

**Luton's Partnership Strategy
to Reduce Health Inequalities:
2010 – 2026**

Contents

Page numbers

Executive Summary	3
Part 1	5
Why tackle health inequalities in Luton?	5
1. Introduction	5
1.1 Overall aim and approach	5
1.2 Defining health inequalities	5
1.3 The inequality gradient	7
2. Policy and evidence context	8
2.1 Background	9
2.2 Public service agreement targets	9
3. Where are we now: Luton?	11
3.1 Local demography	11
3.2 Ethnicity	11
3.3 Deprivation	12
3.4 Life expectancy	13
3.5 Mortality	14
3.6 Cancer and Circulatory Disease	15
3.7 Mental Health (add in intro and Luton figures)	17
3.8 Smoking	17
4. Where are we now: five priority MSOAs?	19
5. Understanding and addressing the inequalities gap	21
5.1 Risk factors	21
5.2 Identifying health inequalities	21
5.3 The effect of interventions	23
Part 2	25
How we will tackle inequality in Luton?	25
6. Where do we want to be?	25
6.1 Aims and objectives	25
6.2 Principles	25
6.3 Targets	25
7. How will we get there?	26
7.1 The Delivery Plan	26
7.2 Partnership working	26
7.3 Improving knowledge and understanding	27
Public Health training	28
7.4 Delivering change	28
7.5 Governance	28
7.6 Reviewing the strategy	29
References	44
Appendix 1	48
Appendix 2: Priority MSOA summaries	53

Executive Summary

This is Luton's partnership strategy to reduce health inequalities to 2026. Through the Local Strategic Partnership structure, all theme groups of the Luton Forum have supported the development of this strategy and have contributed to the delivery plan supporting the implementation of this strategy. The Health and Wellbeing Group has approved the strategy on behalf of the partnership and have responsibility for ensuring that the strategy is implemented.

The main focus of this strategy is to narrow the life expectancy gap between the five middle super output areas (MSOAs) with the lowest life expectancy and the five with the highest and to increase the number of years that people live free from illness and disability. It is also important to reduce the gap in life expectancy between Luton and the rest of England so action to tackle inequalities must be universal *'but with a scale and intensity that is proportionate to the level of the disadvantage. Greater intensity of action is likely to be needed for those with the greater social and economic disadvantage.'* (DH, 2010). Because of the need for universal action across Luton as well as a more focussed approach, this strategy is aligned with the Sustainable Community Strategy (SCS) and the Health & Wellbeing Strategic Plan. It is also closely aligned with NHS Luton's Five Year Strategic Plan 2009/10 to 2014/15 and the Transforming Primary and Community Services Strategy 2010-2015

Shifting resources to focus more on prevention and early intervention is a key national priority. As well as preventing the early onset of disease and avoidable conditions which will improve the quality of people's lives, it will also generate productivity savings which will be essential in the current financial climate.

Despite high levels of social deprivation there has been some progress in Luton. The 2009 Health Inequalities Profile from ERPHO which is based on 2006-08 data highlights the following areas where inequalities between the most and least deprived quintiles have been reduced:

The All Age All Cause (AAAC) mortality rate for females in the most deprived areas is decreasing at a faster rate than in the least deprived areas (06-08). Therefore, despite the gap widening in previous years the relative gap has started to decrease again but not at the same levels seen in 2002-04 and 2004-06.

The smoking attributable mortality data for females has shown a slight decrease. This decrease has narrowed the gap as the rate in the least deprived areas has remained stable and therefore the relative inequality has decreased.

The Life expectancy data for females has shown an increase in the most deprived fifth of areas. This increase is at a faster rate than the increase in the least deprived areas and therefore the relative inequality gap has decreased between the two.

There has also been a narrowing of the gap between for both circulatory disease mortality and cancer mortality in people aged under 75 years between the 20% most deprived areas and the rest of Luton. These rates have reduced at a similar rate to England. However despite this progress there are still stark inequalities within Luton. The gap in average life expectancy between the most deprived quintile and the least deprived quintile of our population is over 6 years for women and 8 years for men.

While Luton has many activities in place to address health inequalities, it has lacked an explicit strategy. This strategic plan takes a highly focussed approach to tackling inequalities by concentrating efforts on the five middle super output areas (MSOAs; c.46,621 people) with the lowest life expectancy. For the first period, up to 2015, these areas fit largely in the wards of Biscot, Challney, Dallow, Farley and High Town.

It is widely acknowledged that action by the NHS alone will not reduce health inequalities. Action on health inequalities requires action across all the social determinants including early child development and education, employment and working conditions, housing and neighbourhood conditions and standards of living. Delivering this strategy will require a co-ordinated response across the local strategic partnership. Tackling health inequalities must be seen as everyone's business and should become central to the way we work. Local policies and strategic plans must address the issue of health inequality.

The aim of this strategy is to narrow the gap in life expectancy between areas in Luton with the worst health outcomes and areas with the best health outcomes in the context of increasing the overall life expectancy of the local population.

Action to tackle health inequalities in Luton will focus on the following five areas:

- Empowering individuals and communities
- Improving access to services
- Addressing lifestyle issues
- Addressing the wider determinants of health
- Improving quality of life

The following targets have been set to 2015 when they will be reviewed and new targets set for a further three year period in line with the Local Area Agreement.

- By 2015 we will have narrowed the gap in life expectancy at birth between the five MSOA areas with the lowest and highest deprivation to 4.85 years for males and 2.72 years for females.
- By 2015 we will have narrowed the gap in life expectancy at birth between the 20% of MSOA areas with the lowest and highest life expectancy to 7.1 years for males and 6.5 years for females.
- By 2015 we will have narrowed the gap in life expectancy between Luton and the rest of England by increasing life expectancy to 78.9 years for males and 82.3 years for females

Part 1

Why Tackle Health Inequalities in Luton?

1. Introduction

1.1 Overall Aim and Approach

This strategy sets out our intentions to address health inequalities in Luton to 2026 and has the following overall aim:

To reduce the health inequalities that exist within the borough by narrowing the gap in life expectancy between the five MSOA areas with the lowest life expectancy and the five with the highest life expectancy.

This aim will be in the context of increasing the life expectancy of the population of Luton and narrowing the gap between Luton and the rest of England

The timescale for implementing this strategic plan is to 2026 in line with Luton's SCS. The plan will be refreshed every three years in line with the Local Area Agreement (LAA), and like the LAA it will have an associated short term delivery plan that sets out the key actions; milestones and performance measures which are required to implement the strategy.

The document builds on and is directed by earlier work including the Joint Strategic Needs Assessment, NHS Luton's Strategic Plan, and consideration of national guidance – in particular the Marmot Review: Fair Society, Healthy Lives (DH, 2010). It also takes account of the evidence on the most effective ways of reducing health inequalities.

In Luton we have agreed that an area based approach will be the most effective way to address inequality. The five Middle Super Output Areas (MSOAs: geographic area with a mean population size of 7,200) with the lowest life expectancy (based on ERPHO data) are the priority areas for targeted interventions. For this first three year period the five priority MSOAs fall largely within the wards of Biscot, Challney, Dallow, Farley and High Town.

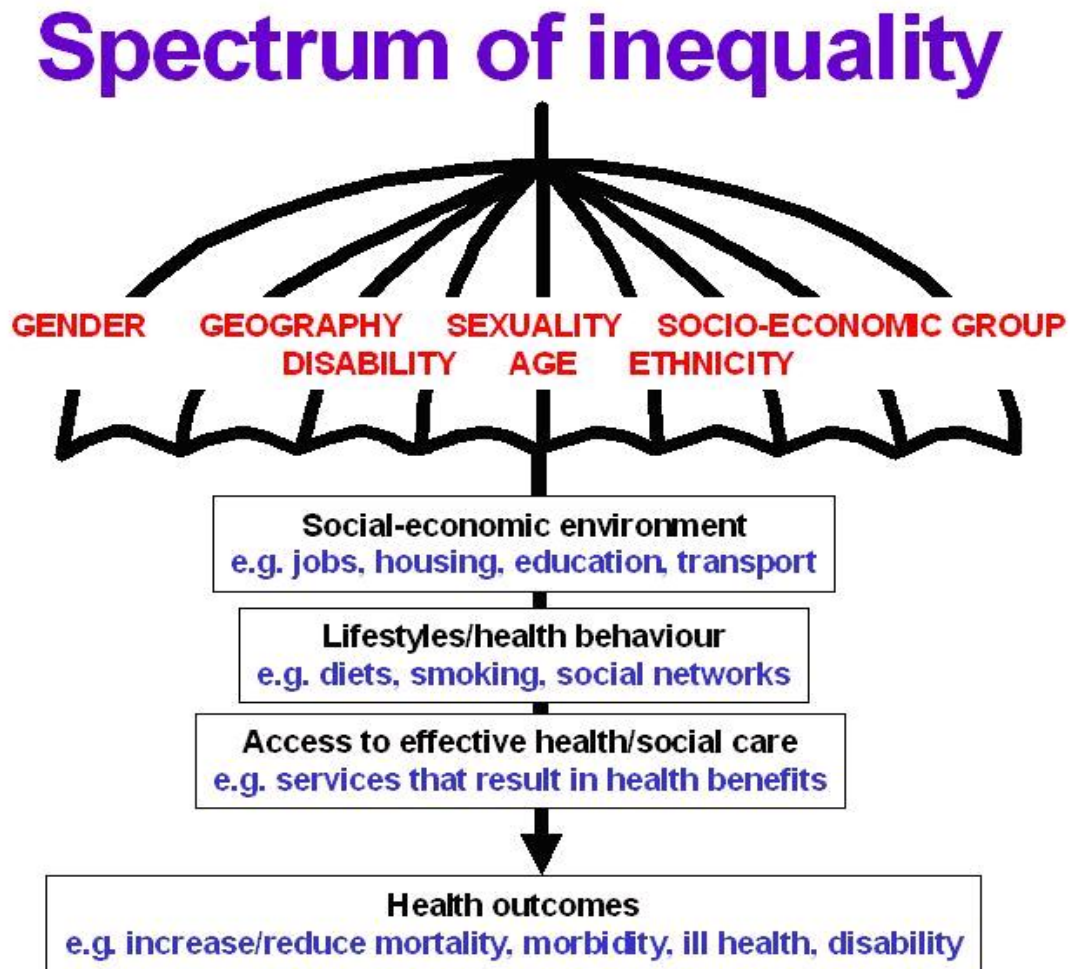
1.2 Defining Health Inequalities

Health inequalities are defined as differences in health status or in the distribution of health determinants between different population groups (WHO, 2008). Figure 1.1 below presents some of the main determinants of health and the influencing factors which lead to different health outcomes.

While a wide range of factors will influence health, it can be helpful to look at three main domains at which interventions can be targeted:

- at the broadest level, the socio-economic environment sets constraints and opportunities that affect people's lives and ability to remain healthy and to withstand risks to health
- individuals' lifestyles and health behaviours such as smoking and drinking alcohol directly impact on health and individual well-being.
- at the local level, access to effective health, social care and other services which result in health benefits.

Figure 1.1. The spectrum of inequality



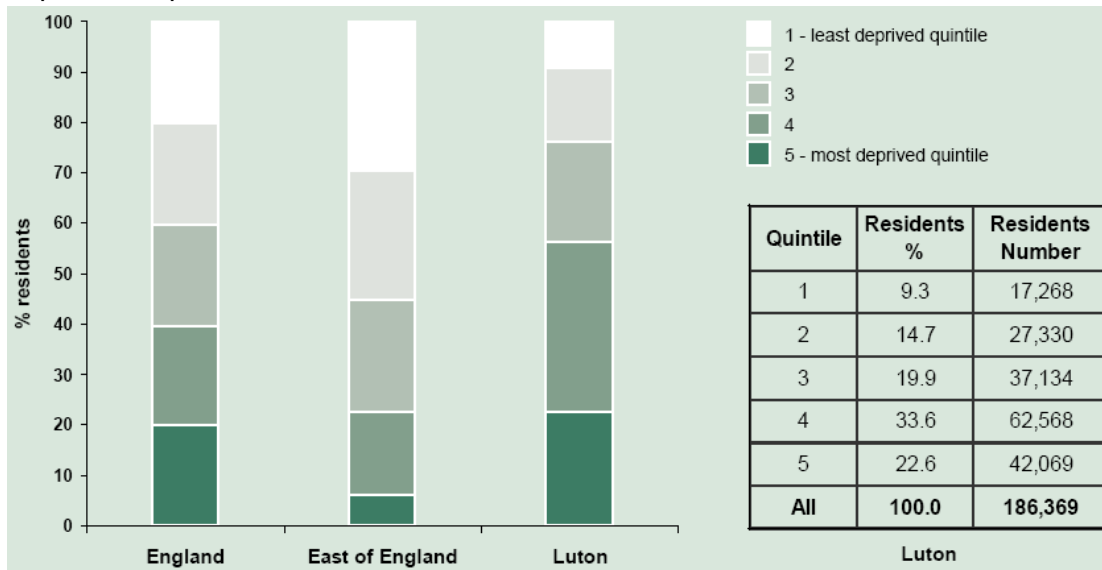
Source: www.who.org.uk/HEALTH_INEQUALITIES/HealthInequalities.aspx

This strategy focuses mainly on geographical areas as a means of tackling socio-economic and other inequalities in Luton. However it is also important to reduce the gap in life expectancy between Luton and the rest of England so action to tackle inequalities must also be universal 'but with a scale and intensity that is proportionate to the level of the disadvantage. Greater intensity of action is likely to be needed for those with the greater social and economic disadvantage.' (DH, 2010). Because of the need for universal action across Luton as well as a more focussed and targeted approach, this strategy will complement the LAA plans of the LSP theme groups as well as the Health & Wellbeing Strategic Plan.

1.3 The Inequality Gradient

Figure 1.2 gives a clear indication of why addressing inequality is important for Luton. 22.6% of Luton's residents fall within the most deprived quintile, almost five times the regional (East of England) proportion which is closer to 5%. 56% of Luton's population (105,000 people) fall within the two most deprived quintiles, the regional figure is closer to 20%. This highlights how poor the health experience of many of Luton's population is likely to be when compared to near neighbours. To help address this we need to focus on those most in need and support them to improved health.

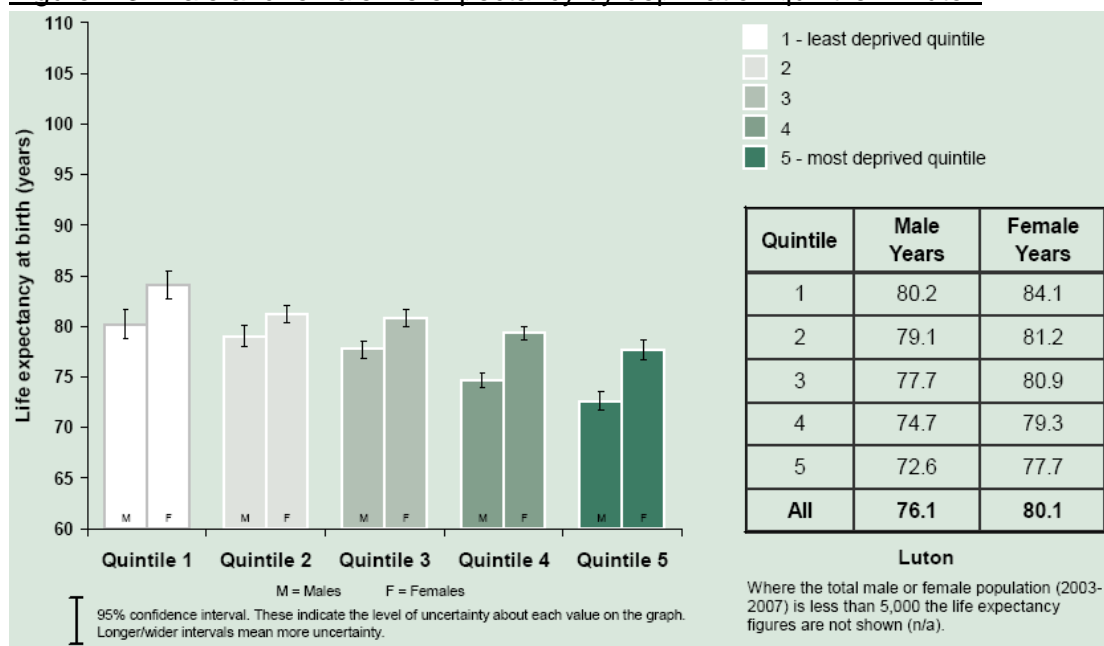
Figure 1.2. Proportion of residents living in neighbourhoods belonging to the five national deprivation quintiles



Source: www.healthprofiles.info 2009

Figure 1.3 shows a clear gradient in life expectancy between the most and least deprived areas in the borough. This gives a strong justification for taking a highly targeted approach to tackling health inequality

Figure 1.3. Male and female life expectancy by deprivation quintile in Luton



Source: www.healthprofiles.info 2009

Similar social gradients can be observed for many different diseases, disabilities, health behaviours and access to services. Asthana et al. (2004) note that there is a consistent social gradient across many specific conditions as well as a gradient in self-reported overall health. The Office of National Statistics (2002) showed that 17% of men and 16% of women in managerial and professional occupations smoked, compared with 34% of men and 30% of women in routine and manual occupations.

Summary

Health inequalities result from social inequalities. Action to address health inequalities requires action across all the social determinants of health

Clear socio-economic gradients exist in relation to health determinants and health outcomes.

There is a complex array of causes of inequalities and these operate at many different levels

The data supports the need for using a highly targeted geographical approach to reduce health inequalities in Luton.

2. Policy and Evidence Context

People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health¹.

¹ Source: Fair Society, Healthy Lives: The Marmot Review Executive Summary. DH 2010, p4

2.1 Background

Since 2000 there has been a clear focus from the DH on tackling health inequalities. The NHS Plan (2000) committed the NHS to addressing health inequalities and 'A Programme for Action' (DH, 2003) set out plans for tackling inequalities around four themes:

- supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of health inequalities
- engaging communities and individuals – to ensure relevance, responsiveness and sustainability
- preventing illness and providing effective treatment and care – making certain that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it
- addressing the underlying determinants of health – dealing with the long-term underlying causes of health inequalities.

These themes were underpinned by five principles:

- preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health
- working through the mainstream by making services more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action from the centre by clear policies effectively managed
- delivering at a local level and meeting national standards through diversity of provision

2.2 Public Service Agreement Targets

A national health inequalities public service agreement target was set in 2001 and updated in 2004. The aim of the target was to reduce inequalities in health outcomes in infant mortality and life expectancy. In 2004 the target was updated and supported by these more detailed objectives around infant mortality and life expectancy:

- starting with children under one year to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole by 2010
- starting with local authorities, to reduce by at least 10% the gap in mortality between the routine and manual occupation group and the population as a whole by 2010.

Although the data relating to these targets shows significant improvements in infant mortality and life expectancy across all groups including the most disadvantaged groups, there has been no narrowing of the gap and little evidence that establishment of spearhead areas and consequent action has made any difference to health inequalities.

In November 2008, Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The key findings from this review include the following:

- There is a social gradient in health – the lower a person's social position, the worse his or her health.

- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
- Reducing health inequalities will require action on six policy objectives:
 - Give every child the best start in life
 - Enable all children young people and adults to maximise their capabilities and have control over their lives
 - Create fair employment and good work for all
 - Ensure healthy standard of living for all
 - Create and develop healthy and sustainable places and communities
 - Strengthen the role and impact of ill health prevention

Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

Summary

Addressing health inequalities has become a significant policy aim

There are existing national targets relating to health inequalities

Government has provided guidance on tackling health inequalities

Tackling health inequalities requires coordinated action across different sectors and willingness amongst partners to support and add value to the activities of others.

While evidence for some interventions is robust, other approaches (especially complex socio-economic interventions) have longer term outcomes and the evidence base is more complex

Activity to address health inequalities need to be universal but disproportionately benefit those in greatest need.

3. Where are we now: Luton?

This section provides a brief overview of some key inequalities within Luton and how they relate to the five priority MSOAs. **Note:** Further information is available in more detailed documents including the Joint Strategic Needs Assessment and the Annual Public Health Report.

3.1 Local Demography

The Office for National Statistics (ONS) estimates that the population of Luton was 188,800 in 2007 and 191,800 in 2008². Luton Borough Council (LBC) estimated that Luton's population was 15,000 more than the ONS estimate at 203,800, which accounts for population changes attributed to migration patterns. Furthermore forecasts estimate that the population of High Town (one of our priority areas), is predicted to grow by approximately 2000 due to housing development (see Appendix 1).

Local forecasts indicate the recent trend of the increasing number of very young children (under 5) is set to reverse from 2011. The number of people in the older age groups will continue to rise, reflecting the national trend. The 5-15 year old age group is projected to increase by 8.7% from 2011 to 2016 (~29,000 to ~31,600), and 16-19 year olds to decrease from 2006 to 2016 (~11,800 to ~10,100) but then increase to 2021 (~10,500). The 'labour force' (the section of the population classified as either 'working or seeking work') is projected to continually decrease to 2021. The 75+ age group is projected to increase by 10.7% from 2006 to 2011 (~9,900 to ~11,000) and then continue to increase thereafter (~13,900 in 2021).

3.2 Ethnicity

Poorer health outcomes are generally more prevalent in people from lower socio-economic groups and Black and Minority Ethnic (BME) communities¹. Also the distribution of infant deaths is influenced by social and ethnic differences and so reducing health inequalities in infant mortality will contribute towards the aim of improving overall life expectancy³. In some areas within Luton, there are higher levels of premature mortality and higher rates of infant mortality and babies born with a low birth weight compared to the national average.

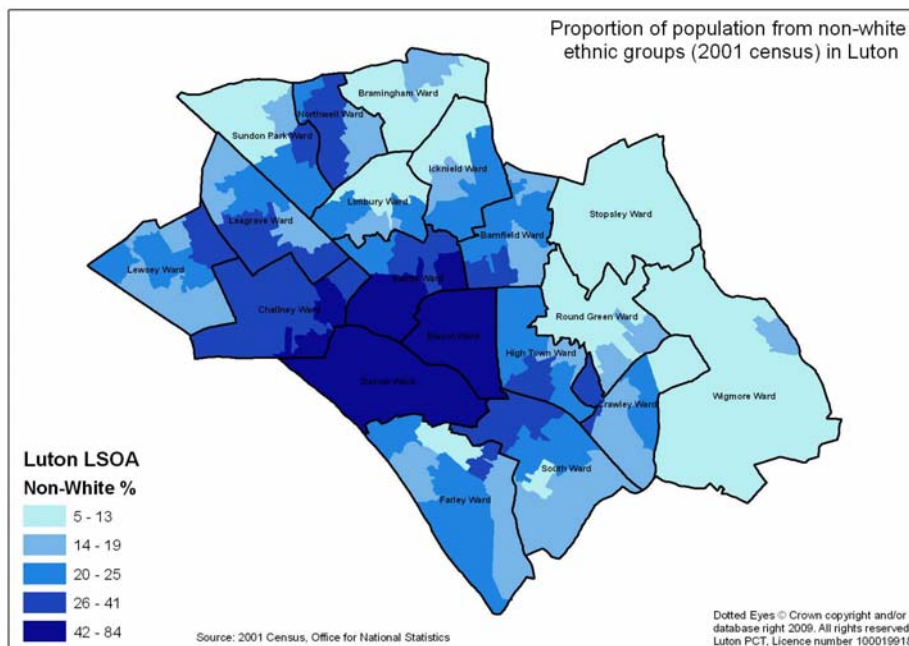
Luton is a very ethnically diverse town, with approximately 35% of the population classified as BME. Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. The experimental estimates of ethnic groups (Appendix 1) provided by ONS in 2007 show an estimated reduction in the White population in Luton from that found in the 2001 Census (71.9% to 65.4%, a reduction of approximately 9,000 people). The largest increases are seen in the Asian population (18.3% to 20.6%) and Black/Black British population (6.3% to 8.6%), both an increase of 5,000 people. The ethnic breakdown of Luton's schoolchildren (Appendix 1) also supports these estimates which show an increase in BME groups. In January 2009 42.7% (~11,300) of Luton's school children were recorded as being from White ethnic groups with 37.1% (~9,800) from Asian ethnic groups, predominately Pakistani (20.1%, ~5,300).

As figure 3.1 illustrates, there is a high density of BME groups in three of our five priority MSOAs particularly Dallow, Biscot and Challney.

² Office for National Statistics 2007 Mid Year Population estimates <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106>

³ Health Inequalities Unit DH Implementation plan for reducing health inequalities in infant mortality: A good practice guide. December 2007 Gateway Reference 8855, Health Inequalities Unit, Department of Health.

Figure 3.1. Non-white ethnic groups (2001 census)



3.3 Deprivation

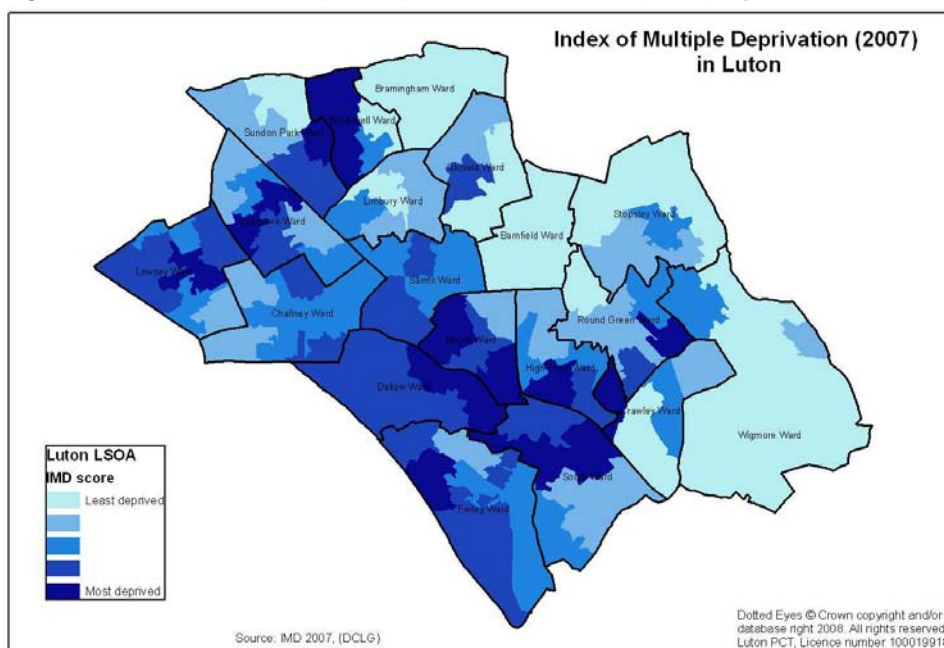
The index of multiple deprivation (IMD, 2007) ranks Luton as the 87th most deprived area out of 354 local authorities in England compared to 101st in 2004. This does not necessarily mean the Luton has become more deprived but perhaps that other local authorities are reducing multiple deprivation at a faster rate than Luton. This is a 'call to action' for all of Luton's strategic partners. Luton also scores poorly on the income and employment scales compared with other boroughs.

Deprivation is a key determinant of health and Luton has pockets of deprivation in all wards, but particularly in the south and west of the borough. The IMD 2007 contains seven domains of deprivation:

1. income deprivation
2. employment deprivation
3. health and disability deprivation
4. education, skills and training deprivation
5. barriers to housing and services
6. living environment deprivation
7. crime

Overall, 22.6% of the Luton population is within the bottom quintile of deprivation nationally (i.e. the bottom 20%) and 56% in the bottom two quintiles. Luton has many more people living in deprivation and far fewer living in relative affluence when compared to England and, especially, the East of England (fig 1.3). Figure 3.2 illustrates that the most deprived areas are distributed in the south west and north west of the borough, which corresponds largely to the areas of low life expectancy (figure 3.3).

Figure 3.2. Index of multiple deprivation in Luton (2007) by LSOA



3.4 Life expectancy

Life expectancy at birth is one of the key measures for the health inequalities national target⁴. Although life expectancy in Luton has shown a steady increase since 1999, life expectancy for both males (76.7yrs) and females (80.4yrs) is still at least one year below the national average (77.9yrs and 82.0yrs respectively)⁵. Men and women in Luton have lower life expectancy than people living elsewhere in the East of England. Life expectancy data for 2006-08 shows that a boy born in Luton can expect to die more than three and a half years earlier than a boy born in St. Albans, only 11 miles away. In comparison with our statistical neighbours⁶ the life expectancy for males in Luton is lower but not significantly different. However, Luton’s life expectancy is significantly lower for females (1.3 years less). Luton is ranked 290 out of 352⁷ local authorities for female life expectancy and 257 for male life expectancy.

Although life expectancy has been rising in Luton, this masks the inequalities that exist between areas. The life expectancy gap between the MSOA areas with the lowest and highest life expectancy is 11 years for men (70.2 to 81.7 years) and 10 years for women (75.5 to 85.5 years).

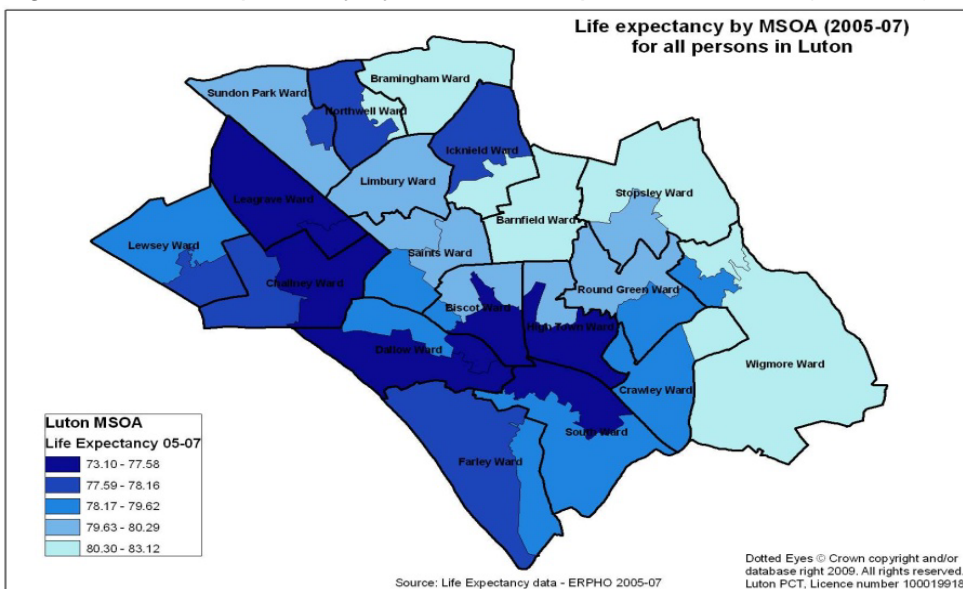
⁴ The Department of Health Public Service Agreements - http://www.dh.gov.uk/en/PublicHealth/Healthinequalities/Healthinequalitiesguidancepublications/DH_064183

⁵ Compendium of Clinical Indicators (NCHOD) available at www.nchod.nhs.uk

⁶ As defined as Hillingdon, Redbridge, Birmingham East and North and Wolverhampton City PCTs by ONS – http://www.statistics.gov.uk/about/methodology_by_theme/area_classification/ha/corresponding_has.asp

⁷ The rank 352 has the lowest life expectancy in the country

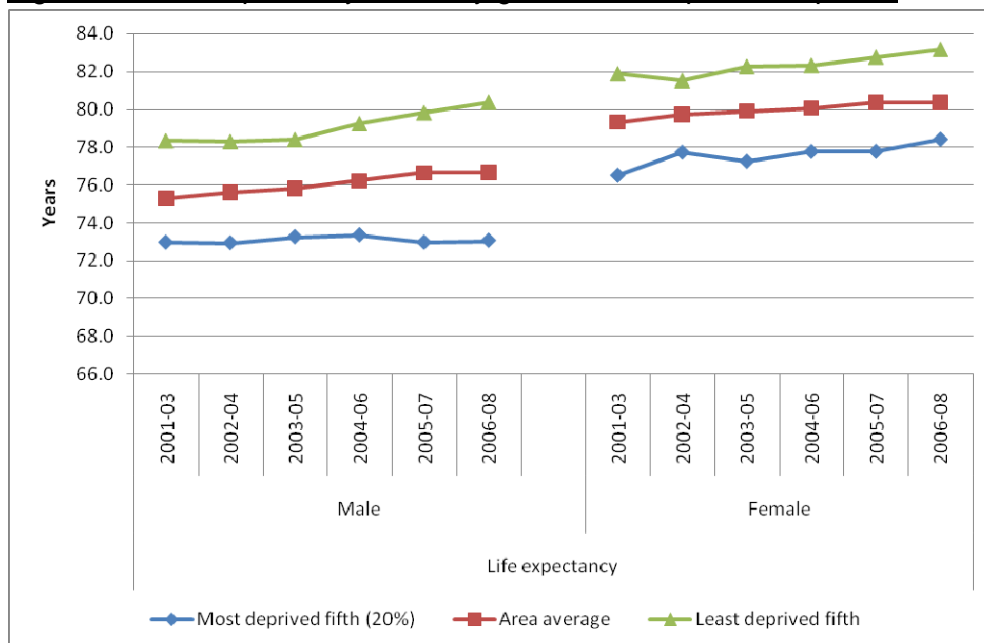
Figure 3.3. Life Expectancy by MSOA for all persons in Luton (2005-07)



Source: ERPHO 2008 Inequalities Profiles

Nationally, life expectancy at birth is increasing for both men and women. However, the inequalities gap is widening as the rate of increase in the most deprived group is slower than the rest of the population. Figure 3.4 shows the inequalities in life expectancy within Luton and shows that the relative inequality gap between the most deprived fifth of areas and the least deprived fifth has continued to widen for males. Life expectancy has increased in both but increased at a faster rate for the least deprived areas. The picture is slightly different for females as the most recent data (06-08) shows a narrowing of the gap with a faster increase in life expectancy in the most deprived group.

Figure 3.4. Life expectancy trends by gender and deprivation quintile



Source: ERPHO Health inequalities Profile 2009

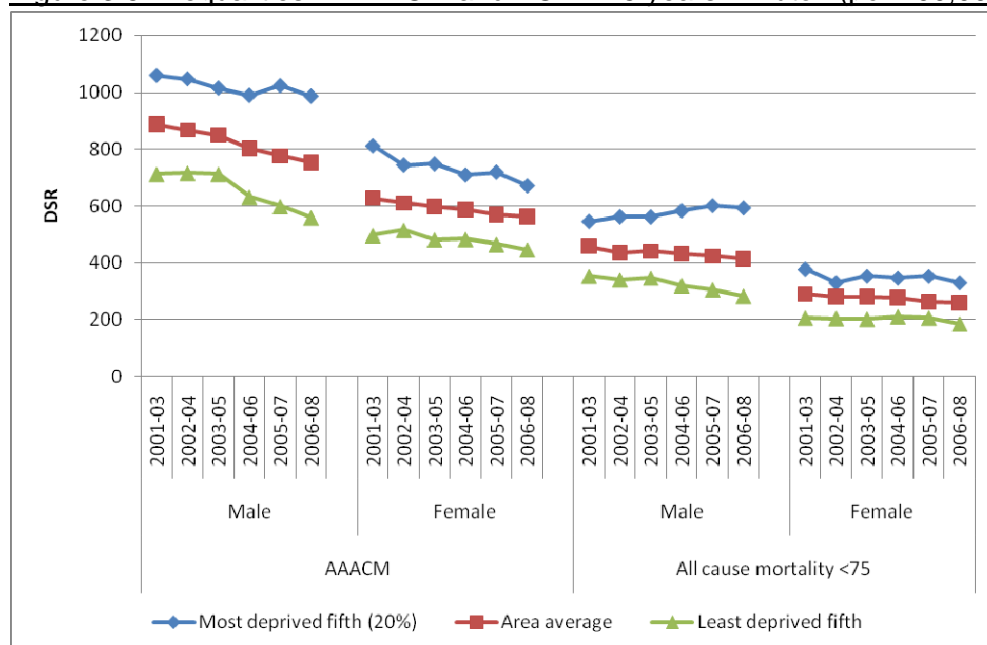
3.5 Mortality

Over the past ten years, deaths from all causes and early deaths from heart disease and stroke in Luton have been higher than the England average. This gap has widened for early deaths from heart disease and stroke and from all cause mortality in women.

All Cause Mortality (ACM) – 2006-08 data shows Luton’s rate is statistically higher than England and East of England for both male and female mortality. AAACM (All Age All Cause Mortality) and ACM for those aged under 75 years has been consistently higher than England and the East of England for the past 10 years.

Figure 3.5 shows that inequalities between the most deprived and least deprived areas have continued to widen for males for AAACM and ACM under 75 years. This is despite a slight reduction in the most deprived mortality rates in 2006-08 as the least deprived areas have seen a faster reduction and therefore the relative inequality between the two has increased. For females the AAACM inequality gap has fluctuated over the years but the most recent data (06-08) shows the gap has narrowed. However, for ACM under 75 years the relative inequality gap has continued to increase, despite a reduction in the mortality rates, as the rate in the least deprived areas has decreased at a faster rate.

Figure 3.5. Inequalities in AAACM and ACM <75 years in Luton (per 100,000 population)



Source: ERPHO Health Inequalities Profiles, 2009

3.6 Cancer and Circulatory Disease

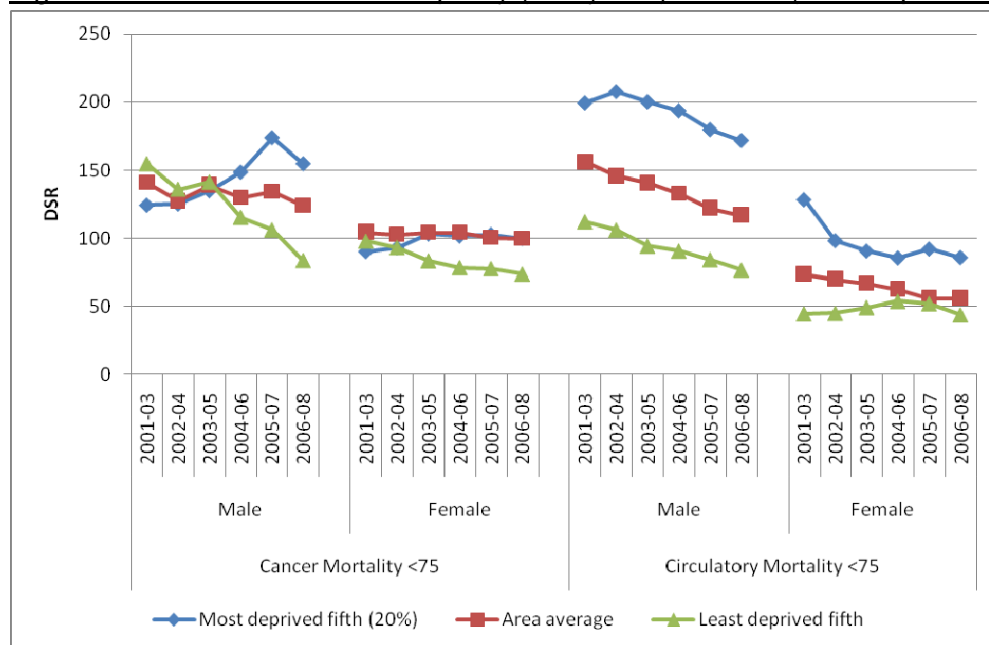
Circulatory disease is the biggest cause of death nationally and also in Luton. Locally there were 458 deaths in 2008 (32% of all deaths); of these one in three were people aged under 75 years. Coronary Heart Disease (CHD) accounts for half (51.8%) of all circulatory disease deaths. In 2006-08 Luton’s overall circulatory disease mortality rate (87.01 deaths per 100,000 population) was statistically higher than England (74.8) and East of England (64.1). The rate for premature (under 75) circulatory mortality has been consistently higher than England and East of England, but in line with its statistical neighbours over the last 10 years.

Cancer is the second largest cause of death in Luton, accounting for almost a quarter of all deaths (24.3%); over half of which are people under 75 years. Lung cancer accounted for 1 in 4 cancer deaths in 2008 in Luton. Luton’s premature mortality rate (<75 years) from cancer is higher than

England and the East of England (though not statistically higher). Trend data suggests that Luton's overall cancer mortality rate has been higher than the East of England (especially in recent years) but similar to the national average and similar areas. Despite this, large inequalities exist within Luton and cancer contributes 8.1% of the male and 11.9% of the female inequalities gap

Figure 3.6 shows how inequalities in death rates vary between sexes. For males, despite the recent decrease in mortality rates, the relative inequality between the most and least deprived areas in premature cancer deaths continue to increase. This is due to rates decreasing in the least deprived areas at a faster rate. For circulatory disease mortality the picture is similar. All mortality rates are decreasing, however in the recent data (06-08) the inequalities gap has widened with a faster reduction in the least deprived areas.

Figure 3.6. CVD and Cancer inequality (<75 years) in Luton (Deaths per 100,000 pop)



Source: ERPHO Health Inequalities Profile 2009

For women, the overall premature mortality rates for cancer have remained constant in recent years, rates in the most deprived fifth have also remained constant and similar to the Luton average. However the relative inequality between the most and least deprived areas has continued to increase due to rates continuing to decrease and at a faster rate in the least deprived areas. Premature circulatory disease mortality in females shows a different picture. There has been a narrowing of the inequalities gap through to 2004-06 caused by reducing mortality in the deprived areas and, surprisingly, increasing mortality in the most affluent areas. However, in 2005-07 and 2006-08 rates in the least deprived areas started to decrease and despite a reduction in rates in the most recent data (06-08) for the most deprived areas as well the relative inequality gap between the two has increased.

Of our priority MSOAs, Dallow, Biscot, and Challney, although not significantly different, have premature cancer mortality rates in the highest 20% in Luton. Dallow, Biscot and High Town, although not significantly different, have premature circulatory disease mortality rates in the highest 20% in Luton.

As Dallow and Biscot feature on both lists, it would suggest they would be of particular priority for lifestyle interventions that impact on both cancer and circulatory disease. (See Appendix 1 for maps to illustrate).

3.7 Mental Health

A significant driver for change within mental health service provision at a local level is the commitment to implement Investing In Your Mental Health (IYMH), the strategy for development of mental health services for all ages agreed by Bedfordshire and Hertfordshire Strategic Health Authority and all local PCTs in December 2005. The main thrust of IYMH was to endorse the principles of mental health promotion, 'mainstreaming' of mental health services, social inclusion and recovery.

Although there is limited local data available, national research has found a social gradient in diagnosis of depression and mental disorders (Lorant et al, 2003). The scale of local need is considerable. Based on estimated expected annual prevalence of psychiatric disorders per 1,000 persons, amongst people aged 15-74 in Luton there are estimated to be:

- 6,217 people with generalised anxiety disorder
- 12,434 with mixed anxiety and depression
- 23,173 with a neurotic disorder
- 15,684 with alcohol and drug dependency

Source: Bedfordshire and Luton Mental Health & Social Care Partnership NHS Trust. Service Development Strategy, 2006/07 – 2011/12

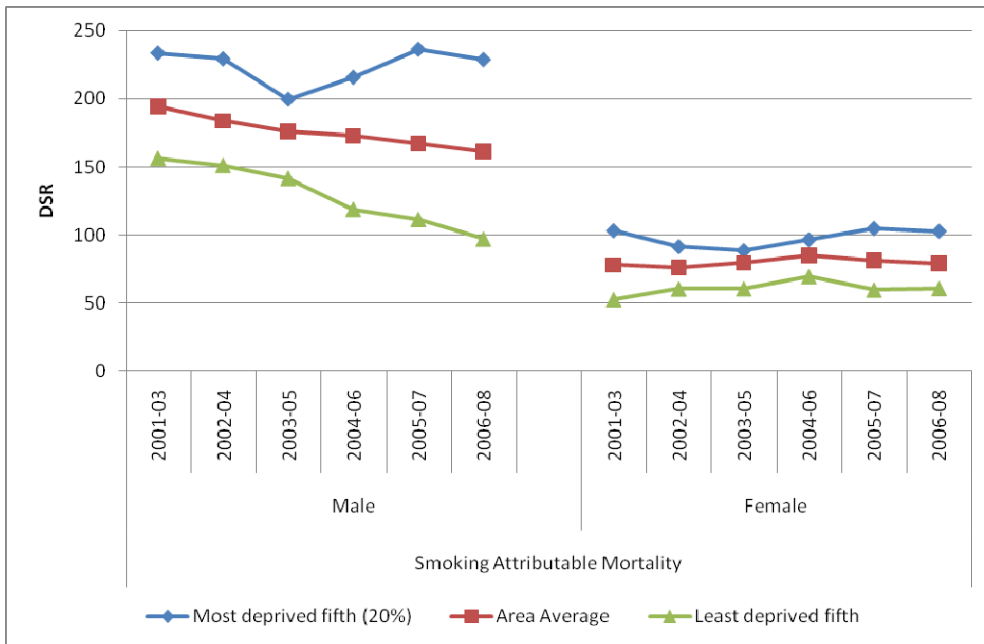
The association between mental health and other problems should not be overlooked. For example, those with mental health problems tend to have poorer physical health, suffer more disability and have more damaging health behaviours, as do people with learning difficulties.

3.8 Smoking

The 2008 East of England lifestyle survey was conducted to obtain data on lifestyle behaviours for PCTs in the East of England. Overall in Luton 21% of the population are thought to smoke, which rises to 23% in the most deprived areas. This is lower than previous estimates however is high when compared to the prevalence of 18.4% smokers in the East of England as a whole. Of current smokers asked, 69% expressed an interest in quitting.

Smoking is a major contributor to mortality and in Luton there were on average 246 smoking related deaths between 2006 and 2008. These deaths are not distributed evenly across areas or between populations. ERPHO's Health Inequalities Profile data shows smoking attributable mortality (SAM) had been increasing in the most deprived areas for both men and women but the most recent data (06-08) shows a slight decrease in rates. For males, it has continued to decrease in the least deprived fifth and Luton overall therefore widening the inequality gap. For females the inequality gap is smaller and has narrowed in recent years (06-08).

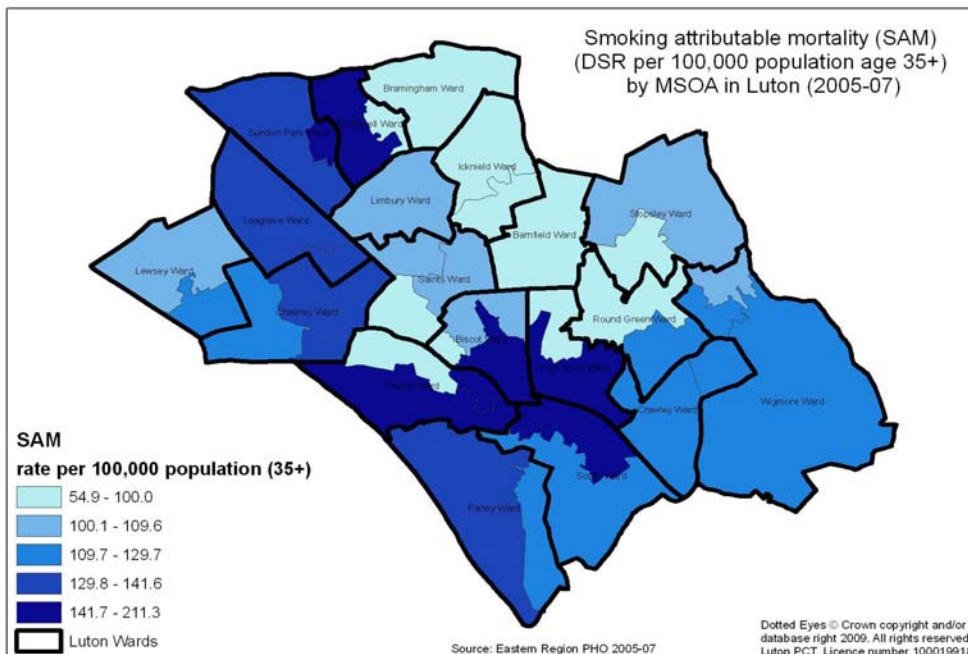
Figure 3.8: Smoking attributable mortality in Luton PCT and deprivation quintile



Source: ERPHO Health Inequalities Profile 2009

Figure 3.9 shows where the smoking attributable deaths occur in Luton, knowing this should enable well targeted interventions. The areas with the highest SAM, although not significantly different, are Dallow, Biscot, High Town, Northwell and South. The first three of these are among the five priority MSOAs, however Dallow and Biscot are not among the Luton areas recognised as having high smoking prevalence (See map in Appendix 1). This suggests a more complex picture that requires further investigation⁸. It is likely that segments of the population are likely to be heavy smokers, while others may have very low smoking prevalence.

Figure 3.9 Smoking Attributable Mortality by MSOA in Luton (2005-07)



Source: Eastern Region Public Health Observatory, Health Inequalities Profile 2008

⁸ It is important to note that rates at such small geographies have large confidence intervals and therefore rates by MSOA are not significantly different to one another.

Summary

Luton has a young, ethnically diverse population which has relatively low levels of employment and income.

Luton is ranked 290 out of 352⁹ local authorities for female life expectancy and 257 for male life expectancy.

Progress has been made in recent years in reducing the life expectancy gap between Luton and the rest of England. However, inequalities within the borough remain considerable and a polarisation can be observed in a variety of health outcomes.

The gap between the most deprived and the least deprived fifths of Luton's population is over 6 years for women and 8 years for men.

Whilst there is a considerable range of local action underway to address health inequalities, the specific contributions of different activities must be made explicit and where possible, quantified so that effective monitoring of programmes is possible.

Cancer and circulatory disease are the biggest causes of mortality

Mental illness is a considerable cause of long term disability.

4. Where are we now: five priority MSOAs

Detailed area based needs assessments have been undertaken by the public health team in the five priority areas: the MSOAs that broadly correspond with the wards of Biscot (MSOA 017), Challney (MSOA 011), Dallow (MSOA 019), Farley (MSOA 020) and High Town (MSOA 018). A brief summary of the key issues is included below and more detailed summaries can be found in appendix 2. The full report for each area is available as a separate document from the NHS Luton inequalities team. This should allow us to draw out particular factors that are unique to that particular population and helps us scope the style of the interventions required.

Summary of Key Issues

Biscot (MSOA 017)

Interventions need to focus on:

- Increasing stop smoking support to reduce the high rates of smoking attributable mortality
- Preventing the uptake of smoking
- Mortality in men and those aged under 75 years
- Reducing deaths from respiratory disease
- Reducing morbidity associated with diabetes and mental illness

Dallow (MSOA 019)

⁹ The rank 352 has the lowest life expectancy in the country

Interventions need to focus on:

- Reducing AAACM and ACM <75 , particularly in males
- Reducing mortality from circulatory disease
- Reducing morbidity associated with diabetes and mental illness

It is worth noting that

- approximately 50% of the local population are <24 years of age.
- Dallow ward has the highest unemployment rate in Luton (7.2% compared to 4.3% in Luton)MSOA 019 has the lowest life expectancy in Luton for males, 6.3 years less than the Luton average.

Challney (MSOA 011)

Interventions need to focus on:

- Increasing stop smoking support to reduce the high rates of smoking attributable mortality
- Preventing the uptake of smoking
- Reducing mortality from stroke and cancer
- Reducing obesity prevalence
- Reducing morbidity associated with diabetes

Farley (MSOA 020)

Interventions need to focus on:

- Reducing deaths from COPD
- Reducing morbidity associated with diabetes and mental illness
- Increasing access to and consumption of fruit and vegetables
- Reducing binge drinking
- Reducing obesity

It is worth noting that:

- MSAO 020 (Farley) has a high percentage of white population, 79.9%, and a comparatively small Asian population
- Owner occupation is far lower than the Luton average and there is a high percentage of lone parent households.

High Town (MSOA 018)

Interventions need to focus on:

- Reducing AAC <75 mortality
- Reducing teenage pregnancy
- Reducing the number of low birth weight babies
- Increasing stop smoking support to reduce the high rates of smoking attributable mortality
- Preventing the uptake of smoking
- Reducing binge drinking

It is worth noting that:

- MSAO 018 has the lowest life expectancy in Luton for females, 4.8 years less than the Luton average.

5. Understanding and Addressing the Inequalities Gap

5.1 Risk Factors

A recent report by the DH (2009) identifies interventions which have the greatest effect on reducing health inequality in life expectancy. At the national level, the most prevalent causes of death which give rise to inequality are: cardiovascular disease (mainly coronary heart disease); cancer; and respiratory disease.

Possible interventions which could act to reduce the difference in mortality rates between the most- and least-deprived quintiles in Luton are: smoking cessation; controlling blood pressure, cholesterol levels, and blood sugar in diabetics; anticoagulant therapy in atrial fibrillation; managing long-term conditions such as COPD and diabetes; and interventions against alcohol abuse.

Interventions to reduce infant mortality, which are outlined in our Infant Mortality Strategy¹⁰, include: action to tackle child poverty; reducing the prevalence of obesity and smoking during pregnancy among those in routine and manual socioeconomic groups; improving housing; and reducing sudden unexpected deaths in infancy.

5.2 Identifying Health Inequalities

To aid with planning services to reduce inequalities in life expectancy, the DH (2008) commissioned the development of a tool which can be used to view the sources of the inequalities, and to estimate the health consequences of interventions against four causes of death. The tool uses data for the period 2001-5.

Figure 5.1 shows the proportions of the sex-specific causes of mortality for the difference in life expectancy between the most-deprived quintile (MDQ) and the least-deprived quintile in Luton. Reducing excess deaths from circulatory diseases and stroke for those in the MDQ has the greatest effect on reducing health inequalities in men and women.

¹⁰ NHS Luton – Luton's Strategy for reducing infant mortality 2010-2013 (2010) unpublished

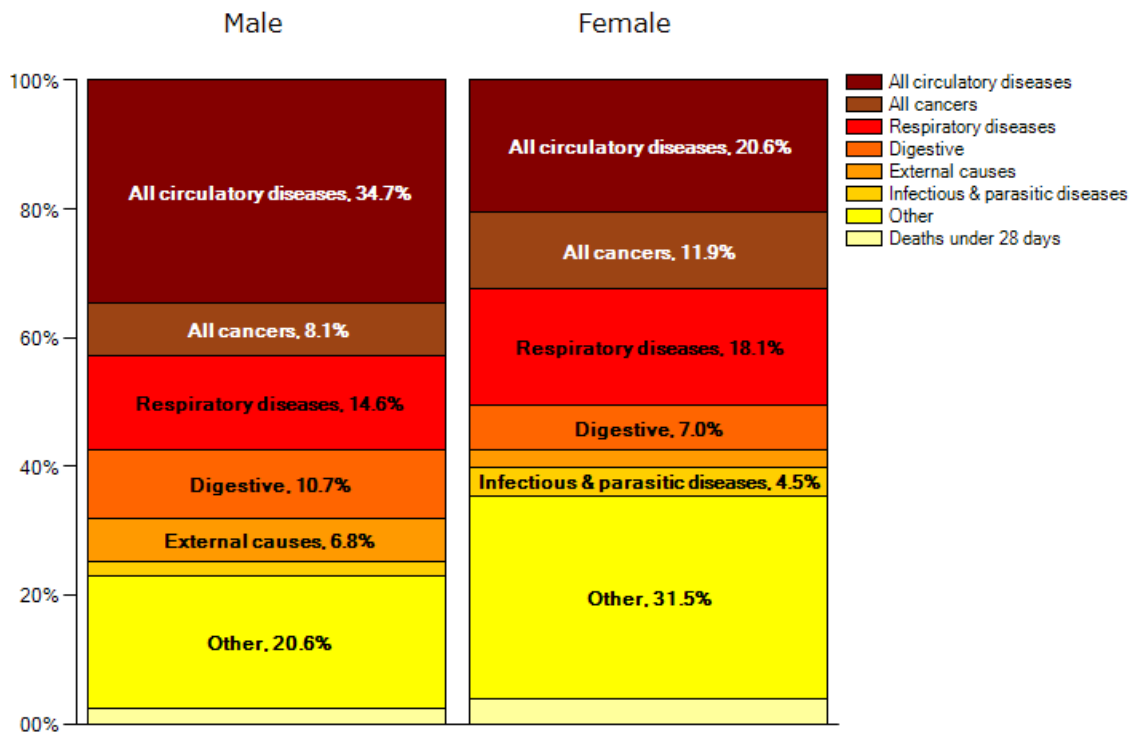


Figure 5.1. Source: Health Inequalities Intervention Tool, London Health Observatory.

Figure 5.2 shows the expected gain in life years if those in the MDQ have the same disease-sex-specific mortality rates as those in the least-deprived quintile. In men, interventions against coronary heart disease and stroke could increase the life expectancy of those in the MDQ by approximately two years. In women, there is no single cause of death that accounts for the difference in life expectancy, suggesting that a broad programme of interventions will be required to reduce the inequality in women's life expectancy

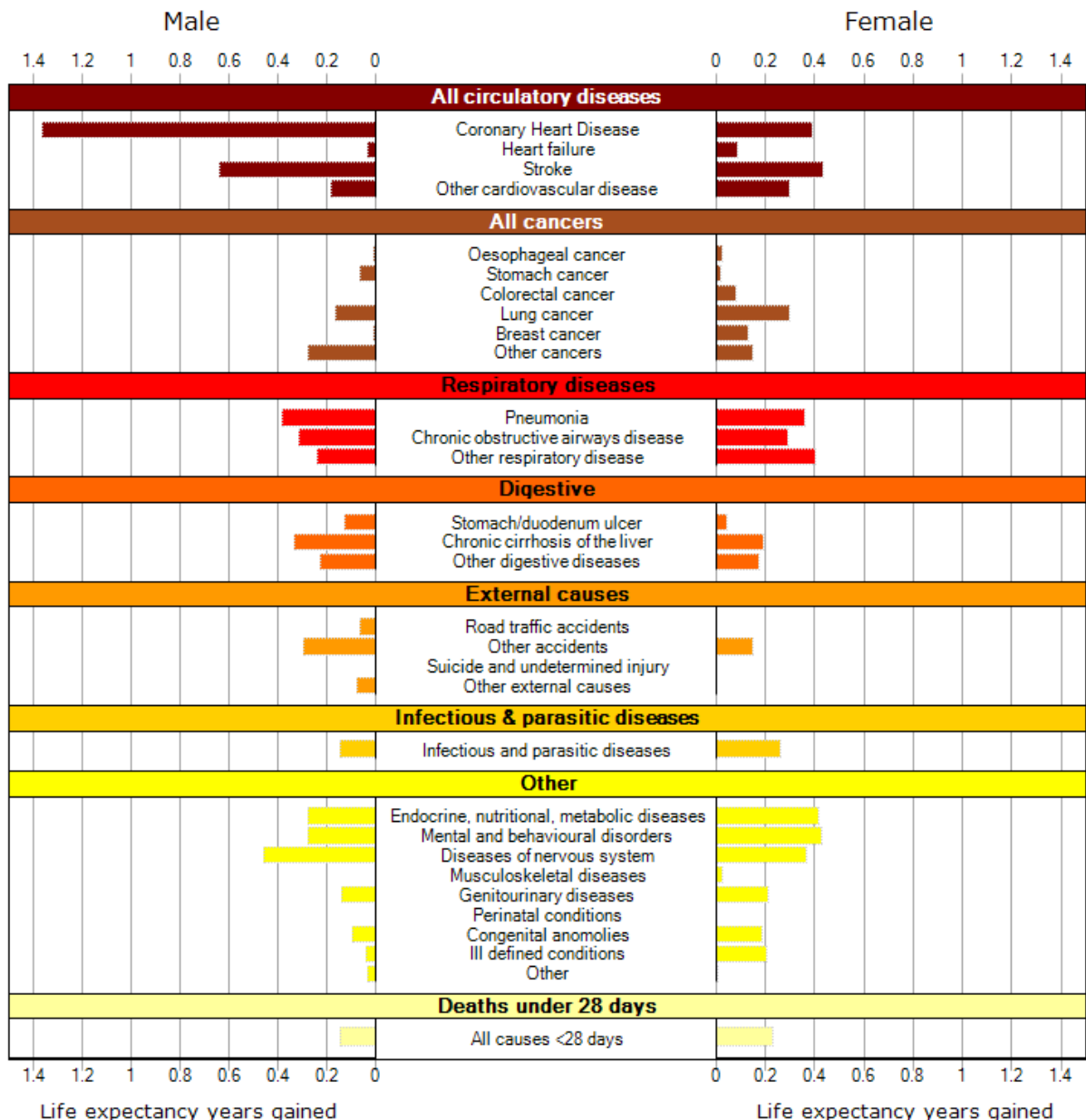


Figure 5.2. Source: Health Inequalities Intervention Tool, London Health Observatory.

In the next section we show the results of using the Health Inequalities Tool to estimate the effect of interventions on differences in life expectancy.

5.3 The Effect of Interventions

We consider the following three interventions:

- support for people giving up smoking;
- controlling blood pressure by prescribing antihypertensives for people without diagnosed cardiovascular disease; and
- controlling cholesterol by prescribing statins for people without diagnosed cardiovascular disease.

Supporting all of the estimated people (2365 men and 2182 women) with hypertension in the MDQ in order to bring their blood pressure down to target levels would add 0.2 and 0.3 years to life expectancy in the MDQ for men and women, respectively. Prescribing statins in combination with managing blood pressure would add an additional 0.1 years of life expectancy for men and women.

If 2684 people quit smoking at 4 weeks, which is twice that achieved in 2006/7, then an additional 0.1 years of life expectancy for men and women would be gained. With all three interventions, men would gain 0.4 years of life expectancy, and women gain 0.6 years.

Matrix Evidence and Bazian (2008) found that there is an average gain of between 0.026 and 0.042 years of life for each person who has a brief intervention for alcohol services in primary care

Summary

1. Interventions against coronary heart disease and stroke could increase the life expectancy of men in the MDQ by approximately two years.
2. No single cause of death accounts for women's life expectancy gap.
3. Gains in life expectancy are marginal for interventions when applied separately, and a combined programme of interventions will be necessary to improve the life expectancy of those in the MDA.

Part 2

How we will Tackle Inequality in Luton?

6. Where do we want to be?

6.1 Aims and Objectives

Our aim is to reduce health inequalities in Luton by narrowing the gap in life expectancy between the five MSOAs with the lowest life expectancy and the five with the highest.

To achieve this aim we will focus on the following objectives:

- Empowering individuals and communities
- Improving access to health and social care services
- Addressing lifestyle issues
- Addressing the wider determinants of health
- Improving quality of life

6.2 Principles

The following principles which have been drawn from the national policy context and have been used to underpin the delivery of the Health and Wellbeing Strategic Plan will also be used to underpin the delivery of the Health Inequalities Strategic Plan.

- **Self-care** - increasing individuals' ability to improve their own health and well being.
- Increasing **choice** for local people.
- Making it easier for people to receive services **in a place and at a time which is convenient** to them.
- **Working in partnership** with other agencies and providers across all sectors to achieve our aspirations.
- **Engaging the local community** in shaping the services that we currently commission and plan to commission, and how those services operate.
- **Prevention and early intervention** - we will shift resources in this direction whenever possible.

Source: Health and Well-being Luton's Partnership Strategic Plan 2009 – 2011.

6.3 Targets

The following targets have been set to 2015. Progress against these targets will be reviewed in 2015 and new targets will be set for the second phase of the strategy

- To narrow the gap in life expectancy at birth between the five MSOA areas with the lowest and highest deprivation to 4.85 years for males and 2.72 years for females by 2015.
- To narrow the gap in life expectancy between the 20% MSOA areas with the lowest life expectancy and with the highest to 7.1 for males and 6.5 for females by 2015.
- To increase life expectancy in Luton to 78.9 years for men and 82.0 years for women by 2015.

Summary

Luton is committed to tackling inequalities both within Luton, and between Luton and England. It has clear strategic aims and set targets to be achieved by 2015.

Five objectives have been identified to focus partnership plans

Six principles will inform the way in which the partnership delivers the strategy.

7. How will we get there?

7.1 The Delivery Plan

The strategy will be supported by a delivery plan which will be refreshed in 2011 and then every three years in line with the LAA process. During 2010-11 the four theme groups of the Luton forum will review their plans and consider how action can be strengthened in the five priority areas. The delivery plan will include actions relating to each of the five key objectives together with outcome measures, timescales and lead organisations.

7.2 Partnership Working

Effective partnership working is crucial to the success of this strategy. The partnership boards that make up the Luton Forum have developed action plans to implement this strategy and will consider the needs of the five priority areas in future strategies and plans to deliver the LAA. The NHS has a key role to play in reducing health inequalities and there is a strong commitment within NHS Luton's strategic plans to focus on the five priority areas and narrow the gap in life expectancy. The Transforming Primary and Community Services strategy, with a network approach, will enable primary and community care to develop to meet the specific needs of the populations within the five areas.

The public health team has carried out health needs assessments in each of the five areas and the actions arising from these assessments form a key part of the delivery plan. However, many health problems have their origins in wider social and economic conditions and reducing inequalities in the longer term will depend on action to improve the life chances of people in greatest need. Tackling health inequalities successfully and sustainably means local service providers working in partnership to address the wider determinants of health such as poverty, employment, poor housing and poor educational attainment.

Local authorities have a crucial role to play in reducing health inequalities. They are well placed to engage with the communities they serve and the range of services they provide impact on the health of all. They provide local community leadership, empower communities, encourage healthy lifestyles and ensure a healthy environment.

Local businesses and voluntary sector organisations in Luton can have a substantial influence on socio-economic factors, lifestyles and service access, and can often reach people who are not involved in mainstream health and social care services.

7.3 Improving Knowledge and Understanding

The success of the strategy will rely on all partners having the knowledge and skills and tools to address inequality. The **Joint Strategic Needs Assessment (JSNA)** will be a key resource for informing local priorities and commissioning plans. Future JSNAs provide an opportunity to look at specific inequalities issues in more depth.

Other tools include:

Health needs assessment (HNA) which help to increase our knowledge base on what and who should be targeted to address inequality. Many of the actions in this strategy are based on the health needs assessments undertaken in the five priority MSOAs.

Needs assessments of child and adolescent mental health and gypsies, Roma and travellers have recently been undertaken, as has some data assessment on children with disabilities. Appropriate actions from these assessments will be incorporated into the delivery plan. Plans are also in place to carry out a needs assessment on child poverty, the homeless and refugees in Luton.

Health Impact Assessment (HIA) are used when contemplating a new project, or significant changes to existing policies or services. The planning process should take health determinants (and their effect on inequalities) into account. Services and amenities should be targeted according to need. This means that those who are most disadvantaged should be prioritised and protected from negative health impacts.

Luton has a good record in carrying out HIAs. For example, three rapid HIAs have recently been completed: Luton & Dunstable Busway; new Farley Hill practice and a housing scheme in the Challney ward. All three of these impact within the five MSOAs and are reflective of the agreed Luton approach to prioritise these areas wherever possible.

The Economic Development Strategy and the Private Sector Renewal Strategy have also been screened for health impacts and a proposal for a HIA has recently been written for the regeneration of High Town.

Equality and diversity impact assessment (EqIA) is a tool for identifying the potential impact of an organisation's policies, services and functions on its residents and staff. It can help staff provide and deliver excellent services to residents by making sure that these reflect the needs of the community.

Health equity audit (HEA) is a useful tool to help identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and to the action needed to ensure that services are provided relative to need. Some health equity audits have already been carried out in Luton and future audits will be based on some of the priority areas in this strategy. In particular smoking cessation and access to antenatal services are within the current programme of HEA.

Social marketing will also be used to ensure that key messages are appropriate to different groups within the population. Messages and approaches need to be tailored to specific groups and communities to bring about the desired behavioural changes to improve health and reduce health inequalities.

Public Health Capacity Building

A comprehensive programme of public health training for staff at all levels has been developed to ensure that people have the knowledge and skills to address health inequalities.

7.4 Delivering Change

Wherever possible, action to address health inequalities needs to be delivered through existing structures and build on existing organisational strategies and plans. Partnership work programmes that can impact on inequality are being developed or redrafted regularly. In the near future the Child Poverty Strategy and Equality Coherence Strategy are being developed, as are the Child and Adolescent Mental Health and Infant Mortality strategies. It is important that these strategies consider the need to target the five MSOAs.

The local strategic partnership (Luton Forum) provides an ideal structure to tackle inequalities in Luton. There is scope for each of the four theme groups to deliver actions linked to their existing national indicators which will reduce health inequalities in the five priority areas and a clear early action to fall out of this strategy is for each theme group to identify which actions in their LAA work programmes lend themselves to this approach.

The Health and Wellbeing Theme Group already has universal plans in place to improve the health and wellbeing of the local population as outlined in the Health and Wellbeing Strategic Plan. Although this strategy will contribute to reducing health inequalities between Luton and the rest of England it is specifically focussed on reducing health inequalities within Luton.

7.5 Governance

The Health and Wellbeing Theme Group of the Luton Forum will be responsible for reviewing the strategy and for monitoring the progress of the delivery plan. They will receive regular reports from the Health and Well-being management group.

The Health and Wellbeing Management Group will be responsible for ensuring that delivery plans are in place to address the five key objectives in this strategy and for monitoring progress towards local targets. The delivery plan will identify lead organizations and intended outcomes for specific actions.

Key issues will be reported to the Luton Public Service Board (LPSB) and NHS Luton's Commissioning Group and Board as appropriate.

Community engagement is essential to inform prioritisation and decision making, to establish public support and ownership over interventions and as a process which itself facilitates access to, and control over, local service provision. A range of activities are required in order to promote and support the involvement of local people, groups and organisations in the commissioning, provision and scrutiny of local health and social care services.

7.6 Reviewing the Strategy

This strategy covers the period 2010 to 2026 and will be reviewed every three years in line with the LAA process and more frequently if changes to local or national policy context or circumstances call for change. The delivery plan for 2010-11 should be seen as an evolving document to allow all theme groups and partners to add to the plan during the year. From April 2011, a three year delivery plan will be prepared bring it into line with the LAA cycle.

Summary

A three year delivery plan will support the implementation of the strategy

The successful implementation of the strategy will rely on effective partnership working

Community engagement is key as actions need to be tailored to the needs of communities and need to have local support

The success of the strategy will rely on all partners having the knowledge and skills and tools to address inequality

Action to address health inequalities should build on existing structures, strategies and plans

The Health and Well-being theme group will be responsible for reviewing the strategy and for monitoring the progress of the delivery plan

The delivery plan will be refreshed every three years in line with the LAA

Health Inequalities Delivery Plan: April 2010 – March 2011
(Work in Progress – Theme Groups and partners still contributing to plan)

1. Empowering individuals and communities

No	MSOA	Action	Lead Agency	Partners	Timescale	Resources	Outcomes/Indicators	Comments/Risks
1.1	Luton Area South?	Neighbourhood Governance Deliver second neighbourhood governance pilot	LBC	NHS Luton, Police			Action plans in place based on needs identified and prioritised by the local community	
1.2	All 5 areas	Health Trainers Increase range of support provided by the Health Trainers in 5 MSOA areas	NHS Luton		Q1	Within Health Trainer Programme	Number of individuals supported by health trainers	
1.3	All 5 areas	Awareness of Services Promote availability of existing services within each of the 5 areas	NHS Luton - Public Health LCST	Local service providers Libraries Luton Assembly's Health and Wellbeing Network	Q1-Q4	Other agencies providing publicity for distribution	A range of methods used to increase community awareness of services information on health available in library sites in 5 MSOA Exhibition at museum Regular communication to the VCS organisations, via the sectors communications links	

1.4	All 5 areas	Air ALERT Improve access to airALERT in all areas	LBC - Environment and Regeneration		Q1-Q4	Officer time	Increase number of people accessing air ALERT	
1.5	Biscot & Dallow	Patient Education Increase access to patient education for individuals diagnosed with diabetes	LCS - community diabetes specialist nurse team	GPs, Desmond Educators, Health trainers, LCST	Q1-Q3	Resources to promote the DESMOND programme	Increased uptake of the Desmond Programme in Dallow and Biscot	
1.6	All	Workplace Work with community partners to develop greater awareness of health promotion issues in workplaces	Health trainers, community dev.	Local employers in 5 areas	Q1-Q4	Health trainer time.	Number of employers signed up to 'healthy workplace'.	Workplace health promo. Use of midlife lifecheck and promo of other health checks/screening.

2. Improving access to Health and Social Care Services

No	MSOA	Action	Lead Person & Agency	Partners	Timescale	Resources	Outcomes/Indicators	Comments/Risks
2.1	All 5 areas	Improving Primary and Community Services Transforming Primary and Community Services Strategy to be developed to address the specific needs in the 5 areas	NHS Luton	LBC - Housing and Community Living		Staff time	Action plan in place to improve primary and community services	
2.2	All 5 areas	HealthCheck Increase access to NHS health check for everyone aged between 40-74 years - focus on hard to reach first	NHS Luton - Public Health	Primary Care, Luton Community Services, Heart Stroke Network	Q1-Q4	DOH information Leaflets	50% (3,039) of Health Checks uptake to be in 5 MSOAs	Lack of engagement by taxi drivers (map where hackney carriage & private hire drivers live in the town and sign post to Health Checks)

2.3	All 5 areas	Cancer Screening Conduct health equity audits (HEA) for cancer screening	NHS Luton - Public health		Q3-Q4	Within the National screening programme	Identify areas of low uptake – improve uptake of breast (75%)/cervical screening (80%)	
	Biscot & Dallow	Increase uptake of bowel cancer screening for men and women aged between 60-69 living in Biscot and Dallow	NHS Luton - Public Health	Pharmacy, Children centres, GPs			Increased uptake of bowel cancer screening	Establish baseline
2.4	Luton wide	Mental Wellbeing Increase access to psychological therapies	NHS Luton		Q1-Q2		Number of people accessing services	
2.5	Farley HighTown Dallow	Sexual Health Identify additional venues to deliver C Card scheme	Public Health Sexual Health Team		Q2		1 new registration or distribution venue for each of the 3 MSOA's	C Card co-ordinator post currently vacant
	HighTown	Set up drop in sexual health clinic for young people at Welbeck once a week for a pilot period of 6 months	Brook	LBC - Welbeck Manager / Team	Q1		Number of young people accessing the new service	
3. Addressing lifestyle issues								
No	MSOA	Action	Lead Person & Agency	Partners	Timescale	Resources	Outcomes/Indicators	Comments/Risks
3.1	All 5 areas	SustainableTravel Increase promotion of sustainable travel	LBC		Q1-Q4	Publicity materials. Events	To increase levels of walking and cycling in Luton	

	Dallow/ Farley	Improved signing of walking routes in Dallow Downs and Stockwood Park	LBC Engineer Services LBC		Q1- Q3	Officer time	Improved access to walking routes in line with the Rights of Way Improvement Plan	
	All 5 areas	Development of Sustainable Travel map for Luton		Sustrans	Q1- Q3	Publicity Materials Printing Costs	Sustainable Travel map on internet and printed	No funding available for printing costs
	Dallow	Build new cycle parking at LBC Depot	LBC Engineer Services		Q1- Q2	Officer time	More staff at depot able to ride to work	
	All 5 areas	Health Trainers to signpost people with risk of or diagnosed with CHD to Sustrans/walk leaders	NHS Luton - Public Health	Sustrans; BRCC	Q1- Q4		Number of referrals / participants / MSOA	
	All 5 areas	Increase access to the bike loan scheme for people in all 5MSOAs	Sustrans / NHS Luton / Active Luton		Q1- Q4	Sustrans materials	Number of referrals / loans per MSOA	
	All 5 areas	Increase number of schools with School Travel Plans	LBC	Schools	Q1- Q4	Staff time publicity materials	All schools have STP	
	All 5 areas	Deliver bikeability cycle training	LBC	Schools	Q1- Q4	Dft cycle training and SSP funding	All year 6 pupils Bikeability trained	Dft Cycle training funding not confirmed yet Schools not taking up cycle training
3.2	All 5 areas	Weight Management Increase access to weight management programmes for Adults and Children	NHS Luton - Public Health	Active Luton, GPs, Pharmacy, Health Trainers	Q1- Q4	Within service provider contracts	Numbers accessing programmes / MSOA area	

3.3	All 5 MSOA	Diet and Nutrition Continue to deliver and increase uptake of school meals in line with government regulations	LBC – Catering Services	Education Welfare	Q1-Q4	Within the existing budget	Increased uptake NI 52	Some schools do not use LBC catering	
	All 5 areas	Continue to deliver cook and eat programmes	Nutrition and Dietetics Service	NHS Luton - Health Trainers	Q1-Q4		Number of people taking part in cook and eat programmes / MSOA		
	Challney & Farley	Set up a fruit and vegetable scheme	NHS Luton - Public Health?		Q1-Q3		Schemes established / numbers participating		BRCC no longer running veg bag scheme as part of nourishing neighbourhoods
	Challney, Dallow, Biscot	Provide weekly 'Grow your own', horticultural therapy and one off 'Grow and take' playscheme sessions	BRCC Nourishing Neighbourhoods?	Dallow Learning Community Centre, Luton MIND, Luton Headway, ACE, CAN, LBC VTS Gardening Gang, LBC playscheme	Q1-Q4		Develop communal food growing sites linked to Chaul End Centre, Dallow Learning Community Centre and All Saints Community Centre		Limited funding and capacity. Big Lottery funded
3.4	Luton wide	Physical Activity Audit opportunities available for physical activity and promote uptake	Active Luton		Q1-Q2	Within SLA with Active Luton	Directory of physical activity services available to people in each MSOA		
		Mapping of exercise classes in Luton	ACL?	Community centres, Children Centres Community /Voluntary group,	Q1		Partners taking time to update mapping exercise		Identify areas underserved

	All 5 areas	Deliver Training to all Children's Centres and their reach areas regarding Start to Play Bags	LBC	schools, colleges, LCST Active Luton/ LBC Children's Centres, Healthy Under Fives Team	Q1-Q4	Children's Centre Revenue Grant	Increase in active play opportunities for under-fives	
	Luton wide	Ensure all eligible settings are participating in Healthy Under Fives Scheme	NDS, LBC	NHS Luton - Public Health	Q1-Q4	Children's Centre Revenue Grant	Improved nutrition and physical activities for under-fives	
	Luton wide	Offer nutritional advice to nurseries based on EETSA report	LBC		Q1-Q2	Officer time	Improved knowledge of nutrition/ Report on numbers of nurseries receiving advice in 5 key areas	Officer numbers to conduct advice as currently recruiting
	Biscot & Dallow	Promote physical and recreational activities to people diagnosed with diabetes	LCS - community diabetes specialist nurse team	GPs , Desmond Educators, Health trainers, LCST	Q1-Q4		Number of diabetics accessing physical activity programmes	
3.5	HighTown Farley	Drugs and Alcohol Co-ordinate and deliver a Sexual Health, Drugs and Alcohol Awareness course for professionals working with young people	LDAP	NHS Luton - Sexual Health Team	Q1-Q4	Venue and trainers to deliver course	Number of staff, community co-ordinators that attend training from HighTown and Farley	Ambulance service may not possess data to begin process
	All 5 areas	Ensure GP's and Health Centres have copies of Drug & Alcohol Guide to Services	LDAP		Q1		Every practice has poster that signposts	Farley Hill Medical Centre – has a direct referral

	All 5 areas	Ensure that information around drugs and alcohol are promoted on notice boards within these venues	LDAP		Q1		individuals to services and copies of the guide	outreach IBA Alcohol worker
	All 5 areas	Work with ambulance service to identify hot spots where young people are drinking excessively	LBC - Trading Standards	LBC Beds & Herts Ambulance Service PCT (Alcohol Services)ASC, GPs	Q1-Q4	Officer time	Action Plan to support people who end up in hospital due to excessive alcohol intake	
	HighTown Farley	Informed brief advice (IBA) referral pathway to be extended to include Whipperley medical centre and Wenlock street surgery	LDAP		Q1-Q4	LDAP commissioned service from ASC	Number of people benefiting from IBA Interventions	
3.6	All 5 areas	Smoking Increase access to Stop Smoking support in 5 priority MSOAs through primary care and community based clinics	LCS - Stop Smoking Service	Health Trainers	Q1-Q4	Within Stop Smoking Service specification	384 smoking quitters from MSOAs by March 2011 150 referrals / year from Health Trainers	
	All 5 areas	Increase of frontline staff trained at L1 and L2 to support smokers to quit	LCS - Stop Smoking Service	LBC, LCS, L&D, Community and Vol sector, workplaces	Q1-Q4	Within Stop Smoking Service specification	Number of staff trained at L1 and L2 by setting	
	All 5 areas	Identify pharmacies in 5 MSOA's for voucher scheme to improve access to treatments	LCS - Stop Smoking Team	Pharmacy	Q1		Pharmacies identified in each areas	
	Dallow Biscot	Deliver targeted work with men who smoke	LCS - Stop Smoking Team		Q2-Q3		Number of men from Dallow and Biscot who access Stop Smoking Services	

		Deliver smoking prevention sessions to all secondary schools	Quit / LBC - Healthy Schools	NHS Luton	Q2-Q4	Funded through Healthy Schools	Number of schools participating and any follow up work identified	Proactive School Engagement will be required
4. Addressing the wider determinants of health								
No	MSOA	Action	Lead Person & Agency	Partners	Timescale	Resources	Outcomes/Indicators	Comments/Risks
4.1	Luton wide but will have benefit to 5 areas	Education and Training? Review of ESOL provision in Luton and Developing a ESOL strategy for Luton	ACL?	Community centres, Children Centres, Community/Voluntary group, Schools/colleges LCST, Active Luton; Parent Support Strategy Group / Learn Direct	Q1	Partners taking time to be part of the process and updating the mapping exercise	Planning deliver of services according to need rather than demand	
4.2	Luton wide	Home Safety Delivery of home fire safety advice and installation of smoke alarms Installation of home safety equipment	Fire and Rescue Service – Community Safety Team Fire and Rescue Service – Community Safety Team	ROSPA	Q1-Q4		Number of home fire safety visits in 5 areas; number of smoke alarms fitted Number of safety gates, locks installed in 5 MSOA areas	

4.3	Farley	Improving the Infrastructure Develop Safer routes to school around Chapel Street nursery	LBC	LBC	Q1-Q2	Officer time	Increase in number of children walking	
	Farley	Improvement of bus stops in Farley					Better access to services	
	Luton wide	Identify specific needs of 5 areas in refresh of Play Strategy					Plan in place to address identified needs in 5 areas	
4.4		Health Impact Assessment HIAs carried out on all major developments		LBC / NHS Luton			Specific needs of 5 MSOA areas identified	
4.5	Luton wide	Housing Review housing to identify any specific needs in 5 areas	LBC - Housing and Community Living					
		Provide DFGs, Decent Homes Assistance Loans, Home Improvement Agency, Affordable Award Interventions	Dave Stevenson	Adult Social Care Age Concern Citizens Advice Bureau Luton and Beds Fire and Rescue Service Warm Front Eastern Training	Annual - on going	Existing	NI 141/2 NI 136	
		Develop a rough sleepers strategy and intervention plan	Mike Dolan	Health, Voluntary sector, Mental Health Police	Autumn 2010	Existing	Access to primary care, supported living settle accommodation NI141/2	
		Severe Cold weather provision	Mike Dolan	Health, Voluntary sector, Mental	Winter 2010 and		Access to emergency over night shelter	Limited health support

				Health Police	2011		primary care, supported living settle accommodation. NI141/2	
		Establishing improved links with homeless households in temporary accommodation awaiting an offer of settled accommodation	Mike Dolan	PCT, Mental Health Trust	Autumn 2010		NI 156	
		Reshape housing related support to those who are vulnerable across Luton through floating support and designated support housing to support reduction of health inequalities, reduce the need for people to have to access more intensive and high cost care and health provision. Promote independence to enable community based health, care and support services to be delivered more appropriately and accessible.	Hilary Bartle	Mental Health trust, PCT – LDAP, Probation service and ASC	(see comments)	Recycling existing funding, developing new joint commissioning and joint funding across the partnership	NI 141, NI142 directly responsible for , Supporting range of health and wellbeing NI's. Promotion Access to Primary health care GPs, Dental, Chiropody. Stabilising home to enable delivery of community based health services to be delivered i.e. CPNs, District Nurses,	Ongoing but specific focus for next 6 months leading to commissioning strategy September 2010 Reshaping services between September 2010 – April 211 – social inclusion short term services April 2011 – April 2012 older people and long term service reshaping. Until April 2011 Luton's Budget through the Supporting People Named ABG = £4.5million Post 2011 – amount unknown as will be allocated as part of CSR (large risk as now within the ABG and unringfenced)

								<p>Extending present service contracts for an additional 1 year to enable reshaping to occur.</p> <p>Risk: partners do not fully engage giving a limited strategic reflection of needs. Mitigation is that a great deal of work has taken place to promote the need to engage with range of partners to deliver more effective, VFM services across Luton within a new outcomes framework of monitoring.</p>
4.6	All	<p>Social Care Older Peoples Luncheon Club review – Carers Project And POPPs services</p>	Hilary Bartle	ASC, Public Health, PCT	report to SMT April 2010	<p>Re-badging luncheon club facilities for Older members of B&ME communities to Health and wellbeing groups as remit is far wider than lunch but covers physical exercise</p>		<p>Review the luncheon clubs, recognise as provider remit and are more of a health and wellbeing group support</p> <p>Table input on main action plan 1.2.1 and 1.2.2. Focus on B&ME elders at present but intend to expand learning and develop universal approach to delivering wellbeing groups</p>

	All	LINKS - Manage contract for host agency of the Local Involvement Networks Next steps - 2011 Annual report produced by LINKs	Hilary Bartle	PCT, NHS Trust, ASC		classes, health promotion, healthy living plans, health checks by nurses. Existing until 2011 – ongoing annual reports available	Nis in process of being agreed	To monitor the effectiveness of the LINKs – annual reports to demonstrate how they have undertaken surveys within hospitals and with those accessing social care to improve deliver of health and social care services to patients, their carers and families.
	All	Monitoring of Social Care SLAs (airport gift aid funds) Review all SLAs, make recommendations as to quality, effectiveness, and VFM for the services.	Hilary Bartle	ASC, PCT,	Ongoing		Nis as per social care outcomes Personalisation, prevention of falls, providing access to improved advice and information for service users of care and health provision.	Work with service providers to build their capacity, knowledge and skills. All providers are Registered Charities and many are extremely small and run solely by Volunteers. Provide signposting to mentoring and information to support these

	All	Monitor national development of performance indicators for health and social care partnerships	Christine Marshall/Maria Silver	LBC – ASC, Housing	2010/11	Capacity Time Resources	Provision of an inclusive picture of the breadth of information available to support health and social care outcomes which can be used to provide effective and timely management information.	agencies to deliver improved health and wellbeing services
	All	Develop mapping across MSOA's to reflect various indicators of health inequality.	Christine Marshall/Maria Silver	LBC – all departments	May 2010	Capacity Time Resources	Map that enables focussed trend analysis of differing indicators across MSOA's	
4.7	All 5 areas	Reducing Supply of Tobacco and Alcohol Increase enforcement around alcohol / tobacco in 5 areas	LBC - Trading Standards	NHS Luton	Q1-Q4	Officer time		
4.8	All	Review LAA Partnership boards to review the LAA targets in the light of the needs of these five priority areas	Partnership boards	NHS, LBC	Q1-Q2	Board member time	LAAs to reflect 5 areas as priority health areas.	
4.9	All	Strategies to be aligned Consult on the development and delivery of the primary and community care strategy to ensure it meets the needs of the five areas populations	NHS, LBC		Q1-Q2	Officer time	Acceptance of 5 priority areas within other strategic doc.'s.	

5. Improving quality of life

No	MSOA	Action	Lead Person & Agency	Partners	Times cale	Resources	Outcomes/Indicator s	Comments/Risks
5.1	All 5 areas	Economy Local Economic Assessment to take into account the needs of the 5 areas; Integration of Workability Champions as part of the Local Economic Assessment	LBC	LBC	Q1- Q2	Officer time	Revised economic strategy	
5.2	Luton wide	Child Poverty Conduct child poverty needs assessment	Children Commissioning Unit	NHS Luton, Police,			Needs identified relating to 5MSOA areas	
5.3	High Town	Health Impact Assessment Complete HIA on the urban village and secure health input to the SPD	LBC/NHS Luton		Q1- Q2	Officer time	Report completed	Financial climate may delay development of village
5.4	Biscot/ Dallow Farley	Pest Control Map levels of pests and reasons for numbers in specific wards Food waste kerb side collection for houses and schools	LBC – Env. Regen.	LBC	Q1 Q1- Q4-	Officer time	Joined action to reduce levels of pests Reduced risk of pests and increased re-cycling	
5.5	All 5 areas	Provide communities for health funding to all areas for specific work to tackle priorities based on HNA	LBC	NHS Luton	Q1- Q2	Officer time	List of areas receiving funding / progress reports	

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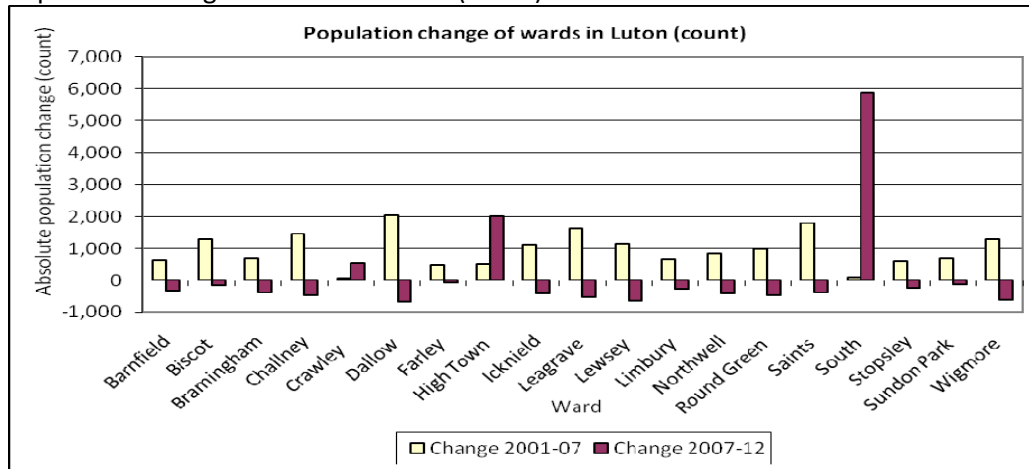
Appendix 1

Proportions of the Population by Age Group for Luton, ONS vs LBC

Estimates	0-14	15-64	65+	Total
ONS (mid-year est)	20.8	66.9	12.3	188,800
LBC estimate	20.3	68.4	11.3	203,800

Source: 2007 ONS mid-Year estimate and LBC 2007 population estimates

Population Change of Wards in Luton (count)



Source: Population estimates and forecasts 2007, Bedfordshire County Council and Luton Borough Council

Table 3.3: Census 2001 and latest experimental statistics from ONS (2007 Mid Year Est)

Ethnic group	2001	2007
White	71.9	65.4
- <i>White: British</i>	65	58.8
- <i>White: Irish</i>	4.7	3.5
- <i>White: Other White</i>	2.3	3.1
Mixed	2.6	2.9
- <i>Mixed: White and Black Caribbean</i>	1.3	1.3
- <i>Mixed: White and Black African</i>	0.2	0.3
- <i>Mixed: White and Asian</i>	0.6	0.7
-- <i>Mixed: Other Mixed</i>	0.5	0.6
Asian or Asian British	18.3	20.6
- <i>Asian or Asian British: Indian</i>	4.1	4.3
- <i>Asian or Asian British: Pakistani</i>	9.2	10.7
- <i>Asian or Asian British: Bangladeshi</i>	4.1	4.6
- <i>Asian or Asian British: Other Asian</i>	0.8	1
Black or Black British	6.3	8.6
- <i>Black or Black British: Caribbean</i>	4.2	4.2
- <i>Black or Black British: African</i>	1.7	3.9
- <i>Black or Black British: Other Black</i>	0.5	0.5
Chinese or Other Ethnic Group	0.9	2.5
- <i>Chinese or Other Ethnic Group: Chinese</i>	0.6	1.8
- <i>Chinese or Other Ethnic Group: Other Ethnic Group</i>	0.3	0.7

Source: ONS Experimental Statistics on Estimated Population by Ethnic Group, 2007 © Crown Copyright

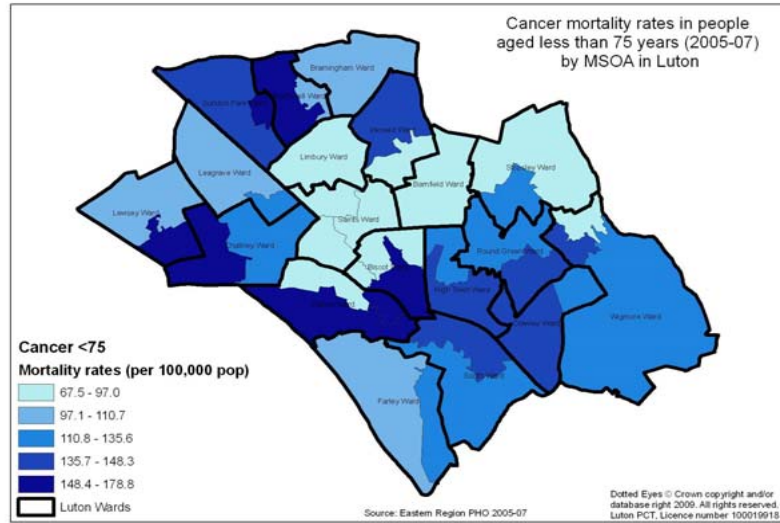
Note: 2007 figures may conceal the impact recent in-migration on Luton's ethnic composition.

Table 3.4: Ethnic background of Luton's school children aged 5+ (Jan 2009)

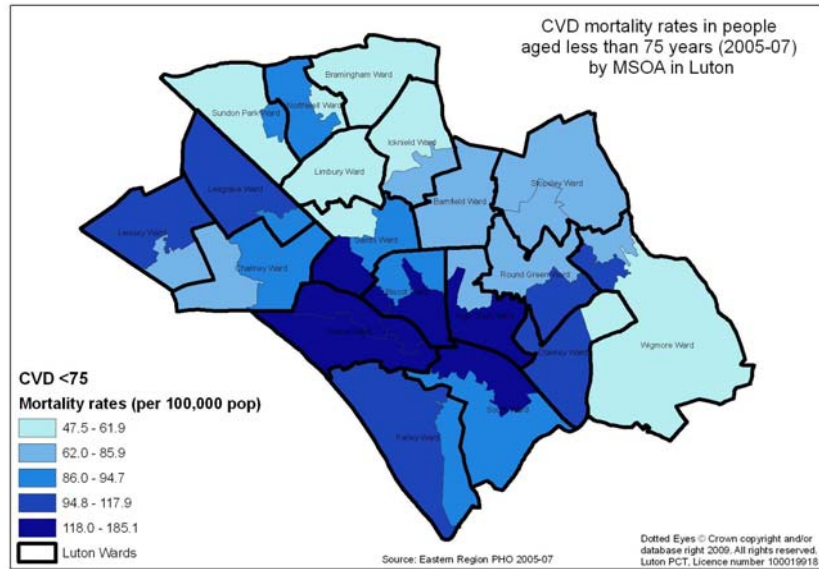
Ethnic Group	%
White British	36.8
White Irish	1.1
White Traveller of Irish heritage	0.2
White Gypsy/Roma	0.1
White Turkish/Turkish Cypriot	0.3
White Other	4.2
Mixed White & Black Caribbean	3.4
Mixed White & Black African	0.6
Mixed White & Asian	1.4
Mixed Any other mixed back- ground	1.7
Asian Indian	3.1
Asian Pakistani	20.2
Asian Bangladeshi	10
Asian Kashmiri other	2.6
Asian other Asian	1.2
Black Caribbean	4.6
Black African	5.6
Black - any other Black background	0.9
Chinese	0.3
Any other ethnic group	1.1
Information not available	0.1
Prefer not to say	0.5

Source: Children and Learning, Luton Borough Council 2009

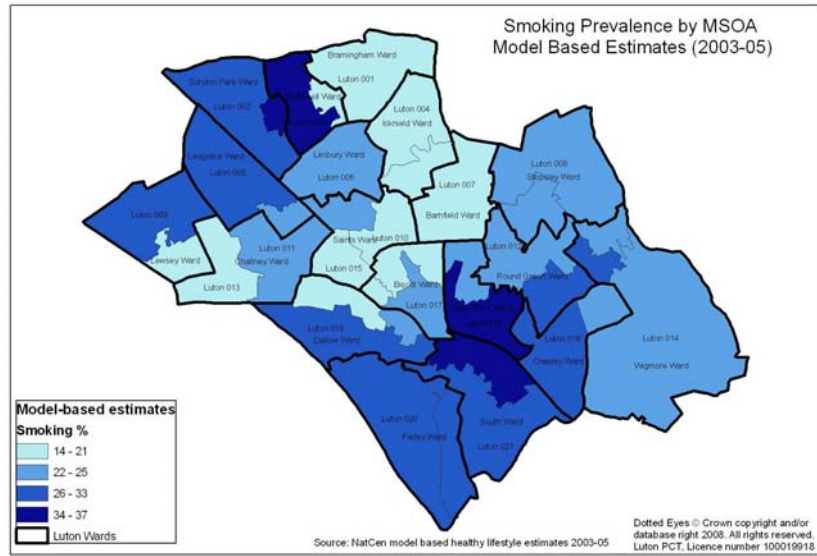
Directly standardised mortality rates for Cancer (< 75 years) by MSOA (2005-07)



Directly standardised mortality rates for CVD (< 75 years) by MSOA (2005-07)



Estimated smoking prevalence



Appendix 2¹¹: Priority MSOA Summaries

Biscot area summary (MSOA 017)

Biscot is an urban area in the centre of Luton comprising parts of Bury Park and the area around Biscot Road. There is a wide range of shops around Bury Park providing good access to fruit and vegetables and containing a range of fast foods outlets and restaurants catering to many different cultures.

The MSOA 017 resident population is estimated (ONS, 2008) to be approximately 9,600 - 53% male and 47% female. There are a high proportion of people under 24 (44.0% compared to 36.6% in Luton overall) and a low number of those aged over 65 (8.3% compared to 12.2% for Luton). According to the 2001 census 56.3% of people in MSOA 017 described themselves as Asian or Asian British, 32.2% described themselves as White.

According to the 2001 census 30% of MSOA 017 working age population were in full time work (42.5% in Luton), many were economically inactive looking after family/home (13.9% compared to 7.6% for Luton), and 20.1% of those unemployed had never worked (nearly double the average in Luton 11.5%). A high percentage of the working age population had no qualifications (38.3% in contrast with 31.3% in Luton), however, 16.2% were students (compared to 9.3% for Luton). Recent Luton Borough Council (LBC) unemployment data (Jan 2010) shows Biscot ward has a relatively high unemployment rate, 6.7% compared with 4.3% of working population in Luton as a whole.

Health in Biscot (MSOA 017)

Life Expectancy - 2005-07 data shows males in Biscot living 4.5 yrs less than the Luton average and 5.7 yrs below England; females live 3.2 yrs less than the Luton average and 4.7 yrs less than England.

Mortality – All age all cause mortality data from 2005-07 indicates the male mortality rate is 1.5 times that of Luton overall (i.e. 50% above) and the female rate is 1.4 times Luton (both significantly higher). For under 75 mortality the difference increases: the male rate in MSOA 017 is 1.6 times that of Luton (62% higher) and the female 1.5 times Luton overall. This indicates that inequality exists for both men and women, but is higher for men and for those aged under 75.

Data on causes of death¹² (2006-08) show cancer, coronary heart disease (CHD), stroke and other circulatory disease contribute a lower proportion of deaths in MSOA 017 than in Luton. Respiratory disease contributes to a greater proportion of deaths in MSOA 017 than in Luton as a whole. Interestingly 36.5% of deaths are listed as 'other' compared to 29.1% in Luton. Of this 36.5% the highest proportion of deaths were from diseases of the nervous system (17.9%) followed by mental and behavioural disorders (15.5%).

¹¹ Please note differences seen at a MSOA level are not always significant due to smaller numbers and wider confidence intervals.

¹² ONS Public Health Mortality Files

Disease specific mortality - MSOA 017 has one of the highest mortality rates from circulatory disease and cancer in Luton for those under 75. MSOA 017 also has the fourth highest mortality rate from stroke (though not significantly different to Luton).

Morbidity - Biscot ward is one of the 20% with the highest estimated diabetes prevalence in Luton. The ward also scores 1.4 on the NEPHO (2008) mental health needs index suggesting there is 40% more mental illness in Biscot than in England overall.

Lifestyle – Based on the local characteristics of the area, MSOA 017 synthetic estimate (NatCen 2003-05) for adults smoking is 22.9%, lower than Luton and England estimates¹³. However smoking attributable mortality in people aged 35 years and over shows the mortality rate to be in the top 20% in Luton. Synthetic estimates for fruit and vegetable intake show that based on the local characteristics of the area 23.8% of people in MSOA 017 are estimated to consume the recommended fruit and vegetable intake. Whilst this is low it is higher than Luton overall, possibly reflecting the good access to fruit and vegetables. MSOA 017 also has an estimated low prevalence of binge drinking among adults aged 16yrs and over and an estimated obesity prevalence of 22.8%. This is similar to other MSOAs who experience much higher life expectancy and lower than the estimated 26.7% of adults who are obese in Luton (differences are not significant).

Dallow area summary (MSOA 019)

Dallow is a large area approximately one mile west of the town centre. Dallow Road is the main route through this area. The recreation ground at the intersection of Brantwood Road and the open wooded hills beginning at Runley Road mark the boundaries. The area has mainly terrace housing.

There are an estimated 7,300 people in MSOA 019; 53.6% male and 46.4% female. It has one of Luton's highest estimated proportion of children aged 0-4 (10.8%) and a high proportion of people aged under 24 (44.1% compared to Luton 36.6%). According to the 2001 census it also had one of the highest proportions of Asian residents: 29.2% Pakistani compared with 9.2% for Luton, and 5.9% Bangladeshi compared with 4.1% for Luton.

According to the 2001 census a high proportion of households were without central heating (13% compared with 6.1% in Luton), and a high percentage of households were without car or van (35.5% compared to 26.4% for Luton). Recent LBC unemployment figures (January 2010) show Dallow ward has the highest percentage unemployed in Luton at 7.2% (Luton 4.3%), and the census showed MSOA 019 had a high percentage of people economically inactive looking after home/family (11.1% compared to Luton 7.6%). The percentage of residents with no qualifications in the 2001 census was high in MSOA 019 at 35.9% compared with 31.3% for Luton.

¹³ Synthetic estimates are the only currently available source to estimate lifestyle indicators at a MSOA level

Health in Dallow (MSOA 019)

Life Expectancy - 2005-07 data shows males in MSOA 019 living 6.3 yrs less than the Luton average and 7.5 yrs below England; females live 3.8 yrs less than the Luton average and 5.3 yrs less than England.

Mortality – All age all cause mortality rate for males is one of the highest in Luton. Data from 2005-07 show the male mortality rate is 1.75 times that of Luton overall (i.e. 80% above) and the female rate is high at 1.5 times that of Luton (both significantly higher). The under 75 mortality difference reduces: - the male rate is high but drops to 1.7 times that of Luton (70% higher) and the female rate is 1.4 times Luton overall. This indicates that inequality exists for both men and women, but is more prominent for men.

Data on causes of death (2006-08) shows that CHD, stroke and other circulatory disease contribute to a similar proportion of deaths in MSOA 019 and in Luton, whereas cancer and respiratory disease are lower. 38.5% of deaths are listed as 'other' compared to 29.1% in Luton. Of this 38.5% the highest proportion of deaths were from diseases of the digestive system (25.4%) followed by mental and behavioural disorders (22.4%).

Disease specific mortality - MSOA 019 has one of the highest under 75 mortality rate from circulatory disease in Luton (2005-07). MSOA 019 has the highest mortality rate from stroke (2003-07) which is significantly higher than the Luton average (2.6 times the Luton overall rate). Dallow ward, although not significantly different, is indicated to have a high infant mortality rate (2003-07) compared to the rest of Luton as a whole.

Morbidity - Dallow ward is one of the 20% with the highest estimated diabetes prevalence in Luton. The ward scores 1.2 on the NEPHO (2008) mental health needs index suggesting 20% more mental illness than England. The ward has one of the highest rates of teenage pregnancy and low birth weight babies.

Lifestyle – Based on the local characteristics MSOA 019's synthetic estimate for adults smoking is 25.8% which is lower than Luton, however smoking attributable mortality shows MSOA 019 to be in the highest 20% of areas in Luton. The synthetic estimates for fruit and vegetable intake shows 27.4% of people in MSOA 019 are estimated to consume the recommended fruit and vegetable intake, whilst this seems low it is above Luton and England. MSOA 019 also has a low prevalence of estimated binge drinking among adults aged 16yrs and over. Based on local characteristics MSOA 019 has an obesity prevalence of 26.1% similar to the proportion of adults who are obese in Luton.

Challney area summary (MSOA 011)

Challney is an urban district in the west of Luton off the main arterial road leading from Luton to Dunstable. It is a residential area with good access to schools and local amenities.

The resident population of MSOA 011 is estimated to be approximately 10,400: 51.9% male and 48.1% female. It has a younger population than Luton as a whole with higher proportion of the population aged 0-24 (40.1% compared to 36.6%) and 25-44 (32.2% compared to 30.2%). According to the 2001 census there were a lower proportion of the population who described themselves as White in MSOA 011 compared to Luton (58.7% compared to 71.9%). There were also high numbers of Asians (28.5% compared with 18.3% in Luton), and Black or Black British (9.4% compared with the Luton average of 6.3%).

According to the 2001 census 43.1% of MSOA 011 working age population were in full time work, slightly higher than Luton average (42.5%). In terms of education, 33.5% of MSOA 011 population had no qualifications compared to Luton (31.3%). LBC unemployment data (Jan 2010) for Challney ward shows the rate is lower than in Luton as a whole (3.7% compared to 4.3%).

Health in Challney (MSOA 011)

Life Expectancy - 2005-07 data shows males in MSOA 011 are living 0.9 yrs less than the Luton average and 2.1 yrs below England. Data shows the female gap to be greater at 2.3 yrs less than the Luton average and 3.8 yrs less than England.

Mortality – All age all cause mortality data from 2005-07 for MSOA 011 show the male mortality rate is 1.3 times that of Luton overall (i.e. 30% above) and the female rate is 1.4 times (40%) that of Luton. The under 75 mortality rates for males and females is not significantly different to that of Luton. This indicates that inequality exists for both men and women, but is slightly more prominent for women and for those aged over 75.

Data on causes of death shows CHD, other circulatory disease, and respiratory disease contribute to a lower proportion of deaths in MSOA 011 than in Luton, whereas Cancer and Stroke contribute more. 35.7% of deaths are listed as 'other' compared to 29.1% in Luton. Of this 35.7% the highest proportion of deaths were from mental and behavioural disorders (21.2%) followed by diseases of the nervous system (19.2%).

Disease specific mortality – MSOA 011 has the second highest mortality rate from stroke, significantly higher than Luton. Circulatory disease and cancer mortality in people aged under 75 years are not significantly different to the Luton average.

Morbidity – Challney ward is within the 40% with the highest estimated diabetes prevalence in Luton. The ward also scores 0.8 on the NEPHO (2008) mental health needs index suggesting there is 20% less mental illness in Challney than in England overall.

Lifestyle – Based on the local characteristics MSOA 011 synthetic estimate for adult smoking is 22.2%, lower than Luton and England, however smoking attributable mortality (in people aged 35 and over) in MSOA 011 is in the highest 40% of areas in Luton. Synthetic estimates for fruit and vegetable intake shows that 26.8% of people in MSOA 011 are estimated to consume the recommended fruit and vegetable intake, whilst this is low it is higher than Luton and equal to the England figure. MSOA 011 also has a low estimated prevalence of binge drinking among adults aged 16yrs and over. Based on local

characteristics MSOA 011 has an estimated obesity prevalence of 29.6% higher than the estimated 26.7% of adults who are obese in Luton and 23.8% in England.

Farley area summary (MSOA 020)

Farley is an urban area situated on a hill in the south of Luton and borders South and Dallow Wards. The M1 motorway runs along one border and a large green space known as Stockwood Park the other. It is centered around 'The Ring' (Whipperley Ring Road) which runs around a small shopping centre. There is mixed housing including a 3-storey flat estate.

The resident population of MSOA 020 is estimated to be approximately 9,600; 49% male and 51% female. There is a high proportion of people over 65yrs (14.6% compared with 12% for Luton) and younger people aged 5-24 (31.6% compared with 29.9% for Luton). According to the 2001 census the majority (79.9%) described themselves as White and there was a small Asian population (10.8% compared with 18.3% in Luton). MSOA 020 had a high percentage of Irish (7.2% compared with 4.7% for Luton) and a high percentage of 'Other White' (3.3% compared with 2.3%).

According to the 2001 census 56% of MSOA 020 households were owner occupied (far fewer than Luton overall 70.8%), and a high percentage of one-person (pensioners) households (15.2% of households compared with 11.1% for Luton) and lone parents (36% of households compared to 28% in Luton).

Nearly 40% of MSOA 020 working age population were in full time work (slightly less than Luton at 42.5%); and a much higher proportion of residents had no qualifications (38.5% compared with 31.3% for Luton). Recent LBC unemployment data (Jan 2010) shows Farley ward has one of the highest unemployment rates (7.1% compared to 4.3% in Luton).

Health in Farley (MSOA 020)

Life Expectancy - 2005-07 data shows males in MSOA 020 living 2.2 yrs less than the Luton average and 3.4 yrs below England; Females live 1.3 yrs longer than the Luton average and only 0.2 yrs less than England.

Mortality – MSOA 020 (Farley) is in the top 40% of areas in Luton with the highest mortality rates. However there are no significant differences to the Luton average for either all age all cause mortality data or the under 75 mortality. The data does indicate higher differences for men than women in comparison with the Luton average and the male mortality rate is significantly higher than the female all age all cause mortality rate and under 75 all cause mortality.

Data on causes of death shows cancer, CHD, stroke and other circulatory disease contribute a similar proportion of deaths in MSOA 020 as in Luton. Chronic Obstructive Pulmonary Disease (COPD) contributes to a greater proportion of deaths (9.5% to 5.8%).

Disease specific mortality - 2005-07 circulatory disease and cancer mortality under 75 data shows the MSOA 020 mortality rate is in the highest 40% of areas within Luton. Differences between males and females are not significantly different. MSOA 020 has the third highest mortality rate from stroke (though not significantly different to Luton).

Morbidity – Farley ward falls within the 40% of wards with the highest estimated diabetes prevalence in Luton. The ward also scores 1.2 on the NEPHO (2008) mental health needs index suggesting there is 20% more mental illness than in England overall.

Lifestyle – The synthetic estimate for adults smoking is 32.5% in MSOA 020, higher than Luton and England (although not significantly different). The smoking attributable mortality rate is in the top 40% of areas in Luton. Synthetic estimates for fruit and vegetable intake, based on the local characteristics, estimate 19.6% of people in MSOA 020 consume the recommended fruit and vegetable intake; this is lower than Luton and England averages. MSOA 020 has a high estimated prevalence of binge drinking among adults aged 16yrs and over. MSOA 020 also has an estimated obesity prevalence of 27.6%, higher than the estimated 26.7% of adults who are obese in Luton and the 23.8% in England.

High Town area summary (MSOA 018)

High Town is located on a hill adjacent to Luton railway station and extends north easterly towards Hitchin. It consists of small shops and Victorian terraced houses, and the district has been recently renovated after many years of neglect.

The resident population of MSOA 018 is approximately 9,700: - 51.1% male and 48.9% female. It has a similar proportion of 0-24 year olds to the Luton average but a lower proportion of 0-14 years olds (14.8% compared to 20.9% in Luton). There is a higher proportion of estimated 25-44 year olds (36.8% compared to 30.2% in Luton). According to the 2001 census MSOA 018 had a slightly higher proportion of White residents as Luton overall (76.9% compared to 71.9%) along with a higher percentage of Irish (6.2% compared with 4.7% for Luton).

MSOA 018 had a lower percentage of Asian population (9.3% compared with 18.3% in Luton) but a slightly higher percentage of Black/Black British (9% compared to 6.3% for Luton).

According to the 2001 census MSOA 018 had a lower percentage of people in full time employment (38.2% compared to 42.5% for Luton). There was a lower percentage with no qualifications (26.0% compared with 31.3% for Luton). Half (50.4%) the households were one person households in MSOA 018 compared to 28.8% in Luton as a whole. Recent LBC unemployment data (Jan 2010) shows High Town ward has one of the highest unemployment rates (7.1% compared to 4.3% in Luton).

Health in High Town (MSOA 018)

Life Expectancy – MSOA 018 has the lowest life expectancy in Luton. The 05-07 data shows males living 5.1yrs less than Luton and 6.3yrs below England; females live 4.8yrs less than Luton and 6.3yrs less than England.

Mortality – MSOA 018 is in the top 20% of areas in Luton with the highest mortality rates. All age all cause mortality data from 2005-07 show the male mortality rate is 1.5 times that of Luton (i.e. 50% above) as is the female rate (both significantly higher). For under 75 mortality the difference increases: the male rate is 1.7 times Luton, the female 1.8 times (80% more) Luton overall. This indicates significant inequality exists for men and women and significance increases for those aged under 75.

Data on causes of death (2006-08, ONS) show a similar proportion of deaths due to circulatory disease compared to Luton as a whole and a lower proportion of deaths due to cancer. There is a similar proportion of deaths due to 'other' causes in MSOA 018 compared to Luton (29.6% compared to 29.1%).

Disease specific mortality - the under 75 mortality rate from circulatory disease in MSOA 018 is in the highest 20% of areas in Luton and in the highest 40% for cancer mortality in people aged under 75 years. Differences between males and females are not significantly different.

Morbidity – High Town ward has lower estimated diabetes prevalence than Luton overall. The ward scores 1.1 on the NEPHO (2008) mental health needs index suggesting 10% more mental illness than in England overall. Teenage pregnancy rates are higher in High Town ward than Luton although rates are not significantly different to the Luton average.

Lifestyle – Based on the local characteristics MSOA 018 synthetic estimate for adults smoking is 34.2%, which is higher than Luton and England. Smoking attributable mortality rates are in the highest 20% of areas in Luton. Synthetic estimates for fruit and vegetable intake shows an estimated 23.8% of people in MSOA 018 consume the recommended fruit and vegetable intake, whilst this is low it is higher than Luton overall. At 20.5% MSOA 018 has one of the highest estimated prevalence of binge drinking among adults aged 16yrs and over. Based on local characteristics MSOA 018 has an obesity prevalence of 22.3% which is lower than the estimated 26.7% in Luton as a whole.