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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 24th April 2025 and 26th 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.

9 **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 the 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.

10 **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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