BNSSG Integrated Care Board (ICB) People Committee Meeting

1. Minutes of the meeting held on 13th February 2025 at 14:00 – 15:00, via Microsoft Teams.

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member – People (Chair) BNSSG ICB	JC
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Deborah El-Sayed	Chief Transformation and Digital Officer, BNSSG ICB	DES
Ellen Donovan	Non-Executive Member – Quality and Performance, BNSSG ICB	ED
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer, BNSSG ICB	ST
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
In attendance		
Astra Brayton	Internal Communications Manager, BNSSG ICB	AB
Cath Lewton	Exec PA to CPO and People Support Officer (note taker), BNSSG ICB	CL
Lara Reading	People Business Partner, CSU	LR
Neil Turney	Head of MH &LDA – Co Chair Staff Partnership Forum BNSSG ICB	NT
Sam Hill	Senior People Business Partner, BNSSG ICB	SH
Apologies		
Aishah Farooq	Associate Non-Executive Member for Bristol, North Somerset and South Gloucestershire	AF
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS

	Item	Action
01	**Welcome and Apologies** The above apologies were noted. JC announced that this would be the last ICB People Committee meeting before the new structure is implemented in April and emphasised the importance of completing all necessary tasks in this meeting to ensure a smooth transition.	
1.1	**Declaration of Interest** None declared.	
02	**Minutes of last meeting** Minutes from the last meeting on 10th October 2024 were recorded as an accurate record.	
03	**Action Log** There were no open actions to review.	
04	**ICB People Committee meetings going forward presented by Jo Hicks** JH proposed reducing the frequency of ICB People Committee meetings to twice a year, in April and October, based on feedback from both executives and non-executives. The HR team has matured significantly, and other communication channels within the organisation are effective. This was discussed and was agreed that the new meeting schedule would help coincide with important events like the Staff survey. Policies requiring review can be handled via email, and emergency meetings can be convened if necessary. SD emphasised the importance of the committee focusing on the delivery of the OD plan during the biannual meetings. The committee should provide an external view on the progress of the OD plan, ensuring that actions are taken and are effective. JC agreed with SD's suggestion and mentioned that the terms of reference should clearly outline the scope of the committee's responsibilities, including monitoring the OD plan.	

	Item	Action
	JH confirmed the OD Plan will be a standing agenda item with six monthly updates. **Action: JH and CL are to review and update the terms of reference to align with the new biannual meeting schedule and ensure clear definition of the committee's responsibilities. This document will be shared with JC and presented at the next committee meeting in April for approval.**	
05	**Sexual Safety Policy and Toolkit presented by Lara Reading** LR presented the sexual safety policy and toolkit, which aims to prevent and address sexual harassment within the workplace. The policy has been through the governance process and is now awaiting final approval from SD. The policy includes steps to prevent sexual harassment, support mechanisms for staff, and an anonymous reporting system. It is based on a national policy framework and has been adapted to fit the ICB's templates. The policy includes an e-learning module on sexual safety training. Although the training is not mandatory, it will be regularly promoted to encourage participation. The policy will be launched with clear communication to ensure staff are aware of the available support. JC raised concerns about the effectiveness of anonymous reporting in a smaller organisation. LR and AB explained that the process would be clearly communicated during the policy launch to ensure staff confidence in the anonymity of their reports. **The ICB People Committee approved the Sexual Safety policy and Toolkit.**	
06	**Workforce KPI Dashboard Q3 presented by Lara Reading** LR presented the workforce KPI dashboard for Q3, highlighting key metrics such as headcount, turnover, and absence rates. The data showed a stable recruitment and leaving activity, with a focus on managing long-term absence cases. The rolling 12-month absence rate was 3.1%, slightly above the target of 3%. The monthly absence rate at the end of December was 3.5%,	

	Item	Action
	with stress, anxiety, and depression being the highest reported reasons for absence. The compliance rate for statutory and mandatory training at the end of Q3 was 86.7%, with an increase in compliance across 13 modules. The data was broken down by directorate to identify areas needing improvement. LR provided demographic data, showing a higher female workforce (75%) and an evenly spread age distribution. The ICB encourages disclosures and records demographics in ESR to monitor diversity and inclusion. LR will be meeting with directorates to review their specific staff survey results and develop local action plans based on the findings.	
07	**Staff Survey Results 2024 presented by Lara Reading** LR shared the staff survey results, which showed improvements in several areas despite the challenges faced during the year. The ICB ranked 11th out of 26 in overall positive scores and 7th in most improved scores. The staff survey had a 78% response rate, higher than the average of 76% and the previous year's 77%. The ICB ranked 11th out of 26 in overall positive scores and 7th in most improved scores. Areas needing improvement included meeting conflicting demands, having enough staff to do the work properly, and treating near misses and incidents fairly. These areas scored lower than the average and will be a focus for future improvement. The ICB improved in all areas of the People Promise except for "We are a team," which remained consistent. Staff engagement and having a voice that counts showed significant improvement, indicating positive progress despite the challenges faced. The next steps for addressing the staff survey results, include meeting with directorates to develop local plans and focusing on areas for improvement.	
14	**Any Other Business**	

	Item	Action
	JH informed the committee about an employment tribunal notification received for an exited member as part of the shaping our future program. The HR team will work on a formal response with legal advisors.	
	Date of next meeting To be confirmed – April 2025	

Cath Lewton
Executive PA to CPO and People Support Officer
February 2025

ICS People Committee

Minutes of the meeting held on Wednesday 27th November 15:00-17:00, via MS Teams

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member, BNSSG ICB (Chair)	JC
Anil Patil	Non-Executive Director, Sirona	AP
Bryony Campbell	Executive Director Transformation & Strategy, One Care	BC
Jan Baptiste-Grant	Non-Executive Director, AWP	JBG
Kelvin Blake	Non-Executive Director, NBT	KB
Ellen Donovan	Non-Executive Director, BNSSG ICB	ED
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Linda Kennedy	Non-Executive Director, UHBW	LK
In attendance		
Corry Hartman	Senior Workforce Analyst, BNSSG ICB	CHm
Louise Carthy	Programme Officer, BNSSG ICB (minute taker)	LC
Melanie Murrell	Associate Director, Nursing Workforce Recovery, NBT	MM
Nicola North	ICS Learning & Development Business Partner, BNSSG ICB	NN
Sam Hill	Senior People Business Partner, BNSSG ICB	SH
Calais Hutchins	ICS EDI Officer, BNSSG ICB	CHu
Caroline Hartley	Associate Director of Culture, Leadership and Development, NBT	CHy
Emma Wood	Chief People Officer, UHBW	EW
Kate Barnes	Adult Social Care Programme Manager, South Gloucestershire Council	KB
Nicola North	ICS Learning & Development Business Partner, BNSSG ICB	NN
Michael Richardson	Deputy Chief Nurse, BNSSG ICB	MR
Holly Hardy	General Practice Associate Dean (BNSSG)	HH
Apologies		
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Linda Ruse	BNSSG Training Hub Programme Manager	LRu
Jeff Farrar	Chair, BNSSG ICB	JF
Mandy Gardner	CEO, Voluntary Action North Somerset (VANS)	MG
Sarah Margetts	Deputy Chief People Officer, NBT	SM
Sonya Wallbank	Chief People Officer, Sirona	SW
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Alex Nestor	Deputy Chief People Officer, NBT	AN
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM

	Item	Action
01	**Apologies** Apologies listed above.	
01	**Declarations of interest** None declared.	
02	**Minutes of the last meeting** The minutes of the meeting on 25th September 2024 were approved as a correct record.	
03	**Action log** The action log was reviewed and updated.	
04	**System EDI Report** SH presented to the committee, highlighting the following points: • Gender pay gap: There is a higher proportion of females in our workforce, however there is a higher proportion of males in the upper pay quartiles. It was observed that different roles often attract different genders. The implications of part-time roles was recognised, noting that the majority of part-time roles seem to be at the lower-mid end of the pay scales, and are more often held by female staff. • Ethnicity pay gap: Not all organisations report on this currently, although it is expected that this will become mandated moving forward. Where it is reported, we are seeing mean and median pay gaps around ethnicity. Barrier to progression is an issue. There is also an underreporting of ethnicity in the upper pay quartiles. Actions to address these issues were outlined. • Workforce Race Equality Standard (WRES): As a System we have seen a 3% increase in BAME staff (22% of total staff). There remains a significant disparity around the appointment of BAME staff. For every 1 BAME person appointed, there are 11 applications. For every 1 white person appointed, there are 5 applications. The relative likelihood of BAME staff entering a formal disciplinary process ranges from 0.76-3.53. Anything over 1 indicates disparity. Statistics around training and CPD are quite positive.	

	Item	Action
	• Workforce Disability Equality Standard (WDES): Disabled staff are underrepresented when compared to the community, non-clinical vs clinical. There is also a potential underreporting of disability, in terms of staff not disclosing disability status within their ESR record. The relative likelihood of disabled staff being appointed varies from 0.32-1.39. Anything over 1 indicates disparity, with a non-disabled applicant more likely to be appointed. The scores are positive around reasonable adjustments being put in place, to enable disabled staff to carry out their work. • The Equality Delivery System (EDS) and High Impact Actions were outlined. Comments and questions were raised as follows: • ED enquired if there were any actions / wins from providers that could be shared in relation to shortlisting vs appointments. SH confirmed that there is a focus on Inclusive Recruitment. NBT have used Positive Action and diverse panels in their recruitment. UHBW are also rolling out Inclusive Recruitment training for line managers and hiring managers; this work will be shared across the system. • CHy advised that NBT have piloted diverse recruitment panels over a 6-month period, focussing on bands 8a and above. Some success has been realised and the target headcount increase has been hit. The pilot process was managed centrally; divisions now want to embed this locally and use it for additional bandings, and in areas with lower representation. CHy further noted that NBT are following the progression of staff who have been employed via positive action routes. • SH confirmed that at system level we have the Inclusive Recruitment Toolkit, and there is EDI representation in our ICS Recruitment Group. • BC noted that General Practice has separate EDI KPIs which are linked into the workstream. SH confirmed that we have tried to include as much General Practice workforce data in the report as is available. We have had General Practice representation in the EDI Leads Group and are now waiting to see what the High Impact Actions will be for General Practice, which NHSE are currently working on. • JC suggested that it would be good to link this work into our social value asks for procurement, scaling this up to include the same metrics that we are working towards to try and encourage that awareness within our suppliers. **Action: SH to take this**	

	Item	Action
	back to our Procurement Team to ask how we might do that. • ED highlighted that some contracts in local government contain quite detailed deliverables around EDI measures, and queried if there was any learning to be taken from this. JH noted that social value links into our green plan, but it is unclear if it goes any wider than that. **Action: JH to look into this**. JH further highlighted that we are a Work Well vanguard for our area, which is about contributing to the economic value of our system by supporting people back into the workplace. An update on this work will be brought back to the committee at a later date.	**SH** **JH**
05	**Zero Acceptance to Racism guidance** CHu presented to the committee. The following points were noted: • The guidance has been created following a discussion between system EDI Leads, thinking about how we tackle racism from colleague to colleague, colleague to patients / service user etc. It is hoped to roll out the guidance across the system to ensure that we are all taking the same approach as ICS partners. • A group was established to work up the guidance. The term 'zero tolerance' was changed to 'zero acceptance', on the basis that tolerance can be measured differently based on different people's personal tolerance levels. • The guidance includes information around how to notice racism, how to act on it, how to report it, and details relating to the employer's duty and any consequences that could come from this. • The intention is that when we are working towards becoming an anti-racist system, we can use the guidance as a foundation so that partners organisations can update their own policies or create their own policies, whilst demonstrating that we are taking a collective approach. Comments and questions were raised as follows: • JC highlighted the service user to colleague perspective, and asked if we had considered the full breadth of what action can be taken legally / at what point do we need to think about the more serious sanctions that there would normally be outside of a healthcare setting. CHu noted that the purpose of the guidance was to assist organisations in creating their own policies, and is fairly broad in order that it may be applied usefully across all of our different partner organisations. **Action: CHu to explore further the full breadth of actions / sanctions**. • EW highlighted the policies in place at UHBW around clinically induced violence and aggression (which can include racism)	**CHu**

	Item	Action
	from patients (e.g. dementia and delirium patients), such as the withdrawal of treatment policy, noting the clinical risk associated with that. The difficulty in finding a balance around this was acknowledged.	
06	**Green Plan Workforce Metrics** CHm presented to the committee. The following points were noted: • The workforce specific metrics within the ICS Green Plan were outlined. Themes included training, engagement and personal action, travel and transport, leading change within our citizens, estates and digital. CHm advised that an update on these had been sought from the Head of Sustainability. • It was confirmed that the metrics are being reviewed, as there have been some challenges around what data can actually be collected. CHm will continue to engage with the Head of Sustainability on what data can be captured moving forward and brought back to the committee. **Action: CHm**. Comments and questions were raised as follows: • JC highlighted the need for all members to consider what their respective organisations are doing in this space. • ED suggested that we focus on a small number of initiatives and really commit to those. • JH highlighted ICS level work such as the NHS @ Home initiative, which supports our workforce to work collaboratively and reduces the need for staff to traverse across the system. It was suggested that these elements of our wider programmes of work were not necessarily captured and measured as much as they could be in evaluation, to understand the sustainability/green outputs and the impacts of those.	**CHm**
07	**Workforce Monthly Monitoring Report & Financial Month 5 position** CHm presented to the committee. The following points were noted: • Substantive staff in post is 154wte above plan. • Agency use is 68wte below plan. • Bank is now 0.3wte above plan, which equates to a variance of +£1.5m against plan. A lot of work has been done to bring this figure down following an expensive Q1, and we are now in a good position with bank spend. • Within General Practice there are 657.4wte GPs in post, which is 19wte above plan. There are 368wte nurses in post, which is 9wte below plan. • NHSE have set a limit on how much can be spent on agency as a % of total pay. The target is 3%, and we are currently below that, which is a good position to be in as we approach the challenging winter period.	

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	• The total workforce costs year to date position is £19.2m above plan. Comments and questions were raised as follows: • ED enquired as to what plans were in place to address the £19.2 overspend. CHm confirmed that the financial position has been raised with the Performance and Delivery Group. All partners are aware that we are currently beyond our funded establishment as a system, and a number of key actions are being taken to reduce that overspend. JH highlighted that as we are heading into several months of winter pressures, there is need to tackle the overspend as much as possible in order to avoid the position worsening. • JC enquired about the wider context and the financial position of other ICSs, and whether they are in a similar position to us. JH confirmed that in terms of financial performance BNSSG are currently one of the best in our region. • JH highlighted that the impact of driving our agency spend down has led to an increase in our bank spend. There is a risk that we may now end up paying more for bank than we have been for agency, due to that shift we have created. This is logged as a risk on the Strategic Workforce Oversight Group (SWOG) risk register and will be escalated further if needed.	
08	**Updates from Provider People Committee Reps** Sirona update provided by AP – points of discussion included: • Current areas of focus include the removal of premium bank rates, the continuing transformation of the People team, and the development of Sirona's cultural identity. • There is a strong commitment to EDI with lots of work going on in this space. • The Podiatry service vacancy rate is at 24%; there are actions in place to try and mitigate this. • INT staffing is an ongoing issue; controls are in place to try and mitigate these risks. Comments and questions were raised as follows: • ED enquired as to how the 24% vacancy rate was being addressed, referencing the current pressures that we are seeing across our system and the need to support system flow. AP confirmed that vacancy rates fluctuate across services and that the 24% vacancy rate was specific to Podiatry. It was acknowledged that vacancy rates across Podiatry and INT are higher than we would want, and there is much work taking place to address this. Other systems were noted to be in a similar position. UHBW update provided by LK – points of discussion included:	

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	• Activities are focussed on their key pillars. • Work around career pathways for registered nurses has been successful – vacancy rates have halved, resulting in reduced agency spend and improved bank. • The leadership programme is going well with a new coaching platform coming online. • Health checks, menopause support and men's health clinics have seen a good rate of uptake and positive feedback. • Areas of focus include the patient-first objective around medical workforce optimisation, and delivering on the pro-equity promise, which is an ongoing programme. • Work will be taking place looking at the standardisation of practices across NBT and UHBW going forwards. • The hospital group are looking at how can we work and collaborate more at a system level to drive patient benefits across partners. <u>One Care update provided by BC</u> – updates included: • A course is being developed to support the retention of staff when they start in General Practice. • It is hoped to link into the Work Well agenda to look at how we can implement that in General Practice. • A fifth agency has joined the Agency MoU. • The end of the EAP pilot is approaching. We have seen steady growth in usage across the whole of the Primary Care workforce, who didn't have access to a standardised EAP previously. A business case will need to be developed to see if we can attract future funding to be able to continue this. <u>Social Care update provided by KB</u> – points of discussion included: • The recent budget is going to impact social care provision significantly, noting the changes to business NI contributions and minimum wage. This may potentially impact the number of providers who are able to remain active in the market. • There has been a significant increase in international recruitment over the last couple of years.14% of our home care direct workforce and 7% of our residential care workforce were recruited from overseas. Because of further changes to immigration law there is an expected decrease over time in that workforce, and an increased focus on the domestic market. There is a risk that this may lead us back into a position of competing in the same recruitment pools for the same people. • There has been a significant number of displaced workers due to license revocations in social care. This has been less of an issue in our system compared to other parts of the South West, however we are still working strongly to ensure ethical	

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	recruitment and reduction of the risk of modern slavery across the sector. • There is a focus on skilling and upskilling of the sector, equipping the community to better support people in their own homes. • Each Local Authority is having daily conversations around discharge and what can be done to support flow. There has been significant investment in the Better Care Fund to build capacity to support this. <u>AWP update provided by JBG</u> – points of discussion included: • Vacancies remain a corporate risk. • There is a continued focus on agency spend alongside system partners, and reduction of bank spend. • The biggest challenges are around medical workforce recruitment, increased violence and abuse against staff, and budget allocation in relation to the impact on Mental Health. Local Authority and VCSE funding is very restricted in the budget and will therefore impact upon AWP's community partnership offers. • There is a need to focus on what we can do as a system to enable internationally educated nurses to feel more secure and supported – not just at the point of arrival, but for a short period of time afterwards. It was suggested that we look at this collaboratively to address the cultural clashes and ongoing challenges that these staff experience, which will benefit us all. HH noted that 50% of the GP training intake across the region are international graduates, and highlighted that once trainees are in post it takes at least 3 months for a someone to feel more settled. This impacts on performance, with performance improving significantly after 3 months. • JH noted that this has been on the system nursing and midwifery agenda for a while, and it was agreed that an update from that group would be brought to a future committee meeting. **Action: MR to take this back to RS**. <u>NBT update provided in writing by KB.</u> There followed a discussion around what one or two things the committee could put its collective weight behind to move forward, to reduce duplication of effort and drive synergies. JH highlighted that the People Programme Board is attended by senior operational colleagues from across the ICS and has a collective system agenda. The minutes of that Board can be brought to the ICS	**MR / RS**

	Item	Action
	People Committee to 'close the loop' and help shape this section of the agenda going forward. **Action: LC**. SC highlighted the patient first methodology, and the focus on doing less things, better. It was suggested that we showcase the good work that is happening in this area, to help assure the committee that we are using best practice to drive real cultural change across our system. EW suggested that the things we should be taking assurance on are the things that mitigate our greatest risks (e.g. our top 3 system workforce risks). It was agreed that JH would bring to the next meeting a summary of everything we are working on, to help the committee collectively identify 2 or 3 things that we would like to take a deep dive into. **Action: JH**.	**LC** **JH**
09	**ICS People Committee Feedback** JC thanked those who responded and provided a summary of the feedback received as follows: • Strengths included leadership, administration and knowledge sharing. • Weaknesses included data limitations (including Social Care and Primary Care insights into the data), representation challenges, and overly detailed meetings with lengthy updates / insufficient time for meaningful discussion. • Opportunities included the meeting format, broader engagement, data improvements and system-wide focus. • Threats included risks, 'tick box' culture (adding value), and external pressures – ensuring that time spent at the committee is time well spent and worthwhile. It was agreed that JC will summarise this and circulate to the committee. **Action: JC**. There followed a discussion around the effectiveness of the committee as follows: • JBG questionned the difference between assurance vs reassurance, and how the committee can ensure that it receives the former. • KB reflected that there isn't an agreed set of objectives that everyone is working to, but contributions to strands of activity. • JH highlighted that there is a strategic system direction, and that it is the responsibility of the committee to ensure that this is followed and that we are working towards the collective aims of the system strategy from a workforce perspective. Provider updates are sought to assure ourselves that there is alignment in what is happening at an organisational level with what is	**JC**

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	happening in terms of the collective system direction of travel that all ICS partners have committed to. • It was acknowledged that this was about system leadership. What is happening locally within partner organisations is one thing, but we are asking that members also recognise and ensure that this is being considered in the system space as well, and that activities are contributing to that wider system picture. It was agreed to consider a reframing of the provider updates. **Action: JC**. • It was highlighted that the committee has been audited; we now need to take the resulting recommendations forward and bring back to the committee in January for a broader discussion alongside the effectiveness feedback. **Action JC / JH**.	**JC** **JC / JH**
10	**Hot Topics / Risks or Matters for Escalation** Leadership and Management Framework: Code of Practice – JH highlighted that this will be a key feature that we will be expected to pivot against as NHS organisations. 2025/26 Operational Plan – JH confirmed that planning days have started. Risk – JH advised that this will link through to our mitigations, and which of those mitigations we want to focus upon as a committee. Redeployment and suitable alternative employment – JH highlighted that NHSE have been in touch around how, at a regional level, we might think about a joined-up approach to redeployment and suitable alternative employment. This relates to staff that are displaced as a result of financial pressures – not just within our system but across the whole of the South West. This will drive some of the other conversations that are taking place around how we support one another as a region. Winter planning – ED highlighted the new winter plan, and it was confirmed that the system COO group will be leading on this.	
11	**AOB** None.	
	Date of next meeting: Wednesday 29th January 2025, 1500-1700.	

Louise Carthy
Programme Officer
Date: 4th December 2024

ICS People Committee

Minutes of the meeting held on Wednesday 29th January 15:00-17:00, via MS Teams

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member, BNSSG ICB (Chair)	JC
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Bryony Campbell	Executive Director Transformation & Strategy, One Care	BC
Jan Baptiste-Grant	Non-Executive Director, AWP	JBG
Kelvin Blake	Non-Executive Director, NBT	KB
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Linda Kennedy	Non-Executive Director, UHBW	LK
Sonya Wallbank	Chief People Officer, Sirona	SW
In attendance		
Corry Hartman	Senior Workforce Analyst, BNSSG ICB	CHm
Georgina Hawkins	Programme Officer, BNSSG ICB (minute taker)	GH
Trisha Quashie-Boney	Associate Director of Strategic People Business Partnering, NBT	TQB
Kate Barnes	Adult Social Care Programme Manager, Department for People, South Glos. Council	KB
Mandy Gardner	CEO, Voluntary Action North Somerset (VANS)	MG
Samantha Champman	Assistant Director Learning and Development, UHBW	SC
Linda Ruse	BNSSG Training Hub Programme Manager	LRu
Laurence Ross	Project Manager, BNSSG ICB	LR
Apologies		
Ellen Donovan	Non-Executive Director, BNSSG ICB	ED
Tim Cooper	Non-Executive Director, Sirona	TC
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alex Nestor	Deputy Chief People Officer, UHBW	AN
Jeff Farrar	Chair of BNSSG ICB	JF
Emma Wood	Chief People Officer, UHBW	EW
Jean Scrase	Associate Director of Education, BNSSG Learning Academy SRO, UHBW	JS
Sarah Margetts	Deputy Chief People Officer, NBT: SRO	SM
Peter Mitchell	Chief People Officer, NBT	PM

	Item	Action
01	**Apologies** Apologies listed above.	
01	**Declarations of interest** RS has become a Non- Executive Director at Gloucestershire Health and Care – a community care provider in Gloucestershire – this is to be added to her DOI.	**RS**
02	**Minutes of the last meeting** The minutes of the meeting on 27th November were approved as a correct record.	
03	**Action log** The action log was reviewed and updated.	
04	**Updates from Provider People Committee Reps** Provider updates in which JC requested key risks faced at the moment as the focus. AWP updated provided by JBG – update included: • Complexity of non-UK citizenship sponsorship which has changed and want to ensure within AWP they don't have anyone that falls foul of this sponsorship. • Ongoing issue around medical staffing and medical workforce. Aware this is a challenge across the system, and noted that they are seeing more consultants leaving rather than joining, and have a significant number of staff doctors and associates that are helping in the gaps of consultant posts. They have an ongoing medical workforce project to looking into this area. This has an impact on agency spend and noted this a high-risk area. UHBW update provided by LK – update included: • Renewing and laying out plan for new group people strategy, expected to be in place by November. This will be done in a joined-up way with UHBW and NBT. • Good performance from the preliminary staff survey results. • Risks – unclear on what level of risks to raise and felt that there were no immediate risks but want to continue sharing of best practice for common ground risks, noting it would be helpful to coalesce what the group will focus on in future meetings. • Working on deep dives in their internal People Committee meeting with the aim of collecting the larger problems and looking into the areas where help and support is needed. ○ LK requested to have ICS People Committee meetings after internal People Committee meetings. JC noted how	

	Item	Action
	calendar juggling is difficult and suggested to the group that we could be sharing in the interim rather than waiting for flags in meetings. <u>NBT updated provided by KB</u> – updated included: • Highest Risk – pressure in the system, affecting staff and ability to cope with this pressure and ensuring wellbeing offer is there to avoid burnout. • Risk – with coming together with UHBW there's a risk in keeping focus in the right areas, both internally focussed and outwardly focussed on patients. • Decrease in number of applicants in last reported (had 2000 applicants in November which is a decrease of almost 600). • Slight increase in vacancies going up by 4% (mostly seen in healthcare workers). • Decrease in new starters (likely due to winter pressures). • Finding pressure on time to hire and flagged that systems and process take too long. So far have reduced time to higher to 13.5 days (for everyone apart from medics from advert to appointment). Medical hire is down to 43 days (down 15 days). • Retention and sickness figures going in the right direction. • Staff survey reports are looking similar to UHBW report. • Risk – increase in violence and abuse from patient to staff, and in some cases staff to staff. A note in the Teams chat from SC to KB flagged that SC is working directly with colleagues at NBT to ensure alignment of approach to patient/staff V&A incidents so there is a consistent approach across the city, working towards communication in the spring. <u>One Care update provided by BC</u> – update included: • Pilot undertaken by One Care across primary care for an Employee Assistance Programme (EAP) – have decided to not continue this as the uptake of this was really low and not as expected. This will be re-negotiated, and practices will be able to purchase directly at a much-reduced rate. • Risk – uptake of workforce initiatives put into General Practice do not have a big uptake per-say. There is no clear rational why this happens apart from capacity and usual other challenges. • Risk – funding. A lot of the workforce initiatives that happen for General Practice are from SDF funding and is not always	

	Item	Action
	decided by the System until September, which then starts at the beginning of the financial year. This is asking organisations to either stop and start their provision or run at risk. • Risk – have no fundamental data for General Practice, which impacts on everything done in terms of workforce. • Risk – the BNSSG Training Hub has a one-year contract running to March 2026 and doesn't have anything confirmed for past this at this stage. There is a National Review working on a three-year contract or programme but should this not be this case then this is a huge risk. Additional comments: LR noted the National Insurance increase is also impacting adversely on General Practice as they are MOT exempt. <u>Social Care update provided by KB</u> – update included: • There is no People Committee for Social Care, and that the commissioned Social Care workforce, the development and resilience of that is developed through each Local Authorities' market sustainability plan. There are national workforce strategies through skills for care, which also have a regional footprint. • There is a strong market in BNSSG for social care, and there is a good diverse market of quality provision, with over 80% of the providers rated good. • Risk – the impact of National Insurance contributions for employers and the increase in minimum wage are causing financial challenges, but as yet they aren't aware of what this will look like but is likely to have an impact. The Local Authority financial grant doesn't allow inflationary uplifts to all providers, so there is a shortfall and unsure what the impact of this will be. • Has a strong international recruitment offer, both for ensuring employers recruit ethically and well and to ensure that employees from overseas are supported and have a reduction in incidents of revocation of license and displaced workers and an increase in retention of the social care overseas workforce. KB to share ethical international recruitment offer with group but noted that this is not for Primary Care. **ACTION.** <u>VCSE Alliance update provided by MG</u> – update included:	**KB**

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	• Risk – impact of National Insurance and increase in minimum wage causing financial challenges. Wrote to government but had no response. • Risk – nature of many of the contracts that are held with health and with other providers are 12 months and many people don't know their budget yet (Local Authorities are really struggling with this). This is causing issues with planning. • Important to note – many colleagues in this sector have been given notice of potential redundancy, please be sensitive and aware of this. • All of this is making life very uncertain in VCSE. <u>Sirona update provided by SW</u> – update included: • The Care Quality Commission (CQC) are currently inspecting and there is a Well Lead Service inspection next week. Also, NHSE have joined on a private provider inspection. These inspections are impacting people and impacting work pressures and balance. • Risk – uptick of sickness and absence by about an average of 1% of where they would be more comfortable, especially long-term sickness. • Noted there are work and regulation pressures. • For the last 18 months Sirona has been working hard on the short-term turnover. For example, within 7 months people are leaving their roles and most likely going back into the acute sector. It was recognised that community work can be more pressured and varies greatly. • There has been a large focus on EDI and this is going well. 18 months ago there was 8% declared EDI and is now at 13% in the last measure. Next steps are to be looking at what's changing and what can be done in the longer term. • Defining what does culture look like as a community organisation, with 90 different sites and lots of different people interacting in different ways. • Health and wellbeing absolute focus moving forward. <u>Additional comments on all provider updates:</u> • AM flagged concerns in primary care, in terms of it being the area we have the least amount of data, and how can we try	

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	and get primary care into a similar position that other providers have been in for many years in terms of gathering data and data sharing. JC noted that across the System we need to find a way of incentivising, even if what is happening Nationally isn't helping. • AM also noted the risk of not having the training hub as it has a really high success rate of getting newly qualified GPs in across BNSSG. • Collective action was seen by the group as a barrier to GPs sharing data - BC asked for collective action to not to be seen as a blocker – there is a process to follow for any new DSAs to be considered - she feels that GPs may not have any issue sharing data if they also saw the benefits to sharing their data, noting that they are frustrated about issues but then their arguments fall flat because there's no data around the workforce piece. BC noted it is unclear how collective action affects general practice workforce metrics, again, without data, we don't truly know. • BC noted in terms of the ICS strategy and 2040 work, until the shift from secondary to primary happens and what this looks like, we don't know as a System what workforce we need. Nationally there was going to be an HR System for General Practice, but this has gone quiet, if this is a debate that could be resurrected or advocated for more strongly, that would be the answer to a lot of these questions. Trying to do this locally or relying on NWRS is not. **ACTION**. • JH commented on one-year funding to reassure that three-year funding is coming in, and there's an expectation that this will happen. • JH noted that the concept of the integrated neighbourhood teams pushed to May – a different conversation needs to happen with Primary Care to shape this and to get this right. This is a longer-term goal and is an intention of Healthier Together 2040 and fully aligns with the three shifts.	**BC/LR**
05	**Workforce Monitoring Report** CHm presented to the committee. The following points were highlighted from the report that was sent out: • Currently generating the December report. • Staff and post taking into account temporary substantive staff – on plan in November, slightly under plan in December but not a concern, and is primarily because we've seen a big change in bank use.	

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	• Turnover rate is 12% (lowest experienced as a System). • Sickness – Sirona sickness has increased November to December, but overall sickness rate is 5.1%. In terms of benchmarking, we have the lowest sickness rate across the southwest, tied with BSW and Gloucester. • Vacancies – 6.5% (1600). For context, a year ago we were at 9% so we are making progress in closing this gap. • Financially in terms of temporary staffing, we've made some positive gains around agency spend. We often come under spend for agency and for bank it's over, but we are reducing the gap. November figures show 0.8 million overspend in bank work but when you start to combine this, it's all the good work that's going on behind the agency underspend and slight overspend in bank, and we can see that we're starting to deliver in month the plan. • Collectively looking at a year-to-date position, we had a challenging first quarter, where there was overspend in agency and bank work. • We are still overspent by roughly 19 million, with three months left of the financial year. Inroads will be made but come March there will still be an overspend but it should be noted that there has been a lot of good work behind this. CHm to link up with BC and LR regarding General Practice data concern to see if we can source something locally, to help feed the reports we have as we do rely on NWS. **ACTION.** Comments and questions were raised as follows: • AM mentioned that it's good to see the system plan and how its outlined. Flagged a danger of averages as it does mask information. Are there any hotspot areas in any aspects in our system that this committee can help? CHm noted that he agrees on the point regarding averages and said that as we shape the operating plan for 25/26, we will bring forward challenges to the group. JH also came in to say that the Strategic Oversight Workforce Group (SWOG) delves deep into the report, and links into comments made by colleagues earlier in this meeting regarding updates. Overall, our position as a System against our plan is really good, for example key stats, temporary staffing and agency use. In the SWOG group Organisations are coming together to share learning and best practice and have a strong handle on this area. Planning days	**CHm**

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	are coming up, and it was noted that this year is reasonably good in terms of workforce, but we do have hotspot areas that we need to focus on and there are action plans. • JBG requested clarification on the executive summary. Noting that the overall position of workforce for the Acutes, AWP and Sirona, in the first bullet point, mentions substantive staff in post is 303 above plan but then the months before the substantive staff was 369 below the plan and wanted to know what created the shift. CHm to look into this and clarify and come back to the group. JH noted normally reasons for differences are highlighted and suggested to CHm that any variations are highlighted in future reports. **ACTION**. • LR flagged detail about key hotspots, for example there were 14 GP applications for 1 GP vacancy and there is a risk of losing GPs outside of our area. • JBG raised that UHBW have fantastic low vacancy rates, and AWP started off with about 13% and are steadily reducing, but still have a high score in turnover rates. Asked for learning from UHBW and is happy to take this offline. **ACTION**: SC to share plan with GH to share with group.	**CHm** **SC/GH**
06	**Workforce Planning 25/26** JH and CHm presented to the committee. The following points were noted: • Still awaiting planning guidance for this year but hasn't stopped early conversations. • Making assumptions, but once the guidance lands there will be more certainty in terms of workforce for the coming year. • The plan is two-fold, including a narrative (that is specific about risks, particular hotspots and areas of concern as well as negotiation with NHSE) and numbers. • This year it is anticipated that the turn-around period will be in a 4-week window, with a planning date in for the 12th February. Organisations are pulling together workforce numbers. • Anticipating specific requirements from NHSE around business operations. Expecting a complete ban on agency and will need to work on those hotspot areas where they are still using agency. Bank and bank spend ask is at present unknown. • An added complication being managed by SWOG is that some bank rates are higher than agency rates and that is due to anomalies around agenda for change and the last two years of pay increments and incentives. This will be escalated here as needed but will come through to People Committees.	

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	• Anticipating specific action/requirements around establishment numbers, though no clarity on this yet. Originally before Christmas there was an ask to reduce admin and clerical by 30%, likely this is coming out of the requirements but don't know what is going in instead. • Highlighted that there will be a significant requirement to increase productivity, and expecting a significant increase in the percentage ask. Keith Brassington and Corry Hartman are briefing the CFOs and the CPOs on the 14th February. • We will have a focus on productivity on the wider return, as this is not only a workforce issue but also an operational and whole systems issue. • The first time the ICS People Committee will see this will be the draft plan due to timing constraints and the quick turnaround required. • The agency ban is on all framework (not all agency) but awaiting further clarification on this. • Anticipated that there's going to be further cuts to bank and agency, as NHSE will stipulate that from where we were in November, further cuts will need to be made. • Acutes have been targeted with a 4% reduction in expenditure, which is likely to equate to workforce. Comments and questions were raised as follows: • RS flagged a risk for the Committee as a CNO, that there are particular groups of workforce which are highly specialist and require agency use. When looking at the big numbers we need to consider sub-specialists where there will be times where we have to bring agency workers in, in order to maintain services to patients. We need to be mindful of clinical risk and operational effectiveness and productivity. This risk lives with CNO colleagues and providers and will need to be kept in mind. • JBG raised in terms of workforce figures that roughly 40% of community pharmacists are either locums or on the agency, so as a System we will likely be challenged to mitigate these sorts of issues in terms of agency reductions.	
07	**Workwell Update** LR presented to the committee. The following points were highlighted from the report that was sent out: • Asked as an ICB to provide information into the spending review delivered by NHSE, concerning work, skills and health	

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	agenda that seems to be growing and is part of the 'Get Britain Working' white paper.
	• NHSE are likely to set regions or ICBs outcomes within an agenda that will need to be met. It will be up to regions/ICBs to decide how these will be met.
	• LR is working on a briefing paper for the Executive Team.
	• Workwell specific numbers:
	  ○ 225 referrals to date and 140 of these have been signed up.
	  ○ 53 sign-ups in January, making this the best month so far.
	  ○ 35 participants awaiting triage.
	  ○ Hovering around 70% conversion rate but has dropped to 61% due to number awaiting triage.
	• Risk (low) that between October-December 2024 we profiled a target of 350 and recruited 87. We're projecting to recruit 360 between January-March this year, against a profile target of 555. When speaking to DWP, they noted this but also said that BNSSG is one of the best regions nationally, and only one other region is hitting targets. It was also noted that we are going from a standing start, whereas the ICB who is hitting their targets is utilising an existing service.
	• The papers that were sent out include EDI data and where we are attracting participants from and the main referral routes as well. Key to note that we currently seem to be receiving referrals from mainly health organisations or health routes rather than through the original job centre routes which means we can fit quite easily into the ecosystem of other provision that is available, e.g. through skills connect or local authorities.
	• Risk of a projected underspend of £250k – a plan has been put together for this spend which was approved by the Workwell Steering Group and are confident that there won't be an over or under spend by the end of this financial year.
	• Recently recruited a Health Liaison Officer who has linked the service in with three treatment pathways and is expanding this, as well as working with GP practices to add Workwell as a link to both Fitnotes and EMIS.
	• Received £89k worth of funding from DWP, working with the Combined Authority, intending to use this to develop a Work Skills and Health Strategy.
	
	Comments and questions were raised as follows:	

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	• AM asked what can we learn from the best performing? LR confirmed quarterly meetings are held to take learning from this and will bring information back to the group. **ACTION.** • AM asked in terms of best practice, where would the referral pattern be and what does good look like? LR noted that what good looked like hasn't yet been laid out by the funding guidance and is very much in a test and learn position. The aim is to be opening other lines of referrals from Primary Care teams, Treatment Pathways, Pain Fatigue Pathways and Musculoskeletal Pathways. Roughly 60/75% referrals are coming from health-related areas, then elements coming from community and only a small number are coming from Job Centre Plus. • JH made a note to say thanks to LR and the wider team as this is a huge agenda that we do not anticipate going away. This is part of the 'Get Britain Working' White Paper and health will play a key feature in that it is likely to take the work and the project outside of the workforce sphere, and why LR will be bring a paper to the Executives. This will come back to our agenda on a regular basis as a People Committee. • JC reiterated thanks to LR, and asked if we have an idea on how it could impact if we're just successful for our own System rather than beyond? Thinking about how we fix things and still line up with the Government agenda in terms of our own workforce. LR noted that more work is needed to be done and are meeting with Sirona to support them and flagged that more work needs to be done with Social Care. They have a target of 3,000 that they are expecting to hit.	**LR**
08	**People Programme Board Minutes** JH presented to the committee. The following points were noted: • JH requested that going forward we attach the People Programme Board (PPB) and Strategic Workforce Oversight Group (SWOG) minutes/notes and actions in future so colleagues can see governance trail through. **ACTION**. • Monitoring report on what organisations are holding and sharing of best practice and actions are taken forward. Focus has been on temporary staffing and productivity. • Had an update on the leadership and management framework and the code of practice which has been shared with NHS organisations to give feedback about the regulation of managers. This will have an impact on performance management and how risks are escalated. More details to	**GH**

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	follow and will bring to the ICS People Committee once we know the impacts and when the implementation is due. • Level 7 apprenticeships were signalled as a risk to NHSE, and we have written a letter on behalf of our System to NSHE regarding the removal of the level 7 apprenticeship levy as this will have a significant impact on our workforce. • System People risks – PPB hold these risks and are updated regularly as part of our governance, and sit in the workbook. • Escalation process for risks – anything that scores over 15 gets put on the ICB register. This month Oliver McGowan training has escalated to that level but since this is now expected to be brought down again.	
09	**Social Partnership Forum Reestablishment** JH presented to the committee. The following points were noted: • At our previous meeting we had received a request from our trade union colleagues to re-establish the Social Partnership Forum (SPF), which has now been actioned. • One meeting has been held since our last meeting as a committee with great attendance, and thanks were noted that our CPO provider colleagues attended as well. • We have reshaped the Terms of Reference (TOR) to show that this is a social partnership forum with a strategic workforce lens and is a space for us to work through with our trade union colleagues some of the biggest strategic issues that will be impacting us as a whole system. • Conversations will be held on agency and temporary staffing, but also moving to one workforce, the cultural work we're doing and the movement of staff. • The forum will meet quarterly. • JH will provide updates to this committee. No questions, but JC noted that it's good it's back on track.	
10	**Hot Topics / Risks or Matters for Escalation** <u>Stopping Work/Shifting Priorities</u> - LK raised a question that there has been good discussion in this group today and wanted to understand do we ever stop anything and if so how? JH has said we had to stop work due to 30% staffing cuts in the ICB and re-evaluate where our resource was. Some requests from NHSE we did say no to or limited as an ICB. From the System lens the drying up of workforce development funds meant we had to decide priorities and mainstream initiatives. JH flagged that next year it may not be as easy as it has	

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	been and that there are likely to be difficult decisions for us all next year in a wider sense of the System as well as in a workforce sense as to where we may pause and stop work. JC mentioned that if there are areas where we could stop work as there may be a better way, then we should be talking about it in this group. JH also noted that there's an opportunity around economies of scale. National Health Service Procurement Slavery and Human Trafficking Regulation - JC wanted to raise that there's a National Health Service Procurement Slavery and Human Trafficking Regulation 2024 consultation that's closing in a few weeks. It may be one that we need to find out where it sits and what questions we should be asking about how our Systems are dealing with recruitment agencies with the modern slavery lens.	
11	**AOB** • JH raised that the ICB board is having a seminar session in February around what it means to be thinking about the intention of an anti-racist system, with a view to an agreement in March • JH noted that elective reform papers have been published and these do have workforce implications (including temporary and bank staff implications) and expect to see this as part of the workforce planning narrative next year and will be coming up in People Committees.	
	Date of next meeting: Wednesday 26th March 2025, 1500-1700.	

Georgina Hawkins,
Programme Officer,
Date: 31/01/2025