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

Date	Thursday 24 April 2025
Time	2.00 pm
Venue	Lees Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL
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 email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Tuesday 22nd April.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

Please note that anyone using recording equipment both audio and visual will not be permitted to leave the equipment in the room where a private meeting is held.

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Please also note the Public attendance Protocol on the Council's Website

https://www.oldham.gov.uk/homepage/1449/attending_council_meetings

MEMBERSHIP OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR NORTHERN CARE ALLIANCE
Councillors Bury: Councillors Fitzgerald, Lancaster, Gold, Oldham: Councillors Adams, Hamblett and McLaren. Rochdale: Councillors Dale, Joinson and Taylor

Item No

1 Apologies For Absence

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

2 Urgent Business

Urgent business, if any, introduced by the Chair

3 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

4 Public Question Time

To receive Questions from the Public, in accordance with the Terms of Reference.

5 Minutes of Previous Meeting (Pages 5 - 8)

The Minutes of the meeting held on 27 February 2025 are attached for approval.

6 Integrated Performance Report (Pages 9 - 26)

To consider the latest Integrated Performance Report.

7 Population and Health Inequalities (Pages 27 - 44)

How the NCA supports population health and addresses health inequalities.

8 Dates of Meetings 2025/26 Municipal Year

Thursday 2.00pm

26th June 2025

25th September 2025

18th December 2025

26th February 2026

9 Work Programme 2025/26 Municipal Year

To consider items for inclusion when developing the Scrutiny Committee's workplan for the 2025/26 municipal year.

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR NORTHERN CARE ALLIANCE
27/02/2025 at 2.00 pm

Oldham Council

Present: Councillor McLaren (Oldham Council) (in the Chair)
Councillors Adams (Oldham Council), Dale (Rochdale Council), Gold (Bury Council) and Joinson (Rochdale Council).

Also in Attendance:
Rebecca Fletcher – Director of Public Health
Rafik Bedair – Chief Medical Officer (Northern Care Alliance)
Jude Adams – Director of Strategy (Northern Care Alliance)
Moneeza Iqbal – Director of Performance (Northern Care Alliance)
Peter Thompson – Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Hamblett (Oldham Borough Council) and Councillor Taylor (Rochdale Borough Council).

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

4 **PUBLIC QUESTION TIME**

There were no public questions for this meeting to consider.

5 **MINUTES OF PREVIOUS MEETING**

Resolved:
That the minutes of the meeting of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance, held on 31st October 2024 be approved, as a correct record.

6 **WINTER PLANNING UPDATE**

Jude Adams, the Northern Care Alliance's Director of Strategy updated the Committee on the Northern Care Alliance's (NCA) winter plan. The NCA Board had previously agreed a two-year winter plan in October 2023, which incorporated the national requirements for 2024/25. The plan was integrated into the ongoing Urgent and Emergency Care (UEC) Excellence programme and involved contributions from Care Organisations and local partners.
A comprehensive winter planning checklist had been developed to attempt to ensure preparedness, focusing on maintaining fundamental care standards, resilience plans, and mutual aid rotas during holiday periods.

Discharge planning and capacity management were considered to be essential components, which also included managing G&A beds, ambulance services, and virtual wards. A significant goal

within the plan had been a move to shift care from acute hospital settings to community-based solutions, thus preventing admissions and supporting effective discharges – this latter being particularly important has it helped to free up space across the Trust's footprint.

The winter plan emphasised the importance of a range of care settings to deliver services, such as Same Day Emergency Care (SDEC), Urgent Treatment Centres, and virtual wards. The NCA's Urgent Emergency Care (UEC) performance had shown stability, although there had been an increase in Emergency Department (ED) attendances, with the virtual bed occupancy being higher than the national average. Additionally, in-patient flows had performed well compared to peers, although changes in local mental health policies had posed challenges and increased ED wait times.

Key initiatives in the plan had included admission avoidance measures, such as the implementation of the "Hospital at Home" program and specialised dementia care services. ED improvements had been introduced to enhance the patient journey. The discharge process had been further strengthened by developing hospital-at-home services and expanding dementia care support.
The NCA had also been working on significant projects, such as Super MADE (multi-agency discharge reviews) and pilot programs for ambulance conveyance. CQC reviews had been conducted, and dementia units were being developed to further improve care. Efforts had also focused on maximising community bed capacity and assessing the benefits of the dementia program.

The plan had outlined future goals, including increasing the use of virtual wards and establishing consistent data collection across localities. Additionally, phased ED improvements and related program rollouts were planned to enhance patient care and improve system efficiency. It was suggested that this was an item that the Scrutiny Committee could continue to monitor at future meetings.

Resolved:
That an update on the experience over the whole of the 2024/25 winter period be presented to the Committee's meeting, scheduled to be held on Thursday, 24th April 2025.

7 **NCA PLANNED AND EMERGENCY CARE PERFORMANCE COMPARISON TO PEERS**

Jude Adams, the Northern Care Alliance's Director of Strategy updated the Committee on the Northern Care Alliance's (NCA) planned and emergency care performance statistics. The Committee was advised of improved performances across the footprint of the Trust, when compared to 2023/24, in terms of key issues such as cancer care treatment and A&E waiting times. The main issue of concern, that was reported, related to staff absence levels.

It was noted that the staffing absence levels, though high, were actually lower than in previous years. The main drivers for absence were short-term absences. There had been a renewed focus, led by the Trust's management, to ensure that 'return to work' interviews were held, so that any underlying reasons for the absences can be captured. The Trust's Occupational Health team were working with those elements, or teams, within the wider workforce that were experiencing the highest rates of staff absences.

Other issues that the Trust were focusing on included measures to tackle dementia related illnesses and an analysis of the bed occupancy rates across the hospitals in the Trust's footprint.

Resolved:
That the report be noted.

8 **INTEGRATED PERFORMANCE REPORT.**

Jude Adams, the Northern Care Alliance's Director of Strategy updated the Committee on the Northern Care Alliance's (NCA) corporate performance statistics for the third quarter of 2024/25 (October – December). The overall performance of the Trust was good, especially when compared with other Trusts in England's North-West region.

The main issue of concern though, highlighted in the report, was staffing. This was in terms of the numbers of absences and the high turnover of staff. It was noted that the areas of the Trust's workforce with the highest levels of absences were amongst the least skilled and lowest paid employees. The staffing absence figures were reported as being at 8%, which represented worrying absence levels for the Trust's management but did though represent an improvement on the 10% figure that was reported for the corresponding period in 2023/24. There was also an issue relating to the numbers of agency staff employed by the Trust. This had a knock-on effect in terms of costs as it was more expensive to employ staff via an agency than for the Trust to directly employee people.

Another issue of concern was the average length of time being taken for ambulance handovers. This was reported as being about 35 minutes against a target time of 30 minutes.

Resolved:
1. That the report be noted.
2. That the issue relating Performance report be considered again at the Trust's next meeting, on Thursday, 24th April 2025.

9 **POPULATION HEALTH AND HEALTH INEQUALITIES**

Dr Rafik Bedair, Northern Care Alliance's (NCA) Chief Medical Officer reported upon Population Health and Health Inequalities that existed across the footprint of the NCA.

Population Health was a key ambition in the NCA Vision10 strategy - Improving Population Health in all our Places, working

with Partners. Major NCA programmes such as the Clinically Led Model, Clinical Strategy and GIRFT had common themes of reducing unwarranted variation which would lead to reduced health inequalities.

The 2024 Darzi report had highlighted that too much of the NHS budget is being spent in the acute sector and too little in community. A key recommendation, arising from the report was to focus on improving population health and shift spending to prevention. The current financial pressures on the NCA had the potential to adversely impact health inequalities, and there was a need for a longer-term strategy to focus on preventative approaches.

In considering Workstream issues the meeting was informed that:

a. The NCA now has a substantive Public Health Consultant in post.
b. Formal governance arrangements were in place with a Population Health and Health Inequalities Oversight Group reporting into board via our Research and Innovation Committee.
c. Local metrics to monitor progress in addressing health inequalities over time were currently being developed and were being incorporated into formal reports to the NCA's Board.
d. An introduction to health inequalities animation has been developed and was now included in the Trust's formal induction programme.

Resolved:
That the report be noted and that the issue be considered again at the Committee's next meeting on 24th April 2025.

10 **WORK PROGRAMME**

The Committee considered its Work Programme for 2024/25.

It was agreed that an extra meeting of the Committee bel held on 24th April 2025 (minute 11 refers) and that the substantive agenda items for that meeting would be:

a. Health Inequalities
b. Integrated Performance Report

Resolved:
That the Committee's Work Programme 2024/25, be noted.

11 **ADDITIONAL MEETING - PROPOSED DATE**

Resolved:
That the next meeting of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance be held on Thursday, 24th April 2025, beginning at 2.00pm in the Civic Centre, Oldham.

The meeting started at 2.00pm and ended at 4.05pm

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Foundation Trust

Integrated Performance Report

Published: March 2025

Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Contents

Using Statistical Process Control

Statistical Process Control (SPC) is a method for viewing data over time to highlight variation. This methodology has long been associated with Quality Improvement and enables us to understand where variation is normal and also where variation is different and requires further actions. This is known as special cause variation.

SPC Charts have upper and lower process limits. Approximately 99% of data points will fall between these two control limits. If a target is outside of the control limits, it is unlikely that it will be achieved without a change in practice.

Icons are used on our SPC charts for ease of interpretation. As well as these icons giving an indication of whether variation is normal or not, there are also icons providing an indication of assurance in terms of performance targets.

SPC charts aren't always appropriate for all metrics and where this is the case, standard run charts will be used showing trends over time, including any applicable targets.

NHS England's SPC Icons

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Understanding the rules of SPC

There are a number of rules that help us interpret SPC charts. These rules indicate something that would not happen through natural variation:

- A single data point outside of the process limit
- Consecutive data points above or below the mean
- Six consecutive points increasing or decreasing
- Two out of three points close to the process limit – an early warning

These rules indicate *special cause variation.*

Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Gertie Nic Philib - Chief Strategy & People Officer: Drive Metrics

People & Learning

Highlights

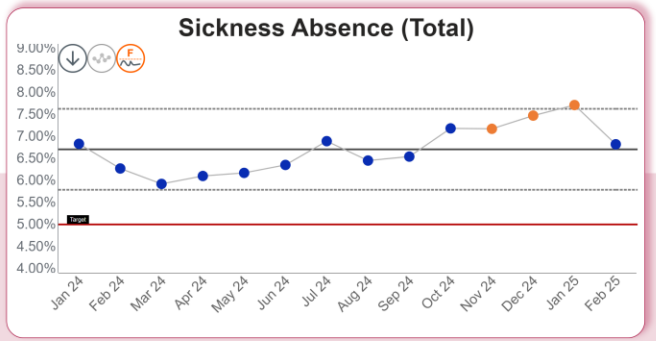
Our staff turnover has reduced to 9.41%
Mandatory Training compliance has remained the same at 93% for the 3rd month in a row.

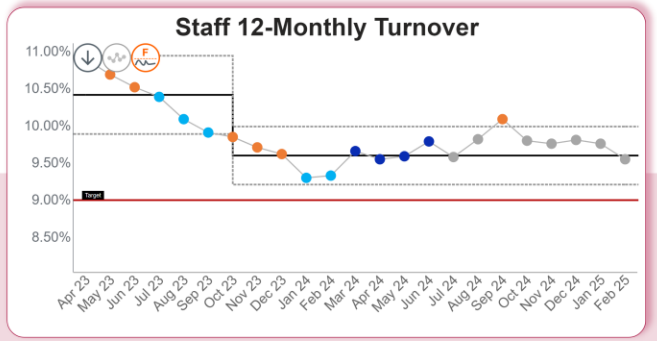
Areas of Concern

Sickness absence continues to rise with short term absence accounting for over 50% of absence.
Our My Time compliance has remains below our 90% target at 86%.
Time to hire from conditional offeris stable at 17 days, remaining below our target of 20 days for a fifth consecutive month .

Forward Look (with actions)

In the coming months we will be focussing on how we embed our values and behaviours through:
- Welcome back to work conversations for colleagues who are absent from work
- Overall reduction in short and long term absence and
- Increasing our My Time and Mandatory Training Compliance.





Technical Analysis

Sickness absence currently demonstrates natural variation after a period of increased sickness absence throughout December and January, which was demonstrating special cause variation.

Staff turnover remains above the 9% target; decreasing in from 9.76% in January to 9.55% in February.

Actions

Sickness absence has increased to 6.82% in month with a rolling 12m average of 6.73% both of which are above our target of 5% for 2024/25.
The top 3 reasons for absence in February 2025 were :
- Coughs Colds and Flu, Gastrointestinal Illnesses and, Stress, Depression and Anxiety.

Turnover continues to be below 10%, for the 12th month in a row and is now at 9.55%.

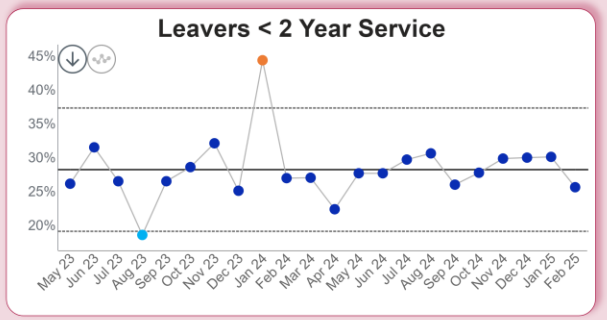
We continue to encourage 'stay with us' conversations to pave the way for improving our retention rates and retaining valued NCA colleagues.

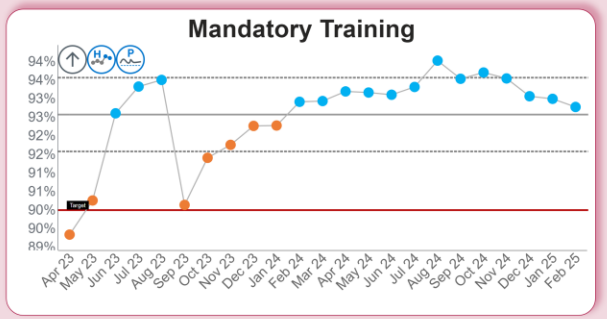
Integrated Performance Report: March 2025

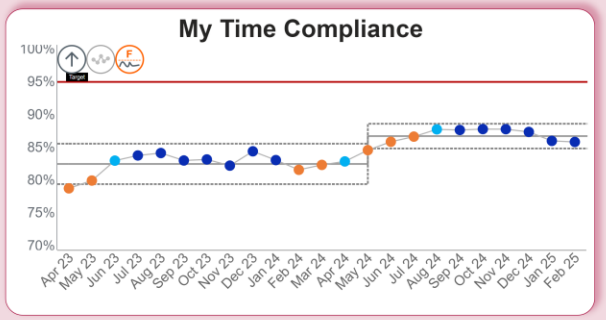
Northern Care Alliance
NHS Foundation Trust

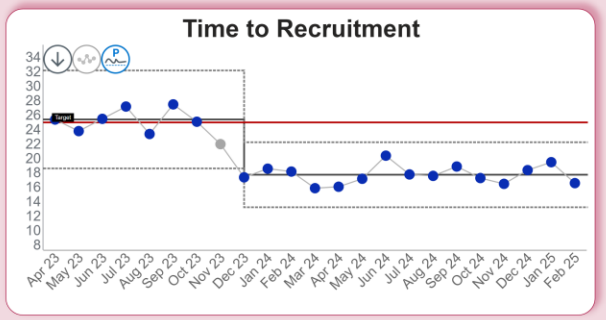
Watch Metrics

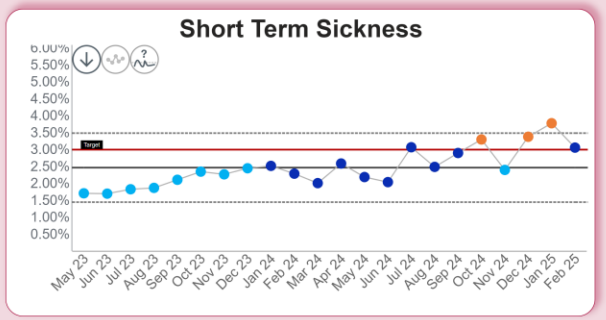
People & Learning

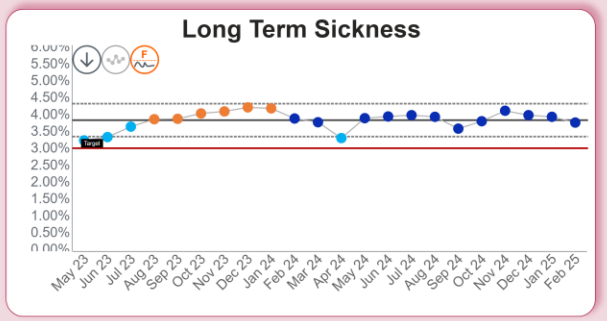


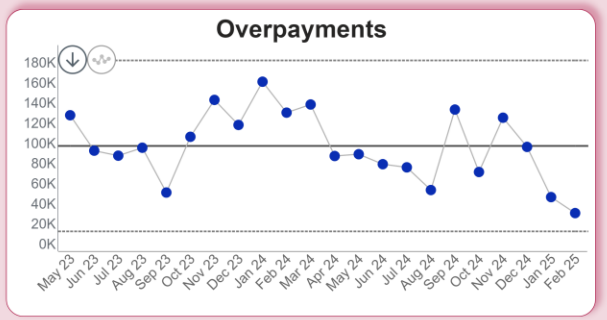












Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Judith Adams - Chief Delivery Officer: Drive Metrics

Elective Care & Productivity

Highlights

Long waits have reduced over the last year, and we met our target for 52 weeks 5 months early. Reductions in patients waiting more than 35 weeks for a first outpatient appointment supports sustainable improvements in overall RTT performance. Productivity shows sustained improvement for Outpatient services.

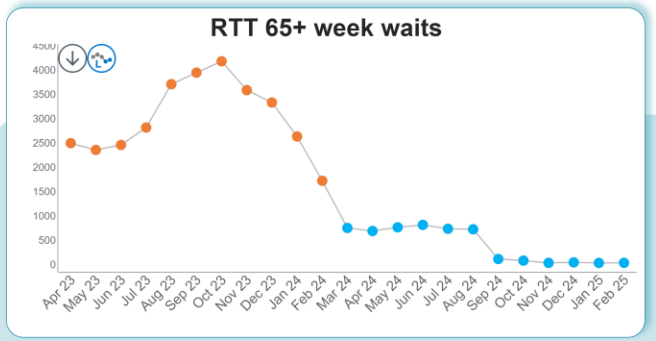
Increased PIFU compliance driven by a new initiative rolled out in Neurology for long term condition MS patients.

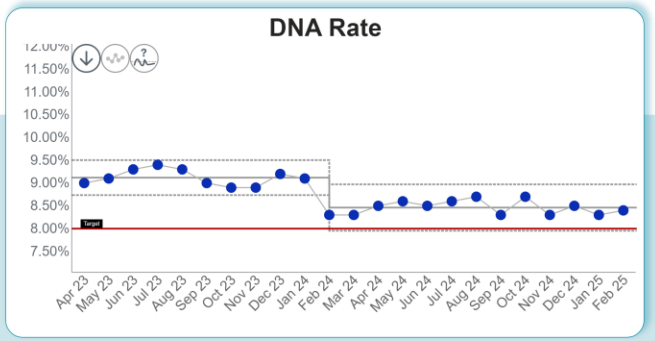
Areas of Concern

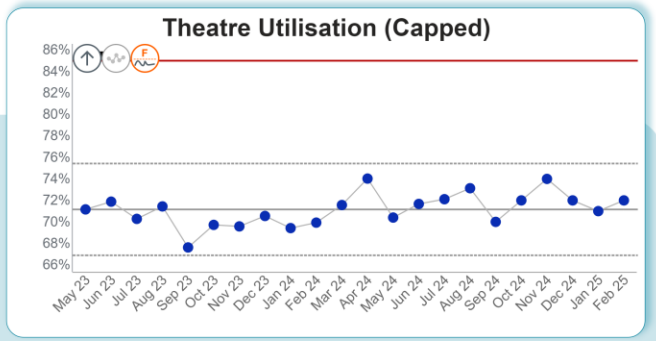
We have improved at a faster rate than the national average but need to clear 65 week waits and accelerate 18 weeks recovery in 25-26. Neurology & Dermatology remain RTT pressures. Physiological test capacity is a constraint driving a diagnostic performance 6 weeks dip over the last month. Our theatre productivity has improved but has not kept pace with peers.

Forward Look (with actions)

Best practice (Getting It Right first Time) guidance is being used to support sustainable improvement & NHSE is visiting us to pilot outpatient work. We are improving our validation processes using learning from our participation in NHS England's validation sprint initiative.







Technical Analysis

65+ week waits remained steady from January, with 41 reported at month end.

The DNA rate remained consistent with previous months at 8.40% in February. This metric was re-baselined due to consistent improved performance from Feb 2024.

Theatre utilisation continues below the 85% target with 72% reported in February. The process is 'in control' demonstrating natural variation since May '23.

Actions

(1) Additional validation of waiting lists; (2) Utilisation of GM Mutual Aid Offers; (3) Increase capacity through use of Insourcing & Outsourcing; (4) Develop plans to close gaps against GIRFT best practice in key specialties, improving productivity

1) Digital Solutions - more services sending text reminders to patients; (2) Standardisation of patient letters - better patient communication of appointments; (3) Validation of waiting lists; (4) Develop and implement invite to book processes; (5) PTL risk of DNA stratification

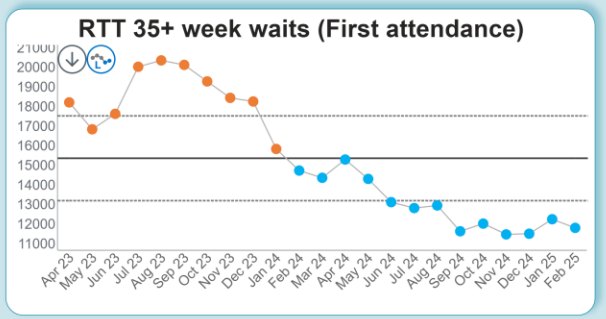
(1) Prioritise reduction of cancellations of surgery & standby patient model; (2) 6-4-2 process on a Trust-wide basis; (3) Review theatre data quality; (4) Implement actions from GIRFT; (5) Single Theatres IT system

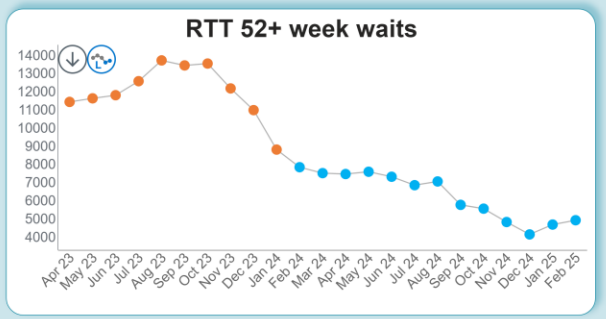
Integrated Performance Report: March 2025

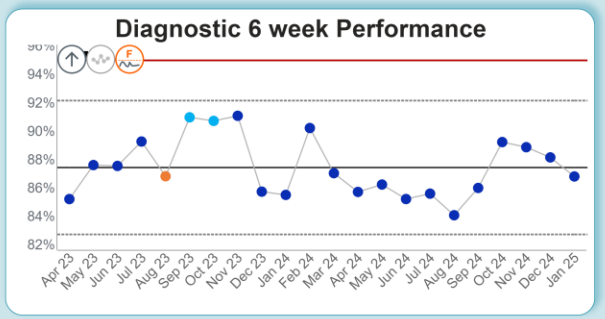
Northern Care Alliance
NHS Foundation Trust

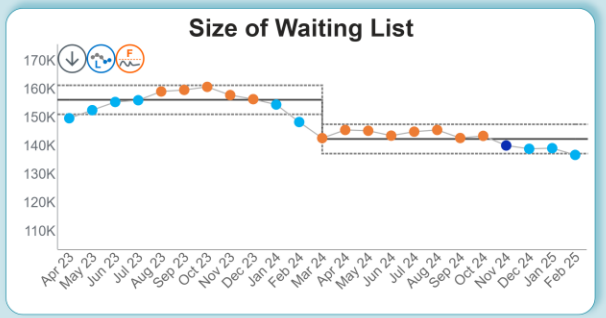
Watch Metrics

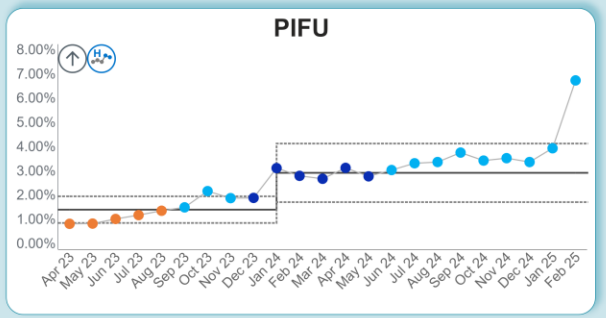
Elective Care & Productivity

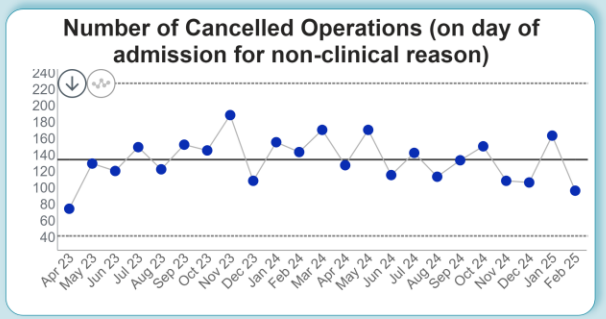












Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Judith Adams - Chief Delivery Officer: Drive Metrics

Urgent & Emergency Care & Cancer

Highlights

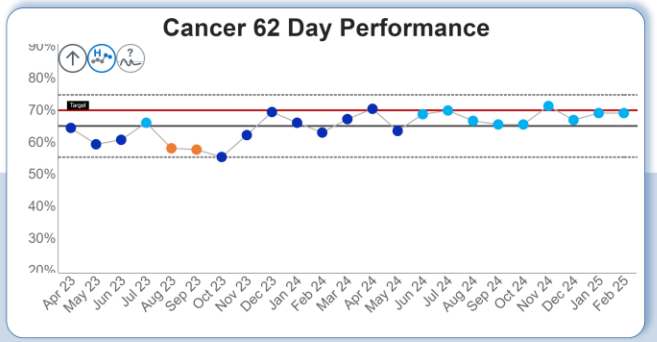
Urgent Care 4 Hour performance is better than last year and remains stable against a backdrop of increasing system-wide demand pressures. Cancer performance has improved and on track against trajectory, driven by skin pathways, with GM Cancer Alliance and NHS England supporting continuation of extra capacity.

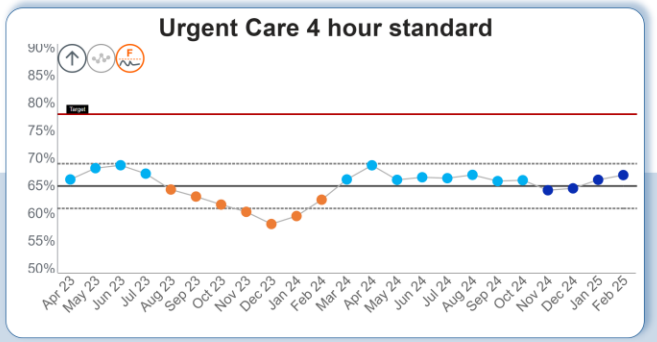
Areas of Concern

Urgent Care is off track against 4 Hour trajectory with ED long waits & we have identified a bed capacity shortfall at ROH. LGI cancer pathways are an improvement priority and sustainability of Skin performance is dependent on additional funding.

Forward Look (with actions)

We are working together with system stakeholders to manage urgent care improvement & have seen better inpatient flow. Additional controls are being deployed for March to meet NHSE requirements. We are working with the ICB to agree funding to sustain Skin cancer pathway performance.





Technical Analysis

January's 62 day confirmed position was 69.12%. Special cause variation has been identified of an improving trend over the past 9 months. Further improvement is required to consistently achieve 70% target.

Performance increased slightly for the third consecutive month reporting 66.97% in February. This remains short of the newly adjusted 78% national target (by March-25).

Actions

(1) Support T&GICFT to maintain cancer capacity (2) Insourced Skin pathway capacity (3) Increase endoscopy capacity, recruiting to vacancies & better productivity (4) Best Timed Pathway compliance (5) Realise benefits from upgrade digital Pathology system

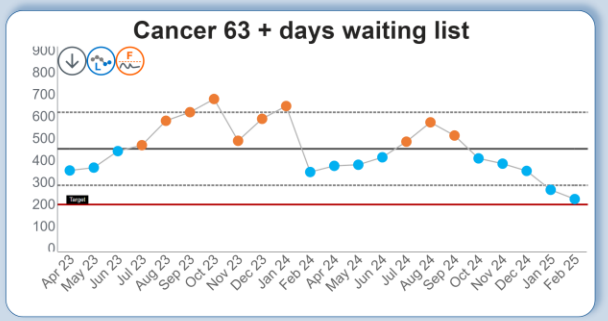
(1) Safety focus – daily huddles (2) UEC improvement plan (Care Coordination, Frontrunner Programme, Virtual ward, Internal Professional Standards) (3) Care Coordination business case; (4) First principles focus (5) ED Acuity tool (6) CFM improvement action

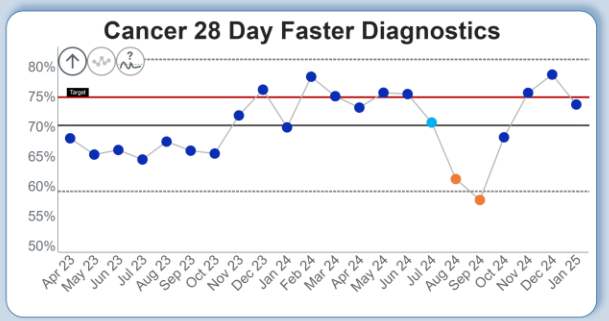
Integrated Performance Report: March 2025

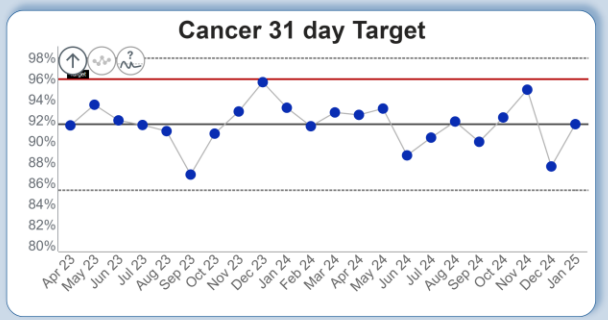
Northern Care Alliance
NHS Foundation Trust

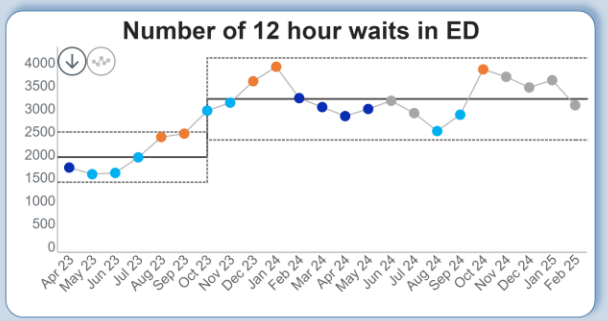
Watch Metrics

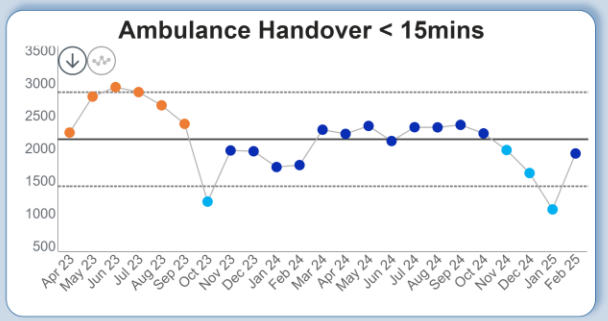
Urgent & Emergency Care & Cancer











Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Craig Carter - Interim Chief Financial Officer: Drive Metrics

Finance

Highlights

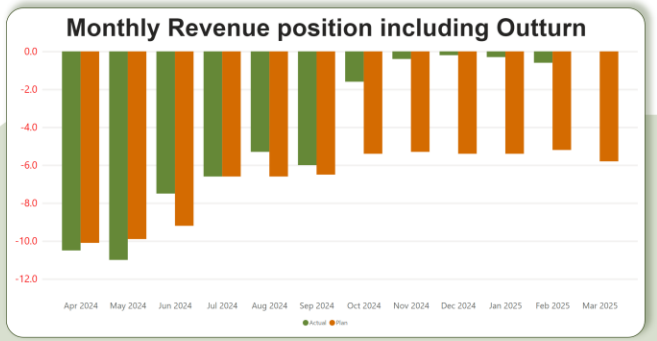
The month 11 year to date (YTD) position is a deficit of £4.5m compared to a planned deficit position of £3.7m, which is £0.8m worse than plan, in line with the variance at month 10.
The position is in line with the forecast recovery trajectory. Year to date the Trust has received £66.7m of the £71.4m non recurrent revenue support expected in year.

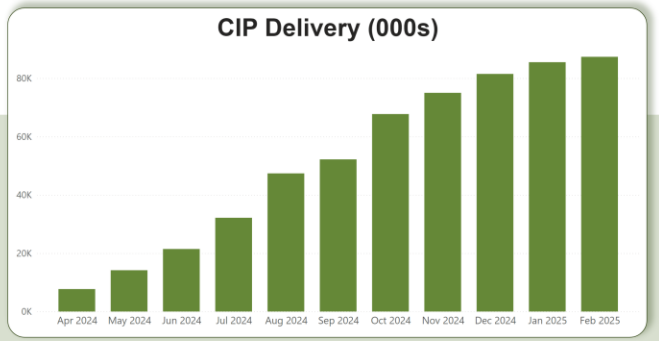
Areas of Concern

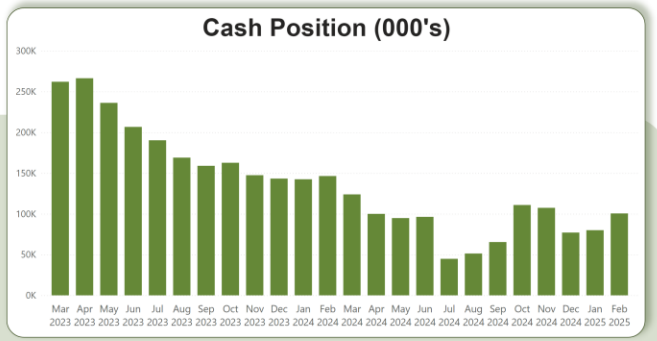
The year-to-date position is on target with the NCA recovery trajectory with the recovery position expected to be a £0.8m adverse variance at Month 11 excluding pay award pressure. The Month 11 actual position is £0.8m adverse variance including the pay award pressure of £1.6m.

Forward Look (with actions)

The 2025/26 financial plan has been submitted with an I&E deficit of £70.7m, which includes a CIP target of £99m, and a capital control total of £88.4m including PDC.







Technical Analysis

In Month, the Trust reported a break-even position against plan. The in month drivers to variance include.
--> Pay award pressure of £(£0.2m)
--> Reduction in CIP overperformance by (£0.5m)
--> ASC pressure of (£0.6m)

CIP target is £85.6m for FY 24/25
->Schemes with a value of £89.1m have been added to eHub. The full year recurrent value is £40.6m against £64.2m target (75% recurrent)
->£87.4m (full year value) has been transacted since the start of the financial year, an increase of £1.9m since last month.

The cash position increased in February to £100,490.00

Actions

The year-to-date position is on target with the NCA recovery trajectory. The NCA is forecasting to deliver a £4.3m deficit which is in line with the current plan.

As of the end of month 11 (based on eHub reporting), £89.1m of schemes, (104% of the overall target) have been identified.
35.7% of schemes on eHub are recurrent in nature.
40.3% of schemes on eHub are pay related. Focus turns now to CIP planning for 2025/26.

At the end of M11 the cash position was £100.5m, and the forecast for the end of the year is £90.8m. The NCA is paying to terms to maintain cash levels. The planned cash position at the end of 2025/26 is c.£4m.

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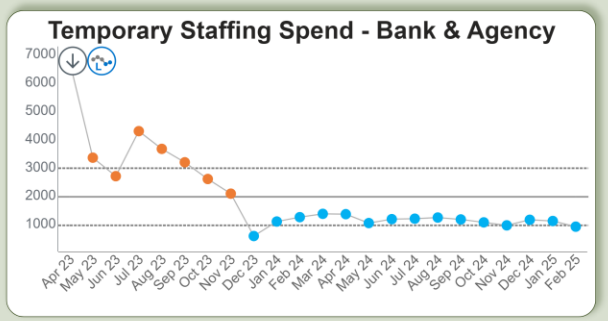
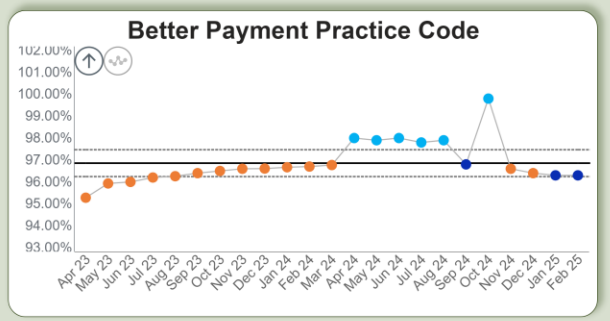
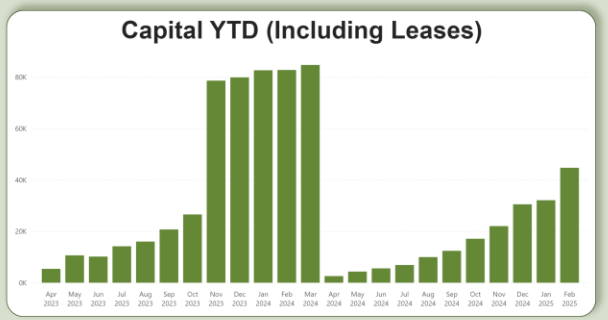
Watch Metrics

Finance







Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Heather Caudle - Chief Nursing Officer: Drive Metrics

Quality

Highlights

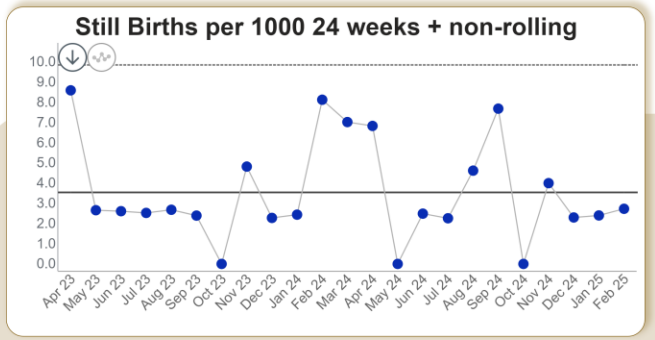
KPI - Complaints 78% - 5 out of 6 Care Orgs achieved KPI. KPI - PALS 66%
Nationally, we ranked 75/135 Trusts and had the second lowest rate in GM for February. We are reviewing additional benchmarking approaches.

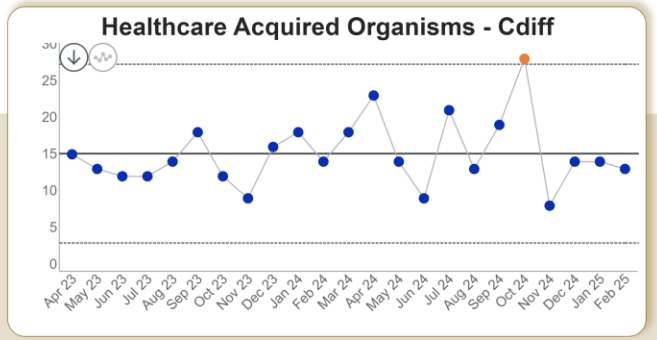
Areas of Concern

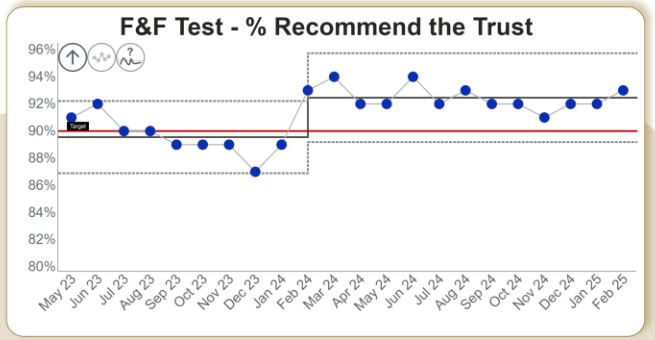
Salford Care Org KPI 54%. High numbers increase pressure in clinical teams leading to poor responsiveness. We have reported 13 cases of healthcare-associated CDI in February, with a YTD total of 176 and exceeding our external threshold of 171 cases.

Forward Look (with actions)

Updated Investigation Report - more streamlined to make for easier completion
Our cases have been extensively reviewed and identified the use of antibiotics for other infections as the prime risk factor. Prescribing is a focus for our local and GM system IPC improvement plan, with clear deliverables around antimicrobial stewardship and IPC practices, monitored by IPCC and GM IPC group.







Technical Analysis

This is demonstrating natural cause variation. There was 1 stillbirth in February.

The average number of cases since April '23 is 14 per month; the data is demonstrating natural variation; there were 13 cases reported in February.

The target responses is close to the average performance meaning that we will inconsistently achieve this target. The last 9 months performance have been above the average. The use of area specific QR codes is anticipated to further increase return rate.

Actions

To continue to monitor all stillbirths through governance processes and report through to the Maternity Improvement Board and Northern Care Alliance Board on a monthly basis.

Prescribing focus as part of local and GM action plan including optimising antimicrobial prescribing, identifying the source of infection, and investigating penicillin allergy prescribing pathway

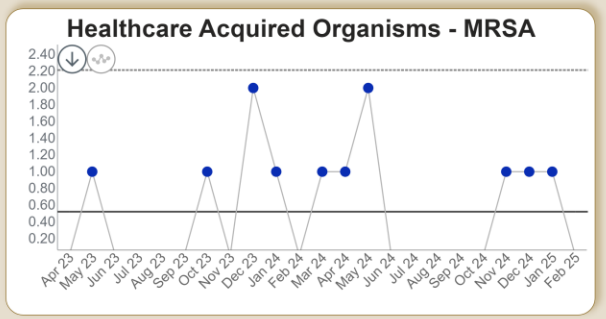
FFT average positive response score 93.76%. Number of responses increased in February: 8607. More use of our website access. Best performing: Bury & Oldham Community 97%, Rochdale Integrated Care 96%. Worst performing: Perinatal Services 84%, Medicine Oldham 87%, Medicine Bury 91%

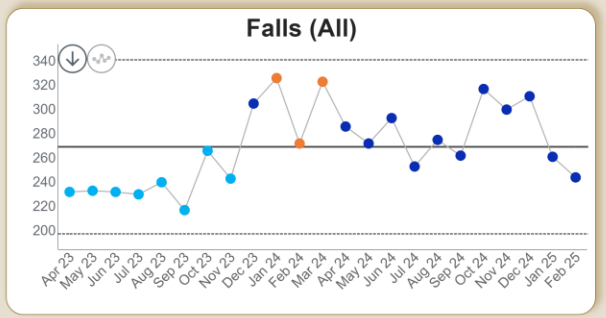
Integrated Performance Report: March 2025

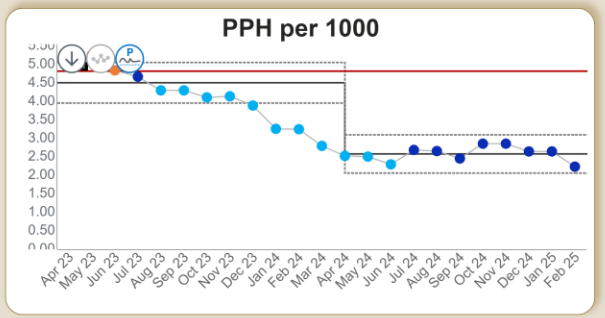
Northern Care Alliance
NHS Foundation Trust

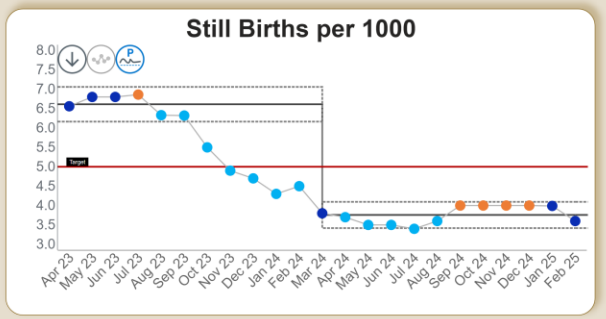
Watch Metrics

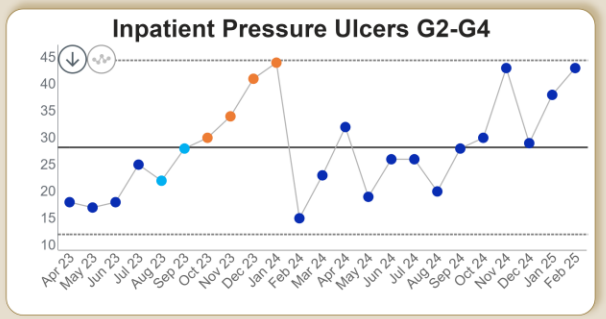
Quality

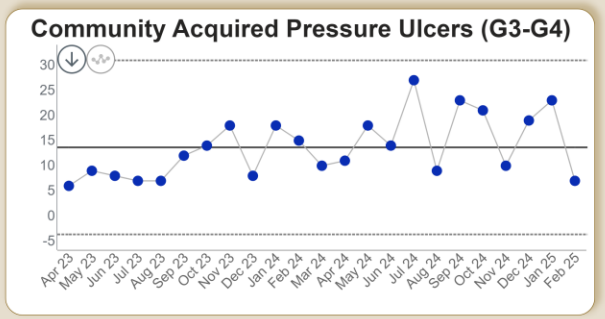


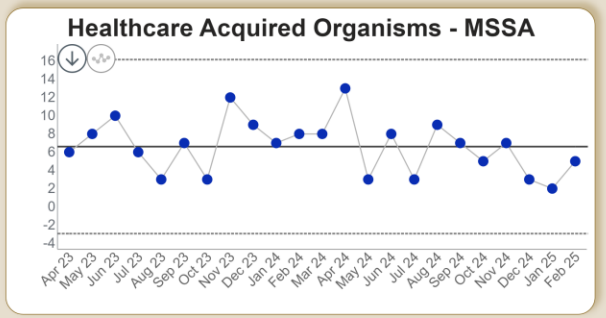


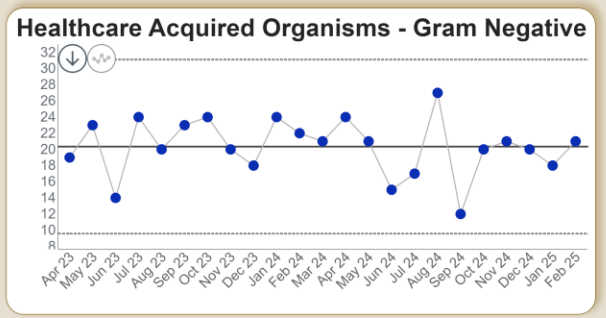


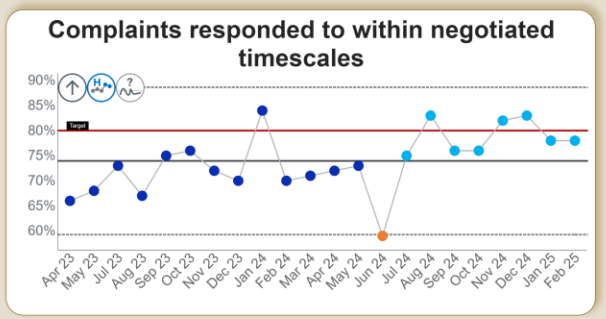












Integrated Performance Report: March 2025

Northern Care Alliance
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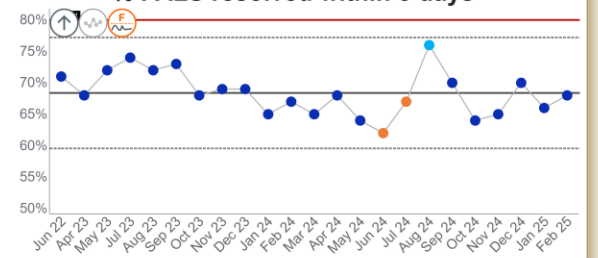
Watch Metrics

Quality

% PALS resolved within 5 days



Number of significant risks (16 or above)

Current Position: 69

Number of significant risks within review date

Current Position: 100%

Integrated Performance Report: March 2025

Northern Care Alliance
NHS Foundation Trust

Rafik Bedair - Chief Medical Officer: Watch Metrics

Safety

Highlights

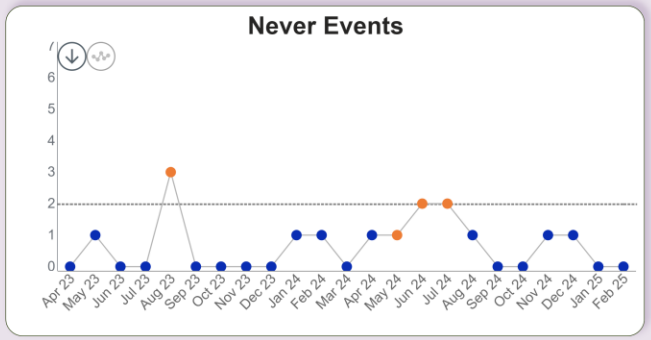
NGPOD Business case approve, T&F groups established to implement. NG training compliance continues to increase

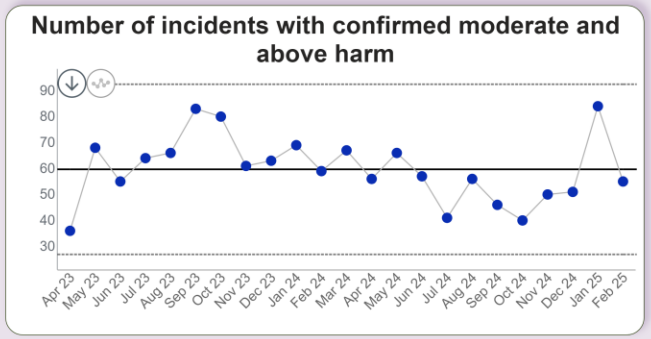
Areas of Concern

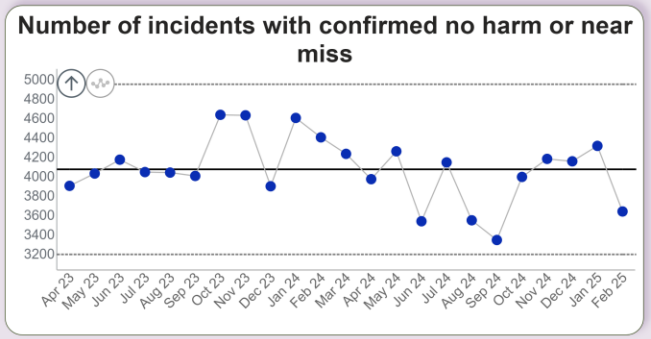
Overdue PSII investigations continue to increase. T&FG being established

Forward Look (with actions)

Good progress implementing Martha's Rule across OCO. Official launch March 25

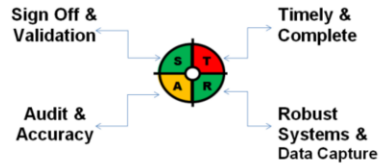






STAR Factors - Part 1

How to read the STAR Factors Icon



Domain	Assurance sought
S - Sign Off & Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T - Timely & Complete	Is the data available and up-to-date at the time of submission or publication? Are all the elements of the required information present in the designated data source, where no elements need to be changed later?
A - Audit & Accuracy	Are there processes in place for either external or internal audits of the data, and how often do these occur (Annual/One-off)? Are accuracy checks built into the collection and reporting processes?
R - Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture, such that it is at a sufficiently granular level?

People & Learning	STAR Factors
Leavers < 2 Year Service	
Long Term Sickness	
Mandatory Training	
My Time Compliance	
Overpayments	
Short Term Sickness	
Sickness Absence (Total)	
Staff 12-Monthly Turnover	
Staff Monthly Turnover (Permanent only)	
Time to Recruitment	

Urgent & Emergency Care & Cancer	STAR Factors
Ambulance Handover	
Cancer 28 Day Faster Diagnostic	
Cancer 31 Day Target	
Cancer 62 Day Performance	
Cancer 63+ Day Waiting List	
Number of 12 hour waits in ED	
Urgent Care 4 hour standard	

Finance/Cost	STAR Factor
BPPC	
Capital	
Cash Position	
CIP Delivery	
Monthly Revenue position including Outturn	
Temporary Staffing Spend - Bank & Agency	

STAR Factors - Part 2

Elective Care & Productivity	STAR Factors
Diagnostic 6 week Performance	
DNA Rate	
Number of Cancelled Operations (on day of admission for non-clinical reason)	
PIFU	
RTT 35+ week waits (First attendance)	
RTT 52+ week waits	
RTT 65+ week waits	
Size of Waiting List (TBC)	
Specialist Advice	
Theatre Utilisation (Capped)	

Quality	STAR Factors
% PALS resolved within 5 days	
Community Acquired Pressure Ulcers G3-G4	
Complaints Responded to within 25 working days	
F&F Test - % Recommend the Trust	
Falls (All)	
Hospital Acquired Organisms - Cdiff	
Hospital Acquired Organisms - Gram Negative	
Hospital Acquired Organisms - MRSA	
Hospital Acquired Organisms - MSSA	
Inpatient Pressure Ulcers G2-G4	
Never Events	
Number of incidents confirmed with moderate and above harm	
Number of incidents confirmed with no harm or near miss	
PPH per 1000	
Still Births per 1000	
Still Births per 1000 24 weeks + non-rolling	

Safety	STAR Factors
% of High Risks within review date	
Number of High Risks (16 or above)	

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Glossary

AAA	Alert, Assure and Advise
ADG	Associate Director of Governance
AHP	Allied Health Professional
AMS	Acute Medical Service
BAF	Board Assurance Framework
BCO	Bury Care Organisation
Cdiff	Clostridium Difficile
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
CO	Care Organisation
CRR	Corporate Risk Register
CTG	Cardiotocograph
DNA	Did not Attend
ED	Emergency Department
ESR	Electronic Staff Record
F&F	Friends and Family
FFT	Friends and Family Test
FGH	Fairfield General Hospital
GM	Greater Manchester
GIRFT	Getting It Right First Time
HCAI	Healthcare-associated infections
IPCC	Infection Prevention and Control Committee
IPR	Integrated Performance Report
KPI	Key Performance Indicator
LocSSIPs	Local Safety Standards for Invasive Procedures
Lower GI	Lower Gastro-Intestinal
MIP	Maternity Improvement Programme
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NCA	Northern Care Alliance
NE	Never Event
NHSE	NHSE England
NG	Nasogastric
OCO	Oldham Care Organisation
PALS	Patient Advice and Liaison Services
PSG	Patient Safety Group
PIFU	Patient Initiated Follow Up
PPH	Postpartum Haemorrhage
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
QMEG	Quality & Management Executive Group
RCO	Rochdale Care Organisation
ROH	Royal Oldham Hospital
RTT	Referral To Treatment
SOP	Standard Operating Procedure
SPC	Statistical Process Control
T&GICFT	Tameside and Glossop Integrated Care NHS Foundation Trust
TVN	Tissue Viability Nurse
UEC	Urgent and Emergency Care
YTD	Year to Date

Population health and health inequalities

Rafik Bedair, Chief Medical Officer

Overview

- What Are Health Inequalities?
- NCA's Approach to Tackling Inequalities
- Looking ahead – plan for 25/26
- Partnership working
- Discussion & Reflections

What are health inequalities?

- Health inequalities are unfair and avoidable differences in health between groups of people.
- They affect how long people live, how healthy they are, and the care they receive.
- As a Trust, we serve diverse and often disadvantaged communities, so tackling these inequalities is central to delivering better care and outcomes for everyone.
- Improving population health is a key priority for the NCA:
  - Included in Vision 10 as a core strategic objective
  - In the NCA Annual Plan
  - Supported by the Population Health & Health Inequalities (PHHI) programme
- And it's a legal duty – NHS organisations are required to consider health inequalities under the Health and Care Act 2022

Examples of health inequalities

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- Health inequalities are **unjust and avoidable** differences in people's health across the population and between specific groups
- The kind of life a person is born into, where they live, the environment they grow up in and where they go to school and work will shape their lives, impact their lifestyle choices, and in turn, influence their physical and mental health.

Homelessness
44
Years in the median age at death (compared to 83 for females and 86 for males in England 2016-2018)

Deprivation
51.4
Years is the healthy life expectancy for women born in the most deprived areas, compared to 71.2 years in the least deprived areas

Asylum Seekers
61
Per cent are likely to experience serious mental distress. 5x more likely to have mental health needs than general population

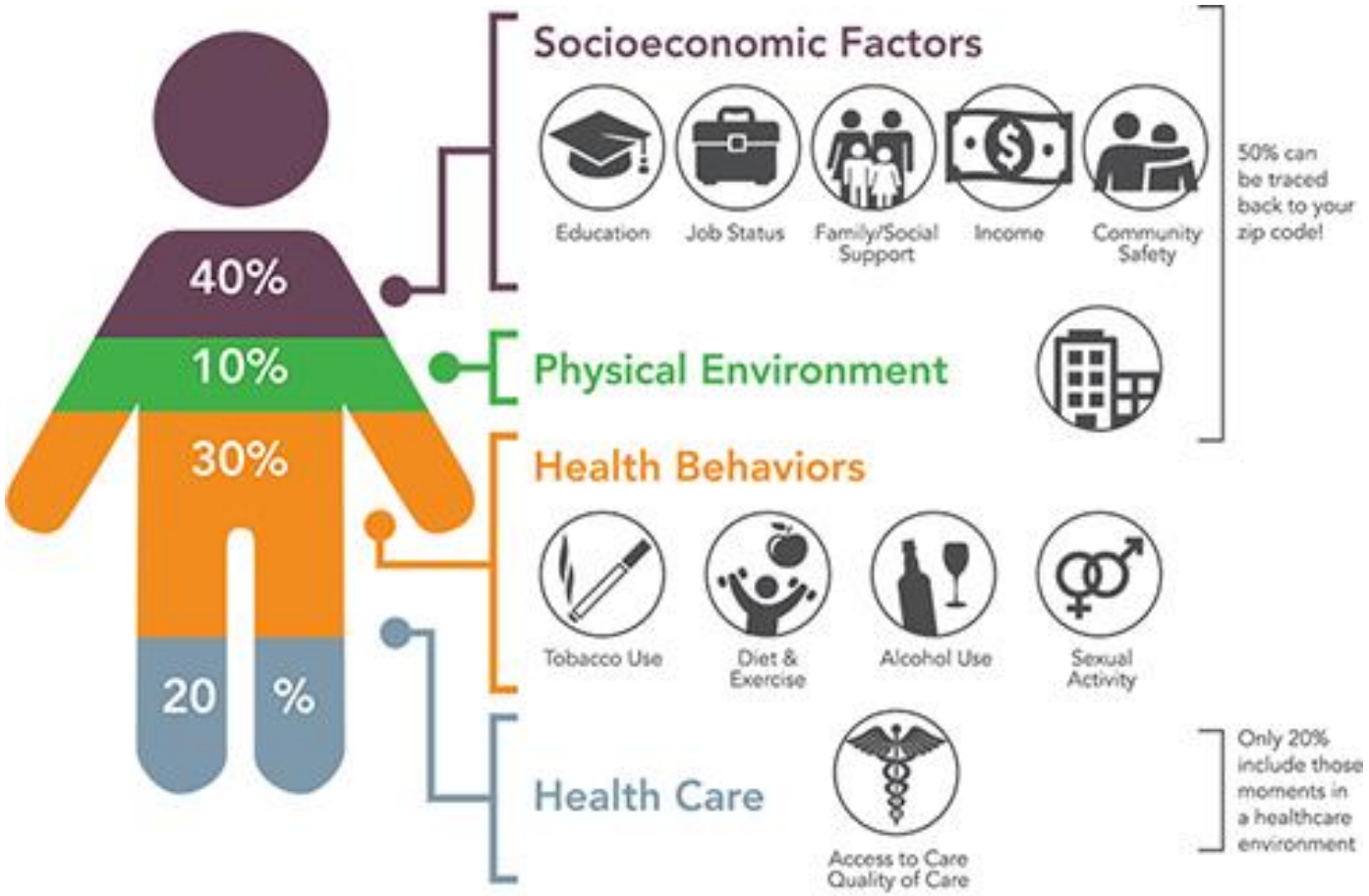
Ethnicity
257
COVID-19 deaths per 100,000 population (age standardised) in Black men compared to 70 in White men in the first wave of COVID-19

Mental illness
390
Per cent excess mortality (aged <75) in people with serious mental illnesses

INSPIRE

Sources: Kings Fund – Health Inequalities in a nutshell; PHE - Disparities in risk and outcomes of COVID-19; OHID Fingertips tool

Causes of health inequalities



Source: Institute for Clinical Systems Improvement - Going beyond walls: Solving complex problems (October 2014)

	Bury	Oldham	Rochdale	Salford	England
Population	193,851 65+: 35,448 (18%)	242,089 65+: 38,614 (16%)	223,773 65+: 36,867 (16.5%)	269,923 65+: 35,924 (13.3%)	56,490,048 65+: 10,401,301 (18.4%)
Population living in most deprived IMD quintile	23.8%	51.5%	46.7%	51.7%	20%
Single-person households	30.8%	29.4%	30.6%	34%	30.1%
Ethnicity	White – 82.9% Asian – 10.6% Black – 1.9% Mixed – 2.6% Other – 1.9%	White – 68.1% Asian – 24.6% Black – 3.4% Mixed – 2.5% Other – 1.4%	White – 74% Asian – 18.5% Black – 3.5% Mixed – 2.4% Other – 1.6%	White – 82.3% Asian – 5.5% Black – 6.1% Mixed – 3.1% Other – 2.9%	White – 81% Asian – 9.6% Black – 4.2% Mixed – 3.0% Other – 2.2%
English as main language (households)	92.3%	86.6%	88.2%	87%	89.3%
Economic activity (residents aged 16+)	Employed – 57.2% Unemployed – 3.2%	Employed – 52.5% Unemployed – 4.1%	Employed – 54% Unemployed – 3.8%	Employed – 58.8% Unemployed – 4.7%	Employed – 57.4% Unemployed – 3.5%
Economic inactivity (due to ill health)	39.7% (4.7%)	43.3% (5.6%)	42.2% (5.9%)	36.5% (5.6%)	39.1% (4.1%)
Education – no formal qualifications	18.5%	24.7%	23.2%	19.7%	18.1%
Self-rated health bad or very bad	5.5%	6.2%	6.2%	6%	5.2%
Long term health problem/disability	25.6%	23.9%	24.9%	24.7%	24.1%

Source: ONS - 2021 Census

NCA approach

Where are we now & examples of delivery

CARE
APPRECIATE
INSPIRE

Improving **Population Health** in all our places, working with Partners

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Evidenced outcomes

Working with academic partners to evaluate our work and show impact on population health

Systematic implementation

Widespread scale up and spread throughout the NCA

Building capacity & capability

Health inequalities training across the NCA
Develop programme management team

Data & Intelligence

Embedding health inequalities measurement & tracking changes over time

Leadership

Executive lead for health inequalities & public health consultant as clinical lead

VISION 10 strategy

Sets direction on improving population health and reducing health inequalities

CARE
APPRECIATE
INSPIRE

Health inequalities self-assessment

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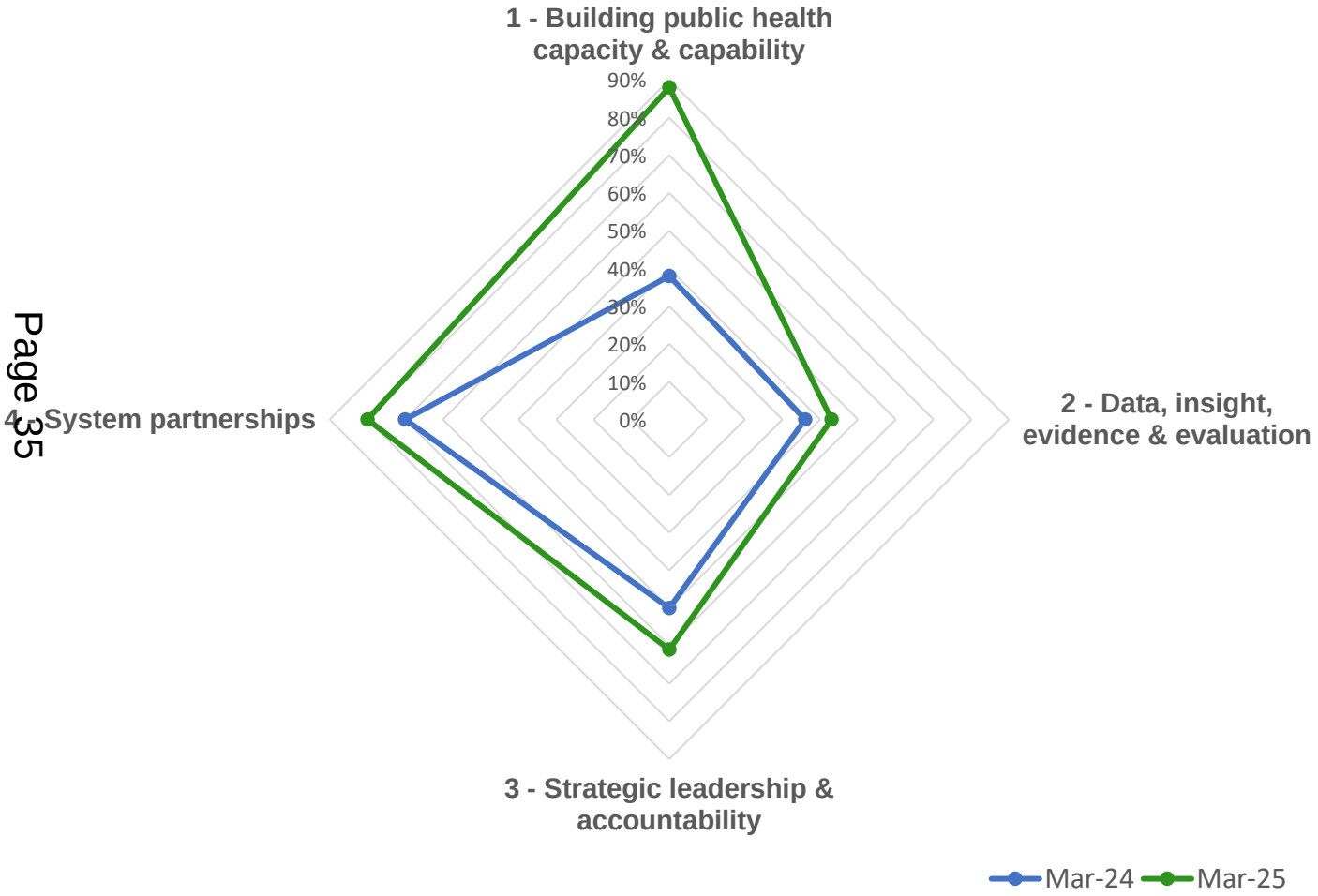


Theme	March 2024	March 2025
1 - Building public health capacity & capability	Developing	Thriving
2 - Data, insight, evidence & evaluation	Developing	Developing
3 - Strategic leadership & accountability	Maturing	Maturing
4 - System partnerships	Maturing	Maturing

CARE
APPRECIATE
INSPIRE

Gestational Diabetes in South Asian women

NHS RACE & HEALTH OBSERVATORY
Breaking barriers for better health

44 women tested **41 or above** when HbA1c tested

4 women tested **48 or above** when HbA1c tested

24 women diagnosed with GDM – 1 with Type 2 Diabetes

Outcomes of our change process of offering HbA1c testing at booking for South Asian women, for earlier identification of and intervention for GDM. HbA1c testing will not impact our outcome measure, but we decided to adopt into our Trust process as we were seeing positive outcomes for some women.

"My sister-in-law was diabetic, but was not diagnosed until the GTT. I am glad to see the test done early as all the women in the family have had diabetes in pregnancy."
- currently pregnant at the NCA.

"Earlier HbA1c testing means we can advise women on diet and exercise early. We aim for our women to have cultural-specific resources." - **Community Engagement Midwife**

"Changing processes may take time to initiate and embed, but long-term benefits include better self-management and a stronger community for our women." - **Staff**

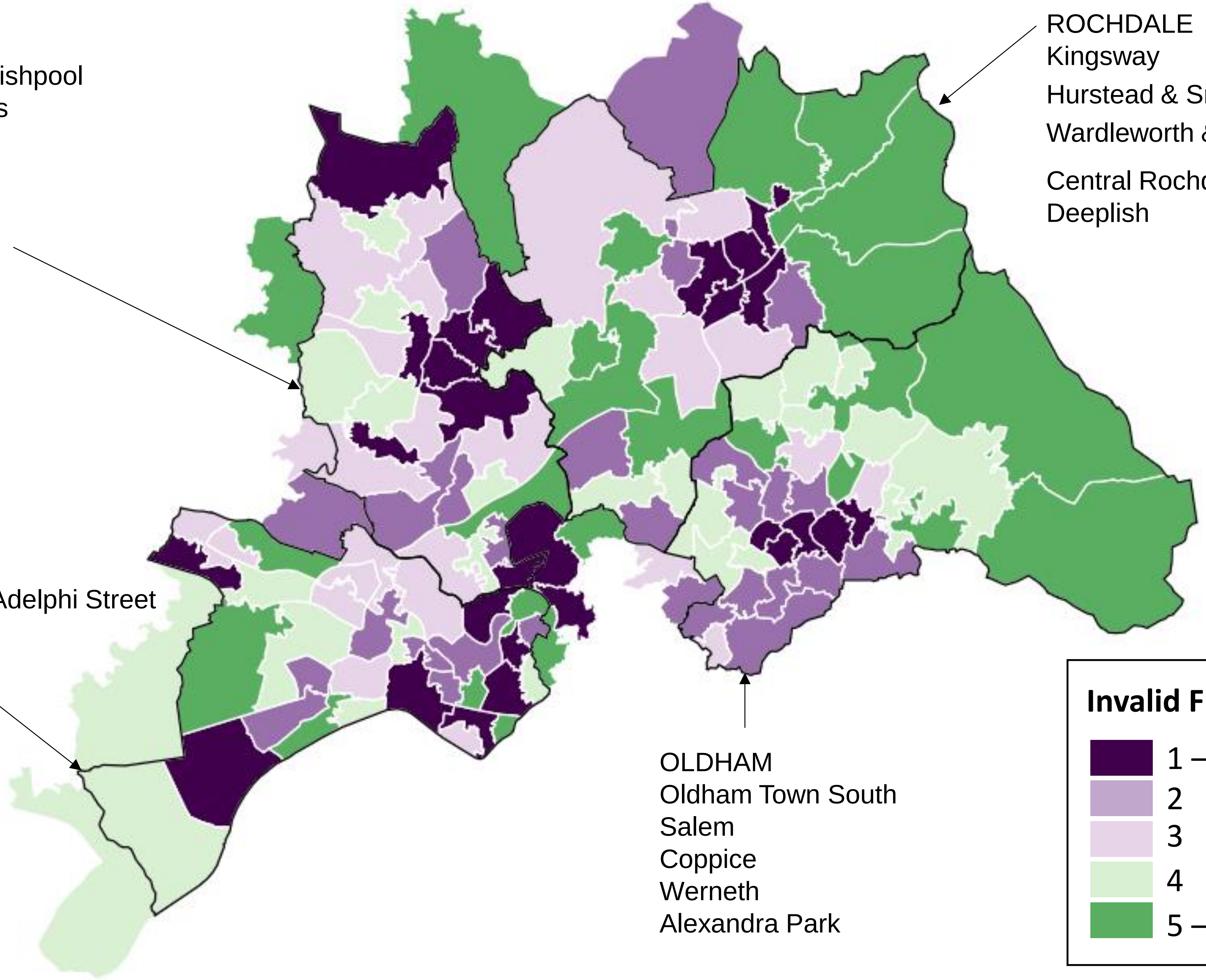
"We have since worked with BadgerNet to ensure 'ethnicity' and 'interpreter' fields are mandatory to better identify patient needs and maintain accurate records." - **Staff**

"I am happy with providing a change to care & treatment. I understand the importance of improving services for South Asian women who are at high risk of Gestational Diabetes. It's easier now, as we know which women are needing the HbA1c test." **- Booking Midwife at our Birth Centre.**

Spatial Inequalities in FIT test validity

BURY
Buckley Wells & Fishpool
Redvales & Hollins
Radcliffe
Fairfield & Jericho
Fernhill & Pimhole
Sedgley Park
Ramsbottom
Whitehead Park

ROCHDALE
Kingsway
Hurstead & Smallbridge
Wardleworth & Newbold Brow
Central Rochdale & Mandale Park
Deeplish



SALFORD
Weaste & Seedley
Higher Irlam
Kersal Dale
University, Crescent & Adelphi Street
Little Hulton South
Broughton West
Ordsall West

OLDHAM
Oldham Town South
Salem
Coppice
Werneth
Alexandra Park

Invalid FIT tests

1 – most invalid tests
2
3
4
5 – least invalid tests

NCA as an Anchor Institution

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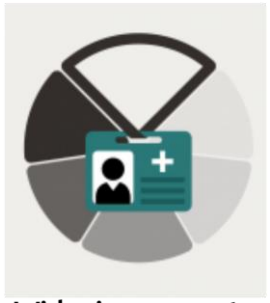

Widening access to quality work

Producing more locally and for social benefit

89.5% of staff reside in GM
(GM Average = 86.4%), highest in GM

41.7% of non-pay spend in local economy
2nd highest in GM (GM Average = 21%)

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Images taken from: Reed S, Göpfert A, Wood S, Allwood D, Warburton W. Building healthier communities: the role of the NHS as an anchor institution. London: The Health Foundation; 2019.

Looking ahead: Our plan for 25/26

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Population health and health inequalities programme

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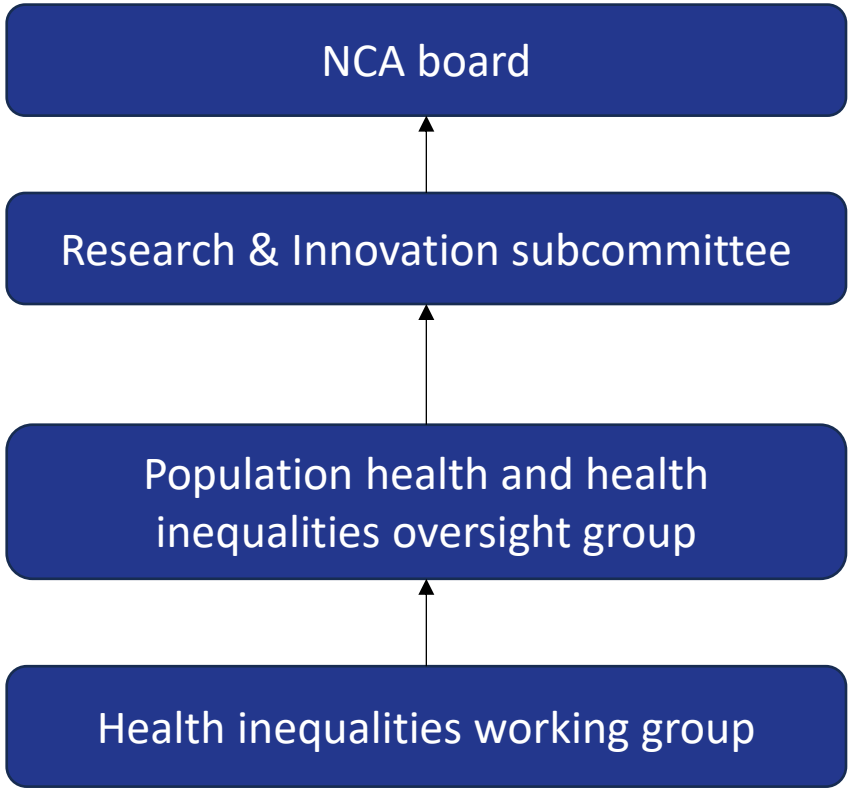

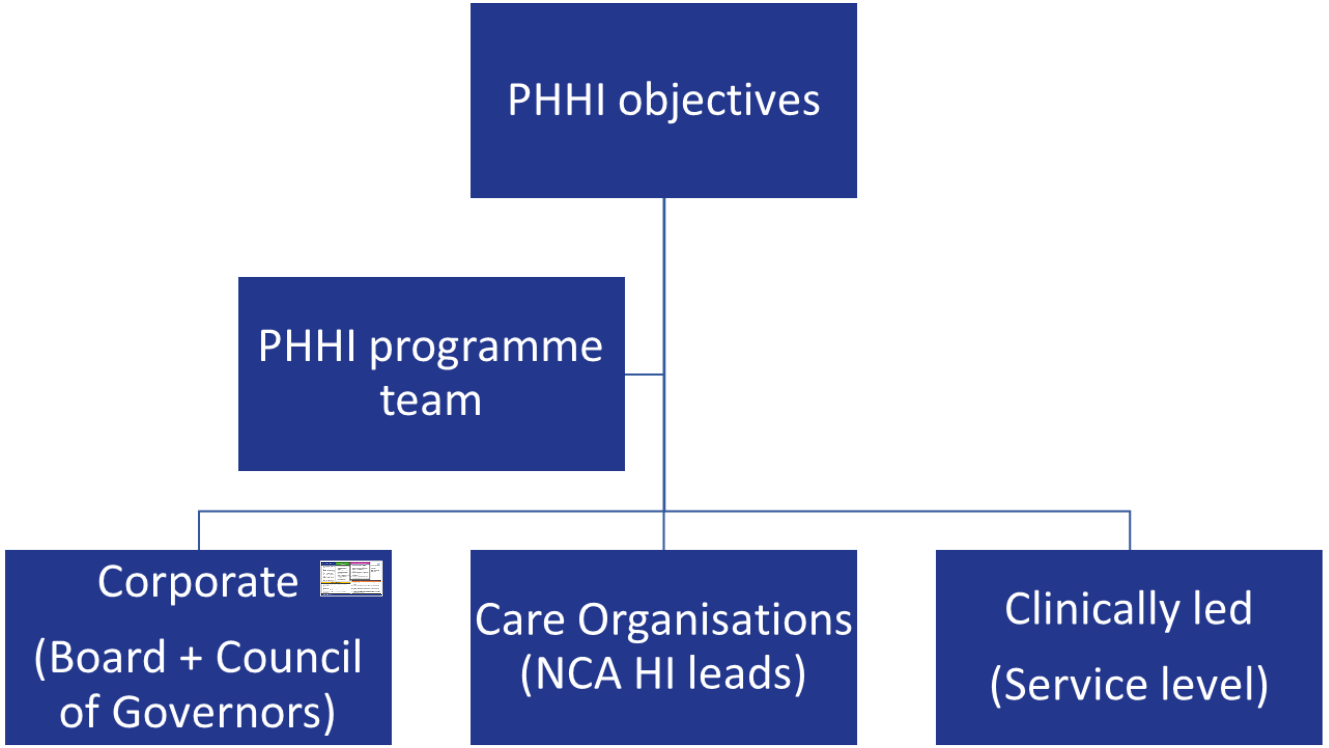

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Service delivery & access

- Reduce waiting times for children and young people
- Embed equity in clinical programmes (e.g. GIRFT)
- Pilot a “Making Every Contact Count” (MECC) approach in one service
- Support return to work and reduce economic inactivity (MSK/spines)

Data, insight, evidence & evaluation

- Improve monitoring of health inequalities metrics
- Build analytic capability to identify and act on disparities
- Explore digital tools (e.g. NHS App) through a health literacy and accessibility lens

Building capacity & capability

- Launch a Population Health for Leaders development programme
- Develop internal programmes to address inequalities in the workforce
- Update Anchor People Strategy to support staff as part of their communities
- Include cultural competence and inclusion in leadership expectations

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25/26 Delivery plan – corporate objectives

System partnerships

- Partner with researchers to evaluate provider-led interventions
- Prioritise procurement from organisations delivering social value
- Support council of Governors to engage with our communities through the membership to support programme

Strategic leadership & accountability

- Maintain robust governance through the PHHI oversight group
- Refresh Vision10 goals to strengthen population health focus
- Include strategic inequality objective in consultant job planning
- Integrate inequalities into clinical governance and quality improvement processes

Strengthening partnerships

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We see the impact of inequality through:

- Emergency admissions for preventable conditions
- Barriers to attending appointments or engaging with care
- Poor housing, financial insecurity, or lack of social support
- Delayed discharge due to unmet community needs

How can we facilitate stronger connections into:

- Housing and homelessness services
- Employment and welfare support
- Early years and education
- Transport to and from healthcare settings
- Community assets: leisure, libraries, social prescribing

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Discussion & reflections

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