



NHS Luton and Luton Borough Council

**Joint Strategic Needs Assessment
SUPPLEMENT**

October 2009

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1. Executive Summary

This JSNA is a supplement to the edition that was published in 2008 and should be read in conjunction with the first edition. Since the publication of the first edition, the Department of Health issued final guidance and this supplement addresses any areas of the core dataset which were not included in the first version and any data where there is a significant difference to that which was included in the 2008 version.

The key issues which commissioners need to take account of when planning services have been summarised at the end of each section. The relevant key issues from the 2008 edition of the JSNA have been included in this supplement to provide a more complete picture of the issues that need to be considered.

The Sustainable Community Strategy (SCS) which was also published in 2008, describes a shared vision for how Luton will be in 2026. It is based on knowledge of Luton and informed by the aspirations of local people. The strategy is underpinned by shorter term (three year) plans set out in the Local Area Agreement. The SCS looks at priorities for Luton under four main areas:

- Stronger and Safer Communities
- Health and Wellbeing
- Environment and Economy
- Children and Young People

For each of these four areas, specific priorities have been identified up to 2014 for the first part of delivering Luton's Sustainable Community Strategy. Many of these priorities are based on evidence from the 2008 JSNA.

Stronger and Safer Communities

- Increasing the numbers of active citizens: people with the motivation, skills and confidence to speak up for their communities and say what improvements are needed
- Strengthening communities: building the capability and resources of community, voluntary and social enterprise groups to bring people together to work out shared solutions
- Creating partnerships with public and private bodies: public bodies willing and able to work as partners with local people
- Reducing antisocial behaviour and the fear of crime, ensuring all people feel safe.
- Reducing crime including serious acquisitive crime, such as burglary, robbery, theft of a motor vehicle, theft from a motor vehicle, along with domestic abuse, criminal damage and hate crime.
- Management of offenders to reduce the number of prolific and persistent offenders
- Tackling alcohol and drug abuse
- Improving road safety
- More well designed safer and accessible open spaces

Health and Wellbeing

- Promoting healthy living and tackling the key risk factors which affect health
- Focusing on prevention and early intervention
- Supporting people to live independently
- Improving housing conditions for existing and new housing
- Improving mental health services

- Improving services for carers
- Improving leisure and cultural opportunities for all, and better access
- Understanding that different service delivery will be necessary to ensure fair health and wellbeing outcomes for all

Environment and Economy

- Successfully adapting and mitigating for climate change
- Protecting and enhancing the natural and built environment, including our rivers and natural habitats within Luton's green spaces
- Reducing consumption of water, energy, materials and minimising waste including addressing issues around the generation of energy
- Enhancing skills for employability and entrepreneurship and reducing differences in achievement levels between communities
- Improving public transport, access and mobility and increasing travel to work by sustainable modes of transport e.g. public transport, walking, cycling
- Increasing economic activity and good local jobs for local people by working with new and existing businesses and social enterprises and inward investors
- Improving the amount and range of housing suitable for the needs of Luton's existing and future residents

Children and Young People

- Listening to the views of children and young people.
- Improving the health of children and young people
- Ensuring children and young people in Luton are safe and well cared for
- Supporting our children and young people to achieve skills and experience to enhance their prospects for the future
- Reducing the differences in educational achievement between ethnic groups
- Providing positive activities for young people and reducing anti social behaviour
- Better meeting the needs of children and young people with disabilities/learning difficulties.
- Supporting Building Schools for the Future

As well as taking account of the key issues highlighted in the JSNAs, commissioners will also have to ensure that future planning addresses the SCS priorities.

The supplement can be accessed from the following websites:

www.lutonpct.nhs.uk

www.luton.gov.uk

www.lutonforum.org

Summary of Key Points included in this JSNA Supplement 2009

Further details can be found in the main body of the document

Population of Luton:

- The population is relatively young and is projected to increase to 2016 and then decline
- The percentage of the population who are from BME communities is increasing
- The numbers of older people are also increasing, including BME communities with implications for long term conditions such as diabetes, heart disease and renal failure. (JSNA 2008)

- The increase in the number of older people and those with a limiting illness will impact on the need for suitable accommodation. (JSNA 2008)
- The population is diverse in terms of deprivation and BME communities with implications for some of the poor health outcomes (JSNA 2008)
- Luton has relatively high rates of unemployment, low income, housing needs including overcrowding and other factors that impact on health and social need. (JSNA 2008)
- Disposable income is decreasing relative to national average
- A significant proportion of older people live in the Council's own rented accommodation. (JSNA 2008)

Children in Luton

Child Poverty:

- A child poverty needs assessment will be carried out locally by April 2010 and the recommendations from this work will inform future commissioning decisions.

Obesity:

Prevention:

- Re-directing resources to ensure greater emphasis and better co-ordination of interventions to prevent overweight and obesity with a particular focus on pregnancy, early years and school age children.

Weight Management:

- Extending the reach of the MEND programme for 7-13 year olds and commissioning additional programmes to support pre-school children, teenagers who are overweight or obese and children and young people who have co-morbidities and more complex needs
- Making effective use of child measurement data to target services more effectively and to establish local targets (JSNA 2008)
- Extending training for clinical and non clinical front line staff to develop skills and knowledge on early identification and lifestyle changes and ensure consistent messages are given out
- Increasing access to fruit and vegetables particularly in priority areas

Alcohol:

- Maintain and develop the comprehensive range of services available from prevention to interventions
- Ensure information and support are available for young people who are vulnerable and at risk
- Continue to develop harm reduction provision
- Increase the flexibilities of services
- Conduct further work on care pathways and access to lifestyle activities
- Increase understanding of the needs of extremely vulnerable young people

Smoking:

- Enforce legislation about sales of tobacco to under 18s (JSNA 2008)
- Identify effective interventions to prevent young people from starting to smoke
- Ensure services are accessible to support young people to quit (JSNA 2008)

Mental Health:

- Focus on prevention through the roll out of early intervention services to all schools in Luton plus 0-5 year old service
- Review service provision for 16-17 year olds including access to in-patient facilities to ensure compliance with new Mental Health Act requirements.

- Develop clear guidelines to cover all aspects of transition both to adult services and between services at all ages
- Complete needs assessment to inform strategic direction for next three years

Children and Young People with Disabilities:

- Build on initial needs assessment to develop more in-depth understanding of profile of children with disabilities in Luton to enable more informed service planning including by location, severity, disability type, gender, ethnicity and age group.
- Develop overarching strategy and steering group to coordinate services for children and young people with disabilities and ensure services are in place to meet growing demand.
- Complete research commissioned by the CYPSP to assess the needs of children and young people from the South Asian communities
- Develop clear guidelines to cover all aspects of transition to adult services

Emergency Admissions

- Review model of urgent care provision for children and young people

Individual lifestyle factors

Smoking:

- The East of England lifestyle Survey (2008) shows Luton's smoking prevalence to be 21% overall and 23% in the most deprived areas, much lower than the estimated prevalence for 2003-05 (27.3%) reported in the 2008 JSNA.. The average smoking prevalence for the East of England is 18.4%
- Smoking prevalence by ward shows significant variation highlighting the inequalities which exist with smoking (JSNA 2008)
- There is under use of the Stop Smoking Service by Bangladeshi/Pakistani men where there is high prevalence of smoking (JSNA 2008)
- There is under use of the Stop Smoking Service by pregnant women (JSNA 2008)
- There are widening inequalities in mortality from smoking, in particular for males with decreasing rates in the least deprived areas and Luton overall and increasing rates in the most deprived areas. Resources need to be targeted at men in the most deprived quintile

Diet:

- Commission a range of weight management services to support adults to lose weight (JSNA 2008)
- Increase access to fruit and vegetables in the 5 priority areas of Luton. The East of England lifestyle survey shows significant inequality in consumption of fruit and vegetables between the most deprived areas and the rest of the PCT.

Physical activity:

- There are high levels of inactivity in Luton compared to the East of England and National average (JSNA 2008). A continued focus on increasing adult participation in physical activity needs to be maintained
- There are significant variances in inactivity by socio economic classification – 65% of people from NS SEC 5-8i were inactive in Luton compared to 46% amongst NS SEC 1-4 (JSNA 2008).

ⁱ NS SEC was developed in 2001 by the Office of National Statistics. The National Statistics Socio Economic Classification replaces the former Social Class based on Occupation and Socio-economic Groups. In summary, NS SEC 1-4 relates more closely to former categories A,B,C1 and NS SEC 5-8 relates to C2, D, E.

- There are low levels of female participation and a substantial variation between male and female participation. A continued focus on increasing female participation in physical activity needs to be maintained
- There is comparatively low participation amongst ages 16-34, 35-54 and 55+ - Luton has significantly lower participation rates across these age groups than the East of England. When compared with Bedfordshire, participation was low across all age groups from 16-55+ (JSNA 2008).
- Participation varied across super output areas – there were distinct areas of inactivity to the west of Luton with middle to high levels of participation found in the south east and north of Luton (JSNA 2008).

Alcohol:

- Alcohol appears to be a bigger problem in males than females with higher deaths and hospital admissions related to alcohol. Action needs to be focus on addressing alcohol related issues with the male population
- Interventions need to focus on reducing alcohol related recorded crime and alcohol related violent crime

Gypsies and Travellers

- Improve access to primary and secondary care health services
- Ensure all staff working with the community receive cultural awareness training
- Identify best practice to increase engagement with traveller men
- Improve children's oral health (JSNA 2008)
- Improve attendance for children's eye or ear appointments (JSNA 2008)
- Action to address the mental health issues within this community (JSNA 2008)

Social Care Needs and Activity

- The need for social care is rising due to the increasing age of the population, particularly the year on year rise of people over 85 who are major users of the services. (JSNA 2008)
- People over 85 are more likely to have dementia and a high level of care need, which in turn will require extra support for carers (JSNA, 2008).
- The number of younger disabled people living longer is increasing due to advances in social and medical care (JSNA, 2008).
- There are a higher and rising proportion of older people within the local population, especially among South Asian and Afro Caribbean communities. Future services will need to reflect not only the increase in demand for services for older people, but for culturally appropriate services. (JSNA 2008)
- There is a high demand for accessible information. Isolation is a significant issue for older people, with the potential consequences for mental health.
- There is a significant impact on health services following a fall for an older person and this will increase in line with the growing number of older people.
- Transport is a significant issue and particularly so for older people, where mobility issues can impact on a person's ability to live independently.
- There is limited data on the number of vulnerable people such as those with learning disabilities. Data held in primary care often shows lower than expected prevalence. (JSNA 2008)

Health Status of the Population

Life Expectancy

- There are significant health inequalities within Luton and future planning must address the gap in life expectancy between the 5 priority MSOAs with lowest life expectancy and the 5 with the highest

- Luton's life expectancy for males is 1.1 years lower than the national average and for females the gap is 1.5 years. The gap for females widened at the beginning of this decade. (JSNA 2008)
- The life expectancy projections suggest that Luton's figures will continue to improve to 2009-11 but that they are not getting closer to national life expectancy levels. (JSNA 2008)
- Luton's life expectancy at the age of 65 years is similar to the national figure for males but is lower than average for females. (JSNA 2008)
- On average about three quarters of people over the age of 65 are expected to be in good health and about half are expected to be free from disability. (JSNA 2008)

Diabetes

- Luton's recorded prevalence of diabetes is higher than both the regional and national averages. (JSNA 2008)
- According to the national (PBS) model, the overall prevalence of diabetes in Luton (which includes those not yet diagnosed) is also above the regional and national averages.
- There is a higher estimated prevalence of diabetes within the Asian and Black communities in Luton and the wards with the highest estimated prevalence are Biscot, Challney and Dallow
- According to programme budgeting data, spend on diabetes in Luton increased by 27% from 2006-07 to 2007-08

Hypertension:

- Estimated prevalence of hypertension in Luton is lower than the national estimate and similar to statistical neighbours for both males and females.
- Further work needs to be undertaken to ensure that all the registers are complete especially among practices with a higher number of patients from a BME background (JSNA 2008).
- To improve the levels of hypertension and reduce the risk of circulatory disease all patients on registers need to have access to health improvement services such as weight management programmes and stop smoking services (JSNA 2008).

Cardiovascular Disease (CVD)

- Mortality rates from circulatory diseases continue to fall (JSNA 2008)
- However, Luton's death rates from circulatory diseases overall, and for CHD in particular, are still higher than the national average. Local figures for stroke deaths are very similar to the national rates (JSNA 2008)
- Male mortality from CHD is twice as high as female mortality, but for stroke there is no significant difference (JSNA 2008)
- Luton appears to have a lower than average number of people on CHD registers, and has a low estimated prevalence of CHD overall. These figures need to be understood further given the population characteristics and high mortality locally. (JSNA 2008)
- Despite relatively high death rates Luton appears to be spending less on circulatory diseases than similar PCTs and the national average. (JSNA 2008) Although spend still remains lower than comparators Luton has increased spend in this area by 28% from 2006-07 to 2007-08

Cancer

- Cancer deaths have declined more slowly than those from circulatory diseases and are now the main cause of death in the under 75s. (JSNA 2008)
- Death rates for males are higher than for females, but the difference is not as great as it is for heart disease. (JSNA 2008)
- The inequality gap for premature mortality from cancer, in males, between the most and least deprived areas is widening
- Luton's death rate from cancers has broadly followed the national trend but with big fluctuations from year to year. (JSNA 2008)

- In the most recent three year period Luton's cancer death rate has been the same as the national average. (JSNA 2008)
- Luton spends less than its comparator PCTs and the national average on cancer, ranked at 149 out of 152 PCTs. (JSNA 2008). Although spend still remains lower than comparators Luton has increased spend in this area by 56% from 2006-07 to 2007-08 and is now ranked 114 out of 152 PCTs.

COPD

- Luton's mortality rate from COPD is higher than the national average (JSNA 2008) although estimated prevalence is lower.
- Mortality is higher for males than females, both locally and nationally (JSNA 2008)
- Prevalence models suggest a much higher number of people with COPD than are recorded on local GP registers and a higher prevalence than the East of England. (JSNA 2008)
- Luton's spend is higher than the national average and comparable PCTs. (JSNA 2008). Although spend still remains higher than comparators Luton has decreased spend in this area by 28% from 2006-07 to 2007-08

Sexually Transmitted Infections

- Luton has a high prevalence of HIV infection, amounting to 286 per 100,000 population.
- The number of new cases of HIV reached a peak in 2003 and has been falling every year since then. (JSNA 2008)
- It is estimated that approximately one third of people who are infected with HIV have not been diagnosed
- Luton's spend on HIV is higher than the national average, but low compared to similar PCTs. (JSNA 2008). Although spend still remains lower than similar PCTs, Luton has increased spend in this area by 56% from 2006-07 to 2007-08
- The gonorrhoea infection rate in Luton has been falling in recent years and is now close to the national average. (JSNA 2008)
- Chlamydia is the most common sexually transmitted infection in terms of the numbers of new cases each year. (JSNA 2008)
- The Chlamydia infection rate has been rising in recent years but fell in 2006. (JSNA 2008)
- The group most at risk from Chlamydia are those aged between 15 and 24 years. (JSNA 2008)
- The uptake of Chlamydia screening is below the national target

Access to Pregnancy Termination services

- The levels of terminations of pregnancy are relatively high in Luton (JSNA 2008)
- The proportion of abortions carried out before ten weeks has increased significantly and is now above the regional and national average.

Immunisations and Vaccinations

- A significant amount of investment by the PCT delivered an immunisation coverage in Luton that was one of the best in the country (JSNA 2008). However, uptake has decreased in 2008/09 and this needs to be addressed
- The increase in MMR coverage is increasing, reflecting improved local systems and the wider acceptance of the vaccine amongst parents. (JSNA 2008)
- Luton has achieved the flu vaccination coverage target for the last 3 years however there needs to be a greater focus on promoting the uptake of immunisations in higher risk groups such as individuals diagnosed with chronic diseases. (JSNA 2008)

Healthcare Activity

- Emergency care episodes account for more than elective and day case episodes combined raising questions about the balance of care. (JSNA 2008)
- The main causes of day case treatment (2008-09) is within

- general medicine (18%)
- general surgery (10%)
- ophthalmology (9%) and
- urology (9%)
- The two main causes of elective hospital admission (2008-09) are:
 - General Medicine (13%)
 - General Surgery and (12%)
 - Trauma and Orthopaedics (12%)
- The main causes of emergency episodes are paediatrics (25%), general medicine (20%) and obstetrics (19%) (2008-09)
- The better management of long term conditions in primary care and the community should reduce secondary care activity.
- NHS Luton should use standardised comparators to measure performance with cluster PCTs and against the national admissions data. (JSNA 2008)

2. The Population of Luton

Demography

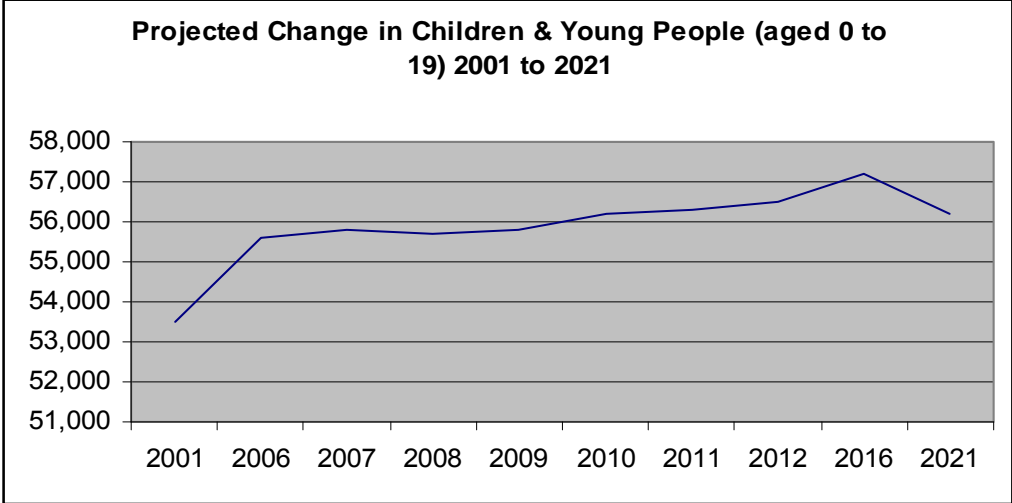
Latest Mid Year Population Estimates from the Office for National Statistics for Luton state the population as 191,800 (2008). Research undertaken by the Borough Council suggests that this is a serious underestimate of the population and a figure of 203,800 is more realisticⁱⁱ. LBC believe that the influencing factor in the difference is migration which they believe is underestimated by ONS.

Population Projections

Bedfordshire County Council and Luton Borough Council have produced a set of population projections for Luton. The base of these projections for the Luton figures is now the LBC Population Estimates, which differs from that of previous years when the ONS Mid Year Estimates were used as a baseⁱⁱⁱ.

Figures 1-4 highlight the key changes projected to occur in the population of Luton to 2021 according to LBC estimates.

Figure 1: Population change in children and young people

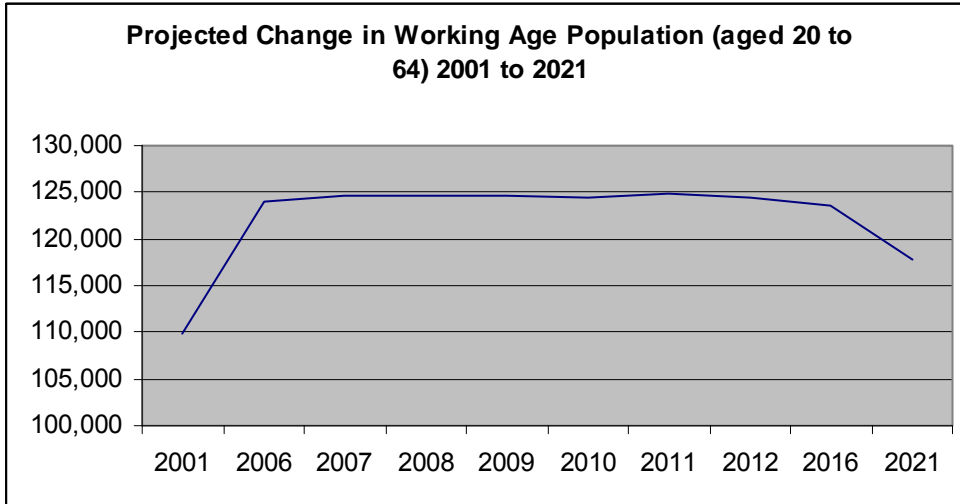


Source: Bedfordshire County Council and Luton Borough Council "Population Estimates and Forecasts 2008"

ⁱⁱ Luton Borough Council (2008). What is the population of Luton available at <http://www.luton.gov.uk/>

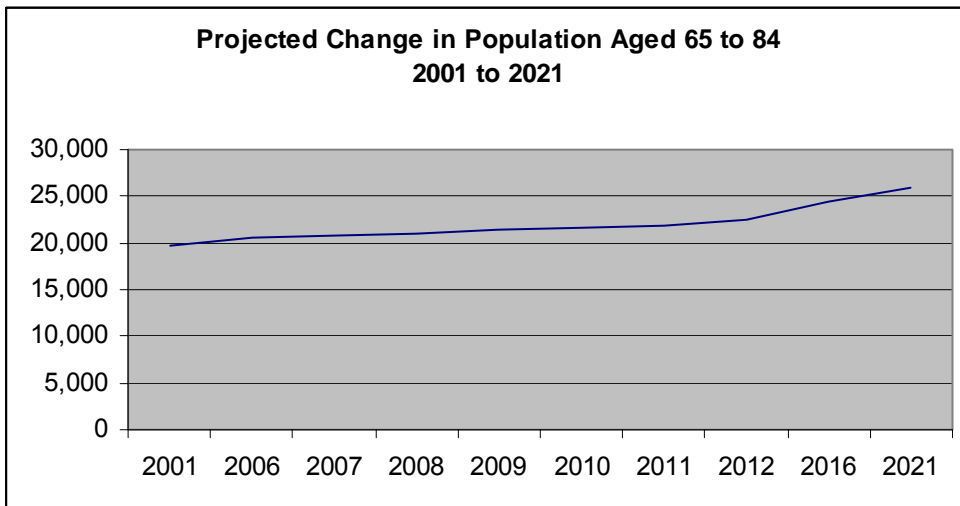
ⁱⁱⁱ Bedfordshire County Council and Luton Borough Council (2008). "Population Estimates and Forecasts 2008" available at <http://www.luton.gov.uk/>

Figure 2: Population change in working age population



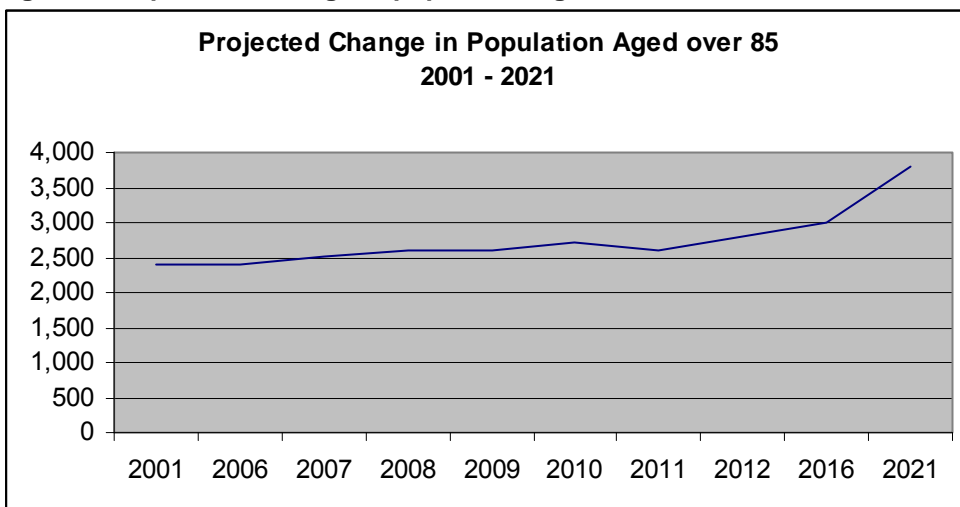
Source: Bedfordshire County Council and Luton Borough Council "Population Estimates and Forecasts 2008"

Figure 3: Population change in population aged 65-84



Source: Bedfordshire County Council and Luton Borough Council "Population Estimates and Forecasts 2008"

Figure 4: Population change in population aged 85+



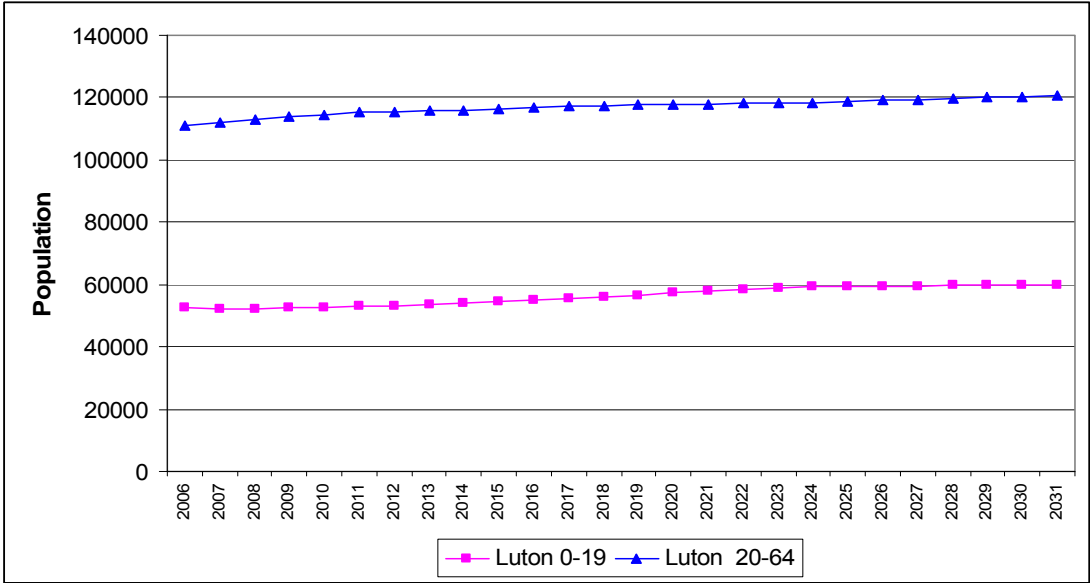
Source: Bedfordshire County Council and Luton Borough Council "Population Estimates and Forecasts 2008"

The trends in these projections clearly show:

- An ongoing increase in the numbers of children and young people to 2016, thereafter a decline is projected.
- Some stability in the numbers of working age population.
- An increase in the elderly population.

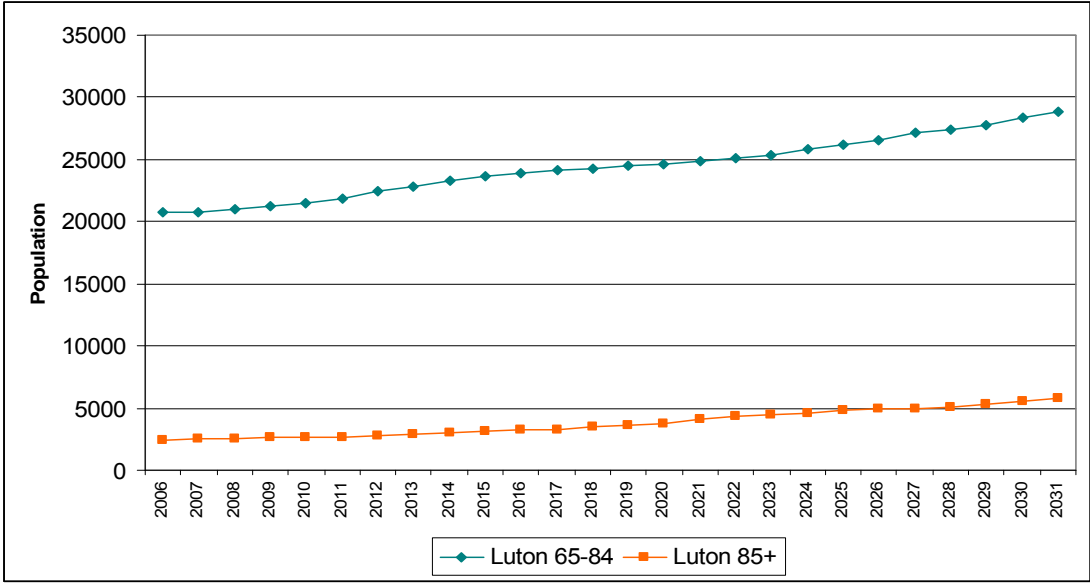
ONS population projections (2006) show similar trends with increasing older populations (see Figure 5 and Figure 6).

Figure 5: Population projections for Luton by age group (0-19 and 20-64)



Source: ONS 2006 Based Sub-national Population Projections

Figure 6: Population projections for Luton by age group (65-84 and 84+)



Source: ONS 2006 Based Sub-national Population Projections

Estimated Population by Ethnic Group 2007

The experimental estimates of ethnic groups (2007) provided by ONS in Table 1 show that there is an estimated reduction in the White population in Luton from that found in the 2001 Census. There is a corresponding slight increase in the Asian population, with the largest estimated increase being in the Black/Black British population, which is estimated to have risen to 8.6% of Luton's population, from 6.3% in the 2001 Census.

Table 1: Latest experimental statistics from the Office for National Statistics (based on the 2007 Mid Year Estimates)

Ethnic group	2007
White	65.4
- <i>White: British</i>	58.8
- <i>White: Irish</i>	3.5
- <i>White: Other White</i>	3.1
Mixed	2.9
- <i>Mixed: White and Black Caribbean</i>	1.3
- <i>Mixed: White and Black African</i>	0.3
- <i>Mixed: White and Asian</i>	0.7
-- <i>Mixed: Other Mixed</i>	0.6
Asian or Asian British	20.6
- <i>Asian or Asian British: Indian</i>	4.3
- <i>Asian or Asian British: Pakistani</i>	10.7
- <i>Asian or Asian British: Bangladeshi</i>	4.6
- <i>Asian or Asian British: Other Asian</i>	1
Black or Black British	8.6
- <i>Black or Black British: Caribbean</i>	4.2
- <i>Black or Black British: African</i>	3.9
- <i>Black or Black British: Other Black</i>	0.5
Chinese or Other Ethnic Group	2.5
- <i>Chinese or Other Ethnic Group: Chinese</i>	1.8
- <i>Chinese or Other Ethnic Group: Other Ethnic Group</i>	0.7

Source: Office for National Statistics Experimental Statistics on Estimated Population by Ethnic Group, 2006 © Crown Copyright

These figures probably conceal the impact recent in-migration has had on the ethnic composition of Luton.

Religion

Luton's proportion of those stating their religion as Christian is the lowest in the East of England, around 9 percentage points below the England & Wales average. Conversely, the Borough has almost five times the proportion of those stating their religion as Muslim as the national average. It is also noticeable that those declaring "no religion" is the third largest group.

Table 2: Percentage of population by religion

Religion	Luton	East of England	England & Wales
Christian	59.6%	72.1%	71.7%
Buddhist	0.2%	0.2%	0.3%
Hindu	2.7%	0.6%	1.1%
Jewish	0.3%	0.6%	0.5%
Muslim	14.6%	1.5%	3.0%
Sikh	0.8%	0.2%	0.6%
All other religions	0.3%	0.3%	0.3%
No religion	14.1%	16.7%	14.8%
Religion not stated	7.2%	7.8%	7.7%

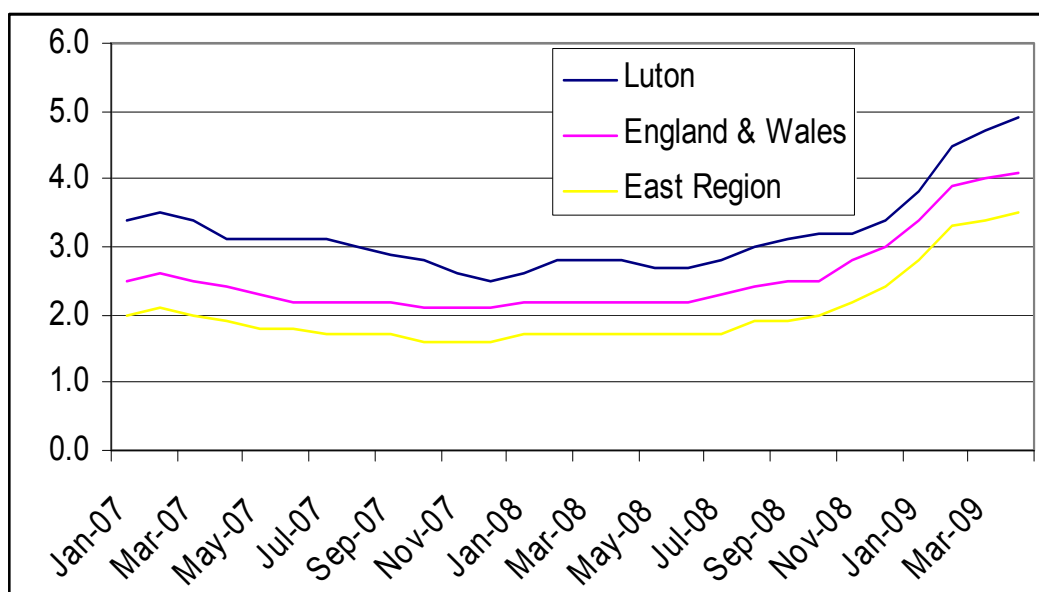
Source: 2001 Census [Key Statistics for Local Authorities] © Crown Copyright.

Economy and Employment

Job Seekers Allowance (JSA) Claimant Count Unemployment

The number of people in the Borough who are receiving Job Seekers Allowance has increased steadily from 2007 (Figure 7). However, although rising, the Luton JSA Claimant Count rates are doing so in line with the national and region pattern.

Figure 7: Job Seekers Allowance Claimant Count Unemployment Rates, January 07 to April 09



Source: JSA Claimant Count rates Jan 2007 to April 2009, ONS via NOMIS

Housing

Housing has an important role to play in determining health and well-being. The role of housing becomes pivotal where services to an individual with complex long-term needs are involved. Such service delivery is often dependent on the accessibility and/or adaptability of the individual's home. Issues such as dampness or cold rooms, uneven floors or loose flooring, a lack of support rails or floors that are slippery when wet can all make it difficult for the occupant to maintain good health and well-being^{iv}.

Types of Housing

In Luton the vast majority of houses are in the private sector (either owned or rented). However the breakdown below shows the tenure by specific age groups, which shows that 21% of people over 85, rent accommodation from the Council and only 66% own their property.

Table 3: Proportion of population aged 55-64, 65-74, 75-84, and 85 and over by tenure, 2001

<u>Tenure</u>	People aged 55-64	People aged 65-74	People aged 75-84	People aged 85 and over
Owned	81.85%	77.49%	70.65%	65.68%
Rented from council	9.99%	15.01%	19.94%	21.35%
Other social rented	2.15%	2.36%	3.34%	4.58%
Private rented or living rent free	6.01%	5.15%	6.06%	8.39%

Source POPPI - Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S017 Tenure and age by general health and limiting long-term illness.

Disabled persons housing needs

There is a need to ensure property is adapted to suit the needs of disabled people. Aids and adaptations are a positive solution to allow many people to live independently for longer. In addition technological solutions can be used. These provisions may include ensuring that there are a number of electrical and telephone sockets in all rooms as well as more sophisticated telecare solutions which are linked to an alarm service.

In the longer term Lifetime Homes standards for all new homes should be considered. Examples of specific measures could be such things as wider doors and higher plug sockets. *Source Homes Standards." Lifetime Home, Lifetime Neighbourhoods, CLG.* Table 4 shows the potential need for housing adaptations based on the data of tenure and illness.

^{iv} Source www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/housing/index.htm

Table 4: People aged 65 and over by age (65-74, 75-84, 85 and over), with a limiting long-term illness, living alone, projected to 2025

Age group	2008	2010	2015	2020	2025
People aged 65-69 with a limiting long-term illness, living alone	517	541	635	588	659
People aged 70-74 with a limiting long-term illness, living alone	813	788	776	913	851
People aged 75-79 with a limiting long-term illness, living alone	915	974	1051	1051	1266
People aged 80-84 with a limiting long-term illness, living alone	852	878	1038	1171	1197
People aged 85 and over with a limiting long-term illness, living alone	966	1005	1198	1468	1855
Total population aged 65 to 74 with a limiting long term illness, living alone	1330	1329	1411	1501	1510
Total population aged 75 and over with a limiting long term illness, living alone	2733	2857	3287	3690	4318

Source POPPI - Figures are taken from Office for National Statistics (ONS) Table C0839, Age (65 and over in 5 year age groups) and Limiting long-term illness (LLTI) by household size, a commissioned table from ONS using information from the 2001 census

Central Heating (2001 census)

Cold and damp homes can affect people's health which will therefore affect their quality of life particularly for the most vulnerable in society. Table 5 shows the breakdown of the older population living with no central heating.

Table 5: People aged 65 and over by age (65-74, 75-84, 85 and over) living in a dwelling with no central heating, year 2001

Age group	Total 65 and over population	Number of 65 and over population with no central heating	Percentage of 65 and over population with no central heating
People aged 65-74	12742	855	6.71%
People aged 75-84	7014	586	8.36%
People aged 85 and over	2373	344	14.5%
Total population aged 65 and over	22129	1785	8.07%

Source POPPI - Figures taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table SO54 Shared / unshared dwelling and central heating and occupancy rating by age.

Housing for those with learning disability

Public Service Agreement 16 (PSA16) and the other 29 Public Service Agreements were announced in October 2007 as the Government's highest priority outcomes for 2008-2011. Public Service Agreements have played a vital role in galvanising public service delivery and driving major improvements in outcomes. They are a clear commitment to the public on what they can expect for their money. The purpose of PSA16 is: to increase the proportion of socially excluded adults in settled accommodation, employment, education or training^v.

PSA16 is highlighted several times within the white paper "Valuing People Now" published in January 2009 – the Government's three-year strategy for people with learning disabilities. 'Valuing People Now' states that by 2011 councils should know about the housing needs of people with learning disabilities and be including this in their housing plans. Learning Disability Partnership Boards have a vital role to play in this^{vi}.

One key issue affecting people with learning disabilities is the need to plan for their future housing needs as many live with increasingly aging parents.

For 2008/9 the Council achieved the following performance.

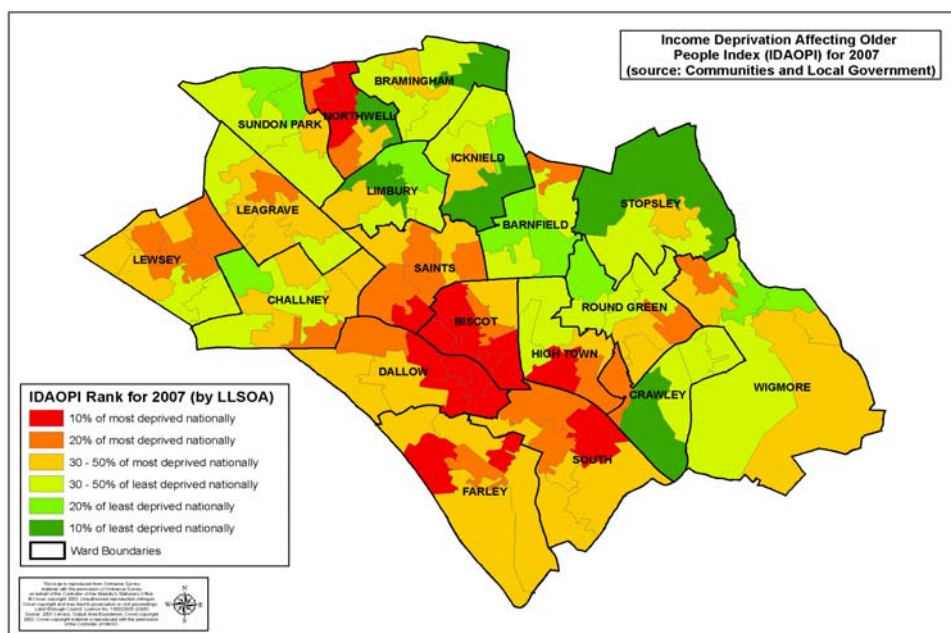
Adults with learning disabilities in settled accommodation (NI 145 and Vital Sign VSC06)	89%
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Source: ASC-CAR Return for 2008/09 for Luton Borough Council

Index of deprivation

Deprivation is also a factor that often affects poor housing and indicates potential levels of over crowding. Figure 8 shows the prevalence of income deprivation amongst older people.

Figure 8: Income deprivation affecting older people (60 year and over)



Source Luton Borough Council, IDAOP 2007

^v Source www.hm-treasury.gov.uk/d/pbr_csr07_psa16.pdf

^{vi} Source: www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_093377

Income

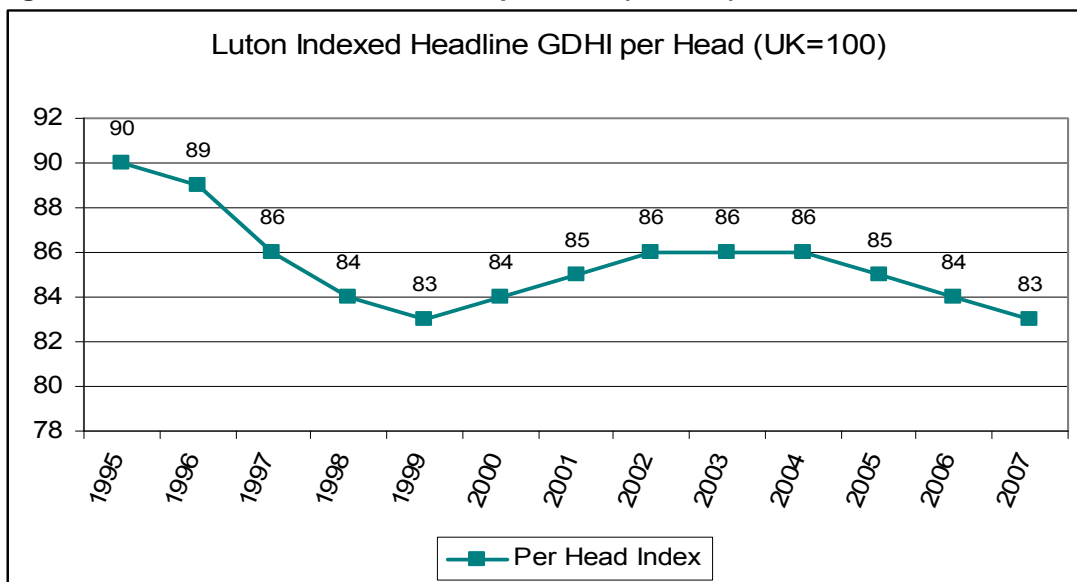
The 2007 Regional and Sub Regional Gross Disposable Household Income (GDHI) estimates illustrate the amount of money that individuals (i.e. the household sector) have available for spending or saving. This is the money left after expenditure associated with income, e.g. taxes and social contributions, property ownership and provision for future pension income. The latest estimates for 2007 show Luton's GDHI per head has increased from £11,432 in 2005 (reported in last years JSNA) to £11,935 in 2007, representing a 4.4% increase. The increase from 2005-2007 nationally and in the East of England has been much larger at 7.6% and 6.2% respectively. The table below shows the 2007 estimates and percentage difference from 2006 which also shows much larger increases nationally and in the region. Luton is the local area within the East region with the lowest indexed GDHI per head.

Table 6: GDHI Estimates 2007

Area	Total GDHI	% Increase on 2006	Total GDHI Per Head	% Increase on 2006	Per Head Index (UK=100)
UK	873,008	2.5	14,317	1.9	100
East of England	85,383	2.5	15,083	1.5	105
Luton	2,253	2.1	11,935	1.0	83

Source: Office for National Statistics © Crown Copyright

Figure 9: Luton Indexed Headline GDHI per Head (UK=100)



Source: Office for National Statistics © Crown Copyright

Figure 9 shows the indexed GDHI by Head for Luton is steadily decreasing from a relatively stable period 2002 – 2004.

Key Issues - 'Population of Luton':

This section highlights the key issues for Luton's population that commissioners will need to take into account when planning services:

- The population is relatively young and is projected to increase to 2016 and then decline
- The percentage of the population who are from BME communities is increasing
- The numbers of older people are also increasing, including BME communities with implications for long term conditions such as diabetes, heart disease and renal failure. (JSNA 2008)
- The increase in the number of older people and those with a limiting illness will impact on the need for suitable accommodation. (JSNA 2008)
- The population is diverse in terms of deprivation and BME communities with implications for some of the poor health outcomes (JSNA 2008)
- Luton has relatively high rates of unemployment, low income, housing needs including overcrowding and other factors that impact on health and social need. (JSNA 2008)
- Disposable income is decreasing relative to national average
- A significant proportion of older people live in the Council's own rented accommodation. (JSNA 2008)

3. Children in Luton

Introduction

The priority areas that were identified in the 2008 JSNA still remain. However the Children's Trust have agreed 3 new priority areas. These are:

- Transition across key periods in a child or young persons life - for example mental health services, disability services, from primary to secondary school and health care provision for young people with mental health services.
- Communication with children and young people
- Improvement in joint delivery - integration of services and the use of facilities including the use of capital resources.

Demography of Children and Young People in Luton

Ethnicity

Table 7: 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 background	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

Table 7 shows 63% of school age children^{vii} in Luton are from BME communities compared to 56% in the 2008 JSNA based on data from August 2006. The biggest ethnic groups in Luton schools are Pakistani/Kashmiri (22.8% compared to 19.6% in 2006), Bangladeshi (10% compared to 8.4%), Black African (5.6% compared to 5.2%) and Black Caribbean (4.6% - same as previous data in JSNA)

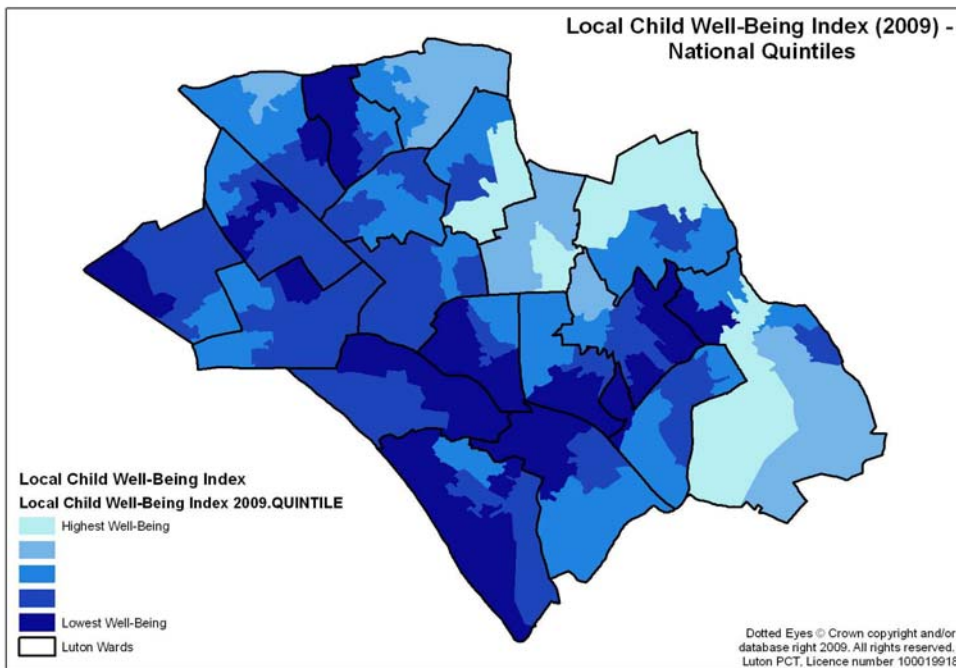
^{vii} Includes children from special and pupil referral units

Child Well Being Index

Communities and Local Government have produced a new index specifically looking at the well-being of children. It uses the same methodology as the Index of Multiple Deprivation but is not specifically a deprivation index. The index covers the major domains of a child's life that have an impact on child well-being (material well-being, health, education, crime, housing, environment and children in need)^{viii}.

Figures 10 and 11 show the overall child well-being score at lower super output area in Luton. Figure 10 shows the data by national quintiles and shows 30% of LSOAs in Luton are in the lowest well-being quintile compared to only 5% in the highest well-being quintile nationally. The areas of low well-being for children are concentrated in areas of high deprivation mainly in the west of Luton.

Figure 10: Local Child Well-Being Index – national quintiles

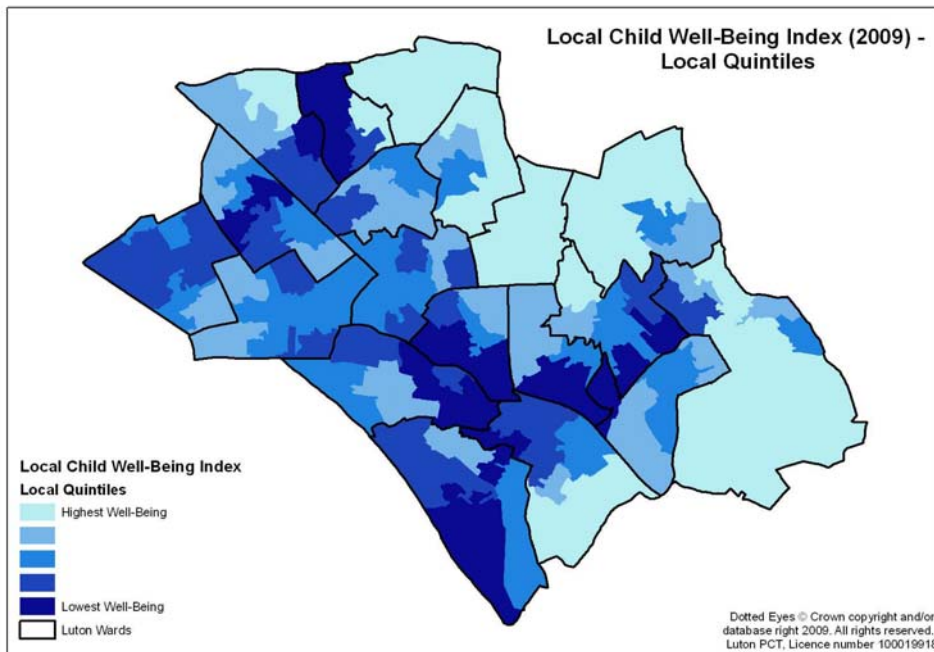


Source: Communities and Local Government, 2009

Figure 11 shows the same child well-being data but looking at quintiles within Luton rather than compared to nationally. This helps to identify which of the areas identified in Figure 10 are of the most concern with the lowest child well-being score. These appear to be mainly in parts of Northwell, Dallow, Biscot, Farley and High Town wards. The last four are priority areas and detailed needs assessments have been completed for each of these areas as well as Challney. The five needs assessments form part of this JSNA supplement and can be accessed at: www.lutonpct.nhs.uk.

^{viii} See <http://www.communities.gov.uk/publications/communities/childwellbeing2009> for more information.

Figure 11: Local Child Well-Being Index – local quintiles



Source: Communities and Local Government, 2009

Lifestyle factors

Obesity

Since the 2008 JSNA, further work has been conducted to help target resources and to provide a trajectory of this major public health issue.

The following maps are based on the most recent validated data (2007/2008) and the darker blue areas indicate where the greatest numbers of obese children in Year R and Year 6 live in Luton.

Figure 12: Year R Pupils Obese and Overweight by Lower Super Output Area (SOA) 2007-8.

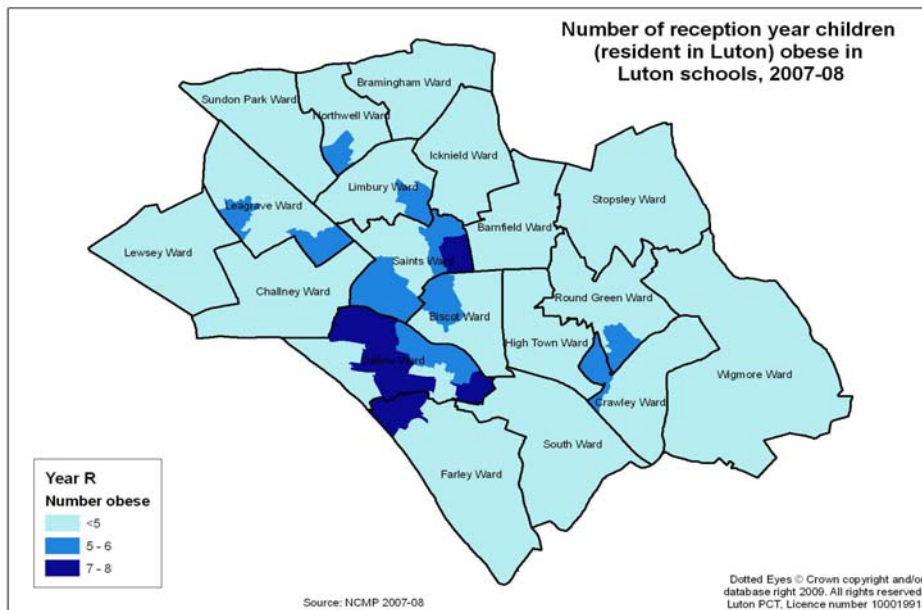
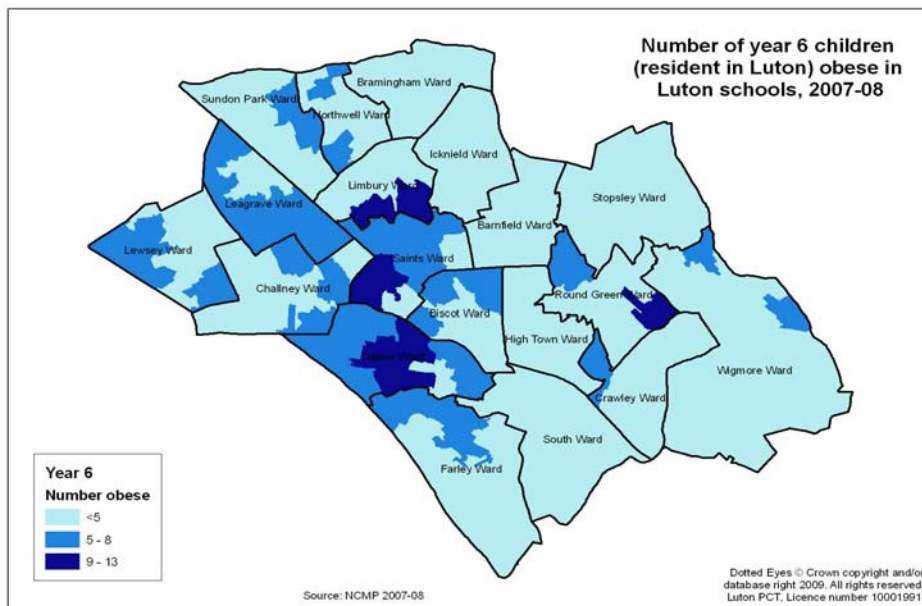


Figure 13: Year 6 Pupils Obese and Overweight by Lower Super Output Area (SOA) 2007-8.

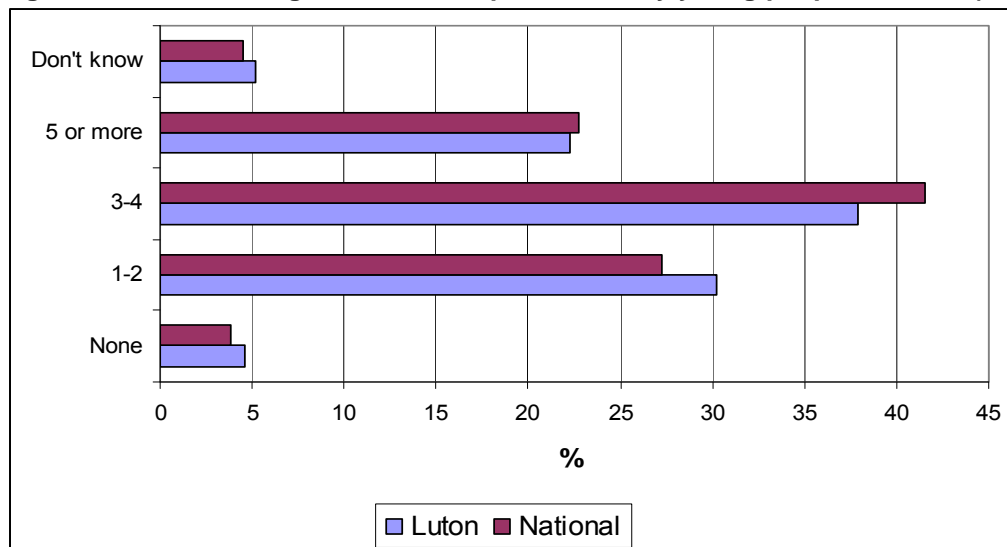


For Year R (4-5 year olds), the map suggests that Saints, Dallow, and the northern part of Farley all have pockets with high numbers of obese children (Fig 12). For Year 6 (10-11 year olds), the map suggests that the highest areas of obesity are more widespread, including areas such as Round Green, Dallow, Saints and Limbury (Fig 13). It is however important to note that cohort sizes vary across the areas. If we look at percentages of the NCMP cohort who are obese rather than numbers, Stopsley, Farley and Limbury for Year R and Limbury, Northwell, South and Dallow for Year 6 have the highest percentage.

Dietary habits

The TellUs3 survey (www.cypp.luton.gov.uk) is a survey of children and young people across England, asking their views about their local area, and including questions covering the five Every Child Matters outcomes. In Luton the proportion of children only eating 1 to 2 portions of fruit and vegetables a day (30%) is significantly higher than the national average (27%) which is a worsening situation from the data reported in the 2007 survey (27% and 26% respectively) where there was no significant difference.

Figure 14: Fruit and vegetable consumption eaten by young people in Luton (2008)



Source: Tellus3 survey 2008

Alcohol and Drugs

Since the 2008 JSNA, another detailed needs assessment has been conducted by Luton's Drug and Alcohol Partnership to establish changing trends in drug and alcohol use by young people under 18 in Luton.

The TellUs3 survey, a national survey of young people in schools conducted in Spring 2008, found that 40% of respondents from Luton aged between 8 and 16 had never had an alcoholic drink compared to 23% nationally, and only 8% of Luton respondents had ever taken drugs which is lower than the national figure of 11%.

This year a comparison with statistically similar areas, based on Criminal Justice indicators, showed that the proportion of young people receiving structured services in Luton is slightly lower than average and the male to female ratio is comparable with the other areas.

Comparison with Redbridge and Birmingham (similar areas based on Health indicators), indicated that Luton has a comparable number of young people using alcohol and drug structured services and completing interventions successfully.

The majority of young people accessing services in Luton use cannabis or alcohol only. There is a very small number of high risk young people who are experimenting with cocaine, crack and heroin.

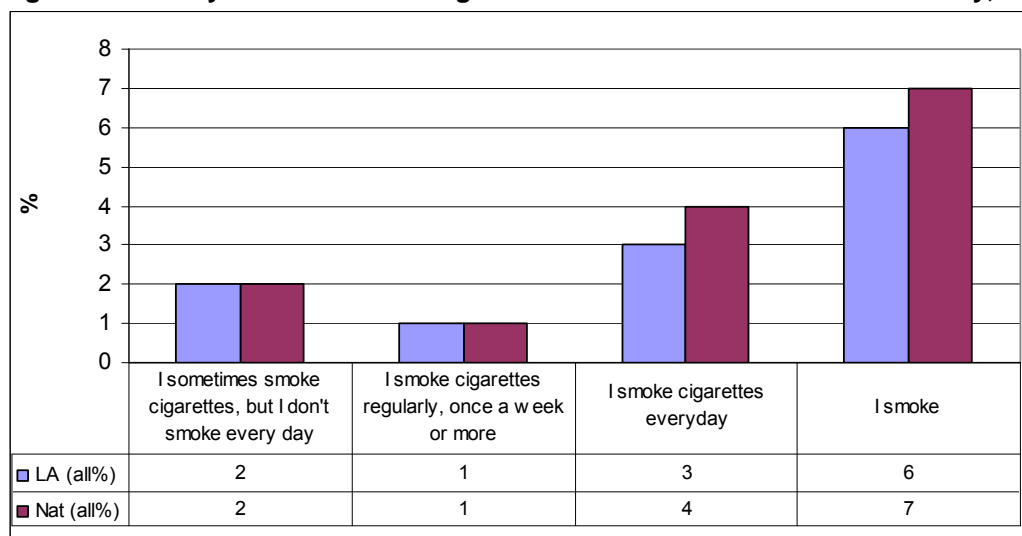
Most young people need information and brief advice and those requiring structured interventions often have complex needs in addition to their drug and alcohol concerns.

Smoking

Evidence indicates that children and young people who smoke under 16 may go on to smoke for the rest of their lives. The most recent data we have in Luton on the prevalence of smoking in under 16 year olds is taken from the annual Tellus3 survey (2008).

Responses about smoking mirrored the national picture - 79% saying they had never smoked a cigarette compared to a national average of 79%. 6% of young people indicated they smoked either regularly / occasionally compared to 7 % nationally.

Figure 15: Have you ever smoked cigarettes? - Results from the Tellus survey, 2008



Source: Tellus3 survey

Child and Adolescent Mental Health Services (CAMHS)

Since the last JSNA, LBC has commissioned a detailed needs assessment of Child and Adolescent Mental Health. This work is underway and will be available later in the year. The work draws heavily on the 2004 ONS report 'Mental Health of children and young people in Great Britain' which is a sound basis for prevalence estimates of child mental illness in Luton. It is also steered by the findings from 'Children and young people in mind' which is the final report of the National CAMHS Review. Table 8 below indicates the likely numbers of diagnosable conditions in Luton's school age child population if prevalence rates for mental illness are the same in Luton as they are nationally.

Table 8: Estimate of numbers of children with mental disorders in Luton by age and sex

Condition	5 – 10 yr olds			11 – 16 yr olds		
	boys	girls	all	boys	girls	all
Emotional disorders:	161	179	340	303	445	748
Anxiety disorders						
Depression	154	171	326	273	379	652
	15	21	36	76	139	214
Conduct disorders	506	200	706	614	372	986
Hyperkinetic disorders	198	29	227	182	29	211
Less common disorders	161	29	190	121	80	202
Any disorder	749	364	1113	956	751	1707

Source: ONS 2005 prevalence estimate applied to ONS 2007 mid-year population estimates

We believe that the prevalence rates included in the table above are likely to be an under estimate for a number of reasons:

- 1) There is a direct link between social deprivation and mental illness and there are a greater proportion of children living in deprivation in Luton than the UK overall. Therefore it is likely there will be more mental illness

and

2) LBC population estimates indicate that there are roughly 3000 or 6% more children in Luton than ONS estimates suggest. Therefore it is likely that the numbers included in the table should in fact be 6% higher than presented.

The ongoing needs assessment will pursue this line of enquiry.

The needs assessment will focus on the following vulnerable groups:

- Looked after children
- Asylum seeker and unaccompanied children
- Homeless children.
- Children in traveler families
- Children on the child protection register
- Children in contact with the youth justice system.
- Young carers
- Children using drugs and alcohol.
- Young people not in education, employment or training (N.E.E.T.).
- Children with disability
- Children with a statement of Special Educational Need.

The next update of the JSNA will highlight any commissioning priorities arising from the needs assessment.

Children and Young People with Disabilities

Since the 2008 JSNA, there has been a detailed assessment of the likely numbers of children with disability in Luton. This was undertaken to support the *Aiming High for Disabled Children* programme and in particular to understand the numbers of children and young people likely to benefit from access to short breaks provision.

Estimating the numbers of children and young people with disabilities is difficult. However, the population of Luton is young, relatively deprived, and has high scores for a number of risk factors broadly associated with disability. This leads to an expectation that the prevalence of children with disability is higher in Luton than regional and national rates.

Number of children and young people with disabilities

Based on the Thomas Coram report methodology which uses national data on the number of children and young people claiming Disability Living Allowance (DLA) and the number of children and young people having a SEN Statement, the disability estimate for Luton falls between 1676 and 3017 children.

Number of children and young people who are severely disabled

Using the 'Aiming High' estimates that between 1.0 and 1.2% of the child population are likely to have a severe disability, based on the LBC population estimate for 2008 there are between 559 – 670 children with a severe disability in the borough.

A second route to estimating numbers of children with a severe disability is to consider the number of DLA claims at the highest level. In August 2008 there were 1,200 claimants less than 16 years of age and 1,370 less than 18 years of age. Those claiming the higher rate can be considered as a proxy

measure for severe disabled. Using this methodology there are likely to be in the region of 546 children with a severe disability.

It is important to note that it is generally accepted that there are children for whom DLA support is appropriate but they do not claim.

Data and information contributing to understanding

Data on Long Term Limiting Illness, social class breakdown, and numbers of low birthweight babies all contribute to the view that numbers of children with disability is likely to be at the upper end of the range indicated above.

Health datasets may also help the understanding of disability in Luton. For example in 2008 the Child Health Development Centre were in contact with 1634 children and young people (almost 3% of the child population) 16.9% were under 5, 76.7% were 5-15 and 6.4% were 16-19 years. Over the last 3 years service contacts have increased year on year. Many of these children are likely to be considered to have a disability, and they may be different to those known through Special Education Need or Disability Living Allowance.

A large number of children and young people with disabilities are supported within health services and the information gathered from these may well compliment the dataset already described.

Future numbers of children with disability

Population projections suggest that there will be an increase in the child population overall in the next 7 years. They also suggest there will be a large increase in the under 5 population in the next 5 years. This may have considerable impact on the need for services as much of the disability in the under 5 population is not yet diagnosed.

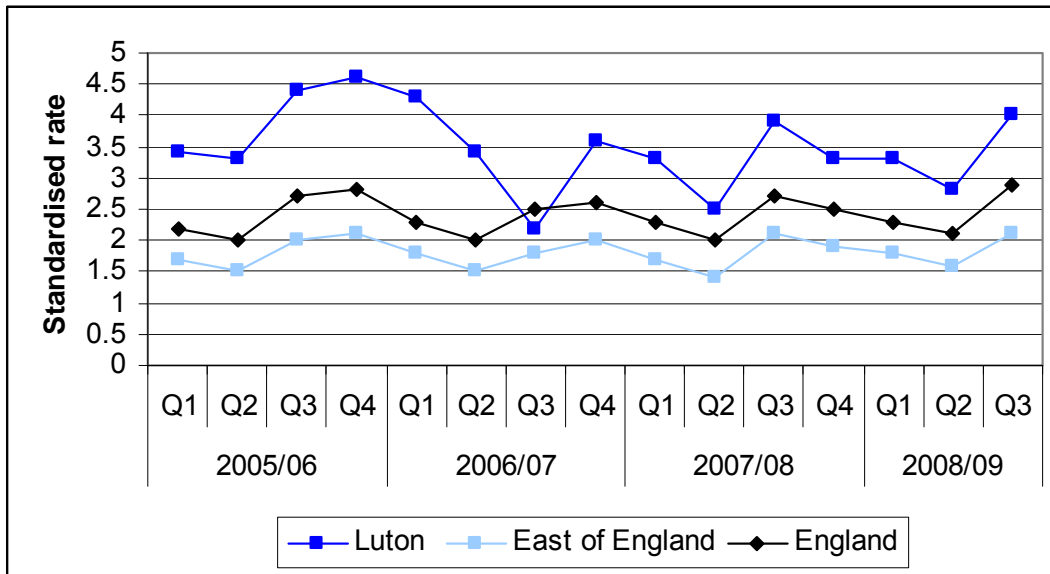
For more detailed information please see the detailed Needs Assessment on www.cypp.luton.gov.uk

Social Care Provision

Emergency and Urgent Care for Children in Luton

Luton has a very young population with approximately 28% being under 19 years. It also has a comparatively high rate of emergency hospital admissions per 100,000 compared with both the East of England and national data. A significant number of children visit the Emergency Department at the Luton & Dunstable Hospital each year. Figure 16 shows standardised rates for emergency paediatric admissions for Luton PCT from 2005/06 to 2008/09. It shows Luton rate has consistently remained higher than England and East of England.

Figure 16: NHS Luton: Emergency Admissions to Paediatrics (Q4 05/06 to Q3 08/09)



Source: NHS Comparators July 2009

Table 9: Emergency Department (A&E) Attendances

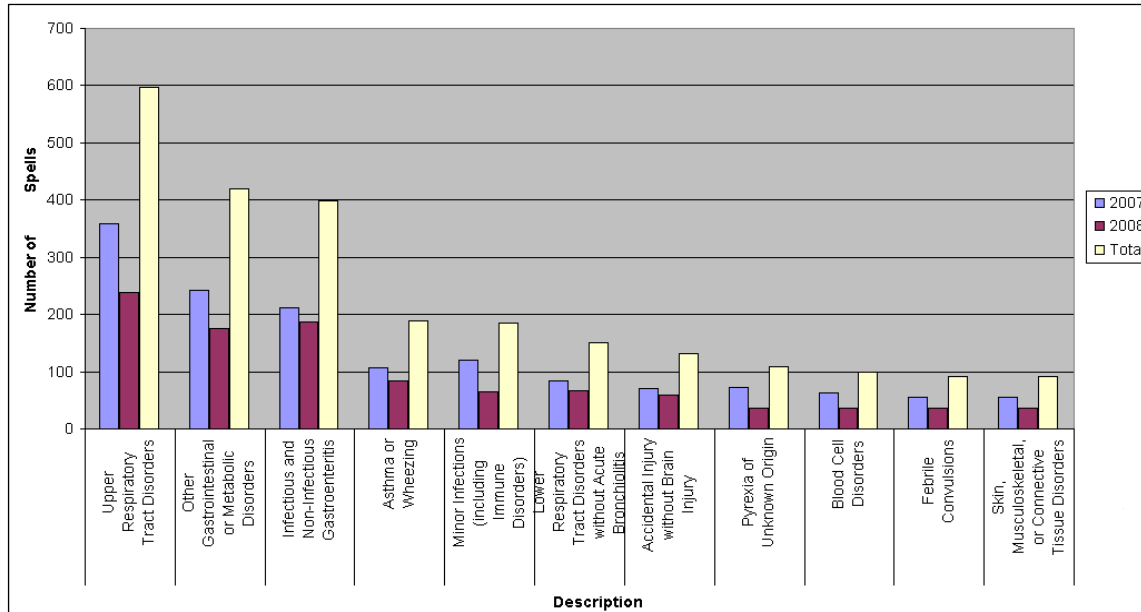
Area	2006/7	2007/8	2008/9
Emergency Department Attendances All Ages - Total	77586	61615	58584
Emergency Department Attendances under 16 - Total	16210	10967	10188

Source: Footman Walker System L&D

Table 9 shows emergency department attendances at the Luton and Dunstable hospital have been decreasing in all ages from 2006-07 to 2008-09 (-24.5%), however a larger decrease has been seen in attendances for children under 16 (-37.2%). This may be as a result of the new Primary Care Urgent Care Centre which was co-located with the Emergency Department in 2007. Approximately 6000 children are seen each year between 18-30hrs and 08-00hrs.

The most commonly occurring conditions that children are admitted to hospital for can be seen in Figure 17. It shows admissions have decreased from 2007 to 2008 in all conditions but the top three conditions have remained the same over the two years as upper respiratory tract disorders, other gastrointestinal or metabolic disorders and infectious and non-infectious gastroenteritis.

Figure 17: Top Ten Health Resource Groups for Paediatric Emergency Admissions in Luton



Source: NHS Luton 2009

In order to address the high number of emergency admissions, Luton is the designated Rapid Improvement Site for the East of England SHA. Working with the NHS Institute for Innovation and Improvement representatives from all parts of the health community acute paediatric and emergency, community, primary care, ambulance service etc are working together to improve clinical pathways commencing with “The Management of Feverish Illness in Children”.

This work is based on best practice including NICE Guidelines and has been localised following input from the public and professionals in Luton.

Further pathways will be developed for respiratory and gastro-intestinal conditions to address the high volume of activity in these areas.

Key Issues: ‘Children in Luton’

This section highlights the key issues for children that commissioners will need to take into account when planning services:

Child Poverty:

- A child poverty needs assessment will be carried out locally by April 2010 and the recommendations from this work will inform future commissioning decisions.

Obesity:

Prevention:

- Re-directing resources to ensure greater emphasis and better co-ordination of interventions to prevent overweight and obesity with a particular focus on pregnancy, early years and school age children.
- Increasing access to fruit and vegetables particularly in priority areas

Weight Management:

- Extending the reach of the MEND programme for 7-13 year olds and commissioning additional programmes to support children and young people between the ages of 2 and 18 years who are overweight or obese and children and young people who have co-morbidities and more complex needs
- Making effective use of child measurement data to target services more effectively and to establish local targets (JSNA 2008)
- Extending training for clinical and non clinical front line staff to develop skills and knowledge on early identification and lifestyle changes and ensure consistent messages are given out

Alcohol:

- Maintain and develop the comprehensive range of services available from prevention to interventions
- Ensure information and support are available for young people who are vulnerable and at risk
- Continue to develop of harm reduction provision
- Increase the flexibilities of services
- Conduct further work on care pathways and access to lifestyle activities
- Increase understanding of the needs of extremely vulnerable young people

Smoking:

- Enforce legislation about sales of tobacco to under 18s (JSNA 2008)
- Identify effective interventions to prevent young people from starting to smoke
- Ensure services accessible to support young people to quit (JSNA 2008)

Mental Health:

- Focus on prevention through the roll out of early intervention services to all schools in Luton plus 0-5 year old service
- Review service provision for 16-17 year olds including access to in-patient facilities to ensure compliance with new Mental Health Act requirements.
- Develop clear guidelines to cover all aspects of transition both to adult services and between services at all ages
- Complete needs assessment to inform strategic direction for next three years

Children and Young People with Disabilities:

- Build on initial needs assessment to develop more in-depth understanding of profile of children with disabilities in Luton to enable more informed service planning including by location, severity, disability type, gender, ethnicity and age group.
- Develop overarching strategy and steering group to coordinate services for children and young people with disabilities and ensure services are in place to meet growing demand.
- Complete research commissioned by the CYPSP to assess the needs of children and young people from the South Asian communities
- Develop clear guidelines to cover all aspects of transition to adult services

Emergency Admissions

- Review model of urgent care provision for children and young people
- The top 3 conditions for children's emergency admissions are upper respiratory tract disorders, other gastrointestinal or metabolic disorders and infectious and non-infectious gastroenteritis.

4. Individual lifestyle factors

The 2008 East of England lifestyle survey^{ix} was conducted to obtain more accurate figures of lifestyle behaviours for PCTs in the East of England (a summary of the survey is provided in appendix 2).

Smoking

Table 10: Smoking prevalence

Indicator	20% most deprived MSOAs	80% least deprived MSOAs	NHS Luton	East of England
Smoking prevalence	23.1% (20.2- 26.2)	20.5% (18.6 - 22.6)	21.1% (19.4 - 22.8)	18.4% (17.8 – 19.1)
Proportion of current smokers who would like to quit	68.2% (64.2 – 78.1)	69.2% (67.3 - 77.5)	69.0% (68.0 - 76.4)	65.4% (66.5 -70.2)

Source: East of England Lifestyle Survey 2008, ERPHO

The East of England lifestyle survey results show Luton to have a smoking prevalence much lower than our estimated modelled prevalence for 2003-2005 (27.3%)^x. Overall in Luton 21% of the population are now thought to smoke compared to 23% in the most deprived areas. This compares to a prevalence of 18.4% in the East of England as whole. Of these current smokers 69% of those asked, expressed an interest to quit.

In 2008-09, The Luton NHS Stop Smoking Service supported 1454 people to quit smoking. This exceeded the vital signs target of 1384 and the LAA stretch target of 1400. The 16+ smoking rate prevalence (NI 123) is a key indicator in our LAA and actions are in place to prevent the uptake of smoking and support smokers to quit.

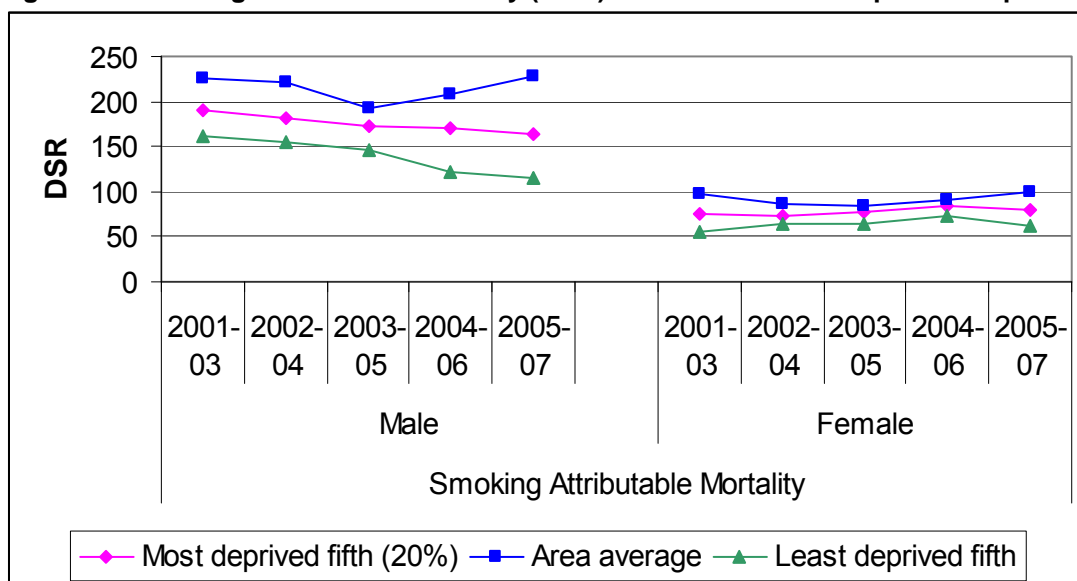
Mortality from smoking

The 2008 Health Inequalities Profile from the Eastern Region Public Health Observatory (ERHPO) shows smoking attributable mortality in males has gone down in the least deprived fifth and Luton overall, however has increased for the most deprived group. This has widened the health inequalities gap for smoking attributable mortality in males. For females the inequality gap is smaller than males and despite narrowing in 2004-06 (mainly due to an increase in mortality in the least deprived group) it has now widened (2005-07). The least deprived groups and area average mortality rates have started to decrease in recent data but the most deprived has continued to increase therefore widening the gap between the two (Figure 18).

^{ix} Ipsos MORI (2008). 2008 East of England Lifestyle survey. East of England SHA available at Eastern Region Public Health Observatory (ERPHO)

^x NatCen (2008). Neighbourhood Statistics: Model Based Estimates of Healthy Lifestyle Behaviours at PCO level 2003-05. The Information Centre, 2008.

Figure 18: Smoking Attributable Mortality (SAM) in Luton PCT and deprivation quintile



Source: ERPHO Health Inequality Profile, 2008

Diet and Physical Activity

Diet

Table 11: Healthy Eating

Indicator	20% most deprived MSOAs	80% least deprived MSOAs	NHS Luton	East of England
Eats 5 portions of fruit or vegetables < 1 day per week	24.1% (21.2 – 27.3)	17.2% (15.4 – 19.1)	18.8% (17.2 – 20.4)	14.5% (13.9 – 15.1)
Eats 5 portions of fruit or vegetables 5-7 days per week	25.9% (22.9 – 29.1)	36.2% (33.8 – 38.6)	33.9% (31.9 – 35.9)	41.9% (41.1 – 42.8)

Source: East of England Lifestyle Survey 2008, ERPHO

The East of England lifestyle survey results show that 5 a day consumption of fruit and vegetables is significantly lower in Luton compared with the region, and there is a significant inequality between the most deprived areas and the rest of the PCT, with the most deprived areas eating less fruit and vegetables on average.

Physical Activity

There are two main sources of local information on physical activity in adults, the 2008 'Active People' survey and the 2008 East of England lifestyle survey. Both are telephone surveys conducted by the same company (Ipsos MORI) but the measures are slightly different. The Active People Survey is measuring moderate activity on at least 3 occasions a week for 30 minutes whereas the lifestyle survey is looking at physical activity for 30 minutes five times a week. There are other differences in questions and methodology which mean results cannot be compared, more details can be found on the ERPHO website (<http://www.erpho.org.uk/lsr/lsr.aspx>) and the Active People website (<http://www.sportengland.org>).

The Active People survey shows a worsening position in the number of adults taking part in the recommended levels of physical activity (Table 12). The East of England lifestyle survey results

(Table 13) show the proportion of men and women undertaking the recommended amount of physical activity are significantly lower than the regional average.

Table 12: The percentage participating in moderate intensity activity (sport and recreation activity) on at least 3 occasions of 30 minutes per week in previous 28 days.

	Luton		East of England		England	
	2007	2008	2007	2008	2007	2008
All	17.8%	15.2%	20.5%	21.2%	21.0%	21.3%
Male	20.7%	n/a	22.5%	23.4%	23.7%	24.2%
Female	14.9%	n/a	18.7%	19.2%	18.5%	18.6%

Source: 2008 Active People Survey

Table 13: Proportion of people participating in 30 mins activity 5 days a week.

Indicator	20% most deprived MSOAs	80% least deprived MSOAs	NHS Luton	East of England
Male – high level of physical activity	41.0% (35.7 – 46.4)	43.0% (39.4 – 46.6)	42.6% (39.5 – 45.7)	46.7% (45.9 – 48.4)
Female – high level of physical activity	31.9% (27.7 – 36.6)	34.0% (30.9 – 37.3)	33.5% (30.9 – 36.3)	39.8% (38.6 - 41.0)

Source: East of England Lifestyle Survey 2008, ERPHO

Alcohol

Table 14 and Table 15 show data from Luton’s alcohol profile produced by the North West Public Health Observatory (NWPHO).

The highest ranked indicator (the higher the rank the worse the indicator) is alcohol related recorded crimes and alcohol related violent crimes ranked 122 and 100 highest out of 152 in the country. Other indicators of most concern appear to be deaths from alcohol attributable conditions in males ranked 97th highest and hospital admissions related to alcohol, in particular for males. Claimants of incapacity benefits, where medical reason is alcoholism, are more than double the average rate in the East of England.

The majority of indicators appear higher than the regional average however there are some indicators that show a better and more positive performance. These include deaths from alcohol specific conditions in females, alcohol specific hospital admissions in females and hazardous drinking estimates.

Table 14: Alcohol profile for Luton – NWPFO alcohol profiles

Indicator Measure	Description	Rate	Year	Sex	Measure	National Rank ^{xi}	Regional Average
Months of life lost	Increase in life expectancy at birth that would be expected if all alcohol-attributable deaths among persons under 75 years were prevented.	Estimate	2004-06	M	10.1	74	7.9
iMonths of life lost				F	4.2	61	3.8
Alcohol-specific mortality	Deaths from alcohol-specific conditions	DSR per 100,000 pop	2004-06	M	13.4	81	8
				F	3.6	26	4.4
Mortality from chronic liver disease	Including cirrhosi	DSR per 100,000 pop	2004-06	M	12.6	66	8.3
				F	6.7	74	5.4
Alcohol-attributable mortality	Deaths from alcohol-attributable conditions	DSR per 100,000 pop	2006	M	45.2	97	32.3
				F	14.6	46	14.4
Alcohol-specific hospital admission		CR per 100,000 pop	2004-07	< 18 year olds	36.8	23	39.6
		DSR per 100,000 pop	2006-07	M	359.4	73	233.8
	F	112.2		17	119.2		
Alcohol-attributable hospital admission	Does not include attendance at A&E.	DSR per 100,000 pop	2006-07	M	1316.3	90	992.4
				F	712.5	86	555.6

Source: Local Alcohol Profile – profile of alcohol related harm for Luton, NWPFO

^{xi} This is the rank of the local indicator value among all 152 primary care organisations in England. A rank of 1 is the best and a rank of 152 the worst. For the indicator related to employees in bars a rank of 1 is the highest and rank of 152 the lowest (what is better or worse has not been determined).

Table 15: Alcohol profile for Luton – NWPFO alcohol profiles

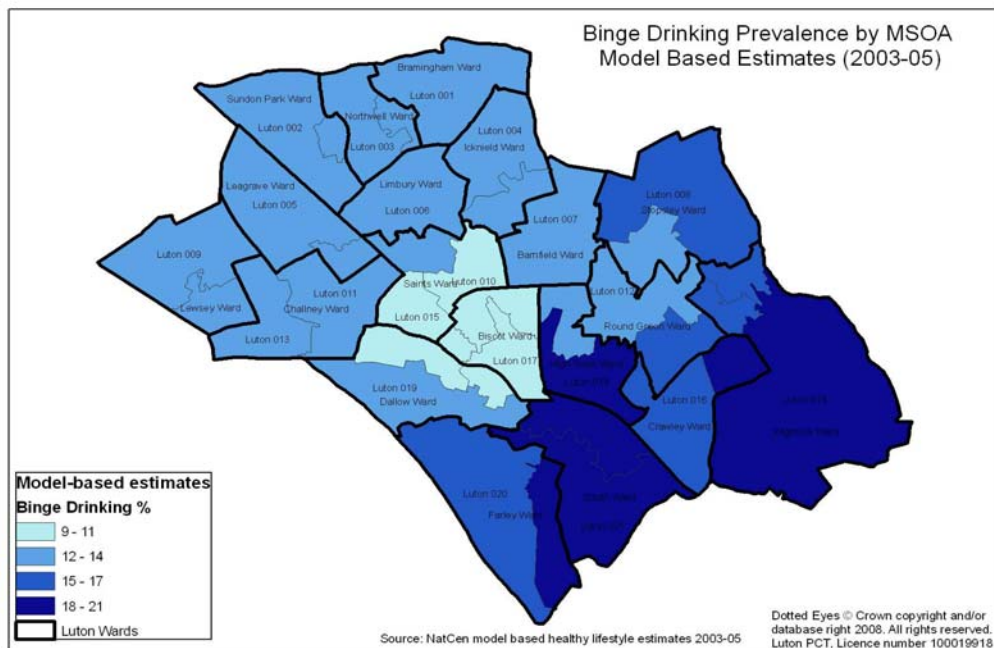
Indicator Measure	Description	Rate	Year	Measure	National Rank ^{xi}	Regional Average
Hospital admissions for alcohol related harm	Admissions for alcohol related injury's	DSR per 100,000 pop	2006-2007	1,740	30	1,235
Alcohol-related recorded crimes	Where arrestees test positive for alcohol by the strategy unit	CR per 1,000 pop	2007-2008	12.7	122	12.7
Alcohol-related violent crimes				7.1	100	4.9
Alcohol-related sexual offences				0.2	118	0.1
Claimants of incapacity benefits - working age	Medical reason is alcoholism	CR per 100,000 pop	2006-2007	152.3	95	72.6
Mortality from land transport accidents	Alcohol irrefutable reaction applied to obtain results	DSR per 100,000 pop	2004-2006	1.5	55	2.2
Hazardous drinking (synthetic estimate)	Consumption of 22-50 males and 15-35 females	% of all pop	2001/2005	16.3	12	18.7
Harmful drinking (synthetic estimate)	16 year or over based on more than 50 units a week	% of all pop	2005	4.6	51	4.3
Binge drinking (synthetic estimate)	Men who consume 8 units or more/women 6 units or more	% of adults	2003-2005	16.1	63	15.2
Employees in bars - % of all employees	Number of employees	% of all pop	2006	1.1	9	1.9

Source: Local Alcohol Profile – profile of alcohol related harm for Luton, NWPFO

Binge drinking

Figure 19 shows the binge drinking estimates within Luton and highlight that areas in south of Luton have the highest estimates which are mainly concentrated in and near the town centre and airport. Neighbouring areas (such as Dallow and Biscot) have relatively low estimates mainly due to higher Asian ethnic groups in these areas.

Figure 19: Binge drinking estimates by MSOA (2003-05)



Vulnerable Groups

Gypsies, Roma and Travellers

In 2008, a local health needs assessment was carried out with the Gypsy, Roma and Traveller community in Luton. This is a summary of the key findings. A copy of the full report can be accessed at http://www.luton.gov.uk/internet/health_and_social_care/social_policy. This report supports the JSNA supplement.

Luton's Community

Luton has one authorised site on St. Thomas' Road, located in the east of Luton. A Housing Needs Assessment of Gypsy, Roma and Traveller People identified that approximately 15 extra pitches are required – although the total numbers of caravans from the bi-annual count show consistent numbers. Whilst extra pitches are required for families who are highly mobile, many Gypsies, Travellers and Roma people are housed in temporary accommodation. This is because family members fall sick and therefore the requirement for a static environment becomes an important need for the health and wellbeing of the individual.

Although housing families is important, it often conflicts with the culture and lifestyle of Gypsies, Roma and Travellers. Data collected from the health needs assessment shows that some of the housed Travellers live in wards of high deprivation (although there is no pattern) this information is congruent with national research.

There are very few services specific to Gypsies, Roma and Travellers, however national research^{xii} suggests that there is no expectation from the community to have this. Luton has an enhanced GP service which is aimed at tackling the health needs of the community. In addition there are two part-time community nurses who are contracted to attend the needs of highly mobile families who arrive in

^{xii} G. Parry et al (2007) Journal of Epidemiology and Community Health, Health status of Gypsies and Travellers in England

Luton and may need medical and health care, for example help with registering as a temporary patient. This work is complimented by the work of the Gypsy and Traveller liaison officer, who offers support, advocacy for all Gypsy, Roma and Travelling people in Luton (irrespective of whether they are new to Luton or housed/on caravan site).

An Irish Housing Association called CARA based in Luton and funded by Luton Borough Council's (LBC) Supporting People Programme works with mainly Irish Travellers supporting them with benefits and sign posting to other services. Luton's Equalities and Diversity Team within LBC's school improvement unit support the educational needs of families and children.

From those surveyed at the authorised site on St Thomas' Road, 100% were registered with a GP which holds the Local Enhanced Service (LES) for the Homeless and Gypsies and Travellers. Over half surveyed were either in charge of medication for others or were on medication.

A majority of respondents (80%) or someone in the family had a long standing illness, disability or infirmity. 70% of respondents were able to say that either they or someone in their family suffered from anxiety or depression. Women expressed an interest in wanting more health promotion on various lifestyle issues.

Key Issues: Individual Lifestyle Factors

This section highlights the key issues relating to Individual Lifestyle factors that commissioners will need to take into account when planning services:

Smoking:

- The East of England lifestyle Survey (2008) shows Luton's smoking prevalence to be 21% overall and 23% in the most deprived areas, much lower than the estimated prevalence for 2003-05 (27.3%) reported in the 2008 JSNA.. The average smoking prevalence for the East of England is 18.4%
- Smoking prevalence by ward shows significant variation highlighting the inequalities which exist with smoking (JSNA 2008)
- There is under use of the Stop Smoking Service by Bangladeshi/Pakistani men where there is high prevalence of smoking (JSNA 2008)
- There is under use of the Stop Smoking Service by pregnant women (JSNA 2008)
- There are widening inequalities in mortality from smoking, in particular for males with decreasing rates in the least deprived areas and Luton overall and increasing rates in the most deprived areas. Resources need to be targeted at men in the most deprived quintile

Diet :

- Commission a range of weight management services to support adults to lose weight (JSNA 2008)
- Increase access to fruit and vegetables in the 5 priority areas of Luton. The East of England lifestyle survey shows significant inequality in consumption of fruit and vegetables between the most deprived areas and the rest of the PCT.

Physical activity:

- There are high levels of inactivity in Luton compared to the East of England and National average (JSNA 2008). A continued focus on increasing adult participation in physical activity needs to be maintained

- There are significant variances in inactivity by socio economic classification – 65% of people from NS SEC 5-8^{xiii} were inactive in Luton compared to 46% amongst NS SEC 1-4 (JSNA 2008).
- There are low levels of female participation and a substantial variation between male and female participation. A continued focus on increasing female participation in physical activity needs to be maintained
- There is comparatively low participation amongst ages 16-34, 35-54 and 55+ - Luton has significantly lower participation rates across these age groups than the East of England. When compared with Bedfordshire, participation was low across all age groups from 16-55+ (JSNA 2008).
- Participation varied across super output areas – there were distinct areas of inactivity to the west of Luton with middle to high levels of participation found in the south east and north of Luton (JSNA 2008).

Alcohol:

- Alcohol appears to be a bigger problem in males than females with higher deaths and hospital admissions related to alcohol. Action needs to be focus on addressing alcohol related issues with the male population
- Interventions need to focus on reducing alcohol related recorded crime and alcohol related violent crime

Gypsies and Travellers

- Improve access to primary and secondary care health services
- Ensure all staff working with the community receive cultural awareness training
- Identify best practice to increase engagement with traveller men
- Improve children's oral health (JSNA 2008)
- Improve attendance for children's eye or ear appointments (JSNA 2008)
- Action to address the mental health issues within this community (JSNA 2008)

^{xiii} NS SEC was developed in 2001 by the Office of National Statistics. The National Statistics Socio Economic Classification replaces the former Social Class based on Occupation and Socio-economic Groups. In summary, NS SEC 1-4 relates more closely to former categories A,B,C1 and NS SEC 5-8 relates to C2, D, E.

5. Social Care Needs and Activity

The full extent of social care needs across the borough is difficult to determine. The most reliable records are from those people who present themselves to the local authority for provision of a service, but this may not always reflect the true level of need, for example those with a learning difficulty (see page 45 section 5 JSNA 2008).

Like many other Councils, Luton has traditionally targeted resources to those who have the most complex needs. With the growing and changing needs of the population this narrow focus needs to change. The statutory duty to deliver social care is only one dimension of a much broader role that the health and well-being partnership needs to undertake.

The future vision for adult social care in Luton – summary:

- The statutory duty of social care is just one dimension of a much broader role.
- The sustainable community’s strategy sets out the need to focus on prevention and early intervention and to supporting people to live independently.
- This is particularly important with the aging populations.

An assessment is completed for any person with a presenting need, and the assessment identifies and evaluates the individual’s presenting needs and associated risks to independence. The seriousness of the risk to independence is then graded into four bands: ‘critical’; ‘substantial’; ‘moderate’; and ‘low’. Like most councils, Luton Borough Council provides services only to those with ‘critical’ and ‘substantial’ levels of need, and signposts all others to a range of agencies providing ‘preventative services’, some of which it also funds.

Figures given below relating to the total number of adults receiving social care services, does not represent data about all need, but only about ‘critical’ and ‘substantial’ need.

The Council is judged on its ability to help people to live independently. In 2008/9 the following numbers were helped.

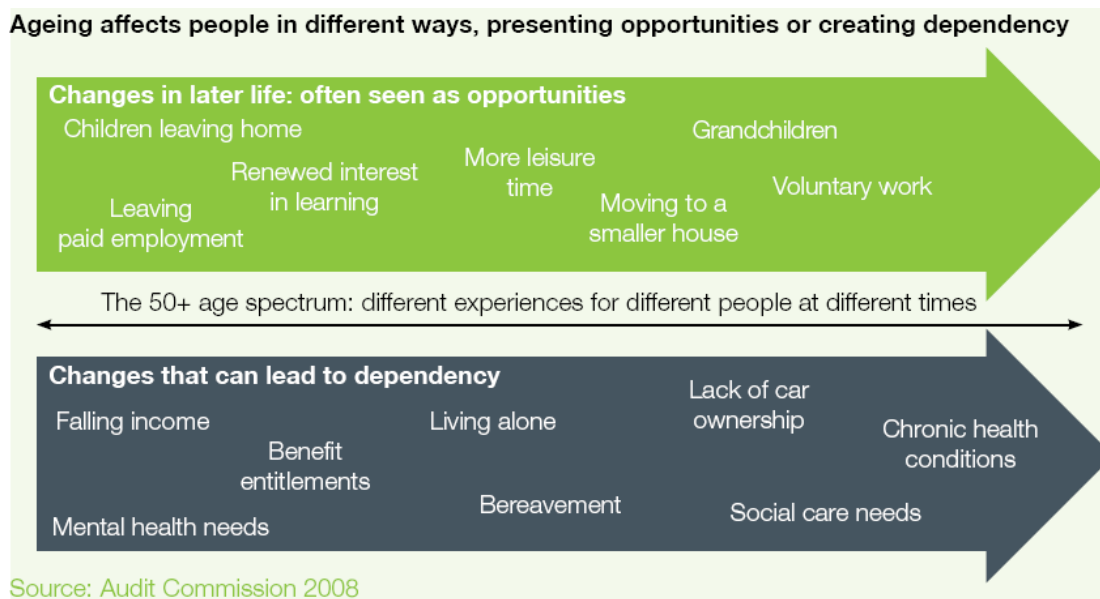
People supported to live independently through social services (NI 136 and Vital Sign VSC03)	2162
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Older people

The national picture

Older people are not a homogenous group that is easily categorised. People in later life have varied experiences. Some people live independently in the community into their 80s and beyond, whereas some younger older people need assistance relatively early in life.

The diagram below shows the diversity of the impact of aging in the 50+ population.



The same document highlights common misconceptions about older people.

Common misconceptions relating to older people

Myth	Fact
“50-65 year olds have good incomes, good social lives and are in good health...”	The unemployment rate of those aged 50 to state pension age is higher than the rest of the working population
	After age 50 annual average pay falls for the first time in working life
	Just over 25% of 50-64 year olds reported a long term illness or disability
	25% of all women aged 50-54 are currently providing unpaid care for a family member, friend or neighbour
“Over 65s are dependent, frail and disengaged...”	Only 15% of people over 65 receive social care
	Only 3% of people over 65, 18% of people over 80 and 28% of people over 90 live in residential care.
	Only 20% of people over 80 suffer from dementia
	75% of people aged over 65 voted in the 2005 General Election

Source: Audit Commission and additional sources, 2008

Older People’s Priorities Nationally

The following were identified as priorities by Age Concern based on 9 focus groups of older people **::

- Improving the range of support for carers – there is still much more to do in recognising and meeting carers’ needs and wishes.
- Making services personal and holistic – focusing on the wishes and aspirations of the individual rather than a series of tasks.
- Recognising the impact of isolation, and the role that social care can play in helping to combat this, and in improving well-being.
- Joining up health and social care at the point of service delivery so that an older person or carer has one point of call.
- Tackling inequalities – help must be available to poorer areas and poorer people.
- Giving people adequate time for discussion – with GPs, home carers and others.
- Considering the transport implications of changes to services and the costs that the individual will have to meet.

- Improving people's ability to eat healthily, especially where food provided by others.

** *Age Concern report: 'What older people want from community health and social care services 2006'*

The Luton Picture

In Luton the University of Bedfordshire was commissioned to evaluate services developed under the partnership for older people (POPP) to extend day opportunities for older people with mental health needs. This report '*Qualitative and quantitative needs analysis findings forms part of the JSNA 2009 supplement and can be accessed at*

http://www.luton.gov.uk/internet/health_and_social_care/older%20people's%20support%20and%20advice:

Part of the focus was to gather data and analyse responses from older people (50+) about the way in which they would like services to be developed.

The summary of this research is shown below, but as information was gathered from focus groups in the main, it is likely this research underestimates the numbers with severe difficulties, those who are isolated and those who need help but do not receive it.

Daily home life

- ❖ Making meals (23% had difficulty), shopping (42% had difficulty) and housework (37% had difficulty)
- ❖ Personal Care and Safety (24% had difficulty with washing, 17% with use of toilet and this rose to 19% in the African Caribbean community and 19% in the Asian Community)
- ❖ Large numbers of people with difficulties in managing at home underlined the need for accessible information about sourcing help and in some cases on an 'as needed basis
- ❖ Long delays in accessing aids and adaptations to help with personal care

Mobility and transport

- ❖ Getting about (*37% had difficulty*)
- ❖ Moving from bed or chair (*16% could not move without assistance*)
- ❖ Carers who lift and move individuals have a need for information about aids and training for lifting techniques
- ❖ Long delays in accessing aids and adaptations to help with personal care
- ❖ Information about new and second hand equipment and fitters readily available.

Health

- ❖ Engagement in Health promoting activities (*64% took regular exercise, but this dropped to 29% in those aged over 85*)
- ❖ Mild and moderate mental health problems (*45% indicated they felt low or sad, 40% felt worried or anxious, 36% felt they felt they needed more company and 26% quite often felt they couldn't cope*)
- ❖ The need for more appropriate exercise for all age groups
- ❖ The need for activities, trips and sociable activities
- ❖ The need to support lonely and isolated older people in all sections of the community.
- ❖ The need to target groups with a 'health risk', giving more information about options to help with hearing, sight and incontinence problems and mental health problems such as depression.

Finance

- ❖ Cost of Living (*30% had difficulty keeping the house warm. Difficulties were exacerbated for members of the BME groups who did not speak English as a first language*)
- ❖ Financial Abuse (*this was not considered a problems by older people in the sample*)
- ❖ The need for more targeted support for older people to claim and receive entitlements, help with insulation etc.

Housing and Neighbourhood

- ❖ Crime issues (*20% complained of high crime rates in their neighbourhood*)
- ❖ Accessing services (*the majority of people felt that their knowledge of what local services are available is low*)
- ❖ Use of Internet (*only 8% used the internet to pay bills, shop or manage*)
- ❖ The need for more positive information about the low probability of becoming victims of crime in tandem with promoting information about home and personal security.
- ❖ Improved information to support individual's independence with simplified process for claims and entitlements.
- ❖ Access to information through places like doctor's surgeries and the shopping mall, including dedicated newspaper, leaflets, publicity, but in formats that are cheap for wide distribution.
- ❖ Local agencies to share information to build on existing work
- ❖ Essential to provide information to those not entitled to statutory services, especially information about the voluntary sector
- ❖ Computer classes aimed at older people

The needs of hard to reach older people

- The majority of people in this category were aged between 50 and 59 and mostly male.
- There was a much higher proportion of indicators of distress (two thirds took medication or received treatment for mental health problems).
- Arthritis was the most frequent cited health problem, followed by respiratory, heart/stroke and diabetes.)
- Appropriate day centres were considered critical by this group.

Source University of Bedfordshire 2008 –Qualitative and quantitative needs analysis findings

Physical disability, frailty and sensory impairment

The majority of people accessing services with a physical disability, frailty or sensory impairment are 65 years and over. Therefore with the ageing population, services will need to be developed alongside the increase in the older population.

Within the borough a lower proportion of people with physical disability aged 18 -64 are helped to live at home (3.7 per 1,000 population aged 18-64) when compared nationally (4.5 England 2007/8). Only 77 people with physical disability aged 18 -64 take up direct payments, which is 17% of the total number of people with physical disability receiving community services. In future we will need to continue to promote people with physical disabilities to live at home if we are to promote independence and provide personalised services.

Timeliness of assessment and provision of care

The Council is judged on the timeliness of providing an assessment to new clients and also on the length of time before care is provided. Expectations are that an assessment will be complete within 28 days of contact being made. Once a client is assessed as having substantial or critical needs, the aim is to provide a care package within 28 days of the assessment.

Direct payments

Direct payment are made by Councils to people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly. The measure by which Councils are judged is shown below; however the actual numbers of direct payments is 150 for the 18-64 age group and 86 for the 65 and over age group. This was a significant increase in 2007/8 and this will be a continued focus in future years, to ensure people have choice and control over their lives.

Carers

A carer is someone who looks after a relative, friend or neighbour, who needs support because of a physical disability, a learning disability, a physical illness, a mental illness, substance misuse problems or limiting illness. The measure by which Councils are judged is shown below, however the actual numbers of carers assessed or reviewed is 456 of which 205 are carers for those persons aged 18-64 and 251 are carers of those aged 65 and over.

The table below shows the Councils performance for 2008/9 for all the indicators mentioned above.

Table 16: Older People Indicators

Adults with physical disability helped to live at home per 1,000 population aged 18-64	3.7
Timeliness of social care assessment (NI 132 and Vital Sign VSC12)	76.2%
Timeliness of social care packages (NI 133 and Vital Sign VSC13)	88.3%
Adults and older people receiving direct payments and/or individual budgets per 100,000 population aged 18 and over (Vital Sign VSC17, NI 130)	182.2
Carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135)	34.8%

Source RAP return 2008/9 for Luton Borough Council

Falls

A fall may be the result of tripping or slipping which may be caused by environmental factors such as wet floors, poor footwear, loose carpets or poor lighting. Additionally, a fall may be caused by a combination of several factors. For example, a condition may present itself in an unusual way in an older person - for instance infection or transient ischemic attack may manifest themselves by way of a fall. Falls can take place in the home, suggesting that the focus should perhaps be on adaptations and Assistive Technology in the home. Elderly people are more prone than younger people to unpredictable and unexpected falls. Therefore with an ageing population, prevalence of falls is set to rise with an expected increase of 41% from 2008 to 2025 compared to 46% increase nationally. Without intervention numbers will continue to increase.

Table 17 shows the estimated number of people aged 65 and over attending A&E as a result of a fall.

Table 17: Falls – A&E attendance in Luton

People aged 65 and over predicted to attend hospital Accident and Emergency (A&E) departments as a result of falls, by age group (65-69, 70-74 and 75 and over), projected to 2025	Year				
	2008	2010	2015	2020	2025
People aged 65-69 predicted to attend hospital A&E departments as a result of falls	190	198	233	215	241
People aged 70-74 predicted to attend hospital A&E departments as a result of falls	239	232	228	269	250
People aged 75 and over predicted to attend hospital A&E departments as a result of falls	983	1030	1172	1286	1494
Total population aged 65 and over predicted to attend hospital A&E departments as a result of falls	1412	1460	1633	1770	1985

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to attend hospital A&E departments as a result of falls to 2025.

Source: POPPI

People accessing services

The following data shows people accessing services during 2008/9, together with an analysis if this service was provided in the community rather than in a residential or nursing care home. Services in the community include: home care, day care, and meals.

Table 18: Access to services

Physical disability, frailty and sensory impairment	For age group 18 to 64	For age group 65 and over
1. Number of clients	551	2225
2. Number receiving services in community	521	1897
Learning disability		
1. Number of clients	399	25
2. Number receiving services in community	338	20
Mental health		
1. Number of clients	389	322
2. Number receiving services in community	372	197
Substance misuse		
1. Number of clients	51	
2. Number receiving services in community	44	

Source RAP return 2008/9 for Luton Borough Council

With the introduction of personalisation and individual choice and control it is expected that over time more people will receive services in the community. As a proxy measure for Luton in 2007-08, 56

older people per 10,000 population aged 65 and over were admitted permanently to nursing / residential care compared with 74 nationally, giving good performance. In 2008-09, performance dropped to 62 older people per 10,000 population. However with prevention services being promoted more widely there may be less people presenting themselves for services that are eligible for social care and this needs to be carefully monitored

Transport and Mobility

Transport is a significant issue and particularly so to older people. The table below shows the numbers of pensioner households who are reliant on transport, In particular the data shows 5515 households who have no transport and therefore reliant on public transport. This suggests that suitable transport needs to be made available as well as ensuring that activities in the neighbourhood are delivered.

Table 19: Pensioner households with or without transport, 2001 Census

Transport	Pensioner households
Living alone with transport	2324
Living alone without transport	5515
Not living alone with transport	3780
Not living alone without transport	1367

Source: POPPI - Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table S062 Household composition by number of cars or vans available.

The data below shows that with the rise in the older population in particular, there will be an increasing need for care and also the need for a range of activities to help people to live in their communities.

Table 20: Mobility - projections

People aged 65 and over unable to manage at least one mobility activity on their own, by age group (65-74, and 75 and over), projected to 2025. Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed					
	2008	2010	2015	2020	2025
People aged 65-74 unable to manage at least one mobility activity on their own	1048	1056	1144	1184	1216
People aged 75 and over unable to manage at least one mobility activity on their own	2496	2616	2976	3264	3792
Total population aged 65 and over unable to manage at least one mobility activity on their own	3544	3672	4120	4448	5008

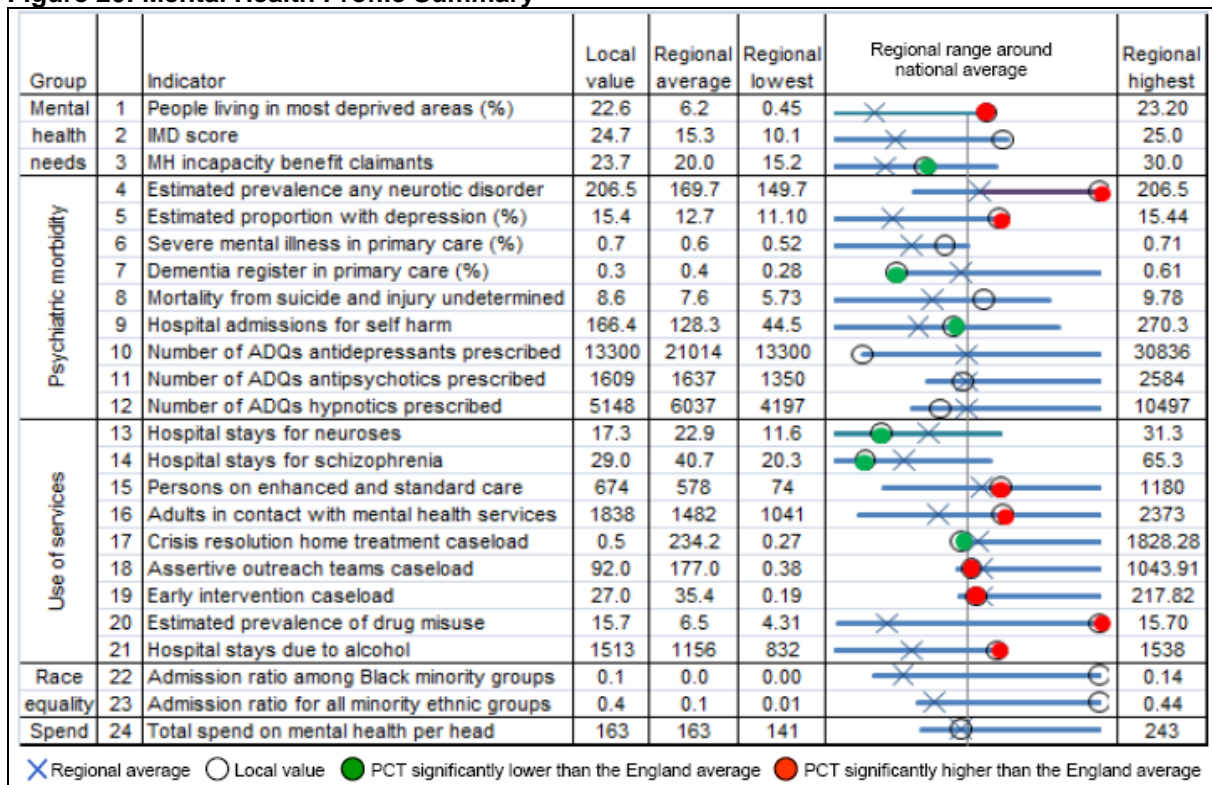
Source: POPPI - The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to be unable to manage at least one of the mobility activities listed, to 2025.

Mental Health

The mental health profiles developed by ERPHO give an overview of the mental health of the adult population and were published in January 2009. Figure 20 shows a summary of the indicators in Luton’s profile. Key risk factors include social deprivation, unemployment, children from poor

households, drug and alcohol problems. Key points from Luton's mental health profile show there were 2800 claimants of incapacity benefits due to mental health conditions in 2006. There were 51 admissions for schizophrenia in 2005/06, an estimated 1914 people aged 15-64 had a problem with drug use in 2004/05 and over 2800 alcohol related inpatients in 2005. In 2006/07 the PCT spent £163 per head on mental health care.

Figure 20: Mental Health Profile Summary



Source: ERPHO Mental Health Profiles 2009 - For further information see <http://www.erpho.org.uk/pub/mhp09.aspx>

Dementia

Table 21 shows the proportion of the population that are estimated to have dementia and shows that the proportion in Luton is lower than those seen nationally for both males and females. This may be due to the younger population in Luton compared to nationally as dementia is more commonly found in the older population. Modelled data also shows Luton's elderly population is projected to increase but this increase is also seen nationally and therefore although Luton's rates of dementia are estimated to increase to 2021 they are still estimated to be lower than national rates.

Table 21: Proportion of the population estimated with dementia

	Luton 2007		England 2007		Luton 2021		England 2021	
	Males	Females	Males	Females	Males	Females	Males	Females
65+ with dementia	4.4	6.6	5.4	8.0	5.4	6.7	6.0	7.9
All with dementia	0.5	0.9	0.8	1.4	0.8	1.2	1.1	1.7

Source: POPPI

Table 22 shows the highest proportion of people with dementia is in the older age groups. In Luton in 2007 98% of females and 96% of males with dementia are aged 65 years and over. This compares to 99% and 96% respectively in England. A breakdown of numbers of people with predicted dementia can be found in Appendix 3. In 2021 in Luton the data shows an estimated increase in the older age group (75+) for males where as rates remain similar for females and in England as a whole.

Table 22: Proportion of people estimated with dementia in each age group, 2007 and 2021

%	Luton 2007		England 2007		Luton 2021		England 2021	
	Males	Females	Males	Females	Males	Females	Males	Females
30-64	4.5	1.9	3.7	1.3	3.5	1.6	2.8	1.2
65-74	26.8	12.6	22.6	9.6	18.6	12.0	19.2	9.6
75+	68.7	85.4	73.5	88.9	77.7	86.3	77.9	88.7

Source: POPPI

Depression in older people

Table 23 and Table 24 shows the number of people aged 65 years and over with depression and severe depression is set to increase by 32% from 2008 to 2025 in Luton compared to a 40% increase nationally.

Table 23: Predicted number of people with depression 2008-2025

	Luton Depression					England Depression				
	People aged 65 and over predicted to have depression, projected to 2025									
	2008	2010	2015	2020	2025	2008	2010	2015	2020	2025
People aged 65 and over predicted to have depression: lowest estimated level of prediction	2,350	2,410	2,670	2,840	3,100	827,980	858,420	971,450	1,056,300	1,158,760
People aged 65 and over predicted to have depression: highest estimated level of prediction	3,525	3,615	4,005	4,260	4,650	1,241,970	1,287,630	1,457,175	1,584,450	1,738,140

Table 24: Predicted number of people with severe depression 2008-2025

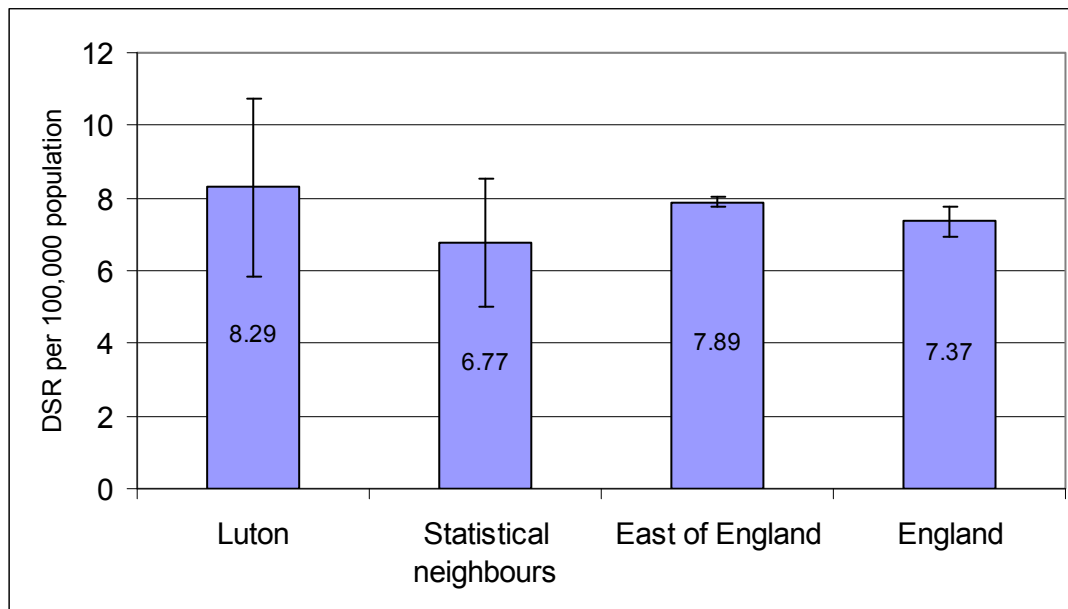
	Luton Severe Depression					England Severe depression				
	People aged 65 and over predicted to have severe depression, projected to 2025									
	2008	2010	2015	2020	2025	2008	2010	2015	2020	2025
People aged 65 and over predicted to have severe depression: lowest estimated level of prediction	705	723	801	852	930	248,394	257,526	291,435	316,890	347,628
People aged 65 and over predicted to have severe depression: highest estimated level of prediction	1,175	1,205	1,335	1,420	1,550	413,990	429,210	485,725	528,150	579,380

Source: POPPI

Suicide

Figure 21 shows Luton's rate, although slightly higher, is not significantly different to England, East of England or its statistical neighbours. This is due to the small number of deaths from suicide and undetermined injury at local levels with just under 50 in 2005-07 in Luton.

Figure 21: Mortality from suicide and undetermined injury in Luton and comparators, 2005-07



Source: NCHOD 2005-07

Living alone

The number of people aged 65 living alone is set to rise by significant amounts by 2025 – a 17% increase in those aged 65-74 and a 49% in those aged 75 years and older. This indicates there will be issues associated with loneliness and also economic poverty if income does not support the household expenses. This in turn may lead to fuel poverty and poor house maintenance.

Table 25: Living arrangements of people aged 65 and over by age bands (65-74, and 75 and over) and gender and numbers living alone, projected to 2025

Living alone	2008	2010	2015	2020	2025
Males aged 65-74 predicted to live alone	1,122	1,105	1,173	1,207	1,224
Males aged 75 and over predicted to live alone	1,288	1,372	1,596	1,792	2,016
Females aged 65-74 predicted to live alone	2,145	2,178	2,442	2,574	2,607
Females aged 75 and over predicted to live alone	3,422	3,540	3,894	4,307	5,015
Total population aged 65-74 predicted to live alone	3,267	3,283	3,615	3,781	3,831
Total population aged 75 and over predicted to live alone	4,710	4,912	5,490	6,099	7,031

Source: POPPI - Figures are taken from the General Household Survey 2004, table 3 Households, families and people, section 3.4 Percentage of men and women living alone by age, ONS. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a sample of the general population resident in private households in Great Britain. Numbers have been calculated by applying percentages of men and women living alone to projected population figures.

Key Issues: Social Care Needs and Activity

This section highlights the key issues relating to Social Care Needs and Activity that commissioners will need to take into account when planning services:

- The need for social care is rising due to the increasing age of the population, particularly the year on year rise of people over 85 who are major users of the services. (JSNA 2008)

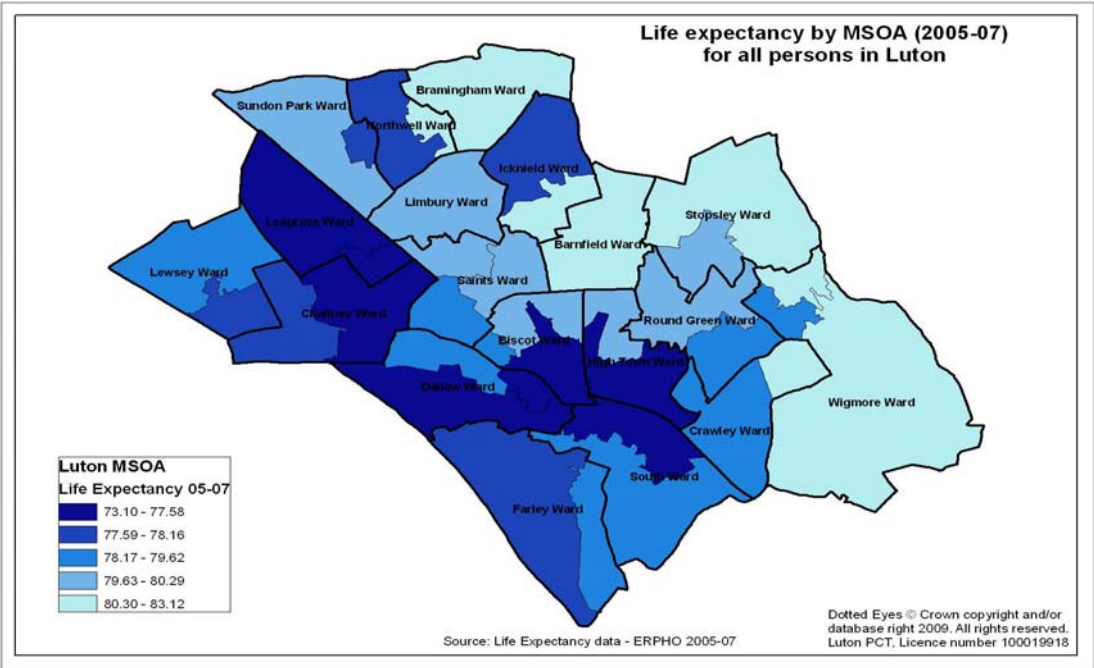
- People over 85 are more likely to have dementia and a high level of care need, which in turn will require extra support for carers (JSNA, 2008).
- The number of younger disabled people living longer is increasing due to advances in social and medical care (JSNA, 2008).
- There is a higher and rising proportion of older people within the local population, especially among South Asian and Afro Caribbean communities. Future services will need to reflect not only the increase in demand for services for older people, but for culturally appropriate services. (JSNA 2008)
- There is a high demand for accessible information. Isolation is a significant issue for older people, with the potential consequences for mental health.
- There is a significant impact on health services following a fall for an older person and this will increase in line with the growing number of older people.
- Transport is a significant issue and particularly so for older people, where mobility issues can impact on a person's ability to live independently.
- There is limited data on the number of vulnerable people such as those with learning disabilities. Data held in primary care often shows lower than expected prevalence. (JSNA 2008)

5. Health Status of the Population

Life expectancy in Luton

Although life expectancy has been rising in Luton, this masks the inequalities that exist between areas. The life expectancy gap between the Middle Super Output Areas (MSOAs) with the lowest and highest life expectancy in areas of Luton is 11 years for men (70.2 to 81.7 years) and 10 years for women (75.5 to 85.5 years)^{xiv}.

Figure 22: Life Expectancy by Middle Super Output Area (MSOA) for all persons in Luton (2005-07)



Areas of lowest life expectancy are situated in the south and west parts of Luton, in particular in Dallow, High Town, Biscot, Challney and Leagrave. In addition, Farley is an area of low life expectancy, particularly for males who are living 2.2 years below Luton average (ERPHO, 2005/07). These inequalities in life expectancy are largely related to low income and deprivation. The lower than average life expectancies indicated in Figure 22 correspond closely with areas of low income and deprivation. Detailed health needs assessments have been carried out in each of these five areas and will be used to develop plans to improve life expectancy. These HNAs form part of the JSNA supplement 2009 and can be accessed from: www.nhs.lutonpct.uk

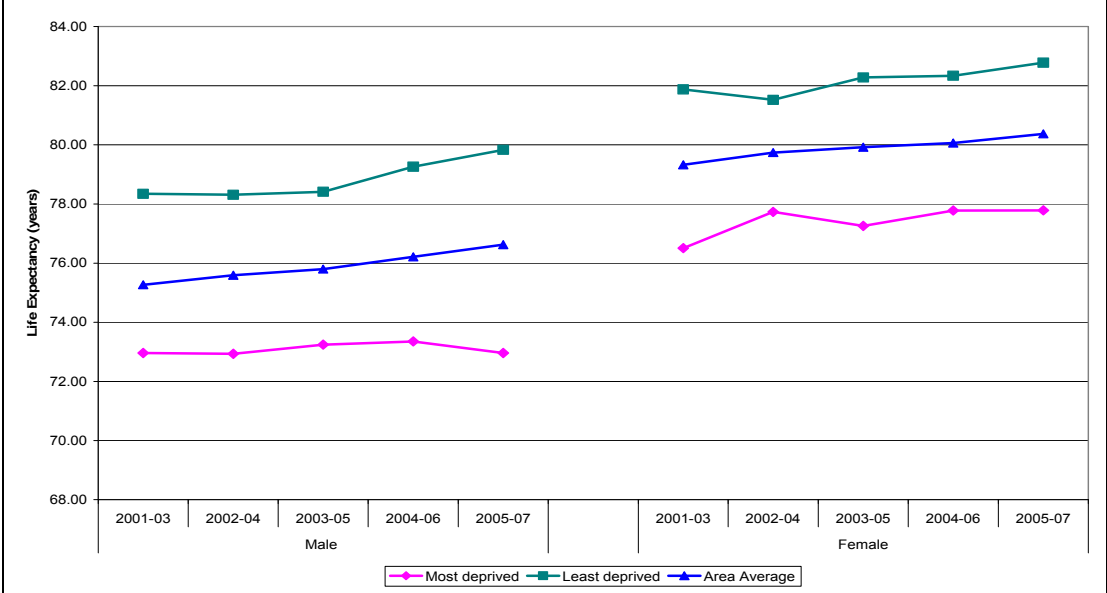
Life expectancy and Deprivation

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.

xiv ERPHO Health Inequalities Profiles 2008 available at www.erpho.org.uk

Figure 23 shows the inequalities in life expectancy within Luton and shows that the gap between the most deprived fifth of areas and the least deprived fifth has widened for males. Despite a narrowing of the gap in 2004-06 for females, the gap has widened in more recent 2005-07 data.

Figure 23: Life expectancy trends by gender and deprivation quintile

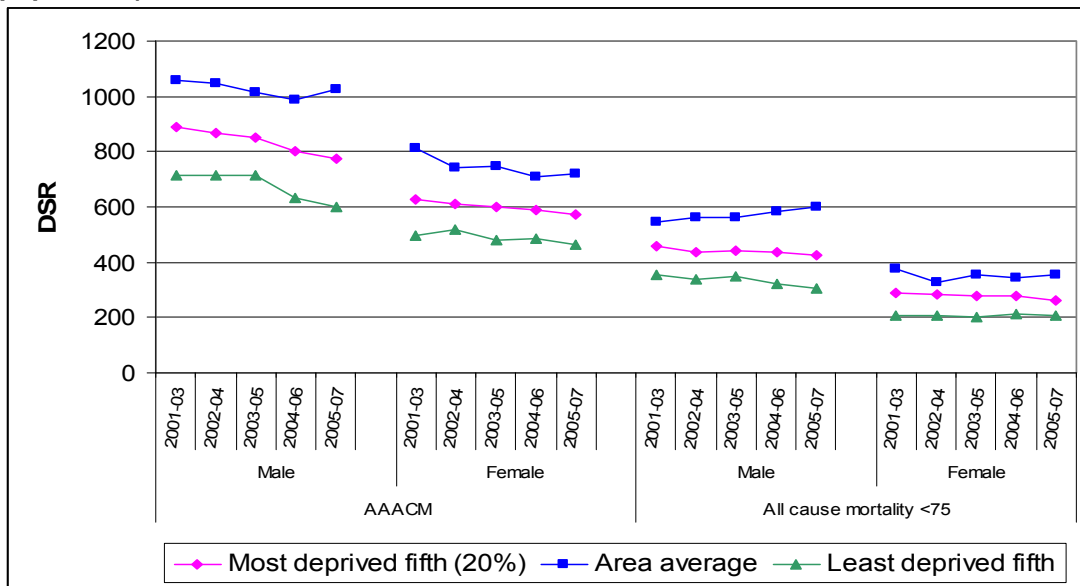


Source: ERPHO Health inequalities Profile 2008

Deaths

Figure 24 shows inequalities have widened for males and females all age all cause mortality (AAACM) and all cause mortality (ACM) under 75 years, with the biggest gap for males. In 2004-06 the AAACM data showed a narrowing in the gap for females. However recent data (2005-07) has shown an increase in mortality rates in the most deprived group and therefore a widening of inequalities. For males although the gap had not narrowed in 2004-06 the mortality rates had been decreasing. The recent data shows that rates for the most deprived group are increasing and widening the inequalities gap. The picture is similar for the ACM in under-75s. Rates have continued to increase for males in the most deprived group while the least deprived group continues to decrease. For females the gap is narrower but rates are increasing slightly in the most deprived group in recent data.

Figure 24: Inequalities in AAACM and ACM (<75 years) in Luton (Deaths per 100,000 population)



Source: ERPHO Health inequalities Profile 2008

Diabetes

Estimated diabetes prevalence in Luton wards - 2005

There are almost 9,000 people in Luton registered with their GP as having diabetes.

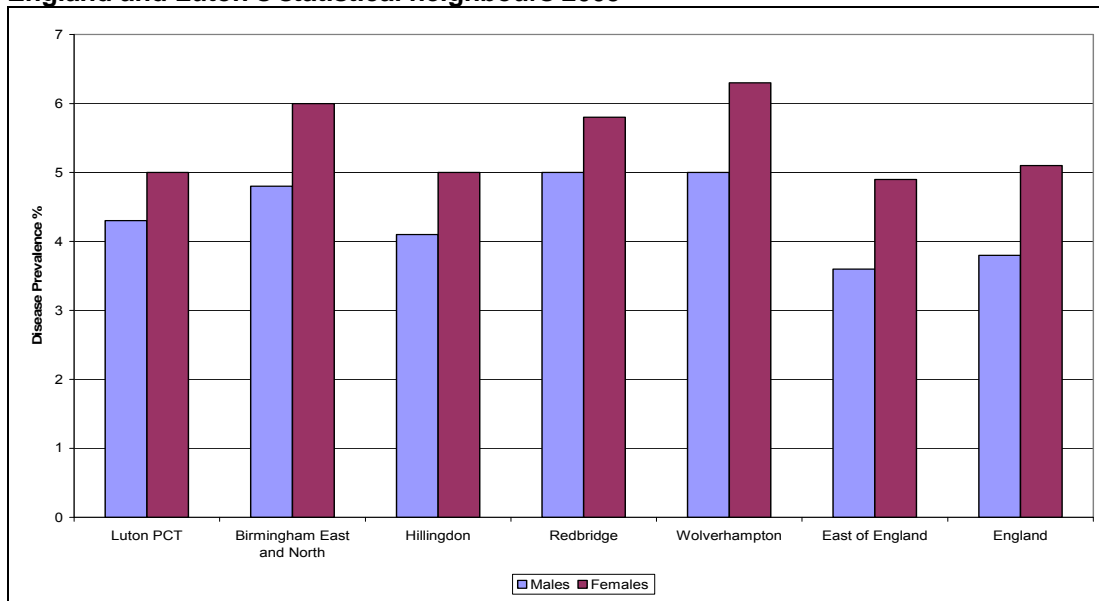
The Yorkshire and Humber Public Health Observatory (YHPHO) PBS diabetes population prevalence model^{xv}, includes both diagnosed and undiagnosed diabetes, and indicates an average prevalence for Luton of 4.7% compared with 4.5% in England. In Luton around 4.3% of men and 5.0% of women are estimated to have diabetes. These rates are higher than the East of England and higher than the national average for men (3.8% and 5.1% respectively).

Although these figures indicate our prevalence is marginally higher than regional and national figures it should be noted that as recorded figures are calculated on the registered population (204,300) and the estimates are calculated on the resident population for 2005 (186,400), actual prevalence is likely to be even higher. Figure 25 shows the estimated expected prevalence compared with Luton's statistical neighbours^{xvi}.

^{xv} Yorkshire and Humber Public Health Observatory (2008). PBS Diabetes Population Prevalence Model - Phase 3 – available at www.yhpho.org.uk

^{xvi} These statistical neighbours are calculated by ONS on a range of indicators and can be found at [http://www.statistics.gov.uk/about/methodology by theme/area classification/ha/corresponding has.a sp](http://www.statistics.gov.uk/about/methodology%20by%20theme/area%20classification/ha/corresponding%20has.a%20sp)

Figure 25: Estimated Number of Type 1 & Type 2 Diabetes by Gender in Luton, East of England, England and Luton’s statistical neighbours 2005



Source: Phase 3 Diabetes Prevalence Model - developed by YHPHO

Under-reporting is likely to be an issue and estimates (NICE 2007) indicate that there are likely to be around 350 new cases of diabetes each year in Luton. The prevalence of diabetes is expected to increase in line with rising levels of obesity and other risk factors and modelling has indicated that 5.4% of the local population is expected to have diabetes by 2010 - around 12,000 people. The burden of diabetes care, and its complications, is therefore set to rise significantly in the coming years.

Figure 26 reflects the estimated prevalence of diabetes in Luton in 2005 by ward, taking into account age, sex and ethnic groups. The 3 wards with the highest level of estimated diabetes are Challney, Biscot and Dallow ward, followed by Leagrave, Icknield and Farley. These largely correlate with the areas in Luton with the lowest life expectancy and NHS Luton’s priority areas (Dallow, High Town, Biscot, Challney, Leagrave and Farley).

Figure 26: Diabetes prevalence by ward

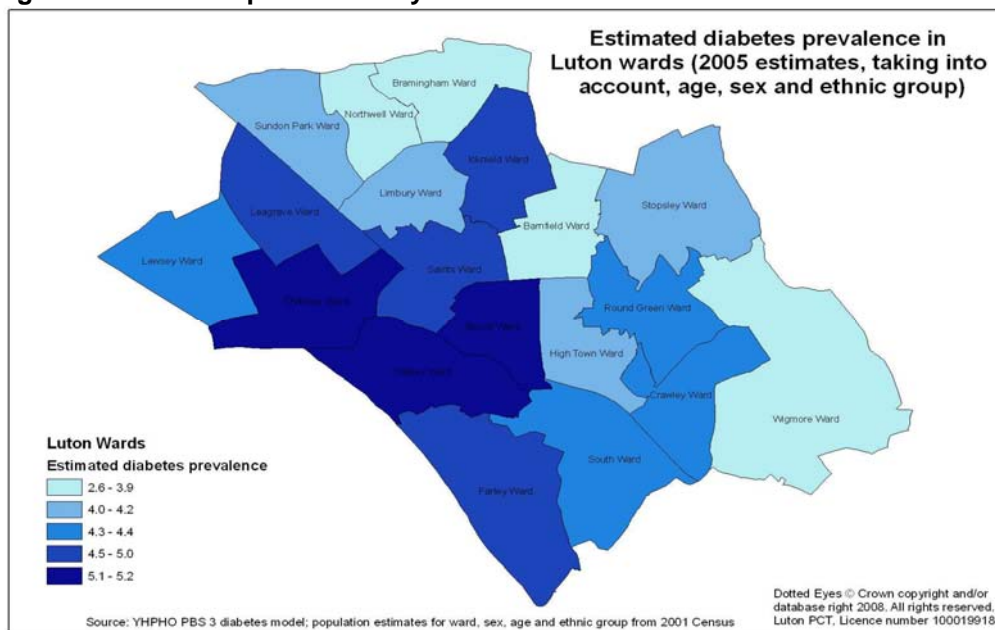


Table 26 displays the estimated prevalence of Type 1 and Type 2 diabetes in Luton by ethnic group. The Asian population has the highest rates of diabetes with an estimated prevalence of almost 6.5% followed by the Black community, which has an estimated prevalence of 5.9%.

Table 26: Estimated diabetes prevalence by ethnic group

Ethnic Group	Estimated diabetes
White	4.1%
Black	5.9%
Asian	6.5%
Other	1.6%

Source: YHPHO PBS Diabetes model

Table 27: Programme budgeting for diabetes in Luton, 2007/08

Spend on diabetes (per 100,000 population)	% change from 2006-07	Rank (out of 152 PCTs)	Average cost - comparable (cluster PCTs)	Average cost - East of England PCTs	National average
2,400,823	27%	16	1,887,498	1,984,248	1,943,582

Source: Department of Health programme budgeting benchmarking tool, 2007-08

Table 27 shows that Luton still spends more than comparators on diabetes per 100,000 population (reflecting the higher need in the area) and has increased this spend by 27% since 2006-07.

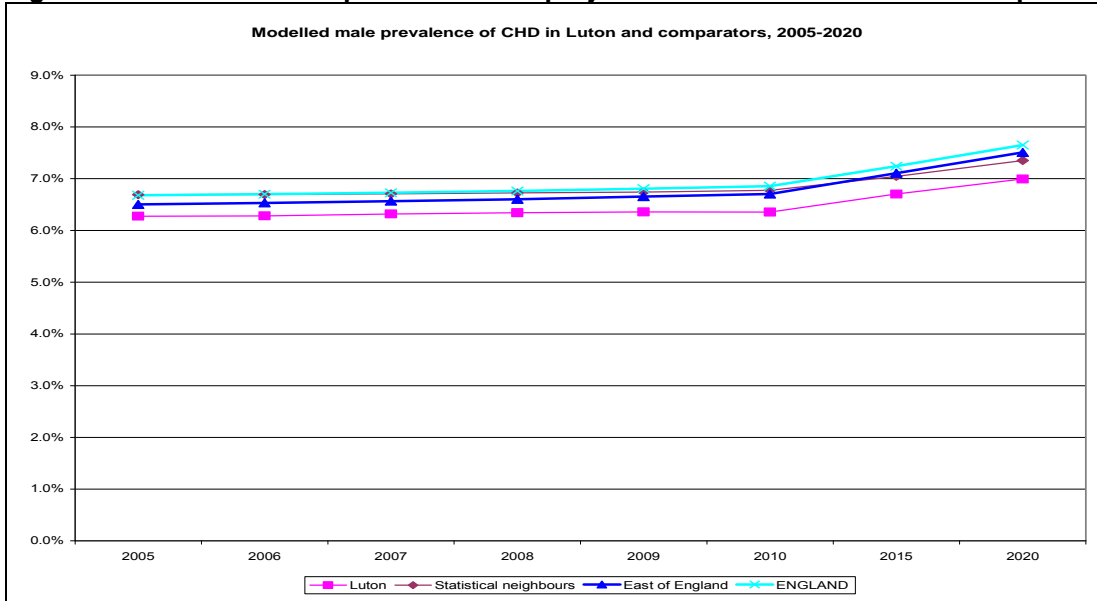
Circulatory Disease (Cardiovascular Disease - CVD)

Circulatory Disease (or Cardiovascular Disease) primarily includes Coronary Heart Disease (CHD) and Stroke.

Coronary Heart Disease (CHD)

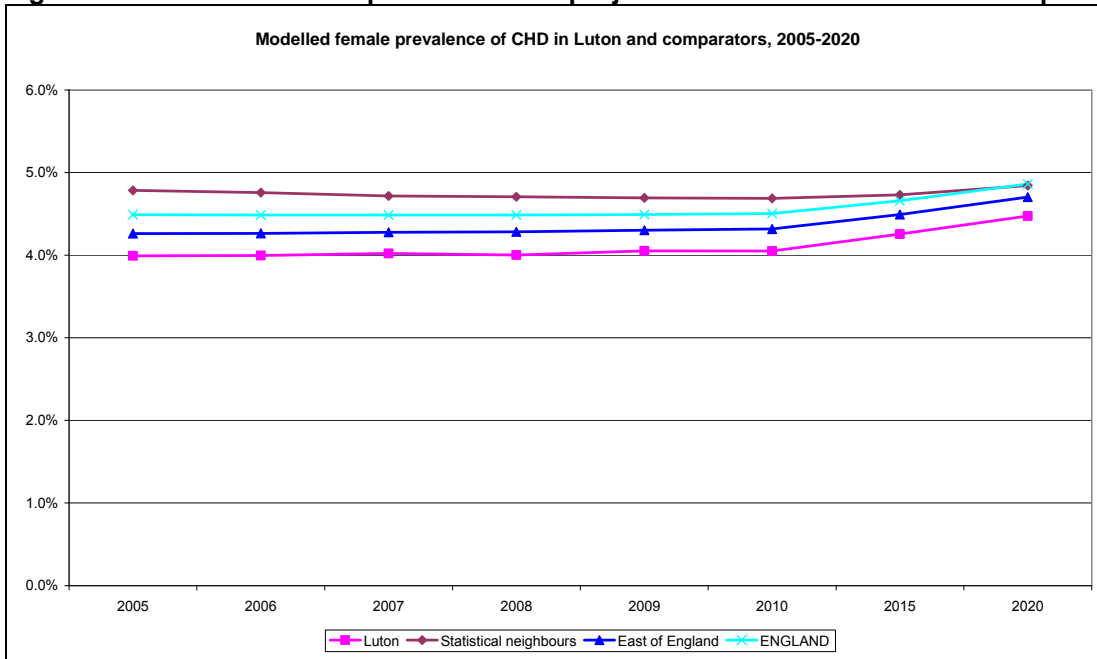
The Association of Public Health Observatories (APHO) CHD model looks at prevalence of CHD in people aged 16 years and over and takes into account age, sex, ethnicity, smoking status and deprivation score. In Luton the estimated and projected prevalence of CHD is expected to rise slightly for both males and females from 2005-2020 (6.3% to 7% for males and 4% to 4.5% for females). The estimated prevalence of CHD for Luton is lower compared to England and East of England for males and females and lower compared to Luton’s statistical neighbours overall (see Figure 27 and Figure 28). This is mainly as a result of the younger age profile in Luton’s population.

Figure 27: Estimated male prevalence and projections of CHD in Luton and comparators



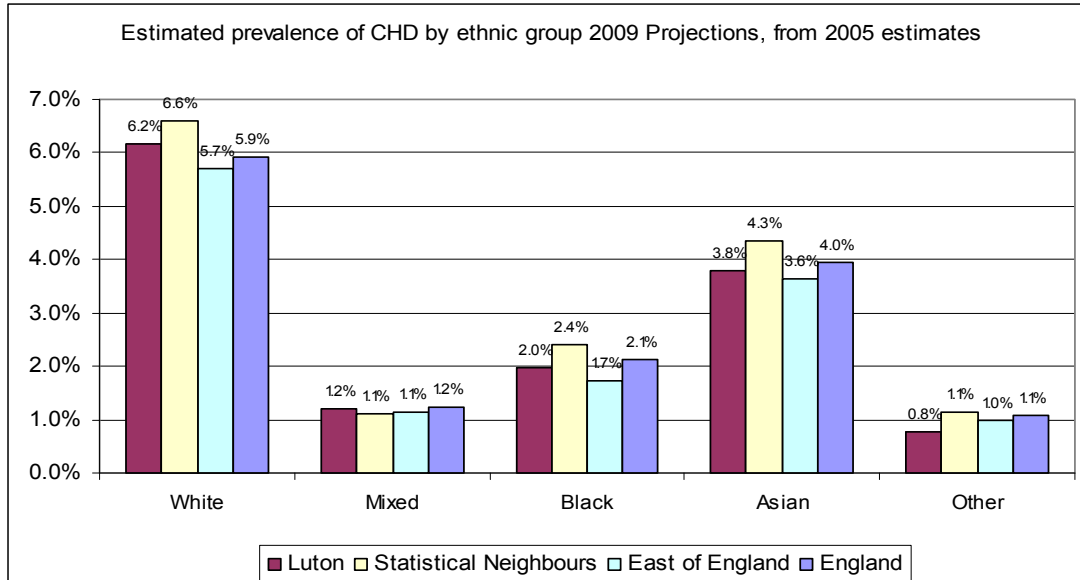
Source: Modelled estimates of prevalence of CHD for PCTs in England, APHO 2008

Figure 28: Estimated female prevalence and projections of CHD in Luton and comparators



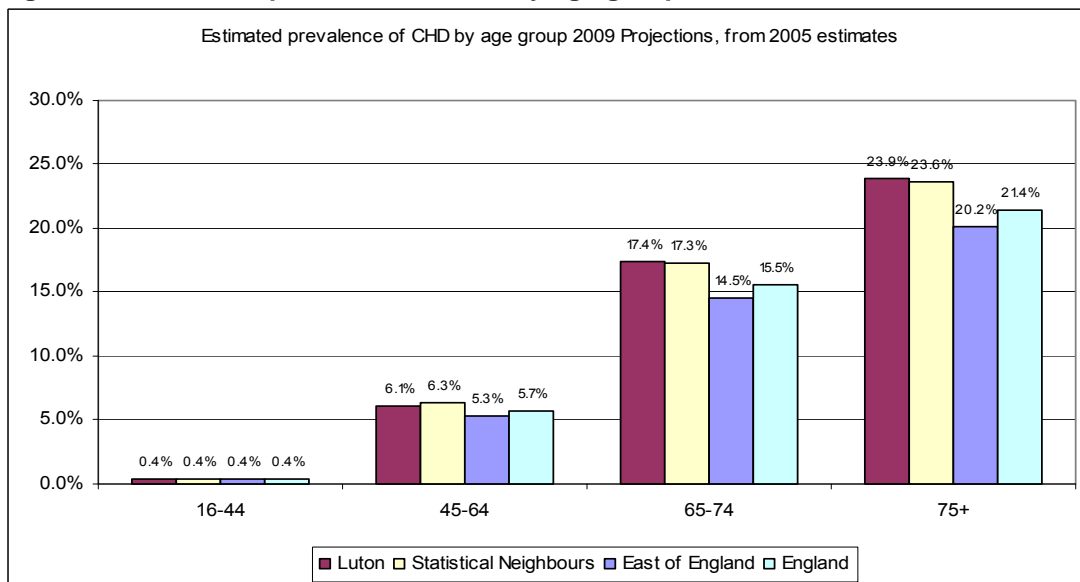
Source: Modelled estimates of prevalence of CHD for PCTs in England, APHO 2008

Figure 29: Estimated prevalence of CHD by ethnic group



Source: Modelled estimates of prevalence of CHD for PCTs in England, APHO 2008

Figure 30: Estimated prevalence of CHD by age group

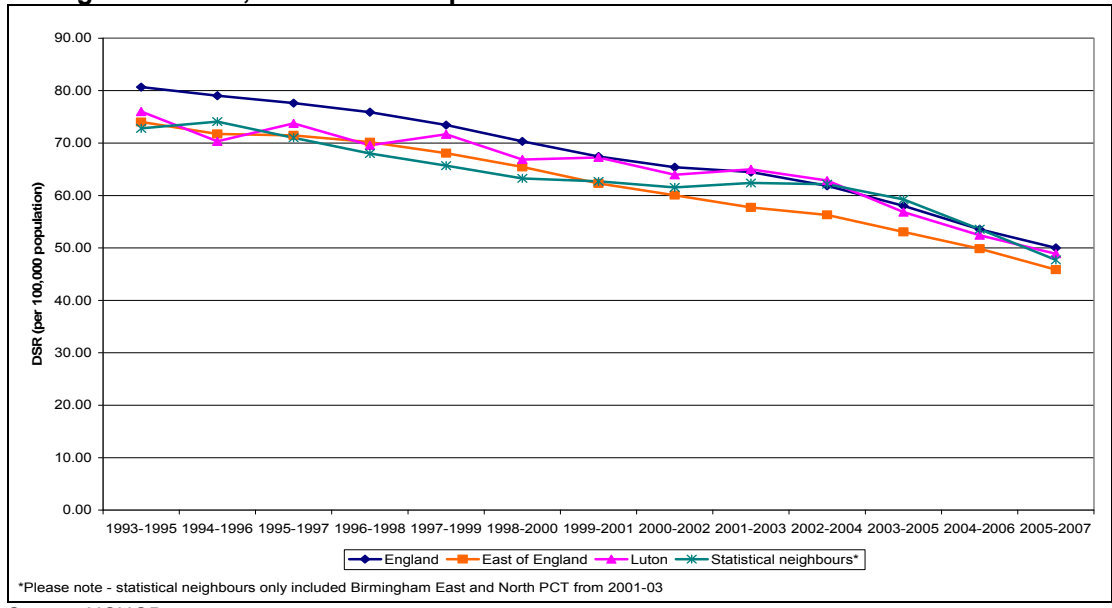


Source: Modelled estimates of prevalence of CHD for PCTs in England, APHO 2008

Figures 29 and 30 show the breakdown of the estimated CHD prevalence by ethnic group and age group. Figure 29 shows Luton's prevalence of CHD by ethnic group is slightly lower compared to England and Luton's statistical neighbours for the Asian, Black and Other ethnic groups. The prevalence is slightly higher in Luton for White ethnic groups compared to England and East of England averages and similar to comparators for the mixed ethnic groups. Figure 30 shows Luton and its statistical neighbours have higher prevalence of CHD in the older age groups (65+) compared to East of England and England as a whole.

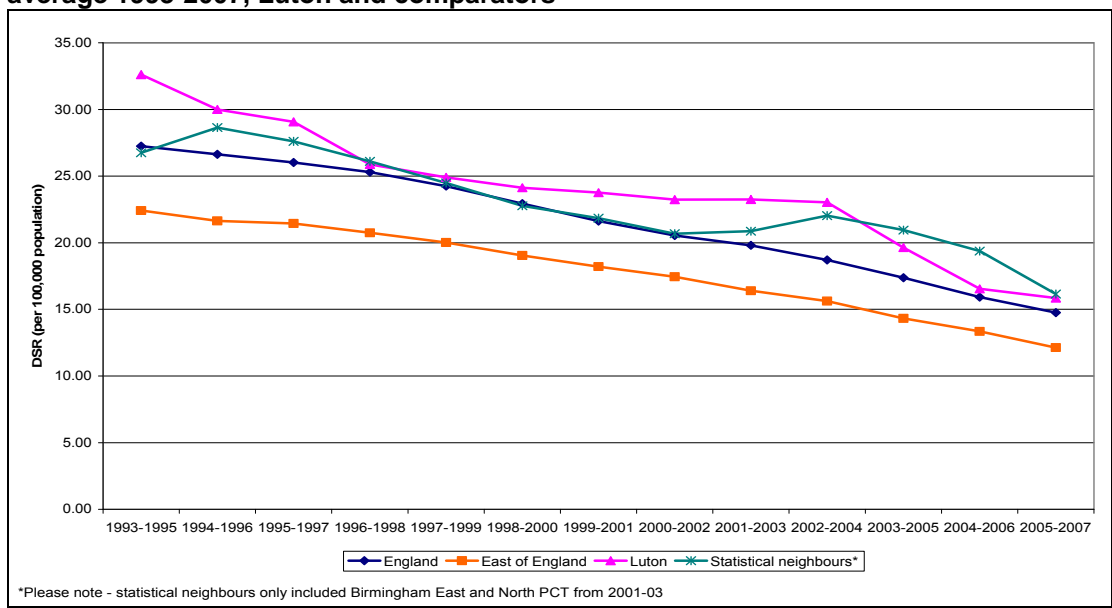
Stroke

Figure 31: Directly Standardised Rate (DSR) for stroke mortality (all ages), three year rolling average 1993-2007, Luton and comparators



Source: NCHOD

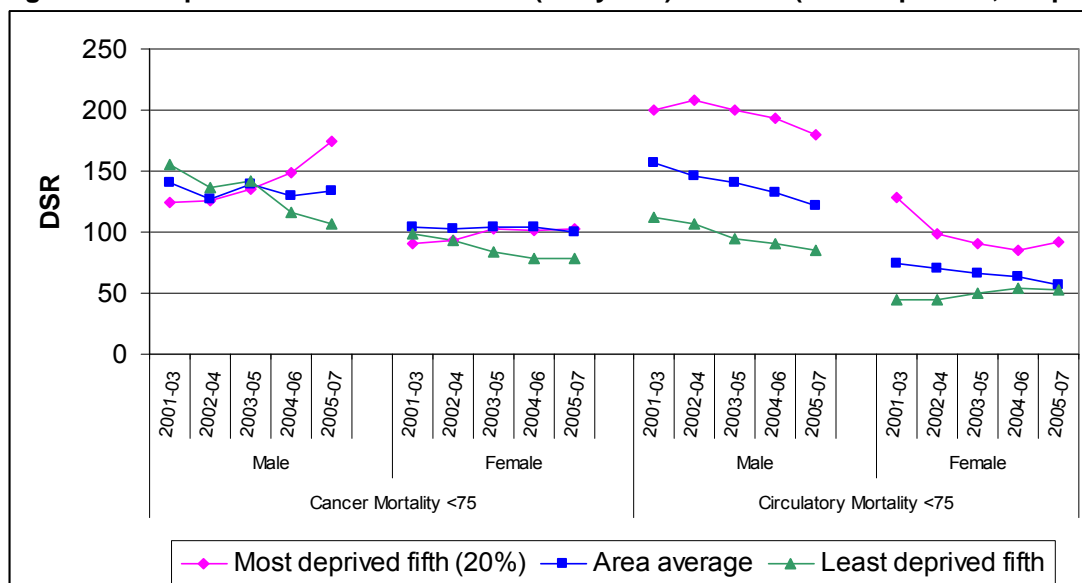
Figure 32: Directly Standardised Rate (DSR) for stroke mortality (<75 years), three year rolling average 1993-2007, Luton and comparators



Source: NCHOD

Figure 31 and Figure 32 show mortality from stroke in all ages and premature mortality (in people aged less than 75 years). They show Luton's rate is higher than England and East of England, although the rates have decreased in recent years for all ages and less than 75 years. Current rates are similar in Luton compared to the average across the statistical neighbours and all rates for Luton are not significantly different to each of the comparators for all ages and premature mortality from stroke.

Figure 33: Inequalities in CVD and cancer (<75 years) in Luton (Deaths per 100,000 population)



Source: ERPHO Health inequalities Profile 2008

For males the inequalities in premature cancer are continuing to increase with rising mortality rates and a widening inequality gap between the most and least deprived areas. Circulatory disease mortality shows a slightly better picture with mortality rates generally decreasing and the gap slightly narrowing, although the gap is larger than for Cancer.

For females the picture is better when looking at cancer. Although mortality rates appear to have remained the same in recent years the gap between the most and least deprived has not widened. Also the mortality rates in the most deprived fifth are similar to the area average for Luton. Premature circulatory disease mortality in females shows a different picture. Despite the narrowing of the inequalities gap in 2004-06 the most recent data (2005-07) shows the mortality rate has increased for the most deprived and decreased in the least deprived. The ideal picture would be to see the mortality rates decreasing in all areas but at a faster rate in the most deprived group to reduce the inequalities that exist.

Table 28: Programme budgeting for circulatory disease in Luton, 2007/08

Spend on problems of circulation (per 100,000 population)	% change from 2006-07	Rank (out of 152 PCTs)	Average cost - comparable (cluster PCTs)	Average cost - East of England PCTs	National average
11,223,862	28%	113	11,293,339	12,910,564	12,476,801

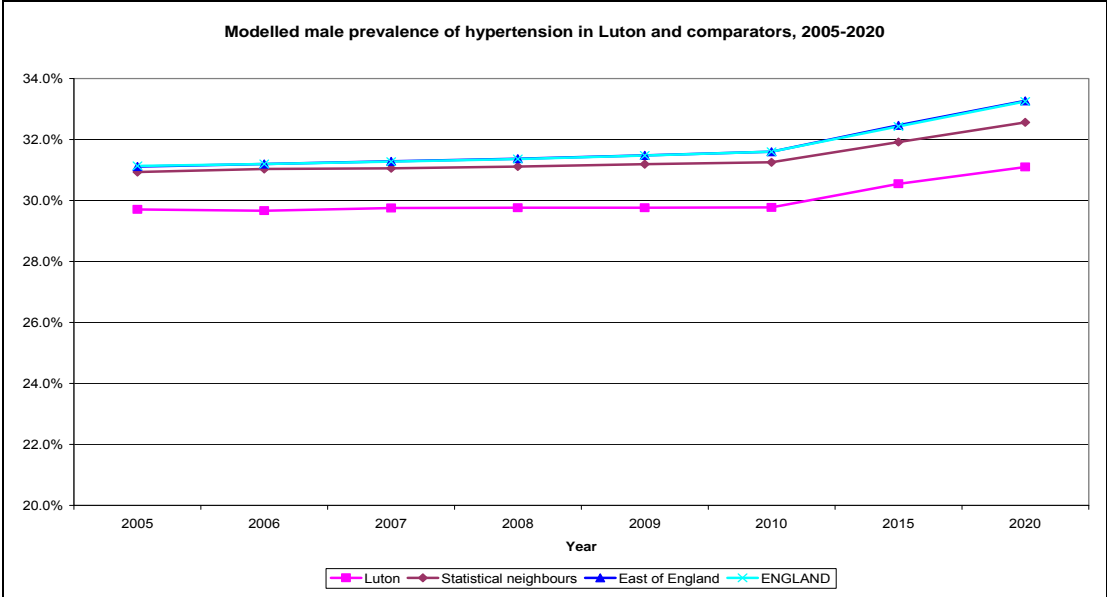
Source: Department of Health programme budgeting benchmarking tool, 2007-08

Table 28 shows that despite relatively high mortality rates Luton's spend on circulatory disease is similar to the average cost per 100,000 population in the cluster of PCTs similar to Luton but less than the average cost in the East of England and England. This may be linked with the lower estimated prevalence of CHD compared to nationally. However, Luton has increased spend in this area by 28% from 2006-07.

Hypertension

The estimates and projections of the prevalence of hypertension in people aged 16+ have been calculated using a model developed at the Department of Primary Care and Social Medicine, Imperial College, London. The model was developed using data from the 2003-2004 Health Surveys for England and takes into account age, sex, ethnicity and deprivation score. Figure 34 and Figure 35 below show the prevalence for males and females and shows Luton’s figure is significantly lower than the England average and similar to the East of England^{xvii} for males and lower for females. This may be due to Luton’s age profile which is relatively younger than these two comparators and may result in lower prevalence of some long-term conditions.

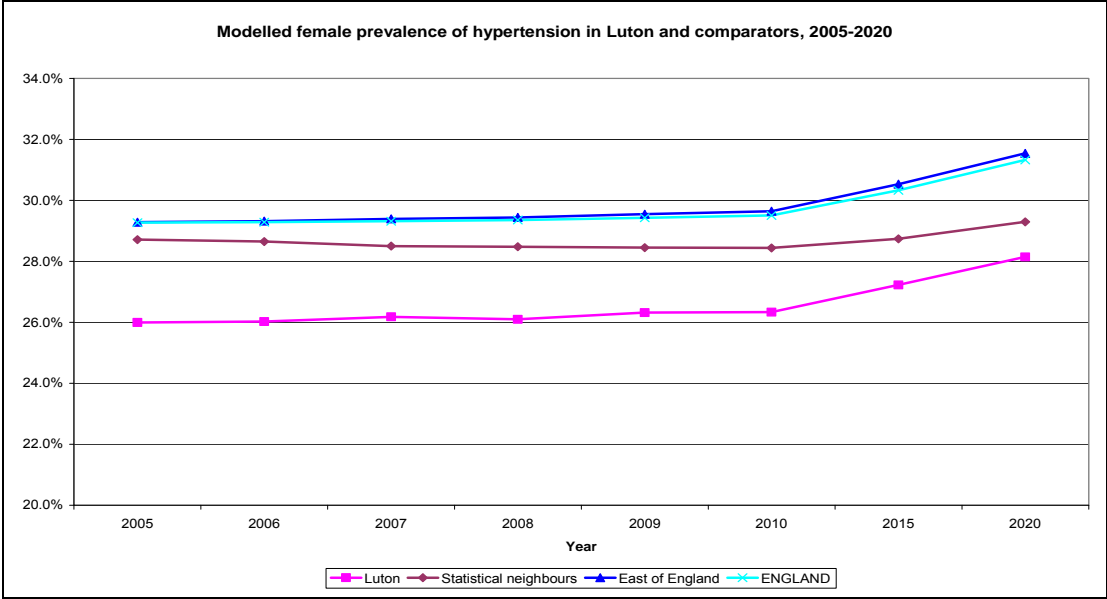
Figure 34: Modelled estimates of male prevalence of hypertension in Luton and statistical neighbours



Source: Modelled estimates of prevalence of hypertension for PCTs in England, APHO 2008

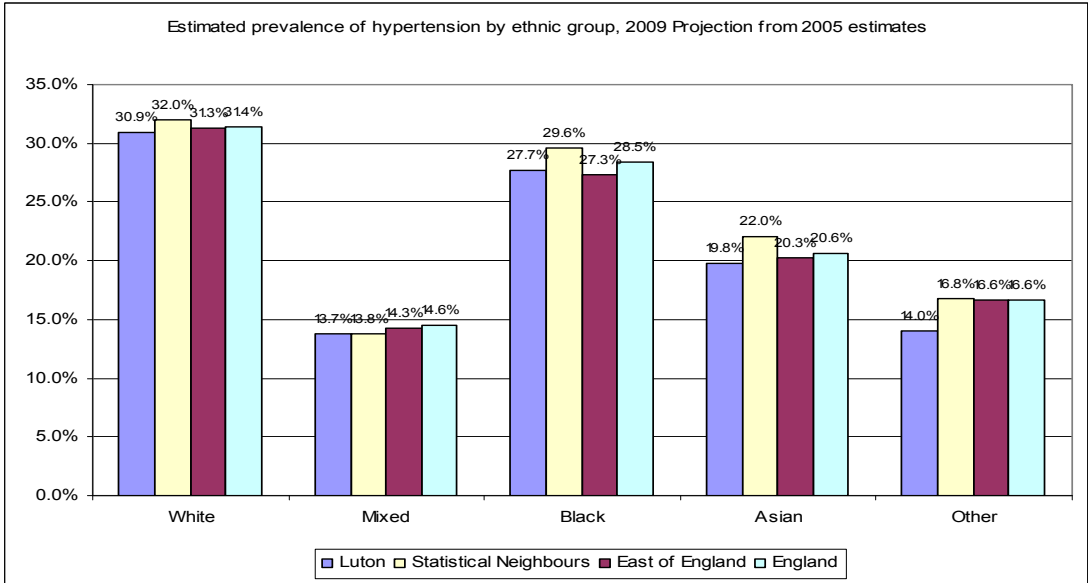
^{xvii} Statistical neighbours as defined by ONS are Hillingdon, Birmingham East and North, Wolverhampton City and Redbridge PCTs – http://www.statistics.gov.uk/about/methodology_by_theme/area_classification/ha/corresponding_has.a.sp

Figure 35: Modelled estimates of female prevalence of hypertension in Luton and statistical neighbours



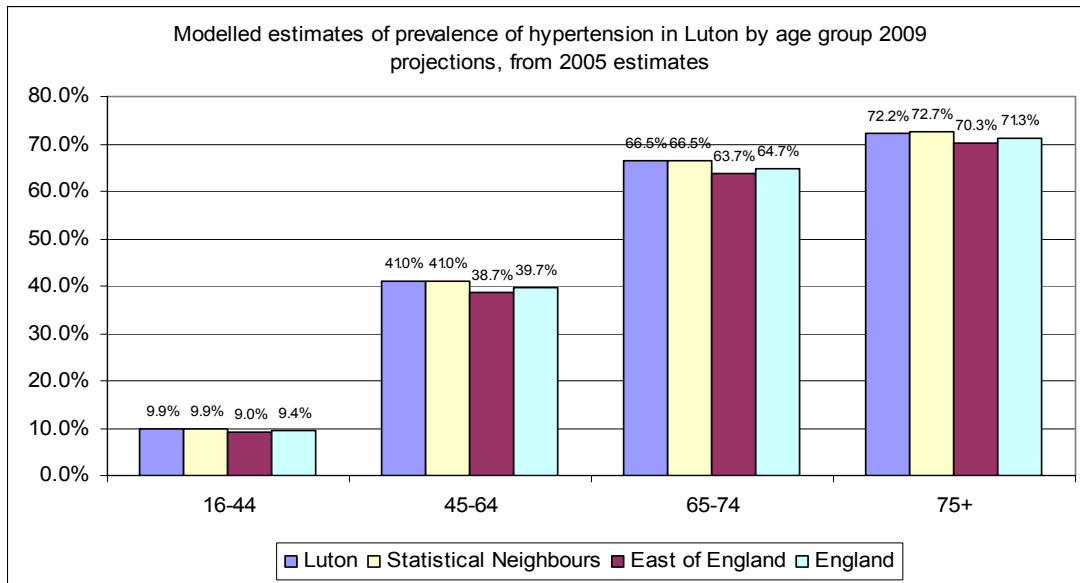
Source: Modelled estimates of prevalence of Hypertension for PCTs in England, APHO 2008

Figure 36: Modelled estimates of prevalence of hypertension in Luton by ethnic group



Source: Modelled estimates of prevalence of Hypertension for PCTs in England, APHO 2008

Figure 37: Modelled estimates of prevalence of hypertension in Luton by age group



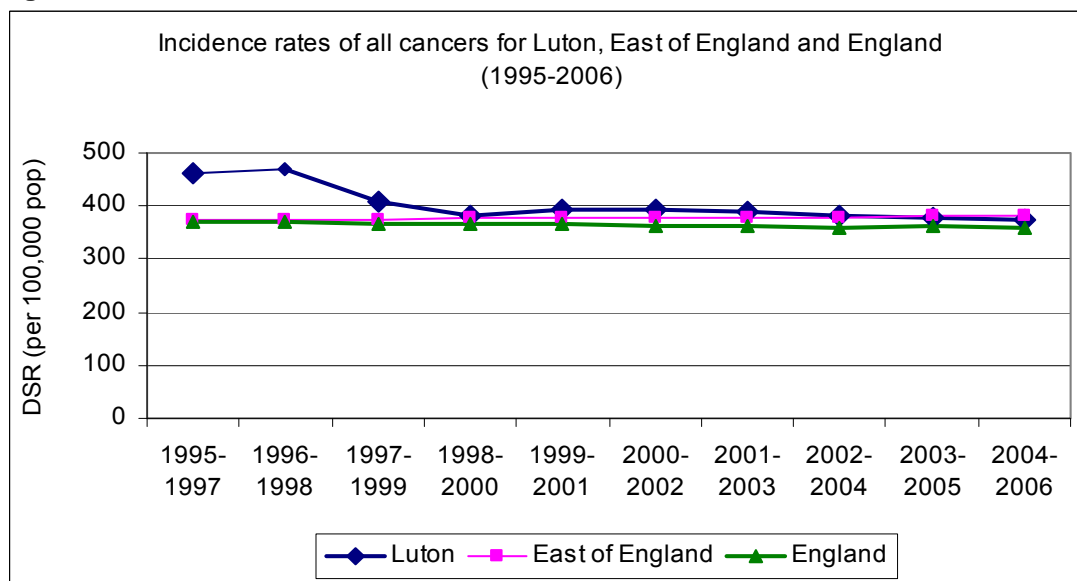
Source: Modelled estimates of prevalence of Hypertension for PCTs in England, APHO 2008

Figure 36 and 37 show the breakdown of the estimated hypertension prevalence by ethnic group and age group. Figure 36 shows Luton’s prevalence of hypertension by ethnic group is slightly lower compared to all comparators for the Asian, Black and Other ethnic groups. This will be mainly as a result of the younger age profile in Luton. Figure 37 shows prevalence of hypertension is similar by age group to the England and statistical neighbours.

Cancer

The following graphs show the incidence of different cancers in Luton compared to East of England and England from 1995-2006. They show overall for all cancers the incidence is similar to England and East of England following a large decrease from 1995-97 when the rates were much higher. This raises a question as to whether higher rates in the more deprived areas of Luton are being masked by the average and whether there is an issue about treatment in these areas.

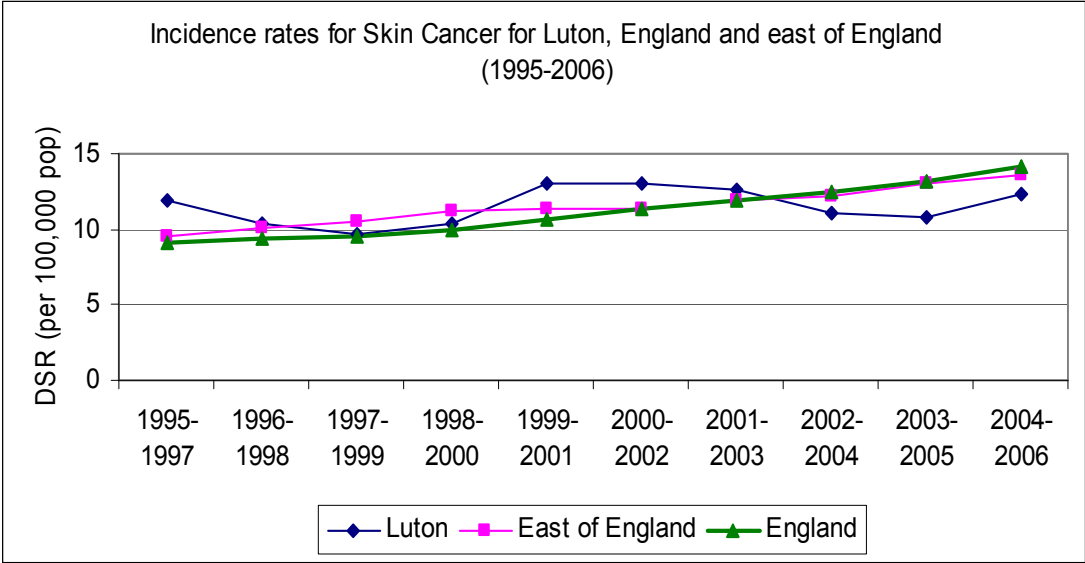
Figure 38: Incidence of all cancers



Source: National Cancer Information Service (NCIS)

Skin cancer incidence has fluctuated over the years. There were higher rates in 1999 to 2002, then the rates started to decrease up to 2005. They have since seen an increase in 2004-06, although the rates still remain lower than England and East of England.

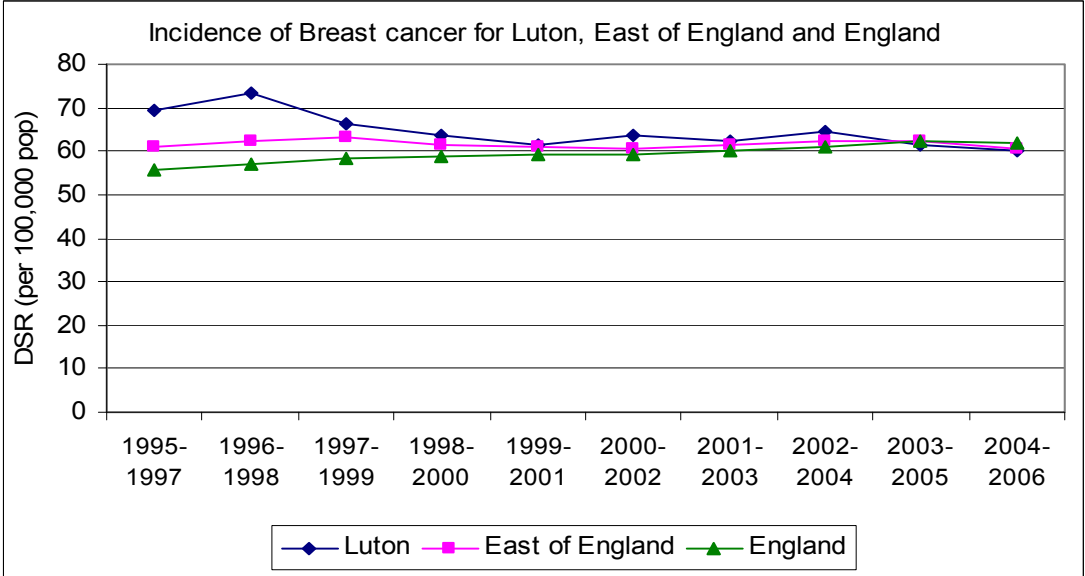
Figure 39: Incidence of skin cancer



Source: National Cancer Information Service (NCIS)

The incidence of breast cancer shows a similar picture to all cancers with similar rates to England and East of England after a decrease from 1995-97 when rates were much higher.

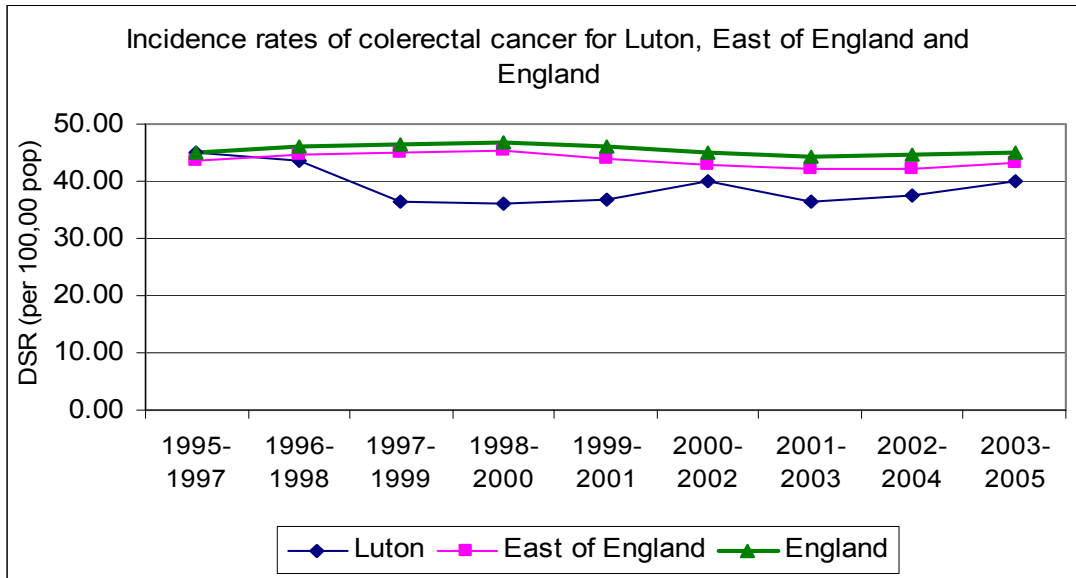
Figure 40: Incidence of Breast cancer



Source: National Cancer Information Service (NCIS)

Trends in incidence rates of colorectal cancer have fluctuated across the years but have remained lower than England and East of England. However, since 2001 rates have been increasing at a faster rate than the comparators.

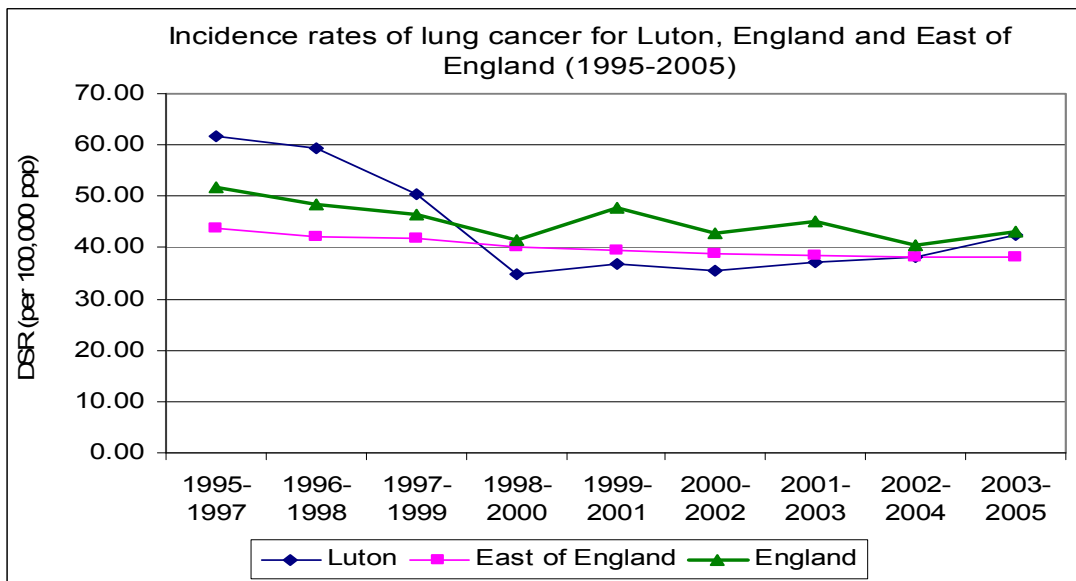
Figure 41: Incidence of colorectal cancer



Source: NCHOD

Trends in incidence rates of lung cancer show a large decrease from 1995 to 2000 in Luton and rates then remained below England and East of England until 2002-2004. Since this the rates started to increase and are now (2003-05) higher than East England but similar to England rates.

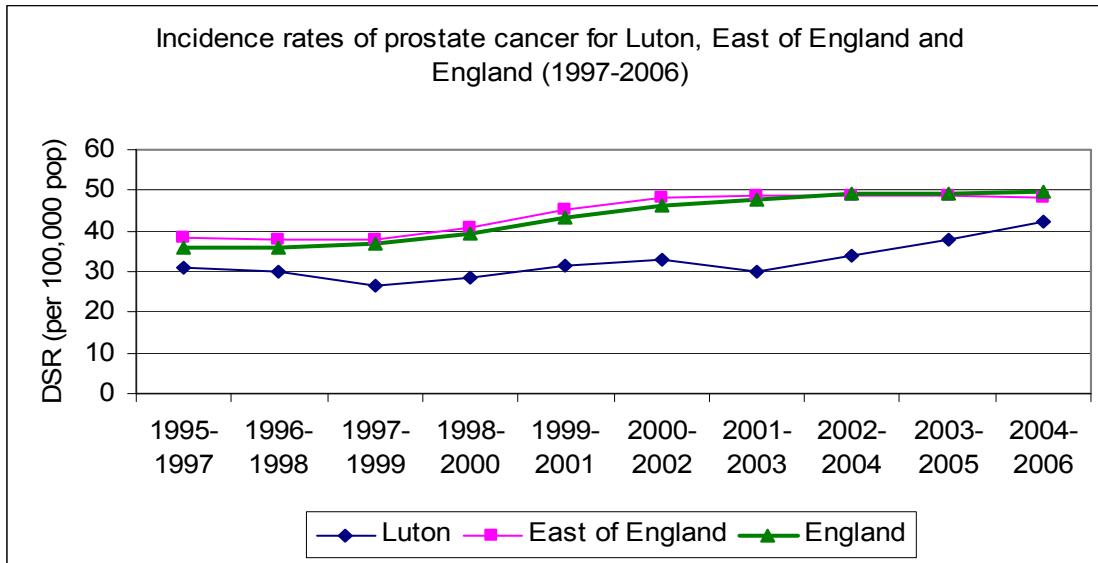
Figure 42: Incidence of lung cancer



Source: NCHOD

Trends in incidence of prostate cancer in Luton show they have been consistently below the England and East of England rates. However, they have been increasing at a much faster rate since 2001 and are now only just below the two comparators.

Figure 43: Incidence of prostate cancer



Source: National Cancer Information Service (NCIS)

Table 29: Programme budgeting for cancer in Luton, 2007/08

Spend on cancers and tumours (per 100,000 population)	% change from 2006-07	Rank (out of 152 PCTs)	Average cost - comparable (cluster PCTs)	Average cost - East of England PCTs	National average
8,007,614	56%	114	7,833,065	9,390,186	9,021,396

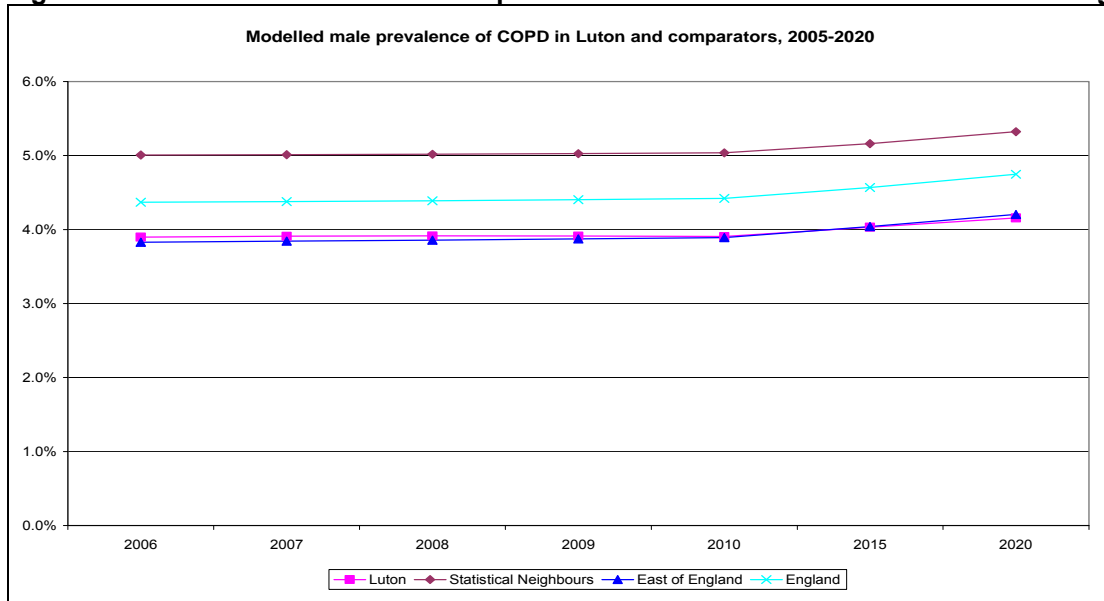
Source: Department of Health programme budgeting benchmarking tool, 2007-08

Table 29 shows that although Luton still spends less than comparators on cancers and tumours per 100,000 population they have increased spend by 56% from 2006-07.

Chronic Obstructive Pulmonary Disease (COPD)

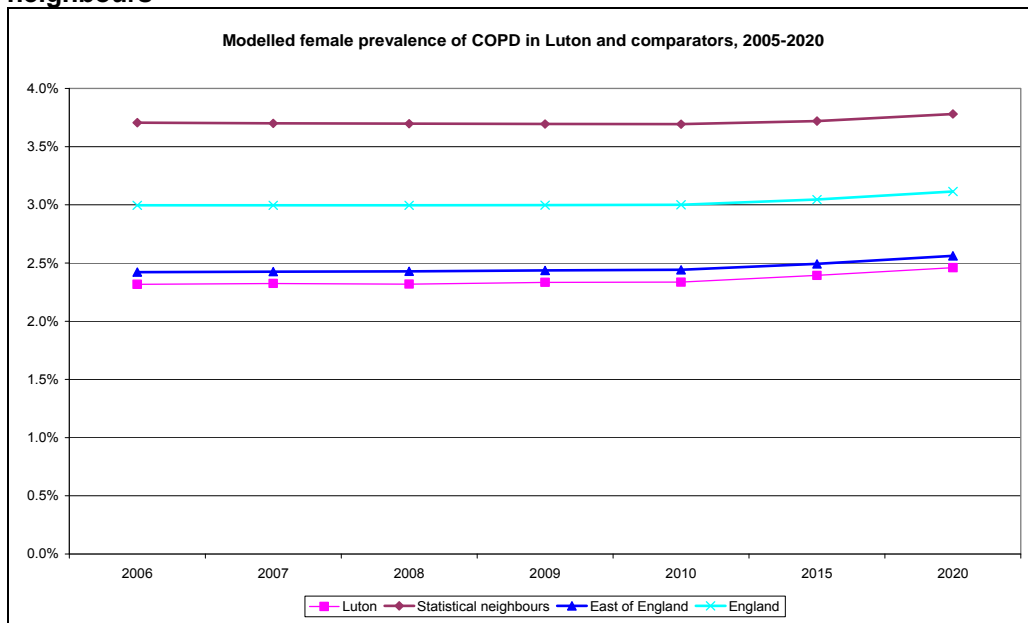
The APHO COPD model looks at prevalence of COPD in people aged 16 years and over and takes into account age, sex, ethnicity, smoking status, rurality and deprivation score. Figure 44 and Figure 45 below show Luton's expected prevalence of COPD (3.1%) is lower than the national (3.5%) and statistical neighbour average but slightly higher than the East of England (2.9%) for both males and females.

Figure 44: Modelled estimates of male prevalence of COPD in Luton and statistical neighbours



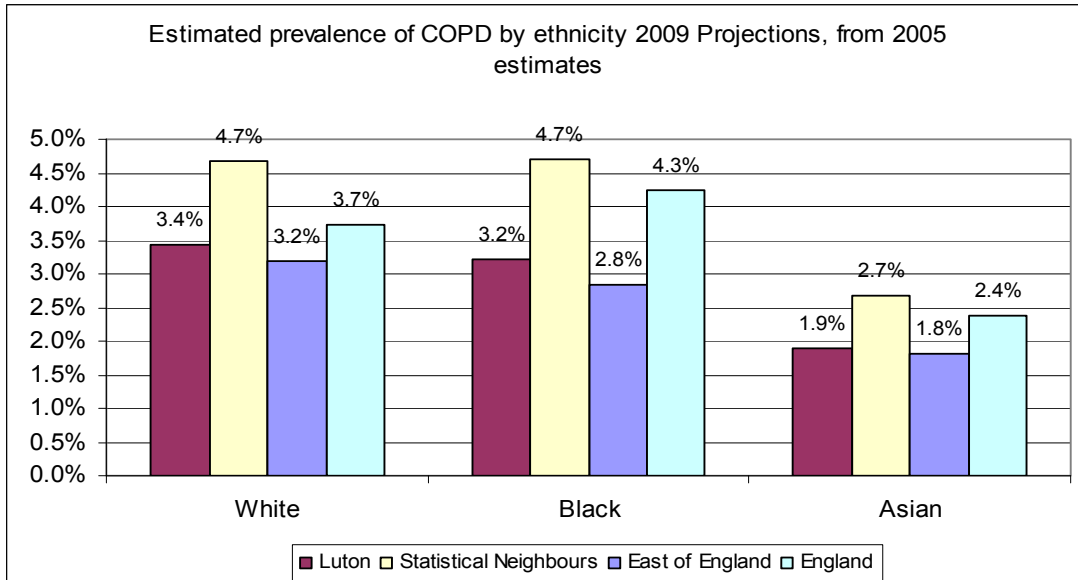
Source: Modelled estimates of prevalence of COPD for PCTs in England, APHO 2008

Figure 45: Modelled estimates of female prevalence of COPD in Luton and statistical neighbours



Source: Modelled estimates of prevalence of COPD for PCTs in England, APHO 2008

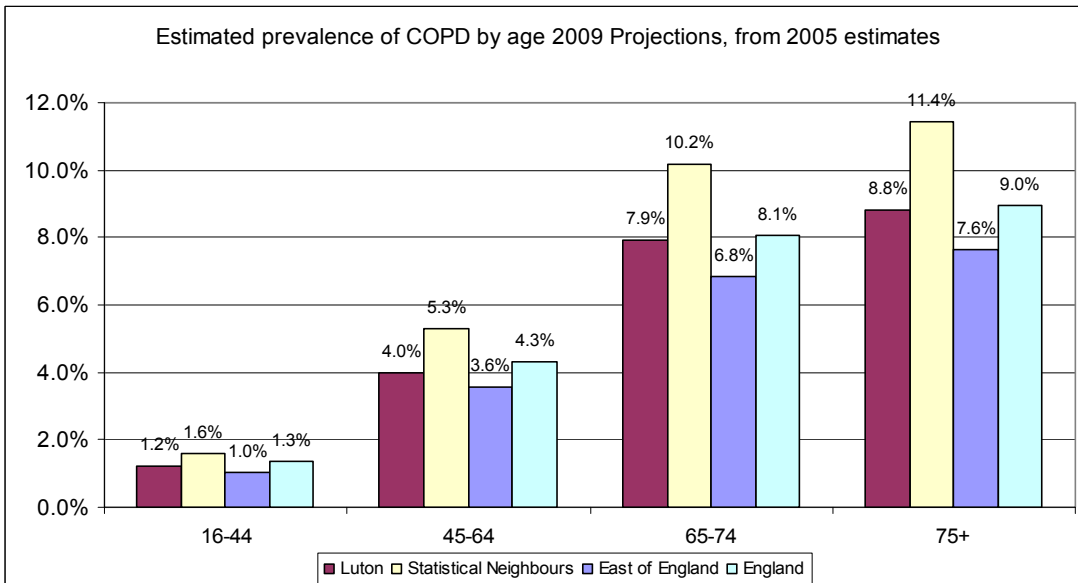
Figure 46: Modelled estimates of prevalence of COPD in Luton by ethnic group



Source: Modelled estimates of prevalence of COPD for PCTs in England, APHO 2008

Figure 46 shows Luton's estimated prevalence of COPD is lower than both the national and statistical neighbour average and slightly higher than the East of England across the three broad ethnic groups.

Figure 47: Modelled estimates of prevalence of COPD in Luton by age group



Source: Modelled estimates of prevalence of COPD for PCTs in England, APHO 2008

Figure 47 shows Luton's prevalence of COPD by age group is very similar to the national average but lower than the average for the statistical neighbours and higher than the East of England in all age groups.

Table 30: Programme budgeting for COPD in Luton, 2007/08

Spend on problems of the respiratory system (per 100,000 population)	% change from 2006-07	Rank (out of 152 PCTs)	Average cost - comparable (cluster PCTs)	Average cost - East of England PCTs	National average
1,089,758	-28%	13	892,872	999,000	1,064,124

Source: Department of Health programme budgeting benchmarking tool, 2007-08

Table 30 shows that Luton still spends more than comparators on COPD per 100,000 population but spend has decreased by 28% from the previous year.

Sexually Transmitted Infections

Chlamydia

Table 31: Chlamydia (uncomplicated) Quarter 3 2004 to 2007 and annual comparisons from 2004 to 2006 diagnosed at Luton and Dunstable.

	Annual comparisons			Quarterly Comparisons			
	2004	2005	2006	2004 Q3	2005 Q3	2006 Q3	2007 Q3
L&D	608	709	647	155	183	160	178

Source: Local Sexual Health Profile: STI Report to Third Quarter 2007. HPA East of England, Regional Epidemiology Unit, September 2008

National Chlamydia Screening Programme

Opportunistic screening for chlamydia in 15-24 year olds outside the GUM setting was piloted by the National Chlamydia Screening Programme (NCSP) in 1999 in two areas of England. Luton joined the programme in Phase 2 of the national roll-out - April 2006.

The aims of the programme are:

- to offer opportunistic screening to sexually active men and women under 25 years of age attending healthcare and non-healthcare settings
- to improve general sexual health awareness;
- to reduce the prevalence and costly sequelae of chlamydial infection in England.

In 2007-08 the Department of Health set the Local Delivery Plan (LDP) target at 15% of each PCT's total population aged 15-24 years old to be screened for Chlamydia via the NCSP. In 2008-09 the target was increased to 17%.

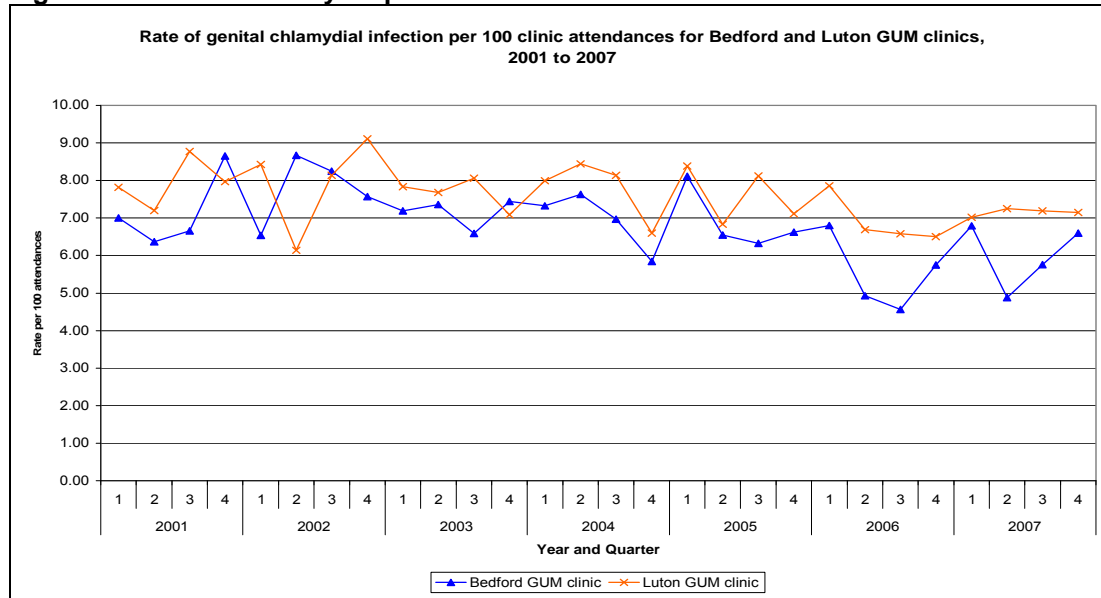
Table 32: Number and percentage of young people <25 screened for Chlamydia in 2007-08

	National Chlamydia Screening Programme			LDP PSA 11d	
	Males <25	Females <25	Total <25	% of 15-24 population	% of sexually active population
Luton	143	674	819	2.9	3.7

Source: NHS Local Delivery Plan data monitoring line (PSA11d). National Chlamydia Screening Programme

In 2008-09, 3889 young people were screened for Chlamydia representing 13.4% of the 15-25 population which was below the target (17%).

Figure 48: Rate of Chlamydia per 100 clinic attendances for Bedford and Luton GUM clinics



Source: Health Protection Agency

Figure 48 shows the rate of Chlamydia per 100 clinic attendances for the GUM clinic in Luton and Bedford. This data shows rates in Luton, on average, are higher in the clinic in Luton and have remained this way since 2004. It must be noted that this data is only for GUM clinics and thus will underestimate the total number of Chlamydia diagnoses made in an area. There is currently no population based denominator that can be used reliably to calculate rates per population for an area at a lower geographic level than the region as a whole. Information on Chlamydia and other STIs can be found at the Health Protection Agency (<http://www.hpa.org.uk/>).

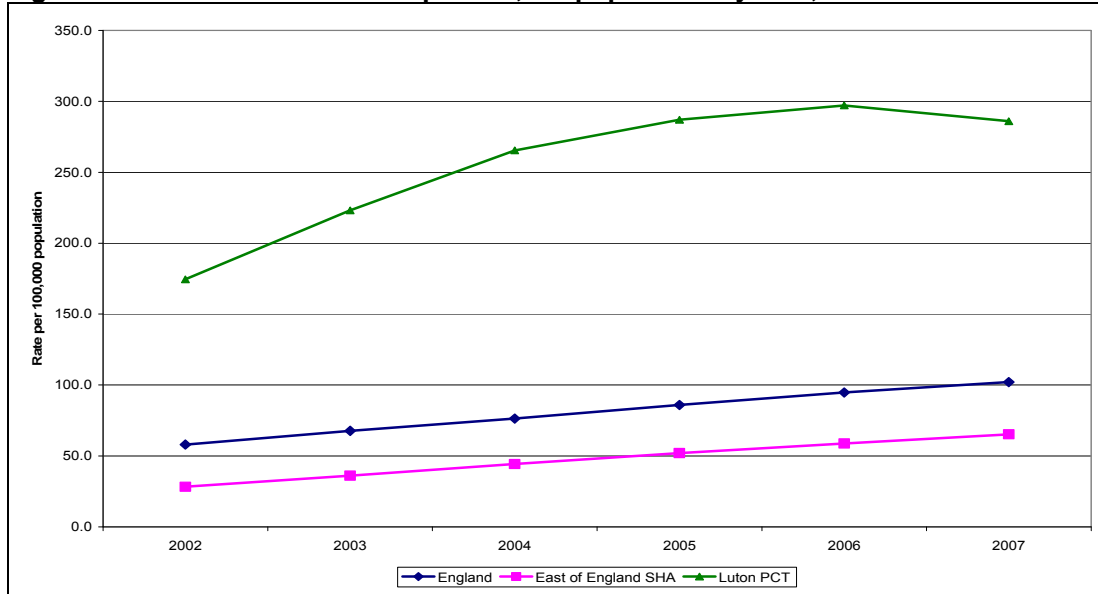
Reducing HIV incidence (local priority)

HIV is still one of the most important communicable diseases in the UK. In 2007 there were an estimated 77,400 people of all ages living with HIV across the UK^{xviii}. 733 people have been diagnosed with HIV at the L&D since 2000 and in 2007, there were approximately 540 Luton residents living with diagnosed HIV infection. However, this is likely to be an underestimate of the real number, since there are an estimated 21,000 people living in the UK who have not had their infection diagnosed.

The rate of HIV in 2007 in Luton is 286 people per 100,000 population which represents a decrease from the previous increasing trend from 2002.

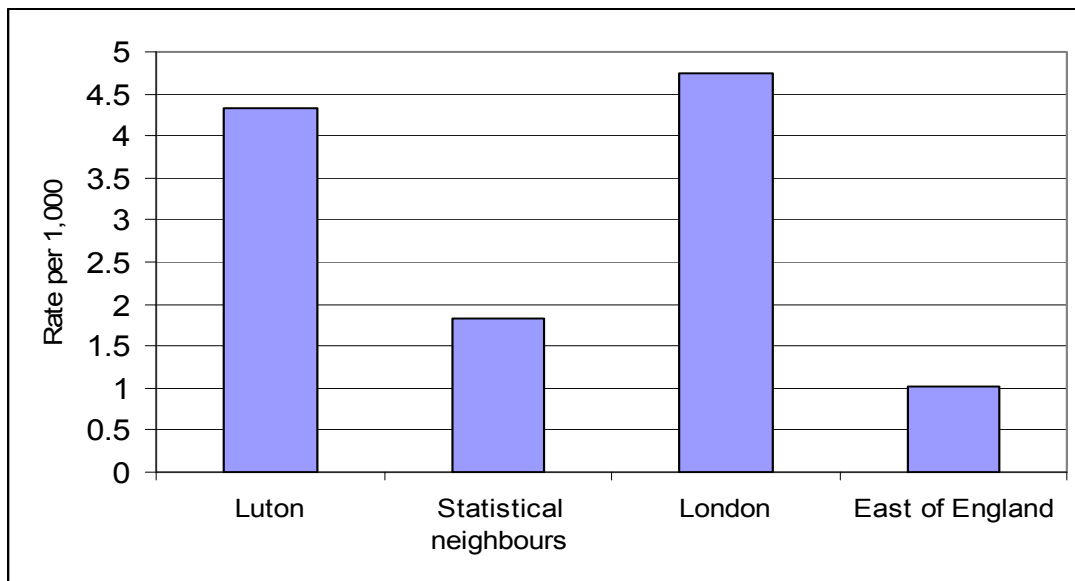
^{xviii} Health Protection Agency (2008). HIV in the United Kingdom: A 2008 Report. Available at http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1227515299695

Figure 49: HIV Prevalence Rates per 100,000 population by PCT, 2002 to 2007



Source: Health Protection Agency

Figure 50: HIV Prevalence Rates per 1000 population aged 15-59 Luton and comparators, 2007



Source: Health Protection Agency

Figure 50 shows Luton's rate is much higher than East of England and its statistical neighbours. This is mainly as a result of higher immigration into Luton from high prevalence countries and its proximity to London which has similar high rates of HIV to Luton. The Health Protection Agency identifies areas for wider HIV testing policies where a rate is above 2 per 1,000 15-59 year olds. The majority of the PCTs identified are situated in London however outside of London Luton has been identified as one with a rate of 4.34 per 1,000 15-59 year olds. There is no other area in the East of England that has a rate above 2.

The number of new diagnoses increased steadily from 50 cases in 2000 to a peak of 153 in 2003. Since then, there has been a steady decline in the number of new cases - 137 in 2004, 122 in 2005, 89 in 2006, 76 in 2007 and 73 in 2008 (KC60 data).

Since 2001 there have been twice as many women as men presenting with HIV. This indicates that heterosexual sex is the most likely route of transmission. The majority of people infected with HIV in Luton are in the 25-39 age groups and are predominantly from sub-Saharan Africa.

Table 33: Programme budgeting for HIV/AIDS in Luton, 2007/08

Spend on HIV/AIDS (per 100,000 population)	% change from 2006-07	Rank (out of 152 PCTs)	Average cost - comparable (cluster PCTs)	Average cost - East of England PCTs	National average
1,185,532	56%	26	1,688,422	344,644	854,431

Source: Department of Health programme budgeting benchmarking tool, 2007-08

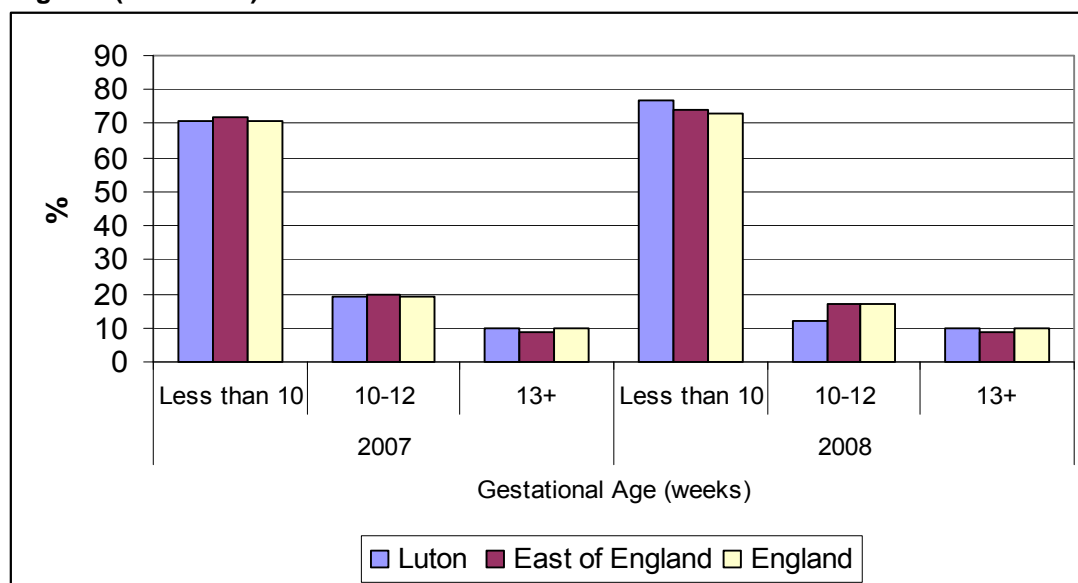
Table 33 shows that Luton still spends less than similar PCTs on HIV/AIDS per 100,000 population but spend has increased (reflecting the higher need in the area) by 56% from the previous year (2006-07).

Sexual Health Services

Access to Termination of Pregnancy services (NHS)

During 2006, 944 terminations were carried out amongst women within Luton giving a rate of 23 per 1000. Of these 64% were conducted under 10 weeks, which was in line with the national average for England and Wales (64.9%). In 2007, there was a reduction in both the number and rate with 905 terminations being carried out giving a rate of 21 per 1000. The percentage under 10 weeks had also increased to 71. The 2008 data showed an increase in the number performed (943) and a slight increase in rate (22/1000) and a significant increase in the number performed under 10 weeks (77%). This compares favourably with both the England average (73%) and the East of England average (74%). The increase in the number performed under 10 weeks may be due to the steps taken in 2007 to commission a provider to provide early medical abortions from a Luton based clinic avoiding the need for women to travel outside Luton.

Figure 51: Legal terminations (NHS funded) by gestational age in Luton, East of England and England (2007-2008)



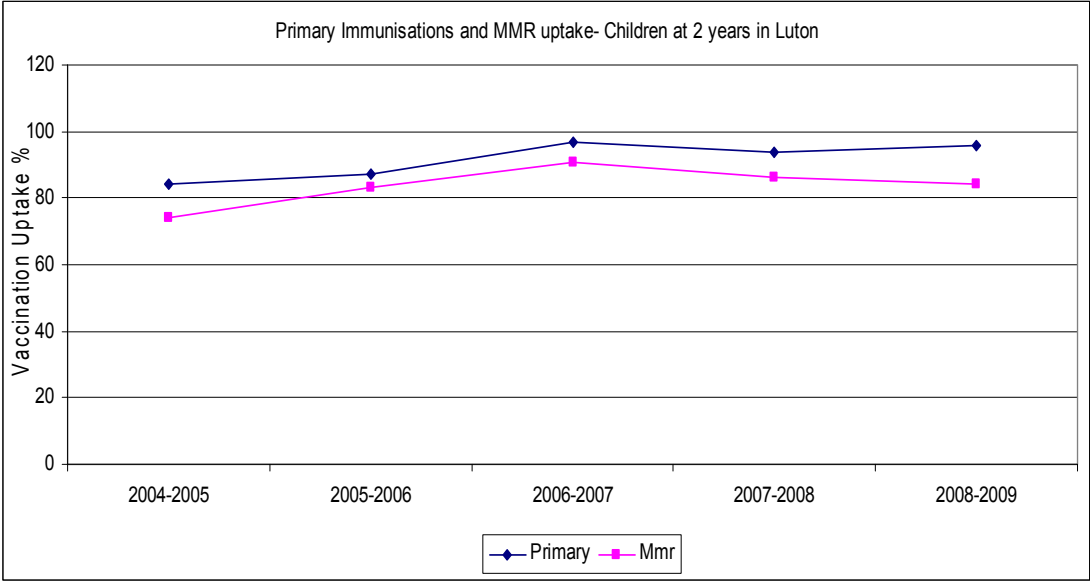
Source: Department of Health, Abortion Statistics

Immunisations and Vaccinations

Childhood Immunisations

The PCT working with LA partners has made child vaccination a priority. The focus has been on improving uptake focussing on children at the age of 2 years. There has been challenges sustaining the improvement that was made in 2006-07 (Figure 52) and processes involving stakeholders are being developed with a focus on maintaining this improved performance. The next step is to address uptake for children at the age of 5 years.

Figure 52: Primary immunisations and MMR uptake at 24 months 2004-2009

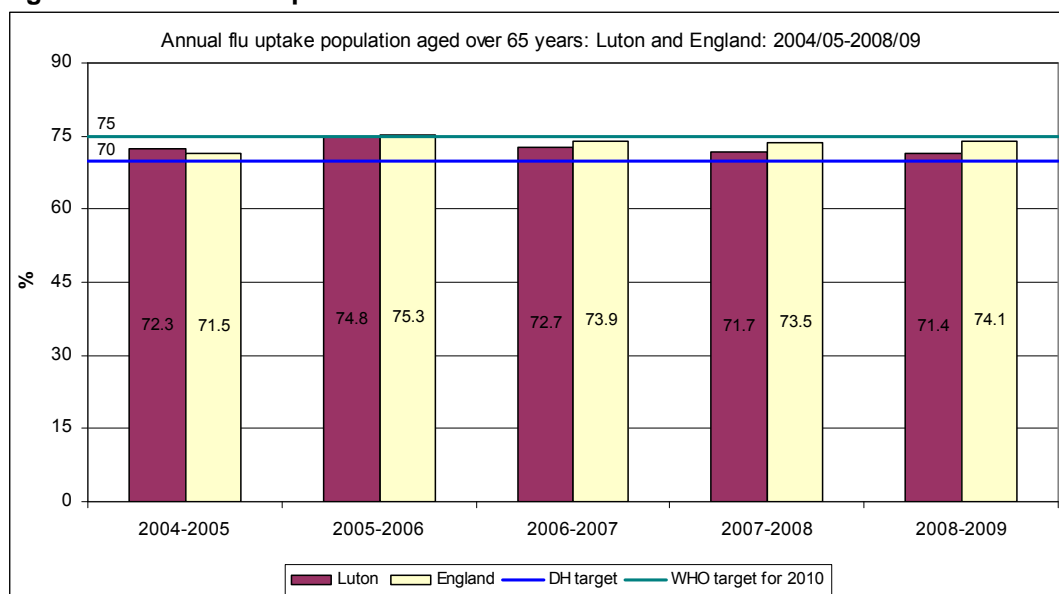


Source: COVER data

Annual Flu vaccinations

The annual influenza vaccination programme is delivered via General Practice to high risk groups based on age (population over the age of 65 years) and individuals over the age of 6 months considered at higher risk of morbidity and mortality associated with flu. The annual programme aims to not only protect the individuals at risk but to reduce the impact of flu and related exacerbations of chronic illness on health services.

Figure 53: Annual flu uptake



Source: Annual flu uptake survey

The national target is to achieve at least 70% uptake in the over 65 age group (there is no national target for high risk younger people) which at PCT level has been consistently achieved. There are however general practices who do not achieve this level of uptake, and the majority of practices have a significantly lower uptake of vaccination for their high risk younger population. As a PCT the uptake for this group by sub groups in 2008/09 can be found in Table 34.

Table 34: Flu Vaccination Uptake: aged 6 months to under 65 years, at risk, by disease: 2008/09

Area	CHD	Chronic Respiratory Disease	Chronic Renal Disease	Chronic Liver Disease	Diabetes	Diabetes on Medication	Immuno-suppression	Stroke/TIA	Chronic Degenerative neuro disease including MS
England	54.6%	45.3%	47.8%	37%	67.5%	70.6%	43.6%	57.3%	33.5%
Luton	54.5%	38.6%	42.5%	35.3%	64.4%	67.2%	40.8%	56%	35.7%

Source: HPA

Key Issues: Health Status of the Population

This section highlights the key issues relating to the Health Status of the Population that commissioners will need to take into account when planning services:

Life Expectancy

- There are significant health inequalities within Luton and future planning must address the gap in life expectancy between the 5 priority MSOAs with lowest life expectancy and the 5 with the highest
- Luton’s life expectancy for males is 1.1 years lower than the national average and for females the gap is 1.5 years. The gap for females widened at the beginning of this decade. (JSNA 2008)
- The life expectancy projections suggest that Luton’s figures will continue to improve to 2009-11 but that they are not getting closer to national life expectancy levels. (JSNA 2008)

- Luton's life expectancy at the age of 65 years is similar to the national figure for males but is lower than average for females. (JSNA 2008)
- On average about three quarters of people over the age of 65 are expected to be in good health and about half are expected to be free from disability. (JSNA 2008)

Diabetes

- Luton's recorded prevalence of diabetes is higher than both the regional and national averages. (JSNA 2008)
- According to the national (PBS) model, the overall prevalence of diabetes in Luton (which includes those not yet diagnosed) is also above the regional and national averages.
- There is a higher estimated prevalence of diabetes within the Asian and Black communities in Luton and the wards with the highest estimated prevalence are Biscot, Challney and Dallow
- According to programme budgeting data spend on diabetes in Luton increased by 27% from 2006-07 to 2007-08

Hypertension:

- Estimated prevalence of hypertension in Luton is lower than the national estimate and similar to statistical neighbours for both males and females.
- Further work needs to be undertaken to ensure that all the registers are complete especially among practices with a higher number of patients from a BME background (JSNA 2008).
- To improve the levels of hypertension and reduce the risk of circulatory disease all patients on registers need to have access to health improvement services such as weight management programmes and stop smoking services (JSNA 2008).

Cardiovascular Disease (CVD)

- Mortality rates from circulatory diseases continue to fall (JSNA 2008)
- However, Luton's death rates from circulatory diseases overall, and for CHD in particular, are still higher than the national average. Local figures for stroke deaths are very similar to the national rates (JSNA 2008)
- Male mortality from CHD is twice as high as female mortality, but for stroke there is no significant difference (JSNA 2008)
- Luton appears to have a lower than average number of people on CHD registers, and has a low estimated prevalence of CHD overall. These figures need to be understood further given the population characteristics and high mortality locally. (JSNA 2008)
- Despite relatively high death rates Luton appears to be spending less on circulatory diseases than similar PCTs and the national average. (JSNA 2008) Although spend still remains lower than comparators Luton has increased spend in this area by 28% from 2006-07 to 2007-08

Cancer

- Cancer deaths have declined more slowly than those from circulatory diseases and are now the main cause of death in the under 75s. (JSNA 2008)
- Death rates for males are higher than for females, but the difference is not as great as it is for heart disease. (JSNA 2008)
- The inequality gap for premature mortality from cancer, in males, between the most and least deprived areas is widening
- Luton's death rate from cancers has broadly followed the national trend but with big fluctuations from year to year. (JSNA 2008)
- In the most recent three year period Luton's cancer death rate has been the same as the national average. (JSNA 2008)
- Luton spends less than its comparator PCTs and the national average on cancer, ranked at 149 out of 152 PCTs. (JSNA 2008). Although spend still remains lower than comparators Luton has increased spend in this area by 56% from 2006-07 to 2007-08 and is now ranked 114 out of 152 PCTs.

COPD

- Luton's mortality rate from COPD is higher than the national average (JSNA 2008) although estimated prevalence is lower.
- Mortality is higher for males than females, both locally and nationally (JSNA 2008)
- Prevalence models suggest a much higher number of people with COPD than are recorded on local GP registers and a higher prevalence than the East of England. (JSNA 2008)
- Luton's spend is higher than the national average and comparable PCTs. (JSNA 2008). Although spend still remains higher than comparators Luton has decreased spend in this area by 28% from 2006-07 to 2007-08

Sexually Transmitted Infections

- Luton has a high prevalence of HIV infection, amounting to 286 per 100,000 population.
- The number of new cases of HIV reached a peak in 2003 and has been falling every year since then. (JSNA 2008)
- It is estimated that approximately one third of people are infected with HIV but have not been diagnosed
- Luton's spend on HIV is higher than the national average, but low compared to similar PCTs. (JSNA 2008). Although spend still remains lower than similar PCTs, Luton has increased spend in this area by 56% from 2006-07 to 2007-08
- The gonorrhoea infection rate in Luton has been falling in recent years and is now close to the national average. (JSNA 2008)
- Chlamydia is the most common sexually transmitted infection in terms of the numbers of new cases each year. (JSNA 2008)
- The Chlamydia infection rate has been rising in recent years but fell in 2006. (JSNA 2008)
- The group most at risk from Chlamydia are those aged between 15 and 24 years. (JSNA 2008)
- The uptake of Chlamydia screening is below the national target

Access to Pregnancy Termination services

- The levels of terminations of pregnancy are relatively high in Luton (JSNA 2008)
- The proportion of abortions carried out before ten weeks has increased significantly and is now above the regional and national average.

Immunisations and Vaccinations

- A significant amount of investment by the PCT delivered an immunisation coverage in Luton that was one of the best in the country (JSNA 2008). However, uptake has decreased generally in 2008/09 and action needs to be taken to address this situation
- The increase in MMR coverage is particularly large, reflecting improved local systems and the wider acceptance of the vaccine amongst parents. (JSNA 2008)
- Luton has achieved the flu vaccination coverage target for the last 3 years however there needs to be a greater focus on promoting the uptake of immunisations in higher risk groups such as individuals diagnosed with chronic diseases. (JSNA 2008)

7. Healthcare Activity

Hospital Admissions

The table below shows a breakdown of the Healthcare Resource Group (HRG) chapters ranked by cost and number of spells. It shows the highest cost in 2008-09 was for musculoskeletal disorders (ranked fourth highest in terms of number of admissions) and the highest number of spells was for diseases of the childhood (ranked fifth highest in terms of cost).

Table 35: HRG chapter with ranking for cost and number of spells in 2008/09.

HRG chapter	Cost rank (1= highest spend)	Spell rank (1 = highest number of spells)
H Musculoskeletal System	1	4
N Obstetrics and Neonatal Care	2	2
F Digestive System	3	3
E Cardiac Surgery and Primary Cardiac Conditions	4	5
P Diseases of Childhood	5	1
D Respiratory System	6	9
L Urinary Tract and Male Reproductive System	7	6
A Nervous System	8	10
C Mouth, Head, Neck and Ears	9	8
G Hepato-Biliary and Pancreatic System	10	16
W Immunology, Infectious Diseases, and other contacts with health	11	14
J Skin, Breast and Burns	12	13
S Haematology, Infectious Diseases, Poisoning and Non-Specific Groups	13	11
M Female Reproductive System	14	15
Q Vascular System	15	17
B Eyes and Periorbita	16	12
K Endocrine and Metabolic System	17	18
V Multiple Trauma, Emergency and Urgent Care and Rehabilitation	18	19
U Undefined Groups	19	7

Source: SOLLIS

Ambulatory care sensitive conditions (ACSC)

Ambulatory care sensitive conditions (ACSC) are a group of 19 diseases for which hospital admission in adults may be avoidable by effective management in primary care. There are three groups, preventable by vaccination, avoidable through secondary prevention or better patient self-management and those amenable to lifestyle interventions. A brief from the Eastern Region Public Health Observatory^{xix} shows considerable variation between PCTs in the East of England, some of which is linked to deprivation and disease prevalence. It must be noted the data looking at admission rate ratios is from 2006-07 and therefore the picture may have changed and will be amended when new data is published.

The briefing identifies that one of the implications is productivity opportunity from avoiding admissions and ensuring services are commissioned or redesigned effectively. This is based on data from the

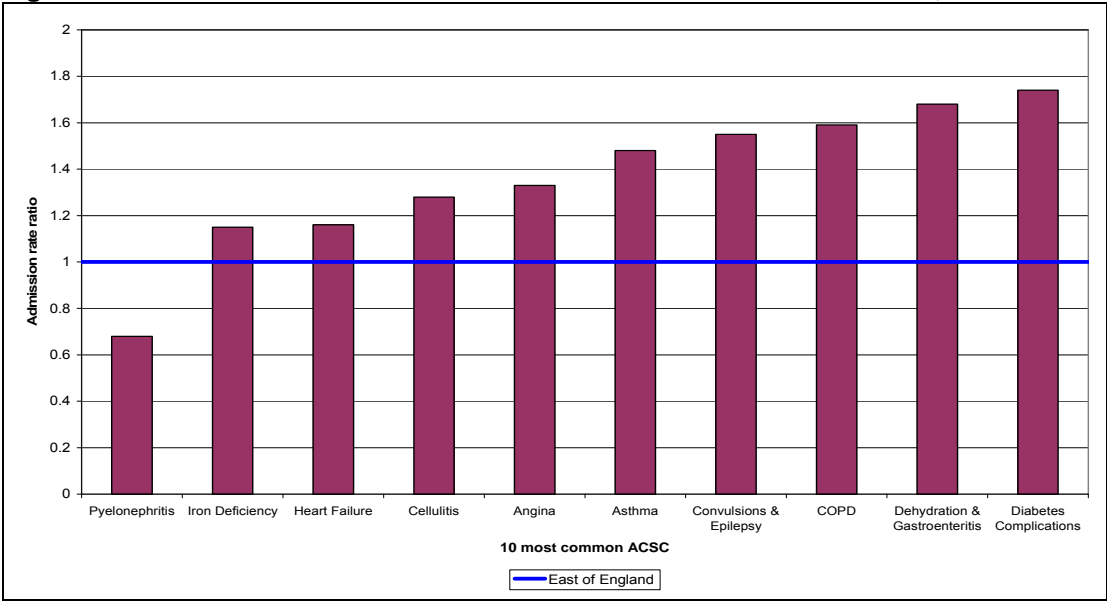
^{xix} Commissioning brief No. 1: Ambulatory care sensitive conditions (ACSC) in the East of England available at <http://www.erpho.org.uk/viewResource.aspx?id=19016>

NHS Institute of Innovation and Improvement through its NHS productivity website (2008-09)^{xx}.

Although the time-periods covered are different the briefing highlights that the data is in agreement as Luton is identified as having a greater than national average productivity opportunity, as well as having high ACSC rates in many conditions (2006-07). Figure 54 shows these admission rate ratios for the 10 most common ACSC in Luton and Figure 55 shows the rate ratio for all ACSC disease across East of England PCTs.

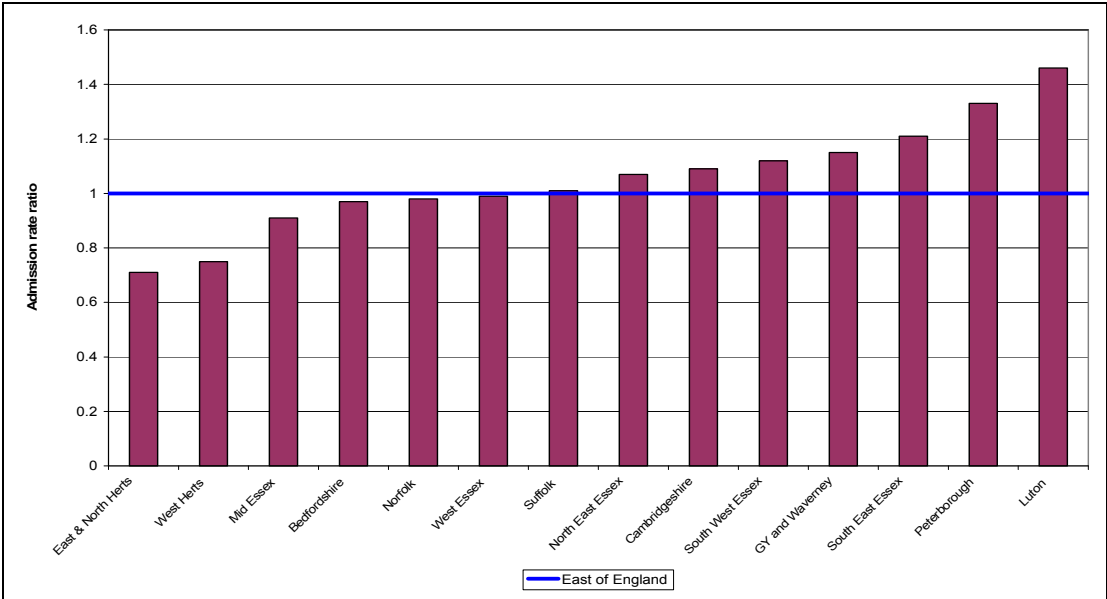
Figure 54 shows Luton has a higher than regional rate in 9 of the 10 most common ACSC diseases, 7 of which are significantly higher. The highest rate ratio is in diabetes complications. Figure 55 shows Luton has the highest rate ratio across the PCTs for all ACSC conditions combined.

Figure 54: Admission rate ratios for the 10 most common ACSC for Luton, 2006-07



Source: ERPHO commissioning brief No. 1 – ambulatory care sensitive conditions

Figure 55: Admission rate ratios for the 10 most common ACSC for East of England PCTs, 2006-07



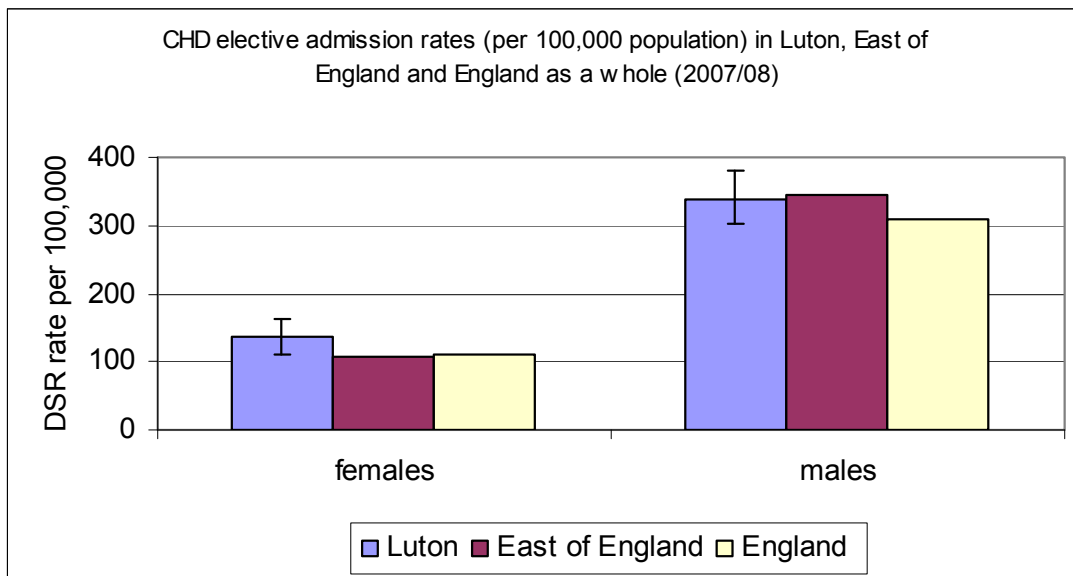
Source: ERPHO commissioning brief No. 1 – ambulatory care sensitive conditions

^{xx} NHS Productivity Website – <http://www.productivity.nhs.uk/>

Coronary Heart Disease hospital admissions

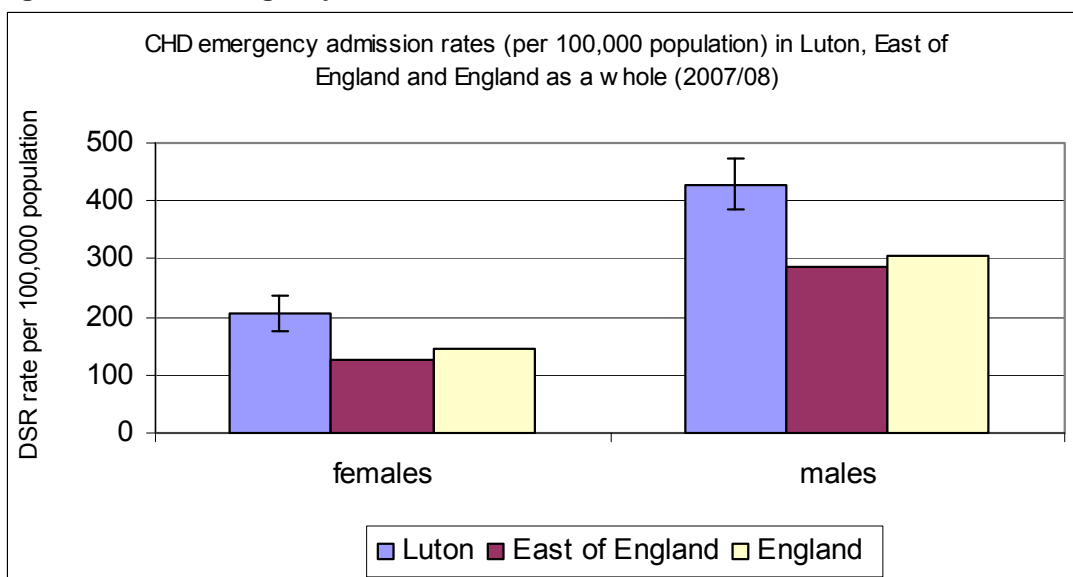
Figure 56 and Figure 57 show CHD admission rates are higher for males than females. The elective admission rates for Luton are not significantly different to the England or East of England average. However the rates for emergency admissions for CHD in Luton in 2007/08 appear higher in relation to the comparators.

Figure 56: CHD elective admissions



Source: APHO HES Atlas

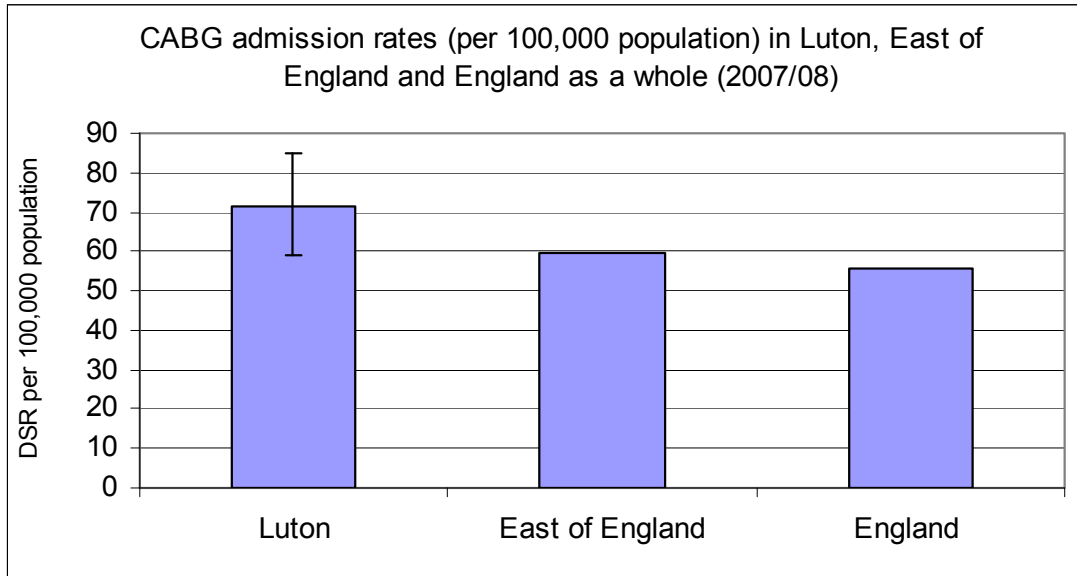
Figure 57: CHD emergency admissions:



Source: APHO HES Atlas

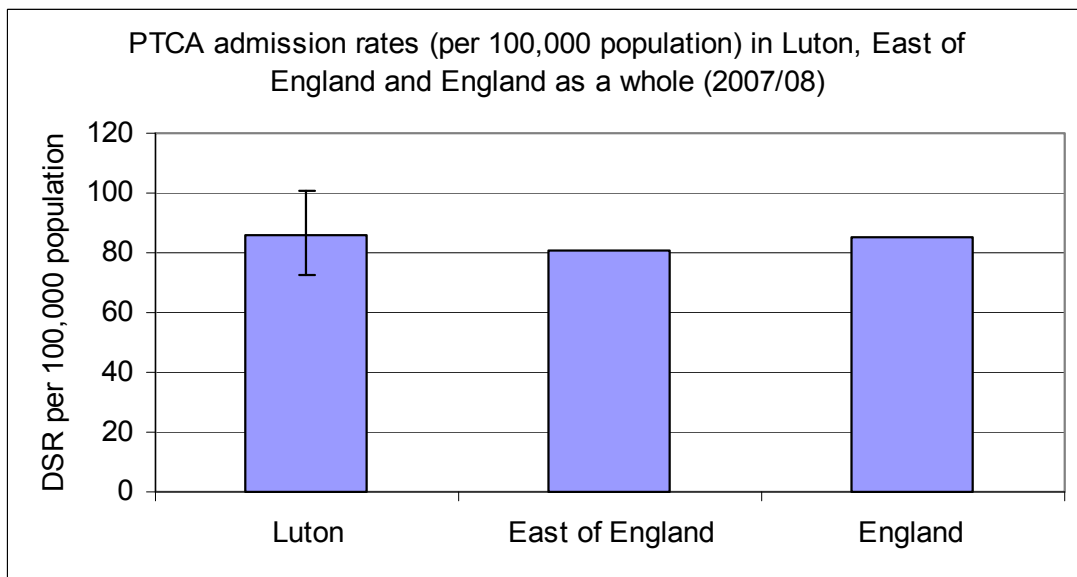
Figure 58 and Figure 59 show two most common procedures carried out on patients with CHD. Luton's rate of admissions for coronary artery bypass graft (CABG) appear higher than East of England and England as a whole although the wide confidence intervals show this is not significantly higher. Luton's rate for percutaneous transluminal coronary angioplasty (PTCA) does not appear to be different to the comparators.

Figure 58: Coronary artery bypass graft (CABG) admission rates



Source: APHO HES Atlas

Figure 59: Percutaneous transluminal coronary angioplasty (PTCA) admission rates

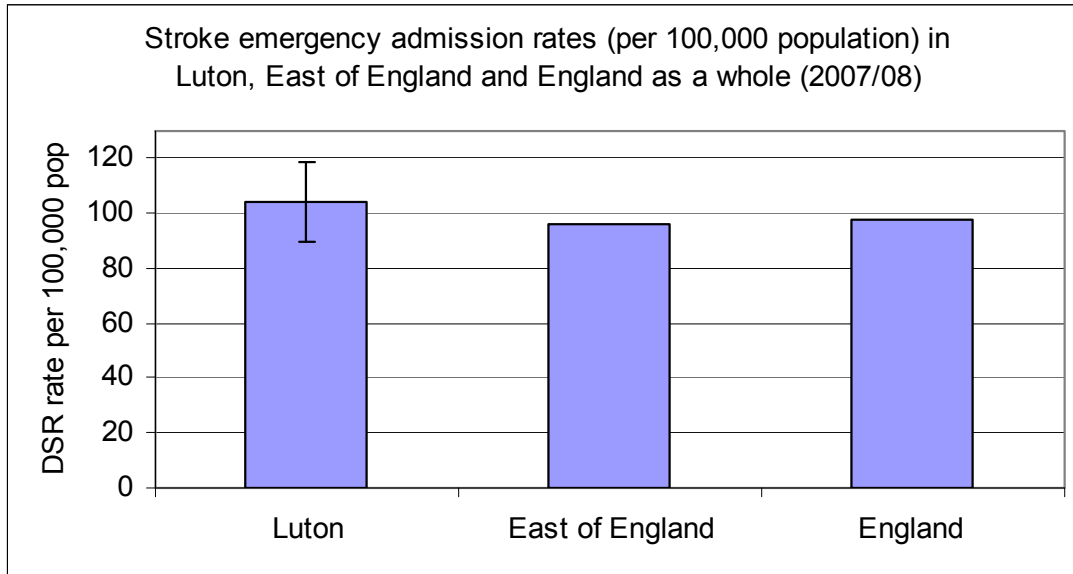


Source: APHO HES Atlas

Stroke hospital admissions

Figure 60 shows the emergency admission rate for stroke in Luton (2007/08) was not significantly different to England and East of England.

Figure 60: Stroke emergency admissions

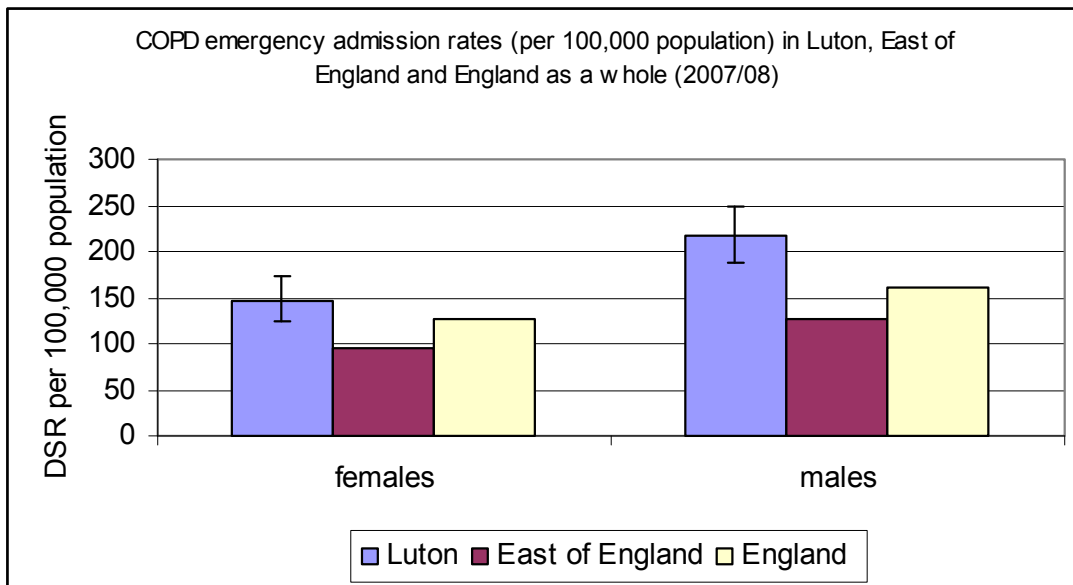


Source: APHO HES Atlas

Other Hospital Admissions

Emergency admissions for COPD in Luton in 2007/08 appear significantly higher than the East of England and not significantly different to the England average as shown in Figure 61.

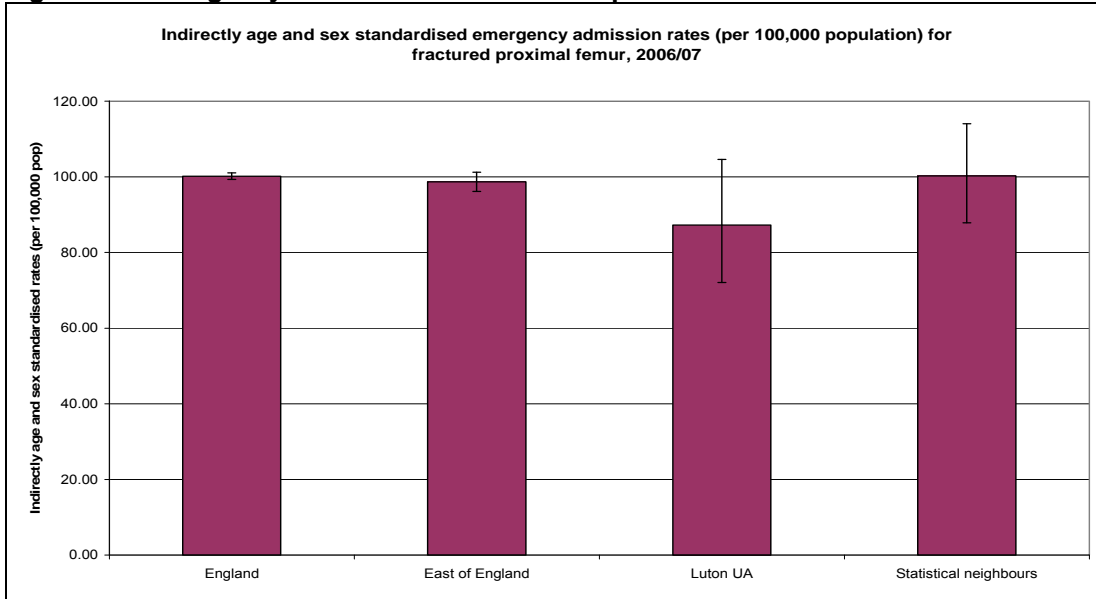
Figure 61: Emergency admissions for COPD



Source: APHO HES E-Atlas

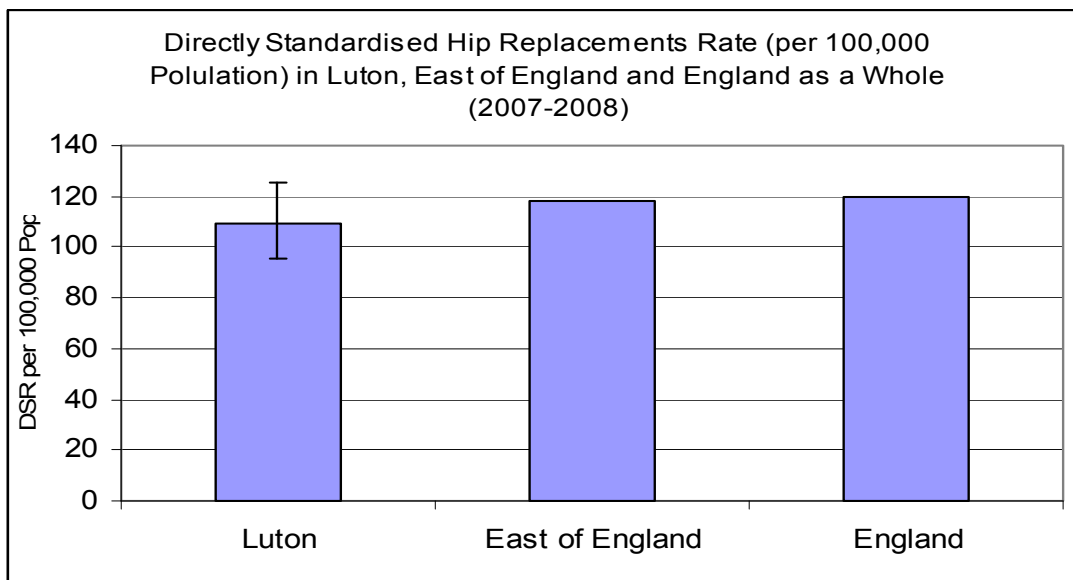
Figures 62, 63 and 64 show emergency admissions for fracture proximal femur (2006/07), hip and knee replacements (2007/08) in Luton are not significantly different to comparators.

Figure 62: Emergency admissions for fractured proximal femur



Source: NCHOD

Figure 63: Directly Age Standardised Rate of Hip Replacements



Source: POPPI

Figure 64: Directly Age Standardised Rate of knee Replacements



Source: Poppi 2008

Key Issues: Healthcare Activity

This section highlights the key issues relating to Healthcare Activity that commissioners will need to take into account when planning services:

- Emergency care episodes account for more than elective and day case episodes combined raising questions about the balance of care. (JSNA 2008)
- The main causes of day case treatment is within
 - general medicine
 - general surgery
 - ophthalmology and
 - gynaecology. (JSNA 2008)
- The two main causes of elective hospital admission are:
 - Trauma and Orthopaedics and
 - General Surgery (JSNA 2008)
- The main causes of emergency episodes are general medicine and paediatrics. (JSNA 2008)
- The better management of long term conditions in primary care and the community should reduce secondary care activity.
- NHS Luton should use standardised comparators to measure performance with cluster PCTs and against the national admissions data. (JSNA 2008)

8. Public Voice

Introduction

Involving, engaging and consulting the public to shape services and improve health and well being lies at the forefront of national policy. As the key agents responsible for planning and delivering local services, the Council and Primary Care Trust play a crucial role in gathering and acting on the views of service users, patients and local residents, including those who are “easy to overlook”.

Improving the quality of local services cannot occur without feedback from the community about what is working well, and what requires improvement. Knowing what works well and what doesn't helps us to plan and press for improvements where they are needed. Feedback also helps us to make commissioning decisions which reflect the needs, priorities and aspirations of the local population, and develop user-led services that are co-created with the community, for the community.

This chapter provides an overview of work undertaken to continue our engagement with the community, and feedback provided by the public since the JSNA was published in 2008.

Update on engagement activity since the previous JSNA

Luton's residents have provided invaluable feedback through a range of engagement opportunities including national and local patient satisfaction surveys, home care surveys, service reviews and specific consultation exercises for example:

the NHS Constitution, the GP Patient Survey, the Sustainable Community Strategy, a health needs assessment of gypsies/roma/travellers, sheltered housing survey, the Carers Commissioning Strategy, Older People Needs Analysis (for the Partnership for Older People Project).

A variety of issues and concerns have been raised by residents through this engagement process which include the following:

- People living with HIV/AIDS are sometimes treated without proper dignity and respect, with breaches of confidentiality by staff. There is also a need to increase awareness of HIV/ sexual health service provision, provide information on wider social issues and clarify the role of care-givers.
- Better information-sharing, follow-up, telephone access and choice in primary care. Improved waiting times for appointments, communication, awareness of services and annual health checks for GP patients were also raised, with preference expressed for generalist GPs providing lifetime care.
- High levels of satisfaction with single sex accommodation at the Luton & Dunstable Hospital, but low levels of satisfaction with waiting times, cleanliness and information about treatment, care and discharge
- Better information and awareness about the Improving Access to Psychological Therapies Service, access to this service outside normal hours, partnership-working and need to develop an inclusive service with a diverse workforce which reflects the diversity of the community.
- Overall satisfaction with community health services rated as “good” or “very good”, including choice of appointment, location, privacy and cleanliness.
- The need for a co-ordinated approach and improving access to the health needs of gypsies, roma and travellers living in Luton

- Health and wellbeing was adopted as one of the four themes for the Sustainable Community Strategy. As part of the consultation on this residents said we have good doctors in Luton but that there is a lack of resources leading to long waiting times and difficulties in getting appointments if it is not an emergency. Residents also felt there was a lack of information about changes from organisations such as the Council and the NHS.
- Greater understanding of the wide range of needs for older people
- Greater understanding of the needs and priorities of carers

Engagement around health services and health issues will continue throughout 2009-2010 with a review of Urgent Care Services, Primary and Community Care Services and work to increase access to dentistry services. The personalisation agenda for social care will also be an important consultation exercise this year.

An older people's whole system strategy is being developed – looking at priorities for people aged over 50, and not just those in contact with health and social care services.

The Place Survey

The national release of the results of the Place survey were delayed until just before the JSNA refresh was produced however some headline results are:

- 72.4% of people say their health is good or very good (NI 119)- the national average is 75.8%
- 25.5% of people think that older people in their local area get the help and support they need to continue to live at home for as long as they need to (N1 139) – the national average is 29.3%

Local Involvement Network

The Luton LINK is now a well-established network of individuals and organisations representing a range of health and social care partners including the voluntary, community and faith sector, statutory agencies (health and social care), regional bodies, individuals and other organisations.

An elected Chair, Vice Chair, core group and working focus groups with a clear governance structure have engaged the local community and decision-makers in five agreed priority areas:

- Commissioning
- Acute Care
- Elderly and Carers
- Transport
- Marketing for the LINK

Early work by the focus groups has concentrated on patient safety and discharge (Acute Care), the Urgent Care Review (Commissioning) and transformation of adult social care (Elderly and Carers). The LINK is also represented on a wide range of local boards and steering groups.

Luton's LINK will be essential in helping us to identify health and social care needs in the local community and obtain the views of patients, residents and carers about services. We will develop action plans with full regard to the evolving nature of the LINK, and sensitivity to its need to develop its own agenda. A joint approach to gathering the views of local people will be adopted, and we will remain fully involved in LINK activities.

Our wish is to see the LINK emerge as a key channel for involvement as it works with other community and voluntary organisations to gather the views of local people. We are also keen to ensure the LINK is an effective “critical friend”, and its representatives are supported to be effective in order to influence decision-making, strengthen the voice of local people and work with partners to engage the community.

Community engagement

The Local Strategic Partnership, the Luton Forum, is developing a comprehensive community engagement strategy to ensure a joined up approach by partners and a project team was set up in April 2009. The Neighbourhood Governance pilot in the West area of the borough is developing an innovative approach to community planning across the partners, with the aim of the pilot being extended across the whole borough.

Community Involvement in the JSNA

Our engagement with the community is an on-going process that continues to grow. Building on early engagement with the voluntary and community sector to consult on the JSNA, NHS Luton held a series of further meetings with voluntary groups to strengthen links with partners, build strong contractual relationships and discuss commissioning priorities. We will ensure this process continues to shape service planning, delivery and decision making, and development of the JSNA.

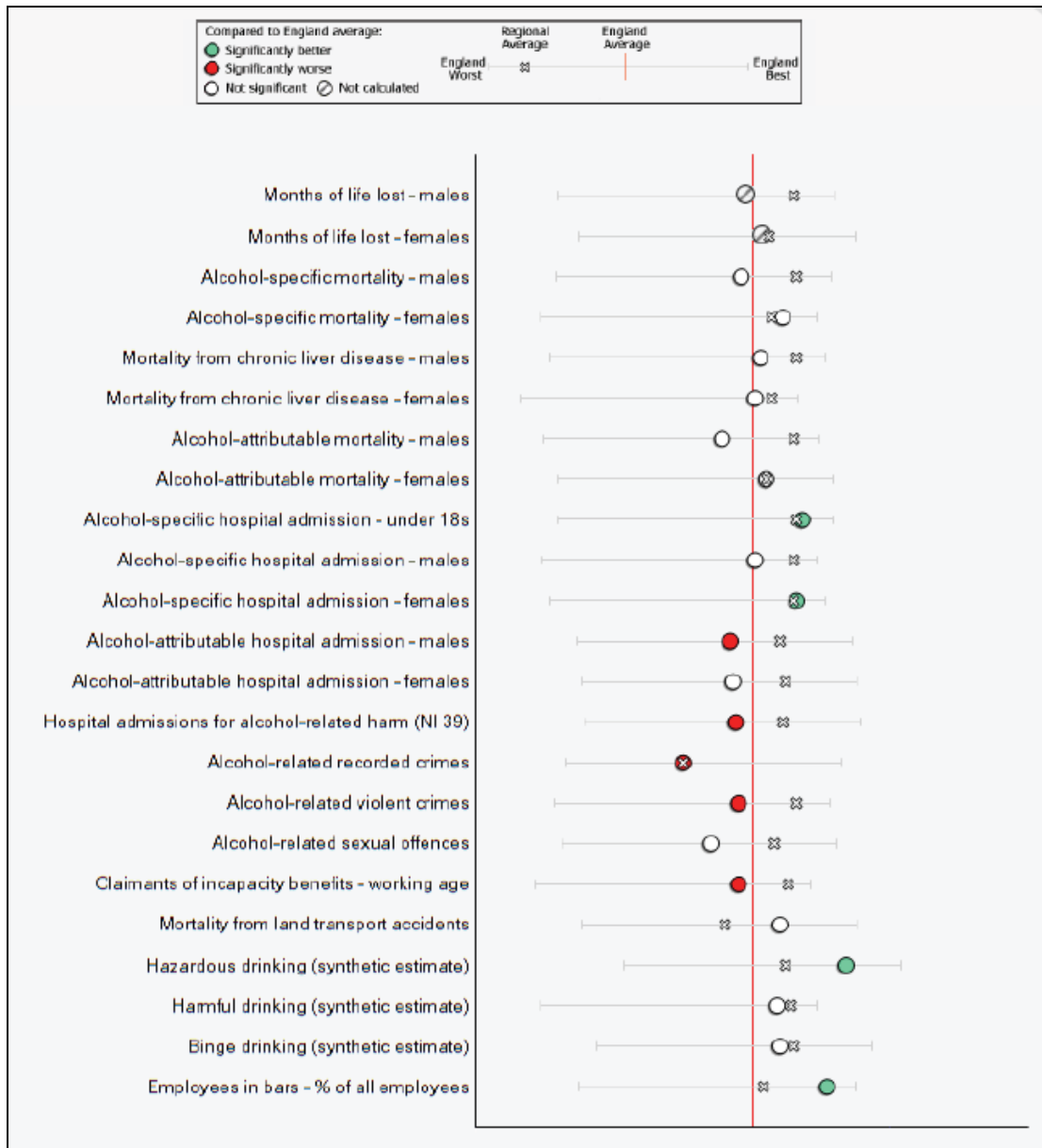
9. Next Steps

The key findings emerging from this JSNA supplement will be disseminated to key strategic partnerships and forums within the Borough to ensure that relevant issues can be addressed in commissioning plans and strategic documents.

The working group will continue to meet and develop plans to produce a revised version of the JSNA. This will be published in time to inform the refresh of the Local Area Agreement in 2011.

Appendix 1

Alcohol profile



Source: Local Alcohol Profile – profile of alcohol related harm for Luton, NWPHO

Appendix 2

East of England Lifestyle Survey - PCT Data Summaries

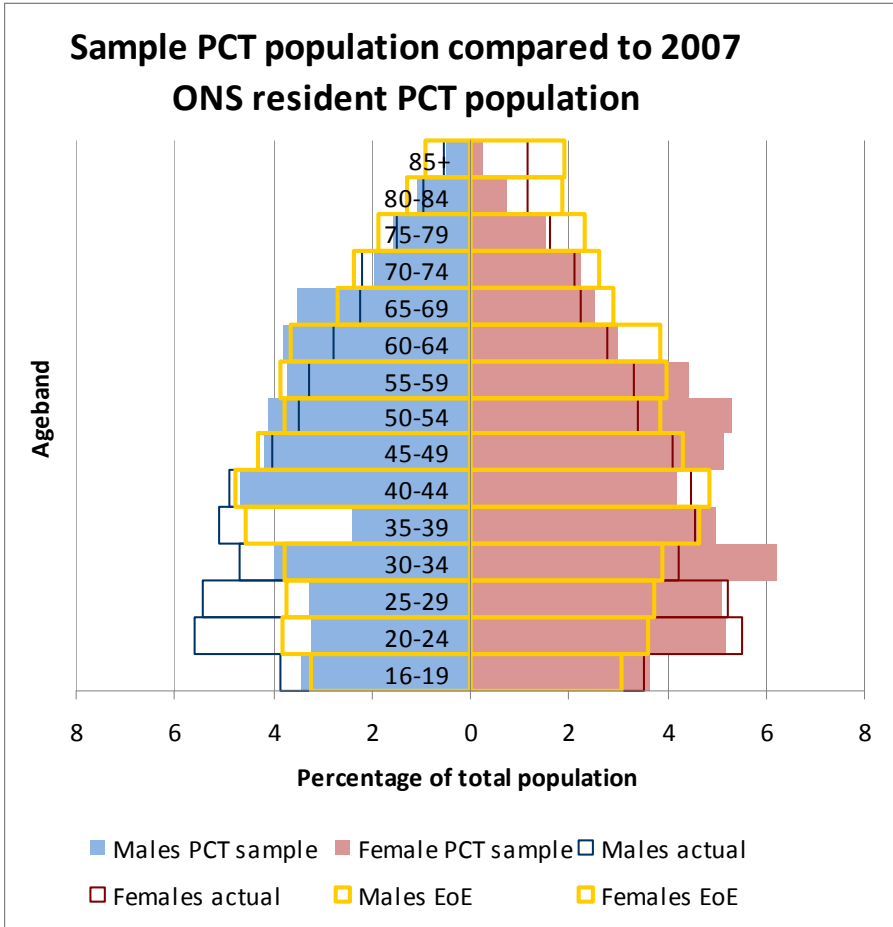
Source: 2008 East of England Lifestyle Survey conducted by Ipsos MORI by telephone between 29/10/2008 and 21/12/2008

Background:

In total, 2,500 Luton residents aged 16+ were interviewed. The sample was designed to enable comparisons to be made between the 20% most deprived and 80% least deprived MSOAs within each PCT. Sampling included quotas on residential deprivation level (middle layer super output area), PCT, gender, age, ethnicity and working status. Data are weighted to reflect the known population profile of each PCT. Where possible, questions were equivalent to those posed in other major surveys such as the Health Survey for England and General Household Survey. The survey will be repeated in 2009.

Calculations:

The prevalence calculations were carried out by ERPHO. Significant tests are to a 95% confidence level. The denominator is the weighted sample population, and invalid responses excluded.



	Indicator	20% most deprived MSOAs	80% least deprived MSOAs	PCT	East of England
Ethnicity	White British	45.2% (41.7%, 48.7%)	69.5% (67.2%, 71.8%)	64.0% (61.9%, 65.9%)	90.7% (90.2%, 91.2%)
	White Other	7.3% (5.6%, 9.3%)	8.2% (6.9%, 9.6%)	7.9% (6.9%, 9.1%)	4.5% (4.2%, 4.9%)
	Black and minority ethnic groups (BME)	47.6% (44.0%, 51.1%)	22.3% (20.3%, 24.5%)	28.1% (26.2%, 30.0%)	4.8% (4.4%, 5.1%)
Social Grade	A/B - managerial and professional	11.4% (9.3%, 13.9%)	19.2% (17.3%, 21.3%)	17.5% (15.9%, 19.1%)	24.2% (23.4%, 24.9%)
	C - skilled manual workers, clerical and junior managerial and professional	48.5% (44.9%, 52.2%)	57.7% (55.2%, 60.2%)	55.6% (53.5%, 57.7%)	55.3% (54.5%, 56.2%)
	D/E - semi- and un-skilled manual workers and those on state benefit	40.0% (36.5%, 43.6%)	23.1% (21.0%, 25.3%)	26.9% (25.1%, 28.8%)	20.5% (19.8%, 21.2%)
Working Status	In full time employment	35.3% (32.0%, 38.8%)	46.5% (44.1%, 49.0%)	44.0% (41.9%, 46.0%)	42.9% (42.1%, 43.8%)
	In part time employment	12.8% (10.6%, 15.3%)	10.2% (8.8%, 11.8%)	10.8% (9.6%, 12.1%)	13.5% (13.0%, 14.1%)
	Retired	16.1% (13.7%, 18.9%)	19.1% (17.2%, 21.1%)	18.4% (16.9%, 20.1%)	24.0% (23.3%, 24.7%)
	Not working for any other reason (incl unemployed, student, disabled, carer)	35.8% (32.5%, 39.3%)	24.2% (22.1%, 26.4%)	26.8% (25.0%, 28.7%)	19.5% (18.8%, 20.2%)
Self perception of Health	Very good/Good	73.3% (70.0%, 76.3%)	77.6% (75.5%, 79.6%)	76.6% (74.8%, 78.3%)	77.4% (76.7%, 78.1%)
	Bad/Very bad	8.3% (6.5%, 10.5%)	5.7% (4.7%, 7.0%)	6.3% (5.4%, 7.4%)	5.2% (4.8%, 5.5%)
LLT	Has longterm limiting illness/disability	15.9% (13.4%, 18.7%)	13.9% (12.3%, 15.7%)	14.4% (13.0%, 15.9%)	16.3% (15.7%, 16.9%)
BMI	Male - overweight	37.9% (32.8%, 43.3%)	38.2% (34.7%, 41.8%)	38.1% (35.1%, 41.2%)	40.3% (39.0%, 41.5%)
	Male - obese	15.6% (12.0%, 19.9%)	15.9% (13.3%, 18.7%)	15.8% (13.6%, 18.2%)	14.4% (13.6%, 15.3%)
	Female - overweight	27.7% (23.6%, 32.3%)	29.2% (26.2%, 32.4%)	28.8% (26.3%, 31.5%)	28.2% (27.1%, 29.2%)
	Female - obese	16.4% (13.2%, 20.4%)	17.0% (14.6%, 19.8%)	16.9% (14.9%, 19.2%)	14.4% (13.6%, 15.2%)
Smoking	Smoking prevalence	23.1% (20.2%, 26.2%)	20.5% (18.6%, 22.6%)	21.1% (19.4%, 22.8%)	18.4% (17.8%, 19.1%)
	Proportion of current smokers who would like to quit	71.6% (64.2%, 78.1%)	72.6% (67.3%, 77.5%)	72.4% (68.0%, 76.4%)	68.4% (66.5%, 70.2%)
Alcohol	Male - Hazardous drinkers (22-50 units per week)	10.6% (7.6%, 14.4%)	17.3% (14.7%, 20.2%)	15.9% (13.7%, 18.2%)	20.6% (19.6%, 21.6%)
	Male - Harmful drinkers (51+ units per week)	5.6% (3.5%, 8.6%)	7.1% (5.4%, 9.2%)	6.8% (5.3%, 8.5%)	6.6% (6.0%, 7.2%)
	Female - Hazardous drinkers (15-35 units per week)	4.0% (2.5%, 6.4%)	11.4% (9.4%, 13.8%)	9.6% (8.1%, 11.5%)	12.6% (11.8%, 13.4%)
	Female - Harmful drinkers (36+ units per week)	1.4% (0.6%, 3.0%)	2.4% (1.6%, 3.7%)	2.2% (1.5%, 3.2%)	2.6% (2.3%, 3.0%)
5-a-day	Eats 5 portions of fruit or vegetables < 1 day per week	24.1% (21.2%, 27.3%)	17.2% (15.4%, 19.1%)	18.8% (17.2%, 20.4%)	14.5% (13.9%, 15.1%)
	Eats 5 portions of fruit or vegetables 5-7 days per week	25.9% (22.9%, 29.1%)	36.2% (33.8%, 38.6%)	33.9% (31.9%, 35.9%)	41.9% (41.1%, 42.8%)
Physical Activity	Male - high level of physical activity	41.0% (35.7%, 46.4%)	43.0% (39.4%, 46.6%)	42.6% (39.5%, 45.7%)	47.1% (45.9%, 48.4%)
	Female - high level of physical activity	31.9% (27.7%, 36.6%)	34.0% (30.9%, 37.3%)	33.5% (30.9%, 36.3%)	39.8% (38.6%, 41.0%)
Healthy Behaviour	Four healthy behaviours - non-smoker, moderate drinker, physically active, 5-a-day	3.7% (2.6%, 5.3%)	7.6% (6.3%, 9.0%)	6.7% (5.7%, 7.8%)	11.5% (10.9%, 12.0%)

Note: Unknown, invalid and 'Don't know' responses have been excluded from denominators.

Highlighted when a significant inequality exists within the PCT

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Key to PCT colouring:
 When high or low values cannot be interpreted as good or bad:

Worse than region	Similar to region	Better than region
Lower than region	Similar to region	Higher than region

Appendix 3

Numbers of people predicted to have dementia in Luton 2008-2025.

Dementia					
People aged 65 and over predicted to have dementia, by age band (65-69, 70-74, 75-79, 80-84 and 85 and over) and gender, projected to 2025					
	2008	2010	2015	2020	2025
Males aged 65-69 predicted to have dementia	50	51	59	54	60
Males aged 70-74 predicted to have dementia	102	96	93	109	99
Males aged 75-79 predicted to have dementia	117	128	133	133	153
Males aged 80-84 predicted to have dementia	153	153	194	214	214
Males aged 85 and over predicted to have dementia	158	177	236	335	414
Total males aged 65 and over predicted to have dementia	580	605	714	844	940
Females aged 65-69 predicted to have dementia	33	34	42	39	43
Females aged 70-74 predicted to have dementia	77	77	77	94	86
Females aged 75-79 predicted to have dementia	156	163	182	182	228
Females aged 80-84 predicted to have dementia	226	239	266	306	319
Females aged 85 and over predicted to have dementia	428	428	454	554	655
Total females aged 65 and over predicted to have dementia	920	941	1,020	1,175	1,331
Total population aged 65 and over predicted to have dementia	1,500	1,546	1,735	2,019	2,271

Source: POPPI

Appendix 4

List of Reports Supporting the JSNA Supplement

1. Biscot Health Needs Assessment: Final Report, July 2009 - www.lutonpct.nhs.uk
2. Challney Health needs Assessment: Final Report, July 2009 - www.lutonpct.nhs.uk
3. Dallow Health Needs Assessment: Final Report, July 2009 - www.lutonpct.nhs.uk
4. Farley Hill Health Needs Assessment: Final Report, July 2009 - www.lutonpct.nhs.uk
5. High Town Health Needs Assessment: Final Report, July 2009 - www.lutonpct.nhs.uk
6. Participatory Health Needs Assessment of Gypsies, Roma and Travellers in Luton, October 2008 – http://www.luton.gov.uk/internet/health_and_social_care/social_policy
7. Qualitative and Quantitative Needs Analysis findings (Luton Older Peoples' Needs Analysis Research), University of Bedfordshire, 2008 - http://www.luton.gov.uk/internet/health_and_social_care/older%20people's%20support%20and%20advice:
8. The TellUs3 survey - www.cypp.luton.gov.uk
9. Estimating Numbers of Children with Disability in Luton - http://www.cypp.luton.gov.uk/14.cfm?s=14&m=735&p=332_view_resource&start=11&kw=&el=&sc=49,39&id=7167