

***JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR  
NORTHERN CARE ALLIANCE***

***Overview & Scrutiny Committee  
Agenda***

Date Thursday 18 December 2025

Time 2.00 pm

Venue JR Clynes building 2nd floor room 1

- 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](mailto: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 16<sup>th</sup> December 2025.
  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.

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

- 1 Apologies for Absence
- 2 Urgent Business  
Urgent business, if any, to be 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 the previous meeting (Pages 3 - 8)  
To consider the minutes of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance held on 25<sup>th</sup> September 2025.
- 6 Integrated Performance Report (Pages 9 - 30)  
To note the Integrated Performance Report.
- 7 Finance Update  
To consider the finance update.
- 8 Widening Access, Inclusive Recruitment and Participation (Pages 31 - 40)  
To consider the report on Widening Access, Inclusive Recruitment and Participation.
- 9 Outpatient Excellence Programme (Pages 41 - 48)  
To consider the report on the Outpatient Excellence Programme.
- 10 NCA Winter Preparedness (Pages 49 - 54)  
To consider the report on NCA Winter Preparedness.
- 11 Work Programme (Pages 55 - 56)  
To consider and note the Joint Health Overview and Scrutiny Committee for Northern Care Alliance's Work Programme 2025/26.



Public Document Pack **Agenda Item 5**  
**JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR**  
**NORTHERN CARE ALLIANCE**  
**25/09/2025 at 2.00 pm**



**Present:** Councillor McLaren (Chair) and Councillor Hamblett (Vice-Chair)  
(Oldham)  
Councillors Dale and Joinson (Rochdale)  
Councillor Fitzgerald (Bury)

Also in Attendance:

Judith Adams	Chief Delivery Officer (NCA)
Jack Grennan	Constitutional Services
Trudy Taylor	Patient Experience (NCA)
Tamara Zatman	Associate Director – Post Transaction Integration (NCA)

1           **ELECTION OF CHAIR**

That Councillor McLaren be appointed as Chair for the remainder of the 2025/26 municipal year.

2           **ELECTION OF VICE CHAIR**

That Councillor Hamblett be appointed as Vice Chair for the remainder of the 2025/26 municipal year.

3           **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Harris from Bury and Councillor Anstee from Rochdale.

4           **URGENT BUSINESS**

There were no items of urgent business for the committee to consider.

5           **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

6           **PUBLIC QUESTION TIME**

There were no public questions received.

7           **MINUTES OF THE PREVIOUS MEETINGS**

Resolved that the minutes of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance meetings held on 24<sup>th</sup> April 2025 and 26<sup>th</sup> June 2025 be approved as a correct record.

8           **INTEGRATED PERFORMANCE REPORT AUGUST 2025**

Jude Adams presented the item, noting that the NHS is entering its most challenging quarter, particularly around delivery and performance during the winter months.

It was noted that there had been positives within the report, highlighting that sickness absence was down and that there had been a focus on welcome back conversations. Consultations were ongoing around some posts, and the financial implications that these would have. Success around managing stress was noted, and it was highlighted that cancer metrics were on track

and in a good position. It was noted that NCA provides the bulk of dermatology work in GM and that the usual dip that is seen in the summer was maintained this year. Planned care performance was static, despite the fact that demand was up, and that work was ongoing to bring down the back log.

Community diagnostics were noted, highlighting that this was part of demand work. Work was also being done on productivity, and it was noted that this was not about working harder but redesigning services. It was highlighted that some metrics shifted when there were focuses into them. It was also noted that extra capacity gets harder through the financial year, which emphasises the need to redesign.

Urgent care metrics were improving, and it was noted that they were 5% better than this time last year. It was also highlighted that the gap to target was much narrower than in previous years.

It was noted that there were several focuses taking place, particularly around vaccines, paediatrics and the rise of respiratory ill health, and the need to do better during the winter months was highlighted. It was noted that the vaccine prevention factor was crucial, particularly as indications suggested that flu season would be worse this year, and that additional resource would be allocated for vaccinators. On paediatrics, it was noted that there would likely be an increase in viruses due to children being back in school. On the rise of respiratory ill health, work was being done on managing these at home, to help avoid hospital cross contamination.

It was also noted that the winter months would lead to other issues, such as the post-Christmas surge in fractures due to falls and slips in icy conditions, and the adverse effect of dark nights on mental health. It was highlighted that it was key to ensure that gains that had been made in all areas were not lost amidst surges in demand. Quality metrics were being watched to ensure this and staff were being urged to go back to basics on infection control, i.e. hand washing.

Members noted the recent political climate around vaccines, and were advised that resourcing would be needed to ensure improvement of around 18% was achieved due to initial lower rates. It was highlighted that a clear comms plan was in place to demonstrate the need for vaccines, including community role models. Messaging was noted as another key theme, including finding out why people who don't get vaccinated choose not to do so.

Members noted that on a recent visit to a hospital, pumps and handwashes were not always stocked. It was noted that this was an estates and facilities responsibility, but that a message around challenging staff on hygiene was key, as were checks on top ups and PPE by senior staff.

Overpayment of staff was also noted by members, and it was noted that these monies are chased up and reported on too.

Members noted that performance metrics were improving but still not reaching targets, and that savings were being looked for at the same time. It was noted that there had been some additional funding, but that this was not the funding required to close the gap, and that metrics were more of a challenge across GM than nationally. It was highlighted that money alone would not close the gap, and that productivity improvements were key as well. It was noted that Outpatients needed to be rethought out structurally as the model of care was not sustainable. It was noted that Jude was happy to bring an item on Outpatients to a future meeting of the Committee.

It was noted that every year that the NHS was behind on improvement plans made future years even more difficult.

Members queried what steps were being taken to stop stress and avoid absences. It was noted that the SCARF Programme provided resources and signposting, and that training to recognise the signs of stress was taking place. It was noted that once staff were off with stress, it was harder to get them back to work. It was noted that welcome back conversations were key, particularly in highlighting what the NHS could do as an organisation. It was also important that staff felt valued and recognised for their contributions.

Members queried whether there were any particular areas for stress to be noted, and it was highlighted that nurses and healthcare support workers were having targeted work carried out. Admin staff were noted as having spikes in work loads, but that vacancies were being filled to try and alleviate this problem. Emergency departments were noted as a particular problem, specifically around violence, overcrowding and aggression incidents. It was highlighted that mental health liaison officers were working to resolve some of these issues in Emergency Departments, but that there was a greater presence of security at weekends due to the business of departments.

Members queried what short term actions would help with bed capacity. It was noted that the question was essentially how to avoid admissions and that this would come down to directing people to other services. It was noted that the bed shortfall was driven by deprivation and that there needed to be a focus on living well activities, as well as being better at lengths of stay and collaborative working was being done around this matter.

Members queried why some of the data was in figures, whilst others were percentages, noting that the data on its own is limited in context, and that percentages would be appreciated. It was agreed that a written explanation would be provided and circulated to members.

## **PATIENT EXPERIENCE**

Trudy Taylor presented the report. It was noted that there were three main streams for collecting feedback: National Feedback systems such as the CQC National Survey Programme and

Healthwatch England, Trust Feedback Systems such as Friends and Family tests and social media, and Locality feedback systems such as local surveys, Patient stories and Patient & Public Voice Partners group. It was noted that feedback was positive and the best indicator so far.



It was noted that there were six national surveys a year, and that action planning takes place after any survey that is published.

Members queried how progress was made against plans and were advised that there are always outstanding actions, but that focus is prioritised on localised feedback. It was noted that the NHS has to deliver against plans.

Members asked about digital tools and whether these are inclusive. It was noted that most digital tools come in six languages and easy read versions. It was noted that one size doesn't fit all regarding inclusivity and that good feedback was coming in. QR codes were being used to enable service users to leave realtime feedback, not just after the fact. Training and communication was also discussed, and members were advised that staff are encouraged to write down verbal feedback they receive, and that there are patient experience ambassador roles who are effective in their positions.

Members noted the positive feedback but highlighted the disagree and strongly disagree results, querying whether there was any way to follow these up. Members were advised that data was not personalised so it would be impossible to give individual responses, but teams did review the themes of data and held closer sessions to discuss feedback with their staff.

Observe, Listen and Act was discussed, noting that it was a developing tool, which looked at service users' journeys. Non-clinical staff were invited for insight, and 320 visits had taken place so far, which was noted as a fantastic response. One of the elements of this approach was to sit down and chat with people, to get personal feedback, which will provide an extra layer of insight. It was noted that good feedback and answers had been received, and that schemes such as 'What Matters Most to Me' and 'You said, we did' helped build good rapport. It was also noted that GM was looking at the NCA's deaf strategy.

Members noted that the delivery of feedback was important, and it was noted that staff feedback was crucial too and that it was important that feedback was passed on.

Members queried what additional signage, for example tactile signage for deaf users, was being provided. It was noted that training and environmental checks were being carried out on sites, and that accessibility was a continuous job. It was also noted that hospitals are not just a building, but sometimes feel more like a village, and that patient voices were crucial for forward thinking.

Members noted that it would be interesting to hear from others' experiences, as people are not just patients in hospitals,

and queried whether the NCA had a full picture through feedback. It was noted that posters were up throughout hospitals to empower users and that volunteer workshops helped not only provide eyes and ears but solutions too.

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#### **WORK PROGRAMME**

Proposals for work programme items were considered and noted. It was requested that invitations to future meetings be amended to reflect the new meeting location.

The meeting started at 2.00 pm and ended at 3.30 pm

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# Integrated Performance Report

Published: October 2025

CARE APPRECIATE INSPIRE

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## 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: October 2025

## Matrix Summary

	 Consistently achieving target	 Inconsistently achieving target	 Consistently failing target	No Target
<b>Special Cause Improvement</b> 	% of Reviews where carers indicate their needs are being met	Staff 12-month Turnover	Welcome Back Compliance Urgent Community Response 2-Hour Performance UEC - 4 hour 63 day waits Cancer	Temporary Staffing Spend
<b>Natural Variation</b> 	Mandatory Training PPH Time to Hire	28 Day Cancer Faster Diagnosis 31 Day Cancer 62 Day Cancer Performance Complaints Response DNA Rate Falls Friends & Family Test Hand Hygiene Compliance Hospital Acquired Organisms - Ecoli PALS resolved within 5 days Pressure Ulcers G2-G4 Risks within review date	C-diff Diagnostics 6 week performance My Time Compliance Number of People Receiving Long term services (12-month rolling) PIFU RTT 52 week waits RTT First attendance within 18 weeks RTT waits within 18 weeks Sickness Absence (In Month) Sickness Absence (Rolling) Size of Waiting List Theatre Utilisation	Ambulance handover Better Payment Practice Code Cancelled Operations on the day Community Acquired Pressure Ulcers Discharge Ready Date Number of 12 hour waits in ED Number of Incidents with harm Number of Incidents with no harm Overpayments Specialist Advice
<b>Special Cause Concerning</b> 	Still Births per 1000		MRSA	Number of Significant Risks

# Integrated Performance Report: October 2025



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

People & Learning

### Highlights

Our substantive staffing plan remains below plan overall and continues a downward trajectory. Time to Hire has reduced further and continues to be below target.

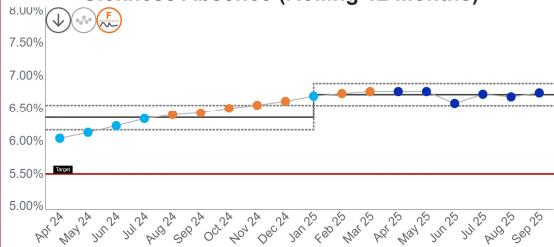
### Areas of Concern

Overpayments have increased significantly although this may be skewed by a large overpayment currently being recouped. Robust measures are being taken to focus in on problem areas and ensure the correct procedures are being followed. Digitalisation of relevant change-forms is due to be rolled out across the BRO sites.

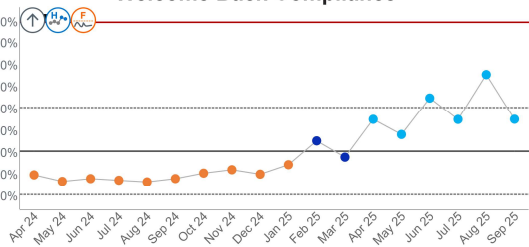
### Forward Look (with actions)

We continue to build on the work to increase compliance with the requirement to hold Welcome Back Health Reviews with all colleagues returning from sickness absence, and additionally are preparing to focus closely on all absences totalling 28 days or more, to ensure all possible wellbeing measures are being offered to colleagues.

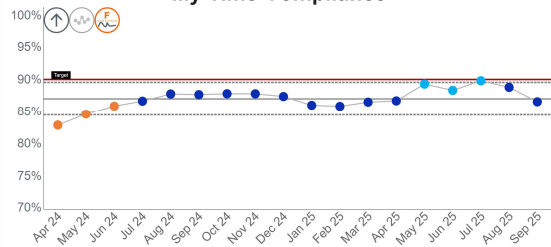
Sickness Absence (Rolling 12 Months)



Welcome Back Compliance



My Time Compliance



### Technical Analysis

The rolling 12 month position increased slightly in September to 6.74%, remaining consistent with previous months. In month absence rate increased to 6.75%; the highest seen since January 2025.

Welcome back compliance decreased in September to 45.47%

My Time Compliance decreased in September, falling slightly to 86.55%. Weekly appraisal compliance monitoring continues to be shared with all line manager and leaders.

### Actions

A plan has been put in place to monitor all absences of 28 days or more, to ensure that each of these colleagues has a robust wellbeing plan in place

HR colleagues are working alongside service managers to interrogate all available information to spot and support areas where compliance is low

The trajectories for improvement developed by each Care Organisation will continue to be monitored by SMT and with a particular focus on areas where improvement is lacking.

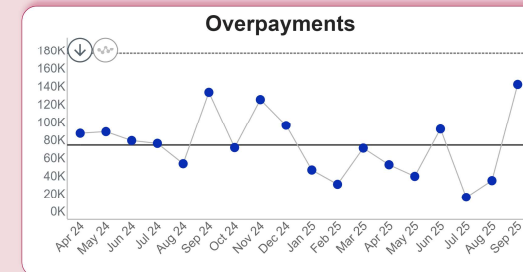
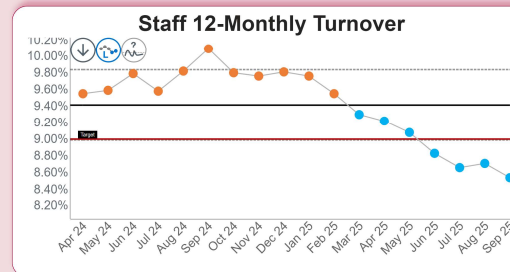
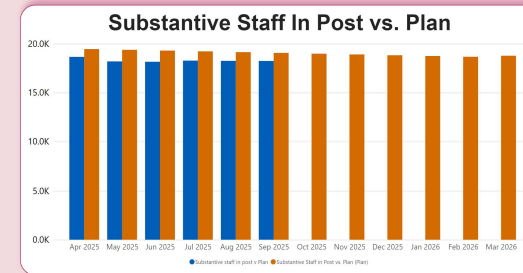
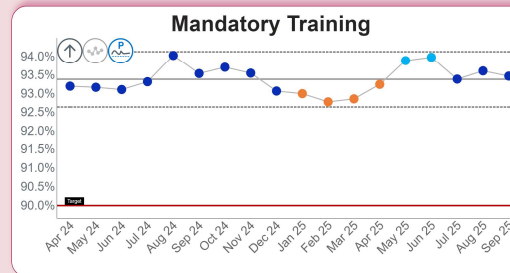
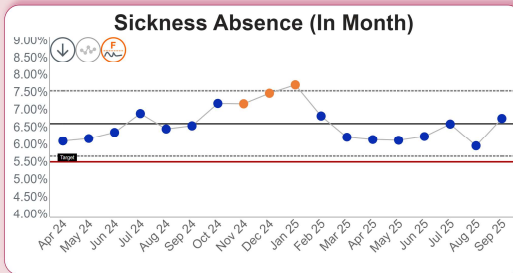
# Integrated Performance Report: October 2025



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## Watch Metrics

## People & Learning



# Integrated Performance Report: October 2025



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Judith Adams - Chief Delivery Officer: Drive Metrics

Elective Care & Productivity

## Highlights

The My Recovery Plan Programme is driving sustained specialty level improvements in Outpatient productivity.

The Outpatient disruption initiative has contributed to a reduction in waits over 52 week during September.

## Areas of Concern

Variation from planning assumptions is contributing to the gap between RTT targets for 18 weeks growing. RTT demand is higher than expected; system demand reduction initiatives are not yet delivering expected impacts; Mutual Aid has reduced; and future 25-26 productivity improvements are being redirected from backlog clearance to support delivery of our financial plan.

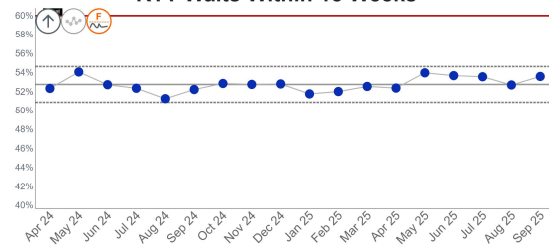
We need to do more to improve theatre productivity.

## Forward Look (with actions)

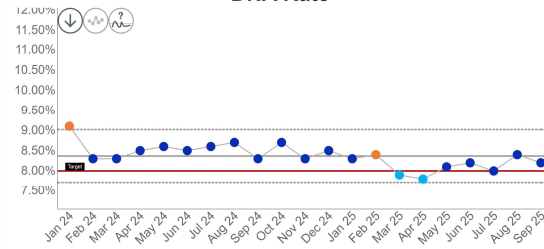
Phase 1 of Outpatient disruption test of change initiative ends in October. Outcomes being collated in November. Five new specialties have been agreed for phase 2. We are agreeing and transacting clinic template changes with our clinical teams.

The theatre Hub sprint started in October with the aim of improving theatre utilisation on both sites. The new theatres digital system will support better productivity

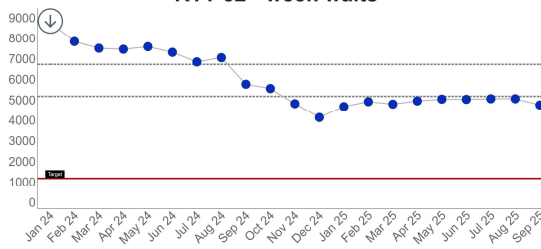
RTT Waits Within 18 Weeks



DNA Rate



RTT 52+ week waits



## Technical Analysis

53.60% of our open pathways were waiting below 18 weeks in September, remaining consistent with previous months but below the 60% target.

The DNA rate continued to demonstrate natural variation, decreasing slightly to 8.20% in September; above the target of 8%

52 week waits reduced by 305 from August.

## Actions

1) My Recovery Plan implemented (2) National validation sprint 3 - Q3 (3) GM Mutual Aid patients transferring since late Sep at reduced levels vs 24-25 (4) Non-core capacity 25-26 (5) Outpatient disruption - Phase 1 Oct-25 & Phase 2 Jan-26; (6) Clinic template changes phase 1 Nov-25, phase 2 Feb-26

1) Text reminders - complete; (2) Validation of waiting lists national sprint 3 - Q3; (3) Develop & implement invite to book processes across services for News - Mar-26; (4) Service level review of DNA reasons started May-25, being used to identify further improvement actions

1) Auto validation digital solutions - Nov-25; (2) Outpatient disruption tests of change phase 1 Oct-25 & phase 2 Jan-26; (3) Manual validation process of community waits - Nov-25; (4) Digital reporting systems for community - Jan-26



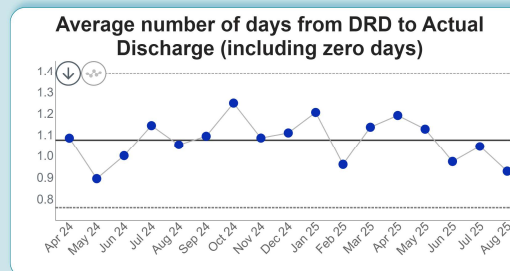
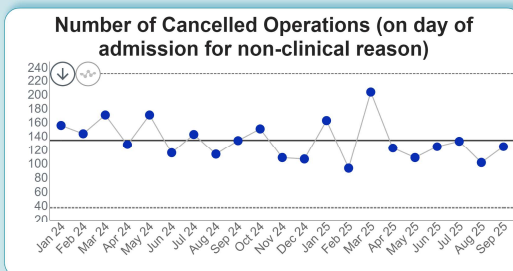
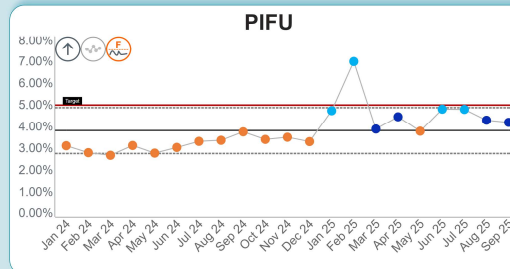
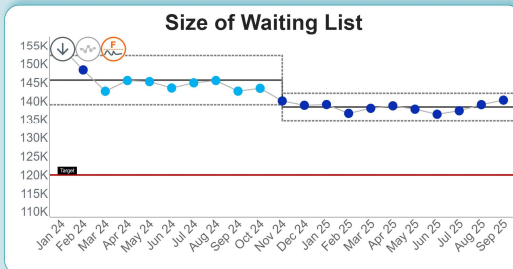
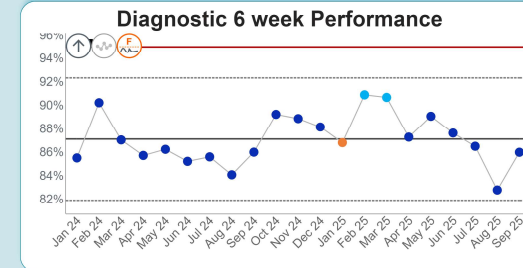
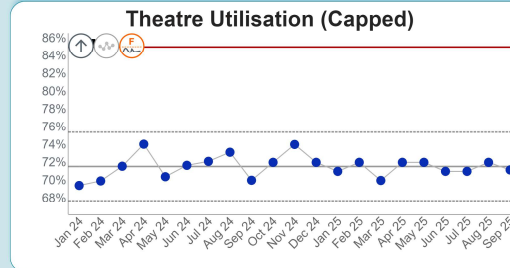
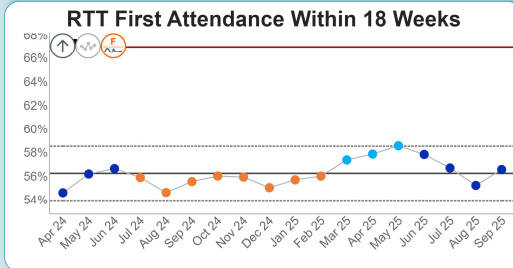
# Integrated Performance Report: October 2025



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## Watch Metrics

## Elective Care & Productivity



Integrated Performance Report: October 2025



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Judith Adams - Chief Delivery Officer: Drive Metrics

Urgent & Emergency Care & Cancer

Highlights

4 Hour Urgent Care performance has improved over the last quarter and is the best it has been in 4 years. Our Type 1 performance was better than the national average and the best in Greater Manchester.

We also met our trajectories for cancer access standards for 62 Day Treatment, 31 Day Treatment, and 28 Day Faster Diagnosis. Our national ranking for all 3 standards improved.

Areas of Concern

We need to work with system partners to deliver capital schemes that will support improvement in 2025-26, noting the ROH beds deficit.

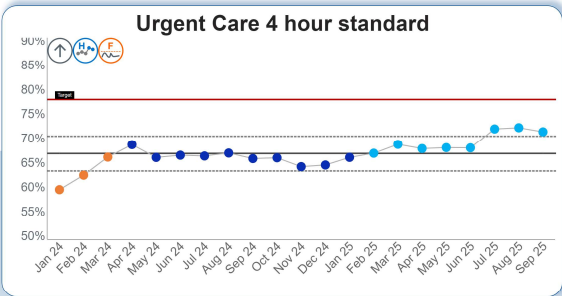
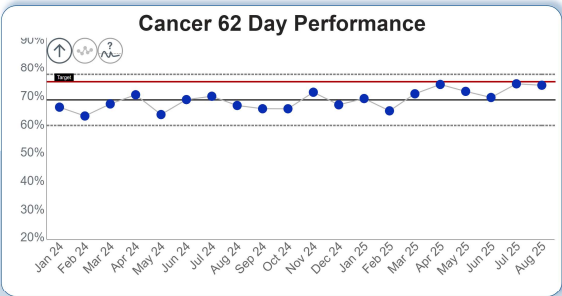
GM system demand reduction initiatives for suspected skin cancer pathways have not yet yielded anticipated benefits. LGI pathway performance is a priority.

Delivery of improvement trajectories becomes more challenging as we move into Q3 & Q4.

Forward Look (with actions)

Deployment of the winter plan over the coming months now that it has been agreed. Continue to work with system partners to improve the ambulance conveyance Single Point of Access that started in June. A Length of stay improvement collaborative is being agreed with clinical leaders. A focus on Board Rounds on AMUs in November.

We continue to work with the ICB to improve suspected skin cancer referral pathways.



Technical Analysis

August's 62 day confirmed position decreased slightly to 73.76%

Performance decreased in September to 71.40%, remaining consistent with previous months and continuing to demonstrate special cause variation.

Actions

1) Prioritise ROH Colorectal treatment capacity – started Q1; (2) Improve Best Timed Pathways compliance – Q3 & Q4, - LGI Straight To Test Sep & step down of benign polyps H2; (3) Increase Derm-Pathology clinical capacity – Q2; (4) Support GM to implement community model - across 25-26

1) Ambulance SPoA started June; (2) Care by appointment live on all sites – Nov-25; (3) Forwards Ops Model – Q3; (4) ROH UTC – Q4; (5) Winter Plan complete; (6) Daily Non-Admitted breach focus – Q4=3; (7) Establish LoS collaborative – Nov-25

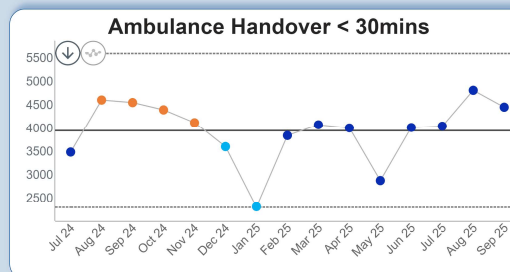
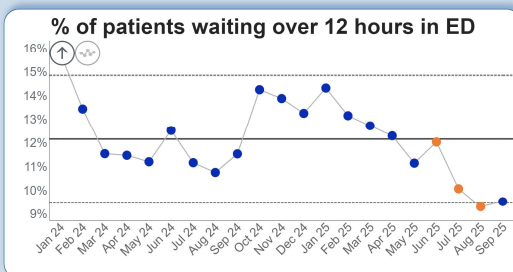
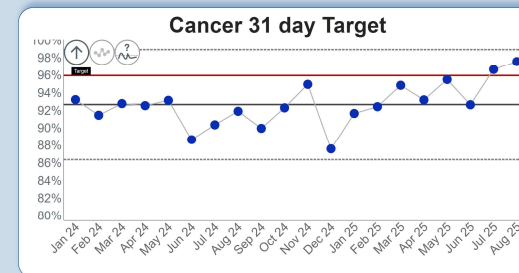
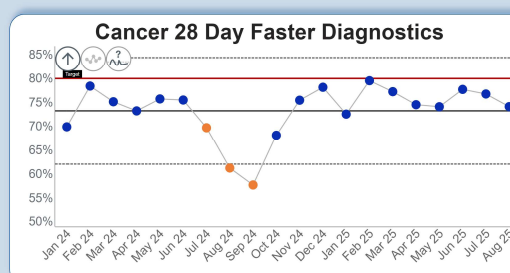
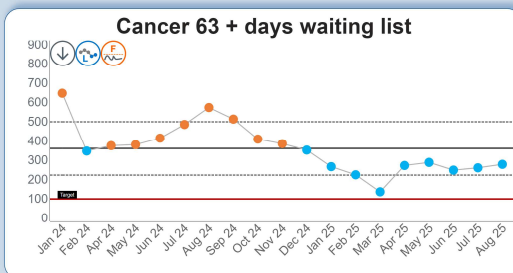
# Integrated Performance Report: October 2025



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## Watch Metrics

## Urgent & Emergency Care & Cancer





# Integrated Performance Report: October 2025



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**Suzanne Robinson - Chief Financial Officer: Drive Metrics**

**Finance**

## Highlights

At Month 6 the year to date position is a £24.04m deficit which is £1.1m better than the Trusts planned deficit position.  
The position, excluding deficit support funding (DSF), is a deficit of £53.0m YTD.  
Within the position CIP delivery has overachieved by £18.6m YTD with £48.5m transacted.

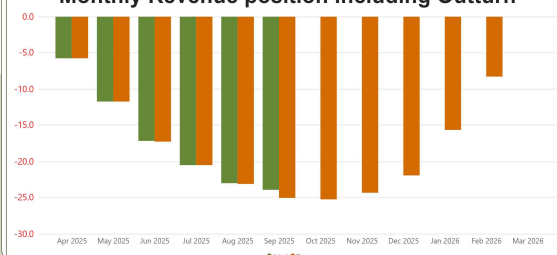
## Areas of Concern

As at Month 6 there are several unplanned and currently unmitigated pressures over and above a challenging CIP + Productivity target assumed in 2025/26 plans.  
The trust plan includes £57.8m of DSF funding, with £33.7m received YTD. Any Loss of DSF in the year would result in a cash risk in 25/26.

## Forward Look (with actions)

The Trust is working through mitigation actions and recovery actions to support delivery of the plan which agreed with the Board and is monitoring the impact on both the financial position, forecast and cash position.

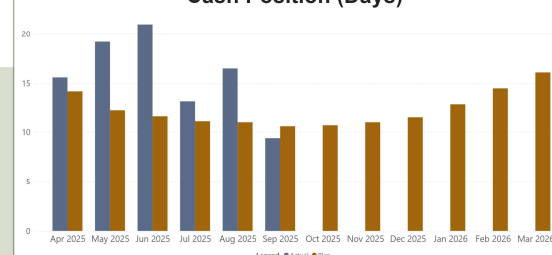
### Monthly Revenue position including Outturn



### CIP Delivery (000s)



### Cash Position (Days)



## Technical Analysis

For Month 6, NCA Group is reporting a position £968k better than plan, with a net deficit of £0.92m. Excluding Deficit Support Funding (DSF) = £5.7m Deficit

Total identified CIP - £110.6m as at 22nd October. £71.6m has been implemented so far in 2025/26.

The cash position decreased in September to £49,975.00

## Actions

The Trust is currently working on mitigation actions and recovery plans at Care Organisation and Trust level. Executive led monthly oversight sessions continue to run to monitor agreed actions on a Monthly basis.

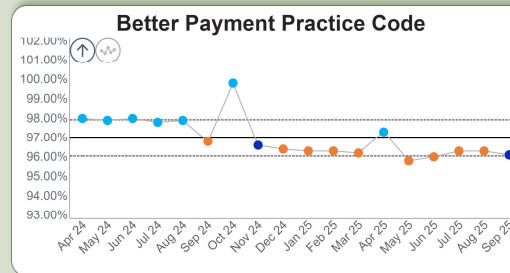
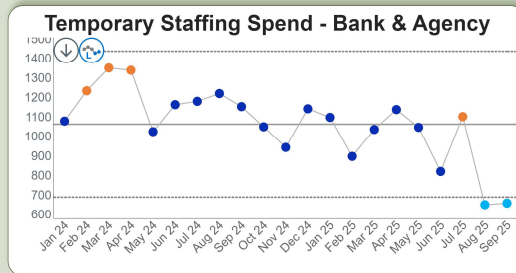
Engagement events held throughout August and September hearing from colleagues on where they see waste, in time, money or resources. These led up to our annual Planning for Improvement event where we had over 300 ideas. Workstreams are now working through these for initial feasibility and scoping

The cash position at the end of September was £50.0m, behind plan by £6m due to an increase in payables related to VAT and other NHS organisations whose cash positions are becoming stressed. Payment for the VAT owed has been received (c£3m) in October.

# Integrated Performance Report: October 2025

## Watch Metrics

## Finance



# Integrated Performance Report: October 2025



Northern Care Alliance  
NHS Foundation Trust



Juliette Cosgrove - Chief Nursing Officer: Drive Metrics

Quality

## Highlights

12% decrease in CDI when compared to September 2024, benchmarking at 2/7 in GM, 91/134 trusts nationally. E coli: 2% reduction, benchmarking 2/7 in GM, and 35/134 trusts nationally. Hand Hygiene (HH) slightly improved, likely normal cause variation and PPH per 1000 returned to normal variation.

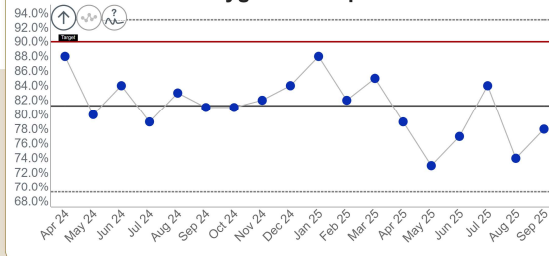
## Areas of Concern

MRSA bacteraemia: 7 cases in SCO. Improvement plan focuses on admission screening, aligned decolonisation therapy, and education on wound/device care. Significant risks rose by 20 over 3 months, likely due to increased awareness and use of the risk register. Stillbirth rolling data shows special cause variation; in-month data returned to normal.

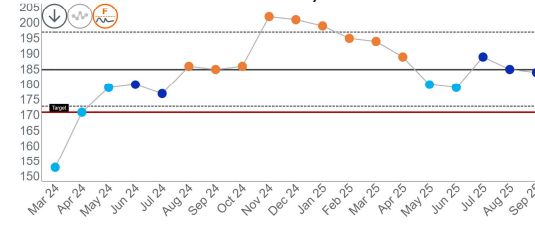
## Forward Look (with actions)

New MRSA policy out in October to align care across NCA. Executive Risk Group forming to strengthen governance. Focus on Salford complaint responses to drive NCA-wide improvement. October HH collaborative highlights communication and training videos.

### Hand Hygiene Compliance



### Healthcare Acquired Organisms - Cdiff (Rolling 12 Months)



## Technical Analysis

Hand hygiene compliance increased in September to 78% demonstrating natural variation; remaining below the target of 90%

There were 12 CDI cases reported in September

## Actions

Compliance reviewed monthly at IPCC. HH perfect weeks held across sites. World HH Day used superhero comms to promote HH in schools and communities. HH collaborative underway with timeline; Oct/Nov focus on comms, training, and compliance videos.

Pharmacy audit data collected in September and case note reviews will establish the role of documented penicillin allergy status across FGH and ROH. Removing penicillin allergy labels from patients with unverified allergy may reduce the incidence of CDI through more appropriate prescribing

# Integrated Performance Report: October 2025

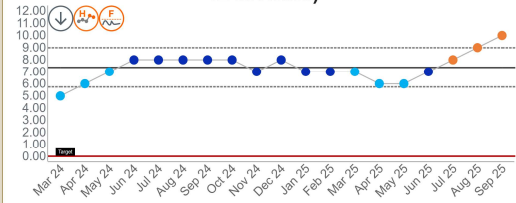


Northern Care Alliance  
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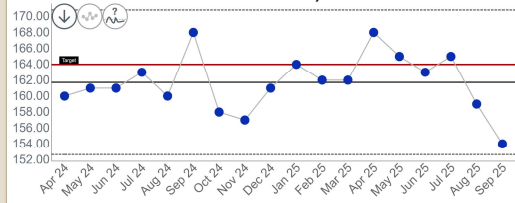
## Watch Metrics

## Quality

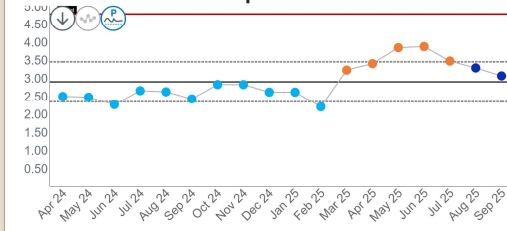
Healthcare Acquired Organisms - MRSA (Rolling 12 Months)



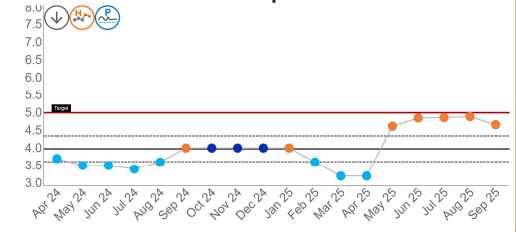
Healthcare Acquired Organisms - E-Coli (Rolling 12 Months)



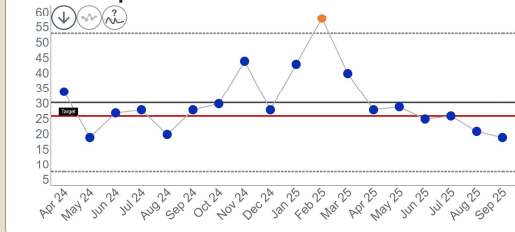
PPH per 1000



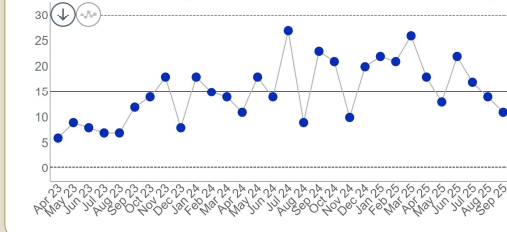
Still Births per 1000



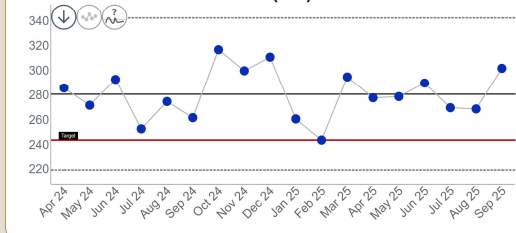
Inpatient Pressure Ulcers G2-G4



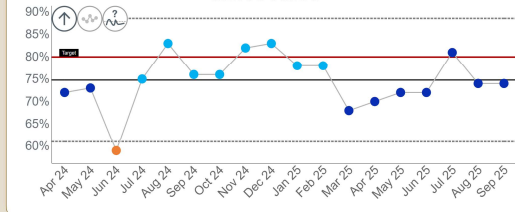
Community Acquired Pressure Ulcers (G3-G4)



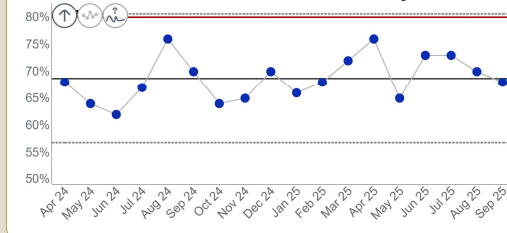
Falls (All)



Complaints responded to within negotiated timescales



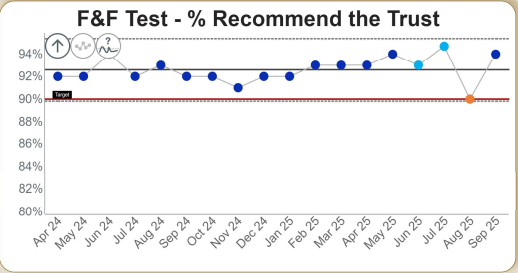
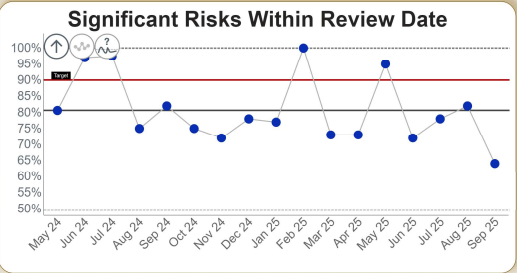
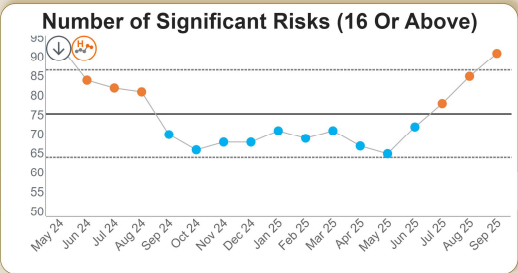
% PALS resolved within 5 days



# Integrated Performance Report: October 2025

## Watch Metrics

## Quality



# Integrated Performance Report: October 2025



Northern Care Alliance  
NHS Foundation Trust



Rafik Bedair - Chief Medical Officer: Watch Metrics

## Safety

### Highlights

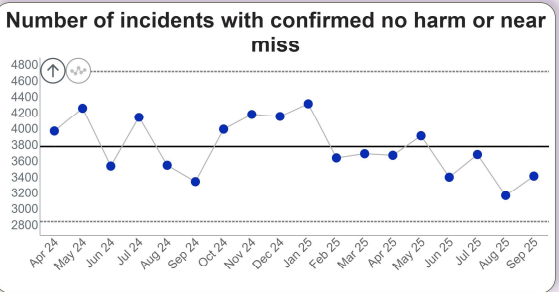
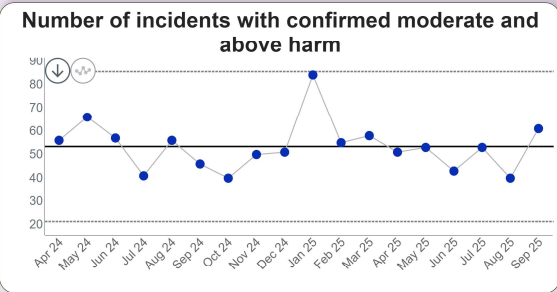
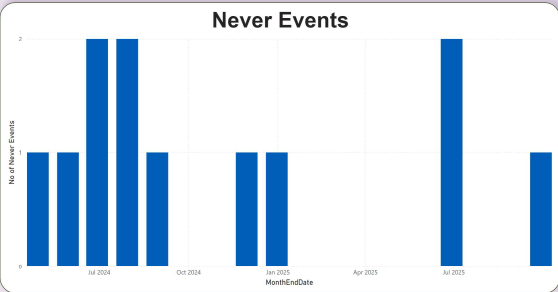
Improvements in UEC (SDEC/MNP) has resulted in reduction in 12hr waits positively impacting low harm/near miss incident volumes.

### Areas of Concern

NE reported in Dermatology, PSII underway. New minimum dataset built into EPR capturing dx, site and photography

### Forward Look (with actions)

Increase in Moderate + harms reported (mainly driven by treatment issue / delays). Work ongoing to reduce waiting lists/ wait times



# Integrated Performance Report: October 2025



Northern Care Alliance  
NHS Foundation Trust



**Judith Adams - Chief Delivery Officer: Watch Metrics**

**Adult Social Care (Salford only) & Community**

## Highlights

We've launched a Community Services Access & Performance meeting to mirror the acute services methodology, with reporting aligned to Performance Group. We're also seeing positive progress in reducing long waits for Children and Young People (CYP).

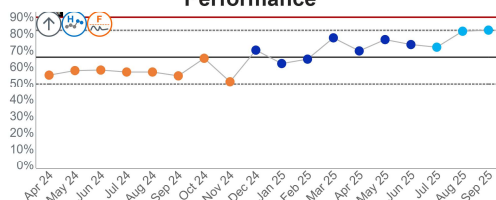
## Areas of Concern

August's 52-week wait performance improved to 4.6% from 7.6% in March, though numbers remain high. Data quality issues in a few services (e.g. podiatry excluded) may reduce 52-week waits, but some will persist especially in CYP and adult Speech and Language Therapy, podiatry, and dietetics. Admin capacity for validation is a concern.

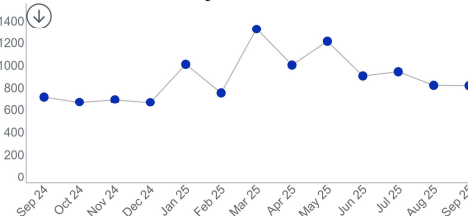
## Forward Look (with actions)

Access & Performance meetings will drive a standardised approach to waiting list validation and SOPs aligned to NCA policy. We're targeting zero 52-week waits by March 2026. An NCA-wide Hospital at Home group is in place to boost virtual ward use.

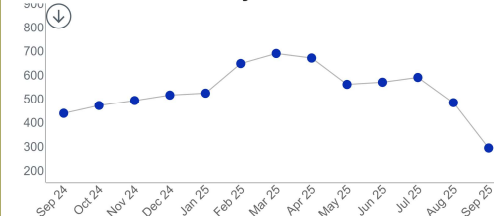
**Urgent Community Response 2-Hour Performance**



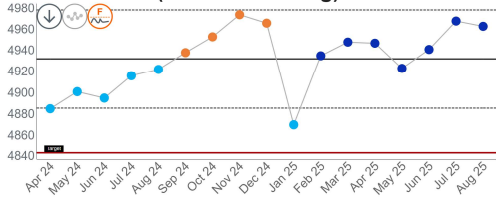
**Community 52+ week waits**



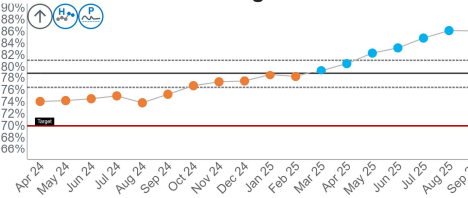
**Community CYP 52ww+**



**Number of People Receiving Long term services (12-month rolling)**



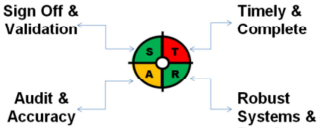
**% of Reviews where carers indicate their needs are being met**





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

Welcome Back Compliance	
Staff 12-Monthly Turnover	
Sickness Absence (Rolling 12 Months)	
Sickness Absence (In Month)	
Substantive Staff In Post vs. Plan	
Overpayments	
Mandatory Training	
My Time Compliance	
Time to Hire	

Urgent & Emergency Care & Cancer

STAR Factors

Cancer 62 Day Performance	
Cancer 28 Day Faster Diagnostic	
Cancer 31 Day Target	
Cancer 63+ Day Waiting List	
Urgent Care 4 hour standard	
% of 12 hour waits in ED	
Ambulance Handover <30 mins	

Finance/Cost

STAR Factors

Monthly Revenue position including Outturn	
Temporary Staffing Spend - Bank & Agency	
CIP Delivery	
Cash Position	
BPPC	
Capital YTD (Including Leases)	



STAR Factors - Part 2

Elective Care & Productivity	STAR Factors
RTT Waits Within 18 Weeks (First attendance)	
RTT First Attendance Within 18 Weeks	
RTT 52+ week waits	
DNA Rate	
Theatre Utilisation (Capped)	
Size of Waiting List	
Number of Cancelled Operations (on day of admission for non-clinical reason)	
Diagnostic 6 week Performance	
PIFU	
Specialist Advice	
Discharge Ready Date	

Quality	STAR Factors
Hospital Acquired Organisms - MRSA	
Hospital Acquired Organisms - Cdiff	
Hospital Acquired Organisms - Ecoli	
Hand Hygiene Compliance	
Falls (All)	
Still Births per 1000	
PPH per 1000	
Inpatient Pressure Ulcers G2-G4	
Community Acquired Pressure Ulcers G3-G4	
F&F Test - % Recommend the Trust	
Complaints Responded to within negotiated timescales	
% PALS resolved within 5 days	
Number of Significant Risks (16 or above)	
Significant Risks Within review date	

Safety	STAR Factors
Number of incidents confirmed with moderate and above harm	
Number of incidents confirmed with no harm or near miss	
Never Events	

STAR Factors - Part 3

Community & Adult Social Care	STAR Factors
Urgent Community Response 2-Hour Performance	
Community 52ww+	
Community CYP 52ww+	
Number of People Receiving Long term services (12-month rolling)	
% of Reviews where carers indicate their needs are being met	

# Integrated Performance Report: October 2025



Northern Care Alliance  
NHS Foundation Trust

## Glossary

AMS	Acute Medical Service
BAF	Board Assurance Framework
BCO	Bury Care Organisation
CTG	Cardiotocograph
CO	Care Organisation
CQC	Care Quality Commission
CEO	Chief Executive Officer
Cdiff	Clostridium Difficile
CDI	Clostridium Difficile Infection
CRR	Corporate Risk Register
CIP	Cost Improvement Programme
DKAFH	Days Kept Away From Home
DNA	Did not Attend
ESR	Electronic Staff Record
ED	Emergency Department
FGH	Fairfield General Hospital
F&F	Friends and Family
FFT	Friends and Family Test
GIRFT	Getting It Right First Time
GM ICB	Greater Manchester Integrated Care Board
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
MHS	Model Health System
NG	Nasogastric
NE	Never Event
NHSE	NHSE England
NCA	Northern Care Alliance
OCO	Oldham Care Organisation
PALS	Patient Advice and Liaison Services
PIFU	Patient Initiated Follow Up
PSG	Patient Safety Group
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PPH	Postpartum Haemorrhage
QMEG	Quality & Management Executive Group
RTT	Referral To Treatment
RCO	Rochdale Care Organisation
ROH	Royal Oldham Hospital
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

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# Widening Access, Inclusive Recruitment and Participation

# Creating Inclusive Pathways into Employment



Northern Care Alliance  
NHS Foundation Trust

	Outcomes	Target	November 2025
Inclusive Employment	Adopt alternative methods of recruitment for entry-level roles to remove barriers and attract diverse talent.	Increase local employment so that 60% of staff are from our localities by 2026.	59.74%
Community Access to Employment	Achieve 85% employment conversion rate from these initiatives.	Support 450 individuals from local communities through pre-employment programmes and recruitment events.	40%
Workforce Inspiration and Engagement	Raising awareness of 350 roles within the NHS and inspiring local people	Maintain a network of 1,000 Career Ambassadors and Work Experience Hosts by end of FY 2025/26.	113%
		Provide 700 work experience placements for local young people and adults.	99%
Supported Pathways	Creating a talent pipeline	Deliver 25 Supported Internships with meaningful work placements.	96%
		Host 160 T-Level learners value added industrial placements.	84%
Apprenticeship Investment	Supporting wider health and social care sector and the community and voluntary sector	Transfer / gift £200,000 of Apprenticeship Levy to support local health and social care employers and Community organisations to developing system wide workforce.	£103,537
National Influence and Knowledge Sharing	Influencing policy	Share our impact and learning through at least 4 national conferences or published articles per year.	1 National conference  Locality Employment and Skills Strategy  National T Level development and influence

# Inclusive recruitment

*Strengthening of our transactional recruitment service*



## Sharing interview questions in advance

Hiring managers are supported to share interview questions with candidates ahead of time, guided by clear and accessible instructions.



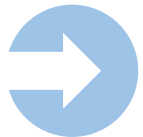
## Recruitment and Selection e-learning

An in-house e-learning programme has been developed to help managers align with best recruitment practice, including how to identify and address inequalities in the recruitment process.



## Overseas recruitment

A greater focus has been given to the onboarding experience of our overseas hires – including the creation of a new international recruitment pack and dedicated Facebook group.



## Person specification application form

We have simplified our application form to allow for better accessibility and applicant experience



## Cultural ambassadors

We invite cultural ambassadors to be involved in the recruitment of all Band 8a and above roles.

## Next steps...

In 2026, we will create a standardised job description bank to reduce variation across the NCA and make it easier for applicants to understand roles in the NHS and assess their suitability.

# Creating Inclusive Pathways into Employment



Since 2023, the NCA has supported **301** individuals into employment.



ROI is £185,115 (based on 2023 calculation £615 saving per candidate)



# Succession Planning

**Attracting young talent:**  
NEETs summer  
employability  
programme supported 8  
young people in Salford

**Salford Trailblazer - 5**  
young people from the  
summer programme  
progressed to the 6-  
month paid trailblazer

# Greater Manchester and National Influence

- **Midwifery T level:** NCA was the first in Greater Manchester to host Midwifery T Level learners during academic year 2024/25. [Greater Manchester launches T Level midwifery placements to grow local NHS talent | Greater Manchester Integrated Care Partnership](#)
- **NHSP Enhanced Pilot:** Building on our existing NHSP agreement to offer our T Level learners paid work, we collaborated with GM ICB, NHSP, Northern Care College Alliance to develop an enhanced pilot to extend the offer across Greater Manchester with a view to national rollout. [T Level enhanced pilot launching this academic year | Greater Manchester Integrated Care Partnership](#)

# Inclusive Employment Recognition

**ERSA Employability  
Awards: Employer  
Partnership - Finalist  
2025**

**Greater Manchester  
Good Employment  
Charter Awards – Highly  
Commended 2024**

**Salford City Mayor's  
Charter Award – For  
raising employment  
standards across Salford  
2024**

**HSJ Awards 2023 – High  
Commendation for  
recruiting differently**

# Next Steps...



Tender for a new Recruitment system to make recruitment more inclusive



Re-designing pre-employment programme



Developing a 6-month HCSW/ HCA Traineeship recruitment programme



Introduce a new internal mailing system for latest job opportunities



Developing HCSW/HCA Apprentice recruitment programme



Seeking approval from PEC for 'Alternative Methods of Recruitment'



Enhance support to BAME nursing to improve career progression



Agreeing Social Economic Duty KPI's as a Trust

# Feedback

## Gemma, HCSW Employability Programme

*"I was given the opportunity to apply for a pharmacy dispensing apprenticeship, something I had never previously considered. From that experience, I received valuable advice and guidance that helped me get to where I am today, making a huge difference in my life and giving me the chance to gain a qualification. During my placement, I was able to experience what the role involved and decide whether it was right for me, while also hoping for the chance to secure the apprenticeship."*

*I learned about the different tasks carried out in the job and was given the opportunity to try some myself, which was both rewarding and insightful. Receiving the email offering me the position made me smile, as it confirmed the progress I had made. Entering a new environment and meeting new people initially felt daunting, but I was quickly made to feel welcome, which boosted my confidence and allowed me to be myself. I would strongly recommend undertaking a placement, as it provides a valuable opportunity to understand the role, gain experience, and decide whether it is the right path for you."*

## Jenna Alshawy, Work Experience

*"I wanted to extend my sincere thanks for helping organise my work experience placement with The Northern Care Alliance NHS Group at Salford Royal Hospital. It was an incredibly insightful and rewarding experience that gave me a deeper understanding of the different jobs in the hospital. The experience has strengthened my interest in pursuing a career in healthcare."*

*"Thank you once again for your support and help."*

# Feedback

## *Calista, T Level 2025/26*

*Hello,*

*I just wanted to send this email with some feedback for the Cadet that was with us recently – Calista Moody. Calista become a valued member of our team quite quickly. Her commitment and enthusiasm were great to witness. Calista was always eager and willing to learn, lend a hand where appropriate and was also fabulous with the patients and family members. Whatever her career choices are in the future, I know she is going to excel.*

*As a ward, we feel lucky to have worked alongside her these past 10 weeks.*

*Please pass on this feedback.*

*Thank you  
Katie Atkin, Sister/PEL, Ward 2 – FGH*

## **Fern & Nia, T Level 2024/25**

We currently have Fern and Nia working on SRU at Salford Royal as nursing cadets.

I just wanted to let you know what an asset they have been to the ward. They are friendly and kind to the patients, able to talk sensibly about how the patients have been, look after upset relatives and have really helped the ward to run smoothly.

They are proactive and look for ways to help the patients, not just waiting to be told what to do.

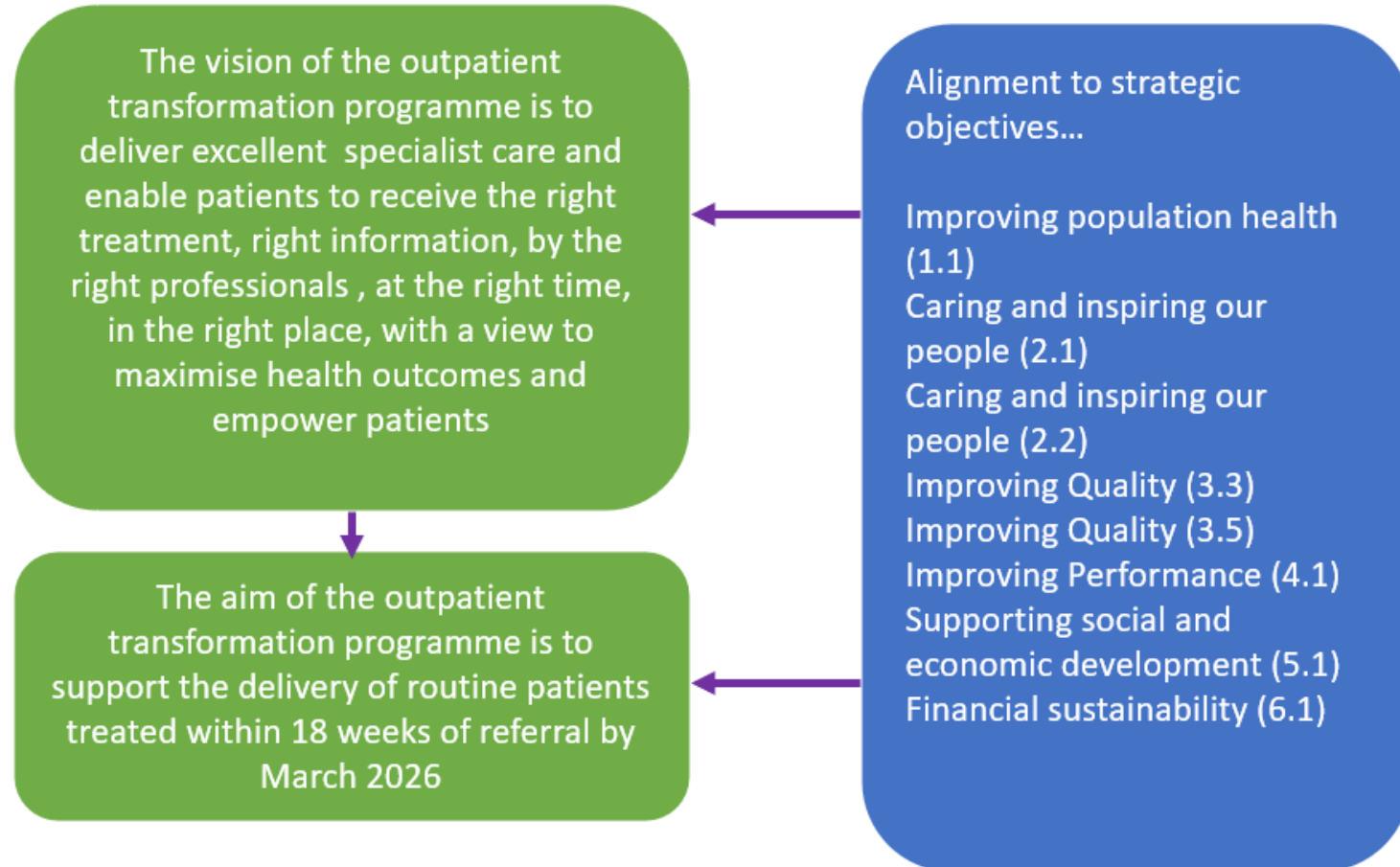
Thank you

Rebecca Grue, Consultant stroke physician SRU Salford

# Outpatient Excellence Programme

Karen Southern, Programme Director

# Programme Aim





# NCA Level KPI Benchmarking



**Northern Care Alliance**  
NHS Foundation Trust

- Internal and external data has been used
- **DNA rate** remains worse than national/peer averages
- **PIFU utilisation rate** is below the 5% target, but better than national/peer averages
- **Remote consultations** remain below the 25% target & continue to decline
- **Wait to first OPA** continues to improve

## Northern Care Alliance - High Level Summary

Key Performance Indicator		Target	Month-Year							SPC Icon	Peer	National	Link
			Mar-24 Baseline	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25				
DNA Rate (excludes Community)	All Apt Types	7.4%	8.7%	8.3%	8.5%	8.2%	8.6%	8.4%	8.4%		7.0%	6.6%	<a href="#">PowerBI Link</a>
PIFU	Utilisation Rate	5%	3.1%	3.8%	4.8%	4.8%	4.3%	4.2%	4.5%		3.3%	3.7%	<a href="#">PowerBI Link</a>
Remote consultations	% performed remotely	25%	21.5%	20.5%	19.8%	19.7%	20.0%	18.8%	19.1%		17.4%	18.3%	<a href="#">PowerBI Link</a>
Specialist Advice	Utilisation Rate (n/100)	21	21.2	25.3	26.8	30.5	27.6	22.7	Not available		24.4	29.7	<a href="#">PowerBI Link</a>
	Diverted volume		1630	2015	2438	2742	2031	2324	995				<a href="#">PowerBI Link</a>
Patient Initiated Cancellations	All		12.2%	13.3%	13.7%	13.1%	13.4%	13.9%	13.7%				
Hospital initiated cancellations	All		13.2%	10.4%	10.8%	11.8%	12.2%	10.6%	11.4%				
Wait to First OPA	Wait in weeks		18.3	15.8	16.8	15.5	14.7	16.7	16.5				<a href="#">PowerBI Link</a>

# KPI Improvement's

## NCA high level summary

Key Performance Indicator	Target	Oct 23	Oct 25	Variance	Latest peer average	Latest national average
Specialist Advice Utilisation rate (n/100)	21	19.8	22.7	+2.9	24.4	29.7
DNA (All types)	7.4%	9.9%	8.4%	+1.5%	7.0%	6.6%
Remote Consultations	25%	20.4	19.1	-1.3%	17.4%	18.3%
PIFU	5%	2.3%	4.5%	+2.2%	3.3%	3.7%

NOTE: deterioration in remote consultations is in line with peer and national performance changes, NCA above peer and national averages

# Our Digital Journey

- Patient Electronic Platform (PEP) Sept 24
- 67% of patients accessing their **appointment** letter via the PEP and 25% via NHS App
- 93% patients receiving an appointment text reminder
- Two-way messaging with patients enable quick contact
- **Consultation** letters via PEP & NHS app – work in progress
- OBC stage for a single EPR
- Data Science Tool and application (DNA high risk)

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# Our Priorities

- Reducing health inequalities – knowing our data
- Identifying vulnerable patients, providing accessible information for patients when they need it
- Collaboration with primary care – making a difference
- ‘You said we did’ – with our volunteer colleagues
- Standardising appointment letters
- Standardising clinic templates (GIRFT recommendations)

# Advise & Guidance

The new Medium Term Planning Framework published at the end of October also sets out a national directive to move towards SPoA model and A&G by default, by July next year

## National Referral Standard

From July 2026, Advice-and-Refer (A&R) will standardise elective referral management through a Single Point of Access.

## Digital-First Patient Models

Integration of Advice-and-Guidance into digital-first, patient-led models enhances healthcare access and patient empowerment.



## Improved Triage Efficiency

The guidance supports enhanced triage efficiency and better clinical decisions to ensure timely care access.

## Call to Action for Providers

Healthcare providers must prepare, engage stakeholders, and develop systems supporting new referral pathways.

# Outpatient Disruption

- ✓ Delivering care differently
- ✓ **Challenge the status quo**
- ✓ Reducing hospital visits for patients
- ✓ Delivering care closer to home
- ✓ Diagnose to refer
- ✓ Productive and efficient

- Recent clinical round table on the 20<sup>th</sup> November united leaders from NHSE, GIRFT, GM Outpatient Improvement, primary care and NCA
- Cardiology, Dermatology, Neurology, Neurosurgery, and ENT shared the benefits of their tests of change from September/October
- Further plans are now underway to extend those initiatives and embed into core practise.

**CARE**  
**APPRECIATE**  
**INSPIRE**

# NCA Winter Preparedness 2025

## Part 1 - Summary

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# NCA Locality Winter Plan 2025 – 26

## - Background

- This year the Chair and Chief Executive were required to sign off a Board Assurance Statement to ensure the Trust's Board has oversight that all key considerations have been met.
- The Assurance Framework required the NCA Board to be assured that winter preparedness plans have been developed with the involvement of partner organisations in the local health and care systems.
- Surges in demand can impact the organisation at different periods across the year. The most sustained period of demand is generally from October – March. This demand presents in waves and is largely driven by three key pathways; **paediatrics, respiratory and trauma**. Testing of the plans has included plans for increasing bed capacity to accommodate a 10%/20%/30% increase in demand for these pathways.
- Winter preparedness has focused on creating capacity to deal effectively and safely with additional demand recognising that winter escalation capacity is dependent upon our people availability.
- Keeping our workforce healthy and in work will be essential to delivery of our plan. Vaccination is the single best preventative measure against the flu virus that circulates each winter.
- Our plans have been developed with partners across our localities and with the North West ambulance service. The plan has been tested at a NW Region-led event and will be tested further at in an EPPR NCA exercise focussing on the key pathways where demand is likely to rise
- Preparation commenced in July 2025, the start of three staged submissions to NHSE and GM ICB. The plan is a 'live plan' which is reviewed and updated regularly.



# Winter Priority Focus

- 3 pathways have been identified as key areas of impact for winter – Paediatrics, Respiratory conditions, Trauma.
- Analysis has been undertaken on the impact of these pathways on admissions and additional bed capacity requirements. (see end of slides)
- Care Organisations and localities have escalation capacity identified that are subject to further EPRR testing to withstand scenarios of capacity surge at 10/20/30%. Capacity plans include use of SDEC, Frailty SDEC, community respiratory hubs, outpatient 'hot clinic slots' and Hospital@ Home as well as in-patient escalation beds.
- Specifics against each of these priority areas are included in each Care Organisation plans and will be tested further at an NCA EPRR testing event on 29<sup>th</sup> September.
- Staff are our capacity in Winter and keeping them healthy and in work is key to our plan. A focus on vaccination, welcome back conversations, and delivering on the commitments we make through listening to staff feedback will be essential to maintaining and improving our absence rates during the winter viral illness period. Care Organisation management of annual leave and rotas over key peak period of demand will ensure our workforce capacity meets patient demand.
- Infection and Prevention and Control teams have a critical role to play over winter. As viral load increases, we need to adjust our capacity to meet that demand, focussing on managing transmissions and outbreaks within our hospitals which add further pressure to an estate that has a constraint on side rooms and isolation facilities.

# NCA Locality Winter Plan 2025 – 26

## - Structure of the Plan

- The NCA plan is structured to take account of NCA wide actions, Care Organisation specific actions (inclusive of locally developed system plans), and those specific to corporate functions such as vaccination, Infection Prevention Control, Workforce wellbeing, and Diagnostics and Pharmacy.
- The plan is structured into the following;
  - **Planning and preparation activities and pre-winter implementation** – this includes services or interventions that have been put in place since the previous winter, and any data planning and prep that may have been done in your care Orgs or systems.
  - **Daily rigour** – these are the activities we have in place to manage flow and sites on a daily basis
  - **Escalation interventions** – this includes policies and activities we undertake when escalating/in escalation
  - **Scheduled developments** – these are being introduced over the winter period
- Following the NW Winter Aegis exercise on 8<sup>th</sup> September, additional themes and activities were identified where we could strengthen our plans and responses. This includes use of retrospective data to support surge prediction, and strengthening support for paediatrics.
- Further stress testing of the plans will take place across the NCA on 3<sup>rd</sup> October.
- Financial provision has been aligned to the winter plan, specifically for staffing of escalation areas when in high Opel scores and for our vaccination programme. Risks and mitigations have been outlined and continued attention must be paid to the actions outlined to control those risks.
- A full QIA and EIA has been approved by the Chief Medical Officer and Deputy Chief Nursing Officer.

# NCA Locality Winter Plan 2025 – 26

## – Key Content

- **Vaccination** – We have established a target and plan to increase workforce flu vaccination rates by >18% this year, to 50%. Our midwives are actively engaged in offering our women who are >28 weeks pregnant the RSV vaccine to prevent respiratory syncytial virus which is a key cause of paediatric demand surge.
- We have modelled the **capacity and demand** based upon previous years to support our planning. Surge commencement dates are predictable and we have modelled bed capacity on 10/20/30% increase in admissions. Staffing in key areas and key roles have been expanded to cover Bank Holiday periods, and key winter months.
- A focus on **safe discharge** back to peoples own homes with community support forms significant content including reduction on Days Kept Away from Home, and a reduction in length of time in specific specialities of Respiratory, General Medicine and Geriatric Medicine.
- **Hospital at Home (virtual ward)** pathways are being expanded to include Flu, Paediatrics and Cardiology/Heart Failure, in the first instance.
- **Infection Prevention and Control** has a specific focus including strengthened support and visibility on our wards, our bed meetings, and weekend on-call. Our cohorting policies, daily patient reviews, microbiology and pharmacological support, staff hand hygiene and PPE are all key enablers to maintaining good patient flow, prevention of cross infection and reduced length of hospital stay.
- **Escalation policies and activities** to support surge demand are included including Full Capacity Protocol, increasing Long Length of Stay meetings, User of Mental Health Action Cards and increased Executive level safety meetings and resolution discussions with PCFT and GMMH are included.
- Admission avoidance through the use of **Call Before Convey** to support paramedics to make best use of admission options is established across all NCA localities and continuous monitoring and improvement of the scheme is ongoing.
- Increasing the use of the **Frailty/Same Day Emergency Care** is an essential part of our winter preparedness, as is the testing and implementation of a **Care By Appointment** model for people attending A&E with minor injuries, who can safely return to hospital the following day.
- Additional support to community based **Respiratory Hubs** is reflected, whilst these are delivered by primary care, they are a key part of surge management of Respiratory conditions, and the admission avoidance and discharge pathways for secondary care.

# Leadership Responsibilities

Leaders (Who)	Responsibilities (What)
Chief Delivery Officer, Chief Officers and Operational teams	Overall accountability for Winter Plan execution. Through Chief Officers and operational teams ensure capacity plans in place to meet surge, align EPRR testing of plans and organisational support. Ensure good flow of patients through effective site management and escalation. Operational support to clinical teams and across key BH periods
Chief Medical Officer and Medical Leaders	Effective leadership of ward rounds and boards rounds, focussing on EDD and discharge decisions alongside admission avoidance and SDEC pathways. Assure medical rotas are aligned to meet patient demand
Chief Nursing Officer and Nurse/AHP leaders	Vaccination Plans, Infection Prevention and Control plans, supporting ward rounds and boards rounds, strengths-based care and criteria led discharge. Community nursing and AHP teams providing urgent response and step up care. Assure nursing rotas are aligned to meet patient demand
Chief of People and HR business partners	Good occupational health support and response to support staff back to work, timely management of employee related cases where staff not in work
Chief Digital Officer and Digital teams	Ensure digital projects over winter are well managed, delivered on time and with business continuity plans in place and well understood.
Chief Finance Officer and Finance teams	Ensure that winter response monies are identified within financial forecast, working with teams to manage and mitigate spend appropriately to align to finance plan delivery
** Executive with Place Based leadership roles to work with Chief Officers to ensure plans across locality are connected and aligned, act as a point of escalation for locality risks and issues	

# Joint Health Overview and Scrutiny Committee

## Work Programme 2025/2026

Agenda item	Purpose	Portfolio lead & officer lead	Method of scrutiny	Additional information
<b>Thursday, 25<sup>th</sup> September 2025</b>				
Integrated Performance Report				
Patient Experience				
<b>Thursday, 18<sup>th</sup> December 2025</b>				
Integrated Performance Report – For Noting only				
Population Health Inequalities/ Widening access and participation				
Out Patients				
Winter plan overview and impact on localities.				
Finance Update				
<b>Thursday 26<sup>th</sup> February 2026</b>				
Integrated Performance Report – For noting only.				
Integrated Care				
National Oversight Framework				
Update on clinical leadership model work and its impact on each locality.				
Workforce Plan update				

Task and finish groups

Deep dive area:	Expanded proposal:

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