Overview & Scrutiny Committee, December 1st 2008
Questions on item 7, Interim Progress Report:
Implementation of Haringey Life Expectancy Action Plan

Page/ Point	Question/Observation	Answer (Where applicable)
	From Councillor Alexander:	
Page 2 – 4 Interim findings from the LEAP Review	4.8 – How does the Haringey TPCT plan to carry forward action to improve detection and management of diabetes in Haringey?	Diabetes is an important cause of premature mortality and morbidity. It contributes to lower life expectancy in Haringey and to health inequalities. The prevention, improved detection and management of Diabetes are key priorities for Haringey TPCT (HTPCT). For example, they are essential parts of the initiatives in the 5 year strategic plan (currently being drafted) that aim to: prevent and manage long term conditions; to establish a vascular disease prevention programme; to improve diabetic retinal screening uptake and to strengthen primary care. This work, builds on activity underway already and requires close working with partners in the voluntary sector, the council (e.g. leisure services, education services), the public and primary care colleagues. Key elements of the work underway and in development are: Primary prevention of diabetes: through implementation of the agreed obesity care pathway and continued support of the stop smoking service, with a focus on “hard to reach” groups. Work with partners e.g. local authority and voluntary sector on

		encouraging physical activity and tobacco control legislation are key to these approaches. Cardio vascular risk assessment and prevention: A programme of inviting 40-74 year olds for cardiovascular disease (diabetes, coronary heart disease, sroke, chronic kidney disease) screening and risk assessment is being developed to build on current work within primary care. It will commence in 2009 with a phased introduction over a few years. This programme, supported by some investment, will assess the risk of individuals for these important causes of disease and of health inequalities and then give appropriate advice (e.g. weight management advice) or treatment (e.g. cholesterol lowering drugs) according to their risk. Diabetes Care Pathway: The diabetes pathway has developed considerably in the last year due, in no small part, to the focus group which is made up of 25 people with diabetes. It draws on best practice and best evidence to manage diabetes. Working with primary care: HTPCT will continue to work with primary care colleagues to ensure greater consistency in the prevention and management of diabetes e.g. through the obesity and diabetic care pathways, staff education and through the vascular prevention programme above. Working with patients: On 27th November the hand held record was launched which is a patient friendly health record to be kept by the patient at home and to be taken to appropriate medical appointments. The record is designed to set out the facts about the medication etc and also to set out how the patient wants to manage their condition, so the patient is in control of what happens with assistance from the professionals around them. It is a flexible pack in that it is a

		generic "long-term conditions" record, with the focus on diabetes to begin with. (*we can supply a copy of the hand held record if members wish to view this)* . This year HTPCT has also invested in developing the DESMOND project with an emphasis on changing the way health professionals inter-act with patients and focusing on encouraging self-management. Diabetic retinal screening: This programme aims to reduce the progression of diabetic retinal disease, an important cause of blindness. HTPCT has invested further in Retinal screening and there has been an increase in the number of patients screened. The programme will ill continue to be monitored and developed. Working with partners and communities: A key element of diabetes prevention and management is to encourage people with risk factors for diabetes, or early diabetes to come forward, particularly from "hard to reach" groups. In the next year we will work with partners in the voluntary sector and the council to engage communities e.g through health trainers or social marketing techniques (targeted marketing of health messages). Plans are underway to get the message out there to our community through links with Mosque and other important and influential community groups to reach those as yet not aware of their condition.
	4.9 – How is the Haringey TPCT addressing high infant mortality rates in Haringey?	Key interventions that will make a difference include: • Improving early access to antenatal care; • Reducing smoking by pregnant women; • Addressing substance and alcohol misuse; • Reducing teenage pregnancy; • Promoting breastfeeding; • Tackling the causes of low birth weight babies;

		• Improving the health of the mother pre-conception and during pregnancy. **What are we doing in Haringey?** An action plan to tackle infant mortality in Haringey was developed in 2004 and is currently being reviewed against the latest guidance from the Department of Health. Key actions include: • Further analyses to understand the factors in perinatal and neonatal deaths and a review of the evidence base for effective interventions; • Improving access to antenatal care including collecting information on late bookers in order to inform the commissioning of antenatal services and to improve how we provide information on antennal services including screening for mothers who may not be accessing services; • Strengthening of the smoking cessation service to increase the numbers of mothers quitting and the development of a targeted social marketing initiative; • The strengthening of Haringey's Teenage Pregnancy Action Plan; • Continued implementation of the Breastfeeding Framework including on-going training and support for midwives and health visitors.


Haringey Council