grants and loans have been made by the Council to improve housing conditions in the private rented sector some targeted at areas of the town with the worst housing conditions.

Homelessness

- The Council is developing a scheme to provide advice and money guidance for homeless families to avoid repeat homelessness.
- Luton Clinical Commissioning Group has an agreement with two Luton practices to provide essential, additional and enhanced services to homeless and hard to reach groups, including outreach services.
- The NOAH (New Opportunities and Horizons) charity provides a range of support to those who are homeless, including emergency shelter and day services.
- Mary Seacole Housing Association provides supported accommodation for young single homeless people between the ages of 16-35 years as well as support plans, training and resettlement services.
- Penrose Synergy, commissioned by the Council, provides supports for vulnerable adults with a range of services including tenancy sustainment, housing advice and accommodation brokerage.

3.4.6 Perspective of the public/service users

The Luton Citizens Panel Survey 2012⁷² reported the main perceived issues in planning for the future over the next 20 years are deciding where development should go (45%), how to find an affordable home (43%), public transport (38%), activities/uses for new developments (33%), car parking (33%) and finding available land (32%).

In terms of development and growth in the local area, the most popular suggestion for improvement is job opportunities (41%), followed by affordable housing (32%), traffic congestion (29%), and activities for teenagers (28%), clean streets (25%), crime (24%) and health services (23%). This puts housing and affordable housing as key issues residents feel strongly about.

3.4.7 Priorities

1. Work with neighbouring authorities and other relevant organisations to ensure the longer-term housing needs of Luton are accommodated within the wider housing market area together with necessary supporting infrastructure.
2. Improve the quality of all tenures of housing (especially private sector rented) accommodation in the town through inspections and enforcement to improve living conditions and reduce fuel poverty.

3. Ensure a supply of appropriate and affordable housing in the town to reduce homelessness, improve choice and prevent excess winter deaths.
4. Ensure questions are asked within the planning process of developers on how the development will improve health and wellbeing.

3.5 Parks and green spaces

3.5.1 Introduction

Green infrastructure can be broadly defined as a strategically planned network of high quality natural and semi-natural areas with other environmental features, which is designed and managed to deliver a wide range of eco-system services and protect bio-diversity in both rural and urban settings.⁷³

There is mounting evidence demonstrating the contribution green spaces can make to mental and physical health and wellbeing.⁷⁴ Green spaces encourage:

- Social contact and integration.
- Provide space for physical activity and play.
- Improve air quality and reduce urban heat island effects (man-made area, such as cities and towns, which are significantly warmer than the surrounding countryside).¹²
- Help support social inclusion and community cohesion.²⁰

3.5.2 Risk factors and vulnerable groups

There is unequal access to green space across England. People living in the most deprived areas are less likely to live near green spaces and will therefore have fewer opportunities to experience the health benefits of green space compared with people living in less deprived areas⁷⁵.

3.5.3 What is the evidence base?

NICE has produced guidance on physical activity and the environment (PH8) which is targeted at professionals who have a direct or indirect role in, and responsibility for, the built and natural environment setting out that places should be provided where children and young people feel safe in taking part in physical activities.⁷⁶

The Faculty of Public Health published a report in 2010 on 'Great Outdoors: How our natural health service uses green space to improve wellbeing;' highlighting the physical and mental health benefits of using green spaces.⁷⁴

A recent PHE briefing suggests that local action to increase access to green space should include:⁷⁵

- Creating new areas of green space and improving the quality of existing green spaces.
- Increasing accessibility of green spaces and improving engagement with local people.
- Increasing the use of good quality green space for all social groups.

DEFRA has published a white paper outlining how it will protect and improve the natural environment⁷⁷ and the National Policy Planning Framework states that access to high quality open spaces and opportunities for sport and recreation can make an important contribution to the health and wellbeing of communities.⁷⁸

3.5.4 Local picture

The Green Flag Award Scheme (the national quality indicator for parks and green spaces) recognises and rewards the best green spaces in the country and provides the benchmark for excellence.^c Seven of Luton's district and neighbourhood parks have achieved the Green Flag standard. The Council also manages a large number of local open spaces. These important green spaces provide a range of facilities including 47 children's playgrounds, and an adventure play area which opened in 2011.

Access to neighbourhood urban parks and gardens in Luton is relatively good across the whole of the borough with a total of 546.68 hectares of green space. However, there is inequality in the distribution of publicly accessible green spaces across Luton.⁷⁸ West and central areas have, on average, significantly less overall green space per person (Table 18). The Green Space Strategy Review⁷⁸ also identified that the overall current provision of green spaces is insufficient given the multifunctional Green Space Standard^d (41.5m²/person) and is projected to worsen given the expected growth in the population.

Table 18: Green space per person (m²)

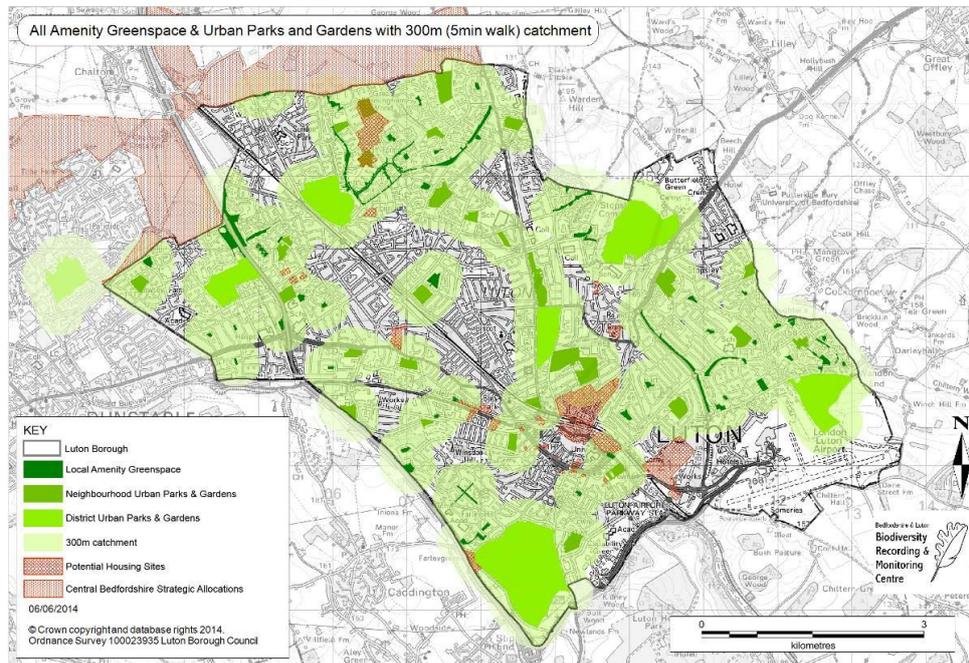
	LUTON	North	East	South	West	Central
Green Space per person (m ²)	28.7	34.5	50.4	33.1	15.7	13.4

Figure 23 shows the areas with no access to green space and urban parks and gardens within 5 minutes are mainly located in the central area in Biscot and Saints wards as well as larger pockets across the borough within Crawley, Icknield and Sundon Park, which also has a potential new housing site.

^c Applications are judged against 8 criteria: A welcoming place; Healthy, safe and secure, Clean and well maintained, Sustainability, Conservation and Heritage, Community Involvement, Marketing and Management.

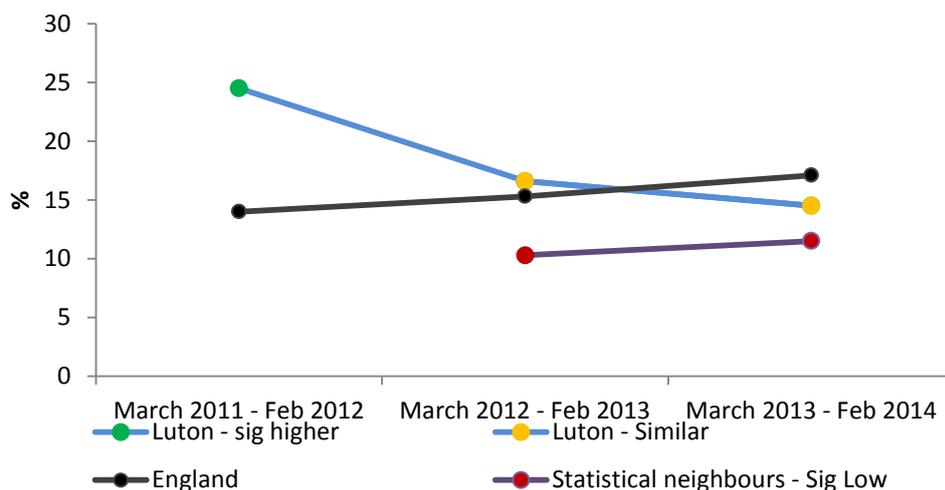
^d Multifunctional Green Space Standard: Amenity Green space (4m²) + Neighbourhood Parks (7.5m²) + District Parks (8.5m²) + Strategic Natural and Semi-Natural Green **space (5.5m²)** + District Natural and Semi-Natural Green space (4.5m²) + Local Natural and Semi-Natural Green space (11.5m²).

Figure 23: Greenspaces in Luton with a catchment of a 5 minute walk.



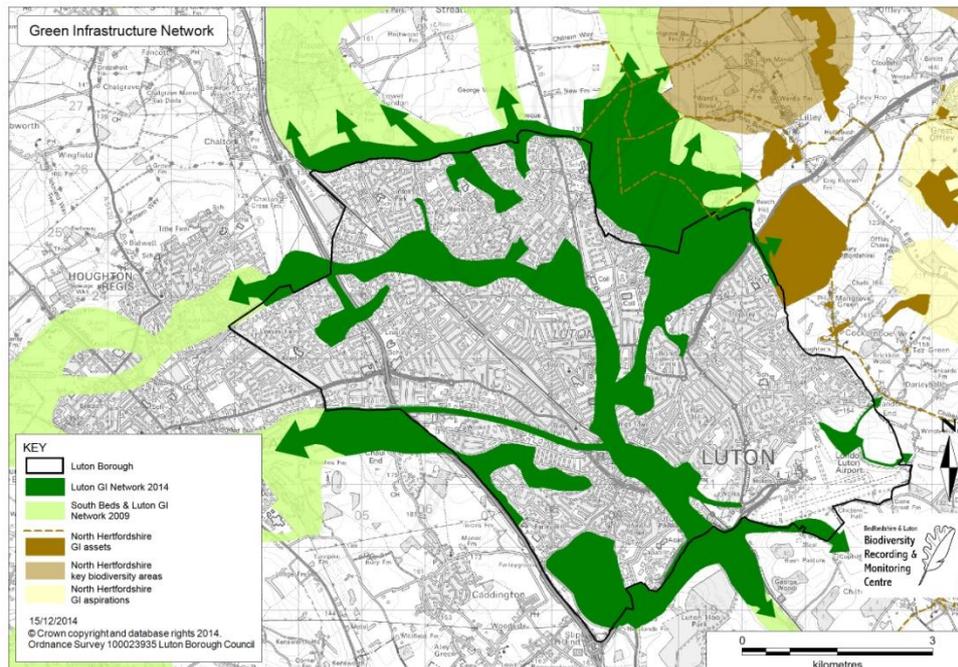
Utilisation of this outdoor space for exercise and/or health reasons has been reducing in Luton from a high of 24.5% of residents visiting the natural environment for health or exercise purposes in 2011/12 to 14.5% in 2013/14 but this is still above the statistical neighbour average of 11.5% (Figure 24).

Figure 24: Outdoor space utilisation for health or exercise purposes



There are 24 county wildlife sites and 13 district wildlife sites in Luton. Natural England recently indicated a desire to review sites associated with Bedfordshire chalk. Surveys of three sites in Luton have shown potential to be Designated Sites of Special Scientific Interest (SSSI). This designation comes with statutory protection.

Figure 25: Green infrastructure network



Allotments have great potential to contribute to health and wellbeing.⁷⁹ Allotment gardening enables people to be physically active, provides access to healthy and affordable food, has a wide range of social benefits and supports sustainability by reducing food miles. The Council has a statutory requirement to provide allotments for the public. The Green Space Strategy⁷⁸ recommends a provision standard of 2m²/person. There is currently a shortfall of approximately 640 plots and it is predicted that unless further allotments are provided, there will be a significant shortfall in the period to 2031 with an estimated 949 plots shortfall for the projected growth within Luton's boundaries. This will become even more significant if further allotments are lost to development.

3.5.5 What is being done locally?

Strategic work undertaken by the Green Infrastructure Consortium looks at joining the existing areas with areas of greatest opportunity (connecting the spaces to the wider countryside), historic environments and critical areas, which are now in deficit. This and the Green Space Strategy Review 2014 plan will guide the council in seeking mechanisms to improve the current provision through the creation of appropriate and accessible routes and green corridors, self-managed allotments and community gardens and improved facilities in district and neighbourhood parks to ensure a holistic approach to delivery of a local green space network to meet the needs of the community.

The Council works with a range of partners including Friends of the Park groups and local environmental trusts to deliver projects to improve green spaces and local play provision, encourage food growing and healthy eating projects, engage with volunteers in outdoor physical activities, and provide accredited education and training programmes.

3.5.6 Perspective of the public/service users

The 2014 resident's survey shows free and cheaper activities and more local choice could encourage residents to increase their levels of physical activity. Utilising free green space is an important aspect of this. See section 9.3 for more information on physical activity.

3.5.7 Priorities

1. Improve the accessibility, connectivity, bio-diversity and recreational value of existing parks, green spaces and natural areas to promote good mental health and physical activity through partnership working across departments.
2. Use healthy urban planning principles to build green and open space of recreational value into new developments to help address the shortfall of open space across Luton.

3.6 Economy and employability

3.6.1 Introduction

Increasing employment and supporting people into work are key elements of the UK Government's public health and welfare reform agendas.⁸⁰

There is a strong association between worklessness and poor health and wellbeing⁸⁰ and it is shown to increase mortality, rates of sickness, disability and mental health problems. It also results in higher medical consultation and use of medication and higher hospital admission rates.⁸⁰

3.6.2 Risk factors and vulnerable groups

Key groups affected are those that tend to suffer from labour market disadvantage such as ethnic minorities, lone parents, disabled people, people living in social housing and people with low or no qualifications. Reducing health inequalities for these groups will have economic benefits such as reducing productivity losses associated with ill-health, reducing welfare payments and treatment costs.¹²

Being in some types of employment may also have a negative impact on health. For example, poor quality, low paid and insecure employment may be no better for health than unemployment.⁸¹

3.6.3 What is the evidence base?

NICE has produced guidance on managing long-term sickness and incapacity for work focusing on:

- Preventing or reducing the number of employees moving from short to long-term sickness absence.
- Helping employees on long-term sickness return to work.
- Reducing the number of employees who take long-term sickness absence on a recurring basis.
- Helping people receiving incapacity benefit or similar benefits return to employment.⁸¹

3.6.4 Local picture

Economy

Luton is an employment centre that provides job opportunities for both its own residents and for those of other areas. There are complex commuting flows in and out of Luton and analysis of travel to work patterns has been used to generate a 'Luton housing market area' that covers Luton Borough and parts of Aylesbury Vale, Central Bedfordshire, Decorum, and North Hertfordshire Council areas.

Productivity

Gross value added (GVA) is a measurement of economic activity. In 2013, GVA per head in Luton was £21,658 (7% lower than the national average); however, GVA has been increasing. Luton's GVA per head increased by 5.3% in between 2012 and 2013 compared with increases of 2.6% for England as a whole and 2.4% in the eastern region.⁸²

Employment and employers

According to the Business Register and Employment Survey (BRES)⁸³ there are 83,300 jobs in Luton. There are more service sector jobs than manufacturing ones; nonetheless, manufacturing

employment is still higher than the national average and has remained stable since the loss of many jobs from Vauxhall in the early 2000s. Major employers in Luton are the council, NHS, EasyJet, TUI UK Ltd, Monarch Airlines, Selex-ES, Hayward Tyler, MTL Industries, Ernst and Young and General Motors.⁸³

London Luton Airport is a major employer and a strong driver of the economy of Luton. In 2013, approximately 8,400 people were employed in connection with the airport equating to around 10% of employment in the town.⁸⁴ The airport will continue to be a key driver of economic activity as planning consent has been granted to permit the expansion of the airport to over 18 million passengers per annum from the current 12 million. This is expected to generate an additional 5000 jobs to 2021.⁸⁴

The claimant count unemployment rate in Luton is 2.1%, which is the same as the national average and higher than the regional average of 1.5%. Unemployment is highest in Northwell (3.4 per cent), Biscot (3.0 per cent,) Dallow (2.9 per cent), and South (2.6 per cent) wards, whilst unemployment is lowest in Bramingham (0.6 per cent) and Barnfield (0.7 per cent) wards.⁸⁵ This broad pattern of unemployment rates within the Borough has been consistent over the past twenty years and matches the wider index of deprivation.

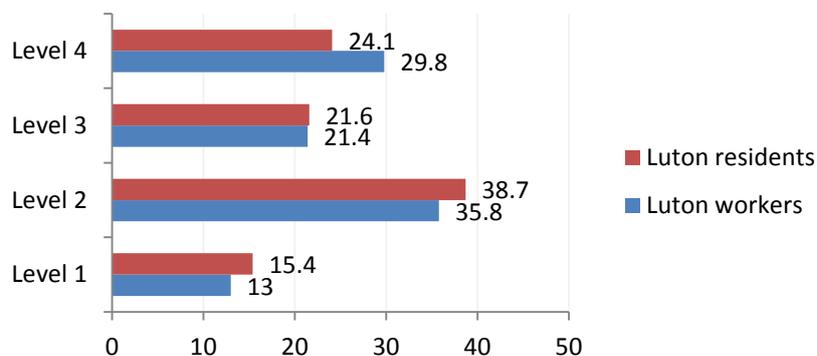
The economic activity rate (EAR) (the percentage of the population 16-64 years, both employed and unemployed, a measure of the degree of success of the economy in engaging the population in some form of production activity) in Luton is relatively consistent at 73% for the last 5 years.⁸⁶ This is below the national average (76.9%) and similar to the statistical neighbour average (71%). This has been fairly consistent over the five year period to December 2014 whereas the national and statistical neighbour rates have been increasing.⁸⁶ EAR for males in Luton have been consistent, whereas for women EAR has been increasing over the same time period.

Earnings

Average weekly earnings of people living in Luton are £479 per week, £39 less than the national average of £518 per week. The average weekly wage of those who work in Luton (but don't necessarily live in Luton) is £486, slightly higher than the residence based figure but lower than the national average.⁸⁷

The Luton Economic Assessment (2014)⁸⁸ showed that Luton residents were on average more likely to be in lower level occupations than the Luton workforce as a whole. The data, from the Annual Population Survey, is shown below (Figure 26). This seems to suggest that either Luton residents are less able, owing to skill, competences or experience, to gain higher level occupations than non-residents.

Figure 26: Percentage in lower level occupations



Source: Annual Population Survey, ONS

Examples of different levels of education. Level 4 - diploma, certificate of higher education, Level 3 – A levels, Level 2 – GCSE A-C, Level 1 – GCSE D-G.

Workforce attainment

Luton had a lower proportion of the workforce with degrees (22.6%) than the national average (26.7%) in 2013; however this figure has increased from 14.9% in 2009.⁸⁶ The proportion of the workforce with GCE A Level qualifications has increased from 18.8% in 2009 to 21.9% in 2013. This brings Luton closer to the regional and national average of 23% and 23.1% respectively.

There is a higher proportion of the workforce with no qualifications in Luton: 12.2% in 2014 compared with 8.6% nationally; however, this has fallen from 17.2% in 2009. There is a sharp decline in the proportion of 16-19 year olds with no qualifications, which now mirrors national and regional averages.

Educational attainment

Luton has a slightly higher than average proportion of good or outstanding secondary schools and slightly lower proportion of primary schools. As at December 2014, 77% of Luton Secondary schools were graded as good or better compared with 72% nationally. 81% of Luton primary schools were graded as good or better compared with 83% nationally.

In terms of pupils attending good or better schools, the proportion of secondary pupils attending a Luton school that is good or better was 82% compared with 76% nationally. The proportion of primary pupils attending a Luton school that was good or better was 80% compared with 82% nationally.

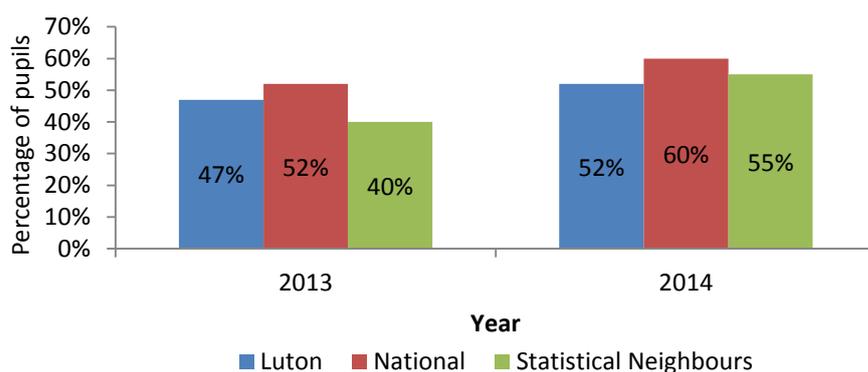
Educational performance in Luton's schools continues to increase at a similar rate to national level, but the gap is not narrowing and there is a need to accelerate the improvements so that attainment is at least in line with national performance.

Early Years Foundation Stage (EYFS):

The percentage of children in Luton reaching a 'good Level of development'^e in the last year (2013 to 2014) increased from 47% to 52%. Whilst the increase is positive, the national and statistical neighbour averages increased at a faster rate and therefore increasing the inequality gap with Luton (Figure 27).

^e Good level of development is defined as children achieving at least the expected levels in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in mathematics and literacy.

Figure 27: Good level of development



Source: DFE and The council

The attainment of free school meals (FSM) pupils increased by 6 percentage points compared with non-FSM children where the increase was 3 percentage points. Outcomes for FSM pupils in Luton are above statistical neighbours and slightly higher than the Eastern region (45% Luton, 40% statistical neighbours, 44% East) and Luton is 4th of 11 LAs in the Eastern region for FSM pupil outcomes.

Key Stage 1 (KS1):

Reading, writing and mathematics improved in 2013 and this was maintained in 2014, although Luton remains in the bottom quartile nationally. Performance in phonics improved from 64% to 68% for all pupils, but remained lower than the England (74%) and statistical neighbour (73%) averages. This improvement was not reflected in the result of children eligible for free school meals where Luton's performance was 57%, although the gap between all pupils and FSM in Luton (11%) is smaller than England average of 13%.

Girls are performing better than boys in all subject areas. Level 3 outcomes for reading are broadly in line with national averages, whereas writing and mathematics Level 3 outcomes are above national outturn. In both areas Luton is 2% above national averages. Boys' writing remains a key area for development.

Key Stage 2 (KS2):

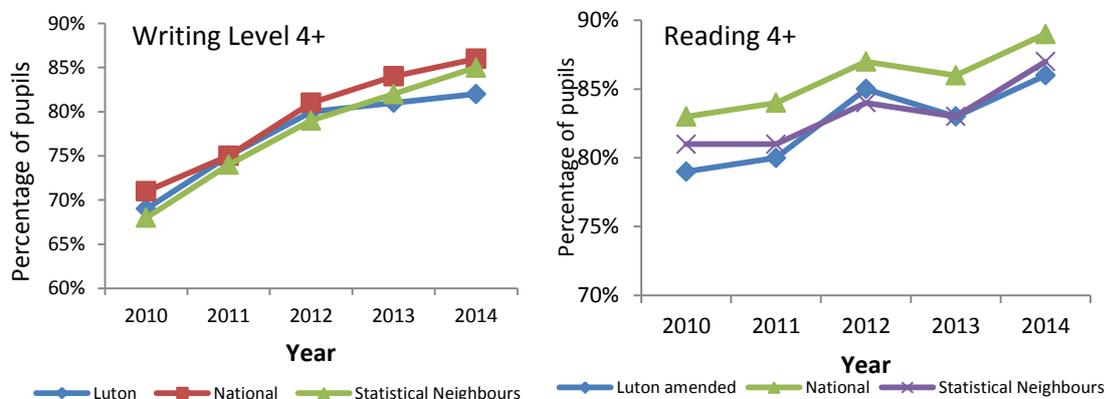
There have been significant changes in assessment at KS2 driven by the national agenda.

There has been an increase overall in Luton in outcomes at Level 4 and Level 5 in reading, with 86% of pupils achieving level 4+ in reading in 2014 compared with 89% nationally (Figure 28). The gap between Luton and national outcomes has not narrowed but Luton remains similar to the statistical neighbour average (87%).

Similarly, there has been an increase in outcomes in writing at Level 4 and Level 5 in Luton, with 82% of pupils achieving level 4+ in writing compared with 86% nationally and 85% in statistical

neighbours (Figure 28). The gap between Luton and national average has not narrowed and the gap has widened between Luton and statistical neighbours.^f This is also the case in mathematics.

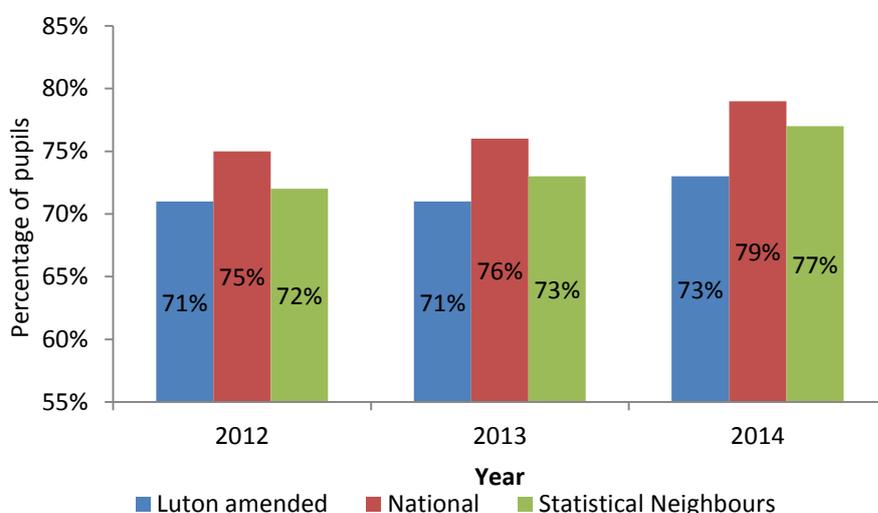
Figure 28: Achievement of level 4+ in reading and writing



Source: DFE and the council

Figure 29 shows the overall achievement in level 4+ reading, writing and maths and that the gap has widened with both England and statistical neighbours since 2012.

Figure 29: Achievement in level 4+ in reading, writing and maths



Source: DFE and the council

^f Figures for Luton will differ with the national first statistical release of key stage 2 outcomes due to results being unavailable for one school. These are now available and have been included in the local analysis for Luton.

Pupil characteristics

Pupil premium

- 11,370 pupils were eligible for the pupil premium in 2013/14, an increase of 52% from two years ago in 2011/12 (7,470).

Free school meals

- The proportion of primary school pupils who were eligible for free school meals at any point in the last six years increased by 0.4 percentage points from 29.8% in 2013 to 30.2% in 2014. This compares with 26.9% England average and 34.2% statistical neighbour average.
- The proportion of secondary school pupils is higher at 36.9%, compared with 29.3% England average and 38.7% statistical neighbour average.

English as an additional language

- Just over half (51.5%) of primary school pupils and 47% of secondary school pupils had English as an additional language in 2014. The year on year increasing trend in Luton is at a greater rate than the England average.

Of the 2,536 young people who completed year 11 in 2014, 2,465 (97.2%) continued education and training, an increase from 93.1% in 2011. The majority of young people choose to continue their studies either at Luton Sixth Form College or a school sixth form, 31.58% choose to continue their studies at a further education college or similar establishment whilst only 2.05% elected employment with training.

The numbers of young people in Luton who are not in employment, education or training (NEET) has decreased over the 2014 coming down from 6.36 % to 4.9%. This is less than the regional average (5.4%), but slightly higher than statistical neighbours (4.6%) and nationally (4.8%).

Skills and employability

The 'Skills and Employability Strategy focuses on the challenges between education and work.⁸⁹ The role of quality advice to school leavers is identified as key to ensuring a success at this time as well, as the availability of quality options for all school leavers (regardless of whether they wish to take routes into education, training or work).

The Employment Land Review, suggests that up to 20,000 jobs could be created in Luton between 2011 and 2031, with a significant proportion of these expected to be derived from airport growth and town centre sites.⁹⁰ Many of these jobs will be in business services, land transport/distribution, healthcare, retail, construction and arts/entertainment.

3.6.5 What is being done locally?

Research by the Joseph Rowntree Foundation and the Centre for Cities⁹¹ suggests there has been a significant shift in the labour market over the past 15 years, with a polarisation with a greater proportion of employees in quality jobs and low quality jobs. This polarisation is seen as reducing social mobility and placing an increased proportion of the labour force in low quality jobs (defined as part-time, low paid, short-term contract, zero hour's contract, and low skilled). Luton is highlighted

as one of the areas of the country where this phenomenon has taken place. The Poverty Assessment will look at the extent to which this has happened and to understand the wider implications.

The council's goal is to achieve strong, sustainable, balanced growth and, in particular: ⁸⁴

- To realise Luton's potential through its people and create a skilled, aspiring workforce.
- To build Luton's reputation as a vibrant place for people and families to live in harmony, work and relax.
- To grow successful businesses through inward investment.
- To maximise Luton's assets – its location, workforce, connectivity and as a centre for excellence in learning and creativity.
- To become an innovation leader in technology, aviation, health and wellbeing.

The council's Local Plan aims to ensure sufficient land for employment purposes is available to meet both the immediate needs of the local population but also Luton's role as a sub-regional employment centre.

Linked to this are the initiatives and interventions to make Luton a more attractive place for investment through improvement in townscape, the retail offer and transportation infrastructure both within the town and in connecting the town to the wider regional and national transport networks.

This work is complemented by the forthcoming skills and employability strategy that aims to ensure the workforce will have the necessary skills to take up the jobs expected to be provided within the town and to promote a culture of continuous learning and development.

3.6.6 Priorities

1. Use the Luton Investment Framework to maintain and enhance quality employment opportunities for all Luton residents and attracting investment in Luton.
2. Increase higher educational achievements and outcomes for all children within Luton and develop a culture of continual development and learning across the town.
3. Ensure school/education leavers are equipped with the necessary skills, attributes and attitudes necessary for the transition to employment through the skills and employability strategy.

3.7 Community cohesion and cultural assets

3.7.1 Introduction

Luton is recognised as being a super-diverse community. This brings both benefits and challenges for individuals as well as the town as a whole. National surveys have found nearly 80% of people had a strong sense of belonging to their neighbourhood and 84% were satisfied with their local area as a place to live (down from 86% in 2010/11). However, the proportion who felt that people in their neighbourhood pulled together to improve it has decreased significantly, from 67% in 2011 to 62% in 2013.⁹²

Nationally the proportion of people involved in community activities at least once in the past year was 23%, yet, 68% were aware of such activities taking place in their local area.⁹²

Culture and leisure can contribute positively towards a number of health and wellbeing issues and engagement with the arts is good for health and wellbeing. Arts programmes have been shown to deliver positive results in various specific contexts, including care home residents and young offenders.⁹³

Arts and culture have demonstrable positive impacts on wellbeing, both directly and indirectly (eg through improved physical health) and help combat loneliness and social isolation, particularly among older people.⁹⁴ This is particularly true of participatory (as opposed to purely spectator) activities such as dance and crafts.^{95,96}

3.7.2 Risk factors and vulnerable groups

There is a general trend that arts participation is higher in more affluent communities⁹⁷ and low status and wealth inequalities reduce participation in civic activities and local democracy⁹⁸.

As deprivation increases, there is a fall in the number of people who agree that people from different backgrounds get on well together; and a fall in the number who agree that residents respect ethnic differences between people.⁹⁹ Strong, cohesive communities tend to have high social capital and the combination of both these factors influences health and wellbeing.

3.7.3 What is the evidence base?

Libraries, museums, theatres and art galleries deliver many benefits for local communities - promoting education and learning, creativity and personal development, and greater identification and belonging for residents within their locality. Such mainstream services are likely to play an important role in helping people socialise, meet new people, go out and engage in specific activities like art and music.¹⁰⁰

NICE has developed local authority guidance on community engagement and health.⁹² NICE recognise this is a highly complex area, however if local authorities and their partners get local communities involved in decisions about how to design or improve services this will make services more effective, cost-effective and sustainable and there will be greater uptake.

Engaging with the community can build trust in local authorities and their partners by improving accountability. It can also help develop a sense of community and encourage people to adopt more healthy attitudes and behaviours. NICE recommends:

- Prerequisites for success: invest long-term, agree levels of engagement and power and build mutual trust.
- Infrastructure to support local practice: build on the local communities’ strengths and provide training and resources and work in partnership.
- Approaches to support and increase levels of community engagement: recruit local people as agents of change, run community workshops, adopt a resident consultancy approach which draws on the skills and experiences of a wide range of individuals and groups.
- Evaluation: involve the community in the planning, design and implementation of evaluation.

3.7.4 Local picture

Many of the challenges faced by Luton have an impact on community cohesion. Luton is one of 30 ‘Prevent’ areas in the country, which recognises specific risks in the town relating to extremism and radicalisation. There have been recent critical incidents which have highlighted community tensions including English Defence League events and counter demonstrations, the death in custody of a local man, and gang-related violence.

In 2011 the Council published Building Cohesion in Luton, the Luton Commission on Community Cohesion report identifying ten recommendations for action. The Neighbourhood Governance Programme’s Residents’ Survey tells us a great deal about how people feel about their local area. The 2014 survey¹⁰¹ asked local residents a range of questions about their satisfaction as a place to live, how people from different backgrounds get on with each other, perception of safety and if they feel they can influence decisions affecting their local area.

Table 19 shows that the majority of people were satisfied in their local area, that people from different backgrounds get on well and feel safe during the day (a statistically significantly increase since 2011). However just under half felt safe in the dark and that they could influence decisions affecting their local area (a significant increase from 2011 baseline).

Table 19: Neighbourhood governance programme's residents' survey results

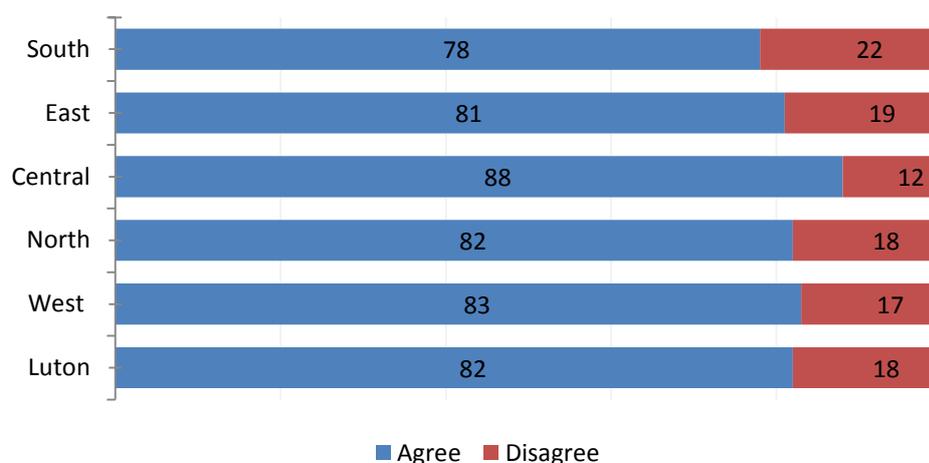
	2013 Based on 1234 responses	2014 Based on 1135 responses	Statistical significant change
% satisfied with the local area as a place to live	72%	73%	No change
% of people who believe people from	78%	82%	Increase

different backgrounds get on well together in their local area			
% of residents feeling safe outside in their local area during the day	79%	83%	Increase
% of residents feeling safe outside in their local area after dark	42%	44%	No change
% of people agreeing that they can influence decisions affecting their local area	39%	50%	Increase

(* Please note that the 2011 findings are based on data collected from the South, Central and West areas of Luton only and exclude North and East Luton. The 2012 and 2013 findings are based on all Luton wards. Statistical testing was applied to 2012, 2013 and 2014 data only.

The Survey also found (as shown in Figure 30) that residents living in Central Luton (88%) were more likely to agree that people from different backgrounds get on well together, compared to residents living in South (78%).

Figure 30: Percentage of people who believe people from different backgrounds getting on well together in their local area, 2014



*Based on 1054 respondents

3.7.5 What is being done locally?

Working with the collective resources which individuals and communities have at their disposal, Luton’s Area Boards bring people together at neighbourhood level to work with public services and allows local people to have a say in local decision-making.

Luton in Harmony is a campaign supported by the Luton Forum aimed at drawing local communities together and to draw more attention to the many positive aspects of the town and its people. The ambition is to improve community cohesion further – building on work that goes back a number of years. Key to this is to identify the protective factors that support health and wellbeing, including developing the coping abilities of individuals and communities.

The programme of Youth Ambassadors engages young people as champions for equality and diversity and there are varied programmes of activity taking place in community centres across the town. These programmes are overseen by the Community Cohesion Contingency Planning Group and Prevent Board.

There is a multi-agency approach to protect people at risk from radicalisation delivered under Prevent. The primary purpose of Prevent is to stop people becoming terrorists or supporting terrorism. Locally, there is a focus on the ongoing development of the referral process called Channel which is chaired by the local authority and is focused on safeguarding both young people and adults from being drawn into committing terrorist-related activity.

Channel uses existing collaboration between local authorities, statutory partners, the police and the local community to:

- Identify individuals at risk of being drawn into terrorism.
- Assess the nature and extent of that risk.
- Develop the most appropriate support plan for the individual concerned.

In addition to the channel panel process, the focus of work has been to improve community and institutional engagement and imbedding Prevent within safeguarding mechanisms. There is a local focus on workforce development and rollout of core training; Workshop to Raise Awareness of Prevent (WRAP3).

The principal provider of cultural services in Luton is Luton Culture. Luton Culture's vision is to open up cultural opportunities for everyone, working with partners to develop and offer welcoming spaces for people to come together to learn, play, reflect and be inspired.

Luton Culture is a registered charity comprising Luton's arts, community centres, libraries and museums. Luton Culture opened Stockwood Discovery Centre and undertook a major refurbishment of the Central Library. There has been a steady growth of its arts programme, overall visit figures for Luton Culture increased by almost 81,000, from 1,160,100 in 2007-8 (when it became a charity) to 1,240,800 in 2012-13.

There are six libraries in Luton and several library access points located within community centres, meaning that over 90% of Luton residents live within a mile of a library. Luton's libraries attract around 1 million visits a year, issuing 850,000 items and providing access to over 100 public computers. A Home Library Service for those unable to visit their local library delivers free books on a regular basis by a team of dedicated staff and volunteers. Books on Prescription is a service for people with mild to moderate mental health issues and Health Information Points are collections of books focusing on the main health priorities for Luton. Self-help health books are available in every library.

The range of museums and theatres in Luton includes:

- Stockwood Discovery Centre - tells the stories of real people behind the collections.
- Wardown Park Museum- offers a range of displays including popular Luton Life Gallery.

- The Hat Factory - Luton's leading arts and entertainment venue features live music, club nights, theatre, dance, films, children's activities, workshops, classes and gallery exhibitions.
- Luton Library Theatre offers a good selection of theatre performance for children, combination of amateur and professional, as well as a range of classical music performances.

Fifteen community centres located across the town offer a wide range of leisure, culture and learning activities, events and initiatives for local people to participate in.

The UK Centre for Carnival Arts based in Luton is a national arts charity dedicated to carnival arts, communities, learning and enterprise. The centre brings together courses, workshops, seminars, exhibitions, showcases, galas and events.

Luton has a range of cultural events that take place on an annual basis. The largest two events are Luton International Carnival and Luton Mela, which draw a combined audience of over 100,000 people. There are also a range of smaller events held within the town on key dates and celebrations such as for St Patricks Day and St George's Day.

Engagement in the arts in Luton is amongst the lowest in the UK at 35%.⁹⁷ However, in conjunction with the Arts Council England, Luton's arts strategy aims to increase Luton's arts engagement by 15%, by creating a town that nurtures, encourages and presents exceptional creativity and innovation.

3.7.6 Perspective of the public

The Luton Citizens Panel Survey 2012¹⁰² reported that 58% of residents helped out their neighbours and 22% were formal volunteers through an organisation. Those most likely to not mention any of the activities that help in the local community were people living in South Luton (9%), those living in the most deprived wards (8%) and males (6%).

3.7.7 Priorities

1. Increase participation in arts and culture through community engagement, building on the communities' strengths and diversity.
2. Work with local communities' to develop and expand community engagement in decision making building on the communities collective resources.
3. Create and enhance a sense of belonging to, and pride in, the town by all residents and businesses making visible, and valuing, the skills, knowledge, connections and potential in the community.

4 Child wellbeing

4.1.1 Introduction

The early years of life are a crucial period of change and brain development. The right kind of early support can shape an infant's life into adulthood to give them the best start in life. Events that occur during pregnancy, infancy and childhood including the quality of relationships, parenting and nurture by parents and primary carers have a lifelong impact. Those who suffer adverse experiences during their childhood, generally achieve less educationally, earn less and are less healthy, and this becomes a cycle of harm.¹⁰³

The Chief Medical Officer (CMO) Report Prevention pays – our children deserve better¹⁰⁴ states that investing in children is a certain way of improving the economic health of our nation, as well as our children's wellbeing. Having a concerted shift away from reactive spending towards early action has the potential to result in better outcomes, reduce public spending over the long term and achieve greater value for money. In short, healthy children are much more likely to become healthy adults and there is an expected return on investment of between 6-10%¹⁰⁵.

The health and wellbeing of parents pre-conception, during pregnancy and throughout their child's early years combined with their parenting ability contributes to the environment in which a child develops. Key to this is the development of a nurturing, parent-child attachment a child experiences which can strongly influence educational attainment, aspiration and opportunity and affects physical, emotional and psychological health and wellbeing throughout life.

4.1.2 What is the evidence base?

The Marmot review¹² reinforced the view that early intervention before birth is critical in improving the health of babies and their chances of leading a healthy life, stating the importance of:

- Ensuring women have adequate levels of income in pregnancy to enable them to maintain sufficient health and nutrition
- Access to a strong midwifery workforce who refer at an early stage to specialist care when appropriate whilst avoiding unnecessary intervention
- Addressing behavioural risk factors in pregnant mothers such as smoking, poor diet and substance misuse
- Intensive home visiting programmes during and after pregnancy that aim to improve the health, wellbeing and self-sufficiency of low income, first-time parents and their children.

NICE has produced guidance covering maternal and child nutrition, social and emotional wellbeing, health visiting and specific medical interventions.¹⁰⁶

Promoting and protecting child and young people's health:

The interventions required as part of a universal, integrated approach for children and families to achieve healthy child outcomes is set out in the Healthy Child Programme (HCP - pregnancy to 5 years) for the early life stages and for older children and young people in the 5-19 HCP. The 0-5 HCP

includes Health Visiting services and Family Nurse Partnerships, a targeted intensive support service for teenage parents.

Nationally, there has been a recruitment plan to increase the number of health visitors as part of the Call to Action to increase capacity and focus on health in the early years and meet the standards set out in the HCP. This is also part of the remit of Children Centres which work in partnership with health and local authority services within the community, playing a key role in supporting families to access information, health intervention and specialist services as required.

From 1 October 2015 the responsibility for commissioning public health services for children aged 0-5 and delivery of the Healthy Child Programme will transfer from NHS England (NHSE) to local authorities. Although NHSE will no longer have responsibility as lead commissioner the expectation by Department of Health (DH) is that they will continue to work closely with local authorities in an assurance role.

The benefit of this transfer is that local authorities know their local needs and what to commission to improve local health and wellbeing. The transition provides an opportunity to link the health visitor (HV) service to wider systems, housing, early years education and enable integration of services; with greater focus on prevention, early intervention and coordinating an improved universal and targeted offer to families. This transition offers considerable opportunities for improvement, not least to link up to the School Nurse Services, the commissioning responsibility for which transferred from the NHS to local authorities in April 2013 to develop an integrated pathway from 0-19 years.

This pathway also takes account of the close link between education and health¹⁰⁷, and so promoting the health and wellbeing of pupils and students within schools and colleges has the potential to improve their educational outcomes and their health and wellbeing outcomes. Five key evidence based points are:¹⁰⁸

- Pupils with better health and wellbeing are likely to achieve better academically – successfully attaining GCSEs (five or more A*-C) is strongly associated with higher levels of life satisfaction among young people.¹⁰⁹
- Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement. For example, pupils with better emotional wellbeing at age seven were a full term more advanced academically than pupils with poorer emotional wellbeing.¹¹⁰
- The culture, ethos and environment of a school influence the health and wellbeing of pupils and their readiness to learn.
- A positive association exists between academic attainment and physical activity levels of pupils.
- Schools 'maintained' by local authorities have a statutory duty to provide a broad based curriculum that meets the needs of all pupils, promotes spiritual, moral, cultural, mental and physical development of pupils at the school and prepares pupils at the school for the opportunities, responsibilities and experiences of life.

This is reinforced by the CMO report¹⁰⁴ which states “promoting physical and mental health in schools creates a virtuous circle reinforcing children’s attainment and achievement that in turn improves their wellbeing, enabling children to thrive and achieve their potential”.

Ofsted has identified a strong correlation between schools that achieved a high grade for personal, social, health and economic education (PSHE) and those that were graded outstanding for overall effectiveness.¹¹¹

Parental behaviours are the main contributory factors that determine the health and wellbeing of all children. The key priorities are set out in Section 5.

4.1.3 What is being done locally?

The prime programme is Flying Start. The aim of the 10 year programme is to make a positive and systematic change to the lives and life chances of children from conception to the age of 5 years. This will be achieved by:

- Reviewing how services are delivered, aligning services and budgets to deliver positive outcomes using current investment.
- Developing collaborative partnerships with all services delivery outcomes for children and families.
- Making a significant impact on the social and emotional development, communication and language and nutrition of our youngest children.
- Providing evidence to prove that 'getting it right' early is not only a good thing to do, but is also a smart and sustainable use of money and resources.
- Ensuring parent and community-led decision making is part of the process as this will positively and systematically change the lives and life chances of children under four in Luton for future generations.
- Focusing on, and using resources to address the key issues of pregnancy, birth, parenting and family relationships, which have a direct effect on child development and family resilience.
- Making generational change by working with teenagers in Luton schools, to develop a life-course approach to health, wellbeing, increased ambition, aspiration and preparing them for adulthood and their role as future parents.

The expected outcomes within 10 years are to have:

- Significantly more children to have age-appropriate communication skills and will interact effectively with adults and children, resulting in better educational outcomes leading to improved employment opportunities.
- More children are securely attached and emotionally resilient, with improved school readiness. In the longer term the impact of poor maternal mental health and associated risk factors on children's outcomes are reduced.
- Babies with improved birth outcomes; with fewer women obese in pregnancy, improved understanding of nutrition and healthy behaviours, breastfeeding will be increased and fewer children are obese or have dental decay, with improved health and wellbeing into adulthood.
- Within 5 years, parent and community-led decision making will positively and systematically change the lives and life chances of children from conception to 5 years and for future generations.
- By 5 years the Flying Start Executive aims to reallocate linked investment from core budgets into sustainable evidence based early intervention programmes and programmes for future parents.

Promoting the health of school aged children in Luton:

The Flying Start Strategy recognises that to affect change requires a generational impact and a focus not only on early years' children and their families but additionally the need to prepare our parents of the future, not only to promote their health and lifestyle but also to increase their resilience, their ability to learn and maximise their education opportunities. Flying Start also recognises that in 2013, the Council commissioned a review of PHSE in Luton secondary schools and identified that the subjects taught as part of that curriculum were varied, and for most schools, not reflective of need of pupils and in some areas not sufficiently quality assured.¹¹²

In response to the PSHE review, a Health in School Education programme was established in 2014 to reduce the variability in health and wellbeing interventions in schools, raising all schools to the standard of the best. This initially focused on sex and relationship education, drugs and alcohol awareness, mental health and risks associated with sexual exploitation.

School Nursing Service

School nurses are the key deliverers of the 5-19 Healthy Child Programme delivering care to school aged children and young people (4 years+ to year 13, the 19th birthday), approximately 40,000 children and young people within schools and community settings.

Working with partner organisations, services and professionals, school nurses are responsible for coordinating local services to address many of the health priorities that affect children in Luton. This includes promoting healthy weight and lifestyles, vaccine administration, supporting children with long term conditions to attend school and to manage their conditions, promoting sexual health and a key role regarding the safeguarding of children and young people.

An annual school health profile for all secondary schools and a primary school profile has been developed which aims to raise awareness and to have a shared understanding of health and wellbeing needs of school aged children across all professional groups providing services.

4.2 Maternity and early years – births

4.2.1 Local picture

In 2013 there were 3,481 live births in Luton, a decrease of 2.7% on the previous year. The number of births by ward varies. As shown in Figure 31, in 2013 Biscot, Dallow and Saints, wards with younger more ethnically diverse populations had the most births compared with less ethnically diverse wards such as Icknield, Bramingham, Stopsley and Limbury.

Figure 31: Live births in Luton (2013)

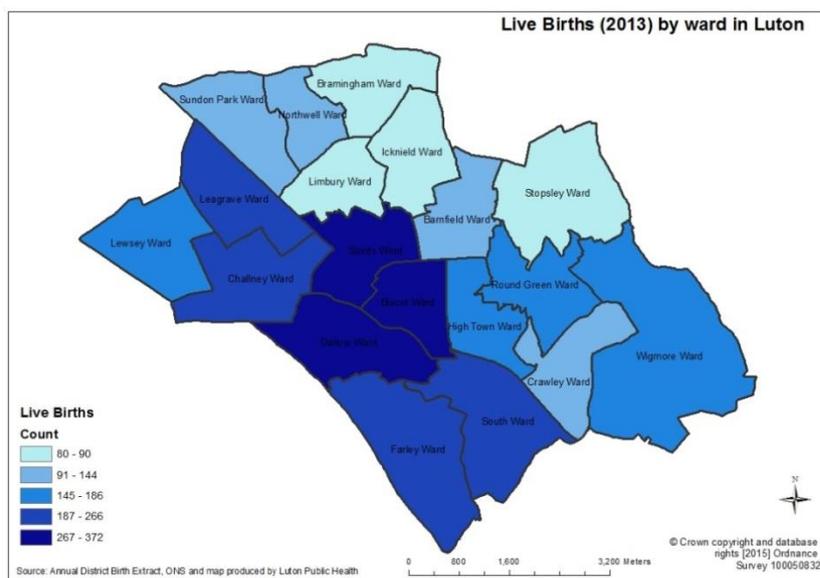


Table 20 shows key birth and fertility data for Luton compared with England and statistical neighbours. In 2013, Luton had the 6th highest general fertility rate (the number of births per 1,000 women of child bearing age) of all local authorities in England increasing from 11th highest in 2009. The wards with the highest fertility rates (per 1,000 females aged 15-44 years) are Biscot, Challney and Dallow all with estimated rates above 85 per 1,000 women. Luton has a higher than average number of children born to each woman compared with England and four of the five statistical neighbour areas.

Table 20: Live births, general and total period fertility rates, 2013

	LUTON	Bradford	Birmingham	Enfield	Slough	England
Number of Live births	3,481	8,039	17,421	4,908	2,601	664,517
General Fertility Rate	76.5	75.1	71.2	69.5	78.7	62.4

Source: ONS

Ethnicity

Ethnicity data is not available in the birth records, and using country of birth of the mother as a crude proxy[§] shows the highest birth rates in Luton are amongst mothers born in Pakistan and Bangladesh with an estimated general fertility rate more than twice that of English born mothers (57.8 per 1000 15-44 year olds). There are also higher estimated rates in mothers born in India, African countries and Eastern Europe compared with English born mothers. Using ethnicity from hospital records for 2011 to 2014 (therefore only including hospital births) shows a similar picture with fertility rates highest in births to mothers of Pakistani ethnicity (79.4 per 1,000), Other White (67.7 per 1,000) and Bangladeshi (65.5 per 1,000) compared with 35.6 per 1,000 in White British mothers.

Low birth weight of term babies (born after 37 weeks gestation)

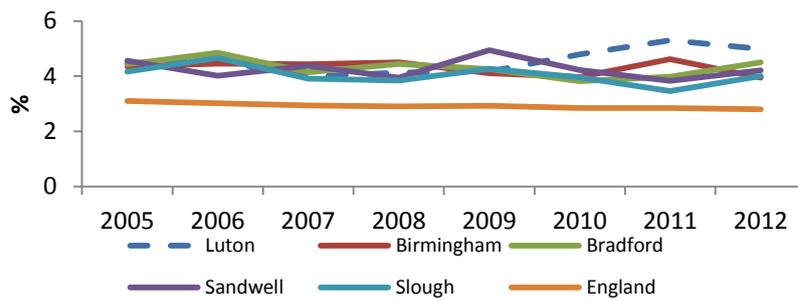
Low birth weight at term is defined as a weight below 2,500g of babies born at 37+ week gestation. Low birth weight is an indicator of population health; low birth weight increases the risk of childhood deaths and disease, developmental problems for the child, and is associated with poorer health in adult life. It is important to distinguish between babies who are born pre-term and have a birth-weight commensurate with their gestational age and babies born at term who are small as a consequence of intra-uterine growth retardation (IUGR). There are a number of variables that can contribute to birth weight:

- Ethnicity - there is strong evidence that south Asian women often give birth to babies with a lower birth-weight.¹¹³
- Age of the mother - younger mothers may have smaller babies.
- Lifestyle of the mother- high BMI, smoking in pregnancy, misuse of alcohol and drugs can often lead to infants with a lower birth-weight.

[§] Using country of birth and estimated female population aged 15-44 based on Luton wide figures.

There is increasing evidence that recognises that some babies born with a weight below 2,500g are a healthy weight when the physical characteristics of their mother are factored in. The West Midlands Perinatal Institute has developed the GROW (Gestation Related Optimal Weight) project to monitor intra-uterine growth. In 2012, 5% of all babies (163) in Luton (a slight decrease from 5.3% in 2011) were born with a low birth weight. This is the second highest proportion of any area in England, consequently a rate significantly higher than England (2.8%).¹ Rates have been consistently declining since 2005 in England (10% decrease) and rates for comparator areas are below that of Luton. Since 2007 there has been a 25% increase in babies born with a low birth weight in Luton (Figure 32).

Figure 32: Low birth weight of term babies, 2005-2012



Source: Public Health Outcomes Framework and Luton PHI

4.3 Maternity and early years - infant deaths

4.3.1 Introduction

Every child deserves a healthy start in life; however, for a number of reasons, some preventable, a very small number of infants under the age of one year die. Infant mortality is an indicator of overall population health and refers to the death of a baby before his or her first birthday, excluding stillbirths (the number of infants born without any sign of life after 24 weeks gestation).

Many, although not all, of these deaths are potentially preventable. The key associated indicators that contribute to the overall picture of infant mortality are:

- Perinatal mortality rate: the number of deaths (including still births) per 1,000 births up to the age of 7 days
- Neonatal mortality rate: the number of deaths per 1,000 live births within 28 days of birth
- Low birth weight of term babies: a birth weight of less than 2,500g after 37 weeks gestation.

Nationally, Sudden Infant Death Syndrome (SIDS) is the most common single cause of death in infants under one year. SIDS is the term used to describe a sudden and unexpected death of a child that is initially unexplained; it is the cause of death attributed to over 200 babies each year in the UK.

The national SIDS rate is 0.48 per 1000 live births (2013). National data¹¹⁴ shows that:

- 90% of these deaths occur in the first six months of life
- Over two-thirds of cases are male children
- The risk is three times greater for babies born with a low birth-weight
- 70% of infants who die are found in the same bed as their parent(s).

4.3.2 Risk factors and vulnerable groups

Biological factors such as birthweight, mother's age and parity (number of previous children) are key determinants of infant mortality. Infant mortality rates (IMRs) vary with social factors such as mother's country of birth and the socioeconomic position of the family (derived from the occupation of the father given at the registration of the birth)¹¹⁵.

Other risk factors include:¹⁰⁴ smoking in pregnancy, alcohol consumption, diet (under-nutrition), obesity, illicit drug use, mental illness, psychosocial stress, domestic abuse, poor housing, academic achievement and employment status.

Risk factors for sudden infant death syndrome/sudden unexpected deaths in infancy (SIDS/SUDI), include exposure to environmental tobacco smoke, non-supine sleeping position, unsafe sleeping environment, eg bed-sharing and co-sleeping (particularly if parents smoke, have been drinking alcohol or have taken drugs).

The safest place for a baby to sleep for the first six months of their life is in a cot in their parents' room.¹¹⁶ Bed-sharing and especially co-sleeping are considered the biggest risk of SIDS, however over 50% of all mothers bed share at least once in the first six months of their Baby's life. Whilst bed

sharing is likely to facilitate ease of breastfeeding, there are considerable risks associated with co-sleeping that professionals must discuss with all new parents.

Other risk factors include late booking for antenatal care and consequently a lack of access to early screening services, low birth weight (below 2,500g) particularly of term infants, gestational diabetes in pregnancy, pre-existing maternal morbidity including diabetes and high blood pressure and maternal mental health disorders during pregnancy and the post-natal period.^{117,118}

4.3.3 What is the evidence base?

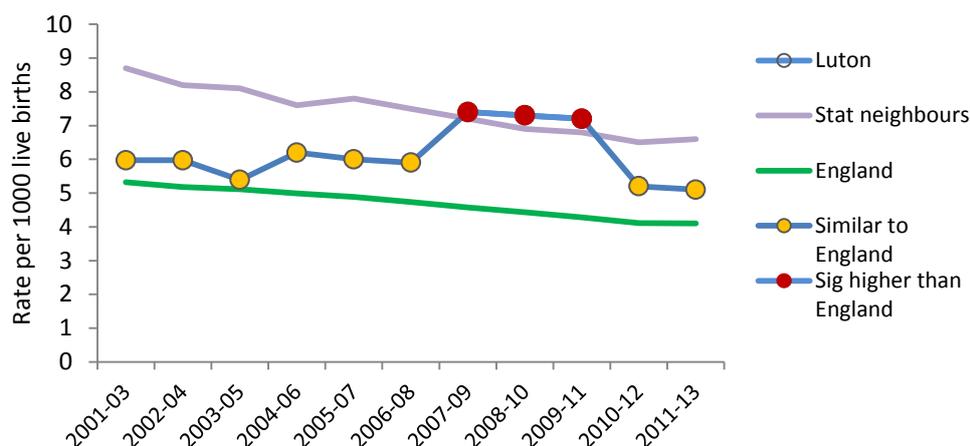
The DH identified key actions to help reduce health inequalities in infant mortality.^{119,120}

- Promote the importance of accessing maternity services before the 13th week of pregnancy; late bookings increase the risk of poor outcomes for the infant.
- Reduce prevalence of maternal obesity through the use of evidence-based behaviour change techniques that include providing brief advice, information and support on diet and physical activity pre-conceptually and during pregnancy, as well as offering community-based opportunities for recreation and weight management interventions.
- Reduce maternal smoking through the provision of stop smoking interventions in pregnancy. This can include staff in maternity services and universal children's services providing brief advice as part of routine contact with pregnant women and signposting women who need more intense one-to-one support to stop smoking services.
- Reduce teenage pregnancy and improve support and care for teenage parents and their babies by providing high quality sex and relationship education and accessible contraceptive and sexual health services.
- Identify women with a history of mental health problems or alcohol and substance misuse problems early in the pregnancy and ensure additional support and coordination with other clinical services during pregnancy and through infancy.

4.3.4 Local picture

The infant mortality rate (IMR) is defined as the number of deaths of children under the age of one year per 1,000 live births. The rate in Luton is decreasing but remains higher than the national rate. There is a similar picture for each of the associated indicators. The IMR for Luton has reduced from 7.4 in 2007-09 to 5.2 in 2010-12 and provisional data for 2011-13 shows a further decrease. Luton now has the lowest IMR amongst its statistical neighbours and the gap between Luton and the England rate (4.1) is closing. This rate is the lowest between 2001-03 and 2011-13.

Figure 33: Infant mortality rate 2001/03 - 2011/13



Identifying ward areas with high rates of infant mortality is a challenge due to the small number of deaths in each area.^h Using pooled data for the five year period 2009-2013 we know that although the wards with the highest IMR are Northwell and Farley, the highest numbers are in Biscot and Dallow.

Risk factors for infant deaths in Luton:

Sudden infant deaths: Child Death Overview Panel (CDOP) data identified 15 cases of SIDS in Luton between April 2008 and March 2014.

Modifiable factors were identified in 90% of these cases, with 43% having more than one modifiable factor. These factors include parental smoking, prematurity and a raised room temperature. The main modifiable risk factor was safe sleeping; 80% of the cases in Luton the infant was not in a cot sleeping on their back when found. Of these cases there was only one where the infant was being breastfed which has a protective impact and reduces the risk of SIDS.

Genetic risk: an important risk of increased infant mortality exists for children born to families, particularly of South Asian families who are disproportionately affected by life-limiting illnesses (LLI) and disabilities, notably as a result of hereditary (genetic) conditions often associated with marriage within the extended family, consanguinity. Between 2009 and 2013, the Child Death Overview Panel found 36% of child deaths in Luton were as a result of genetic conditions associated with cousin marriage.

In Luton there is a high level of child disability, particularly children with complex needs (see children with disability section). Although some of these children die before their first birthday, many survive into later child and young adulthood supported by comprehensive care packages. High levels of child disability and LLI affect not only the quality of life for the child and family, but add to family economic disadvantage. Meeting the care needs of these children has a considerable impact on

^h There should be at least 20 in the numerator (infant deaths) to calculate a rate that is stable. Numbers are smaller when broken down to ward areas, despite pooling five years' data. This means that any rates calculated are unstable and small numerator changes will lead to large changes in the rate.

local health and social care services. For more information see Luton's Children with Disabilities Needs Assessment.^a

4.3.5 What is being done locally?

There are a number of interventions being delivered in response to local intelligence that are contributing to the year, on, year reduction and aiming to improve health in pregnancy and childhood.

Other actions being taken are:

- Addressing Low Birth Weight: The Luton and Dunstable Hospital which provides care for the majority of babies born in Luton have introduced the GROW project, as with other hospitals across the East of England. This is a stillbirth reduction tool that identifies the healthy growth of an infant based on the maternal physical characteristics
- A specialist public health midwife has been funded to work with maternity staff and partner organisations to educate staff in areas that improve health and reduce risk including safe infant sleeping to reduce the risk of sudden infant death, reducing smoking during pregnancy and maternal obesity and increasing breastfeeding rates and to identify ways to more effectively engage pregnant women to promote a healthy pregnancy.
- Targeted support for women to quit smoking during pregnancy and the development of a healthy weight pathway for pregnant women
- The council has revised the Infant Mortality Plan to include genetic risk which local data showed significantly contributed to infant and child deaths in Luton. Community engagement with the Luton Pakistani and Kashmiri community was commissioned to explore community views of cousin marriage; the key findings from this consultation are being used to inform local service planning.
- In anticipation of the commissioning transition of 0-5 services to local authority, the subsequent join up with 5-19 services, the recommendations from the Children Centres Review taking place in 2015, and in line with Better Together, to develop an integrated family based 'Early Help Hub' for children aged 0-19 that supports all children, young people and their families to have the best start in life, to maximise ability and opportunity and prepare young people to be ambitious and resilient young adults.

4.3.6 Priorities

1. Improve coordination of early years' provision under Flying Start to ensure there is an evidenced based core offer to reduce the modifiable risk factors as part of contract arrangements.
2. Ensure the delivery of the Child death Overview Panel plan and continue to monitor and reduce modifiable risk factors in SIDS
3. Continue to reduce the proportion of women who smoke during pregnancy through targeted stop smoking support, and reduce the proportion of women who are overweight or obese during pregnancy by implementing the healthy weight in pregnancy pathway and its interventions.

5 Early years - parental behaviours

5.1 Breastfeeding and vitamins

5.1.1 Introduction

Breastfeeding is a priority for improving children's health, and research continues to emphasise the importance of breast milk as the best nourishment for babies aged up to six months. Breastfeeding has been shown to have benefits for mother and baby including promoting emotional attachment between them. Breastfed babies have a reduced risk of respiratory infections, gastroenteritis, glue ear and ear infections, allergic disease and Sudden Infant Death Syndrome (SIDS) and breastfed children have better neurological development and are at lower risk of tooth decay and cardiovascular disease in later life. Women who breastfeed are at lower risk of breast cancer, ovarian cancer, hip fractures/reduced bone density¹²¹ and obesity post birth.

5.1.2 At risk and vulnerable groups

Women who are less likely to breastfeed are those from lower socioeconomic groups, teenage parents or who have left full-time education at an early age. Women from black and minority ethnic groups are more likely to initiate breastfeeding, but not to exclusively breastfeed for a period of six months¹²² which is UK policy.¹²³

5.1.3 What is the evidence base?

UNICEF Baby Friendly Initiative is the 'gold standard' approach to improving breastfeeding rates. Evidence suggests that mothers receiving care in baby friendly accredited hospitals and community services are more likely to initiate and continue breastfeeding.¹²⁴

NICE guidance recommends easily accessible breastfeeding peer support programmes, where peer supporters are part of a multidisciplinary team and seen as an information provider, educator and listening resource.¹²⁵ Specifically training health visitors in breastfeeding support has been shown to be effective in improving breastfeeding rates.¹²¹

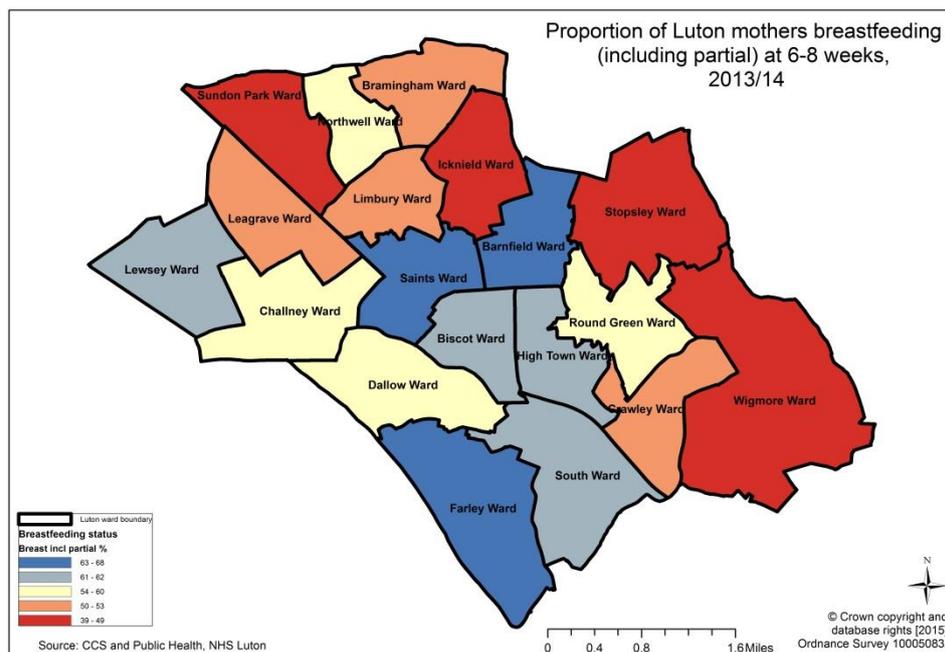
Providing direct support to mothers, babies and families in hospitals, GP settings and through home visits, the health services and partners should work closely with and through children's centres. Facilities should be made available to the public for breastfeeding in all NHS and Council premises that deliver services to the public, and relevant Council directorates should encourage the inclusion and development of baby friendly facilities. Education and social care partners, schools and colleges and the wider community, including business and the third sector, should also be engaged in efforts to raise awareness, change attitudes and develop innovative services.

Breastfeeding is one of the six early years high impact areas from the DH and Local Government Association.¹²¹ Guidance suggests that health visitors should be responsible for ensuring a whole system approach to promoting breastfeeding by implementing the UNICEF Baby Friendly Standards and supporting other settings such as children's centres to become baby friendly. This includes training early years staff in breastfeeding support as this has been shown to be effective in improving breastfeeding rates.

5.1.4 Local picture

Breastfeeding initiation rates in 2013/14 show that over three quarters of women (76%) initiated breastfeeding with 56% still fully or partially breastfeeding 6-8 weeks post-delivery, of which 34% were fully breastfeeding and 21.9% mixed feeding. The highest prevalence of breastfeeding is in Barnfield ward with 68% of mothers breastfeeding (including partial), significantly higher than the Luton average. The lowest prevalence can be seen in Icknield, Stopsley, Sundon Park, and Wigmore all with fewer than 50% of mother's breastfeeding. Sundon Park (39%) and Wigmore (49%) are both significantly lower than the Luton average of 56% (Figure 34).

Figure 34: Breastfeeding prevalence at 6-8 weeks, 2013/14



5.1.5 What is being locally to address this issue?

Luton has taken proactive action to promote breastfeeding. There is a breastfeeding and infant feeding service which aims to increase initiation and sustained feeding through one-to-one contact with new mothers and provides education to early years services to create community capacity. Breastfeeding cafes where mothers can access professional and peer support have also been established.

Healthy start vitamins

The aim of the national Healthy Start vitamin programme is to ensure that families on low incomes get access to vitamins that supplement their diet to optimise child development to pregnant and breastfeeding women and children in families who receive certain benefits. The aim is to bring the health of the poorest up to the standard of their classmates from better-off backgrounds. Vitamins include A, C and D – all critical for growth, vision, healthy skin and strong bones and reduces the number of cases of rickets and vitamin D deficiency problems. Vitamin D deficiency is particularly common in people who originate from Black and Asian communities.

Nationally low numbers of eligible families take up the offer of vitamin D for their children. Increasing uptake is important for healthy child development. All children centres in Luton have vitamins available for families who are eligible for the free scheme and for non-eligible families to purchase at low cost.

5.1.6 Priorities

1. Increase breastfeeding in women through education and promoting the normality of breastfeeding, supporting initiation and access to support in hospital and the community to maintain feeding.
2. Increase uptake of healthy start vitamins especially for families eligible for the free scheme; this will be through maternity, early years professionals and children centres promoting awareness of the scheme and increasing access to vitamins.

5.2 Smoking in pregnancy:

5.2.1 Introduction

There is strong evidence regarding the adverse effects of smoking during pregnancy and the harm it causes the mother and the baby, particularly their growth and development.¹²⁶ Women who smoke are more likely to have complications during pregnancy and during delivery, including bleeding during pregnancy, placental abruption and premature rupture of membranes.

Babies born to mothers who smoke tend to be smaller, are at increased risk of pre-term birth and are around 40% more likely to die within the first four weeks of life compared with babies born to women who are non-smokers.^{127,128} Pregnancy is a pivotal motivational stage for women to adopt a healthier lifestyle and encouraging women to stop smoking during pregnancy increases the likelihood of a permanent quit.¹²⁹

5.2.2 Risk factors and vulnerable groups

Smoking in pregnancy is much higher among younger women and those affected by social deprivation.¹²⁶ Women in low paid jobs are three times more likely to smoke during pregnancy than professional women.¹³⁰

5.2.3 What is the evidence base?

NICE has produced a range of guidance to reduce smoking in pregnancy and recommend that all pregnant women who smoke and all those who are planning a pregnancy or who have an infant aged under 12 months should be referred for help to quit smoking.¹³¹

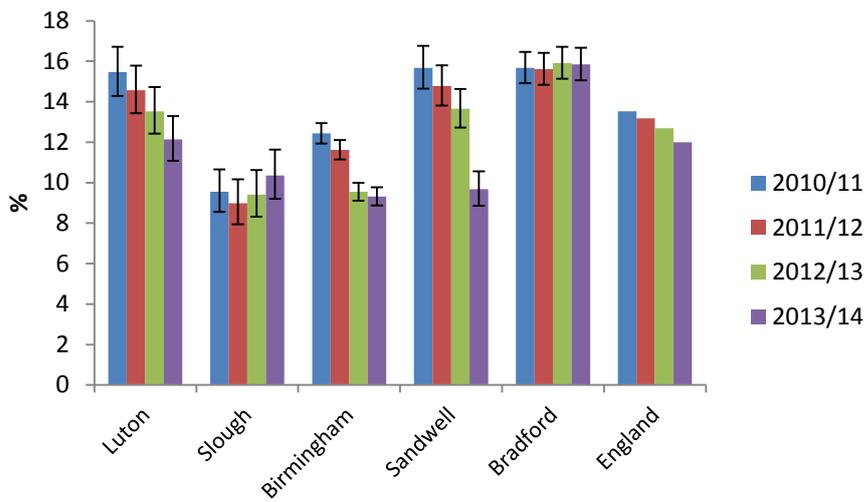
NICE also recommends that secondary care has responsibility to ensure:¹³²

- Strong leadership and management to ensure premises remain smoke free
- All hospitals have an on-site stop smoking service.
- Identifying people who smoke, offering advice and support to stop.
- Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care.
- Integrating stop smoking support in secondary care with support provided by community-based services.
- Ensuring staff are trained to support people to stop smoking while using secondary care services.
- Supporting staff to stop smoking or to abstain while at work.
- Ensuring there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

5.2.4 Local picture

The 2013/14 rate of smoking at time of delivery in Luton (12.1%) was similar to the national average (12%), Slough and Bradford but significantly higher than Birmingham and Sandwell. In Luton smoking in pregnancy rates have been reducing at a faster rate than seen nationally and therefore reducing inequalities (Figure 35). There has been a 22% decrease since 2010/11 in Luton compared with an 11% decrease seen nationally.

Figure 35: Smoking at time of delivery, 2010/11 to 2013/14



Source: PHOF

For further information on what is happening locally and local priorities please see the Tobacco Chapter (Section 9.7).

5.3 Healthy weight management in pregnancy:

5.3.1 Introduction

Obesity in pregnancy carries significant risks and it has been identified that over half the women who died either directly or indirectly from pregnancy-related causes were overweight or obese¹³³. Babies born to obese women face several health risks including a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, large for gestational age babies and subsequent obesity¹³⁴. The UK prevalence rate of maternal obesity (having a BMI ≥ 35 at any time during pregnancy) is around 5% and there has been a general trend of increasing prevalence of obesity amongst pregnant women presenting to hospital for maternity booking¹³⁵.

Reducing maternal obesity either through promoting healthy weight management during pregnancy or ideally preventing obesity throughout childhood and adolescence and throughout the pre-conception years should be a priority.¹³⁶

5.3.2 Risk factors and vulnerable groups

There is also clear evidence associating lower socio-economic status with the likelihood of children and adults being overweight or obese¹³⁷. Similarly, maternal obesity is related to socioeconomic deprivation, inequalities within minority ethnic groups and poor access to maternity services.

A pregnant woman who is obese is more likely to have an induced or longer labour, instrumental delivery, caesarean section or postpartum haemorrhage¹³⁸. Women who are obese may also experience reduced choices about where and how they give birth. In addition, they are more likely to spend longer in hospital because of weight-related morbidity compared with those with a healthy weight¹³⁹. Obese women are more likely to have preterm birth which consequently increases the risk of complications to health and infant mortality.

5.3.3 What is the evidence base?

Healthy eating which for some women may lead to healthy weight loss during pregnancy is recommended for all pregnant women who are obese. The period before, during and after pregnancy provides an opportunity to give women practical advice to help them to eat healthily, become more physically active and to help them manage their weight effectively¹⁴⁰.

NICE recommends that weight management interventions should be commissioned that impact on all women of childbearing age, because up to 50% of pregnancies are likely to be unplanned. All women of childbearing age need to be aware of the importance of a healthy diet and physical activity and be encouraged to achieve a healthy weight before they become pregnant.¹⁴⁰

NICE public health guidance PH27 recommends that all pregnant women are weighed and have their BMI calculated and recorded by a healthcare professional and that pregnant women with a BMI of 30 kg/m² or more are offered a referral to a dietitian or appropriately trained health professional. After pregnancy, it is recommended that women with a BMI of 30 kg/m² or more are offered a structured weight-loss support programme or if more appropriate, a referral to a dietitian or an appropriately trained health professional.¹⁴¹

5.3.4 What is being done locally?

Slimming World intervention for pregnant women

Pregnant women in Luton with a body mass index (BMI) of 30, or 28 if they have any co-morbidity, can be referred by their midwife to Slimming World, which offers a specific healthy weight

management programme for pregnant women. Since September 2013, 28 Luton women have completed the full 36 week programme.

Uptake of the programme is low compared with need. A new (April 2015) public health midwife role embed this referral pathway into maternity care and ensure that many more eligible pregnant women who meet the BMI threshold recognise the importance of healthy weight management in pregnancy and access the service.

Recruiting a Public Health Specialist Midwife

Improving infant health outcomes needs to commence at conception and therefore maternity services are in a pivotal position to ensure that healthy lifestyles and education for pregnant women is given and reinforced at every opportunity to support expectant and new parents to make healthy decisions that will impact on the healthy development of their child.

A specialist public health midwife has been funded to work with maternity staff and partner organisations to educate staff to achieve these outcomes notably focussing on: safe sleeping, smoking during pregnancy and increasing breastfeeding, healthy weight management and improving maternal mental health.

5.3.5 Priorities

1. Review current practice against NICE guidance and improve data collection, collation and analysis.
2. Develop a healthy weight pathway for pregnant women to increase usage of current commissioned services.

6 Early years, children and young people:

6.1 Maternal mental health:

6.1.1 Introduction

Maternal mental ill-health has a long-term effect on maternal wellbeing, family relationships and the mental health, social adjustment and attachment of the child during the first critical years of life, therefore prevention, early diagnosis and intervention is vital.¹⁴²

The mental health of the mother has a significant effect on the health of her children during pregnancy but also throughout the child's life with a significant influence on foetal and early brain development.¹² Poverty and low socioeconomic status are associated with poor psychological and physical health when women come to pregnancy and are determinants of pregnancy outcome bringing about social disparities in pregnancy.^{143,144} Mental health problems in pregnancy and the postnatal period are associated with adverse outcomes for the foetus and the baby as well as for the woman herself; for example, severe depression is associated with an increased risk of lower birthweight and premature babies, particularly for families affected by socioeconomic deprivation, self-harm and suicide.¹⁴² Perinatal mental illness is complex and covers a range of conditions of varying severity including post-partum psychosis, mental ill-health and depression, perinatal obsessive compulsive disorders and anxiety.

There is emerging evidence that untreated mental health problems in pregnancy may be associated with poorer long-term outcomes for children beyond the immediate postnatal period; for example, depression in pregnancy has been associated with internalising and externalising disorders in the children and depression in adolescents and young adults; and anxiety in pregnancy is associated with an increased risk of internalising problems and emotional and behavioural difficulties in children.¹⁴² Therefore tackling mental health issues is essential.

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; some women may experience both. Depression and anxiety can also affect around 15-20% of women in the first year after childbirth. Anxiety disorders including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth) can occur on their own or coexist with depression.

In addition, psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects about 1 in 1,000 women who have given birth. Women with bipolar (type) I disorder are at particular risk, but postpartum psychosis may also affect women with no previous psychiatric history.

Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher. Low birthweight has been associated with maternal history of anorexia nervosa and women with binge eating disorder have an elevated risk of babies that are large for gestational age, and worse foetal and infant outcomes are reported for drug and alcohol-use disorders.¹⁴²

6.1.2 Risk factors and vulnerable groups

The causes of mental ill-health during pregnancy and following childbirth are not well understood. Some factors known to increase risk are:

- Individual or family history of mental ill-health.
- Being a lone parent or within a poorly functioning couple relationship.
- Low social support and social capital.
- Experience of a recent adverse life event.
- Socioeconomic disadvantage.
- Being a teenage parent.
- Early emotional trauma or abuse.
- Unwanted pregnancy.

Ethnicity and social isolation play an important role in mental ill-health risk. However, there are fewer than expected women from BME groups diagnosed and treated for perinatal mental ill-health despite high levels of morbidity and social risk factors.¹⁴²

6.1.3 What is the evidence base

The NICE clinical guidelines make recommendations for the recognition, assessment, care and treatment of mental health disorders in women during pregnancy and the postnatal period (up to one year after delivery). It includes advice on the care of women with an existing mental health disorder who are planning a pregnancy, and on the organisation of mental health services.

It recommends that a Clinical Network should be established for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers.¹⁴²

The NICE quality statement on postnatal care recommends that women who have transient psychological symptoms (baby blues) not resolved at 10–14 days after the birth should be assessed for mental health problems.¹⁴⁵

The Department of Health and Local Government Association have produced six early years high impact areas, one of which is maternal (perinatal) mental health.¹⁴⁶ The guide suggests that close working with midwives is essential to share risk factors identified during pregnancy eg. by midwives with health visitors. Additionally, health visitors contribute to awareness-raising, education and training of the wider early years' workforce and working with early years' professionals in children's centres. The health visitor is well placed to lead the implementation and delivery of group-based postnatal support and other preventive or early interventions to promote mental health, such as promoting physical activity, peer support groups and fathers' groups. They also provide information on issues that impact on mental health and wellbeing such as welfare benefits.

6.1.4 Local picture

A perinatal mental health needs assessment was completed in 2014 and aimed to understand the estimated need in Luton for women affected by mental ill-health, the current level of service provision and to identify any gaps in prevention, early intervention and treatment provision.¹¹⁷

The assessment found a high proportion of women with risks that contribute to perinatal mental health. Based on estimates, in Luton:

- 4% of mothers who give birth (approximately 140 women) will require advice and support from a specialist perinatal mental health service, resulting in roughly 14 women admitted to a specialist mother and baby unit.
- 8% (280 women) will require and accept referral for psychological therapies.
- 8% (280 women) will experience mental ill-health but will not require, or do not accept, the offer of, treatment.

The assessment found a lack of local data regarding the number of women diagnosed with perinatal mental illness, although it recognised that this was a local and a national issue. Current information databases capture information regarding 'at risk' rather than capturing data regarding diagnosis and severity of illness. The main data source was Luton & Dunstable Hospital midwifery data, cause for concern. Over a 24 month period (2011-13), 15% of women giving birth were identified in this category, with 9% (over a 6 month period) having antenatal mental ill-health and 4.5% having mental ill-health in the post-natal period.

The needs assessment identified that White British women have the highest percentage of diagnosed perinatal mental ill-health, significantly higher than the Luton average and women classified as Indian, other White, Bangladeshi and Pakistani communities, which were significantly lower. Based on estimates, this suggests that ethnic groups are under-represented which may indicate that women in these groups either do not have perinatal mental health need or are not presenting with it to health services and this would indicate undiagnosed and unmet health need.

6.1.5 What is being done locally?

The needs assessment recognised that whilst there are a number of services available to support and treat women with perinatal mental ill-health, there is a gap in knowledge and awareness of these services which suggests that some women are not diagnosed and getting the interventions they require. Recommendations from the needs assessment are being picked up through the Flying Start programme.

6.1.6 Priorities

1. To fully implement the recommendations from the perinatal mental health needs assessment through the Flying Start programme and CCG commissioning. Specifically to:
 - Improve data collection and analysis.
 - Develop a strategy and care pathway that health and social care professionals will use to refer appropriately.
 - Monitor the quality and impact of services through commissioning and performance management of outcomes.
 - Educate staff to recognise signs and symptoms, thresholds for referral and which services to refer women to.
2. In the transition of health visiting to the local authority ensure the service specification includes the high impact action to improve outcomes in maternal mental health.

6.2 Child accident prevention

6.2.1 Introduction

Unintentional injuries in and around the home are a leading cause of preventable death for children under 5 years and a major cause of injury and serious disability.¹⁴⁷ Every year in England approximately 60 children and young people die, 450,000 attend AandE and 40,000 are admitted to hospital as an emergency as a result of an accident.¹⁴⁸

6.2.2 Risk factors and vulnerable groups

There is a persistent social gradient for child unintentional injuries, and inequalities have widened in recent years. Emergency hospital admission rates for unintentional injuries amongst the under-fives are 45% higher for children in the most deprived areas compared with children from the least deprived.¹⁴⁸ Boys are at a greater risk of all types of injury, ranging from minor to fatal, within the first 5 years of life.¹⁴⁹

6.2.3 What is the evidence base?

NICE produced three pieces of guidance on how to prevent unintentional injuries among under-15s;

- Strategies to prevent unintentional injuries among the under 15s.¹⁵⁰
- Unintentional injuries on the road.¹⁵¹
- Provision of home safety equipment and home risk assessments.¹⁵²

Public Health England has produced guidance on what works to prevent unintentional injuries which includes:¹⁴⁸

- Targeting deprived families and communities.
- Training early years' workforce.
- Focussing on priority areas: choking, suffocation and strangulation, falls, poisoning, burns and scalds and drowning.

Health visitors and children centres are a trusted source of knowledge, advice and information for parents and are often the first point of contact for parents who are unsure on the best course of action when their child is unwell. As such they play an important role in the primary care team and can help to reduce the burden on busy GP surgeries and AandE departments.

Health visitors are able to provide help and support to new parents on a range of common minor childhood illness such as fever, cough and colds, vomiting and diarrhoea, building parental confidence and knowledge on self-management and when to seek help.¹⁴⁷

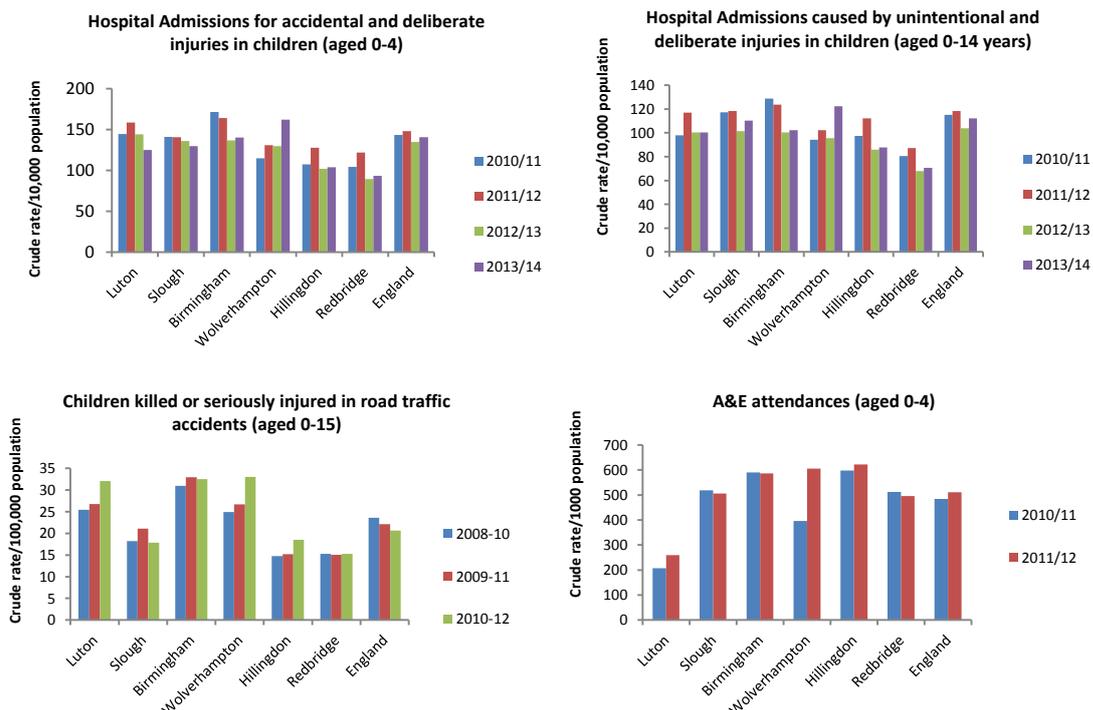
6.2.4 Local picture

Hospital admissions for accidental and deliberate injuries in children aged 0-4 years in Luton has gone down from 159 per 10,000 populations in 2011/12 to 125 per 10,000 in 2013/14 while admissions caused by unintentional and deliberate injuries in children aged (0-14 years) is fairly steady as shown in Figure 36 and and Figure 37.

The number of children aged 0-15 killed or seriously injured in road accident in Luton has increased from 25 per 100,000 in 2010 to 32 per 100,000 in 2012 (Figure 38). Also AandE attendances among children aged 0-4 went up from 206 per 1,000 population in 2011 to 259 attendances per 1,000 populations in 2012, but remains below the national average and statistical neighbour averages.

Figure 36: Hospital admissions for accidental and deliberate injuries and Figure 37: Hospital admissions caused by unintentional and deliberate injuries

Figure 38: Children killed or seriously injured in road traffic accidents and Figure 39: AandE attendances



Source: Public Health England (PHE). Available from: <http://fingertips.phe.org.uk/profile/cyphof/data#gid/8000025/pat/6/ati/102/page/0/par/E12000006/are/E06000032/iid/90809/age/28/sex/4>

6.2.5 What is being done locally?

Luton ‘Safe at Home’ is a child accident prevention programme delivered through a local multi-agency partnership, Luton Child Injury Prevention Group, led by the Pre-School Learning Alliance, the Council and Bedfordshire Fire and Rescue, and supported by local and national child accident specialists, Kid Rapt and RoSPA, the NHS and Bedfordshire Police.

The scheme provides an assessment service delivered by staff trained to identify accident risks in the home, educate families and provide safety equipment free to eligible families. This is installed by Bedfordshire Fire and Rescue service who as part of the programme fit smoke detectors and CO² monitors. In addition, the scheme aims to raise awareness of nationally identified risks in the home, for example, choking from nappy sacks, ingestion of button cell batteries, E-cigarette refills, infant safe sleeping and accidental strangulation from blind cords, and every three months focuses on a local risk issue. An annual child safety event linking to CAPT (Child Accident Prevention Trust) Child Safety Week is run in June. The scheme has recently been reviewed by RoSPA and is an exemplar of

good practice and has been incorporated into the Early Years Flying Start Strategy in addition to which is one of the health visiting six high impact areas for development. The number of families accessing the scheme has increased year-on-year and in 2014/15, 730 families were assessed through the scheme.

6.2.6 Priorities

1. Review the impact of the current accident prevention scheme across Luton and link to the Better Together programme outcomes.

6.3 Oral health in children

6.3.1 Introduction

Good oral health is an important part of general health, contributes to wellbeing and allows people to eat, speak and socialise without discomfort or embarrassment. Oral diseases are among the most common chronic diseases in the United Kingdom, and levels in Luton are relatively high. Oral diseases can have serious consequences. Poor oral health can result in disruption to an individual's life by contributing to loss of sleep, time off work and school, loss of self-esteem and limited food choices.¹⁵³

While children's oral health has improved over the past twenty years, 28% of five-year olds still had tooth decay in 2012.

Many factors influence poor oral health including:

- Poor diet and nutrition, particularly the frequent consumption of sugary foods and drinks
- Using formula feeds rather than breast feeding young infants
- Lack of oral hygiene and tooth brushing
- Low exposure to fluoride therapies including using toothpastes with low fluoride concentrationsⁱ
- Trauma or injury to teeth.

The implications of poor dental health in young infants include malformation and discolouration of the underlying permanent teeth which can require multiple extractions under general anaesthetic (GA). This can be a traumatic experience, particularly if this is the child's first experience of dentistry.

6.3.2 At risk and vulnerable groups

There is a strong association between oral diseases and deprivation¹⁵⁴ and results of the three-year-olds oral health survey show that inequalities in oral health start from a very early age¹⁵⁵.

6.3.3 What is the evidence base?

Effective disease prevention and oral health promotion should have both generic and specific elements. Helping children and their families to develop good dental habits at a young age can help maintain healthy teeth for life. Children should be encouraged to eat healthy food and drink water. Sweet snacks and drinks should be kept to a minimum. A diet high in sugary food and drink can also cause obesity and long term health problems so reducing sugar in the diet at the earliest opportunity has multiple health benefits¹⁵⁶.

Children should be supervised when brushing their teeth and should start as soon as teeth are seen in the mouth. Regular dental check-ups are important to identify any oral health concerns and to ensure families receive oral health advice or interventions as required.

ⁱ Recommendations are 1000ppm fluoride concentration of toothpaste for children < 3 years old, and 1350-1500ppm fluoride concentration of toothpaste for older children

Advice for the prevention of caries (tooth decay and cavities) in children includes:

- Brush twice daily with fluoridated toothpaste (1,350 ppm fluoride or above); brush last thing at night and on one other occasion during the day
- Spit out after brushing and do not rinse
- Reduce the frequency and amount of sugary food and drinks and when consumed, limit these foods and drinks to mealtimes. Sugars should not be consumed more than four times per day
- Sugar-free medicines should be recommended.

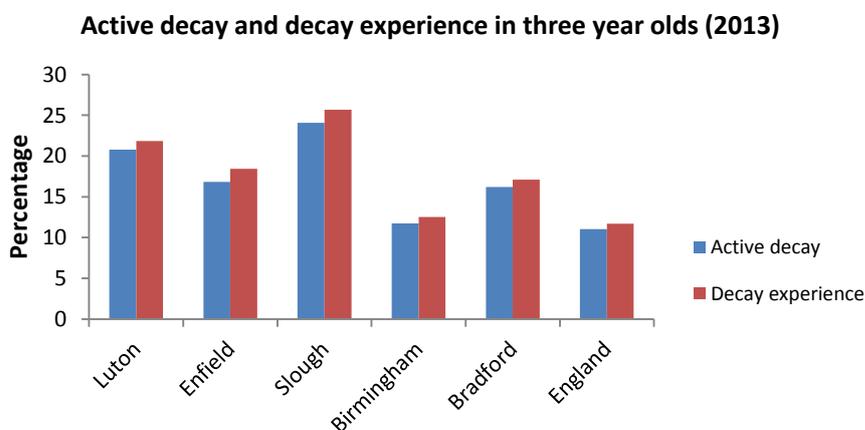
Guidance published by Public Health England¹⁵⁶ and NICE¹⁵⁷ provides direction, advice and support for local authorities to commission programmes to improve oral health¹⁵⁷ and recommends:

- Developing a locally tailored oral health strategy
- Providing leadership for oral health and include oral health as a priority in the health and wellbeing strategy
- Using the Commissioning Better Public Health for Children and Young People Toolkit¹⁵⁶ to ensure all services for children have integrated oral health improvement
- Using the opportunities that the changes in 0-5 commissioning brings to integrate oral health into service specifications particularly for the health visiting service
- Having schools and early year settings on board in oral health promotion
- Involving the private sector, for example healthy eating awards, limiting sugar intake and sugar swaps.

6.3.4 Local picture

Figure 40 shows Luton's dental survey results for 3 year old children in comparison with England and statistical neighbours. The results show that 22% of 3 year old children in Luton have decay experience and 21% have active decay compared with 12% and 11% respectively in England. Compared with statistical neighbours, Luton has the second highest tooth decay.

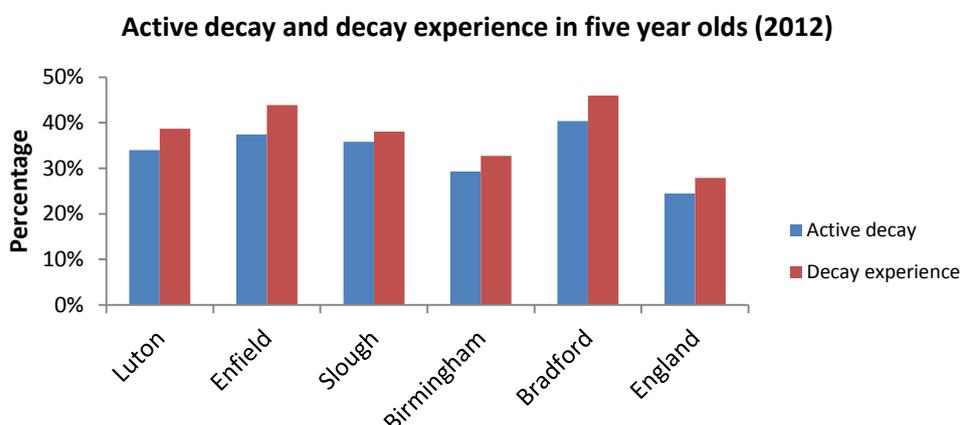
Figure 40: Active decay and decay experience in three year olds, 2013/14



By the age of 5 years,¹⁵⁸ there is a sharp increase in tooth decay and active disease. 39% of five year olds in Luton have experienced tooth decay and 34% had active tooth decay at the time of the

survey. This compares to 28% and 25% respectively for England. The results for Luton are similar to statistical neighbours as shown in Figure 41.

Figure 41: Active decay and decay experience in five year olds, 2011/12



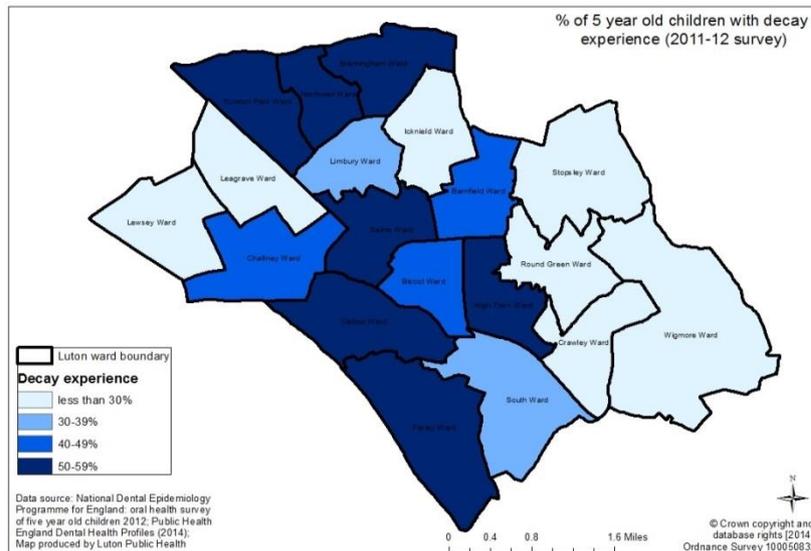
Although the results are concerning, the survey results show an improvement in Luton children's dental health in comparison with the 2007/08 survey in which 44% had experienced tooth decay and 37% had active tooth decay at the time of the survey. The survey also showed that 15% of children had signs of early childhood caries; this is closely linked to long term bottle feeding containing drinks with high sugars, or dummies which have been dipped in sugar and used as pacifiers; this is an improvement from 18% of children showing signs of caries in the 2007/08 survey.

Table 21: Tooth decay, five year olds (2011/12)

LA	% of sample examined	% of children with experience of tooth decay	Average dmft with dental caries experience	% with active/current decay	% with one or more missing teeth	% recorded with sepsis present	% of teeth with decay which have been filled
England	65.2%	27.9%	3.38	24.5%	3.1%	1.7%	11.2%
Luton	73.6%	38.7%	4.23	34.0%	7.1%	4.1%	14.9%
Bradford	52.1%	46.0%	4.30	40.4%	6.1%	4.9%	9.9%
Birmingham	62.3%	32.7%	3.57	29.3%	3.4%	4.0%	11.2%
Enfield	84.5%	43.9%	4.67	37.4%	7.0%	3.6%	13.4%
Slough	65.3%	38.0%	4.35	35.8%	1.9%	2.2%	9.4%

Figure 42 shows the proportion of decay experience in 5 year olds in Luton by ward (based on the 2011-12 survey). The wards with the highest child decay experience are Bramingham, Dallow, Farley, High Town, Northwell, Saints and Sundon Park.

Figure 42: Decay experience in 5 year olds (2011-12)



6.3.5 What is being done locally?

Oral health education provided in Luton contains evidence based information on fluoride interventions to improve oral health.¹⁵⁹ Community Dental Services deliver oral health education programmes in pre-school settings and to looked after children and their carers in Luton.

A fluoride varnish programme is delivered in the areas of Luton where there are a higher proportion of three year old children with decayed, missing and filled teeth. Children found to have tooth decay are advised to attend their local dentist while those that have high levels of decay are fast-tracked for a general anaesthetic (GA) assessment. There is access for all children at local dentists.

6.3.6 Priorities

1. Review current oral health promotion programmes including the fluoride interventions to see if they are having the expected impact and provide value for money.
2. Develop a locally tailored, evidenced-based oral health strategy, engaging services commissioned under 0-5, Flying Start programmes, schools and children's centres.
3. Recommission Public Health dental services in partnership with Bedfordshire and Milton Keynes.

6.4 Childhood immunisation

6.4.1 Introduction

Immunisation is the most important way of protecting individuals and the community from vaccine-preventable infectious diseases.¹⁶⁰ The World Health Organisation recommends that 95% of children are immunised in order to protect those that are not immune and wide population illness should an infection start to spread.¹⁶¹ As part of the Healthy Child Programme, children at certain age milestones are invited for universal and, when required, targeted vaccinations as part of the national programme schedule.

The universal programme comprises:

- Primary immunisation from the age of two months and completed with the first Measles, Mumps, and Rubella (MMR) by the age of 13 months.
- From 2013, all children aged 2, 3 and 4 years are offered an annual influenza vaccination and older children will be vaccinated as part of a phased implementation of the programme.
- Pre-school boosters are administered before the child's fifth birthday, and include the second MMR vaccination.
- Boosters for school leavers are given in year 10 (age 14/15 years), these are the final universal vaccinations a young person receives.

The targeted vaccination programme comprises:

- All children born in Luton are vaccinated against TB (BCG vaccination) at birth similar to other areas nationally with a high TB incidence.
- A course of Hepatitis B vaccination is administered to children born to women who are identified through screening in pregnancy up to the age of one year.
- Human papilloma virus vaccination that protects against the virus that leads to cervical cancer is given to girls through a school vaccination programme in year 8 (age 12/13 years).

The following groups of children and young people are at risk of not being fully immunised:

- Those who have missed previous vaccinations (as a result of parental choice or otherwise).
- Looked after children.
- Those with physical or learning disabilities.
- Children of teenage or lone parents.
- Those not registered with a GP.
- Younger children from large families.
- Children who are hospitalised or have a chronic illness.
- Those from some minority ethnic groups.
- Those from non-English speaking families.
- Vulnerable children, such as those whose families are Gypsy travellers, asylum seekers or are homeless.¹⁶²

6.4.2 What is the evidence base?

NICE guidance on the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years recommends the following:

- Use a structured, systematic method to record, maintain and transfer accurate information on childrens' immunisation status.
- Ensure all staff involved in immunisation services are appropriately trained.
- Send tailored reminders to parents when immunisations are due. When a child does not attend an appointment, send tailored recall invitations and then follow-up by telephone or text message or consider a home visit.
- Improve access to immunisation services by providing longer appointment times, walk-in vaccination clinics, services with extended hours and mobile or outreach services. Ensure parents know how to access these immunisation services.
- Provide parents with tailored information, advice and support so they are aware of the recommended routine childhood vaccinations and the benefits and risks.¹⁶²

These actions are the responsibility of NHS and other commissioners, children's services, local authorities, education services and all those who look after the health and wellbeing of children.

6.4.3 Local picture

Luton has a long history of low recorded uptake of vaccinations. It is known that uptake is greater than that recorded on the child health database, the information system from which national and local vaccination uptake is reported, as evidenced by routine data cleaning and cross-checking general practice records.

Uptake has improved for all vaccination programmes in Luton in recent years. The highest uptake is for the earliest age vaccinations, and uptake reduces considerably for children at pre-school booster stage, see Table 22. The target for all vaccination programmes is 95% uptake; this is the level at which spread of a vaccine preventable illness can be contained, also referred to as herd immunity level.

Table 22: Childhood immunisations in Luton

Indicator	Period	Luton	Birmingham	Sandwell	Slough	Bradford	England
Population vaccination coverage - MenC (1 year old) <90% ≥90%	2012/13	93.3	88.0	92.6	92.3	95.9	93.9
Population vaccination coverage - Hib / Men C booster (5 years) <90% ≥90%	2013/14	93.3	91.3	93.5	90.7	96.4	91.9
3.03v - Population vaccination coverage - PCV <90% ≥90%	2013/14	94.3	91.2	92.9	93.4	94.9	94.1
Population vaccination coverage - Hepatitis B (2 years old)	2013/14	87.5		100.0	89.7	100.0	-
Population vaccination coverage - MMR for one dose (5 years old) <90% ≥90%	2013/14	94.8	94.1	93.1	92.0	97.2	94.1
Population vaccination coverage - Dtap / IPV / Hib (1 year old) <90% ≥90%	2013/14	95.1	91.5	93.3	93.6	95.2	94.3
Population vaccination coverage - MMR for one dose (2 years old) <90% ≥90%	2013/14	91.5	88.3	91.3	91.0	94.6	92.7
Population vaccination coverage - Hepatitis B (1 year old)	2013/14	100.0		100.0	100.0	93.9	-
3.03vii - Population vaccination coverage - PCV booster <90% ≥90%	2013/14	92.0	88.9	91.5	90.8	94.6	92.4
Population vaccination coverage - Hib / MenC booster (2 years old) <90% ≥90%	2013/14	93.3	86.2	92.6	90.8	94.8	92.5
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% ≥90%	2013/14	96.7	93.1	95.4	95.1	96.8	96.1
Population vaccination coverage - HPV (females 12-13 years old) <previous year's England value ≥previous year's England value	2013/14	86.0	87.9	95.1	85.1	90.2	86.7
Population vaccination coverage - MMR for two doses (5 years old) <90% ≥90%	2013/14	84.6	84.3	88.0	82.2	93.2	88.3
Children in care with up to date immunisations	2013	87.5	96.4	90.9	100.0	86.8	83.2

At 2 years of age, Luton is below the national performance target of 95% for MMR and Hib/Meningitis C booster. However, for DTaP/IPV/Hib Luton exceeds the target.

HPV vaccination is a school-based vaccination programme that commenced in September 2008 and is delivered routinely to 12/13 year old girls (school year 8) to protect against cervical cancer. In the first three years a catch up scheme ran alongside the programme. This catch up was administered through the school nurses for eligible females in education and through GP surgeries for those not in education and those preferring to access their GP for vaccination.

The uptake shows a number of trends:

- The later the catch up was completed the higher the uptake, although for some cohorts this is marginal. This suggests that greater awareness contributes to increased uptake.
- Uptake for the routine cohort (Year 8 girls) improves as the programme became more established.
- Uptake has plateaued for the last three years. Learning and actions need to be put in place to identify why this has happened and what action can be taken to increase uptake.

6.4.4 What is being done locally?

NHS England commissions and coordinates the national immunisation programme. Uptake of all vaccinations is monitored by Luton Health Protection Committee, chaired by the Director of Public Health. Working with NHS England, PHE, the CCG and the community providers, the priority is to accurately record and increase uptake by the following:

- Ensuring accurate data is available; in Luton this is exacerbated by non-scheduling of immunisations and different databases. Many practices have now migrated to using SystemOne, the same information system used by the local Child Health Information Service (CHIS) which is systematically improving data accuracy.
- Reducing late vaccinations - approximately 8% of children are being vaccinated late, after their 5th birthday. The CCG and PHE are working with practices where this is occurring to identify reasons for late vaccination and remedial actions.
- Reducing variability in uptake of vaccinations by GPs based on service delivery processes. Common issues are lack of practice nurse capacity and systems not in place to follow up children who fail to attend their vaccination appointment.

6.4.5 Priorities

1. Ensure primary care use a systematic method to record and maintain accurate information on children's immunisations including inviting children to attend for vaccination at the appropriate scheduled age (call and recall) and recommend the use of Child Health Information Service to manage this 'scheduling' function.
2. Improve uptake of child vaccinations particularly pre-school boosters and hepatitis B by using best practice of how general practices invite families to attend for child vaccinations.
3. Ensure the importance of immunisation is promoted and appropriate training is given to Early Years professionals including, health visitors, school nurses and within children's centres.

7 Children and young people

7.1 Mental and emotional health and wellbeing

7.1.1 Introduction

The emotional wellbeing of children is fundamental to their future health and life chances. Undiagnosed and untreated emotional and mental difficulties impact negatively on a child's development and are the leading cause of disability in young people and present a challenge for families and the wider community.¹⁶³

Mental health is defined as: "A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".¹⁶⁴

Emotional wellbeing is defined as: "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."¹⁶⁴

Mental ill-health is defined as "a clinically recognisable set of symptoms or behaviour associated in most cases, with considerable stress and substantial interference with personal function".^{165,166}

The burden and impact of mental ill health on children and young people nationally is:

- Approximately 10% of adolescents suffer from a mental health problem at any one time.¹⁶⁷
- 50% of people with lifetime mental health problems experienced their first symptoms by the age of 14 and 75% before they were 18 years.^{167, 168}
- 25% of children are likely to have some sort of mental health problem from mild anxiety to a mental disorder requiring complex treatment.¹⁶⁹
- The short term costs of emotional, conduct and hyperkinetic disorders among children aged 5-15 to be £1.58 billion and the long term costs £2.35 billion each year.¹⁶⁷

7.1.2 Risk factors and vulnerable groups

Resilience and vulnerability are not individual personality characteristics, but are closely related to socioeconomic factors.¹⁷⁰ Age, gender, class, race/ethnicity, disability, sexuality and physical health influence risk and protective factors for mental health and the way in which mental distress is expressed. The relative impact of population characteristics is in turn affected by wider factors: the experiences of childhood, old age, coming from a working class family, belonging to a Black or Minority Ethnic community, being gay or lesbian, living with a physical or learning disability or suffering from chronic illness vary considerably. Fiscal policy, welfare benefits, housing, education, legislation on age, racial and sex discrimination all contribute to the mental health impact of growing up.¹⁶⁴

In adolescence, protective factors include attachment to school, family and community, positive peer influence, opportunities to succeed and problem solving skills. 'Social capital' indicators (friends, support networks, valued social roles and positive views on neighbourhood) predict onset

and persistence of emotional and behavioural disorders.¹⁶⁴ Table 23 identifies groups known to have a higher risk of poorer mental ill health.

Table 23: Risk factors for mental ill-health in children and young people

Vulnerable groups	<ul style="list-style-type: none"> • Children in care • Children in need of protection (including children subject to abuse), • Refugees or asylum seekers • Young carers
Education/ employment	<ul style="list-style-type: none"> • Young People Not in Education or Employment Training(NEET) • Low educational attainment
Family risks for child and young person	<ul style="list-style-type: none"> • Parental Unemployment • Parental mental health • Single-parent household • Low income households • Living in rented accommodation
Lifestyle	<ul style="list-style-type: none"> • Substance misuse • Teenage parent • Youth offender
Health	<ul style="list-style-type: none"> • Physical illness • Disabilities
Demography	<ul style="list-style-type: none"> • Children and young people from BME communities • Sexuality – Lesbian, Gay, Bisexual, Transgender

7.1.3 What is the evidence base?

NICE have produced guidance on the social and emotional wellbeing for children and young people¹⁷¹ and recommends that arrangements are put in place for integrated commissioning of universal and targeted services for under-5s. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers and children and families with multiple needs have access to specialist services, including child safeguarding and mental health services.

For children in primary education:

- There should be developed and agreed arrangements to ensure all primary schools adopt a comprehensive whole school approach to children's social and emotional wellbeing. They

should provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems.

- Include social and emotional wellbeing in all relevant local and school policies for attaining improved outcomes for children and young people.

Secondary education:

- All secondary education establishments to adopt a comprehensive organisation-wide approach to promote the social and emotional wellbeing of young people. This should encompass organisation and management issues as well as the curriculum and extra-curricular activities.
- Ensure secondary education establishments have access to the specialist skills, advice and support they need.

NICE also recommend that local authority scrutiny committees for health and wellbeing should review delivery of plans and programmes designed to improve the social and emotional wellbeing of vulnerable children and assess the progress made by education establishments in adopting an organisation-wide approach to social and emotional wellbeing.

The Department of Health and Public Health England have produced guidance for schools nurses and health visitors and recommend that, along with partner agencies, they have a crucial role in positive mental health within a family context and in creating confident communities¹⁷². The guidance ensures emotional health and wellbeing is promoted and ensures that seamless services are provided. The following need to be addressed:

- Raising the profile of health visitors and school nurses' contribution to emotional wellbeing and mental health.
- Developing guidance / tools for transition with clear role definition for health visitors and school nurses to ensure clear transition pathways.
- Actively engaging promoting transition points across the life course for children and young people – providing a joint and holistic approach to support the child and family.
- Ensuring shared training opportunities and regular updating of resources.
- Ensuring effective support during transition paths.

7.1.4 Local picture

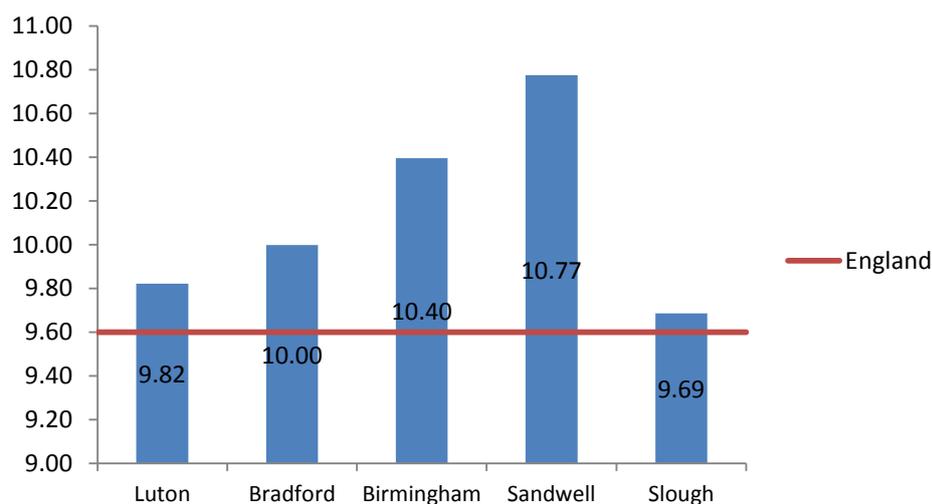
Pre-school children

In 2007, a local Mental Health Needs Assessment for the under 5s reported 2,657 0-4 year olds having psychological problems, a prevalence of 20%. This was lower than expected given Luton's levels of poverty and the numbers of vulnerable families. Of 194 participants, almost half (48%) had an issue related to emotional wellbeing and a third due to neglect (36%). Luton's high birth rate is likely to have a significant impact on future planning and capacity of services.¹⁷³

School age children

The estimated prevalence of mental health disorders for children and young people aged 5-16 years in Luton is 9.82% compared with 9.6% in England (Figure 43). This is slightly lower than comparator areas with the exception of Slough. Early intervention for mental health is key to a positive and successful long-term prognosis.¹⁶⁸

Figure 43: Estimated prevalence of any mental health disorder: % population aged 5-16 (2013)



Source: PHE

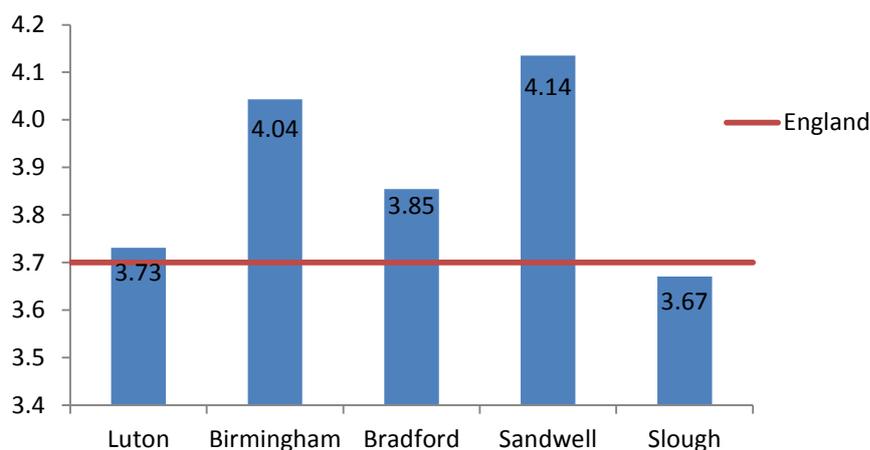
It is more likely that older children and adolescents will be identified as experiencing classifiable mental health disorders as these tend to manifest more often in adolescence if mental health problems and risk are not resolved earlier in childhood.

For young people aged between 17-19 years, prevalence estimates indicate 1,898 young people have diagnosable mental health disorders in Luton. More than two thirds of these are young women with their mental ill-health stated as 'mixed anxiety depression'.¹⁷⁴

Whilst there is no local evidence to suggest that ethnicity by itself is a risk factor for mental ill-health, the impact of ethnicity on mental ill-health is complex. There is national evidence to suggest that there are inequalities in accessing mental health services from BME communities and this affects all age ranges including children and young people.¹⁷⁵

The estimated prevalence of emotional disorders for children and young people aged 5-16 years in Luton is 3.73% compared with an England average of 3.7% (Figure 44). For children with normal development and for children with developmental delays, high quality early intervention services have been shown to positively impact outcomes across developmental domains.¹⁷⁶

Figure 44: Estimated prevalence of emotional disorders: % population aged 5-16



Source: PHE

7.1.5 What is being done locally?

East London Foundation Trust currently provides child and adolescent mental health services (CAMH) services for Luton.

The Tier 2 service focuses on early detection through schools and children's' centres by identifying children who may be at risk of mental ill-health or showing signs of emotional health and wellbeing issues and allowing schools to directly commission additional CAMHs services to support a child requiring additional support. There is a children and young people's Increasing Access to Psychological Therapy (IAPT) service and a single access route to services to improve service access.

Training is to staff in cognitive behaviour therapy (CBT) or CBT-based parent training for individuals and groups.

Tier 3 service focuses on specialist work for children and young people with complex, severe and/or persistent needs.

LCCG will commission multi-disciplinary teams and a range of assessment and treatments for children and young people with complex mental health problems or learning disabilities for specialist tiers. This can involve individual, joint work or medication related treatments, often working with other professionals.

7.1.6 Views of children and young people

In 2011, Relate Bedfordshire and Luton surveyed 890 young people (30% in Luton, 267) aged between 6 and 23 years across the county about their main health and wellbeing concerns¹⁷⁷. Questions were asked about their perception of counselling and wellbeing services. The results showed:

- Females had greater concerns about body image and self-esteem compared with males.
- The nature of concerns varied by age group.
- Up to 13 years of age: bullying, family relationships, puberty and physical development.
- Aged 14-17 years: drugs and alcohol, crime and violence, peer pressure, sex pressure.

- 16-19 year olds: relationships, jobs, money and drug issues.

7.1.7 Priorities

Carry out a CAMHS needs assessment to:

1. Develop prevention and early intervention programme for both children and their families to prevent mental health problems escalating and therefore reduce avoidable demands on services with specific focus on adolescent resilience.
2. Ensure there is a universal and targeted programme of mental wellbeing support is commissioned across general practice, maternity, health visiting, school nursing and children's centres.
3. Continue to survey mental health needs of children and young people to build an evidence base upon which to commission improvements and carry out an annual audit of services and expenditure.

7.2 Childhood obesity

7.2.1 Introduction

The World Health Organization has identified childhood obesity as one of the most serious public health challenges of this century¹⁷⁸.

Levels of obesity are increasing across the UK. It is estimated that by 2050 approximately 25% of children in the UK will be obese and 40% overweight¹⁷⁹. The long-term cost of childhood obesity is estimated to be as high as £700 million each year.¹⁰⁴ However, reducing obesity amongst children and young people by 1% could save the NHS £1 billion each year on long-term health problems and the need for health treatment.¹⁷⁹

Obese children can experience health-related limitations and require more medical care than their peers who are of normal weight. The most important consequence of childhood obesity is its persistence into adulthood, leading to a higher risk of morbidity, disability and premature mortality in adult life (see Adult obesity section in Section 9.4).¹⁸⁰ There are a number of increased long term health risks associated with child and adolescent obesity:

- Mental health problems.^{10, 11, 12, 13}
- Musculoskeletal problems.¹⁴
- Type 2 diabetes.⁶
- Cardiovascular risk and damage.⁹
- Asthma (obese children have a 40-50% increased risk compared with normal weight children⁷).
- Sleep apnoea.⁸

7.2.2 Risk factors and vulnerable groups

The underlying causes of obesity are complex. There are a number of risk factors that increase the likelihood of child obesity, for example, socioeconomic status, ethnicity and child disability, specifically:

- Children born to obese mothers are more likely to become overweight or obese.
- A lower incidence of obesity at 5 years old in breast-fed babies compared with those bottle-fed¹⁸¹, women from higher socioeconomic groups are more likely to breast-feed.
- Higher levels of obesity for children in both Reception and Year 6 in more deprived areas.
- Children who have a disability (especially a learning disability) are more likely to be obese or overweight (or underweight), (40% of children aged under 8 years old with a limiting illness and learning disability are obese or overweight compared with 22.4% of children who have neither condition).¹⁸²

In addition, obese children are more likely to experience episodes of illness, health related limitations and require more medical care than normal weight children¹ and as a consequence have more school absence leading to difficulty keeping up with the curriculum. This can have an adverse impact on their educational attainment.

7.2.3 What is the evidence base?

Obesity is a complex problem for which there is no simple solution. It cannot be addressed through single interventions undertaken in isolation. NICE has produced a local authority briefing on preventing obesity and helping people to manage their weight¹⁸³. Broad actions are covered in the adult obesity section. However, specific actions for parents, carers and everyone in regular contact with children and young people are to:

- Encourage and support children to be active at every opportunity (such as active play, travel, sport or leisure activities).
- Eat meals with children and young people.
- Encourage children and young people to get enough sleep. Explain to parents and carers that this is because lack of sleep may increase the risk of excess weight gain in children and young people.¹⁸⁴

Commissioned weight management services for children should be multi-component and include diet, behaviour and physical activity and involve the whole family. Specialist intensive clinical services should be aimed at those with complex medical or educational needs and weight reduction drugs should only be prescribed for severely obese young people with co-morbidities who are attending specialist clinics. Surgery should only be considered for post-pubertal young people with very severe-to-extreme obesity.¹⁸⁵

7.2.4 Local picture

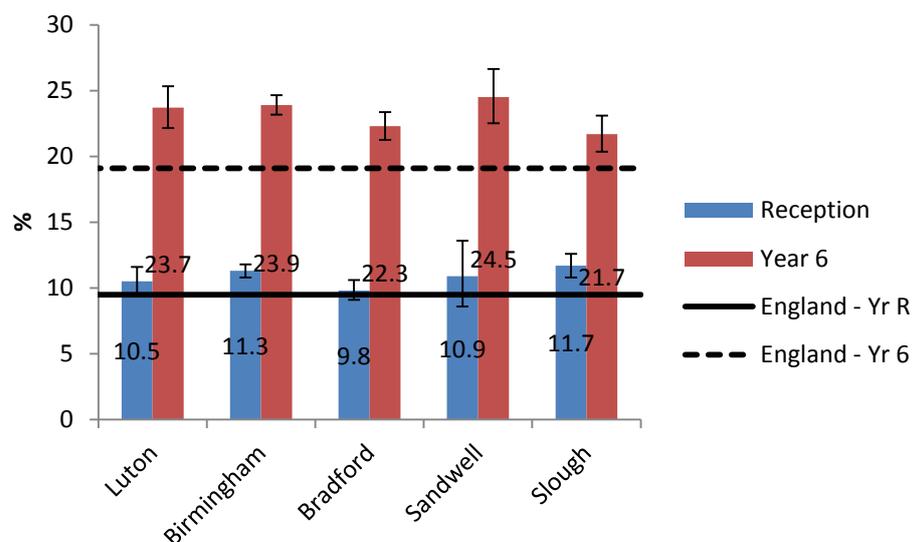
Data from the 2013/14 National Child Measurement Programme (NCMP) shows the prevalence of obesity in children at both ages measured, Reception year (aged 4-5 years) and year 6 (aged 10-11) years is higher in Luton than England but similar to Luton's statistical comparator areas, and prevalence in Year 6 is increasing.

Prevalence

The prevalence of obesity in Reception Year children is 10.5% which is the lowest for this year group since the inception of the NCMP in 2006/07. It is similar to the England average and comparator areas (Figure 45).

The prevalence of obesity in Year 6 children is 23.7% and is significantly higher than the England average (19.1%) but similar to comparator areas (Figure 45).

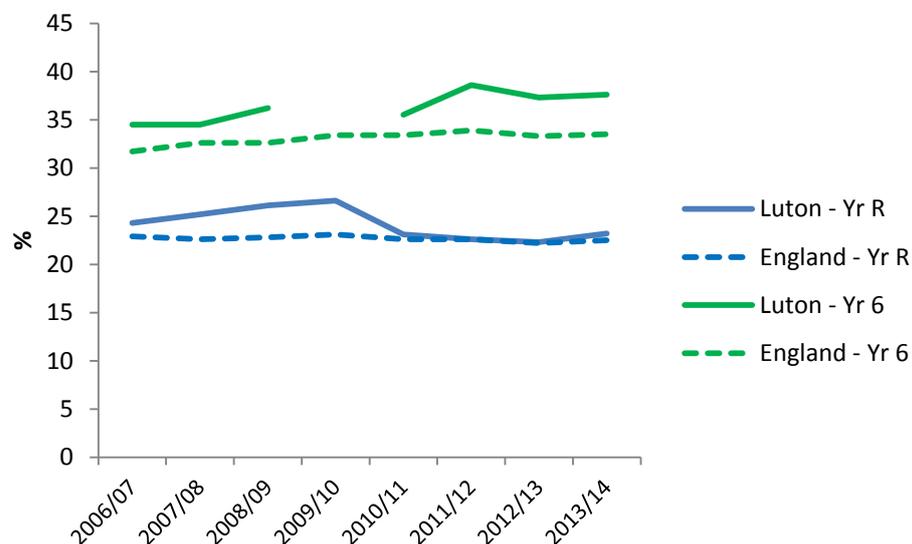
Figure 45: Prevalence of obesity in reception year and year 6 children, 2013/14



Source: NCMP

Trend data shows prevalence of excess weight (overweight and obese) in Reception Year children is decreasing and in line with the national average. However, prevalence in Year 6 children has been increasing and the gap with England has not reduced (Figure 46).

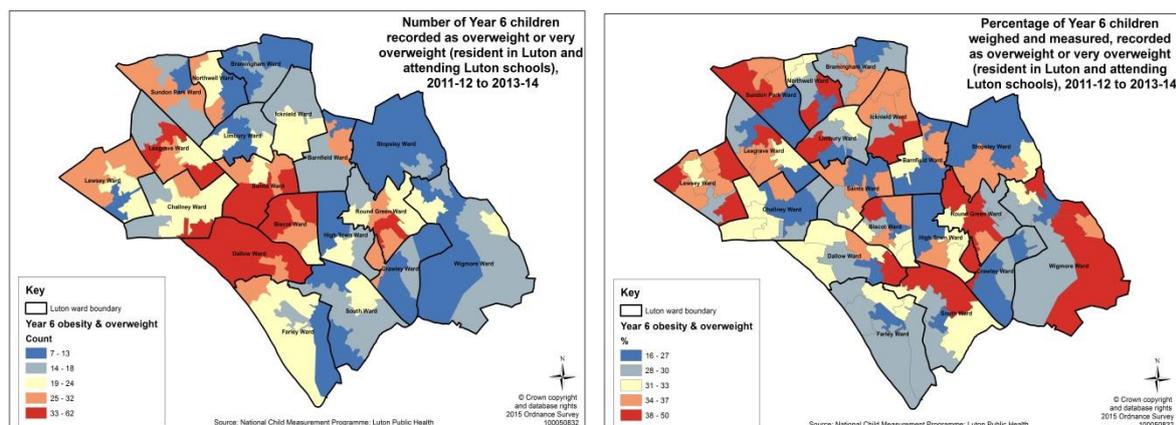
Figure 46: Excess weight in reception year and year 6 children, 2006/07 to 2013/14



Source: NCMP and PHOF

Figure 47 shows the geographical spread of childhood obesity (aged 10-11 years) across Luton over the last three years. The highest numbers of children overweight or obese are in the more deprived wards where there are larger numbers of children and births. The highest proportion of children measured as obese or overweight are geographically spread across pockets in a number of different wards.

Figure 47: Number and percentage of year 6 (10-11 year olds) obese or overweight in Luton (2011-12 to 2013-14).



There is a strong association between deprivation and childhood obesity, with increased obesity prevalence for both Reception and Year 6 children with increased deprivation. Obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10%.¹⁸⁶

There is no straightforward relationship between obesity and ethnicity, with a complex interplay of factors affecting health in minority ethnic communities in the UK.¹⁸⁶ In Luton, prevalence of excess weight is highest in the Black African and Caribbean ethnic groups in both Reception and Year 6 although the differences are not significant.

7.2.5 What is being done locally?

There are a range of services and support available across Luton to support healthy weight in children. The universal Free School Meal programme provides healthy meals to school children across Luton.

The Family Food First initiative encourages families with young children to adopt healthier lifestyles to reduce the burden of diseases such as obesity and tooth decay. Work is focused on early years' settings including nurseries, pre-schools and children's centres.

The local Vegfest project promotes healthy eating and gentle exercise aimed at primary school children and their families to learn about nutrition, where their food comes from, and what is meant by healthy eating.

Breastfeeding is encouraged for all new mothers through maternity and a community breastfeeding service and pregnant women and new mothers are supported to reduce obesity and promote healthy weight management through a Slimming World programme (see Early Years section) that is endorsed by the Royal College of Midwives and has a midwife in attendance. LiveWell Luton provides weight management programmes for children aged 5-15 years.

7.2.6 Perspectives of the public/services users

Service user case studies:

Feedback A

I loved that my child and I got to work alongside each other in the classroom session. The food tasting was great as we both got to try new things. We have made real changes at home since starting, we have new plates that are smaller for portion control, we spend less time on the iPad and more time cooking together in the kitchen. My child brought her bed time forward to 8pm and chooses healthier snacks and less treats. I like to take her food shopping with me so we can encourage each other to make healthy choices. Over all it has been a great experience that I would recommend to others.

Feedback B

All mentors were interested in each individual and family group. They were able to bring the entire group into the sessions. We loved the taster sessions and felt it was a good idea as peer pressure allowed mentees to taste without prejudice. Everyone tried and I'm convinced we all will carry on with these choices as we have tasted them. The activity is the most important part of the sessions, my son mainly came for this, but he learnt from the nutritional element too. Can I say (despite my disabilities), I so enjoyed interacting with him and the group. Personally I think you have hit the right spot with this course.

7.2.7 Priorities

1. Develop a multi-agency approach to reduce obesity with a specific offer for schools that recognises the different education needs of different age groups.
2. Implement and monitor the child healthy weight pathways covering early intervention and treatment.
3. Work with fast food outlets and other outlets that provide food for children to support them in reducing the salt, fat and sugar content in their menus.
4. Review and strengthen physical activity and nutrition programmes in pre-school settings.

7.3 Teenage pregnancy

7.3.1 Introduction

Teenage pregnancy is defined as the number of conceptions per thousand young women under 18 years of age, which may lead to a live birth or termination of pregnancy. Whilst for some young women having a child can represent a positive point in their lives, for many others bringing up a child is a challenge and can result in poor outcomes for both the teenage parent and their child. Teenage pregnancy and early motherhood has a generational impact and is linked to poor educational achievement for the mother, leading to poor employment prospects, poor physical and mental health (for both mother and child), social isolation and poverty.^{187,188,189}

Since the launch of the National Teenage Pregnancy Strategy in 1998¹⁹⁰ considerable progress has been made in reducing teenage pregnancies. Recent data shows that the U18 conception rate continues to fall; in 2013 the rate for England was 24.3 per 1000 compared with 46.6 per 1000 in 1998.¹⁹¹

7.3.2 Risk factors and vulnerable groups

Teenage pregnancy is complex. Factors known to increase the likelihood of teenage pregnancy (including risk factors for becoming young fathers) can be grouped into four main risk categories¹⁹². Examples are given in each category below:

1. **Behaviour** (sexual activity at a young age; poor contraceptive use; involvement in crime; repeat abortions; alcohol and substance misuse).
2. **Education-related factors** (low educational attainment; disengagement from school and education; leaving school at 16 or before with no qualifications).
3. **Family/background factors** (aspiration to be a parent; ethnicity – white, deprived; child of teenage parents; in care or a care leaver; sexual abuse/ exploitation (young fathers are twice as likely as older fathers to have been sexually abused); eligibility for free school meals).
4. **Environmental** (the area a young person lives, unemployment rate, analysis across England showed that unemployment rate accounted for 67% of variation in U18 conception rate, suggesting that the higher the unemployment rate, the higher the U18 conception rate. Young fathers have double the risk of being unemployed at age 30 – even after taking account of deprivation).¹⁸⁸

7.3.3 What is the evidence base?

Reviews into teenage pregnancy prevention programmes have identified two factors that have the greatest impact on teenage sexual behaviour and use of contraception;¹⁹³

1. sex and relationship education – learning about emotional, social and physical aspects of growing up, healthy relationships; sex; human sexuality and sexual health.
2. contraception – young people able to access services in locations and at times which are convenient to them.

Local areas that have had the most success have made sure there is specifically targeted support to at risk groups. This includes young people in and leaving care, not in employment, education or training (NEETs) and those in the criminal justice system. There is also a need to invest in dedicated

and co-ordinated support post-birth (for those who become teenage parents), including more intensive support through family nurse partnerships¹⁹⁴, a programme for first time teenage parents that will commence in Luton from September 2015.

NICE guidance on contraceptive services with focus on young people up to the age of 25¹⁹⁵ covers:

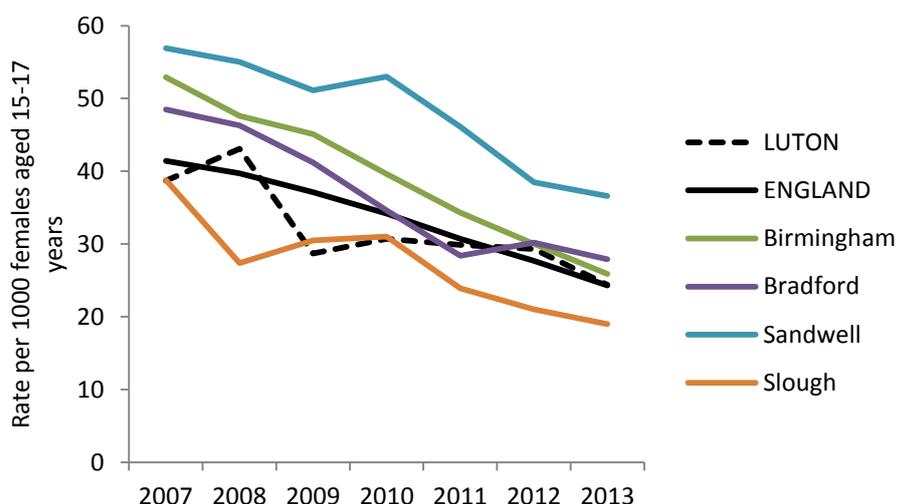
- How to offer culturally appropriate, confidential, non-judgemental, empathic advice tailored to needs.
- Ensuring young people understand their information will be kept confidential.
- Providing contraceptive services after pregnancy and abortion.
- Encouraging use of condoms and other forms of contraception.
- How schools and other educational settings can provide contraceptive services.

The DH document A Framework for Sexual Health Improvement in England¹⁹⁶ states that the ambition is to continue to reduce the rate of under-16 and under 18 conceptions. The framework suggests all young people receive appropriate information and education to enable them to make informed decisions and have access to the full range of contraceptive methods and where to access them.

7.3.4 Local picture

Figure 48 provides a summary of the under 18 conception rate in Luton from 2007 to date compared with England and statistical neighbours. Rates have reduced overall during this period. The latest figure shows the conception rate in Luton (24.4) to be similar to that of England (24.3) and lower than that of each of the statistical neighbours with the exception of Slough.

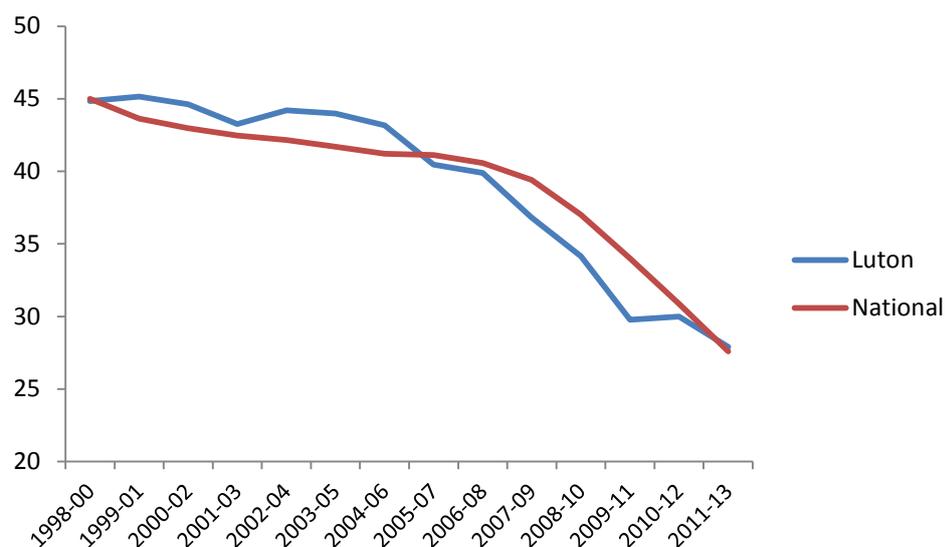
Figure 48: U18 conception rate in Luton, England, comparators, 2007 to 2013



Source: ONS

Given the fluctuations in rates on an annual basis, it is useful to pool the data to help identify any overall trend. Figure 49 shows the 3-year pooled average U18 conception rates in Luton and England from 1998 to date. Rates continue to reduce and the latest pooled data shows the England (27.6) and Luton (27.9) rates to be similar.

Figure 49: 3-year pooled U18 conception rates for Luton and England



Source: ONS

7.3.5 What is being done locally?

Tackling teenage pregnancy requires a range of actions that aim not only to reduce U18 conceptions, but also support young parents and their child.

Provision of contraception and sexual health services

Brook Luton delivers the majority of sexual health prevention services for young people under the age of 25 years. This includes a condom distribution scheme and providing emergency contraception (hormonal and device). Emergency Hormonal Contraception (EHC) is available from 27 pharmacies across Luton.

A health promotion programme for children excluded from mainstream education has been piloted in the Pupil Referral Unit in Luton. As part of this programme pupils are offered health checks, Chlamydia testing and contraception provision, and are provided with tailored health and lifestyle information, including safe sex and relationship information.

The national '3Cs programme' (chlamydia screen, contraceptive advice and free condoms) is designed to support general practices to deliver basic sexual health in 13 GP practices in Luton. This is offered during any routine consultation with young adults (15 – 24 year olds).

LCCG commissions local pregnancy termination services. The service can be accessed through self-referral or via GPs and other health services.

Sexual and relationship education (SRE)

The school nursing service is rolling-out student health drop in sessions at each Luton secondary school following a pilot at one school. Pupils are able to access information and guidance around sexual health, contraception and signposting to other appropriate services.

In October 2014, Luton launched a Schools Health and Wellbeing Award, a locally accredited whole school programme that encourages schools to use public health data to raise awareness of key health priorities upon which they focus to achieve award status. Schools are provided with a directory of local service providers, who can assist with lesson delivery in these targeted subjects; SRE is a priority.

Support for young parents

A programme offering education, information and guidance to help young parents gain a basic Level 1 education qualification is run by a local provider organisation. This programme provides wrap around support such as CV writing, accessing care to learn, confidence building and aspiration raising. There are 15 young parents accessing this programme each year.

A young fathers and young mothers support worker works on a one-to-one basis with local young parents acting as an advocate and ensuring they receive appropriate information and guidance to enable them to parent to the best of their ability. This can also include support with housing, employment, health, lifestyle, and legal issues.

A range of ante-natal and post-natal parenting courses are offered as part of universal services, which young parents are able to attend. Parenting programmes are being reviewed to ensure courses commissioned are appropriate to young parents.

Although progress has been made which has resulted in a positive impact on rates, momentum needs to be maintained if rates are to continue to reduce and the introduction of Family Nurse Partnership in September 2015 will be part of the local toolkit to achieve this.

7.3.6 What is the perspective of the public?

Information collected from young women who become pregnant can be used to help provide a better picture of the characteristics of this group and to understand why they planned a pregnancy or were not able to access contraception. Using data from the 2013/14 U18 pregnant cohort in Luton:

- 55% of pregnant teenagers were not using contraception at the time of conception.
- 22% had planned their pregnancy.
- 35% of the pregnant teenagers were NEETs.
- 54% were living with their family at the time of pregnancy¹⁹⁷.

In 2014 a root cause analysis¹⁹⁸ was conducted with a small number of young mothers, with the intention of gaining a better understanding of the reasons behind the pregnancy. The young mums reported that the information they were given at school in terms of PSHE and contraception was variable; some stated it was good, whilst others suggested it was very limited or the teacher was not confident in teaching the subject. All young mums stated they would advise other young girls to not rush to have babies, and wait until they had finished their education and were financially secure before doing so. The young mums that had planned for another baby suggested they would wait until they were more settled and had finished their education before doing so.

7.3.7 Priorities

1. Continue to reduce the U18 conception rate via both universal and targeted prevention programmes focusing on access to contraception through school and community based clinics and working directly with young people that schools refer for 1-1 support.
2. Review the current interventions available to teenage parents particularly in light of the local implementation of Family Nurse Partnership (FNP) to ensure all teenage parents have access to support, information and are empowered to make informed choices.
3. Ensure all schools offer age appropriate quality assured sex and relationship education in the school environment and are provided with unbiased non-judgemental information.
4. Support young parents to parent to the best of their ability by providing opportunities for young parents to access education, training and employment.

7.4 Drugs and alcohol – young people

7.4.1 Introduction

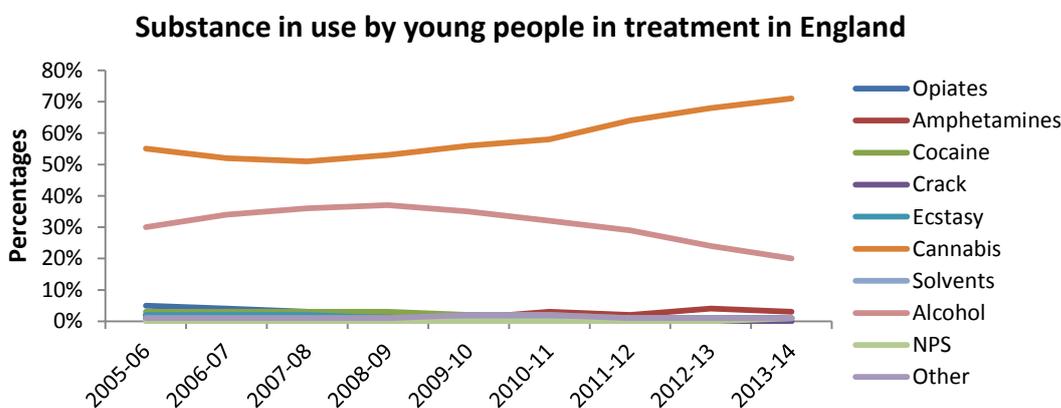
Drug and alcohol misuse pose a significant risk to a young person’s physical and psychological health and development. The use of legal and illegal drugs by young people is associated with immediate and long term risks to their health and wellbeing, particularly the relationship between drug use and mental health. Over time drug users increase the risk of dependence.

The chief medical officer (CMO) advises that the healthiest and best option is ‘an alcohol-free childhood’¹⁹⁹. Alcohol use at a young age, particularly heavy and regular drinking can result in physical and mental health problems including:

- Over 60 medical conditions including alcohol poisoning, cirrhosis of the liver, psychiatric, neurological, gastrointestinal, cardiovascular condition and several types of cancer.
- Impaired brain development.
- Inability to work and socialise; truancy, unemployment, relationship breakdown.
- Violence and anti-social behavior including youth offending.
- Unprotected sex leading to unplanned teenage pregnancy, and sexually transmitted infections.

Among young people in drug and alcohol treatment in England, Cannabis is the most used drug and its use among young people is on the increase in the last four years. Alcohol is the second most used substance among young people in drug and alcohol treatment and its use is decreasing among young people in treatment. Despite the downward trend in alcohol use among young people in England, the level of alcohol consumption in England is still higher than in most other European countries.

Figure 50: Trends in illicit drug use among young people.



Source: Public Health England (PHE)

Tackling the root causes of drug and alcohol problems and reducing the long term negative effects on health, wellbeing and quality of life is key²⁰⁰ and part of the national strategy on drug use.²⁰¹

7.4.2 Risk factors and vulnerable groups

The majority of young people who seek help for substance misuse have other emotional or social problems, such as self-harming, offending and family issues. They are also less likely to be in education, employment or training.²⁰² There is greater risk of problem drug and alcohol use amongst children and young people who are²⁰²:

- In local authority care.
- Truant or excluded from school;
 - Facing challenges in their academic study.
 - Who are not in education, employment, training (NEET).
 - Peer pressure.
- Experiencing abuse or neglect.
- Offenders and are involved in anti-social behavior.
- Experienced early sexual activity.
- Exposed to parental substance misuse.

This has important implications for effective co-ordination, interagency working and information sharing.

7.4.3 What is the evidence base?

NICE has produced guidance on interventions to *reduce substance misuse among vulnerable young people*²⁰³ and recommends that local areas should have a strategy to reduce substance misuse in vulnerable young people in their area. Services and professionals should identify young people at risk of using drugs, and refer them to services that can support them. These services should include family based support and parental skills training.

NICE has also published a range of guidance covering the causes and consequences of drug misuse.²⁰⁴

Public Health England has produced good practice prompts for planning comprehensive interventions²⁰⁰. The pack includes above about early intervention, specialist services and the workforce required to deliver effective interventions.

7.4.4 Local picture

In Luton, there are almost 12,000 young people under the age of 18 who live with parents who misuse alcohol and or drugs. 57% of adults in drug treatment have children living with them and 64% of adults in treatment for alcohol use have children living with them.²⁰⁵

Drug use:

In Luton, there are 47 young people under 18 (14-17 years old) in drug treatment. 91% of the young people are in treatment for cannabis use, 60% for alcohol use, and less than 5% of them are being treated for cocaine use.

Alcohol use:

The following data from Public Health England demonstrates the extent of drug and alcohol treatment for young people across Luton during 2012/13 and was published in 2013/14:

The crude rate per 1,000 population of young people in Luton aged 15-24 who use opiates and/or crack cocaine is 8.1 whereas in Birmingham, one of Luton's direct comparator areas, it is 5.3. (2012/13). The crude rate per 1,000 population for young people in Luton who are currently receiving structured drug and alcohol treatment is 1.8 whereas Birmingham recorded 3.9. (2012/13).

This indicates that Luton has a greater prevalence of opiate and/or crack cocaine use among young people aged 15-24 and fewer young people access drug and alcohol treatment when compared with comparators. A considerable improvement in the level of treatment uptake among young people in Luton who use opiates and/or crack cocaine is required.

Of those young people in drug and alcohol treatment in Luton, 73% are aged 15 and under, 57% of these are young men and 51% of those in treatment were recorded as white British.

The most commonly used drug among young people in treatment is cannabis and 83% recorded cannabis as the primary drug of choice. 66% recorded that alcohol was their main problem substance.

Drug and alcohol related offences

The Luton Youth Offending Service (YOS) records show that during 2013/14 there were 51 young people charged with drug related offences, 45 for possession, 6 for drug supply and 24 young people received a deferred decision.

Drug/alcohol-related admissions

The latest publication from the National Child and Maternal Health Intelligence Network shows hospital admissions due to alcohol-specific conditions for young people 18 years and under is decreasing in Luton, while admissions due to drug use in young people aged 15 to 24 years has increased²⁰⁶. This is shown in Figure 51 and 52 and is similar to the national pattern and amongst statistical neighbours.

Figure 51: Hospital admissions due to alcohol specific conditions (aged 18 yrs and under)

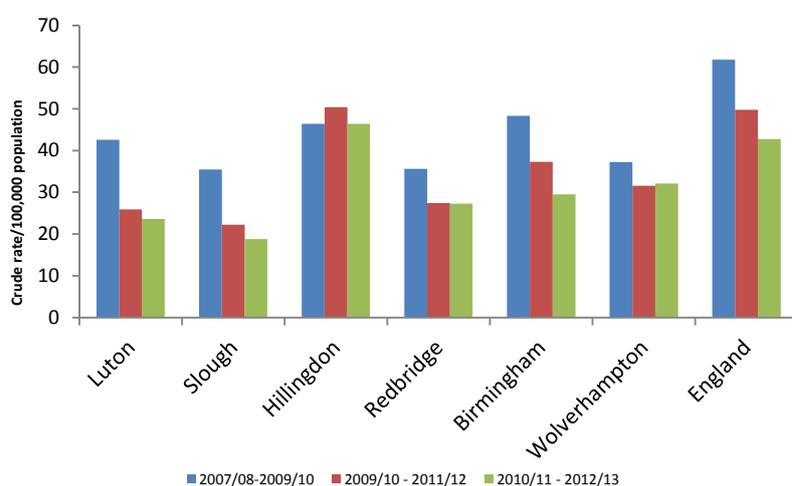
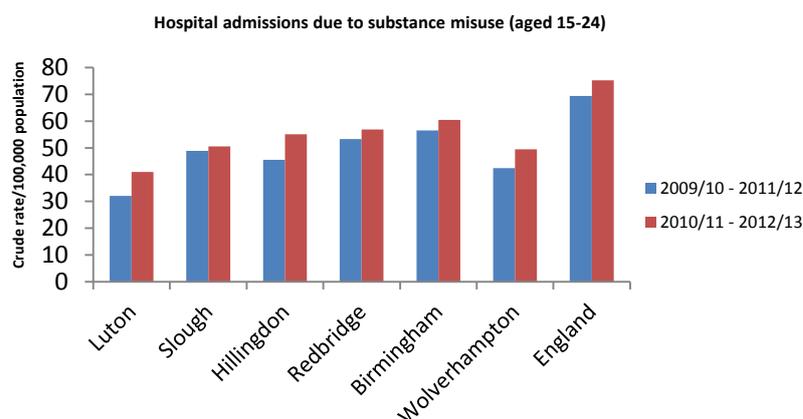


Figure 52: Hospital admissions due to substance misuse (aged 15-24)



Source: Public Health England (PHE). National Child and Maternal health Intelligence Network. (2014)

Drug and alcohol treatment

In 2013/14, 100% of people referred for treatment to the Luton Young Person's Drug and Alcohol Service were seen within three weeks, with 55% of the referrals coming from the Justice System.

21% of those in treatment spent 12 weeks or less in treatment. PHE states that for treatment to be considered as effective it needs to have lasted more than 12 weeks or be successfully completed within 12 weeks. The average length of time in treatment in Luton is 44.73 weeks, therefore the majority of young people are considered to be in effective treatment.

The treatment outcome for this cohort was: 28% of young people in treatment discharged as drug free and 39% discharged as occasional users.

New Psychoactive Substances

Luton has experienced an increase in problems recently with new psychoactive substances, 'legal highs'. Young people have been taken to hospital as a result of their use and they are seen as a problem on the streets and their use contributes to anti-social behaviour.

7.4.5 What is being done locally?

In 2012, a Local Alcohol Use Needs Assessment was completed and informed the 2012 – 2015 Luton Alcohol Strategy; the primary aim of which is to prevent young people from being harmed from alcohol use by:

- Continually improving the quality of prevention services for young people and ensuring support for the most vulnerable
- Exploring the use of the national Community Alcohol Partnership framework for use in wards or discreet areas of the town that have evidence of high rates of under-age drinking
- Increasing the promotion of support services available to children living with adults who use alcohol harmfully.

A Young Person's Drug and Alcohol Needs Assessment is currently being undertaken which will inform a new Young Person's Drug and Alcohol Strategy which will be completed in 2015.

In delivery of the strategy, a number of workshops on drugs and alcohol have been delivered in Luton schools through various community groups where parents are also encouraged to attend. They provide advice focused on dealing with problems of drug and alcohol among young people.

SNAP is a young people's service provider in Luton and offering a creative arts drop-in for vulnerable young people and sessions in schools for young people who are vulnerable and at risk of school exclusion.

To restrict supply, Trading Standards runs a number of 'secret-shopper' exercises during the year that specifically target the off-sale trade. A scheme called Challenge 25 is a retailing strategy that targets anyone under the age of 18 who needs to carry ID when buying alcohol. It also encourages retailers to request proof of age before a purchase is made. The scheme builds on the successes of the Challenge 21 scheme developed by the Retail Alcohol Standards Group in 2005 and is regarded as an effective tool to tackle underage purchases.

There are various drug and alcohol services in Luton commissioned to firstly prevent drug and alcohol use by young people across Luton whilst dealing with problematic drug and alcohol use through the provision of effective support and interventions for young people and their families.

The young people's drug and alcohol service in Luton, SAFE (Support, Advice, Facts and Education) has been commissioned and for young people up to the age of 25 which includes support for young people transitioning to adult services. The services provided include:

- Structured intervention for young people who use drugs and alcohol to support them to become drug and alcohol free or an occasional safe user, for example, controlled drinking
- Brief interventions provided for young people and their families, especially for young people who are most vulnerable and at high risk
- Workers supporting AandE services between midnight and 5.00 am on Friday and Saturday nights providing information and brief interventions for young people and their families admitted following excessive alcohol use
- Drug and alcohol worker in YOS who provides advice, support and interventions for young people.

Young people who use drugs and alcohol often face additional lifestyle issues such as smoking and sexual health problems. Referrals can be made to services such as Brook, GUM and stop smoking services. These referrals can be made through self-referral, GP or through the YP Drug and Alcohol service.

The council wishes to be proactive about legal highs to ensure Luton is as resilient as it can be to the changes in the drug landscape and that young people and others are not harmed by these substances. A blanket ban on the sale of some substances which is aimed to reduce availability is currently being considered nationally.

7.4.6 Perspective of public/service users

Informal conversations with service users suggest many young people's initial access to services is via supporting a friend. There is a lack of knowledge among young people on the side effects of increasing alcohol intake while taking medication or increasing medication as a substitute for lack of alcohol.

Young people report that peer pressure can play a significant factor in their drinking. Consequently, it is often felt there is a lack of things to do once drinking had reduced, therefore a need to provide alternative activities for young people to do once drinking has reduced.

7.4.7 Priorities

Central to the recommendations is the implementation of the Luton young person's drug and alcohol strategy which will aim to reduce the impact of drugs and alcohol on young people in Luton, specifically:

1. Increase the number of young people accessing targeted services by changing service provision.
2. Develop a pathway in relation to 'legal highs', psychoactive substances.
3. Increase the successful completion rate of young people exiting interventions by 10% by changing the delivery model.
4. Reduce the number of drug and alcohol related hospital admissions for young people by investing in early intervention and prevention.

8 Vulnerable children

8.1 Children with disabilities

8.1.1 Introduction

Children and young people with disabilities are one of the most vulnerable groups in society.²⁰⁷ They are at greater risk of underachieving, often excluded from the opportunities available to their non-disabled peers, can experience greater poverty and, as a consequence, have both poorer physical and mental health outcomes. The needs of disabled children, young people and their families are unique to them, often complex, and change over time. The challenge is to understand these needs and develop a system around them that is flexible enough to meet the needs of the young person and their family.

Children with long-term disability are a diverse group. Some will have highly complex needs requiring multi-agency support across health, social services and education and, for a few, their care needs will be technology-dependent, many more children will require less support. These include children with:

- Physical or learning disability.
- Sensory impairment (hearing, visual or speech).
- Autistic spectrum conditions-behaviour that challenges.
- Complex health needs and may have life limiting or a life threatening condition.

The health and wellbeing outcomes for disabled children are often worse when compared with their non-disabled peers²⁰⁸, in particular the:

- Reported general health is worse.
- Prevalence of psychiatric disorders is higher (almost four times greater number than children without a disability). Children with disabilities account for 14% of all British children with a diagnosable psychiatric disorder.
- Educational attainment of disabled children is lower than that of non-disabled children and fewer than 50% of schools have accessibility plans.
- Risk of abuse is greater; however these children are less likely to be in receipt of a child protection plan.
- Level of unmet need, isolation and stress of families with disabled children is higher with approximately 29% of disabled children nationally living in poverty.

Smoking in pregnancy increases the risk of having a child with certain disabilities.¹³¹ Regular or heavy alcohol consumption in pregnancy is associated with behavioural disorders and impaired brain development, for example, foetal alcohol spectrum disorder (FASD).²⁰⁹ Addiction or substance abuse interferes with parenting and contributes to developmental, behavioural and health problems in children.²¹⁰

A mother's pre-birth diet is known to influence foetal growth, normal development and gestational weight gain. Maternal obesity is associated with an increased risk of a number of poorer outcomes

including birth defects such as spina bifida, heart or circulation anomalies, and limb reduction anomalies.²⁰⁹

Teenage pregnancy and pregnancy at advanced maternal age (35 years or older) are both associated with adverse pregnancy outcomes such as premature delivery and low birth weight.²¹¹

Families with a child who has a special educational need (SEN) or disability are more likely to live in poor housing and poverty, lack employment and face social isolation and discrimination; these are associated with poorer health and educational outcomes.

A further risk is associated with genetic anomalies as a result of hereditary disorders, and in Luton this is particularly associated with cousin marriage (see section infant mortality).

8.1.2 What is the evidence base?

Good quality maternity care provides the opportunity to offer advice on lifestyle behaviours such as smoking, alcohol, medication and diet; advice which can help to reduce the risk of poor outcomes for children such as disabilities.²⁰⁹ The CMO recommends a named GP should be available for every child with a long-term condition to provide continuity of care.¹⁰⁴

The Government White Paper, Support and aspiration: A new approach to special educational needs and disability sets out a range of evidence that relates to what works in learning and achieving for children with SEN and disabilities:

- The most important factor in learning and achieving for a child with disabilities is the quality of teachers and teaching.
- High quality teachers trained to support a range of SEN are effective in driving up attainment.
- The most effective way for teachers to develop, after initial training, is to learn from each other. Those that have specialist knowledge and experience of working with children with SEN and disabilities are often well placed to develop the skills of their colleagues.
- For teaching assistants and support staff to have a positive impact, they need to be trained, supported, deployed and managed effectively in order to make a difference to the achievement of children with SEN.
- Schools that have used evidence-based therapeutic interventions as part of the Targeted Mental Health in Schools (TaMHS) approach for children with emerging mental health or behavioural problems have reported improved behaviour, improved attendance and fewer exclusions.²¹²

The Children and Families Act (2014)²¹³ introduced a new, single system from birth to 25 for all children and young people with SEN and their families. The Act aims to give children, young people and their parents and/ or carers greater control and choice in decisions and ensuring needs are properly met by:

- Each child having a new birth- to-25 education, health and care plan.
- Offering families personal budgets to commission the care they need.
- Improving cooperation and coordination between all the services that support children and their families, particularly requiring local authorities and health services to work together.

8.1.3 Local picture

There are four levels of learning difficulties:

1. Specific difficulties (like dyslexia).
2. Moderate learning difficulties.
3. Severe learning difficulties.
4. Profound and multiple learning difficulties.

A profile of learning disabilities in Luton is shown in Table 24 in which red/green denote statistically higher/lower than England.

Table 24: Learning disability profile in Luton, 2013/14)

	Luton	Birmingham	Sandwell	Slough	Bradford	England
Children with moderate learning difficulties known to schools per 1,000 pupils	14.9	32.5	24.3	12.1	18.0	15.6
Children with severe learning difficulties known to schools per 1,000 pupils	7.09	3.47	3.93		4.82	3.73
Children with profound and multiple learning difficulties known to schools per 1,000 pupils				0.92	1.97	1.27
Children with autism known to schools per 1,000 pupils	8.0	12.9	3.5	9.2	6.4	9.1

(Green – significantly better than England Average, Amber – similar to England average, Red – significantly worse than England average)

There were 457 children and young people on Luton’s disability register in 2014 compared with 376 in 2013. The register includes information on the type of disability; the number of professionals/services working with a family and the family’s evaluation of the impact their child’s disability has on the family (measured as high, medium or low) which is used to plan services accordingly.

At 31st March 2014, 509 of all ‘Children In Need’ were recorded as having a disability, this accounts for 14.9% of total ‘Children in Need’ compared with 13.2% nationally²¹⁴.

8.1.4 What is being done locally?

The Disabled Children’s Charter was launched in 2013 to support Health and Wellbeing Boards meet their responsibilities towards disabled children and their families.²¹⁵ The Council has signed the charter demonstrating its commitment to improving health outcomes for disabled children, young people and their families.

Luton’s disability register has 465 families registered (August 2014) of which approximately 100 families are not currently accessing social services.

For families who have a disabled child and are in need of additional support to manage their needs, support can be provided by the Luton Disability Team within Children’s Social Care. This includes short breaks (overnight and day care) as well as residential care for those children whose needs are so complex, they are unable to remain at home. Some children with a disability will also be subject of a child protection plan.

The Children with Disability team provided support to 407 children (31st December 2014). Of these, 331 children (81%) were receiving short breaks (66 of which were overnight breaks) and 275 were receiving direct payments during the first nine months of 2014/15.

Short breaks for disabled children and young people are broken into two categories:

- Group A includes those with Autistic Spectrum Disorder or those children and young people whose challenging behaviour is associated with other impairments such as severe learning disabilities.
- Group B includes those with complex health needs including those with disability and life limiting conditions, and/or those who require palliative care and/or those with associated impairments such as cognitive or sensory impairments and/or have moving / handling needs and/or require special equipment / adaptations.

In 2013/14, 323 children with disabilities were in receipt of short breaks, 79% were categorised as Group A and 21% as Group B. The number of children/young people in receipt of short breaks has gone down in recent years, however the number of hours has gone up, see Table 25.

Table 25: Children/young people in receipt of short breaks in Luton, 2010-14.

	2010/2011	2011/2012	2012/13	2013/14
Number of short break hours	72,865	84,428	83,541	89,938
Number of children/young persons in receipt of short breaks	515	532	474	323

To support those children who are coming to the end of their lives Luton has developed a comprehensive palliative care strategy detailing the pathways of care and multi-agency partnership and support arrangements.

1.1.1. Perspective of public/service users

The Council, through the Participation Officer, runs an annual ‘Take over Day’ event - a one day conference hosted and organised by young people with adults as the delegates. Delegates include The Council staff, NHS staff, Bedfordshire police, local Councillors, businesses and community members. In 2013, the event had a disability focus to raise awareness of the issues disabled children and young people face. Parents of disabled children are encouraged to feedback their views on services at their child’s review, through the Council’s website and via the compliments and complaints procedures.

1.1.2. Priorities

1. Improve outcomes and quality of life for disabled children, young people and their families through ongoing parent and child consultation to ensure services are responsive to need,

provide short breaks, childcare including 2 year old places, integrated care, early help and support and timely intervention.

2. Ensure all children with long-term conditions have a named GP who co-ordinates their disease management.
3. Ensure preventative action to reduce the number of children born with disabilities is taken (see parental behaviours and infant sections).

8.2 Young carers

8.2.1 Introduction

Young carers is the term used to describe a young person aged 18 years or younger who helps look after a relative who has a disability, physical illness, mental health condition or a drug or alcohol problem. They provide care often in the form of cooking, cleaning, or helping someone to get washed, dressed and move around. Young carers often provide emotional support to their parents, siblings and extended family members. It is estimated all carers save the economy £87 billion per year.²¹⁶

A national survey of 700 young carers aged 6-18 year identified:

- 39% of young carers' schools were unaware of their caring role.
- 60% of young carers said their teachers had no understanding of what life is like for them.
- over 50% did not feel supported even when teachers were aware of their caring role.
- 38% were worried about the person they care for while they are at school.²¹⁷

There is growing evidence that being a young carer has an adverse impact on the health, academic attainment and future employment opportunities and social and leisure activities of these young people. For example, young carers have significantly lower educational attainment at GCSE level, the equivalent to nine grades lower compared with their peers and are less likely to be in employment, education or training between the ages of 16-19²¹⁸. Despite growing awareness of the needs of young carers and increasing services available to support them, young carers remain less likely than other children to be in contact with social services and educational welfare services, services mandated to offer them support.²¹⁹

Young carers are more likely to:

- Come from a BME community: young carers are one and a half times more likely than their peers to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language.
- Have a disability: young carers are one and a half times more likely than their peers to have a special educational need or a disability.
- Live within a family in poverty: the average annual income for families with a young carer is £5,000 less than families who do not have a young carer.²²⁰

8.2.2 What is the evidence base?

The Young Carer (Need Assessment) Regulations 2015²²¹ states that from April 2015 all local authorities must carry out a young carer needs assessment in a manner appropriate and proportionate to the needs and circumstances of the young carer to whom it relates. This will identify what help the carer and/or family might need. The local authority must ensure those undertaking the assessments are appropriately trained.

If the young person is 16 or over, and not in full-time education they may be eligible for help finding work as well as help with family finances, for instance through benefits such as Carer's Allowance²²².

The Carers Trust 2012 guidance, Commissioning Services for Young Carers and their Families, outlines good practice in supporting young carers and their families requiring:

- A whole family approach.
- Targeted support for young carers and families.
- Early intervention and prevention.
- Support accessing to education, employment and training.
- Improved access to transport for young carers.
- Improving and maintaining the health and wellbeing of young carers.
- Transition support: seamless support from young to adult carer.
- Personalisation: individual budgets and direct payments.
- Workforce development and raising public awareness.
- Giving young carers a voice.²²³

In 2009, the Association of Directors of Children’s Services and Association of Directors of Adult Social Services published a model for Council’s to use to create a joint memorandum of understanding between directors of children’s and safeguarding services and adult social care. The guidance gives local authorities the tools to clarify thresholds and responsibilities in a document that can be used by all agencies working with young carers.²²⁴

There are five NICE Quality Standards with specific quality statements relevant to carers, including:

1. QS2 stroke.
2. QS1 dementia.
3. QS13 end of life.
4. QS11 alcohol dependency and harmful alcohol use.
5. QS3 venous thromboembolism prevention.

Young carers may be caring for adults with substance misuse (Sections 9.5 and 9.6), mental health problems (Section 9.2) or disability (Section 12).

8.2.3 Local picture

There were 2,018 young people known to be providing care in Luton in 2011, representing an increase of nearly 7% since 2001. There are an estimated 496 persons aged under 15 years who provide unpaid care in the borough, a 42% increase compared with 2001.²²⁵ The proportion of children providing care is shown in

Table 26. Young carers also tend to be younger in Luton compared with young carers nationally with:

- 2.7% (2.1% in 2001) of carers were aged under 15 years old, compared with 2.1% in England
- 11.1% of carers in Luton were aged under 25 years compared with 7.6% in England.²²⁵

Table 26: Children providing care in Luton, 2011.

	Luton	Birmingham	Sandwell	Slough	Bradford	England
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	0.21%	0.25%	0.29%	0.18%	0.21%	0.21%
Children providing care: % children aged < 15 who provide unpaid care	1.06%	1.10%	1.21%	1.12%	1.04%	1.11%

8.2.4 What is being done locally?

In 2014 there were 135 young people on the local Family Action (previous local provider) database, of these only a quarter were in receipt of mandated support services as of March/April 2014. Many of the families had not been in receipt of services for three years or more.

In April 2014, the charity 'Chums' (Child Bereavement and Trauma Service) was appointed the new provider for young carer's service. Referrals for young carer's service come from a range of services including education, social care, Child and Adolescent Mental Health Services (CAMHS) as well as self-referrals. They currently support 65 young carers and 39 families (September 2014) and provide:

- Support for young carers and their families including sports/activity days, workshops, one-to-one and group support and activities for whole family.
- Engagement with schools - 10 schools participate in the young carer's project and seven further schools are interested in participating in the scheme.
- Developing links with health services - an agreed referral process having been set up, and general information/literature to be made available and displayed within each surgery.
- Partnership working with VCS including Stepping Stones and Changing Lives, and parent groups to expand their reach to young carers.

8.2.5 Perspective of public/service users

As part of the national Children's Commissioner Takeover Day, young people in Luton are able to talk about the issues that really matter to them. The Takeover Day is organised and hosted by young people, with professionals from a variety of fields in Luton invited to gain a unique insight into the concerns and opinions of the town's youth. In 2014 a workshop on young carers provided an opportunity to raise awareness and increase understanding of the issues they face. Key feedback was that young carers didn't want to keep explaining their situation and they wanted their teachers and school to understand their carer responsibilities and be more supportive. Young people also perceived there was no strategic buy in and investment and there needed to be better information sharing, training of staff to identify and support young carers and offer carer respite.

8.2.6 Priorities

1. Reduce barriers to accessing services by raising awareness of the needs of young carers by providing training to schools, colleges, drug and alcohol services, primary care, domestic violence services and promote services on a range of different media.
2. Establish links and partnership working between services to identify young people in need of services and establish regular young carer forums especially within schools.
3. Improve data recording and sharing between services to better understand the needs and assets of young carers.

8.3 Children and young people living away from home

8.3.1 Introduction

Children who do not live within a secure family environment are at risk of achieving poor outcomes and failing to achieve their potential. This often includes children who could be either:

- Looked after children taken into care from Luton families and in home placements either in Luton's boundaries or in other areas of the country, and for whom the Council is responsible for ensuring and being assured of their care.
- Looked after children placed with carers in Luton by other local authorities who remain responsible for their care.
- Care leavers, who are young people who are transferring from being a looked after child to being an adult and responsible for their own care
- In private fostering arrangements.

Adverse health and wellbeing needs and outcomes for looked after children and care leavers can be significant, with an increased risk of mental, behavioural and emotional problems and often at least one physical health need. They are more likely to have speech, language, social and emotional attachment problems, bedwetting, soiling, coordination difficulties and vision problems. They are twice as likely than those not in corporate care to develop drug and alcohol problems, mental health issues and other unmet health needs. Females who have been in care have a significantly higher risk of a teenage pregnancy and are at greater risk of child sexual exploitation. Looked after children therefore often have quite considerable needs and require additional support to help them achieve their potential.²²⁶

At the end of March 2014, there were 68,840 looked after children and young people in England, the majority of whom were placed for reasons of abuse or neglect (55%). Three quarters of looked after children and young people were in a foster placement, while 12% were cared for in residential accommodation (secure units, children's homes and hostels).²²⁷

8.3.2 Risk factors and vulnerable groups

HM Treasury²²⁸ found that children in families experiencing five or more of the following issues were significantly more likely than other children to be excluded from school; enter care, or come into contact with the criminal justice system:

- Mental health problems.
- Disability.
- Substance misuse.
- Domestic violence.
- Financial stress.
- Neither parent in work.
- Teenage parenthood.
- Poor basic skills.
- Poor housing.

For some children and young people, care will be the best option for their secure health and wellbeing. The quality of services available to support families and help them to make the changes that will allow the child to live at home safely and identifying which children should enter care is a difficult decision, and factors which contribute to a child being more likely to enter care include:

- Parental abuse or neglect, or poor parenting due to parents' own needs such as poor mental health, a severe disability, or substance misuse.
- High conflict with their families.
- Significant conduct problems, making them difficult for their parents to manage and putting them at risk.²²⁹

8.3.3 What is the evidence base?

Services to support children living away from home are heavily led by legislation and associated guidance, and councils have a specific duty to these children as their corporate parents. The Children Act 1989, The Care Standards Act 2000 and accompanying regulations and guidance provide the legal framework for providing services to looked-after children and young people. Additionally the Family Justice Review (2011); Public Law Outline (2013); National Adoption Action Plan (2013) and the increased Government funding for adopter recruitment and adoption support have influenced local Council's responses.

The Department of Education has produced a number of statutory guidance document for looked after children in order to safeguard children and young people including;

- Designated teacher for looked after children.
- Roles and responsibilities of directors of children's services.
- Promoting the education of looked after children.
- Working together to safeguard children²³⁰.

NICE has produced a quality standard (QS31) defining the best practice for the health and wellbeing of looked after children and young people from birth to 18 years and care leavers and tailored resources for corporate parents²³¹.

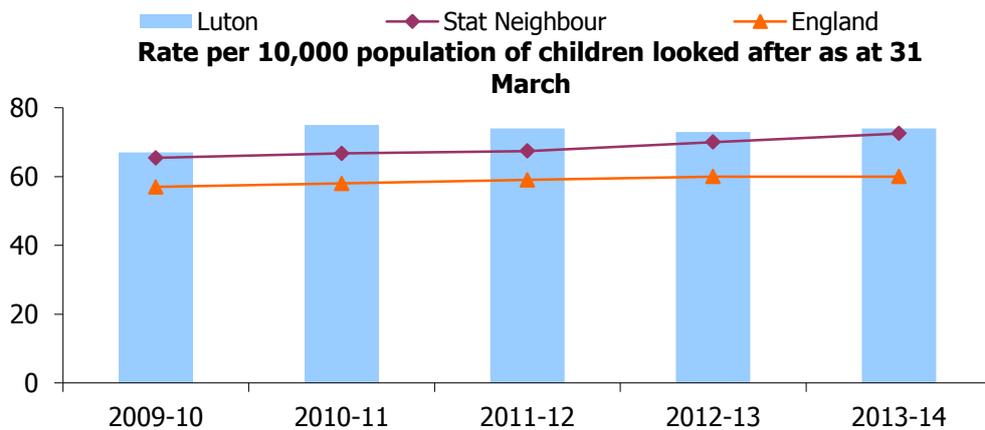
8.3.4 Local picture

Looked after children

In 2013/14, 180 children became looked after and under the care of the local authority, an increase on previous years. A further increase is anticipated in 2014/15 (170 children became looked after in the nine months to 31 December 2014).

At 31 March 2014 there were a total 397 looked after children (74 per 10,000 population) in Luton (Figure 53). This is slightly higher than the national average and statistical neighbours, but Luton's rate has remained relatively stable since 2010-11 compared with an increasing trend nationally. This rate is largely in line with expected levels based on the level of deprivation in Luton.²²⁷

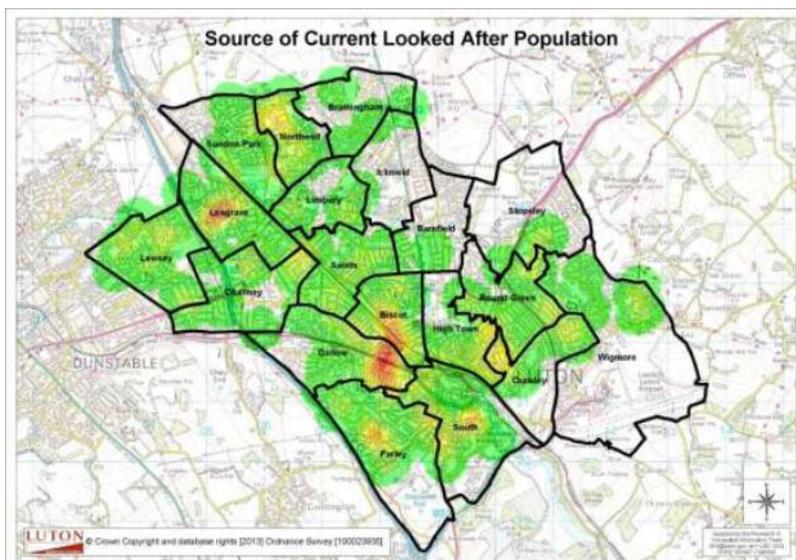
Figure 53: Looked after children, 2009/10 to 2013/14



Stat Neighbour = Comparator Areas.

Mapping the originating address of looked after children in 2013²³² showed that the children were largely (but not exclusively) mirroring the areas of greatest deprivation and over 80% of children coming into care were in rented accommodation and/or in households receiving benefits and/or overcrowded households.²³³

Figure 54: Looked after children population



Abuse and neglect and family dysfunction were the two main reasons why children in Luton become looked after (Table 27).

Table 27: Reasons for becoming looked after

Category	Luton (%)	Stat Neighbour (%)	England (%)
Abuse or neglect	59.0	64.5	55.0
Child's disability	4.0	2.5	2.0
Parents illness or disability	-	2.7	3.0
Family in acute stress	-	10.0	10.0
Family dysfunction	24.0	9.8	19.0
Socially unacceptable behaviour	-	7.1	4.0
Low income	0.0	0.0	-
Absent parenting	8.0	9.1	6.0

Source: DfES Children looked after in England (including adoption and care leavers) year ending 31 March 2014.

There has been a reduction in the number of children becoming looked after due to absent parenting, largely as a result of fewer unaccompanied asylum seeking children. However, the proportion of children becoming looked after due to a child's disability is twice the England average.

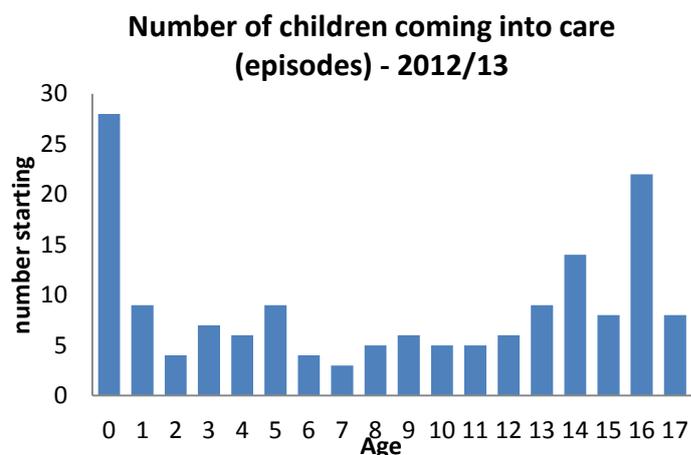
The Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) 2012²³⁴ required all remanded young people be treated as 'looked after' with financial responsibility passing to local authorities. In 2013/14 there were 14 young people in Luton in this category, all male, 50% of whom were already looked after children at the time of their remand.

Following the Laming report²³⁵ in response to the death of Victoria Climbié, regulations relating to private fostering were amended and strengthened by The Children (Private Arrangements for Fostering) Regulation 2005²³⁶. Private fostering arrangements can be a positive response from within the community to difficulties experienced by families, but privately fostered children remain a diverse and potentially vulnerable group of children who tend to be under-reported and hard to identify by many local authorities. Luton had fewer than 5 known about privately fostered children at 31 March 2014, and there has been little change in numbers over the past three years, in line with other authorities.

Age, gender and ethnic breakdown

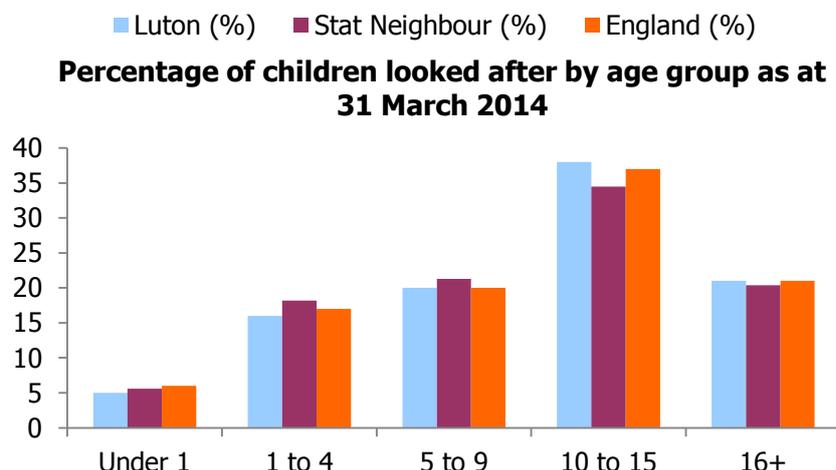
The key ages when children become looked after are babies (0 years old), age 5 and age 16 (Figure 55 and Figure 56). Reasons for children aged 16 and 17 years coming into care are less likely to be due to abuse or neglect and are usually due to absent parenting, family dysfunction or the family being in acute stress a national issue which is more pronounced in Luton. It is expected that a major factor for children aged 16+ coming into care will be the Southwark judgement²³⁷ which has realigned the housing responsibilities for homeless 16 and 17 year olds.

Figure 55: Number of children coming into care.



Source: The council Childrens Services.

Figure 56: Looked after children by age group, 2013/14.



Stat Neighbour = Comparator Areas.

Source: DfE Children looked after in England (including adoption and care leavers) year ending 31 March 2014.

The age profile of all looked after children at 31 March 2014 mirrors the national profile, with one in five children coming into care being under 5 years of age, 41% are under 10 years old, and 59% over 10 years old. However, in recent years the age profile has changed with babies coming into care again mirroring a national trend likely to be due to earlier identification of risk, particularly during pregnancy.

The ratio of male to female children coming into care is 53:47% respectively. The ethnic origin of Luton’s children in care was:

- 61% white.
- 12% mixed origin.
- 11% Asian.

- 10% Black.
- 5% 'Other' ethnic group.
- 2% information not recorded.

Compared with the ethnic profile of Luton's children as a whole there is underrepresentation in the Asian ethnic group and overrepresentation from the White ethnic group. There was no unaccompanied asylum seeking children reported in Luton during 2013/14.

Placement sufficiency

As at 31 March 2014, 77% of the 397 children in care were placed within the Luton area. Of these 59% were placed locally within the borough; 18% were placed in neighbouring areas and 22% were placed at a distance more than 21 miles from home. The vast majority of looked after children live in family based care^j with just 3% in specialist residential placements.

The reasons for placing children away from Luton include:

- Their safety.
- For adoption.
- To live with family members or carers who had moved away.
- Highly specialist placements.
- A suitable placement in Luton was unavailable at the time of need.

A total of 165 children ceased to be looked after in 2013/14. The rate was higher than comparator or England averages and has shown little change over the last three years. Almost half (48.5%) of children returned home, more than the England average of 33.8%. The proportion ceasing to be looked after due to adoption was low (3%), half that of the England average (6.1%); however, there more children were adopted in 2014/15. Almost a fifth (24%) of children ceased to be in local authority care for other reasons.

Outcomes

Health assessments, dental checks and immunisations are all key indicators for assessing looked after children's health. In 2013-14 health assessments were completed for 87.5% of looked after children, dental checks were completed for 71.8% and 78.2% of looked after children had up-to-date immunisations. There were 10 (3.9%) looked after children in 2013 who had a substance misuse problem compared with 3.6% in statistical neighbours and 3.5% nationally.

All looked after children between the ages of 4 – 16 years should have a strengths and difficulties questionnaire (SDQ)²³⁸ which assesses the emotional and behavioural health of children. During 2014 of the 217 eligible children, 122 (56%) questionnaires were completed and the average score of 14.1 (meaning slightly raised difficulties) was marginally higher than the previous year indicating increasing levels of difficulties and needs.

^j Foster carers, family / friends; supported lodgings or adopters.

The percentage of looked after children achieving 5 GCSEs grade A-C was 13.8% which was less than national average and statistical neighbours and significantly worse than non-looked after children in Luton.

Care leavers

It is important to ensure that young people have accommodation when leaving care to improve their outcomes and chances of making a successful transition to independence and adult life. Most (88%) care leavers were in suitable accommodation in 2013/14, compared with 78% nationally. In Luton 14% were in higher education compared with 6% nationally.²²⁷

Missing children and young people

Since April 2013 police forces have agreed new definitions of 'missing' and 'absent' in relation to children and adults reported to the police:

- Missing: anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be the subject of crime or at risk of harm to themselves or another.
- Absent: a person not at a place where they are expected or required to be.

Children missing from home

It is estimated that up to 10,000 children per year go missing from care²³⁹ and around 3,000 young people repeatedly go missing from care in England each year²⁴⁰ (representing approximately 4.5% of the looked after children population). If this estimate was applied to Luton, 18 looked after children may repeatedly go missing every year. Throughout 2013/14 and in 2014/15 year to date, the number of children who are missing at any one time is less than 5, but this may be the result of under-reported. During the period 1 April to 7 October 2014, 12 children had repeatedly gone missing from care.

The majority of all missing children are aged between 13 and 16 years of age, the highest number being at 15 years of age. Of the 431 reported missing incidents in Luton between April to December 2013 there were 5 who were victims of crime whilst absent and 21 who were involved in crime.

Children placed in Luton by other local authorities

Local authorities who place their looked after children with carers or children's homes in Luton are required by legislation to inform Children's Social Care, Education and Health services. Notification when these children arrive and move back out of the local area is not always made and therefore understanding the numbers of children from other local authorities can be a challenge. There are mechanisms to capture information, for example by liaison with providers in Luton and mailshots to all local authorities requesting information. As of 31st March 2014 there were 145 looked after children from other authorities placed in Luton.²⁴¹ Of all children looked after living in Luton, 38% were the responsibility of other authorities which is in line with comparator authorities and the England average (39%).

8.3.5 What is being done locally?

The Luton Children and Young Peoples Trust Board²⁴² has identified looked after children's as a priority in the Children and Young People's Plan. Luton's Children in Care Strategy 2013-2015 identifies objectives which reflect the key issues impacting the lives of looked after children and care leavers:

1. Support for children to remain with or safely return to their families.
2. Provide and commission the right mix of placements.
3. Improve outcomes, maximise the children's potential and celebrate achievements.
4. Plan effectively to promote stability and permanence.
5. Consulting with and involving children, young people, families and carer.
6. Promote positive transition into adulthood including enabling care leavers to live with their former foster carers up to the age of 21 ("stay put").

The council is leading on a collaborative framework agreement with Central Bedfordshire Council and Bedford Borough Council to promote and deliver better choice, access and quality of foster placements. The council has identified the need for more local placements and support.²⁴³

A new local strengths and difficulties questionnaire (SDQ) pathway was launched in November 2013 to improve the pathway for children who need additional support through child and adolescent mental health services (CAMHS) to improve emotional and mental health outcomes. The health needs of children in care are identified through their statutory health checks and assessments. Two new partnership pathways have been developed - a health assessment pathway and a strengths and difficulties pathway. These have been implemented to improve partnership working and services to looked after children. Luton Clinical Commissioning Group has commissioned a full time nurse to provide a health service for looked after children and care leavers up to the age of 21 or 25 if in full time education. Work is currently underway to improve coordination across this pathway.

For children in care with specific emotional health needs, referrals can be made to the MALT (Multi Agency Liaison Team) which provides intensive support including early intervention and CAMHS.

Luton's virtual school for children in care provides a focus on the education needs of all children of statutory school age who are in care. The virtual school supports schools, foster carers and social workers through training and advisory support. It also oversees the provision of the statutory Pupil Education Plan (PEP) and Premium Plus funding and support for looked after children.

The 16+ Homeless and care leaver's service provides 110 places for young people. This includes two mother and baby units providing 15 places. Approximately 50% are for homeless people including homeless young people aged 16+.

8.3.6 Perspective of the public/service users

National Youth Advocacy Service (NYAS) provides an Independent Visiting, Mentoring and Advocacy Service for looked after children in Luton²⁴⁴. Luton has a looked after children council, the Young People's Panel²⁴⁵, made up of young people in care and care leavers who advise the Council on improvements that should be made to the local care system. Key themes which came out of the Young People's Panel Action Plan include:

- **Choice:** improving placement choice and children/young people's opportunity to meet prospective carers prior to placement.
- **Information:** improving information for looked after children and care leavers about key professionals and how to contact them; review and refresh the 'Pledge' (a set of local authority commitments to looked after children).
- **Participation:** improved participatory and statutory reviews; Improve consultation with parents of looked after children.
- **Family and sibling contact:** children and young people want more unrestricted, informal contact with siblings; ensuring contact arrangements do not impede on children / young people's current social activities and education.
- **Readiness for independence:** improved support and readiness for leaving care; improved arrangements for savings, long term savings and access to bank accounts.

The panel has created a 'pledge' of what is expected, which has been implemented across Luton.

8.3.7 Priorities

1. Services should focus on supporting children to remain with, or safely return to, their families and take action to reduce the increasing demand on services'.
2. The Council and its partners should provide/commission the right mix of short and long term placements and work together to support improved outcomes for looked after children in all areas of their health, wellbeing, learning, safety, and economic well being.
3. The Council and its partners should provide services and support to promote positive transition of care leavers into adulthood, including enabling care leavers to live with their former foster carers up to the age of 21.

8.4 Children and young People involved in the Criminal Justice System

8.4.1 Introduction

Those aged under 18 years (10-17 years old), who have committed a criminal offence are classified as 'young offenders'.²⁴⁶ In 2012/13 there were 1.07 million arrests for notifiable offences in England and Wales of which 126,809 (11.8%) were of people aged 10-17 years.²⁴⁷ The number of arrests of young people fell by 24% between 2011/12 and 2012/13. This continues the downward trend seen since the peak in arrests in 2006/07.

Reductions have been seen in the number entering the system for the first time (first time entrants), as well as reductions in those receiving sentences in and out of court, including those receiving custodial sentences. The reoffending rate has increased, but there were significant falls in the number of young people in the reoffending cohort, the number of reoffenders and the number of re-offenses. Since 2010/11, there have been 51% fewer young people coming into the Youth Justice System and 40% fewer young people (under 18) in custody.

8.4.2 Risk factors and vulnerable groups

The majority of young people who offend have health, education and social care needs which, if not met at an early age, can lead to a lifetime of declining health and worsening offending behavior. The majority (73%) of young people released from custody re-offend within a year.²⁴⁸ Young offenders experience health that is worse than other people of their age, particularly in terms of behavioural and mental health problems^{249,250}.

The main risk factors of being a young offender include:

- **Gender:** more likely to be male.
- **Parenting/household:** living away from parents eg looked after children; problems at home or with their family; harsh discipline at home; trauma post abuse/neglect/domestic violence; homelessness or unstable accommodation.
- **Health:** previous history of alcohol or drug use, mental health problems (including emotional problems/attachment difficulties).
- **School:** experiencing bullying; being absent from school or being excluded from school; peer pressure.
- **Environment:** gang affiliation; limited access to youth-related services.
- **Disability:** quarter of those in custody have learning disability.^{251,252,253 254,255 256,254,257.}

8.4.3 What is the evidence base?

International and national evidence in reducing the risks of young people's involvement in drug misuse, crime and other antisocial behaviour include:

- Frequent home visiting by health professionals during pregnancy and infancy.
- Parenting support.
- High quality nursery education.
- School tutoring and changing school environment ie separate tutoring for high risk pupils.
- Behaviour and life skills strategies.
- Family therapy eg. behavioural parent training, multisystemic therapy, family function therapy and multi-dimensional treatment care.

- Treatment foster care (an evidenced based programme).
- Constructive leisure opportunities.
- Mentoring programmes.²⁵⁸²⁵²²⁵⁹

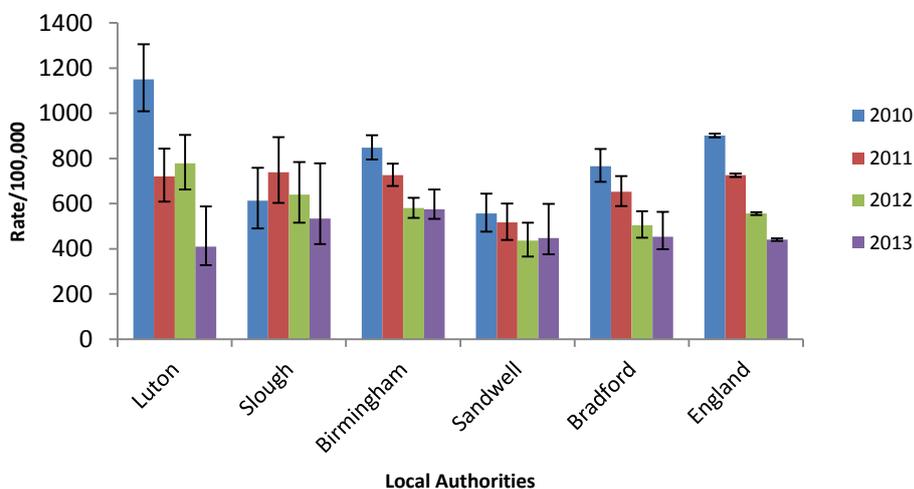
The Social Exclusion Unit when identified nine key factors influencing the likelihood of re-offending: education, employment, drug and alcohol misuse, mental and physical health, attitudes and self control, institutionalisation and life-skills, housing, financial support and debt, and family networks. for example, being in employment reduced the risk of re-offending by between a third and a half, and having stable accommodation reduced the risk by a fifth.²⁶⁰

Programmes which employ a broad range of interventions, applied to different risk factors are effective and cost effective²⁶¹ at reducing youth crime.²⁶²

8.4.4 Local picture

The primary aim of the youth justice system is to prevent youth offending, and the effectiveness of the system is therefore judged in part on its progress in reducing the number of young people entering the criminal justice system for the first time. In 2013, 87 juveniles aged 10-17 years old within Luton were first time entrants to the youth justice system (0.8% of the youth population 10-17 years old). The rate (410 per 100,000) is a 64% reduction compared with 2010 (1,151 per 100,000), which is a greater reduction than England (51% reduction) over the same period. Luton's rate is now below the England average, whereas it was significantly higher in 2010. Figure 57 shows Luton's rate for youth first time entrants to the youth justice system in comparison with England and statistical neighbours.

Figure 57: First time entrants to the youth justice system (10-17yrs)



In relation to its comparators, Luton had the highest rate in 2010 but the lowest in 2013. The rate of decline from 2010 to 2013 was greater than all other comparators as shown in Figure 57.

Of the Youth Offending Service (YOS) supervised caseload in 2013/14, the majority were aged 15-17 years old (81%), and male (87%). Those classified as White were the highest ethnic group (43%), followed by Asian or Asian British (22%), Black or Black British (18%) and Mixed (17%). Based on the 2011 census, this is a true representation of the proportion of the white population of 15-17 years old in Luton which has 46% white and under representation of the Asian/Asian British population

which has 33% Asian/Asian British, and over representation of the Black/Black British and the mixed population which has 11% and 8% respectively.

A third of cases (33%) were from LU4 postcode, with LU1 and LU2 having just under a fifth (18%) in 2013/14. This is a similar distribution to 2011/12, but this was more evenly distributed.

The reoffending rate in Luton 2014/15 was 36.3%, this is in line with national rate and that of the statistical neighbours.

The proportion of youth offenders classified with an emotional wellbeing need has increased from 57% (of 274) in 2010/11 to 73% (of 150) in 2013/14. There has been an increase in percentage of referrals to mental health services (25% to 31% during same time period); although a slight reduction in percentage of self-harm and previously attempted suicide (5% to 4%). The YOS has specific provision and defined pathways into specialised mental health services (Tier 3 and Tier 4).

Offenders with substance misuse needs have increased from 51% (of 140) in 2010/11 to 83% (of 125) in 2013/14; cannabis and problematic alcohol use are the main issues for children and young people known to the YOS.²⁶³

8.4.5 What is being done locally?

The purpose of the youth justice system is to prevent offending by children and young people between 10 and 17 years old, while safeguarding their welfare. Much of the local work has been based on national recommendations regarding the wellbeing of young people known to the criminal justice system such as The Bradley Report: five years on²⁶⁴ as well as third sector bodies such as The Prison Reform Trust²⁵⁴ and that of the Youth Justice Board.

The YOS works closely with other service providers including carers (CHUMS); criminal services (Police) and Adult Health providers. A Care Quality Commission (CQC) Inspection of YOS in 2012 highlighted the need for coordinated health assessment. All children known to YOS now have a health and specific speech and language screen to ensure there is a holistic assessment of their needs.

Training to non-NHS staff has been delivered on health issues, including concerns on substance misuse and mental health issues. There has been an increased focus on greater partnership working to have a more whole family approach.

Since 2012, the provision of dedicated health support has been developed in Luton and the YOS works with young people aged 10-17, as well as their families and carers. Carers/parents/siblings are supported and intensive family support is specifically targeted at most vulnerable including those identified within the stronger families programme.

The YOS is a key partner on the Bedfordshire wide Child Sexual Exploitation Panel and work in the development and launch of Multi-Agency Gangs Panel (MAGPAN) in Luton to ensure there is coordinated support for vulnerable children. Luton has been part of a Home Office peer review regarding Serious Youth Violence and Gangs, and YOS has the statutory responsibility for the delivery of risk-led interventions regarding under 18s for this area.

The YOS works closely with partners across Luton to implement the Luton Community Safety Partnership (soLuTiONs), Partnership Plan 2014-17²⁶⁵, particularly Priority 1 – gang crime, organised crime and most serious violence and Priority 3 – anti-social behavior.

There is a triage approach in Luton Police Station which provides a holistic assessment of all detained children/young people using common assessment framework/early help assessment. Where appropriate children are referred into appropriate support services. Children and young people who offend are defined as specific needs group within the Luton Emotional Health and Wellbeing Strategic Group Action Plan.

8.4.6 Perspective of the public/service users

In the Luton residents survey 2014²⁶⁶ residents were asked what issues caused problems in their local area. Residents reported an issue with gangs and youth violence in Luton and the perception was that the issue was getting worse. Almost a third of respondents (29%) believed there was an issue across Luton, 41% identified this was in some communities, whereas 29% believed there were localised issues. Just under two thirds (61%) felt the problem had worsened. This highlights youth-related anti-social behavior is a concern for Luton residents.

The annual evaluation from users of the YOS (43 responses) found that 74% of respondents reported that the YOS always or most of the time took their views seriously, 100% reported that the YOS did enough to help them take part in their YOS work and 84% reported that there wasn't anything that made them feel afraid. Most reported that things have got better for them at school, college and getting and job and 82% reported their work with the YOS has made them less likely to offend.

8.4.7 Priorities

1. YOS to continue and expand to develop a seamless approach of prevention with key partners including the police, schools and stronger families programme
2. Undertake qualitative evaluation with service users and partners to better understand their views and co-produce services between service users and professionals
3. Implement the Comprehensive Health Assessment Tool (CHAT) to ensure those in the secure estate and in the community receive a comprehensive assessment of their physical and mental health, substance misuse and neuro-disability needs and provide clarity of the needs of children and young people in the criminal justice system are supported.

8.5 Young person related violent crime, including gangs

8.5.1 Introduction

Young person related-violent crime and gangs involves a small number of individuals overall; however, the small number of young people who are involved have a disproportionately large impact on the communities around them in some parts of the UK.²⁶⁷ Young person related violent crime is any violent crime involving an offender aged 25 or below.

Young person-related crime can be a cause of ill health and poor wellbeing in local communities. As well as the personal cost, it can impose a considerable financial burden on local healthcare systems. Significant health inequalities are experienced by both those who are at risk of causing violence and those who are the victims of violence. It is clear that gang membership increases the risk of serious violence. Violence impacts on the wider wellbeing of local communities yet violence is preventable through appropriate targeted interventions, especially in childhood.²⁶⁸

A gang is defined as a relatively durable, predominantly street-based, group of young people who see themselves (and are seen by others) as a noticeable group, and engage in a range of criminal activity including violence. They may lay claim over territory have some form of identifying structural feature or be in conflict with other gangs.²⁶⁹ The crimes that are gang related are typically difficult to quantify. It is not always clear who is regarded as being gang members and it is not known which violent crimes are motivated due to gang affiliation or association.

Gang and knife-related youth violence has become a key cause of concern in England.²⁶⁷ Throughout the early to mid-2000s, both fatal and non-fatal violence involving young people increased. Homicides by 13-24 year olds peaked in 2007/08 (at around 180) and emergency hospital admissions for violence peaked in 2006/07 (at over 15,000). While both figures have since reduced, hospital admission rates for violence remain higher than they were a decade ago.²⁶⁸

8.5.2 Risk factors and vulnerable groups

There are particular risk factors and triggers that young people experience in their lives that can lead to them becoming involved in gangs. Many of these risk factors are similar to involvement in other harmful activities such as youth offending more generally or violent extremism.²⁷⁰ The Assessment of Children in Need and Their Families²⁷¹ grouped risk factors under the three headings: child development, parenting capacity and family/environment, as shown in Table 28.

Table 28: Risk factors for children in need

Child development	Parenting capacity	Family/environment
<ul style="list-style-type: none"> • Early problems with antisocial and criminal behaviour • Persistent offending • Unable to regulate own emotions and behaviour • Physical violence and aggression • Permanent exclusion from school • Friends condoning or 	<ul style="list-style-type: none"> • Historically involved with, or known to, social services • Lax parental supervision • Lack of parental attachment to child • Conflict and violence in the home • parental abuse • Parents aggressive towards, or unwilling to engage with, statutory 	<ul style="list-style-type: none"> • Family members involved with or associated with gangs • Wider family involved with gangs • Community norms that tolerate crime • local tensions between ethnic/cultural/religious gangs • Known gang recruitment at school

involved in antisocial and aggressive behaviour <ul style="list-style-type: none"> Alcohol and drug misuse 	agencies <ul style="list-style-type: none"> Child is not protected from significant harm or danger, including contact with unsafe adults 	<ul style="list-style-type: none"> presence of gangs in community High level of local crime including drugs market
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8.5.3 What is the evidence base?

Comprehensive interventions have a positive, but not statistically significant, effect in size reducing crime outcomes compared with usual service provision. These included:

- Case management/provision personalised to individual offenders.
- Community involvement in the planning of interventions.
- Community involvement in the delivery of interventions.
- Expertise shared between agencies.
- delivery of incentives to gang members to change offending behaviour, as part of a wider comprehensive intervention approach; for example, educational opportunities, tattoo removal, financial assistance, and recreational activities which may be more effective than those that did not contain one or more of these components.²⁷²

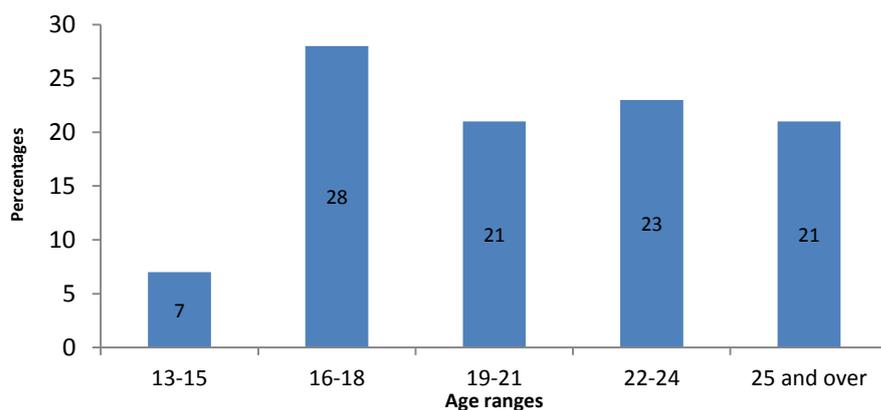
National policy²⁶⁷ on reducing gang crime focuses on providing expert advisors, promoting intensive family support, identifying mental health and substance misuse problems of those in custody, supporting ex-gang members to be re-housed and extending police powers to take out gang injunctions. There is also a focus on promoting local partnership working through multi-agency safeguarding hubs (MASH) and data sharing eg AandE departments to share anonymised data on knife and gang assaults.

8.5.4 Local picture

Since a high profile murder in Luton in September 2012, Bedfordshire Police recorded an increasing number of firearms and other related violent offending. Further research on the issue identified that this increase was largely influenced by violent crime involving individuals aged 25 and below, specifically those aged 18 or under, some of whom had links to gang related activity. In January 2014, the characteristics of a sample of people identified as related to this issue in Luton were analysed to produce a profile of gangs in the local area and to identify risk factors that lead towards youth-related violent crime²⁶⁵.

During May 2013, 160 individuals were linked to youth violence, either through involvement in specific incidents, or association or affiliation to particular groups. This group of individuals changes on a regular basis; however based on the cohort in May 2013, the age profile is, shown in Figure 58, which shows a fairly even split of gang members between the ages 16-24 years old.

Figure 58: Percentage of young people (by age) linked with youth violence, May 2013



Source: Bedfordshire Police

This cohort was predominately African Caribbean (63%) or White British (32%) and the areas of residence of gang members are concentrated in areas with higher deprivation, with Leagrave, Lewsey and Northwell having higher rates with fewer in Limbury and Icknield areas. The North and West of Luton have been the sites of substantial increases in most serious violence relating to offenders under 18 since end of 2012 and gang members generally live in specific, confined areas and offend within their own localities with the exception of the town centre area, which draws offending to the location.

Gang members are more likely to use cannabis, but there is little evidence of using harder drugs including cocaine and heroin. National studies have identified a potential link with substance misuse and health needs of offenders²⁷³. However offending is unlikely to be driven by drug addiction and is more likely to relate to more organised offending for financial reward or for reason of respect within peer groups.

A number of gang related individuals have had domestic violence and child abuse within their family backgrounds, and a number have been involved with social services and in foster care in the past. Almost half (47.5%) of gang related individuals are currently, or have previously, been linked to social or council housing addresses in Luton.

In Luton there is a relatively higher percentage of households rented from the local authority, especially in Lewsey, Leagrave and Northwell which are the areas with higher a residence of gang members. This is also the case in small areas of Icknield, Crawley and Round Green where gang member home addresses appear to be concentrated.

Over half of all gang related offenders have been excluded from school on at least one occasion, over two thirds of these exclusions relate to reasons of physical assault. Gang related offenders are more likely to target their friends and figures of authority between the ages of 13-15 years. This coincides with the average age for exclusions and may be an indication of violent or bullying behaviour within school.

Gang members appear to be grouped in areas where there are 20%-40% of households without qualifications. High concentration where for 20% to 25% households, the highest qualification is

National Qualifications Framework (NQF) level 1 and gang member home addresses correlate with areas of unemployment benefits claimants, especially in the Northwell.

Crime

Offending behavior of the Serious Youth Violence (SYV) group has been compared with general offending populations. In comparison to other offenders, those believed to be involved in SYV offending are more likely to be involved in gangs and gang related persons are 12 times more likely to commit murder than the rest of the offending population, however, some crime types, such as rape occur at a small level overall.

Gang members compared with the general offending population are more likely to be in possession of firearms; commit repeat robberies; rape or commit other sexual offences against females, have evidence of sexual exploitation (see section on Child Sexual Exploitation) and domestic violence; witness intimidation; and supply drugs²⁷⁴.

Victims of gang related crime in the main were males aged 16 to 24 years of age; however, there were also some potential issues identified in terms of female victimisation, specifically in the areas of domestic violence and sexual exploitation, which occurs at an average age of 15 years for offenders.

8.5.5 What is being done locally?

There is a broad range of prevention actions happening across Luton to reduce the risks of young people becoming involved in crime and gangs; these include actions within Flying Start programme around parental attachment, family nurse Partnership, supporting young mothers, youth substance misuse prevention, reduction of domestic violence and community development and engagement.

Tackling youth and young adult serious violence and gang related activity has become a priority for the Luton Community Safety Partnership (SoLUTiONs). The Gangs and Youth and Young Person Violent Crime Partnership Strategy Luton 2015-18²⁷⁵ is being implemented. It identifies, co-ordinates and leads on all aspects of the developing work on tackling and reducing gang related crime and disorder and the impact upon local communities. It covers all partners who together make up the Serious Youth Violence Coordination Group, in addition to wider identified community partners. This Gang Strategy is owned by the SoLUTiONs partnership.

The Community Safety Partnership Co-ordination Group has commissioned the introduction of a multi-agency referral system (MAGPan) to help agencies throughout Luton reduce gang violence. The intention is to identify lower level offenders who may be at risk of becoming involved in gang violence and to ensure that agencies are able to work with them before they become involved in more serious crime.

An individual can be referred to the MAGPan if they are involved, affected by or deemed to be at high risk of gang activity. The focus of the MAGPan is to support individuals, and where appropriate and their families so that they and the public are safeguarded. The over-arching purpose of the MAGPan is to safeguard the communities of the town from this type of serious criminal behaviour by delivering interventions to individuals and families that ideally prevent their involvement or, failing that, disrupt their criminal behaviour, whilst also providing support where appropriate.

Locations can be referred to the MAGPan when there is evidence/intelligence of a large number of incidents of serious violence and/or gang activity. This could be a single address or a larger geographical area, eg. a block of flats, park or parade of shops.

8.5.6 Perspective of the public/service users

A local survey conducted during August 2014²⁶⁶ indicated that those who live and work in Luton identified an issue of gangs and youth violence in Luton and the perception was that this is getting worse. 29% believed there was an issue across Luton, 41% identified that this was in some communities, whereas 29% believed there were a few localised issues of gang and youth violence. This highlights youth related anti-social behaviour is a concern for Luton residents.

8.5.7 Priorities

1. Develop shared data protocols to include data from accident and emergency and information pertaining to mental and sexual health to improve the targeting of preventative action.
2. Review the actions and outcomes of the Gang and Youth and Young Person Violent Crime Partnership Strategy to ensure there is appropriate impact of the strategy.

8.6 Child sexual exploitation

8.6.1 Introduction

Safeguarding children and young people from sexual exploitation defines child sexual exploitation (CSE) as:

"Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (such as food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities".²⁷⁶

CSE can occur through the use of technology without the child's immediate recognition; for example, being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Barnardo's has identified three different models of activity which are not exhaustive, and show a spectrum of exploitation:²⁷⁷

1. Inappropriate relationships usually involving one perpetrator who has inappropriate power or control over a young person.
2. 'Boyfriend' model of exploitation and peer exploitation.
3. Organised/networked sexual exploitation or trafficking young people.

CSE tends to be a hidden activity and much more likely to take place in private residences than visibly on the streets. It is unclear how many people are affected by CSE nationally or locally. Nationally there were 2,409 confirmed victims of CSE in either gangs or groups during the 15-month period from August 2010 to October 2011, although this is thought to be a substantial undercounting. In the year to March 2011, at least 16,500 children nationally displayed three or more signs or behaviour indicating they were at risk of CSE.²⁷⁸

Sexual exploitation can have a serious impact on the life of children and young people and the health impact on victims of child sexual exploitation are broad:²⁷⁹

- Long-term sexual, physical and psychological harm.
- Developing drug and alcohol misuse habit.
- Increased sexually risky behaviour (in some cases leading to teenage pregnancy or forced miscarriages).
- Domestic servitude, neglect and violence.
- Self-harm and suicide.

8.6.2 Vulnerable and at risk groups

Any child or young person may be at risk of sexual exploitation, regardless of their family background or other circumstances. This includes boys and young men as well as girls and young women. However, some groups are particularly vulnerable to CSE and typical vulnerabilities include:²⁸⁰

- Living in a chaotic or dysfunctional household (including parental substance misuse, domestic violence, parental mental health issues and criminality).
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect).
- Recent bereavement or loss.
- Gang association either through relatives, peers or intimate relationships.
- Attending school with young people who are sexually exploited.
- Learning disabilities.
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families.
- Friends with young people who are sexually exploited.
- Homelessness.
- Lacking friends from the same age group.
- Living in residential care.
- Low self-esteem or self-confidence.
- Being a young carer.

Technology forms part of most people's lives, especially those of young people. As a result it has been rare to identify cases of CSE where the use of technology has not been a factor. Information technology is having a direct impact in a multitude of ways on the means by which people are able to sexually exploit children.²⁸⁰

8.6.3 What is the evidence base?

The Office of the Children's Commissioner's inquiry into CSE in gangs and groups²⁸¹ identified 9 essential foundations of effective practice for safeguarding children and young people from sexual exploitation:

1. Focus on the child.
2. Gaining a child's confidence.
3. Effective leadership.
4. Strategic planning.
5. Everyone on alert.
6. Spotting the warning signs.
7. Joined-up working.
8. Early identification and pre-emptive action.
9. Scrutiny and oversight.

A briefing by Barnado's for local authorities²⁸² outlined the key components of effective local action on CSE:

- Raising awareness.
- Understanding what is happening.
- Developing a strategic response.
- Supporting victims of exploitation.
- Facilitating policing and prosecutions.

The Children's Commissioner study of gang-associated sexual violence towards, and exploitation of, young people in England²⁸³ recommends:

- Every school, education and health provider, youth service and other relevant universal service needs to promote understanding of healthy relationships, the concept of consent and the harm caused by rape and sexual assault.
- Every school and education provider must develop and implement whole school approaches to address all forms of sexual violence and exploitation, including sexualised bullying and coercive behaviour.
- All 'Ending Gang and Youth Violence areas should profile their street gangs with reference to sexual exploitation, identify girls and women associated with gang members, and link strategies that tackle serious youth and/or gang violence with those combating child sexual exploitation.
- Every local authority with a gang-affected neighbourhood – as part of their multi-agency gang work – should have trained and supported mentors and advocates to support young people who are at risk of becoming, or are, gang involved or affected by gang-associated sexual violence or exploitation.

8.6.4 Local picture

It is nationally recognised that it is difficult to provide an accurate estimate of an issue and activity likely to be greatly under identified and under reported²⁸⁴. Using information from a range of sources across the borough, Luton is starting to build a picture.

In the eleven months to end of February 2015, Children's Social Care had 99 assessments undertaken following referral that had CSE as one of the presenting factors (4.6% of all assessments). Three quarters (75%) of children and young people were female and 65% were aged 11-16 years. Just over half of the assessments resulted in a strategy discussion²⁸⁵, whilst 5% were stepped down to early help or other services, and 16% of children became children in need (eg. in receipt of children's social care services). Only 5% resulted in no further action due to assess level of risk, which is a much lower proportion than the proportion of all assessments for any reason, which result in no further action.

At 24 February 2015, 77 children were recorded as currently at risk of CSE on the children's social care database. These would be children who have been the subject of a risk assessment or referred to Child Sexual Exploitation Panel (CSEP). Analysis of the same information as at 7 October 2014 (76 children), 26% were children in need, 21% were looked after or cases closed and 16% care leavers.

The CSEP is a multi-agency meeting (statutory and voluntary sector agencies, ie housing, health, substance misuse providers, and criminal justice services involved in supporting children and young people who are or might be at risk of organised CSE) operating across Bedfordshire and acts as a

mechanism for referring and acting upon cases of suspected sexual exploitation. There were a total of 63 cases heard by the Bedfordshire CSE between January and September 2014 covering Luton and Beds. Almost half (31) of these related to Luton (determined by home address of victim). A large number of organisations contributed towards these referrals, including youth offending, health, and police; however the main sources of referrals in Luton were children's services and school/s colleges (7 each).

Owing to low numbers, it is not possible to identify hotspots of activity, however there is an identified vulnerability linked to looked after children and those in foster or care homes. There have been a number of offenders involved in exploitation on more than one occasion, either operating alone or as part of more organised groups.

The Council participated in an Ofsted thematic inspection in October 2014. This highlighted that a lot of work had been done in Luton. However, to further progress there is a need to: continue joining up our services and develop our workforce (knowledge of our social workers and developing use of enforcement processes).

8.6.5 What is being done locally?

Preventing CSE and intervening to protect and support victims can only be effective through effective multi-agency and partnership working. The Council and partner agencies recognise the risks posed by organised CSE and within neighbouring authorities such as Central Bedfordshire and Bedford Borough.

Service developments have, and will continue to be informed by the recent Ofsted Thematic Inspection on CSE and the commissioned National Working Group Review on CSE, which is due to be reported on in 2015.

CSE is a potentially significant issue for Luton due to factors including deprivation, an international airport, major road links and lastly the availability of cheap rental properties available across the town.

A draft Sexual Exploitation Strategy (covering both children and adults) and detailed strategic action plan has been developed and shared with the Pan-Bedfordshire Missing Children and CSE Strategic Group, which is accountable to the Bedford Borough, Central Bedfordshire and The Luton Safeguarding Children Boards.

This strategic group supports and fulfils the Board's statutory responsibility to co-ordinate, monitor, and evaluate the effectiveness of local arrangements to safeguard missing children and young people at risk of sexual exploitation, gangs, forced marriage, trafficking and female genital mutilation. The work of this group is supported by operationally by CSEP, where cases are reviewed following a single assessment and the completion of the Pans Beds CSE risk assessment tool.

A key priority contained within the strategic action plan is to ensure that the workforce, across the partnership, is sufficiently equipped, through professional knowledge, with skills and support to safeguard young people and adults, ably assisted by the right tools, resources and performance management systems.

The risk assessment in relation to CSE, was originally developed in relation to the CSE guidance in 2009 and updated by research undertaken by the University of Bedfordshire in 2012 and further updated in 2015. The tool is a guide to aid professional practice covering:

- Risk levels.
- Risk Indicators.
- Evident behaviours.
- Actions required.
- Pathways to referral/action.

A further intelligence mapping exercise across the authority and development of a performance management tool that sit alongside the Luton Sexual Exploitation Strategy and action plan will enhance the understanding of CSE, which will be completed in 2015 and provide supporting evidence for further enhancing our performance measures.

8.6.6 Perspective of the public/service users

The takeover day in 2012 which explored sexual exploitation found young people felt they needed to understand more about healthy relationships and this type of education should begin in primary schools. Young women felt a lack of confidence to say 'no' to sex and this was linked to low self-esteem.²⁸⁶

8.6.7 Priorities

1. Ensure there is a clear governance structure relating to CSE across the borough and pan Bedfordshire.
2. Develop a coordinated approach to the collection and collation of information locally to better understand CSE in Luton and update the sexual exploitation action plan accordingly
3. Implement the CSE Action Plan to ensure all relevant strategic documents and policies relating to safeguarding of children include risk of CSE.
4. Reduce and prevent the incidence of child sexual exploitation by raising awareness and improved communication across all agencies and in the wider community.

8.7 Safeguarding

8.7.1 Introduction

All services provided to children and their families have a duty to keep children safe. Child protection processes are set by legislation and supporting guidance which provide the framework in which services undertake these duties. Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcome²⁸⁷.

In the UK 142,500 child protection (Section 47) investigations were carried out during 2013/14 and 48,300 children were the subject of child protection plans in England.²⁸⁸ Poverty, poor housing and drug and alcohol availability are known to increase the likelihood of child abuse and neglect²⁸⁹.

8.7.2 Risk factors and vulnerable groups

Children in the following groups are particularly vulnerable:

- Disabled and having specific additional needs.
- Special educational needs.
- A young carer.
- Shows signs of engaging in anti-social or criminal behaviour.
- Lives in a family circumstance that presents challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- Previously been in care and has returned home to their family showing early signs of abuse and/or neglect.²⁹⁰

Contributory risk factors associated with to the need for increased safeguarding activity were highlighted by the Association of Directors of Children's Services (2014) (Safeguarding Pressures Phase 4):

- Funding reductions.
- Toxic trio^k and family circumstances.
- Welfare reforms and child poverty.
- Increasing population, and demographic factors.
- Special Educational Needs and Disability (SEND) reforms through the Children and Families Act 2014 which generate significant changes for disability services, schools, health and services supporting SEN children and their families.²⁹¹

^k The term 'Toxic Trio' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

Of those surveyed by the Association of Directors of Children Services, 52% of authorities believed the trajectory of demand for safeguarding services will continue to increase.

8.7.3 What is the evidence base?

The Children Act 2004²⁹² and Working Together 2015²⁹⁰ outline good practice for all professionals and set out procedures that must be adhered to; two key principles required for safeguarding services to be effective are that:

- Safeguarding is everyone's responsibility: each professional and organisation should play their full part.
- A child-centred approach is necessary: services should be based on a clear understanding of the needs and views of children.

It also asserts that for safeguarding procedures to be effective they must reflect the following:

- The child's needs are paramount, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates.
- All professionals who come into contact with children and families are alert to their needs and any risk of harm that individual abusers, or potential abusers, may pose to children.
- All professionals share appropriate information in a timely manner and can discuss any concerns about an individual child with colleagues, health services and local authority children's social care.
- High quality professionals are able to use their expert judgement to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child.
- All professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes.
- Luton safeguarding Children's Board (LSCB) coordinate work across agencies to safeguard children locally and monitor and challenge the effectiveness of local arrangements.
- When things go wrong to investigate and ensure that Serious Case Reviews (SCRs) are published and transparent about any mistakes which were made so that lessons can be learnt.
- Local areas innovate and change is informed by evidence and the examination of the data.

8.7.4 Local picture

The local picture described below follows the child's journey from the initial contact raising concern to social care services through child protection processes. The source of this data ranges from nationally available information such as DfE statistical first releases of statutory return data,²⁸⁸ Ofsted's Social Care Analysis Tool²⁹³, ADCS Safeguarding Pressures Research²⁹¹ and local in-year data for 2014/15 (nationally published in Autumn 2015).

Contacts and referrals

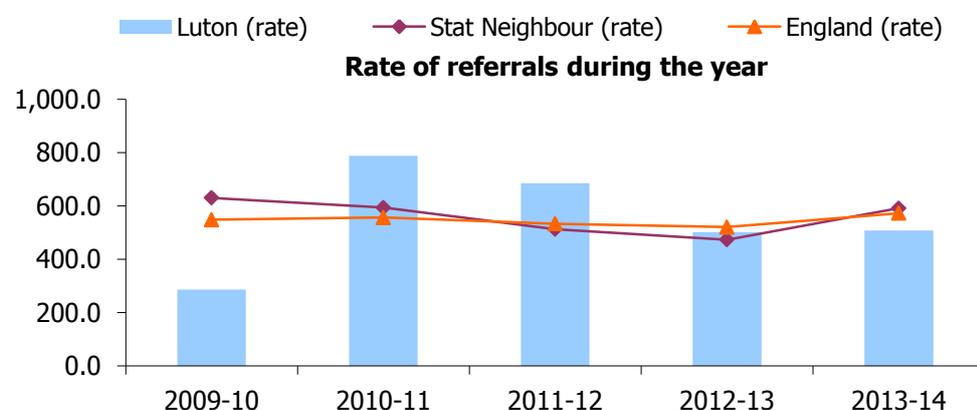
A 'contact' refers to a request for services or a notification made to Children's Social Care (in Luton, the Specialist Family Support Services). There has been some debate nationally as to the definition of a contact as processes differ from one local authority to another making comparison difficult. There were 16,375 contacts in Luton during 2013/14, equating to rate of 2,742 per 10,000 0-17 population (Table 29), a higher rate than England.

In 2013/14 there were 2,723 referrals received by children services in Luton. Over three quarters of these contacts resulted in 'no further action' for the service as either the contact was for information only, or the contact did not meet the threshold for a referral to social care services. Historically, there have been fewer referrals per 10,000 0-17 population in Luton than comparator authorities or England average (508 compared with 591 and 573 respectively). However this trend has now reversed with provisional in-year data during 2014/15 indicating that there was approximately 25% increase in referrals during this period (Figure 59).

Table 29: Contacts

Contacts: Rate per 10,000 0-17 population		Source					Total
		Education	Police	Health	Parent / Carer / Family	All Other	
2013/14	England Ave - Rate per 1000	230	682	257	210	643	2,021
	England Ave -%	11%	34%	13%	10%	32%	
	Luton -Rate per 1000.	387	971	426	216	743	2,742
	Luton - %	14%	35%	16%	8%	27%	

Figure 59: Referrals



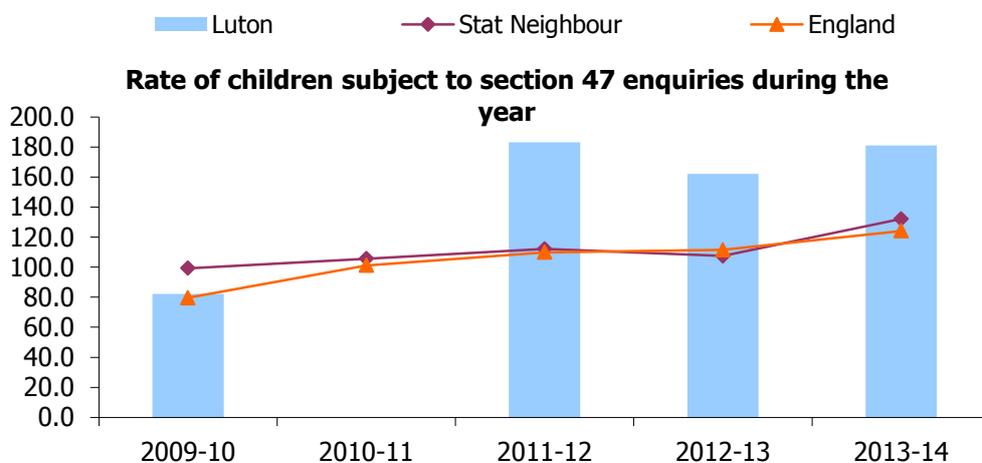
The largest source of referrals originated from Police (35%) or other (27%). This is in part explained by the process of police notification of all domestic violence call outs. Currently there are more children being referred at an earlier age (under 1) but referral also shows an increase in referrals in the 11-16 age group.

In 2013/14 there was a high and increasing proportion of total contacts being re-referrals (26%), a lower proportion of referrals that led to no further action (3.1% compared with 14.1% nationally) and more initial assessments per 10,000 0-17 population were completed in Luton (365) compared nationally (268) and with comparator authorities (296). Of the children referred who did go on to have an assessment, 18.7% were assessed to be children in need, similar to the England average of 19.4%. From February 2014, Luton introduced the single or continuous assessment to replace initial and core assessments, 1,822 of which were completed in the nine months to 31 December 2014.

Section 47 Enquiries and child protection conferences

Following a referral, when child protection issues are suspected an investigation is carried out under Section 47²⁹⁴ of the Children Act 1989. If substantiated it leads to an initial child protection conference and a multi-agency panel decision as to whether a child protection plan (CPP) is required to support the family together with a plan setting out changes required to keep the child safe.

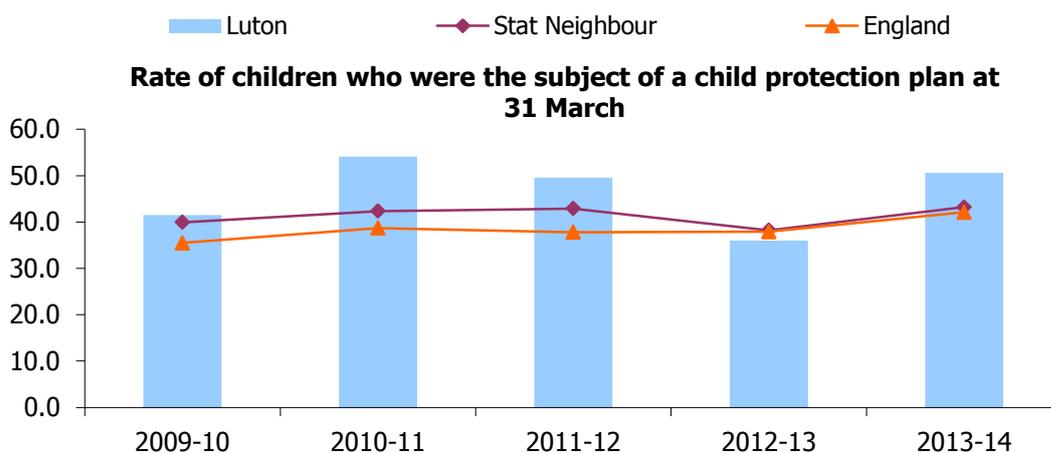
Figure 60: Children subject to section 47 enquiries



In 2013/14, there were 970 children in Luton subject to Section 47 (child protection) enquiries, a rate of 181 per 10,000 0-17 aged population, significantly higher than England and comparator authority averages (Figure 60). More children in Luton were also the subject of initial child protection conferences than nationally and the proportion held within 15 working days of the Section 47, a national performance indicator, was good at 76.1% compared with 69.3% nationally.

390 new children became subject of a plan in 2013/14, again much higher than comparators and an increase from previous years (Figure 61).

Figure 61: Children subject to a child protection plan



Over the past three years, the proportion of children who were the subject of second or subsequent child protection plans had increased to 24.6%. However, reduced to 16.0% at 31 December 2014 as a result of targeted actions. 271 children were the subject of child protection plans at 31st March 2014, with numbers increased to 312 at 31 December 2014.

Table 30 shows 44.3% of children were the subject of a plan under the category of Neglect, and 36.8% Emotional Abuse which are similar proportions to the England average, but fewer were the subject of Physical Abuse and more 'Multiple' categories (ie. more than one category which could reflect different ways of recording in other local authorities).

Table 30: Category of CPP

	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple
Luton (%)	44.3	-	-	36.9	14.4
Stat Neighbour (%)	38.7	7.5	5.8	40.7	11.5
England (%)	42.7	8.4	4.4	35.6	9.0

Approximately three quarters (76%) of children subject of child protection plans at 31 March 2014 were aged 0-10 years, slightly higher than comparator authorities. Children will generally remain subject of a child protection plan for less than two years, with a higher proportion compared with comparator areas ceasing within three months or six months (Table 31).

Table 31: Length of CPP

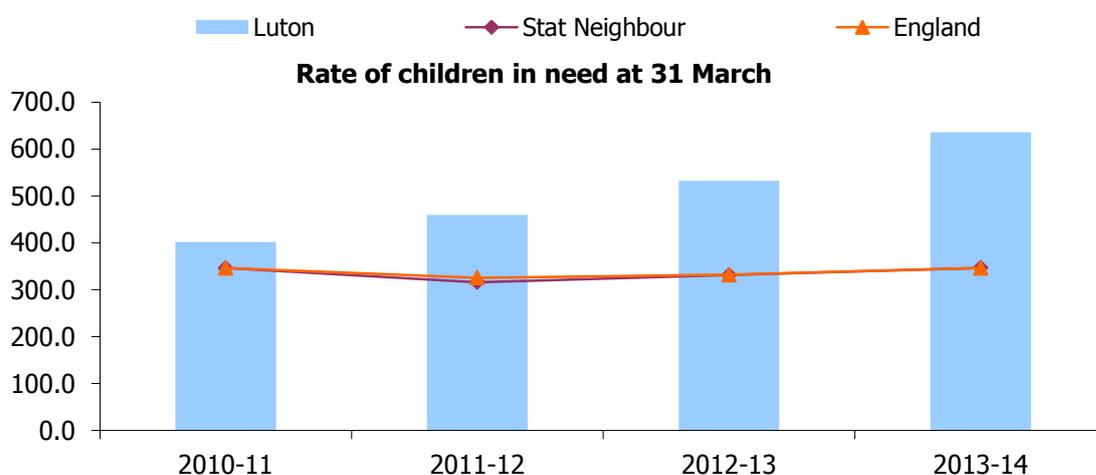
2013/14 (percentage)	3 months or less	Over 3 months, up to 6 months	Over 6 months, up to 1 year	More than 1 year, less than 2 years	2 years and over
Luton	32.7	17.5	27.5	15.2	7.1
Statistical Neighbours	21.0	11.5	39.8	23.9	3.7
England	20.3	10.3	40.4	24.5	4.5

In summary, whilst the profile of children subject of child protection plans and categories are broadly in line with comparators and England average, there is a greater number of children involved than comparator authorities which could be due to a combination of greater levels of need, and/or lower thresholds for CP, also evidenced by the plans lasting a shorter length of time.

Children in need

There were 3,408 children in need²⁹⁵ at 31 March 2014 in Luton. There has been a year on year increase for the past four years and significantly higher than comparator authorities and England. The number started to show a decrease in 2014/15 to 2,672 at 31 December 2014 with a forecast for a continued decrease.

Figure 62: Rate of children in need



Within Luton, cases were open for longer than national and comparator authorities. 26.8% children in need cases were open for over two years compared with 31.6% England average.

509 of the children in need at 31st March 2014 (14.9% of the total) were children with a disability, compared with 13.2% England average. Latest matched education data (2012/13) shows that the proportion of children in need with a statement of special educational needs (24.5%) is in line with the England average.

8.7.5 What is being done locally?

Local qualitative audits have shown that some children may be subject to the more intrusive Child Protection response than that of their identified needs. Actions to reduce the number of children subject to a child protection plan, children in need and a review of services have been undertaken recently. These include remodelling the 'front door' for children's social care through a Rapid Intervention and Assessment (RIA) Team which has started to have an impact on how referrals are managed and intervene more rapidly to resolve problems at the earliest opportunity.

A specialist single point of contact team was created in February 2015 to work alongside RIA to provide responses where child sexual exploitation and/or domestic abuse were presenting issues, or

where children are missing. This team works closely with the police to identify, risk assess and to support this vulnerable group co-ordinate agencies.

The Children and Learning Department is undertaking a longer term strategic improvement programme throughout 2015/16 to provide support through a remodelled early help service. The aim will be to maintain services to children who meet the social care threshold (children in need and children who are the subject of child protection plans), and through clarifying thresholds at key decision points; reducing social work caseloads through additional social work posts and actively addressing recruitment and retention of social workers; and improving processes and practice within the service. Together with LSCB developments to strengthen the partnership approach to safeguarding and provide a better multi-agency picture of safeguarding.

8.7.6 Perspective of the public/service users

Working Together²⁹⁰ states that children identified that they need:

- Vigilance: to have adults notice when things are troubling them.
- Understanding and action: to understand what is happening; to be heard and understood, and to have that understanding acted upon.
- Stability to be able to develop an ongoing stable relationship of trust with those helping them.
- Respect: to be treated with the expectation that they are competent.
- Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans – especially about themselves.
- Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response.
- Support: to be provided with support in their own right as well as a member of their family.
- Advocacy: to be provided with advocacy to assist them in putting forward their views.

8.7.7 Priorities

1. Improve the voice of the child in safeguarding and ensure views and wishes of children are explicit in all children's safeguarding.
2. Reduce caseloads, and ensure that any delays in child protection and looked after children work is minimised.
3. Make sure that thresholds and step up and step down processes between early help and children's social care services promote the right help for children and families at the right time, resulting in a reduction in re-referrals.
4. Embed the newly formed Single Point of Contact team to improve the borough-wide response to domestic violence, child sexual exploitation and children who go missing.

9 Adult wellbeing

9.1.1 Background

Much ill health could be prevented through addressing some of the key lifestyle issues in Luton including smoking, obesity, physical inactivity, and alcohol and drug misuse. Through local consultation with the public and other stakeholders, mental health was highlighted as a specific issue – not just the focus on improving services for people with mental health problems but also the need to promote positive mental health and wellbeing and so this along with dementia, adults with learning disabilities and autism are included as new priorities within this section. This JSNA identifies population groups with specific health and wellbeing needs and provides detailed information on the following areas:

Adults	Ageing Well	Vulnerable Adults
<ul style="list-style-type: none"> • Alcohol-related harm • Drug-related harm • Long term conditions • Mental health and wellbeing • Obesity • Physical activity • Sexual health • Tobacco 	<ul style="list-style-type: none"> • Care during last years of life Dementia • Demographics • Falls • Independent living • Social Isolation and loneliness 	<ul style="list-style-type: none"> • Autism • Carers and their health • Domestic violence and abuse • Learning disabilities

9.2 Adult mental health and wellbeing

9.2.1 Introduction

Mental health is described as 'the emotional and spiritual resilience which enables people to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of wellbeing and underlying belief in people's own and others' dignity and worth'.²⁹⁶ Mental health influences how people think and feel about themselves and others and how they interpret events. It affects capacity to learn, to communicate and to form and sustain relationships as well as influencing ability to cope with change, transition and life events²⁹⁷. Mental health and wellbeing has a strong impact on physical health and is central to all health and wellbeing.

The World Health Organization concluded that the impact of depression on a person's functioning was 50% more serious than angina, asthma, diabetes or arthritis.²⁹⁸ Mental ill health is Britain's biggest social problem.²⁹⁹ At present, 40% of disability is due to depression and anxiety. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also result in £15.1 billion in reduced productivity. Poor quality of life through physical illness is closely related to mental health problems.

Impact and consequences of mental health problems:

- At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time with about one in 100 people having a severe mental health problem.³⁰⁰
- Adults with mental health problems are twice as likely to report experiencing a long-term illness or disability and over two-thirds of people with a persistent mental health problem have a long term physical complaint.
- Mental ill health is the largest single cause of disability.
- People with severe mental illness die on average 20 years earlier than the general population.
- Adults with mental health problems are among the most excluded groups in society.

9.2.2 Risk factors and vulnerable groups

There are many mental health risk factors. Some of the key mental health risk factors include:

- Socioeconomic factors – such as inadequate housing, debt and levels of social support at both an individual and community level.
- Unemployment – this is both a cause and a result of mental ill health.
- Social exclusion – rates of mental illness are higher in socially excluded groups such as offenders, refugees, some immigrant groups and homeless people.
- Sexuality – coming to terms with an identity that is different to that of most of your peers, or coping with ignorance, prejudice and discrimination can be confusing and distressing. People who are lesbian, gay, bisexual or transgender (LGBT) are at greater risk of some mental health problems.
- Ethnicity – African Caribbean people are more likely to be diagnosed with and admitted to hospital for psychosis than any other group. Rates of depression have been shown to be higher in Indian and Pakistani women.³⁰¹

9.2.3 What is the evidence base?

NICE has produced a number of guidance documents to help identify and treat mental illness and improve mental wellbeing in adults. These include:

- Antenatal and postnatal mental health: clinical management and service guidance.³⁰² – evidence-based advice on recognition, assessment, care and treatment of mental health problems in women planning pregnancy, during pregnancy and the postnatal period.
- Occupational therapy and physical activity interventions to promote mental wellbeing of older people in primary care and residential care.³⁰³
- Promoting mental wellbeing at work³⁰⁴ - recommendations cover five areas: strategy, assessing opportunities for promoting mental wellbeing and managing risk, flexible working, the role of line managers, and supporting micro, small and medium-sized businesses.
- Quality standard for service user experience in adult mental health³⁰⁵ - outlines the expected level of service from NHS mental health services.

Guidelines and quality standards are in development to be published over the next two years including mental health of adults in contact with the criminal justice system and antenatal and postnatal mental health.

9.2.4 Local picture

Various social, economic and physical environments affect a person's mental health at different stages during their life. One major contributor is social inequality; Luton's population may therefore be at a greater risk of mental health problems compared with England because there is a higher level of socioeconomic deprivation which can lead to:

- Low educational attainment.
- Material disadvantage.
- Unemployment.
- Debt.
- Social isolation.^{306,307}

In Luton, it is estimated that in 2014 there were 21,055 people aged 18-64 years with a common mental disorder³⁰⁸ - approximately 6% of the 18-64 age group. Of these:

- 587 are estimated to have a borderline personality disorder (best understood as a disorder of mood and how a person interacts with others).
- 467 are estimated to have anti-social personality disorder (characterised by impulsive, irresponsible and often criminal behaviour).
- 523 are estimated to have a psychotic disorder (psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions).

Common mental health disorders

Common mental health disorders include mild to moderate depression and anxiety disorders (including Generalised Anxiety Disorder (GAD), Phobias, Obsessive Compulsive Disorder (OCD), and Panic Disorder).

Figure 63 shows self-reported wellbeing scores and emergency admissions for neuroses in Luton were similar to England and comparators. The proportion of referrals (in month) waiting less than 28 days for first treatment and those accessing IAPT services as a percentage of all patients with anxiety/depression known to GP's is significantly higher than England. As is new cases of depression, however this could be due to differences in levels of diagnosis and data recording between practices rather than true incidence. In addition, completion of IAPT services, assessment of depression and adults with depression known to GPs were significantly lower than England. Luton's IAPT service, known as the Luton Wellbeing Service, was not set up until 2014.

Figure 63: Common mental health disorders – snapshot of indicators from profile

Indicator	Year	Luton	Eng Avg	Eng Worst	England Range	Eng Best
1 Self-reported well-being - high anxiety score	2013-14	23.4	20.0	29.3		9.3
2 Self-reported well-being - low happiness score	2013-14	10.6	9.7	15.0		5.8
3 Self-reported well-being - low satisfaction score	2013-14	5.0	5.6	12.7		3.3
4 Self-reported well-being - low worthwhile score	2013-14	4.2	4.2	7.7		2.9
5 Emergency admissions for neuroses	2011-12	12.8	16.8	57.7		0.0
6 New cases of depression	2013-14	1.2	1.1	2.1		0.5
7 Access to IAPT services	March 2014	17.0	12.9	0.3		57.2
8 Completion of IAPT treatment	Q3 2014-15	240.0	278.1	66.8		580.9
9 Waiting < 28 days for IAPT	June 2014	74.6	65.9	7.1		100.0
10 Assessment of depression	June 2014	62.1	75.8	47.2		90.2
11 Adults with depression known to GPs	2013-14	5.4	6.5	3.1		12.4

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Source: This is a snapshot of the PHE Common Mental Health Disorders Profile³⁰⁹, more indicators are available; spine chart re-created by Luton Public Health.

Table 32 summarises the prevalence estimates for Luton population aged 18-64 years from 2014 to 2018. It shows (if prevalence estimates remained the same) the numbers expected to have a mental health problem in Luton based on population growth.

Table 32: Estimated prevalence aged 18-64 years

	Males					Females				
Mental Health	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Common mental disorder	8,388	8,513	8,650	8,738	8,850	12,667	12,766	12,904	13,022	13,081
Borderline personality disorder	201	204	208	210	212	386	389	393	397	398
Antisocial personality disorder	403	409	415	409	425	64	65	66	66	66
Psychotic disorder	201	204	208	210	212	322	324	328	331	332
Two or more psychotic disorders	4,630	4,699	4,775	4,823	4,885	4,823	4,860	4,913	4,958	4,980

Source: PANSI308

Severe mental illness

Severe mental illness may include conditions such as bi-polar disorder or schizophrenia but for a diagnosis of severe mental illness certain criteria are met which are dependent on the severity and the duration of the mental health problem. The key points from the current severe mental illness profile³¹⁰ are:

Estimated incidence of psychosis in adults aged 16-64 years

- Significantly higher in Luton (35.4 per 100,000) compared with England (24.2 per 100,000).
- Similar in Luton to comparator areas¹ (33.06 per 100,000).

Mental health admissions to hospital

- Significantly higher in Luton (127 per 100,000) compared with England.
- Significantly higher in Luton than comparator areas (63 per 100,000).

Physical health checks for people with serious mental illness

¹ Birmingham South and Central CCG, Hillingdon CCG, Redbridge CCG, Slough CCG and Wolverhampton CCG (for historical purposes)

- Significance not tested but lower in Luton (69.2%) compared with England (76%) and increasing at a slower rate (1% compared with 6%).
- Lower than all comparator areas and increasing at a slower rate (1% increase in Luton compared with an average 9% increase in comparator areas).

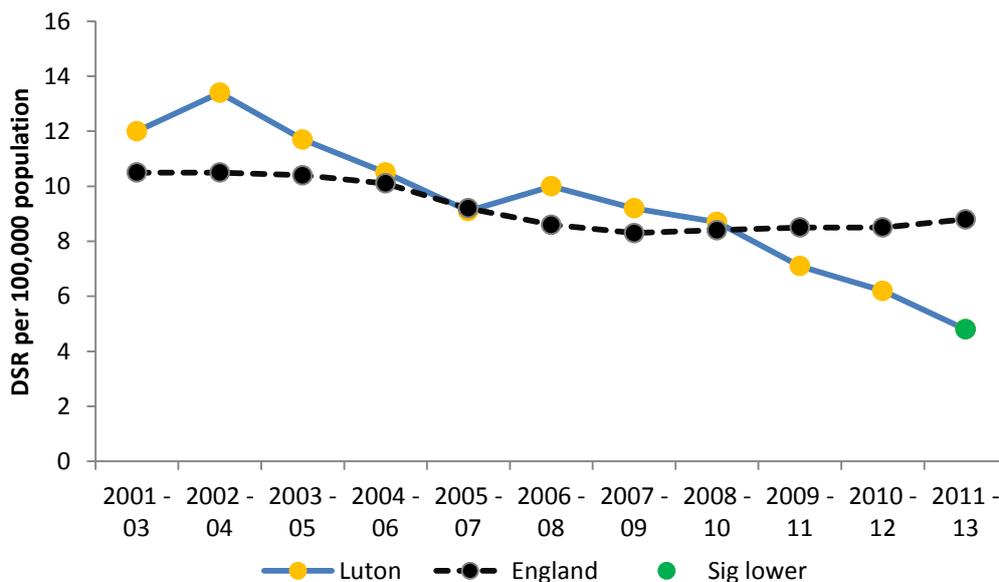
Excess premature deaths in adults with serious mental illness

- The rate in Luton (320.4 per 100,000) is similar to England (347.2) but increasing at a faster rate (45% increase compared with 6% nationally from 2009/10 to 2012/13).

Suicide and undetermined injury

There were 30 deaths in Luton from suicide and injury undetermined between 2011 and 2013. As shown in Figure 64 the figures for Luton were previously higher than England (2008-10) but not significantly different. Since 2006-08, the directly standardised rate for Luton has been on a downward trend and the latest data (2011-2013) shows a rate of 4.8 per 100,000 people. This is, for the first time in over ten years, significantly lower than England (8.8 per 100,000 people).

Figure 64: Suicide rate



Source: PHOF and Luton Public Health

A local suicide audit was conducted at the Bedfordshire Coroner's Office for 2013-14 which reported nine suicides (eight males, one female) and four open verdicts in Luton (some complex cases can take several months to reach the Coroner's Court and it is possible that not all the data may yet have been captured for the year 2013-14). Overall suicide figures have not changed significantly compared to suicide audits for 2011-12 and 2012-13.

9.2.5 What is being done locally?

Luton Clinical Commissioning Group is currently reviewing the structure of reporting and governance arrangements that relate to mental health and wellbeing provision across Luton to enable a more co-ordinated approach.

In 2014 a Luton specific Self Harm and Suicide Reduction Group was set up with key partners across Luton with the aim of reducing suicide and self-harm. Part of the work plan is to continue to undertake an annual suicide audit to better understand the local picture and an action plan is being developed.

A public health mental health work plan is being implemented which aims to raise awareness and improve the understanding of mental health issues, reduce the stigma and discrimination associated with mental ill health, and to encourage people to get early support if required. To this end a programme of Mental Health First Aid (MHFA) training is being rolled out across Luton within communities and workplaces. This is part of a national programme and links to other campaigns and events such as the Time for Change programme and World Mental Health Day. Other work includes support for, a Books on Prescription scheme through the local libraries, promoting the Five Ways to Wellbeing messages, developing Health Champion volunteering programmes and looking at what specific support some more vulnerable groups may require.

In 2014, the Council researched the nature and extent of loneliness and social isolation in the community and suggested ways forward to reduce the impact (See section 11.7). Much of this work is being incorporated into a new Social Prescription programme in Luton which aims to identify and support people with mild to moderate mental health problems or social isolation issues to access appropriate services, learning opportunities or community initiatives.

A new IAPT service, which started in 2014 takes referrals from GPs and other health professionals and accepts self-referrals and links are now being made with other statutory and third sector organisations ie Live Well Luton to increase its reach. There is a primary care liaison officer based at each GP cluster to support primary care.

A Mental Health Crisis Care Concordat is being developed across Bedfordshire and Luton which aims to improve the outcomes for people experiencing mental health crisis. This concordat looks at issues around early intervention, emergency access to crisis care, the quality of treatment and care when in crisis and recovery and staying well.

9.2.6 Perspective of the public/service users

The Adult Social Care Survey results for 2012-13 show the satisfaction of patients with social care, support and protection was significantly lower than England with 60.1% reporting satisfaction with care and support compared with 64.1% nationally and 63.5% reported that services made them feel safe and secure compared with 78.1% nationally. These relate to all adult social care users, not just those with mental health conditions.

9.2.7 Priorities

1. Identify high risk groups and improve physical health of people with mental illness including encouraging take up of the NHS Health Check programme.
2. Expand prevention and wellbeing services to reduce the need for acute services and hospital admissions, to include the set up and roll out of a social prescription programme and a programme of Mental Health first Aid (MHFA).

3. Introduce Individual Placement and Support (IPS) to support people with mental health into employment and to stay in employment.

9.3 Adult physical activity

9.3.1 Introduction

Physical inactivity has been identified as the fourth leading risk factor for global mortality.³¹¹ Increasing physical activity levels has the potential to dramatically improve both physical and mental wellbeing, reduce all-cause mortality and improve life expectancy; For example, increasing physical activity levels helps to prevent and manage more than 20 long-term conditions including coronary heart disease, cancer, diabetes, dementia, musculoskeletal disorders, obesity, stroke and mental illness.³¹² The estimated direct cost of physical inactivity to the NHS across the UK is more than £1.6 billion per year.³¹³

Recommendations by the Chief Medical Officer state that adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate-intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.³¹⁴ Physical activity includes everyday activity such as walking and cycling, work-related activity, housework, DIY and gardening. It also includes recreational activities such as working out in a gym, dancing, or playing active games, as well as organised and competitive sport.

Benefits of maintaining the recommended levels of physical activity include:

- A 30% lower risk of early death;
- Up to a 35% lower risk of coronary heart disease and stroke.
- Up to a 50% lower risk of type 2 diabetes.
- Up to a 50% lower risk of colon cancer, up to a 20% lower risk of breast cancer.
- Up to an 83% lower risk of osteoarthritis, up to a 68% lower risk of hip fracture, a 30% lower risk of falls (among older adults).
- Up to a 30% lower risk of depression.
- Up to a 30% lower risk of dementia.³¹²

9.3.2 Risk factors and vulnerable groups

Key risk factors of those more likely to be inactive are:

- Females, starting from adolescence.
- Adults, especially older adults.
- Black and minority ethnic groups.
- Living in a low-income household.
- People living with a disability.

9.3.3 What is the evidence base?

The NICE local government briefing for physical activity highlights the need for a wide ranging programme of initiatives involving all local authority departments;³¹⁵ these include encouraging change in:

- Service planning and commissioning – ensuring local strategies support physical activity.

- Walking and cycling – including reducing road danger and perceptions, ensuring adequate network of paths and recognising health benefits.
- Leisure and sport facilities – safe, easy to reach and suitable for a range of population groups.
- Natural environment – green spaces and play areas.
- Built environment – encourage physical activity such as use of stairs.
- Schools and colleges – multi component physical activity programmes and playground design.
- Workplaces – work based physical activity programmes.

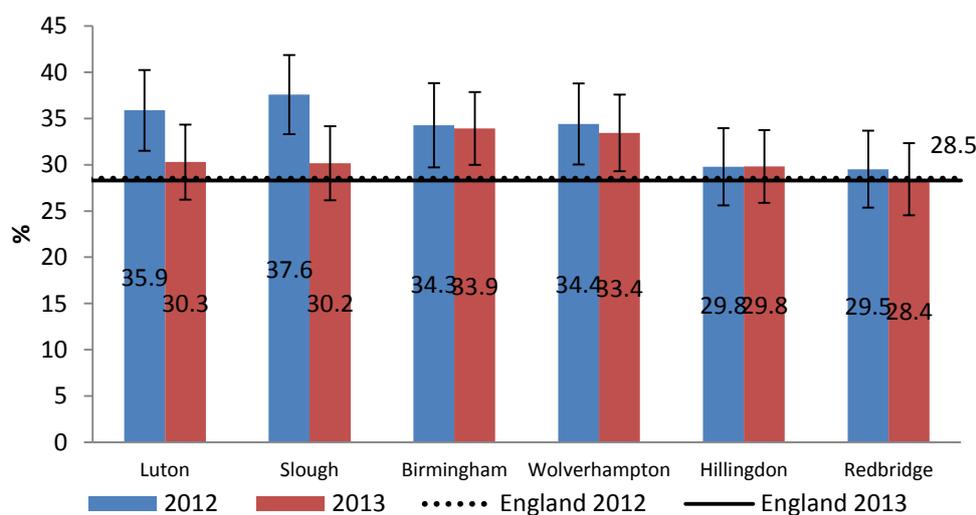
Recent guidelines are available for exercise referral schemes that try to increase physical activity among people who are inactive or sedentary and are otherwise healthy or who have an existing health condition or other risk factors for disease.³¹⁶ Commissioning guidance is available for those working in primary care whose remit includes offering lifestyle advice, examples include: exercise professionals, GPs, health trainers, health visitors, mental health professionals, midwives, pharmacists, practice nurses and physiotherapists.³¹⁷

9.3.4 Local picture

In 2014, Luton was identified as the 12th (out of 150) most inactive local authority area in England.³¹⁸ Luton also had a higher-than-average rate of premature deaths: 306.7 per 100,000 compared with 281 per 100,000 in England.

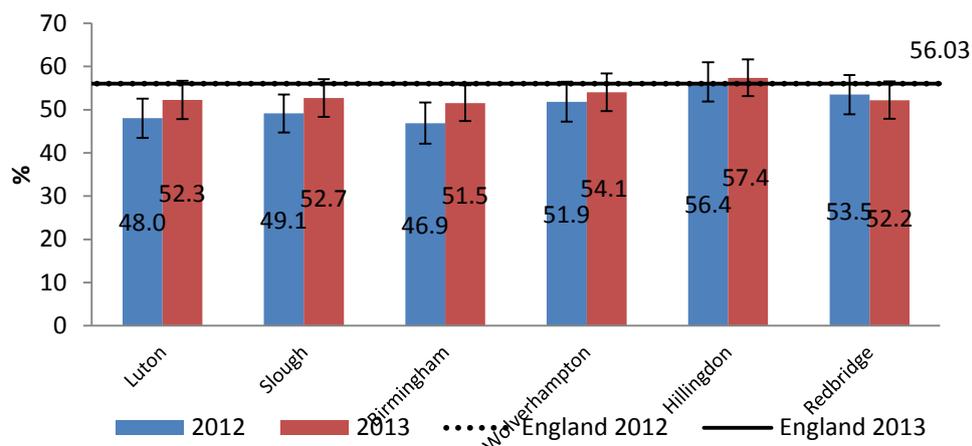
Figure 65 shows that in 2013 around 1 in 3 (30.3%) of the adult population in Luton were physically inactive - a reduction from 35.9% in 2012, which is higher than England, but is no longer significantly different. The percentage of physically active adults in Luton achieving at least 150 minutes of physical activity per week (Figure 66) was 52.3% in 2013 (an increase from 48% in the previous year). Although lower than England, the gap is closing and the rate is similar to comparator areas.

Figure 65: PHOF indicator 2.13ii - the percentage of adults classified as "inactive"



Source: PHOF and Luton Public Health Intelligence

Figure 66: PHOF indicator 2.13i – percentage of adults achieving at least 150 minutes of physical activity per week



Source: PHOF and Luton Public Health Intelligence

There has been a decrease in the percentage of inactive adults in Luton between 2005/06 and 2012/13 from 54.0% to 52.8%.³¹⁹ However, a greater proportion of those aged 26-34 years do not participate in any sessions of moderate intensity physical activity. In 2012/13 inactivity in Luton was:

- Higher among females (59.5%) than males (46.3%), in England these values are females (51.9%) and males (41.9%).
- Higher in the White ethnic group (53.8%) than the non-White groups (50.5%), in England the White group is more active with a value of 46.7% compared with 48.4%.
- Higher (72.9%) than the England average (69.9%) for those with limiting disabilities.
- Higher (59.7%) in the population working in National Statistics Socio-Economic Classifications (NS-SEC) 5-8 (lower supervisory, semi-routine, routine and manual jobs and never worked and long-term unemployed) compared with 44.0% in NS-SEC 1-2 (higher and lower managerial, administrative and professional occupations).³¹⁹

9.3.5 What is being done locally?

There have been a number of initiatives designed to increase access to physical activity. Improving physical activity levels in a population is supported by developing an environment where people actively choose to walk and cycle as part of everyday life.³²⁰ The following areas have an impact on physical activity:

- Access to sports and leisure facilities, see Section 3.7 on cultural assets.
- Planning.
- Transport, see Section 3.1.
- Parks and green spaces, see Section 3.5.
- Promoting physical activity in the workplace – in the Council this included a walk-off challenge which saw 180 employees accumulate more than 6 million steps. The county sports partnership is also managing the Workplace Challenge initiative, a national online programme to encourage organisations, big and small to get their workforces active.

Other activities include the following:

- LiveWell Luton - provides an opportunity for the local population to become more active with the assistance of community health coaches.
- Active Luton - Exercise on Referral supports adults registered at a Luton GP surgery.
- Active Luton also provides bespoke exercise sessions for individuals who suffer from:
 - chronic obstructive pulmonary disease.
 - multiple sclerosis and Parkinson’s disease.
- Let’s Get Moving - supports patients with certain conditions to take part in physical activity through an 11-week motivational interviewing process with a community exercise professional.
- Get Back Into - provides adults of any age with a range of sporting and physical activity opportunities through a series of coached/tutored sessions over a 6-10 week period.
- Full of Life Clubs and Active Retirement Club - a programme of activity sessions for older and retired people with an emphasis on socialising and having fun while undertaking light intensity sport and physical activity.
- Me Time – a Sport England funded programme providing a community based sport and physical activity opportunities six days a week for women and girls aged 14 years and over.
- Community health and wellbeing clubs – aims help people aged 50+ years to be active and independent in the community for as long as possible as well as helping them to lead a socially inclusive lifestyle.
- Walking football - aims to engage older men in sporting activity as well as providing the opportunity to meet new people, play with friends and have fun.
- No Limits Disability Sport Programme - initiative designed to create more sustainable opportunities for disabled people aged 14 and over to take part in sport and physical activity in Bedfordshire.

9.3.6 Perspective of public/service users

In 2014, three questions were included in the town-wide Your Say, Your Way residents survey on participation in sport and physical activity. These questions asked residents about the levels of participation, where they participated and what would enable them to increase their participation in sport and physical activity. 1,095 residents participated in the survey and the results indicated:

- How often?
 - just under 50% of those who completed the survey participated in sport and/or physical activity on 3 or more days a week.
 - 22% of those surveyed stated that they did no sport and physical activity whatsoever.
- Where?
 - 41% and 43% of those surveyed indicated that they participated in sport and physical activity either at a local park/field or at home respectively.
 - 17% used an Active Luton facility.
 - other venues included community centres, at work, on a golf course and general walking.
- What would increase levels of activity?
 - many responses indicated time, money and childcare.
 - access and programming were also mentioned – including the particular need for women-only activities.

9.3.7 Priorities

1. Reduce the percentage of inactive adults and increase participation in physical activity by making facilities more accessible and targeting 'at risk' population groups.
2. Support physical activity initiatives across the life course: training in early years settings; increasing number of sport/physical activity-related jobs and involvement of adults and older people in designing and developing sport and physical activity.
3. Maximise the linkages across the Investment Framework to invest in sport and physical activity opportunities including environments supportive of physical activity.

9.4 Adult obesity

9.4.1 Introduction

The prevalence of obesity in England is one of the highest in Europe as well as in the developed world.³²¹ As recently as the 1980s, obesity rates among adults in England were one third of what they are today. It is estimated that excess weight costs the NHS as much as £5 billion per year.

Obesity develops from an accumulation of excess body fat which occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity. A commonly used measure of obesity is body mass index (BMI) which is weight, in kilograms (kg), divided by height, in metres (m) squared, with a BMI > 30 kg/m² considered obese.

The consequences of excess weight and obesity include:

- An estimated reduction in life expectancy of 2-4 years in those with a BMI between 30-35 kg/m² and 10 years in those with severe obesity.³²²
- Increased risk of developing type 2 diabetes, cancer and heart disease.
- A reduction in a person's prospects in life, affecting an individual's ability to get and hold down work, self-esteem and underlying mental health.

9.4.2 Risk factors and vulnerable groups

A range of factors influence the risk of obesity, including:

- Biology - an individual's genetics and their influence on ill health.
- Environment - the influence of the environment on an individual's physical activity behaviour, for example, a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers.
- Physical activity - the type, frequency and intensity of activities an individual carries out, such as sport and leisure recreation.
- Societal influences - the impact of society, for example the influence of the media, education, peer pressure or culture.
- Individual psychology - for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences.
- Food environment - the influence of the food environment on an individual's food choices, for example, a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home.
- Food consumption - the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet.³²³

Obesity is higher in people affected by socioeconomic deprivation and there are variations in obesity prevalence between and within ethnic minority groups. Rising obesity rates can result in increased ill-health among disadvantaged communities and among BME.³²⁴ This can lead to widening inequalities in health and social care. Obesity may also result in adverse social impacts such as discrimination, social exclusion and reduced earnings.³²⁵

9.4.3 What is the evidence base?

NICE has published guidance and quality standards on tackling obesity at local level including:

- Working with local communities - covering recommendations such as sustainable community-wide approaches, integrated commissioning, involving local business and social

enterprises in the local area, local authorities as exemplars of good practice, monitoring and evaluation and cost effectiveness.³²⁶

- Managing overweight and obesity in adults – lifestyle weight management services - recommendations covering the provision of effective multi-component lifestyle weight management services for adults who are overweight or obese.³²⁷
- Identification, assessment and management of overweight and obesity in children, young people and adults.³²⁸
- Prevention of overweight and obesity in adults and children.³²⁹
- Quality standard for nutrition support in adults.³³⁰

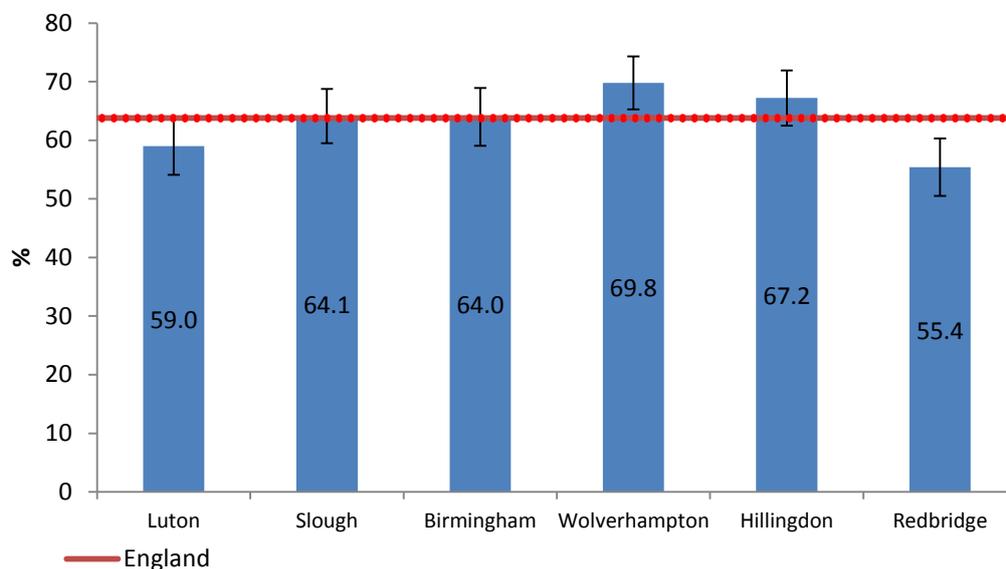
There are also more in development such as focussing on maintaining a healthy weight and preventing excess weight gain, maternal and child nutrition and prevention and management in adults.

NICE has also published advice in the form of local authority briefings on BMI thresholds for preventing ill-health among BME groups and preventing obesity and helping people to manage their weight pulling together the recommendations from the guidance documents mentioned above.³³¹

9.4.4 Local picture

In 2012, 59.0% of Luton’s adults were estimated as overweight (including obese). This is lower than in England (63.8%), but not significantly different and similar to most comparators although significantly lower than Wolverhampton (see Figure 67).

Figure 67: Excess weight in adults, 2012.



Source: PHOF and Luton PH

In 2014 it is estimated, based on results from the Active People Survey that less than half of the adult (16+) population in Luton (43.8%) eat the recommended 5 portions of fruit and vegetables a day which is significantly below the England average (56.3%). The mean portions of fruit and vegetables are significantly lower than England as shown in Table 33.

Table 33: Fruit and vegetable indicators, 2014

PHOF indicator	Luton	England
2.11i - Fruit and veg '5-a-day'	43.84	56.27
2.11ii - Average portions of fruit eaten	2.3	2.64
2.11iii - Average portions of vegetables eaten	1.98	2.36

Source: PHOF

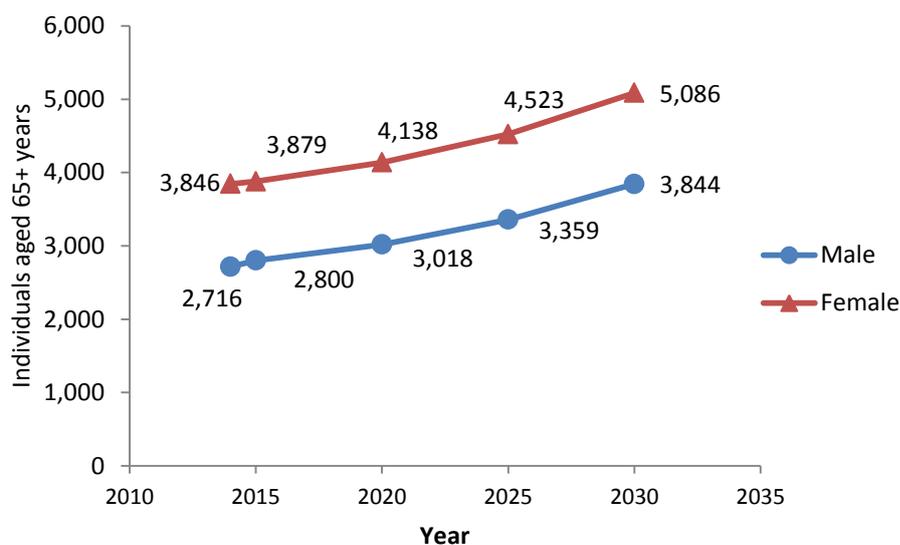
Nationally, the prevalence of obesity and overweight changes with age.

- Prevalence of overweight and obesity is lowest in the 16–24 years age group, and generally higher in the older age groups among both men and women.
- Women living in low-income households have the highest prevalence of obesity and those living in high-income households have the lowest. There is no clear pattern for men.
- Prevalence of obesity (2006-10) is higher in women compared with men for Black African and Pakistani ethnic groups. Prevalence of obesity is higher among women of Black Caribbean, Black African, and Pakistani ethnicities, compared with the other ethnic groups.³³² However, research has shown that current BMI thresholds may overestimate obesity among Africans and underestimate obesity in South Asians.³³³

There is a clear relationship between socio-economic deprivation and obesity.³³⁴

Forecasts of obesity in adults aged 65+ years obtained from Projected Older People Population Information (POPPI) are shown in Figure 68. By 2030, if prevalence estimates remained the same, the number of people aged 65+ who have a BMI of 30 or more will have increased from 3,846 to 5,086 for women (32% increase) and from 2,716 to 3,844 for men (42% increase).³³⁵

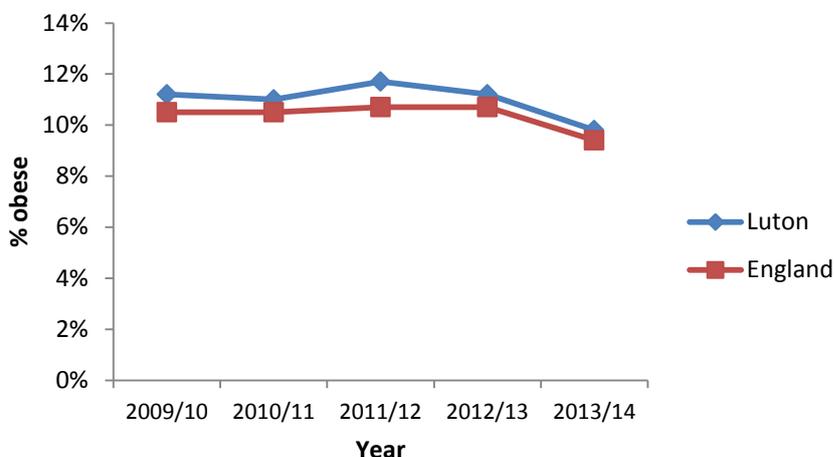
Figure 68. Forecasts of obesity 2014-30 for men and women aged 65+ years in Luton.



Source: POPPI and Luton Public Health

Quality Outcomes Framework prevalence for obesity in Luton is shown in Figure 69.³³⁶ In 2013/14, 9.8% of patients aged 16 and over with a BMI of 30 kg/m² or more in the previous 12 months were recorded on practice disease registers. It is significantly higher than England (9.4%).

Figure 69: QOF prevalence of obesity in Luton and England.



Source: Health and Social Care Information Centre and Luton Public Health

There is variation between general practices in Luton in the proportion of registered patients recorded as obese. Although some variation will arise from differences in age, deprivation and ethnicity, it is likely that most practices are significantly underdiagnosing obesity in their registered patients. The overall recorded prevalence is 9.8%, less than half the estimated prevalence of 24.3%, suggesting the existence of widespread under-diagnosis and under-recording.

9.4.5 What is being done locally?

Since the 2011 JSNA, the following recommendations have been achieved:

- Improved provision of weight management programmes for overweight and obese adults:
 - Livewell Luton has been commissioned to provide in-house weight management programmes for adults and it can also refer patients to Slimming World and Weight Watchers.
 - a special Slimming World programme has been set up for pregnant women.
- An obesity care pathway has been developed to reduce the variability in clinical practice and improve outcomes.
- The NHS Health Checks programme has been implemented and more adults are being supported to manage their weight.
- A healthy workplace programme Luton's Working Well, has been launched and provides support to local businesses around weight management.
- Policy makers and planners are required to assess the health impact of their policies and plans.
- Local action to increase physical activity is already highlighted in Section 1.1.

9.4.6 Priorities

1. Review and develop an overall strategic multi-agency approach to reduce obesity.
2. Develop and deliver a training programme for health and non-health professionals on the management of overweight and obesity.

3. Ensure the healthy weight pathway is used by health professionals and is evaluated so it adheres to national standards.³³⁷
4. Work with fast food outlets and other outlets to support them in reducing the salt, fat and sugar content of their menus.

9.5 Drug-related harm

9.5.1 Introduction

Drug use is a major issue in England and is responsible for the majority of crime across the UK.³³⁸ Problematic drug use continues to have a negative effect on the health, wellbeing and quality of life of many people, for example, crimes related to drugs cost the UK £13.3 billion every year. There are approximately 320,000 heroin and/or crack cocaine users in England of whom around 170,000 are in treatment in any one year. Offenders who use heroin, cocaine or crack cocaine are estimated to commit between a third and a half of all acquisitive crime.³³⁸

Problematic drug use is not restricted to illicit drugs; it may include drugs prescribed by a doctor as many prescription drugs are equally as addictive as illicit drugs. Problematic drug use is also about the effect the substance creates on health and social functioning which can range from non-problematic to dependent. Around 1 in 11 (8.8%) adults aged 16 to 59 had taken an illicit drug in the last year.³³⁹

Outcomes and effects of drug misuse include:

- Mental health problems.
- Increased risk of contracting blood borne viruses like Hepatitis B or C, HIV or deep vein thrombosis.
- Increased risk of being poisoned by drugs and overdosing which can lead to death.
- Impact on relationships, employment and finances.

9.5.2 Risk factors and vulnerable groups

- People who wish to block out trauma such as abuse or death of a close family member. Initially the drug use eliminates the immediate pain but repeat use is required to continue the blocking effect very quickly leading to addiction.
- Socio-economic deprivation.
- Close association between drug use and the sex trade. The most vulnerable sex workers are girls who have been involved in the sex trade before the age of 18. These were women who were in the sex trade in order to fund their drug habits - not only their personal drug habits, but potentially the habits of a controller or a boyfriend.³⁴⁰
- Occasionally drug use stems from an individual being curious and experimenting with drugs. This often starts with substances like alcohol and gradually builds to cannabis and then cocaine, heroin, crack etc.
- Other less common reasons people begin to use drugs are boredom, stress, energy boost, feeling of emptiness, trying to forget the painful memories of the past.
- Ethnic and cultural issues create differing perspectives on drug use. In some cultures certain drug use is seen as common behaviour.

9.5.3 What is the evidence base?

The National Institute of Health and Care Excellence (NICE) published a local government briefing on Tackling Drug Use.³⁴¹ This highlights the types of activities covered by NICE's recommendations published up to May 2014 using the best available evidence from their guidance and quality standards. They are grouped as:

- Provide clean injecting equipment to people who inject drugs to prevent the transmission of blood-borne viruses – including assessing local need and providing needle and syringe programmes.
- Provide other harm reduction services through a range of open access services such as needle and syringe programmes.
- Increase testing and treatment for blood borne viruses among drug users.
- Support people who are trying to stop using drugs.
- Provide treatment for managing opioid dependence.
- Provide assessment and psychosocial support to drug users and their families.

These are informed by the following NICE guidance and quality standards on tackling drug use:

- Drug misuse: psychosocial interventions.³⁴²
- Drug misuse: opioid detoxification.³⁴³
- Needle and syringe programmes.³⁴⁴
- Quality standard for drug use disorders.³⁴⁵
- Psychosis with coexisting substance misuse: assessment and management in adults and young people.³⁴⁶

The 2010 National Drug Strategy³³⁸ mandated a new aspiration for drug treatment in the UK. It states *‘the investment made in the drug treatment system over the last decade has built capacity and enabled people to access treatment for a sufficient period of time to bring about substantial health gains. We now need to make the same progress in treating those with more severe alcohol dependence and to become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence so they can recover fully’*.^{338 (p.18)}

NICE guidelines on drug misuse prevention are currently in development.

9.5.4 Local picture

Prevalence

Figure 70 shows that the estimated 2013/14 drug dependency prevalence rate per 1,000 opiate/crack user in Luton is higher in comparison with national prevalence (13.5 per 1,000 compared with 8.7 per 1,000) and similar to statistical neighbours.³⁴⁷

Figure 70: Drug prevalence estimates and rates per 1,000 population aged 15-64

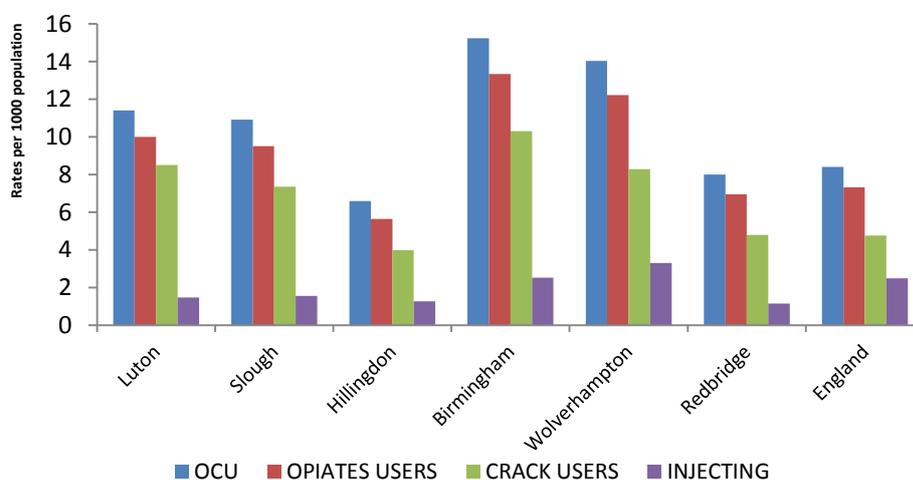
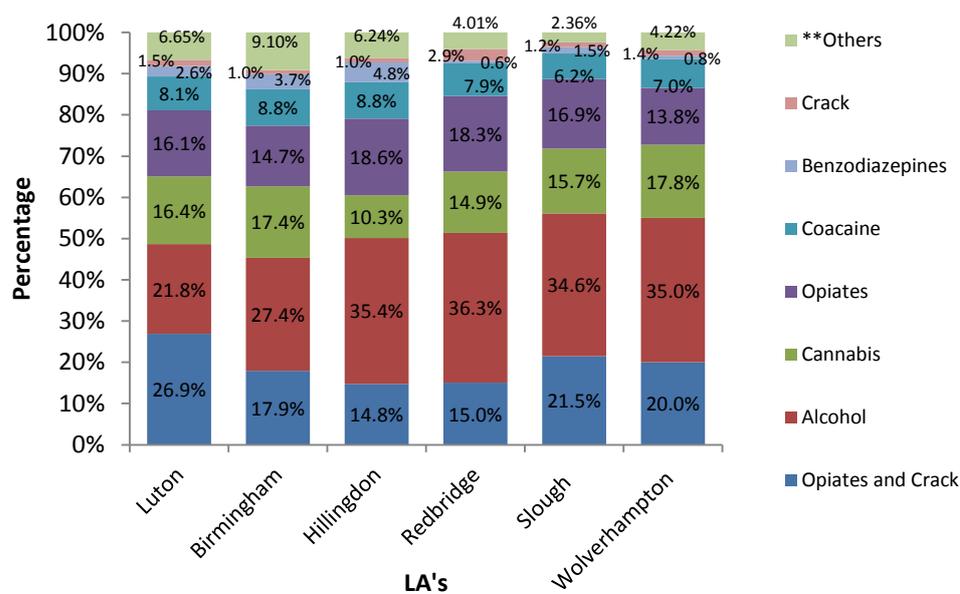


Figure 71 shows the number people in drug treatment in Luton and its comparator areas in 2013/14 and the drugs commonly used. It shows Luton has a higher rate of opiate and crack use compared with comparator areas but lower rates of alcohol use. All other rates are similar to the comparator average.

Figure 71: People in drug treatment, 2013/14



Source: PHE/NDTMS

**Others include drugs such as amphetamines, prescription drugs, Ecstasy, hallucinogens, solvents, barbiturates, major tranquilisers, anti-depressants, novel psychoactive substances, other (excluding novel). Note also that those who reported using alcohol were also using other drugs, but alcohol was reported as the main problematic substance.

Drug-related offences

There were 3.5 drug offences per 1000 population in Luton (2012/13).³⁴⁸ Most of these offences stemmed from the fact that the perpetrators are problematic drug users who engaged in crime to fund their drug habits. Trend data shows Luton's rate has fluctuated over the years but has shown an increase since 2007/08 from 2.8 per 1000. Data is only available for East of England and West Midlands. A comparison with the two West Midland comparator areas, Birmingham (3.9 per 1,000) and Wolverhampton (2.9 per 1,000) show Luton's rate (3.5 per 1,000) is not significantly different to Birmingham but significantly higher than Wolverhampton.

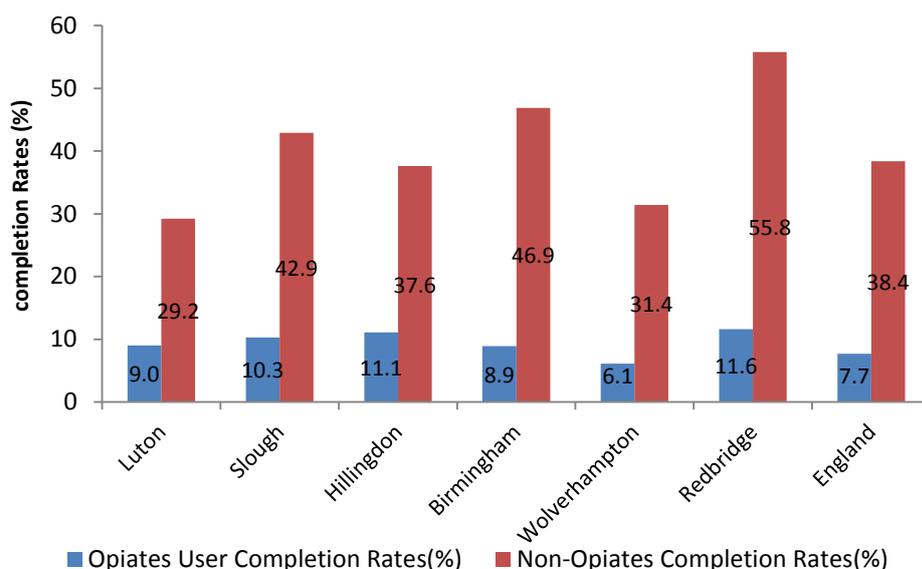
Drug treatment

Between March 2013 and February 2014 there were 875 drug users who were over 18 years old in effective treatment in Luton and 357 drug users who started treatment. Of those who started drug treatment, 280 were retained in treatment for more than 12 weeks, meaning they were in effective treatment. Of those in effective treatment who started treatment in that period, 9 of them completed treatment and were therefore discharged as drug free. Regardless of whether they

started treatment in the same year there were 85 adults in total who were discharged as drug free or occasional users in March 2014.³⁴⁷

Figure 72 shows (2013/14) drug treatment completion rates for Luton and its comparator areas. Note however that the chart represents all those that completed treatment in that year, some of whom may have been in treatment for more than five years. It shows Luton’s treatment completion rate is similar to comparator areas for opiate users but lower than comparators for non-opiate users.

Figure 72: Drug treatment completion rates (%)



Source: NDTMS

Drug-related deaths

Luton’s drug-related death rate has reduced by 68% from a rate of 3.37 per 100,000 in 2005-07 to 1.06 per 100,000 in 2009-11. It is below the regional average (2.27 per 100,000) and comparator areas of Wolverhampton (2.3 per 100,000) and Birmingham (3.42 per 100,000) but only significantly lower than Birmingham.³⁴⁸

9.5.5 What is being done locally to address the issue?

The Luton Drug and Alcohol Partnership (LDAP), which includes the health services, the Council, police, probation, housing associations, voluntary agencies, clients, families, religious groups and members of the community, has a drug strategy in place with priorities relating to adults, young people and the wider community.

Drug use and drug treatment in Luton has not changed significantly over the last 5 years. The only noticeable difference is that opiate drug users and clients in drug treatment generally are getting older, and this is due to the fact that people are spending a long time in treatment on substitute drugs. This suggests that the current service delivery model is ‘holding’ individuals in treatment as opposed to enabling them to achieve independence and personal recovery.

Reducing demand

Following a comprehensive review of services, LDAP is leading a transformation project to realign services to offer individuals a realistic and achievable option of beating drug addiction. A new treatment pathway is being developed that will focus on recovery, building a visible Recovery Community to attract and inspire more individuals to seek abstinence.

Recovery communities also help tackle the transmission of intergenerational substance misuse, helping families to avoid infecting their children and other family members with drug addiction.

Restricting Supply

To combat the supply of drugs in the community, the Community Action Against Drug Dealing (CAADD) group was formed. The CAADD is a partnership between the local community, Bedfordshire Police, Police Crime Commissioner, The council, and Health in response to listening to local communities on the issue of drug dealing.

The impact of the illicit drugs market constitutes a major element of harm across society. It affects not only those buying, selling and using illegal drugs, but their families, friends and communities. With that in mind, there is the need to recognise the importance of local people in tackling the impact of drugs, and standing together with local public services to drive dealers out of the communities and prevent children and young people from becoming engaged in that lifestyle.

Although evidence suggests a rise in the reporting of drug crime, more needs to be done to instil confidence in communities to report drug crime and to deal with this growing issue affecting individuals, families and communities.

The aim of the group is to develop confident communities to play their role in preventing drug dealing crime and its main objectives are to:

- Educate and raise awareness amongst communities of drug dealing.
- Provide community members with accurate information about drug dealing.
- Empower community members to report drug dealing to the Police or Crimestoppers.
- Ensure that young people do not see drug dealing as a lifestyle choice and to send out message on consequences.
- Provide feedback at community events about action taken locally.

9.5.6 Perspective of the public/service users

LDAP takes a “whole person approach” to support drug users (especially those women who use drugs and sell sex) rather than just their presenting drug use needs. Clients are encouraged to shape their own journey, which helps them to develop a sense of personal responsibility and improves progress towards goals.

The Luton Youth Offending Service (YOS), Reconnect and SAFE which are three separate drugs and alcohol treatment providers in Luton reported that clients have commented that the provision of supplementary support such as electro-stimulation therapy (EST), self-management programmes, relaxation groups and nutritional advice has helped them to improve health and social functioning

which have contributed to them achieving self-reliance and independence in life. NICE recommends a combination of pharmacological approaches and psychosocial interventions such as self-help groups to provide an important element of an overall treatment package.³⁴⁹ Clients have also been positive about the extent of support from health workers including offering welfare advice.

Generally, service users in Luton seem to be satisfied with the core treatment offer being provided by the various drug services in Luton, but also wish to see enhanced service provision to help them move forward in their battle with addiction.

A recent qualitative needs assessment identified a number of key gaps in delivery:

- Specialist provision for the most vulnerable groups.
- Geographical access to services.
- Integrated care for multiple needs clients eg mental health.
- Service user-led provision.
- An independent care co-ordination service to include a single point of assessment.
- Recovery-focussed aftercare provision.
- Limited menu of interventions available.

9.5.7 Priorities

1. Develop a new integrated pathway to support clients to successfully exit treatment and remain drug free by:
 - Developing a visible community of those that have successfully beaten substance use and addiction to serve as an inspirational / aspirational focus for those currently involved in drug or alcohol use.
 - Developing a cross partnership care co-ordination model and service, to ensure no clients become 'stuck' in the treatment system.
 - Developing a more aspirational treatment system allowing service users the opportunity to have a drug free lifestyle.
 - Minimising the harm and build resilience for the Luton community in respect of new psychoactive substances.

9.6 Alcohol-related harm

9.6.1 Introduction

Alcohol consumption can affect lives in a number of ways, especially when consumed excessively. Alcohol consumption is the third highest risk factor for avoidable ill health in England and is related to many public health priorities.³⁵⁰ The DH estimates that harmful use of alcohol costs the NHS £2.7 billion in a year and approximately £21b per year for health care, crime and lost productivity costs combined.³⁵¹ In 2011 there were 8,748 deaths directly related to alcohol in the UK.³⁵² Alcohol is a legal drug sanctioned overall by cultural and social norms in the UK. However, some cultures, ethnic groups and religions do not approve of the consumption of alcohol.

Alcohol is a central nervous system depressant, although in smaller amounts it can have a mild stimulant effect, affecting control of judgment and leading to loss of inhibition. It has been established that people with alcohol-related health conditions are not necessarily alcoholics. They are people who have regularly drunk more than the recommended level for some years.³⁵³

9.6.2 Risk factors and vulnerable groups

Effects of harmful use of alcohol include:³⁵⁴

- Links to over 60 medical conditions including alcohol poisoning, cirrhosis of the liver, psychiatric, neurological, gastrointestinal, cardiovascular conditions and several types of cancer.
- Inability to work and socialise (including relationship breakdown).
- Violence and anti-social behaviour including drink driving and domestic abuse.
- Poor parenting.
- Unprotected sex leading to unplanned pregnancies and sexually transmitted infections.
- Homelessness.

Alcohol is often an aggravating factor in many crimes against the person, with either the perpetrator or victim having consumed alcohol in the time leading up to the crime. Where alcohol is used in conjunction with other substances, such as cocaine, it formulates other chemicals in the body such as cocaethelene which can lead to extreme violent behaviour.³⁵⁵

9.6.3 What is the evidence base?

The Government's Alcohol Strategy³⁵⁶ released in 2012 makes a commitment to:

- Reduce the availability of cheap alcohol.
- Act on unacceptable marketing.
- Encourage local communities to take action including having greater community involvement in licensing decisions.
- Create shared responsibility with industry.
- Support individuals to change through prevention and early intervention.

It builds on the Drugs Strategy 2010,³⁵⁷ which emphasised the importance of supporting people with alcohol dependency. The National Institute of Health and Care Excellence (NICE) have published guidance on alcohol-related problems including:

- Public health guidance on prevention and early identification of alcohol-use disorders among adults and adolescents.³⁵⁸
- A guide for commissioners on services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults.³⁵⁹
- A clinical guideline on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people.³⁶⁰
- A quality standard on alcohol dependence and harmful alcohol use.³⁶¹

- A quality standard is in development covering preventing harmful alcohol use in the community.

9.6.4 Local picture

Prevalence

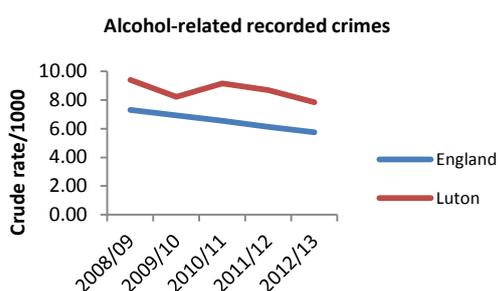
The majority (67.4%) of people in alcohol treatment in Luton are males and 86% are of white ethnicity. This is higher than the national average, and considering that Luton is a town with diverse ethnicity, there may be an under representation of those in services from BME communities.

A recent report from Public Health England showed that during 2012/13 there were 632 adults in alcohol treatment in Luton.³⁶² There were 1,170 people admitted to hospital with alcohol-related conditions and 37 people were admitted to hospital with alcohol specific conditions. In 2012/13, there were 1,595 alcohol related recorded crimes in Luton and 21.7% of adults in Luton are estimated to consume more than 600 units of alcohol per month.

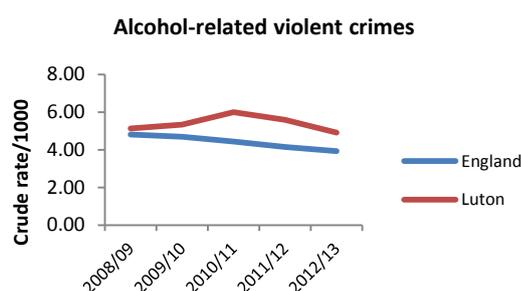
Alcohol-related offences

Alcohol-related recorded crime in Luton has been on a downward trend since 2010/11 from a crude rate per 1,000 of 9.16 to 7.83 in 2012/13. There has also been a downward trend for alcohol-related violent crime with a figure of 6.01 per 1,000 crude rate in 2010/11 to 4.92 per 1,000 in 2012/13. However, both remain above the national average. Figure 73 and Figure 74 show the trend for alcohol related offences in Luton.

Figure 73 and 74: Alcohol-related recorded and violent crimes (crude rate/1000)



Source: LAPE (2014)

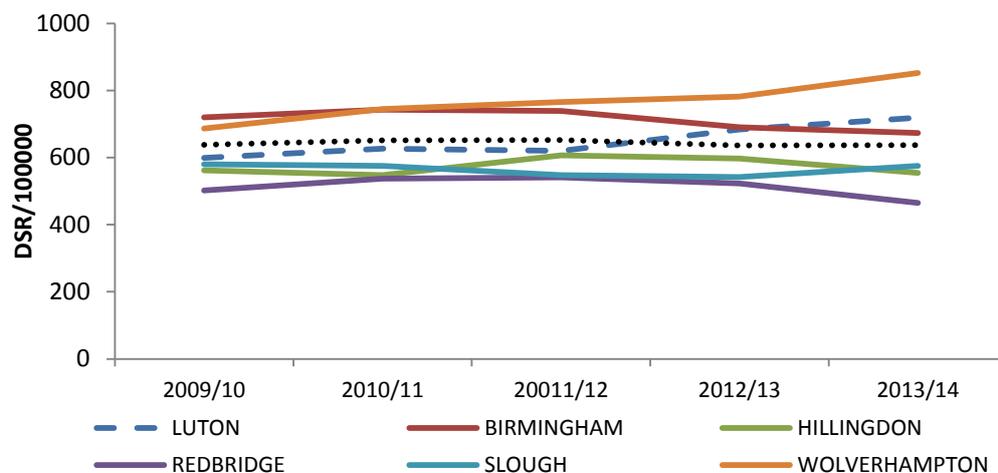


Source: LAPE (2014)

Alcohol-related hospital admissions

The number of people in alcohol treatment has been fairly constant in the past three years, though trend data shows that alcohol-related hospital admissions in Luton have been increasing in the last five years as shown in decrease Figure 75. Since 2009-10 Luton's rate has increased by 20% compared with a 0.3% decrease seen nationally. This could partly be due to increased identification as a result of the brief intervention service at LandD. In comparison with statistical neighbours Luton's is the second highest increase behind Wolverhampton (24%), whereas all other areas have seen a decrease.

Figure 75: Alcohol related admissions (DSR/100000) Luton and comparator areas



Source: LAPE (2014)

9.6.5 What is being done locally?

Since the last JSNA, a needs assessment was completed in 2012 by LDAP looking at alcohol use in the borough. This process then informed the 2012 – 2015 Luton Alcohol Strategy.

The main aims of this strategy are to:

- Support adults to reduce the harms caused by excessive alcohol use.
- Prevent young people from being harmed by alcohol use.
- Ensure Luton is a vibrant and safe town for residents and visitors.

An annual plan is compiled which gives a focus to service providers on the key areas for service delivery each year.

In 2015 a project was launched to address the high levels of street drinking taking place within Luton. The project will deliver on three key outcomes.

1. Engage directly with those who participate in street drinking to signpost and encourage them to access support services and realise the impact on their health and their community.
2. To gather a comprehensive snapshot of exactly what street drinking is in Luton- the who, where, what and why.
3. Produce an options paper of potential solutions to address any identified issues.

9.6.6 Perspective of the public/service users

A recent qualitative needs assessment identified a number of key improvement areas for the current alcohol service.

- Improve accessibility and provision for specialist cohorts for example, women.
- Develop and sustain of service user groups.
- Improve the interface between primary and specialist care provision.
- Develop aftercare provision / support.

9.6.7 Priorities

1. Undertake a detailed review of services to inform a refreshed Luton alcohol strategy.

2. Work with stakeholders to address the findings from the street drinking project.
3. Develop new detoxification and rehabilitation pathways to match national aspirations for more recovery-focussed outcomes which will increase successful completion rates by 5% over the next two years.
4. To reduce the level of alcohol-related crime and disorder in Luton.

9.7 Tobacco

9.7.1 Introduction

Tobacco use is the leading behavioural cause of health inequalities in the UK.³⁶³ Reducing the prevalence of smoking is a national priority as smoking is the biggest single preventable cause of disease and premature deaths in the UK.³⁶⁴ Preventing people from starting smoking is key to reducing the harms and inequalities associated with tobacco use. In 2013-14 the government received £9.5 billion in revenue from tobacco tax (excluding VAT). In 2012-13 the Government spent £87.7m on services to help people stop smoking and a further £58.1m on stop smoking medication.

Tobacco products are made entirely or partly of leaf tobacco as raw material intended to be smoked, sucked, chewed or snuffed. All contain the highly addictive psychoactive ingredient, nicotine.³⁶⁵ Smokeless tobacco (also called oral tobacco) use is prevalent in the UK's South Asian communities. Although the use of these other forms of tobacco is not well researched, some of the health impacts are likely to be similar to those of cigarette smoke.³⁶⁶

Consequences of tobacco use include:

- Smoking tobacco is linked to an estimated 86% of lung cancers in the UK³⁶⁷ and is associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.³⁶⁸
- An association with respiratory infections including chronic obstructive pulmonary disease (bronchitis and emphysema), pneumonia, asthma, and other ear, nose and throat problems.³⁶⁹
- Smoking tobacco damages heart and blood circulation, increasing risk of developing conditions such as: coronary heart disease, heart attack, stroke, peripheral vascular disease, cerebrovascular disease.³⁷⁰
- People who breathe in secondhand smoke are at risk of getting the same health conditions as smokers; for example, breathing in secondhand smoke increases a non-smoker's risk of developing lung cancer or heart disease by about 25%. Infants and children are particularly vulnerable to effects of secondhand smoke resulting in developing respiratory infections.

9.7.2 Risk factors and vulnerable groups

- Two thirds of adult smokers start before the age of 18 and few people take up smoking after the age of 21.³⁷¹
- Prevalence of smoking decreases with age, with more than one in five 18-24 year olds and nearly one in four 25-29 year olds smoking compared with less than 10% in those aged 70 years and over.³⁷²
- There is a higher rate of tobacco use amongst certain Black and Minority Ethnic groups. Nationally, it is estimated that 40% of Bangladeshi men, 30% of Irish men, 29% of Pakistani men and 25% of Black Caribbean men smoke. Men from Chinese, Indian and Black African backgrounds have lower rates of smoking. Apart from Black Caribbean (24%) and Irish women (26%), smoking amongst women from ethnic minority groups is generally very low. However, chewing tobacco is popular in the Bangladeshi community and 9% of men and 19% of women say they chew paan. Self-reported use of all tobacco products in the Bangladeshi community is 44% for men and 17% for women and when a saliva cotinine test was used to assess prevalence of tobacco use, it rose to 60% of men and 35% of women.³⁷³
- Tobacco use amongst people with mental health conditions and with those with addictions is significantly higher in people with mental health conditions than in the general population, and

is responsible for the additional deaths observed in mental health mortality statistics.³⁷⁴ Round 42% of tobacco use in the UK is by people who have a mental health problem.

- A higher smoking prevalence than England average in those with no religion in Gay/Lesbian and Bisexual populations and men.

There is a strong link between tobacco use and socio-economic status. People from socio-economically deprived backgrounds are more likely to smoke than wealthier people.³⁷⁵ Smoking accounts for over half the difference in risk of premature death between the highest and lowest social classes in the UK. Although just as likely to want to quit, trends in smoking in these groups makes stopping smoking more challenging. In 2013, 14% of adults in managerial and professional occupations smoked compared with 29% in routine and manual occupations.³⁷⁶

The reasons for this are complex and incompletely understood, but include reduced social support for quitting, low motivation to quit, stronger addiction to tobacco, increased likelihood of not completing courses of drug treatment or behavioural support sessions, psychological differences such as lack of self-efficacy, and tobacco industry marketing. Whatever the explanation, smoking is an important contributor to health inequalities.³⁷⁵

9.7.3 What is the evidence base?

The NICE Local Government Briefing on Tobacco³⁷⁷ highlights the types of activities covered by NICE's recommendations published up to January 2015 using the best available evidence from their guidance and quality standards. They are grouped as:

- Leadership – including workplace smoke free policies and supporting employees to quit, training, monitoring and evaluation of services, community engagement, including secondary care in local strategies, ensuring referral systems are in place and including tobacco harm-reduction approaches when commissioning services.
- Prevention – including working with schools to discourage children and young people from smoking.
- Complying with legislation – including ensuring environmental health and trading standards services prioritise tobacco control, auditing test purchases, training for retailers and prosecutions.
- Communications – including regional and local campaigns integrated with national communication strategies.
- Innovation and learning – providing flexible, coordinated and accessible services which are planned and developed with disadvantaged groups.
- Helping people to quit or reduce harm from smoking – including flexible and accessible stop smoking services, partnership working, harm reduction, realistic performance targets, auditing of services, effective brief interventions, action in the workplace and interventions in pregnancy and following childbirth.

These are informed by the following NICE guidance and quality standards on engaging people and successful smoking cessation:

- Smoking cessation services.^{378, 379}
- Workplace interventions to promote smoking cessation.³⁸⁰
- Quitting smoking in pregnancy and following childbirth.³⁹⁰
- Brief interventions and referral for smoking cessation.³⁸¹
- School-based interventions to prevent smoking.³⁸²
- Tobacco harm reduction.³⁸³

There is reasonable evidence to support that smoking cessation interventions that work for the general population can also work for people with a mental disorder and may be just as effective.³⁸⁴

Two further smoking quality standards are in development due to be published in 2015 focussing on harm reduction and reducing tobacco use in the community.

9.7.4 Local picture

Prevalence

Prevalence of adult smoking in Luton in 2013 was 19.98%. The rate remained above the national average (18.5%) but was not significantly different. As shown in Table 34 the rate also remained above the London comparator areas (Hillingdon and Redbridge with the latter showing a rate significantly below the England average).

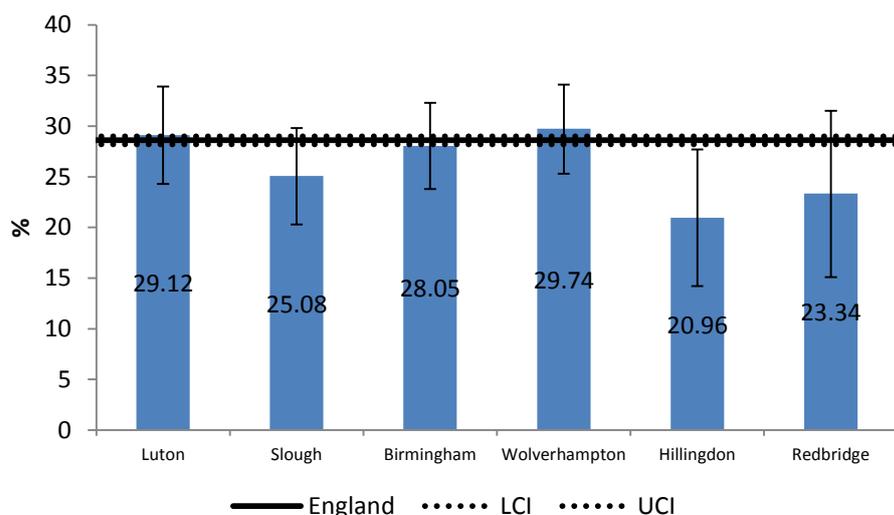
Table 34: Adult smoking prevalence

	2010	2011	2012	2013	Trend
Luton	22.89	20.76	21.22	19.98	
Slough	20.39	24.30	21.35	21.97	
Birmingham	21.05	20.84	17.46	19.28	
Wolverhampton	20.23	21.97	22.85	22.01	
Hillingdon	18.37	17.66	17.51	16.25	
Redbridge	14.99	15.93	14.72	13.53	
England	20.79	20.21	19.53	18.45	

Source: Integrated Household Survey, Office for National Statistics; graph by Luton Public Health; Green = significantly lower smoking prevalence compared with England; Amber = no significant difference; Red = significantly higher prevalence

Prevalence amongst routine and manual occupations is considerably higher than the rest of population in Luton at 29.1%, which is a contributing factor to health inequality. The rate is similar to comparator areas and the national average as shown in Figure 76.

Figure 76: Smoking prevalence in routine and manual occupations.

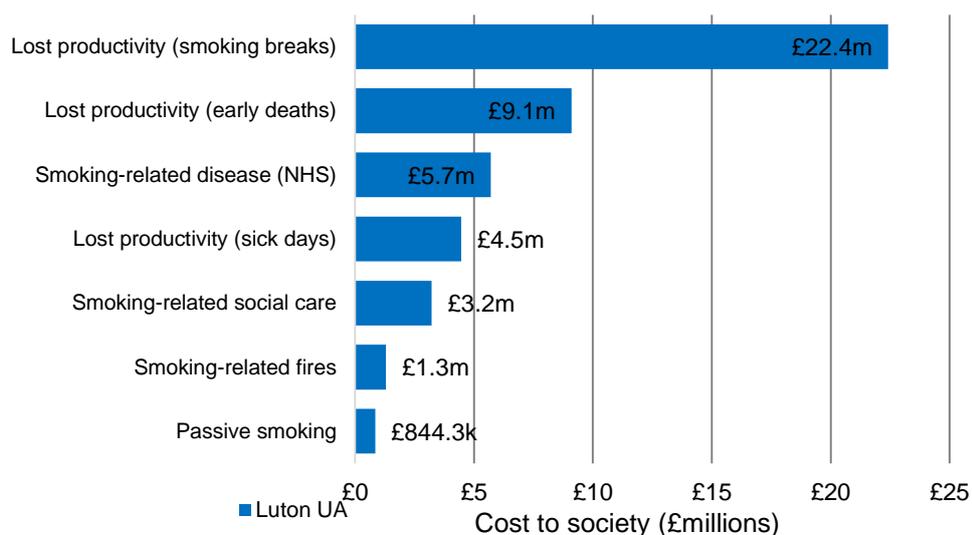


Source: PHE Tobacco Profiles and Luton Public Health

Smoking attributable illnesses

Smoking presents an economic challenge, costing the NHS an estimated £2 billion a year to treat related illness.³⁸⁵ Modelled estimates of the impact of tobacco in Luton (shown in Figure 77) suggest a £47 million loss to the total economy which includes NHS, fire, litter, absenteeism and lost productivity.³⁸⁶ For adult social care the cost to the local authority and self-funders is estimated at £3.2 million, which is approximately 1,440 people requiring some level of support due to a smoking-related illness.³⁸⁷ More detailed return on investment work will be carried out as part of the evaluation for the refreshed Smoking strategy, due to be produced in 2015-16.

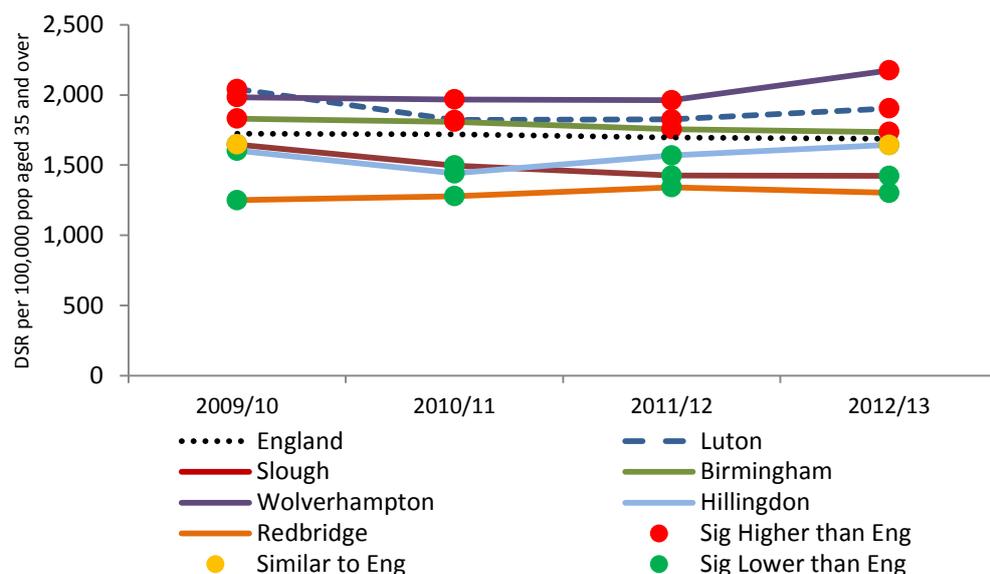
Figure 77: Estimated costs due to smoking in Luton



Source: ASH

Figure 78 shows smoking attributable admissions in Luton are significantly higher than in England and increased slightly in 2012-13, widening the inequality gap with England. The rate is similar to comparators from the West Midlands but higher than comparators from the South of England.

Figure 78: Smoking attributable admissions per 100,000 population aged 35 years and older.

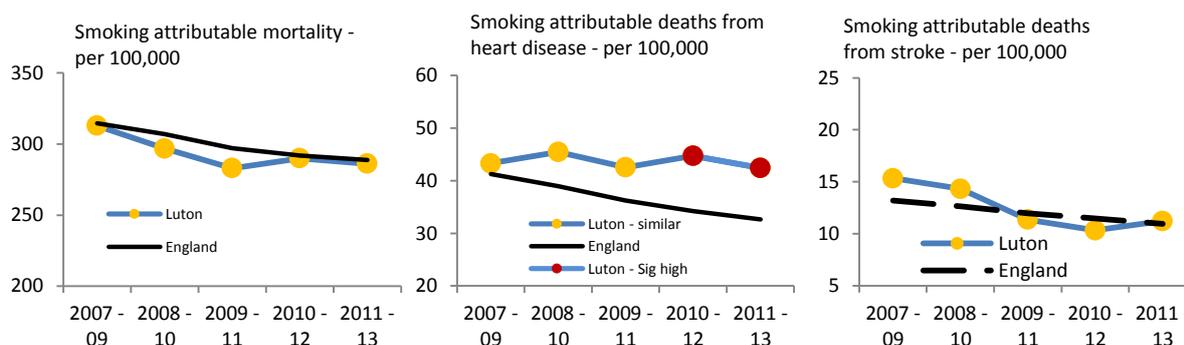


Source: PHE Tobacco Profiles and Luton Public Health

Smoking attributable mortality and inequality

Smoking remains the biggest single cause of preventable mortality and morbidity in the world.³⁸⁸ It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths. Figure 79 shows the smoking attributable mortality (SAM) rate for Luton is following a similar trend to England as a whole. SAM for cardiovascular diseases and stroke are similar to the national rate, however heart disease SAM is significantly higher (Figure 79).

Figure 79: Smoking attributable mortality, Luton and England



Source: PHE tobacco profiles and graphs by Luton Public Health

Smokeless tobacco

Smokeless tobacco refers to any type of product containing tobacco that is placed in the mouth or nose and not burned and which is typically used in England by people of South Asian origin. The phrase people of South Asian origin is used in this context to mean people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.³⁸⁹ Smokeless tobacco is highlighted in many studies to be linked to certain cancers. However, there are other health risk factors to its usage such as poor oral health, reduced fertility in men and in pregnancy higher risk of pre-eclampsia, premature birth and low birth weight.³⁶⁶

The findings from the local smokeless tobacco needs assessment³⁶⁶ showed the use of smokeless tobacco is more prevalent in the Bangladeshi community, especially older women, in Luton. The recommendations from the report included support for those using smokeless tobacco in the local stop smoking service, raising awareness in local communities, training of healthcare professionals, smoking education sessions to children, better collection of local data and compliance of retailers of products in regards to labelling and the age of sale.

Smoking in pregnancy

See Section 5.2

Smoking during pregnancy causes complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. It also increases the risk of infant mortality by an estimated 40%. Children exposed to tobacco smoke in the womb are more likely to experience asthma, bronchitis and pneumonia. It is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance.³⁹⁰

Smoking status at time of delivery continues on a downward trend in Luton and is now not significantly different from the England average. This was a reduction from 14.6% in 2011/12 to 12.1% in 2013/14. Estimated NHS savings based on implementing NICE guidelines in 2011/12 predicted savings of around £31,000 per year over the following three years.³⁹¹

9.7.5 What is being done locally?

Tobacco Free Luton is the partnership responsible for the strategy and annual action plan and reports to the Health Inequalities Delivery Board. It undertook a self-assessment in 2013 and a peer review in 2014 through the national CLear programme.³⁹² The partnership was commended for the high engagement of senior officers and elected members and for embedding tobacco control in local strategies. Recommendations included closer working with NHS partners and responding to Luton's changing demographics. Below are highlights of the previous three years work.

Pregnancy and early years

- In 2012 Luton introduced the NICE recommendations for routine carbon monoxide monitoring in all pregnant women with the acute trust which increased referrals into the stop smoking service.
- The smokefree homes message is integrated into the Baby Safe programme delivered through children's centres and partners.

Young people and adults

- Targeted smoking cessation work took place in Leagrave/Hockwell Ring area for women smokers.
- Social norms project in Luton Sixth Form College to change perception of the number of young people who smoke.
- QUIT, a national charity, delivered a youth advocacy programme over two years.
- A new smoke free policy for the Council.

Niche products

- A smokeless tobacco health needs assessment was conducted in 2013 with recommendations for supporting people who use these niche products. Initial scoping took place for a harm reduction service in partnership with Dental Health Promotion and a dental surgery for implementation in 2015.
- A shisha enforcement and education campaign targeting businesses and communities.

- Youth shisha campaign using social media to change perceptions and raise awareness of the health risks.

Supra-local tobacco control

- Continued participation in regional networks and an illegal tobacco campaign which ran in 2012 involving local partners and regional Trading Standards and HM Revenue & Customs. This continues as a key work strand for Trading Standards.

9.7.6 Perspective of the public/service users

Three public surveys were conducted since the 2011 JSNA

- Shisha survey for 16-25 year olds (2012) – the survey highlighted the need to do targeted work to debunk myths and provide clear facts on the health harms of shisha use, linking it to tobacco. The survey provided intelligence for the enforcement activity.
- Smokeless tobacco health needs assessment (2013) – the survey provided insight into communities, product use and willingness and support needed to stop. A harm reduction approach was recommended and will be implemented in 2015.
- The council Citizen Panel survey on smoking and vaporisers (electronic cigarettes) (2013). the survey indicated a lower smoking prevalence in Luton than data released nationally. Vaporiser use was low and reflects national data. Public Health will continue to monitor the trends in smoking prevalence.

9.7.7 Priorities

1. The Tobacco-Free Luton Strategy ends in 2015. It is recommended that the strategy is evaluated and the findings from this and the CLear peer review are used to refresh the strategy and action plan. It is expected that three of the key recommendations to come out of the review are:
 - a. Invest in sustained, evidence-based prevention work with young people and those with diagnosed mental health problems.
 - b. Incorporate a harm reduction approach to tobacco by the beginning of commissioning year 2016/17.
 - c. Support Tobacco-Free Luton partners to further embed tobacco control within their organisations, including enhanced smoke-free policies and smoke-free grounds.
2. Understand the three key gaps in local data and understanding are:
 - Smoking prevalence and behaviour amongst young people under 18 years.
 - Baseline data for niche tobacco product use. An attempt was made to establish prevalence of shisha amongst young people (16-25 years) and smokeless tobacco products; however the sample size was insufficient to draw firm conclusions.
 - Impact of migration on smoking prevalence in routine and manual groups. Large fluctuations in communities emigrating from countries with a significantly higher smoking rate is likely to have an impact on prevalence in the lower socio-economic groups and potentially those who are pregnant.

9.8 Sexual health

9.8.1 Introduction

Sexual health is an important element of physical and mental health. Good sexual health requires relationships to be safe and equitable, with ready access to high quality information and services that reduce the risk of unintended pregnancy, illness or trauma.

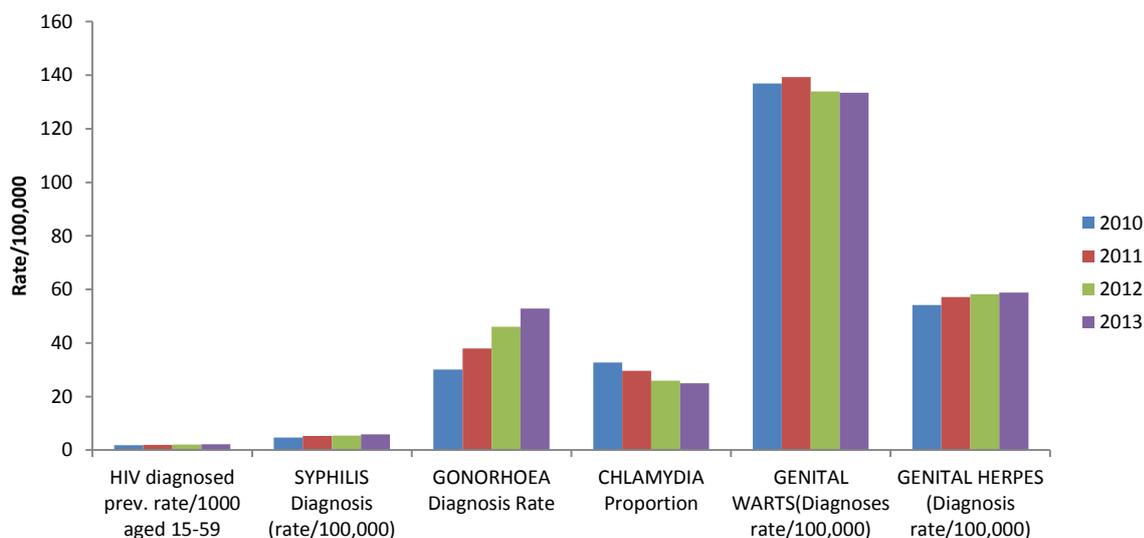
Sexual ill health is influenced by a complex network of factors ranging from sexual behaviour and quality of SRE (sex and relationship education), through to biological risk and genetic predisposition as well as health inequalities, which extend beyond health.³⁹³

Rates of common sexually transmitted infections (STI) are rising nationally (Figure 80). Gonorrhoea diagnosis rates rose from 30.11 per 100,000 in 2010 to 52.88 per 100,000 in 2013 and those of syphilis rose from 4.73/100,000 in 2010 to 5.86/100,000 in 2013. It is important these are prevented or treated early to avoid long-term complications and the risk of onward transmission to others. The health consequences of poor sexual health include:

- STIs and HIV.
- Pelvic inflammatory disease, leading to ectopic pregnancies and infertility.
- Cervical and other genital cancers.
- Hepatitis, chronic liver disease and liver cancer.
- Premature delivery of new-born babies and still births.
- Unwanted pregnancies and abortions.
- Psychological consequences of sexual coercion and abuse.
- Reduced life expectancy.

In England, the highest rates of acute STIs occur in 15 to 24 year olds.³⁹⁴ Poor sexual health is closely linked to other unsafe behaviours such as alcohol use and to low socioeconomic status.³⁹⁵

Figure 80: Common sexually transmitted infections in England (2010-2013)



9.8.2 Risk factors and vulnerable groups

Risk groups for sexually transmitted infections include those with socio-economic deprivation, young people and men who have sex with men.³⁹⁴ Rates of acute STIs are highest in residents of urban areas.

Note: teenage conceptions and personal social health education (PSHE) are covered in the children's section of the JSNA.

9.8.3 What is the evidence base?

Improving sexual health requires a coordinated and comprehensive multi-agency approach.

Programmes that bring together education about relationships, sexual health and alcohol and substance misuse components of PHSE education are likely to be effective in improving sexual behaviour.³⁹⁶ Rapid access to services improves sexual health outcomes and such services need to be confidential, open-access, accessible at convenient times and provided from within a range of settings.³⁹⁷

NICE has published guidance on:

- Prevention of sexually transmitted infections and under 18 conceptions, recommending consistent use of condoms and reducing the number of sexual partners as the best way of preventing sexually transmitted infections.³⁹⁸
- Increasing the uptake of HIV testing among men who have sex with men.³⁹⁹
- Increasing the uptake of HIV testing among Black Africans in England.⁴⁰⁰
- Increasing testing for Hepatitis B and C in high risk settings including GUM clinics.⁴⁰¹

The National Aids Trust published guidance in 2013 on reducing late diagnosis of HIV which is associated with a poorer prognosis. Late diagnosis is defined as a CD4 count <350 cells/mm³. In areas of high prevalence, defined as greater than 2 per 1,000 population, such as Luton, routine opt – out testing, partner notification, community HIV testing and the use of financial incentives to encourage testing is recommended.⁴⁰²

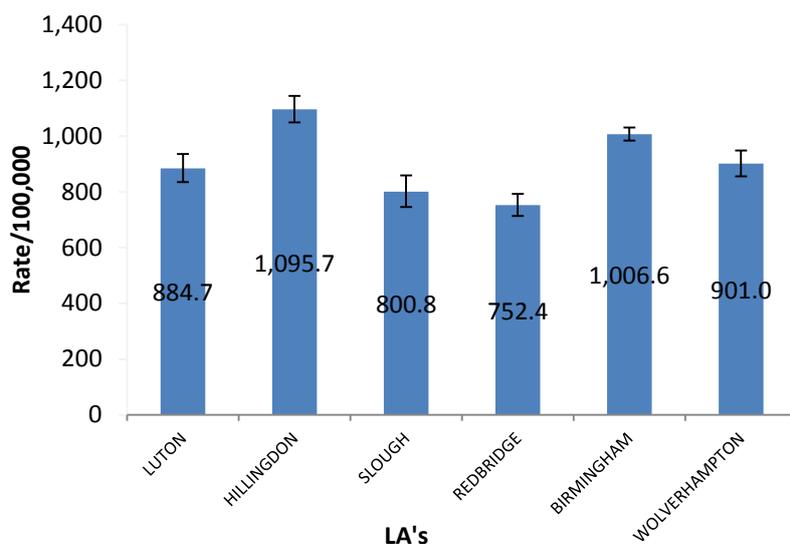
Public Health England has produced guidance for commissioning sexual health, reproductive health and HIV services` to support commissioning bodies to ensure the delivery of high quality sexual health, reproductive health and HIV services in line with their responsibilities set out in the Health and Social Care Act 2012.⁴⁰³

9.8.4 Local picture

In 2013, 1,208 new STIs were diagnosed, excluding chlamydia in people aged under 25 years. This shows Luton as having a higher rate per 100,000 than the England rate, 885 compared with 832 per 100,000 for England. Figure 81 shows Luton has a higher rate than Slough and Redbridge but lower than Hillingdon, Birmingham and Wolverhampton.

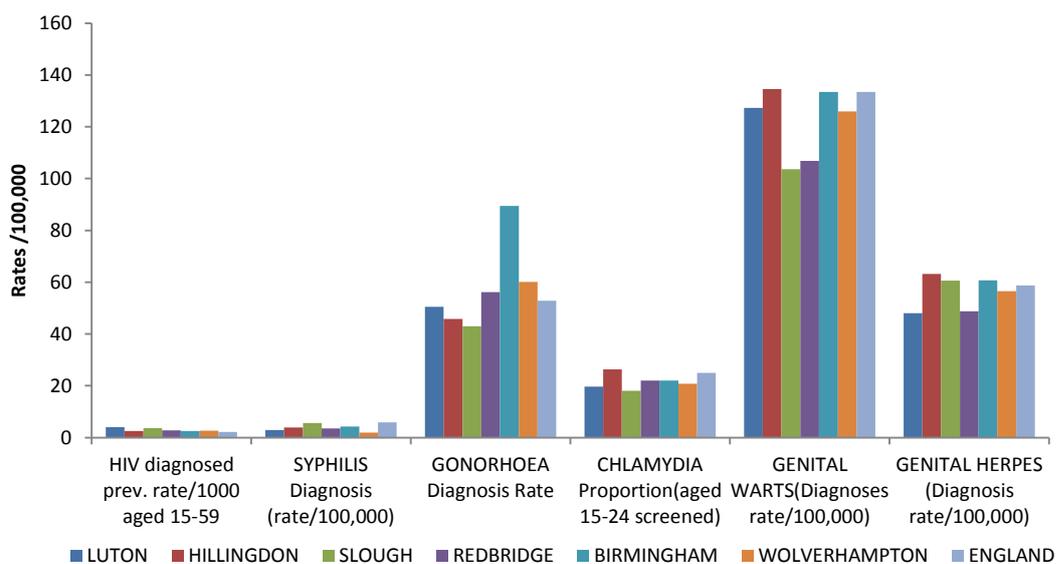
Also shown in Figure 82 are the most common sexually transmitted infections in Luton and the comparator areas.

Figure 81: All new STI diagnoses (excluding chlamydia aged <25) / 100,000.



Source: Public Health England (PHE).2013

Figure 82: Common sexually transmitted infections (2013) for Luton and comparator areas.



Source: Public Health England (PHE).2013

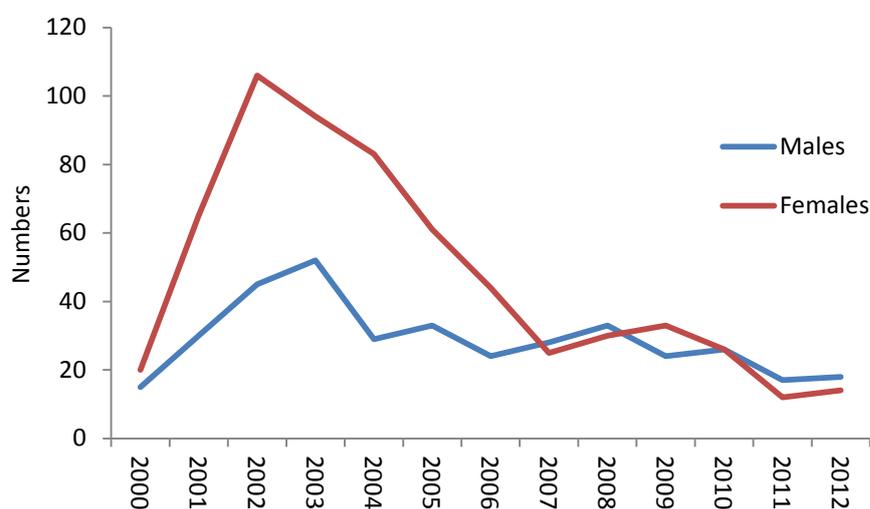
Over half of all STI diagnoses in 2013 were in young adults aged 15 to 24 years old, with slightly more cases observed across all ages in men than women (471 male compared with 364 female). In addition to young people, the impact of STIs at a national level remains greatest in men who have MSM. However this is not the picture in Luton where only 8% of all infections in 2013 were diagnosed amongst MSM.

The highest proportion of diagnoses in 2013 was amongst White groups at nearly 60% of all cases. However, the highest rate of STIs were among persons of Black ethnicity which is a similar picture found nationally.⁴⁰⁴

HIV

Locally, cases of HIV infection increased substantially between the late 1990s and 2002. New cases of HIV peaked in 2002, with 151 new diagnoses. Since then there has been a steady decrease with 37 cases diagnosed in 2012 (Figure 83).

Figure 83: Number of new HIV diagnoses, Luton and dunstable hospital (2000-2012).



The number of people now living with HIV in Luton has increased from 328 in 2003 to 526 in 2013. Over the past decade in Luton:⁴⁰⁵

- Black-African men and women are the largest group affected by HIV followed by men who have sex with men (MSM).
- 6 in 10 newly diagnosed cases were amongst women.
- New diagnosis was highest amongst those aged 30-39 (40%) followed by the 25-29 age group (20%).
- Heterosexual sex was the main probable route of transmission over the ten year period, accounting for 86% of all cases.

Despite the 79% decrease in newly diagnosed cases in the last 10 years and a reduction in prevalence from 4.2 per 1,000 in 2012 to 4.07 in 2013, Luton is still considered an area of high HIV prevalence^m being higher than all its comparators and the fourth highest outside of London.

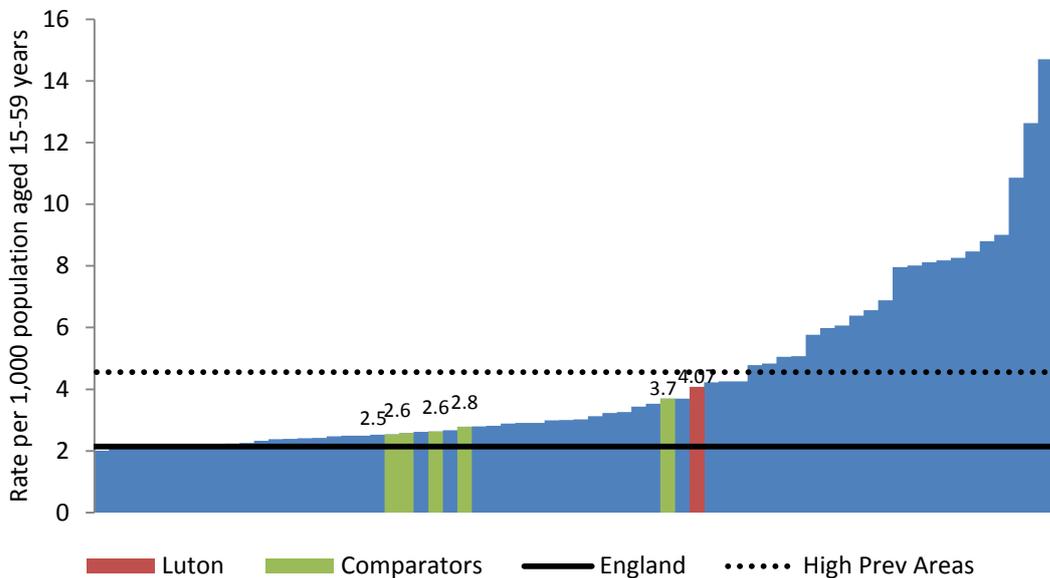
Approximately 25% of people in the UK are unaware of their HIV infection.⁴⁰⁶ This increases the chances of unknowingly transmitting the virus on to others and delaying commencement of treatment. Individuals with a late diagnosis of HIV have an eleven-fold increased risk of death within one year compared with those diagnosed promptly.ⁿ This also increases the risk of onward

^m High prevalence is considered to be areas which had a diagnosed HIV prevalence of ≥ 2 per 1,000 population aged 15-59 years.

ⁿ A late diagnosis is defined as having a CD4 count below 350 cells/mm³ within three months of diagnosis. Prior to 2008, a late diagnosis was having a CD4 count below 200 cells/mm³ within 91 days of diagnosis; this is now referred to as a 'very late HIV diagnosis'

transmission. In 2010-12, half of all diagnoses amongst Luton residents were at a late stage of HIV infection. This is a reduction from 60.8% in 2008-10 but was the highest of all Lutons comparators.

Figure 84: High prevalence areas >2 per 1,000: Luton and comparators (2013)



Source: PHOF and Luton PHI

Chlamydia screening

Chlamydia is the most common bacterial, sexually transmitted infection and often has no symptoms, but can have serious health consequences (eg pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility). Opportunistic screening remains an essential element of good quality sexual health services, although only 19% of 15-24 year olds were tested in 2013 for chlamydia (a total of 5,884 tests).

Luton has a low diagnostic rate at 1,799 per 100,000 (2013) compared with England, at 2,016 per 100,000 (2013).⁴⁰⁷

Contraception

Since 1974, contraception has been free on the NHS. However, despite widespread availability of contraception it is estimated that almost half of all pregnancies in England are unplanned.⁴⁰⁸

Long acting reversible contraception (LARCs) methods such as contraceptive injections, implants, intra-uterine system (IUS) or intrauterine device (IUD) are more effective as they do not depend on daily compliance and their increased uptake could contribute to reducing unintended pregnancies.⁴⁰⁹

In 2013, Luton had a rate of 42.6 per 1,000 women aged 15 to 44 years of GP prescribed LARCs – significantly lower than the England average of 52.7. Of the various methods of contraception prescribed within primary care settings, oral contraceptives remain the most popular method used by women, 81.5% in Luton compared with 83.6% in England. Only 15% of patients choose LARC in Luton.

9.8.5 What is being done locally?

The Luton Sexual Health Strategy aims to improve the sexual health of Luton's population by providing clear direction and focus for sexual health improvement. The strategy has five locally agreed strategic priorities:

1. **HIV/AIDS** reduce onward transmission of and proportion of late HIV diagnoses.
2. **Sexually transmitted infections (STIs)** - effective management of STIs with a specific focus on increased diagnosis of chlamydia.
3. **Pregnancy, contraception and abortion** - continue to reduce the under 18 conception rate and lower the proportion of under 25 repeat abortions.
4. **Sexual exploitation, violence and abuse** - protecting and supporting children and young people from exploitation, violence and abuse.
5. **Service provision and sexual health promotion** - residents to have access to high quality services and accurate, age-appropriate sexual health information.

Each of the priority areas is supported by current prevalence data, national policy and best practice evidence. The strategy will be underpinned by an annual multi-agency action plan, managed by the Luton Sexual Health Strategy Group.

9.8.6 Perspective of the public/service users

Patient and public involvement present particular challenges for sexual health services due to stigma and confidentiality issues. Stigma and discrimination can prevent individuals from getting early diagnosis and treatment, disclosing to friends and family and getting the support they need.

A public consultation exercise was undertaken in May and June 2015 to ensure residents' needs were defined and to inform the design process for an integrated model of sexual health services. The identified target groups (ie BME communities; people with physical or learning disabilities and / or mental health issues and those living in the more socially deprived areas of Luton) were contacted to ensure they have an opportunity to respond to the survey.

9.8.7 Priorities

1. Commission a fully integrated model of sexual health services in line with national strategy and guidance.
2. Increase access to LARC with specific focus on general practice and pharmacy settings.
3. Increase the volume of chlamydia screening in vulnerable groups and young adults with risky behaviours.
4. Increase the availability of HIV testing in clinical, non- clinical and community settings including the piloting of HIV self-sampling.
5. Ensure all staff in provider services receive training on child sexual exploitation, sexual violence and abuse and female genital mutilation (see children's chapter on child sexual exploitation).

10 Long term conditions

10.1 Introduction

A long term condition is defined as a condition that cannot at present, be cured but can be controlled by secondary prevention, medication and other therapies.⁴¹⁰ 15.4 million people in England (over a quarter of the population) have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million in 2018). People with long term conditions use a significant proportion of health care services (50% of all GP appointments and 70% of days spent in hospital beds), and their care absorbs 70% of hospital and primary care budgets in England⁴¹¹.

This chapter covers diabetes, cardiovascular disease, respiratory disease and cancer. Due to the interrelationships between different conditions, what is being done locally and perspectives of the public and priorities have been pulled together.

10.2 Diabetes

10.2.1 Introduction

There are two main types of diabetes: Type 1 where the body is unable to produce insulin (a hormone which reduces blood sugar) and Type 2 (90% of all diabetes) which is caused by a resistance to insulin (usually a consequence of obesity) and/or insufficient insulin production. A third less common type is gestational diabetes. This develops during pregnancy when some women have high levels of blood glucose which their bodies are unable to produce enough insulin to absorb.⁴¹²

Symptoms of diabetes include passing urine more often than usual, increased thirst, increased tiredness, weight loss and blurred vision. Symptoms can be quickly relieved once diabetes is under control.

Diabetes is a long term condition that is known to affect over 3 million people in the UK and a predicted additional 850,000 people who have not yet been diagnosed. It can lead to complications such as cardiovascular disease, foot disease, diabetic nephropathy (kidney disease), diabetic retinopathy (eye disease), and glaucoma.

10.2.2 Risk factors and vulnerable groups

Diabetes does not impact everyone equally and inequalities exist in the risk of developing diabetes, for example, in accessing services and health outcomes. Areas with high levels of deprivation are associated with a greater prevalence of diabetes.⁴¹³

Those who are overweight, physically inactive or have a family history of diabetes are at increased risk of developing diabetes. Obesity is the most important modifiable risk factor (see Section 9.4 for information on obesity in adults in Luton). Smoking is also associated with multiple complications for people with diabetes (see Section 9.7 for information on tobacco in Luton).⁴¹⁴

The prevalence of diabetes rises steeply with age: one in twenty people over the age of 65 in the UK have diabetes and this rises to one in five over the age of 85 years. People of South Asian, African, and African-Caribbean descent have a higher than average risk of developing Type 2 diabetes than the population as a whole.⁴¹⁵ The frequency of diabetes in England is higher in men than in women; however, women with diabetes are at relatively greater risk of dying than men.⁴¹⁵ This is possibly due to how gender compounds other aspects of inequality such as social-economic differences in the prevalence of diabetes and obesity. In addition, pre-menopausal women with diabetes do not have the same protection against CHD as women who do not have diabetes.⁴¹⁵

Women who have had gestational diabetes are also at increased risk of developing Type 2 diabetes.⁴¹² Having polycystic ovary syndrome increases the risk of diabetes, especially combined with being overweight or obese.⁴¹⁶

10.2.3 What is the evidence base?

Primary prevention

Interventions to reduce the prevalence of diabetes risk factors in the general population include smoking cessation, increasing physical activity and healthy eating.⁴¹⁷ These interventions also reduce

complications in those already diagnosed with diabetes.^{418, 419} See Section 9 for information on smoking, obesity, and physical activity.

Case-finding and early diagnosis

Identification and assessment of people at high risk of diabetes through case-finding strategies in primary care.

Management and control

Management of diabetes in primary care and secondary care for people with established disease to prevent deterioration and complications leading to hospital admissions and premature death. Treatment and management should include lifestyle advice, prescribing appropriate medication, and regular review of indicators such as cholesterol, blood pressure and BMI.

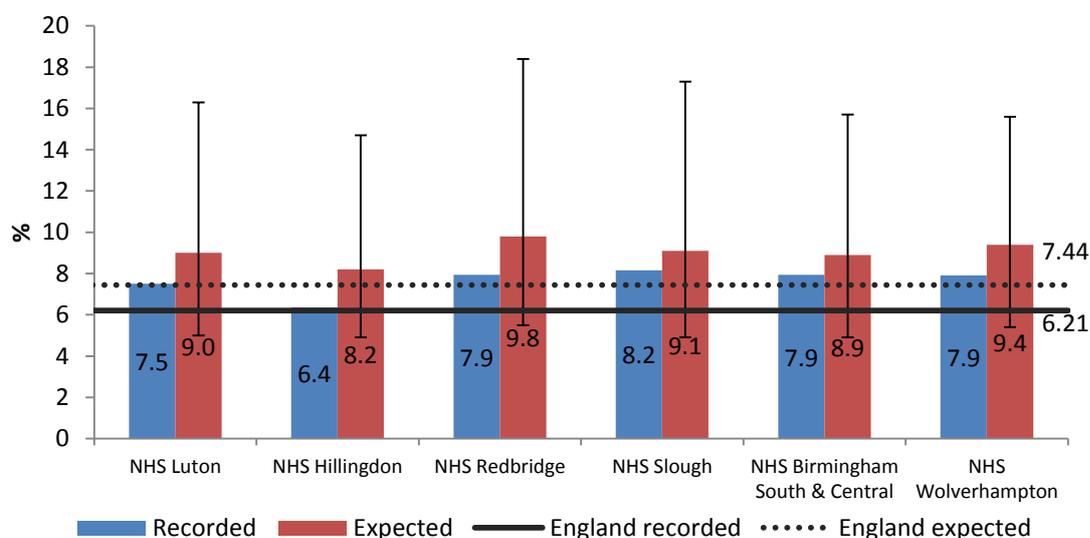
10.2.4 Local picture

Prevalence

In 2013/14, the prevalence of diagnosed diabetes in people aged 17 years and older in Luton was 7.5% compared with 7.6% in similar local authorities.⁴²⁰ This is a slight increase on the previous year (7.26%).⁴²⁰ The expected prevalence (2012 model) shows an estimated 9% of the population has diabetes suggesting an estimated 1,571 adults in Luton could have undiagnosed diabetes (Figure 85).

The National Diabetes Information Service estimated that if the current trends in population change and obesity persist, the total prevalence of diabetes in Luton is expected to rise to 9% by 2020 and 10.3% by 2030. People with diabetes in Luton were 74% more likely to have a heart attack, 47.3% more likely to have a stroke, 85.8% more likely to have a hospital admission related to heart failure and 23% more likely to die than the general population in Luton.⁴²¹

Figure 85: Diabetes recorded prevalence (2013/14) aged 17+ and expected prevalence (2012) 16+ years.

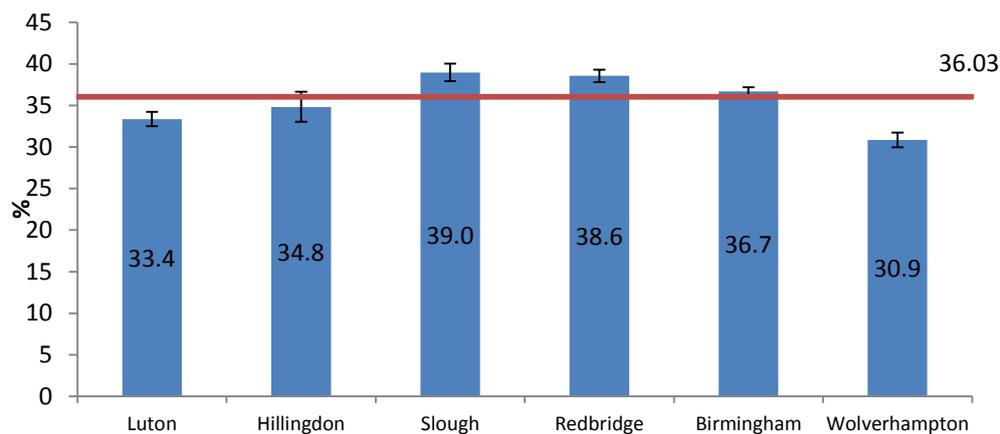


Source: QOF and PHE

Treatment

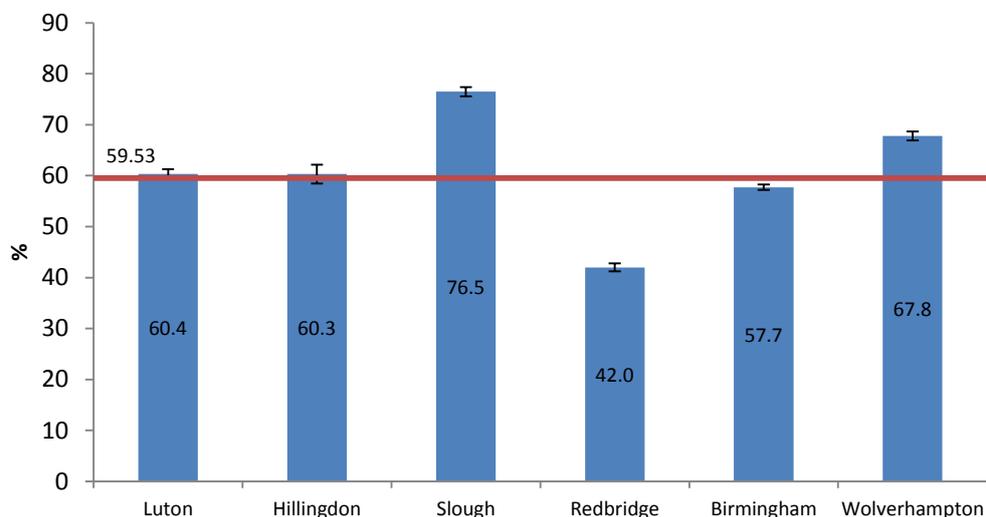
People with diabetes meeting treatment targets in 2012 (% of people registered with diabetes achieving NICE-defined treatment targets for glucose control, blood pressure and blood cholesterol) were 33.4% of the 11,070 people receiving treatments which is significantly below the England average (36%). The percentage of people registered with diabetes receiving eight of the nine recommended care processes by NICE was 60.3% in 2012 which is similar to the national average (59.5). As shown in Figure 86 and Figure 87.

Figure 86: People with diabetes meeting treatment targets (2012) (all ages).



Source: Public Health England (PHE). Available from: <http://fingertips.phe.org.uk/diabetes>

Figure 87: People with diabetes having check-ups (2012) (all ages).

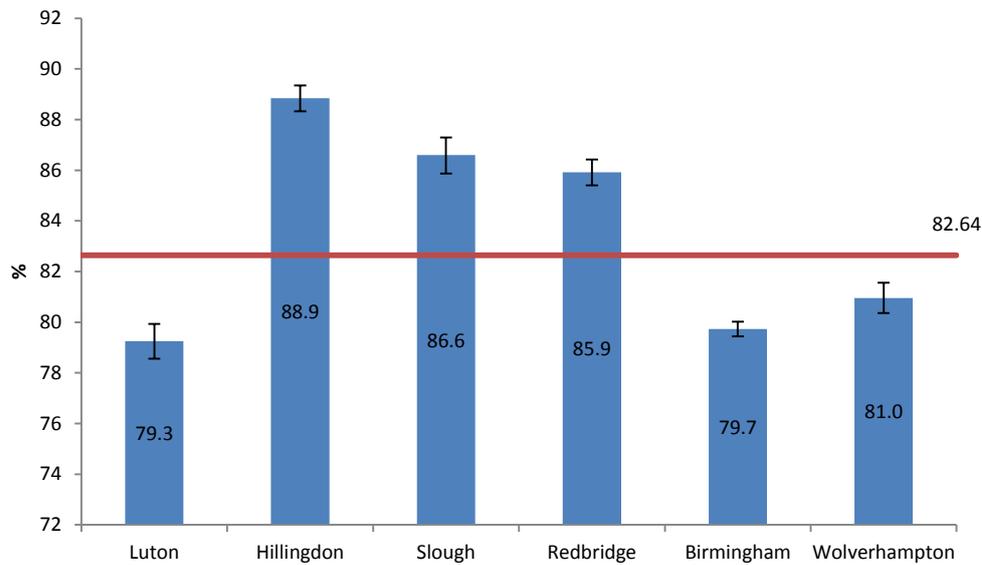


Source: Public Health England (PHE). Available from: <http://fingertips.phe.org.uk/diabetes>

Retinal screening

In comparison with Luton's statistical neighbours and nationally, the percentage of diabetes patients in 2014 who have a record of retinal screening in the past 12 months is low at 79.3%. Figure 88 shows how Luton compares nationally and to its neighbours.

Figure 88: Percentage of all diabetes patients who have a record of retinal screening in the previous 12 months (2013/14).



Source: Public Health England (PHE). Available from: <http://fingertips.phe.org.uk/diabetes>

Spend

The 2012/13 spend on primary care prescribing for diabetes per 1,000 weighted population in Luton was £15,565 which is higher than £12,611 spent on average nationally.

A total of £3 million was spent on prescriptions for diabetes items by Luton Clinical Commissioning Group (LCCG) between April 2012 and March 2013. Average spend on items to treat diabetes was higher in England compared with Luton but not statistically significant. Average spend on prescriptions for items to treat those with diabetes in 2012/13 was £249.08 in Luton compared with £281.52 across England per adult.

10.3 Cardiovascular disease

10.3.1 Introduction

Cardiovascular disease (CVD) is an overarching term that describes a family of diseases (including stroke, heart attack, hypertension and peripheral vascular disease) sharing a common set of risk factors.

CVD is the second largest cause of death in England (28% of all registered deaths in 2013). Around 46% of all deaths from CVD are from coronary heart disease (CHD) and a quarter from stroke (25%). CHD is the most common single cause of death in England (13% of all deaths in 2013).⁴²² CVD is the largest cause of death in Luton accounting for 29.5% of all deaths (see section 2.1.7).

CHD occurs when the flow of oxygen-rich blood to your heart is blocked or reduced by a build-up of fatty material (atheroma) in the coronary arteries. A stroke is a serious medical condition that occurs when the blood supply to part of the brain is cut off. CHD alone is estimated to cost the UK more than £7 billion each year,⁴²³ while the National Audit Office estimated the cost of stroke in England as about £7 billion per year.⁴²⁴

10.3.2 Risk factors and vulnerable groups

The main risk factors for CVD are: smoking, an unhealthy diet and a lack of physical activity and their consequences: obesity, high cholesterol, high blood pressure and diabetes. These lifestyle risk factors increase the likelihood of getting CVD and also contribute to the deterioration of existing CVD.⁴²⁵

There are large variations in the prevalence of CVD across the population resulting in significant health inequalities. In 2008, deaths from CVD were 50% higher in the most deprived quintile compared with the least deprived.⁴²³ Deaths from coronary heart disease are three times higher among unskilled men than among professionals, and around 50% higher in South Asian communities than in the general population. The CHD death rate in female workers with routine jobs five times is higher than those with managerial or professional jobs.⁴²⁶ Even though men have higher rates of premature CHD than women, the inequalities between women from different socioeconomic groups are more marked than among their male counterparts.⁴²⁷

People with mental health problems also have significantly higher rates of long-term health problems, including CVD. A 2014 survey of more than 2,500 homeless people across England found that more than 40% of homeless people reported a long-term physical health problem, compared with just 28% of the general population.⁴²⁸

10.3.3 What is the evidence base?

There is a large amount of guidance from NICE on the prevention and treatment of cardiovascular disease.⁴²⁹ It includes guidance on preventing the uptake of smoking by children and young people and on promoting physical activity, through to the management of clinical conditions such as raised blood lipids, chronic heart failure and hypertension. The guidance indicates that to prevent CVD avoid smoking, be physically active and follow a healthy diet.⁴³⁰

For those with CVD, self-care management and plans have been shown to be effective in reducing the impact of the disease, particularly after an acute episode.⁴³¹

The CVD Outcomes Strategy sets out action to improve the outcomes for people with or at risk of CVD.⁴³² It highlights the need to take an integrated approach to reducing CVD, ensure there is a programme of prevention and risk management, appropriate response to acute CVD and provide ongoing support for those living with CVD and during the end of life.

10.3.4 Local picture

Prevalence

Recent figures show that recorded prevalence of CHD in Luton in 2013-14 was 2.56% compared with the national rate of 3.29% and an average of 2.77% in similar local authorities. Although figures show that prevalence in Luton is below the England average, figures may be under-reported as they rely on patients being registered with a GP. In 2013/14 there were 5,622 people diagnosed with CHD in Luton, the expected all age prevalence (2011 model) shows an estimated 3.7% of the Luton population has CHD. Applying this to Luton's population shows the total number of expected cases is likely to be around 8,100.⁴³³

In 2014 there were 26,360 people on GP lists in Luton with diagnosed hypertension. This equated to 12.0% of the population registered with a GP; however, it was estimated the prevalence of hypertension in Luton was 21.1%, meaning that 9.1% or 20,000 adults could have hypertension that has not been diagnosed.⁴³³

Atrial fibrillation is a known risk factor for stroke. The diagnosed prevalence in Luton is 0.9% and the estimated prevalence is 1.7%. There could be an additional 1,800 people with undiagnosed atrial fibrillation in Luton.⁴³³

Hospital admissions

In 2013/14 the admission rate for CHD in Luton was 917.7 per 100,000 people (1,318 admissions), significantly higher than England (559.6 per 100,000).

In 2013/14 the admission rate for heart failure for all persons in NHS Luton CCG was 153.1 per 100,000 (208 admissions). This was higher than England. The admission rate for heart failure in Luton has increased by 6% between 2003/04 and 2013/14.

In 2013/14 the emergency admission rate for stroke in Luton was 125.2 per 100,000 (175 admissions). This was significantly lower than England (174.3). The emergency admission rate for stroke in Luton increased by 5.5% between 2003/04 and 2013/14.

Mortality

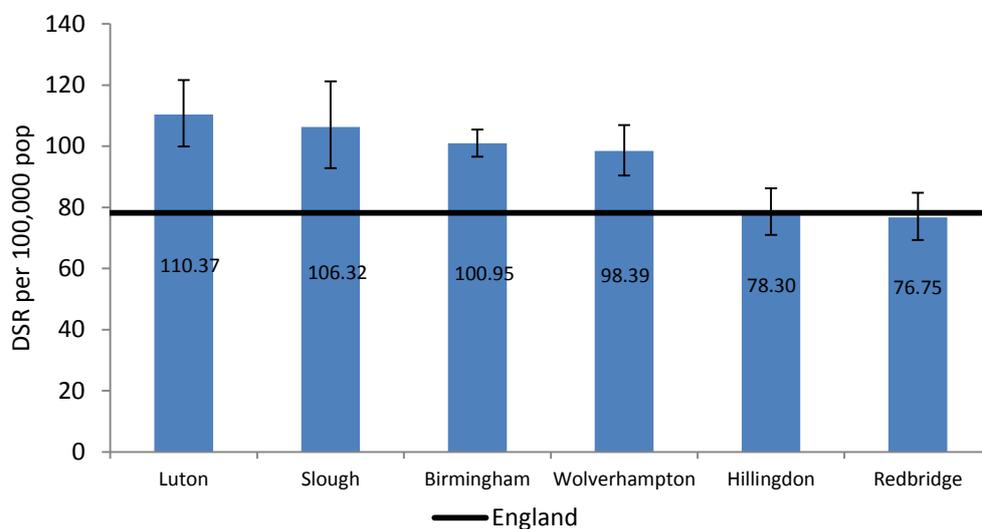
Premature mortality rates from CVD (less than 75 years) in 2011-13 were significantly higher in Luton than the national rate and some statistical neighbours; Hillingdon and Redbridge (Figure 89).

In 2013, the early mortality rate for CHD in Luton was 67.5 per 100,000. This is a decrease of 28% since 2003, which was lower than the England change. In England, the mortality rate has decreased by 47% over the same 10 years. The rates in the East of England strategic clinical network decreased by 46% over the same time period.

Early mortality rates (under 75 years of age) for stroke in Luton were 21.1 per 100,000 people. This was higher than, but not statistically different to the England rate (13.7). Between 1995 and 2013 there were 54% fewer stroke deaths, down from 148 per 100,000 people in 1995 to 67 per 100,000 in 2013.⁴³³

The Commissioning for Value dataset shows a number of indicators of concern in Luton in regards to CVD indicators and, in comparison with statistical neighbours. Table 19 shows where Luton falls within the worst 13.5% of local authorities in England.

Figure 89: Premature CVD mortality 2011-13



Source: PHOF 2011-13

Table 35: CVD indicators - commissioning for value

Commissioning for Value indicator†	Time Period	Luton CCG (06P)	Slough CCG (10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
		Value	Value	Value	Value	Value	Value
% of patients with CHD whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (CHD 06)	2012/13	83.7	89.2	87.1	88	86.4	88.1
% of patients with CHD whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (CHD 08)	2012/13	70.2	72.8	73.1	72.4	71.5	72.5

Commissioning for Value indicator†	Time Period	Luton CCG (06P)	Slough CCG (10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
		Value	Value	Value	Value	Value	Value
% of patients with hypertension whose last blood pressure reading (as measured within the last 9 months) is 150/90 or less (BP 05)	2012/13	73.5	79.4	77.9	77.5	76.9	77.4
Spend on non-elective (emergency and other non-elective) admissions for CHD per 1000 population	2012/13	£12,423	£11,230	£11,630	£4,170	£8,738	£7,916
Mortality from CHD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	2009-11	47.4	48.8	34	44.9	30.2	34.6
Mortality from acute MI: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	2009-11	25.6	20.4	16	17.7	10.6	14

Commissioning for Value indicator†	Time Period	Luton CCG (06P)	Slough CCG (10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
		Value	Value	Value	Value	Value	Value
% of patients with stroke or TIA whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (STROKE 06)	2012/13	82.2	87.6	86.2	84.8	83.6	85.5
% of patients with a non-haemorrhagic stroke or TIA with a record that an anti-platelet agent or an anti-coagulant is being taken (STROKE 12)	2012/13	86.5	91.4	88.8	89.8	90.2	90.5
% of patients with atrial fibrillation in whom the risk of stroke has been assessed using CHADS2 in the previous 15 months (AF 05)	2012/13	93.1	96.2	94.8	95.6	94.9	94.9

Source: Commissioning for value dataset and Luton PHI

10.4 Respiratory conditions

10.4.1 Introduction

Respiratory tract diseases are diseases that affect the air passages, including the nasal passages, the bronchi and the lungs. They range from acute infections, such as pneumonia and bronchitis, to chronic conditions such as chronic obstructive pulmonary disease (COPD) and asthma.⁴³⁴ This section covers COPD and asthma.

COPD is the name given to conditions related to difficulty breathing and long term damage of the lungs. It is a disabling illness which affects people in different ways such as breathlessness, bad cough and repeated chest infections and also impacts upon quality of life when the disease is advanced. Asthma is an obstructive lung disease and is a common condition which causes the airways to become narrower. People with asthma have difficulty breathing, often wheezing, coughing and a tightness feeling in their chest. Unlike COPD, asthma symptoms of airflow obstruction are reversible with clinical interventions.⁴³⁵

Respiratory diseases are the most common single cause for emergency admissions in the United Kingdom accounting for 12% of all admissions.⁴³⁶ Respiratory diseases are one of the main factors contributing to reduced life expectancy, and are the third (14.5%) leading cause of deaths in Luton after circulatory disease and cancer, see Sections 10.3 and 10.5.

10.4.2 Risk factors and vulnerable groups

Higher levels of deprivation and smoking are generally linked with higher prevalence rates of COPD. Smoking is the most significant risk factor for developing COPD and is responsible for over 85% of COPD cases. Generally, lower educational attainment and household income are related to greater disease severity, poorer lung function and greater physical function limitations.⁴³⁷

10.4.3 What is the evidence base?

For asthma, there are a number of NICE guidelines for therapeutic agents delivered by inhaler. Further guidance on diagnosis and monitoring, and management will be published in July 2015 and June 2017 respectively.

Services for people with COPD are published as a NICE Commissioning Guide (CMG43).⁴³⁸ An updated Quality Standard will be published in January 2016.

Effective interventions that can assist in preventing the development of respiratory disease or reducing its impact include:

- Immunisation against seasonal flu, pandemic flu and pneumonia.
- Prevention and cessation of smoking.
- Smoke free environments.
- Low levels of air pollution.
- Warm, well-maintained homes that are not damp.

10.4.4 Local picture

In 2013/14, Luton CCG spent £14.8m or 6.4% of its budget on problems of the respiratory system. The majority of this spend is split between primary care prescribing and pharmaceutical services (23.8%) and non-elective admissions (35.9%).⁴³⁹

Data for 2012/13 indicates that Luton is statistically significantly worse than its closest 10 CCG comparators for:

- Percentage of COPD patients with a record of Forced Expiratory Volume in 1 second (FEV1) in the preceding 15 months.
- Percentage of COPD patients having had a review in the previous 15 months.
- Spend on non-elective (emergency and other non-elective) admissions for Obstructive Airways Disease per 1,000 populations.
- Percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility.
- Percentage of asthma patients who have had a review in the preceding 15 months.⁴⁴⁰

COPD prevalence

In 2013/14, there were 2,626 people recorded on the primary care COPD disease register. This was a recorded prevalence of 1.2%. The prevalence is ranked within the lowest fifth of all CCGs across the country (33 of 211). The prevalence between 2009/10 to 2013/14 increased at a slightly faster pace than England (19% compared with 17%). Modelling of prevalence suggests that there are approximately 1,987 people with undiagnosed COPD across Luton. There remains a wide variation between practices ranging from 0.24 to 2.18, which suggests that some practices are better at identifying COPD patients than others.

COPD mortality

From 2011/2013, there were approximately 167 premature deaths in Luton related to a respiratory disease. This was a rate of 45.4 per 100,000 persons. Although, the rate is higher than 2007/09, it is no longer significantly higher than England. Mortality from causes related to respiratory disease has reduced by more than a fifth compared with 2007/09 (highest reduction amongst Luton's comparators).

From 2008/10 to 2010/12, England saw an increase in premature COPD mortality rates by as much as 48% whereas Luton saw a relatively modest increase of 4%. The most recent figure from 2010/12 shows Luton had a rate of 12.19 per 100,000 persons. This was 2nd lowest amongst its five other comparators. In 2008/10, Luton was higher than England (but not significantly so). In 2010/12, Luton is now significantly lower than England.

Premature mortality from COPD is more common amongst males than females. In 2010/12, across England the figure was 33% higher for males compared with females - a figure that has remained consistent since 2007/09. However, for Luton the figure has now gone from 50% higher for males in 2007/09 to 59% higher for males in 2010/12.

Asthma prevalence

In 2013-14, there were 11,823 people recorded on the primary care asthma disease register. This was a recorded prevalence of 5.38%. The prevalence was ranked within the lowest fifth of all CCGs across the country (42 of 211). From 2009-10 to 2013-14, the prevalence for Luton has increased from 5.33% to 5.38% whereas for England it has reduced.

The Luton respiratory pathway involves the care of patients with all forms of respiratory disease. Care is given by multidisciplinary respiratory teams involving doctors, specialist respiratory nurses, community respiratory teams, respiratory physiotherapists and specialist respiratory technicians as well as other general medical staff in the Luton and Dunstable Hospital and the community services teams.

Previous work has been undertaken by Luton PCT and CCG on improving the patient pathway by:

- Introducing a COPD commissioning for quality and innovation payment (CQUIN) for discharge with care bundles.
- Introducing risk stratification in primary care.
- Commissioning pulmonary rehabilitation in the community services and the acute hospital.

The CCG is now undertaking a review of all respiratory services in Luton.

10.5 Cancer

10.5.1 Introduction

There are more than 200 different types of cancer and the most common are lung, breast, prostate and bowel cancers which account for more than half the diagnoses each year in the United Kingdom.⁴⁴¹ One in three people will develop cancer in their lifetime, and cancer causes more than 1 in 4 of all deaths. However, the number of people living with and beyond a cancer diagnosis is expected to rise to 3 million people by 2030.⁴⁴² It has been calculated that for the UK, the cost of cancer was £18.33 billion in 2008, and that these costs will increase to £24.72 billion by 2020.⁴⁴³

10.5.2 Risk factors and vulnerable groups

Risk factors other than family history often play an important role in the development of cancer (only 5-10% of cancers are thought to be caused by an inherited faulty gene).⁴⁴⁴ Two important fixed risk factors are age and gender. Cancer incidence and deaths increase with age, for example, males 75 years or older are most likely to die from cancer than any other group. Men are more likely to have and die from cancer than women, although the gender gap in cancer incidence is reducing.⁴⁴¹ Mortality rates in England are also significantly higher than the average in the 40% most deprived areas.¹

It is estimated that up to half of all cancer cases diagnosed in the UK could be avoided if people made changes to their lifestyle, such as stopping smoking, moderating alcohol intake, maintaining a healthy bodyweight and avoiding excessive sun exposure.⁴⁴⁵

10.5.3 What is the evidence base?

Key actions from Government policy include:⁴⁴⁶

- Changing lifestyles to reduce the risk of cancer – there are national action plans in place for reducing smoking,⁴⁴⁷ reducing obesity and improving diet⁴⁴⁸ and reducing harmful drinking.⁴⁴⁹
- Making sure people know the signs of cancer.
- Getting an earlier diagnosis through screening - the most effective way of improving cancer outcomes is diagnosis at an early stage which greatly increases the chance of survival.⁴⁵⁰
- Improving treatment.
- Improving access to cancer services.
- Helping survivors live more comfortably.

As cancer is not one disease, there is a range of best practice evidence for management of different cancers available from NICE.⁴⁵¹ Cancer Research UK published Key Messages for Cancer Commissioners for 2013, a compendium of evidence-based and cost-effective best practice including a range of effective interventions on prevention, public awareness and early diagnosis, effective clinical leadership across the whole of the patient pathway, support for research, and monitoring Trusts' Patient Experience Survey results.⁴⁵²

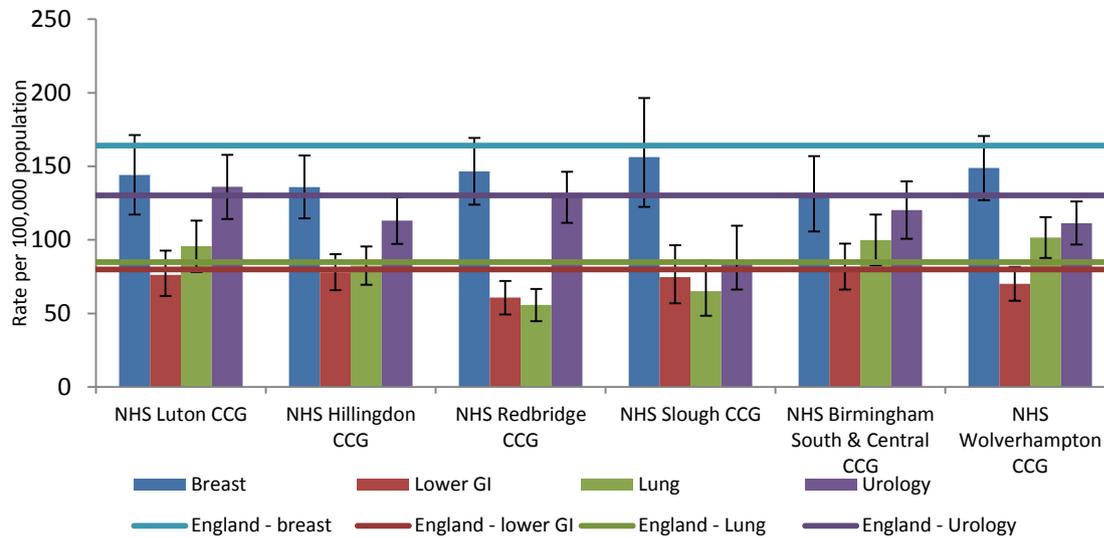
10.5.4 Local picture

Incidence

In Luton, there were 600 new cancer diagnoses per 100,000 people in 2012 which is similar to the England average (599 per 100,000 people).⁴⁵³ The four most common tumour groups diagnosed

within Luton were breast (144.2 per 100,000), lower gastrointestinal (76.1), lung (95.7) and Urology (136). All were not significantly different to incidence rates in England as a whole and were broadly similar to comparator areas (Figure 90).

Figure 90: Age standardised incidence rates by tumour groups, 2012



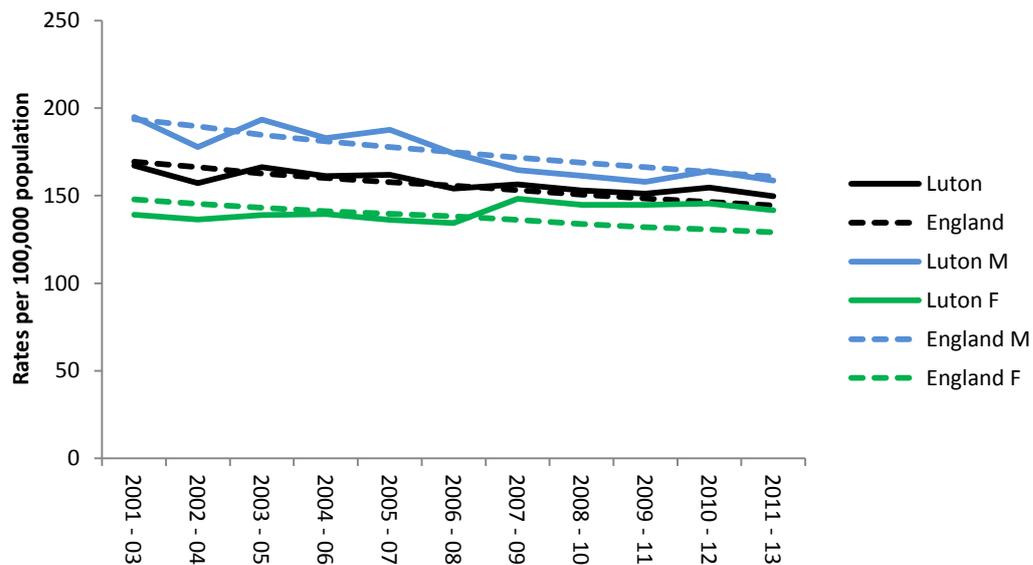
Source: Local Cancer Intelligence⁴⁵³

Mortality

Cancer is the second biggest cause (28%) of deaths in Luton (Figure 13). In 2013 there were 369 deaths with the underlying cause recorded as cancer. Just under half (47%) were premature deaths under the age of 75 years. The premature cancer mortality rate is not significantly different from England with 150 premature cancer deaths per 100,000 people in 2011-13 compared with 144 per 100,000 people in England as a whole. Luton’s premature mortality rate (less than 75 years) has been decreasing at a similar rate to comparators (Figure 91). The trend for males is in line with reduction seen nationally but the rate for females has remained consistently above the national average with widening inequalities, although not significantly different.

Luton’s Annual Public Health Report (2010-2011) showed that White ethnic communities had higher death rates from cancer than Asian and Black communities both in Luton, statistical neighbours and nationally.⁴⁵⁴ Cancer Research UK⁴⁵⁵ has also shown that people from BME communities were at significantly lower risk of getting cancer than those from the White community.

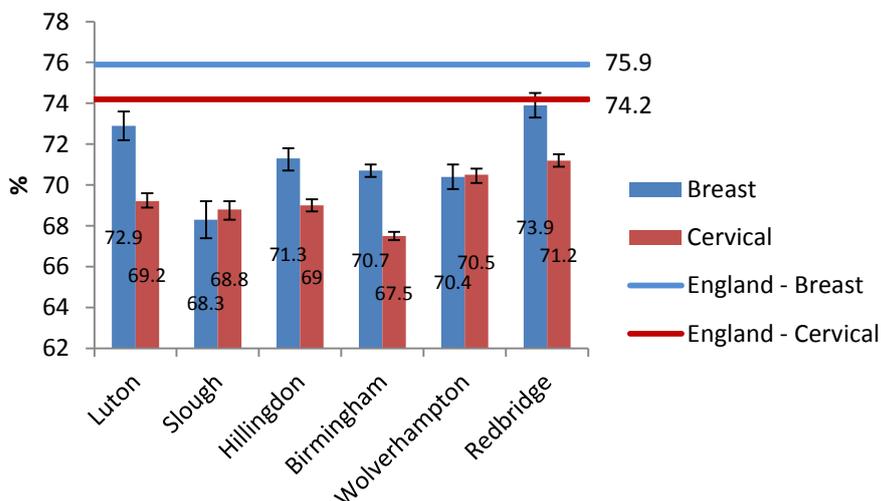
Figure 91: Premature cancer mortality rates, Luton and England



Screening

Cancer screening aims to detect early stage cancers or pre-malignant disease. Currently, three national cancer screening programmes for breast, bowel and cervical cancer are offered to eligible populations in Luton. Screening coverage for both breast and cervical cancer in Luton is significantly lower than the England average as shown in Figure 92 but similar to comparator areas.

Figure 92: Breast and cervical screening coverage, Luton and comparators, 2014.



Using the Commissioning for Value dataset shows a number of indicators of concern in Luton in regards to cancer indicators and in comparison with statistical neighbours where Luton falls within the worst 13.5% of local authorities in England (Table 36).

Table 36: Cancer indicators - commissioning for value

Commissioning for Value indicator†	Time Period	Luton CCG (06P)	Slough CCG (10T)	Redbridge CCG (08N)	Birmingham South and East CCG (04X)	Hillingdon CCG (08G)	England
		Value	Value	Value	Value	Value	Value
Spend on primary care prescribing for breast cancer per 1,000 weighted population	2012/13	£625	£388	£337	£329	£340	£418
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99	2011 (2012)	66.7	69	68.9	69.8	68.8	69.5
% of people aged 60-69 who were screened for bowel cancer in the previous 30 months	2013	50.8	41.1	49.4	47	52.3	58.8
% of colorectal cancers detected at an early stage (1 or 2)	2012	26.9	14.6	34.3	32.7	41.6	37.2
Mortality from colorectal cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	2009-11	12.3	6.8	6.6	10.9	7.6	10.1

Source: Commissioning for value dataset and Luton PHI

10.5.5 What is being done locally?

There are a number of different programmes that support those with different LTC. The Health Check programme is delivered across all GP practices in Luton and aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74 who has not already been diagnosed with one of these conditions or does not already have known risk factors is invited once every five years for a health check. A health Check will assess their risk and they will be given support and advice to help them reduce or manage identified risk.

The local services offered by the primary care teams, community services and the local secondary care providers help people with diabetes in Luton to improve the quality and length of their life, by supporting them to understand and self-manage their condition.

A range of patient education programmes, support groups and direct clinical support is offered to patients through the commissioned services.

Local services are provided to patients with respiratory disease through their primary care team, community service provider and a range of services at the Luton and Dunstable Hospital. LCCG are currently working with all providers to ensure services are consistent, coordinated, and centred around the needs of the patient.

The Cancer Action Group (CAG) consisting of MacMillan GPs and nurses, commissioners, cancer managers and public health, and the Luton and Dunstable Hospital focus on issues impacting on services and patient experience. The Cancer Action Plan focuses on the national key performance indicators for cancer, particularly relating to the 62 day access to treatment targets. Luton CCG in partnership with all providers is focussing on improving early diagnosis and long term survival rates.

The action plan includes actions to review the pathways starting with lung and upper and lower GI pathways. A project is underway to increase the uptake of the National Bowel Cancer Screening programme among Luton patients as Luton has one of the lowest uptakes in the country. A further issue in Luton is the number of patients that do not attend their testing for cancer once referred from their GP. This is being addressed with GPs, and the screening programmes within the hospital.

The delay in commencing treatment following diagnosis when treatment is delivered by a tertiary provider, this is particularly prevalent when patients are referred for radiotherapy. The CAG is leading on a project to implement a tertiary referral protocol to aid timely referrals for treatment.

10.5.6 Perspective of public/service users

In a 2013/14 GP Patient survey, 63% of patients in Luton (all with a long term health condition; 9% of respondents stated they had diabetes) said they have received enough support compared with 64% in England and 91% said they were very or fairly confident of managing their own health compared with 93% in England.⁴⁵⁶

Data from the Health Survey for England show that smokers with COPD tended to be more addicted to cigarettes but show no greater desire to stop smoking than other smokers.⁴⁵⁷

The National Cancer Patient Experience Survey (CPES)⁴⁵⁸ measures the experience of care of people who have been a hospital inpatient or day case of cancer. The 2013 data for Luton Clinical Commissioning Group (CCG) found that:

- 83% of people rated their overall care as excellent or very good compared with 88% in England

- 63% reported that hospital and community staff always worked well together (compared with the England average of 64%).

Luton and Dunstable University Hospital is in the top ten for patient experience across England, according to results released by Macmillan Cancer Support, based on research commissioned by NHS England. The results also showed that cancer services at the LandD had one of the best improvement rates in the country. Patients were asked about their experience of hospital care and to rate hospitals according to measured aspects of care, such as:

- Were their diagnosis and treatment options explained clearly?
- Did they feel supported in their care?
- Did they feel that they were treated with respect?

10.5.7 Priorities

1. Support the primary prevention of long term conditions through awareness raising and education amongst the population and coordinated preventative action on reducing smoking, eating more healthily and increasing physical activity.
2. Accelerate the Health Check programme to identify those at risk in order to take preventative action and develop a programme of pre-disease education programme.
3. Undertake further in-depth needs assessments to inform how to address the variation in the screening, diagnosis, treatment and outcomes for people with long term conditions
4. Develop a long-term condition personalised and integrated model of support with the community and voluntary sector and primary and secondary care that includes risk profiling, continuity of care, promotes self-care, offers provision of psychological support and ensures integrated pathways that provide the best possible experience and outcomes for patients.
5. Continually monitor the outcomes for patients, review performance against key national targets, and benchmark services to ensure the local population receives high standards of integrated care.

11 Ageing well

11.1.1 Background

The population of the UK is growing and becoming increasingly older. As elsewhere, the number of older people in Luton is expected to increase as people live longer (see population chapter). The fact that people are living longer is a cause for celebration, and reflects improved living standards and healthcare. However, the ageing population raises specific challenges for the future of health and social care services where limited resources will need to be allocated to support more people. The ageing process brings increased risks to independence and wellbeing through disease, frailty, sensory impairments and other long term conditions, especially in the oldest old ie people over the age of 85. However, we need to ensure that as many people as possible have good health and maintain their independence for as long as possible.

This chapter focusses on Luton's population mainly aged 65 years and over and their health and socioeconomic needs. This chapter outlines the demography of older people in Luton, health disability and disease, inequalities and deprivation affecting older people, the services in place and recommendations for action.

NICE has a range of guidance covering older people:

- Falls: assessment and prevention of falls in older people (CG161).⁴⁵⁹
- Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care (PH16).⁴⁶⁰
- Quality standard for the mental wellbeing of older people in care homes (QS50).⁴⁶¹
- Local government advice on older people in care homes.⁴⁶²

And a range in development:

- Disability, dementia and frailty in later/ mid – life approaches to prevention.
- Excess winter deaths and illness.
- Home Care.
- Older people – independence and mental wellbeing.
- Social care of older people with multiple long-term conditions.
- Workplace health – older employee's.

Age UK has produced a series of evidence reviews⁴⁶³ providing in-depth reports on evidence to underpin decision making, commissioning and service development in relation to support for older people.

11.2 Introduction

Growing older brings many challenges and changes to the lives of people. Ageing affects individuals in different ways. Some people will live long lives with few health and social care needs, whilst others will rely on long term support. These differences are the result of a variety of factors such as gender, ethnicity and family history ie genetic background and inherited conditions. Other factors relate to experiences in individuals' lifetimes: for instance, lifestyle, socioeconomic background and illnesses, conditions and injuries.

When older people do require services and support, the reasons vary:

- The effects of existing conditions, illnesses and impairments may have reached the point where existing support is no longer enough to ensure safety and wellbeing.
- The development of new illnesses and conditions which are most commonly experienced in old age eg dementia and Parkinson's disease.
- The impact of frailty, which can include limited mobility, risk of injury, sensory impairments and incontinence.
- Loneliness, isolation and depression.

Older people are not a uniform group and there is a wide range of diverse needs within the population aged 50 years and above. Older people can broadly fit into one of three groups.

Entering old age - those who have completed their career in paid employment and/or child rearing (this includes people as young as 50). Many are active and independent and will remain so into later old age. The aim for this group is to maintain a healthy, active life and ensure their well-being.

Transitional phase – older people in transition between healthy, active life and frailty. This often occurs in the seventh or eighth decades of life. The aim is to identify emerging problems ahead of crises and ensure effective responsive services, preventing crises and reduce long-term dependency.

Frail older people – those who are vulnerable as a result of health problems such as stroke or dementia, social care needs, general frail old age or any combination of these. Frailty is often experienced later in old age, so services for older people and their carers should be designed with such needs in mind. The aim is to anticipate and respond to these support needs, recognising the complex interaction of physical, mental and social care factors, which can compromise independence and quality of life.⁴⁶⁴

11.3 Demographics of older people (65 years plus)

11.3.1 Population

Luton has a relatively young population as identified in the Healthy people Section. However, as the projections showed in Table 17, the older age groups (65+) are predicted to increase by 40% over the next 20 years and, within this, is a 91% increase in the very elderly (85 years and over). Therefore it is important that, when planning services for this age group, their needs are understood in respect of health and well-being. Estimates show 12% (24,981) of Luton's current population is aged over 65 years compared with 17% for England as a whole.⁴⁶⁵ The age breakdown is shown in Table 37.

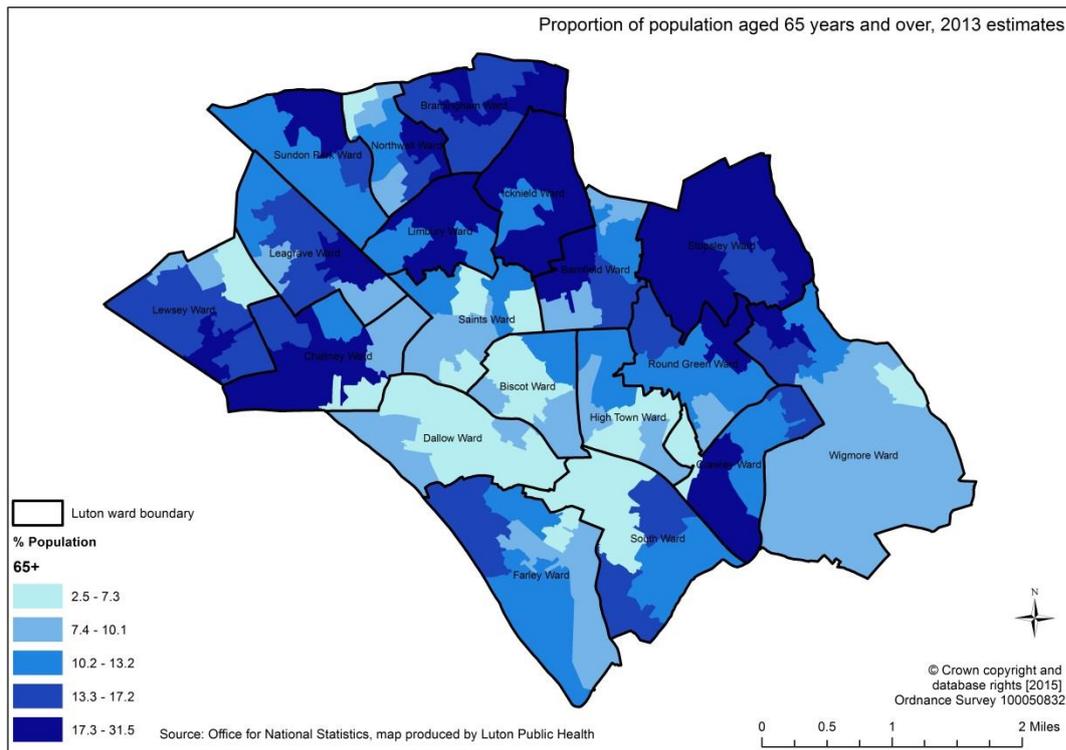
Table 37: Age breakdown of 65+ population, 2013 mid-year estimates

Age group	Count	% total population	
	Luton	England	
65-74	12899	6.2%	9.3%
75-84	9066	4.4%	5.7%
85+	3016	1.5%	2.3%

Source: ONS

Figure 93 shows the areas in the North of Luton have the highest proportion of the population aged 65 years and over in wards such as Bramingham, Icknield and Stopsley. There are also pockets with high proportions of those aged 65 years and older in Challney, Crawley, Lewsey and Northwell.

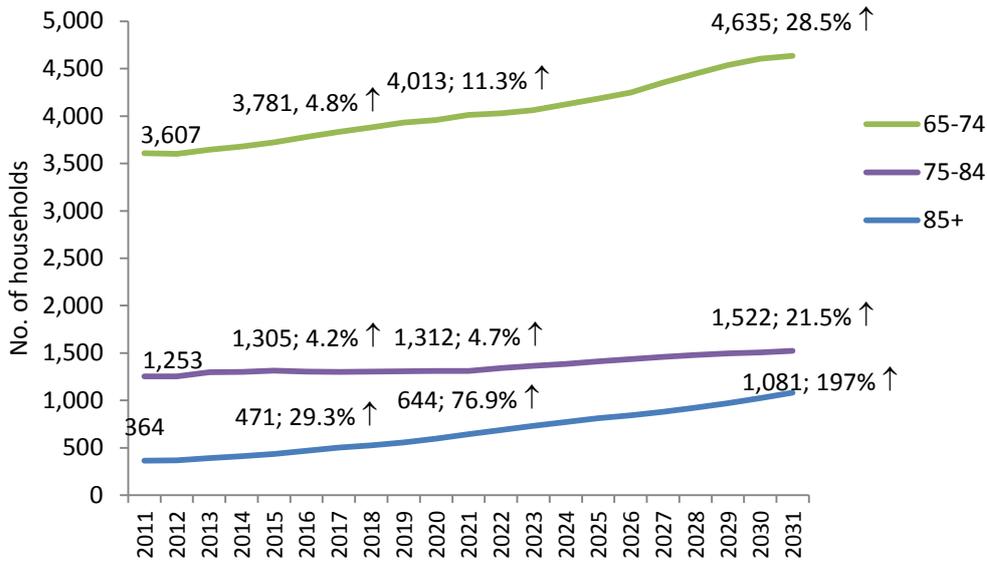
Figure 93: Population aged 65 years and over, 2013.



In addition household projections show households with couples aged 65 years and over are projected to increase by 6% in the next 5 years, 14% in the next 10 years and 39% in the next 20 years. Male single person households are also projected to increase as shown in Figure 95.

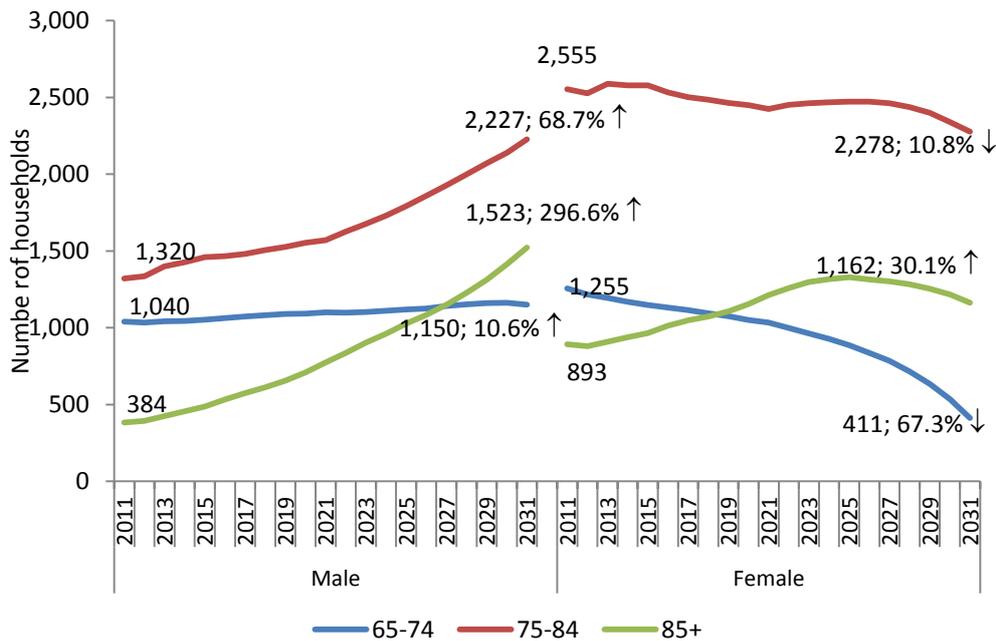
Couple households aged 65 years and over are predicted to increase by 6% in the next 5 years, 14% in 20 years and 39% in the next 30 years. Figure 94 shows the differences by age group. Single person households aged 65 years and over are also projected to increase but only for males with a predicted 78.5% increase over the next 30 years and an 18% decrease for females. This is a consequence of the expected increase in life expectancy for males. Figure 95 shows the breakdown by ages.

Figure 94: Couple household projections 65 years and over.



Source: Luton research and intelligence team.

Figure 95: Single person household projections 65 years and over.



Source: Luton research and intelligence team

11.3.2 Ethnicity

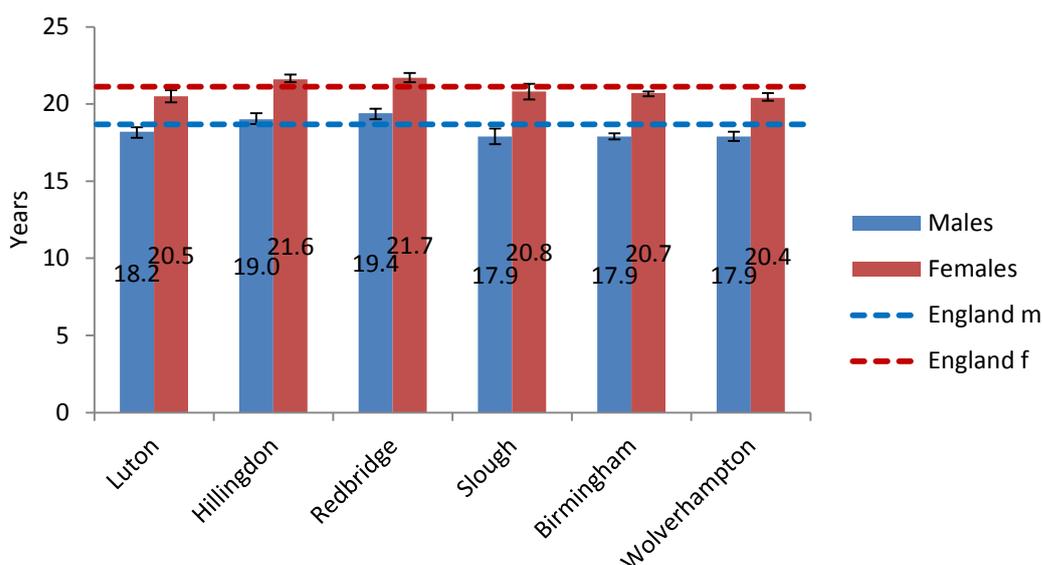
The 2011 census showed there were 6,984 people aged 65 and over from non-White British communities, which was 29.3% of the 65 and over age group. Within that group of older people, 9% were White Irish, 4.6% Pakistani, 4.4% are from African Caribbean communities, 3.9% Indian, 2.4% from the White Other communities and 2.1% are from Bangladeshi communities.⁴⁶⁶

- Within these communities there is a higher and rising proportion of people, especially among South Asian and African Caribbean communities, with longer-term conditions including diabetes, cardiovascular diseases, high blood pressure and stroke. This is likely to place greater demand on services within the next five years with the predicted increases in the ethnic minority populations.
- As people grow older, health and social status changes and become more of an issue affecting independent living.

11.3.3 Life expectancy

Male and female life expectancy at age 65 years (2011/13) in Luton (18.2 years and 20.5 years) is significantly lower than the national life expectancy at age 65 (18.7 years and 21.1 years). Compared with statistical neighbours Luton's life expectancy is significantly lower than the two London comparators but similar to the others (Figure 96). Male life expectancy at age 65 has increased at a slightly slower rate to the national trend from 2000/02 to 2011/13 (15.2% increase compared with 15.8% nationally). For females, it has increased at a faster rate (12.6% increase compared with 9.9%). However, in more recent years since 2008/10 the inequality gap for both males and females has slightly widened (Figure 97).

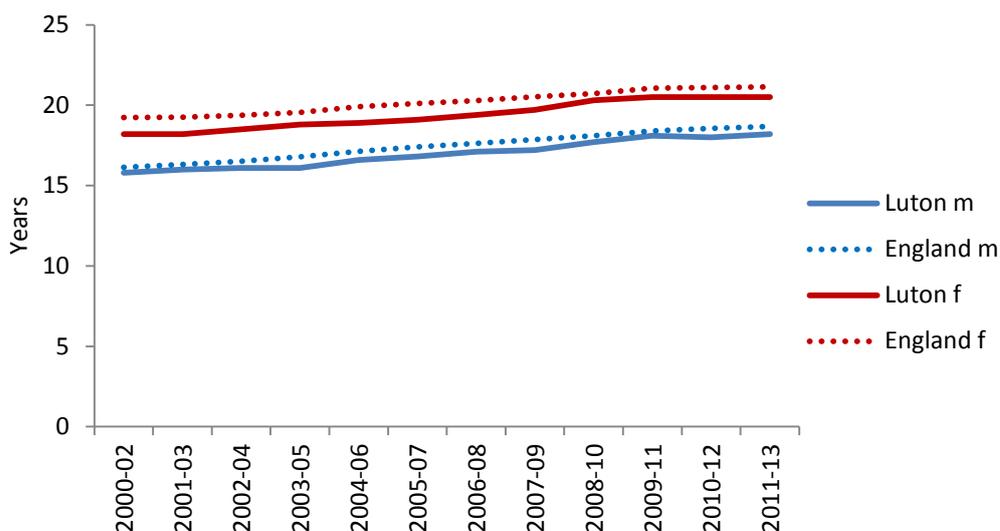
Figure 96: Male and female life expectancy at age 65 years, 2011/13.



Source: ONS and reproduced by Luton Public Health

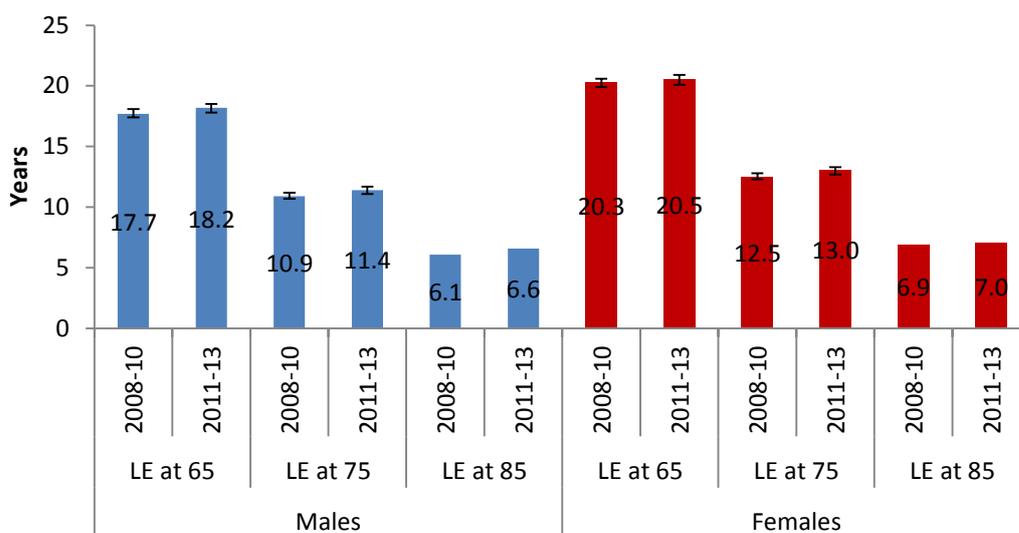
Male and female life expectancy at age 75 years (2011-13) in Luton (11.4 years and 13 years) was similar to the national figure (11.3 years and 13.1 years). Male and female life expectancy at age 85 years was higher in Luton than nationally (6.6 years and 7.0 years compared with 5.8 and 6.8). Increases have been seen in Luton for both male and female life expectancy between 2008/10 and 2011/13 at ages 65, 75 and 85 years (Figure 98).

Figure 97: Life expectancy at age 65, 2000/02 to 2011/13.



Source: ONS and reproduced by Luton Public Health

Figure 98: Differences between 2008/10 and 2011/13 in Luton male and female life expectancy at 65, 75 and 85 years

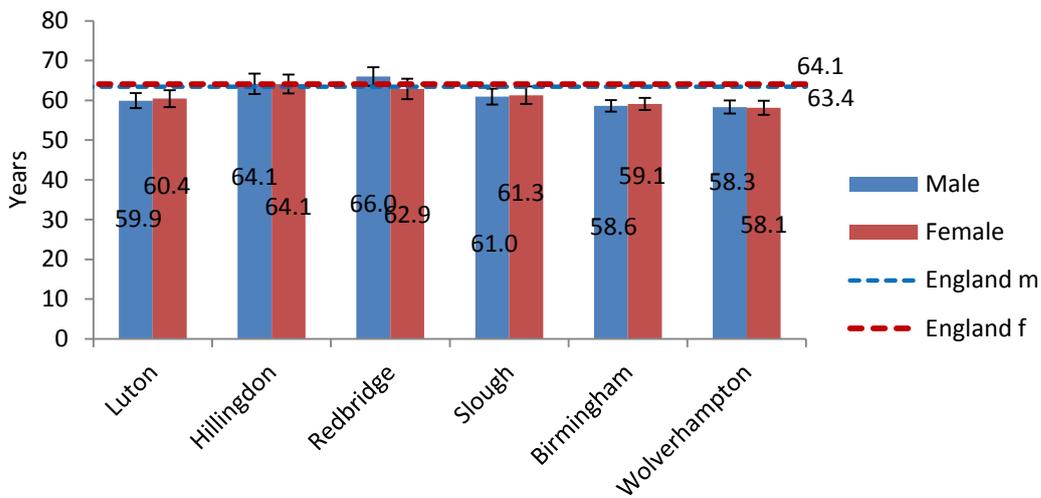


Source: ONS and reproduced by Luton Public Health

Healthy life expectancy (HLE)

Male HLE at age 65 in Luton is ranked as 114th out of 150 upper tier local authorities and female HLE is ranked as 109 (a rank of 1 has the highest HLE). Luton's HLE at age 65 years is significantly below England for both males and females but generally similar to comparator areas (Figure 99).

Figure 99: Healthy life expectancy at age 65 years, 2010-12.

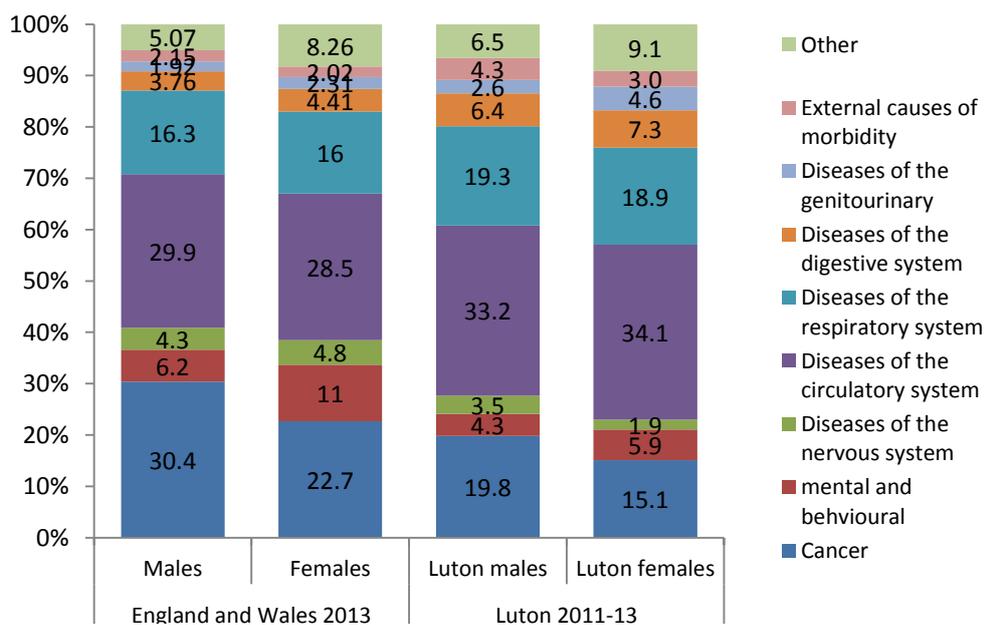


Source: ONS and reproduced by Luton Public Health

11.3.4 Causes of death and illness

Figure 100 shows the main causes of death of those aged 65 years and over in Luton compared with England and Wales. It shows that although cancer remains one of the main causes of death, it accounts for a smaller proportion in Luton than seen nationally for this age group. This is similar for mental and behavioural diseases and diseases of nervous system such as dementia and Alzheimer’s. However, diseases of the circulatory system, such as CHD and stroke, account for a higher proportion in Luton than seen nationally, as well as respiratory disease deaths (such as pneumonia and COPD), diseases of the digestive system, diseases of the genito-urinary system and external causes.

Figure 100: Main causes of death, 65 years and over



Source: ONS and Luton Public Health

Limiting long term illness (LLTI)

In 2011, 29,646 (14.7%) people in Luton recorded in the census they had a long term health problem or disability, which limited their day to day activities either a little or a lot. Of these nearly half 12,190 (41%) were aged 65 years and over and represented more than half of the 65 years and over population (53%). Half of these (6,125) reported their day to day activities were limited a lot which represented 26.5% of all people aged 65 years and over.

Figure 101 shows two maps displaying those aged 65 years and over who stated their day to day activities were limited a lot by their long term health problem or disability, shown as a proportion of the total 65 years and over population. Looking at actual counts of the population shows the largest numbers were in those areas identified with higher numbers of those aged 65 years and over (Figure 93). Looking at the proportion of the older population shows the highest proportions with LLTI were concentrated in pockets in the south of Luton across a number of wards (Biscot, Dallow Saints, Farley, High Town and South Wards). This shows that the areas with lowest overall proportion of 65 years and over populations had the highest proportion of their population reporting that they have a long term health problem or disability that limits their day to day activities a lot.

Figure 101: LLTI (a lot) in those aged 65 years and over, 2011 (% and count).

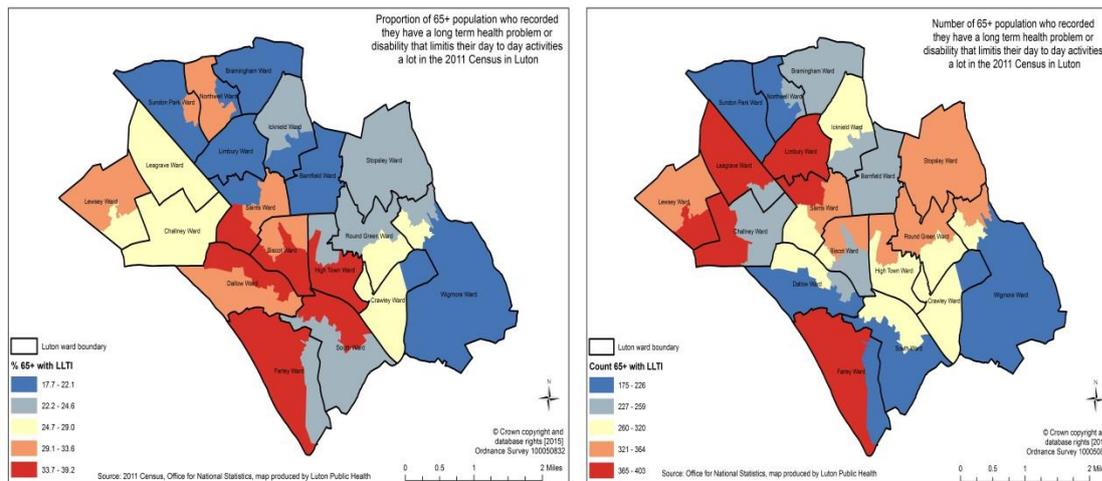
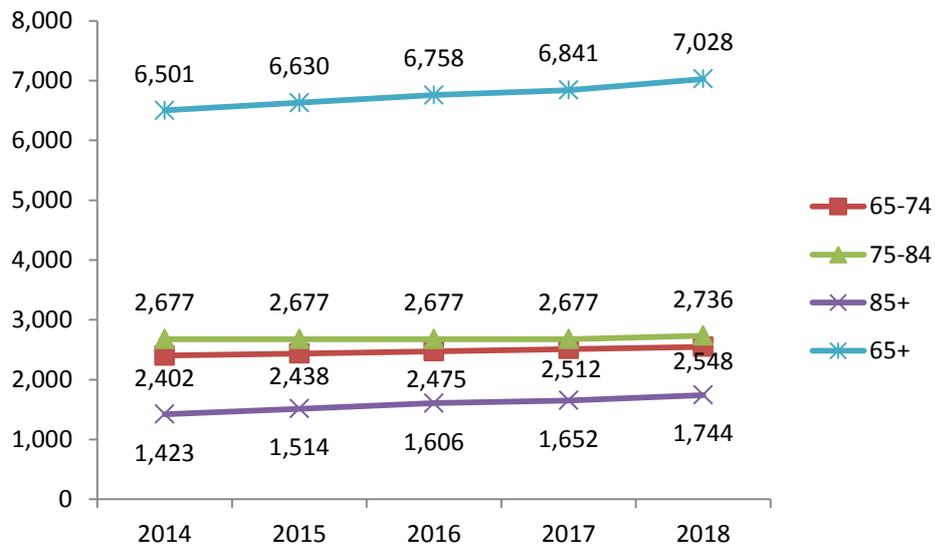


Figure 102 shows the projected numbers of people aged 65 years and over to have a limiting long term illness (where activities are limited a lot) based on population growth alone, the numbers are projected to increase from 6,501 in 2014 to 7,028 in 2018.

Figure 102: Projected number of people aged 65 years and over with a LLTI



Source: POPPI and Luton Public Health

11.4 Independent living

11.4.1 Introduction

Independent living means all older disabled people having the same freedom, choice, dignity and control as other citizens at home, work and in the community.⁴⁶⁷

The population aged 65 years and over is projected to increase by 40% over the next 20 years (see Demographics of older people (65 years plus) section) and with an ageing population there will be an increase in demand for health and social care services including physical health, mental health and particularly social isolation.

As people get older, their housing needs often change. Some people need support to be able to continue living in their own homes. Some people, of all ages, have disabilities that mean their homes need to be adapted.

This can be managed by supporting people to remain independent for longer. The aim is to maintain independent living by developing the range of community-based support so that older people and their carers can live independently in their own homes for as long as they choose.

11.4.2 Risk factors and vulnerable groups

More women (61%) than men (of all ages) receive community-based social care services.⁴⁶⁸ People with physical and mental disabilities are affected by a range of issues which limit their ability to lead independent lives, including environmental constraints and attitudes which limit expectations and aspirations in their care.⁴⁶⁸ Evidence also suggests that lower socioeconomic status may be associated with poor access to information about care options.⁴⁶⁸

11.4.3 What is the evidence base?

NICE has produced a range of guidance focused on older people⁴⁶⁹ which will support independent living. This includes preventing falls and excess winter deaths and promoting mental wellbeing in older people. In development are: older people – independence and mental wellbeing, care and support for older people with learning disabilities, and social care of older people with multiple long-term conditions.

The White Paper Caring for our future: reforming care and support⁴⁷⁰ set out the Government's ambitions to prevent, postpone and minimise people's needs for formal care and support and that people should be in control of their own care and support. This has led to a number of changes in policy and legislation including the proposed changes in primary care⁴⁷¹ and the Care Act⁴⁷². The Care Act sets out how local authorities should be meeting local needs and focusing on wellbeing. This includes focusing on prevention, having good information and advice and a range of services provided to support people's needs.

For those seeking advice, FirstStop⁴⁷³ is a free, independent national information and advice service for older people, their family and carers. Funded by the Department for Communities and Local Government (DCLG), it provides joined-up advice about housing, care and finance rights and issues.

11.4.4 Local picture

The Adult Social Care Outcomes Framework (ASCOF) indicators (Table 38) show the proportion of people who use services who have control over their daily life, and the proportion of people who use services who find it easy to find information about services, are lower in Luton compared with the

England average and comparators but not significantly different; however, the overall satisfaction with services is significantly lower than the national average and lower than comparators.⁴⁷⁴

Table 38: Adult social care outcomes framework indicators

ASCOF indicator*	Good is	Luton	Slough	Hillingdon	Birmingham	Wolverhampton	Redbridge	England
		Value	Value	Value	Value	Value	Value	Value
1 B - Proportion of people who use services who have control over their daily life	High	70.7	72.3	72.3	69.7	77.6	87.0	76.8
3 A - Overall satisfaction of people who use services with their care and support	High	54.7	58.0	58.6	62.4	62.5	76.5	64.8
3 D1 - Proportion of people who use services who find it easy to find information about services	High	67.8	74.7	72.4	73.5	74.3	82.8	74.5

11.4.5 What is being done locally?

There is a range of existing public sector funded services that support a person to live independently, and aim to reduce need for health and social care services or support ageing well, which are covered elsewhere. One main programme is Better Together⁴⁷⁵ which aims to:

- Redirect investment to help people to keep healthy and help people to manage their conditions, putting them in control of their health.

- move more healthcare to home or in the community and out of hospitals enabling people to benefit from a more co-ordinated approach between health and care services and supporting them to be able to manage their conditions at home or in the community.

There are a range of other current services including:

Housing support and adaptations

- Housing-related support provides services meeting the varying needs or directly providing accommodation for the residents of Luton to assist the service user to remain independent and maintain a tenancy/prevent homelessness. Supported Living Schemes offer accommodation with daily support workers present to those who wish to live independently but need assistance to do so.
- Sheltered housing enables older and vulnerable people to live in a safe and secure environment in their own home with the reassurance of a 24 hour support service via community alarms which are integrated into the Telecare (a remote and automatic monitoring system) service. The council owns and manages 22 sheltered schemes which comprises 1,021 properties in various locations throughout the town.
- Extra care is provided for those living independently who require some extra care. Support is mainly physical or relating to complex care or dementia and exists to promote independence and avoid the more formal care arrangements.
- Across the town a range of home adaptations are provided. Such as the home improvement Agency installs equipment and undertakes minor repairs including fitting key safes, grab rails and dealing with trip hazards. Over 1,500 repairs were completed in 2012/13. Home support provides domestic housekeeping services to over 300 households, providing over 21,000 hours of support in 2013/14.
- Private sector housing is monitored to ensure standards are maintained and notices are served on landlords to bring properties up to standard; over 350 notices have been served in 2014/15. Additionally households are assisted with adaptations, particularly around disability and provide healthy heating grants to either top-up ECO-heating initiative or provide urgent repairs to vulnerable people the private sector.

Hospital discharge and reablement

- The hospital discharge meet and greet scheme facilitates faster discharge to a safe home environment, provides supervision for a settling in period and monitoring of the service user for six weeks post discharge. During 2012/13, over 460 people were assisted under this scheme. There is an agreed discharge protocol between The council, the Luton & Dunstable Hospital and mental health teams for current medical or psychiatric inpatients to have a smooth and planned discharge from the hospital setting to home.
- The Council has focused on reablement by providing short term support that enables the service user to return home (from hospital) or remain at home and reductions in admissions to residential care. This has led to the numbers of admissions into residential care being stabilised with greater number of elderly clients being supported at home via domiciliary care services.

Community services

- There is a range of community services offered across the town to support people to stay independent, including podiatry, falls service and prevention and wellbeing groups. The wellbeing groups are for those over 50 years old and offer a social environment to meet people, participating in light exercise, and have a basic health check. The groups also promote healthy options and living as well as give information concerning the major diseases affecting their community.

11.4.6 Perspective of service users/public

Most people and their carers want to remain independent and live at home for as long as possible⁴⁷⁶, and are supportive of a preventative approach to maintain independence. People would also like services between the local authority, health, primary care, acute care and the voluntary sector more joined up.⁴⁷¹

11.4.7 Priorities

1. Focus on prevention, early intervention and safeguarding ensuring that the Care Act requirements are implemented.
2. Increase responsiveness of services so people can access the information and services they need in a timely manner to make informed decisions.
3. Reduce seasonal excess deaths by implementing a systematic approach to vulnerable older people.

11.5 Dementia

11.5.1 Introduction

Dementia describes a set of symptoms that may include memory loss and difficulties with thinking; problem solving or language and is caused when the brain is damaged, most commonly by diseases such as Alzheimer’s disease (the most common cause) or a series of strokes.⁴⁷⁷ The specific symptoms that someone with dementia experiences will depend on the parts of the brain that are damaged and the disease that is causing the dementia.

There are around 800,000 people with dementia in the UK, and the disease costs the economy £23 billion a year. By 2040, the number of people affected is expected to double - and the costs are likely to treble.⁴⁷⁸

11.5.2 Risk factors and vulnerable groups

The causes of dementia are not fully understood. Dementia can affect anyone whatever their gender, ethnic group or class; however, the risk of developing dementia increases as one gets older (the condition usually occurs in people over the age of 65).⁴⁷⁹ There are modifiable and non-modifiable risk factors of dementia as shown in Table 39. Actions to change the modifiable risk factors are described in other sections of the JSNA.

Table 39: Risk factors for dementia

Non-modifiable risk factors	Modifiable risk factors
Age (the greatest risk factor)	Diabetes (see section 10.2)
Genes	Harmful drinking (see section 9.6; 10.5.3)
Family history	High cholesterol (see section 10.3.2)
Down’s syndrome	History of depression (see section 9.2)
	Hypertension (see section 10.3)
	Low educational attainment or cognitive inactivity (see section 11.5.4;11.5.5;11.7.1;11.7.2)
	Obesity (see section 7.2.3;9.4)
	Physical inactivity (see section 9.3;11.8.2;12.2.3)
	Smoking (see section 4.3;5.2;9.7)

Source: Alzheimer’s disease International⁴⁸⁰

Once a person has dementia they will get progressively worse over time until the end of their life. Although most types of dementia cannot be cured, if it is detected early there are ways it can be

slowed down and mental function maintained for a period of time. Treating the symptoms of dementia and offering appropriate support services can make a significant difference to the lives of people with dementia, their families and carers.⁴⁸¹

The numbers of young people with dementia are small. However, there are certain types of dementia inherited as a single gene that can cause the disease amongst those under 65 (known as early-onset dementia).⁴⁸²

There is an association with learning disabilities, as the incidence of dementia for those with Down's syndrome is about twelve times higher than general population.⁴⁸³

There is a growing body of evidence suggesting prevalence of dementia is greater among African-Caribbean and South Asian UK populations. African-Caribbean communities may also experience a lower age of onset due to the increased presence of risk factors for vascular dementia, such as hypertension.⁴⁸⁴

11.5.3 What is the evidence base?

The National Dementia Strategy contained 17 key objectives covering three main areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.⁴⁸⁵ This was followed by an outcome focused implementation plan covering four priority objectives:⁴⁸⁶

- Good quality early diagnosis and intervention for all.
- Improved quality of care in general hospitals.
- Living well with dementia in care homes.
- Reduced use of anti-psychotic medication.

A good practice compendium was also developed to support local delivery.⁴⁸⁷

NICE also provides a range of guidance⁴⁸⁸ and other materials on dementia including:

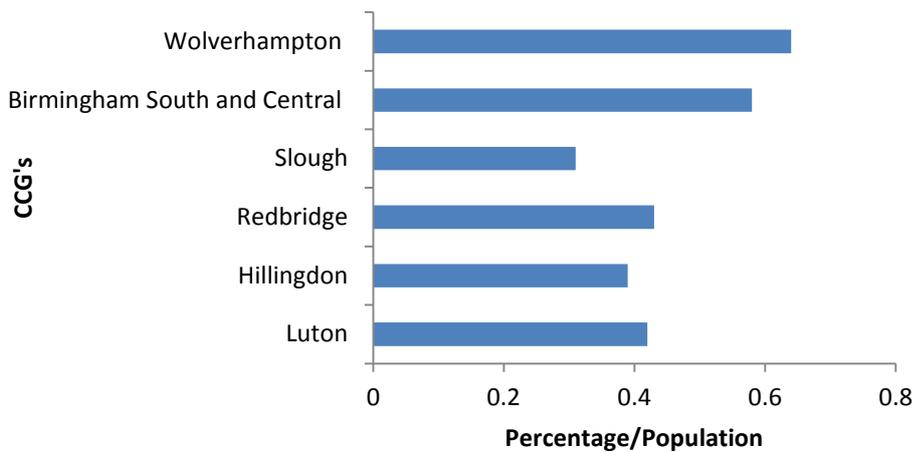
- Quality standards for supporting people to live well with dementia.⁴⁸⁹
- Guidance with recommendations for the identification, treatment and care of people with dementia and the support of carers as well as best practice advice emphasising the principles of a person-centred approach.⁴⁹⁰
- Support for commissioning dementia care – summarising key commissioning issues and the resource impact of NICE recommendations.⁴⁹¹

11.5.4 Local picture

It is estimated that 1,759 people in Luton aged 65 and above will have dementia in 2015⁴⁹² whereas those recorded on the dementia GP register as of 2013/14 was only 924⁴⁹³ suggesting more than 50% of patients with dementia could be unknown to their GPs. The prevalence of dementia in Luton is estimated to be 0.42% of the population (Figure 103).⁴⁹³

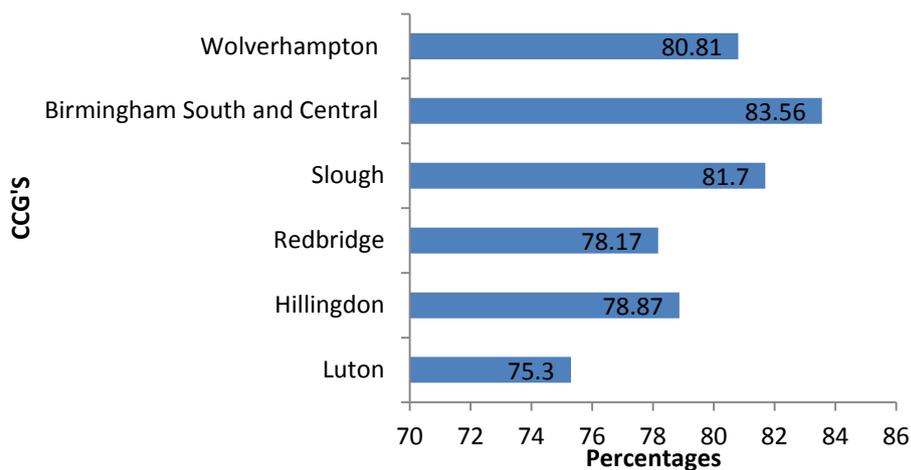
The Mental Health Observatory briefing projected in 2008 that 2,256 people in Luton would have dementia in 2015, an increase of 22% from the estimated figure of 1,756 people in 2008. The projection predicts that more women (1,320) will have dementia than men (935).⁴⁹⁴

Figure 103: Dementia prevalence, 2013/14.



Source: CQRS and GPES database - 2013/14 data as at end of June 2014, Health and Social Care Information Centre

Figure 104: Dementia patient receiving intervention, 2013/14

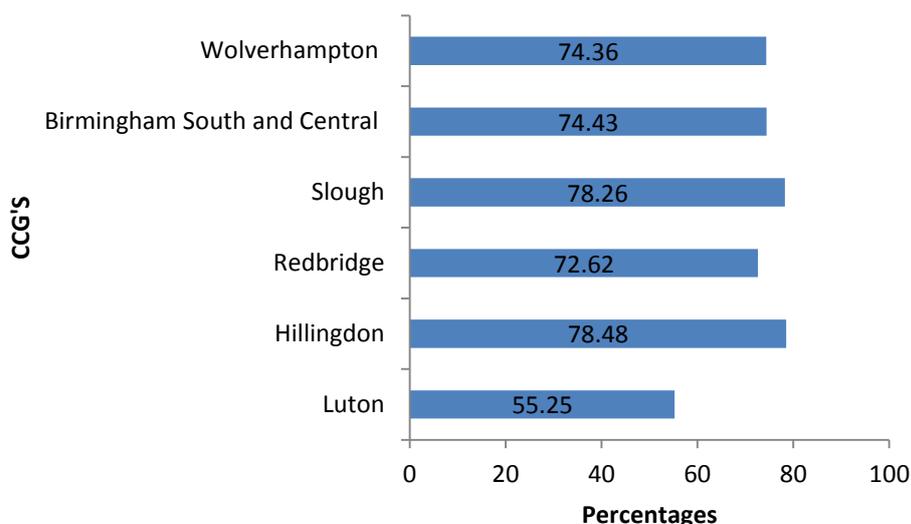


Source: CQRS and GPES database - 2013/14 data as at end of June 2014, Health and Social Care Information Centre

The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 75.3% during 2013/14. This was lower when compared with Luton comparator areas as shown in Figure 104. Source: CQRS and GPES database - 2013/14 data as at end of June 2014, Health and Social Care Information Centre.

The percentage of patients with a new diagnosis of dementia recorded in 2013/14 with a record of full blood count, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 6 months before or after entering on to the register is the lowest compared with Luton's comparator areas and among the lowest nationally (Figure 105). This is an indicator used to identify whether reversible dementia screen has been carried out to rule out other causes of cognitive impairment.

Figure 105: Patient with a new diagnosis of dementia.



Source: CQRS and GPES database - 2013/14 data as at end of June 2014, Health and Social Care Information Centre

Early on-set dementia (aged 30-64 years)

People diagnosed with dementia under the age of 65 are often described as younger people with dementia by health and social care professionals.⁴⁹⁵ Other terms used include early onset dementia, young-onset dementia, and working age dementia. The symptoms of dementia may be similar regardless of a person's age, but younger people may have different needs and require some different types of support.⁴⁹⁶ Currently, there are approximately 40-50 people with early onset dementia in Luton. There is a recognition that more needs to be done to decide how best to support these individuals and discussions with the Alzheimer's Society are taking place on how best to provide this.

11.5.5 What is being done locally?

A multi-agency Dementia Strategy Group has been operating since 2010 supported by three work stream groups which have implemented the objectives of a Joint Commissioning Strategy for Dementia Services in Luton⁴⁹⁷. An overarching care pathway for dementia services was established and this has been refined in the last two years with the development of a number of more detailed, subsidiary pathways (for example GP involvement and specialist diagnosis). The strategy has two main areas of focus:

1. Ensure better knowledge about dementia and remove the stigma
 - a. Removing stigma - by becoming a dementia-friendly community.
 - b. Raising awareness – through an annual dementia conference for both professionals and the general public.
 - c. Training of staff and public- education and training for all public-facing organisations (26 local organisations and businesses have signed up) and there are over 40 dementia champions and over 3,000 dementia friends trained.

2. Ensure early diagnosis, support and treatment for people with dementia and their family and carers.
 - a. Early Diagnosis- ensuring GPs have adequate training to recognise the signs and symptoms of the early stages of dementia and then refer to the Memory Assessment Service, where support services are available at the point of diagnosis.
 - b. Provision of support services for people living with dementia, including: cognitive stimulation, activity groups, peer support networks, singing for the brain, music therapy and dementia cafés.
 - c. Support for families and carers - Carers Information and Support Programme (CrISP) and Information Programme for South East Asian Families (IPSAF) which provide training to families and carers of people living with dementia at different stages of the disease.
 - d. Services to meet changing needs – Luton & Dunstable hospital has a nurse dementia specialist to ensure people have a good experience when they are at the hospital and Hospital to home supports people living on their own when they return home following a stay from hospital.

11.5.6 Perspective of public/service users

There has been a range of views collected from the public and professionals through training and dementia conferences held in Luton. Many carers, family and friends and those living with dementia reported a range of materials locally and nationally to support them and they could find support when needed. It is recognised locally that Luton is providing a range of services not available in other areas, and that support is available but people are not always aware of it.

11.5.7 Priorities

1. Review and refresh the Dementia Strategy for Luton connecting preventative actions on modifiable-risks to reduce dementia – this will be done in line with the New National Strategy.
2. Increase number of people identified and treated for dementia within primary care.
3. Increase the number of professional staff and community members trained as Dementia Friends.
4. Co-produce a response to the issue of carer breakdown/crisis and how to reduce this.

11.6 Care during the last years of life

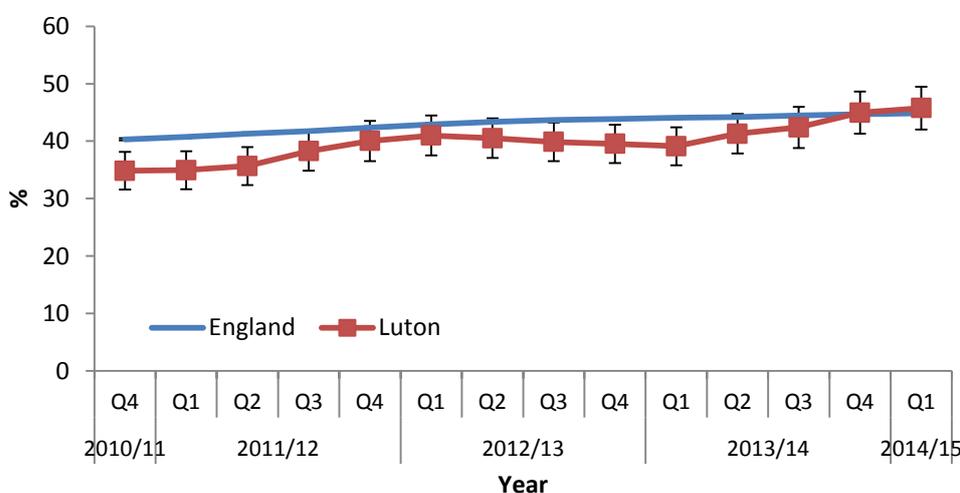
11.6.1 Introduction

End of life (EOL) care provides support for people identified as being in their last year of life. Palliative care offers a holistic approach to care to support people to live as well as possible and to die with dignity in their preferred place of care. End of life care is specific to the individual and the associated advanced care plan supports the provision of a care package and plan to identify and deliver patients preferences and wishes. In Luton, too many people approaching death are admitted to hospital when they could have received more appropriate care in the community. This could result in a poorer end of life experience for the patient and their family or carer compared to if they had died in their usual place of residence. In Luton, more people have been enabled to die at home since 2007 (as shown in the local picture below) and this trend needs to continue.

11.6.2 Local picture

The number of people dying in their usual place of residence, that is, at home or in care homes, has increased from 34.8% (95% CI: 31.6%-38.1%) in 2010/11 to 45.8% (42.0%-49.4%) in 2013/14 Q2-2014/15 Q1.⁴⁹⁸ The target for 2013/14 was to increase the number of people who were able to die at home, if they choose to do so, to 43%. This was exceeded with 45% of people dying in their usual place of residence. Figure 106, shows the rolling average over the preceding four quarters for the percentage dying at usual place of residence; Luton is now comparable to the England average.

Figure 106: Percentage dying at usual place of residence for Luton and England.



Source: National End of Life Care Intelligence Network

Each quarter represents a rolling annual average, for example Q1 2014/15 represents Q2 2013-14 to Q1 2014-15.

11.6.3 1.1.2 What is the evidence base?

The recently published document on the choice of end of life care identifies seven statements outlining what patients and families wanted at the end of life.⁴⁹⁹ A national equality impact assessment on the End of Life Care Strategy found that older people and those with a learning disability or severe mental illness would need further information and support to make the right

choices for themselves.⁵⁰⁰ Services would need to be aware of potential language barriers and religious and cultural beliefs in some communities to ensure assumptions are not made about sexuality. The report also highlights that consideration should be made for homeless people about the place of death, also that carers should be recognised for their role and to consider flexible access to make the death of a loved one easier.

There is a lower uptake of palliative and end of life care services in BME groups compared with White groups, and there is evidence of poorer outcomes, such as symptom burden or dying in their preferred place.⁵⁰¹ People with learning disabilities are less likely to have access to specialist palliative care and are more likely to have their deaths described as not being planned.⁵⁰² Approximately one third of people aged over 60 years will die with dementia, many with complex physical and psychological needs and yet many receive poor quality care towards the end of life.

11.6.4 What is being done locally?

There is a range of actions locally to support people to make the right care choices for themselves at the end of their life. This starts with identifying people approaching end of life through practice-based registers and working with them to identify their wishes and needs, which are then supported by regular reviews to coordinate care.

Within Luton, specialist services work collaboratively to provide multidisciplinary, multi-agency, health and social care education programmes. These enable staff to increase their confidence and help demonstrate the knowledge, skills and behaviours that are needed to promote high quality, individualised, palliative and end of life care, to patients, their families and carers, wherever they are supported. This is achieved through a variety of blended learning (e-learning, workshops and structured programmes of study) across acute and primary care (including nursing homes and domiciliary agencies, based upon the principles and practices of end of life care including; communication, symptom management, holistic assessments of a patient's needs, advance care planning, identifying dying and caring for the patient and their families within the last days of life, through to identifying and supporting those individuals who are at risk within their bereavement.

The avoiding unnecessary admissions (AUA) scheme was launched in 2014, in which practices identify the top 2% of patients that are likely to access AandE in the next 12 months. Being at end of life was one of the factors associated with AandE admission and therefore patients that are identified as being end of life should be on the scheme. Community services are being developed to support integration of care.

There has been an increase in coordination of care through care plans, with the person's consent, readily accessible to all professionals who may be involved in their care through a secure, electronic palliative care co-ordination systems developed on SystmOne, a data system used by GPs. This allows rapid access across care boundaries to key information about an individual approaching the end of life, including their expressed preferences for care. An improved gold standard template is being finalised and will be introduced onto SystmOne which will further improve the co-ordinated care to patients identified as being end of life.

My Care Coordination Team and Palliative Support Workers, based at Keech Hospice, provide coordinated 24/7 care to patients with end of life care needs. Patients identified as being at end of

life, and who consent, are added to the register and the My Care Coordination Team becomes the first point of contact for patients, carers and those who co-ordinate the multi-disciplinary care with patients. The My Care Co-ordination Team ensures medical, nursing and personal care and carers' support services can be made available in the community to help more people live and die in the place of their choice.

The Luton End of Life and Palliative Care group provides a strategic approach to partnership working in the provision, planning and commissioning of local palliative/end of life care. The LIG will facilitate ensuring services meet local health and social needs in line with local and national priorities/intentions and contribute to the CCG priorities to reduce hospital admissions and improve communication across all areas delivering end of life services. There are two Macmillan GPs who lead on palliative care, improving cancer services and increasing the uptake of screening programmes.

There are well established monthly multi-disciplinary meetings at Keech Hospice for palliative patients with a non-malignant diagnosis. This ensures all palliative patients may access services and receive equitable care.

11.6.5 Perspective of public/service users

The National Bereavement Survey collects information on bereaved people's views on the quality of care provided to a friend or relative in the last three months of life, for England.⁵⁰³ The survey identified:

- Quality of care was rated significantly lower for people who died in a hospital, compared with people dying at home, in a hospice or care home.
- For those dying at home, the quality of coordination of care was rated significantly lower in 2013 compared to 2012.
- The dignity and respect for patients shown by hospital nurses and hospice nurses has increased between 2011 and 2013.
- Pain is relieved most effectively in the hospice setting (62%) and least effectively at home (18%).
- Only half of people (50%) who express a preference to die at home actually die at home.

11.6.6 Priorities

- 1 Ensure everyone at the end of life is identified and offered palliative care by reviewing end of life end of life services and pathways to ensure there is adequate provision to increase community-based care and increase patient and carer involvement in reviewing and designing services including integrating work from My Care Coordination Team and Avoiding Unnecessary Admissions caseloads.
- 2 Refresh the End of Life Care Strategy to join up end of life care services across Luton Increase through the LIG to increase patient opportunities to die in their preferred place.
- 3 Increase end of life training for staff across services including primary and secondary care, Luton Community Services, staff within care homes (especially helping staff to identify those nearing end of life) and how to have conversations with patients and relatives.

11.7 Social isolation and loneliness

11.7.1 Introduction

Loneliness can be understood as an individual's personal, subjective sense of lacking desired affection, closeness, and social interaction with others. Social isolation refers to an objective lack of contact with family or friends, community involvement, or access to services.⁵⁰⁴

Loneliness and social isolation have an impact on health and wellbeing. People with a high degree of loneliness are twice as likely to develop Alzheimer's as people with a low degree of loneliness.⁵⁰⁴ 59% of adults aged over 52 who report poor health say they feel lonely some of the time or often, compared with 21% who say they are in excellent health⁵⁰⁵ and loneliness and low social interaction are predictive of suicide in older age.⁵⁰⁶

Loneliness increases the risk of high blood pressure, onset of disability, cognitive decline,⁵⁰⁵ depression⁵⁰⁷ and developing clinical dementia.⁵⁰⁷ The effect of loneliness and isolation on death exceeds the impact of well-known risk factors such as obesity and has a similar impact as cigarette smoking.⁵⁰⁸

Lonely individuals are more likely to visit their GP, have higher use of medication, higher incidence of falls, increased risk factors for long term care, have earlier entry into residential or nursing care and use A&E services more.⁵⁰⁸

Loneliness affects all age groups in society:

- Over half (51%) of all people aged 75 and over live alone.⁵⁰⁶
- 17% of older people are in contact with family, friends and neighbours less than once a week and 11% are in contact less than once a month.⁵⁰⁶
- 41% of pre-adolescents (6-13 years) felt lonely.⁵⁰⁹
- 60% of those aged between 18 and 34 felt lonely often or sometimes, compared with 35% of those aged over 55 years.⁵¹⁰
- 36% of people aged 65 and over in the UK feel out of touch with the pace of modern life and 9% say they feel cut off from society.⁵⁰⁴
- Half of all old age people (about 5 million) consider the television as their main form of company.⁵⁰⁴

However, there is a pattern that both loneliness and isolation increase with age.⁵⁰⁴ It is estimated in Luton (as shown in Table 17) that approximately 16% of the population will be aged 65 or above within the next 20 years, representing a 40% increase.

11.7.2 Risk factors and vulnerable groups

The following factors are associated with people saying they feel lonely:⁵¹¹

- **Age** - the likelihood of expressing self-perceived loneliness increases with age.⁵⁰⁴
- **Ethnicity and language** - there is evidence that ethnic minority elders may be among the loneliest.
- **Gender** – research has found that men and women respond differently to loneliness and social isolation. Older women are more likely to admit to feeling lonely than older men.
- **Living arrangements and marital status** - people who live on their own are more likely to say they are 'often' lonely. 63% of adults aged 52 years or over who have been widowed, and 51%

of the same group who are separated or divorced report, feeling lonely some of the time or often.

- **Housing** - older people living in residential care report feeling more lonely than those in the community.
- **Health** - poor health, reduced mobility, cognitive impairment and sensory impairment increase older people's likelihood of being lonely.
- **Income** - a direct correlation exists between low income and loneliness and isolation among older people.
- **Providing informal care** – 61% of the carers surveyed found it difficult to maintain friendships as a result of their caring responsibilities; however, there is no clear evidence of a relationship between the provision of informal care by older people and risk of being lonely.
- **Sexual orientation** - gay men and lesbians seem to be at greater risk of becoming lonely and isolated as they age.

11.7.3 What is the evidence base?

Interventions that enhance a feeling of social connectedness can alter self and others' perceptions, improve the quality of social interactions, and reduce feelings of loneliness. To be effective schemes that target loneliness must involve people at every stage, including planning, development, delivery and assessment.⁵⁰⁴ The most common 'social interaction' interventions include:

- General group activities – targeting many people at once.
- Specialised group activities – such as day centres, lunch clubs, social clubs, and creative activities.
- Community engagement – encouraging people to use existing programmes such as libraries, civic participation and volunteering.
- One-to-one interventions – for frail or housebound people such as befriending.
- Community navigator or wayfinding initiatives – helping individuals find appropriate interventions.
- Internet – helping people use the internet to keep in contact with others – these types of interventions have had mixed results.

The Local Government Association has developed a Framework for Action which identifies three tiers of action: at the strategic level across local authorities at the level of the community and at the level of the individual.⁵¹² There are a number of NICE quality standards that refer to avoiding loneliness or isolation including psychosis and schizophrenia in adults,⁵¹³ anxiety disorders,⁵¹⁴ faecal incontinence,⁵¹⁵ mental wellbeing of older people in care homes,⁴⁶¹ epilepsies in adults,⁵¹⁶ attention deficit hyperactivity disorder,⁵¹⁷ and for people with dementia.⁴⁸⁹

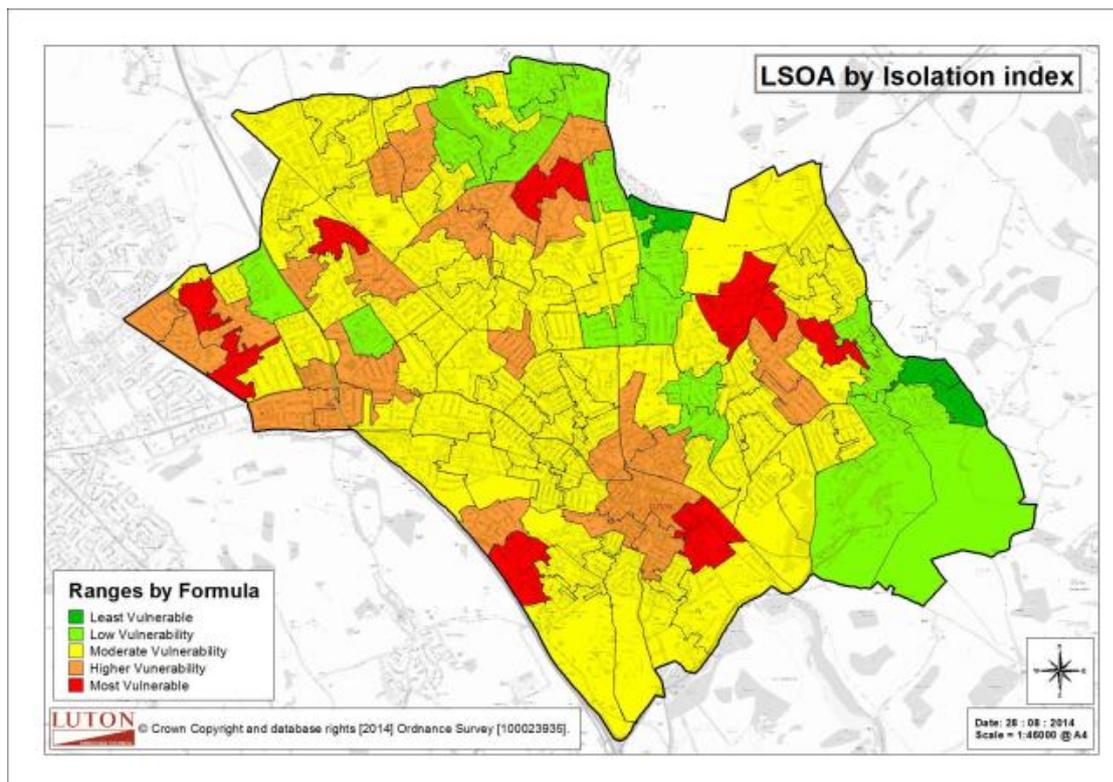
11.7.4 Local picture

The Luton Residents Survey 2014⁵¹⁸ found that 12% of respondents said they were lonely quite often or very often. This is consistent with national studies; most research finds between 6% and 13% of the UK population described themselves as often or always lonely.

The Council has created an index of social isolation, allowing the mapping of household vulnerability to social isolation across Luton. The index is based on data from selected indicators of social isolation from the Experian Mosaic Grand Index matched with Experian's household data for Luton.⁵¹⁹

The Lower Super Output Areas (LSOA) in red (Figure 107) are those identified as most likely to be at risk from social isolation and loneliness. There are areas within Farley, Icknield, Lewsey, Leagrave, South, Stopsley and Wigmore wards.

Figure 107: Social isolation vulnerability by lower layer super output area.



Source: Experian Mosaic and Ordnance Survey (The council Research and Geospatial Information)

11.7.5 What is being done locally?

The Council's Community Development Service has completed an initial one-year project aimed at researching and understanding the extent of loneliness and social isolation in Luton, identifying and evaluating potential solutions through community led projects and making recommendations. Work has focused on three strands:

1. Researching loneliness and social isolation in Luton and learning from good practice elsewhere
2. Support and evaluation of eight relevant participatory budget and other community-led projects across Luton currently focusing on reducing loneliness and social isolation
3. Establishing neighbourhood networks in two areas (Biscot and Stopsley) to assess neighbourhood issues and design appropriate partnership community development interventions to address and reduce loneliness and social isolation.

11.7.6 Perspective of the public/service users

The overall project involved eight focus groups and 15 in-depth interviews which gathered experiences and views of loneliness and isolation across a range of population groups, service users and vulnerable people within Luton.

Key findings included:

- Most respondents reported experiencing loneliness and social isolation at some times in their lives. This was generally seen as a painful experience, however not everyone desires social contacts at all times
- Loneliness was the result of a complex set of factors, in which personality played a crucial role.

- Experience in childhood was important and helped determine resilience to loneliness in later life
- Women reported to be more willing to take part in activities than men, especially in older age groups.
- There was a link between alcoholism, loneliness and social isolation.
- The role of being a carer frequently led to experiences of social isolation.
- Bereavement was a major cause of loneliness and social isolation.
- A lack of reliable and affordable transport was a cause of social isolation. This was a particular challenge for older people and for people with disabilities.
- Personal safety was identified as a particular issue for older people, the young, people without access to cars, disabled people and people on lower incomes.
- Respondents reported that uneven pavements, poor winter weather and early winter nights were seen as concerns, particularly for people with disabilities and older people.
- A key barrier to achieving a desired level of social contact was a lack of awareness of the possibilities available. People reported that it was quite hard to find out what activities were taking place with most introductions to activities taking place by word of mouth.
- When advertising activities, the local free newspapers (including the Council's Lutonline) were considered the most likely to elicit a response.
- Activities provide friendship, support and positive opportunities for socialising and respondents felt less depressed when taking part in activity.
- People who take part in evaluated activity also generally tended to take part in other organised activities.

11.7.7 Priorities

1. Increase the profile and understanding of loneliness and social isolation as a key issue affecting health and well-being and include it in future decision-making and commissioning outcomes.
2. Support the promotion, development and integration of support for vulnerable people (including those who are lonely or socially isolated) through community and neighbourhood volunteering, co-ordinated by the Council and involving all key stakeholders.
3. Integrate work on loneliness and social isolation with the development of Social Prescription in the town involving local communities and the wider Health and Social Care system.

11.8 Falls

11.8.1 Introduction

When an older person falls, it can have devastating consequences. A third of people over 65, and half of people over 80, fall at least once a year.⁴⁵⁹ Falls are the most common cause of death from injury in the over 65s and cost the NHS over £2bn a year and over 4 million bed days.⁵²⁰ Nearly 9 million or one in six people in the population in England were 65 or over at the time of the last census,⁵²¹ and the figure is forecast to rise by another 2 million by 2021.⁵²⁰

At an individual level, falls are the number one causing factor for a person to lose their independence and going into long term care. A first fall can set in motion a downward spiral of fear of falling which, in turn, can lead to more inactivity, loss of strength and a greater risk of further falls.

11.8.2 Risk factors and vulnerable groups

Falls are linked to a range of risks, which often co-exist in older people. Over 25 different risk factors have been identified and include:⁵²²

- Medical conditions including (Parkinson's, dementia, circulatory disease, respiratory disease, depression and arthritis).⁵²³
- The effect of commonly prescribed medicines, especially in combination (for example the Medications for cardiovascular disease or depression).
- Physiological changes (poor eyesight, loss of muscle strength and balance).
- Environmental hazards (ill-fitting shoes, poor lighting, and slippery surfaces).
- Lifestyle (excessive alcohol, physical inactivity).

Although 35% of people aged 65 years and over living in the community are likely to fall at least once a year, the fall rates among institution residents are much higher. Approximately 50% of older people in residential care facilities fall at least once a year and up to 40% fall more than once a year.⁵²³

The risk of falling increases with age. However, the presence of more than one of the following factors further increases the risk of a fall:

- Falls history.
- Gait deficit.
- Mobility impairment and/or inactivity.
- Fear of falling.
- Visual impairment.
- Urinary incontinence.
- Home hazards.
- Number and type of medications.
- Psychotropic and cardiovascular medications.
- Muscle weakness.

For the younger older person, fall rates for men and women are similar. However, among the older old (over 85 years), women fall more often than men and are more likely to incur fractures when they fall. People living alone are considered to be at higher risk of falling – part of this appears to be related to certain types of housing that older people may occupy.⁵²³ Evidence suggests White ethnic groups fall more frequently than African-Caribbean, Hispanics or South Asians. However, there are no papers reporting ethnicity variations for those from continental Europe.⁵²³

11.8.3 What is the evidence base?

A multi-faceted approach to falls prevention, including home exercise programmes, medication review and assessment of balance, gait, and blood pressure and addressing environmental risk factors can reduce the impact and cost of falls. Interventions that are likely to be beneficial include a programme of muscle strengthening and balance training, as well as a comprehensive risk assessment.

NICE recommends the following interventions to prevent falls.⁴⁵⁹

1. Older people (65+) in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
2. Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance (see falls annex for details of tests).
3. Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment^o. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.^p

The DH recommends a systematic approach to falls and fracture prevention⁵²⁴ and Age UK has a range of resources which explain the evidence base and benefits expected if programmes are put in place.⁵²⁵

11.8.4 Local picture

The rate of admission for falls in Luton for people aged 65 and over is higher than the rate in Wolverhampton and slightly higher than the rate for England, but lower than all other comparator areas for Luton as shown in Figure 108.

^o **Multifactorial assessment** may include the following: identification of falls history assessment of gait, balance and mobility, and muscle weakness, assessment of osteoporosis risk assessment of the older person's perceived functional ability and fear relating to falling, assessment of visual impairment, assessment of cognitive impairment and neurological examination, assessment of urinary incontinence, assessment of home hazards, cardiovascular examination and medication review

^p **Multifactorial interventions** commonly include; strength and balance training, home hazard assessment and intervention, vision assessment and referral, medication review with modification/withdrawal.

Figure 108: Admissions for falls, aged 65 years and over, 2010/11.

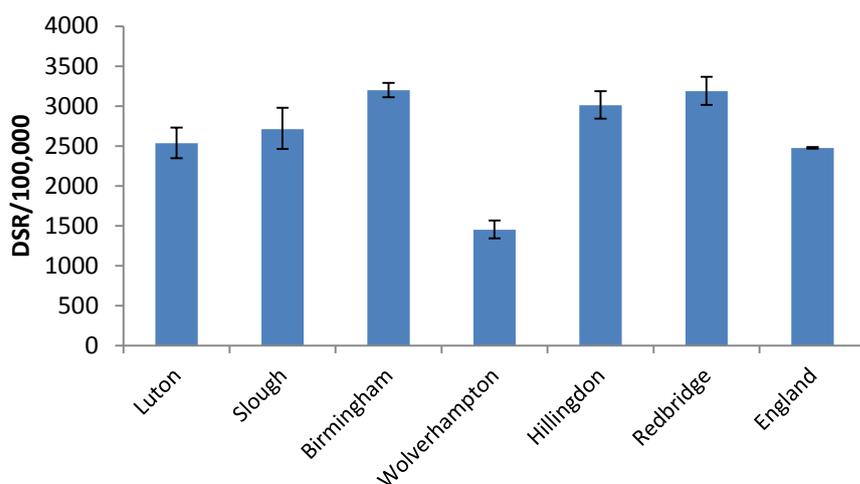
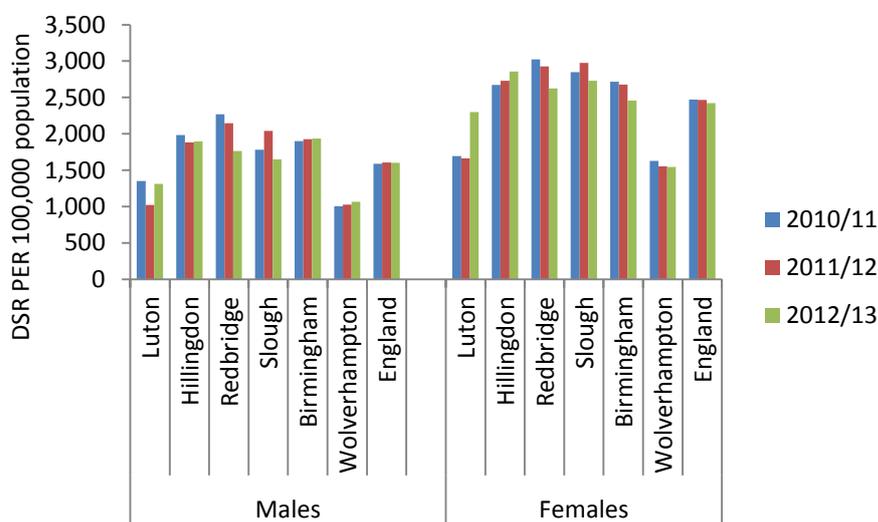


Figure 109 below shows the rate of injuries due to falls in males and females aged 65 and over in England, Luton and its comparator areas. The rate is lower than most comparators; however, the most recent data shows an increase for both males and females. The rate for males remains significantly below the England average whereas the female rate is now similar. There has been a similar increase in rate (31% increase) from 2010/11 to 2012/13 in those aged 65-79 years (133 to 174 per 100,000) and those aged 80 years and above (220 to 287 per 100,000).

Figure 109: Injuries due to falls in people aged 65 years and over.

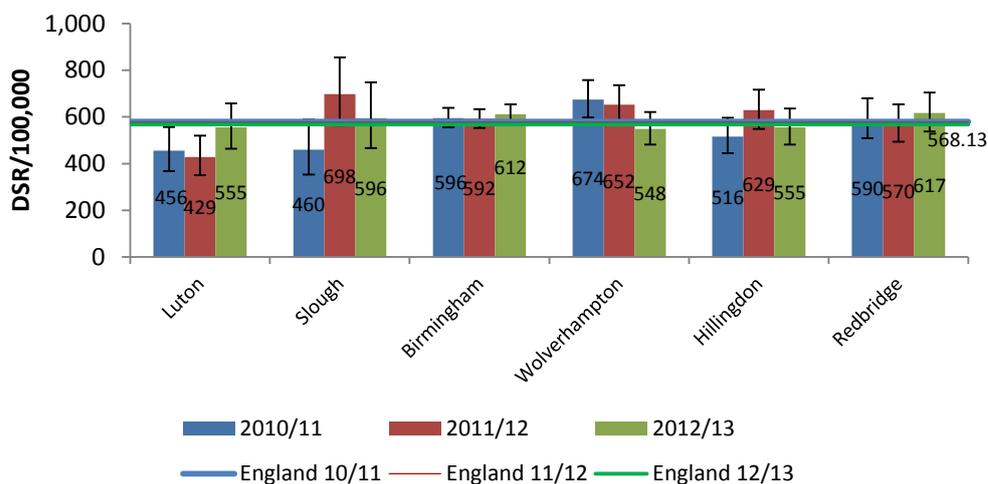


Source: Public Health England (PHE) and Luton Public Health Intelligence.

Hip fractures in Luton for people aged 65 and above have increased from a rate of 455.84 per 100,000 in 2010/11 to 554.93 per 100,000 in 2012/13 (Figure 114). The 2012/13 rate is lower than the England average and lower than the rate in all the comparator areas but not significantly different. However, the 21% increase in hip fractures is the second largest behind Slough (29%).

The rate of hip fractures in Luton is significantly higher in older people aged 80 years and above (1,282 per 100,000) compared with those aged 65-79 (304 per 100,000). However, there has been a considerable increase in hip fractures for people aged 65-79 from 131.80 in 2010/11 to 304.27 in 2012/13 while the rate in people aged 80+ has decreased from 1395.58 in 2010/11 to 1281.82 in 2012/13.

Figure 110: Hip fractures in people aged 65 years and over.



Source: Public Health England (PHE) and Luton Public Health Intelligence.

11.8.5 What is being done locally?

The Luton Falls Service, provided by the Cambridge Community Services, accepts referrals from the ambulance service, clinical navigation team and Community matron. The service is available to all patients registered with a Luton GP and to patients living in Luton and registered with a Bedfordshire GP (this is a reciprocal arrangement with Central Bedfordshire Council).

The falls co-coordinator manages the falls care pathway. The pathway provides criteria for evidence-based interventions which aim to restore independence and reduce future injuries. The falls team:

- Provides a rapid intervention service between the hours of 08:00 and 22:00 for falls patients assessed by the ambulance service as being fit to remain at home.
- Works with other organisations including community teams, GPs, the Council and voluntary organisations to set up care, equipment and support for patients who have fallen or at risk of falling, with the aim of avoiding unnecessary hospital admissions.
- Completes a multi-factorial falls assessment for patients referred by the ambulance service who are not conveyed to the hospital.
- Provides training to other teams to ensure older people at risk of falls are identified and receive an appropriate assessment.
- Refers on to other professionals.

There is a consultant-led Falls and Syncope Clinic at Luton and Dunstable Hospital and they assess/treat any medical reasons for falls.

Active Luton provides Full of Life clubs and activity sessions for over 50s. There is a broad range of activities; table tennis, short mat bowls, badminton, line dancing, walking football and general group fitness classes provided at High Town Community Sports and Arts Centre and Lewsey Sports Park and Pool. Activities are designed to maintain and develop mobility as well as providing social activity to reduce isolation.

11.8.6 Perspective of the public/service users

The Falls Service routinely collects information on patients who have used the service. Between January to April 2015, 31 patients responded to the Friends and Family Test; 77% said they would be extremely likely to recommend the service and 23% likely to recommend the service.

11.8.7 Priorities

1. Improve the coordination of falls prevention across Luton including the connecting social isolation and loneliness work.
2. Improve the prevention, identification and treatment of those at risk of a fall, by health and social care professionals including GP's, District Nurses and Home Care staff.
3. Develop a community programme of muscle strength and balance for high risk groups in order to reduce the incidence of falls.

12 Vulnerable adults

12.1 Introduction

In recent years several serious incidents have demonstrated the need for immediate action to ensure vulnerable adults, who are at risk of abuse, receive protection and support⁵²⁶.

A vulnerable adult is someone aged 18 or over who is, or may be, in need of community services due to age, illness or a mental or physical disability and/ or who is, or may be, unable to take care of himself/herself, or unable to protect himself/herself against significant harm or exploitation.

This chapter covers:

- Adult carers.
- Adults suffering domestic violence.
- Adults with autism.
- Adults with learning disabilities.

12.2 Adults with learning disabilities

12.2.1 Introduction

There are many different types of learning disability. Most develop before or during birth or because of a serious illness in early childhood. A learning disability is life-long and usually has a significant impact on a person's life.

Learning disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development.⁵²⁷

Approximately 1.5 million people in the UK are expected to have a learning disability and it is thought that this is severe in up to 350,000 people.⁵²⁸ People with learning disabilities find it harder than others to learn, understand and communicate. This affects their health and wellbeing, with the impact increasing with the severity of the person's disability.

12.2.2 Risk factors and vulnerable groups

Conditions which cause learning disabilities could arise at conception, during pregnancy, labour and after birth. They could be genetic, infectious, metabolic, traumatic or environmental. For people with severe learning disabilities, the cause is sometimes known, but for those with milder learning disabilities the underlying cause is more often unknown.

People with learning disabilities are more likely to experience common social determinants of poor health including poverty, poor housing, unemployment, social isolation and discrimination.

There is a higher prevalence of learning disabilities in South Asian communities which has been linked to increased levels of material and social deprivation, combined with poor access to maternal health care and higher rates of environmental or genetic risk factors.⁵²⁹

12.2.3 What is the evidence base?

People with learning disabilities are at increased risk of having other long-term conditions including heart disease, diabetes and clinical obesity. Much of this increased risk is attributed to lifestyle factors, including physical inactivity and an unhealthy diet.

Valuing People, first published in 2001, enshrined four key principles - civil rights, independence, choice and inclusion.⁵²⁷ Updated in 2009, it has become the framework through which services across England have been developed.⁵³⁰

Improving the Health and Wellbeing of People with Learning Disabilities provides guidance to CCGs on commissioning general and specialist health services for people with learning disabilities.⁵³¹ The Learning Disabilities Good Practice Project highlighted six different areas of work to improve the health of those with learning disabilities.⁵³²

NICE is developing guidance for:

- Challenging behaviour and learning disabilities.
- Mental health problems in people with learning disabilities.^{533, 534}

12.2.4 Local picture

The 2014 Learning Disabilities Profile for Luton (Figure 112) shows that, compared with England, Luton is statistically:

- Lower for:
 - adults with a learning disability known to GPs.
 - children with autism known to schools.
 - rates of referral for abuse of vulnerable persons per 1,000.
- Higher for:
 - adults with a learning disability known to local authority
 - children with severe learning difficulties known to schools.
- Worse for adults with learning disabilities in settled and non-settled accommodation.

There has been a large improvement in the uptake of NHS Health Checks for those with a learning disability. In 2009/10, proportions were 9.3% for Luton and 40.7% for England. In 2013/14, Luton (46.7%) exceeded the England average (44.2%).

The proportion of people with learning disabilities in paid employment in 2013/14 is higher in Luton (12.7%) than in England (6.7%). This is a considerable improvement on 2009/10 when 3.8% were employed for Luton and 6.1% for England.

The prevalence of learning disabilities estimated from GP registers is shown in Figure 111. In 2013/14, there were 684 people registered with learning disabilities. Forecasts indicate that prevalence on GP registers is increasing faster than for England, and that by 2018/19 this will be higher than England.

Figure 111: Percentage and forecast of GP-registered patients aged 18+ years on learning disabilities register.

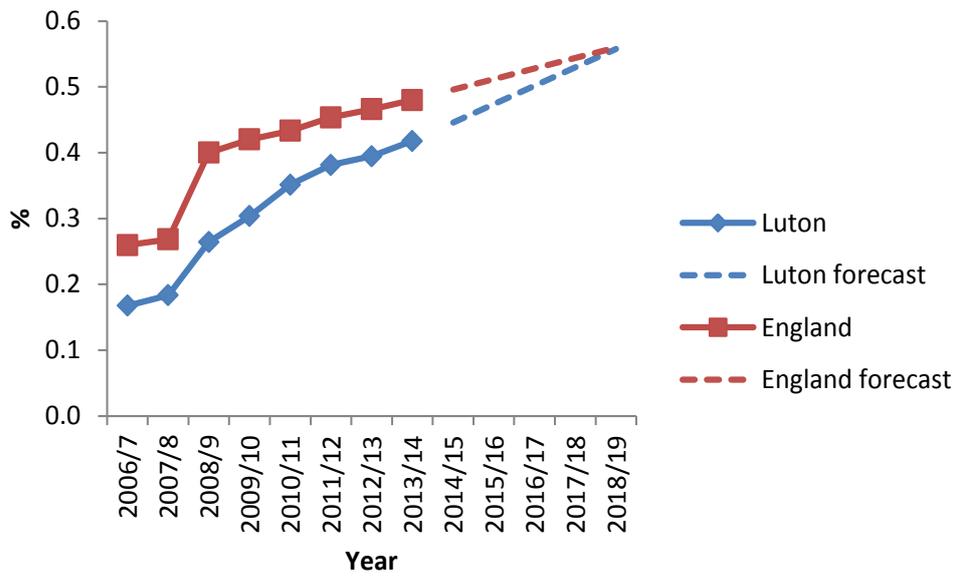


Figure 112: Learning Disabilities Profile for Luton, 2014.

Population

Compared with benchmark: ● Better ● Similar ● Worse ● Lower ● Similar ● Higher
○ Not Compared



* a note is attached to the value, hover over to see more details

Indicator	Period	Luton		Region	England	England		
		Count	Value	Value	Value	Worst/Lowest	Range	Best/Highest
Learning disability: QOF prevalence (18+)	2013/14	738	4.2%	4.8%	4.8%	2.2%		7.2%
Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	630	4.9	4.4	4.3	2.1		8.8
Children with Moderate Learning Difficulties known to schools	2013/14	545	14.9	16.5	15.6	5.8		50.7
Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	260	7.09	3.73	3.73	1.05		7.67
Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	-	*	1.08	1.27	-	-	-
Children with Autism known to schools per 1,000 pupils	2013/14	292	8.0	8.4	9.1	3.5		22.1

Health

Indicator	Period	Luton		Region	England	England		
		Count	Value	Value	Value	Worst/Lowest	Range	Best/Highest
Proportion (%) of eligible adults with a learning disability having a GP health check	2013/14	345	46.7%	49.3%	44.2%	0.0%		76.1%

Accommodation and social care

Indicator	Period	Luton		Region	England	England		
		Count	Value	Value	Value	Worst/Lowest	Range	Best/Highest
Adults with learning disabilities in settled accommodation	2013/14	435	69.0%	73.9%	74.9%	47.6%		94.4%
Adults with learning disabilities in non-settled accommodation (%)	2013/14	195	31.0%	25.0%	21.7%	42.0%		1.6%
Adults with learning disabilities living in accommodation whose status is unknown to LA (%)	2013/14	0	0.00%	1.17%	3.38%	36.11%		0.00%
Adults with learning disabilities living in severely unsatisfactory accommodation (%)	2013/14	0	0.00%	0.25%	0.25%	10.24%		0.00%
Adults with learning disabilities in employment	2013/14	80	12.7%	7.2%	6.7%	0.8%		22.5%
Adults with learning disabilities receiving direct payments (%)	2013/14	155	29.8%	30.7%	30.5%	4.3%		96.2%
Rates of referral for abuse of vulnerable person per 1,000	2012/13	30	49.6	132.5	109.3	7.4		430.4

Coordination and local planning

Indicator	Period	Luton		Region	England	England		
		Count	Value	Value	Value	Worst/Lowest	Range	Best/Highest
Comparison of LA and QOF prevalence estimates	2013/14	0	17.3%	0.0%	-0.1%	-0.7%		53.9%
Comparison of pupils with learning difficulties and LA prevalence estimates	2013/14	-	*	81.0%	80.2%	-	-	-
Comparison of pupils with severe and Profound and multiple LD and LA prevalence estimates	2013/14	1	54.9	8.0	13.5	-	-	-
Adults using day care services supported by the LA (per 1,000 people)	2013/14	205	325.4	349.2	323.7	0.0		658.8
Adults receiving community services supported by local authorities (per 1,000 people with learning disabilities)	2013/14	500	794	746	754	300		1,023
Children with learning disabilities known to schools per 1,000 pupils	2013/14	-	*	21.3	20.6	-	-	-

12.2.5 What is being done locally?

In 2014, a Commissioning Strategy for Adults with a Learning Disability was developed jointly by Luton CCG and The council. It highlighted that the issues relevant to people with a learning disability include access to health services, employment, day support opportunities, a place to call home, keeping safe and getting around.⁵³⁵

Helping people with a learning disability to live healthier lives

GPs are commissioned to provide health checks and health action plans for people with learning disabilities. Health checks help detect unmet health needs and support positive health action planning. In 2012/13, 28 out of the 31 Luton surgeries signed up to offering health checks to individuals with a learning disability and 232 health checks were carried out. In 2013/14 and 338 Health Checks were completed by GPs. Currently 319 people in Luton are recorded as having a Health Action Plan.

As part of East London Foundation Trust's (ELFT) specialist learning disability provision, two learning disability nurses are located in the hospital. They offer specialist support to the individual, carer and medical professionals during a person's stay in hospital.

Access to health services

There is currently limited data identifying whether individuals with learning disabilities are accessing local mainstream dentists, opticians, podiatry and sexual health services. While we know individuals are being referred on to other health intervention services, it has been difficult to monitor the number of individuals with a learning disability who are accessing these.

Approximately 200 people with a learning disability receive day care, of which 135 people access day services run by the Council. Services are currently being transformed into a community-based model. Alongside the development of small community groups based across Luton, a new specialist building for people with complex physical disabilities and a specialist service for people with behaviours that challenge are being created. The new way of delivering day support opportunities will be fully operational by April 2016.

Help those with a learning disability to live as independently as possible

More than 80 people with a learning disability were known to live in their own accommodation and supported to become more independent. A further 123 people lived in residential homes and 408 supported to live at home with their family. The shared lives scheme offers the opportunity for a person with a learning disability to either move permanently into someone else's home, or, for those currently living with their family, it offers the individuals a short break and respite from their caring role.

In addition to the development of a new building for day care, a nine bed building-based short breaks/ respite unit is also being built. The service will be available to anyone with a learning disability and their carer who meets eligibility criteria.

Access to personal budgets has enabled more individuals with a direct payment to become responsible for purchasing their own services. Of those customers known to Adult Social Care, 96 people have a personal budget. This enables individuals to have choice and control over the provision they want to use and when they use it.

Supporting people with a learning disability to participate in community and/or have employment opportunities

Specialist learning disability health services are provided by ELFT. Whilst ELFT offers a wide range of health services to people, the Health Facilitation Service in particular assists individuals who live independently to access health services. Their role is to ensure individuals fully understand their medical needs; medical conditions as well as the importance of attending appointments. The

Intensive Support Team also delivered by ELFT, offers a quick response mechanism for Individuals with a learning disability who require additional mental health services. Working with the new provider, it is expected the service can be developed further to meet the increasing demand for this provision.

Luton is committed to ensuring that more people with a learning disability are offered employment as an option or are supported to develop skills that will enable them to secure employment opportunities in the future. A Carers Service has been established to specifically support parents of people with a learning disability.

The Learning Disability Partnership; Voice Groups and Learning Disability Carers' Forum offer people with a learning disability, carers, and service providers the opportunity to discuss matters affecting the lives of people with a learning disability. They act on the issues or give carers the chance to air their views and experiences as well as receive updates on services to support both themselves and the person they care for.

12.2.6 Priorities

1. Ensure both specialist and mainstream health services are accessible and produce similar outcomes to those with a disability.
2. Increase availability of good quality housing and support to help those with a learning disability live as independently as possible and increase break provision to enable carers to have respite from their caring role.
3. Improve participation in, and access to, activities and employment opportunities within the community and ensure people feel safe within their environment.

12.3 Autism

12.3.1 Introduction

Autism Spectrum Condition (ASC) is a condition that affects social interaction, communication, interests and behaviour. It includes Asperger syndrome and childhood autism.⁵³⁶

For many individuals the condition is a hidden disability and may be undiagnosed which can be significantly detrimental to the health and wellbeing of the person with the condition. Individuals with autistic spectrum conditions ASCs are particularly prone to mental health issues. Due to the communication problems associated with autism it is often not until a mental illness is well developed that it becomes recognised with serious consequences such as total withdrawal, increased obsessional behaviour, aggression, paranoia and suicidal ideation.⁵³⁷

The exact causes of autism spectrum conditions are unknown, although it is thought that several complex genetic and environmental factors are involved. Factors thought to increase the risk of developing autistic spectrum conditions can usually be divided into five main categories:⁵³⁶

- Genetic factors.
- Environmental factors.
- Psychological factors.
- Neurological factors – specific problems with the development of the brain and nervous system could contribute to the symptoms of ASCs.
- Other health conditions – certain health conditions associated with higher rates of ASCs.

12.3.2 Vulnerable and at risk groups

People with autism are some of the most excluded and least heard people in society and experience a number of inequalities including social and economic exclusion as well as poor health outcomes.⁵³⁸

Without adequate support, these factors then place them at high risk of severe health and mental health problems, homelessness, and descent into crime or addiction. There was no evidence found to suggest that autism is more prevalent in any particular ethnic group.

12.3.3 Evidence/what works

The 2010 National Autism Strategy 'Fulfilling and Rewarding Lives'⁵³⁹ set a framework for all mainstream services across the public sector working together for adults with autism focussing on awareness and understanding of autism and clear and consistent pathways for diagnosis. This has since been updated with the 'Think Autism'⁵⁴⁰ Strategy with fifteen priority challenges and three key areas for particular drive and focus:

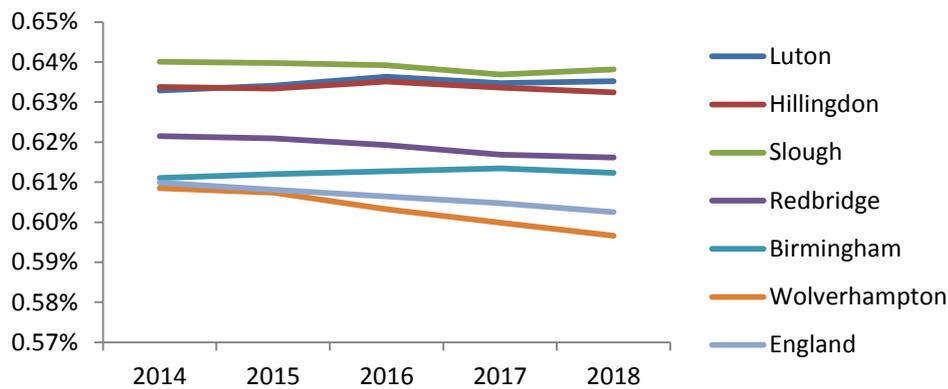
- Build communities that are more aware of, and accessible to the needs of people with autism.
- Innovative local ideas, services or projects which can help people in their communities.
- How advice and information on services can be joined up better.

Based on the findings and recommendations of the 2010 strategy, NICE has developed a range of guidance in relation to the recognition, referral, diagnosis and management of people with autism.⁵⁴¹

12.3.4 Local picture

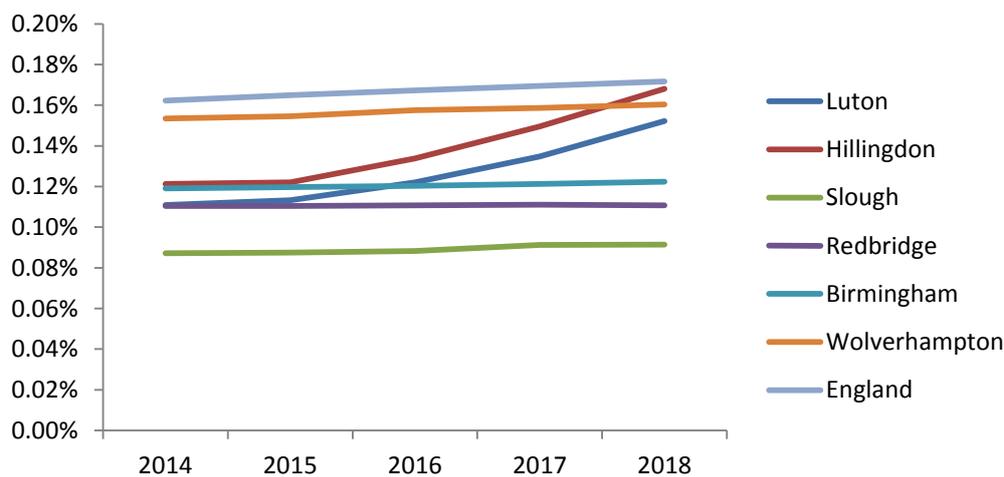
Based on national estimates in 2015 approximately 0.74% of all adults in Luton are likely to have an autistic spectrum disorder this would mean approximately 1,597 adults in Luton⁵⁴². In addition 0.8% of school pupils in Luton were diagnosed with autistic spectrum disorders in 2014.⁵⁴³ Figure 113 and Figure 114 show five year projections for autistic spectrum disorders in Luton and comparator areas.

Figure 113: Percentage population of age 18-64yrs predicted to have autistic spectrum disorders.



Source: Institute of Public Care (IPC), Oxford Brookes University. Available from: <http://www.pansi.org.uk/index.php?pageNo=383&arealD=8640&loc=8640>

Figure 114: Percentage population of age 65yrs and over predicted to have autistic spectrum disorders.



Source: Institute of Public Care (IPC), Oxford Brookes University. Available from: Available: <http://www.poppi.org.uk/index.php?pageNo=314&arealD=8640&loc=8640>

12.3.5 What is being done locally?

Luton has a Joint Commissioning Strategy: Adults with Autism in Luton directed at improving provision and support to individuals with ASCs.⁵⁴⁴ One aim of the strategy is for the Council and CCG

to work in partnership with other public sector bodies, as well as private and voluntary sector organisations, to make sure that there is increased understanding of ASCs, the impact of the condition on individuals and that organisations are making reasonable adjustments so that individuals are able to access services where required.

There has been significant progress implementing the strategy:

- There has been improved recording of autism and Adult Social Care records now clearly indicate when an individual has a diagnosis.
- There is now a local diagnostic service across Luton and Bedfordshire.
- Clear pathways across housing and social care and a dedicated social worker for vulnerable adults.
- Over 1,400 people in Bedfordshire and Luton across health, social care and public sector bodies have now received training to raise awareness and needs of individuals with ASCs to enable people to work more confidently with the condition.
- Support is offered to individuals with ASCs to prepare for work and find jobs.
- Developing personal budgets for individuals with ASCs.

In March 2014 the Luton and Bedfordshire Think Autism Partnership Board voted on the priorities that they would like to see a focus on over the next three years. These were:

- Education, employment, training and volunteering.
- The criminal justice system.
- Community care assessments for all individuals with ASCs.
- Sustainability.

12.3.6 Perspective of the public/service users

A local survey undertaken by Autism Bedfordshire to understand the perception of autism services for adults in the area found the majority of respondents with autism lived at home with parents/carers and were unemployed. Employment support was ranked as the highest development need, as well as building relationships and social skills. Greater awareness of autism was identified by the parents/carers and professionals as needed within local services such as the job centre and health service.⁵⁴⁵

12.3.7 Priorities

1. Review and refresh the Adults with Autism Strategy for Luton; this will be done in line with the New National Autism Strategy and other new legislative requirements.
2. Continue to develop the local diagnostic service and pathways to ensure the service fully meets the needs of the local population.
3. Undertake a needs analysis around employment support and health and social care needs of individuals (including young people going through transitions) to develop an operational plan to meet needs.
4. Work in partnership with the police, probation service and local prison service to ensure that individuals with (suspected) ASCs have access to appropriate health and social care and that there is a better understanding of the needs of people with ASCs within the criminal justice system.

12.4 Carers and their health

12.4.1 Introduction

A carer is anyone who cares, unpaid, for a friend or a family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.⁵⁴⁶

They are usually a relative or a friend, and are not the same as someone who provides care professionally, or through a voluntary organisation.

The Care Act 2014 relates mostly to adult carers (people aged 18 years or older who are caring for another adult).

Carers are vital to the wellbeing and independence of people and vital to the delivery of both health and social care. With the ageing population the number of carers is increasing and will continue to increase.

The 2011 Census reported that 5.8 million people in England and Wales identified themselves as carers, compared with 5.2 million people in 2001.⁵⁴⁷ It is estimated that adult carers in the UK are providing unpaid care to the value of £87 billion which demonstrates the substantial contribution that unpaid carers contribute to the social care system in the UK.⁵⁴⁸

Caring often comes at a cost, for example:

- Carers UK found that 84% of carers said that caring has a negative impact on health (including limiting carers' ability to take exercise).⁵⁴⁹
- Health of carers deteriorates more quickly than that of non-carers due to lack of support 64% reported a lack of practical support and two in five carers postpone their own treatments due to lack of support.⁵⁵⁰
- 92% of carers said that their mental health has been affected by caring with only 1% saying that caring has improved their mental health.⁵⁴⁹
- Reduced ability to study and work leading to poor finances: one in five employees are forced to give up work because of caring responsibilities and half of carers report a lack of financial support people providing high levels of care are twice as likely to be permanently sick or disabled.⁵⁵¹
- Older carers who report 'strain' have a 63% higher likelihood of death.⁵⁵²

These costs not only damage the health and wellbeing of individual carers and their families, but also threaten their ability to continue in their caring role which has consequences for public spending.

12.4.2 Risk factors and vulnerable groups

Every day 6,000 people become carers.⁵⁵³ For some it is sudden, ie someone your love one is taken ill or has an accident or your child is born with a disability. For others, caring creeps up unnoticed ie parents cannot manage on their own any longer or partner's health gets gradually worse.

Below are some conditions that are most susceptible to caring than others:

- 58% of carers look after someone with a physical disability.
- 20% look after someone with a sensory impairment.
- 13% care for someone with a mental health problem.
- 10% care for someone with dementia.⁵⁵⁴

The 2011 census showed women were more likely to be carers than men. Of those who are caring for 50 hours or more a week, 60% were female. Women make up 73% of the people receiving Carer's Allowance for caring 35 hours or more a week.

Caring also tends to affect men and women at different times. Women are much more likely to care in middle age.⁵⁵⁵

The 2011 Census showed that there were just under 600,000 Black and Minority Ethnic (BME) carers in England and Wales. The 2011 data indicated that a smaller proportion of the BME population provided care than the White British population. However, the BME populations were much younger and therefore less likely to have older parents or other relatives needing care. Analysis by University of Leeds, suggested that when age is accounted for, BME families are more likely to provide care for older or disabled loved ones.⁵⁵⁴

Carers UK's evidence indicates that BME carers are less likely to be receiving practical and financial support with caring and more likely to miss out on accessing support for longer – often as a result of a lack of advice and information and struggling to access culturally appropriate services.⁵⁵⁴

12.4.3 Local picture

Prevalence: as of 2011 there were estimated to be 18,256 people who provide unpaid care in Luton, 9% of the population. This was a 14% increase compared to 2001 (16,083) and was a rate of increase higher than that of the population change for the same period (10%).⁵⁵⁶ The estimated proportion of carers (9%) within Luton was lower than the national average (10.2%), which might be expected given the comparatively younger population in Luton.

Hours of unpaid care: almost a quarter (24% or 4,445 people) of carers providing unpaid care in Luton provided 50 or more hours a week. This was significantly higher than the national average (23%) and Luton's comparators (Hillingdon, Redbridge and Slough) but significantly lower than Birmingham and Wolverhampton).

Social isolation: is a problem amongst carers and figures show that compared with adult social care users there is a higher proportion who feel they do not have as much social contact as they would like. For Luton, the figure for carers (41%)⁵⁵⁷ is similar to England and the gap compared with adult social care users is not as significant compared with some of Luton's neighbours.

Quality of life: carer-reported quality of life is 8.1 for Luton out of a possible score of 12. Of Luton's comparators, it is the only borough whose carer reported quality of life has increased since 2011/12 and is now higher than the national average.⁵⁵⁸

People being cared for: the Carers' Survey^q showed more than 1 in 2 (53.1%) of the people cared for in Luton were over the age of 75 in 2012/13. Those aged 18-44 and 45-74 accounted for 20.6% and 26.3% respectively. Approximately 69% of carers stated they found it easy to find information about services. This is the same as the national average and higher than most of Luton's comparators.

Table 40: Provision of unpaid care and self-reported health, 2011.

Hours unpaid of care/ week	Total population	Very good or good health	Fair health	Bad or very bad health	Total
	All ages	65+ years			
1-19	10,975	784	439	121	1,344
20-49	2,836	163	162	57	382
50+	4,445	509	550	197	1,256
Total	18,256	1,456	1,151	375	2,982

^q Adult Social Care Carers Survey Results 2012/13* (based on responses from 390 Carers in Luton)

Source: ONS (Hours of unpaid care/wk.)

12.4.4 What is being done locally?

The Luton Carers Strategy Caring for carers aims to ensure carers are recognised and valued as being fundamental to strong families and stable communities and have opportunities to live healthy, fulfilling and enjoyable lives.⁵⁵⁹

The strategy sets out the types of services needed by carers and how they will be provided in the future. The strategy identifies four commissioning priorities based on the 2010 National Carers Strategy:

1. Identifying and recognising the contribution of carers.
2. Enabling carers to fulfil their potential.
3. Personalised support for carers.
4. Supporting carers to be healthy.⁵⁶⁰

The Care Act 2014 will require the Carers Strategy to be refreshed to encompass all the legislation.

12.4.5 Perspective of public/service users:

In December 2014 a carers' network was launched in Luton to provide information to carers about the various services and facilitate partnership working. The network is looking to organise follow up events to glean carers views points on an annual basis.

12.4.6 Priorities

1. Ensure that when services are commissioned to support carers, they take into account the Care Act 2014 legislation and guidance.
2. Use the 10 Commissioning for Carers Principles (NHS) to ensure joined-up commissioning as health and social care work closer together.

12.5 Domestic Violence and abuse

12.5.1 Introduction

Domestic violence is defined as, ‘any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 and over who are or have been intimate partners or family members, regardless of gender or sexuality⁵⁶¹. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, and emotional. The definition also covers stalking and so-called honour based violence (HBV) such as female genital mutilation (FGM), forced marriage and some forms of elder abuse.

Domestic abuse and violence can have significant and long lasting impacts on the health and wellbeing of those it affects. In the most severe cases it can cause death or permanent disability. Even in less severe cases it can cause a range of physical injuries as well as significant psychological harm increasing the risk of depression and suicide.

Estimates suggest that domestic violence costs £5.47 billion per year in England. This is a combination of costs of physical and mental health, criminal justice, social services, housing and refuges, civil legal services and lost economic output⁵⁶².

12.5.2 Risk factors and vulnerable groups

Domestic violence affects people from all ethnic backgrounds, age groups, gender, sexual orientations and social groups. Whilst the Luton Community Safety Partnership acknowledges and works within the Home Office definition above, it also recognises that domestic violence is experienced by children and young people under the age of 16. As such, while these victims are not identified in police data, it is crucial to recognise the needs of this group as well as considering the impact on older victims.

- 1 in 4 women (including lesbian and bisexual) have experienced domestic abuse from a partner or ex-partner.
- 1 in 10 men have experienced domestic abuse from a partner or ex-partner.
- Having a long-term illness or disability almost doubles the risk of experiencing domestic abuse.

Women are also more likely to experience repeat victimisation and more severe abuse and violence with 85% of domestic homicide victims in England and Wales being female.

There is a strong correlation between domestic abuse and substance misuse among victims, who may seek to self-medicate using either alcohol or prescribed and non-prescribed drugs.

The risk of domestic abuse during pregnancy is greatest for women who experienced physical abuse before the pregnancy. Additional factors increase the risk during pregnancy: being young and poor and if the pregnancy was unintended. Domestic abuse during pregnancy can physically harm the developing child both due to the risk of physical assault and as a result of high stress and hormone levels in the mother.

12.5.3 What is the evidence base?

The national 'Ending Violence Against Women and Girls Strategy' advocates a multi-agency, co-ordinated response to addressing domestic violence and abuse.⁵⁶¹ Furthermore, as domestic violence often recurs with the level of violence often escalating over time, identifying and supporting victims early can reduce the risk of more serious harm. The following principles and interventions are generally considered good practice in relation to addressing domestic violence.

- Early identification and referral for support, including the use of routine enquiry by health professionals to identify victims at an earlier stage.
- Multi-Agency Risk Assessment Conferences (MARAC) to provide co-ordinated support to high risk victims.
- Use of Independent Domestic Violence Advocates (IDVAs) to provide direct support to high risk victims with a focus on increasing their safety.^f
- Provision of Community Based Perpetrator Programmes, to address attitudes and behaviour which support domestic abuse and provide help to perpetrators to change their behaviour.
- Delivery of school-based interventions to increase awareness and encourage disclosures⁵⁶³

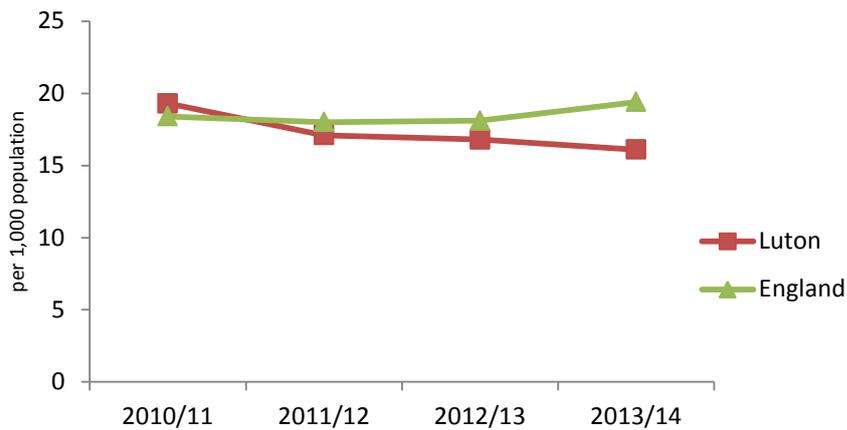
12.5.4 Local picture

Figure 115 shows the trend of domestic abuse incidents recorded by police in Luton compared with England from 2010/11 through to 2013/14. The figures show that the rate for Luton has decreased and the rate for England has increased slightly. It should be noted that the figures are very small and have consistently been between 15-20 per 1,000 year on year for both Luton and England. These data only includes incidents reported by victims aged over 16 and therefore may not be an accurate representation of domestic abuse as a whole. Local police data shows the number of domestic abuse offences increased by 13% from 2012 to 2013 and then again by 34% from 2013 to 2014. Increasing reports is one of the Community Safety Partnership's key strategic objectives and may indicate a greater confidence in reporting this type of crime.

Domestic abuse is widely acknowledged as being under reported which affects the reliability and interpretation of data. This is a particular issue for male victims, as twice as many male victims do not tell anyone about the domestic abuse compared with women.⁵⁶⁴ Research has shown that 30% of women and 17% of men aged 16 and over will be victims of domestic abuse in their lifetime. Extrapolating these figures to the population of Luton would suggest that approximately 30,000 women and 18,000 men would be the victim of domestic abuse sometime in their lives.

^f Safety in Numbers. Highlighted 87% of service users reported feeling safer following intervention from an IDVA and 82% reported a cessation of violence in the 6months following case closure.

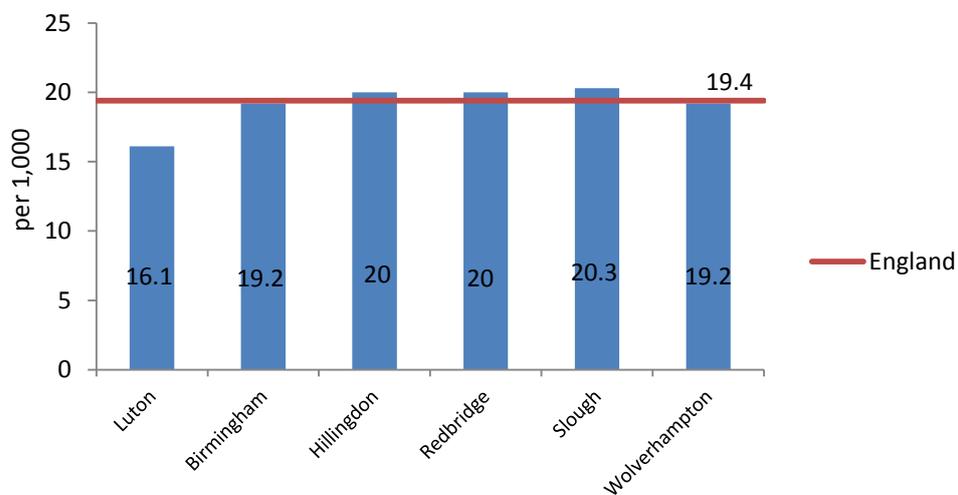
Figure 115: Domestic abuse in Luton and England, 2010/11 to 2013/14.



Source: PHOF 2015

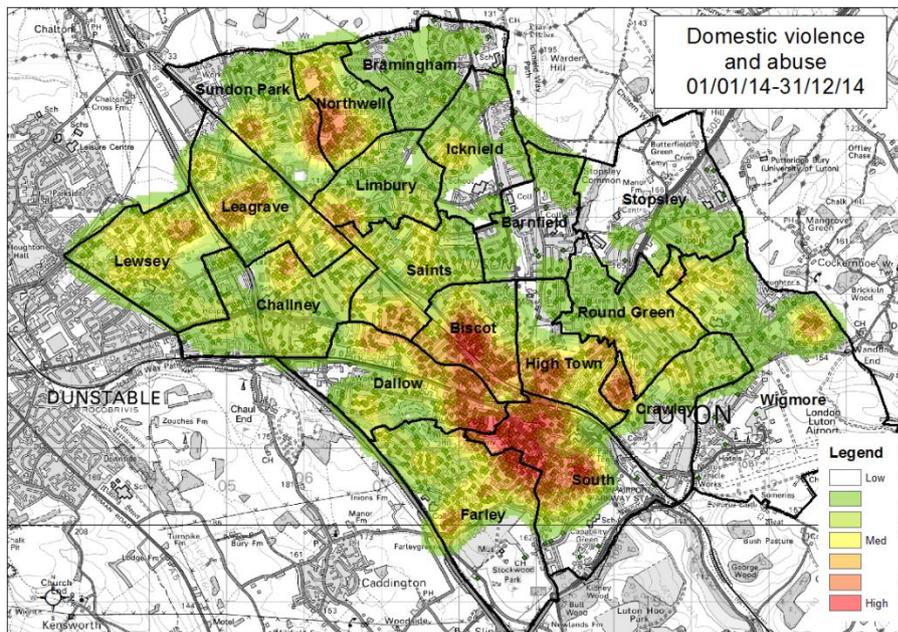
Figure 116 compares the rate of domestic abuse in Luton compared with statistical neighbours for the period 2013/14. Luton rates are significantly lower than each statistical neighbour which may be due to under-reporting to the police rather than a lower rate amongst the Luton population.

Figure 116: Domestic abuse in Luton and statistical neighbours, 2013/14



Source: PHOF 2015

Figure 117: Domestic violence and abuse January - December 2014



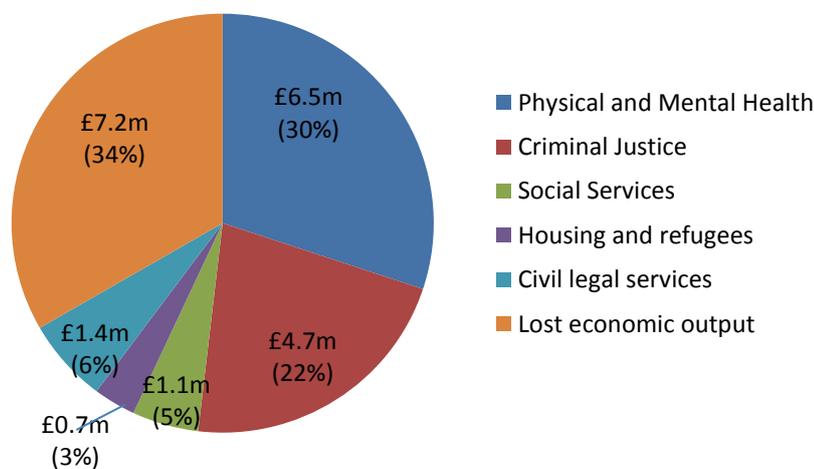
Source: Bedfordshire Police

The local map of domestic abuse and violence in Luton shows that there is a widespread hotspot area in and around the town centre, the most prominent parts of which are located in Biscot and South (Figure 117).

Cost of domestic violence

The estimated annual cost of domestic abuse to Luton is £21.6 million. The highest cost being ‘loss to economic output’, which is limited solely to time off work due to injuries (Figure 118).

Figure 118: Annual cost of domestic violence in Luton by service (2011)



Source: Henry Smith Charity 2011

12.5.5 What is being done locally?

The Luton Domestic Abuse Strategic Group is a multi-agency group made of statutory and voluntary partners committed to reducing the prevalence and impact of domestic abuse in Luton. The group is responsible for the development and delivery of the Luton Domestic Abuse Strategy and Action Plan which outlines the priorities and objectives in relation to tackling domestic abuse in Luton.

The Luton domestic abuse partnership website (www.lutondomesticabuse.co.uk) provides single source of information regarding local and national services for victims of domestic abuse, their children, perpetrators and professionals working with those affected. The Domestic Partnership information phone line provides further access to information about local services and support.

Multi-Agency Risk Assessment Conference (MARAC) meetings are held every three weeks ensuring there is co-ordinated support to high risk victims.

Luton has four refuges within the borough accommodating victims and their children. The Luton Independent Domestic violence Advisory (IDVA) service employs 8 IDVAs providing support to both male and female High Risk victims. The service works directly with children and young people experiencing domestic abuse as well as those with complex health needs.

A voluntary, community based perpetrator programme has been established to support domestic abuse perpetrators to address and change their behaviour.

12.5.6 Priorities

1. Raise awareness of support for standard to medium risk victims of abuse including promoting the Domestic Abuse Partnership website and helpline and ensure there is multi-agency domestic abuse training programme accessible to all staff working within Luton.
2. Develop joint initiatives between schools, health visitors, the police and local authority children's services to extend provision of dedicated children's services to ensure children affected by domestic abuse are offered support and appropriately safeguarded.
3. Develop the Multi-Agency Domestic Abuse Forum to ensure that evidence and research-based practice is promoted and integrated into local responses to domestic abuse and to ensure that victims from minority groups (including; male victims, those in same sex relationships, those from minority ethnic backgrounds and those with disabilities) are identified and supported.
4. Implement an Integrated Offender Management initiative to include a cohort of domestic abuse perpetrators.

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