JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR NORTHERN CARE ALLIANCE
24/09/2026 at 2.00 pm

Present: Councillors FitzGerald (Chair) and Simpson (Bury)
Councillors Brownridge and Klonowski (Oldham)
Councillor Dale (Rochdale)

Also in Attendance:

Nicola Bailey	NCA Director of Improvement
Mike Barker	Executive Director Health and Care (Deputy Chief Executive)
Juliette Cosgrove	Chief Nursing Officer
Alistair Craig	NHS - Northern Care Alliance
Jack Grennan	Constitutional Services
Leah Robins	Northern Care Alliance
Tamara Zatman	Associate Director – Post Transaction Integration (NCA)

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillors Joinson (Rochdale) and Sheldon (Oldham).

2 **URGENT BUSINESS**

There were no items of urgent business received.

3 **DECLARATIONS OF INTEREST**

There were no declarations of interest to declare.

4 **PUBLIC QUESTION TIME**

There were no questions received for the Committee to consider.

5 **MINUTES AND ACTIONS OF THE PREVIOUS MEETING**

RESOLVED that the Minutes of the Joint Health Overview and Scrutiny Committee for Northern Care Alliance held on 25th June 2026 be approved as a correct record, and that the responses to the Committee's questions be noted.

Members requested examples on what had changed around sexual safety incidents, and it was highlighted that an unwanted behaviours campaign had been launched, and whilst it was too early for an impact to be seen, it was being monitored.

Members also asked whether sexual safety incidents could form part of the Staff Experience item that was due to appear before the Committee in December, and it was agreed that it could be.

6 **NCA CHANNEL 4 PROGRAMME, ANY EARLY NOTICE OF**

THE OUTCOME OR FEEDBACK OF THE WELL-LED INSPECTION AND AN UPDATE ON INDUSTRIAL ACTION

The Chair provided an update on the current situation at the Northern Care Alliance, including covering what scrutiny that had been carried out at the local level.

The interim Chief Operating Officer provided an update to the committee, noting that NCA Hospital sites had different demand and capacity characteristics. Stakeholder communications were discussed, particularly around the need for better updates where possible and wanting to be in a position of 'no surprises'. Work had been ongoing around safety, quality and governance with feedback coming from internal reviews, media coverage and patient and staff feedback. It was noted that it was key to have appropriate governance in place. It was highlighted that there were some issues around industrial action and the impact that was having.

Regulatory action was discussed, particularly the Section 29A notices and the System Improvement Board. It was noted that an integrated improvement plan was going through the internal governance mechanisms and that there were six strategic improvement themes – Safe and effective care; people and culture; governance; digital, data and information; operational delivery and performance; and financial sustainability and productivity.

Members queried the spinal services, particularly around how the new service would be different and what the timescales would be for the roll out. It was noted that the new spinal service had been established and, in relation to instrumental spinal services in particular, a multi-disciplinary team had been brought together. It was highlighted that the previous approach consisted of two teams (Neuro-spinal and Orthopedic), and these had now been brought together to reduce variances, and to ensure that they were to the same standard. It was noted that the spinal improvement plan had been programmed over a set amount of time with target dates for various elements.

Members queried when the Committee would see the integrated improvement plan, and it was noted that it was going through a private NCA Board next week, but that the evidence of assurances would start being seen from December onwards. It was highlighted that there was a legislative and regulatory hampering of this information being brought to the Committee, and it was questioned whether the Committee could communicate this to NHS England. Members also highlighted that a workflow would be helpful, and it was agreed that a workflow diagram would be created showing the workflow from the NCA to the Joint Health Overview and Scrutiny Board to local scrutiny boards.

Members noted issues that had been raised with them about the industrial action, particularly in regard to the overtime issue and the use of agency staff. It was noted that generally, agency staff

are not used, instead staff come from a 'bank'. It was highlighted that overtime had been reduced and vacancies were being permanently recruited to in order to reduce the reliance on overtime and bank staff.

Members also queried how treatment cancellations decided during industrial action, and it was noted that it would be primarily non emergency/trauma surgeries that would be impacted, with patients being risk rated and procedures being moved forward or to the following week. It was noted that it was the trade unions who make the offer on the surgery lists, not the NCA proposing them. It was noted that this was not the right level of cover that the NCA needed, but that it was part of the existing legislation and that it had been raised regionally and nationally.

The Chair sought clarity on this, and it was noted that the impact on surgeries was coming from a difference of opinion between the NCA and the trade union from an emergency point of view but what the trade union was doing was legally permissible. Members queried what was being done to reduce this gap in viewpoint and it was noted that talks were ongoing.

Members questioned what shortfalls were identified as part of the Section 29A notice, and it was highlighted that a key issue was the need to share wider learning beyond wards and services. It was noted that this had been improved since with the use of bulletins, safety huddles and creating an environment where this could routinely take place. A request was made by the Committee on reporting to the Committee on the different learnings.

Members queried what practical things were being done around staff concerns and enabling them to raise issues. It was noted that internally, there were a network of 'freedom to speak up' champions, and it was noted that the 'people' bit was key in all of the NCA's work.

Members queried whether NDAs were used at the NCA. It was noted that this would be picked up as part of the Staff Experience item in the work programme.

7 **CLINICAL LEADERSHIP UPDATE - TO INCLUDE AN UPDATE ON THE PALS / CUSTOMER COMPLAINTS AND ANY OTHER KNOWN IMPACTS**

The item was introduced by the Director of Clinical Strategy and Development, outlining why changes were made, particularly due to different outcomes and variants. It was noted that this was a move to an alternate model with single NCA services. It was noted that the impact would be known as the work moved into the benefit realisation stage.

Members queried whether, under a single leadership, local accountability would be maintained. It was noted that there were different aspects to this work, with site management at each site

working with the central leadership team, and that work was ongoing to identify more locally involved team partnerships. Members queried whether this was clear to patients, and it was noted that there would be no changes at ward level, but that there would be a standardised approach to complaints.

Members queried which services received the most complaints, and it was noted that, whilst the officers didn't have the information to hand, they were aware that responsiveness was key as it required clinical input. It was agreed that a breakdown could be provided and that gynaecology was a big area of complaints.

Members queried whether, with the legacy governance arrangement issues that were in place, could mission creep be avoided for meetings. It was noted that a clinical voice was key in some meetings but that the speed of any organisation could be impacted with more structures. It was highlighted that the new model was a real opportunity for a leaner structure and that 'Out of meeting' time was a benefit metric.

Members noted PALs and complaints, and noted that the loss of familiar local structures was an issue. It was noted that, when the Clinical Leadership model went live, not all the site directors had been recruited. They were all now in post and were starting partnerships, which would hopefully rectify some of these issues.

Members asked whether reassurances had been received from all the wider communities, and it was noted that they had.

It was agreed that the Committee would receive an annual report on the clinical leadership model.

8 **COST IMPROVEMENT PLANS AND PATIENT IMPACT**

Members noted that the constructive impact of cost improvements and the impact on patients would be beneficial for the Committee. It was also requested that examples be provided for the Committee.

9 **INTEGRATED PERFORMANCE REPORT**

Members noted the complaints process and asked whether it was explained to members of the public. It was noted that there were posters with the process on and it was available on the website, but the NCA was happy to take learning if members had concerns about it not being clear. Members noted that some members of the public had concerns that raising complaints would lead to an adverse impact on treatment. Members were assured that this should not be the case and that it was the learning from the complaints that was key to the whole process.

The Chair asked whether complaints would be covered during the Patient Experience item in the Work Programme, particularly Key Performance Indicators on the number of complaints

received. It was noted that this would be covered in the item but it was highlighted that there was an impact caused by an increasing number of AI-generated complaints.

Members highlighted that corridor care figures were lower now than they had been twelve months ago and questioned whether there was a reason for this positive outcome. It was noted that there had been a focus on corridor care and data validation, as well as an ongoing focus on reducing corridor care and ensuring that patients were in the right place.

National Oversight Framework (NOF) figures were provided to ensure that the Committee had comparative data. Members also noted the positive figures within the Community metrics.

RESOLVED that the Committee note the Integrated Performance Report.

10 **WORK PROGRAMME**

The Work Programme for the 2026/27 municipal year was discussed, and it was agreed that the Integrated Performance Report would be taken as the first item in the next meeting, and that case studies would be provided as part of the Financial Update item.

It was also agreed that the NCA Sites item would be moved to the February meeting.

RESOLVED: That the Work Programme 2026/27 as amended be noted.

The meeting started at 2.00 pm and ended at 4.00 pm