Health and Adult Scrutiny Committee 7.3.24

Chair: Janet Battye (JB, LD)

Report by Michael Hanley

1. Minutes of Previous Meeting
M. Hanley (MH, L): Commented on the omission of questions and comments by himself and other councillors. He said that this is a scrutiny committee whose function is to examine what the providers of social services and health are doing and ask pertinent question and make challenges if there are problems. These interventions need to be recorded. The chair agreed and asked the note taking officer to do this.

2. Smoke Free by 2030. Presented by Public Health Department.

Vicky Hepworth-Putt (VHP, Director of Public Health): The aim is to reduce the percentage of local smokers to 5% of the population. In April 23 the department received a grant of £440k to do this. There are higher rates of smoking in the lower socio-economic groups.
JB: We have a higher rate of teenage pregnancies and that is an area of concern.
MH: Asked whether vaping (one of the ways of getting smokers to reduce self harm) has harmful effects as the person is still using nicotine.
VHP: We are trying to get people to switch to vaping which is less harmful. I am not a medical doctor so I cannot answer your question.
H Chaffey (HC, LD): Impressed with the 60% who have stopped smoking. Well done. I am uncomfortable with transitioning people from smoking cigarettes to vaping which is still addictive.
VHP: We do have a nicotine-free route.
H Hodgson (HH, LD): Asked about relapses and keeping in touch with those who have been treated.
VHP: We follow up for twelve months.
G Simpkins (GS, LD): Do you cover the Kirkby Stephen area?
VHP: Yes.
JB: A lot of people don't use social media (advertising of the service is there). Are we using anything else?
Other Public Health person (OPH): Currently we are not, only on social media.
MH: Will you be working with GPs?
OPH: Yes, we will have workers in Primary Care.

3. Development of Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

Ellusia Kilgallen (EK, Registrar in Public Health): We need to assess local needs and review existing community engagement. We need to look at priorities for Health and Wellbeing (HWB). The building blocks for HWB are: housing, family, food and education. Also important factors are: high blood pressure, high cholesterol, smoking, excess alcohol and obesity. Isolation plays a part in mental health. Health inequalities result from deprivation.
There are also vulnerable groups. In a recent survey 39% of people requested help to have a healthy and active lifestyle. People need support with the Cost of Living Crisis.
The average person born and brought up in Furness lives 5 years less than the similar person in Eden. Life expectancy now in women is less than it was in 2003. Early preventable death is six

times more common in Barrow compared to Penrith.
In Barrow the average person has a longer period of ill health before death, 20 years compared to 10 in the Eden area.
We need to increase prevention. Primary prevention is where you stop the disease (eg: stopping smoking at 30 thus preventing cancer of the lung at 70). Secondary prevention is where the rate of severity of the disease is slowed down.
We need to reduce inequalities. To increase the emphasis on healthy lifestyles. Poverty is a major driver. In 2022 there were 5400 children living in poverty in this area. 15,600 people live with fuel poverty (15%).
With regard to mental health, 41% of primary school children are afraid of going to school because of bullying. Furness has the highest rate of suicide in the Northwest and 4th nationally. Also in Barrow, teenage pregnancy rate is higher than the national average. A quarter of 4-5 year old children are obese and levels are rising in most deprived areas.
Since 2012 there has been a rise in health risk factors. These factors were falling rapidly before. In 2018 Furness was the 4th highest area for drug deaths in the UK.
By 2040 over 27% of the population will be over 65. It is predicted that there will be an increase in people with dementia by 38%. Eden has high levels of elderly living alone.
HC: Asked what we mean by partnership (referred to in a slide).
EK: Discussed this.
V Hughes (VH, LD): Disappointed about the low number of people who responded to the survey (which feeds into the strategy).
EK: The strategy will work over 10 years. We are required to have a HWB strategy. This will be adopted in July.
GS: Were there any positives that you found in the survey? We seem to be behind in most things.
EK: There are lots of areas where we are doing better than national average, especially in Eden and South Lakes. We do have inequalities across the area.
HH: Asked about obesity and activity. We will have to reduce sugar in the diet so we will have less diabetes.
EK: The level of health depends on those building blocks. The environment is very important. Poverty and poor housing are the main drivers. Healthy weights is a long strategy, there are other causes of diabetes besides obesity (genetics, damage to the pancreas due to viral infection etc).
VH: Asked about healthy snacks for children.
EK: Yes we would support this.

5. Retention and Recruitment of NHS Workforce.

Charlotte Moul (CM, Workforce Manager, Lancs and South Cumbria ICB):
Challenges: high vacancy rates, poor workplace, challenges from other employers (BAE in Barrow), high absence rates. This area is a net loser of health staff (after training they move to more urban areas).
South Cumbria is ahead of the game in developing a workforce programme. There have been 350 Health and Social Careers events in the last year. Internship, work experience, careers insight days and apprenticeships have been provided.
D Blacklock (DB, Healthwatch): Discussed staff satisfaction rates. Do you have any information on this?
CM: Discussed moves to enhance the workplace experience.
JB: Said that she is concerned about GPs. How are we doing in attracting GPs?
CM: In Cumbria we have a lowered doctored area. This is a national problem.
JB: I would have thought that doctors would have been attracted to the area.
CM: It seems that only physios who are attracted to this area.

MH: Commented that the shortage of doctors, dentists and nurses is a national problem and it is nothing new When he came to Alston to work as a GP in 1992, there were 80 other applicants for the job. When he retired two years ago, no doctor responded to adverts to work in Alston.
The UK has under-produced doctors for at least 70 years. In the 1960s, thousands of doctors came from India and Pakistan to work in hospitals and GP surgeries. By the 1970s at least a third of all GPs were from India and Pakistan.
Also Ireland and the EU provided a lot of doctors. At the time of the Brexit referendum 45% of EU doctors said that they intended to return home if the vote resulted in the UK leaving the EU.
In 2015, Jeremy Hunt was the minister for Health. He promised to increase the number of GPs by 5000 within 5 years. By 2020 there were 290 fewer GPs.
In 2016 The Royal College of Physicians declared that there were not enough doctors to meet demand. In 2016 there were fewer medical students than in 2010.
In 2017, Jeremy Hunt said that we were training 6500 doctors per year but we needed 8000 per year. That had improved and the output of the UK medical faculties is about 9000 per year. However this is about half the output of Ireland which produces 24.9 doctors per 100,000 population as opposed to the UK's 13.8.
In the EU there is an average of 3.4 doctors per 1000 population, whereas the UK has 2.8. So the EU has just under 20% more doctors per capita.
CM: Agreed that the UK needs to produce more doctors etc.
J Scattergood (JS, LSCICB): Discussed the strategy for Primary Care growth. A problem is that locally there are fewer community health centres (more surgeries owned by the GPs which makes planning more difficult).
HC: I have worked in a lot of big organisations including Proctor and Gamble. There was always annual appraisal. This means that the organisation cares for you as an individual.
CM: We looked into appraisal and 10-25% of respondents said they were well supported.
HC: I suggest that looking at how other organisations do appraisals might be helpful.
VH: Nurses are a bit fearful about having their appraisal. Asked about apprenticeships.
D Edwards (DE, LD): Said he had been involved with sports apprenticeships.

6. Retention and Recruitment of Adult Social Care Workforce

Joel Burchett (JB, Adult Social Care): We have additional challenges: rurality, lack of housing (expensive), shrinking labour market, low pay, competition with the BAE. Young people leave for university and it's difficult to get them back.
We have simplified the recruitment process, reducing the processing time from 15 to 7 weeks. Overtime pay before was and extra £0.72 per hour. It is now 30% extra for working weekends and nights. This has reduced the usage of agency staff by 52%. There has been improved support for student placements. Six new social workers have started.
JB: Is there anything we can do (as councillors). Possibly improved access to housing. We need to help social workers to get cars.
C Whalley (CW, Director of Adult Social Care): We developed career paths to suit two different types, those who want to progress to management and those who want to keep working with client contact. Care load and feeling well supported is very important. Appraisals need to focus on support. We are seeing social and occupational therapists coming and wanting to work in this area. There has been a decline in the numbers of agency staff. Car parking is the most important thing after the above. Affordable homes will be also important, we will be working with WAFC to improve this.
HC: Asked about pay.
JB: Pay in private companies is slightly higher. Due to lack of housing in South Lakes, workers have to travel in from other areas.

MH: Commented on the importance of parking. When he was a junior hospital doctor, parking was free whereas now all junior hospital doctors (all those except the consultants) have to pay for the parking.
HC: Agreed this was a problem.

7. Care Quality Commission (CQC) Assurance.

Adult Social Care (ASC) previously was not assessed. From now it will be, by the CQC. This item was about how ASC will prepare for the inspection.
HC: We should be ready everyday.
Davina Richardson (DR): We are preparing for our first visit. We don't know when this will be. We have created a programme. There are 4 working groups including one looking at the inspection process, another at policy and planning and another at operations (how things are done rather than the surgical variety). What do we need to change?
DB: Lancashire have had the CQC inspection and they focused on customer experience. We could help with that.

End of meeting.