Public Document Pack

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR NORTHERN CARE ALLIANCE
Overview & Scrutiny Committee
Supplementary Agenda

Date	Thursday 26 February 2026
Time	2.00 pm
Venue	J R Clynes Second Floor Room 1 - The JR Clynes Building
Notes	1. Declarations of Interest- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Alex Bougatef or Constitutional Services at least 24 hours in advance of the meeting. 2. Contact officer for this agenda is Constitutional Services or email constitutional.services@oldham.gov.uk

Membership of the JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR NORTHERN CARE ALLIANCE
Bury: Councillors Fitzgerald and Harris
Oldham: Councillors Z Ali, Hamblett (Vice-Chair) and McLaren (Chair)
Rochdale: Councillors Anstee, Dale and Joinson

Item No

5 Minutes of the previous meeting (Pages 3 - 6)

To consider the minutes of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance held on 18th December 2025.

8 Integrated Care and Update on clinical leadership model work and its impact on each locality (Pages 7 - 22)

To consider the report on Integrated Care and the verbal update on the Clinical Leadership Model.

Queries Raised at JHOSC relating to the NCA Integrated Performance Report on 18 December 2025

Query raised	NCA response
Page 2: Members noted the summary and queried whether, for metrics with no target, this was due to it being difficult to quantify one.	There are several metrics that currently do not have defined targets, typically due to gaps in national standards. For example, Discharge Ready Date is a new metric introduced in the NOF and does not yet have a specific target. As it is relatively new within the NHS, we are focusing on monitoring its performance and driving improvement over time. Similarly, for Number of Incidents with Harm, our aim is to reduce these occurrences, but there is no national benchmark to reference. Conversely, for Number of Incidents with No Harm, we would like to see an increase, as this reflects a positive reporting culture within the organisation. However, we have not set a formal target for this metric, as it serves more as an indicator of cultural maturity rather than a performance measure.
Page 3: Members noted that sickness absence had grown and stayed high, and requested an explainer for why this was the case.	In the context of around 38% of working-age adults in Greater Manchester living with a long-term health condition and higher deprivation levels in our communities than the England average, NCA sickness absence levels have historically been above the England average. The top five reasons for sickness in NCA colleagues since April 2024 are Stress/ Depression/Anxiety, Musculoskeletal, Gastrointestinal, Coughs/Colds/Flu and Chest/Respiratory. The crucial issue for sickness absence is the increase in mental health related absence reasons (Stress/Depression/Anxiety etc) and there are many influencing factors on this. This is consistent with national trends. The new co-produced Wellbeing and Attendance Management policy has delivered a fundamental shift to individualised approaches to supporting wellbeing with removal of ineffective punitive triggers and a wide range of supportive targeted intervention, prevention and lifestyle support. We are therefore providing better support and people are returning to work sooner for periods of absence that are more than 28 days. Data shows that we have shifted the balance of short and long term sickness, reducing long term sickness from 64.51% in April 2024 to 55.88% in November 2025, while an increase in short term sickness was seen in the same period increasing from 35.49% to 45.12%. The

	new policy has prevented further increases as data shows that sickness is lower on average when you compare across the years since the inception of the new policy.
Page 4: Members noted that overpayments had been raised at the previous meeting and that the measures were not working.	The IPR showed natural variation and does not signify an increase in overall organisational overpayments. In line with the IPR commentary, this is due to one significant overpayment currently being recouped.
Page 6: Members noted that theatre utilisation was significantly under target and asked why this was the case. It was noted that there had been lots of activity around this with an intensive programme on improving these figures. Members queried what constituted theatre utilisation.	Definition of Capped Theatre Utilisation from NHSE: 'Capped theatre utilisation (CTU) is an NHS performance metric measuring the percentage of planned operating session time (e.g., 9 a.m.–5 p.m.) used for patient "touch time" (surgery/anaesthesia), specifically ignoring any time used during overruns. It is used to assess efficiency by capping, or truncating, the total surgical time to match the scheduled session, with a target often set above to improve productivity.' It is measured from the first patient into the anaesthetic room or theatre (whichever is sooner) to the patient leaving the operating theatre for recovery. The capped utilisation of theatres is measured from the proposed start time and completion of the list. So for example if the session is planned to start at 08:45 and finish at 12:45 then there is opportunity for 240 minutes of theatre activity. Turn around is the time associated to the last patient leaving the theatre to the next patient coming into the anaesthetic room or theatre, whichever is first.
Page 7: Members noted that there was an area of concern around GM system demand reduction initiatives for suspected skin cancers pathways not yet yielding anticipated benefits, and it was queried why this was the case and what plans were in place to make sure that the benefits are realised.	NHS Greater Manchester is leading a Dermatology Transformation Programme to improve how referrals are managed before patients attend hospital. This includes introducing a single point of access using specialist referral software to guide GPs towards the most appropriate pathway. Adoption across Greater Manchester has been variable and the approach remains under pilot review. A second element of the programme was the recommissioning of community dermatology services to a standardised specification, including treatment of low risk basal cell skin cancers that are often referred on urgent cancer pathways. The procurement process and awarding is currently paused due to challenges to the outcome and a revised mobilisation date has not yet been confirmed. Locally, progress has continued to streamline pathways. Teledermatology has been successfully implemented, enabling rapid assessment of skin lesions at the point of referral. Around 9,000

	suspected cancer referrals are expected to use this pathway in the coming year. Approximately 35% of patients can be safely discharged with reassurance based on specialist review of clinical images alone, allowing faster diagnosis and reducing unnecessary hospital visits. Further pathway integration with primary care remains a priority. A pilot GP skin cancer lead role has been secured for a 12 month period April 2026, supported by the GM Cancer Alliance, to strengthen education, quality improvement and referral management at practice level.
Page 12: Members highlighted that hand pumps had been empty on a recent hospital visit and queried why this was. It was agreed that these concerns would be highlighted. Members noted that hand hygiene was going down which was concerning given the flu season. Members noted the MRSA Improvement Plan as an area of concern, querying what pressure this puts on wards. It was noted that, as this related to 7 cases, it would depend on when infection happens and that it is monitored closely.	We have been reviewing the availability of hand gel in public areas. We have recently transitioned to a new supplier for the hand gel dispensers. During flu season, usage increases significantly across patients, visitors and staff. We have identified that the new dispensers hold a smaller volume of product, which means they require more frequent replenishment to maintain availability. To ensure consistent coverage and assurance, all public-area dispensers are now included in a daily replenishment schedule, supported by a daily checklist completed by the team. These checklists are then audited monthly to ensure compliance and to identify any gaps or trends. Recent audit data for 8 Entrance points across the Oldham site confirmed that gel was replenished daily Monday to Friday and available for use. The domestic helpdesk phone number has been publicised to request that all staff report to the Domestic Helpdesk any empty dispensers to ensure adhoc replenishments to support IPC measures, particularly during winter.
Page 12: Members highlighted that whilst the number of still births was still below target, the figures were rising and queried whether this had been picked up.	The service saw a peak in stillbirths in April 2025 which has led to special cause variation within the SPC charts and rolling 12-month data. There were no themes identified within the stillbirth reviews. Since April 2025 the stillbirth rate has remained within normal variation. All stillbirths are reviewed using the Perinatal Mortality Tool to identify causal factors and learning, the reviews are externally assured to identify any further learning. Mortality rates are tracked monthly within the service and externally through the Local Maternity & Neonatal system.

Page 14: Members expressed concern about the never events and would like further detail and assurance about these.	Never events are reported to the Executive team at the point of declaration and monthly to the patient safety group which reports to the NCA Quality Committee and subsequently NCA Board. A regular thematic analysis is performed which supports a regular review of our NCA local patient safety priorities. The number of Never Events reduced in 2025 compared to 2024 (9 vs 13) with reduction in NG tube related events noted. At present, Wrong Site Surgery and retained foreign body object are the trusts highest reported NE categories. NCA has recently commissioned an independent review of our approach to Never Events.
Page 15: It was noted that the increase in carer needs being met is positive, there was a request to understand how this has been achieved and what lessons can be learnt.	As part of reviews carers get asked if their needs are being met. The team calculates the number of people who said yes and divide that by the total number of carer reviews completed over a rolling 12 month period. A larger proportion of carers are now indicating that their needs are being met.

Northern Care Alliance
NHS Foundation Trust

NCA Community Services and Integrated Care

Joint Health Overview and Scrutiny Committee
February 2026

CARE APPRECIATE INSPIRE

Summary

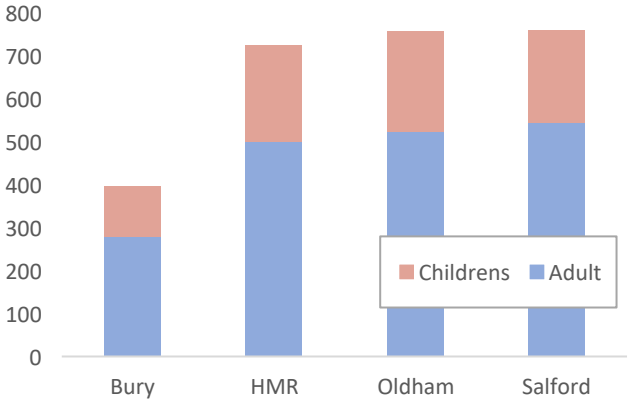
- Overview of NCA Community Services
- Examples of Integrated Care delivering improved performance
- Future NCA Clinical Strategy

NCA Community Services

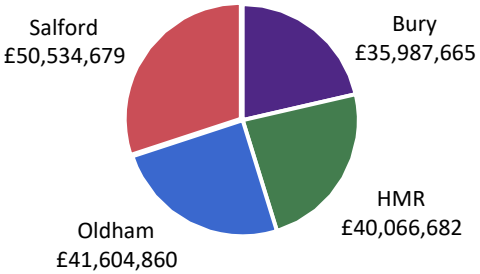
Northern Care Alliance
NHS Foundation Trust

4 localities served, covering a population of 929,600 over 190 square miles

Workforce of 2636 staff



£168,194,000 income from ICB localities (25/6)



Our District Nurses provide c **967,000** domiciliary visits per year, or **80,800** per month. Around **25,000** of these per year are urgent call outs, preventing hospital admission or supporting discharge

CARE APPRECIATE INSPIRE

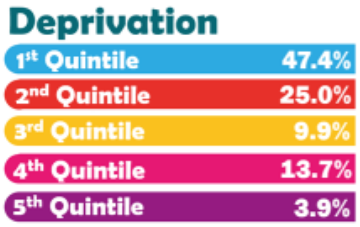
Rochdale Operating Model
Our shared challenge

Northern Care Alliance
NHS Foundation Trust

We need to deliver improvement in the context of **increasing demand and acuity** across all parts of the health and care system

Yet – the health and care system is complex and delivered through **multiple, complex and siloed** organisations with different accountabilities…leading to "failure demand" in A&E and care settings…leading to **increased costs and poor experience**.

And – we know that health and care services are only a fraction of what contributes to individual's health and wellbeing:



Building blocks to better health and wellbeing

We understand our challenges and know that we are more likely to deliver improvement if we work together as a whole system

CARE APPRECIATE INSPIRE

Delivering integration – Our Social Operating Model

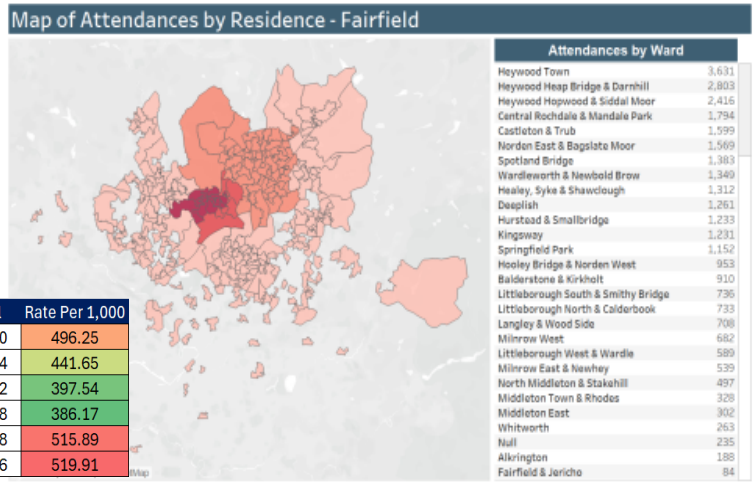
Northern Care Alliance
NHS Foundation Trust

Describing the features that make our system work is difficult, some are hard to define, and we are still on a journey.
We think our characteristics include, but are not limited to these five things…

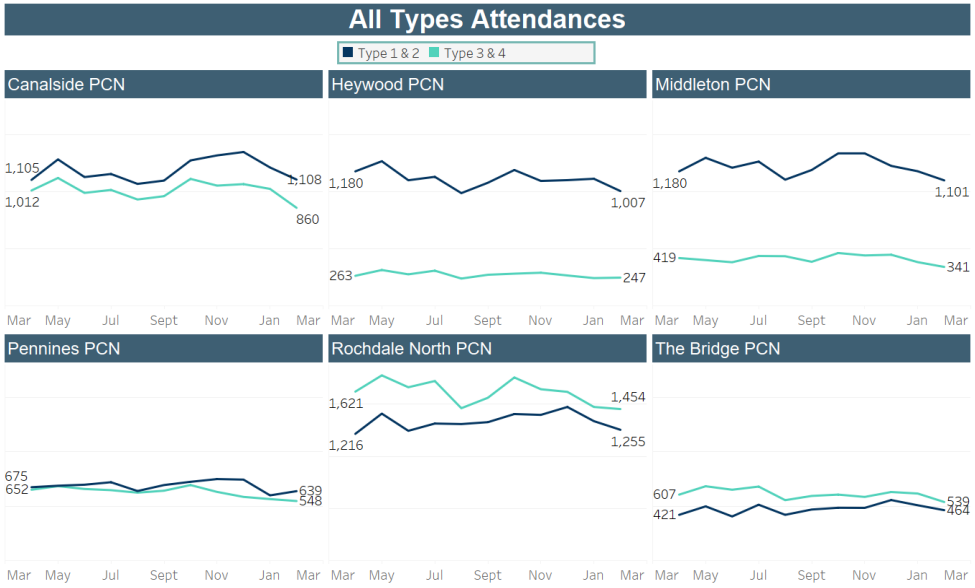
Enable us to…

Integration delivering improved performance

Northern Care Alliance NHS Foundation Trust

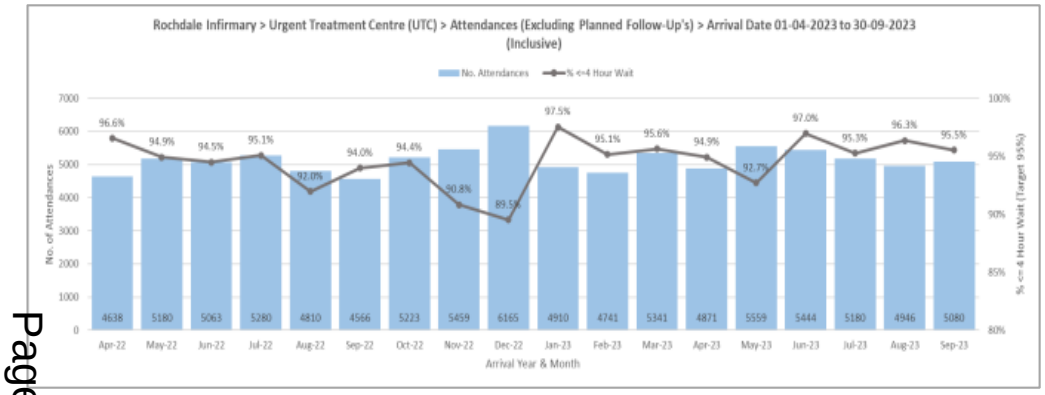


PCN	Type 1 & 2	Type 3 & 4	Total	Rate Per 1,000
Canalside	13,113	11,157	24,270	496.25
Heywood	12,264	3,000	15,264	441.65
Middleton	13,443	4,539	17,982	397.54
Pennines	7,579	6,939	14,518	386.17
Rochdale North	14,700	17,758	32,458	515.89
The Bridge	5,231	6,755	11,986	519.91



Integration and financial sustainability

Northern Care Alliance NHS Foundation Trust

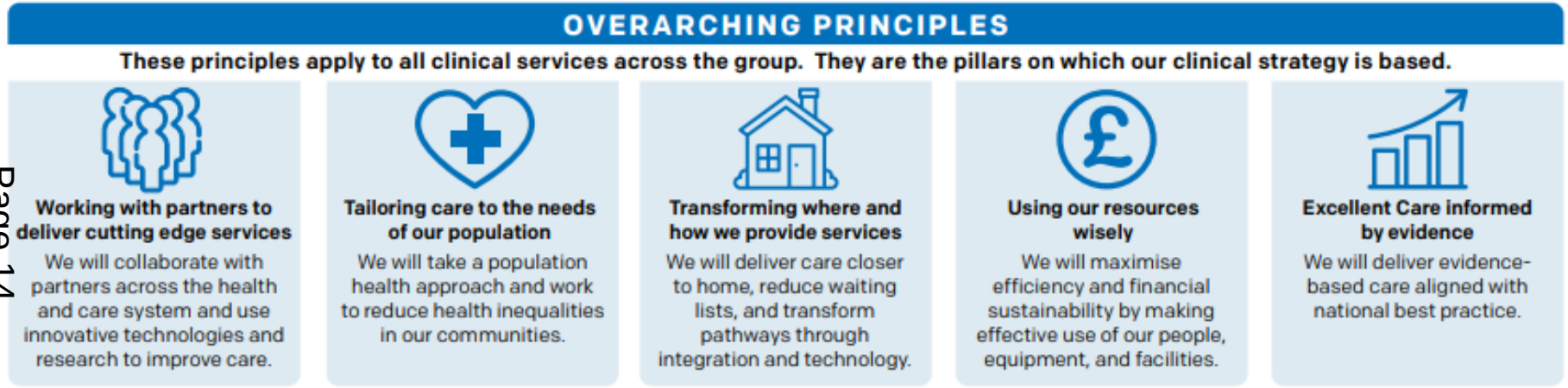


- Integrated Urgent Care delivery model
- System wide pathways
- Blended roles
- 47% cheaper than DGH model

		Fairfield Hospital	Rochdale Hospital
	Comparison of Emergency Care costs and activity at Rochdale Infirmary and Fairfield Hospital 2022-23		
HRG	**HRG Description**	**Average Cost**	**Average Cost**
VB01Z	Emergency Medicine, Any Investigation with Category 5 Treatment	£469	£175
VB02Z	Emergency Medicine, Category 3 Investigation with Category 4 Treatment	£793	£299
VB03Z	Emergency Medicine, Category 3 Investigation with Category 1-3 Treatment	£560	£223
VB04Z	Emergency Medicine, Category 2 Investigation with Category 4 Treatment	£535	£289
VB05Z	Emergency Medicine, Category 2 Investigation with Category 3 Treatment	£309	£222
VB06Z	Emergency Medicine, Category 1 Investigation with Category 3-4 Treatment	£148	£120
VB07Z	Emergency Medicine, Category 2 Investigation with Category 2 Treatment	£283	£197
VB08Z	Emergency Medicine, Category 2 Investigation with Category 1 Treatment	£296	£189
VB09Z	Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment	£145	£118
VB10Z	Emergency Medicine, Dental Care	£73	£69
VB11Z	Emergency Medicine, No Investigation with No Significant Treatment	£135	£86
UZ01Z	Data Invalid for Grouping	£141	£72
Total		**£298**	**£159**

Clinical Strategy – Our Vision for Transforming Care

NHS
Northern Care Alliance
NHS Foundation Trust



These principles will guide the future direction of our clinical services. Underpinning this is the recognition that healthcare delivery across the NCA footprint needs to radically change to meet our current challenges and the demands of the future.

NHS
Northern Care Alliance
NHS Foundation Trust

Future Delivery Pillars

Our Mission:
To create a sustainable health and care model with our partners across our four localities

Delivered consistently at scale

In partnership with our localities

NCA Wide Transformation Programme

Pillars

Prevention and Population Health
We will strengthen a trust-wide approach to prevention, population health, and health inequalities. This will support earlier intervention to prevent avoidable harm, reduce inequalities, and improve outcomes, embedding prevention and equity across acute pathways as well as through partnership working with neighbourhood and system partners.

Neighbourhood Led Health
We will deliver neighbourhood led services in the community in partnership that are built around the needs of people, focusing on integrated pathways of care for frailty, long term conditions and end of life care. .

A New Outpatients Model
We will transform our outpatients model so that a hospital setting is no longer the default, through better specialist advice provided earlier in the pathway, digital alternatives at scale and more effective delivery models when patients need to be seen on a hospital site.

Hospital at Home
We will provide safe, specialist care for medical conditions at home supported by digital, clinical and neighbourhood infrastructure – delivering a full virtual hospital model. We will support people to live independently, and to die in a place of their choice.

Integrated Urgent and Emergency Care
We will create an urgent and emergency care offer that is a network of services which ensures patients are seen in the right place, at the right time, by the right service – reducing avoidable admissions and ensuring patients return to their home as early as possible following a hospital stay.

Underpinned by

People | Digital Strategy | Estates Strategy | Financial Sustainability Plan

CARE APPRECIATE INSPIRE

Northern Care Alliance
NHS Foundation Trust

Clinical Leadership Model (CLM) Update

Joint Health Overview and Scrutiny Committee
26 February 2026

CARE APPRECIATE INSPIRE

The Clinical Leadership Model update

- Clinical leadership at the heart of decision-making
- NCA wide services
- Connectivity to Place / Population

Clinical Leadership Model

How will CLM feel different?

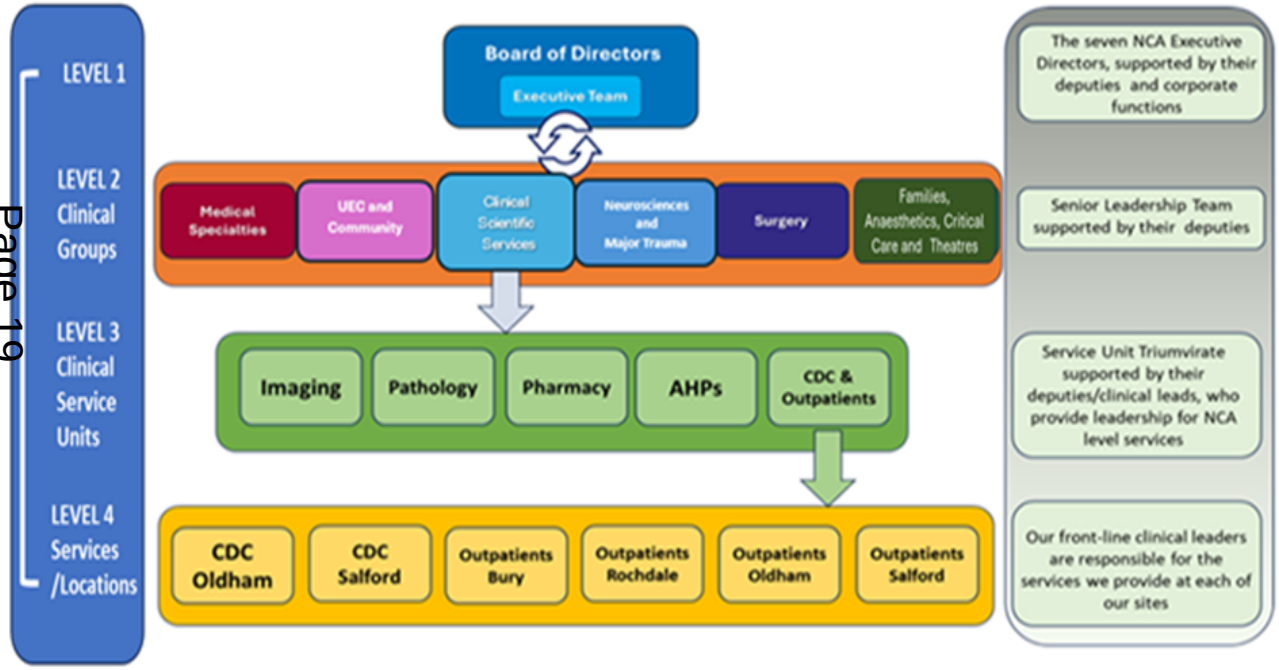
Much more than a structural reset – the structure is just an enabler.

- Stronger clinical leadership at every level
- Clearer accountability in Clinical Service Units and Clinical Groups
- Faster, clinically owned decision-making, closer to patients
- Fewer layers from ward to board
- Trust wide networking in governance, audit and improvement

Clinical Leadership Model

CLM operating model v current operating model

The example of Clinical Scientific Services is used to illustrate the leadership levels within the new CLM organisational structure

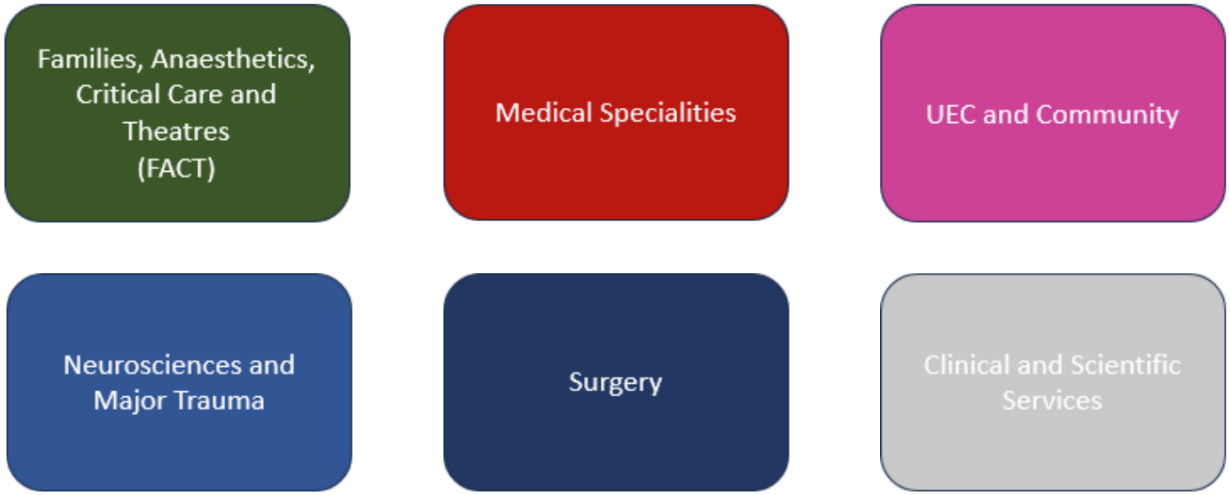


Current Operating Model: At present the NCA is structured vertically operating across four localities; Salford, Oldham, Bury and Rochdale. Some services, such as Diagnostics and Pharmacy, centralised corporate teams and parts of Estates and Facilities operate across the four localities. There are currently five leadership levels of the organisation from the Board to the frontline services we deliver to patients.

The CLM Operating Model: Introduces a simplified, four-level leadership structure which replaces the previous five levels of leadership. Roles and responsibilities at each level will be standardised wherever feasible. The CLM operating model will remove a leadership level – delivering on the ambition of better connecting our senior leaders with our clinical teams.

Clinical Leadership Model

Operating model: Clinical Groups



The Clinical Groups have now been confirmed during the consultation period. They are based on the work from over 200 colleagues who supported design teams to develop the six Clinical Groups.

Clinical Leadership Model

Connectivity to Place

Northern Care Alliance
NHS Foundation Trust

1. There are existing Place Executive leads within the NCA who will support strategic Locality priorities and forums.
2. 6 Clinical Groups will exist with Band 9 Ops, Nursing and Medical Directors, all of whom will need to interact with Place in varying degrees.
3. Existing Place based arrangements will need supporting to ensure continued shared ownership of key performance , quality and financial ambitions e.g.
   - ✓ System risks of ED performance
   - ✓ Development of community services alternatives
   - ✓ Deployment of BCF funding
4. Site leadership : Roles for Salford, Oldham and Bury& Rochdale will support system EPRR processes
5. Place based roles hosted through the NCA, commissioned by localities for Place support and service delivery will remain. These roles are currently out of the scope of Consultation, as these roles will form a key component of Place Based Partnership arrangements working in conjunction with the ICB locality team and other local partners

Clinical Leadership Model

Next Steps: Mobilisation and Transition timeline

Northern Care Alliance
NHS Foundation Trust

Clinical Groups Draft Arrangements: By March 2026

Consultation will be completed, and the new leadership teams for clinical groups will be selected. The shape of clinical groups will be defined including how they will work with each other and with Place, as well as how they will align to the new Operating Model and Accountability Framework.

Delivery of 30-day plan to Clinical Group Go Live in April

Clinical Group Go Live: By April 1st 2026

All key milestones set out in the Critical Path will be met so CLM teams can operate in the new CLM environment safely and effectively, with minimal disruption to services, patients and colleagues, with the required capacity and capability. Clinical group leadership teams and clinical service unit leadership teams will be in place. Clinical Groups and fundamental activities required for 'Go Live' will be transferred from Care Organisations – for example there will be a new Finance Ledger, aligned to the ESR Hierarchy and Active Directory.

Post April 2026 – Post Transition Implementation Plan (PTIP)

Following the Clinical Groups 'Go Live' in April 2026, work will still be required for the full implementation of CLM and the Clinical Groups, for example longer-term service integration, benefits realisation and any tasks not completed by April 2026. It is likely the roles, responsibilities and governance for place for will continue to evolve, post April 2026, and the implementation will be need to iterative to align with changes to the national, regional and ICB strategic direction of travel.