Healthy Partnerships

Foreword

I am pleased to present my annual public health report for 2006/2007.

The report is for everyone concerned with improving health and reducing inequalities in Luton. It provides the latest information on Luton's health, has an update on key public health priorities and shows progress against some key health improvement targets.

Every public health report has a particular theme, and this year we highlight the importance of partnership working. The factors that affect Luton's health are very complex, and require joint action if we are to make sustainable improvements. The case studies in this report demonstrate the commitment we have to working with colleagues from a wide range of organisations.

A number of recent policy documents have set the scene for joint action. The 2004 Public Health White Paper, Choosing Health: Making Healthy Choices Easier, recognised that real progress in improving health depends on effective partnerships; the 2006 White Paper, Our Health, our care, our say: a new direction for community services, pointed the way for closer integration between the NHS and local authorities to achieve better health, and later in 2006, the strong and prosperous communities White Paper outlined a clear structure for improved partnership working between the NHS and local government.

The commitment to retain a PCT that is coterminous with the local authority in Luton has enabled the strong partnership working in the town to continue. This will now be strengthened by the appointment of a joint Director of Public Health across Luton PCT and Luton Borough Council.

A key public health measure introduced in England since the last report has been the introduction of smoke-free enclosed public places and workplaces. Smoking continues to be the single biggest preventable cause of ill health and this measure should result in a significant reduction in smoking related mortality. It is too early to tell what impact this has had in Luton, but this will be monitored very closely over the next few years. Our next big challenge is to tackle obesity. This will require effective partnership working across all sectors and at all levels, but the rewards for success will be significant for both individuals and the community as a whole.

I would like to thank everyone who has contributed to this report. This includes all members of the Public Health team within the PCT as well as many colleagues across the town. In particular I would like to thank Kelly O'Neill, Kate Folkard and Karen Tate for advising on the contents of this report and Louise Choo for providing the data.

I hope you will find the report useful and informative.

Morag Stewart
Acting Director of Public Health
Luton teaching Primary Care Trust
December 2007
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Section 1: A Profile of Luton

1.1 Luton’s Population: An Update

The number of people who live in Luton is estimated to be 186,800 (2006). Table 1 shows that the town has a high proportion of people aged under 15 (20.8%) compared to 17.7% in England) and a low proportion of people aged 65 and over (12.4%, compared to 15.9% nationally).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>England</th>
<th>Luton</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>17.7%</td>
<td>20.8%</td>
<td>15.9%</td>
</tr>
<tr>
<td>15-64</td>
<td>66.4%</td>
<td>66.8%</td>
<td>12.4%</td>
</tr>
<tr>
<td>65+</td>
<td>15.9%</td>
<td>12.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 1: Proportions of the population by age group, Luton & England 2006

Source: ONS Mid-2006 Population Estimates

Breaking Luton’s population down into more detail, there are noticeably greater numbers of women over the age of 75 than men (Table 2). That reflects the life expectancy differences between men and women both locally and nationally. Conversely, there are a greater number of males between the ages of 25 to 39 years than women in that age group. The reason for this warrants further investigation.

Table 2: 2006 mid year population estimates for Luton

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>7,500</td>
<td>7,000</td>
<td>14,500</td>
</tr>
<tr>
<td>5-9</td>
<td>6,100</td>
<td>6,000</td>
<td>12,100</td>
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<td>10-14</td>
<td>6,300</td>
<td>6,100</td>
<td>12,300</td>
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<tr>
<td>15-19</td>
<td>7,000</td>
<td>6,500</td>
<td>13,500</td>
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<td>20-24</td>
<td>7,600</td>
<td>7,800</td>
<td>15,300</td>
</tr>
<tr>
<td>25-29</td>
<td>7,700</td>
<td>7,300</td>
<td>15,000</td>
</tr>
<tr>
<td>30-34</td>
<td>7,000</td>
<td>6,400</td>
<td>13,000</td>
</tr>
<tr>
<td>35-39</td>
<td>7,900</td>
<td>6,800</td>
<td>14,600</td>
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<td>40-44</td>
<td>6,900</td>
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<td>13,500</td>
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<td>45-49</td>
<td>5,800</td>
<td>5,900</td>
<td>11,800</td>
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<tr>
<td>50-54</td>
<td>5,000</td>
<td>4,900</td>
<td>9,900</td>
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<td>55-59</td>
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<td>5,000</td>
<td>9,900</td>
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<td>60-64</td>
<td>3,900</td>
<td>3,900</td>
<td>7,800</td>
</tr>
<tr>
<td>65-69</td>
<td>3,500</td>
<td>3,400</td>
<td>6,900</td>
</tr>
<tr>
<td>70-74</td>
<td>3,200</td>
<td>3,000</td>
<td>6,200</td>
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<tr>
<td>75-79</td>
<td>2,200</td>
<td>2,400</td>
<td>4,600</td>
</tr>
<tr>
<td>80-84</td>
<td>1,400</td>
<td>1,700</td>
<td>3,100</td>
</tr>
<tr>
<td>85-89</td>
<td>500</td>
<td>1,100</td>
<td>1,600</td>
</tr>
<tr>
<td>90+</td>
<td>200</td>
<td>600</td>
<td>800</td>
</tr>
<tr>
<td>Total</td>
<td>94,500</td>
<td>92,300</td>
<td>186,800</td>
</tr>
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Source: ONS 2004-based Sub-national Population Projections

The population of the United Kingdom is increasing. In 1971 it was 55.9 million people, which has increased to 60.2 million in 2006. Population growth has not occurred evenly across all age groups and nationally there has been an increase in over 65s and a decline in the under 16s. This is as a result of declines both in birth (fertility) rate and in death (mortality) rate, leading to an ageing population.

1.2 Population Projections

Projecting population change is an important part of anticipating, and planning for, future health and social care service needs and demands.

The population of Luton is projected to rise by 3.2% from 2004 to 2029. Figure 1 highlights that there is a projected year on year growth for the over 65 age group.

Figure 1: Population projections by age group in Luton, 2003-2028

Source: ONS 2004-based Sub-national Population Projections

The Office for National Statistics (ONS) projections for 2003 to 2028 detailed above, is trend-based and represent what would happen if recent (five year) trends, for example birth, death and local migration rates, continue. The projections do not take into account the future implications of local, regional or national policies such as new housing developments.

The ‘Population Estimates and Forecasts’ published by Bedfordshire County and Luton Borough Council provides key population data to inform service planning in the area. These are based on the mid-year 2001 population estimates included within the methodology.

According to this report, Luton’s population was forecast to increase up to 2006 and is now set to decline to 2016. Table 3 and Figure 2 show the predicted change by age group. This information provides a more detailed breakdown than the ONS age group forecasts above. It indicates that the recent trends in children’s age groups are set to reverse over the next 10 years and that the number of people in the older age groups will continue to rise.

Table 3: Luton’s population change by age structure, 2001 - 2016

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</thead>
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<tr>
<td>Pre-School (under 5s)</td>
<td>+13.3%</td>
<td>-6.3%</td>
<td>-3.7%</td>
</tr>
<tr>
<td>School Age (5 to 15s)</td>
<td>-5.9%</td>
<td>+2.1%</td>
<td>+2.1%</td>
</tr>
<tr>
<td>School Leavers/Higher Education (16 to 19s)</td>
<td>+9.1%</td>
<td>-8.4%</td>
<td>-7.8%</td>
</tr>
<tr>
<td>Working Adults (20-64s)</td>
<td>+0.1%</td>
<td>-0.8%</td>
<td>-3.3%</td>
</tr>
<tr>
<td>Post Retirement (65-74s)</td>
<td>+4.0%</td>
<td>+1.3%</td>
<td>+10.0%</td>
</tr>
<tr>
<td>Older People (Over 75s)</td>
<td>+2.3%</td>
<td>+10.0%</td>
<td>+10.0%</td>
</tr>
</tbody>
</table>


Three other significant changes anticipated in coming years are that:

- The proportion of Luton's population from minority ethnic groups is projected to grow further, with particular increases in Pakistani, Bangladeshi, Black African and 'White Other' (e.g. Eastern European) groups. This will result from both the tendency of new immigrants to join established immigrant communities, and the higher than average birth rate amongst minority ethnic groups.

- Luton's population is getting older and there clearly needs to be a joint approach from partner organisations to address the needs of the older population and the development of a joint long term health and social care strategy for older people should be considered.

- Luton is part of a sub-regional growth area (Milton Keynes and South Midlands) that will see a big rise in population in coming decades. The population of the whole MKSM area is projected to rise from 1,632,000 in 2006 to 1,744,000 in 2011, with much larger increases from then until the year 2031.

There are variations within the MKSM area, for example the population growth projected in Luton is 0% while in Corby it is 110% between 2006 and 2031. It is important to recognise that population projections can be quite different depending on the source of the data and it is therefore essential that there is a degree of flexibility in planning future services.

### 1.3 The Influence of Migration on Population Growth

Luton's population from black and minority ethnic (BME) groups was recorded as 28% of the total population in the 2001 census, which remains the most comprehensive source of information on ethnicity (Table 4). It is known that the recent expansion of the European Union has led to an increase in the number of Eastern Europeans living in Luton. These are most notably young, economically active people from Poland, living and working in the town. Recent data on National Insurance registrations in Luton show that there were 2,530 provided to people from Poland in 2006/07, which represents 47% of the registrations for non-UK nationals in the town.2

There is a lack of information regarding the health status of this community group in Luton and a health needs assessment should be considered to identify unmet health care needs.

### Table 4: Luton's ethnic composition compared to England, 2001

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<tr>
<th>Ethnic group</th>
<th>Luton %</th>
<th>England %</th>
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<tbody>
<tr>
<td>White</td>
<td>71.9</td>
<td>90.9</td>
</tr>
<tr>
<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 ethnic group.</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: ONS 2001 Census

### 1.4 Births in Luton:

Luton has a high birth rate. Table 5 shows the number of births recorded in Luton by year from 1996 to 2006. The live birth rate is the number of births in a year per 1000 resident population and this has recently increased, as has the England and Wales average. Using the standardised fertility ratio we can compare Luton with the rest of England and Wales taking the age structure of the population into account. The national figure is a ratio of 100, with numbers greater than 100 being above the national average. Luton's ratio is consistently higher than the rest of England and Wales.

In 2006 Luton had the fifth highest recorded general fertility rate in England. 80.6 live births per 1000 women aged between 15-44 years. The national average was 60.3 births per 1000 women in that age group.

### Table 5: Births data for Luton, 1996 – 2006

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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>
<td>3085</td>
<td>3181</td>
<td>3196</td>
<td>3325</td>
</tr>
<tr>
<td>Live Birth Rate</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>
<td>16.6</td>
<td>17.2</td>
<td>17.4</td>
<td>17.8</td>
</tr>
<tr>
<td>Standardised Fertility Ratio</td>
<td>116.0</td>
<td>115.0</td>
<td>115.0</td>
<td>117.0</td>
<td>124.0</td>
<td>125.0</td>
<td>133.0</td>
<td>129.0</td>
<td>130.0</td>
<td>134.0</td>
<td>134.0</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1, 2 and 5

### 1.5 How long people in Luton live and what they die of:

Table 6 shows mortality data for Luton and includes the standardised mortality ratios (SMRs) which take age and sex structure into account (the national figure is set at 100). Luton has a high mortality ratio, which fits with the fact that life expectancy in the town is worse than the national average. Luton's high mortality ratio for the under 75 age group indicates a high level of premature mortality although this has reduced from the extremely high levels seen between 1996 and 2001.

---

2 Source: Department for Work and Pensions
### Table 6: Deaths data for Luton, 1996 – 2006

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths (all ages)</td>
<td>1445</td>
<td>1513</td>
<td>1426</td>
<td>1483</td>
<td>1478</td>
<td>1563</td>
<td>1539</td>
<td>1559</td>
<td>1477</td>
<td>1464</td>
<td>1441</td>
</tr>
<tr>
<td>Crude Death Rate (all Ages)</td>
<td>8.7</td>
<td>8.9</td>
<td>8.5</td>
<td>8.6</td>
<td>8.1</td>
<td>8.5</td>
<td>8.4</td>
<td>8.4</td>
<td>8.1</td>
<td>8.0</td>
<td>7.7</td>
</tr>
<tr>
<td>Standardised Mortality Ratio (all Ages)</td>
<td>98</td>
<td>101</td>
<td>98</td>
<td>100</td>
<td>108</td>
<td>116</td>
<td>109</td>
<td>110</td>
<td>110</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Deaths (Under 75)</td>
<td>655</td>
<td>653</td>
<td>615</td>
<td>657</td>
<td>624</td>
<td>274</td>
<td>597</td>
<td>610</td>
<td>606</td>
<td>619</td>
<td>597</td>
</tr>
<tr>
<td>Standardised Mortality Ratio (Under 75)</td>
<td>134</td>
<td>133</td>
<td>123</td>
<td>132</td>
<td>124</td>
<td>130</td>
<td>114</td>
<td>116</td>
<td>115</td>
<td>116</td>
<td>114</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1, 2 and 5

### Life Expectancy

In Luton, life expectancy at birth continues to increase for both men and women (Figure 3). However for men and women in Luton, life expectancy remains below the national average by over a year for each gender (males 76.1 years compared to 77.2 nationally and females 80.0 compared to 81.5).

**Figure 3: Life expectancy at birth; males and females; Luton compared to England & Wales, 1991-93 to 2004-06 and projection to 2009-11**

![Life expectancy graph]

Source: ONS, 2006

Based on current projections by 2010 life expectancy at birth in Luton will be 77.1 years for males (1.5 years below the 2010 target for England) and 80.1 years for females (2.4 years below the 2010 target for England). Figure 4 highlights the inequalities that exist between wards in Luton. There is 8.4 years difference between the wards with the highest life expectancy and the wards with the lowest life expectancy.

**Figure 4: Luton Life expectancy by MSOA, persons 2004-2006**

![Life expectancy map]

Source: espho 2007

Based on 2001 Census, Output Area Boundaries.

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### 1.6 Deprivation in Luton

The map below (Figure 5) clearly shows there are both areas of high affluence and deprivation in Luton. The Index of Multiple Deprivation 2004 (IMD 2004) is the most comprehensive measure of multiple deprivation available. The concept of multiple deprivation underlying the IMD 2004 is that separate types of deprivation exist and are measurable. The IMD 2004 consists of seven types or “domains” of deprivation, each of which contains a number of individual measures, or indicators such as employment, income, health and disability, educational attainment, crime, the living environment and barriers to housing and services.

![Deprivation map]
Within each domain, the indicators are combined to create a score, which indicates the levels of deprivation in an area, and a rank, which relates the levels of deprivation to other areas across England. Figure 5 shows the rank scores of deprivation by super output areas (SOA). The most deprived SOA in England is allocated the rank of 1. All other SOA areas are ranked against the most deprived. There are a total of 32,482 SOAs in England.

Luton is the 2nd most deprived of all Counties and Unitaries across the East of England region, with only Peterborough more deprived. The most deprived areas in Luton are Northwell (ranked 1,555 in England), Dallow and Biscot wards. In terms of areas being highly deprived on a number of measures, Northwell and Dallow are in the most deprived 10% of areas across the country.

The DH Health Profile 2007 gave a snapshot of health in Luton to support local government and PCTs to work together to improve health and reduce inequalities. Table 7 gives the key points.

Table 7: Mortality rates for specific causes, Luton and England.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of deaths in Luton</th>
<th>Luton mortality rate</th>
<th>England average rate</th>
<th>England worst rate</th>
<th>England best rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths from Smoking(^5)</td>
<td>260</td>
<td>253.6</td>
<td>234.4</td>
<td>366.5</td>
<td>147.6</td>
</tr>
<tr>
<td>Early Deaths: Heart Disease and Stroke(^6)</td>
<td>177</td>
<td>104.4</td>
<td>90.5</td>
<td>151.3</td>
<td>44.9</td>
</tr>
<tr>
<td>Early Deaths: Cancer(^7)</td>
<td>202</td>
<td>121.9</td>
<td>119.0</td>
<td>168.0</td>
<td>81.6</td>
</tr>
<tr>
<td>Infant Deaths(^8)</td>
<td>17</td>
<td>5.3</td>
<td>5.1</td>
<td>9.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Road Injuries and Deaths(^9)</td>
<td>50</td>
<td>31.9</td>
<td>59.9</td>
<td>214.1</td>
<td>20.2</td>
</tr>
</tbody>
</table>

Source: DH: Health Profile for Luton: 2007

The health profile 2007 measures the above indicators against the England average. Statistical analysis of the data reveals that Luton’s mortality rates are:

- Significantly higher than average for smoking and for heart disease and stroke
- Not significantly different to the national average for cancer and for infant deaths
- Significantly better than average for road injuries and deaths

1.7 Health Inequalities

Luton’s population is young, ethnically diverse and transient. The town has very specific public health needs that contrast markedly with other areas in the East of England. The public health challenges are more akin to those found in larger urban conurbations.

Over the last 50 years, there have been impressive social, economic and health improvements in this country. Overall, people are healthier and are living longer than ever before. Unfortunately, not everyone has been able to share these benefits, and some health indicators suggest that the gap between different groups remains as wide as ever. Health inequalities are unacceptable. They start early in life and persist not only into old age but subsequent generations. Tackling health inequalities is a priority nationally, regionally and locally, and is focused on narrowing the health gap between disadvantaged groups, communities and the rest of the country. Concerted action to reduce the health gap permeates national and local health programmes.

This section highlights some of the health inequalities that exist within Luton. However health is also affected by many other factors such as housing, educational attainment and employment. The Health Profile for Luton states that 15.9% of people living in Luton are dependent on means tested benefits (2003), 11.7% of households on the local authority housing register are statutorily homeless (2004/05), 25.4% of children are living in low income households (2001), only 51% of children achieve 5 A* - C grades at GCSE (2005/06), and violent crime is 26.3 per 1000 residents in Luton (2005/06). All of these indicators are significantly worse than the England average.

Reducing the health inequalities that exist within Luton is a key priority for both the tPCT and Luton Borough Council. The remaining sections of this report highlights some of the action taking place to reduce these inequalities.

---

\(^5\) Deaths from smoking: Directly age standardised rate/100,000 population aged 35 or over 2003 - 2005
\(^6\) Early Deaths: Heart Disease and Stroke: Directly age standardised rate/100,000 population under 75, 2003 - 2005
\(^7\) Early Deaths: Cancer: Directly age standardised rate/100,000 population under 75, 2003 - 2005
\(^8\) Crude Rate/1000 live births, 2003 - 2005
\(^9\) Crude Rate/100,000 population, 2003 - 2005
2 Introduction

This section of the report looks at four key areas of public health, all of which are vital to the effort to reduce inequalities in health:

- Health Protection
- Smoking
- Sexual Health
- Obesity

2.1 Health Protection

Health protection priorities include ensuring there is adequate planning and response in relation to the health implications of major incidents such as a disruption to transport, adverse weather, terrorism or an outbreak of a communicable disease, health screening programmes, child and adult immunisation services, infection control in the community and healthcare associated infections. This report focuses on some of the key areas where there has been targeted intervention in the last year. Details of local work on child immunisations are given in section 4.1 of this report.

2.1.1 Tuberculosis and BCG Vaccinations

Introduction

Tuberculosis (TB) is an infectious disease caused by the bacterium Mycobacterium tuberculosis. In England, TB cases have increased by 25% in the last 10 years, with about 7000 cases reported each year in the UK. The Tuberculosis in the UK, 2007 annual report from the Health Protection Agency identifies that in 2006 the largest percentage of TB cases in England, Wales and Northern Ireland was reported in the 15-44 year age group (62%), 73% of the cases were non-UK born and the rate of TB in that group is recorded as 95 per 100,000 population compared to 4 per 100,000 among the UK born population. For the non-UK born cases where information was available regarding their time of entry into the UK, 81% had entered the UK more than 2 years prior to diagnosis.

Coming from a high TB prevalence country is a key risk factor, and many cases of TB are amongst people who were infected while living overseas but then become ill in the UK. The origin of the non-UK born cases identified in 2006 was highest in those from South Asia (47.1%) and Sub-Saharan Africa (37.2%). Table 8 shows the difference in TB rates between individuals who were born abroad and those born in the UK.

Table 8: Rate of TB in England, Wales and Northern Ireland by place of birth, and ethnic origin, 2006.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number of Cases</th>
<th>Rate per 100,000</th>
<th>Number of Cases</th>
<th>Rate per 100,000</th>
<th>Number of Cases</th>
<th>Rate per 100,000</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK Born</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1295</td>
<td>3</td>
<td>244</td>
<td>10</td>
<td>1732</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>96</td>
<td>26</td>
<td>83</td>
<td>38</td>
<td>197</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>81</td>
<td>32</td>
<td>1774</td>
<td>395</td>
<td>1943</td>
<td>278</td>
<td></td>
</tr>
<tr>
<td>Indian/ Pakistani / Bangladesh</td>
<td>379</td>
<td>36</td>
<td>2377</td>
<td>210</td>
<td>3019</td>
<td>139</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>7</td>
<td>15</td>
<td>86</td>
<td>59</td>
<td>104</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Other (includes black other)</td>
<td>74</td>
<td>-</td>
<td>673</td>
<td>-</td>
<td>797</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>10</td>
<td>-</td>
<td>65</td>
<td>-</td>
<td>321</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1942</td>
<td>4</td>
<td>5302</td>
<td>95</td>
<td>8118</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Protection Agency

Because of the nature of the bacteria that causes TB, treatment lasts 6 months and ensuring that individuals complete their full treatment is key to their recovery and reduces the risk of drug resistance to the TB medication occurring. About 77% of individuals treated for TB in the East of England (2006) completed their treatment course, compared to a national completion rate of 79.2%. This completion rate was below the national target of 85%. The proportion of people infected with TB who were found to have a strain of the disease resistant to first-line drug treatment was small (less than 5%).

What we are doing in Luton?

In July 2005 the Department of Health (DH) announced changes to the national BCG vaccination programme. Areas of high prevalence (>40 cases per 100,000 population) such as Luton are required to administer a universal BCG vaccination to all newborn babies up to the age of 1 year old. Children over a year old who have not had a BCG vaccination are only to be vaccinated if their parents and/or grandparents originate from a country where there is a high prevalence of TB. Routine BCG for secondary school students is no longer required based on the epidemiological evidence of the changing nature of the disease.

The TB nursing service now vaccinates all newborn babies born to a Luton address with their mothers consent. In addition all new cases of TB are ‘strain typed’ to determine the likely origin from which the individual contracted the infection.

Priorities for 2007-08

The priority for Luton is to review existing TB service provision in Luton in line with the recently published Department of Health TB commissioning Toolkit (DH, 2007) and ensure that service capacity is adequate to meet need and to build on the work that is already being effectively delivered.
2.1.2 Emergency Planning

Introduction

The purpose of Emergency Planning (EP) is to ensure preparedness for an effective response to any major incident or emergency situation and ensure that normal services resume as soon as possible. Planning needs to be sufficiently flexible to deal with a range of situations that are likely to increase in significance, duration and complexity, and which may affect more than one service, health region, commissioning authority, or service provider.

The Civil Contingencies Act (2004) introduced a new updated definition of an emergency which focuses on the risks we face in the 21st Century. The definition of emergency in the Act focuses on the consequences of an emergency and defines an emergency as:

- An event or situation which threatens serious damage to human welfare
- An event or situation which threatens serious damage to the environment or
- War or terrorism which threatens serious damage to security

Source: Civil Contingencies Act, 2004

Luton PCT is working with other health, local authority and voluntary agencies as part of Bedfordshire and Luton Local Resilience Forum (BLLRF) to ensure that there is local capacity and capability to:

- Respond to incidents outside normal working experiences and which are of such a scale that special arrangements are required
- Effectively contribute to the combined response of all emergency services and other agencies

Pandemic Flu

A significant investment in time and resources this year has been directed towards preparation for the management of a pandemic flu outbreak. A flu pandemic occurs when a new influenza virus, which people have no immunity to, emerges and starts spreading as easily as normal influenza. Pandemic flu should not be confused with seasonal flu, or indeed the severe form of avian flu – H5N1, which has been spreading among poultry and other birds predominantly in South East Asia since 2003. While people have contracted H5N1 and a high proportion have subsequently died there is no evidence that the strain has the ability to pass easily between people – a determining factor of a pandemic flu.

The main concern over a potential pandemic influenza has arisen from the risk that the H5N1 virus may develop this ability or mix with a seasonal flu virus to create a new, more transmissible strain that can pass between people. The virus’ capacity to change in this way is a natural phenomenon that makes further pandemics highly probable, leading to the Chief Medical Officer declaring that it is not a case of “if” but “when” a pandemic occurs.

There have been three flu pandemics in the last century: in 1918, Spanish flu killed more people than the First World War (an estimated 40 million people worldwide), while Asian flu in 1957 and Hong Kong flu in 1968 both killed approximately 1 million people.

Likely Impact

Although health care has improved in the last decades, epidemiological models from the Centers for Disease Control and Prevention, Atlanta, USA, project that today a pandemic strain is likely to result in 2 to 7.4 million deaths globally. In high income countries alone, models project a demand for 134–233 million outpatient visits and 1.5–5.2 million hospital admissions. However, the impact of the next pandemic is likely to be the greatest in low-income countries because of different population characteristics and the already strained health care resources.

The Department of Health has used modelling to predict the likely impact of a flu pandemic in the UK.

It is anticipated that:

- 25% or more of the UK population would be affected in one or more ‘waves’ of the disease
- 25% of workers in the UK would need to take between 5-8 days off sick over its duration
- There would be significant increase in NHS demand
- There would be high absenteeism in the NHS and other essential services including food and fuel deliveries
- A potential shortage of drugs and essential supplies is likely
- Disruption to infrastructure including transport, commerce and public order

Source: www.clean-safe-care.nhs.uk

2.1.3 Infection Control and Reducing Healthcare Associated Infections

Introduction

Infection control is a series of strategies and practices aimed at the prevention and control of infection and communicable diseases that underpin all aspects of healthcare. This is a vital part of ensuring patient safety.

Local Arrangements

The NHS has invested significant effort to put plans in place across the country to ensure a consistent, standardised frontline response. All NHS Trusts have developed service continuity plans to prioritise key services, and make provision for high absenteeism.

Luton PCT is working with all the Bedfordshire and Luton NHS Trusts and the local councils to develop cohesive planning arrangements to help ensure care and essential services are delivered.

One important part of the response to pandemic flu would be the provision of vaccinations. While, non-specific flu vaccines may provide limited protection, until a pandemic strain emerges there is no template to enable the manufacture of a more specific and effective vaccine. Once the specific vaccine is manufactured (which could take up to 6 months after the strain is identified) the aim will be to vaccinate priority groups and then continue to the rest of the population as required.

Testing Planning Arrangements

Major incident plans are regularly tested and updated, and exercises are held on a regular basis. In October 2006, Luton PCT and Luton Borough Council with its partners in Bedfordshire and Luton Local Resilience Forum (BLLRF) were involved in an exercise that tested the ability of the local NHS and other agencies to vaccinate the population of Bedfordshire and Luton within 7 days. Lessons learned through the exercise are being addressed by the Pandemic Flu Coordinating Committee for Beds and Luton (a committee replicated by areas all over the UK). A further exercise is planned for October 2007 to test local plans for the distribution of antiviral medication.

Priorities for 2007-08

The priority is to continue to develop resilience through BLLRF, continue the testing of plans and to engage the wider business community and general public to develop their own resilience arrangements with the support of local emergency planners.

MRSA

MRSA stands for Methicillin Resistant Staphylococcus Aureus. It is a highly contagious strain of the Staphylococcus Aureus family of bacteria, which cause a number of infections, some of which are serious. The reason that MRSA is such a problem for hospitals and care homes – and why it has become known as a superbug – is that it is resistant to common antibiotics. The Staphylococcus Aureus family of bacteria is a very common cause of bacterial infections such as boils, carbuncles, infected wounds, deep abscesses and bloodstream infection (bacteraemia).

It was first identified in the 1880s and a major breakthrough was the introduction of penicillin in the 1940s. This helped tackle these infections, but after a while some strains of the bacteria began to be resistant to the antibiotic and by 1959, about 90-95% of S.aureus strains in patients with clinical infections were resistant to penicillin. Although newer drugs such as Methicillin were developed, resistance to the new drugs developed.

In the mid-1990s ‘epidemic’ strains of MRSA became established in hospitals throughout the UK. These strains are easily transmissible, passing between and colonising both patients and hospital staff, and have the capacity to cause serious disease.

MRSA can infect a range of tissues and body systems, depending on how it enters the body. As a result, patients may have general and ambiguous symptoms that are common to many different infections caused by other bacteria.

MRSA can be detrimental to health if an individual has poor immunity, an open wound or receiving treatment that is invasive such as intravenous therapy. Severe illness may occur if the bacteria enters the bloodstream. This is referred to as an MRSA bacteraemia and it is on these cases that Health Care Trusts are making efforts to meet national targets.

In the period April 2005 – March 2006 there were 32 cases of MRSA at the Luton and Dunstable Hospital a 68% increase on 2004-05. A national target for 2007/08 was set that there would be no more than 12 cases in that year.
Table 9: MRSA cases at Luton and Dunstable Hospital 2003-2007

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>21</td>
<td>19</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>Rate</td>
<td>1.17</td>
<td>1.05</td>
<td>1.82</td>
<td>1.19</td>
</tr>
<tr>
<td>England</td>
<td>1.59</td>
<td>1.76</td>
<td>1.77</td>
<td>1.59</td>
</tr>
</tbody>
</table>

Source: HPA

Clostridium difficile

Introduction

Clostridium difficile infection is the most important cause of healthcare-acquired diarrhoea. It is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. However, Clostridium difficile rarely causes problems in children or healthy adults, as it is kept in check by the normal bacteria found in the intestine. When certain antibiotics disturb the balance of bacteria in the gut, Clostridium difficile can multiply rapidly and produce toxins which cause illness.

Infection ranges from mild to severe diarrhoea to, more unusually, severe inflammation of the bowel (known as pseudomembranous colitis). People who have been treated with broad-spectrum antibiotics (those that affect a wide range of bacteria), people with serious underlying illnesses and the elderly are at greatest risk. Over 80% of Clostridium difficile infections reported are in people aged over 65 years.

Clostridium difficile infection is usually spread on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. Spores are produced when Clostridium difficile bacteria encounter unfavourable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

In 2006 there were 383 reported cases of Clostridium Difficile at the Luton and Dunstable Hospital Foundation Trust among patients aged 65 and over; a rate of 4.02 cases per 1000 bed days. The national rate in 2005 was 2.22 cases per 1000 bed days.

The target is to reduce Clostridium difficile cases in 2007 by 25% from the total number in 2006 and have no more than 285 cases.

Table 10: Clostridium difficile cases at Luton & Dunstable Hospital 2003-2006

<table>
<thead>
<tr>
<th>C.DIFFICILE</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases &gt; 65 L&amp;D</td>
<td>221</td>
<td>342</td>
<td>383</td>
</tr>
<tr>
<td>Rate</td>
<td>2.31</td>
<td>3.59</td>
<td>4.02</td>
</tr>
<tr>
<td>England</td>
<td>1.92</td>
<td>2.23</td>
<td>2.39</td>
</tr>
</tbody>
</table>

Source: HPA

2.2 Sexual Health

Introduction

The sexual health status of the population of Luton is poor but recent data indicates some improvement. Rates of syphilis, gonorrhoea and chlamydia are all higher than the national average. The teenage pregnancy rate is slightly above the national average and has been reducing less quickly than the national rate. The termination of pregnancy rate is also high. In addition to this, the number of cases of HIV infection has increased substantially since 1998, posing a significant threat to public health.

Improving the sexual health of Luton’s population is a key priority for the iPCT with a particular focus on four main areas:

- Sexual health promotion and young people
- Chlamydia screening
- HIV and
- Teenage pregnancy

National Perspective

Sexual health is a national priority as well as being a local priority. There are two key national strategies for improving sexual health, the National strategy for Sexual Health and HIV (DH, 2001) and the National Teenage Pregnancy Strategy (2000). The ‘Choosing Health’ White Paper published in 2004 also identified sexual health as a key national priority.

The National Strategy for Sexual Health and HIV sets out five main aims:

- To reduce the transmission of HIV and sexually transmitted infections (STIs)
- To reduce the prevalence of undiagnosed HIV and STIs
- To reduce unintended pregnancy rates
- To improve health and social care for those living with HIV
- To reduce stigma associated with HIV and STIs

Access to genito-urinary medicine (GUM) clinics is a nationally defined priority for all PCTs. One of the most important NHS targets is that by March 2008 100% of patients attending GUM clinics should be offered an appointment to be seen within 48 hours of contacting a service.

Plans for the National Chlamydia Screening Programme (NCSP) were included in the Department of Health’s National Strategy for Sexual Health and HIV. The aim of the programme is to implement and monitor opportunistic screening for genital chlamydia and trachomatis infection for young women and men aged under 25 across England.

The following sections set out local performance against key national and local targets in six key areas: chlamydia, gonorrhoea, HIV, access to GUM service, teenage pregnancy and termination of pregnancy.

Chlamydia

The National Picture

Chlamydia is a sexually transmitted infection caused by the bacterium chlamydia trachomatis. It can be passed on during unprotected vaginal, anal or oral sexual intercourse with an infected partner. Pregnant women can also pass the infection to babies during birth.

In the UK, the number of new cases has been steadily increasing since the mid-1990s and it has now become the most commonly diagnosed bacterial infection in GUM clinics. The prevalence is highest in sexually active adults, especially women aged 16 to 24 years and men aged 18 to 29 years.

Due to the asymptomatic nature of chlamydia (in both men and women) it can often go undiagnosed leading to pelvic inflammatory disease (PID), ectopic pregnancy and infertility in women. In men it can lead to a painful infection in the testicles and reduced fertility. However, chlamydia is easily treated with a course of antibiotics. The annual cost of treating chlamydia infection and its consequences in the UK is estimated to be more than £100 million.

The Local Picture

The NCSP was introduced in Luton in October 2004. Young people under the age of 25 are offered opportunistic screening from a range of health and non-health care sites across the town. Home testing kits are available online or can be collected from a number of pharmacies, the GP aligned to the University of Bedfordshire and from an FE college. Screening is also conducted via ‘Pee-in-the-Pot’ days and other outreach events.

As part of the NCSP, Luton aims to screen 15% of sexually active under 25 year olds. Achieving this target has proved challenging. During 2006-2007, 1,090 under 25s were screened in Luton which was well below the target figure. Concerted action needs to be taken to increase activity in this area.

Figure 7 indicates that the year on year rise in chlamydia has now been reversed in Luton in line with Bedfordshire and England and Wales. The chlamydia rate for persons of all ages in Luton in 2006 was 206 per 100,000 population compared to 226 per 100,000 population in 2005.

What are we doing in Luton to reduce Healthcare Associated Infections (HCAI)?

Luton iPCT is working with the Luton & Dunstable Hospital to achieve these targets. Joint working across the whole healthcare system is fundamental to achieving them. The most important actions include:

- Ensuring staff receive infection control training and recognise the importance of hand washing by all carers whether they be hospital or community based
- Working with doctors and nurses who prescribe antibiotics to treat infections with microorganism specific antibiotics rather than broad-spectrum antibiotics known to cause HCAIs
- Establishing an intravenous therapy team at the L&D Hospital
- Supporting residential and nursing care homes to identify their infection control risks through surveillance and staff training
Gonorrhoea

The National Picture

Gonorrhoea is a sexually transmitted infection, caused by a bacterium called neisseria gonorrhoeae or gonococcus. The bacteria is found mainly in the semen of infected men and vaginal fluids of infected women, therefore gonorrhoea is easily passed between people through sexual contact. It is the second most common sexually transmitted infection in the UK with over 19,000 cases reported in 2006. Young men aged 20-24 years and women aged 16 - 19 are most commonly affected.

If treated early with antibiotics, gonorrhoea is unlikely to lead to any complications or long-term problems. However without treatment gonorrhoea can lead to Pelvic Inflammatory Disease in women and infections of the testicles and prostate glands in men.

The Local Picture

Figure 9 shows that there has been a steady decline in the number of cases of gonorrhoea in Luton in line with the national trend. In 2006, the gonorrhoea rate for persons of all ages in Luton was 33.1 per 100,000 population.

The highest rates of gonorrhoea are again seen in young people under the age of 25 (figure 10), with more cases being observed in females within this age range than males (figure 11).
HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high cost treatment and care, significant mortality and high number of potential years of life lost. Each year, many thousands of individuals in the UK are diagnosed with HIV. The infection is still frequently regarded as stigmatising and has a prolonged ‘silent’ period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK. For these reasons several surveillance methods are needed in order to understand the epidemiology of the disease within the UK.

**The National Picture**

Key Facts:

- In 2006 there were an estimated 73,000 persons of all ages living with HIV in the UK of whom approximately 21,600 were unaware of their infection.
- An estimated 7,800 persons were newly diagnosed with HIV in the UK in 2006; this number is similar to the estimate for 2005 (7,900) indicating that the annual number of new diagnoses has stabilised.
- The 2006 figure amounts to 13 persons newly diagnosed per 100,000 population.
- Two fifths of newly diagnosed persons in 2006 probably acquired their infection in the UK, of whom approximately two thirds were men who have sex with men.
- In 2006, a third of persons newly diagnosed with HIV in the UK were estimated to have been diagnosed late (defined as on diagnosis with HIV the CD4 cell count was below the recommended threshold for starting therapy (< 200 cells/mm³).
- Over 52,000 HIV-infected persons accessed care in the UK during 2006; this number has more than tripled since 1997. Almost 4,000 persons with HIV were aged 55 years or over in 2006, accounting for over one in every 13 persons accessing HIV-related care.
- 70% of HIV-infected persons who accessed care in the UK in 2006 were prescribed antiretroviral therapy. Almost one in five severely immunosuppressed adults were not receiving any antiretroviral therapy in 2006.
- The crude mortality rate among HIV-infected persons declined from 4.7% in 1997 to 0.95% in 2006.

**The Local Picture**

733 people have been diagnosed with HIV at the Luton and Dunstable Hospital since 2000. In 2006, there were approximately 550 Luton residents living with diagnosed HIV infection however this is likely to be an underestimate of the real number as there are an estimated 21,000 people living in the UK who have not had their infection diagnosed. Figure 12 shows HIV prevalence rates in Luton, Bedfordshire and England & Wales. The rate of HIV in Luton is 300 per 100,000 population.

**Human Immunodeficiency Virus (HIV)**

**Introduction**

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high cost treatment and care, significant mortality and high number of potential years of life lost. Each year, many thousands of individuals in the UK are diagnosed with HIV. The infection is still frequently regarded as stigmatising and has a prolonged ‘silent’ period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK. For these reasons several surveillance methods are needed in order to understand the epidemiology of the disease within the UK.

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The number of new diagnoses increased steadily from 50 cases in 2000 to a peak of 148 in 2003. Since then, there has been a steady decline in the number of new cases - 137 in 2004, 122 in 2005 and 89 in 2006.

Since 2001 there have been twice as many women than men presenting with HIV. This indicates that heterosexual sex is the most likely route of transmission. The majority of people infected with HIV in Luton are in the 25-39 age groups (figure 13).

Figure 13: HIV Infected People Resident in Luton tPCT by Age Group & Year (SOPHID)

![HIV Infected People Resident in Luton tPCT by Age Group & Year (SOPHID)](image)

Source: Bedfordshire Health Protection Unit

- 60% of HIV infected people in Luton are aged 25-39
- 85% - route of infection is documented as sex between men and women
- 83% of HIV infected cases are Black-African

Source: SOPHID Data, Health Protection Agency, 2006

Although there has been a decline in the number of new diagnoses of HIV, investment in prevention, early detection and treatment services should continue to be a commissioning priority in Luton.

**Access to Genitourinary Medicine (GUM) Service**

**The National Picture**

Poor access to sexual health services has been highlighted as a contributory factor to the continued increase in sexually transmitted infections. Until 2004 there were no routine data on waiting times for these services, but surveys suggested increasing problems as demand for services increased. In 2004, the HPA carried out two national audits of waiting times for genitourinary medicine (GUM) clinics in England, showing that less than half of patients were seen within the 48 hours recommended in the public health white paper ‘Choosing Health’.

Following the publication of Choosing Health, waiting times for GUM services have become indicators for sexual health performance management. From May 2007, these waiting times will be continuously monitored with the development of electronic systems, but in the short term it has been agreed that a quarterly waiting times audit will provide access data.

**GUM Access Targets**

- 100% of patients offered an appointment within two working days
- 95% of patients seen within two working days

**The Local Picture**

The quarterly HPA audit of GUM waiting times indicated that between May 2005 and November 2006 the percentage of clients seen within 48 hours at the Luton and Dunstable Hospital GUM clinic increased from 42% to 57%. Figure 14 shows that during 2005/06 the percentage of patients seen within 48 hours at the L&D was below the level of the East of England and England.

**Figure 14: Percentage of Patients seen within 48 hours by GUM services in Luton compared with East of England and England, 2005-2006**

![Percentage of Patients seen within 48 hours by GUM services in Luton compared with East of England and England, 2005-2006](image)

Source: Health Protection Agency (HPA) GUM Waiting Times Audit:
A national audit of access to Genitourinary Medicine Clinics

**Teenage Pregnancy**

The under 18 (U18) conception rate for Luton is on a downward trend and there has been a decline of 3.7% since 1998. The rate of decline is not as great as the decrease in the national rate and is affected by fluctuations from year to year. The current rate for Luton is slightly above average at 41.5 per thousand females aged 15-17 years of age compared to 41.1 for England.
It is also encouraging to note that the under 16 conception rate for Luton is lower than both the regional and national rate.

Table 11: Under 18 conception rate by age group, 2002-04

<table>
<thead>
<tr>
<th></th>
<th>&lt; 16</th>
<th>16-17</th>
<th>&lt; 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>6.1</td>
<td>36.1</td>
<td>42.1</td>
</tr>
<tr>
<td>East England</td>
<td>6.3</td>
<td>27.3</td>
<td>33.6</td>
</tr>
<tr>
<td>England</td>
<td>7.9</td>
<td>24.2</td>
<td>42.0</td>
</tr>
</tbody>
</table>

Nationally there is a high correlation between teenage pregnancy rates and levels of deprivation across England with half of all conceptions in U18 year olds in England occurring in the 20% most deprived wards. This situation is largely replicated in Luton with the more deprived wards having the higher rates of under 18 conceptions (Figure 17).

The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. Nationally, deprived wards with poor levels of educational attainment have on average an under 18 conception rate double that found in similarly deprived wards with better levels of educational attainment. Figure 18 shows the relationship between teenage conception rate and educational achievement by ward in Luton.
The teenager pregnancy strategy developed a stream of work focusing on raising aspirations and building on young people's self esteem to enable them to make positive and healthy choices. This work, called 'Who Do I Want to Be?' involves face to face work with young people, training for professionals and a summer residential for young people.

Parentline Plus coasters were distributed to a wide range of venues, including pubs, encouraging parents to discuss relationships and sex with their children.

Implementation of a delaying early sex training programme for professionals working with children and young people

Increased access to contraception for young people through expansion of condom card scheme.

### HIV / AIDS:

- Production of the Luton and Bedfordshire HIV Services Professionals' Directory to increase awareness of HIV/AIDS and increase access to local services
- Production of 'Supporting Children Infected or Affected by HIV - a good practice guide for professionals working with Children's Services and in formal and informal educational settings in Luton
- Two local workshops were held to engage local faith leaders in tackling HIV/AIDS resulting in greater involvement in local efforts to tackle HIV/AIDS. This has been demonstrated through increased signposting to services and enhanced provision of social care and support

### Sexual Health Services:

- Re-commission new community based, integrated sexual health services
- Improve access to the GUM Service to meet targets

### Teenage Pregnancy:

- Increase face to face work with vulnerable young people to reduce teenage pregnancy and improve sexual health
- Extend the range and reach of teenage pregnancy training to all professionals working with children and young people and agree mandatory training requirements with key agencies

### HIV/AIDS:

- Establish community based rapid HIV testing service

### Chlamydia Screening:

- Increase chlamydia screening activity

### Termination of Pregnancy:

- Support the British Pregnancy Advisory Service to obtain a licence to perform early medical abortions (EMAs) and avoid women having to travel out of Luton for terminations prior to 12 weeks. The new service should increase the proportion of terminations performed before 10 weeks gestation

### What we achieved in 2006 - 2007

During 2006 a wide range of activity was undertaken to improve the sexual health of the Luton population.

#### Sexual Health Services:

- The process of re-commissioning sexual health services in Luton began in Spring 2006. This will create community based integrated sexual health services for those aged under 25 and also for those aged 25 and over. It is anticipated that re-configured services will be operating from April 2008.
- Three years funding was secured for Lea Manor TLC - the first school based health service. This will improve access to sexual health services for young people in the area of Luton

#### Teenage Pregnancy:

- The Teenage Pregnancy Partnership Board took the decision to invest funding in more face to face workers who can support vulnerable young people at risk of teenage pregnancy. These face to face workers have developed links with a wide range of partner agencies and now regularly deliver sessions in conjunction with Entry to Employment providers, Youth Offending Team, 16+ team (care leavers service), Education Welfare Services, Connexions, Youth Service and others
- The Teenage Pregnancy Partnership Board has been instrumental, with the local education authority, in lobbying for the creation of a dedicated Sex and Relationship Education adviser to support secondary schools and FE colleges in improving the quality and coverage of SRE delivery

#### Key priorities for 2007-08

**Sexual Health Services:**

- Re-commission new community based, integrated sexual health services
- Improve access to the GUM Service to meet targets

**Teenage Pregnancy:**

- Increase face to face work with vulnerable young people to reduce teenage pregnancy and improve sexual health
- Extend the range and reach of teenage pregnancy training to all professionals working with children and young people and agree mandatory training requirements with key agencies

**HIV/AIDS:**

- Establish community based rapid HIV testing service

**Chlamydia Screening:**

- Increase chlamydia screening activity

**Termination of Pregnancy:**

- Support the British Pregnancy Advisory Service to obtain a licence to perform early medical abortions (EMAs) and avoid women having to travel out of Luton for terminations prior to 12 weeks. The new service should increase the proportion of terminations performed before 10 weeks gestation
2.3 Smoking

Introduction

Smoking is widely recognised as the biggest preventable cause of premature death in the country. The introduction of smoke-free enclosed public places and workplaces is a very important public health measure which should result in a significant reduction in smoking related mortality. It is too early to tell what impact this is having in Luton, but this will be monitored very closely over the next few years.

The National Picture

In England, the current estimate of smoking prevalence in adults aged 16 or over is 23.3%\(^1\). Nationally the smoking prevalence has fallen steadily from 28% in 1998 to 23.3% in 2005. The National Statistics\(^2\) data shows that smoking prevalence is higher among men than women. In 2005, 25% of men and 23% of women were cigarette smokers.

The data also highlights the variation in smoking behaviour among different age groups. Since the early 1990s, the prevalence of cigarette smoking has been higher among those aged 20 to 24 (32%) than among those in other age groups. Smoking prevalence is lowest among men and women aged 60 and over. In 2005, smoking prevalence in this age group was 14%.

There are striking differences in the smoking prevalence of different socio-economic groups. Smoking is more prevalent among those in manual working groups than those in non-manual working groups. In England in 2005, 29% of those in manual groups were cigarette smokers, compared with 33% in 1998.

Key Facts

- In England estimates of current smoking prevalence in Adults (aged 16 or over) has been falling steadily since 1998.
- The prevalence of cigarette smoking is higher:
  - In men
  - In the 20-24 age group
  - In Bangladeshi, Pakistani and Irish minority ethnic groups, particularly for men
  - In the Routine and Manual socio-economic groups

Figures 19 and 20 illustrate the prevalence of cigarette smoking among adults by age, ethnicity and gender.

Figure 19: Prevalence of cigarette smoking among adults by age group, 2005

![Figure 19 - Prevalence of cigarette smoking among adults by age group, 2005](image)

Source: General Household Survey, 2005

Figure 20: Prevalence of cigarette smoking by ethnic group and gender, 2005

![Figure 20 - Prevalence of cigarette smoking by ethnic group and gender, 2005](image)

Source: General Household Survey, 2005

The Picture in Luton

In Luton, the estimated smoking prevalence is 23.3%\(^2\). Smoking prevalence is fairly static in Luton and is not coming down in line with the national trend. Smoking prevalence by ward shows significant variation highlighting the inequalities which exist with smoking. Figure 21 shows that there is a difference of 18.6% between the wards with the highest and lowest prevalence in Luton.

Figure 21: Smoking prevalence by Luton ward, 2005

![Figure 21 - Smoking prevalence by Luton ward, 2005](image)

Source: General Household Survey, 2005

Footnotes:

2. General Household Survey, 2005
There are approximately 260 smoking related deaths per year\(^6\) in Luton. Recent data indicates that the gap between smoking related deaths in the most deprived and the least deprived wards in Luton is reducing and the inequality is now no longer statistically significant\(^7\).

### Smoking and Pregnancy

#### The National Picture

The health benefits to both mother and baby of stopping smoking during pregnancy are well documented. In England, according to the early results of the 2005 Infant Feeding Survey,

- 32\% of mothers reported smoking in the 12 months before or during pregnancy
- 17\% per cent of mothers continued to smoke throughout pregnancy - this is a decrease from 20\% in 2000
- 49\% of smoking mothers gave up before or during pregnancy

#### The Local Picture

From the information shown in figure 22 younger mothers, particularly those aged 20 or under and 20-24, are more likely to smoke before or during pregnancy than older mothers and are also more likely to continue to smoke throughout pregnancy. 68\% of mothers aged 20 or under, reported smoking before or during pregnancy and 45\% continued to smoke throughout pregnancy, compared with 20\% and 9\% respectively of mothers aged 35 and over. Comparing the results of the 2000 and 2005 Infant Feeding Survey, the proportion of mothers who smoked throughout pregnancy fell between 2000 and 2005 for all age groups apart from 20 and under. For mothers in this age group, the percentage smoking increased from 39\% in 2000 to 45\% in 2005.

#### The National Picture

The prevalence of regular smoking (at least one cigarette a week) in 2006 was 9\%, and has remained unchanged since 2003. In 2006, 61\% of pupils said they had never smoked. The proportion of pupils who have never smoked rose from 47\% in 1982 to 61\% in 2004, and has remained at a similar level since 2004. The prevalence of regular smoking increased sharply with age: 1\% of 11 year olds smoked at least once a week, compared with 20\% of 15 year olds. Following the trend found in previous years, girls were more likely than boys to be regular smokers: 10\% of girls compared with 7\% of boys.

#### The Local Picture

Table 12 shows that 5.5\% of pupils in Year 8 (12/13 year olds) reported smoking on a regular basis compared to 15.5\% of pupils in Year 10 (14/15 year olds). Overall between the ages of 12 and 15, 10\% of Luton pupils reported smoking regularly. Although there is no significant difference in the smoking behaviour of boys and girls in Year 8, by Year 10, girls are smoking more than boys which mirrors the national trend.

#### Table 12: Self reported smoking status for school age children in Luton, 2004

<table>
<thead>
<tr>
<th></th>
<th>% of 12/13 year old (Year 8) pupils who describe themselves as smoking regularly (1)</th>
<th>% of 14/15 year old (Year 10) pupils who describe themselves as smoking regularly (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Females</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: D. Balding, Uni of Exeter, SHEU, 2004

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\(^6\) DHFIC Health Profiles, 2007

\(^7\) DHFIC Health Inequalities Profile, 2007
Stop Smoking Service

There has been a year on year increase in the number of people who have been supported to quit smoking by the Luton NHS Stop Smoking Service (Table 13).

Table 13: Summary of performance of the stop smoking service 2002/03-2006/07

<table>
<thead>
<tr>
<th>Year</th>
<th>No. setting a quit date</th>
<th>No. of 4 week quitters</th>
<th>LDP Target</th>
<th>% of target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/2003</td>
<td>811</td>
<td>493</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>2003/2004</td>
<td>1025</td>
<td>603</td>
<td>610</td>
<td>99%</td>
</tr>
<tr>
<td>2004/2005</td>
<td>1093</td>
<td>681</td>
<td>978</td>
<td>70%</td>
</tr>
<tr>
<td>2005/2006</td>
<td>1406</td>
<td>907</td>
<td>1353</td>
<td>67%</td>
</tr>
<tr>
<td>2006/2007</td>
<td>1930</td>
<td>1342</td>
<td>1328</td>
<td>101%</td>
</tr>
</tbody>
</table>

Source: Luton NHS Stop Smoking Service

An equity audit carried out in 2006 showed that in general, more females than males accessed the Stop Smoking service in 2003-2005 (Table 14).

Table 14: Percentage of stop smoking service users and quitters by gender, 2003/04-2004/05

<table>
<thead>
<tr>
<th>Year</th>
<th>Service Users</th>
<th>4 week quitters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male Female</td>
<td>Male Female</td>
</tr>
<tr>
<td>2003/2004</td>
<td>47.8 52.2</td>
<td>46.9 53.1</td>
</tr>
<tr>
<td>2004/2005</td>
<td>48.1 51.9</td>
<td>45.7 54.3</td>
</tr>
</tbody>
</table>

Source: Luton NHS Stop Smoking Service

Table 15 summarises the audit findings in relation to the percentage of Stop Smoking service users and quitters by broad ethnic group in the financial years 2002-05.

Table 15: Percentage of stop smoking service users and quitters by broad ethnic group, Luton, 2002/03 – 2004/05

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Service Users %</th>
<th>Quitters %</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>85.3</td>
<td>85.1</td>
</tr>
<tr>
<td>Mixed</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Asian</td>
<td>7.6</td>
<td>8.3</td>
</tr>
<tr>
<td>Black</td>
<td>2.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Chinese &amp; Any Other Ethnic Group</td>
<td>2.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: Luton NHS Stop Smoking Service

Whilst useful for reference, the figures describing the percentage uptake of the Luton NHS Stop Smoking Service do not take account of the ethnic structure of Luton. Figures 24 and 25 show the rates of service uptake in the combined financial years of 2003-04 and 2004-05 by broad ethnic group and gender adjusted to take account of the ethnic breakdown in Luton. The uptake rates of both service users and quitters are lower in the Asian and Black broad ethnic groups.

Figure 24: Rates of stop smoking service users by gender and broad ethnic group per 1000 population, 2003/04-2004/05

Figure 25: Rates of stop smoking quitters by gender and broad ethnic group, 2003/04-2004/05
Progress in 2006 - 2007

Health Inequalities:
- An inequalities outcome related to smoking related deaths was included within the Local Area Agreement (LAA).
- A stretch target relating to smoking quitters was included as a reward outcome in the LAA.
- A specialist Stop Smoking Advisor identified for Marsh Farm

Smoking in Pregnancy:
- A Specialist Stop Smoking Advisor was identified to support pregnant women.
- Level 1 training was delivered to 25 community midwives and all staff in 6 Children’s centres
- 1 Sure Start midwife and 1 health visitor were trained as level 2 smoking advisers
- Dedicated smoking cessation clinics at the NHS drop in centre for pregnant mothers, their partners and family members was introduced
- Stop Smoking clinics delivered through children’s centres and the Sure Start programme were started

Smoking and Young People:
- Since 2004 Luton PCT have commissioned the national charity QUIT to deliver their smoking prevention programme ‘Breakfree’ in local schools, targeting schools in areas where there is a high prevalence of smoking
- Both QUIT and the Luton NHS Stop Smoking Service provide Stop Smoking support to young people

Priorities for 2007-08

Reducing Health Inequalities:
- A targeted programme of workplace ‘Stop Smoking’ support with specific focus on companies employing manual workers
- Increasing support for hard to reach groups with particular focus on Bangladeshi and Pakistani men

Smoking in Pregnancy:
- To ensure that 100% of women who smoke receive information to enable access to stop smoking services at the point of planning a pregnancy / accessing maternity services
- To deliver Level 1 training to the remaining 5 Children’s centres in Luton

Home visiting to be made available for pregnant women

Smoking and Young People:
- Commission ‘QUIT’ to deliver ‘Breakfree’ to Year 7 pupils in all Luton High Schools

Other:
- Set up a ‘Stop Before the Op’ service – aimed at supporting people to stop smoking before they go for elective surgery based on evidence that this will reduce post operative complications
- Introduce Patient Group Direction (PGD) to enable pharmacists to prescribe nicotine replacement medication

2.4 Obesity

Introduction
Preventing the increasing rise in overweight and obesity for both children and adults is a key priority for Luton, as well as a national priority.

It is estimated that the cost of the obesity epidemic in terms of health care provision and lost work hours could be in the region of £4.5 billion a year by 2050. Any efforts to tackle obesity will only be successful if the problem is recognised, owned and addressed at every level and every part of society.

The National Picture
There is a growing national policy context for the prevention and management of obesity. The first national guidance on obesity was published by NICE in December 2006 and summarises the available evidence on tackling obesity effectively.

Obesity reduces life expectancy on average by 9 years and is responsible for 9000 premature deaths a year in the UK. Being overweight and obese increases the risk of a wide range of chronic diseases and illnesses including heart disease, type 2 diabetes, some cancers and arthritis. The prevalence of obesity has trebled in the UK since the 1980s.

Key Facts:
- 22.7% of men and 23.8% of women are obese
- 27.7% are overweight (including obese)
- 29.6% of boys are overweight compared to 25.9% of girls
- 14.9% of boys are obese compared to 12.5% of girls
- Between the ages of 2-10, there is a steady increase in the proportion who are overweight (including obese) and obese only in both sexes
- Obesity prevalence is lowest among children in managerial and professional households and highest among children in routine and semi-routine households
- Mean BMIs are significantly higher among Black Caribbean and Black African boys and girls than in the general child population
- Prevalence of overweight and obesity among Black African, Black Caribbean and Pakistani boys is significantly higher than the general population.
- Black Caribbean and Black African girls have a markedly higher prevalence of overweight and obesity than the general population
- Obesity is almost four times as common in BME groups, particularly among women
- Mean BMI levels are significantly higher in lower socioeconomic and socially disadvantaged groups, particularly among women
- The prevalence of women’s obesity is much lower in managerial and professional households than in households with routine and semi-routine occupations
- In women, the mean BMI is higher in Black Caribbeans and Black Africans than in the general population, and markedly lower in Chinese

Prevalence of overweight and obesity among children:
- 13.7% of children aged 2-10 years are obese and 27.7% are overweight (including obese)
- 29.6% of boys are overweight compared to 25.9% of girls
- 14.9% of boys are obese compared to 12.5% of girls
- Between the ages of 2-10, there is a steady increase in the proportion who are overweight (including obese) and obese only in both sexes
- Obesity prevalence is lowest among children in managerial and professional households and highest among children in routine and semi-routine households
- Mean BMIs are significantly higher among Black Caribbean and Black African boys and girls than in the general child population
- Prevalence of overweight and obesity among Black African, Black Caribbean and Pakistani boys is significantly higher than the general population.
- Black Caribbean and Black African girls have a markedly higher prevalence of overweight and obesity than the general population
- Obesity is almost four times as common in Asian children than in white children

National and Local Targets
The recently revised national PSA target is “halt the year on year rise in obesity among children under 11 years by 2020, in the context of a broader strategy to tackle obesity in the population as a whole” (DH 2004). Data from the child weighing and measuring programme will enable a Luton baseline to be established which can be used to set local targets and monitor progress.

A local target has been agreed to support 488 children and their families in Luton over the next 3 years through the MEND children’s weight management programme. This programme started in October 2007 and is delivered in partnership with Active Luton.

The Department of Health has also approved a local reward outcome for inclusion in the Local Area Agreement (LAA). The target is to support 350 adults in Luton (20% from BME groups) to achieve and sustain a 5% reduction in weight through the Counterweight Programme between 2006-2009.

The Luton Picture
Luton is well placed strategically to tackle obesity. Obesity has been identified as a priority in the PCT’s three year strategy for improving health as well as being included in the LAA. The East of England Strategic Health Authority (SHA) has identified childhood obesity as a priority for health improvement in the region and the Children and Young People’s Board (CYPB) in Luton have also prioritised childhood obesity as a key area for action. A multi-agency strategy is in place locally to tackle the prevention and management of both childhood and adult obesity.

Adults
The estimated prevalence of adult obesity based on a survey conducted with local GP practices in 2006 was 25.7% (22.9% for males, 28.0% for females), which is higher than the estimated national prevalence. Synthetic data suggests that the prevalence of obesity in Luton compared to that in England can be summarised as follows.

Section 2: Public Health Priorities in Luton

Appendix 2: Public Health Priorities in Luton

Footnotes:
1 NICE clinical guideline 43
2 Choosing Health? Resource Pack: Key Facts on obesity, 2004
3 Lightening the load: tackling overweight and obesity, National Heart Forum in association with the Faculty of Public Health, 2007

Section 2: Public Health Priorities in Luton

Annual Health Report 2006 - 2007

Annual Health Report 2006 - 2007

Annual Health Report 2006 - 2007
Table 16: Prevalence of adult obesity in Luton, 2000/02-2003/05

<table>
<thead>
<tr>
<th>Area</th>
<th>2000-2002</th>
<th>2003-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>23.7%</td>
<td>26.7%</td>
</tr>
<tr>
<td>England</td>
<td>22.1%</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

Source: Synthetic Estimate of Healthy Lifestyle Behaviours provided by the Health and Social Care Information Centre (HSCIC).

The model based estimate for the period 2003-2005, published by the Office for National Statistics in December 2007, indicates that for all adults the Luton rate of 26.7% is not significantly different from the national average. However, the Luton results are higher than the national average and they appear to be increasing at a faster rate.

Children and young people

Based on a NICE formula there are an estimated 3074 obese children aged between 7 to 13 years living in Luton. Routine BMI data collected from 4 to 5 year olds in 1998/99 and 2002/3 across Bedfordshire and Hertfordshire Strategic Health Authority found that obesity prevalence rates were similar to the rest of England. However, compared to other PCTs in the SHA, Luton had the highest proportion of obese 5 year olds (Bed & Herts SHA, 2002/3). Based on findings from national data, prevalence is likely to be higher in the more deprived areas of Luton and in certain ethnic groups.

Figure 26 indicates that prevalence is increasing. From Luton's 2004/5 data, 23.4% of 5 to 6 year olds were overweight and/or obese. In 2005/6, the figure was 23.9%. Figure 24 shows that by the year 2010/11, the prevalence of:
- Overweight and Obese Children (OW+OB) is expected to be around 33%
- Overweight Children (OW) is expected to be around 23%
- Obese Children (OB) is expected to be around 11%

Based on the current trajectory, this demonstrates that to halt the year on year rise in childhood obesity is a significant challenge (figure 26).

Progress in 2006 - 2007

- A system is in place to weigh and measure Reception Year and Year 6 children annually. This will help to monitor trends in obesity prevalence
- Funding has been secured to deliver a weight management programme (MEND) for children aged 7-13 years and their families. The ten week rolling programme will be delivered from three sites in Luton in partnership with Active Luton
- A 12 week adult weight management programme (Counterweight) is being delivered by 12 GP practices in Luton and group sessions are being run from four community sites across the town. Active Luton provides physical activity sessions to support the Counterweight programme
- A network of local stakeholders has been set up to co-ordinate prevention work with young people
- 105 local frontline staff from across health, local government and community sectors have been trained in the prevention and management of childhood obesity

Priorities for 2007-2008

- To extend the MEND and Counterweight programmes to reach more people in partnership with Active Luton
- To develop longer term sustainability strategies for MEND and Counterweight in partnership with Active Luton
- To set up a weight management programme for young people aged 14 to 17 to address the gap between MEND and Counterweight
- To review the provision of specialist services such as bariatric surgery and those for obese children with complex disabilities and/or co-morbidities
- To make better use of child measurement data to target services more effectively and to establish local targets
- Continue to deliver training across all sectors on the prevention and management of obesity to increase local knowledge and skills
- To ensure services, information and training reach BME groups and those at greatest risk of obesity
Section 3: Performance against Key Targets

This section provides an overview of local performance against some of the Government’s key targets for improving health.

Many of these targets form a Public Service Agreement (PSA) for the Department for Health, against which its performance in delivering public services is monitored. Most of the targets are in common use in local performance management frameworks such as the Local Delivery Plan (LDP). They also form a common health indicator base for the Luton Forum (the Local Strategic Partnership) and for the ‘State of Luton’ report that monitors progress on the Luton Community Plan.

“The PSA framework is central to the Government’s strategy for delivering high quality public services. PSA’s set out the key priorities for Government, focusing on the outcomes that really matter to the public. They send a clear message to the public about what they can expect the Government to deliver, whilst focusing departments on delivering results.”

(PSA White Paper, 2004)

The Department of Health public service agreement targets for 2005-08 are intended to measure performance in a national context, and local data is not necessarily available for all of the indicators. In these cases, and where possible a related proxy indicator has been used. The recent publication of a new set of national PSA targets and indicators for 2008-2011 brings the opportunity to make changes to local data collection where necessary.

### PSA 1: Reduce Heart Disease, Cancer and Suicide Mortality Rates

<table>
<thead>
<tr>
<th>PSA Target</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substantially reduce mortality rates by 2010 (from a 1995-97 baseline):</td>
</tr>
<tr>
<td></td>
<td>- From heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities between the fifth of areas with the worst health and deprivation indicators and the population as a whole</td>
</tr>
<tr>
<td></td>
<td>- From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole</td>
</tr>
<tr>
<td></td>
<td>- From suicide and undetermined injury by at least 20%</td>
</tr>
</tbody>
</table>

### Performance

<table>
<thead>
<tr>
<th>PSA</th>
<th>Luton</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons – 104.37</td>
<td>↓</td>
<td>Persons – 90.45</td>
</tr>
<tr>
<td>Males – 140.59</td>
<td>↓</td>
<td>Males – 126.78</td>
</tr>
<tr>
<td>Females – 66.75</td>
<td>↓</td>
<td>Females – 56.44</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons – 121.93</td>
<td>↓</td>
<td>Persons – 118.95</td>
</tr>
<tr>
<td>Males – 139.26</td>
<td>↓</td>
<td>Males – 132.64</td>
</tr>
<tr>
<td>Females – 104.17</td>
<td>↓</td>
<td>Females – 106.62</td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons – 8.50</td>
<td>↓</td>
<td>Persons – 8.48</td>
</tr>
<tr>
<td>Males – 13.13</td>
<td>↓</td>
<td>Males – 12.86</td>
</tr>
<tr>
<td>Females – 3.67</td>
<td>↓</td>
<td>Females – 4.28</td>
</tr>
</tbody>
</table>

### Comment

The mortality rate for the under 75 year age group for:

- Circulatory disease: Luton is significantly higher than both the East of England and England rates. The male mortality rate is approximately double the female mortality rate and this reflects both the regional and national picture.
- Cancer: Cancer in Luton is similar to the England rate but above the average for the East of England. There are higher rates in men than women.
- Suicide/Undetermined Injury: Suicide and undetermined injury (for persons of all ages) in Luton is similar to the England rate and higher than the East of England rate. The male mortality rate is 3 times higher than the female mortality rate, reflecting the regional and national picture.

### Targets

- **Circulatory disease**: YES - Luton is on target to meet the PSA target of a 40% reduction in the mortality rate from all circulatory diseases by 2010.
- **Cancer**: YES - Luton is on target to meet the PSA target of a 20% reduction in the mortality rate from all cancers by 2010.
- **Suicide/Undetermined Injury**: Not Known – The trend shows small sample fluctuations which make predictions based on trend problematic.

Notes: Mortality rates shown are per 100,000 persons aged under 75 (all persons for suicide) for 2003-2005
Source: Department of Health Compendium of Clinical and Health Indicators
Circulatory Diseases

Circulatory diseases (which include heart disease and stroke) have remained the most common cause of death in England and Wales over the last 90 years among both males and females, with the exception of the years 1918 to 1919. Nationally male death rates from circulatory disease are higher than those for females, and death rates from heart disease are higher than stroke among both males and females.

However, for people aged under 75 the number of deaths from cancers is now higher than the deaths from circulatory diseases.

Figure 27 demonstrates that in general the mortality rate for ‘All Circulatory Disease’ in the under 75 year age group is declining in England and in Luton. The decline is particularly marked in males, thus narrowing the gap between male and female mortality rates.

Figure 27: Trends in mortality from all circulatory disease for people under 75 years, 1993 – 2005

![Graph showing trends in mortality from all circulatory disease for people under 75 years, 1993 – 2005](image)

Source: [Health and Social Care Information Centre - Compendium of Clinical and Health Indicators](source)

Cancer

Cancers are now the second most common cause of death among males and females in the UK. An individual’s risk of developing cancer depends on many factors, including smoking behaviour, diet and genetic inheritance. The trend in mortality from cancer in Luton is similar to the national picture - a general decline and a narrowing of the gap between men and women. Due to small numbers the annual rates for both men and women in Luton fluctuate.

Figure 28: Trends in mortality from all cancers for people under 75 years, Luton and England, 1993 – 2005

![Graph showing trends in mortality from all cancers for people under 75 years, 1993 – 2005](image)

Source: [Health and Social Care Information Centre - Compendium of Clinical and Health Indicators](source)

Table 17: All cancer mortality by gender and cancer type, Luton, 2002 - 2004

<table>
<thead>
<tr>
<th>Cancer Type</th>
<th>Males %</th>
<th>Females %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digestive Organs (Including Oesophagus, Stomach, Colon, Liver, Pancreas)</td>
<td>27.1</td>
<td>21.7</td>
</tr>
<tr>
<td>Respiratory and Intrathoracic Organs (Including Sinus, Lung, Bronchus)</td>
<td>25.5</td>
<td>20.3</td>
</tr>
<tr>
<td>Male genital organs</td>
<td>12.8</td>
<td>NA</td>
</tr>
<tr>
<td>Breast</td>
<td>0</td>
<td>18.5</td>
</tr>
<tr>
<td>Other</td>
<td>34.6</td>
<td>39.5</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: [ONS Annual District Death Data](source)

Figure 29 shows the total number of hospital admissions for cancer by age group and financial year for Luton residents. The majority of admissions are from people aged 65 and over, reflecting the fact that cancer is primarily a disease of older people. Overall, it is estimated that more than one in three people will develop some form of cancer during their lifetime, compared to an estimated risk of 1 in 27 for people aged up to 50 years.

---

1. Pandemic flu outbreak responsible for approximately 40 million deaths worldwide – also great number of deaths as a result of war

2. Cancer Research UK
Suicide and Undetermined Injury

Luton’s mortality rate from suicide and undetermined injury for persons of all ages is similar to both the East of England and England rates. In general the male mortality rate is three or more times higher than the female mortality rate, reflecting both the regional and national picture. However the disparity is greater in Luton than nationally, with the male rate being above average and the female rate being below average.

Figure 31 shows that in general, the mortality rate from suicide and undetermined injury is in line with England. The Luton rates are based on a relatively small number of cases and as a result show considerable fluctuation from year to year.

The National Confidential Inquiry (NCI), based in the Centre for Suicide Prevention at the University of Manchester, is a research project funded by the National Patient Safety Agency (NPSA), the Scottish Executive and the Health and Social services in Northern Ireland. The NCI examines all incidences of suicide and homicide that occur under mental health services in the UK with the aim of improving mental health services and helping to reduce the risk of future suicides. A selection of the key findings from the 2005 report based on data from 1997 to 2003 is summarised as follows.

- Approximately 25% of individuals who commit suicide in the UK (1,200 cases per year) had been in contact with mental health services in the year before their death
- Hanging and self-poisoning by overdose were the most common methods of suicide
- Younger suicide cases often had a history of schizophrenia, personality disorder, drug or alcohol misuse and violence
- In England and Wales, most people with schizophrenia who committed suicide were unemployed and unmarried and 4% of suicides were the lone carers of children
- Mental health teams in England and Wales regarded 22% of the suicides as preventable, with lower figures in Scotland and Northern Ireland
- Factors identified that could have reduced the risk of an individual committing suicide included improved patient compliance with treatment and closer supervision
- 6% of suicide cases in England and Wales, 2% in Scotland and 1% in Northern Ireland were from an ethnic minority group
- Suicide cases from ethnic minorities usually had a diagnosis of severe mental illness and high rates of recent non-compliance with treatment

2 The full report and details of other findings can be found at http://www.national-confidential-inquiry.ac.uk.

Source: Hospital Episode Data (2006)

Source: Health and Social Care Information Centre - Compendium of Clinical and Health Indicators

The latest data indicates that, the circulatory disease trend is very likely to achieve the 2010 target, however, the cancer trend will only just achieve the 2010 target and there is a significant risk that it will not be achieved.

There is a need to review the cancer results in more detail in order to identify specific causes, age and sex groups, or geographical areas where improvements in performance are required.
Infant Mortality Rate
This is the rate of deaths in children under the age of one year. The trend is that Luton's infant mortality rate has been falling overall and moving towards the national average, however the rate between 2004–2006 has increased. This increase needs to be closely monitored.

Figure 32: Infant mortality rate in Luton compared to England & Wales, 1996–2006 (pooled data)

Table 18: Selected child health indicators for Luton, 1996-2006

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<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>
<td>3085</td>
<td>3181</td>
<td>3196</td>
<td>3325</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>
<td>22</td>
<td>31</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Low Birth Weight (Under 2500g)</td>
<td>269</td>
<td>251</td>
<td>252</td>
<td>273</td>
<td>262</td>
<td>298</td>
<td>275</td>
<td>301</td>
<td>361</td>
<td>296</td>
<td>337</td>
</tr>
<tr>
<td>Standardised Fertility Ratio</td>
<td>116</td>
<td>115</td>
<td>115</td>
<td>117</td>
<td>124</td>
<td>125</td>
<td>133</td>
<td>129</td>
<td>130</td>
<td>130</td>
<td>134</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>9.0</td>
<td>10.2</td>
<td>7.1</td>
<td>9.7</td>
<td>5.9</td>
<td>8.6</td>
</tr>
<tr>
<td>Perinatal Mortality Rate (PNMR)</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>
<td>9</td>
<td>13.4</td>
<td>8.1</td>
<td>12.2</td>
</tr>
<tr>
<td>Infant Mortality Rate (Under 1 year)</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>
<td>3.9</td>
<td>6.3</td>
<td>5.6</td>
<td>6.6</td>
</tr>
</tbody>
</table>

Source: ONS Vital Statistics 1, 2 and 5

Notes: Infant Mortality is measured as a crude rate per 1000 live births.
The Local Picture

We know that Luton has the fifth highest birth rate in England, and key indicators for child health remain poorer than the national average. There is targeted action in progress to improve child health outcomes through local partnerships. Low birth weight (LBW) has been identified as a priority by the Children and Young People Board, and birth weight and infant mortality are priorities for further action in 2008-09 in Luton LPPCT’s 3 year health strategy.

Since 2004 the L&D Hospital and the LPPCT have worked together to reduce the number of stillbirths. New interventions, such as telephone access to bilingual maternity staff for worried parents and a review of all stillbirth incidents to identify where improvement can be focused, are in operation. The LPPCT have also concentrated on key high risk factors that can lead to poorer maternal and child health. This includes significant work to reduce teenage pregnancies, promoting the uptake of Stop Smoking Services for pregnant women who are smokers, improved maternal nutrition, and promoting breastfeeding.

Priorities for 2007-08

Improvement targets have been set as follows:

- To narrow the gap between the rate of low birth weight and perinatal mortality between Luton and the national average by 0.5 per 1000 each year. Baseline 2003 - 05 pooled data – PNMR 10.2 per 1000 births / LBW 10.0%)
- 100% of women who smoke during pregnancy will receive advice on smoking cessation at the point of accessing maternity services – aim to reduce the rate of women smoking at delivery by 1% each year (baseline: 17.5%, 2006)
- 100% of women who access health care professionals in Luton at the point of advising of a planned pregnancy/ accessing maternity services will be informed of the importance of good nutrition and are encouraged to take supplements including folic acid

It is recognised that a whole systems approach is required to improve health outcomes in this area and a long term strategy is required. A health needs assessment will be carried out to assess the current situation in Luton and a ‘whole system’ action plan to deliver improvement will be developed.

Male and Female Life Expectancy

See Section 1 for commentary on life expectancy.

What are we doing in Luton?

Specific focus on improving male life expectancy has been a local priority in the Local Area Agreement (LAA) as part of a multi-agency approach to tackling inequalities in health. Recognising that men are historically a difficult group to access, especially manual workers, plans are in place through the LAA to deliver workplace health MOTs. Details of this work can be found in section 4.

Following a health equity audit of Stop Smoking Services in 2004, the service has put additional resources into this work can be found in section 4.

PSA 3: Tackle Inequalities and the Underlying Determinants of Ill Health

<table>
<thead>
<tr>
<th>PSA Target</th>
<th>Tackle the underlying determinants of ill health and health inequalities by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reducing adult smoking rates to 21% or less by 2010 with a reduction in the prevalence of smoking among manual groups to 26% or less</td>
</tr>
<tr>
<td></td>
<td>Halting the year on year rise in obesity among children under 11 by 2020 in the context of a broader strategy to tackle obesity in the population as a whole</td>
</tr>
<tr>
<td></td>
<td>Reducing the under 18 conception rate by 50% by 2010 (against 1998 baseline year) as part of a broader strategy to improve sexual health (Note: target for Luton is 45% reduction)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance</th>
<th>Luton</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>Rate 2003-2005</td>
<td>Trend</td>
</tr>
<tr>
<td></td>
<td>27.3</td>
<td>↓</td>
</tr>
<tr>
<td>Child Obesity</td>
<td>A baseline will be established based on 2006/07 child measurement programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>41.5 per 1000 females aged 15-17 years</td>
<td>↓</td>
</tr>
</tbody>
</table>

Notes: Smoking rate is a % Modelled Estimates from the Health Survey for England: 2003-2005
See Section 2 for full commentary on smoking, child obesity and teenage pregnancy.

Priorities for 2007

- Recognising the importance of tackling groups in the community who are more deprived and as a result have poorer health, Luton LPPCT will extend the health improvement work with partners and evaluate improvement
- A health needs assessment will be carried out to identify the factors in different areas that contribute to the significant difference in life expectancy across the areas in Luton and a cross-organisational action plan will be implemented to tackle the issues identified

Targets

- Smoking: Unlikely - rates do not appear to be reducing at present, although the effects of the smoking ban are not accounted for in current data
- Child Obesity: Unlikely – based on current trends the rate of child obesity continues to rise
- Teenage pregnancy: Unlikely – Rate of reduction needs to increase significantly over next five years if the 2010 target is to be achieved

To be achieved?

- Smoking
- Child Obesity
- Teenage pregnancy
Section 4: Working in Partnerships to Improve Health in Luton

Introduction
In the last three years a number of government White Papers have highlighted the importance of effective partnership working in improving health and reducing health inequalities. Luton has a strong track record of partnership working and this section highlights how partners from all sectors have come together to develop and implement programmes to improve the health of local people.

4.1 Case Study 1: Increasing the Uptake of Child Immunisations in Luton

Aim:
To increase the primary immunisation\(^4\) and Measles, Mumps and Rubella (MMR) uptake rate from 84% and 74% respectively to above 95% to ensure there is sufficient coverage to prevent an outbreak and protect children living in the town from preventable communicable disease.

Links to national and local priorities:
The primary immunisation and MMR uptake rate is a national performance target set at 95%. In 2004/5 Luton was identified as being in the bottom three PCTs in the country for child immunisation uptake at 2 years of age. The Children and Young People’s Strategic Board identified this work as a priority.

Partner Involvement:
- Luton PCT
- Luton Borough Council (LBC)
- Provider Services at Luton PCT
- most notably child health
- PSU\(^5\)
- General Practices in Luton

From the initial process of mapping the child immunisation pathway it was recognised that a number of health care professionals and organisations were involved in administering, reporting and recording the immunisation process. Luton Borough Council provided specialist information systems to support the project and the Practitioner Services Unit provided information regarding changes to individual child details, notably addresses and changes in general practice registrations.

This allowed for the follow up of children where there was incomplete immunisation records to get an accurate picture of which children had accessed immunisations. Where required the health visitor service contacted families to provide information regarding the importance of immunisation and encourage uptake by families.

This partnership approach, using different organisations with access to additional resources allowed Luton PCT to accurately record immunisation uptake and improve the service, carry out a health equity audit of MMR uptake across Luton to identify which population groups needed to be targeted.

Delivery:
The project was time limited for a period of 12 months and a task group representing all the key stakeholders established. The focus was to review the existing care pathway, and the process of immunisation recording and monitoring, with the aim of identifying where improvements could be made. It soon became evident that data quality was poor, and that accurate figures on Luton's immunisation status were required to enable resources to be targeted to areas where uptake was low.

Following a systematic review of the existing processes, an alternative streamlined system was developed in order to simplify procedures and make the responsibilities of key stakeholders clear.

A new immunisation reporting protocol was introduced which if followed correctly standardised the role of each stakeholder in the immunisation process and provided assurance that children who did not attend for immunisation or had moved into, out of, and around Luton did not get lost in the 'health care' system and that they accessed immunisation and wider child development surveillance.

Achievements and Impact:
A substantial improvement in the annual uptake of primary immunisations and MMR was achieved as a result of these actions. This is detailed in following graph.

Lessons learned:
Partnership working enabled all stakeholders to recognise their role and that of their partners and provided support to ensure the work was sustained. Specialist knowledge and skills were available from different organisations where appropriate.

Having childhood immunisations identified as a strategic priority on the Children and Young People’s Plan helped to secure commitment of partners and drive the work forward more quickly than may otherwise have been possible.

This work won a national competition sponsored by the NHS Information Centre and Ordnance Survey.

4.2 Case Study 2: Access to health care for vulnerable people with alcohol problems

Aim:
To improve access to health care for vulnerable people with alcohol problems

Links to national and local priorities:
- Reducing the use of emergency services and acute hospital beds
- Reducing alcohol related harm
- Reducing anti-social behaviour

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\(^4\) Primary immunisations are the first vaccinations given to babies at the age of 2,3,4 months and protect against the childhood illnesses of diphtheria, pertussis (whooping cough), tetanus, polio, haemophilus influenza type B, and recently extended to include meningitis C.

\(^5\) PSU (Practitioner Services Unit) manages the Exeter database which holds information of GP registrations and addresses of individuals registered to each practice.
4.3 Case Study 3: ‘Who Do I Want To Be?’ Personal development youth residential – August 2007

Aim: To raise young people’s self esteem, explore their life choices and aspirations and to support young people in making positive and healthy life choices.

Links to national and local priorities:
- Reduce the prevalence of sexually transmitted infections (STIs), teenage pregnancies and HIV
- Reduce the use of alcohol and drugs and improve physical and psychological health
- Reduce health inequalities between different communities and localities in Luton
- Improve the overall population health by tackling key risk factors that impact on life expectancy

Partner Involvement
- Luton tPCT – Public Health
- Luton Borough Council – Youth Service, Education Welfare, Youth Offending Team
- Connexions
- Alcohol Services for the Community
- Luton and Bedfordshire Youth Association
- University of Bedfordshire ‘Aim Higher’ team

Delivery: 13 vulnerable young people attended a four-day residential in August 2007 at the youth hostel in Cheshunt, Hertfordshire. The residential consisted of:
- Drama workshops which resulted in a DVD of drama sketches being produced
- Personal development workshops focusing on self esteem, decision making, choices, aspirations and how to achieve them
- Outdoor / team building activities: kayaking, climbing and raft building

Achievements and impact:
Each young person developed their own ‘life plan’ outlining what they want to achieve, what they need to do personally to achieve it, and what support they need to achieve their aims. The young people had detailed discussions during the residential about healthy choices and what influences the decision they make regarding their health behaviour.
Both during and since the residential, staff working with the young people who attended have seen a significant change in their thinking and how they go about making choices. Particular comments from young people include:
- What have you learnt?
  - ‘Be confident, people should like me for who I am’
  - ‘Being with someone I love’
  - ‘Pay attention, stop smoking, do more activities’
- The residential also impacted more widely on young people’s thinking:
  - ‘How to achieve goals’
  - ‘How to behave in school’
  - ‘How to believe in myself and stay positive’
  - ‘Want to achieve more’
  - ‘Going to college’
- ‘Started college today!! Was so scared to start. Then I was thinking WH0 DO I WANT TO BE?’

Sustainability:
Appropriate agencies have continued to support young people who attended the residential as required. Discussions are underway with partners to run future residential courses. A teaching pack is being developed to accompany the DVD of drama sketches that will be distributed to schools and youth agencies across Luton.

Lessons learned:
The tPCT does not have the capacity to deliver this type of project without support from partner organisations. The project brought together a range of skills and experience from a number of agencies.
A key lesson learned was the need to invest sufficient time in planning to ensure everyone is well prepared to deliver such a complex project.

4.4 Case Study 4: Lea Manor High School ‘TLC’ – Luton’s first school based health service

Aim: To improve young people’s access to health services by providing holistic health advice and information to young people, in a place and at a time that suits them.

Links to national and local priorities:
- Reduced prevalence of STIs, teenage pregnancies, HIV
- Reduce health inequalities between different communities and areas in Luton
- Improve overall population health by tackling the key risk factors that impact on life expectancy
- Contributing to ‘Choosing Health’ priorities and ‘Every Child Matters’ five outcomes

Partner Involvement
- Luton tPCT – Public Health, Stop Smoking, school nursing
- Lea Manor High School
- Lea Manor Borough Council – Youth Service
- Alcohol Services for the Community
- Marsh Farm Community Development Trust (MFCDT)

To deliver a holistic health service in a school setting required the engagement of a range of partners – in particular the school governors and the school community. The service is managed on a day-to-day basis by the youth service. Health professionals from statutory and voluntary agencies, plus a local GP, provide health advice and information on a wide range of health related topics.

Delivery:
Lea Manor TLC runs every lunchtime during term time and is open to all pupils from Lea Manor High School. There is a common room area where young people can drop in, have general discussions, ask questions and find out more. There is also a private consultation room where young people can speak to a health professional in confidence. TLC addresses a wide range of health issues: healthy eating, physical activity, emotional health, bullying, friendships, relationships, sexual health, drugs, alcohol, smoking and much more.
Achievements and Impact:
The project is now an established part of the school community and is well used by young people from all year groups. It now has a secure financial basis, enabling the coordinator to focus on developing the service to meet the wider needs of the Lea Manor pupils.

There has been an increase in the number of young people accessing health services in this area of Luton - approximately 30 young people access ‘TLC’ daily.

Consultations on sexual health have increased from 23 per month in January 2006 to 37 per month in March 2007 (60% increase over 14 months).

Sustainability:
Lea Manor ‘TLC’ has received three year’s funding from Marsh Farm Community Development Trust (MFCDT) which has provided a firm foundation from which the project can develop and make plans for the future. Although a dedicated co-coordinator is now in post, the partner agencies continue to contribute to the day-to-day delivery of the project. Exposing young people to a range of health professionals and encouraging lifelong use of health services is a key aim of the project.

Lessons learned:
It is not possible for one agency alone to deliver a school based health service, as it requires youth work input as well as input from health professionals. Through the range of organisations involved in the project, young people gain valuable experience of using mainstream organisations that will stand them in good stead for the rest of their lives. However working with partner agencies involves considerable planning and commitment at a senior level within organisations.

4.5 Case Study 5:
Involving Faith Leaders in tackling HIV/AIDS in Luton

Aim:
To work with Christian faith leaders to tackle HIV/AIDS in Luton’s African and other faith communities, particularly with regard to reducing the stigma associated with the disease.

The objectives of the work:
To engage Christian faith leaders as key partners in tackling HIV/AIDS in Luton through:

- Raising basic awareness of HIV and AIDS among faith leaders
- Creating opportunities for Christian Faith leaders to share experience in tackling the issue of HIV & AIDS in their community
- Identifying further opportunities for Luton iPCT to work with and support Christian faith leaders to address health and social care issues

Links to national and local priorities:
- Reduce health inequalities
- Reduce new cases of communicable disease
- Reduce the transmission of HIV and the prevalence of undiagnosed HIV
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV

Partner Involvement
Luton iPCT
- The Lodge (sexual health and reproductive healthcare services)
- Luton Borough Council
- Centre for African Families (CAFPH)
- Family Relationship Crisis Centre
- Luton Council of Churches
- Churches Together in Luton
- The Grassroots

Participating churches include the Church Of England, Roman Catholic, Methodist, Seventh Day Adventist, Four Winds Ministries, Church of God of Prophecy, The Baptist, Everlasting Covenant

Faith leaders are directly or indirectly mentioned in many national and local strategies such as Luton iPCT’s Strategy to improve health & health services (2007-2010), HIV strategy for Luton 2004-2007, National Strategy for Sexual Health and HIV 2001 and the HIV & AIDS in African Communities - A Framework for better prevention (July 2006). These documents articulate the vision of the statutory, voluntary and community based organisations working together to respond to the increasing prevalence of HIV. Christian faith leaders have a significant number of followers suffering from or affected by HIV/AIDS over whom they have significant influence.

Engaging faith leaders was a recommendation in the Pachedu Zenzele report (2004). Due to the complex nature of this work and the related issues, it was recognised from the outset that a multi-agency approach would be required to meet the aims of this work.

Delivery:
Joint consultation with key organisations formed the planning stage. Implementation consisted of two conferences for Faith Leaders in Luton involving presenters who had both a faith and health background. Alongside this, a working group of faith leaders and community members identified the most effective ways in which to engage faith communities on issues of HIV, and faith leaders were trained in HIV awareness.

Achievements and Impact:
- 8 Faith leaders and 6 fellow members were trained in HIV/AIDS awareness
- Over 55 people were reached through the conferences
- 1 church has subsequently invited the iPCT to address their congregations on HIV and other health issues.
- 1 church donated £1000 pounds to a local HIV charity and another £50
- Faith leaders in Luton are now addressing HIV/AIDS. This can be demonstrated through churches beginning to refer people to health services

Sustainability:
Faith communities are now contributing to health and social care for people living with HIV
- Faith communities are now contributing to "the African Drum" - a Luton newsletter which provides a unique platform for engaging Luton’s African communities in health and social issues

4.6 Case Study 6:
Men’s Health MOTs: Workplace Programme

Aim:
To reach men in Luton with the poorest health outcomes (those in routine and manual groups) through a multi agency health intervention to tackle the key risk factors and reduce health inequalities.

Links to national and local priorities:
- Reducing health inequalities
- Reducing the prevalence of smoking and obesity
- Improving mental health and well being
- Reducing the number of undiagnosed diabetics

Partner Involvement:
Luton iPCT - Stop Smoking Service, Drug and Alcohol Partnership, community nursing
- Luton Borough Council (LBC) - Environment & Regeneration, occupational health, transport, street cleansing, the Depot
- Active Luton (sport and leisure provider)

A multi-disciplinary team of professionals was needed to meet the range of health needs of this target group. Working in partnership with LBC was also a very effective way of reaching a large number of people from this particular target group in one place and time. Partners were also able to benefit from the skills of each other.

Delivery:
A range of health professionals conducted health MOTs for transport drivers and street cleaners from the Council over three days. Individually tailored information, interactive activities (demonstrations, exercises, quiz, etc.) and support was combined with screening (e.g. blood pressure, blood sugar and carbon monoxide monitoring, Body Mass Index) and provided on a drop in basis. Some women and managers also took part.

Achievements and Impact:
Ninety people, mostly male street cleaners and transport drivers participated in the health MOTs. Most had blood pressures and BMIs checked and completed a quiz to test their knowledge and awareness of health and well-being. Many also had carbon monoxide levels taken; upper body strength tested, blood sugar monitored and lung capacity measured and participated in stress management activities, according to need. Information was provided on other key health issues such as drugs and alcohol, healthy eating, physical activity, mental and sexual health.
A significant number of men had raised blood pressure and were overweight or obese. Individuals were referred according to need to health programmes such as Counterweight (weight management programme) and the Stop Smoking Service or advised to make an appointment with their GP to follow up identified health concerns.

- 19 people signed up for a Workplace Stop Smoking programme
- 2 people with high blood sugar levels were referred to their GP for diabetes screening

Other outcomes included a proposal to address the availability of healthy food options at the workers’ café. The ‘Health MOT’ was well received by many men who had never previously accessed any ‘well men’ screening programmes.

**Sustainability:**
This project was a successful pilot that is now being extended to reach other men in the context of a wider healthy workplace programme in partnership with LBC. The next Healthy Workplace MOT is for taxi drivers in Luton.

**Lessons learned:**
To deliver the Health MOTs effectively required considerable planning and the commitment of each organisation. The pilot relied on the good will of partners and this needs to be formalised to ensure its sustainability. In addition, clear referral processes need to be developed to promote easy access for those who traditionally find it difficult to access healthcare.

**4.7 Case Study 7:**
**Healthy Steps to Employment**

**Aim:**
To support people in Luton and Bedfordshire who are on incapacity benefit (IB) back into work by helping them to address their immediate health problem/s and promoting their longer-term health and wellbeing.

**Links to national and local priorities:**
- Reducing health inequalities
- Reducing the prevalence of smoking and obesity
- Improving mental health and well-being
- Increasing physical activity

This is a regional priority supported by the East of England Development Agency (EEDA) through the Investing in Communities (IIC) programme. It is framed by the government’s Department of Work & Pensions (DWP) paper.

‘Out of work’ sickness benefit levels are highest in the most deprived areas across the eastern region including Luton. In several Luton wards more than 8% of the working age population is receiving out of work sickness benefits, and many of these people are under the age of 30. Prior to the Healthy Steps to Employment programme, many of these people had received little or no support to help them address their health issues and return to work.

**Partner Involvement:**
- Luton tPCT
- Bedfordshire PCT
- Job Centre Plus
- Bedfordshire County Council
- Luton Borough Council
- EEDA
- MIND
- Investing in Communities
- Active Luton

Strong and effective partnership is essential for this programme to work. Job Centre Plus brings the expertise and the systems to identify people on IB who meet the criteria for the Healthy Steps programme. The Health & Wellbeing Advisors (HWBAs) bring the clinical expertise and skills to help people address their health problems and to refer on appropriately. Bedfordshire and Luton PCTs bring the management and public health expertise needed to ensure the programme is effective and targeted. MIND and Active Luton provide tailored interventions.

**Delivery:**
There is good evidence to show that the longer people are on IB the more their health deteriorates and the less likely they are ever to return to work. It is also the case that many people who claim IB have not received any significant support to help them address their health issues. To reduce the high number of people claiming IB in Luton, a team of Health and Wellbeing Advisors (HWBAs) have been appointed to support clients referred to them from Job Centre Plus. The advisors help clients to address their specific health problems through the development of a personal health plan. Clients are referred on to specific interventions which address their need/s. The HWBAs support these clients, many of whom have complex needs, on their journey back into employment.

**Achievements and Impact:**
This project reaches a very vulnerable and excluded group within the community. The multi-disciplinary team is working effectively to address complex needs and produces significant savings both in human and financial terms.

The programme began in Luton in November 2006, and there have been 250 referrals in the first year. Of these, 29 people have returned to work and 29 are no longer claiming IB. There is also much anecdotal evidence to demonstrate the enormous impact this programme has had on people’s lives.

**Sustainability:**
Learning from this project combined with anticipated changes in the benefits system will enable this programme to move upstream to be more preventative, by working with employers and employees before there is a need to claim IB.

**Lessons learned:**
People often have complex and multiple needs and usually need significant support and intervention before they are able to return to work. This is especially the case the longer people have been claiming IB. It takes time for people to go through the programme.

The Health & Wellbeing advisors with the support of partner agencies are the backbone of the project and benefit from each other’s skills.

**4.8 Case Study 8:**
**Health Improvement Support (HIS) Training**

**Aim:**
To build the public health capacity of frontline staff across all sectors and settings to support health improvement in Luton.

**Links to national and local priorities:**
- Reducing health inequalities
- Reducing the prevalence of smoking and obesity
- Improving mental health and well-being
- Increasing physical activity
- Increasing public health capacity within Luton

This programme also supports the recommendation by Wanless for people to be “fully engaged” with public health so that NHS costs can be reduced. (Wanless, D, HM Treasury 2002).

**Partner Involvement:**
- Luton tPCT
- Luton Borough Council
- Children’s Centres

Luton tPCT cannot improve health alone. A critical mass of frontline workers with a good knowledge of health inequalities and health improvement is necessary to identify opportunities to promote health in their various roles and settings. LBC and the tPCT are two large organisations, with different systems and ethos, but with a shared objective to improve the health and wellbeing of Luton’s population.

**Delivery:**
HIS training was delivered jointly by the tPCT and LBC to LBC officers following a managers briefing. The training was then delivered for children’s centre staff (with a focus on children & families). The training included information on health inequalities in Luton, local health priorities, key health messages and health services to enable participants to signpost effectively. Participants identified opportunities within their usual work remit for promoting health and developed action plans for taking this work forward.

**Achievements and impact:**
As a result of this programme, 41 managers and frontline staff from LBC and Children’s Centre’s have received training resulting in an increased number of frontline staff signposting to key services - stop smoking, weight management, physical activity, sexual health, drug and alcohol services. In addition, Luton’s library services now use a range of mechanisms to proactively promote public health campaigns to their service users.

**Sustainability:**
The HIS training model can be adapted to meet the needs of a range of organisations. A full time post has been created within the tPCT to increase public health capacity across all sectors and plans are in place to deliver the training to LBC environmental health officers and to a range of voluntary sector organisations.

**Lessons learned:**
The joint planning and delivery of HIS training with LBC was critical in developing an effective model that worked for partners and can be adapted for different groups according to need. The training needs to engage and have the support of managers so learning can be reinforced to increase the impact of the training. It should also be a key element of an induction programme for all new staff.
Section 5: Recommendations

5.1 Progress on the recommendations in the 2004/05 Annual Public Health Report

In the 2004/05 annual public health report four key recommendations were made to improve health across Luton.

Recommendation 1: Debate on Luton’s future should be informed by health impact assessment especially on planning for long-term developments such as the airport expansion.

An initial health impact assessment was carried out to accompany the master plan for airport expansion published in 2005. This reviewed the key health issues and points to areas for further investigation. Since that report was produced the airport operators withdrew their expansion plans in favour of more modest development. However Luton is still undergoing a period of major change; with developments such as Power Court, the widening of the M1 and a changing demographic profile due to economic migration and other factors. Key changes would benefit from undergoing health impact assessment so that possible affects on the health of the community can be recognized and addressed.

Recommendation 2: A more detailed study of the trend in Luton’s female life expectancy should be undertaken and recommendations made.

At the time of the last public health report there was evidence suggesting a growing gap between Luton’s female life expectancy and the national average. More recent data indicates that the position in Luton has improved and that the gap has narrowed slightly (it is now 1.2 years for both males and females). Further analysis should focus on whether there are any specific conditions that account for the greater loss of life-years in Luton’s population compared to England as a whole. For women there is a need to investigate why there is such a difference in life expectancy for women living in different wards of Luton.

Recommendation 3: Public Health White Paper funding allocated to Luton should be used to support effective action on a small number of specific priorities, taking into account current pressures and other funding streams. The following should be the priorities:

- Reducing obesity
- Reducing harm caused by alcohol
- Protecting against communicable disease
- Promoting health of school children
- Improving sexual health

Since the last report Luton tPCT, like many other PCTs in England, have been going through a period of financial recovery and there has been no new money to invest in these priorities. All of these issues have been identified as priorities in the tPCT’s three year health strategy and significant progress has already been made in relation to obesity, sexual health, communicable disease and promoting the health of school children by making the best use of existing resources and securing additional funding from other sources. A detailed report of progress in these areas can be found in Section 2. Plans are in place to increase action in all of these areas in 2008-09.

Recommendation 4: Joint work across Luton tPCT and Luton Borough Council should be strengthened by developing an integrated public health function. This should include joint appointments and a joint public health work programme across the two organisations.

Work with Luton Borough Council has developed with the joint appointment of a Health Inequalities Officer. This has gone some way to ensuring that there is a common understanding of the key public health priorities across both organisations. Robust partnership arrangements are now in place to tackle obesity, smoking and teenage pregnancy and there is a strong alignment between the public health priorities identified in the tPCT’s three year health strategy and those in the Local Area Agreement (LAA). A further development has been the Health Improvement Support training, further details of which can be found in Section 4. All of this work will be further strengthened by the appointment of a joint Director of Public Health.

5.2 Recommendations from this Report

This year the report identifies 7 recommendations:

5.2.1 The joint Director of Public Health should further develop and strengthen existing work across the two organisations to improve health and reduce health inequalities through the development of a joint public health strategy for Luton

5.2.2 A long term health and social care strategy for older people should be developed based on the findings of the Joint Strategic Needs Assessment (JSNA) to address the needs of our ageing population

5.2.3 Multi-agency action to reduce health inequalities within Luton should be escalated with particular emphasis on:
   - Removing the gap in life expectancy between the worst and best wards
   - A health needs assessment to determine the reason why there is a 6 year difference in life expectancy in women in different areas of Luton
   - Narrowing the gap in smoking prevalence between the worst and best wards
   - Narrowing the gap in mortality of CHD/cancer between men and women

5.2.4 Multi-agency action to reduce the prevalence of smoking and obesity in Luton should be escalated

5.2.5 A ‘whole systems’ action plan should be developed and implemented to continue the downward trend in infant mortality

5.2.6 Multi agency action to reduce HCAI should be escalated to ensure greater involvement of Luton Borough Council and to increase the level of public knowledge

5.2.7 TB services should be reviewed using the recently published TB Commissioning Toolkit
Appendix 1: Health summary for Luton

The Chart below shows a number of indicators of people's health in this local authority. It shows the local value for each indicator compared to the England worst, England best, England average and regional average. The circle indicating the local value is shown in amber if it is significantly better or red if it is significantly worse than the England average. An amber circle may still indicate an important public health burden. A white circle is not significantly different from the England average. For technical information about each indicator, see www.communityhealthprofiles.info

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local No. Per Year</th>
<th>Local Value</th>
<th>Eng Avg</th>
<th>Eng Worst</th>
<th>England Range</th>
<th>Eng Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Income deprivation</td>
<td>29435</td>
<td>15.9</td>
<td>12.9</td>
<td>31.1</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>2 Ecological footprint</td>
<td>n/a</td>
<td>5.345</td>
<td>5.470</td>
<td>6.430</td>
<td>4.904</td>
<td></td>
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<tr>
<td>3 Homelessness</td>
<td>392</td>
<td>11.7</td>
<td>7.8</td>
<td>35.8</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>4 Children in poverty</td>
<td>11022</td>
<td>25.4</td>
<td>21.3</td>
<td>58.8</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>5 GCSE achievement*</td>
<td>1197</td>
<td>51.0</td>
<td>57.5</td>
<td>33.6</td>
<td>81.9</td>
<td></td>
</tr>
<tr>
<td>6 Violent crime</td>
<td>4835</td>
<td>26.3</td>
<td>19.8</td>
<td>41.1</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td>7 Smoking in pregnancy</td>
<td>5.345</td>
<td>17</td>
<td>5.7</td>
<td>40.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Smoking in pregnancy</td>
<td>n/a</td>
<td>3.2</td>
<td>3.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Physical activity</td>
<td>n/a</td>
<td>27.4</td>
<td>19.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Youths in youth custody</td>
<td>n/a</td>
<td>473.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Teenage pregnancy (under 18)*</td>
<td>177</td>
<td>43.3</td>
<td>42.1</td>
<td>95.3</td>
<td>12.8</td>
<td></td>
</tr>
<tr>
<td>12 Adults who smoke*</td>
<td>n/a</td>
<td>26.8</td>
<td>26.0</td>
<td>37.3</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>13 binge drinking (adults)</td>
<td>n/a</td>
<td>13.9</td>
<td>18.2</td>
<td>29.2</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>14 Healthy eating (adults)</td>
<td>n/a</td>
<td>22.8</td>
<td>23.8</td>
<td>11.4</td>
<td>38.1</td>
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<tr>
<td>15 Physically active adults</td>
<td>n/a</td>
<td>9.0</td>
<td>11.6</td>
<td>7.5</td>
<td>17.2</td>
<td></td>
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<tr>
<td>16 Obesity (adults)</td>
<td>n/a</td>
<td>23.4</td>
<td>21.8</td>
<td>31.0</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>17 Life expectancy - male*</td>
<td>n/a</td>
<td>75.7</td>
<td>76.9</td>
<td>72.5</td>
<td>82.2</td>
<td></td>
</tr>
<tr>
<td>18 Life expectancy - female*</td>
<td>n/a</td>
<td>79.9</td>
<td>81.1</td>
<td>78.1</td>
<td>86.2</td>
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<tr>
<td>19 Deaths from smoking</td>
<td>260</td>
<td>253.6</td>
<td>234.4</td>
<td>366.5</td>
<td>147.6</td>
<td></td>
</tr>
<tr>
<td>20 Early deaths: heart disease &amp; stroke*</td>
<td>177</td>
<td>104.4</td>
<td>90.5</td>
<td>151.3</td>
<td>44.9</td>
<td></td>
</tr>
<tr>
<td>21 Early deaths: cancer*</td>
<td>202</td>
<td>121.9</td>
<td>119.0</td>
<td>168.0</td>
<td>81.6</td>
<td></td>
</tr>
<tr>
<td>22 Infant deaths*</td>
<td>17</td>
<td>15.3</td>
<td>5.1</td>
<td>9.9</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>23 Road injuries and deaths</td>
<td>59</td>
<td>31.9</td>
<td>39.9</td>
<td>214.1</td>
<td>20.2</td>
<td></td>
</tr>
<tr>
<td>24 Crime in poor health</td>
<td>n/a</td>
<td>8.1</td>
<td>7.8</td>
<td>15.4</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>25 Mental health</td>
<td>2730</td>
<td>23.5</td>
<td>27.4</td>
<td>72.0</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>26 Hospital stays due to alcohol</td>
<td>403</td>
<td>225.7</td>
<td>247.7</td>
<td>652.4</td>
<td>85.6</td>
<td></td>
</tr>
<tr>
<td>27 Drug misuse</td>
<td>1914</td>
<td>15.7</td>
<td>9.9</td>
<td>34.9</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>28 People with diabetes</td>
<td>8099</td>
<td>4.4</td>
<td>3.7</td>
<td>5.9</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>29 Children's tooth decay</td>
<td>n/a</td>
<td>1.8</td>
<td>1.5</td>
<td>3.2</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>30 Sexually transmitted infections</td>
<td>n/a</td>
<td>123</td>
<td>473.5</td>
<td>565.3</td>
<td>936.8</td>
<td>259.7</td>
</tr>
</tbody>
</table>

Appendix 2: Glossary of Key Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG Vaccination</td>
<td>Immunisation given to prevent Tuberculosis.</td>
</tr>
<tr>
<td>Body Mass Index – BMI</td>
<td>Used to measure overweight and obesity in adults. BMI is calculated as a fraction: BMI = Weight (kg) / Height (m2)</td>
</tr>
<tr>
<td>Coronary Heart Disease (CHD)</td>
<td>Debilitating disease that results from partial or total blockage of the coronary arteries that can lead to heart attack, angina, heart failure, abnormal heartbeat and sudden death</td>
</tr>
<tr>
<td>Children and Young People's Strategic Board</td>
<td>A board consisting of the Chief Executives of the main local agencies involved with commissioning or service provision for children. The group's purpose is to identify, plan and implement new initiatives aimed at improving the range and delivery of services to children and families in Luton</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Genital Chlamydia trachomatis infection is the most commonly diagnosed bacterial sexually transmitted infection in the United Kingdom</td>
</tr>
<tr>
<td>Choosing Health</td>
<td>This White Paper, published by the DH in 2004 sets out the key principles for supporting the public to make healthier and more informed choices in regards to their health</td>
</tr>
<tr>
<td>Chronic</td>
<td>Describes a disease, condition or health problem that persists over a long period of time. The illness may recur frequently and in some cases may lead to partial or permanent disabilities. Examples include arthritis and diabetes</td>
</tr>
<tr>
<td>Circulatory Diseases</td>
<td>Diseases affecting the circulation of the blood in the heart, arteries, capillaries or veins</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>Illness capable of being transmitted from person to person including infectious diseases such as measles and chicken pox</td>
</tr>
<tr>
<td>Community Plan</td>
<td>An overarching strategy aimed at improving the economic, environmental and social well-being of people living in Luton</td>
</tr>
<tr>
<td>Confidence Levels</td>
<td>Provide a measure of assurance that a particular value truly lies within a defined range</td>
</tr>
<tr>
<td>Congenital Conditions</td>
<td>A condition that is recognised at birth or that is believed to have been present since birth</td>
</tr>
<tr>
<td>Critical Incident Analysis</td>
<td>A mechanism for learning from incidents and planning for future practice</td>
</tr>
<tr>
<td>Demography</td>
<td>The study of the characteristics of human populations, such as size, growth, density, distribution and vital statistics</td>
</tr>
<tr>
<td>Deprivation</td>
<td>A term used to refer to a combination of factors indicating low living standards, a high need for services or both. There are a number of ways of measuring deprivation, suitable for different purposes, e.g. IMD 2004, Jarman and Townsend</td>
</tr>
<tr>
<td>Elective Admissions</td>
<td>Admissions to hospital that are planned and not as a result of an accidental injury or sudden onset illness</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>An ethnic quality or affiliation resulting from racial or cultural ties</td>
</tr>
<tr>
<td>Health Equity Audit</td>
<td>A process through which local partners systematically review inequities in the causes of ill health, in access to effective services and their outcomes for a defined population. Actions required to make services more equitable are agreed and incorporated into local plans, services and practice</td>
</tr>
<tr>
<td>Health Impact Assessment</td>
<td>Helps to determine how a proposal will affect people's health. Recommendations to improve the proposal are produced, particularly to help the most disadvantaged</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus (HIV)</td>
<td>Virus which gradually destroys the body's normal immune response and leads to a fully developed AIDS syndrome which leaves the individual open to opportunistic infections and cancers infrequently seen in people with a normal function immune system</td>
</tr>
<tr>
<td><strong>Immunisation Programme</strong></td>
<td>Immunisation is the process of protecting individuals from infection through passive or active immunity</td>
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<td>----------------------------</td>
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</tr>
<tr>
<td><strong>Index of Multiple Deprivation (IMD)</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Inequality</strong></td>
<td>Differences in opportunities and experiences between groups based on factors such as social class, ethnic groups, age, place of residence etc</td>
</tr>
<tr>
<td><strong>Inequity</strong></td>
<td>Unfair and changeable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically</td>
</tr>
<tr>
<td><strong>Infant Mortality Rate</strong></td>
<td>Number of deaths from the first day of life to the end of the first year of life per 1000 live births per year</td>
</tr>
<tr>
<td><strong>Life Expectancy</strong></td>
<td>Average lifespan expected from birth to death</td>
</tr>
<tr>
<td><strong>Local Area Agreement</strong></td>
<td>Set out the priorities for a local area agreed between central government and Local Strategic Partnership</td>
</tr>
<tr>
<td><strong>Low Birth Weight</strong></td>
<td>Babies with a birth weight below 2500 grams</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>The middle value in a set of values arranged in order of size</td>
</tr>
<tr>
<td><strong>Meningococcal Menigitis</strong></td>
<td>Meningococcal meningitis is a systemic infection caused by the bacteria Neisseria meningits</td>
</tr>
<tr>
<td><strong>Morbidity</strong></td>
<td>Ill Health</td>
</tr>
<tr>
<td><strong>NRF</strong></td>
<td>Neighbourhood Renewal Fund</td>
</tr>
<tr>
<td><strong>National Service Frameworks (NSF)</strong></td>
<td>A national document setting out standards, strategies and implementation timescales for a defined service or care group</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>Usually defined in adults as a body mass index greater than 30kg/m2</td>
</tr>
<tr>
<td><strong>Perinatal Mortality Rate</strong></td>
<td>The number of still births and deaths of babies up to the age of 1 week per 1000 total births per year</td>
</tr>
<tr>
<td><strong>Prevalence</strong></td>
<td>The number of people in a population who have a disease at a specific point in time</td>
</tr>
<tr>
<td><strong>Pursuing Perfection</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
<td>An environmental exposure, lifestyle or inherited characteristic that is likely to be associated with the occurrence of a specific outcome and thought to be on the casual pathway</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>A programme to detect a specific disease before the presence of symptoms</td>
</tr>
<tr>
<td><strong>Standardised Mortality Ratio</strong></td>
<td>SNRs 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. The comparative national figure will be 100. A value greater than 100 indicates an increased incidence and below 100 a reduced incidence</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infections (STIs)</strong></td>
<td>Those infections whose primary mode of transmission is through sexual contact</td>
</tr>
<tr>
<td><strong>Still Birth</strong></td>
<td>Baby born dead after 24-week gestation</td>
</tr>
<tr>
<td><strong>Still Birth Rate</strong></td>
<td>Number of stillbirths per 1000 total births per year</td>
</tr>
<tr>
<td><strong>Tuberculosis (TB)</strong></td>
<td>Chronic, progressive infection that commonly affects the lung but may affect other organs and tissues such as bone, kidney and intestine</td>
</tr>
<tr>
<td><strong>Ward</strong></td>
<td>An electoral ward is a division of an administrative area used to elect councillors to serve on a council</td>
</tr>
</tbody>
</table>

**Appendix 3: Useful Websites**

- **Luton teaching Primary Care Trust**
  [www.lutontpc.nhs.uk](http://www.lutontpc.nhs.uk)
  - Information about the health priorities for Luton PCT and the services it provides

- **Luton & Dunstable Hospital**
  [www.ldh.nhs.uk](http://www.ldh.nhs.uk)
  - Offers key information about Luton & Dunstable Hospital’s healthcare services and offers links to related websites

- **Bedfordshire & Luton Mental Health and Social Care Partnership NHS Trust**
  [www.blpt.nhs.uk](http://www.blpt.nhs.uk)
  - Provides details of specialist care services, particularly in relation to mental health, offered across Bedfordshire & Luton in collaboration with PCTs and social services

- **Luton Borough Council**
  [www.luton.gov.uk](http://www.luton.gov.uk)
  - Information about the Council and the services it provides, as well as information about the local community

- **Luton Forum**
  [www.luton.gov.uk](http://www.luton.gov.uk)
  - The Forum is an umbrella partnership to link the community and key organisations which provide services in Luton and Bedfordshire

- **Offices of National Statistics**
  [www.statistics.gov.uk](http://www.statistics.gov.uk)
  - Publishes information on all aspects of Britain’s economy, population and community at both national and local level

- **Eastern Region Public Health Observatory (ERPHO)**
  [www.erpoho.org.uk](http://www.erpoho.org.uk)
  - Provides access to population health data, methods and expertise

- **Department of Health (DH)**
  [www.dh.gov.uk](http://www.dh.gov.uk)
  - Latest information on the Department of Health’s work and priorities, along with guidance and details of publications

- **Health Protection Agency**
  [www.hpa.org.uk](http://www.hpa.org.uk)
  - The Health Protection Agency brought together a number of organisations dedicated to protecting people’s health. Provides information on communicable disease and other health protection issues

- **Health survey for England**
  - Information on local health, government initiatives, inequalities, “Improving opportunity, strengthening society”

- **National emergency planning/ pandemic flu information**
  - Information on local health, government initiatives, inequalities, “Improving opportunity, strengthening society”

- **General information for the public regarding reducing Baby born dead after 24-week gestation**
  - General information for the public regarding reducing the risk from emergencies

- **Pandemic flu: Effects on services**
  - National emergency planning/ pandemic flu information

- **Health survey for England**
  [http://www.blpt.nhs.uk](http://www.blpt.nhs.uk)
  - Health survey for England

- **Sets out the priorities for a local area agreed between central government and Local Strategic Partnership**
  - Provides information on communicable disease and other health protection issues

- **Luton Observatory**
  [http://www.data-archive.ac.uk/findingData/](http://www.data-archive.ac.uk/findingData/)
  - Some of the modelling applications might be useful e.g. mapping the Health Acorn categories
This report is available on Luton tPCT website. Hard copies can be obtained from:
Public Health Team
Luton tPCT
The Atrium
Unit 2 Burr's Place
Luton
LU1 3BE
Tel: 01582 528840
Email: enquirieslpct@luton-pct.nhs.uk