Annual Public Health Report
2010 – 2011

The health of Luton’s ethnic and migrant communities

30th June 2011

Director of Public Health
NHS Luton and Luton Borough Council
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>APHO</td>
<td>Association of Public Health Observatories</td>
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<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guérin</td>
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<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
</tr>
<tr>
<td>CDOP</td>
<td>Child Death Overview Panel</td>
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<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence interval</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
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<tr>
<td>DMFT</td>
<td>Decayed, missing and filled teeth</td>
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<tr>
<td>ERPHO</td>
<td>Eastern Region Public Health Observatory</td>
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<tr>
<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
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<tr>
<td>IHS</td>
<td>Integrated Household Survey</td>
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<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
</tr>
<tr>
<td>LSOA</td>
<td>Lower Layer Super Output Area</td>
</tr>
<tr>
<td>LTC</td>
<td>Long term conditions</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles, mumps and rubella</td>
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<tr>
<td>MSOA</td>
<td>Middle Layer Super Output Area</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in employment, education and training</td>
</tr>
<tr>
<td>NHSCSP</td>
<td>NHS Cancer Screening Programmes</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PSHE</td>
<td>Personal, Social and Health Education</td>
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<td>QOF</td>
<td>Quality Outcomes Framework</td>
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<td>TB</td>
<td>Tuberculosis</td>
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We would like your comments

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This document can be downloaded at  
www.luton.nhs.uk/publichealthreport
The Annual Public Health Report provides me with the opportunity to present an independent report on the health of the people of Luton. This year’s report brings together the local, national and research evidence that we have available to take a closer look at the health of Black and minority ethnic (BME) communities in Luton. Where local data were not available, I have used national data and research to help us to gain a greater understanding of the health needs of BME communities in Luton. Where possible I have compared the health outcomes in Luton with areas with similar populations including some London boroughs and parts of the Midlands. Our outcomes tend to be similar to our statistical neighbours. I hope that the report adds to our understanding of the inequalities in health in Luton, providing a different approach to the geographical approach that we sometimes focus on and therefore providing Luton Borough Council, NHS Luton and partners with a greater understanding of and perspective on tackling health inequalities.

In many cases BME communities have poorer health outcomes when compared to the overall population. Patterns vary between health conditions and of course communities. Evidence suggests that the poorer socio-economic position of some BME communities is the main factor driving ethnic health inequalities, and the report looks at some socio-economic factors in Luton to determine what part these factors may play locally. Several policies have aimed to tackle health inequalities in recent years, although to date, ethnicity has not been a consistent focus. This annual public health report reviews the evidence on ethnic health inequalities, the causes, and local plans.

Recording and coding of ethnicity has greatly improved in recent years, but there are areas where data on ethnicity are not available or not part of the routine data collection. This remains an obstacle to further study.

My key recommendations include:

- programmes of regeneration, employment and skills training should ensure that they reach and raise the life chances of all of our communities;
- the Children’s Trust Board are asked to take the findings of this report into account in the implementation of the Early Intervention Strategy and Family Poverty Strategy;
- prioritise engagement with local communities to address issues around consanguinity, infant mortality and disability;
- given the gap around life expectancy for women in Luton, and that many women in Luton are not economically active, develop mechanisms to engage with women from all of our communities;
- improve the identification of long term conditions prevalent in BME communities in primary care to ensure earlier and better treatment;
- carry out a needs assessment on mental health to determine whether commissioned services meet the needs of Luton’s population; and
- continue to prioritise programmes on childhood obesity and tobacco control, using social marketing techniques to target high prevalence communities appropriately.

I hope that you find this report and the recommendations in it useful.

Gerry Taylor
Joint Director of Public Health
Acknowledgements

I would like to thank the Public Health team for their help in producing this report, Caroline Thickens, Wayne Thompson, Stuart Lines and Sarah Annetts in particular. Thanks also to colleagues at Luton Borough Council for their contribution including Paul Barton. I am also very grateful to Eastern Region Public Health Observatory for linking data and calculating results for use in this report.
Luton at a glance

Luton is a multicultural urban town situated approximately 30 miles north of central London, and covers an area of approximately 16 square miles. Luton has excellent communication links including its own international airport, and has recently bid for city status as part of the Queen’s diamond jubilee celebrations.¹

Estimates of population size obtained from the Office for National Statistics (ONS) are 190,500 in 2008 and 194,300 in 2009.² Luton Borough Council estimated that Luton’s population in 2009 was 204,700, that is, 10,400 higher than the ONS estimate, with the difference mainly arising from migration.³ In a study commissioned by Luton Borough Council, it was estimated that there are approximately 77,000 households in Luton with a total minimum population of 202,748.⁴

In general, Luton’s population is younger than that in the East of England and England, see Table 1. Although Luton has a comparatively younger population, the proportion of older people is increasing, which reflects the national trend of an ageing population.

<table>
<thead>
<tr>
<th>Age</th>
<th>Luton</th>
<th>East of England</th>
<th>England</th>
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<tr>
<td>Under 15 years</td>
<td>21%</td>
<td>18%</td>
<td>18%</td>
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<tr>
<td>15-64 years</td>
<td>67%</td>
<td>65%</td>
<td>66%</td>
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<tr>
<td>65+ years</td>
<td>12%</td>
<td>17%</td>
<td>16%</td>
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Source: ONS mid-2009 estimates.

Table 1. Age distributions.

Approximately 32% of Luton’s population are from BME communities, particularly the Pakistani, Bangladeshi, Indian and African Caribbean communities.⁵ The School Census in 2010 showed that 63% of children attending a school in Luton were from non-white ethnic communities. In recent years, the diversity of the population has increased due to an increased number of international students attending the University of Bedfordshire, and the arrival of migrants from European Union countries, notably Poland and other Eastern European countries. Section 2.1 provides further details about the ethnic composition of Luton’s population.

Based on the Index of Multiple Deprivation (IMD), Luton’s deprivation score increased from 24.73 in 2007 to 25.78 in 2010, and the rank dropped from 87 out of 354 to 60 out of 326 local authorities (with 1 indicating the most deprived authority).⁶ In 2010, Luton had 18 Lower Layer Super Output Areas (LSOAs) among the 10% most deprived in England according to the Income Deprivation Affecting Children Index; and 22 LSOAs among the worst 10% in England according to the Income Deprivation Affecting Older People Index.

Over a quarter (25.9%) of Luton residents are in the worst national quintile of deprivation, and 58.6% are in the worst two quintiles. Luton has many more people living in deprivation when compared to the East of England and England, see Figure 1.
1. Luton at a glance

Source: Department of Communities and Local Government (IMD 2010) and ONS population estimates.

**Figure 1.** Deprivation in Luton and the East of England compared to national quintiles.

Figure 2 shows that the most-deprived areas are located in the south-west and north-west of the borough, which corresponds to the areas with lower life expectancy, see Figure 7 in Section 2.2.1.

**Figure 2.** Deprivation (IMD 2010) in Luton.

Some ethnic communities are more likely to live in areas which are more deprived. Bangladeshi and Pakistani communities make up a four-times-higher proportion of the population in the most-deprived local areas than of England as a whole.⁷
Our strategy to reduce health inequalities in Luton is to target interventions in the five Middle Layer Super Output Areas (MSOAs) with the lowest life expectancy, namely, Biscot, Challney, Dallow, Farley and High Town, as defined by the 2004 – 2006 life expectancy data in the Eastern Region Public Health Observatory (ERPHO) 2007 Health Inequalities Profile.\(^8\)

Life expectancy is increasing for the residents of Luton, but, for females, it has not increased as quickly as the national rate. Consequently, the gap between life expectancy for females in Luton compared to England has widened. Inequalities between the most- and least-deprived areas in Luton have continued to widen in both males and females. Circulatory diseases are the main causes of death in Luton, and contribute to the inequalities in life expectancy in the borough, and between Luton and England. Further information about life expectancy and major diseases can be found in Section 2.2.

For Luton, the International Passenger Survey suggests that there have been net inflows of approximately 3,000 per year since 2006. Prior to this, net inflows were more modest. Knowledge about the health status of migrants is often limited because migrants are often excluded from surveys. There may be several reasons for this, including insufficient knowledge of the language, lack of professional interpreters, and greater costs when conducting surveys and interviews among migrants. Evidence shows that there is greater morbidity among migrants, especially mental health problems, depression, post-traumatic stress syndrome, psychosomatic complaints and anxiety, certain chronic diseases such as diabetes, and infectious diseases such as TB and hepatitis B.\(^9\)

Additional information about health needs in Luton can be found in the Joint Strategic Needs Assessment, which is available at:


This is a key document produced jointly by NHS Luton and Luton Borough Council which identifies future health and wellbeing needs for our population. The next edition of the Joint Strategic Needs Assessment will be published in the summer of 2011.
2. Focusing on ethnicity and health

Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person’s identity and how they are seen by others. People identify with ethnic groups at many different levels. People may see themselves as British, Asian, Indian, Punjabi and ‘Lutonian’ at different times and in different circumstances. However, to allow data to be collected and analysed, ethnicity is often treated as a fixed characteristic. BME communities are usually classified by the methods used in the UK census, which asks people to indicate to which of 16 ethnic groups they feel they belong.

2.1. Ethnicity

Findings of a local study into the ethnic composition of Luton’s population revealed the following.\(^4\)

- There is a wide variation in household size among different ethnic communities – with South Asian households being larger than average.

- There have been significant shifts in the ethnic composition of Luton since the 2001 census including:
  - generally increasing ethnic diversity among the population;
  - growth in the South Asian population from 33,600 to 50,200;
  - the Black African and Black Caribbean populations increasing from 11,700 to 19,800;
  - a decline in the White and ‘other’ population from 139,000 to 132,000; and
  - concentrations of different communities across the town, for example, Turkish people in Farley.

The estimated proportion of ethnic communities in each ward is shown in Figure 3 (proportion that is ‘White and other’ is indicated). There is a greater-than-average proportion of the Pakistani community in Biscot, Challney, Dallow and Saints, and a greater-than-average proportion of the Bangladeshi community in Biscot, Dallow and Saints.

Figure 4 shows the proportion of non-white ethnic communities in Luton. Biscot, Challney and Dallow are three of our five priority MSOAs. Dallow and Challney have the highest mortality rates from stroke; Biscot and Dallow have some of the highest mortality rates from circulatory diseases. This suggests an association between areas with the highest proportions of BME communities and preventable causes of early mortality.
2. Focusing on ethnicity and health

Figure 3. Proportion of ethnic communities in each ward.

Figure 4. Proportion of non-white ethnic communities.

Source: Luton Borough Council.
2.2. Life expectancy and major diseases

Large-scale surveys show that BME communities are more likely to report ill-health, which starts at a younger age, than in the White British community. There is more variation in the rates of some diseases by ethnicity than by other socio-economic factors. However, patterns of variation in health among ethnic communities are extremely diverse, and have many overlapping factors:

- some BME communities experience worse health than others, for example, Pakistani, Bangladeshi and Black Caribbean communities report the poorest health, Indian, East African, Other Asian and Black African communities report similar health to the White British community, and the Chinese community report better health;

- patterns of ethnic inequalities in health vary from one health condition to the next, for example, BME communities tend to have higher rates of cardiovascular disease (CVD) than the White British community, but lower rates for many cancers; and

- ethnic differences in health vary across age groups, genders, and generations.

Many BME communities experience higher rates of poverty than the White British community in terms of income, benefits use, worklessness, lacking basic necessities, and area deprivation. Much of the variation in self-reported health between and within BME communities can be explained by differences in socio-economic status. However, there is a complex interplay of factors affecting ethnic health, such as the long-term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility.10

2.2.1. Life expectancy

Improving life expectancy is one of the key priorities in the Joint Strategic Needs Assessment. In the following sections we illustrate the health inequalities that exist in Luton, and the differences in health outcomes for different ethnic communities.

Figure 5. Trends in male and female life expectancy.
Although life expectancy in Luton has shown a steady increase since 1999, life expectancy for both males (77.2 years) and females (80.6 years) is at least one year less than the national average (78.3 years and 82.3 years, respectively). Luton is ranked 357 out of 404 local authorities for female life expectancy, and 276 for male life expectancy (with 1 indicating the authority with greatest life expectancy).^11

Figure 5 shows that female life expectancy in Luton, although rising, has slowed in recent years and, consequently, the gap in female life expectancy between Luton and England has widened. Males in Luton have a life expectancy similar to that for our statistical neighbours. The life expectancy for females is generally lower in Luton compared to our statistical neighbours.

**Inequalities in life expectancy**

There are inequalities between different socio-economic groups. The difference between the lowest and highest life expectancies in Luton’s MSOAs is 8.9 years for males (72.0 – 80.9 years) and 9.1 years for females (76.1 – 85.2 years). The Slope Index of Inequality measures the difference in life expectancy between the most- and least-deprived deciles of the population over a five-year period. The latest data (2005 – 2009) shows a gap of 8.5 years for males and 7.4 years for females. Figure 6 shows that the gap for females has started to increase recently from its lowest point in 2003 – 2007, whereas the gap for males continues to decrease.

![Figure 6. Slope Index of Inequality.](image)

Figure 7 shows the distribution of life expectancy by MSOA in Luton for 2005 – 2009. Generally, lower life expectancy occurs in the more-deprived areas in Luton, see Figure 2 in Section 1.

Figure 8 shows the life-expectancy-years gained if those in the most-deprived quintile of Luton experienced the same mortality rates as those in the least-deprived quintile. For males, coronary heart disease (CHD) and stroke are the main causes of the life-expectancy gap. For females, many diseases contribute to this gap, including stroke, respiratory diseases, endocrine, nutritional, metabolic diseases and mental and behavioural disorders.
2. Focusing on ethnicity and health

Figure 7. Life expectancy by MSOA for males (left) and females (right), 2005 – 2009.

Source: Health inequalities intervention tool, London Health Observatory.

Figure 8. Causes of death contributing to the life-expectancy gap.

Mortality

Figure 9 shows causes of deaths in Luton in 2007 – 2009. The two main causes of death in Luton were circulatory diseases, comprising CHD, stroke and other circulatory diseases (30%) and cancer (26%). This is similar to the national pattern.
2. Focusing on ethnicity and health


**Figure 9. Most common causes of death, 2007 – 2009.**

The mortality rate in Luton during 2007 – 2009 was significantly higher than England for both males and females. All-age, all-cause mortality and all-cause mortality for those aged under 75 years has been consistently higher than in England for the previous decade. These differences in mortality rates and life expectancy are largely a reflection of the socio-economic characteristics and demography of Luton.

### 2.2.2. Cancer

Cancer accounted for more than a quarter (27.5%) of all deaths in 2009, just under half (183, 48%) of which were people aged under 75 years. Lung cancer caused 1 in six cancer deaths in 2009 in Luton. Figure 10 shows that Luton’s premature (less than 75 years) cancer mortality rate has been similar to England and our statistically-similar neighbours in recent years. Despite this, large inequalities exist in Luton, see Figure 12 in Section 2.2.3. Cancer accounts for 8.1% of the male, and 11.9% of the female life-expectancy gap.

**Figure 10. All-cancer mortality rate in persons under the age of 75 years.**

Cancer survival rates in Luton are poorer than the national average, and are a priority identified in the Joint Strategic Needs Assessment. The one-year survival rates for lung cancer and colorectal cancer are lower.
than the national average. The recent trend for lung cancer survival is increasing, while that for colorectal cancer is decreasing. The five-year survival rates for prostate cancer (lower than the national rate, but increasing), lung cancer (remained static in recent years) and colorectal cancer (lower than the national rate, and decreasing) are of concern.

A report published by Cancer Research UK aimed to identify cancers for which BME communities were more at risk than white communities, and to determine whether BME communities had poorer outcomes than white communities. The report used broad categories to describe BME communities: White, Asian, Black, Chinese and Mixed, and found that, generally, people from these BME communities were at a significantly lower risk of getting cancer than those from the White community. Differences in incidence and survival are summarised in Table 2 and Table 3, respectively.

<table>
<thead>
<tr>
<th>Community</th>
<th>Cancer</th>
<th>Incidence compared to White community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>Liver</td>
<td>1.5 – 3 times more likely, with statistically significant results for both sexes, of all ages and in all age groups.</td>
</tr>
<tr>
<td></td>
<td>Mouth</td>
<td>Significantly increased risk for females. Males may have a lower risk.</td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td>Significantly lower risk under 65 years (ratio 0.3 – 0.8), significantly higher risk over 65 years (ratio 1.1 – 2.7).</td>
</tr>
<tr>
<td></td>
<td>Breast, prostate, lung and colorectal</td>
<td>Significantly lower risk.</td>
</tr>
<tr>
<td>Black</td>
<td>Prostate</td>
<td>Males higher, ratios between 1.1 and 3.4 across &lt;65 and &gt;65 age groups</td>
</tr>
<tr>
<td></td>
<td>Stomach</td>
<td>Males and females had higher rates for those aged over 65 years (ratios between 1.1 and 2.5) as well as liver and myeloma.</td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td>Higher risk over 65 years.</td>
</tr>
<tr>
<td></td>
<td>Breast, lung and colorectal</td>
<td>Significantly lower risk.</td>
</tr>
<tr>
<td>Chinese and Mixed</td>
<td>Breast, prostate, lung and colorectal</td>
<td>Significantly lower risk.</td>
</tr>
</tbody>
</table>

Table 2. Incidence of cancer compared to White community.

<table>
<thead>
<tr>
<th>Community</th>
<th>Cancer</th>
<th>Survival compared to White community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>Breast</td>
<td>Significantly reduced aged 15-64 years at three years (89% and 91% respectively) but not at one year and not for those aged over 65 years.</td>
</tr>
<tr>
<td></td>
<td>Lung</td>
<td>Significantly improved outcomes at both one and three years for all ages (e.g. 20% vs. 11% for three year age-standardised survival in males).</td>
</tr>
<tr>
<td></td>
<td>Colorectal</td>
<td>No significant difference.</td>
</tr>
<tr>
<td>Black</td>
<td>Breast</td>
<td>Significantly poorer survival at both one and three years aged 15-64 years (85% compared with 91% at three years). There was no significant difference for those aged over 65 years.</td>
</tr>
<tr>
<td></td>
<td>Lung</td>
<td>Males had better survival at both one and three years (13% compared with 8% at three years).</td>
</tr>
</tbody>
</table>

Table 3. Cancer survival compared to White community.
Smoking is a major cause of lung cancer. Thus, differences in smoking prevalence between ethnic communities are likely to contribute to the health-inequalities gap between those communities. The relatively high smoking prevalence in South Asian men is, therefore, of particular concern (see Section 5.3 for information on smoking prevalence and ethnicity).

In order to calculate mortality rates (2006/07 – 2008/09) by broad ethnic community (White, Asian, Black and Other), the Eastern Region Public Health Observatory linked mortality data to hospital episodes. Owing to the small number of observations, it is not possible to present results using a finer categorisation of ethnic group.

![All-cancer mortality rate by ethnic community, 2006/07 – 2008/09.](image)

**Figure 11.** All-cancer mortality rate by ethnic community, 2006/07 – 2008/09.

All-cancer mortality rates for Luton are shown in Figure 11. The mortality rate is higher in the White community compared to other communities. The Other ethnic community is only a small group in Luton. Comparison is made with Luton’s ONS statistical neighbours, which are the most similar Primary Care Trusts (PCTs) based on factors describing demography, health inequalities and burden of disease. In Hillingdon, Redbridge and England, the Other ethnic community has the highest mortality rate. The lowest rates are seen in the Asian and Black communities across all comparators. Nationally, in 2006 – 2009, the highest rates for males were in the Other, White and Black communities, and for females in the Other and White communities. Mortality rates for males in each ethnic community were significantly higher than those for females.

### 2.2.3. Circulatory diseases

In the UK, one in five men, and one in six women die from coronary heart disease. For South Asian communities living in the UK – Bangladeshi, Indian, Pakistani and Sri Lankan – the risk is even higher. In the UK, the highest rates of CHD mortality are in people born in the Indian sub-continent. South Asian men have an age-standardised mortality rate approximately 40% higher than the general population, and for women the figure is 51%. However, the many ethnic groups comprising the South Asian community are heterogeneous in relation to social custom and risk factors. Black Caribbean males are 50% more likely to die of stroke than the general population, but they have much lower mortality due to CHD. Key risk factors such as smoking, and raised blood pressure, obesity and cholesterol fail to account for these differences, and there is debate about how much they can be explained by socio-economic factors alone or whether there is a biological component.
2. Focusing on ethnicity and health

Prevalence

<table>
<thead>
<tr>
<th>Ethnic community</th>
<th>Angina %</th>
<th>Heart attack %</th>
<th>Heart murmur %</th>
<th>Abnormal heart rhythm %</th>
<th>Other heart trouble %</th>
<th>Stroke %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>3.4</td>
<td>1.5</td>
<td>3.2</td>
<td>1.4</td>
<td>1.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Black African</td>
<td>0.7</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
<td>0.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Indian</td>
<td>4.9</td>
<td>3.2</td>
<td>3.9</td>
<td>1.0</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Pakistani</td>
<td>6.9</td>
<td>2.5</td>
<td>4.1</td>
<td>1.1</td>
<td>2.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>3.1</td>
<td>2.0</td>
<td>2.9</td>
<td>0.6</td>
<td>0.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.6</td>
<td>1.2</td>
<td>0.3</td>
<td>-</td>
<td>1.6</td>
<td>0.8</td>
</tr>
<tr>
<td>Irish</td>
<td>4.0</td>
<td>2.5</td>
<td>3.0</td>
<td>0.8</td>
<td>2.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Population (2003)</td>
<td>4.8</td>
<td>3.4</td>
<td>3.8</td>
<td>1.7</td>
<td>3.1</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Table 4. Prevalence of cardiovascular conditions in males (M) and females (F).

The Health Survey for England in 2004 focussed on the health of BME communities. Nationally, it was found that the prevalence of angina and heart attack was higher in Indian and Pakistani men. Prevalence of stroke was highest in the Black Caribbean and Irish communities. For women, there was less variation between communities, see Table 4.

Mortality

Mortality due to circulatory disease has a significant impact on life expectancy in Luton, and is a local priority to reduce premature deaths.

Circulatory disease is the main cause of death nationally and in Luton. In Luton, there were 398 deaths in 2009 (29% of all deaths) due to circulatory diseases, 29% of these were aged under 75 years. In 2007 – 2009, Luton’s premature circulatory disease mortality rate (77.1 deaths per 100,000 population) was not significantly greater than that in England (70.5 per 100,000) and the gap has started to decrease. Rates have been comparable with our statistical neighbours during the previous decade. The most recent data (2007 – 2009) shows that the gap between Luton and England has narrowed. High mortality rates are observed in the central areas of Luton including Biscot, Dallow, High Town and Saints, which are wards with higher proportions of BME communities.

Looking at CHD and stroke separately: CHD accounts for half (200, 50.3%) of all circulatory disease deaths. There was an increase in premature mortality rates for CHD in 2006 – 2008. Data for 2007 – 2009 shows that this rate has decreased, and is similar to our statistical neighbours for CHD, and has decreased slightly for stroke but is still higher than comparators. The wards with the highest stroke mortality rates are Challney and Dallow; and the lowest rates are in Round Green and Sundon Park.

Inequalities – cancer and circulatory disease

Despite a decrease in mortality rates, the inequality between the most- and least-deprived quintiles of the population in Luton for premature cancer and circulatory disease deaths continues to increase. This is due to mortality rates in the least-deprived quintile decreasing more quickly than in the most-deprived quintile, see Figure 12.
2. Focusing on ethnicity and health

In a review of ethnicity and CVD, it was found in the UK that Black African and Caribbean and South Asian communities were at a particularly high risk of CVD. There are also differences between communities for prevalence of CVD conditions and cardiovascular mortality. African populations have a high incidence of stroke and end-stage renal failure, but CHD is less common in this community. Mortality from stroke in Black Africans is also high. There is consensus that among people of African origin, hypertension is three to four times more prevalent than in the UK white population. This observation fits with the excess risk of stroke and renal disease in these populations. South Asians have a much higher incidence of CHD, and high mortality from CHD in South Asian populations appears to be a feature across the world. South Asians living in the UK, have a 50% greater risk of premature death from CHD than the general population, particularly high rates occur in people of Pakistani and Bangladeshi backgrounds.

Figure 13 shows that there is a significantly higher mortality rate in the Asian community for CHD compared to other communities in Luton. Nationally, there were significantly higher rates in both Asian males and females compared to other communities, excluding the Other category which had a significantly higher rate. Nationally, mortality from stroke in males is significantly higher in the Asian and Black communities than in the White community. For females, the Asian community has a significantly higher mortality rate than the White community. The mortality rate for stroke in the Black community is similar to that in the White community. There is a similar picture seen locally, although numbers are too small to observe significant differences, see Figure 14.

Source: Eastern Region Public Health Observatory Health Inequalities Profile 2009.

Figure 12. CVD and cancer mortality rates per 100,000 population (<75 years) in Luton.

Ethnicity
2. Focusing on ethnicity and health

2.2.4. Diabetes

There are two types of diabetes:

- People with Type 1 diabetes do not produce any insulin. This type of diabetes is less common than Type 2 diabetes. It usually develops in children and young adults.

- People with Type 2 diabetes do not produce enough insulin, or their cells lose the ability to use insulin. Most people with diabetes (approximately 90%) have Type 2 diabetes. This condition tends to develop gradually after the age of 40 years, and is usually associated with being overweight or obese. It is a worrying trend that, in recent years, Type 2 diabetes is being diagnosed more and more in younger people, and even in children.
Almost 1.9 million people in the UK have diabetes, and there are likely to be another half a million more adults who have developed diabetes but are undiagnosed. South Asian people who live in the UK are up to six times more likely to have Type 2 diabetes than the white European population, and with diabetes prevalence in England predicted to increase by 47% by 2025, the condition is expected to have a considerable impact on South Asian communities across the UK.\textsuperscript{24}

People are more likely to develop Type 2 diabetes if they have some or all of the following risk factors:

- not being physically active enough;
- being overweight;
- having a family history of Type 2 diabetes; and
- previous diabetes in pregnancy.

The risk of developing Type 2 diabetes can be significantly reduced by two lifestyle changes: increasing physical activity; and reducing body weight.

**Prevalence**

Recorded and expected prevalence of diabetes for those aged 17+ years in Luton and comparators for 2009/10 are shown in Table 5. It is seen that the prevalence of 6.40% is less that the expected value of 8.4% which might indicate a large undiagnosed population with diabetes in Luton.

<table>
<thead>
<tr>
<th>Comparator</th>
<th>QOF register</th>
<th>Prevalence</th>
<th>Expected number</th>
<th>Expected prevalence (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>9,923</td>
<td>6.40%</td>
<td>12,132</td>
<td>8.4% (5.3% – 13.7%)</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>12,022</td>
<td>5.70%</td>
<td>15,176</td>
<td>7.6% (5.0% – 12.1%)</td>
</tr>
<tr>
<td>Redbridge</td>
<td>14,223</td>
<td>6.90%</td>
<td>17,962</td>
<td>8.9% (5.4% – 15.0%)</td>
</tr>
<tr>
<td>Birmingham East &amp; North</td>
<td>21,198</td>
<td>6.30%</td>
<td>27,155</td>
<td>8.9% (5.9% – 13.9%)</td>
</tr>
<tr>
<td>Wolverhampton City</td>
<td>13,886</td>
<td>4.91%</td>
<td>18,143</td>
<td>9.7% (6.4% – 15.2%)</td>
</tr>
<tr>
<td>East of England</td>
<td>244,281</td>
<td>5.2%</td>
<td>331,449</td>
<td>7.1% (5.2% – 10.7%)</td>
</tr>
<tr>
<td>England</td>
<td>2,338,813</td>
<td>5.4%</td>
<td>3,099,853</td>
<td>7.4% (5.3% – 10.8%)</td>
</tr>
</tbody>
</table>


**Table 5.** Prevalence of diabetes for those aged 17+ years, 2009/10.

The Health Survey for England in 2004 found that, compared with men in the general population, recorded diabetes, after adjusting for age, was:

- almost four times as likely in Bangladeshi men; and
- almost three times as likely in Pakistani and Indian men.

Compared with women in the general population, diabetes was:
2. Focusing on ethnicity and health

- more than five times as likely among Pakistani women;
- at least three times as likely in Bangladeshi and Black Caribbean women; and
- two-and-a-half times as likely in Indian women.

Almost all cases of diabetes in Black and South Asian men were already diagnosed, whereas at least two-fifths of cases of diabetes in Irish men and in males in the general population were undiagnosed. More than three-quarters of cases of diabetes in South Asian women were diagnosed, with an even higher proportion of cases diagnosed in Black and Irish women and women in the general population.

NHS Luton commissions education programmes for people with diabetes. The Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) programme aims to help people adjust to living with diabetes and support them to manage their condition better. The training is delivered in English, Urdu and Bengali.

2.2.5. Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) accounted for 5.4% (228) of all deaths in 2007 – 2009. The majority (69.7%) of these deaths were in people aged over 75 years. Figure 15 shows that Luton has a significantly higher mortality rate than England and higher rates than our statistical neighbours.

![Figure 15. COPD mortality rate per 100,000 population, 2007 – 2009.](image)

Although COPD is a common cause of death and disability, little is known about the effects of socioeconomic status and ethnicity on health outcomes. Generally, lower educational attainment and household income are related to greater disease severity, poorer lung function and greater physical functional limitations. Although being of black ethnicity has been found to be associated with greater COPD severity, lower education and lower income have a stronger effect than ethnicity on the risk of acute COPD exacerbation.

The Department of Health commissioned research from the Picker Institute. One aspect of this research was to interview a range of BME patients in order to examine whether there were ethnic difference in experience and understanding of the condition. The main findings were that there were few significant differences between the experience of patients with COPD from BME communities compared to the white population, and that there were fewer patients from BME communities known to healthcare providers than would be expected. However, a common theme emerging from COPD patients from BME communities was
that there was little understanding about their condition. There was some evidence that patients from South Asian communities did not access services such as pulmonary rehabilitation or self management due to issues including transport, and not understanding the role of exercise. Patients from BME communities appreciated the specialist COPD teams, and were likely to engage more if they were encouraged by health professionals. Most were aware that their smoking had contributed to their condition.

2.2.6. Communicable diseases

**HIV**

The number of people living with the human immunodeficiency virus (HIV) in the UK reached an estimated 86,500 in 2009, with a quarter of these unaware of their infection status.27 HIV and acquired immunodeficiency syndrome (AIDS) have disproportionately affected African communities. Latterly, after gay men, Africans are the largest community affected by HIV, and, since 1999, new diagnoses among Africans have overtaken new diagnoses in other communities.28 However, since 2008, there has been a steady increase of new diagnosis from non-African communities.

In the first half of the last decade, Luton has seen an increase in the number of new migrants from various parts of the world, in particular Zimbabweans.29 It is against this background that HIV in Luton remains a public health priority.

HIV infection rates in Luton have increased slightly from 4.49 per 1,000 in 2008 to 4.70 per 1,000 in 2009.30 In Luton, rates of new diagnosis in non-African communities have been increasing since 2000. Out of 57 newly diagnosed cases in 2009, 23 were from Black Caribbean, Black Other/Unspecified, Chinese, Indian, Pakistan, Bangladesh, other Asian and other mixed ethnic communities.27

Changes to the national antenatal HIV testing policy in 2000 (from being a selective test, to one offered to all pregnant women) has led to increased detection of pregnant women with HIV, and, as a consequence, reduced mother-to-child transmission of HIV. Since this change in policy, there have been no reported cases of mother-to-child infection.

NHS Luton is aware that despite the advances in HIV treatment, Africans have not benefited to the same extent as other communities, and HIV is often diagnosed at a much later stage of disease progression, limiting the effectiveness of drug treatments.28 NHS Luton commissioned community-based groups, namely the Centre for All Families Positive Health and Embrace Life, to provide health promotion and social care support to people living with HIV in addition to the existing HIV statutory services from Luton Borough Council Social Services and community genitourinary medical services.

**Tuberculosis**

Tuberculosis (TB) is a bacterial infection that can cause disease in the lungs (pulmonary), but can also affect other parts of the body (extra-pulmonary). Only the pulmonary form of TB disease is infectious. Transmission occurs through coughing of infectious droplets, and usually requires prolonged close contact with an infectious person. TB is curable with a combination of specific antibiotics, but treatment must be continued for at least six months.

Over the last 20 years there has been a gradual rise in the number of TB cases in the UK, see Figure 16. The rate of TB infection in the UK population in 2009 was 15 per 100,000 people.
2. Focusing on ethnicity and health

The rate of TB infection in Luton is 43 per 100,000 and in the East of England it is 8.4 per 100,000. In 2009 there were 438 cases of TB reported in the region with 90% of cases from non-UK born residents. The rate of TB is highest among: non-UK born people originating from countries where TB is prevalent; the homeless; asylum seekers; and people who are living with HIV.

As a high-prevalence area, all babies born in Luton, and young children moving to the UK from a high-prevalence country who have not been vaccinated, are offered a BCG vaccination. Uptake of vaccination as part of the neonatal BCG vaccination programme is over 98%.

HIV and TB co-infection

People living with HIV may have a compromised immune system, and this can activate a dormant TB infection. TB is the most common opportunistic infection and cause of death in HIV-positive people. Among TB cases reported in 2008 for England, Wales and Northern Ireland, 6.7% (553/8,258) were known to be HIV infected. This was slightly less than the proportions observed between 2002 and 2006 (between 8.0% and 9.5%) and similar to that in 2007 (6.6%).

In Luton, a dedicated TB-nurse-led service provides the key components of a care pathway that increases detection, treatment completion and infection eradication by:

- identifying patients with symptoms;
- testing, diagnosis and treatment including directly observed treatment for patients whose compliance with their treatment is in doubt; and
- surveillance and close contact monitoring of family, friends and colleagues of someone with TB.

Source: Enhanced Tuberculosis Surveillance; Enhanced Surveillance of Mycobacterial Infections and ONS mid-year population estimates.

**Figure 16.** Tuberculosis case reports and rates in the UK, 2000 – 2009.
## Key Points

1. There is an association between areas with the highest proportion of BME communities and preventable causes of mortality.

2. Deprivation and ethnicity are often closely linked, so it may be difficult to assign the causes of disease or of premature mortality to a single causal factor.

3. BME communities are generally at lower risk of developing cancer than the White community.

4. South Asian communities have significantly higher rates of diabetes and CHD.

5. Recorded prevalence for long term conditions (LTC) such as diabetes is lower than expected, and efforts should be made to identify and treat people with LTC earlier.

6. Luton continues to experience high rates of HIV and TB prevalence, particularly in the Black African community.
Health inequalities are differences in health status that are driven by inequalities in society. Health is shaped by many different factors, such as lifestyle, material wealth, educational attainment, job security, housing conditions, psycho-social stress, discrimination and the health services. Health inequalities represent the cumulative effect of these factors over a person’s life-course; they can be passed on from one generation to the next through maternal influences on baby and child development. These factors are seen in Figure 17 which shows the collective effect on health of poor housing and transport links, social isolation and people’s ability to exercise control over their lives.  

Figure 17. The main determinants of health.

### 3.1. Education

Poverty is an underlying determinant of ill health, and education is seen as a means of enabling social mobility. Research on health inequalities has frequently shown that those with poorer levels of education experience poorer health. This may be because level of education is a strong indicator of a person’s socio-economic status.

The Marmot Review outlined the relationship between education and health, and demonstrated that poor health outcomes are linked to educational attainment and economic participation. The proportion of young people who are 16-18 years old and not in employment, education and training (NEET) in Luton is 6.3% (March 2010), and is slightly higher than the regional value of 6.1%.

In May 2010, there were 397 young people in the NEET group. During the last 4 years, the highest number was 535 in Sept 2007. The majority of those in the NEET group are White British, but there are substantial numbers in the Pakistani and Bangladeshi communities.

Figure 18 shows that Asian children achieve higher grades at GCSE than other ethnic communities in Luton and in most of the ONS corresponding local authority areas. Achievement in the Black community is also higher in Luton than in other comparators, but is similar to the East of England and England. However, there
are differences by gender, with higher achievement in girls in most communities except the Asian community where 58% of boys achieved 5 or more GCSEs at grades A*-C compared to 54% of girls.

Source: Department for Education.

**Figure 18.** Proportion of children achieving 5 or more GCSEs grades A*-C grades, 2009/10.

Figure 19 shows that the Asian community had a lower achievement in Early Years Foundation Stage than other communities in Luton. In contrast to other comparators, the Black community is one of the highest achievers in the Early Years Foundation Stage.

Source: Department for Education.

**Figure 19.** Proportion with good achievement in Early Years Foundation Stage, 2009/10.
3. Wider determinants of health

3.2. Employment

The Office for National Statistics Longitudinal Studies Centre showed that there were a number of adverse health outcomes associated with unemployment including poorer mental health, substance misuse, teenage pregnancy, suicidal behaviours and limiting long-term illness.\(^\text{33}\)

In November 2010, Luton’s unemployment rate was 5.4% of the male working-age (16-64 years) population, and 2.9% of the female working-age population. This compares with 3.8% and 1.8%, respectively, in the East of England and 4.9% and 2.1%, respectively, in Great Britain.

The Annual Population Survey in 2004 showed that, nationally, unemployment rates for people from non-white communities were generally higher than those from white communities.\(^\text{34}\) For women, the highest rates of unemployment were in: Pakistani (20%), Black African (12%), and Mixed (12%) communities. All of which were three or more times higher than the White British and White Irish communities (4% each). Other communities (Black Caribbean, Indian and Chinese) were approximately twice this rate (8%).

For men, the highest unemployment rates were seen in Black Caribbean, Black African, Bangladeshi and Mixed communities (between 13% and 14%); all nearly three times the rate of the White British and White Irish men (5% each). Other communities (Pakistani and Chinese men) were twice this rate (10%).

Local data from October 2009 to September 2010 shows that the proportion of the ethnic minority working-age population that were unemployed was 13.8%, similar to Luton’s comparators, but much higher than the Luton average (5.4% in November 2010), see Figure 20.

![Figure 20. Proportion of BME working-age population unemployed, October 2009 – September 2010.](image)

Non-white communities were also more likely than the White community to be economically inactive (not available for work and/or not seeking work). Women are more likely than men to be economically inactive across all communities. The highest rates were seen in Bangladeshi and Pakistani women at 75% and 69%, respectively, in Great Britain, which were three times that of the White British, White Irish and Black Caribbean women (between 25% and 26%). The majority of those economically inactive were looking after family or home compared to the highest rates for men in the Chinese community (37%) which were mainly students.
In Luton, the rate of economic inactivity in BME communities was 34% compared to 32% nationally. Of our statistical neighbours only Birmingham had higher rates at 39%, see Figure 21.

**Figure 21.** Proportion of BME working-age population economically inactive, October 2009 – September 2010.

Figure 22 shows that the highest rates of unemployment are in Biscot, Dallow, Farley, High Town, Northwell and South.

**Figure 22.** Proportion of working age population unemployed by ward, November 2010.
3.2.1. Child poverty

In a Child Poverty Needs Assessment conducted in Luton, it was found that:

- almost one in three children are living in poverty;
- there is a marked difference in child poverty rates in Luton, for example, in Biscot and Dallow, which have high proportions of BME communities, child poverty rates are more than double the national average (21.6%), whereas in Barnfield, Bramingham and Stopsley child poverty rates are less than half the national rate; and
- an estimated 6,902 (22.3%) children in Luton claim free school meals.

The national Households Below Average Income Survey shows that children living in households headed by someone from an ethnic minority are more likely to live in low income households. This is particularly the case for households headed by someone of Pakistani, Bangladeshi or Black Non-Caribbean ethnic origin.  

3.3. Homelessness

Statutory homeless people are legally homeless and qualify for government housing support, while non-statutory homeless do not. The risk and burden of ill health among homeless people is largely with the non-statutory homeless, especially rough sleepers, and statutory homeless children living in insecure or temporary accommodation.

Table 6 shows housing applications and acceptances in 2009/10.

<table>
<thead>
<tr>
<th>Community</th>
<th>Accepted</th>
<th>Not accepted</th>
<th>Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>80 (57.6%)</td>
<td>59 (42.4%)</td>
<td>139</td>
</tr>
<tr>
<td>White Irish</td>
<td>4 (50.0%)</td>
<td>4 (40.0%)</td>
<td>8</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>21 (77.8%)</td>
<td>6 (22.2%)</td>
<td>27</td>
</tr>
<tr>
<td>Pakistan</td>
<td>25 (56.8%)</td>
<td>19 (43.2%)</td>
<td>44</td>
</tr>
<tr>
<td>Black African</td>
<td>21 (63.6%)</td>
<td>12 (36.4%)</td>
<td>33</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>9 (50.0%)</td>
<td>9 (50.0%)</td>
<td>18</td>
</tr>
<tr>
<td>Unclassified</td>
<td>9 (69.2%)</td>
<td>4 (30.8%)</td>
<td>13</td>
</tr>
<tr>
<td>All</td>
<td>169 (59.9%)</td>
<td>113 (40.1%)</td>
<td>282</td>
</tr>
</tbody>
</table>

Table 6. Housing applications and acceptances, 2009/10.

The recently completed BME Housing Strategy Action Plan indicates that both Pakistani and African communities are over-represented among homeless applicants, while the White British community remains under-represented, which might be a factor in why there is an over-representation of the White community among rough sleepers.

3.3.1. Rough sleepers

Luton Borough Council estimates that there are at least 17 regular rough sleepers in Luton, based on the number of people who used the severe winter weather shelter in 2009. Almost 80% of these are Eastern or Central European migrants, with a minimum of 12 rough sleepers originating from A8 countries (Latvia, Lithuania, Estonia, Hungary, Slovakia, Czech Republic, Poland, and Slovenia).
The NOAH Enterprise runs the night shelter during the winter months. Table 7 shows the number of rough sleepers accessing NOAH Enterprise services during 2010/11.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>58 (28.6%)</td>
</tr>
<tr>
<td>White other</td>
<td>41 (20.2%)</td>
</tr>
<tr>
<td>Black African and Caribbean</td>
<td>7 (3.5%)</td>
</tr>
<tr>
<td>Black Other</td>
<td>8 (3.9%)</td>
</tr>
<tr>
<td>Mixed</td>
<td>4 (2.0%)</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Pakistani</td>
<td>6 (3.0%)</td>
</tr>
<tr>
<td>Asian other</td>
<td>8 (3.9%)</td>
</tr>
<tr>
<td>Not stated</td>
<td>71 (35.8%)</td>
</tr>
<tr>
<td>All</td>
<td>203</td>
</tr>
</tbody>
</table>

Table 7. Rough sleepers accessing Dallow Road night shelter, 2010/11.

The high proportion of ‘Not stated’ is due to clients either not wishing to reveal this information, or they are in a chaotic condition at the initial presentation, and are unable to state their ethnicity immediately. Another group of people accessing NOAH enterprise services are those staying with friends. These were not included in these data even though they are considered to be homeless or rough sleepers.

### Key Points

1. Poor health is linked to educational attainment and economic participation. These, in turn, are linked to deprivation and these indicators may play a large part in the differences in health outcomes seen between ethnic communities.

2. BME communities tend to have higher rates of unemployment and are less likely to be economically inactive than the White community.

3. The Pakistani and Black African communities appear to be over-represented in housing applications.

4. In Luton, Asian children had the highest achievement at GCSE.

5. The child poverty rate in Biscot and Dallow is more than twice the national rate.

6. There are small numbers of rough sleepers, the majority from Eastern Central European communities.

7. Programmes of regeneration, employment and skills training should ensure that they reach and raise the life chances of all of our communities.
Establishing a healthy start in life

4.1. The importance of a healthy start

Evidence demonstrates that improving early years’ health contributes to better health outcomes in later life. Poor diet and inactivity in childhood are associated with an increased risk of CVD, several cancers, musculoskeletal problems and tooth decay, as well as overweight and obesity in later life. Overweight and obesity increase the risk of Type 2 diabetes, and can have an adverse impact on emotional wellbeing and self-esteem.\(^{36}\)

Inequalities appearing at pregnancy, birth and the early years often have a significant bearing on maternal health and the subsequent development of the child, and its health, happiness and productivity in society. Poor and unequal access to health services contribute to health inequalities and we know that those who are at the greatest risk of poor pregnancy outcomes are the least likely to access and benefit from the care that they need.\(^{36}\)

A report by the Audit Commission found that children from BME communities have poorer health outcomes and their parents are less likely to access mainstream health services due to lack of awareness, cultural preferences or language barriers.\(^{37}\) Some BME service-users believe that children’s centres are not hospitable to their community and find difficulties in communicating with healthcare staff. Even if a translator service is available, some do not feel comfortable asking for additional support. The report noted that BME communities were more likely to rely on family members for advice and support in caring for their children, using their own traditional health cultures and practices rather than mainstream health services.

4.2. Pregnancy and childbirth

In 2009, Luton had the 8\(^{th}\) highest birth rate in England, and births from women in Luton accounted for approximately 80% of all deliveries at the Luton and Dunstable Hospital.

Birth registrations do not record ethnicity. However the majority of births occur in hospital where ethnicity is recorded. Table 8 shows hospital births to Luton residents in 2009. 29.3% of births were to White British mothers, and 25.1% to Pakistani mothers. Births rates calculated for births at the Luton and Dunstable Hospital suggest that the highest rates are in the Pakistani, Bangladeshi and Black Other communities.
4. Establishing a healthy start in life

<table>
<thead>
<tr>
<th>Community</th>
<th>Births</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>906</td>
<td>29.3</td>
</tr>
<tr>
<td>Pakistani</td>
<td>775</td>
<td>25.1</td>
</tr>
<tr>
<td>White Other</td>
<td>391</td>
<td>12.7</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>305</td>
<td>9.9</td>
</tr>
<tr>
<td>Black African</td>
<td>219</td>
<td>7.1</td>
</tr>
<tr>
<td>Asian Other</td>
<td>119</td>
<td>3.9</td>
</tr>
<tr>
<td>Indian</td>
<td>108</td>
<td>3.5</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>77</td>
<td>2.5</td>
</tr>
<tr>
<td>Black Other</td>
<td>35</td>
<td>1.1</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>32</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>1.0</td>
</tr>
<tr>
<td>White Irish</td>
<td>28</td>
<td>0.9</td>
</tr>
<tr>
<td>Mixed Other</td>
<td>17</td>
<td>0.6</td>
</tr>
<tr>
<td>Not stated</td>
<td>17</td>
<td>0.6</td>
</tr>
<tr>
<td>Chinese</td>
<td>15</td>
<td>0.5</td>
</tr>
<tr>
<td>White and Black African</td>
<td>6</td>
<td>0.2</td>
</tr>
<tr>
<td>White and Asian</td>
<td>6</td>
<td>0.2</td>
</tr>
<tr>
<td>Total</td>
<td>3,088</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: ONS 2009 ethnic group estimates.

Table 8. Number of births by ethnic community, 2009.

4.3. Infant and child mortality

Reducing infant mortality is a priority for NHS Luton due to Luton’s higher-than-national rates of infant mortality, perinatal mortality, stillbirths, and babies born with low birth-weight. Infant mortality rates for 2007 – 2009 are shown in Table 9. The infant mortality rate for Luton is 7.4 per 1,000 live births which is significantly higher than in England, and the second highest among our statistical comparators.
4. Establishing a healthy start in life

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Live births</th>
<th>Number of deaths &lt; 1 yr</th>
<th>Rate per 1,000 live births (95% CI)</th>
<th>Significantly different to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham East &amp; North</td>
<td>20,447</td>
<td>172</td>
<td>8.4 (7.2 – 9.8)</td>
<td>High</td>
</tr>
<tr>
<td>Luton</td>
<td>10,546</td>
<td>78</td>
<td>7.4 (5.9 – 9.2)</td>
<td>High</td>
</tr>
<tr>
<td>Wolverhampton City</td>
<td>10,059</td>
<td>65</td>
<td>6.5 (5.1 – 8.2)</td>
<td>High</td>
</tr>
<tr>
<td>Redbridge</td>
<td>12,351</td>
<td>63</td>
<td>5.1 (4.0 – 6.5)</td>
<td>Not</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>12,178</td>
<td>62</td>
<td>5.1 (4.0 – 6.5)</td>
<td>Not</td>
</tr>
<tr>
<td>East of England</td>
<td>212,384</td>
<td>901</td>
<td>4.2 (4.0 – 4.5)</td>
<td>Not</td>
</tr>
<tr>
<td>England</td>
<td>1,999,224</td>
<td>9,421</td>
<td>4.7 (4.6 – 4.8)</td>
<td></td>
</tr>
</tbody>
</table>

Source: National Centre for Health Outcomes Development.

**Table 9.** Infant mortality, 2007 – 2009.

![Diagram showing infant mortality rates](image)

Source: National Centre for Health Outcomes Development.

**Figure 23.** Infant mortality in Luton, England and Wales, 1996 – 1998 to 2007 – 2009.

Figure 23 shows that Luton’s infant mortality rate has been consistently higher than the national rate for the last decade. Preliminary data for 2010 suggests a lower infant mortality rate than in 2009.

The proportion of low birth-weight births in Luton in 2009 is significantly higher than in England (10% compared to 7.5% of all births). Figure 24 shows that the wards in Luton with the highest proportion of low birth-weight births are Challney, Round Green and Stopsley.
It is not possible to analyse local data on infant mortality and ethnicity. This is because ethnicity is not included in the birth and mortality registration data, and, there are few infant deaths annually, so further classification by ethnicity makes analysis difficult to interpret. This section, therefore, looks at the national evidence on infant mortality and ethnicity.

ONS has identified differences in the infant mortality rates of ethnic communities in England and Wales.\textsuperscript{38} In Table 10, infant mortality rates in both the Pakistani and Black Caribbean communities was nearly twice that of the White British community at 9.6 and 9.8 deaths per 1,000 live births compared to 4.5 deaths per 1,000 live births in the general population.

Causes of infant death vary between ethnic communities. Nationally, the Black Caribbean community had particularly high neonatal mortality rates (in the first month of life) and the Pakistani community had high rates throughout the first year. Half of all infant deaths in the Pakistani community were due to congenital anomalies, compared with only a quarter of deaths in the White British community. In the Black Caribbean community the majority (67%) of infant deaths were related to low birth-weight and premature birth compared to less than half of all infant deaths in the White British community.

In Luton in 2006 – 2010 more than 50% of the 122 infant deaths had either prematurity (39%) or congenital malformations (17%) recorded as the primary cause of death. Of the 3,528 births in 2009, 9.8% were of low birth-weight (<2,500g) and more than half of these (52%) were to mothers born outside the UK.
4. Establishing a healthy start in life

<table>
<thead>
<tr>
<th>Community</th>
<th>Live births</th>
<th>Deaths</th>
<th>Infants</th>
<th>Rates per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Early neonatal</td>
<td>Late neonatal</td>
<td>Post-neonatal</td>
</tr>
<tr>
<td>All</td>
<td>645,887</td>
<td>1,695</td>
<td>544</td>
<td>961</td>
</tr>
<tr>
<td>Bangladeshi, Asian/Asian British</td>
<td>8,181</td>
<td>17</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Indian, Asian/Asian British</td>
<td>15,944</td>
<td>51</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Pakistani, Asian/Asian British</td>
<td>24,064</td>
<td>107</td>
<td>42</td>
<td>82</td>
</tr>
<tr>
<td>African, Black/Black British</td>
<td>19,606</td>
<td>66</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Caribbean, Black/Black British</td>
<td>7,455</td>
<td>39</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>White British</td>
<td>416,113</td>
<td>958</td>
<td>315</td>
<td>586</td>
</tr>
<tr>
<td>White Other</td>
<td>33,328</td>
<td>79</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>All other ethnic communities</td>
<td>50,421</td>
<td>144</td>
<td>52</td>
<td>75</td>
</tr>
<tr>
<td>Not stated</td>
<td>69,902</td>
<td>213</td>
<td>55</td>
<td>89</td>
</tr>
</tbody>
</table>

Source: ONS. Early neonatal, deaths aged under 7 days; Late neonatal, 7 - 28 days; Postneonatal, 28 days – 1 year; Infant, under one year.

Table 10. Infant mortality in England and Wales, 2005.

NHS Luton is currently working with providers to reconfigure services to ensure that where appropriate care is available in the community (GPs, children’s centres, and health centres) delivered by means of individual care plans from the time that women become known to services. NHS Luton is actively working with partners to improve the nutrition of pregnant and breastfeeding women and babies by rolling out the Healthy Start programme which provides free vitamins, fruit and vegetables to women and families on low incomes.

4.3.1. Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a process which has been a statutory requirement since April 2008. There is one CDOP for Bedfordshire and Luton with accountability to the Local Safeguarding Children Boards.

The annual CDOP report states that between April 2008 and March 2011 a total of 98 child deaths (under 17 years) in Luton were reported. 39% of these were early neonatal deaths, with many dying in the first hours or days from complications related to prematurity and known anomalies. 66% of all deaths reported were in children under the age of 1 year.
The ethnic origin of the children was reviewed and local data shows that of the 98 child deaths in Luton investigated; 31% were Pakistani, 28% White British, 11% Bangladeshi, 9% Black African and 6% of children were Black Caribbean.

The report acknowledged the high number of infant deaths among ethnic minorities in Luton and that consanguinity appears to be a significant factor especially the number of children with disabilities born to families of Pakistani origin. Other factors that contributed to the deaths include smoking in pregnancy, high maternal BMI, and drug and alcohol use.

4.3.2. Consanguinity

Consanguinity refers to when both members of a couple in a relationship are related to each other by at least one common ancestor. Marriage between cousins is legal and considered a means of maintaining close links with the extended family.

Children of consanguineous couples are at an increased risk of morbidity and early mortality. Higher infant mortality rates and children born with congenital anomalies are reported among the South Asian community. The level of risk depends on the degree of relationship of the parents.

The risk for children born to first cousins of congenital/genetic disorders and of early mortality is 2%-8% and approximately 4% respectively, at least double the risk of children born to unrelated parents. The excess risk is mainly caused by autosomal recessive disorders which are genetic conditions that can cause disability where both parents are carriers and have passed the same defective gene that they have inherited from their common ancestor to their child. Many of these conditions may not yet have manifested themselves in the wider family and may come as a shock to the family.

First cousin marriages are more common among British South Asian communities, especially those of British Pakistani origin, than in the general population. British Pakistani women are 13 times more likely to have children with recessive disorders than the general population, and, nationally, although they account for 4% of all births, they account for 30% of all British children with recessive disorders with highly detrimental consequences for infant mortality. 39

Evidence from the investigations of the CDOP which is responsible for reviewing all child deaths in Bedfordshire and Luton suggests that of the 98 deaths reported in Luton between April 2009 and March 2011, consanguinity was a modifiable factor identified in 20% of the deaths.

NHS Luton is working with partners to understand the inter-generational attitudes and beliefs towards consanguineous relationships, the general awareness and risk perceptions, and to openly discuss these sensitive issues sensibly. Key actions planned are:

- training of health professionals to deliver consistent and evidence-based information that is not hampered by concerns regarding cultural sensitivities;
- target community groups where consanguineous relationships are more common so that information is available before marriage and conception regarding associated risk, and engage the extended family in making decisions; and
- improve access to counselling and support services for parents in consanguineous marriages who have suffered a child death or have a child with a birth anomaly.
4.3.3. Children with disabilities

Luton has an increasing number of children with disabilities, and there are a large proportion of children from BME communities notably South Asian families. There is however a lack of robust data regarding ethnicity, nature of disability and possible causes.

In 2009 the University of Bedfordshire was commissioned by Luton Borough Council and NHS Luton to explore the needs of children with multiple, complex disability and learning disabilities from the Pakistani and Bangladeshi communities in Luton. The objective of the research was to use existing data to take account of the significant demand for health, social care and educational services over the next five years in light of the increasing number of children with complex health needs in these communities in Luton.

The neonatal unit at the Luton and Dunstable Hospital identified that the incidence of rare congenital conditions and multiple genetic abnormalities is significantly greater among the South Asian community in Luton than any other BME group. This is also reflected in referrals to the Child Disability Team where the caseload shows 40% of children are of South Asian origin.

Additionally as children grow older and access education, there is a growing demand for special needs education placements for children from South Asian families. For the academic year 2008, 69% of special needs placements at Lady Zia Werhner, a school for children with severe, profound multiple learning disabilities, are for children from South Asian families. This demand is expected to increase.

The report identified that attitudes to disability within these communities vary, and there was a perceived need for access to services to support care that was predominantly being delivered solely by the family. In addition, the families with disabled children interviewed wanted more information regarding the cause of disability and how they could find out about services available and access them. Luton Borough Council and NHS Luton have reviewed the recommendations and are implementing them as part of their children’s commissioning priorities.

4.4. Antenatal care

There are a number of antenatal tests that are routinely available to mothers during their pregnancy to detect anomalies in their unborn child including screening for Down’s Syndrome, infectious diseases, and structural abnormalities. Nuchal screening that detects Down’s syndrome has been offered to all women as part of their maternity care from 2009.

There is some evidence that ethnic communities access prenatal testing differently. Early booking by 12-weeks gestation facilitates antenatal diagnosis and planned management. Ensuring that all women, including those in lower socio-economic groups and BME communities, for example, South Asian, and younger mothers, book early to access antenatal care is important as these pregnancies are at higher risk of an adverse outcome for the child.

Current models of antenatal care and recommended visits (monthly until 30 weeks, then fortnightly to 36 weeks, and then weekly until delivery) are based on national guidelines. All women who book their pregnancy by 12 completed weeks access a universal pathway of care. The pathway includes additional testing and treatment when intervention can benefit health and wellbeing, and reduce the risk of an adverse pregnancy outcome.

A key area that improves the pregnancy outcome and health of the baby and mother is to support the mother to stop smoking during pregnancy and after birth. Smoking during pregnancy is associated with a number of complications from labour through to post-delivery. These include increased risk of miscarriage,
4. Establishing a healthy start in life

premature birth, still birth, low birth-weight, and infant mortality.\textsuperscript{40} The Infant Feeding Survey for England in 2005 showed that 33% of all mothers were smoking in the year before pregnancy. 48% gave up at some point before birth and 17% continued to smoke throughout their pregnancy. 30% of mothers who had quit were smoking again by the time their baby was 9-12 months old, and 11% of mothers who had smoked throughout pregnancy had stopped by this point.\textsuperscript{41} In Luton during 2009/10, 16.6% of mothers were smoking at time of delivery compared to 14.1% of mothers in England.

Smoking cessation services provided at the Luton and Dunstable Hospital focus on offering support to pregnant women who smoke.

4.5. Antenatal and newborn screening

Newborn screening is offered to all pregnant women, and combines a series of ultrasound scans and blood tests to identify markers that may indicate either a foetal anomaly of risk to the child and mother as a result of infection or risk of exposure to infection during pregnancy.

The newborn screening programme for sickle cell and thalassaemia is offered to all infants as an integral part of the national Newborn Bloodspot Screening Programme. These conditions are among the world’s most commonly inherited genetic disorders.

Sickle cell disease affects an estimated 12,500 people, with a further 240,000 thought to be carriers.\textsuperscript{42} The highest prevalence is found among Black African and Caribbean communities, with a high risk of sudden death in the early years of life.\textsuperscript{43} Thalassaemia is less common, with the highest prevalence found among people from the Cypriot, Indian, Pakistani, Bangladeshi, Chinese, and other Asian communities. Both conditions can restrict a child’s or an adult’s ability to conduct normal daily activities, and can have profound psychosocial effects on individuals and their families.\textsuperscript{44} Early detection and effective management will improve quality of life.

Luton is a high-prevalence area for sickle cell disease which means prevalence is greater than the threshold of 1.5 babies with sickle cell disorders per 10,000 live births. Locally, more than 98% of babies have a sickle cell screening test up to a week after birth.

4.5.1. Newborn hearing screening

1 to 2 per 1,000 babies in the UK are born with a permanent hearing loss or deafness in one or both ears. In addition, 90% of hearing-impaired babies are born to families with no history of hearing loss. Early identification of hearing loss, coupled with good quality early support, is important for language and social development of the child.

Luton has higher than national rates of babies born prematurely, and low birth-weight. This might indicate poorer maternal health, which can increase the risk of health complications, and is often linked with Black and Asian communities.\textsuperscript{45}

4.5.2. Newborn and Infant Physical Examination Programme

The NHS Newborn and Infant Physical Examination Programme offer parents the opportunity of a head-to-toe physical examination of their baby to check for problems or abnormalities. The examination is carried out within 72 hours of birth and then again at 6-8 weeks of age.
These examinations have been undertaken routinely in NHS hospitals for many years, however until March 2008, when the Newborn and Infant Physical Examination Standards and Competencies were launched, there was little national guidance necessary to deliver a good service.

Currently the national programme is delivering a range of key-stakeholder events and training days to support implementation of the standards for the examination carried out at 72 hours. Standards for the routine examination at 6-8 weeks are under development. The aim is that the programme will be implemented fully during 2012/13.

4.6. Breastfeeding

Increasing the rates of breastfeeding in Luton has been a local priority, and has led to the establishment of a dedicated breastfeeding support service. A number of health visitors and staff at children’s centre have been trained by the UNICEF Baby Friendly Initiative to provide education and support to promote breastfeeding.

Breastfeeding initiation in Luton is lower than most comparators with 67.6% of mothers in 2009/10 initiating breastfeeding compared to 73.1% in England, see Figure 25. Initiation rates have been increasing in Luton, with an increase from 57.2% in 2006/07 to 68.2% in 2009/10. Breastfeeding prevalence at 6-8 weeks compares well with our comparators, see Figure 26.

![Breastfeeding Initiation, 2009/10](source)

Source: Department of Health - no data available for Birmingham East and North PCT for 2009/10.

**Figure 25.** Breastfeeding initiation, 2009/10.
4. Establishing a healthy start in life

**Figure 26.** Breastfeeding prevalence at 6-8 weeks, 2009/10.

Figure 27 shows that the White British community is the least likely to breastfeed (23.4%) compared to over 40% in Black mothers. Black African mothers are the most likely to breastfeed or mix feed.

**Figure 27.** Proportion of mothers by feeding method at 6-8 weeks and ethnicity, 2009/10.

Source: Department of Health.

Source: Luton Community Services.
4.7. Childhood immunisation

A universal childhood immunisation programme is available to all children. This vaccination schedule covers infectious diseases such as, diphtheria, tetanus, polio, haemophilus influenza type B, pertussis, meningitis C, pneumococcal, and measles, mumps and rubella (MMR).

Other vaccinations are targeted at children who are at high risk of a specific infection, for example, BCG vaccination to prevent TB (offered to newborn babies in Luton as a high-prevalence area), Hepatitis B offered to babies born to mothers who have been found to be positive through infectious disease screening in pregnancy and HPV vaccination to prevent cervical cancer which is offered to all girls aged 12-13 years.

National evidence suggests that uptake of childhood immunisation appears to be similar or higher among most BME communities than the general population, particularly South Asian communities.46

Vaccination uptake

Extensive work was carried out to improve the uptake of child immunisations in Luton. The challenge has been to sustain this level of uptake through better reporting and monitoring. The current uptake is shown in Table 11.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary immunisation</td>
<td>97%</td>
<td>94%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>MMR</td>
<td>91%</td>
<td>86%</td>
<td>84%</td>
<td>88%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Table 11. Child immunisation uptake at 2 years of age in Luton.

A local challenge is to ensure that an adequate number of children complete the universal vaccination schedule. Immunisation rates for children under 2 years of age are good.

A key vaccination milestone is to ensure that children access ‘booster’ vaccinations prior to school entry from the age of 3 years and 4 months till their 5th birthday. This vaccination milestone aims to strengthen the child’s immunity against these infections especially at a time of increased exposure to children who may carry the infection.

In 2009/10 work started to improve ‘booster’ uptake rates by initially identifying all children who had not accessed their second MMR vaccination, and inviting parents to get their child vaccinated. This work continues and will be extended to other targeted vaccination programmes.

4.8. Oral health

Good oral health is an integral part of general health promotion. The four main areas of concern for oral health are tooth decay (dental caries), dental erosion, gum disease, and unintentional injury causing tooth fracture or loss.36 There is considerable evidence that untreated decay is concentrated in children from deprived areas and, as a result, there are inequalities across Luton.

The proportion of children in Luton seeing an NHS dentist in the last 24 months is less than that in most comparators, see Figure 28. In Luton, the proportion of adults seeing a dentist has increased since 2006, however, the proportion of children seeing a dentist has decreased, see Figure 29.
Establishing a healthy start in life

There is some evidence to show that BME communities face difficulties in accessing health services. Such barriers include language, cultural and lack of awareness. In a recent CAB/MORI survey, a significantly lower proportion of non-white respondents said they had seen a dentist in the last two years.

Dental health of young children is a growing problem. In Luton, according to data from the NHS Dental Epidemiology Programme (2007/08 dental survey of 5-year-olds), just under half (44%) of all 5-year-olds surveyed had decay experience. The mean decayed, missing and filled teeth (DMFT) in 5-year-olds in Luton is significantly higher than in England, see Table 12. The mean DMFT for children with decay experience in
Establishing a healthy start in life

Luton is 4.36 teeth, the second highest of all comparators. Luton children have the highest proportion of decayed teeth filled.

<table>
<thead>
<tr>
<th>Comparator</th>
<th>5 yr old pop (mid 2007)</th>
<th>Number Examined</th>
<th>Mean DMFT (95% CI)</th>
<th>% children with decay experience</th>
<th>Mean DMFT of children with decay experience</th>
<th>Care Index % decayed teeth filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton UA</td>
<td>2,591</td>
<td>569</td>
<td>1.94 (1.69 – 2.19)</td>
<td>43.9%</td>
<td>4.36</td>
<td>22</td>
</tr>
<tr>
<td>Bradford MCD</td>
<td>7,050</td>
<td>750</td>
<td>2.42 (2.17 – 2.67)</td>
<td>52.0%</td>
<td>4.42</td>
<td>12</td>
</tr>
<tr>
<td>Birmingham MCD</td>
<td>13,528</td>
<td>7,656</td>
<td>1.35 (1.29 – 1.41)</td>
<td>35.9%</td>
<td>3.68</td>
<td>13</td>
</tr>
<tr>
<td>Enfield LB</td>
<td>3,685</td>
<td>325</td>
<td>0.96 (0.72 – 1.20)</td>
<td>27.1%</td>
<td>3.39</td>
<td>17</td>
</tr>
<tr>
<td>Slough UA</td>
<td>1,572</td>
<td>508</td>
<td>2.08 (1.80 – 2.36)</td>
<td>46.2%</td>
<td>4.46</td>
<td>6</td>
</tr>
<tr>
<td>East of England</td>
<td>62,935</td>
<td>12,064</td>
<td>0.83 (0.80 – 0.87)</td>
<td>24.8%</td>
<td>3.22</td>
<td>19</td>
</tr>
<tr>
<td>England</td>
<td>558,566</td>
<td>139,727</td>
<td>1.11 (1.10 – 1.12)</td>
<td>30.9%</td>
<td>3.45</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: North West Public Health Observatory [http://www.nwph.net/dentalhealth/](http://www.nwph.net/dentalhealth/)

**Table 12.** Deciduous milk teeth – 5-year-olds.

There is some evidence to suggest that children from BME communities and low-income groups have poorer oral health. However, the evidence also suggests that the relationship may be related to deprivation.

Source: North West Public Health Observatory.

**Figure 30.** Mean DMFT per child in Luton, 2007/08.
rather than ethnicity. One study from Glasgow examined changes over ten years in caries experience among children in deprived areas, and aged 4-5 years. They found significant improvements in caries and oral health among white children over the decade, and although less marked, these were mirrored among South Asian children. There is considerable evidence that untreated decay is concentrated in children from deprived areas and, as a result, there are inequalities across the country. Lower-income families absorb disproportionately the effect of dental diseases due to lack of education, food availability and selection, and access to early preventive care.

A dental survey in 5-year-olds contains estimates of decay experience at ward level. Areas with higher decay experience are situated in the more-deprived areas of Luton where there is a higher proportion of South Asian residents.

An intervention that can improve oral health is fluoridated water. Children in areas with fluoridated water have healthier teeth than those in unfluoridated areas. Luton does not have fluoridated water, but there are health promotion activities locally promoting the benefits of fluoride varnish for children, especially those at greater risk.

### 4.9. Childhood obesity

Nearly a quarter of people in England are obese. Unless we take effective action, it has been estimated that nearly 60% of the UK population could be obese by 2050.

Since 2005, the National Child Measurement Programme has required each PCT to record height and weight for pupils in Reception Year (aged 4-5 years), and in Year 6 (aged 10-11 years). In 2009/10, the PCT received excellent coverage (96.6%) for measuring children in Reception Year. Owing to errors in the collection of data in 2009/10, the latest data available for children in Year 6 is 2008/09, for which the participation rate was 98.8%.

#### 4.9.1. Reception Year

Table 13 shows that children aged 4-5 years old are at lower risk of being overweight (12.3%) than the national average (13.3%). However, they have a significantly higher risk (14.3%) than the national average (9.8%) of being obese. Although this risk is higher than the previous year (12.7% in 2008/09), it is not statistically significantly.

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Underweight</th>
<th>Overweight</th>
<th>Obese</th>
<th>Overweight or obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>1.2% (0.8 – 1.6)</td>
<td>12.3% (11.0 – 13.6)</td>
<td>14.3% (12.9 – 15.7)</td>
<td>26.6% (24.9 – 28.4)</td>
</tr>
<tr>
<td>England</td>
<td>0.9% (0.9 – 1.0)</td>
<td>13.3% (13.2 – 13.4)</td>
<td>9.8% (9.7 – 9.9)</td>
<td>23.1% (23.0 – 23.2)</td>
</tr>
</tbody>
</table>

**Table 13.** Prevalence of underweight, overweight and obese children in Reception Year, 2009/10.

Figure 31 shows the number of overweight or obese children in Reception Year in each LSOA. Biscot, Dallow and Saints have the highest numbers of overweight or obese children aged 4-5 years.

In Luton, prevalence of overweight and obese children is similar to the national average, with higher prevalence for boys in the Black and White Other communities. However, the national pattern is not seen for Bangladeshi boys who have a similar prevalence to the White British, Pakistani and Other communities. Results are shown in Figure 32 and Figure 33. For girls, the Black communities have a higher prevalence of
being overweight or obese, especially the Black African community, which is the only community significantly higher than the Luton average. The only community with significantly lower prevalence is the Asian Other (including Indian) community.


**Figure 31.** Number of children in Reception Year at risk of being overweight or obese, 2009/10.


**Figure 32.** Boys aged 4-5 years at risk of being overweight or obese by ethnic community, 2009/10.
4. Establishing a healthy start in life


Figure 33. Girls aged 4-5 years at risk of being overweight or obese by ethnic community, 2009/10.

4.9.2. Year 6

Data for Luton in Year 6 is only available for 2008/09. Children aged 10-11 years who were at risk of being overweight (14.9%) and overweight or obese (21.3%) was higher than the national average (14.3% and 18.3% respectively).


Figure 34. Number of children in Year 6 at risk of being overweight or obese, 2008/09.
4. Establishing a healthy start in life

Figure 34 shows the number of overweight or obese children in Year 6 in each LSOA. Dallow and Farley wards have the highest numbers of overweight or obese 10-11-year-olds.

![Figure 34](image)


**Figure 35.** Boys aged 10-11 years at risk of being overweight or obese by ethnic community, 2008/09.

In Luton, the prevalence of being overweight or obese is higher for boys and girls in the Black African community, although not significantly higher than the Luton average. There is a higher prevalence in Indian boys compared to Indian girls. All other communities have similar rates between the sexes and other communities, see Figure 35 and Figure 36.

![Figure 35](image)


**Figure 36.** Girls aged 10-11 years at risk of being overweight or obese by ethnic community, 2008/09.

![Figure 36](image)

4.10. Teenage pregnancy

In 1998 (the baseline year for teenage pregnancy), Luton’s under-18 conception rate was 43.1 per 1,000. Trends are shown in Figure 37.

Figure 37. Teenage conception rates per 1,000 population.

2006 saw a dramatic drop in the under-18 conception rate for Luton – from 41.7 per 1,000 to 34.7 per 1,000. The latest estimate of the conception rate is 29.4 per 1,000, which is the lowest value since the start of the strategy, and significantly less than that our statistical neighbours, the East of England and England, see Table 14.

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Number of conceptions</th>
<th>Rate (95% CI)</th>
<th>2008-9 % change in rate</th>
<th>Significantly different to England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>109</td>
<td>29.4 (28.0 – 30.9)</td>
<td>-31.8%</td>
<td>Low</td>
</tr>
<tr>
<td>Birmingham</td>
<td>975</td>
<td>48.7 (48.0 – 49.4)</td>
<td>-16.5%</td>
<td>High</td>
</tr>
<tr>
<td>Enfield</td>
<td>208</td>
<td>38.5 (37.2 – 39.8)</td>
<td>-17.0%</td>
<td>Not</td>
</tr>
<tr>
<td>Slough</td>
<td>78</td>
<td>35.1 (33.1 – 37.1)</td>
<td>-37.8%</td>
<td>Low</td>
</tr>
<tr>
<td>Bradford</td>
<td>430</td>
<td>41.0 (40.1 – 41.9)</td>
<td>-28.4%</td>
<td>High</td>
</tr>
<tr>
<td>East of England</td>
<td>3,308</td>
<td>31.3 (31.0 – 31.6)</td>
<td>-17.4%</td>
<td>Low</td>
</tr>
<tr>
<td>England</td>
<td>35,966</td>
<td>38.2 (38.1 – 38.3)</td>
<td>-18.1%</td>
<td></td>
</tr>
</tbody>
</table>

Table 14. Teenage conception rates, 2009 (provisional).
Data by ethnicity shows that the White British community accounts for 75% (43) of all conceptions under 18 years of age. Data are too few to analyse by ethnic community, however it does suggest that the largest communities other than White British are Black African and Black Caribbean, who accounted for 16% of teenage conceptions in 2010.

### Key Points

1. Nationally, infant mortality rates in the Pakistani and Black Caribbean communities are twice that of the White British community. Consanguinity is an important factor in infant mortality and plans to work with communities should be prioritised.

2. The White British community is less likely to breastfeed and should be a focus of initiatives to improve uptake.

3. Poorer oral health is associated with deprivation and ethnicity, and a focus on fluoridation, the use of fluoride varnish, and an increase in children attending dental checkups are required.

4. There are high rates of childhood obesity in Luton. A higher proportion of Black African girls are overweight or obese. Tackling childhood obesity should remain a priority.
5. Improving adult lifestyles

5.1. Drug use

Based on an estimate provided by the University of Glasgow, there are approximately 1,525 problematic heroin or crack-cocaine using adults living in Luton. Local needs assessments found that 75% of these problematic drug users are known at either structured or harm-reduction services.

At any one time, some 600 Class A drug users are receiving structured treatment, and, during 2009/10, 908 individuals engaged with structured drug treatment services. 76% of individuals accessing drug treatment were male, 64% were aged 26-40 years, and 84% were heroin users, with more than half also using crack-cocaine.

67% of individuals accessing structured drug treatment were White, 19% were Asian, 7% were Black, 4% were of mixed ethnicity, and 2% were recorded as Other. 87% of individuals were born in the UK. The proportion of clients from BME communities (33%) is largely reflective of the diversity of Luton’s overall population. However, Black African or Caribbean clients have been identified as a community that is under-represented in the treatment system. Clients from these communities indicate that most men do not recognise that their drug use is problematic until something very serious happens, and that traditionally they seek support from their friends rather than services.

5.2. Alcohol use

Using a model developed by the National Treatment Agency, local research identified the following areas of concern:

- hazardous drinking by units per week but not yet experiencing difficulties – 25,000 people in Luton are drinking over 14 units (women) and 21 units (men);
- harmful drinking and suffering physical, economic and emotional harm – 6000 people will be drinking over 35 units (women) and 50 units (men) per week;
- 750 people or more have moderate or severe symptoms of alcohol dependency; and
- 1 in 7 people admitted to hospital have a problem with alcohol.55

In 2009/10, 510 adults aged over 18 years engaged with alcohol services for structured interventions:

- 73% were male;
- 5% were aged under 25 years and 57% were aged 40 years or over, the average age of individuals accessing structured interventions was 43 years;
- 88% of individuals were White, 4% were Asian, 4% were Black, 2% were of mixed ethnicity, and 2% were recorded as Other – the proportion of clients from BME backgrounds (12%) is lower than the proportion in Luton’s general population;
5. Improving adult lifestyles

- 69% of individuals engaging in structured interventions were born in the UK, 4% in other European countries, 1% were born in Africa, 1% in Asia and 24% did not disclose this information;

- 373 clients were discharged from structured alcohol services in 2009/10 – 164 individuals had successfully completed interventions, 23 were referred on to other services for continuing support, and 186 left before completing interventions; and

- numbers of individuals from BME communities seeking support for problematic alcohol use is low, prompting concerns that there are hidden issues in some communities where drinking alcohol is forbidden.

The East of England Lifestyle Survey (2008 and 2009 combined) shows that in Luton White ethnic communities have the highest proportion of respondents whose self-reported alcohol consumption was classed as hazardous and harmful. The Asian Other communities (including Pakistani and Bangladeshi communities) had the highest proportion of respondents stating they were non-drinkers, see Figure 38.

![Figure 38. Alcohol consumption drinking type by ethnic community in Luton, 2008 – 2009.](image)

Source: East of England Lifestyle Survey 2008 and 2009 combined

5.3. Smoking and tobacco products

Tobacco is the leading cause of health inequalities in the UK. It accounts for a significant proportion of inequalities in life expectancy at birth, contributing particularly to cardiovascular and respiratory diseases, and many cancers.

The Integrated Household Survey (IHS) conducted in April 2009 – March 2010 estimated smoking prevalence in Luton at 25.2% for adults aged 18 years and over, compared to 33.2% for routine and manual groups. Estimates from the East of England Lifestyle Survey (2008 and 2009 combined) were 22.4% in adults, and 24.9% for the 20% most-deprived areas. There are no plans to repeat this regional survey, and the local data now available through the annual IHS is felt to provide a robust estimate of prevalence in the general population.
National estimates are 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 (between 20% and 21%). Apart from Black Caribbean women (24%) and Irish women (26%), smoking among women from BME communities is generally very low. However, chewing tobacco is popular in the Bangladeshi community, and 16% of Bangladeshi women chew paan. Figure 39 and Figure 40 shows the prevalence of smoking in Luton.


**Figure 39.** Proportion of Luton male survey-respondents who reported they smoke.


**Figure 40.** Proportion of Luton female survey-respondents who reported they smoke.
The national Smoking, Drinking and Drug Use Amongst Young PeopleSurvey in 2009 shows 20% of pupils aged 11-15 years have tried smoking at least once. This was the lowest figure since the survey began in 1982 when 53% of pupils had tried smoking. The prevalence for regular smoking in this age group is 6%.\textsuperscript{57} Girls are more likely to smoke than boys. Black and mixed race pupils were less likely to be regular smokers than white pupils.

Deaths from smoking have decreased in Luton from an average of 260 per annum between 2003 – 2005 to an average of 246 per annum between 2006 – 2008.\textsuperscript{58, 59} Most of these deaths are due to three main diseases caused by smoking: lung cancer, COPD and CHD.

Tobacco is the leading cause of mouth cancer regardless of type of product – cigarettes, chewing tobacco, paan, areca nut and guthka. In Luton there were 121 hospital spells for mouth cancer between 2008 and August 2010, which cost over £275k, and there were 9 deaths due to mouth cancer during this period.

Smoking-attributable mortality rates in Luton had been increasing in the most-deprived areas for both men and women but the most recent data (2006 – 2008) shows a slight decrease in rates, see Figure 41. This is mainly evident in females where the inequality gap between the most- and least-deprived areas in Luton has narrowed in recent years. For males, the smoking-attributable mortality rate has decreased faster in the least-deprived quintile compared to the most-deprived quintile, which has widened the inequality gap. The areas with the highest smoking-attributable mortality rates are Biscot, Dallow, High Town, Northwell and South.

Source: Eastern Region Public Health Observatory Health Inequalities Profile 2009.

**Figure 41.** Smoking attributable mortality rate in Luton by deprivation quintile.

Increasing smoking quitters is a key local priority. Figure 42 shows the ethnicity of smoking quitters in 2010/11. Just over half (62.6%) of all service users were White British, 12.7% of service users were from the Indian, Bangladeshi or Pakistani communities, and only 3.3% were from the White Irish community.
5. Improving adult lifestyles

5.4. Diet and physical activity

5.4.1. Adult diet

The most recent estimates suggest that fruit and vegetable consumption in Luton is not significantly different to the England average, see Table 15.

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Indicator value (95% CI)</th>
<th>Significantly different to England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton UA</td>
<td>29.89 (25.43 – 34.77)</td>
<td>Not</td>
</tr>
<tr>
<td>Birmingham MCD</td>
<td>24.10 (21.92 – 26.43)</td>
<td>Low</td>
</tr>
<tr>
<td>Hillingdon LB</td>
<td>34.43 (30.29 – 38.80)</td>
<td>High</td>
</tr>
<tr>
<td>Slough UA</td>
<td>28.47 (24.02 – 33.37)</td>
<td>Not</td>
</tr>
<tr>
<td>Wolverhampton MCD</td>
<td>22.65 (20.68 – 24.76)</td>
<td>Low</td>
</tr>
<tr>
<td>East of England</td>
<td>30.32 (28.42 – 32.30)</td>
<td>Not</td>
</tr>
<tr>
<td>England</td>
<td>28.65 (28.02 – 29.29)</td>
<td></td>
</tr>
</tbody>
</table>

Table 15. Modelled fruit and vegetable consumption, 2006 – 2008.

The National Obesity Observatory reported that “Many people from minority ethnic groups have healthier eating patterns than the White population”. However, there are, of course, considerable variations in dietary patterns between and within ethnic communities. These eating patterns are influenced by many factors including availability of food, level of income, health, food beliefs, dietary laws, religion, cultural...
patterns and customs. Additional factors include age (and in particular, generation), region of origin and occupation.\textsuperscript{60}

One qualitative study, examining the food and eating practices of British Pakistanis and Indians with Type 2 diabetes, found that many respondents attempted to balance the perceived risk of eating South Asian foodstuffs against those of alienating themselves from their culture and community.\textsuperscript{61}


**Figure 43.** 5-a-day consumption in Luton by ethnic community, 2008 – 2009.


**Figure 44.** 5-a-day consumption by deprivation and ethnic community in Luton, 2008 – 2009.
Local data obtained from the East of England Lifestyle Survey in 2008 and 2009 shows that the Asian communities had the lowest proportions consuming 5-a-day; all significantly lower than the White British community. The highest rate is in the Black Other community, see Figure 43.

Figure 44 shows that, for the White British community, a significantly lower proportion of the people in the most-deprived areas in Luton eat 5 or more portions of fruit and vegetables a day compared to the rest of the population. Although numbers are smaller in other communities, this pattern is similar in the White Irish community and the Black communities. The opposite picture can be seen in the Indian and Other communities with all others showing similar rates.

5.4.2. Physical activity

The Active People Survey is now conducted annually to identify the ways in which participation in physical activity varies from place to place and between different communities in the population. The survey measures the proportion of the adult population who volunteer in sport on a weekly basis, club membership, involvement in organised sport/competition, receipt of tuition or coaching, and overall satisfaction with levels of sporting provision in the local community. In the 2007/08 survey, 10.6% of Luton adults reported taking part in moderate intensity sport and active recreation on at least three days a week (at least 12 days in the last four weeks) for at least 30 minutes continuously in any one session. This percentage increased to 13.5% for 2009/10.

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton UA</td>
<td>504</td>
<td>503</td>
<td>502</td>
<td>501</td>
<td>Increase</td>
<td>Increase</td>
</tr>
<tr>
<td></td>
<td>10.6%</td>
<td>10.1%</td>
<td>13.5%</td>
<td>15.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hillingdon</td>
<td>501</td>
<td>512</td>
<td>506</td>
<td>509</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>17.4%</td>
<td>16.7%</td>
<td>14.7%</td>
<td>15.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slough UA</td>
<td>507</td>
<td>502</td>
<td>504</td>
<td>505</td>
<td>No change</td>
<td>Increase</td>
</tr>
<tr>
<td></td>
<td>14.8%</td>
<td>10.7%</td>
<td>16.4%</td>
<td>16.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>518</td>
<td>511</td>
<td>504</td>
<td>500</td>
<td>Increase</td>
<td>Increase</td>
</tr>
<tr>
<td></td>
<td>10.3%</td>
<td>12.7%</td>
<td>16.7%</td>
<td>17.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birmingham</td>
<td>5,265</td>
<td>5,273</td>
<td>1,289</td>
<td>1,016</td>
<td>No change</td>
<td>Increase</td>
</tr>
<tr>
<td></td>
<td>14.5%</td>
<td>14.4%</td>
<td>16.2%</td>
<td>17.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td>24,734</td>
<td>25,689</td>
<td>24,245</td>
<td>24,001</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>16.2%</td>
<td>15.8%</td>
<td>15.7%</td>
<td>15.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National overall</td>
<td>191,324</td>
<td>193,947</td>
<td>188,354</td>
<td>182,444</td>
<td>Decrease</td>
<td>Decrease</td>
</tr>
<tr>
<td></td>
<td>16.4%</td>
<td>16.6%</td>
<td>16.5%</td>
<td>16.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 16. Active People Survey.

The National Obesity Observatory reported that “A number of studies have shown low levels of physical activity among minority ethnic groups in the UK”. This is particularly true for South Asian populations, where markedly lower levels of physical activity compared to the White community have been found to remain significant even after adjusting for age, sex, education, amount of fatty tissue and self-reported health variations. Further analysis of South Asian communities suggests that people from the Bangladeshi community have markedly lower levels of physical activity than other South Asian communities, while those of Indian ethnicity have the highest levels; although still lower than the White population.
A recent systematic review of the literature on participation in sport and recreation by BME communities confirms the relatively low levels of participation in sport compared to the White community, with greater gender disparity. People from Bangladeshi and Pakistani communities were least likely to participate, with Bangladeshi and Pakistani women’s participation rates consistently below those of White and other BME communities. However, the Mixed ethnic community showed consistently higher levels of participation than any other community including White British. In addition, when individual sports were examined, relatively high proportions of Pakistani and Bangladeshi men were seen to play football and cricket. Even these figures were not quite what they seemed as the higher participation might in large part be explained by the younger age profile of minority ethnic communities.

A combination of personal, socio-economic, cultural and environmental barriers may discourage people from BME communities from engaging in physical activity. The majority of relevant studies have explored the views of the South Asian population, rather than other minority communities. Particular barriers to physical activity have been reported by South Asian women including dress codes, modesty and lack of single-sex facilities. Other obstacles cited as barriers to regular physical activity include difficulties in identifying suitable and safe walking routes, time constraints, dependent relatives or availability of childcare, and a perceived lack of culturally appropriate exercise services. There were reports from younger generations of South Asian women that negative attitudes to physical activity had been instilled by their parents who had the view that sport and femininity were incompatible.

Local data by ethnicity is available from the East of England Lifestyle Survey, see Figure 45. It can be difficult to compare measures of physical activity, the Chief Medical Officer recommends that adults should spend at least 30 minutes doing moderate physical activity at least 5 times a week. The Luton data in the Lifestyle Survey does not entirely reflect the pattern from the national evidence with higher rates of physical activity in the Black Other and Black Caribbean communities. The lowest physical activity is seen in the Other Asian and other communities although not significantly different from most other communities.

![Figure 45. Physical activity by ethnic community.](image-url)
Key Points

1. The Black African and Caribbean communities may be under-using drug treatment services.

2. BME communities appear to be under-represented in their use of alcohol services.

3. Asian communities have the highest proportion of ‘non-drinkers’.

4. 11-15-year-olds in the Black and Mixed communities are less likely to smoke than those in the White community.

5. Given the high smoking prevalence in Bangladeshi and Pakistani males, and in the White Irish communities, the uptake of stop smoking services appears low. Access should be improved through social marketing techniques.

6. There are lower levels of physical activity in the South Asian community compared to the White community; with people from the Bangladeshi community having markedly lower levels of physical activity than other South Asian communities.

7. Where data on lifestyle is available use this to target programmes effectively using social marketing approaches.
Most BME communities access primary care at rates in line with the general population (in relation to need). However, there is also some evidence of lower access to hospital care among BME communities. For example, South Asian communities have been found to have lower access to care for CHD. For prevention activities, rates of smoking cessation have been lower in BME communities than in White communities. In addition, rates of dissatisfaction with NHS services are higher among some BME communities than their White British counterparts. According to Healthcare Commission patient surveys, South Asians report poorer experiences as hospital inpatients.

6.1. Mental health

It is estimated that during their lifetimes a quarter of people will develop a mental health problem, with between one in eight and one in five people developing severe depression or a complex and enduring mental illness. For Luton, this is approximately 50,000 people. There is a clear impact of mental illness on physical health: depression increases the risk of heart attack four-fold and is a major cause of mortality following heart attack.

Findings from the 2010 national mental health and learning disability ethnicity census in England and Wales are shown in Table 17.71

| Rates of admission (excluding patients on a community treatment order) | Lower than average for the White British, Indian and Chinese communities. |
| In line with the average for the Pakistani and Bangladeshi communities. |
| Higher than average for the other minority communities (particularly for the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed communities, who had rates two to six times higher than average). |
| Community treatment order | Higher than average rates for the South Asian and Black communities. |


The census concluded that these findings do not necessarily show that mental health services are failing to meet the needs of people using services from BME communities, and highlighted the need for prevention, early intervention and collaboration across sectors to reduce the risk of admission and detention.
During the period April – December 2010, there were 375 admissions for mental health services in Luton. These comprised: adult inpatient services (83%), psychiatric intensive care unit (2%), older people inpatients (11%), rehabilitation (2%), and learning disabilities (1%). The number of admissions for adult inpatient services by broad ethnic community shown in Figure 46. The Black communities appear to be over-represented in mental health admissions, with 15% of admissions arising from 7.4% of Luton’s population. This is in line with national findings.

![Figure 46. Number of adult inpatient admissions, April – December 2010.](image)

In an audit of the caseloads of four community mental health teams in Luton, it was found that areas with high indices of deprivation, and a large ethnic minority and migrant population had higher rates of psychosis.

In Luton there is unmet need and gaps in service provision, or example:

- insufficient capacity for the talking therapy service to reach 14 day referral to treatment target; and
- limited access to specialist secondary care services such as the complex needs team (for people with complex personality disorders) and memory assessment service (for people with suspected dementia).

The government’s new mental health strategy *No Health without Mental Health* outlines the intention to improve existing services for people with mental health conditions and tackle the wider underlying causes of mental ill health. This is the vision for improving mental health services in Luton.

**Mortality from suicide and undetermined injury**

Suicide rates are significantly higher in males compared to females for Luton and comparators, see Figure 47. Trend data shows a reduction in rates in Luton from 2002 – 2004 to 2005 – 2007, but differences are not significant.
In 2005 – 2009, there were 79 deaths among Luton residents from suicide and undetermined injury, three quarters of these (75%) were males, a third (33%) were under 35 years of age, and more than three quarters (77%) were under the age of 55 years. Of the 79 deaths, 72% were people born in the UK, 13% were born in Eastern Europe and 15% were born elsewhere.

### 6.2. Cancer screening

There are three national NHS Cancer Screening Programmes (NHSCSP) - breast cancer screening of women aged 50-70 years, cervical cancer screening for women aged 25-64 years, and, more recently, bowel cancer screening for both men and women aged 60-69 years.

Breast and cervical cancer screening has been in place for many years, and Luton achieves a screening uptake comparable with similar areas. Bowel cancer screening was introduced in 2009 and uptake for this programme is especially poor, see Table 18.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Date</th>
<th>Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Q3 2010/11</td>
<td>72.1%</td>
<td>70%</td>
</tr>
<tr>
<td>Cervical</td>
<td>2010/11</td>
<td>76.6%</td>
<td>80%</td>
</tr>
<tr>
<td>Bowel</td>
<td>Q1 2010/11</td>
<td>43.50%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Table 18. Uptake in Luton for the national cancer screening programmes.

There is evidence that BME communities have lower uptake for breast and cervical cancer screening in the UK. The main reasons for low uptake are consistently reported as being lack of knowledge and poor clinical communication. The NHSCSP has commissioned work looking at access to screening for minority communities which draws similar conclusions.

In March 2011, NHS Luton and NHS Bedfordshire conducted health equity audits for breast and cervical cancer screening. It was found that a large number of GP practices fell short of national targets for coverage for cervical screening, this was a particular problem in the younger age group (25-49 years).
6. Accessing health services

Figure 48 shows that cervical screening coverage is significantly different across all age groups, and with the highest coverage in the most affluent practices. The opposite result can be seen in the older age groups with higher coverage in the more deprived practices. Ethnicity may play a role in the coverage of the younger age groups compared to older age groups, with slightly less coverage in the Asian and Black communities.

Figure 48. Cervical screening coverage for all ages in Luton by quintiles of deprivation.

For breast cancer screening, coverage is higher in the more affluent quintiles. Mortality for breast cancer showed no association with deprivation.

Figure 49. Breast screening coverage for all ages in Luton by quintiles of deprivation.

In 2006, the NHS Bowel Cancer Screening Programme was launched, and is now fully rolled out across England. An evaluation of uptake BME communities, commissioned as part of the pilot, indicated significantly lower uptake by South Asian populations, even after adjusting for deprivation and other demographic factors.79
NHS Luton is working in partnership with health trainers in Luton to begin to address the poor uptake rates, with particular focus on raising awareness of the screening programme within local minority ethnic community groups and events. Regionally, the Mount Vernon Cancer Network is part of a national pilot to raise the awareness of bowel cancer symptoms in Luton.

Screening programmes are complex, and ensuring that eligible people are invited, screened, and, when required, referred to further testing can be challenging. The involvement of clinicians and good communication is essential for good detection, assessment and treatment outcomes.

A number of leaflets are produced by the NHSCSP to help individuals understand the screening process, what results may be received from screening, and what happens if a potential problem is detected. Because some people from minority ethnic communities may be unable to read information, even if provided in their own language, key screening leaflets have been recorded onto CD in the top six most requested languages - Arabic, Bengali, Cantonese, Polish, Punjabi and Urdu. These leaflets outline the benefits and disadvantages of screening, so that each person can decide whether to attend based on what factors are most important to them. The key information leaflets are now available in 18 languages.

### 6.3. Hospital admissions

Understanding patterns of hospital use by ethnicity is important for service planning. Using data provided by the Eastern Region Public Health Observatory for 2007/08 to 2009/10, Table 19 shows the proportion of Luton residents admitted to hospital compared to their overall proportion in the borough. It shows that the community most over represented are the Asian communities.

Nationally, in 2009/10, 88.11% of hospital records have a valid ethnic code compared to 88.13% in Luton.

<table>
<thead>
<tr>
<th>Community</th>
<th>% of population</th>
<th>% of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68.4</td>
<td>66.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Asian</td>
<td>18.9</td>
<td>24.4</td>
</tr>
<tr>
<td>Black</td>
<td>7.4</td>
<td>6.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics 2007/08 – 2009/10 provided by ERPHO, and ONS 2009 ethnic group estimates.

**Table 19.** Proportion of population and admissions by ethnic community.

Directly age-standardised admission rates are calculated for broad ethnic groups by primary cause of admission.

#### 6.3.1. Cancer

Table 20 shows that the White community is the only over-represented community for cancer admissions. This is in line with mortality rates. Figure 50 confirms this in Luton with age-standardised admission rates significantly higher in the White community compared to the Asian and Black communities. A different pattern is seen in the other comparators with higher rates in the Black and Other communities.
6. Accessing health services

<table>
<thead>
<tr>
<th>Community</th>
<th>% of population</th>
<th>% of admissions</th>
<th>% of cancer admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68.4</td>
<td>66.5</td>
<td>80.5</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Asian</td>
<td>18.9</td>
<td>24.4</td>
<td>12.5</td>
</tr>
<tr>
<td>Black</td>
<td>7.4</td>
<td>6.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.2</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.7</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics 2007/08 – 2009/10 provided by ERPHO, and ONS 2009 ethnic group estimates.

**Table 20.** Proportion of population and cancer admissions by ethnic community.

![Graph showing cancer admission rates in Luton and comparators, 2007/08 – 2009/10.](image)

Source: Hospital Episode Statistics data provided by ERPHO.

**Figure 50.** Cancer admission rates in Luton and comparators, 2007/08 – 2009/10.

Figure 51 shows that, for females, the highest admission rates are in the White and Black communities, both significantly higher than the admission rate for the Asian communities. For males, the admission rate for cancer in the Black communities is significantly lower than all other communities. The highest rate for males is in the Other community, which is significantly higher than all communities, and significantly higher than the rate for females.
6. Accessing health services

Figure 51. Cancer admission rates in Luton by gender and ethnicity, 2007/08 – 2009/10.

6.3.2. Coronary heart disease

Table 21 shows that the Asian communities are the most over-represented community in admissions for CHD. Figure 52 shows that the age-standardised admission rates are significantly higher in the Asian community than all other communities in Luton and comparators. This may be due to a raised prevalence of CHD in South Asian communities. The Other community in Luton is also significantly higher than the White and Black communities. This is a similar pattern across all comparators with significantly higher rates in the Asian and Other communities.

<table>
<thead>
<tr>
<th>Community</th>
<th>% of population</th>
<th>% of admissions</th>
<th>% of CHD admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68.4</td>
<td>66.5</td>
<td>68.2</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian</td>
<td>18.9</td>
<td>24.4</td>
<td>27.0</td>
</tr>
<tr>
<td>Black</td>
<td>7.4</td>
<td>6.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.2</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics 2007/08 – 2009/10 provided by ERPHO, and ONS 2009 ethnic group estimates.

Table 21. Proportion of population and CHD admissions by ethnic community.
6. Accessing health services

Figure 52. CHD admission rates in Luton and comparators, 2007/08 – 2009/10.

CHD admission rates are higher in males than females which reflect the morbidity for this disease. Asian communities have the highest admission rates for both males and females. However, the rate for males is significantly higher than females, which is also the case for the White and Other communities. The admission rates for the Black communities are similar between genders.

Figure 53. CHD admission rates in Luton by gender and ethnicity, 2007/08 – 2009/10.
6.3.3. Stroke

Table 22 shows the ethnic community most over-represented in the admissions data for stroke is the White community with 80% of all stroke admissions compared to 65.4% in the population as a whole. However, when age is taken into account and standardised across the communities in it shows the Asian community has significantly higher admissions rates for stroke than the White and Black communities in Luton, see Figure 54. This is surprising given the national increased prevalence of stroke within Black communities.

<table>
<thead>
<tr>
<th>Ethnic community</th>
<th>% of population</th>
<th>% of admissions</th>
<th>% of stroke admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68.4</td>
<td>66.5</td>
<td>80</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.2</td>
<td>*</td>
</tr>
<tr>
<td>Asian</td>
<td>18.9</td>
<td>24.4</td>
<td>16</td>
</tr>
<tr>
<td>Black</td>
<td>7.4</td>
<td>6.8</td>
<td>3.3</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.2</td>
<td>0.3</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.7</td>
<td>*</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics 2007/08 – 2009/10 provided by ERPHO, and ONS 2009 ethnic group estimates. *numbers less than 6

Table 22. Proportion of population and stroke admissions by ethnic community.

Source: Hospital Episode Statistics data provided by ERPHO, ONS population estimates. Numbers too small in Other category for Luton.

Figure 54. Stroke admission rates in Luton and comparators, 2007/08 – 2009/10.

Stroke admission rates are higher in males than females for the White and Asian communities although this is significant only in the White community. Asian communities have the highest admission rates for both males and females, both significantly higher than the White community. However, the rate for males is lower in the Black communities although the difference with females is not significant.
6. Accessing health services

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Figure 55. Stroke admission rates in Luton by gender and ethnicity, 2007/08 – 2009/10.

6.3.4. Chronic obstructive pulmonary disease

Table 23 shows that, in line with mortality rates, the White community is most over-represented in admissions for COPD. Age-standardised admission rates show the White and Asian communities have significantly higher admissions rates for COPD than Black communities in Luton, this is a similar pattern for all comparators, see Figure 56.

<table>
<thead>
<tr>
<th>Community</th>
<th>% of population</th>
<th>% of admissions</th>
<th>% of COPD admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>68.4</td>
<td>66.5</td>
<td>89.2</td>
</tr>
<tr>
<td>Mixed</td>
<td>3.0</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian</td>
<td>18.9</td>
<td>24.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Black</td>
<td>7.4</td>
<td>6.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.2</td>
<td>0.3</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>1.3</td>
<td>0.7</td>
<td>*</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics 2007/08 – 2009/10 provided by ERPHO, and ONS 2009 ethnic group estimates. *numbers less than 6

Table 23. Proportion of population and COPD admissions by ethnic community.
6. Accessing health services

COPD admission rates are significantly higher in males than females for the White and Asian communities. The rates are similar in the Black communities, see Figure 57.

Source: Hospital Episode Statistics data provided by ERPHO and ONS population estimates.

**Figure 56.** COPD admission rates in Luton and comparators, 2007/08 – 2009/10.

**Figure 57.** COPD admission rates in Luton by gender and ethnicity, 2007/08 – 2009/10.
Key Points

1. There are variations in admissions to secondary care by ethnicity, however in some cases these appear to be related to the prevalence of those conditions in the different communities.

2. National evidence indicates that service use for mental health conditions varies by ethnic community. Data for mental health locally is sparse, and a needs assessment is required to determine whether services are meeting local need.

3. Care is required in communicating to all communities appropriately around screening, with particular attention required for bowel cancer screening.

4. South Asian communities are over-represented in local hospital admissions.

5. The White community is over-represented in cancer admissions which may be related to higher prevalence for some forms of cancer.

6. Asian men have a higher admission rate for CHD and stroke. CHD rates may be in line with prevalence, but stroke appears higher than expected and justifies some attention.

7. Admission rates for stroke appear lower than expected for Black communities, given the national high prevalence, but appear to be in line with local mortality rates.

8. The White community has the highest admission rates for COPD which is likely to relate to smoking.

9. In the Asian communities, many more men are admitted for COPD than women. This is likely to be related to smoking. Therefore smoking requires specific attention in these communities.
7. Engaging communities

7.1. The importance of local engagement

Public health is everyone’s business and as such it is vital that public health professionals engage with the communities they serve. Many of the factors affecting health and wellbeing are due to societal and community factors. These include the physical environment, social inclusion, access to services and employment experiences. Therefore, interventions to promote improved health and wellbeing are often best delivered at a local level, and involvement with the local community at every stage of planning, implementation, monitoring and evaluation can be pivotal to the success of the intervention.

The level of engagement and scale of intervention must be appropriate to the scale of the problem. BME communities and marginalised groups, such as the homeless, refuges and asylum seekers, and gypsies and travellers, often require a greater effort to achieve an appropriate level of engagement. This may be due to language and cultural barriers, or to perceived barriers in accessing services, such as cost or eligibility.

The Marmot Review, commissioned in 2008, carried out an independent review of the most effective strategies for reducing health inequalities in England post-2010. This review has had a large influence on the Public Health White Paper and it concluded with six policy objectives, the fifth of which is “create and develop healthy and sustainable communities.” It is recommended that there is a need to remove barriers to community participation and action, and a need to reduce social isolation. This is to be achieved through several suggested mechanisms, including “increased opportunities for participation and community activity among local residents” and “reduction in social isolation of elderly/deprived communities.”

In November 2010, a Community Engagement Steering Group was developed, led by Luton Community Services and with partners from Luton Borough Council, NHS Luton and several voluntary sector groups representing different faiths, cultural and ethnic backgrounds. The purpose of this group is to create a forum to share experience, expertise, knowledge and skills to plan for, and provide service that truly reflect, the diverse needs of the communities in Luton. Many opportunities exist and have been created to allow for better engagement, such as the links with the local authority’s Neighbourhood Governance programme which places decisions on priority issues in the hands of local communities through a democratic voting process. Also, over the last year, health needs assessments have been conducted with marginalised groups. We now have a clearer understanding of the health, and wider issues affecting health such as housing and transport, of some of our most vulnerable groups within our local community.

7.1.1. Health Trainers initiative

The National Health Trainer Programme was launched in 2005, and seeks to bring individuals into more effective contact with mainstream health improvement. The Health Trainer Programme focuses attention on individuals from the five MSOAs with the lowest life expectancy. Since the launch of the programme in 2009, health trainers have engaged with a wide ethnic mix of clients, see Figure 58.
Health trainers were recruited from the five targeted MSOAs, and reflect the ethnic and gender mix of these areas. They have an age range of 26-50 years and speak seven community languages.

The evaluation of the Health Trainer Programme showed that health trainers can work in a wide range of settings, and with different clients. A good example is the smoking cessation work carried out in the mosques during Ramadan. A health trainer was visible and available to offer support during a time in the religious calendar when practising Muslim refrain from ‘everyday evils’ and try to purify themselves through self-restraint and good deeds. Promoting the Stop Smoking Service during this period was successful in attracting Muslim men after prayers. This was possible because the health trainer was known in that community and had previously worked closely with the Imams from the mosques to explain the benefits of giving up smoking. Health trainers have delivered information and awareness sessions to women’s groups, including Ghar-se-Ghar and Shanitona about healthy eating and Healthy Heart, which has been approved by the British Heart Foundation.

7.1.2. Promoting health and wellbeing in the community

Health and wellbeing are influenced by many factors, including the wider determinants outside the influence of health care. We need to harness the potential of the wider public health workforce by developing their knowledge and skills through a programme of ongoing capability training. This will require staff training, education and social marketing in the community.

The Public Health Capacity Building Programme contributes to the development of the wider public health workforce to promote health and wellbeing and addresses health inequalities. This workforce is located in various settings not confined to the NHS. Much work goes on in other public sector organisations, voluntary and community sectors, and private organisations such as care homes and businesses. Our participants are drawn from all these sectors.

Promoting health and wellbeing and enabling individuals to adopt healthy lifestyles is central to the work of a wide variety of practitioners. This work ranges from engaging individuals about their own health, to working with communities to identify their needs and developing activities to address them.
7.2. Community groups providing health services

There are many community-based voluntary organisations that provide health services to BME and migrant groups. The following are examples of some of the organisations with which NHS Luton currently works.

Centre for All Families Positive Health

Is peer-led and all efforts are made to involve people living with HIV/AIDS in the development and improvement of services at all levels. Due to increasing numbers of HIV/AIDS infections in Bedfordshire and surrounding areas, and the lack of a peer-led organisation, the need arose to set up a centre to provide peer support for families affected by HIV/AIDS that is culturally sensitive, respectful and empathetic.

Embrace Life

Embrace Life, provides support to people living with HIV. However, other people affected by HIV are also welcome to access preferred services. Embrace Life services include but are not limited to sex and relationships support, home and hospital visits, HIV information and support groups, welfare benefits advice, complementary therapies.

NOAH Enterprise

The Noah (New Opportunities And Horizons) Enterprise provides services to homeless people in Luton, many of whom are from BME communities. They take a holistic approach to homelessness and exclusion, and, no matter which service a person first accesses, they are encouraged to make use of as many services provide by the enterprise as necessary to enable them to reach their potential. Noah provides support around healthcare, counselling and drug and alcohol support. They also run a social enterprise, which gives their clients the opportunity to gain work experience and provides skills to increase their employability.

Centre for Youth and Community Development

Through a dedicated and professional system of youth and community development work, the organisation seeks to improve the quality of life of the community, alleviate poverty and promote good health through the provision of education and training, including social education programmes, advocacy, advice, information, outreach and centre-based activities, and liaison with other similar service providers.

Nyabingi

Nyabingi is a charitable organisation started as one of the Ashanti Groups with the main emphasis to undertake work with members from the African and Caribbean communities who are experiencing mental health issues and prepare them for independence.

The major focus of Nyabingi is group work, developing service users as leaders and developing the learning of social work students. Nyabingi is a community organisation that supports service users as a collective. For Nyabingi it is important to keep the distinction between activities provided by themselves and those provided by Social Services.

Asian Drug Information Befriending Outreach Programme

This service caters for the need of all local communities, by raising drug and alcohol awareness in a culturally sensitive manner. Services offered include
7. Engaging communities

- family support - information, support and understanding drug related issues, home visits, staff who speak English, Urdu, Phari and Bengali;
- signposting and referrals - where there is a need other organisations will be involved, for example, drug treatment, housing, and employment;
- school work - PSHE drug education in classrooms, targeted focus groups; and
- community based work - raising drugs awareness and cultural issues in mosques, community centres and groups, youth clubs through workshops and stalls.

7.2.1. Advice services

Factors such as housing, employment, welfare rights, immigration and education all have a disproportionate affect on BME communities. The following services can be accessed to provide support with these issues.

Race Advisory Forum

Luton Borough Council has a Race Advisory Forum, which is a vehicle for the Council to consult with BME communities in devising policies and services relevant to their needs. The forum currently has about 35 voluntary organisations and/or individual members who meet six times a year. Members come from diverse backgrounds but they all have one thing in common, they care about race equality.

MyUKinfo

www.myUKinfo.com is a website for migrant workers, which provides information on a range of issues, such as housing, finance, UK life and health. The health area has recently been personalised for each area and migrant workers in Luton can now access this site and find information that is locally relevant for them.

Key Points

1. Given the gap in life expectancy for women and that many women in Luton are not economically active, it is important to develop mechanisms to engage with women.

2. The community must be engaged in all processes of health and wellbeing interventions.

3. BME communities and marginalised groups often require a greater effort to achieve an appropriate level of engagement.

4. We must harness the potential of the wider public health workforce by developing their knowledge and skills through a programme of ongoing capability training.
8. Conclusions and recommendations

8.1. Conclusions

The focus of this report is on the health of BME communities.

8.1.1. Demography

With approximately a third of its population coming from a BME community, and almost two-thirds of school age children coming from a non-white ethnic group, Luton has one of the most ethnically diverse populations outside of London.

The borough’s population appears to be higher than official estimates indicate. This may be a result of Luton being a ‘hub’ for new migrants, particularly those from South Asia and Eastern Europe.

Luton’s population is also relatively deprived and has a greater proportion of people living in deprivation when compared to the East of England and England.

8.1.2. Information on ethnicity

Ethnicity data is not routinely collected in relation to health and health service utilisation. Wherever possible data has been acquired on ethnicity, but there will inevitably be some inconsistencies and caveats that need to be taken into account when drawing conclusions. Without clear and unambiguous information it will be difficult to truly understand the needs of our population.

8.1.3. Ethnicity, deprivation and health

The relationship between ethnicity and deprivation is often difficult to disentangle. For example, poor health is often linked to educational attainment and economic participation. These, in turn, are linked to deprivation. Similarly, BME communities tend to have higher rates of unemployment than the population as a whole.

In some cases, BME communities have worse health compared to the overall population and evidence indicates that the generally poorer socio-economic position may be key in driving ethnic health inequalities.

There are of course exceptions, for example, BME communities are generally at lower risk of developing cancer that White communities. However, South Asian communities have significantly higher rates of CHD mortality and diabetes prevalence when compared to the general population. Luton also continues to experience higher rates of HIV and TB prevalence, particularly in the Black African community.

A key example is the fact that the burden of CVD is not evenly spread within the population. Several sectors of society have a higher incidence of CVD, such as high heart attack incidence among South Asians and stroke mortality rates being twice as high in African Caribbeans compared to the overall population. However, socio-economically deprived populations also experience higher rates of both heart attack and stroke and differences in the incidence of CVD are largely related to the social distribution of CVD risk factors. Health inequalities based on differential incidence of CVD events are therefore related to both ethnicity and social deprivation. As such, and as deprivation and ethnicity are often so closely linked, it may be difficult to assign the causes of disease to a single causal factor.
8.1.4. Migration

Although data on migration status is largely incomplete and inadequate we know that migrants generally experience worse health outcomes and poorer access to health services than the general population. Their health may be affected by a combination of factors – pre-existing health conditions, a sense of alienation or loss, poverty and homelessness.

8.1.5. Establishing a healthy start

Experiences in early childhood are crucial to health outcomes in later life. Prenatal and antenatal care is an important first step in the process of ensuring a healthy start. However, some BME groups are more likely to present late for antenatal care.

The Pakistani community also experiences higher rates of congenital abnormalities than average. Improved rates of screening and improved awareness will help counteract this.

There is also a strong link between deprivation and poor child health, for example, poor dental health and the number of children attending for dental checkups.

8.1.6. Improving adult lifestyles

Lifestyle risk factors are a major determinant of health. Their relationship to ethnicity, and deprivation, is not always straightforward. Examples include Asian communities having the highest proportion of ‘non-drinkers’, the very high proportion of Bangladeshi men who smoke, the lower proportion of 11-15-year-olds in the BME communities who smoke, Black mothers are more likely to breastfeed than the White British community and a higher proportion of Black African girls are overweight or obese.

Alcohol misuse is damaging to the health of both the individual and to society as a whole. Smoking is the biggest single cause of preventable death. Participation in regular physical activity can help to prevent and treat many LTC, but too few people in Luton take enough physical activity. Deprivation also has far-reaching effects on overall health. Understanding the prevalence and distribution of lifestyle risk factors for chronic diseases, particularly smoking, diet and physical activity, continues to be a challenge in Luton, as it is across the country. Prevention of these risk factors will be of key importance in reducing premature mortality from a range of diseases in the medium to longer term.

8.1.7. Accessing health services

It is essential that services to promote and sustain health and well-being meet the needs of Luton’s diverse communities equally.

Data limitations often make it difficult to assess how services are being used by BME communities. For example there are limited data around mental health services.

There is evidence to suggest that some BME communities have higher health needs than others but that they do not always access the services they need. An example is provided by BME access to mental health and drug and alcohol treatment services. Similarly, screening for breast and cervical cancers reduces mortality but women from some communities are less likely to use such services. Cultural sensitivities may act as barriers.
8.1.8. Engaging communities

Improving health and wellbeing cannot be achieved by the NHS alone. Effective action requires a partnership approach involving all organisations with a role in community engagement and service provision. Most importantly, communities themselves need to be empowered to define their own needs and to develop community-based approaches to meeting these needs with the support of statutory agencies.

8.2. Recommendations

Specific key points and recommendations are made at the end of each chapter. The recommendations below are overarching recommendations to tackle some of the issues identified in this report. My key recommendations are highlighted in **bold**.

8.2.1. Improving access to services

- Improve the identification of long term conditions prevalent in BME communities in primary care to ensure earlier and better treatment.

- Ensure that all children have the healthy start they need to build the foundations for a healthy adulthood. The Children’s Trust Board are asked to take the findings of this report into account in the implementation of the Early Intervention Strategy, and Family Poverty Strategy.

- Certain communities appear to be under-represented in drug and alcohol services, ensure that these services are appropriate to meet the needs of all of our communities.

- Ensure that commissioners reduce inequalities in health through the contracting process and engage positively with all service providers to improve the patient’s experience.

- More work is needed to understand the extent of unmet need and the potential barriers to accessing services, and to ensure that services are accessible to everyone.

8.2.2. Engaging with local communities and empowering people to improve their own health

- Given the gap in life expectancy for women and that many women in Luton are not economically active, it is important to develop mechanisms to engage with women from all communities.

- Prioritise engagement with local communities to address issues around consanguinity, infant mortality and disability.

- Continue to prioritise programmes on childhood obesity and tobacco control. By engaging with our local communities develop effective communications strategies and social marketing techniques to target high prevalence communities appropriately.

- The move of Public Health to local authority may facilitate this further but more will still need to be done over the coming years to develop our approach.

- Develop information sources that are relevant to our different communities in order to encourage positive lifestyle and behaviour change.
8.2.3. Tackling the wider determinants of health and socio-economic factors

- Programmes of regeneration, employment and skills training should ensure that they reach and raise the life chances of all of our communities.

8.2.4. Improving understanding

- National evidence indicates that service use for mental health conditions varies by ethnic community. Data for mental health locally is sparse, and a needs assessment is required to determine whether commissioned service meet the needs of Luton’s population.

- We must understand potential language and cultural barriers that may prevent people accessing services. It is important to have a culturally competent workforce with the necessary skills to match the needs of our diverse population.

- Data collection and analysis on health, ethnicity and migration need to be improved so that we can better understand the extent of unmet need and how best to respond to this.
This section contains explanations and definitions of terms used in this report.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Cardiovascular disease or heart disease</strong></td>
<td>Diseases that involve the heart or blood vessels.</td>
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<tr>
<td><strong>Confidence interval</strong></td>
<td>An interval which contains the unknown value of a population parameter with a specified probability called the confidence level, and conventionally taken to be 95%.</td>
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<tr>
<td><strong>Directly age-standardised mortality rate</strong></td>
<td>This is calculated by dividing the number of deaths by the actual local population in a particular age group multiplied by the standard population for that particular age group and summing across the relevant age groups. The rate is usually expressed per 100,000. See <a href="http://www.lho.org.uk/LHO_Topics/Data/Methodology_and_Sources/AgeStandardisedRates.aspx">http://www.lho.org.uk/LHO_Topics/Data/Methodology_and_Sources/AgeStandardisedRates.aspx</a></td>
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<tr>
<td><strong>Ethnicity</strong></td>
<td>A quality or affiliation arising from race or culture.</td>
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<tr>
<td><strong>Index of Multiple Deprivation</strong></td>
<td>Index of the level of deprivation in an area taking into account income, employment status, health and disability, housing, education and training opportunities, and access to services.</td>
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<tr>
<td><strong>Life expectancy</strong></td>
<td>Average lifespan from birth to death. Life expectancy is used as a summary indicator of the health status of an area.</td>
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<tr>
<td><strong>Lower Layer Super Output Area and Middle Layer Super Output Area</strong></td>
<td>More about ONS geographical boundaries is available at <a href="http://www.statistics.gov.uk/geography/ons_geog.asp">http://www.statistics.gov.uk/geography/ons_geog.asp</a></td>
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<tr>
<td><strong>Prevalence</strong></td>
<td>The proportion of a group of people who have a specified disease or outcome at a given point in time.</td>
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<tr>
<td><strong>Quintiles</strong></td>
<td>Points that divide a distribution of a characteristic of interest into fifths. The first quartile represents the lowest fifth of the data (1-20%); the second quartile represents the second fifth (21% - 40%) etc.</td>
</tr>
<tr>
<td><strong>Ward</strong></td>
<td>Electoral wards/divisions are the base unit of UK administrative geography such that all higher units are built up from them. They are also used as a base unit for other geographies such as parliamentary constituencies and Primary Care Trusts. Electoral wards are found across Scotland, Northern Ireland and most of England, whereas the equivalents in Wales and the Isle of Wight are known as electoral divisions.</td>
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</table>
All internet web addresses were accessed on 28th June 2011.


10. References


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10. References


