Health Inequalities in Luton -
Getting to the Point

Annual Public Health Report
2003
I am really pleased to present this public health report for Luton 2003. Public health directors are required to publish an independent annual report on the health of the population. The report should be a good source of local information but, more importantly, should recommend action to improve health. This report focuses clearly on reducing inequalities. It examines the causes of health inequalities, describes the local picture and makes recommendations for the future.

Luton’s health is poor compared to England as a whole and there are also health inequalities within Luton itself. The town has benefited from some additional project funding through the former Health Action Zone, but over the same time local NHS services have been under-funded to the tune of tens of millions of pounds in relation to our fair share of the national budget.

But inequalities in health are not just about NHS services - they result mainly from the social, economic and environmental circumstances in which people live. Luton’s story of health inequality is the story of manufacturing decline, of low paid part time jobs and, more recently, of people fleeing from oppression.

Reducing inequalities in health is now high on the national and local agenda - it is no longer hidden under euphemisms such as ‘variations in health’. We can be proud that Luton organisations are more committed than most to doing something about inequality, for example through the health and social care theme group of the Luton Forum. Indeed this report itself is a multi-agency effort.

This year’s public health report is the first in a new series covering the area served by Luton teaching Primary Care Trust (tPCT). It has not tried to examine every subject, and other topics will be included in future reports. Your ideas on this would be welcome.

Finally, I would like to thank everyone who has contributed to this report. Kelly O’Neill in particular has acted skilfully as project manager, and I am also very grateful for contributions from Paul Adams, Camille Alexis, Glynis Allen, Sarah Allen, Paul Barton, Chantal Bradley, Heidi Cresswell, Catherine Dummett, Margaret Eames, Alison Jack, Kanan Kannan, Sabina Khanoum, Karen Malone, Emma Morbey, Pat Nair, Remi Omotoye, Rushma Patel, Shahin Pathan Daksha Pitroda, Varsha Patel, Jennifer Russell, Gavin Sandmann, Rosemary Simpson, Paul Singer, Morag Stewart, Mike Streather, Mark Thaxter, Edmund Tiddeman, Jane Trundle, Christine Watson, and Sandra White.

Paul Brotherton
Director of Public Health
Luton teaching Primary Care Trust
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INTRODUCTION AND SUMMARY

This report outlines health inequalities in Luton and the action we need to take to overcome them. A recent national report stated that:

“Overall, health and life expectancy are still linked to social circumstances and childhood poverty. Despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. Some parts of the country have the same life expectancy as the national average for the 1950s. These inequalities mean poorer health, reduced quality of life and early death for many people”1.

This report describes those inequalities as they relate to Luton. While not the worst in the country, Luton’s health statistics do not read well. The average man in Luton can expect to live four years less than his neighbour in St Albans. The average woman three years less. The report describes inequalities within Luton too.

These persistent inequalities are not only unjust but they represent a huge and unnecessary waste of life and of talent to the country and to this town. Our challenge is to reduce inequality by making Luton a more equitable place to live and work. Equity is about fairness and social justice. It means that health care and other resources should be distributed according to population need rather than simply giving the same to everyone. A key theme of the Government’s approach to inequalities is that resources need to be targeted more to those who are most in need. Providing the same service to everyone is simply not enough.

Summary

This report faces the challenge by following a journey illustrated by the pyramid diagram.

The first chapter describes the population of Luton. It provides key demographic information and some overall health indicators for the town. It shows that:
- Luton has a young population
- The number of older people is likely to grow over the next 10 years
- Biscot and Dallow wards have the highest levels of multiple deprivation
- 28% of Luton’s population are from black and minority ethnic groups
- Luton has a high birth rate
- Luton’s perinatal mortality rate is high and the gap with the rest of the country is growing
- Luton has a lower than average life expectancy and again the gap has been growing.

The report then focuses on some of the key factors that affect our health. Some of these relate to broad social and economic factors and others relate to our lifestyle. They affect different groups unequally and contribute to inequalities in health.
- Overcrowded housing, poor education, poverty and unemployment all combine to reinforce the cycle of social deprivation and ill-health
- Environmental issues such as air and noise pollution pose a threat in some parts of Luton
- Poor diet and low levels of physical activity both contribute to obesity and increase the risk of heart disease, cancer and other conditions
- Alcohol and drug use affect the health of thousands of people in Luton
- Every year about 250 Luton people die early because they smoke

Moving up the pyramid, we then pick out some of the health conditions where we have good evidence that Luton faces particular challenges. The chapter shows that:
- Coronary heart disease remains the biggest single cause of premature death in Luton
- About 4% of Luton’s population are recorded as having diabetes, but the real figure will be higher
- Luton’s perinatal mortality rate is high, even compared to similar areas around the country
- There is a rapidly growing sexual health problem in Luton, and over 400 local people have HIV/AIDS
- Tuberculosis has made a come-back, with a growing number of Luton people infected
- Luton’s oral health is poorer than the rest of the country.

The fourth chapter looks at access to health care in the community and in hospital. Key findings include:
- There are wide inequalities in access to primary care services, for example relating to asylum seekers
- New developments such as the Walk In Centre are designed to make access to healthcare more equitable
- Equity audit is an important tool in measuring and reducing inequity.

Finally we present recommendations to help reduce health inequalities in Luton. The chapter challenges some myths, and calls for healthy decisions based on good evidence to address Luton’s priorities.
- Recommendations for healthy decisions:
  - Ensuring that the Community Plan has a clear focus on benefiting the worst off
  - Not undertaking major airport, motorway or housing development without health impact assessment
  - Creating a mechanism to bring health considerations into the borough planning process
- Helping schools and other organisations to consider health impact and how best to reduce inequality

• Recommendations for good evidence:
  - Developing a core set of health indicators to monitor progress
  - Filling gaps in ethnic recording and monitoring
  - Ensuring that major initiatives to reduce inequalities are based on good evidence and have a clear evaluation mechanism
  - Ensuring that audit programmes cover smoking and sexual health

• Recommendations for Luton’s priorities. The following are put forward for priority attention locally. Addressing these will also help to reduce other inequalities:
  - Sexual health including HIV
  - Coronary heart disease
  - Tuberculosis
  - Perinatal mortality
  - Community development
  - Language support

The report ends with some further information including a list of useful websites. The data in this report is just the tip of the iceberg, the point is to take action to close the health gap.
LUTON’S POPULATION

Introduction

We start this report at the base of the pyramid. The make-up of the population sets the scene for all the health information to follow. This chapter begins by looking at the demography of Luton and then goes on to look at some high-level health information, including key births and deaths indicators.

Luton’s population is young, rapidly changing, and diverse. It combines areas of social deprivation with areas of greater affluence. One way to picture our population is to imagine 100 typical Luton residents gathered in a room. In that room there would be:

- 50 males and 50 females
- 24 people under 16 years of age
- 16 people aged 65 years or over
- 28 people from black and minority ethnic backgrounds
- 20 people who were born outside the UK
- 60 Christians, 15 Muslims and 14 with no religion
- 8 people who say their health is not good

Luton’s health is often compared with neighbouring areas in Bedfordshire and Hertfordshire, showing big differences between the town and the rest of the strategic health authority area. However these comparisons are not always helpful and they often mask the considerable inequalities within Luton and between neighbouring PCTs. In this report we compare Luton with the above family of PCTs for some key indicators of health. Further comparisons are likely to be made in future public health reports.

Resident Population

The resident population of Luton, as measured in the 2001 Census, was 184,371. The average age in Luton is 34.9 years, compared to 38.6 in England and Wales. Table 1 and Figure 3 gives more detail about Luton’s age profile.

Table 1: Resident population by age group, 2001

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Luton%</th>
<th>England &amp; Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>23.5</td>
<td>20.2</td>
</tr>
<tr>
<td>16 to 19</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>20 to 29</td>
<td>15.4</td>
<td>12.6</td>
</tr>
<tr>
<td>30 to 59</td>
<td>39.3</td>
<td>41.5</td>
</tr>
<tr>
<td>60 to 74</td>
<td>11.2</td>
<td>13.3</td>
</tr>
<tr>
<td>75 and over</td>
<td>5.1</td>
<td>7.6</td>
</tr>
<tr>
<td>All Ages</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

Figure 3: Population of Luton: Age distribution: 2001

This report compares Luton with the above family of PCTs for some key indicators of health. Further comparisons are likely to be made in future public health reports.

It is also helpful to compare Luton with ‘similar’ areas around the country. The Eastern Region Public Health Observatory (ERPHO) was asked to identify PCTs which have a similar profile to Luton on two key characteristics - the level of social deprivation and the proportion of people from South Asian backgrounds. Their analysis revealed the following areas as good comparators:

- Brent
- Ealing
- Hounslow
- North Kirklees
- Slough


Luton’s Annual Public Health Report 2003
Much of the information about Luton in this report is broken down into local authority ward areas. The 2001 ward boundaries have normally been used but some data have been shown for the new (May 2003) boundaries. Figure 4 illustrates the differences in population profiles. Biscot, Dallow and Saints have relatively young populations, whilst Icknield has the highest proportion of people aged 75 and over. These differences will have an effect on the type of primary care and other services required in different localities.

Population Projections

The population of Luton is projected to rise by 3.9% from 2000 to 2010. Figure 5 highlights that there is year on year growth in the age groups 15-74 and 75 years plus. There will be a 14% increase in the number of people aged 75 and over which will bring additional need for many health and social care services. The 0-14 age group is forecast to decline by 6%.

However, the population projection used by the Local Authority (which calculates the birth and death rate adjusted to take into account local changes such as agreed planned housing developments in that period, migration and immigration), forecasts a decline in Luton’s population by 2.7% to 2011.

‘Creating Sustainable Communities: Making it Happen’ proposes very substantial housing and economic development in the Milton Keynes and South Midlands area. This includes thousands of new homes around the Luton area. Major population growth would have three main implications for health:

- Additional needs for health care services
- A need to assess the health impact of specific developments such as major roads
- The need to maintain socially cohesive communities during the growth

It should be emphasised that these developments have not yet been agreed, and it is important that the implications be properly investigated and widely understood throughout the full consultation process.

The different population projections, without taking into account the implications of the above development proposal, make it important that health service and other plans are flexible enough to meet future demands.

Figure 5: Population projections by age group in Luton: 2000-2010

Table 2: Luton's Population Projections by age group: 2000-2010: (Numbers in 1000s)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
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<tr>
<td>0-14</td>
<td>41.9</td>
<td>41.7</td>
<td>41.5</td>
<td>41.1</td>
<td>40.9</td>
<td>40.7</td>
<td>40.3</td>
<td>40.1</td>
<td>39.8</td>
<td>39.6</td>
<td>39.4</td>
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<td>15-74</td>
<td>132.1</td>
<td>133.2</td>
<td>134.1</td>
<td>134.9</td>
<td>135.7</td>
<td>136.6</td>
<td>137.4</td>
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<td>140.3</td>
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<td>75+</td>
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<td>All Ages</td>
<td>183.2</td>
<td>184.2</td>
<td>184.9</td>
<td>185.3</td>
<td>186.1</td>
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<td>188.4</td>
<td>188.9</td>
<td>189.7</td>
<td>190.2</td>
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Social and Economic Conditions

In the ‘determinants of health’ chapter we will see many examples of how poor social, economic and environmental circumstances cause poorer health. Bringing some of these factors together the Department of the Environment, Transport and the Regions (DETR) publishes the Index of Multiple Deprivation (IMD). The IMD 2000 is a ward level Index and is made up of six components:

- Income
- Employment
- Health deprivation and disability
- Housing
- Education, skills and training
- Geographical access to services

Figure 6 shows the position of Luton wards on the index of multiple deprivation. The higher numbers indicate higher levels of deprivation.

A child poverty index has also been calculated at ward level, using data more specifically relating to the circumstances and well being of children. The index shows that Biscot and Dallow are the wards with the highest child poverty scores, which would suggest poorer health and a higher need for health services than most. Icknield and Putteridge are again the wards with the lowest poverty scores.

Figure 6: Index of Multiple Deprivation score for Luton Wards: 2001

Key Deprivation rank (1=low)

<table>
<thead>
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<th>Rank</th>
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<tbody>
<tr>
<td>1 to 7.9</td>
</tr>
<tr>
<td>8 to 14.9</td>
</tr>
<tr>
<td>15 to 22.9</td>
</tr>
<tr>
<td>23 to 30.9</td>
</tr>
<tr>
<td>31 to 37.9</td>
</tr>
<tr>
<td>38 to 44.9</td>
</tr>
<tr>
<td>45 to 51.9</td>
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<tr>
<td>52 and over</td>
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</table>

Source: ONS, derived from 2001 census.
Ethnicity

Ethnicity and health is a key theme running through this report. Later sections give a more detailed analysis of the differences between ethnic groups on specific health topics. A recent review of evidence suggests that it is not the case that all black and minority ethnic groups are uniformly at greater risk of poor health compared to whites. However people from Bangladeshi, Pakistani and Caribbean backgrounds are at overall greater risk. It concludes that most of the difference in health status can be accounted for by material deprivation and consequent poorer living standards and that racism appears to be an important factor.

The ethnic profile for Luton contrasts markedly with the national picture (see Table 3). There are also substantial differences in the ethnic make-up of different areas of Luton. These are shown in Figure 7.

Table 3: Percentage of resident population by ethnic group: 2001

<table>
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<tr>
<th>Percentage of resident population in ethnic groups:</th>
<th>Luton%</th>
<th>England%</th>
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<tr>
<td>White</td>
<td>71.9</td>
<td>90.9</td>
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<td>(of which White Irish)</td>
<td>(4.6)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>18.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Indian</td>
<td>4.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>9.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>4.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Other Asian</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>6.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Caribbean</td>
<td>4.2</td>
<td>1.1</td>
</tr>
<tr>
<td>African</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Other Black</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Chinese or Other</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

Figure 7: Ethnicity by Ward: 2001

Source: ONS 2001 Census. Note: Based on new (May 2003) ward boundaries.

Early Years

Luton has a high birth rate. Table 4 and Figure 8 shows that this has been consistently higher than the rest of England and Wales. Even when the age structure of the population is taken into account the number of births in Luton is very high. In fact in 2002 Luton had the second highest general fertility rate in the country, some 74.8 live births per 1,000 women aged 15-44. The national average was 54.9 births per 1000 women in that age group.

Table 4. Live Birth Rate: 1996-2002 - Live births per 1000 resident population

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>16.6</td>
<td>16.2</td>
<td>15.8</td>
<td>15.6</td>
<td>15.7</td>
<td>15.6</td>
<td>16.9</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>12.5</td>
<td>12.3</td>
<td>12.2</td>
<td>11.9</td>
<td>11.5</td>
<td>11.2</td>
<td>11.4</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1

Figure 8: Crude Live Birth Rate: 1996-2002

Improving the life chances of the very young is a key component of reducing health inequalities. Important indicators of population health are the perinatal mortality rate and the infant mortality rate. Perinatal mortality is the number of stillbirths and the deaths of babies up to the age of one week, per 1000 total births. Table 5 shows that the rate in Luton is not only higher than average but has sadly risen in recent years. Because of the extent of this problem a later section of the report looks at perinatal mortality in more detail.

Table 5: Perinatal Mortality Rate: 1996-2002
Still births & deaths under 1 week combined per 1000 total live and still births

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>8.9</td>
<td>10.8</td>
<td>9.7</td>
<td>12.5</td>
<td>11.3</td>
<td>11.8</td>
<td>14.0</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>8.6</td>
<td>8.4</td>
<td>8.2</td>
<td>8.2</td>
<td>8.2</td>
<td>8.0</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1

ONS 2002.
In 2002 the Luton Forum, a partnership of local public sector organisations, and representatives of the voluntary, community and business sectors, agreed a series of targets across different aspects of life in Luton to be achieved by 2010. One of the shared health targets is to:

“Close the gap between the rates of death in babies in Luton and the rest of the country”.

In recent years the gap has become greater not smaller. It will be a major challenge to bring perinatal mortality down but the NHS locally has set itself the aim of eliminating all avoidable stillbirths in the town.

Infant mortality relates to deaths in children under the age of one year. Table 6 shows that infant mortality in Luton remains consistently higher than the national average. The trend is also shown in Figure 9, but it should be borne in mind that there will be fluctuations at PCT level from year to year. An NHS target is to reduce by at least 10% the gap in infant deaths between manual social groups and the population as a whole, by the year 2010.

Table 6: Infant Mortality Rate: 1996-2002
Deaths under 1 year per 1000 live births

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>9.3</td>
<td>7.8</td>
<td>7.0</td>
<td>8.4</td>
<td>9.4</td>
<td>6.3</td>
<td>7.7</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>6.1</td>
<td>6.0</td>
<td>5.7</td>
<td>5.8</td>
<td>5.6</td>
<td>5.5</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1

Figure 9: Infant Mortality Rate in Luton - 1996-2002

Source: ONS Vital Statistics 1
Life Expectancy

The average lifespan we can expect to live from birth is a key indicator of a population’s health. Inequalities are striking, with gap across the country of some 9.5 years for males and 6.9 years for females. On average Luton people live about a year less than the national average. Table 7 shows the current position, including the gap between the life expectancies of men and women.

Table 7: Life Expectancy of men and women in Luton: 1999-2001

<table>
<thead>
<tr>
<th>Life Expectancy</th>
<th>Luton</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>74.3 years</td>
<td>75.4 years</td>
</tr>
<tr>
<td>Women</td>
<td>79.5 years</td>
<td>80.2 years</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics

Luton’s other health target for Vision 2010 is to:

“Halve the gap between life expectancy in Luton and the rest of the country”.

Again, the gap between Luton and the rest of the country has widened in recent years. In the early 1990s the difference was only a few months. As with perinatal mortality we have a real challenge to reverse the trend and meet the town’s target.

Life expectancy is one of the comparisons we have made with other PCTs. Figures 10 and 11 show how Luton compares with the other five in the group as well as the national average. Luton’s position is poor, being second lowest in the group for both male and female life expectancy. Life expectancy in Luton is significantly lower than the national average for both men and women.

*Note: In this report the word ‘significantly’ is used when the difference between two figures is unlikely to be due to pure chance. A statistical test has been applied and the results would indicate that there is less than a 5% chance of this health gap being due to chance. The results that could have been found by chance are shown by the lines at the top of each bar in the graph.

Figure 10: Male Life Expectancy: 1999-2001

Source: Eastern Region Public Health Observatory (ERPHO)

Main Causes of Death in Luton

In 2002 there were a total of 1523 deaths of Luton residents. Figure 12 shows the main causes of death in the town. In common with most places across the country, the largest cause of death locally is circulatory diseases (including coronary heart disease) and the second largest cancer.

To make a realistic comparison with the rest of the country it is important to standardise the death rates by taking age and gender into account. The following ‘standardised mortality ratios’ (SMRs) show Luton’s death rate as a percentage of the England and Wales rate. All figures of more than 100 indicate that Luton has a high death rate and those lower than 100 show the opposite.

In general Luton has high death rates, which fits with the fact that the town has a lower life expectancy than average. Childhood deaths stand out as a particular problem relative to the rest of the country. Some causes of childhood death are examined later in the report, but others will need further investigation.

**Table 8: Standardised Mortality Ratios for Luton for selected age groups/ causes, based on 1999 and 2001 pooled data.**

<table>
<thead>
<tr>
<th>Luton’s SMR</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages and all causes of death - Females</td>
<td>112</td>
</tr>
<tr>
<td>All ages and all causes of death - Males</td>
<td>105</td>
</tr>
<tr>
<td>All ages and all causes of death - M&amp;F</td>
<td>109</td>
</tr>
<tr>
<td>All causes of death - ages 0-15 only (M&amp;F)</td>
<td>143</td>
</tr>
<tr>
<td>All causes of death - ages 16-64 only (M&amp;F)</td>
<td>111</td>
</tr>
<tr>
<td>All causes of death - ages 65-74 only (M&amp;F)</td>
<td>111</td>
</tr>
<tr>
<td>Circulatory diseases only - all ages</td>
<td>106</td>
</tr>
<tr>
<td>Cancers only - all ages</td>
<td>96</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators 2002

---

**Figure 11: Female Life Expectancy: 1999-2001**

Source: Eastern Region Public Health Observatory (ERPHO)

**Figure 12: Main Causes of Death in Luton: 2002**

Source: Compendium of Clinical and Health Indicators 2002
Percieved Health Status

Much of this report is based on births, deaths and other ‘objective’ data. But health is essentially a subjective concept and it is important to understand people’s perceptions of their health and of how it can be improved.

In the 2001 Census people were asked about their general health over the previous 12 months and to describe it as “good”, “fair” or “poor”. These figures were not adjusted for the age distribution of each area, therefore those areas with a higher proportion of older people may have a higher proportion of people viewing their health as “fair” or “poor”. 8% of people in Luton viewed their health as poor compared to the national average of 9%.

Table 9: Perceived Health Status: 2001

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Luton%</th>
<th>England &amp; Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>69.6</td>
<td>68.6</td>
</tr>
<tr>
<td>Fairly good</td>
<td>22.4</td>
<td>22.2</td>
</tr>
<tr>
<td>Not good</td>
<td>8.0</td>
<td>9.2</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

People were also asked whether they thought they had a “limiting long-term illness” (LLTI) - a health problem, or disability, which limits their daily activities or the work they can do. This included problems relating to old age. It is interesting to compare the figures for those who identify themselves as suffering from poor health and those who have a LLTI. It is possible that some people who have a LLTI do not actually rate their health as poor as they are used to dealing with their long-term condition. 15.3% of people in Luton assessed themselves as having a LLTI compared to the national average of 18.2%. This reduced level may again reflect the young population of the town, but it may also be that people’s perceptions and expectations of their health vary across the country.

Table 10: Residents with a limiting long-term illness: 2001

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Luton%</th>
<th>England &amp; Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a long-term illness</td>
<td>15.3</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

For the first time, the 2001 Census asked a question about any voluntary care provided to look after, or give any help or support to family members, friends, neighbours or others because of long term physical or mental ill-health, disability, or problems relating to old age. Nearly 9% of Luton’s population said that they were in that position. The needs of carers themselves have become increasingly recognised and have become an important priority in health and social care.

Table 11: Unpaid carers: 2001

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Luton%</th>
<th>England &amp; Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided unpaid care</td>
<td>8.7</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

This chapter has given a profile of Luton’s population and outlined some of the broad issues affecting health in the town. It has set the scene for the more detailed analysis to come in the following chapters. Other population statistics are set out in the appendices, and more data can be found from some of the websites listed at the end of the report.
DETERMINANTS OF HEALTH

Introduction

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care”

WHO: 1948

The above World Health Organisation quote looks rather old fashioned now and there have since been many more declarations and aspirations that urge policy-makers to achieve good health for all. The reality is that millions of people around the world face ill health or death from poor living conditions or infectious disease.

Although a very rich country, the UK is not immune from these problems. The most socially and economically deprived are those that suffer the worst health, and some health inequalities are widening. This chapter looks at some of the main factors (or ‘determinants’) affecting our health. They help explain why it is that some communities are relatively healthy and some are not.

Housing

Decent accommodation is a basic human requirement, and has an important affect on health. As with many of the determinants of health, the quality of housing is strongly related to income. The relationship between housing and health has been investigated in many different studies. The picture is complex, however, as the health of people living in sub-standard accommodation may also be affected by factors such as poor diet, smoking and fuel poverty.

A report from the British Medical Association indicates that some of the most vulnerable groups in the UK are suffering health problems because of poor housing and social exclusion. These health problems include a range of respiratory diseases such as bronchitis and asthma, coronary heart disease and stroke, increased risk of injury in the home, mental health problems, depression and, for more vulnerable households, it can mean early death during the colder months of the year. Older people are at particular risk, and the poorest pensioners are almost twice as likely to live in energy inefficient housing than those who are better off. As well as the quality of the home (for example in terms of cold, dampness and mould), the level of overcrowding is also crucial. This can contribute to the spread of infectious diseases such as tuberculosis.

Housing and Households in Luton

There were 70,755 households in Luton in 2001. Ninety nine per cent of the resident population live in households, with the remaining 1% of the population living in communal establishments. The average size of a household in Luton is 2.6 people, compared to 2.4 in England and Wales. More facts and figures on households are shown in Table 12. For many indicators Luton is similar to the rest of the country, although there are fewer pensioner households and more with children.

1WHO. 1948. Declaration of Human Rights - 1948
Changes in the social housing sector have particular consequences for the vulnerable who may be excluded from other sectors and are at particular risk from the effects of poor accommodation. Dwindling provision of social housing through ‘Right to Buy’ schemes have contributed to homelessness and increased the use of temporary accommodation.

We know from comparison between the Luton House Condition Survey 2000 and the 1996 English House Condition Survey that:

- There are approximately 750 Houses in Multiple Occupation (HMOs) in Luton, representing 1% of the housing stock, which is above the national average of 0.3%.

- Approximately 5% of privately owned/rented property is unfit, compared to a national figure of 7.5%.

A range of schemes are available to improve housing standards. Disabled Facilities Grants (DFGs) are available to a mandatory limit of £25,000, although discretionary funding can be used where the cost of the works exceeds this limit. In addition fast-tracked ‘Home Repair Assistance’ grants are available, targeting older and vulnerable people, where the work has a clear health gain.

‘Renovation Grants’ and ‘Common Parts Grants’ are only available within the Housing Plus (H+) area, which is known to contain the oldest housing, the highest levels of unfitness and the lowest incomes in the town. The Housing Plus area is made up of Dallow and Biscot wards and part of High Town.

Luton is a beacon site for its Affordable Warmth Strategy. Key aims include a rolling programme of energy efficiency improvements to council housing stock, a range of initiatives designed to promote and maximise take-up of benefits, energy efficiency grants and discounts in private sector households. There is an opportunity to better involve NHS staff in raising awareness within vulnerable population groups.

Table 12: Composition of Households in Luton: 2001

<table>
<thead>
<tr>
<th>Housing</th>
<th>Luton%</th>
<th>England and Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>One person households</td>
<td>28.8</td>
<td>30.0</td>
</tr>
<tr>
<td>Pensioners living alone</td>
<td>11.1</td>
<td>14.4</td>
</tr>
<tr>
<td>Other all pensioner households</td>
<td>7.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Contains dependent children</td>
<td>34.3</td>
<td>29.5</td>
</tr>
<tr>
<td>Lone parent households with dependent children</td>
<td>6.8</td>
<td>6.5</td>
</tr>
<tr>
<td>Owner occupied</td>
<td>70.8</td>
<td>68.9</td>
</tr>
<tr>
<td>Rented from Council</td>
<td>12.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Rented from Housing Association or Registered Social Landlord</td>
<td>3.8</td>
<td>6.0</td>
</tr>
<tr>
<td>Private rented or lived rent free</td>
<td>12.8</td>
<td>11.9</td>
</tr>
<tr>
<td>Without central heating</td>
<td>6.2</td>
<td>8.5</td>
</tr>
<tr>
<td>Without sole use of bath, shower or toilet</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

---

Overcrowding

Overall, there is evidence of overcrowding in 8% of dwellings in Luton, with a third of those being seriously overcrowded. This is a particular problem in the housing association stock, and accommodation is extremely limited in the inner wards of Biscot and Dallow. These areas show the greatest indicators of need and have a low supply of good quality rented social housing.

Figure 13 shows the different levels of overcrowding in Luton’s wards.

* The occupancy rating provides a measure of under-occupancy and overcrowding. For example, a value of -1 implies that there is one room too few and that there is overcrowding in the household. The occupancy rating assumes that every household, including one-person households, requires a minimum of two common rooms (excluding bathrooms).

Homelessness

Local councils have a duty to provide temporary accommodation, usually in the form of Bed and Breakfast within council owned hostels, hotels and properties leased from the private sector. The main groups given assistance are those with dependent children or where a pregnant woman is part in the household. There are established lines of communication between Luton Borough Council and Luton tPCT. This enables the Healthcare for the Homeless, Asylum Seekers and Travellers (HHAT) team to inform health visitors and school nurses of the addresses of all newly homeless families.
What next?

Housing is an important part of the environmental strategy outlined in the Community Plan\(^9\). The focus is on protecting the residential role and the environment of housing areas, developing more affordable housing, developing new sites, bringing former residential sites back into family use, and ensuring support for homeless people.

There are also important requirements relating to the standard of housing as well as the supply. For example over 14,600 dwellings do not have adequate loft insulation, and cavity wall insulation could be provided in 33,800 dwellings. In addition the potential demand for disabled facilities grants at £9.5 million is beyond the current level of funding available.

Current pioneering work on tackling fuel poverty is currently being incorporated into the single assessment process for older people. There is a need to develop greater links with health services, including hospital discharge. This will help ensure that problems such as cold homes, low income and home safety that may have precipitated or aggravated illness can be dealt with wherever possible.

Education

Breaking the link between deprivation and poor educational performance is fundamental to improving the social well-being and health of the population. This view is endorsed by House of Commons Education Select Committee (1999), which claimed that "education must be the engine of equality", allowing children from all backgrounds an opportunity to reach their full potential. However, educational achievements continue to reflect social inequalities rather than challenge them.

Statutory Education in Luton

Some 32,326 pupils are in Luton Local Education Authority (LEA) schools\(^10\). Luton has 83 schools, comprising 12 High Schools, 61 Primary Schools, 3 Special Schools, 6 Nursery Schools and 1 main and 2 satellite Pupil Referral Units who address the education needs of pupils who have been permanently excluded from mainstream schools.

As part of the national curriculum all pupils are assessed at the end of each Key Stage, at ages 7, 11, 14 and 16. Figure 14 summarises the data

\(^{10}\) Luton Local Education Authority Jan 2003
and indicates that Luton’s overall performance is a little lower than the national average.

The education service routinely collects information on the ethnicity of Luton schoolchildren and on educational attainment. Some ethnic groups appear to achieve better results than others in formal tests, although the reasons are complex and exam results are strongly affected by social class and levels of deprivation. Table 13 sets out the current make-up of Luton’s school population, showing that some 45% are from black and minority ethnic groups.

Note: Ethnic classifications were extended for 2003- some of the classifications were not used in 2002.

Table 13: Ethnicity of Luton schoolchildren: 2001-02/2002-03

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>01/02</th>
<th>02/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>58.5%</td>
<td>55.3%</td>
</tr>
<tr>
<td>Mixed background: White and Black Caribbean</td>
<td>N/A</td>
<td>3.0%</td>
</tr>
<tr>
<td>Mixed background: White and Black African</td>
<td>N/A</td>
<td>0.2%</td>
</tr>
<tr>
<td>Mixed background: White and Asian</td>
<td>N/A</td>
<td>1.1%</td>
</tr>
<tr>
<td>Mixed background: Any other mixed background</td>
<td>N/A</td>
<td>1.5%</td>
</tr>
<tr>
<td>Indian</td>
<td>3.7%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>17.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>6.8%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Kashmiri</td>
<td>N/A</td>
<td>2.6%</td>
</tr>
<tr>
<td>Other Asian background</td>
<td>N/A</td>
<td>0.6%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>4.8%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Black African</td>
<td>2.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Black Other</td>
<td>1.9%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>4.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Luton LEA annual schools census.
For Key stage 1, the assessment of 7 year olds, Luton results are close to the national average. However, although the gap between boys and girls in reading is closing, there is still a substantial gap in writing. There is no gap in achievement in maths. Ethnic monitoring shows that at this stage Luton’s Indian and Black Caribbean pupils achieve higher than average results, White UK pupils’ results are similar to the national average, and pupils from Bangladeshi and Pakistani backgrounds achieve below the national average.

In Key stage 2 (11 year olds), girls consistently achieve more in English and boys more in Maths, but there is no gap in science. Indian pupils are again the highest attaining group, achieving above the national average in all areas. White UK heritage pupils achieve broadly in line with national expectations, but Black Caribbean, Bangladeshi and Pakistani heritage pupils achieve below the Luton and national average.

At Key stage 3 (14 year olds) a substantial gap of 18% has developed between boy’s and girl’s attainment. The results by ethnic group are similar to Key Stage 2, but with a further reduction in the results achieved by Black Caribbean pupils.

Finally, Luton schools achieved a 1% increase in the proportion of pupils achieving five A*-C grades in their GCSE exams in 2002, with girls achieving 10% more than boys. Indian heritage pupils are the highest attaining group with standards well above the national average. Bangladeshi pupils are then next highest achieving group, but white UK, Pakistani and Black Caribbean pupils are all well below the national average. Only 16% of the latter attained five A*-C grades - some 35% below the national average.

Higher Education

“Girls go to college to get more knowledge,
Boys go to Jupiter to get more stupider”

Ellie- aged 9

Luton has a large resident student population. In 2003 the University of Luton had in excess of 12,400 students. Nearly one-third of these students were from outside the UK - almost double the national average for international recruitment to a British university. The university also has one of the most diverse student populations in the country, including 45% of students aged over 24, and 30% of students from minority ethnic groups11.

Table 14: Students and schoolchildren aged 16 and over in Luton: 2001

<table>
<thead>
<tr>
<th></th>
<th>Luton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of full-time students aged 16 and over</td>
<td>11,846</td>
</tr>
<tr>
<td>Percentage of total resident population aged 16-74</td>
<td>6.4%</td>
</tr>
<tr>
<td>Total number aged 16 to 17</td>
<td>4,086</td>
</tr>
<tr>
<td>Total number aged 18 and over</td>
<td>7,760</td>
</tr>
</tbody>
</table>

Note: Students and schoolchildren were counted at their term-time address.
Source: 2001 Census, ONS

Despite the presence of a university, Table 15 indicates that educational achievement for the population of Luton remains below the national average.

Table 15: Education Levels Attained: 2001

<table>
<thead>
<tr>
<th></th>
<th>Luton%</th>
<th>England &amp; Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had no qualifications</td>
<td>31.3</td>
<td>29.1</td>
</tr>
<tr>
<td>Qualified to degree level or higher</td>
<td>15.0</td>
<td>19.8</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

11 University of Luton website. 2003.
What next?

The Community Plan again summarises some of the actions to improve educational outcomes in Luton. One of the plan’s ‘Vision 2010’ targets is to ‘provide educational achievement levels in Luton schools which are above the national average at all stages’. It lists a wide range of initiatives to help reach this target, including a mentoring project aimed at African Caribbean and mixed heritage pupils.

One promising initiative is the ‘Flying Start’ programme which began three years ago and which now includes 20 schools. The initiative is a partnership between schools, parents and the voluntary sector aiming to raise children’s educational achievements with a proactive focus on early years education.

The results of this approach in the key stage 1 age group have shown that children in the first eight Flying Start schools progressed at a faster rate than children from schools not participating in the scheme. The rate of improvement in reading and writing was 18% compared to a 1% improvement for all other Luton schools.

An evaluation completed by the University of Cambridge highlighted an increase in parental involvement, leading to greater awareness of their children’s learning and progress. More parents took advantage of family and adult learning opportunities and there was increased access to early years education for 3 and 4 year-olds. It is important that schemes like this help to break the cycle of poor education, poor jobs and poor health.

Poverty and Unemployment

The relationship between poverty and poor health has become increasingly clear in recent years. Low income directly affects people’s access to, and choices about, all aspects of life, from eating and staying warm to housing, education, training and access to employment, pensions and security in old age. People living in poverty experience worse health and die sooner than the rest of the population.

The effects of poverty are not random. Specific groups of people are more vulnerable to, or at risk of, poverty. Those at greater risk include older people, particularly women, black and some minority ethnic groups, people who are long-term sick, disabled and lone parents. Socio-economic status also has a major influence on experiences of poverty, with semi and unskilled worker households far more vulnerable to poverty than skilled worker/professional households.

An example of the effect of poverty on living conditions, and subsequent health, can be seen in recent research by the National Consumer Council, which identified that millions of households are either living without basic utilities (water, gas or power), are under threat of disconnection or are amassing debts to pay their bills. Older people living on low incomes in cold homes with repair and heating needs are at particular risk.

A Private Sector House Condition Survey carried out in Luton in 2000 identified 28% of households living in fuel poverty - defined as needing to spend 10% of their disposable income on fuel. Many of these households do not claim their full benefit entitlement and are not aware of free government funded grants for energy efficiency measures for their homes.

The Community Legal Service Strategic Plan for 2002 recognised that 8 wards in Luton appear to be in the top 5% of wards nationally who do not have enough advice provision and, even where it is available, many, (particularly those over 50), do not know where to access it.
Using national figures as a baseline, and local work around maximising benefit take-up, it is clear that many vulnerable households - (those with residents over 60, long term sick and disabled and young children) fail to claim all the benefits to which they are entitled thus leaving them living on lower incomes than necessary.

Unemployment

Unemployment is a strong indicator of poverty. The risk of unemployment varies with age, ethnicity, gender and previous employment, being more common amongst semi and unskilled manual workers. Black and minority ethnic groups are more likely to be unemployed than white groups. People of Pakistani, Bangladeshi and African ethnicity are much more likely than the rest of the population to be out of work but wanting to work.

Young unemployed people on New Deal programmes (for the 18-24 age group) often have wider health and social needs that must be addressed in order for them to access sustainable employment. If wider issues are not addressed they often slip off New Deal into what are called ‘unknown destinations’. This can mean living without benefits and sometimes slipping into the ‘informal economy’ with associated risks to health and well-being.

However getting a job does not always provide a route out of poverty, particularly for households that may fluctuate between work and unemployment through insecure employment and short-term contracts. Labour market trends suggest that low paid jobs with little security are becoming increasingly common. People can find that they come off benefits into short term low paid contracted employment and when this ends they go back on to lower rates of benefits thus sinking further into poverty with its associated health risks.

Unemployment in Luton

Recent data suggests that unemployment in Luton is higher than average. Female unemployment locally stands at 1.6%, compared to 1.4% in Great Britain, and male unemployment at 4.5% compared to 3.6% nationally. Overall 3.1% are unemployed in Luton. Of these 28% are aged 24 years or younger, and 15% have been unemployed for a year or more.

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Table 16 gives an overview of employment in Luton taken from the 2001 census.

With a four-fold variation in unemployment rates between different ethnic groups, only White and Chinese groups have lower than the average unemployment rate in Luton. Figure 15 shows the pattern locally.

Table 16: Economic Activity in Luton: 2001

<table>
<thead>
<tr>
<th>Status</th>
<th>Luton%</th>
<th>England and Wales%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>59.6</td>
<td>60.6</td>
</tr>
<tr>
<td>Unemployed</td>
<td>3.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Economically active full time students</td>
<td>3.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Retired</td>
<td>10.9</td>
<td>13.6</td>
</tr>
<tr>
<td>Economically inactive students</td>
<td>5.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Looking after home/family</td>
<td>7.6</td>
<td>6.5</td>
</tr>
<tr>
<td>Permanently sick or disabled</td>
<td>4.6</td>
<td>5.5</td>
</tr>
<tr>
<td>Economically inactive</td>
<td>4.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: 2001 Census, ONS

Figure 15: Unemployment in Luton by Ethnic group, (% of those economically active): 2001

What next?

Following the decline in manufacturing, most notably recently with the Vauxhall closure, a great deal of effort is going into promoting and regenerating Luton as a place to live and work. Its proximity to London and its good transport links make it an attractive location for investment.

However, new jobs need to be good jobs in order to help lift people out of poverty. They also need to be accessible, and it is important that flexible public transport and affordable childcare is available to allow people to secure employment with local employers. Efforts are also being made to improve training to equip people with the skills for employment.

For those without work, on pensions or low income, it is important that there is good advice to allow people to receive the benefits they are entitled to. This should include continuing outreach work and improved links across health organisations and the Local Authority to make such advice more accessible.
Environment

"By addressing the wider determinants of health, including food, housing standards, health and safety, air quality, noise and environment issues generally, environmental health makes a fundamental contribution to the maintenance and improvement of public health and improving quality of life and well-being."

Some of the environmental issues that affect health in Luton include:
- Air Quality
- Noise
- The Airport
- Provision of green spaces
- Environmental health risks

Air Quality

The Department of Health Advisory Group on the Medical Aspects of Air Pollution Episodes identified three common types of air pollution episode:
- Summer smog- the main pollutant being ozone
- Vehicle smog- the pollutant being Nitrogen oxide
- Winter smog- Sulphur being the main pollutant, combined with Nitrogen oxide.

All three types of pollution episode can have adverse effects on health. For people with chronic respiratory disease, such as asthma this can lead to deterioration in health requiring increased medication and possible medical intervention. Older people suffering from chronic cardiopulmonary disease are also at increased risk of poorer health when the air quality locally deteriorates.

Motor traffic is the most significant source of air pollution in the UK. The M1 motorway passes through the town and has 4 lanes at places in order to accommodate the heavy vehicle volume.

All Local Authorities are required to carry out a review assessment of air quality in their areas. In December 2001 Luton Borough Council published a report that concluded that air quality within an area around the M1 motorway would not comply with the Air Quality Standards Objective for Nitrogen Dioxide (NO₂) after the end of 2005.

The Council’s Environmental Protection Group is developing an Air Quality Action Plan (AQAP) and will be consulting interested parties on what might be done to seek compliance with the objective in the longer term. The Highways Agency, who is responsible for the M1 Motorway, will therefore be key in any consultations.

Noise

A European Environment Agency report in 1995 stated that noise intensities above 55 decibels (dB) are high enough to cause annoyance, aggressive behaviour and sleep disturbance. Routine exposure to 65dB can result in hypertension and noise above 75dB can lead to

Table 17: Decibel level of various sound sources

<table>
<thead>
<tr>
<th>dB</th>
<th>Community Noise Levels (outdoors)</th>
<th>Home &amp; Industry Noise Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>Aircraft at one nautical mile (6080 ft) before landing</td>
<td>Newspaper printing press</td>
</tr>
<tr>
<td>80</td>
<td>Diesel train 45 mph at 100 ft</td>
<td>Food blender</td>
</tr>
<tr>
<td>70</td>
<td>Car at 65 mph at 25 ft</td>
<td>Vacuum cleaner</td>
</tr>
</tbody>
</table>

21Luton Borough Council Website.
increased stress levels, increased heart rates and potential hearing loss. The type of sound and the level of background noise can affect levels of noise. To put noise into perspective Table 17 compares the dB levels of sound sources.

Again road traffic is a significant culprit in this form of pollution. The major source of Road Traffic Noise (RTN) in Luton is the Motorway. Quiet wearing surfaces have recently been laid and noise barriers erected. However traffic is increasing and there is a proposal for further widening of the motorway to accommodate yet more vehicles.

**Luton Airport**

“I have lived there for nearly 5 years. I like the area where I live, apart from the fact that the loud aeroplanes are a bother”

14-Year-old Luton girl

The airport is an important asset for Luton and helps generate much-needed jobs for local and other people. The Department for Transport has recently consulted on the future development of air transport in the UK\(^2\), which potentially has major implications for Luton. The number of passengers at Luton could increase from 6 million in 2000 to a capacity of up to 31 million in 2030. The number of plane movements each year could increase from 54,000 to a capacity of 240,000 per annum under the most radical option.

A substantially expanded airport would lead to more air and noise pollution from aircraft and to increased pollution from road traffic. Other issues to be considered include soil and water contamination and the risk of accidents. One way of assessing the effect on health is to carry out a detailed independent health impact assessment. This would draw up a balance sheet of the positive effects, for example due to increased employment, with the negative effects from pollution and other causes. It is important that key decisions affecting the town for decades to come are made with full and open information about the likely effects on local people.

**Provision of green spaces**

‘The quality of the local area is important to health, well being and the quality of life experienced by residents.’\(^2\)\(^5\) Green spaces are important assets, helping provide spaces for exercise and relaxation and also contributing to reduced noise and air pollution. Within Luton there is one nationally important wildlife site, six county wildlife sites and many other locally important green spaces. These are precious resources, particularly in the light of proposals to increase the urbanisation of the surrounding counties.

Green spaces appear to benefit people of all ages. A recent study by Japanese researchers found that the quality of an older person’s surroundings was a good indicator of their survival chances - even after their wealth and actual ages had been accounted for. The researchers concluded, “The factor of walkable green streets and spaces near the residence significantly and positively influenced the five year survival of senior citizens. Master plans for urban development should pay more attention


Environmental health risks

“There’s a park where we live, we call it ‘Motorway Field’ because it’s right by the motorway, and it’s just covered in dogs muck… you just don’t like to go there, people let their dogs go anywhere. So, we’d like to play football there, but because you don’t know where the dogs muck is, you don’t play because you don’t want to get covered in it.”

Harry (Luton teenager)

Environmental health is an important facet of Public Health practice. The role of Environmental Health officers (EHO) employed by Luton Borough Council is to prevent, detect and control environmental hazards that affect human health; therefore it is essential that the Public Health team and the Environmental Health team build on the joint work that has started.

In this year’s public health report we briefly outline two of these environmental risks - rodent control/pest notifications and risks from food premises.

The main rodent pests are rats. They cause damage to furnishings, spoil food, and can carry bacteria which if spread to humans may cause disease. The only disease carried by rats of public health importance in the UK is Leptospirosis, a bacterial infection spread by rats’ urine contaminating water and food.

The number of rat infestations notified to Luton Borough Council has increased by 83% in the last three years, from 921 notifications in 1999/2000 to 1684 notifications in 2002/03, which reflects the general increase in rodent complaints received by urban local authorities. In the last 3 years cockroach infestations have risen to 36 cases in 2002/3. Cockroaches are common in commercial premises associated with the production and handling of food.

Table 18 shows the total number of significant pest notifications in Luton by ward in 2002. It is unsurprising considering the population size, levels of deprivation, and dense housing, that Biscot, Dallow and Saints wards have the highest number of notifications.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sundon</td>
<td>48</td>
</tr>
<tr>
<td>Biscot</td>
<td>351</td>
</tr>
<tr>
<td>Challney</td>
<td>181</td>
</tr>
<tr>
<td>Crawley</td>
<td>74</td>
</tr>
<tr>
<td>Dallow</td>
<td>432</td>
</tr>
<tr>
<td>Farley Hill</td>
<td>95</td>
</tr>
<tr>
<td>Hightown</td>
<td>138</td>
</tr>
<tr>
<td>Icknield</td>
<td>122</td>
</tr>
<tr>
<td>Leagrave</td>
<td>117</td>
</tr>
<tr>
<td>Lewsey</td>
<td>54</td>
</tr>
<tr>
<td>Limbury</td>
<td>130</td>
</tr>
<tr>
<td>Putteridge</td>
<td>109</td>
</tr>
<tr>
<td>Saints</td>
<td>414</td>
</tr>
<tr>
<td>South</td>
<td>121</td>
</tr>
<tr>
<td>Stopsley</td>
<td>123</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2509</strong></td>
</tr>
</tbody>
</table>

Table 18: Significant pest notifications in Luton by ward 2002

In 2002 approximately 430 infectious disease notifications were investigated in Luton. 371 of these notifications were cases of food poisoning. Table 19 breaks down these cases into type of organism.

Table 19: Food poisoning by Organism in Luton- 2002

<table>
<thead>
<tr>
<th>Type of Organism</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>243</td>
</tr>
<tr>
<td>Cryosporidium</td>
<td>26</td>
</tr>
<tr>
<td>Escherichia Coli</td>
<td>5</td>
</tr>
<tr>
<td>Giardia</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>7</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>22</td>
</tr>
<tr>
<td>Salmonella</td>
<td>55</td>
</tr>
<tr>
<td>Shigella</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>371</strong></td>
</tr>
</tbody>
</table>

A food-borne illness occurs as a result of consuming food contaminated by a microorganism such as bacteria, virus, helminth (worms), or protozoa. Relatively small numbers of microorganisms are required to cause an infection which can lead to illness. The type of microorganism that has caused the illness determines the nature of the signs and symptoms that will be experienced by an individual.

All food businesses are risk rated by the EHOs during inspections. The higher the risk, the shorter period of time between inspections. In Luton 62% of food businesses are classed as high risk (inspection frequency between 6-18 months). There is currently no comparable data for England. To support this role training courses on basic food hygiene standards are provided in a number of languages.

A target of the Food Standards Agency is to reduce by 20% the incidence of food borne disease by April 2006. In order to achieve this it is vital to continue work on local infectious disease investigations and inspection of food businesses.

What Next?

The coming years will see some crucial decisions about Luton’s environment. Topics for consideration are likely to include the future of the airport, the widening of the M1 motorway and the extent of housing and economic development in the Milton Keynes and Bedfordshire areas. It is important that health considerations are high on the agenda in these decisions, and this can only be done if people have access to good information about the effects on health. More specific recommendations on this are made at the end of this report.

Health effects need to be taken into account in land-use planning. This would include the development of local planning policies as well as key decisions on a small number of major developments. Integrated Pollution Prevention and Control (IPPC) applications require consultation with the local primary care trust, which allows them the opportunity to comment on industrial processes that might affect the health of local people.

The environmental health function has specific responsibilities to protect public health. It is important that the service is adequately resourced to keep up with growing demand, and that all people have good access to environmental health, for example through the provision of a free pest control service.

Finally, a recent consultation document highlighted the links between environmental health and public health outlining a vision for an integrated approach to environmental health over the next decade. This will help us ensure that the issues highlighted in this section will be high on the agenda in coming years.

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28Bedfordshire Communicable Disease Control Report 2001/02
**Food and Diet**

Food is a major factor in our health. Poor diet increases the risk of coronary heart disease, stroke, hypertension, cancer, dental caries, diabetes and other conditions. There is a growing awareness of the problems caused by obesity, reflected in the following quote from the Chief Medical Officer:

> "The growth of overweight and obesity in the population of our country - particularly amongst children - is a major problem. It is a health time bomb with the potential to explode over the next three decades into thousands of extra cases of heart disease, certain cancers, arthritis, diabetes and many other problems." 

Obesity is defined as having a body mass index (BMI) of over 30. This is the person’s weight in kilograms, divided by their height in metres squared. The proportion of the population who are obese has risen drastically and now stands at 21% of adult men and 24% of women\(^3\). It is estimated that it is currently responsible for more than 30,000 premature deaths in England, reducing lifespan by an average of nine years for those affected\(^3\). This toll is likely to get much bigger in future.

The National Diet and Nutrition Survey\(^3\) of children aged 1½ to 4½ reported that intake of fruit and vegetables were limited. One in eight children aged 1½ to 2½ was anaemic, reflecting that the children had low intakes of meat, fruit and vegetables.

Health advice is that fruit and vegetables should form about a third of the food eaten in an average day. The aim should be to eat at least five portions (80g each) of a variety of fruit and vegetables each day. This can include fresh, frozen, canned, dried or 100% juiced, as illustrated below.

**Diet and Health Inequalities**

Like other determinants of health, diet is an inequalities issue - households with the lowest incomes tend to eat less fresh fruit and vegetables and more fats, oils and sugar compared to the general population. Factors that can affect access to healthy food include income, transport and access to shops, and the fact that people living with low incomes may not feel empowered to make healthy food choices.
Ethnicity can also be a factor. The average diet of South Asians in this country has not been shown to be significantly different from that of the rest of the population. The increased risk of coronary heart disease and diabetes is thought to be linked to increased insulin resistance and central obesity.

Whilst absolute rates of obesity are similar or lower than average in South Asians, waist to hip ratios are much higher, highlighting the greater prevalence of central obesity. To address this, the WHO suggests that the BMI cut off points that define obesity should be amended for South Asian groups to:

- BMI 23-25 to be considered overweight
- BMI > 25 to be considered obese

35% of African-Caribbean women are obese, which is substantially higher than the general population. The rate for men is similar to the general population.

People of African-Caribbean origin have higher death rates due to stroke and hypertension. However Coronary Heart Disease rates are much lower than the general population. It has been suggested that African-Caribbean people may be more sensitive to salt intake.

Type 2 Diabetes is also much higher in African-Caribbeans, with an age standardised relative risk of 2.8% for women and 2.2% for men. More information on these topics is contained within the sections on coronary heart disease and diabetes.

Food in Luton

Local data from the Health Related Behaviour Questionnaire for Luton and Bedfordshire schools showed that on most days, one third of children in years 8 and 10 did not take milk or dairy foods, half ate sweets and chocolate whilst less than half ate fruit or vegetables. A recent survey carried out by the Community Dental Service in Luton and Dunstable nurseries and primary schools suggests that only 39% of children aged between 3 and 11 years are drinking school milk.

The Bedfordshire and Luton Food Strategy was published in 2001 with recommendations to local partnerships including the Luton Forum on how work on food might be taken forward. Implementation of the strategy is being co-ordinated by the Luton Food Network, which reports to the Health and Social Care Executive Group of the Luton Forum.

There are many projects in Luton with an emphasis on food. In particular, Luton has been at the forefront of using peer workers such as cookery club leaders, community food workers and infant feeding advisers to target those from minority ethnic and disadvantaged communities.

Asian Cookery Club

This project was developed to encourage women to learn new cooking skills to help them make changes to their families’ diet and has previously been an NHS Beacon site.

Local South Asian women are recruited and trained as cookery club leaders to run clubs for women in their communities. Club leaders are able to recruit hard to access women from their...
own communities. They provide dietary information in a practical informal way in appropriate languages and using healthy dishes adapted from traditional recipes.

The role of the cookery club leader also includes:
- Providing general health information
- Signposting onto other activities
- Helping to tackle social isolation

Clubs are run throughout the town for most South Asian communities. Approximately 500 women have attended the 5-session course since it was established.

Other food initiatives in Luton include:
- Community Food Advisers, working with individuals and groups
- Infant feeding advisers working with Pakistani and Bangladeshi families
- Under fives healthy eating award, supporting nurseries, preschools, child minders and foundation units
- Breakfast and after school clubs
- The Community Food Growing Project, focussing on affordable locally grown and organic food
- The ‘Ballistic Zone Café’ on the Lewsey Farm Estate
- A programme of training courses ‘Food and Health in the Community’

Nationally there are a range of strategies that emphasise the need for healthier eating. These include Our Healthier Nation⁴¹, The NHS Plan⁴² and the COMA Coronary Heart Disease⁴³ recommendations. A major national effort is needed to support these recommendations, including action relating to the food industry and advertising.

Many local organisations can contribute to healthier eating. These include schools, employers and retailers as well as health organisations. The planning system can also contribute to making decisions on the location of takeaways selling unhealthy products. Some areas of the town have been identified as food deserts, where it is difficult to buy healthy food. Healthy food provision within community centres, leisure centres, summer schemes and fun clubs should be supported and provision of healthy choices should be encouraged.

The Luton Food Network is working to develop a greater overview of the work that is already going on and what additional work should be done. Lessons learned from the fruit and vegetable bag scheme (providing bags of fresh fruit and vegetables to local people for £1) should be used to support communities to develop their own schemes to improve access to fruit and vegetables. The Network supports this by offering practical assistance to communities.

Exercise

Physical activity is now accepted as a major contributor to good health and an increasingly important focus for health promotion. Evidence clearly indicates that morbidity and mortality from a range of chronic diseases are lower in physically active groups compared to sedentary groups. Half an hour a day of moderate physical activity helps to prevent and reduce the risk of coronary heart disease, stroke, high blood pressure, diabetes, obesity, osteoporosis, cancer of the colon and mild depression. As people age, keeping active becomes particularly important in helping to maintain strength, co-ordination, cognitive functioning and balance. It is estimated that one third of all coronary heart disease cases and a quarter of strokes could be prevented with appropriate exercise. However studies have shown that six out of ten men and seven out of ten women are not active at the recommended level. Men are more physically active than women and those in the lowest income and education groups are less physically active than their more affluent, higher educated counterparts. The prevalence of physical activity declines with age, with over 80% of adults aged 65-74 years insufficiently active.

In 1999, the focus of the Health Survey for England (HSE) was ethnic minority groups. It reported that overall, 33% of men were meeting the physical activity guidelines. By comparison, a lower proportion of Pakistani (29%), Bangladeshi (24%) and Chinese (23%) men were meeting the guidelines. The proportion of women meeting the guidelines was lower in Pakistani (16%), Bangladeshi (10%), Chinese (18%) and Indian (17%) women compared with 21% in the general population. For both men and women a higher proportion of Black Caribbeans were meeting the activity guidelines compared to the general population (39% men, 28% women).

Exercise in Luton

Luton became a Sport Action Zone (SAZ) in 2001. The needs assessment undertaken by the Luton SAZ identified that 65% of the local population participated in sport/physical activity at least 4 times in an average 4-week period, with walking being the most popular activity. 6 out of 10 adults (58%) had been on at least one walk or hike of two miles or more in the last 12 months, and 3 in 10 people have been swimming. Luton residents participate in a wide variety of sports, but 1 in 4 do not participate in any sporting activities. When excluding walking this rises to around one third of the population (32%).

A survey of schoolchildren in 2000 identified that 41% of Year 6 pupils reported they were fit. This fell to 40% in Year 8 and 31% in Year 10. The same survey indicated that 1 in 5 Year 10 girls did not do any exercise which made them breathe harder. Overall, levels of physical activity in school decline with age with the decline more marked girls than with boys.


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What next?

The SAZ has substantially increased opportunities to participate in physical activity within the most deprived wards in Luton. Through the SAZ, the School Sports Co-ordinator Programme and the Healthy Schools Initiative, there have also been increased opportunities for young people to participate in sport both within the school setting and in the community. However there is still a need to target those who are most at risk of, or experiencing poor health due to lack of physical activity.

‘Health linx’ - a local exercise on prescription scheme was launched in Luton in November 2003. Adults with ‘low risk’ health problems are referred by their GP to a 12-week gym based programme at Luton Regional Sports Centre. Funding has been secured to run this as a pilot to the end of March 2004, but there are plans in place to extend the scheme to include a broader range of activities including health walks and swimming if further funding can be secured.

There is an urgent need to develop programmes to prevent and reduce overweight and obesity in children and young people and to increase the activity levels of teenage girls. A strategy for the treatment and prevention of obesity in adults and children will also be produced by March 2004. Another priority is to develop a range of programmes aimed at increasing the amount of physical activity taken by older people.

Alcohol and Drugs

Alcohol

Over 90% of adults in Britain, nearly 40 million people, consume alcohol. It is widely associated with pleasure and relaxation, and drinking in moderation can confer some health benefits. However drinking to excess is a major problem in Britain and it has become recognised as an important public health issue. Epidemiological studies have clearly indicated that:

- Certain types of cancer and liver disease are caused by alcohol.
- Drinking heavily constitutes a severe risk to the development of cardiovascular disease.

FACTS

- Alcohol-related disease accounts for 1 in 26 NHS bed days (circa 2 million)
- Up to 35% of all A & E attendance and ambulance costs, £0.5bn, are estimated to be alcohol related
- Some 40% of A & E admissions are alcohol-related
- Up to 150,000 hospital admissions are related to alcohol use
- Up to 1.3m children are affected by alcohol use in the family

Reference National Alcohol Harm Reduction Strategy Interim Analysis September 2003

Binge drinking mainly affects young people between the ages of 16 and 24 with a high risk of accidents and alcohol poisoning. Young men are at more risk of committing violent offences or being victims of such offences, whilst women are more at risk of sexual assault and domestic violence. Research also suggests that most young peoples’ first sexual experience occurs after drinking alcohol, which can lead to a failure to follow safe sexual practices.

Alcohol in Luton

Approximately 15% of the adult population experience problems as a result of alcohol use, which would equate to about 21,000 people in Luton.

Community Alcohol Services identified that alcohol use was a factor in 47% of domestic violence incidents locally and that parents drinking affects 15,000 children in Luton.

Alcohol consumption can vary between different cultural communities and amongst different religious groups. Many communities tend to promote social drinking but there are different, less tolerant attitudes towards problematic use.

Luton Drug and Alcohol Partnership has commissioned Alcohol Concern to draft an Alcohol Strategy for the town, and through the Luton strategic partnership an action plan for implementation will be developed. Examples of local action already underway include:

- Trading Standards Officers have visited all alcohol retailers in the town advising on enforcing the under age sales legislation and will be using teenage volunteers to test purchase for them later this year. Retailers will be prosecuted for selling alcohol to young people.
- Luton teaching PCT funds Community Alcohol Services that are working to improve the knowledge of health workers about alcohol and prevention work.
- The James Kingham Project provides support, assessment and day care for adults and support for children.
- Prevention, Understanding Knowledge and Education (PUKE) offers support and brief interventions to young people whose drinking has caused problems.

What next?

Luton’s strategy and action plan for alcohol misuse will address the needs of:

- **Young People** - with strategies aimed at promoting safe working and playing
- **Supply** - To promote awareness amongst pubs, clubs and off sales retailers about the dangers of excessive consumption and how they can balance profit with the potential harm that could be caused to the individuals
- **Health and Treatment services** - ensuring that services are accessible by being in the right location, at the right time of day and are sensitive to the needs of service users
- **Community Safety** - by prioritising forward planning and prevention strategies as a means to reduce harm, through which local people can work with the alcohol industry and local services to lessen the damage to communities.

Drug Use

Home Office figures estimated that there are some 250,000 problematic Class A users in England, the majority of whom fund their habit by criminal activity. The pre-disposition to misuse drugs lies in a wide range of influences: deprivation, unemployment, social exclusion, and poor educational status. However all social groups are at risk, including the well educated and more affluent.\(^4\)

Chaotic drug users are at high risk of blood borne diseases such as Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV), drug overdoses and infection due to poor general health. Heroin dependency is regarded as a chronic relapsing condition, which can take many years to recover from. Drug users experience discrimination and excuses to avoid treating them. Many GPs will not prescribe for

drug users, preferring to send them to specialist services.

An important distinction to make when considering data is that between prevalence of lifetime use and active problem use. For example, whilst roughly 50% of 16-29 year olds have used an illicit substance at least once in their lifetime, only 2% of the general population is actively dependent on an illicit substance.

Evidence shows that maintenance on substitute medication with key worker support can support recovery. It is a daunting challenge for drug users to change their life style, find new employment, change and improve their personal relationships, reduce their criminal activity and stabilise their housing, all of which may be necessary to avoid relapse.

Drugs in Luton

Many young people experiment with cannabis, ‘dance drugs’ such as amphetamines and ecstasy, and some try crack and heroin. Because these drugs are illicit it is difficult to gauge the extent of use in any community.

Over the past year Luton has expanded the number of treatment places available to treat drug use. Currently there are approximately 400 people in treatment, the majority tackling heroin dependency and seeking support to control their use of crack cocaine.

Prevalence studies estimate that for every one person in drug treatment there are four or five users who are not currently seeking treatment but may seek assistance in the future. This would suggest that some 2000 - 2400 people are using illicit Class A drugs in Luton. Many of these people will be in control of their habit, but when users lose their self-control the health risks are high and many steal, share needles and risk serious infection.

What Next?

Luton’s challenge is to help young people avoid becoming problematic drug users by protecting and supporting vulnerable children and young people as they grow up.

The challenge for adult services is to retain users in treatment, attract more users into treatment and to develop a wider range of treatment with limited resources.

A range of programmes are in place to tackle the supply of drugs, however the most effective way of doing this is to reduce demand which involves strengthening communities to resist drugs.

Smoking

“Smoking is the principal cause of the inequalities in death rates between rich and poor. Put simply, smoking is a public health disaster.”

Alan Milburn, Former Secretary of State for Health 2002.

Smoking kills over 120,000 people in the UK every year. Most die from one of the three main diseases associated with cigarette smoking: cancer, chronic obstructive lung disease (bronchitis and emphysema) and coronary heart disease. Premature deaths from lung cancer are five times higher among men in unskilled manual work compared with those in professional work.

There is a gradient in smoking prevalence with social class. In social class 1 around 15% of men and 14% of women smoke cigarettes. In social class 5 smoking prevalence reaches 45% for men and 33% for women. However, this obscures the very high levels observed among the most deprived groups, where smoking prevalence reaches over 70%.

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Smoking has thus been identified as the primary reason for the gap in life expectancy between rich and poor. Among men, smoking is responsible for over half the excess risk of premature death between the social classes\(^57\).

Spending to reduce smoking is a cost effective use of NHS resources. It reduces the potential of the 50 plus diseases linked to smoking, and has a direct impact on tackling health inequalities. The NHS Cancer Plan\(^58\) sets a target to reduce smoking prevalence in manual groups by 6% (from 32% in 1998 to 26% in 2010) as a means of reducing the health gap between manual and non-manual occupational groups.

Deaths and illnesses caused by smoking

Smoking causes 84% of deaths from lung cancer, and 83% of deaths from chronic obstructive lung disease, including bronchitis. Smoking causes 46,500 deaths from cancer in the UK - 3 out of 10 cancer deaths. Smoking causes 1 out of 7 deaths from heart, stroke and circulation diseases - 40,300 deaths a year in the UK from all circulatory diseases. Smoking is also linked to many other serious conditions including asthma and brittle bone disease.

Treating smoke-related illnesses costs the NHS £1.7 billion every year.


Smoking in Luton

There are limited data related to smoking in Luton, but improved General Practice records and data collected by the smoking cessation service have begun to provide baseline information. These will inform the targeting of resources.

A survey of school pupils from 2 Luton secondary schools and their primary feeder schools carried out in 2000\(^59\), showed that:

- At year 6 (10 to 11 year olds) a small number of pupils had started smoking - 4% of boys and 1% of girls said that they had smoked in the last 7 days
- Two years later (year 8) 10% of boys and 6% of girls smoked.
- In year 10 (14 to 15 year olds) smoking had increased, especially amongst girls; 14% of boys and 34% of girls stated they had smoked in the last 7 days.

The problem of girls smoking is not unique to Luton but is a major risk to their health in future years.

There is no doubt that smoking during pregnancy has an adverse effect on the unborn child. The more the mother smokes, the greater the risk to the baby. Low birth weight and perinatal mortality are major risks, with the average reduction in birth weight of a baby born to a smoker in the order of 150-250 grams. There is an estimated 28%\(^61\) higher risk of mortality.

Table 20 estimates the number of lives lost due to smoking in Luton over a five-year period. It has been calculated by looking at the cause of death of Luton residents and then applying research evidence on the effects of smoking to estimate how many of these deaths will have been caused by smoking rather than by other factors. The death toll is huge. In Luton, there are an estimated 1277 deaths caused by smoking over five years, an average of 255 deaths from smoking each year.

Figure 16 allows us to make fairer comparisons by taking account of population size in each ward. The figure shows that the average number of deaths caused by smoking each year per 100,000 population aged 35 years and over. Biscot clearly has the highest rate of female deaths, while Biscot and South wards are just above several other wards for male deaths. The reasons for this would need further investigation.

Smokers who quit on their own without medication only account for 3% of quitters. However, success rates increase significantly with added support, with the smoking cessation service seeing success rates of up to 70%. In Luton smoking cessation group programmes

<table>
<thead>
<tr>
<th>Ward</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnfield</td>
<td>23</td>
<td>12</td>
</tr>
<tr>
<td>Biscot</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>Bramingham</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Challney</td>
<td>61</td>
<td>43</td>
</tr>
<tr>
<td>Crawley</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>Dallow</td>
<td>52</td>
<td>26</td>
</tr>
<tr>
<td>Farley</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>High town</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>Icknield</td>
<td>47</td>
<td>34</td>
</tr>
<tr>
<td>Leagrave</td>
<td>52</td>
<td>38</td>
</tr>
<tr>
<td>Lewsey</td>
<td>54</td>
<td>30</td>
</tr>
<tr>
<td>Limbury</td>
<td>36</td>
<td>17</td>
</tr>
<tr>
<td>Northwell</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Round green</td>
<td>42</td>
<td>27</td>
</tr>
<tr>
<td>Saints</td>
<td>48</td>
<td>37</td>
</tr>
<tr>
<td>South</td>
<td>58</td>
<td>34</td>
</tr>
<tr>
<td>Stopsley</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Sundon park</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Wigmore</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Luton</td>
<td>780</td>
<td>497</td>
</tr>
</tbody>
</table>

Source: Beds and Herts Public Health Intelligence Unit, based on ONS deaths data

Figure 16: Smoking attributable mortality rate by ward: 1998-2002

Table 20: Estimate of deaths attributable to smoking in Luton split by ward 1998-2002 aged 35 years (+/- Peto method)

Source: Beds and Herts Public Health Intelligence Unit, based on ONS deaths data
have been held in Marsh Farm, Lewsey Farm, Farley Hill, and Stopsley.

Reducing smoking in pregnancy has been extremely difficult but there is now a smoking in pregnancy specialist advisor for Bedfordshire and Luton. Evidence suggests that working closely with maternity services and offering home visits is very much the key to tackling this area.

Other local projects include proof of age cards in a small area of Luton linked in with local schools and developing a directory of smoke-free eating-places in South Beds and Luton.

What next?

Although there are several projects to prevent smoking and to encourage people to quit, the scale of the problem merits a much more substantial effort to reduce smoking in Luton and nationally. There is also increasing awareness of the health problems caused by second-hand smoke and a greater willingness to debate options to control tobacco.

A strategy to reduce smoking in Luton needs to have several strands. One is to provide more information on the effects of smoking and on ways of giving up, particularly with young people. Another is to provide greater support to those who do want to quit, by expanding specialist smoking cessation services and by better co-ordination of the efforts of a wide range of professionals offering advice and support. Finally, a high profile and well-managed approach to smoking throughout Luton would help to reduce smoking in workplaces and public places. As the Chief Medical Officer says:

"International experience has shown the only way to rapidly and successfully tackle the health risks from second-hand smoke is to introduce a ban on smoking in public places".

KEY HEALTH PRIORITIES

Having looked at Luton’s population, and at some of the factors that affect our health, the report now gives more detailed information on some key health conditions affecting Luton. These are:

• Coronary heart disease - the biggest single cause of premature death in Luton
• Diabetes - a major cause of disability which affects some groups in Luton more than others
• Perinatal mortality - Luton has very high levels of stillbirths compared to the rest of the country
• Sexual health - a growing problem across the country, and particularly in Luton
• HIV/AIDS - Luton has high and increasing levels of infection
• Tuberculosis - again Luton’s infection rate is high and increasing
• Oral health - a substantial problem illustrating inequalities in health.

Coronary Heart Disease

Introduction

Heart and circulatory disease is the United Kingdom’s biggest killer. The White Paper “Saving Lives: Our Healthier Nation” recognised that the United Kingdom is at present one of the worst countries for deaths from circulatory disease and identified coronary heart disease (CHD) and stroke as one of the four priority areas to tackle.

CHD in Luton

CHD is a disabling and life threatening condition and the largest single cause of death in Luton. CHD accounted for 18.5% of deaths in Luton in 2001, of this total 45% were people under 75 years of age. Table 21 provides more details of this toll:

Table 21: Number of deaths from coronary heart disease in Luton, by age: 2001

<table>
<thead>
<tr>
<th>Age/ Years</th>
<th>Total</th>
<th>1-4</th>
<th>5-14</th>
<th>15-34</th>
<th>35-64</th>
<th>65-74</th>
<th>75+</th>
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<tbody>
<tr>
<td>MEN</td>
<td>175</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>46</td>
<td>49</td>
<td>80</td>
</tr>
<tr>
<td>WOMEN</td>
<td>114</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>27</td>
<td>79</td>
</tr>
</tbody>
</table>

Source: Department of Health. 2002. Compendium of Clinical and Health Indicators

Both locally and nationally the death rate from CHD is falling. Figures 17 and 18 show the trend between 1993 and 2001, having been standardised to take age into account. To make an easy comparison, the mortality rate for England & Wales in 2001 has been shown as 100, with all the other data adjusted to reflect this. In general Luton’s improvement has mirrored the national picture, but relatively speaking the CHD death rate for Luton women has worsened in recent years.
Figure 19 provides more detail by looking at CHD death rates for local authority wards in Luton. Numbers of deaths are smaller at this level and it is hard to reach firm conclusions. However it appears to show that 8 out of Luton’s 16 wards have CHD death rates which are at least 10% higher than the national average.

Differences between social classes, ethnic groups, male and females

There are a number of recognised lifestyle risk factors for CHD, the most important of which are smoking, a poor quality diet and the lack of physical activity. People’s exposure to and acceptance of risk reflects choices they make about how to live their lives. However, the circumstances in which people live; their physical and emotional environment; their access to education; to employment; to an affordable healthy diet; to decent housing and to supportive communities, heavily influence these choices.

People from deprived communities are likely to eat less fruit and vegetables and to smoke more than those from more advantaged communities, and more commonly will experience high blood pressure. Substantial evidence identifies that there is a higher death rate from CHD in manual workers as opposed to non-manual workers. The premature death rate from CHD for male manual workers is over 50% higher than in non-manual workers and for female manual workers CHD is twice as high.

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A further inequality is the different levels of CHD amongst ethnic groups. For example, South Asians living in the UK have a higher premature death rate from CHD than the population in general, whereas the level of CHD in the African-Caribbean community is much lower than the national average.

This contrasts with the premature death rate in stroke, where although the rate for South Asians is significantly higher than the national average, the death rate from stroke for Caribbean and West Africans is even higher.

Action

The National Service Framework (NSF) for CHD established a common set of standards and targets for the prevention and treatment of coronary heart disease. Examples of the areas covered include:

- Prevention of CHD though policies on smoking, exercise, diet and obesity
- Improved primary care services including the establishment of registers of people with CHD and those at high risk, improved drug treatment and audit
- Hospital care, including standards for treatment in A&E, the establishment of rapid access chest pain clinics and targets for heart surgery
- Rehabilitation, both in hospital and in the community over a longer period of time.

Primary Care Trusts have lead responsibility for implementing the NSF and to carry out much of the work on prevention and on developing local CHD services with partner organisations. Some of the more specialist services, such as cardiac surgery, are planned by a wider cardiac network on behalf of local NHS Trusts. In this area, the cardiac network covers all the Trusts in Bedfordshire, Luton and Hertfordshire.

Action to reduce smoking, improve diet and increase physical activity has been described elsewhere in this report, but we finish this section by outlining two of the initiatives to reduce CHD in the primary care setting.

Prescribing of Statins within Luton tPCT

Cholesterol is a type of fat made by the body that is essential for good health. However a high cholesterol level can lead to a narrowing of blood vessels as fatty deposits build up and increase risk of CHD and stroke. There are a number of ways to reduce cholesterol levels that include eating a healthy diet low in saturated fat and increasing the amount of exercise. For many people lifestyle changes by themselves are not enough to reduce high cholesterol levels, and drug treatment with a statin is required. Luton tPCT encourages the prescription of these drugs to patients at risk from CHD.

Luton tPCT Quality in Medicines Management Team have been working closely with a number of General Practices across the tPCT to target patients likely to benefit from statin treatment in accordance with local and national guidance.

Figure 20 shows the increase in the number of prescriptions issued for statins from 1,573 in August 2000 to 4,278 in July 2003.
Disease Registers

The use of information technology in primary care is helping to track the level of disease in the population. Thirty-four of the 35 practices have a computerised CHD disease register in place. To date, 22 practices have undertaken the full-computerised CHD audit. Figure 21 shows the prevalence of CHD in these practices and shows that the proportion of people recorded as having CHD ranges from 0.8% to 5.3% of the practice population.

Figure 20: Number of prescriptions issued for statins within Luton tPCT per month: August 2000- July 2003

Source: Quality in Medicine Management Team - Luton tPCT

Figure 21: Prevalence (from Disease registers) of CHD in Luton by General Practice: 2003

Source: PRIMIS data- take from general Practice CHD registers
**Diabetes**

**Introduction**

Diabetes is a chronic and progressive disease that impacts on almost every aspect of life. It can affect all ages from infancy to old age and is becoming more common. Diabetes can result in premature death, ill health and disability, which can be avoided or delayed by high quality care.

There are 1.3 million people diagnosed with diabetes in England and every year the number of people living with diabetes increases. Diabetes is particularly associated with poor diet, lack of exercise and obesity and can lead to heart disease, stroke, kidney disease and circulatory problems, sometimes resulting in amputations.

Diabetes is characterised by a high blood sugar level either because the body has inadequate insulin or because the body becomes resistant to the effects of insulin. When the body produces no insulin it is called Type I diabetes and tends to occur in younger people. Type I accounts for 15% of diabetics. Eighty-five per cent of diabetics have Type II of the disease where inadequate amounts of insulin is produced to manage circulatory sugar, or if the body is resistant to the effects of insulin. The number of people with Type II diabetes is doubling approximately every 15 years.

Diabetes has historically been an illness of older age but is increasingly being seen in children and young people. It is particularly common amongst people of South Asian origin, with 31% of the South Asian over 65-year age group being affected. The national prevalence is 3.8%, rising to 8% for those over 65 years.

**Diabetes in Luton**

The reported prevalence of diabetes in Luton is 4.1%. The prevalence rate can vary between general practices depending on the location of their surgery, size and demography of their practice population and the quality of their data recording. Figure 22 shows that this ranges from 1.6% in the lowest practice to 6.4% in the highest. It should be emphasised that this prevalence relates to only the 22 of the 35 practices who have completed an audit of their disease registers.

*Source: PRIMIS data- take from general Practice Diabetes registers*

*Figure 22: Prevalence (from Disease registers) of CHD in Luton by General Practice: 2003*

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Action

In 2001 the Department of Health published a National Service Framework (NSF)\(^9\) for diabetes setting national standards of care and outlining how these should be achieved between now and 2012.

Luton has an active local Diabetic Service Advisory Group overseeing the implementation of the NSF. Action being taken includes:

- A baseline assessment of diabetic services in Luton
- Arrangements to ensure that 80% of diabetics have eye checks by the end of 2004, rising to 100% by 2005
- Establishing General Practice based diabetic registers through the Primary Care Information Service (PRIMIS).

This work is coordinated by the NSF Implementation Group, which has professional and patient representation. The overall aim of this group is to develop and implement strategies where the outcome is for:

- Fewer people to develop diabetes
- People with diabetes to be identified earlier
- People with diabetes to have greater control over their care
- People with diabetes to develop fewer complications
- Complications to be identified and treated earlier
- Effective in-patient care to be available where necessary
- Healthier pregnancies for diabetics.

Prevention

Focussing on lifestyle measures, such as healthy eating and increased exercise, can reduce the increase in numbers of people with diabetes in our communities. The Food, Diet and Exercise sections earlier in the report provide full details of the work that is going on locally to promote healthy eating and exercise initiatives.

School nurses and health visitors have an active role in our strategy for reducing obesity in children. This is an important group if we are to make a difference to future levels of diabetes in the community.

Early Detection

Early detection of diabetes helps to reduce the long-term complications of the condition. Luton tPCT has been selected as one of only 9 communities in the UK to participate in a new screening project to detect early signs of increased risk of diabetes, heart disease, and stroke in order to prevent progression of these illnesses. This will involve screening all people over the age of 40 years who wish to take up the opportunity in three Luton practices. The outcomes of this pilot will help develop future services.

Treatment

In order to ensure that patients with diabetes in Luton receive optimum care in a setting closest to home, Luton tPCT will be developing enhanced diabetic community services in the new Diagnostic and Treatment Centre on the old St Mary’s Day Hospital site. People will be seen here by trained GP specialists, supporting care from the patient’s own GP and avoiding unnecessary trips to the hospital. The centre will also provide a focus for user education and support groups.

Luton tPCT Prescribing for Diabetes

In the last 3 years the quality of prescribing and other care received by diabetic patients has been influenced by a number of evidence-based guidelines. Expenditure on medicines used in diabetes within Luton tPCT has almost doubled over the last 3 years from £63,903 in August 2000 to £115,938 in July 2003. The number of prescriptions issued has increased by approximately 2000 per month in the same period (figure 23).

Figure 23: Number of prescriptions issued for diabetes care within Luton tPCT per month: August 2000 - July 2003

The Luton tPCT Quality in Medicines Management team are supporting this area by including a diabetes audit as part of the 2003/2004 Prescribing Efficiency Scheme.
Perinatal Mortality

Introduction

The Perinatal mortality rate is the number of stillbirths and early neonatal deaths (those occurring in the first week of life) per 1000 live and stillbirths.

Perinatal death is a tragedy on a personal level for each of the families and communities associated with a stillborn baby or an early neonatal death. In Luton the perinatal mortality rate is above the national and Eastern Region averages. Perinatal mortality reflects maternal health, the characteristics of the local population and the quality of antenatal and neonatal services.

Perinatal mortality in Luton

The perinatal mortality rate and still birth rate in Luton continues to increase despite a decline nationally. Table 22 presents the case numbers and rates per 1000 births, and figures 24 and 25 compare Luton’s perinatal mortality and stillbirth rates to the national picture.

Table 22: Perinatal Mortality and Still Births in Luton 1996-2002

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Live births</td>
<td>3016</td>
<td>2933</td>
<td>2875</td>
<td>2851</td>
<td>2885</td>
<td>2854</td>
<td>3114</td>
</tr>
<tr>
<td>Still births</td>
<td>17</td>
<td>19</td>
<td>20</td>
<td>27</td>
<td>23</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Perinatal mortality rate</td>
<td>8.9</td>
<td>10.8</td>
<td>9.7</td>
<td>12.5</td>
<td>11.3</td>
<td>11.8</td>
<td>14</td>
</tr>
<tr>
<td>Still birth rate</td>
<td>5.6</td>
<td>6.4</td>
<td>6.9</td>
<td>9.4</td>
<td>7.9</td>
<td>9</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Source: Department of Health. 2002. Compendium of Clinical and Health Indicators

Figure 24: Perinatal Mortality Rate, Luton compared to England & Wales: 1996-2002

Source: Department of Health. 2002. Compendium of Clinical and Health Indicators
The cluster of 5 other PCTs identified as similar in make-up to Luton all have higher perinatal mortality and stillbirth rates than the national average. However Luton’s rates are even higher than these other 5 areas (Figure 26 and 27).

There is increasing evidence that health in the first year of life is an important factor affecting future health. For example, babies who are born the correct weight and maintain this weight have lower rates of heart disease in future life. Figure 28 shows the proportion of babies with a low birth weight (less than 2500 grams) for Luton and the other PCTs in the cluster. In this case Luton is closer to the cluster average, but has more low birth weight babies than the country as a whole.
An analysis of contributory factors to perinatal mortality in Luton and Bedfordshire was completed in 2001\(^{10}\). Findings included greater perinatal mortality associated with women born in South Asia than those born in all other countries. The perinatal death rate was also strongly linked to social deprivation.

A pilot audit of stillbirths at the Luton & Dunstable hospital\(^{11}\) completed in 2001 highlighted that 50% of the women who had a stillbirth had experienced a previous miscarriage, stillbirth or neonatal death. However for 41% of the mothers, the stillbirth was their first pregnancy. Stillbirths from Asian women were higher than that expected by the birth rate, however the audit identified that a quarter of the maternity records did not have ethnicity recorded.

Action

Wider determinants of health such as poverty and ethnicity have an effect on the perinatal death rate. Luton tPCT has identified perinatal mortality as a major health priority and the following is underway locally as part of a ‘Pursuing Perfection Programme’.

Audit of stillbirths at L&D Hospital

- The aim of the study is to identify any common themes in maternal, baby, and antenatal care in stillbirth cases in Luton & Dunstable Hospital during 1998-2003.

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\(^{13}\)Chisholm DK. 1989. Factors associated with late booking for antenatal care in central Manchester. Public Health.103: 459-466

The results of this work will also take account of the key recommendations made in the 8th CESDI annual report and relevant good practice guidelines.

**Sexual Health**

Sexual health is an important part of physical and mental health. The consequences of poor sexual health can be serious and in the case of Human Immunodeficiency Virus (HIV), life threatening. Poor sexual health continues to disproportionately affect those who are often already vulnerable or socially excluded, including young people, gay men, women, and black and ethnic minority communities. There is a strong link between social deprivation and Sexually Transmitted Infections (STI), abortions and teenage conceptions. Unintended pregnancies increase the risk of poor social, economic and health prospects for both mother and child. Girls from poorer backgrounds are ten times more likely to become teenage mothers than girls from wealthier backgrounds.

Nationally we are seeing a rapid decline in sexual health:

- Around one in ten sexually active young women are infected with chlamydia
- Syphilis rates have increased by 500% in the last six years
- Gonorrhoea rates have doubled in the last six years
- Newly diagnosed HIV infections continue to rise year on year and HIV prevalence by the end of 2003 is expected to be 40% higher than the 1999 level
- England has the highest rate of teenage pregnancies in Western Europe
- Sexual health services are under extreme pressure and many are ill equipped to cope with the crisis that confronts them.

In response to this situation, the Department of Health published a national strategy for sexual health and HIV in 2001 followed by the publication of an implementation action plan which sets out 27 clear action points.
Sexual Health in Luton

Locally, the sexual health status of our population is very poor. Key issues include:

- An increase in the number of reported HIV infections
- An increase in dual infection of HIV and tuberculosis
- Rates for chlamydia and gonorrhoea are increasing and are higher than for England and Wales with the greatest increase being seen in the 15 - 25 age group (Figure 29).
- Under 18 conceptions have increased by almost 6% between 1998 and 2001 in Luton compared to a 10% decrease nationally
- Between January and September 2003, 46 cases of syphilis were reported across the whole of the Eastern region of which twenty one of these reports were from Luton
- Attendance at the Genito-Urinary Medicine clinic has more than doubled in 10 years.

Action

Two recent sexual health conferences have helped to identify strengths and weaknesses in current service provision. Although local sexual health services are stretched, there is a sound infrastructure in place on which to build and some excellent practice taking place in relation to the three main areas of the national strategy - treatment, prevention, and social care and support. In addition to addressing the capacity issues of local sexual health services it will be important to improve coordination and communication between primary, secondary, community and voluntary sector service providers. This is fundamental to ensure that services are developed to meet the needs of local people.

Other priorities for action are to:

- Develop a preferred local model for delivering sexual health services
- Improve the provision of sexual health services within primary care settings
- Develop a training programme to increase sexual health knowledge and skills of health and other associated professionals - which includes confidentiality and cultural awareness
- Develop treatment and support services for children and families affected by HIV / AIDS
- Improve access to termination of pregnancy services
- Improve services for asylum seekers
- Improve contraception services for young people
- Increase uptake of HIV antenatal screening and chlamydia screening
- Developing a strategy for user involvement.

A key task will be to ensure that all service developments are informed by evidence based research or ‘best practice’ guidelines.

Figure 29 illustrates the problem by showing the trend in Chlamydia infection in Luton and nationally.

Figure 29: Chlamydia infection rate in Luton: 1995-2001

23Genito-Urinary Medicine data
24Teenage Pregnancy Unit 2003.
**Human Immunodeficiency Virus (HIV)**

**Introduction**

HIV is a fast growing and serious health condition. The infection can be transmitted through an infected person's blood, semen, vaginal fluid or breast milk. This can occur through unprotected sexual intercourse, whether anal, vaginal or oral, by injecting using shared needles, by blood transfusion (rarely), and from an infected mother to her child. A person infected with HIV may not exhibit symptoms for a long period of time after being infected, but as the immune system is compromised the individual becomes at greater risk of opportunistic infections such as pneumonia and Tuberculosis. These infections, which are not usually life-threatening to a healthy person, can be so to a person infected with HIV.

**Figure 30: HIV prevalence in adults in sub-Saharan Africa: 1986-2001**

- **Source:** World Health Organisation
- **26**Health Protection Agency website.
- **28**Communicable Disease Review 125-8, 7(9): 97
HIV in Luton

In Luton the number of cases of HIV infection has increased very substantially since 1998. The total number of patients diagnosed with HIV infection living in the Luton tPCT area was 328\(^{19}\) by the end of December 2002. It is likely to be over 400 now. Figure 31 shows the number of people with newly diagnosed HIV and AIDS seen at the Luton & Dunstable Hospital each year.

Of the 328 people living with HIV in Luton, 140 were male and 188 female, which highlights a major shift in the epidemiology of this infection. The main mode of transmission of HIV in Luton in previous years has been sex between men. Whilst the trend in this group has not changed, more recently people have acquired the infection heterosexually. This accounts for the increased incidence of HIV in the female population. The main causes of HIV infection in Luton are shown in Figure 32.

\(^{19}\)SOPHID Data. 2002.

Figure 31: Number of newly diagnosed HIV & AIDS (Luton and Dunstable Hospital): 1995-2002

Figure 32: Diagnosed HIV infected people in Luton by gender and probable route of infection - 2002
The majority of new HIV infections in Luton have been acquired abroad, but it is only a matter of time before we start to see secondary spread within the local population.

HIV therefore continues to be a major public health issue locally. The combination of HIV and opportunistic infections such as tuberculosis, add to the importance of this condition.

Better survival rates combined with the growing numbers of new infections mean that the number of people living with HIV is rising and this is putting treatment, support and care services under extreme pressure. There are also a growing number of children and families affected by HIV and an urgent need to develop services which are appropriate to meet their needs.

This increase in affects many clinical services, including, primary general medical, nursing and dental care, secondary care services for adults and children, and antenatal and postnatal care.

**Action**

Action on HIV is an important part of local work on sexual health outlined in the previous section. It also includes specific initiatives such as the Pachedu-Zezele project working with African communities.

In order to tackle the increase in HIV infection, there needs to be more effective coordination and joint working with all involved in prevention and treatment. Known priorities for action include:

- Secondary and primary care should jointly establish a care plan for the treatment and management of those infected with HIV and related infections.
- To strengthen the preventative measures in place especially those targeting the higher risk groups.
- To ensure mother to child transmission is prevented by appropriate intervention, with the clinical care of mother and baby addressed appropriately.
- To evaluate and audit targeted health promotion activities to ensure effectiveness.
- To establish training for healthcare workers to address changes in epidemiology and the varied needs of the population.
- To build the capacity of HIV and sexual health services to cater for the diverse needs of those affected directly by the disease and develop culturally sensitive services.
- To involve the community in service development.
- Ongoing programmes addressing safer sexual practice.
Tuberculosis

Introduction

Tuberculosis (TB) is caused by Mycobacterium tuberculosis. It is a chronic, progressive infection that commonly affects the lungs (Pulmonary TB), but may affect other organs and tissues such as the kidney, intestine and bone. Transmission of TB occurs through person-to-person spread, almost exclusively by the respiratory route. Therefore close continuous contact is usually required for transmission to occur. Treatment for TB requires a combination of three or four drugs for at least 6 months.30

All forms of TB are compulsorily notifiable under the Public Health (Control of Disease) Act. The number of notified cases of tuberculosis in England and Wales, which had been declining for several decades, started to rise in 1987. A national survey of tuberculosis in 199831 found an annual rate of increase of 21% since 1988, though there is significant variation between regions and ethnic groups. Rates among the white population continue to decline and those from the Indian sub-continent remain stable though continue to be very high. Increasing rates were found among recent immigrants to the UK, particularly those from Africa.

In recent years due to issues such as homelessness, immigration, overcrowding, HIV disease and non-compliance with treatment, Multi-Drug Resistant TB (MDRTB) has become a public health problem.32

TB in Luton

Luton, with its diverse community, is experiencing a high rate of TB. Figure 33 shows that notifications are increasing and had reached 92 reported new cases in 2002. This increase in TB coincides with a steady increase in the number of people in Luton with HIV who are susceptible to opportunistic infections such as TB.

Action

TB services are well established in Luton and incorporate a dedicated team of clinical staff. The pattern of TB is changing with the population, with an increase of co-infection with HIV. This makes it increasingly important that all those clinicians engaged in the care of patients work together to ensure ease and equity of

Figure 33: Number of new cases of TB in Luton, 2000-2002

Source: Communicable Disease Report 2001-2002

access. It is also imperative to have systems in place to continually monitor the identification, treatment and management of cases so as to minimise the effects of this disease.

In response to these concerns, the tPCT was allocated funds by the Department of Health to improve TB services. An audit is currently being undertaken to identify the effectiveness of existing services and to outline how those services could be improved.

In addition a focus group of patients has met to discuss the experience of being treated for TB in Luton. These views will strongly influence the development of patient-led services.

The findings of this project will form the basis for staff development, service improvements and the production and dissemination of local policies and procedures.

**Oral Health**

Oral Health has been defined as ‘a standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being’\(^{33}\).

National surveys conducted every 10 years show that adult dental health is improving. In 1998, 87% of adults had natural teeth. The bulk of filled teeth are amongst older adults whilst the number in young adults is falling. Almost 1 in 3 young adults (16-24) have no fillings\(^{34}\).

However tooth erosion caused mainly by acidic drinks (fizzy pop) affects 50% of children in the UK\(^{35}\) and together with tooth wear in adults is a cause for concern.

The key national target for improving the oral health of children is for five-year-old children by 2003 to have on average no more than one decayed, missing or filled primary tooth, and for 70% of five year olds to have no experience of tooth decay. In 2001, 40% of 5-year-old children in the UK showed evidence of dental caries\(^{36}\).

Mouth cancers account for about 1% of all newly diagnosed cancers in the UK each year\(^{37}\). The 5-year survival rate for oral cancer remains around 50%.

During the 2002-2003 financial year, around 1.7 billion pounds were spent by the NHS on dental care\(^{38}\). The cost of treating dental disease exceeds the cost of treating all cancers and heart disease\(^{39}\).

‘Lifestyle influences, including diet, effective oral hygiene, and smoking are key factors in oral diseases’. There is also a correlation between oral health status and social and environmental factors. ‘In many instances oral ill health is the result of food policy, of poor housing and of social deprivation, including unemployment and poor educational opportunities.’\(^{40}\)

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Oral health in Luton

Oral disease varies with gender and between age groups, ethnic groups, socio-economic groups and geographical locations.

The average number of decayed, missing or filled (dmf) teeth in 5-year-old children in the UK is 1.47 teeth. In Luton the corresponding figure is 2.06 teeth, higher than the national average and higher than the rest of Bedfordshire (Figure 34).

Figure 34: Mean number of Decayed, Missing or Filled teeth: Luton compared to Bedfordshire: 2002

Source: British Association of Study of Community Dentistry 5 year old survey

Figure 35 shows that Luton also has the highest percentage of children locally with 5 or more teeth that are decayed, missing or filled.

Figure 35: Percentage of 5 year olds with 5 or more decayed, missing or filled teeth by PCT: 2002

Source: British Association of Study of Community Dentistry 5 year old survey

Nationally the proportion of adults who report attending for regular check-ups has risen over the last 20 years. Registration rates are relatively stable in Luton with 40% of under 18 year olds and 43% of over 18 year olds being registered with an NHS dentist.

There are a small number of people diagnosed with mouth cancer in Luton each year. Anyone can develop mouth cancer, but older age groups are more at risk. Eighty percent of those who are diagnosed with mouth cancer are over 50 years old. Men are more likely than women to develop mouth cancer and it is more common in socially deprived groups and those who use health services infrequently. There are also links with ethnic minorities and the development of mouth cancer due to gutka chewing. There is a strong association between tobacco use (both smoking and chewing) and mouth cancer. There is also evidence to suggest that alcohol and tobacco combine to increase the risk of mouth cancer.

Action

Key messages for improving oral health are:

• Water fluoridation
• Reduce the consumption and frequency of intake of sugar-containing food and drink
• Clean the teeth and gums thoroughly each day with fluoride toothpaste
• Attend a dentist regularly

Systematic reviews on water fluoridation have shown it to be effective and decay rates remain consistently lower in fluoridated areas.


Fluoridation decreases inequalities in dental caries between areas and between socio-economic groups. Fluoridation of Luton’s water supply would need to follow public consultation, taking into account evidence of the advantages and disadvantages. Continuous efforts should be made to raise awareness of fluoridation to the population and key stakeholders, to encourage an informed debate. On 10th November 2003 Parliament approved plans to allow health authorities the right to consult populations regarding fluoridation of drinking water.

Encouraging healthy eating and drinking, and reducing the level of sugar in the diet, is fundamental to oral health as discussed previously in the report. Other important priorities for the future are to:

- Target preventative measures for mothers and very young children living in deprived areas.
- Ensure that primary care workers are aware of oral health problems, particularly affecting older people, such as detecting and preventing oral cancer.
- Work with voluntary and local authorities to communicate effective messages about diet, oral hygiene and to develop healthy food policy.
- Ensure carers are trained to help with oral hygiene.
- Ensure vulnerable people can access prevention and treatment services.
- Ensure continued access to NHS primary dental care services, specialist and secondary care oral health services, and out of hour’s emergency dental services.
- Encourage registration of children with general dental services.

ACCESS TO HEALTHCARE

Introduction

So far this report has focussed on populations, on the wider determinants of health and on ‘lifestyle’ factors that affect health. But the role of healthcare itself in reducing socio-economic health inequalities should not be neglected. For example it can influence major risk factors for CHD by providing support for smoking cessation, by identifying and treating high blood pressure, and by identifying and treating high cholesterol levels. The healthcare system is responsible for establishing equal access to effective healthcare according to need.

Over the course of a year 1.4 million people miss, turn down or simply choose not to seek healthcare. This poor access to healthcare causes problems both for patients and for the service itself. The ability to choose to be treated is not the same as choosing how and where to be treated.

Those with the greatest need of healthcare often have the lowest level of use and the poorest access to healthcare services. However, access to care is not the same as access to high-quality care. Improving access to healthcare must also mean improving access to high quality services that have a positive effect on health.

This chapter begins by highlighting the importance of equity and good access. It then looks at specific topics, with a particular focus on primary care services and on groups with particular needs. The chapter finishes by highlighting ways of improving our understanding of equity in healthcare.

Equity and Access

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided.”


Access to healthcare by disadvantaged groups, especially those from ethnic minority populations is often reduced, perpetuating a cycle of inequity, disadvantage and poor health. This is because using or accessing some services may require particular competencies, such as being able to speak English, being able to be insistent or articulate, or may depend on particular types of help-seeking behaviour. Access is also affected by the supply of services and by the way they are organised and delivered.

Studies in the early 1990s concluded that there was a ‘pro-poor’ bias in access to local primary healthcare in the UK. More recent studies now indicate otherwise, and inequalities in access and healthcare provision are different depending on which area of the UK you live.
Key conclusions from this recent research were that:

- Although higher rates of consultation were associated with greater deprivation, the quality and length of time of the consultation were poorer for lower income groups.
- Chinese, Africans and young Pakistanis had low consultation rates relative to need.
- The further away patients lived from their GP the less likely they were to consult.
- There was inequitable distribution of GPs, with the position worsening for those living in the most deprived areas of the country and improving in the least deprived.
- Deprived areas suffered increasing difficulty in recruiting GPs due to poor quality of primary care premises, large numbers of single-handed practices, GPs approaching retirement and practices without training status.
- The ‘inverse prevention law’ existed, whereby communities most at risk of ill health had the least access to range of effective preventative services, including cancer screening programmes, health promotion and immunisation.

Access to Primary Care Services

Access to NHS primary care services is important for two reasons. Firstly, the general practitioner is the first point of contact with the healthcare system for most people. Secondly, inequalities in access to secondary care may originate in, and therefore need to be addressed in, the primary care sector. Increased access to these services, through shorter waiting times and through new models of care, is an important priority.

Current situation in Luton

Luton has 35 General practices of which 14 are practices with one doctor. In total there are 83 GPs. A key issue in Luton is the shortage of GPs and large case-list size for those GPs. There are currently 8 GP vacancies in Luton, and list sizes are far higher than the optimum size of 1780 patients per GP used by the Department of Health. Many local doctors have resorted to closing their lists to new patients to ensure that an adequate and safe standard of care can be provided to their existing patients.

In 2002/03 the national target was for 90% of patients to be seen by a GP within 2 working days and by a primary care professional within 1 day of requesting an appointment. For 2003/2004 the target is 100%. Despite the shortage of GPs locally, the tPCT currently exceeds both targets with 95% of practices offering an appointment with a GP within 48 hours and 100% of practices offering access to a primary care professional within 24 hours.

Primary care patient survey

Although most NHS users are satisfied with the service they receive surveys also show that many people think NHS services are inflexible and hard to access. NHS bodies are required to undertake an annual patient survey reviewing:

- Access and waiting
- Safe, high quality coordinated care
- Better information, more choice
- Building relationships
- Clean, comfortable, friendly place to be

The survey for 2003 was sent to a random sample of 850 patients registered with GPs in Luton. A response rate of 40% was achieved, which accounts for 321 completed and returned questionnaires. Of these respondents 61% were female, 27% were from minority ethnic groups and a good mix of age groups was achieved.

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Access to health promotion was viewed as very good, especially:

- Contraception and family planning
- Giving up smoking
- Healthy eating
- Getting enough exercise
- Healthy alcohol intake

The results for access to primary care treatment services were less encouraging. These are shown in the table below.

**Table 23: Survey results for access to primary care in Luton: 2003**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waited more than 48 hours to see a GP</td>
<td>25.3%</td>
</tr>
<tr>
<td>Waited longer than wanted to see a GP</td>
<td>46.3%</td>
</tr>
<tr>
<td>Unable/found it difficult to get through to out-of-hours service</td>
<td>41.6%</td>
</tr>
<tr>
<td>Put off going to GP due to inconvenient opening times</td>
<td>24%</td>
</tr>
<tr>
<td>3 weeks or longer to get dentist appointment</td>
<td>17.5%</td>
</tr>
<tr>
<td>Couldn’t find NHS dentist/ inconvenient times/too expensive</td>
<td>26.1%</td>
</tr>
</tbody>
</table>


**Breast and cervical screening**

Screening is an important health intervention that saves many lives each year. However uptake for breast and cervical screening in Luton is variable. Nine GP practices are below their target for breast screening and 5 for cervical screening. A local study was undertaken to understand the reason for this low uptake, taking into account any demographic or other factors in general practices. This resulted in the development of a pilot scheme to introduce Health Educators to improve the uptake of breast and cervical screening, targeting women predominantly from Pakistani, Bengali, White and Black African/Caribbean communities in Luton. The Health educators will work with the surgeries to provide outreach to women in their own environments.

**Flu vaccination**

Influenza (Flu) is a highly infectious acute viral infection, which affects people of all ages, mainly during the winter months. While most people recover without complications in a short period of time, flu can cause serious illness and death, especially with older people. Flu epidemics result in widespread illness and in major disruption of health and other services.

An annual programme for vaccination against influenza is carried out by Luton tPCT. The 70% target rate set by the DoH has not yet been achieved locally, but Luton’s uptake rose from 45% of people aged 65 and over in 2001/02 to 61.5% in 2002/03. A further improvement is expected in 2003/04. Like many aspects of primary care performance the rate does vary substantially from practice to practice (from 38% to 74.8% in local practices in 2002/03).
**Luton’s new walk-in centre**

Recognising the need to improve access to primary health care, Walk-in Centres (WIC) are an alternative healthcare facility that build on existing services and provide flexible convenient access to primary health care for minor health problems. Luton’s WIC is due to open in January 2004 and has the following objectives:

- Fast, easy and convenient access to local NHS advice, information and treatment - a flexible service which meets the needs of modern lifestyles
- Equity of access to health care services (for example for ethnic minority groups, working parents, people without GPs, asylum seekers and homeless people)
- To provide quality care for minor illnesses/injuries, healthcare advice and information and emergency contraception
- To inform the general public how to understand and use the NHS more effectively.

At the new Luton WIC these objectives are to be achieved by:

- Opening 7 days a week, 365 days a year. Between 7am and 10pm weekdays, and 9am to 10pm at weekends.
- Being sited in the heart of the town in the busy Market Square area.
- Having a ‘no appointment’ system
- Easing people into the system by allowing self referral from any area
- Facilitating equality of access, e.g. working parents can bring their children after work, people who travel to work outside the area can call in late in the day, and those without GPs can attend.

It is vital to monitor WIC service use by the local population to determine the extent to which objectives are met. In Luton the evaluation will include measuring the use by ethnic group and by people not registered with a local GP. Local evaluation will also aim to determine the effect of the WIC on the local health economy, highlighting whether there are changes in the demand for General Practitioner services, NHS Direct and Accident and Emergency attendances for minor illness and injuries.

**Access to Hospital Care**

There is a strong positive relationship between levels of deprivation in an area and hospital admission rates. For outpatients, attendances are either higher among disadvantaged groups or similar to those who are better off, after adjusting for need. Although access to general hospital services appears largely equitable, there is strong evidence showing systematic inequalities in access to investigations and treatment for specialist cardiac services and in survival after treatment for cancer.

An example of a service that often has unexplained variations in access is revascularisation (surgery to deal with blocked coronary arteries, which can involve unblocking the artery itself or by-passing it). Minimum targets for this operation were set in the Coronary Heart Disease National Service Framework in 2000. These were to achieve a rate of 1500 procedures per million population. Table 24 shows the operation rates for the PCTs in the Bedfordshire and Hertfordshire Health Authority area.

In general the population of Hertfordshire PCTs have higher level of surgery despite having a healthier population than those in Bedfordshire. Luton has a lower surgery rate than Beds and Herts as a whole, although the gap has narrowed in the last couple of years.

A further level of analysis would be to analyse which population groups are getting access to

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such services. It may be that surgery rates vary between ethnic groups, for example. Although ethnic recording is becoming more common in health services the use of this data to assess equity in service use is still very limited.

**Access for Asylum Seekers**

Asylum seekers started arriving in Luton in 1998, and by July 2003 the town had 2,230 known asylum seekers. During 2003 there has been a significant reduction in asylum seekers as a result of the Nationality, Immigration and Asylum Act, implemented on 8th January 2003. This Act requires people to claim asylum immediately on entering the country. If they choose to stay with family or friends they receive no financial support.

The origin of asylum seekers has changed over the years, reflecting world events. For example, 587 people arrived from Kosovo between 1999-2000 and more recently 202 people came from Zimbabwe and 112 from Somalia. In December 2002 Luton received 120 people when the Sangatte camp was closed in Calais.

The health of asylum seekers has been a concern nationally in that many of their needs have not been adequately met over the years. A report published by the British Medical Association reviewed the healthcare requirements of asylum seekers and examined the implications of the immigration process on health.

Certain health problems are common among asylum seekers and some are more specific. Threats to health are mostly linked to deprivation and overcrowding, and many health problems are therefore similar to those of other deprived and excluded groups. Health problems specific to asylum seekers originate from the physical or mental torture, or other harsh conditions from which they have escaped. There are few studies that directly address the health needs of asylum seekers, but it is suggested that 17% have a physical health problem severe enough to affect

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**Table 24: Revascularisation rates per million people, Beds and Herts PCTs, 2002/3**

<table>
<thead>
<tr>
<th>PCT</th>
<th>Total revascularisation procedures</th>
<th>Overall revascularisation rate per million people (rounded to nearest 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford and Three Rivers</td>
<td>279</td>
<td>1,600</td>
</tr>
<tr>
<td>Hertsmere</td>
<td>126</td>
<td>1,400</td>
</tr>
<tr>
<td>Dacorum</td>
<td>191</td>
<td>1,300</td>
</tr>
<tr>
<td>Royston, B&amp;Bs</td>
<td>91</td>
<td>1,300</td>
</tr>
<tr>
<td>South East Herts</td>
<td>213</td>
<td>1,200</td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td>117</td>
<td>1,200</td>
</tr>
<tr>
<td>North Herts &amp; Stevenage</td>
<td>201</td>
<td>1,100</td>
</tr>
<tr>
<td>St Albans and Harpenden</td>
<td>139</td>
<td>1,100</td>
</tr>
<tr>
<td>Bedford</td>
<td>160</td>
<td>1,100</td>
</tr>
<tr>
<td>Luton</td>
<td>207</td>
<td>1,000</td>
</tr>
<tr>
<td>Heartlands</td>
<td>212</td>
<td>800</td>
</tr>
<tr>
<td>Beds and Herts total</td>
<td>1,936</td>
<td>1,200</td>
</tr>
</tbody>
</table>

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their life, and over 60% have experienced significant anxiety or depression\textsuperscript{18}.

There are certain barriers to healthcare that need to be overcome in order to adequately meet the healthcare needs of asylum seekers, including language and cultural differences. The UK has insufficient translation services and the historical use of family, friends and other asylum seekers as translators is discouraged as it denies patients the right to confidentiality within their family and community.

Asylum seekers also have difficulty finding information about healthcare services especially primary care. The BMA report\textsuperscript{19} presents the Healthcare for the Homeless, Asylum Seekers and Travellers team (HHAT) in Luton as an example of good Practice, where a multidisciplinary approach from a team of nurses, advocacy workers, link-workers and health visitors provide a drop in clinic for medical and non-medical services\textsuperscript{20}.

### Luton General Practice case study

On a typical week in January 2003, 44 new patients were registered with the practice, of which 42% came from Africa (mainly Zimbabwe). The newly registered patients are different in profile from the existing practice population. They are generally younger and more deprived and have had no previous NHS General Practitioner. Women tended to have more pregnancies and no history of cervical cytology screening. These new patients have visited the surgery between 1 and 5 times in their first 6 months, and most required an appointment on the day of registering or within the first week. On assessment many required referral onto 4 or more other health care services.

The HHAT also offers healthcare to all people on traveller sites, ranging from pregnant women needing antenatal referral and babies a few days old, to the health problems of older people. A key pressure is the lack of time to provide a service and to maintain continuity of care - there are often just a few days before eviction in which to provide and organise a wide range of services.

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\textsuperscript{18}Carey Wood J et al. 1995. The settlement of refugees in Britain. HMSO. London


Choice and Equity

“Choice mechanisms enhance equity by exerting pressure on low-quality or incompetent providers. Competitive pressures and incentives drive up quality, efficiency and responsiveness in the public sector. Choice leads to higher standards. The overriding principle is clear. We should give poorer patients... the same range of choices the rich have always enjoyed. In a heterogeneous society where there is enormous variation in needs and preferences, public services must be equipped to respond.”

Tony Blair- 23rd January 2003

Although users have some choice in healthcare it very much depends on their circumstances. Some choice is restricted, for example the inability of patients to refer themselves directly to a specialist would bypass primary care and could lead to inappropriate use of expensive resources. These restrictions are based on the assumption that professionals know best how to treat a patient and that the ability of patients to treat themselves was limited by their lack of expertise. These assumptions are no longer as acceptable as they were, and a range of initiatives aims to give more choice to the user at different stages of treatment.

The opportunity for people to become expert patients is evident where they have to live with their illness for long periods of time. Life expectancy is growing and the balance of ill health is shifting from acute to chronic conditions. People with chronic illnesses become familiar with their condition and are more likely to take lifestyle and other factors into account. As a result the role of ‘Expert Patient’ (acknowledged in the white paper Saving Lives: Our Healthier Nation\(^2\)) and further developed in a 2001 report\(^3\) states that today’s patients can ‘become key decision-makers in the treatment process’.

The challenge in areas like Luton is to make choice equitable. Choices of treatment locations or types depend on good information being given to users at the right time. This includes giving people information in a language and format that they understand and ensuring that available services are appropriate to the needs of different groups. Without these measures greater choice could widen the health gap between rich and poor.

Improving Equity of Access

Improved access to effective healthcare interventions for disadvantaged groups may not be the most important way of reducing health inequalities but it has a very important contribution to make. Poor health outcomes are often associated with problems of gaining timely and good quality access to healthcare. Services should be targeted more effectively at those who would benefit most from them.

Health equity audit is one way of assessing the extent to which services are provided equitably and of doing something about it if they’re not. It is now a requirement set out in the new NHS Planning and Priorities Framework 2003-2006\(^2\) and will inform the implementation of local delivery plans, community strategies and local neighbourhood renewal strategies.

Equity audit is a process by which local partners:

- Systematically review inequities in the causes of ill health, and in access to effective services and their outcomes, for a defined population.
- Ensure that action is agreed and incorporated into local plans, services and practice.
- Evaluate the impact of the actions on reducing inequality.

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It provides a framework for systematic action and an opportunity for PCTs and partners to develop a common understanding of the key local health inequalities and to ensure that resources are allocated to tackle them.

Equity audit depends on good information being collected and made available. A key part of this is to record and use information about the ethnicity of practice populations and of health service users. A requirement of the Race Relations (Amendment) Act 2000 is that all public sector organisations must monitor their activities for any adverse impact on race equality and demonstrate that they are making progress. Within the health service the recording of ethnicity has improved in recent years, particularly in the hospital sector. The picture in GP practices is different and many are unable to provide a profile of their patient lists. For both hospital and primary care there needs to be more use of this data to ensure that services are equitable for the populations they serve. This is highlighted as a priority area as we move into the final chapter of this report - the recommendations for reducing health inequalities in Luton.

**Ways of using equity audit**

There are a number of ways in which a health equity audit can assess equity in service delivery in the NHS, local government or elsewhere. This can include a review of:

- Equal access for equal need: such as greater availability of free fruit in schools in the most deprived areas
- Equal use for equal need: such as greater use of smoking cessation services among low-income smokers
- Equal quality of care for all: such as culturally appropriate and relevant maternity services for black and minority ethnic communities.
- Equal outcomes for equal need: such as greater reductions in coronary heart disease mortality among lower socio-economic groups.

*Health Equity Audit Made Simple: A briefing for Primary Care Trusts and Local Strategic Partnerships Working document January 2003, HDA.*
Reducing inequalities

This report has shown that Luton’s health is poorer than the country as a whole, and that for some health problems the gap is getting wider. It has also shown inequalities between different groups and localities within Luton itself. The challenge now is to do more about it. This chapter sets out an approach to tackling health inequalities and makes recommendations for action.

Expanding our circle of influence

Stephen Covey\(^{24}\) writes of two circles, an outer circle of concern (things that bother us) and an inner circle of influence (things that we can do something about). Public health has a huge circle of concern. We are concerned about the global economy creating a gulf between rich and poor. We are concerned about the spread of infectious disease that could be brought under control by basic sanitation and vaccination. Locally, we also see over two hundred Luton people dying each year due to smoking. We can readily apportion blame to tobacco companies, fast food companies and drug dealers making money at the expense of local people’s health.

In the face of these things we could think that our circle of influence is small. But the public health movement is large and growing. It consists of all those who act to improve health and reduce inequalities, only some of whom work in health services. The question is how can we work together to make a real difference?

Challenging the myths

One important step is to challenge some myths. For example:

\`
\textbf{\textit{We don’t have enough information}}
- in reality the information collected by all local agencies is enormous. The data in this report is just the tip of the ice-berg. The challenge are to organise ourselves to get access to the information and to use it wisely.
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\textbf{\textit{Reducing inequalities would be a diversion from other targets}}
- the opposite is probably true. Much health care and other services is consumed repeatedly by the worst off. If we can meet targets for the most disadvantaged we can meet them for everyone.
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\textbf{\textit{Health services in poor areas will always perform more badly than those in rich areas}}
- while some areas present particular challenges, there are many examples of excellent service delivery that demonstrate what can be done if resources are used effectively.
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\textbf{\textit{We’re too busy already}}
- time and effort are limited, but can we be sure that we’re making best use of them now? Many local interventions in recent years have not been evaluated adequately.
\`

\`
\textbf{\textit{We don’t know what works}}
- there is a growing body of evidence about effective interventions to reduce inequalities. The Health Development Agency is just one of these sources. Again, the challenge is to think carefully about how to use this information to best effect locally.
\`

Making a difference

To make the biggest impact we need to bring two key principles to bear: efficiency and equity. Equity has been discussed elsewhere in the report and is vital if we are to ensure that any intervention benefits those with greatest need. Clear targeting of resources is an accepted part of Government policy on health inequalities. This should focus on the most disadvantaged and excluded, but is not exclusive to these groups. The national strategy suggests that “to reduce health inequalities and achieve the targets will require us to improve the health of the poorest 30-40% of the population where the greatest burden of disease exists”.

Efficiency is sometimes forgotten in the world of inequalities. It is vital to allocate scarce resources efficiently and to ensure that they are used efficiently once allocated. We have a tendency to create many small projects that subsequently fade away and are replaced by other small projects. This often results from the way funding is allocated to organisations in the first place, with each having different objectives and reporting mechanisms. They can have a symbolic rather than practical value. Organisations working together and using their mainstream allocations can have a much more powerful effect.

The efficiency of any intervention can only be known if its outcome can be monitored - a project may be inexpensive, but it is not possibly be efficient if it has no useful outcome. This means that we need to continue to develop an evidence-based rather than opinion-based approach to reducing health inequalities.

To make a difference locally we therefore need:

**Healthy decisions, based on Good evidence, to address Luton’s health priorities**


Recommendations for healthy decisions

Decisions affecting community health are made at all levels, from the individual up to national Government. The focus here is on local organisations making decisions that reduce rather than widen the health gap.

Health and social care is one of the theme groups of the Luton Forum, the town’s local strategic partnership body. The other theme groups also have a major influence on health inequalities through their work on regeneration, education, the environment, housing and other determinants of health.

Bridging the health gap means that this work should specifically address the localities and population groups that have the greatest needs. These have been described earlier in the report. It is not sufficient to promote the economic expansion of Luton and to hope that the benefits will readily ‘trickle down’ to the poorest. For example London is one of the richest cities in Europe but also has some of the continent’s poorest and most unhealthy populations.

- The Luton Forum theme groups are now revising the Community Plan. It is recommended that this should:
  - focus on a small number of major objectives
  - consider how best to address the Luton health priorities set out below
  - focus explicitly on benefits to the poorest and most disadvantaged
  - use the expertise of members of the health theme group to consider the possible impact of decisions on the wider determinants of health
• The future environment of Luton may be affected by major decisions on housing expansion, on the M1 widening and on the airport. It is recommended that:
  - no substantial housing, motorway or airport development should take place without a detailed and independent health impact assessment, so that the effects on health and health inequalities can be described and taken into account.

• Smaller scale plans may also have an effect on health and inequalities. It is recommended that:
  - LBC and Luton tPCT work together to identify a simple mechanism through which health considerations can be identified and taken into account in the borough planning process. The newly created jointly funded health impact assessment post should be instrumental in carrying out this work.

• Local organisations also make decisions that affect health inequalities. For example schools that encourage the collection of crisp packet or chocolate vouchers are contributing to growing levels of obesity. It is recommended that:
  - health promotion work with schools, employers and other organisations help them to consider their health impact and how best to reduce inequality.

Recommendations for good evidence

• This report provides some of the evidence needed to develop a coherent approach to tackling health inequalities in Luton. Good information underpins public health, but is often scattered, difficult to access and untimely. It is recommended that:
  - the Health and Social Care Theme Group should develop a core set of health indicators and should monitor trends on a regular basis to inform its work. This information should be shared with the constituent organisations of the group. The information should cover a range of factors including wider determinants of health and data relevant to the health priorities set out below.

• There continues to be gaps in the data needed to assess equity in health care. Most importantly some services do not collect ethnicity data and many do not appear to use it to assess whether services are provided equitably. It is recommended that:
  - gaps in ethnic recording should be identified and a target coverage of 100% achieved by all health services by the end of 2004/05. This should be a component of the new GMS contract and appropriate support provided.
  - all local services should use this data to carry out at least one ethnic monitoring exercise, reporting and acting on the results at senior management level by the end of 2004/05.

• In relation to evidence of effectiveness it is recommended that:
  - all major initiatives to reduce health inequalities should be able to demonstrate that they have searched for, found and interpreted relevant evidence on the effectiveness of the intervention they propose to implement.
  - all such initiatives within the tPCT should have a clear form of evaluation which is agreed by an appropriate party external to the project. The tPCT’s Evidence-based Practice Group may be an appropriate body to fulfil this role.
• Audit programmes should reflect local health priorities. Two of these (perinatal mortality and tuberculosis) are already underway. It is recommended that:
  - audit priorities for 2004/05 should include smoking cessation and sexual health.

Recommendations for Luton’s health priorities

The public sector often complains of ‘priority overload’ – a large ‘circle of concern’ ends up being a huge action list for local organisations. This report has taken a broad view of health and has stressed the importance of influencing the wider determinants of health to help reduce inequalities. It would, however, help to focus attention on a smaller number of priorities for special attention. This does not mean that other topics are not important, nor that they should be neglected. From the evidence of this report the following are recommended for priority action:

• Sexual health including HIV. Luton has high rates of STIs and HIV compared to the rest of the region and to the country as a whole. Rates are rising and pose a substantial risk to public health. Action should include developing more accessible and integrated sexual health services as part of a focussed and co-ordinated plan. Work should focus explicitly on young people and on specific communities most affected.

• Coronary heart disease. This remains the biggest single cause of premature death in Luton and shows a sharp gradient across social classes and ethnic groups. Action should focus on reducing risk factors and on improving primary care for the least well off. A special effort should be made to achieve a measurable reduction in smoking in Luton, with the main partnership being a local one with other Luton organisations. This would help reduce CHD and cancer deaths.

• Tuberculosis. This is another infectious disease showing a big increase locally. A TB audit is being completed and the early signs are that service changes are needed. Service development should be based on the evidence gathered in the audit process.

• Perinatal mortality. Rates in Luton are significantly higher than the national average and are also higher than comparable PCT areas. Again an audit is being undertaken, as part of the ‘pursuing perfection’ programme. A reduction in perinatal mortality will require a joint approach focussing on specific parts of the town such as Biscot and Dallow and on specific communities.

• Community development. A theme of this report has been the health inequalities faced by different ethnic groups in Luton. The causes are complex and will not be addressed by a ‘medical model’ approach. It is important to help strengthen communities, working directly with those who are more vulnerable rather than solely through community leaders. More focused work is needed with communities to help create a basis for reducing the risks of diabetes, CHD, perinatal mortality and other health problems.

• Language support. There continues to be evidence that more effective use of health care can be achieved through better language support. Although good services exist they may benefit from improved co-ordination and easier access. This has been identified as a priority in developing health services in Luton for the year ahead.
Looking Forward

The public health report should stimulate debate and action to help reduce health inequalities in Luton. The challenge is a big one and will need people and agencies to pull together in the same direction. Luton has a good record of joint working on health and has laid the foundations for future action. This public health report has looked at the big picture but then focussed down on a smaller number of priorities. Future annual reports are likely to be smaller in scale. They’ll provide updated information and will include some of the topics not covered in this year’s document. We trust that we will get to the point - closing the health gap in Luton.

APPENDICES

APPENDIX 1: Age profile of Luton wards, 2001

<table>
<thead>
<tr>
<th>Ward</th>
<th>All People</th>
<th>0-4 Years</th>
<th>5-14 Years</th>
<th>15-24 Years</th>
<th>25-44 Years</th>
<th>45-64 Years</th>
<th>65-74 Years</th>
<th>75-84 Years</th>
<th>85+ Years</th>
</tr>
</thead>
<tbody>
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<td>1,046</td>
<td>756</td>
<td>2,294</td>
<td>1,573</td>
<td>424</td>
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<tr>
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<td>2,126</td>
<td>2,682</td>
<td>3,689</td>
<td>2,098</td>
<td>622</td>
<td>324</td>
<td>181</td>
</tr>
<tr>
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<td>480</td>
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<td>869</td>
<td>2,682</td>
<td>1,822</td>
<td>423</td>
<td>217</td>
<td>63</td>
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<tr>
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<td>2,515</td>
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<td>1,345</td>
<td>400</td>
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<td>151</td>
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<td>Saints</td>
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<td>1,955</td>
<td>3,356</td>
<td>2,089</td>
<td>663</td>
<td>414</td>
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<td>900</td>
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<td>1,942</td>
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<td>81</td>
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<tr>
<td>Luton</td>
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<td>13,286</td>
<td>27,389</td>
<td>27,678</td>
<td>55,889</td>
<td>38,000</td>
<td>12,742</td>
<td>7,014</td>
<td>2,373</td>
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Source: ONS Census data, 2001
### APPENDIX 2: Ethnic profile of Luton wards, 2001

<table>
<thead>
<tr>
<th>Ward</th>
<th>White British %</th>
<th>White: Irish %</th>
<th>White: Other %</th>
<th>Mixed: White &amp; Black Caribbean %</th>
<th>Mixed: White &amp; Black African %</th>
<th>Mixed: White &amp; Asian %</th>
<th>Mixed: Other %</th>
<th>Asian or Asian British: Indian %</th>
<th>Asian or Asian British: Pakistani %</th>
<th>Asian or Asian British: Bangladeshi %</th>
<th>Asian or Asian British: Other Asian %</th>
<th>Black or Black British: Caribbean %</th>
<th>Black or Black British: African %</th>
<th>Black or Black British: Other Black %</th>
<th>Chinese or other ethnic group: Chinese %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnfield</td>
<td>73.9</td>
<td>3.8</td>
<td>1.1</td>
<td>0.1</td>
<td>1.0</td>
<td>0.4</td>
<td>7.1</td>
<td>4.0</td>
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<td>3.0</td>
<td>0.7</td>
<td>0.3</td>
<td>0.9</td>
<td>100%</td>
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<td>0.5</td>
<td>0.4</td>
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<td>0.6</td>
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<td>1.8</td>
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<td>3.5</td>
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<td>0.4</td>
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<td>4.0</td>
<td>2.8</td>
<td>1.2</td>
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<td>1.1</td>
<td>0.3</td>
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<tr>
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<td>4.2</td>
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<td>6.4</td>
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<td>0.3</td>
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<td>1.4</td>
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Source: ONS Census data, 2001

### APPENDIX 3: Selected Health Indicators: 1996-2002

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<td>Infant Mortality Rate</td>
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<td>9.4</td>
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<td>Perinatal Mortality Rate</td>
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<td>5.1</td>
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<td>Deaths (all ages)</td>
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<td>1513</td>
<td>1426</td>
<td>1483</td>
<td>1478</td>
<td>1563</td>
<td>1539</td>
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</table>

Source: ONS, 2002
**GLOSSARY**

**Body Mass Index**  Used to clarify overweight and obesity in adults. BMI is calculated as a fraction: 
\[ \text{BMI} = \frac{\text{Weight} (\text{kg})}{\text{Height} (m)^2} \]
- Acceptable BMI = 18.2 - 25
- Overweight = 25-30, Obese = >30

**Child Poverty Index**  Child poverty is a multi-dimensional issue, encompassing such matters as educational attainment, health inequalities and social stability as well as income and living standards.

**Cholesterol**  Type of fat made by the body which if excessive can lead to heart disease.

**Clinical Governance**  Framework through which health organisations can work to improve and assure the quality of services for patients.

**Confidence Intervals**  Provide a measure of assurance that a particular value truly lies within a defined range.

**Coronary Heart Disease (CHD)**  Debilitating disease that results from partial or total blockage of the coronary arteries that can lead to sudden death, heart attack, angina, heart failure and abnormal heartbeat.

**Demography**  The study of the characteristics of human populations, such as size, growth, density, distribution, and vital statistics.

**Dental caries**  The formation of cavities in the teeth by the action of bacteria; tooth decay.

**Ethnicity**  An ethnic quality or affiliation resulting from racial or cultural ties.

**Food Standards Agency**  Food Standards Agency are charged with protecting health in relation to food, with powers to act throughout the food chain to develop soundly based, balanced policies. It advises consumers and ministers and the food industry on all aspects of food safety and standards.

**Fuel Poverty**  Occurs when people need to spend more than 10% of their income on fuel to achieve adequate levels of warmth in the home.

**Health Action Zone**  Partnerships between the NHS, local authorities, community groups and the voluntary and business sectors to tackle local health inequalities.

**Hepatitis A**  Virus spread by the mouth. Symptoms include fever, tiredness, abdominal pain, and loss of appetite, followed by jaundice within a few days.

**Hepatitis B**  Virus spread usually by the blood but other body fluids also contain the virus. The symptoms similar to Hepatitis A. A small number of individuals become ‘carriers’ where they feel well but are carrying the virus.

**Human Immunodeficiency Virus**  Virus which gradually destroys the body’s normal immune response and may lead to a fully developed AIDS syndrome which leaves the individual open to opportunistic infections and cancers infrequently seen in people with a normal functional immune system.

**Hypertension**  Raised blood pressure

**Incidence**  A measure of how often new cases of a disease or condition arise over a particular period of time.

**Index of Multiple Deprivation**  Index of the level of deprivation in an area taking account of income, employment status, health and disability, housing, education and training opportunities, access to services.

**Infant Mortality Rate**  Number of deaths from the first day of life to the end of the first year of life per 1000 live births per year.

**Insulin**  Hormone secreted by the pancreas that regulates carbohydrate metabolism by controlling blood glucose levels.

**Life Expectancy**  Average lifespan expected from birth to death.

**Live Birth Rate**  Live births per 1000 total live and still births.

**Local Authority**  Local government council, covering a set geographic area with responsibilities for running social and other local services, such as environmental health.

**Low Birth weight**  Babies with a birth weight below 2500 grams.

**Luton Forum**  Partnership of local public sector organisations.

**National Service Framework (NSF)**  National Service Framework. NSFs help establish clear national standards for services to improve quality and reduce unacceptable variations in standards of care and treatment. There are NSFs for coronary heart disease, mental health, older people, and the NHS Cancer Plan. NSFs for children, diabetes, and renal services are also being developed.

**National Mortality Rate**  Deaths under 4 weeks per 1000 live births.

**Osteoporosis**  A disease in which the bones become extremely porous, are subject to fracture, and heal slowly, occurring especially in women following menopause.

**Perinatal Mortality Rate**  The number of still births and deaths of babies up to the age of 1 week per 1000 total births per year.

**Prevalence**  The number of people in a population who have a disease over a given period or at a specific point in time.

**Pursuing Perfection programme**  Pursuing Perfection is a health care improvement initiative. Through partnership with health care trusts and local authorities the aim is to achieve major improvements across health and social care.

**Primary Care**  GPs, ophthalmologists, pharmacists and dentists on the frontline of the NHS - the part officially called ‘primary care’. Many other health professionals work as part of this frontline team - nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists.

**Primary Care Trust**  An NHS organisation with the function to improve the health of a community; develop primary and community health services; and commission secondary cares services.
PRIMIS  Primary Care Information Services is a service to primary care organisations to help them improve patient care through the effective use of their clinical computer systems.

Revascularisation  Surgical procedure to unblock coronary arteries, by either unblocking the artery itself or bypassing it.

Serum Ferritin  Iron levels in the blood of an individual.

Single Assessment Process  An arrangement where health and social care workers work together to provide better co-ordinated and more consistent services for older people.

SOPHID  Survey of Prevalent HIV Diagnoses.

Standard Fertility Ratio  Observed live births as a % of expected live births expected = number that would occur if the population of Luton experienced the age specific fertility rate of England & Wales.

Standardised Mortality Ratios  SMRs allow comparisons of populations with different age and sex structures. Calculations involve applying national age-specific death rates to the local population in order to calculate a ratio of expected to observed deaths. This figure is then multiplied by 100. The comparative national figure will be 100. A value greater than 100 indicates an increased incidence and below 100, a reduced incidence.

Statins  Drugs that lower body cholesterol.

Still Birth  Baby born dead after 24-week gestation.

Still Birth Rate  Number of stillbirths per 1000 total births per year.

Tuberculosis  Chronic, progressive infection that commonly affects the lungs but may affect other organs and tissues such as bone, kidney and intestine.

Very Low Birth Rate  Births under 1500 grams

Ward  An electoral ward is a division of an administrative area used to elect councillors to serve on a council.

Useful Websites

Luton Public Health Report 2003 has been created with the help of a number of organisations. You may find the following sources of information useful.

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
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<tbody>
<tr>
<td>Luton teaching Primary Care Trust <a href="http://www.lutonpct.nhs.uk">www.lutonpct.nhs.uk</a></td>
<td>Information about the health priorities for Luton tPCT and the services it provides</td>
</tr>
<tr>
<td>Luton &amp; Dunstable Hospital <a href="http://www.ldh.nhs.uk">www.ldh.nhs.uk</a></td>
<td>Offers key information about Luton &amp; Dunstable Hospitals healthcare services, and offers links to related websites</td>
</tr>
<tr>
<td>Bedfordshire &amp; Luton Community NHS Trust <a href="http://www.blct.nhs.uk">www.blct.nhs.uk</a></td>
<td>Provides details of specialist care services, particularly in relation to mental health, offered across Bedfordshire &amp; Luton in collaboration with PCT’s and social services</td>
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<tr>
<td>Luton Borough Council <a href="http://www.luton.gov.uk">www.luton.gov.uk</a></td>
<td>Provides information about the Council and the services it provides, as well as information about the local community</td>
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<tr>
<td>Luton Forum <a href="http://www.luton.gov.uk">www.luton.gov.uk</a> Link to the Luton Forum</td>
<td>The Forum is an umbrella partnership to link the community and key organisations which provide services in Luton</td>
</tr>
<tr>
<td>Health Development Agency (HDA) <a href="http://www.hda.org.uk">www.hda.org.uk</a></td>
<td>Identifies the evidence of what works to improve people’s health and reduce health inequalities, developing guidance across sectors to get evidence into practice.</td>
</tr>
<tr>
<td>Office of National Statistics (ONS) <a href="http://www.statistics.gov.uk">www.statistics.gov.uk</a></td>
<td>Publishes information on all aspects of Britain’s economy, population and community at both national and local level</td>
</tr>
<tr>
<td>Eastern Region Public Health Observatory (ERPHO) <a href="http://www.erpho.org.uk">www.erpho.org.uk</a></td>
<td>Provides access to population health data, methods and expertise.</td>
</tr>
<tr>
<td>Department of Health (DoH) <a href="http://www.doh.gov.uk">www.doh.gov.uk</a></td>
<td>Latest information on the Department of Health’s work and priorities, along with guidance and details of publications.</td>
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<tr>
<td>Health Protection Agency (HPA) <a href="http://www.hpa.org.uk">www.hpa.org.uk</a></td>
<td>The Health Protection Agency includes a number of organisations dedicated to protecting people’s health.</td>
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