Annual Public Health Report
The wider social determinants of health
Luton Borough Council
Director of Public Health

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It has long been acknowledged that the inequalities we see in health are influenced by a range of issues beyond health services and individual lifestyle choices. The Black Report (1980) states:

“While health care services can play a significant part in reducing inequalities in health, measures to reduce differences in material standards of living at work, in the home and in everyday social and community life are of even greater importance.”

More recently Marmot noted:

“Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.”

Many authors comment that it is not only absolute inequality, but relative inequality that causes the disparity in health we see in an affluent country such as the UK. This can also help to explain the inequalities we see in a small area such as Luton.

This year, my independent Annual Public Health (PH) Report therefore focuses on these wider social issues, known as the wider determinants of health. This report forms the fourth in a series looking at inequalities in Luton. Recent reports have looked in detail at the inequalities in health faced by Black and minority ethnic communities and women, and it is pleasing to see the inequalities gap for women in Luton has started to reduce.

Focusing on the wider determinants of health is ambitious and I acknowledge it is impossible to do justice to all the issues which impact on health, such as social inclusion, sustainability and the environment. There is more to do in looking in detail at these issues. We would hope to work in collaboration with Public Health England around sustainability. However, with the move of Public Health (PH) into local government and Luton Borough Council’s new responsibility to improve the health of the population, I feel this report is timely. Luton Borough Council, working with partners, can influence many of the wider determinants of health. Part of Council’s responsibility in improving health is to take health into account in all decision making. The use of an integrated impact assessment supports this, but there is more to do in making sure this makes a real difference.

We cannot remove health inequalities in Luton if we do not make a sustained effort to tackle these issues working across the borough and population as a whole, but also making a focused effort where inequalities are most stark. There is a great deal of good work underway to tackle these issues, as shown in the case studies I have included. The new Wellness Service, Live Well Luton, brings together a number of health improvement services and seeks to focus on both health risks and wider determinants by linking with services such as benefit services. However, there is much to do to tackle these wider issues. To that end, the Council will be
setting aside some of the PH grant, a Public Health Fund, to support work to tackle these issues and identifying how all departments can help to achieve PH outcomes. I therefore make a number of recommendations in the report, the most significant being:

• refresh the Health Inequalities Strategy with a specific focus on the wider determinants of health
• develop and support initiatives to ensure Luton residents in work have a sufficient income to fund a healthy lifestyle
• prioritise early years by increasing support for families to achieve improvements in early child development, and continue to improve the quality of pre-school education to ensure a healthy start in life
• increase awareness of mental health issues in the workplace to reduce stigma and discrimination through Mental Health First Aid (MHFA) training
• continue to support people into employment through skills and employability programmes with a particular focus on people with mental health issues and disabilities
• update the Housing Conditions Survey in 2014 in partnership with the Building Research Establishment to identify where areas of housing improvements should take place and potential cost savings
• ensure strategies to tackle community safety issues such as violence and sexual exploitation incorporate evidence-based, preventative interventions.

I have made every effort to ensure this report is as complete and accurate as possible and any omissions or inaccuracies are mine.

Gerry Taylor
Director of Public Health
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Introduction and context

1.1. Introduction

The purpose of the Director of Public Health’s Annual Public Health Report (APHR) is to give an overview of issues that influence the health of the local population. This year’s report focuses on the wider, social determinants of health. The World Health Organisation (WHO) describes the social determinants of health as:

“The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between people [countries]."  

There are multiple causes of ill-health; some we cannot change such as our genetic inheritance, but many are modifiable (Figure 1). It is well known that lifestyle factors such as smoking, exercise and diet can affect our health. However, there are other factors, referred to as the wider determinants of health, which are also influential. These include the circumstances in which we are born, grow, live and work. These factors combine to have a positive or negative impact on health and help to explain differences in health and life expectancy between the poorest and richest in society.

Figure 1 Determinants of health.

This report examines the impact of the key determinants of health such as housing, education and employment on health. It reviews what is currently in place and presents case studies to demonstrate where progress has been made as well as identifying areas where greater focus is needed.
1.2. Different timescales for interventions

Given that the wider determinants of health are the underlying causes of inequalities, it is important to understand the timescales a project or intervention will need in order to make a visible difference. The National Support Team for Inequalities in Health developed a model which demonstrated that interventions to modify the social determinants of health could take up to fifteen years to have their full impact (Figure 2).

Figure 2 Different gestation times for interventions on tackling health inequalities.

1.3. National drivers

1.3.1. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010

The Marmot Review into health inequalities, Fair Society, Healthy Lives, gives a comprehensive overview of the effect the social determinants of health have on ill-health and mortality in Britain. This review, commissioned by the Government in 2008, highlights that health inequalities are not inevitable and can be significantly reduced. They stem from avoidable inequalities in society such as income, education, employment and neighbourhood circumstances. We know from evidence that disadvantage starts before birth, accumulates throughout life and can be generational.

The review proposes action should be taken to reduce inequalities throughout peoples’ lives and identifies six key policy objectives (see below). Of these six, giving every child the best start in life is paramount, in line with evidence that suggests that the first three years of life are critical in determining a child’s life chances.

The six policy objectives to reduce health inequalities are:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
• ensure a healthy standard of living for all
• create and develop healthy and sustainable places and communities
• strengthen the role and impact of ill health prevention.

These policy objectives are reflected in the priorities in Luton’s prospectus as well as those in the Health and Wellbeing Strategy.

Marmot has highlighted the significant role for local authorities working with the NHS and other partners in improving health and in particular tackling ‘the causes of the causes’ of health inequalities. A study in America\(^5\) has suggested that socioeconomic factors have the largest impact on health accounting for 40 per cent of all influences – far greater than the impact of clinical care and health behaviours. The majority of local government services influence the conditions in which people live, work and grow and therefore impact on the health of their residents.

1.3.2. Health and Social Care Act 2012 and the role of local authorities

Building on the Marmot review, the 2012 Health and Social Care Act transferred the responsibility for public health to local authorities from April 2013 and gave them a duty to improve the health of their population. The transfer of responsibilities recognises the unique position of local authorities for driving the strategic direction and delivery of services which address the social determinants of health (such as education, environment, employment and housing). Most council functions contribute to improving population health and wellbeing (Figure 3).

Figure 3 Public Health Outcome Framework indicators.

1.4. Local drivers

1.4.1. Luton Borough Council Prospectus 2013-16\(^6\)

Luton Borough Council’s Prospectus has set the direction for the authority to 2016. The prospectus, based on a three point plan, highlights the link between health and some of the key wider determinants. It is based on the premise that more businesses will create more jobs; investment in education and training will help local people to get those jobs and this will increase their resilience, improve their health and reduce their need for public services.
The three key themes in the prospectus are:

- business and growth
- education and lifelong learning
- safe, supported and healthy.


Luton’s first health and wellbeing strategy (HWBS) focusses on three outcome areas:

- every child and young person has a healthy start in life
- a reduced gap in health inequalities within Luton Borough Council
- healthier and more independent adults and older people.

The overall success of the strategy is measured through improvements in:

- life expectancy
- disability free life expectancy
- infant mortality.

A key commissioning priority for outcome 2 is to strengthen integrated working across the wider determinants of health with a particular focus on improving housing conditions, supporting more people into employment, and developing a sustainable planning policy which promotes a healthy environment.

1.4.3. Luton’s Family Poverty Strategy 2011-2014

Family poverty can have life-long negative impacts on physical health, educational outcomes, employment status and the family’s mental health and wellbeing. The 2010 Child Poverty Needs Assessment for Luton highlighted the following as the drivers of child poverty in Luton which includes some of the key wider determinants of health:

- benefit dependency
- poor educational attainment
- low skills
- lack of certain types of childcare
- poor public transport
- limited job availability
- high financial exclusion
- growing personal debt
- poor health
- poor housing in some areas
- high levels of crime in some areas.
Luton’s Family Poverty strategy builds on the Child Poverty Needs Assessment and sets out six priorities for action.

1. Build a clearer understanding of the needs of children and families in poverty to help plan effective services.
2. Improve communication about family poverty.
3. Ensure strategic commissioning decisions are informed by, and deliver positive outcomes for, families in poverty.
4. Maximising income for families in poverty.
5. Improving adult skills and access to better employment opportunities.
6. Improving the health and wellbeing and life chances for children, young people and families living in poverty.

With the changing landscape brought about by the national Welfare Reform programme, many areas of the Luton Family Poverty Strategy now fit more closely under the recently formed Welfare Reform Group. Council departments working alongside other public sector organisations and independent and third sector providers ensures a holistic approach, not just to the impact of welfare reform but also the wider implication of poverty and health inequality.

The Welfare Reform Act 2012 became law on 8 March 2012. The Act introduced a wide range of reforms to the benefits and tax credits system. The introduction of the Benefit Cap and the Social Rent Size criteria (’bedroom tax’) has directly affected the amount of housing benefit received. In total, as a result of these two key changes, there is a loss of just over £1.7 million a year to people eligible for housing benefit in Luton. Reforms are having the greatest impact on poorer households and on families with children. Evidence suggests the welfare reforms, together with the economic downturn, are likely to have health impacts including an increase in mental health problems such as depression and an increase in suicide and attempted suicide. Possible longer-term impacts include increased cardiovascular mortality.

Unemployment, debt, poor housing and low productivity are a big cause of poor mental health – and they can also themselves be caused by poor mental health. In times of recession, this vicious circle is even more pronounced and particularly hardest hit are the poor, the very people who experience higher rates of common mental disorders in the first place.

Local actions to address the issues of family poverty and reduce the impact of the welfare reform programme include:

- setting up the Luton Foodbank
- Luton Advice Network providing outreach support for clients accessing the Foodbank
- Social Prescribing Pilot in South Luton GP practice providing independent free and confidential advice around welfare benefits, debt, money management and legal matters
- targeted work in Children’s Centres with families of children under five who are living on a low incomes. This includes Let’s Talk about Money budget course for parents and close work with Job Centre Plus and Adult Education providers
- additional targeted support to families with complex needs through the Stronger Families programme.
- work to increase the uptake in Free Schools Meals (FSM) resulting in approximately 2000 extra children receiving FSM since April 2012. This has led to a saving for parents of £360 per year per child.
The Council has been working in partnership to provide additional support for those affected by Welfare Reform. The partnership working is not exclusive to, but includes the following agencies:

- Luton Advice Network
- Job Centre Plus
- Money Advice
- Local Housing Associations.

Two multi agency open days have been held where households affected by the impact of Welfare Reform were invited to attend and receive the advice on:

- skills and training
- money management support and advice
- debt management
- housing advice.

Case study: Supporting people affected by Welfare Reforms

Over 60 households have benefitted from the advice and support received from the partnership. The Council’s housing service has also been proactively identifying those currently affected by the cap or under occupying, and supported them on to the housing transfer list. By the end of August 2013, over 120 tenants had agreed to downsize their accommodation and are currently on the transfer list awaiting suitable properties. While every effort has been made to ensure those affected are supported, overall rent arrears have increased in Luton by £180,000 to £696,534 as at 14 April 2014.

A single parent household was supported when set to lose considerable financial support because of the benefit cap. The parent worked with the Job Centre and Council officers, and from this support she was able to find work and is no longer subject to the cap. This has allowed her to remain in her home and to work for the first time in a number of years.

1.5. Mental wellbeing

The Government strategy No health without mental health\(^1\) aims to enable more people of all ages and backgrounds to have better wellbeing and good mental health and for fewer people to develop mental health problems by starting well, developing well, working well, living well and ageing well.

Luton’s adult mental health needs assessment (MHNA) highlights a range of factors which contribute to the development of mental health problems including poverty, deprivation, unemployment and ethnicity. The recent recession may have a further negative impact on mental health.

The move of Public Health into Luton Borough Council provides opportunities for a greater whole system approach to mental health promotion to influence the determinants of mental health, for example in the areas of housing, environment, education, work, welfare and community engagement.
However, the key to a public mental health approach is the fact that responsibility for promoting mental health and wellbeing does not lie with any one individual, organisation or sector. Everybody who lives or works in Luton has a role to play in improving the town’s mental health and wellbeing by challenging the determinants that can lead to poor mental health and developing resilience to them.

1.5.1. Improving mental health in Luton

Four main areas have been prioritised for improvement based on the available evidence:

1. Improving working lives
   - Improving mental health awareness and prevention at work – Mental Health First Aid (MHFA) training
   - Training workplace health champions
   - Increasing employability of the unemployed - through volunteering for example.

2. Positive steps for mental health
   - Social prescribing through primary care and health checks, such as stop smoking service, exercise on prescription, books on prescription, computerised therapy, voluntary work and weight management classes
   - Capacity building, such as Making Every Contact Count (MECC) – brief intervention training for professionals working on the wider determinants of health
   - Awareness raising and reducing stigma and discrimination in the general public about mental health, such as MHFA, Health Champions, World Mental Health Day and promoting the Five Ways to Wellbeing.

3. Black and Minority Ethnic Communities
   - Increasing access to mental health promotion opportunities, such as social prescribing, primary care and psychological therapies
   - Developing a health champion programme through faith organisations
   - Developing culturally appropriate resources.

4. Later life – healthy later years
   - Improving opportunities for social involvement, such as volunteering
   - Healthy lifestyle support, such as physical activity, smoking cessation, healthy eating/weight management, sensible drinking and stress reduction
   - Supporting communities and environmental improvements.

The following sections will continue to highlight the important link between mental health and the social conditions in which people are born, grow, live, work and age.
Case study: Mental health first aid training for Luton

Public Health in conjunction with MIND is rolling out a programme of Mental Health First Aid (MHFA) courses within Luton. MHFA is part of a national training programme which aims to increase awareness and reduce stigma and discrimination around common mental health issues. Short courses are proving to be very popular within businesses and internally with Council staff as part of the workplace health programme. Along with the two day adult MHFA course, there is great demand for the two day Youth MHFA course which is designed for people who work with or care for young people between the ages of 11 and 18.

This is particularly encouraging because the majority of enduring mental health problems start in adolescence and the sooner a young person can be identified and given support, the better the outcome for that individual. These courses are proven to be effective and are an excellent way to support people in the community and workplace with mental health issues, as well as the participants themselves becoming more aware of their own mental wellbeing and increasing their personal resilience.

1.6. Recommendations

**Health Inequalities Strategy**

- Refresh the Health Inequalities Strategy with a specific focus on the wider determinants of health.

**Family Poverty/Welfare Reform**

- Develop and support initiatives to ensure Luton residents who are in work have a sufficient income to fund a healthy lifestyle.
- Model the impacts of welfare reform on health and mental wellbeing and identify actions to mitigate negative impacts.
- Ensure all front line staff have the knowledge and skills to signpost individuals to the help and support available, based on the Making Every Contact Count principle.
- Ensure that advice, support and advocacy are joined up and there is consistency in the advice given. This will prevent the duplication of support, allow case management of the individual/household and ensure a positive outcome for all concerned.

**Mental Health**

- Ensure mental health providers support people with mental health problems into employment or volunteering.
- Increase awareness of mental health issues in the workplace to reduce stigma and discrimination through MHFA training.
Public health outcomes in Luton

2.1. Introduction

"Fair Society, Healthy Lives" focuses on the ‘causes of the causes’ of health inequalities. Consideration of wider social, political, economic and environmental contexts are vital in helping address inequalities in health and wellbeing. This section considers the data available that describe the health and wellbeing inequalities seen in Luton. These are drawn from the Public Health Outcomes Framework (PHOF). This new framework of indicators concentrates on two high-level outcomes to be achieved across the public health system:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities.

The outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Using a measure of both life expectancy and healthy life expectancy enables the use of the most reliable information available to understand the nature of health inequalities both within Luton and between Luton and other areas.

2.2. Life expectancy

Life expectancy at birth in Luton is 78 years for males and 82.1 years for females. This is an increase on the previous year (77.9 years and 81.9 years respectively) and is one year below that of England (79.2 years and 83 years respectively).

Male life expectancy in Luton is ranked at 276 and female life expectancy at 275 out of 346 local areas. The ranking has improved from the previous year’s rank for females (276) but has worsened for males (263).

Life expectancy for males and females in Luton is similar to our statistical neighbours (Figure 4).

**Figure 4 Life expectancy at birth 2010-12.**

Source: ONS life expectancy data and Luton Public Health
Male life expectancy in the most deprived areas has remained the same as the previous year. Therefore the relative inequality with the rest of Luton has increased with a continued increase in life expectancy in the rest of Luton (Figure 5).

**Figure 5 Male life expectancy comparison between most deprived areas in Luton and the rest of Luton.**

For females, life expectancy in the most deprived areas has increased. Therefore the relative inequality with the rest of Luton has decreased (narrowing of the gap) due to the life expectancy in rest of Luton remaining the same as the previous year (Figure 6).

**Figure 6 Female life expectancy comparison between most deprived areas in Luton and the rest of Luton.**
2.3. Healthy life expectancy

Healthy life expectancy (HLE) is the average number of years a person can expect to live in full health by taking into account years lived in less than full health due to disease and/or injury. The most recent data (Figure 7 and Figure 8) shows significantly lower figures than the national average for both males and females. Male HLE is ranked 108 and female HLE is ranked 122 out of 150 areas with 1 the highest HLE in England. HLE in Luton is similar to comparator areas for both males and females.

Overall, the outcomes for Luton and our statistical neighbours tend to reflect deprivation. Hillingdon and Slough have lower levels of deprivation and tend to have better outcomes, whereas Birmingham and Wolverhampton are more deprived and tend to have poorer outcomes (Table 1).

Figure 7 Male healthy life expectancy, 2009-11.

![Figure 7 Male healthy life expectancy, 2009-11.](image)

Source: ONS and Luton Public Health

Figure 8 Female healthy life expectancy, 2009-11.

![Figure 8 Female healthy life expectancy, 2009-11.](image)

Source: ONS and Luton Public Health
2.4. Deprivation and life expectancy

The Slope Index is a modelled estimate of the range in life expectancy at birth across the whole of Luton from the most to least deprived areas. Based on mortality rates from 2006-10 this range is 8.9 years for males and 6.4 years for females (Figure 9). Overall, the gap has reduced by one year for both males and females since 2001-05 (Figure 10).

**Figure 9 Slope Index of Inequality – number of years between the most and least deprived individuals.**

<table>
<thead>
<tr>
<th>Local authority</th>
<th>IMD rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>69</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>138</td>
</tr>
<tr>
<td>Slough</td>
<td>93</td>
</tr>
<tr>
<td>Birmingham</td>
<td>9</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Luton Borough Council JSNA Core Dataset.

**Figure 10 Slope Index of Inequality – number of years between the most and least deprived individuals 2001-05–2006-10.**

Source: PHE and Luton Public Health
The ward data (Figure 11) shows Barnfield and Bramingham have significantly higher male life expectancy compared to Luton average and Farley, High Town and Dallow wards have significantly lower male life expectancy. Stopsley, Wigmore and Bramingham have significantly higher female life expectancy and Dallow and Leagrave have significantly lower female life expectancy compared to the Luton average (Figure 12). It should be noted that the wards with higher and lower life expectancy differ for males and females.

**Figure 11 Estimated male life expectancy by ward, 2006-10.**

Source: PHE and Luton Public Health

**Figure 12 Estimated female life expectancy by ward, 2006-10.**

Source: PHE and Luton Public Health

To make it possible to monitor progress annually, a national set of supporting indicators, the Public Health Outcomes Framework (PHOF) has been identified and these indicators have been organised into four domains (Figure 13):

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality.

The majority of indicators relevant to this annual report, which focuses on the impacts the wider determinants have on health, are contained in the first of these domains and are referred to in this section.
The Luton JSNA also contains a wealth of information on these topics and the associated core data set includes relevant comparative and trend statistics.

**Figure 13 Overview of Public Health outcomes and indicators.**

### Table 2 Wider determinants of health – indicator values.

<table>
<thead>
<tr>
<th>Domain 1: Wider determinants of health</th>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01ii. Children in poverty (under 16s)</td>
<td>2011</td>
<td>24.9</td>
<td>20.6</td>
<td>26.9</td>
<td>decrease</td>
</tr>
</tbody>
</table>

There is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults (Marmot Review, 2010). Reducing the number of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

A quarter of Luton’s children live in poverty. This is higher than England as a whole. However, compared to our statistical neighbours Luton fares better (24.9% compared with 26.9%).

The recently implemented welfare reforms may have a negative effect on the number of children living in poverty. See Section 1 for further information on family poverty in Luton.
Domain 1: Wider determinants of health

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.03. Pupil absence</td>
<td>2011/12</td>
<td>5.18</td>
<td>5.11</td>
<td>5.05</td>
</tr>
</tbody>
</table>

Improving attendance, such as tackling absenteeism, in schools is an important part of the Government’s commitment to increasing social mobility and to ensuring every child can meet their potential. Improving school attendance (reducing absence) needs all services that work with young people to talk to one another and agree local priorities.

Luton’s rate is slightly higher than England (5.11%) and our statistical neighbours (5.05%).

See Section 3 for further information on pupil absence.

1.04. First time entrants to the youth justice system

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.04. First time entrants to the youth justice system</td>
<td>2012</td>
<td>755 / 100,000</td>
<td>537 / 100,000</td>
<td>579 / 100,000</td>
<td>decrease in 2012/13</td>
</tr>
</tbody>
</table>

Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. This indicator is included to ensure that vulnerable children and young people (aged 10-17) at risk of offending are included in mainstream planning and commissioning.

Luton has a much higher rate of first time entrants to the youth justice system (755) compared to England (537) and our statistical neighbours (579). However, there has been a sustained reduction over a 5 year period. In the 12 month period up to March 2013, Luton recorded below 100 new entrants for the first time since the introduction of the national indicator measure. Some success can be attributed to the introduction of Triage Assessment between Luton Youth Offending Service, Luton Police and Community Resolutions and Diversionary Interventions.

1.05. 16-18 year olds not in education employment or training (NEET)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.05. 16-18 year olds not in education employment or training (NEET)</td>
<td>2012</td>
<td>6.0</td>
<td>5.8</td>
<td>5.7</td>
<td>Decrease</td>
</tr>
</tbody>
</table>

Young people who are not engaged in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. This indicator is included to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work.

Luton’s rate (6.0%) is slightly higher than England (5.8%) and our statistical neighbours (5.7%).

See Section 3 for further information on NEET

1.06i. Adults with a learning disability who live in stable and appropriate accommodation

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value 2011/12</th>
<th>England 2011/12</th>
<th>England 2011/12</th>
<th>England 2011/12</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.06i. Adults with a learning disability who live in stable and appropriate accommodation</td>
<td>2011/12</td>
<td>74.4</td>
<td>70.0</td>
<td>62.8</td>
<td>n/a</td>
</tr>
</tbody>
</table>

1.06ii. Adults in contact with secondary mental health services who live in stable and appropriate accommodation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.06ii. Adults in contact with secondary mental health services who live in stable and appropriate accommodation</td>
<td>2012/13</td>
<td>77.20</td>
<td>58.50</td>
<td>69.43</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Section 2

Domain 1: Wider determinants of health

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The nature of accommodation for adults with a learning disability or mental ill-health has a strong impact on their safety and overall quality of life and reducing social exclusion.

Luton performs well on both of these indicators, with a higher rate than England and our statistical neighbours.

1.08i. Gap in the employment rate between those with a long-term health condition and the overall employment rate

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>7.9</th>
<th>7.1</th>
<th>7.7</th>
<th>n/a</th>
</tr>
</thead>
</table>

1.08ii. Gap in the employment rate between those with a learning disability and the overall employment rate

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>53.6</th>
<th>63.2</th>
<th>59.7</th>
<th>n/a</th>
</tr>
</thead>
</table>

The 2006 evidence review *Is work good for your health and wellbeing* concluded that work was generally good for both physical and mental health and wellbeing. The strategy for public health takes a life course approach and this indicator provides a good indication of the impact of long-term illness on employment among those in the ‘working well’ life stage. It also provides a link to indicators in the NHS and Adult Social Care Outcomes Frameworks.

Luton performance (7.9%) is worse than England (7.1%) and our statistical neighbours for indicator 1.08i. For indicator 1.08ii Luton’s gap (53.6%) is smaller (better) than England (63.2%) and our statistical neighbours (59.7%).

1.09i. Sickness absence - The percentage of employees who had at least one day off in the previous week

<table>
<thead>
<tr>
<th></th>
<th>2009 - 11</th>
<th>2.45</th>
<th>2.23</th>
<th>2.20</th>
<th>n/a</th>
</tr>
</thead>
</table>

1.09ii. Sickness absence - The percentage of working days lost due to sickness absence

<table>
<thead>
<tr>
<th></th>
<th>2009 - 11</th>
<th>1.44</th>
<th>1.51</th>
<th>1.46</th>
<th>n/a</th>
</tr>
</thead>
</table>
Domain 1: Wider determinants of health

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The independent review of sickness absence was commissioned by government to help combat the 140 million days lost to sickness absence every year. The review provided an important analysis of the sickness absence system in the UK; of the impact of sickness absence on employers, the State and individuals; and of the factors which cause and prolong sickness. This is in line with the Government’s strategy for public health, which adopts a life-course approach and includes a focus on the working-age population in the ‘working well’ stage to help people with health conditions to stay in or return to work.

Luton performance (2.45%) is higher (worse) than our statistical neighbours (2.20%) and England (2.23%) for sickness in the previous week, but lower for the percentage of working days lost due to sickness (1.44%), statistical neighbours (1.46%) and England (1.51%).

Healthy Workplace programmes are in place to promote the health of Council employees and employees in local businesses including the promotion of Mental Health First Aid.

1.10. Killed and seriously injured casualties on England’s roads

| 2010 - 12 | 27.17 / 100,000 | 40.55 / 100,000 | 33.32 / 100,000 | same |

The indicator is an established measure used to monitor and assess improvements in road safety. Road safety has implications for the safety of communities and the long-term costs to the health and social care systems, as well as to the wider economy.

Luton performs very well (27.17/100,000) when compared to England (40.55/100,000) and our statistical neighbours (33.32/100,000).

See Section 5 for further information on road traffic accidents.

1.12i. Violent crime (including sexual violence) - hospital admissions for violence

| 2010/11 - 12/13 | 62.91 / 100,000 | 57.59 / 100,000 | 63.42 / 100,000 | increase |

1.12ii. Violent crime (including sexual violence) - violence offences

| 2012/13 | 13.30 / 100,000 | 10.61 / 100,000 | 14.00 / 100,000 | decrease |
The inclusion of these indicators enables a focus on the interventions that are effective and evidence-based including a greater focus on prevention and treatment, which need to be considered alongside criminal justice measures for a balanced response to violent crime.

- For hospital admissions for violence, Luton 62.91/100,000 is higher than the England rate (57.59/100,000) but is lower than our statistical neighbours (63.42/100,000).
- For recorded violent offences, Luton (13.30/100,000) is also higher than England (10.61/100,000), but lower than our statistical neighbours (14.00/100,000).

Violent crime is a key crime type for the soLUTiONs Community Safety Partnership. Partnership activity focuses on the neighbourhoods adjacent to the town centre (High Town, Dallow, Biscot, South not including the town centre) as well as the town centre with a focus on the night time economy. Full details can be found in the Partnership Plan: http://www.luton.gov.uk/Community_and_living/Lists/LutonDocuments/PDF/Community%20Safety/soLUTiONs/Refreshed%20Partnership%20Plan%202012-2013.pdf

### 1.13i. Re-offending levels - percentage of offenders who re-offend

<table>
<thead>
<tr>
<th>Year</th>
<th>Luton</th>
<th>England</th>
<th>Statistical Neighbours</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>24.93</td>
<td>26.89</td>
<td>27.22</td>
<td>Decrease</td>
</tr>
</tbody>
</table>

Tackling a person’s offending behaviour is often closely linked to their physical and mental health, and in particular any substance misuse issues. This outcome therefore cannot be addressed in isolation.

The rate of re-offending in Luton (24.93%) is slightly lower than that seen in England (26.89%) and our statistical neighbours (27.22%). For the average number of re-offences per offender Luton (0.75) is slightly lower than our statistical neighbours (0.79) and England (0.78).

The multi-agency Integrated Offender Management scheme is making a significant contribution to reducing the re-offending rate amongst Luton’s most prolific offenders.

### 1.13ii. Re-offending levels - average number of re-offences per offender

<table>
<thead>
<tr>
<th>Year</th>
<th>Luton</th>
<th>England</th>
<th>Statistical Neighbours</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0.75</td>
<td>0.78</td>
<td>0.79</td>
<td>Increase</td>
</tr>
</tbody>
</table>

Tackling a person’s offending behaviour is often closely linked to their physical and mental health, and in particular any substance misuse issues. This outcome therefore cannot be addressed in isolation.

The rate of re-offending in Luton (24.93%) is slightly lower than that seen in England (26.89%) and our statistical neighbours (27.22%). For the average number of re-offences per offender Luton (0.75) is slightly lower than our statistical neighbours (0.79) and England (0.78).

The multi-agency Integrated Offender Management scheme is making a significant contribution to reducing the re-offending rate amongst Luton’s most prolific offenders.

### 1.14i. The percentage of the population affected by noise - Number of complaints about noise

<table>
<thead>
<tr>
<th>Year</th>
<th>Luton</th>
<th>England</th>
<th>Statistical Neighbours</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>5.16 / 1000</td>
<td>7.51 / 1000</td>
<td>6.83 / 1000</td>
<td>Decrease</td>
</tr>
</tbody>
</table>

### 1.14ii. The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime

<table>
<thead>
<tr>
<th>Year</th>
<th>Luton</th>
<th>England</th>
<th>Statistical Neighbours</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>9.78</td>
<td>5.42</td>
<td>8.18</td>
<td>n/a</td>
</tr>
</tbody>
</table>
There are a number of direct and indirect links between exposure to noise and health outcomes such as stress and heart attacks.

Luton scores highly on noise exposure related to transport compared with our statistical neighbours and England as a whole. Luton Airport is likely to make a significant contribution to this.

In relation to the number of noise complaints Luton has a lower rate (5.16/1000) than England (7.51/1000) and our statistical neighbours (6.83/1000). It is difficult to determine why the number of complaints is relatively low. However, the figures have been consistent over the last three years. This warrants further investigation. See section 5 for specific recommendations on noise complaints.

Households that are accepted as being homeless or in temporary accommodation can have greater health needs than the population as a whole.

Luton has high rates for both homelessness indicators compared to England and our statistical neighbours.

See Section 4 for further information on homelessness.

There is strong evidence to suggest that outdoor space has a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and use.

Luton has a higher percentage use of outdoor space (16.62%) than England (15.33%) and our statistical neighbours (7.95%) but there has been a decrease in the use of space in the last year.

See Section 5 for further information on green space.
Section 2

Domain 1: Wider determinants of health

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>12.83</td>
<td>10.90</td>
<td>12.16</td>
<td>n/a</td>
</tr>
</tbody>
</table>

There is evidence that the drivers of fuel poverty (low income, poor energy efficiency and energy prices) are strongly linked to living at low temperatures and a range of negative health outcomes.

Luton has a greater percentage of households (12.83%) classified as living in fuel poverty than England (10.90%) and our statistical neighbours (12.16%).

See Section 4 for further information on fuel poverty.

<table>
<thead>
<tr>
<th>Time period</th>
<th>Luton value</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>43.50</td>
<td>43.20</td>
<td>41.83</td>
<td>increase</td>
</tr>
</tbody>
</table>

There is a clear link between loneliness and poor mental and physical health. Initially, this indicator focuses on social care users and carers, rather than the broader population. However, the problems of loneliness and social isolation are not limited to these groups, and all parts of the health and care system have a role to play in preventing and reducing social isolation and loneliness in the broader population.

Luton (43.50%) has a similar rate of those who have sufficient social contact as England (43.20%) and slightly higher proportion than our statistical neighbours (41.83%).

A pilot project is being launched in Luton to:
- test out approaches to reducing loneliness and isolation across all sections of the community with a focus on interventions in two neighbourhoods;
- enable skills and knowledge gained during the project to be mainstreamed and become transferable to other areas; and
- evaluate the pilot and consider implications, opportunities and recommendations for future commissioning of preventative services in health and social care.

Domain 2: Health Protection

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Luton</th>
<th>England</th>
<th>Average of statistical neighbours</th>
<th>Trend from previous period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>6.40</td>
<td>5.40</td>
<td>6.25</td>
<td>Same</td>
</tr>
</tbody>
</table>

The burden of particulate air pollution in the UK was estimated to be equivalent to nearly 29,000 deaths in 2008 at typical ages and an associated loss of population life of 340,000 life years lost.  

The fraction of mortality that is estimated to be attributable to particulate air pollution Luton is 6.40%, which is higher than England (5.40%) but similar to our statistical neighbours (6.25%).

See Section 5 for further information on air pollution.
Education, skills and employment

“Education and health are the two most important characteristics of human capital. Their economic value lies in the effects they have on productivity: both education and health make individuals more productive. Education and health have a considerable impact on individual wellbeing, as well. The wealth of nations is to a large extent determined by the educational attainment and the health status of its population.”

3.1. Introduction

There is strong correlation between education, employment and health. Greater levels of education help to create better employment, wealthier economies and populations. However, the benefits of education go far beyond economic ones. A good education improves the life chances and opportunities of people for good future employment and a healthier lifestyle.

This section will examine the relationship between education, employment and health. It will compare and contrast educational indicators for Luton against national averages and those of neighbouring areas. It will also show how education and employment can improve public health, contribute to the development of children and adults through education and employment and consequently support improvements in social capital, local communities and the local economy.

3.2. Education and health

A good education helps to promote and sustain healthy lifestyles and positive choices. This is particularly true in relation to physical activity, diet, smoking and sexual activity. However, the relationship between alcohol consumption and education is less straightforward. There are different behaviours prevalent in some groups; those with A level education or higher are more likely to drink alcohol than those with no qualification\(^2\)_1, men with lower education levels are 3 times more likely to binge drink than those with higher levels and highly educated women are more likely to binge drink in their 20s but curb the habit by the time they reach their 40s with the opposite trend for women with fewer qualifications\(^2\)_2.

Education provides individuals with better access to information, improves critical thinking and cognitive skills which accounts for up to 30% of the education effect on health behaviours\(^2\)_3. What this means is that people with more education tend to be better-informed and make better use of the information they acquire when making health-related choices.

In 2013, Public Health commissioned a review of Personal, Social and Health Education (PSHE) in secondary schools in Luton. The review highlighted significant variability in content, method of delivery, and quality of PSHE between schools and showed that in most cases, the curriculum is not sufficiently flexible to address the specific personal, social and health needs of young people.

The findings from the review are being discussed with schools with the aim of developing a more integrated package of support which addresses the key health issues and meets the needs of young people in Luton. The key aim is to improve health outcomes for children and young people in all schools, starting with secondary schools, with an initial focus on those schools where young people are most at risk of poor health.
3.2.1. Educational attainment

Research and data on educational attainment shows a direct relationship between deprivation and lower education attainment. Department for Education (DfE) statistics and research by the Joseph Rowntree Foundation\(^{24}\) show that the attainment gap begins to emerge early in children’s lives, even before entry into school, continues throughout childhood and culminates in a considerable gap at age 16 and beyond:

- by age three, there is a significant gap in cognitive test scores between children in the poorest fifth of the population compared with those from more affluent backgrounds
- the attainment gap at age five grows during the primary school years and by the age of:
  - 7 years - the highest early achievers from low-income households are overtaken by lower-achieving children from more affluent backgrounds
  - 11 years - 75% of children from the poorest quintile of families reach the expected level at Key Stage 2 compared to 97% of children from the most affluent quintile.
- although the gap between the richest and poorest children has started to fall over the last decade, the gap at GCSE level remains large. The latest DfE figures show that 30.9% of pupils who are eligible for free school meals achieved five or more A-C GCSEs compared to 58.5% of children not eligible for FSMs.
- Poorer children are half as likely to go on to study at university compared to their more affluent peers.
- The Millennium Cohort Study found that at the age of five, children from the most advantaged groups were found to be over a year ahead in vocabulary compared to those from disadvantaged backgrounds\(^{25}\). This finding reinforced those of a previous study which found that by the age of three, children from privileged families have heard 30 million more words than children from underprivileged backgrounds\(^{26}\).

3.3. Early years education

*What a child experiences during the early years lays down the foundation for the whole of their life. A child’s physical, social, and cognitive development during the early years strongly influences their school-readiness and educational attainment, economic participation and health.*\(^{27}\)

Although poverty is an important factor, good pre-school and early years’ education has a positive effect on both educational and health outcomes and improves cognitive skills\(^{28}\). While beneficial for all children, those from disadvantaged backgrounds are more likely to benefit from pre-school education and parent engagement to reap benefits in later education. Parental interest in their child’s education has four times more influence on attainment by age 16 than socio-economic background\(^{29}\). Parental involvement in their child’s reading has been found to be the most important determinant of language and emergent literacy\(^{30}\).

Schemes for early years education targeting disadvantaged children are particularly important to redress inequality and reduce the risk associated with the lagging behind of children from more disadvantaged families.
3.3.1. National early years education

The early years foundation stage (EYFS) sets out the statutory standards that all early years providers must achieve. Providers include all maintained schools, non-maintained schools, independent schools and all providers on the Early Years Register. The EYFS aims to provide:

- quality and consistency in all early years settings
- a secure foundation that allows all children good progress through school and life
- partnerships between different practitioners, parents and carers
- equality of opportunity for all children.

Early years education in Luton

Ensuring good quality early years provision is essential for good development and school readiness at 5 years. Locally, the quality of early year’s education is improving. Table 3 shows that of those inspected, a higher proportion of childcare providers were judged to be good or outstanding in Luton than our statistical neighbours and comparable to the national average.

Table 3 Percentage of childcare providers good or outstanding.

<table>
<thead>
<tr>
<th>Inspection type</th>
<th>Luton</th>
<th>Statistical neighbours</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child-minder</td>
<td>62%</td>
<td>57%</td>
<td>67%</td>
</tr>
<tr>
<td>Childcare, non-domestic</td>
<td>68%</td>
<td>64%</td>
<td>68%</td>
</tr>
</tbody>
</table>

3.3.2. Early years attainment in Luton

Due to a change in the Early Years Foundation Stage assessment in 2013, it is not possible to compare this year’s outcomes with previous years. The 2013 EYFS assessments showed that 47% of children achieved a good level of development compared to 52% for England and 40% for statistical neighbours. In all areas, Luton was either comparable or exceeded the level achieved by statistically similar areas but below the national attainment level.

Within Luton there is inequity within the achievement level that needs to be addressed:

- 54% of girls achieved a good level of development compared to 41% of boys
- 50% of pupils not eligible for free school meals (FSM) achieved a good level of development compared to 40% of pupils eligible for FSM.

3.4. Education attainment at key stages

The national curriculum is organised into blocks of years called key stages (KS). At the end of each key stage, a child is formally assessed to measure performance and progress (Figure 14).

* Good level of development is defined as children achieving at least the expected levels in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in mathematics and literacy.
3.4.1. Key Stage 1: Reception to age 7

In 2013, performances in reading, writing and maths had increased from 2012. Luton was in line with national performance at key stage 1:

• girls have performed better than boys in reading, writing and in maths over the last 5 years
• the gap between children not eligible for FSM compared to eligible fell from 15% in 2012 to 9% in 2013 for reading. There was no change to the gap for writing and maths.

3.4.2. Key Stage 2: Age 7-11

There is a positive picture for educational attainment at key stage 2 in Luton with improvements in maths, reading and writing and the gap in attainment between children eligible and not eligible for FSM closing. Highlights are:

• maths has increased from 81% in 2012 to 82% in 2013 at level 4+ and 30% in 2012 to 36% in 2013 at level 5+
• for combined reading, writing and maths the percentage of pupils achieving Level 4+ remained at 71% in 2013. Achievement at L5+ increased from 15% in 2012 to 16% in 2013
• girls continued to perform better than boys in reading and writing over the last five years and for both, attainment decreased for reading in 2013 compared to 2012
• boys' attainment in writing and maths increased slightly in 2013 compared to 2012 but girls decreased slightly in writing and remained the same for maths
• the gap between pupils not eligible for free school meals (non FSM) and those pupils eligible for free school meals (FSM) fell between 2012 and 2013:
  • from 10% in 2012 to 5% in 2013 in reading at L4+
  • from 12% in 2012 to 10% in 2013 in writing L4+
  • from 11% in 2012 to 8% in 2013 in maths L4+.
3.4.3. Key Stage 4: Age 14-16

The proportion of pupils achieving 5+ A*-C including English and Maths has increased over the last 5 years from 46% in 2009 to 58% in 2013 and Luton is on par with statistical neighbours and slightly below the national average (60%). The data also shows that:

- girls continue to perform better than boys in achieving at least 5+ A*-C grade GCSEs including English and Maths over the last 5 years
- boys’ performance has increased over the last 5 years although there was a slight decrease in 2013
- there has been a steady increase in performance of pupils eligible for FSM 5+ A*-C including English and Maths, performance improved from 44% in 2012 to 48% in 2013 (Figure 15) and was higher than the national average.

Figure 15 Percentage of young people achieving 5 A*-C at GCSE, including English and Maths, young people eligible for FSM compared to those ineligible, and Luton compared to all LA areas 2009-13.

Source: DfE

3.4.4. Key Stage 5

Key Stage 5 results for 2013 show that for academic subjects (primarily ‘A’ levels) Luton institutions had an average points score per learner (the achievement of the programme overall; a measure of breadth) of 711.2 (compared to 785.6 England – state funded schools and colleges) and 203.0 per entry, (the level of achievement per subject), compared to England 211.2. For vocational subjects (primarily BTEC) Luton achieved 592.5 and 220.4 compared to 561.7 and 213.6 for England. There are no published comparisons for other qualifications (notably occupational ones which learners may be studying at Barnfield) or for those qualifications studied post 16 which are not at Level 3.

In 2013 the methodology changed for KS5 and so a direct comparison with previous years cannot be given. However, in general terms it would seem that both measures present an improvement on previous Luton performance data.
3.4.5. Attainment at 19 years of age

Figure 16 shows the year on year improvement in 19 year olds achieving 5 GCSE A*-C or equivalent. The attainment is comparable to all Local Authority Areas (LAs).

Figure 16 Percentage of 19 year olds achieving Level 2 qualifications: Luton compared to England 2010-12.

![Graph showing improvement in 19 year olds achieving Level 2 qualifications]

Source: DfE

Table 4 shows a year on year increase in the percentage of 19 year olds achieving Level 2 (5 GCSE A-C and other qualifications) and a narrowing of the gap over 3 years between those eligible and not eligible for FSM.

Table 4 Percentage of 19 year old students achieving Level 2.

<table>
<thead>
<tr>
<th>Level 2</th>
<th>All</th>
<th>Not eligible FSM</th>
<th>Eligible FSM</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>78</td>
<td>80</td>
<td>85</td>
<td>81</td>
</tr>
<tr>
<td>All LA’s</td>
<td>79</td>
<td>82</td>
<td>84</td>
<td>81</td>
</tr>
</tbody>
</table>

Source: DfE

Table 5 shows the year on year increase in the percentage of 19 year old students achieving Level 3 (‘A’ Level or equivalent). 55% of students achieved Level 3 in 2012, the same performance as all LAs. 44% of those eligible for FSM achieved a level 3 compared to 34% in all LAs. Although the gap between those eligible and not eligible for FSM has increased slightly over the last three years in Luton, it is significantly less than the gap for all LAs (14% compared to 24%).

Table 5 Percentage of 19 year old students achieving Level 3.

<table>
<thead>
<tr>
<th>Level 3</th>
<th>All</th>
<th>Not eligible FSM</th>
<th>Eligible FSM</th>
<th>Gap between young people eligible for FSM and not eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>50</td>
<td>54</td>
<td>55</td>
<td>52</td>
</tr>
<tr>
<td>All LA’s</td>
<td>51</td>
<td>54</td>
<td>55</td>
<td>54</td>
</tr>
</tbody>
</table>

Source: DfE
3.4.6. Overall educational attainment in Luton

The following series of graphs shows the percentage of young people in Luton achieving A*-C GCSE level 2), and A level qualifications (level 3). In comparison with the national attainment data, in the last 3 years Luton has closed the gap between attainment in the town and national attainment at both level 2 and 3, with level 2 attainment now exceeding the national performance (Figure 17).

Figure 17 Luton attainment at level 2 and 3 compared to England, 2010-12.

Source: DfE

Whilst the picture overall is positive, there remains an inequity in performance at Level 2 and 3 between those eligible for FSM and those not eligible. Figure 18 show that for level 2 and 3 the attainment of children eligible for FSM is increasing every year, however while the gap for level 2 between the two cohorts has decreased by 5 percentage points over the three academic years, the gap at level 3 has widened by 2 percentage points.

Figure 18 Attainment gap between children eligible and non-eligible for FSM 2010-12.

Source: DfE

3.5. Attendance and exclusion in Luton

There is a clear link between good school attendance and good educational achievement. Young people absent from school are more likely to become involved in or become a victim of crime and antisocial behaviour.

Attendance rates in Luton schools have been rising consistently over the last few years and are comparable with national rates at both primary and secondary level. Schools and the local authority work together, utilising strategies and applying sanctions consistently so that irregular attendance is identified and addressed speedily.

Persistent absentee rates, defined as a pupil exceeding an absence of greater than 15%, are lower than the national average. Unauthorised absence rates, including unexplained or unjustified absences and arriving late, are similar to national levels.
Nationally, there had been a downward trend in permanent exclusions over the last four years (Figure 19). This reflects the national pattern of a steady decline up to 2012/13. The majority of these exclusions are boys. The increase in exclusions in 2012/13 is based on a small increase in the number of incidents not any change in criteria.

**Figure 19 School exclusions by gender 2009/10–2012/13 in Luton.**

![School Exclusions by Gender](image)

Source: DfE

### 3.5.1. Post 16 participation: 16-19 years

There is overwhelming evidence of the negative consequences of leaving education or training at the age of 16\(^3\). Those that leave school at the first opportunity are disproportionately from poorer families. There is an increased likelihood that these young people do not access further education, employment or training (NEET) and are at greater risk of low income employment opportunities and associated poorer health including as a result of lifestyle behaviours and engaging in risky behaviours that have an adverse impact on health.

Employment prospects for 16 to 18 year olds without formal training are only marginally better than for young people classed as NEET. For both of these groups, targeted interventions to improve prospects are required not only to address the lifestyle and health of the individual but to achieve intergenerational benefits for their children similar to that seen for children of those who participate in education for longer who have improved education, employment opportunities and health.

### 3.5.2. Raising the participation age

In March 2013 the DfE issued guidance to Local Authorities\(^3\) that set out responsibilities for Raising the Participation Age (RPA). This statutory requirement came into effect from the start of the 2013/14 academic year and requires local authorities to support all young people to participate in education or training until the end of the academic year in which they turn 17 and from the summer term of 2015 until their 18th birthday. Implementing RPA aims to give all young people the opportunity to develop the skills they need for adult life and to achieve their full potential.
3.5.3. Post 16 participation in Luton

In Luton, 89% of 16 and 17 year olds (95% at 16 and 84% at 17) were participating in education and work-based learning in 2011, similar to the national average (England: 91% at 16, 84% at 17 and 88% overall). The reduction at 17 years needs to be addressed, particularly as September 2013 saw the introduction of the RPA.

In Luton the Local Authority has set up a Progression and Transition Board with membership drawn from all providers of education and training for 14 to 19 year olds, the University, Economic Development, Youth Advice and other key stakeholders. The Board has a broad remit which includes all of the issues relevant to the education and training of young people in the 14+ age group. The primary purpose of the Board is the development of a strong education and training system which operates across and within organisations to support growth in the economy and to give young people the opportunity to progress to further/higher study, to access productive employment and to meet the economic and civic needs of the area.

3.5.4. Destinations of young people

Figure 20 presents a snapshot of the destination choices of 2,514 year 11 Luton students in 2012. 56% (1,415) continued education in a sixth form and 32% (818) moved to a further education college. Only 0.4% (10) accessed an apprenticeship and 0.7% (18) went into employment.

![Figure 20 Destination of year 11 school leavers in Luton 2012.](image)

Source: Luton Borough Council

3.5.5. Young people not in education, employment or training (NEET)

5.8% of young people aged 16-18 in Luton are NEET (Oct – Dec 2013). Generally, NEET levels in Luton reflect national trends. The current level is better than the national average (7.6%), although there has been an increase over the last few months. This is partly due to seasonal variation with young people who have completed college courses, but not yet started their next activity; be that education, training or employment.

RPA will help to reduce the number of young people who are NEET. Where Personal Advisors (PA) are working in schools, they will identify young people who may leave and are potentially likely to fall into the NEET category and work with them to ensure that they have appropriate offers for when they leave school.
3.6. Apprenticeship participation 16-19 years

Apprenticeships play an important role in increasing skills and employability. A Luton wide apprenticeship strategy was introduced in November 2012. The strategy aims to:

- increase the number of apprenticeships available in Luton
- increase the awareness of and stimulate the demand for apprenticeship places by young people as a measure to aid meeting the RPA target.

As a major employer in Luton, the Council has developed its own strategy for the recruitment, training and employment of in-house apprentices on behalf of local employers and a requirement for tenders in respect of procurement for local authority contracts to include in their bids a requirement for the recruitment and employment of apprentices.

Figure 21 shows the number of young people participating in apprenticeships over the last three years. The reduction over the three years is due to a high number of short term ICT Apprenticeships which are no longer offered owing to quality issues.

**Figure 21 Apprenticeship participation, young people aged 16-19 in Luton 2010/11–2012/13.**

![Graph showing apprenticeship participation from 2010-11 to 2012-13](image)

Source: Skills Funding Agency.

In 2012/13 there were a total of 311 new apprenticeship starts within the age range 16-18, delivered through a range of providers. Figure 22 shows the level at which they started their programme.

**Figure 22 Apprenticeship Starts, young people aged 16-19 in Luton 2010/11–2012/13.**

![Graph showing apprenticeship starts from 2010-11 to 2012-13](image)

Source: Skills Funding Agency.
Although there was a small increase in 2012/13 for intermediate apprenticeship starts, the number of advanced apprenticeship starts dropped significantly (96) between 2011/12 and 2012/13. This reduction was seen both nationally (-11.6%) and regionally (-10.8%), but the reduction for Luton (-23%) was significantly greater although similar to statistical neighbours (-22.9%).

The uptake of apprenticeships is different between groups of young people:

- by gender: in 2012/13 the number of female starts increased from 37.9% in 2011/12 to approximately 50% in 2012/13
- disability: the number of young people reporting a disability increased from 5.7% in 2011/12 to 10.9% in 2012/13, whilst the percentage of young people who preferred not to declare dropped by 0.4%.

The Skills Funding Agency (SFA) does not release ethnicity data for apprenticeship take up.

There are a variety of apprenticeship programmes offered in Luton; the most popular are business administration, engineering, hairdressing and child care.

There were a number of initiatives to support Luton apprenticeships during 2013:

- the development of a bank of Apprenticeship Ambassadors for schools to promote and increase the uptake of apprenticeships
- recruitment of employers of apprentices to act as ambassadors in promoting apprenticeships to other businesses
- two Apprenticeship Expert programmes for school staff.

### 3.6.1. Apprenticeship performance in Luton

Success rates for apprenticeships are measured by the number successfully completing their apprenticeship in the timescale stated by the provider at the outset. Many apprentices go on to complete their apprenticeship after this stated time but their achievements will not be included in the published success rates.

In 2011/12 the overall success rate for Luton residents was 66.4% which was significantly below that for the region (72.1%) and nationally (73.1%). When viewed separately, the success rate for the intermediate apprenticeship (Level 2) was 74.4%, better than both the regional (71.5%) and national (71.9%) levels (Figure 23). Level 3 (advanced) success rate for Luton at 58.2% is well below that for the region (74.2%) and national (76.5%) (Figure 24). The decline in success rates in 2012/13 is seen in all programme types, most notably advanced apprenticeships, locally, regionally and nationally.
Figure 23 Success rates for intermediate apprenticeships 16-19 years.

Source: Skills Funding Agency.

Figure 24 Success rates for advanced apprenticeships 16-19 years.

Source: Skills Funding Agency.

The Council’s Local Statement of Need (LSN) for 2012/13 concluded that although participation in apprenticeships is increasing, there is still further work to do in convincing young people, their parents, carers and advisers and Luton’s employer base of the validity of apprenticeships as a route into employment and a credible and viable alternative to ‘A’ Level and University study. The challenge is to improve the number of people starting apprenticeship programmes and their success rates.

Case study: Apprentice Steps

In 2012-13, the Council’s Adult Learning developed a unique programme providing a classroom/work placement framework which mirrored that of a traditional apprenticeship aimed at adults with learning difficulties and disabilities. The programme Apprentice Steps was designed to offer the opportunity to acquire skills important to employers and experience a work placement. The first cohort of apprentices are now in work placements with the Luton and Dunstable Hospital. Apprentice Steps has attracted much attention from the National Apprenticeship Service.
3.7. Adult learning

Adult learning also exerts a considerable positive impact on health. Feinstein and Sabates identify specific outcomes of adult learning and a process for the wider benefits of adult education (Figure 25).

Figure 25 The wider benefits of adult learning.

The wider health benefits of education are not limited to the individual and extend to the family and the community as a whole. At a family level, this may lead to the dissemination of positive messages about education, potentially affecting the behaviours of children, encouraging them to stay in education and promoting a generational impact.

3.7.1. Current adult qualification levels in Luton

Adult education is particularly important in Luton as qualification levels tend to be lower than the national average. 16% of 16-64 year olds in Luton have no qualifications compared to 11% in Great Britain (GB) as a whole. However there have been some improvements in recent years:

- 30.6% of people in Luton now have qualifications at NVQ Level 4 and above which has resulted in the gap closing between people in Luton qualified at this level and people in GB
- at NVQ 2 and 3 there has been a smaller reduction in the gap between Luton and GB
- there has been a reduction in the number of adults with no qualifications in Luton.

Reducing the number of people with no qualifications and increasing the number with NVQ Level 3 and 4 qualifications is still a significant challenge. The working-age population in Luton remained less qualified than the working-age population across England between 2001 and 2011. 64.5% of Luton’s working-age population possess National Qualifications Framework (NQF) level 2 qualifications or above compared to the national figure of 74.1%. 46.4% have NQF level 3 qualifications or above compared to 54.3% nationally and 29.6% have NQF level 4 qualifications or above compared to 35.0% respectively. The prospective workforce currently being educated is achieving significantly higher attainment at these qualification levels.
Figure 26 shows that people with NQF Level 3 qualifications and above are more likely to be in employment.

**Figure 26 Employment rate by qualification level in Luton.**

![Graph showing employment rate by qualification level](image)

Source: Annual Population Survey 2011 (TBR Ref: W6/C16)

### 3.7.2. Adult learning in Luton

There are a wide range of adult education providers in the town offering a diverse range of courses. Barnfield College and the Council through Luton Adult Learning are the two main providers of Adult and Community Learning in the borough. In recent years, Luton Adult Learning has added apprenticeships to its programme and aligned adult provision to reflect the Council’s priorities and the Job Centre Plus agenda.

Funding for learning for adults is complex and ranges from free courses in English and maths for learners in receipt of unemployment benefit, to a new Government initiative encouraging progression to level 3 courses by allowing access to a 24+ age learner through an Advanced Learning Loan. The Advanced Learning Loans have proved successful with 22 learners having applied for a loan bringing an additional £40,000 funding for Luton Adult Learning. The loans have predominantly been in the subject areas of Support Teaching and Learning (Teaching Assistants) and Childcare.

Literacy and numeracy courses are free to anyone who does not have a level 2 qualification or who is in receipt of work related benefits. These courses are subsidised by the Skills Funding Agency (SFA) as part of the Government’s drive to up-skill the nation to at least level 2 in functional English and Maths (Table 6).

**Table 6 Adult learning provision.**

<table>
<thead>
<tr>
<th>Adult Learning provision for Literacy, Numeracy and ESOL 2011/12 (number of learners)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literacy</td>
</tr>
<tr>
<td>Numeracy</td>
</tr>
<tr>
<td>ESOL²</td>
</tr>
<tr>
<td>286</td>
</tr>
<tr>
<td>162</td>
</tr>
<tr>
<td>683</td>
</tr>
</tbody>
</table>

Source: Skills Funding Agency
3.7.3. Adult apprenticeships for participants aged 19+ years

Luton Adult Learning’s apprenticeship programme, run by the Council, has grown substantially within the last 2 years extending the previous Council-only provision to work with external employers. In the most recent Ofsted inspection (June 2012), the apprenticeship programme was judged to be ‘outstanding’ (Table 7).

Table 7 Number of people starting apprenticeships in Luton.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>2010-11</th>
<th>2011-2012</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton Adult Learning</td>
<td>54</td>
<td>68</td>
<td>104</td>
</tr>
</tbody>
</table>

Source: Luton Borough Council

3.7.4. Employer need

Evidencing knowledge and skills need is important in order to develop a local workforce that meets the need of local employers. Training providers, schools, colleges and universities may need to refine their courses to ensure that their leavers and graduates have the skills required.

Anecdotal evidence from local businesses suggests there are skill shortages in Luton and overall skill levels are low at population level based on Labour Insight data. These data identify gaps in skills and education by reviewing advertised vacancies in Luton to show the skills required to meet local employment opportunities.

The current gap is a shortage of people with communication skills. The Skills Survey suggests that in general, people consider their skills to be sufficient and therefore the need for change and aspiration to change is low. This indicates a significant challenge for Luton, not only to raise skill levels but to change attitudes towards learning and skill development (Figure 27).

Figure 27 Skills in demand by Luton employers 2012-2013.
3.8. Employment

Employment is vital to good public health. There is a close relationship between employment and health.

“Being unemployed is rarely good for one’s health, but while ‘good work’ is linked to positive health outcomes, jobs that are insecure, low paid and that fail to protect employees from stress and danger make people ill.”

3.8.1. Employment in Luton

NOMIS, the official labour market statistics, shows the unemployment rate in Luton for the period October 2012 to September 2013 was 8.4%, which was higher than the unemployment rate for any year between 2004 and 2011 and above the national unemployment rate (7.7%).

Luton is part of the South East Midlands Local Enterprise Partnership (SEMLEP). This partnership plays a key part in determining priorities for the local area and undertaking activities to promote growth. Table 8 shows the working age population and employment rate in Luton and other geographical areas. Luton has the lowest rate. The reason these areas are used is because job vacancies in the surrounding area may provide opportunities for people looking for work in a geographical area.

Table 8 Employment rate across comparator areas.

<table>
<thead>
<tr>
<th>Area</th>
<th>Total (Working Age)</th>
<th>Employed</th>
<th>Employment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>132,400</td>
<td>85,800</td>
<td>64.8</td>
</tr>
<tr>
<td>Bedford</td>
<td>105,900</td>
<td>80,800</td>
<td>76.4</td>
</tr>
<tr>
<td>Central Bedfordshire</td>
<td>164,900</td>
<td>126,400</td>
<td>76.7</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>163,300</td>
<td>124,000</td>
<td>75.9</td>
</tr>
<tr>
<td>St Albans</td>
<td>88,500</td>
<td>68,800</td>
<td>77.7</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>714,600</td>
<td>537,300</td>
<td>75.2</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>310,000</td>
<td>235,700</td>
<td>76.0</td>
</tr>
<tr>
<td>South East Midlands LEP</td>
<td>1,107,600</td>
<td>826,300</td>
<td>74.6</td>
</tr>
<tr>
<td>East of England</td>
<td>3,706,800</td>
<td>2,753,000</td>
<td>74.3</td>
</tr>
<tr>
<td>England</td>
<td>33,717,700</td>
<td>23,713,500</td>
<td>70.3</td>
</tr>
</tbody>
</table>

Source: Annual Population Survey April 2011 – March 2012 (TBR Ref: W6/55)

3.8.2. Luton’s economic profile

The structure of the Luton economy has undergone change in the last few years and offers a more diverse and well-balanced economy. Luton’s economy is dominated by service industries rather than the manufacturing industries of the past. Key points are:

- 80.3% of the labour market (69,500 people) who are employed are in service industries such as transport, banking and finance, leisure and communications
• the proportion of the labour market in Luton employed in service industries has increased by 5.8% since 2004 due to increases in public sector employment and the transport and communications sector
• although similar increases in service sector employment have been seen in other comparator areas, they have not been at the same rate.

There have been some positive signs for the future, with high rates of business start-ups in Luton in 2011 (720 or 13.4% of the total enterprise stock). This proportion of start-ups was greater than the both the East of England Region (10.5%) and England (11.4%).

Recent trends show Luton performing well in terms of economic output. Between 2000 and 2009, Luton experienced a faster rate of growth in total Gross Value Added (a measurement of economic activity) per head than England as a whole or any of the town’s comparator areas.

Luton has been able to attract a number of larger, more productive firms while losing smaller, less productive firms to other areas. The net effect in terms of employment has been a gain of 3,500 jobs and £400m in economic output, resulting in the town becoming more productive in 2013.

The working age population in Luton tends to be younger, reflecting the town’s demography, with consistently fewer people aged between 50 and 64. This situation is likely to continue as the town’s population (and workforce) is not forecast to age as rapidly as England. The consequence of this trend is that the natural workforce turnover (where people retire and are replaced by younger workers) will be less pronounced in Luton therefore maintaining the quality of, and focus on, lifelong learning and adult education is important.

3.8.3. What is being done in Luton to improve employment opportunities?

Luton has a Skills and Employability Strategy to address Luton’s skills shortage and unemployment issues. The vision set out in the strategy recognises that the skills of Luton’s workforce have an important role to play in helping Luton to reach its full economic potential.

“Luton will have a skilled workforce creating better opportunities and supporting a vibrant business economy. This includes developing a culture of aspiration and high achievement that provides the skills for the sustained development of the economy and improves the life chances of all residents.”

Areas of work that the Council is focusing on include:

• Creating quality jobs through:
  - inward investment – marketing Luton to businesses considering relocation or expansion, offering a red carpet service to assist, ranging from single point of contact liaison to Business Rate Relief scheme
  - business engagement and support, liaising with major businesses in Luton to help understand their pressures and inform Council strategy. This support is focused around key clusters for Luton; Airport and Aerospace, Automotive and Engineering, ICT and Electronics and Creative Industries.
• Developing skills and employability: this is being achieved by:
  - increasing engagement in participation in learning and employment
  - improving qualification levels in Luton
  - increasing the number of apprenticeships
  - ensuring the skills and qualification requirements of Luton’s specialist sectors and high growth businesses can be met by the local population
  - reducing unemployment and workless-ness levels in Luton
  - increasing the involvement of employers in offering training
  - working closely with Job Centre Plus and other partners to run Employment, Training and Skills Fairs that leads to increasing the number of out of work people moving into employment or training.

The inter-relatedness of this wider determinant of health is clear. Good health in childhood and adulthood is influenced by the intergenerational impact of parental education, employment and income on their children and the increased likelihood these children will have better access to good education, good jobs and better lifelong health. For some families there needs to be a break in the cycle of poor educational attainment, workless-ness, and poor employment opportunities.

3.9. Recommendations

Education

• Work with schools to implement the recommendations of the PSHE review
• Prioritise early years by increasing support for families to achieve improvements in early child development and continuing to improve the quality of pre-school education to ensure a healthy start in life
• Maintain a focus on reducing the inequalities gap in educational attainment between girls and boys and between those eligible and not eligible for free school meals.

Skills and Employment

• Continue to improve links with major employers in the town to better understand their needs as employers and how best the schools, adult education and apprenticeship providers can skill up young people for future employment.
• Use research tools to monitor qualifications and skills looked for in job adverts and use this data to inform Job Centre Plus, education and training providers in the town to better identify future skills needs.
• Promote the value of apprenticeships with young people, their parents, carers and advisers and Luton’s employer base as a route into employment and a credible and viable alternative to ‘A’ Level and University study.
• Continue to support people into employment through skills and employability programmes with a particular focus on people with mental health issues and disabilities.
4.1. Introduction

The links between housing and health (physical, mental and social) are well established and there are a broad range of specific elements relating to housing that can affect health outcomes. Poor housing conditions often coexist with other forms of deprivation such as unemployment, poor education, ill health and social isolation making it difficult to isolate, modify and assess the overall health impact of housing conditions. Having a home which is safe and affordable is generally considered to be a basic need. Stable surroundings help to maintain health and wellbeing. Poor quality housing can have a significant negative effect on physical health. It can cause or be a contributor to many health problems including respiratory illness, hypothermia, heart attack and stroke. Unsuitable housing can contribute to the development of mental health problems. Stress and anxiety can lead to feelings of helplessness increasing the risk of depression and other mental health conditions or can make existing mental health problems more difficult to manage. Dealing with the effects of poor housing is estimated to cost the NHS at least £600 million per year.

Experience of multiple housing problems increases children’s risk of ill-health and disability by up to 25 per cent during childhood and early adulthood.

Poor housing covers a wide range of issues, and this section focuses specifically on housing in poor physical condition, overcrowding, fuel poverty, homelessness and accidents in the home.

4.2. Housing in Luton

Luton experiences high levels of deprivation, homelessness and poor housing stock, particularly in the private rented sector. Recent data on housing needs shows a continuing imbalance between supply and demand, with demand significantly outstripping supply. The most recent housing needs study (2006) concluded a shortfall of 934 units per year, with nearly 50% of this shortfall being affordable housing.

4.2.1. Housing tenure

In Luton, 60% of dwellings are owner-occupied (Figure 28) which is below the regional average and the number of rented properties (roughly four in ten) is well above average for most urban areas in the Eastern Region. Almost two thirds of Luton’s rented sector is private rented and this has nearly doubled since the last Census (13% to 23%). The largest number of private rented households are located in Biscot, Dallow, High Town and Luton South accounting for almost half of the private rented market in Luton.

According to the 2006 private sector stock condition survey, households in the private rented sector are likely to have high levels of non-decency (37.2%). Of the 37.2% of private rented housing that is non-decent, 23.3% is due to poor thermal comfort and more likely to be fuel poor. Private rented houses have the highest standardised repair cost.

12.4% of private rented houses are said to be overcrowded. It is estimated that over a quarter of private rented dwellings are Houses of Multiple Occupation (HMOs).
4.2.2. What is in place to improve housing conditions in Luton?

The Council has a number of interventions aimed at improving housing conditions, such as the Disabled Facilities Grant (DFG). This grant provides adaptations to the homes of people with disabilities. Also, based on evidence from the JSNA, Decent Homes Assistance (the system of providing owner occupiers with interest free loans to bring homes up to standard) target homes in deprived areas such as Biscot.

Council housing officers also have enforcement powers which can be used against private landlords to improve the living conditions of private tenants.

4.2.3. Overcrowding

Overcrowding can adversely affect health, although it is difficult to measure its precise effect as it is often associated with additional components such as family income, energy efficiency, design and location of the property, which may in turn influence other housing-related factors such as damp, cold, noise penetration, smoking behaviour and indoor air quality.

Overcrowding can also have significant negative impacts on family cohesion and wellbeing. Living in overcrowded conditions can lead to increased anxiety, depression and relationship breakdown. The effects of living in overcrowded conditions can have a significant effect on children. Children living in overcrowded and unfit conditions are more likely to experience respiratory problems and contract communicable diseases such as meningitis and TB. The space available within a home can also impact on educational attainment owing to lack of quiet, warm space for children to do their homework. Family relationships can also be affected by the level of privacy available\(^{40}\).
There is evidence to suggest that those living in HMOs are four times as likely to suffer injury and twice as likely to die in a fire as those in single dwellings\textsuperscript{41}. Many tenants find themselves living in HMOs owing to job loss, mental ill-health or marriage breakdown and if the HMO is in poor condition, this can add to their mental health problems.

Luton’s Private Sector Housing Stock Condition Survey (2006)\textsuperscript{39} suggested that approximately 7.6% of all private sector households in Luton are overcrowded, with around 7.4% being seriously overcrowded. Figure 29 shows that Luton has relatively high proportions of households with a bedroom deficiency of 1 or more.

HMOs often exhibit higher levels of overcrowding than other forms of housing. With the universal benefit system approaching, it is expected there will be an increase in shared houses used to house people on benefits (Figure 29).

**Figure 29 Overcrowding in Luton compared to East of England and England.**

A further breakdown of overcrowding by ward shows that Biscot and Dallow have the highest level of overcrowding with over 25% of households having a bedroom deficiency of 1 bedroom or more. Dallow ward shows that almost 10% of households have a bedroom deficiency of 2 or more and Saints and Luton South wards are also heavily overcrowded areas by 18% and 16% respectively.

### 4.2.4. What is currently in place to reduce overcrowding in Luton?

In August 2013, the Council introduced an Additional Licensing Scheme for HMOs. The scheme complements the existing mandatory licensing scheme and existing enforcement powers and requires all shared privately rented accommodation in the borough to have a property licence. Licences will run for a five year period and the scheme itself will be reviewed five years from its introduction. By operating the Licensing Scheme in Luton, Environmental Health Officers are able to ensure there is a restricted number of occupants living in the property and therefore, reducing the risks of hazards and improving safety.

As part of the Council’s mutual exchange scheme, households in receipt of housing benefit can exchange with other households to relieve a household that is currently overcrowded.
4.2.5. Fuel poverty

The Government is adopting a new definition for fuel poverty which focuses on the low income/high cost (LIHC) framework, rather than the definitive 10% or more of household income spent on fuel. The LIHC definition takes into account if a household is spending above the national median on fuel, and whether the residual income left after paying for fuel is below the official poverty line. Under the new definition, in 2011, 10.9% of households in England were estimated to be living in fuel poverty, whilst the previous definition had the figure at 14.6%.

“The annual cost to the NHS of treating winter related disease due to cold private housing is £859 million. This does not include additional spending by social services, or economic losses through missed work. The total costs to the NHS and the country are unknown. A recent study showed that investing £1 in keeping homes warm saved the NHS 42 pence in health costs…”

There are a number of direct and indirect health impacts from living in fuel poverty and cold homes (Table 9).

Table 9 Direct and indirect health impacts from living in fuel poverty and cold homes.

<table>
<thead>
<tr>
<th>Direct Health Impacts</th>
<th>Indirect Health Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Around 40% of excess winter deaths (EWDs) are attributable to cardiovascular diseases.</td>
<td>Cold housing negatively affects children’s educational attainment, emotional well-being and resilience.</td>
</tr>
<tr>
<td>Around 33% of EWDs are attributable to respiratory diseases.</td>
<td>Fuel poverty negatively affects dietary opportunities and choices</td>
</tr>
<tr>
<td>There is a strong relationship between cold temperatures and cardio-vascular and respiratory diseases.</td>
<td>Cold housing negatively affects dexterity and increases the risk of accidents and injuries in the home.</td>
</tr>
<tr>
<td>Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems as children living in warm homes.</td>
<td>Lack of specific sleeping areas for infants has led to incidents of sudden infant death syndrome (SIDS) as a result of co-sleeping with parents and siblings.</td>
</tr>
<tr>
<td>Mental health is negatively affected by fuel poverty and cold housing for any age group.</td>
<td></td>
</tr>
<tr>
<td>More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing.</td>
<td></td>
</tr>
<tr>
<td>Cold housing increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism</td>
<td></td>
</tr>
</tbody>
</table>

Cold homes contribute to more people dying during the winter months (November to February) than the rest of the year. In 2012/13 there were an estimated 31,100 excess winter deaths nationally, a 29% increase compared with the previous winter. Excess deaths in winter are an important public health issue in the UK, which is potentially amenable to effective intervention.

*We could prevent many of the yearly excess winter deaths – 35,000 in 2008/09 – through warmer housing.*\(^4^4\)
4.2.6. Fuel poverty in Luton

Latest data (2011) from the PHOF states that 12.8% of households in Luton are living in fuel poverty. However, Luton has slightly altered the definition to include the term ‘disposable income’ to reflect that a household will have to spend money on rent/mortgage and food before they spend on fuel. Based on this definition, 16.9% of households are estimated to be living in fuel poverty.

Almost all wards have levels of fuel poverty affecting over 11% of households. Farley, South, High Town, Biscot, Saints, Challney, Dallow, Stopsley and Icknield have areas where fuel poverty affects over 20% of households.

The consequence of fuel poverty can be considered in the latest local mortality figures which show a 13.8% rise in deaths in Luton during the colder months of the year compared to the rest of the year. Many of these deaths, known as excess winter deaths, are preventable through warmer housing.

4.2.7. What is currently in place to reduce fuel poverty in Luton?

The Council has established a local policy for helping vulnerable households and several discretionary forms of assistance have been developed and these are targeted at clients in receipt of income-related benefits:

- Decent Homes Assistance provides support to applicants to repair their properties on the condition that the property after repairs achieves the Decent Homes Standard. This assistance is available in post code areas with the highest number of non-decent homes and lowest life expectancy

- Luton’s Home Improvement Agency (HIA) helps older and vulnerable people to take advantage of services they might not otherwise be aware of. Led by Private Sector Housing, the HIA works with a number of other organisations, both locally and nationally, that help with grants, loans or day-to-day assistance. Luton’s Handyman scheme is also included as part of this service.
4.3. Homelessness

Homelessness takes different forms including rough sleeping which can be very visible, squatting and sofa surfing which tends to be less visible and those living in hostels, night shelters or temporary accommodation provided by their local authority. This last group is known as statutory homeless and local authorities have a duty to offer accommodation to those in priority need and who have not made themselves intentionally homeless. This can include families with dependent children, pregnant women and adults who are assessed as vulnerable.

Non-statutory homelessness refers to households or individuals who are not found to have a priority need or who are deemed to be ‘intentionally’ homeless or have not gone through the legal application for housing.

Despite improvements in the health of the general population over the last 15 years, the average life expectancy for homeless people is 47 years for men and 43 years for women. This is compared to 79.2 years for men and 83.3 years for women within the general population.49

Risk factors associated with becoming homeless include drug or alcohol problems, poor educational attainment/qualifications and ongoing mental health issues. Triggers can include bereavement, job loss, crime, leaving an institution (including the armed services), and a sudden deterioration in mental health. Relationship or family breakdown can be both a risk factor and a trigger.30

Homelessness damages people’s capability through loss of skills, through an inability to think about employment whilst worrying about housing, and through their health becoming impaired whilst homeless. Homelessness also damages people’s resilience, self-esteem and self-confidence.51

Whilst disease causes the majority of deaths amongst the general population, homeless people are more likely to die from external causes. There are much higher incidences of suicide and deaths as a result of traffic accidents, infections such as tuberculosis, and falls. Drugs and alcohol are major causes of death amongst homeless people and are both a cause and consequence of homelessness. Homeless people often leave health problems untreated until they reach a crisis point and present at accident and emergency departments.

A Homeless Link briefing52 highlights the complex health needs of people with a long and sustained history of homelessness:

- 82% of homeless people have one or more physical health needs
- 45% have a long-term mental health need
- 52% of homeless people use drugs
- 75% consume alcohol and 20% drink alcohol at harmful levels
- 44% use drugs or alcohol to help them cope with their mental health problems
- an estimated 60% of adults living in hostels in England have a personality disorder and have experienced complex trauma, compared to 10% in the general population.
In 2011, Crisis\textsuperscript{53} made the following recommendations for improving services for homeless people:

- local councils should provide meaningful advice and assistance to single homeless people when they are not considered a priority for housing
- improve access to mainstream healthcare services such as GP surgeries by making it easier to register without a permanent address and providing more out of hours and drop-in services
- outreach health provision and information should be made available within existing homelessness services such as hostels and day centres
- physical and mental health services need to be joined up to provide a holistic approach to meeting the specific needs of homeless people
- increase the number and type of drug and alcohol treatments available as well as specialist services for those with dual diagnosis of mental health and drug or alcohol use.

### 4.3.1. Homelessness in Luton

Homelessness is part of the many challenges faced by the borough’s residents. It is inextricably linked to poverty – including child poverty, worklessness and health inequalities.

Latest data (2011) in the PHOF shows that the rate of homelessness acceptances in Luton is 5.7/1000 households compared to 2.3/1000 for England. The rate of households in temporary accommodation in Luton is also significantly higher than England with a rate of 9.8/1000 households compared to 2.3/1000 for England. There are currently over 8000 households on Luton’s Housing Register.

### 4.3.2. Main causes of homelessness

The table below illustrates the top three main causes of homelessness within Luton for those it owes a statutory duty (Table 10).

**Table 10 Main causes of homelessness in Luton.**

<table>
<thead>
<tr>
<th>Main Causes of Homeless Application</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents or other relatives or friends no longer willing or able to accommodate their children</td>
<td>182</td>
<td>167</td>
<td>224</td>
</tr>
<tr>
<td>Loss of rented or tied accommodation</td>
<td>89</td>
<td>97</td>
<td>136</td>
</tr>
<tr>
<td>Violence</td>
<td>67</td>
<td>64</td>
<td>84</td>
</tr>
</tbody>
</table>

Source: Luton Borough Council

The main cause of statutory homelessness within Luton is parents or family and friends unable to accommodate, which accounted for 42% of the 1372 applications accepted between 2010 and 2013. Other reasons included eviction from private rented accommodation and relationship breakdown (including violence). Homelessness due to loss of home following mortgage arrears remains a relatively small cause.
What is currently in place to reduce homelessness in Luton?

The availability of privately rented accommodation has decreased owing to changes in housing benefit and the introduction of universal credit, making landlords less likely to take households on benefit or on low incomes, leaving more people vulnerable to becoming homeless. There are currently 900 households in temporary accommodation. The Council is reviewing the service and is developing an improvement plan to tackle the issue and reduce homelessness locally.

A review of housing related support including accommodation for people with mental health problems will start in 2014 to help identify the gaps and future needs in service provision to inform commissioning decisions.

LAMP is a local independent Christian charity that has worked in Luton, supporting young vulnerable and disadvantaged people between the ages of 16-25 who find themselves, through no fault of their own, in a homeless situation. LAMP provides a safe living environment, and delivers the Move on Project. This project enables young homeless people to develop an individual support plan in partnership with LAMP advisers giving step by step career guidance, life skills and financial management skills.

Mary Seacole Housing Association is a friendly society with charitable status that provides quality supported accommodation to young single homeless people between the ages of 16 and 35 years. The Association provides supported accommodation in six hostels across Luton and develops support plans with the client in order to prioritise their needs. In addition to training, the Association offers a resettlement service that gives young people one to one support to either maintain their current accommodation or move on into secure permanent accommodation. To date, the Association has had a 100% record in its resettled clients maintaining their independence.

Penrose Synergy is a relatively new service in Luton that offers floating support to 300 Luton based clients. The service has been commissioned by the Council and provides support for generic and complex need and client-led support to vulnerable adults. Amongst the many services offered to Luton residents, Synergy offers tenancy sustainment, housing advice and accommodation brokerage.

The Council contributes to providing emergency cold weather provision for non-statutory homeless people within the town in partnership with NOAH Enterprise. This funding supports rough sleepers in Luton by offering access to an emergency shelter when the temperature is either zero or below for three consecutive days. NOAH has extended this service to take into account the wind chill factor.
The Luton Clinical Commissioning Group has an agreement with 3 Luton practices to provide essential, additional, and enhanced services to homeless and hard to reach groups. This includes a twice weekly outreach service at The Day Centre run by NOAH Enterprise offering an in-house services for families affected by homelessness.

Whilst the Council deals with statutory homelessness, NOAH Enterprise is one of the main charities that provide practical support through their Welfare Centre and Street Outreach Team to homeless people who are either new to the streets or entrenched rough sleepers. In addition to the GP service, community psychiatric nurses provide a twice weekly clinic for those with mental health and drug and alcohol issues. A mobile dentist also visits once a week. Clients coming to the Welfare Centre also have access to other support services such as resettlement advice, showers, clothing and food.

From December 2012 to March 2013, 75 rough sleepers accessed the NOAH Enterprise Emergency Cold Weather Service. This year (December 2013-January 2014) NOAH has already seen 39 people. Of the 39 clients, 18 are Polish, 19 British and 2 are other; 35 are male and 4 female.

**Case study: No Second Night Out**

The No Second Night Out (NSNO) project is currently funded through the Homelessness Transition Fund (HTF) and is being delivered through the NOAH Enterprise street outreach team. The objective of the project is to deliver the Government’s NSNO strategy across Bedfordshire. The project engages with people new to rough sleeping with the aim of preventing them becoming entrenched homeless. People will be supported to find temporary accommodation, whilst more appropriate accommodation is organised. This could be supporting someone with complex needs, such as mental health conditions, to access supported living.

Ian (name changed) is a man in his 50s referred to the NSNO project through our referral group, comprising representatives from the police, local authority, drug and alcohol services and mental health team. When we first engaged with Ian approximately 18 months ago he was a rough sleeper, alcohol dependent, in very bad physical health and leading a chaotic lifestyle.

Ian had come to the attention of the police on a number of occasions and was in conflict with his peers. Additionally, he was not claiming any welfare benefits and he was severely ill.

Our first priority was to arrange a physical health assessment. Ian was taken to the L&D Hospital and admitted straight away. Whilst Ian was in hospital, we were able to apply for accommodation with the Council and this application was accepted on the grounds of Ian’s poor physical health. We were also able to support Ian with an application for Employment Support Allowance which was also successful.

Ian has now completed his treatment successfully and is occasionally working with his family. Ian feels he is in the best place he has ever been and wants to build on this progress with his family’s support.
4.4. Accidents in the home

Every year in the UK more than 5,000 people die in accidents in the home and 2.7 million attend A&E seeking treatment\(^5^4\). Falls account for 49% of injuries and are the cause of most home accidents. The majority of these are due to tripping over on the same level, falling out of a pram or off a bed/sofa or falling from a height such as out of a window, off balconies and down stairs. Some environmental hazards associated with home accidents are related to poor design and inadequate maintenance of the dwelling.

4.4.1. Older people and falls

The majority of both fatal and non-fatal accidents are falls involving older people. 30% of people aged 65 years or over are likely to fall at least once a year. This rises to approximately 50% in those aged 80 years or over\(^5^5\). Almost three-quarters of falls among the 65 and over age group result in arm, leg and shoulder injuries. Older people are also more likely to injure more than one part of their body when they fall.\(^5^4\)

Evidence based actions to reduce the risk of falls among older people:

- make available strength/balance/exercise classes or advice for frail older people, especially those with known weaknesses or low bone density\(^5^6\)
- undertake targeted risk assessments and work with home improvement agencies to provide aids and adaptations to make it possible for people to remain independent and in their own homes for longer, particularly if integrated with other social care support provided by local authorities
- develop handyperson schemes to support vulnerable people to improve the safety of their homes, and link these with hospital discharge schemes to help prevent further accidents.

Latest data (2011) in the PHOF shows that the rate of emergency hospital admissions for injuries due to falls in adults aged 65 years and over is significantly lower than England and our statistical neighbours. The picture is similar for both males and females and aged 65-79 and 80+. However, locally, there is a lack of robust data on the total number of falls. The main problem with producing data on the number of falls is that many falls are not reported and frequently it is only after a fall resulting in injury that the individual admits to previous slips, trips or falls. Those that are reported may be reported to a number of organisations.

Despite these challenges, there are studies that use various methods to quantify the estimated incidence of falls. With approximately 28,000 people over 65 living in Luton (set to rise to 30,00 by 2016) it is estimated that between 8,400 and 9,000 people over 65 will experience one or more falls in a year.

4.4.2. What is currently in place to reduce falls in Luton?

Luton’s local falls team aims to prevent unnecessary admissions to hospital following a fall and reduce the risk of further falls. The service includes a comprehensive assessment by a Falls Support Worker who identifies what additional support and/or equipment is needed to enable the person to remain at home safely and reduce their risk of further falls. This may include:
• new or increased care package
• provision of equipment
• environment check and recommendations
• referral on to other organisations, such as the Community Assessment and Rehabilitation Team, Social Services and Age Concern
• advice on reducing the risk of further falls.

Referrals to the service can be made from three sources: the Ambulance Service, Clinical Navigation Team and Community Matron.

Active Luton provides activity sessions for older people under the banner of Full of Life. Activities range from table tennis and short mat bowls to badminton, line dancing and general group fitness classes including aqua fit. Activities are designed to maintain and develop mobility as well as providing a social activity to reduce isolation. At present there are no formal referral pathways in place between Active Luton and key services such as the Falls Service.

4.4.3. Injuries in children

Children growing up in disadvantaged areas and low income families are particularly vulnerable to home accidents. Accidental injury among under 15s results in two million visits to A&E each year of which almost half are children under the age of 4 years, with a cost of approximately £146 million to the NHS. Hospital admissions among the under 5s have been rising by 5% per annum nationally, and children living in the lower income families have 13 times the rate of death and injury of those in the most affluent families.

Evidence based actions to reduce child accidents in the home:
- installing safety gates for stairs and doorways, window restrictors and cupboard locks
- providing non-slip bath/shower mats, corner cushions and fireguards
- training relevant staff (including health visitors and family support workers) and community members to run their own schemes.

Prioritise high-risk groups, targeting interventions at those:
- with children under five
- living in rented or overcrowded conditions
- on low incomes.

Latest data (2012-13) in the PHOF shows the rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) in Luton is 100.4/10,000 resident population. This is a decrease from 2011-12, similar to the England average (103.8) but higher than our statistical neighbours (95.8). Currently, the local child accident data does not separate unintentional injuries from deliberate injuries.

The under 5s Safe @ Home Scheme is a project working with various partners to enable parents to access vital advice and support to understand the causes of home accidents and take the steps to prevent them.
4.5. Recommendations

**General housing conditions**
- Update the Housing Conditions Survey in 2014 in partnership with the Building Research Establishment (BRE) to identify where areas of housing improvements should take place and potential cost savings.
- Commission BRE to undertake a quantitative Health Impact Assessment in addition to the conditions survey.

**Fuel poverty**
- Develop a coordinated action plan jointly led by Private Sector Housing and Public Health with the aim of targeting fuel poor households and improving knowledge and understanding amongst key partners on the issues and extent of fuel poverty in Luton.

**Homelessness**
- Ensure the new Homeless Strategy recognises the importance of prevention and addresses the health needs of homeless people.
- Maintain and improve access to Primary Care services for homeless people in Luton.

**Unintentional injuries**
- Review NICE Guidance ‘Preventing unintentional injuries among the under-15s in the home’ (PH30) to ensure the recommendations are being implemented locally.
- Explore the options for collecting appropriate data specifically on under 5s accidents and falls in the over 65s in order to plan interventions based on local trends and highest risks.
- Develop formal referral pathways between the falls service and exercise programmes designed to improve mobility.

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**Case study: Safe at Home project**

Bedfordshire Fire and Rescue Service (BFRS) is working in partnership with the Luton Pre-School Learning Alliance (PSLA) to deliver the Safe at Home Scheme. This partnership provides child home safety equipment to the most disadvantaged families in areas with the highest accident rates and also provides the families with fire safety advice and smoke alarms.

PSLA identifies families through referrals from Children’s Centres and funds a Home Fire Safety Advisor post at BFRS. In addition to the standard fire safety advice provided by the Fire Service, the Home Fire Safety Advisor working on this partnership fits a range of safety products such as stair gates and window locks in order to reduce the number accidents in the home. The scheme has been running since 2009 and is responsible for approximately 1800 Home Fire Safety Checks being carried out in the homes of young families who are at risk both in term of health and fire safety.
Healthy environments

“The creation of healthy, sustainable places and communities should go hand in hand with the mitigation of climate change and have a shared policy agenda. Access to good quality air, water, food, sporting, recreational and cultural facilities and green space all contribute to reducing inequalities as well as helping to create sustainable communities”.

5.1. Introduction

Environmental inequalities may be defined as the unequal impact of environmental influences on health and wellbeing. These environmental influences may include housing, public spaces, environmental planning, travel and transport, access to nature and environmental problems arising from unsustainable lifestyles and climate change such as poor air quality or increased heating costs.

The Marmot Review found a number of key areas where socio-economic status correlated with environmental disadvantage: transport, green space, pollution, food, housing and community participation and social isolation. In the most deprived areas, approximately 45% of the population experience two or more unfavourable conditions, compared to less than 5% in the least deprived areas. The relationship between deprivation and unfavourable environmental conditions holds true across the social gradient.

In addition to health gains, there are considerable savings to be made from improving the environment to promote walking and cycling and making roads and neighbourhoods safer and more pleasant. A Cabinet Office report highlighted the annual costs to society of transport induced air quality, ill health and road accidents to be in excess of £40 billion. Getting just one more person to walk to school could pay back £768 and for every person that cycles instead of using a car, annual savings are estimated to be between £539 and £641.

5.2. Planning and health

The National Planning Policy Framework (NPPF) sets out the Government’s planning policies for England and provides the framework within which local people and councils can produce their Local and Neighbourhood Plans to guide development in their area.

The Council is currently producing its Local Plan which will influence location, scale and quality of new developments for the next 20 years. The Local Plan will ensure the built and natural environment will be protected where appropriate to support health and wellbeing.

Issues include:

• needs of the forecasted population growth in terms of new housing
• need to provide an appropriate level of affordable housing that is commensurate with the identified housing needs and at the same time constitutes viable development
• need to accommodate new development for employment, education, health, retail and other community facilities commensurate to the population growth
• limited land to accommodate all the different needs; available land for residential development within the built up area is capable of accommodating approximately 5,700 new homes in the plan period.
The challenge for Luton is therefore balancing the need between the requirements for extra schools and school places, housing and business/retail development, while protecting valuable green spaces and distinctive places with character.

Planning policy can make a significant contribution to reducing the ‘obesogenic’ environment. Creating an environment where people actively choose to walk and cycle can have a significant impact on public health. Safe, accessible outdoor spaces can enhance active outdoor play and recreation. Encouraging a mix of shops and facilities offered at neighbourhood centres which may offer alternative choices could influence food purchasing habits.

‘It is unreasonable to expect people to change their behaviours when the environment discourages such changes’.63

5.2.1. Luton Local Transport Plan 2011-2026

The local transport plan recognises the key link with health improvement and highlights the following as key challenges:

- improving local access by walking and cycling, especially to green space and parks
- increasing the number of children walking and cycling
- continuing to increase the number of adults who walk and cycle, especially to work
- increasing the number of people who walk and cycle for leisure/recreation
- mitigating the impact of noise generated by new development and associated traffic
- continuing to improve air quality and ensure that no new Air Quality Management Areas are declared, especially as a result of new development.

The following sections on active travel, air pollution and road traffic accidents outline progress in relation to these key challenges.

5.2.2. Green spaces

The Public Health White Paper, Healthy Lives, Healthy People, refers to access to green space as having a positive impact on the health and wellbeing of communities.44 There is evidence that living close to areas of green space such as parks, woodland and other open spaces, can improve health, regardless of social class64. Numerous studies point to the direct benefits of green space to both physical and mental health and wellbeing. One study examined the difference between green space being three kilometres or one kilometre from one’s home, and found that having green spaces within one kilometre reduced disease prevalence.65

The presence of green space also has benefits such as providing space for physical activity and play and improving air quality66. Children’s physical activity levels are increased when they live closer to parks, playgrounds and recreation areas.67

The Marmot review also highlights the importance of the quality of green space. Some groups, including children, can feel excluded if spaces are not designed appropriately and poor maintenance or cleanliness can impact more widely on perceptions of safety.

Evidence based actions to increase access to green space to improve health.

- Work with local communities to help them develop strategic plans for green space within broader neighbourhood plans. This will help to stimulate physical activity in local communities.
• Prioritise access to green space in planning developments – particularly for lower socio-economic groups.
• Ensure parks are well maintained and anti-social behaviour does not act as a disincentive for people to enjoy the space and derive health benefits from it.69
• Actively engage community groups and volunteers in the management and maintenance of green spaces.
• Proactively plan the use of leisure facilities to maximise local residents’ health. Birmingham’s Be Active programme, for instance, offered free use of leisure centres during working hours and at weekends. More than half of those who signed up through the scheme were overweight or obese, and one-fifth reported poor or very poor health.
• Commission and support GPs to implement activities such as walking groups in green spaces, consistent with the Department of Health’s Let’s Get Moving toolkit.70

5.2.3. Green space in Luton

It is acknowledged that there is a lack of green space of recreational value in Luton to meet the needs of all sections of the community. The development of the new Local Plan contains policies that will assist in dealing with this issue and protect this valuable resource.

The green spaces in Luton make an important contribution to the health of its residents and by increasing residents’ use of the facilities they gain health benefits. Some of the key barriers to accessing quality green spaces and areas of biodiversity include the absence of accessible footpaths for people with moderate health and mobility issues.

In May 2013 the Council’s Parks Service hosted a 10 week course in Wardown Park aimed at people with mild to moderate mental health problems. Working in partnership with Mind and the local Groundwork Trust, the project provided opportunities to increase confidence and skills by exploring and helping to conserve some of Luton’s parks, combined with self-development to help participants feel ready for work or to continue volunteering.

In 2014-15 a small contribution from the Public Health grant was used to extend this project to provide further opportunities for this target group to actively engage in a programme of hands on physical activity and environmental tasks in the local parks and other green spaces. Opportunities could include skills as varied as coppicing, general woodland management, bulb planting, assisting to plan and creating new landscapes and opportunities to increase confidence in social skills through on-site surveys.

Case study: ‘i-tree eco study’ in Wardown Park

Trees are a source of air cleaning, producing oxygen, intercepting airborne particulates, and reducing smog. Access to trees and green spaces not only improves mental wellbeing and physical health but also offers environmental benefits.71

A study was undertaken of the trees ability to adsorb pollutants using software entitled ‘i-tree eco’. By measuring the quantity of leaf canopy and the type of tree/shrub, it was calculated that the trees in Wardown Park annually remove a total of 0.9 tonnes of pollutants including 0.1 tonnes of nitrogen dioxide (NO2), proving trees have a direct impact on reducing pollutants in the atmosphere.
5.3. Active travel

An efficient transport network has positive effects on health by enabling access to education, employment, health services, leisure and recreation amenities and social networks. Conversely, transport can also have a negative impact on health through increased air pollution and road accidents and can act as a disincentive to people making healthier choices such as walking and cycling. Good transport planning can reduce the number of preventable deaths and injuries, particularly among vulnerable groups.

Creating an environment where people actively choose to walk and cycle as part of everyday life can have a significant impact on public health and may reduce inequalities in health. Evidence from NICE suggests that being inactive is a major health risk with 65% of men and 75% of women in England not achieving the level of physical activity recommended by the Chief Medical Officer (at least 150 minutes of moderate intensity activity a week). Moderate activity such as brisk walking or cycling can help to reduce the risk of diseases such as diabetes, cardiovascular disease and cancer. Evidence also suggests that people who walk or cycle as a mode of transport tend to be more physically active overall. Studies show that adults whose active travel increased over the course of a year reported about two hours more physical activity per week on average, whereas those whose active travel decreased reported about two hours less. Moving people from being physically inactive to physically active through promoting a modal shift to active travel is the biggest potential public health benefit of transport policies.

Evidence based actions to promote active forms of travel:

• work with employers to promote cycling to work which reduces the risk of cardiovascular disease and obesity, and leads to better general health, resulting in lower absenteeism
• use NICE guidance (PH41) to design and implement policies that promote cycling and walking
• change public perceptions about cycling being dangerous by promoting the message that its health benefits outweigh the risk of accidents
• promote the Cycle to Work scheme which reduces the upfront costs of buying a bike for commuting purposes among local authority staff, and encourage local businesses to do the same.
5.3.1. Active travel in Luton

Latest data from the Active People’s Survey highlights the need to increase the physical activity levels of adults in Luton as only 15.1% participate in 3 sessions per week of sport or active recreation.79

Walking and cycling provides an easy way of fitting exercise into everyday life. To promote active travel, the Travel Luton Team, established by the Council in 2011, has been present at over 60 workplace and community events and visited over 23,000 households in Luton providing tailor made information and support for people to choose to walk, cycle and use public transport more often. Over the last two years, 4,053 people have committed to a walking challenge and 2,095 people have signed up to a cycling challenge. Travel Luton follows up to see whether people have increased their active travel following a challenge. They found that 45% of participants had increased their level of walking and 21% had increased their cycling levels from the first year of the project.

5.3.2. What is in place to increase active travel?

The Local Transport Plan makes an explicit commitment to promote active travel. Within the Plan, the Luton Rights of Way Improvement Plan (RoWIP) has several projects that encourage walking by utilising the footpaths and bridle ways in and around Luton80. They showcase areas of outstanding natural beauty and encourage people to access the surrounding countryside. Whilst there are less than 15km of public footpaths and bridleways, they are vital in improving access between surrounding villages and the town and encouraging active travel.

The Council carried out Bikeability cycle training for Years 5, 6 and 7 in participating Luton schools. From April 2013–April 2014, about 2000 children will have undertaken courses. Group adult cycle training sessions for new or returning cyclists are provided by the Council and Travel Luton and about 40 adults have taken part in courses of up to 6 sessions.

In summer 2013, four employers in Luton led a workplace cycle challenge to encourage cycling to and from work. 122 staff members completed the challenge with 18 taking part in an advanced challenge. Travel Luton will carry out the competition again in summer 2014.

Case study: Dallow Downs Project

The Dallow Downs Project offers trail workshops for local schools and residents and provides special school activities (led by volunteers) such as tree planting and clearing existing rights of way paths. The Upper Lea Valley Walk is a guided route that takes walkers and cyclists from the source of the River Lea through Luton to the boundary where it meets the longer Lea Valley walk on its way to London81. The leaflet encourages walkers and cyclists (as part of the National Cycle Network Route 6) to experience important habitats and opportunities to cycle, walk and access natural play areas. Although cyclists can access NCN 6 from Dunstable and Leighton Buzzard to Luton, we only have cycle counts for sections within Luton. Monitoring shows that around 200 cyclists use NCN 6 daily, with a peak of cyclists at early morning and late afternoon. This indicates that most cyclists are using the route to cycle to work or college.
5.4. Air pollution

Air pollution has a significant impact on Public Health in the UK, with an effect equivalent to 29,000 deaths a year\textsuperscript{82}. Particulate matter (PM) and ozone are the two types of air pollution believed to have the most significant impacts on public health. Moderate levels of air pollution are unlikely to have any serious short term effects, particularly in the young and those in good health. Higher levels and/or long term exposure to air pollution can lead to more serious symptoms and conditions mainly affecting the respiratory and inflammatory systems. These higher levels can lead to conditions such as heart disease and cancer\textsuperscript{83}. People with existing lung or heart conditions and the very young and very old are much more susceptible to the acute effects of air pollution. People who live near busy roads are at particular risk of exposure to the health harms of air pollution.

5.4.1. Air pollution in Luton

Air pollution is a key indicator in the PHOF and the most recent estimate (2011) suggests that Luton had a higher percentage of adult mortality (6.4%) related to long term exposure of current levels of anthropogenic particulate air pollution than England (5.4%) but similar to statistical neighbours. The main source of air pollution in Luton is from road traffic, particularly those areas bordering the M1 motorway.

Nitrogen dioxide (NO\textsubscript{2}) is currently being monitored at 43 sites across the town. Results from this monitoring show NO\textsubscript{2} levels in the vicinity of the motorway have been in excess of the target level set in the Air Quality (England) Regulations 2000. As a result, the Council has declared an Air Quality Management Area (AQMA) that covers the 431 dwellings situated near the M1 motorway. Air quality monitoring is also in place within the airport boundary. To improve air quality around the airport, surface access targets for passengers and staff are set out in the Airport Surface Access Strategy 2012-2017.

Following the declaration of the AQMA, the Council produced an action plan with the aim of addressing the elevated nitrogen dioxide levels. As this pollution is due to high traffic volumes, these actions were incorporated into the local transport plan. The impact of these measures will be monitored through the continuing air quality monitoring programme.

5.5. Road traffic accidents

Road traffic accidents are a significant cause of accidental injury and death, particularly among children and young people. Children from social class V have five times the mortality rate from road traffic as children from social class I. Pedestrians and cyclists are among the most vulnerable road users, and road danger is a barrier to the uptake of active travel. Most pedestrian injuries occur on built-up roads in towns and cities, and the risk is greatest when car use is at its highest. The greatest risk for cyclists is associated with crossing junctions\textsuperscript{84}.

However, road traffic accidents are preventable. The Department for Transport has demonstrated the financial costs to society and the NHS for seriously injured casualties aged 0-15 years. The approximate costs for medical and ambulance costs are £13,500 per child but the human cost is estimated to be around £153,000 per child.

Evidence based actions to to make roads safer:

- create safe, attractive and enjoyable local environments with roads that prioritise place over cars to increase walkability
• introduce 20mph speed zones where appropriate
• prioritise densely populated areas areas with consistently high accident rates, and residential areas around common urban destinations, including developing safer routes to school (as recommended by RoSPA).

5.5.1. Road traffic accidents in Luton

An average of 55 people have been killed or seriously injured (KSI) on Luton’s roads per year in the last three years (2010-2012) which is a rate of 26.9 per 100,000 population. This is lower than the England average of 33.4 per 100,000 population. There has been an average of just over 600 slight casualties on Luton’s road (during the same period) - a rate of 295 higher than the England average of 249 per 100,000. The total number of road casualties in 2012 was nearly 25% lower than the 1994 to 1998 average (Figure 30).

Figure 30 Three-year average for all casualties by type of road user.

The Road Safety Plan 2011-2015 sets out the approach in road safety engineering, education, training and publicity. Using the 2004 to 2008 average it identifies the key groups at risk. These are:
• pedestrians - 4 to 19 year olds are most at risk, especially males
• motorcycle and moped riders –14 to 19 year olds are most at risk and the 35 to 44 year old age group is also at risk but to a lesser extent. In both groups males are significantly more at risk than females
• car drivers - 17 to 29 year olds are most at risk, especially males
• car passengers –15 to 24 year olds are most at risk.

5.5.2. What is in place to increase safe travel?

Road traffic collisions are monitored for patterns and clusters. The highest priorities are analysed to see whether engineering measures can resolve the issue cost effectively. However, there are very few sites that can now be engineered cost effectively. An extensive engineering programme of traffic calming, 20mph speed limits and zones has been carried out over the past few years. It is envisaged that the majority of suitable residential streets and areas outside schools will have a 20mph speed limit by 2015.
Case study: Young drivers cinema advert

Bedfordshire and Luton Casualty Reduction Partnership working in partnership with Cambridgeshire and Peterborough Road Safe Partnership and Heart FM produced a cinema advert called Two Second Mistake. An audience of 17 to 24 year olds were invited through a Heart FM competition to view the advert. The advert involved two friends in a car on the way to meet another friend. They were late so the passenger phoned the friend who was actually in the cinema. The friend sitting in the cinema audience told him that there was a girl in the audience that just looked like their friend’s (the driver) ex girlfriend and he texted a photo to the passenger. The driver wanted to see and was momentarily distracted and crashed. The film and 3 short follow up films about the consequences of the advert appeared on YouTube.86

5.6. Recommendations

Planning and health

Development of local areas should ensure that the health and wellbeing of residents are improved by:
• designing future plans that promote active travel such as walking and cycling
• ensuring safety and good access to key services (including community health services) are integral in planning policy.

Green spaces

• Continue improvement of the play area stock and outdoor fitness equipment in appropriate locations within the town.
• Continue to develop links with organisations to support people with mental health issues to develop skills through active involvement in environmental projects in local parks and green spaces.
• Promote access to green space including working with General Practice to explore options to increase social prescribing such as Green Prescriptions.

Air quality

• Develop a business case to extend the current AQMA to include the monitoring of small particulates as well as nitrogen dioxide.
• Review the health impact assessment (HIA) submitted as part of the airport planning application with a view to developing a health management plan.

Road safety

• Prepare a child safety audit report and develop a plan to implement the recommendations.
Alcohol, illegal drug use and community safety

6.1. Introduction

The wider determinants of health such as deprivation, poverty, poor housing and limited economic opportunities have a significant impact on how people live and their lifestyle choices. There is a correlation between these factors and the excessive use of alcohol or illegal drugs, which in turn has a significant impact on physical and mental wellbeing. In areas of high deprivation, lack of community confidence in reporting antisocial behaviour and enforcement measures impacts significantly on victims and their emotional wellbeing.

6.2. Alcohol

Alcohol has a significant role in British culture and the economic benefits of a safe and lively entertainments industry are well established. However, excessive alcohol consumption can have serious consequences for young people, adults and communities as well as increasing pressure on public services. Nationally it is estimated that alcohol is a factor in almost half of violent assaults, 27% of child protection serious case reviews mention alcohol problems and 16% of road fatalities are found to be alcohol related.

It has been estimated that problematic alcohol use costs the NHS £2.7 billion a year, almost twice the equivalent figure in 2001. But the cost of alcohol to society as a whole is even greater, estimated to stand at £17-22 billion, and by some estimates is as high as £55 billion.

6.2.1. Alcohol use in Luton

The Local Alcohol Profiles for England (LAPE) 2011 estimates that in Luton:

- 25% of the population 16+ are estimated to abstain from drinking alcohol
- 61% drink within recommended limits 14 units (women) and 21 units (men) weekly and are categorised as drinking at a lower risk level
- 12% are estimated to be drinking over recommended limits (up to 50 units for males and 35 for females) and are categorised as drinking at a harmful level
- 3,797 (2.6%) people are estimated to be drinking over 35 units (women) and 50 units (men), suffering physical, economic and emotional harm and are categorised as drinking at a hazardous level.

The profile shows Luton is performing better than national and regional averages against binge drinking estimates and the rate of alcohol-specific hospital admissions for under 18s at 33 per 100,000 population.

However, alcohol-related recorded crimes and alcohol-related violent crimes are both significantly higher than the regional and national averages. The trend data shows that in 2011/2012, the rate of alcohol-related recorded crimes was 10 per 1,000 population, compared to regional rate of 6; and the rate for alcohol related violent crimes was 7 per 1,000 compared to a regional average rate of 4.4.
One way of measuring the impact of alcohol consumption in a town is by the rate of increase in alcohol related hospital admissions. Luton’s rate of increase in alcohol related hospital admissions has been declining but the most recent trend data 2012/2013 shows an increase. This rate of increase is greater than the increase in similar comparative areas and is higher than the national rate. This trend is subject to further analysis and may be attributable to improved recording and increased awareness by hospital staff.

6.2.2. What is in place to reduce excessive alcohol use in Luton?

Alcohol information campaigns are promoted throughout the year and customised to issues in Luton. The most recent, Waisted, highlights calorie consumption in addition to alcohol unit values. Services in Luton are commissioned in line with evidence based practice and NICE guidance. Information and advice for young people is commissioned to be provided in schools, colleges, hospital and community settings and a town centre intervention service is easily accessible for young people under 25 with more complex issues.

Services for adults offer a range of different interventions and treatments including advice and information, counselling, substitute prescribing, stabilisation, community and residential rehabilitation and mutual aid support networks.

Case study: Hospital-based alcohol brief advice service

The hospital-based alcohol brief advice service was first commissioned by the Luton Drug and Alcohol Partnership (LDAP) in 2009. Alcohol workers employed by the local voluntary alcohol agency in reach to the hospital. The Emergency Assessment Unit (EAU) was the first ward to pilot alcohol screening, which resulted in 159 patients receiving brief advice. The service expanded and in 2012/13 918 patients received brief advice. The majority of these were patients drinking at hazardous levels, but had no intention of seeking support from an alcohol agency. The service has been extended to provide alcohol brief advice on the surgical and psychiatric wards.

“I didn’t realise how much alcohol was affecting my health until I was asked about it on my last visit to hospital; I may consider changing it now.” EAU patient.

The ambition of the Luton Alcohol strategy is to improve awareness of alcohol harm among young people and delay the age of first use, encourage lower risk drinking to be the norm for those who drink and target services at those who are most at risk whilst responding and reducing the harm to those who have already developed problems.

Local communities and families can make a key contribution by challenging the social acceptability of excessive alcohol consumption and by supporting responsible drinking and access to good information, advice and interventions help reduce the impact alcohol has on the lifestyle of the individual, their families and communities. The multi-agency approach to the night time economy, Luton Safe, aims to reduce alcohol related crime and support those who become vulnerable through the Street Pastor scheme and the Luton SOS Bus.
6.3. Illegal drug use

Drug use and drug dealing are complex issues linked to deprivation and poverty. Many drug users face structural exclusion from the labour market, often compounded by homelessness, a criminal record and dependence on state benefits. Uncontrolled drug use is one of the key drivers of crime and effective drug treatment contributes significantly to reducing reoffending.

Although relative poverty by itself is not the cause of drug problems, evidence supports the view that there is a strong association between the extent of drug problems and a range of social and economic inequalities. Therefore narrowing these inequality gaps should contribute significantly to a reduction in high levels of damaging drug use.

The majority of drug users come to drug agencies as self-referrals and are looking to become drug free. To be successful, drug treatment needs to take a holistic approach, tackling associated problems such as health, housing and employment and not just focusing on drug use itself. Drug users often have complex needs and the progression from drug use to a drug-free life is challenging.

“It all takes time. There is no magic cure and life’s a maze that we must all work out one day at a time. As long as you have inner strength and a pinch of selfishness for yourself, it will all fall into place eventually.” Drug free client 2008

By preventing harm to children, young people and families affected by drug use and by engaging with communities of young people, their families and friends to provide easily accessible alcohol and drug harm prevention information, the numbers of problematic adult users has reduced over the past decade and most young people are better informed to make choices about their lifestyle.

A focused enforcement process, aimed at protecting communities and ensuring that drug dealing is perceived in Luton as a high-risk activity, supports the prevention and intervention work with young people and adults.

6.3.1. Illegal drug use in Luton

The latest estimates provided by the University of Glasgow suggest there are approximately 1,793 problematic heroin or crack-cocaine using adults living in Luton. This is a higher prevalence compared to the England average, but similar to other comparators area except for Hillingdon with approximately 1,362 drug users in a population of about 181,600 which is significantly better than England average (Table 11).

Table 11 The number of drug users in Luton and comparator areas.

<table>
<thead>
<tr>
<th>Area</th>
<th>Drug users</th>
<th>Area population</th>
<th>Compared to England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillingdon</td>
<td>1,362</td>
<td>181,600</td>
<td>Significantly better than England average</td>
</tr>
<tr>
<td>Slough</td>
<td>1,066</td>
<td>94,200</td>
<td>Significantly worse than England average</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>2,135</td>
<td>161,100</td>
<td>Significantly worse than England average</td>
</tr>
<tr>
<td>Birmingham</td>
<td>10,263</td>
<td>695,000</td>
<td>Significantly worse than England average</td>
</tr>
<tr>
<td>Luton</td>
<td>1,793</td>
<td>132,400</td>
<td>Significantly worse than England average</td>
</tr>
</tbody>
</table>

Data from NDTMS (National Drug Treatment Monitoring System) indicates that around 75% of these problem drug users are known to structured treatment services in Luton. 45% of opiate and crack users were actively engaged in structured services at the end of March 2013. 28% were women and 36% of clients were from BME communities.

Nationally Class A drug use is declining and in line with these trends the overall number of people accessing structured interventions has declined over the last three years. The age of clients is increasing as older long term users begin treatment.

The Luton Drug Profile (2011) shows a higher percentage of residents think drug use or dealing is a problem in Luton more than in other areas in the region. The prevalence of opiate and crack users is similar to London boroughs although the prevalence is declining, particularly with the under 30s, which is in line with national trends. Luton performs worse than the national average on the percentage of unplanned exits from drug treatment. Whilst the number of successful completions is increasing, poverty, poor health, unsafe housing and the lack of employment hampers progress.

6.3.2. What is in place to reduce illegal drug use in Luton?

Services in Luton are commissioned in line with evidence based practice and NICE guidance. Information and advice for young people are commissioned to be provided in schools, colleges and community settings and a town centre intervention service is easily accessible for young people under 25 with more complex issues. Services for adults offer a range of different interventions and treatments including advice and information, counselling, substitute prescribing, stabilisation, community and residential rehabilitation and mutual aid support networks.

Luton residents who have problems with alcohol and/or drug issues often suffer poor physical and mental health and can be reluctant to access health services. The LDAP strategic ambition is that drug and alcohol users achieve independence and self-reliance and are offered services that support this. Tackling the wider risks are crucial to improving health and wellbeing. In particular, safe housing for vulnerable clients is difficult to obtain but a key factor in improving drug treatment outcomes. In addition access to volunteering, education and training followed by stable employment is difficult to find in Luton but has a significant impact on an individual’s future health and life style.

6.4. Community safety

Crime and antisocial behaviour affects the health of our communities and individuals within them, both directly and indirectly. The Nacro report Better Health Lower Crime identifies five ways in which crime affects health:

- directly – for example, through violence, injury, rape and other offences against the person
- indirectly through the psychological and physical consequences of injury, victimisation and isolation because of fear - these effects persist across time
- as a determinant of illness along with poverty and other inequalities which increase the burden of ill health on those communities least able to cope
- by reducing the effectiveness of our health care systems through violence against staff damage to patients properties and revenue lost in replacement liabilities/risk, repair and security
- by preventable health burdens such as alcohol related crimes, motor vehicle incidents and drug dependency.
6.4.1. Community safety in Luton

Luton has a well-established community safety partnership known as soLUTiONs. This is a partnership of organisations that work together in the town to address crime, antisocial behaviour, drug and alcohol incidents and reoffending behaviour. SoLUTiONs produces an annual strategic assessment and partnership plan setting out the priorities and actions for tackling crime and antisocial behaviour across the town. The most recent plan highlighted that levels of all crime in Luton fell by 12% in the last year; this was a decrease of 2085 offences. This was following a slight (6%) increase in crime levels from 2010-2011.

Luton’s comparative performance against similar community safety partnerships (as measured by the Home Office) remains favourable with decreasing levels projected.

Key areas of work of the soLUTiONs Community Safety Partnership which specifically overlap with health and wellbeing include:

- **domestic abuse** – including the implementation of the Domestic Abuse Strategy, case conferencing around victims of domestic abuse (at the multi-agency risk assessment conferences – MARAC), provision of support and assistance from the Independent Domestic Violence Advisors (IDVA) and Independent Sexual Violence Advisors (ISVA), provision of a Police Domestic Abuse Repeat Offender Unit (DARO)

- **antisocial behaviour** – launching a new model of working which routinely risk assesses repeat and vulnerable victims of antisocial behaviour, including an assessment of the impact on their health and wellbeing, disability or learning difficulty if appropriate, and overall impact of the antisocial behaviour on the victim and their household; and creating the soLUTiONs Antisocial Behaviour Team to provide a hub for tackling antisocial behaviour – including case management of priority antisocial behaviour cases and increased resources through third party providers for victim support

- **integrated offender management** – providing a dedicated multi-agency approach to tackling the most prolific offenders in the town. Fast tracking support to health services, housing and benefits

- **Cleaner, Safer, Greener Spaces** – working in partnership to improve public spaces, including sharing intelligence and action planning around Dangerous and Status Dogs, removing and investigating fly tipping, graffiti and abandoned vehicles, targeting action on repeat locations of arson and deliberate fires, carrying out Environmental Action Days and carrying out crime prevention improvements.

The current community safety strategic assessment is considering issues that have emerged concerning serious youth violence and child sexual exploitation, serious sexual violence and on-street sex trade. The partnership is developing strategies and action plans to tackle these issues including a focus on prevention, and some public health interventions are already underway. It will be important to consider public health interventions to support work on these areas.
Case study: Antisocial behaviour

Mrs X reported antisocial behaviour in the communal areas in her block of flats by groups of young people smoking cannabis and drinking alcohol and she had had a window smashed. She had moderate health problems and was very frightened. Bedfordshire Police Antisocial Behaviour Case Prioritisation System graded her situation at the most serious level and she was allocated a case manager from the Partnership Priority Antisocial Behaviour Team. Following an investigation the following action occurred:

- five young people were identified and behaviour sanctions were agreed
- environmental improvements were made to the location
- regular police patrols were organised for high visibility and to reassure the community.

The antisocial behaviour stopped quickly and the young people have been not been involved in it since. The impact on Mrs X’s health reduced as she had engaged with a range of services and developed a support network in her community.

6.5. Recommendations

Illegal drug use

- Improve access to safe housing, education, training and employment for alcohol and drug users seeking to re-establish alcohol and/or drug free lifestyles.
- Continue the development of local licensing policies concerning the availability of alcohol.
- Ensure Making Every Contact Count (MECC) is widely promoted in all agencies to ensure alcohol and drug use is considered alongside other health information.

Community safety

- Ensure strategies to tackle community safety issues such as violence and sexual exploitation incorporate evidence-based, preventative interventions.
- Strengthen joint working between the key agencies to improve services to victims and offenders.
## Summary of key recommendations

### Health Inequalities Strategy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Authority</th>
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<tbody>
<tr>
<td>Refresh the Health Inequalities Strategy with a specific focus on the wider determinants of health.</td>
<td>Health Inequalities Group</td>
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</table>

### Family Poverty/Welfare Reform

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Authority</th>
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</thead>
<tbody>
<tr>
<td>Develop and support initiatives to ensure Luton residents in work have a sufficient income to fund a healthy lifestyle.</td>
<td>Welfare Reform Board</td>
</tr>
<tr>
<td>Model the impacts of welfare reform on health and mental wellbeing and identify actions to mitigate negative impacts.</td>
<td>Welfare Reform Board</td>
</tr>
<tr>
<td>Ensure all front line staff have the knowledge and skills to signpost individuals to the help and support that is available based on the Making Every Contact Count principle.</td>
<td>Welfare Reform Group</td>
</tr>
<tr>
<td>Ensure that advice, support and advocacy are joined up and there is consistency in the advice given. This will prevent the duplication of support, allow case management of the individual/household and ensure a positive outcome for all concerned.</td>
<td>Welfare Reform Group</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Authority</th>
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<tbody>
<tr>
<td>Ensure new mental health provider supports people with mental health problems into employment or volunteering.</td>
<td>Mental Health Local Implementation Group</td>
</tr>
<tr>
<td>Increase awareness of mental health issues in the workplace to reduce stigma and discrimination through MHFA training.</td>
<td>Public Health</td>
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### Education

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<tr>
<th>Recommendation</th>
<th>Responsible Authority</th>
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<tr>
<td>Work with schools to implement the recommendations of the PSHE review.</td>
<td>Council - Public Health</td>
</tr>
<tr>
<td>Prioritise early years by increasing support for families to achieve improvements in early child development and continuing to improve the quality of pre-school education to ensure a healthy start in life.</td>
<td>Council – Children and Learning</td>
</tr>
<tr>
<td>Maintain a focus on reducing the inequalities gap in educational attainment between girls and boys and between those eligible and those not eligible for free school meals.</td>
<td>Council – Children and Learning</td>
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</table>
## Section 7

### Skills and employment

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Council</th>
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<tr>
<td>• Continue to improve links with major employers in the town to better understand their needs as employers and how best the schools, adult education and apprenticeship providers can up-skill young people for future employment.</td>
<td>Environment and Regeneration (E&amp;R)</td>
</tr>
<tr>
<td>• Use research tools to monitor qualifications and skills looked for in job adverts and use this data to inform Job Centre Plus, education and training providers in the town to better identify future skills needs.</td>
<td>E&amp;R</td>
</tr>
<tr>
<td>• Promote the value of apprenticeships with young people, their parents, carers and advisers and Luton’s employer base as a route into employment and a credible and viable alternative to ‘A’ Level and University study.</td>
<td>E&amp;R, Children and Learning and Housing and Community Living (HCL)</td>
</tr>
<tr>
<td>• Continue to support people into employment through skills and employability programmes with a particular focus on people with mental health issues and disabilities.</td>
<td>E&amp;R and HCL</td>
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</table>

### General housing conditions

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<th>Recommendation</th>
<th>Responsible Council</th>
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<tbody>
<tr>
<td>Update the Housing Conditions Survey in 2014 in partnership with the Building Research Establishment (BRE) to identify where areas of housing improvements should take place and potential cost savings</td>
<td>HCL</td>
</tr>
<tr>
<td>Commission BRE to undertake a quantitative Health Impact Assessment in addition to the conditions survey.</td>
<td>HCL and Public Health</td>
</tr>
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### Fuel poverty

<table>
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<tr>
<th>Recommendation</th>
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<tr>
<td>Develop a coordinated action plan with the aim of targeting fuel poor households and improving knowledge and understanding amongst key partners on the issues and extent of fuel poverty in Luton.</td>
<td>HCL and Public Health</td>
</tr>
</tbody>
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### Homelessness

<table>
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<tr>
<th>Recommendation</th>
<th>Responsible Council</th>
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<tbody>
<tr>
<td>Ensure the new Homeless Strategy recognises the importance of prevention and addresses the health needs of homeless people.</td>
<td>HCL</td>
</tr>
<tr>
<td>Maintain and improve access to Primary Care services for homeless people in Luton.</td>
<td>Clinical Commissioning Group</td>
</tr>
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### Unintentional injuries

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Council</th>
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</thead>
<tbody>
<tr>
<td>Review NICE guidance ‘Preventing unintentional injuries among the under-15s in the home’ (PH30) to ensure the recommendations are being implemented locally.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Summary of key recommendation</td>
<td></td>
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<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Explore the options for collecting appropriate data specifically on under 5’s accidents and falls in the over 65’s in order to plan interventions based on local trends and highest risks.</td>
<td>Council – Public Health</td>
</tr>
<tr>
<td>Develop formal referral pathways between the falls service and exercise programmes designed to improve mobility.</td>
<td>Council – HCL</td>
</tr>
<tr>
<td><strong>Planning and health</strong></td>
<td></td>
</tr>
<tr>
<td>Development of local areas should ensure that the health and wellbeing of residents are improved by:</td>
<td></td>
</tr>
<tr>
<td>• designing future plans that promote active travel such as walking and cycling</td>
<td>Council – E&amp;R</td>
</tr>
<tr>
<td>• ensuring safety and good access to key services (including community health services) are considered in all planning decisions.</td>
<td>Council – E&amp;R</td>
</tr>
<tr>
<td><strong>Green spaces</strong></td>
<td></td>
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<td>Continue improvement of the play area stock and outdoor fitness equipment in appropriate locations within the town.</td>
<td>Council – E&amp;R</td>
</tr>
<tr>
<td>Continue to develop links with organisations to support people with mental health issues to develop skills through active involvement in environmental projects in local parks and green spaces.</td>
<td>Council – E&amp;R</td>
</tr>
<tr>
<td>Improve access to green space including working with General Practice to explore options to increase social prescribing such as Green Prescriptions.</td>
<td>Council – E&amp;R</td>
</tr>
<tr>
<td><strong>Air quality</strong></td>
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<tr>
<td>Develop a business case to extend the current AQMA to include the monitoring of small particulates as well as nitrogen dioxide.</td>
<td>Council - E&amp;R</td>
</tr>
<tr>
<td>Review the health impact assessment (HIA) submitted as part of the airport planning application with a view to developing a health management plan.</td>
<td>Council – Wider Determinants of Health Group</td>
</tr>
<tr>
<td><strong>Road safety</strong></td>
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</tr>
<tr>
<td>Prepare a child safety audit report by and develop a plan to implement the recommendations.</td>
<td>Council - E&amp;R</td>
</tr>
<tr>
<td><strong>Illegal drug use</strong></td>
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<tr>
<td>Improve the access to safe housing, education, training and employment for alcohol and drug users seeking to re-establish alcohol and or drug free lifestyles.</td>
<td>Luton Drug and Alcohol Partnership</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Responsible Party</td>
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<tr>
<td>Continue the development of local licensing policies concerning the availability of alcohol.</td>
<td>Luton Drug and Alcohol Partnership</td>
</tr>
<tr>
<td>Ensure Making Every Contact Count (MECC) is widely promoted in all agencies to ensure that alcohol and drug use is considered alongside other health information.</td>
<td>Luton Drug and Alcohol Partnership</td>
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<tr>
<td><strong>Community safety</strong></td>
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<tr>
<td>Ensure strategies to tackle community safety issues such as violence and sexual exploitation incorporate evidence-based, preventative interventions.</td>
<td>Community Safety Partnership</td>
</tr>
<tr>
<td>Strengthen joint working between the key agencies to improve services to victims and offenders.</td>
<td>Community Safety Partnership</td>
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</tbody>
</table>
## Update on recommendations in 2012-13 Annual Public Health Report

<table>
<thead>
<tr>
<th>Recommendation</th>
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<th>Lead organisation/individual</th>
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</table>
| Ensure the skills and employability strategy meets the needs of Luton’s women  | In 2012-13, Luton Adult Learning assisted 1050 female learners to gain qualifications in a range of subjects and levels of qualification and delivered support sessions and one to one advice to 1017 women. An ESF funded project provides employment support for those with caring responsibilities (children or dependent adult) which has mainly female participants. Job Centre Plus is running two new programmes targeting mainly women:  
  - The Employability Programme for Lone Parents is linked to the Retail sector. A 4-part programme consisting of a 3-day work-focused training programme, leading to a 2 week work placement in a retail store, followed by a group session and ending with a 6 week post placement support with job searching.  
  - The Sports for Wellbeing is a 12 week programme designed to build confidence and improve English. It includes 1 hour swim or badminton in an all-female environment.  
In the last year, 21% of women supported by the National Career Service have gone into learning and 35% have found work. | Environment and Regeneration                                           |
### Section 8

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Progress</th>
<th>Lead organisation/individual</th>
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<tbody>
<tr>
<td>Increase uptake of stop smoking services among young women, pregnant women and women aged 55-64 years</td>
<td>Continuing to support the routine CO monitoring of pregnant women at booking for referral into the Stop Smoking Service. The CO monitors were upgraded this year for more accurate and more client friendly results. Between April 2013 and February 2014: • 1124 women set a quit date (552 of whom were over 40) • 77 pregnant women set a quit date The percentage of women smoking in pregnancy has reduced from 14.6 in 2011-12 to 13.6 in 2012-13.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Undertake a health needs assessment to identify issues and establish a local baseline for use of smokeless tobacco products. From this work an action plan will be developed</td>
<td>Health Needs Assessment completed and action plan to take work forward. Key recommendation to raise awareness in community and deliver sessions with community groups.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Develop obesity services for women of child bearing age, ensuring appropriate care pathways for women including before and during pregnancy</td>
<td>Adult weight management support has been provided to 1,659 Luton residents in the past 10 months (April 2013 to January 2014). 62% are women of child bearing age of whom 64% lost weight with 21% losing 5% or more of their weight within 12 weeks. 35% are still active and their level of success is currently unknown. Since August 2013 Gynaecology, Obstetrics and Midwifery at the L&amp;D hospital have been referring women to a specialist Slimming World group, supported by a midwife. Between August 2013 and January 2014, 32 women have been referred to the group. Of those that completed the programme, 75% reduced their body weight, with 11% losing 5% or more of their body weight.</td>
<td>Public Health</td>
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<td>Recommendation</td>
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<tr>
<td>Develop an adult weight management pathway, integrating physical activity guidelines and ensure frontline staff can deliver brief interventions, ensuring they are tailored to gender and ethnic specific needs</td>
<td>A new clinical healthy weight steering group has been set up to lead on child and adult pathway development. A literature review has been undertaken to support the development of a physical activity strategy for Luton. A list has been compiled of all physical activity schemes across Luton.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Continue to raise awareness that women should drink fewer units of alcohol than men and women considering and during pregnancy should avoid alcohol altogether</td>
<td>Information about safer drinking for women and not drinking when considering pregnancy is included in alcohol awareness workshops provided in schools, colleges and the community. It is also included in the brief advice interventions provided in the hospital and the community.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Deliver Mental Health First Aid training to increase awareness of mental health issues, including the links to physical health and to encourage early diagnosis and support</td>
<td>Two day adult Mental Health First Aid (MHFA), two day Youth MHFA and half day MHFA Lite courses have been set up in Luton in conjunction with Mind BLMK. These courses are part of a national mental health awareness programme. By the end of 2013, over 100 people working and living in Luton have been through the training programmes.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Encourage NHS Health Checks for women with mental health problems and promote healthy lifestyle services such as Stop Smoking Services, Weight Management, sensible drinking and volunteering opportunities</td>
<td>People with Mental Health problems have been included as priority group to be targeted as part of the Health Check agreements with both General Practice and the Community Provider.</td>
<td>Public Health</td>
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<tr>
<td>Identify women living with undiagnosed disease, particularly diabetes, heart and respiratory disease</td>
<td>The NHS Health Check programme is helping to identify adults with undiagnosed vascular diseases and those at an increased risk of heart disease and stroke. An action plan is in place to detect those patients with a major undiagnosed health condition such as COPD that are not known to be on a chronic disease register in primary care. A business case is being developed for a private provider (Insight Solutions) to deliver Data Quality Assessment (DQA) for all GP Practices in Luton. This will identify patients who have a high probability of a disease.</td>
<td></td>
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<tr>
<td>Encourage the uptake of NHS Health Checks in women aged 40-44 and increase data quality in ethnicity reporting and postcode to be able to determine deprivation</td>
<td>The Health Check agreement directs GPs to give priority to individuals from ethnic minority groups and those living in deprived areas of the town. An audit is currently taking place to look at uptake of health checks by ethnicity, gender and socio-economic status. 6007 women aged 40-44 have been identified as being eligible for a Health Check. To the end of quarter 3 (2013-14), 25% had been offered a Health Check and 9% had received a Health Check.</td>
<td>Public Health</td>
</tr>
</tbody>
</table>
| Develop actions that promote the completeness of disease registers and enable joint working between the NHS and local authority to empower communities to present earlier | The CCG has a number of strategies in place to systematically improve quality and reduce variability in primary care. Examples include:  
  • risk profiling (to identify patients with LTCs who are at risk of an emergency admission). GPs review these patients alongside community multidisciplinary teams to produce a patient care plan.  
  • local enhanced service review. To ensure good quality services, required to meet the needs for Luton’s population, are easily accessible to all.  
  The Public Health Team is supporting the CCG with needs assessment and demographic profiling. | CCG and Public Health                 |
<table>
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<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Deliver a community based peer education project to increase awareness of the</td>
<td>A project manager was appointed at the end of February 2013. 45 volunteers have been recruited and trained as cancer peer educators and are now active in the community and at local events. An awareness benchmarking survey was completed in three key wards in early June and this will be followed up towards the end of the financial year to evaluate impact.</td>
<td>Public Health</td>
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<tr>
<td>signs and symptoms of cancer - the cancer peer education project will be</td>
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<td>focussed initially in the wards with the highest premature mortality rates and</td>
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<tr>
<td>then rolled out to other areas</td>
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<tr>
<td>Cervical screening uptake in the 25-34 and 55-64 years age groups are</td>
<td>Working with NHS England, the current commissioners, to target age cohorts with low uptake in GP practices. NHS England is commissioning research to identify the cause of poor uptake from the University of Hertfordshire.</td>
<td>Public Health</td>
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<td>particularly low, therefore a focus is required on improving uptake through</td>
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<td>education and awareness</td>
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<tr>
<td>Recruit and train volunteer Health Champions to outreach to the local community,</td>
<td>Through Luton Borough Council’s volunteering programme over 50 people from local communities have been recruited and trained to become Community Health Champions. This is in addition to another 16 people recruited as Workplace Health Champions. These Health Champions have been active in their local communities to signpost people to healthy lifestyle support services and to engage in a number of health events. To increase the focus on improving women’s health, Councillor Ayub has taken on the role of women’s health champion.</td>
<td>Public Health and Community Development</td>
</tr>
<tr>
<td>raise awareness of key health issues and signpost to relevant services for</td>
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<tr>
<td>women</td>
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<tr>
<td>Raise awareness amongst GPs of the scale and consequences of undiagnosed CHD,</td>
<td>This is in the work plan of the Primary Care Prevention Group. It will be developing an action plan to raise awareness of this issue.</td>
<td>Public Health</td>
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<tr>
<td>COPD and diabetes</td>
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### Section 8

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<th>Recommendation</th>
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<tr>
<td>Increase access to NHS Health Checks at community venues to supplement existing Primary Care service focusing on priority wards and ‘at risk’ populations</td>
<td>Since November 2013 a community provider has been commissioned to offer NHS Health Checks in the priority wards and to the ‘at risk’ populations. To end of February 2014, the provider completed 537 NHS Health Checks. The data will be analysed to see what percentage are from the target groups.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Further investigation is needed in relation to improving disability free life expectancy. In particular, using the 2011 census results (published in 2013) to identify areas of focus</td>
<td>No new DfLE data. Healthy Life Expectancy at birth is an overarching indicator in the PHOF. This is the average number of years a person would expect to live in good health. Latest data (2009-11) for males is 60.6 years and females 59.6 years. This is lower than England but similar to comparator areas.</td>
<td>Public Health</td>
</tr>
<tr>
<td>Monitor mortality from pneumonia, investigating reasons for the increase and investigate the risk factors and causes of death in the ‘other’ respiratory disease category</td>
<td>Mortality from pneumonia is monitored. Latest data indicates that the excess mortality rate for women observed in 2008-10 (DSR of 2.39 per 100,000 population) persists. In 2010-12, the excess mortality rate was 2.02 per 100,000 population. Further detailed review required.</td>
<td>Public Health</td>
</tr>
</tbody>
</table>
## Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APHR</td>
<td>Annual Public Health Report</td>
</tr>
<tr>
<td>AQMA</td>
<td>Air Quality Management Area</td>
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<tr>
<td>BFRS</td>
<td>Bedfordshire Fire and Rescue Service</td>
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<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<tr>
<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CHD</td>
<td>Coronary heart disease</td>
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<tr>
<td>CO</td>
<td>Carbon monoxide</td>
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<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>DALY</td>
<td>Disability-adjusted life year</td>
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<tr>
<td>DARO</td>
<td>Domestic abuse repeat offender</td>
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<tr>
<td>DFG</td>
<td>Disabled Facilities Grant</td>
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<tr>
<td>DfE</td>
<td>Department for Education</td>
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<tr>
<td>DFLE</td>
<td>Disability-free life expectancy</td>
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<td>DSR</td>
<td>Directly age standardised rate</td>
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<td>ESOL</td>
<td>English for speakers of other languages</td>
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<tr>
<td>EWD</td>
<td>Excess winter deaths</td>
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<tr>
<td>EYFS</td>
<td>Early Years Foundation Stage</td>
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<tr>
<td>FE</td>
<td>Further Education</td>
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<tr>
<td>FSM</td>
<td>Free school meals</td>
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<td>HIA</td>
<td>Home Improvement Agency</td>
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<tr>
<td>HLE</td>
<td>Healthy life expectancy</td>
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<td>HMO</td>
<td>Houses of Multiple Occupation</td>
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<tr>
<td>HWBS</td>
<td>Health and Wellbeing Strategy</td>
</tr>
<tr>
<td>HWBB</td>
<td>Health and Wellbeing Board</td>
</tr>
<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
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<tr>
<td>IDVA</td>
<td>Independent Domestic Violence Advisors</td>
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<tr>
<td>ISVA</td>
<td>Independent Sexual Violence Advisors</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>KS</td>
<td>Key Stage</td>
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<tr>
<td>LA</td>
<td>Local Authority</td>
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<td>LAPE</td>
<td>Local Alcohol Profile for England</td>
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<td>LDAP</td>
<td>Luton Drug and Alcohol Partnership</td>
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<tr>
<td>LIHC</td>
<td>Low income, high cost</td>
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<tr>
<td>LSN</td>
<td>Local Statement of Need</td>
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<td>LTC</td>
<td>Long term condition</td>
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<tr>
<td>MECC</td>
<td>Making Every Contact Count</td>
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<tr>
<td>MHFA</td>
<td>Mental health first aid</td>
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<td>MHNA</td>
<td>Mental health needs assessment</td>
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</table>
**Abbreviations and acronyms**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>NCN</td>
<td>National Cycle Network</td>
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<tr>
<td>NDTMS</td>
<td>National Drug Treatment Monitoring System</td>
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<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
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<tr>
<td>NICE</td>
<td>National Institute of Health and Care Excellence</td>
</tr>
<tr>
<td>NPPF</td>
<td>National Planning and Policy Framework</td>
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<tr>
<td>NQF</td>
<td>National Qualification Framework</td>
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<tr>
<td>NSNO</td>
<td>No Second Night Out</td>
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<td>NVQ</td>
<td>National Vocational Qualification</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>PHO</td>
<td>Public Health Observatory</td>
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<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
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<td>PM</td>
<td>Particulate Matter</td>
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<td>PSLA</td>
<td>Pre-School Learning Alliance</td>
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<td>QOF</td>
<td>Quality Outcomes Framework</td>
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<td>RoWIP</td>
<td>Right of Way Improvement Plan</td>
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<td>RPA</td>
<td>Raising the Participation Age</td>
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<tr>
<td>SEMLEP</td>
<td>South East Midlands Local Enterprise Partnership</td>
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<tr>
<td>SEPT</td>
<td>South Essex Partnership Trust</td>
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<tr>
<td>SFA</td>
<td>Skills Funding Agency</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YLL</td>
<td>Years of life lost</td>
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10. References


Section 10


