BNSSG Integrated Care Board (ICB) People Committee Meeting

1. Minutes of the meeting held on 23rd October 2025 at 14:00 – 16:00, via Microsoft Teams.

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member – People (Chair) BNSSG ICB	JC
Alison Moon	Non-Executive Member – Primary Care Committee, BNSSG ICB	AM
Ellen Donovan	Non-Executive Member – Quality and Performance, BNSSG ICB	ED
Jeff Farrar	Chair of the BNSSG ICB	JF
Jo Hicks	Chief People Officer, BNSSG ICB	JH
In attendance		
Calais Hutchins	ICS Workforce Equality, Diversity and Inclusion Manager, BNSSG ICB	CH
Cath Lewton	Exec PA to CPO and People Support Officer (note taker), BNSSG ICB	CL
Lara Reading	People Business Partner, CSU	LR
Sam Hill	Senior People Business Partner, BNSSG ICB	SH
Apologies		
Aishah Farooq	Associate Non-Executive Member for Bristol, North Somerset and South Gloucestershire	AF
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD

	Item	Action
01	**Welcome and Apologies** The above apologies were noted.	
1.1	**Declaration of Interest** No new declarations were made.	
02	**Minutes of last meeting** Minutes from the last meeting on 10th June 2025 were recorded as an accurate record.	
03	**Action Log** There were no open actions to review.	
04	**Job Matching Guidance presented by Lara Reading** LR explained the job matching process was co-developed with Gloucestershire ICB to support organisational change. While BNSSG ICB had previously used a similar process, Gloucestershire had not, requiring adaptations—especially as job evaluation data was not available across both organisations. The process was reviewed by both ICBs' Staff Partnership forums (SPF), with Gloucestershire's SPF scheduled to provide feedback after a presentation. The process is aligned with the organisational change policy, which increased ringfencing to include the current band, one above, and one below. Matching is based on the current substantive post and band. Addendums can be used to reflect extra responsibilities, but only within the same band. Five areas are scored: • Job purpose (30%) • Core functional responsibilities (30%) • Knowledge, skills, and qualifications (15%) • Hierarchical/managerial responsibilities (15%) • Communication and autonomy (10%)	

	Item	Action
	Scoring is based on whether criteria are fully met, partially met, or not met, with half or full weighting applied accordingly. Panels will include HR, SPF representatives, and senior managers/executives from both ICBs. HR will lead the initial sift, using Copilot for data extraction, followed by manual review. Moderation panels with executives and SPF representatives will review and ensure fairness in matching decisions. Slot-ins—where a postholder matches at least 66% to a new post at the same band and meets essential criteria, they are slotted in automatically. Competitive Matching - if more people than posts meet the threshold, a competitive interview is held. If not matched, ringfencing or internal competition applies. Ringfencing - considered for those with similar skill sets who do not meet the slot-in threshold but may be suitable for a ringfenced interview. Internal/External Competition - if not matched or ringfenced, posts go to internal, then external competition, with suitable alternative employment considered for at-risk staff. Visual flowcharts are included in the documentation to clarify each stage. Staff can appeal if they believe they have been incorrectly included or excluded from consideration for a post, as per the appeals policy. This is referenced in the documentation, but not yet in the flowchart, LR agreed to add it. Appeals are available after slot-in decisions and before moving to ringfencing or further stages. AM asked about learning from previous job matching rounds. LR said the process now places greater weight on job purpose and responsibilities, and appeals are available at each stage. LR acknowledged potential challenges where similar roles are banded differently across ICBs, but matching will only occur within the same band. JC emphasised the need for transparency in job description changes and consensus between ICBs to avoid perceptions of unfairness.	

	Item	Action
	ED asked if the process applies to executives. SH confirmed it does, and that independent HR leads from both ICBs will conduct matching for exec roles. SH clarified the distinction between job matching for organisational change and job evaluation, noting that although both use the term "matching," they are separate processes, and this should be clearly communicated to staff to avoid confusion. Moderation panels, including executives and SPF representatives, will review matching decisions for fairness. The process is designed to match job to job, not person to job, to ensure objectivity. Concerns were raised about Gloucestershire staff feeling disadvantaged due to less recent job reviews. The use of addendums and moderation panels is intended to mitigate this. The process is designed to be robust, fair, and transparent, with oversight from both ICBs and SPFs. **Action:** LR to add explicit reference to the appeals process in the job matching flowchart.	LR
05	**Organisational Change update presented by Jo Hicks – Frequency of ICB People Committee** JH proposed moving the BNSSG ICB People Committee meetings from bimonthly to quarterly, citing duplication of work with the newly established transition committee and increased demands on capacity due to additional committees and workstreams. She explained that the transition committee now handles much of the organisational change work, and future governance structures may involve joint or revised people committees as the cluster organisation develops. JH sought agreement from the committee to make the current meeting the last of the calendar year, with the next meeting scheduled for February, and to stand down the December meeting. JF supported the proposal, emphasising the need to avoid duplication and siloed working, and reiterated the importance of adhering to fair and open processes during the merger, without favouring either BNSSG or Gloucestershire.	

	Item	Action
	ED agreed, suggesting similar review for Romcom and highlighting the value of non-executive directors building relationships across organisations to foster trust and counter perceptions of a "takeover." AM supported the reduction in meeting frequency, noting the importance of continuing to meet statutory obligations as an organisation and ensuring that quarterly meetings are sufficient for oversight without creating unnecessary bureaucracy. JH confirmed that the ICS People Committee will remain bimonthly to meet system requirements. **The committee agreed to the change, with JH and JC confirming that clear mapping of responsibilities will ensure nothing is missed during the transition.** **Action:** CL to stand the December committee down to align with the new quarterly format.	CL
06	**Competitive Selection during Organisational Change and Equality and Diversity Representatives (EDR) Training presented by Sam Hill** SH presented guidance for competitive selection processes (competitive match interviews, ring fence interviews, open competition) developed jointly with Gloucestershire ICB colleagues and reviewed by Inclusion Council and SPF. Stressed the guidance applies equally to both organisations, aiming for clarity and fairness in expectations, including job descriptions, person specifications, and interview processes. Highlighted guaranteed interview schemes for candidates with disabilities, armed forces experience, or care experience, mirroring external recruitment best practice. Emphasised the need for reasonable adjustments and inclusive practices, with interview questions provided in advance to support fairness. Introduced mandatory Equality Diversity Representative (EDR) training, a 30-minute session developed by CH, covering the Equality Act, types of discrimination, bias, privilege, and inclusive shortlisting/interviewing. All panel members must complete it.	

	Item	Action
	CH confirmed the EDR training content and its mandatory nature for interview panel members. JF raised concerns about unconscious bias in selection processes, noting previous organisational change disproportionately impacted Black and minority ethnic staff. He suggested involving Tracy Joliff (IAG chair) for process check and challenge, as her expertise could help identify issues others might miss. He clarified that having a diverse panel is not enough; the process itself needs robust challenge and review. **AM** asked what support is provided to candidates, especially those from underrepresented groups, to improve their chances of success in competitive interviews, referencing known disparities in interview outcomes. SH noted previous interview and CV writing sessions offered and suggested more targeted support for protected characteristic groups could be developed, possibly in collaboration with CH and Tracy Joliff. SH confirmed every interview will include an EDI question, aiming to recognise lived experience and commitment to equity. CH stated that lack of trust and confidence in the process is a barrier for black and brown colleagues, and that EDR training aims to address privilege and build trust, though more is needed. She emphasised the importance of candidates feeling valued and supported, not just technically prepared. JC suggested asking about lived experience in interviews to better understand candidates' perspectives, especially as reporting issues are often underrepresented. **Action:** SH to consult with Tracy Joliff (IAG chair) for check and challenge on the competitive selection process and EDR training, ensuring robust review for unconscious bias and inclusivity and to develop targeted support for candidates from protected characteristic groups in competitive interviews.	SH
07	**ICB WRES and WDES Reports for approval presented by Calais Hutchins** CH provided a detailed analysis of WRES and DES data, highlighting both progress and ongoing disparities. Key areas were: • Disability declaration rates are at their highest, but unknowns have decreased, suggesting previous underreporting.	

	Item	Action
	• Clinical bands 8C to VSM have no staff declaring a disability; non-clinical lower bands have higher disability representation. Board-level disability representation is low, with a significant unknown category. • Recruitment data shows underrepresentation of disabled applicants, though proportionality improves at shortlisting but drops at appointment. Relative likelihood of non-disabled candidates being appointed is 1.24, nearing equity. • No formal disciplinary cases for disabled staff, but higher reports of harassment/bullying. Perceptions of equal opportunity and satisfaction are similar between disabled and non-disabled staff, and most report receiving reasonable adjustments. However, career progression for disabled staff remains limited. • Recommended actions: targeted positive action for disability in higher bands, zero tolerance for discrimination, improved reporting, better data collection (especially intersectionality), and continued flexible/hybrid working policies. **WRES Data** • NHS data groups as White, BME, or Unknown; CH provided a more granular breakdown. • BME staff are concentrated in lower bands; no racial diversity in clinical bands 8C and above. Board is 66.7% White, 16.7% BME, 16.7% Unknown. • High BME application rates (34% Asian, 32% Black), but significant drop-off at shortlisting and appointment. White candidates are 2 times more likely to be appointed from shortlisting than BME, 8 times more than Asian, and 11.5 times more than Black candidates. From application to appointment, White candidates are nearly 49 times more likely to be appointed than Asian or Black candidates. • No formal disciplinary cases for BME staff, but higher reports of harassment/discrimination than White staff. • Recommended actions include inclusive recruitment e-learning, overhaul of recruitment processes (especially shortlisting), anti-representation training at all recruitment stages, targeted in-house upskilling for underrepresented groups, anti-racism	

	Item	Action
	training for leaders, improved data collection, and policy/process review to remove bias. ED praised the clarity of the data, called the disparities "shocking," and suggested sharing the simple stats with the board. She questioned whether the issue is skills/qualifications or lack of support for BME candidates and raised concern about ongoing bullying of disabled staff. CH commented that as people do not have to list reasons why they have not been taken through to shortlisting it makes it difficult to get this information. AM echoed the need to focus on the recommended actions, noting that the actions are relevant for both steady state and organisational change. She emphasised the importance of supporting underrepresented groups through competitive processes. CH noted that the new way of presenting data makes year-on-year comparison difficult but will allow for better measurement of progress going forward. JH agreed the actions should be part of the transition committee's work and suggested consulting Tracy Joliff for a sense check. She emphasised the need to maintain focus on EDI work during organisational change and to compare with Gloucestershire's data. SH highlighted that the EDR training and anti-racism leadership programme are direct responses to the data. She noted that anonymised shortlisting may disadvantage those unfamiliar with NHS application norms and that bullying/discrimination is reported in staff surveys but not through formal channels, indicating a need to improve staff confidence in reporting. JC suggested mandating feedback for unsuccessful candidates to better understand decision-making and address disparities. **Action:** CH and SH to consult with Tracy Joliff for a sense check on the proposed actions related to WRES and DES data, ensuring the actions are robust and appropriate before integration into transition committee work and organisational development plans.	
08	**Update from the Inclusion Council (25th September) presented by Sam Hill** SH gave an overview of the Inclusion Council, highlights were: • Discussed and provided feedback on the competitive interview guidance and Employee Diversity Representative (EDR)	

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	training, suggesting amendments and improvements to ensure inclusivity and effectiveness. • All staff networks are being proactive, with the Disabled Staff Network notably providing strong feedback and initiating fortnightly peer support groups for members. • The Proud Network is interested in collaborating with its Gloucestershire counterpart, aiming to strengthen cross-organization inclusion efforts. • The Empowered Network updated on Black History Month activities, including a bring-and-share lunch event and ongoing work to support Black and minority ethnic staff. • The Council reviewed the latest Workforce Race Equality Standard (WRES) data, which had already been presented to them by Calais Hutchins in a previous session, reinforcing the need for action on race equality. • Updates were shared about an upcoming staff event in December, focused on connection, reflection, and celebration, as part of ongoing efforts to maintain staff engagement during organisational change. Overall, the Inclusion Council's discussions closely mirrored the main committee's agenda, ensuring alignment and reality-checking of inclusion-related initiatives.	
09	**Update from the Staff Partnership Forum (SPF) (9th October) presented by** JH provided a summary of the previous SPF meeting, outlining the principal highlights: • SPF reviewed and discussed the job matching process, competitive selection guidance, and the Pregnancy and Baby Loss Policy, aligning with items already covered in the main committee. • An update on organisational change was provided, which is a standing item, ensuring staff are kept informed about the current position and national updates. SD also communicates similar updates weekly via "Have We Got News for You." • A key discussion focused on the new data protection sharing agreement (DPIA) with Gloucestershire ICB, allowing restricted	

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	HR staff to access employment records for organisational change and transition purposes. Honorary contracts are in place for those with access, and staff can opt out by exception. Sensitive data like disciplinary or appraisal records are excluded from sharing. Information about this agreement is available on the staff hub, with wider communications planned. • Discussed the upcoming staff event on December 10th, which will be a "connection event" rather than a recognition awards ceremony, based on staff feedback. The event will focus on reflection, celebration, and social connection, with over 60 staff already signed up.	
10	**Policies:** • **Pregnancy and Baby Loss – National Framework** LR explained that the policy is based on the NHS People Policy national framework and has been adapted into the ICB's local template for accessibility. It has already been reviewed by the Corporate Policy Group and SPF. The main purpose is to provide support and clear signposting for staff experiencing pregnancy or baby loss, supplementing existing maternity, paternity, and adoption leave policies. No significant changes were made to the national content; the focus was on ensuring appropriate language and accessibility. The Staff Partnership Forum responded positively to the policy. AM asked regarding about the timeliness of the policy's review, as it was last reviewed by SPF in September 2024 but only now brought to the committee. LR explained this was due to a missed step in the approval process, not an issue with the policy itself. The policy is expected to be aligned with Gloucestershire ICB, as it is a national framework, but confirmation is needed. AM emphasised the importance of formally checking Gloucestershire's position for all policies going forward. EM raised the need for a robust, centralised policy register and oversight process, especially during transition, to prevent future delays or omissions. JH agreed to ensure this is addressed in governance workstreams. LR confirmed there is a central policy	

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	register, but this new policy may have been missed initially; it is now included. **The committee supported the policy, recognising its value in providing support and visibility for staff affected by pregnancy or baby loss.**	
11	**Workforce KPI Metrics (Quarter 2) presented by Lara Reading** LR provided a summary of the shared slide deck outlining key elements: • 16 staff left during Q2, the highest in the past four quarters but not outside expected variation. Reasons included end of fixed-term contracts (4), promotions (4), education (1), and one due to incompatible relationships (case reviewed and understood). No major concerns identified. • Exit Questionnaires had a 56% completion rate (9 of 16 leavers), an improvement over previous quarter. Feedback was generally positive, with some leavers citing career progression as a factor. • Three new staff joined: two on fixed-term contracts (expected during change) and one permanent clinical role. • Turnover started at 16% and declined to 11.4% by period end (about a 5% reduction over 12 months). Excluding fixed-term leavers, turnover drops to 8.2%. • Statutory/Mandatory training compliance remains steady at around 82%. Alison noted the Office of the Chair and Chief Executive's compliance dropped by 6% and role-modeling should be better. • Sickness Absence sees a slight increase in both long-term and short-term absence, with about 9–10 long-term cases. Reasons are mixed (personal and work-related stress). HR is closely supporting affected staff and managers. Comparison with other ICBs shows similar or lower absence rates. • Fewer performance management cases, with only one formal and a few informal cases; focus is currently on managing sickness absences. • Flu Vaccination uptake appears good via Sirona clinics and voucher schemes, but exact figures are not available.	

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	Encouragement continues, especially as other providers have seen declining uptake. AM queried the flu vaccination offer and uptake, asking if the offer had gone out, what the uptake was, and how it compared to last year, noting the importance due to a tough flu season. LR explained that uptake data is hard to track due to multiple routes (Sirona clinics, vouchers), but anecdotal evidence suggests good uptake. JH added that system-wide monitoring is ongoing and that all staff are encouraged to get vaccinated. AM asked about the drop in statutory/mandatory training compliance in the Office of the Chair and Chief Executive, emphasising the need for this group to be role models. LR acknowledged the compliance drop and said she would follow up. SH agreed to relay the feedback to the relevant manager and noted that small directorates can show large percentage swings if one person is non-compliant. JC noted that the People Directorate's annual turnover was 2.8% above target and asked if this was due to the trauma of being at the HR front line. LR clarified it was due to fixed-term contracts ending, not substantive staff leaving. **Action:** SH to relay feedback to the Office of the Chair and Chief Executive relevant manager via Colin Burlison the talent and learning manager regarding the drop in statutory/mandatory training compliance.	SH
14	**Hot topics/Risks/ Matters for Escalation or Communication** • JH reported receiving a letter from NHS England leadership requiring all organisations to adopt the International Holocaust Remembrance Alliance's working definition of anti-Semitism and to ensure anti-racism work explicitly includes anti-Semitism. The ICB will publish this and integrate it into ongoing anti-racism efforts. More information will follow as the letter was received recently. SH noted that, based on recent Equality and Health Impact Assessment (EHIA) data, no staff have declared Judaism as their religion, which may reflect reluctance to disclose due to concerns about treatment. This will be considered in future anti-racism and anti-Semitism work. • JH updated on the risk regarding the Oliver McGowan mandatory training program. The region will not offer Tier 1 training from April 2026 but plans to procure it from April 2027. The ICB may retain its current function for an additional year as	

	Item	Action
	a commercial offer to the system, pending business case approval. This provides a year's extension for staff involved, but the situation will need to be revisited next year.	
15	**Any Other Business** None were raised.	
	Date of next meeting February 2026	

Cath Lewton with the assistance of Copilot
Executive PA to CPO and People Support Officer
October 2025

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

ICS People Committee

Minutes of the meeting held on Wednesday 24th September 15:00 - 17:00, via MS Teams

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member, BNSSG ICB (Chair)	JC
Alison Moon	Non-Executive Director, BNSSG ICB	AM
Bryony Campbell	Executive Director Transformation & Strategy, One Care	BC
Jan Baptiste-Grant	Non-Executive Director, AWP	JBG
Jean Scrase	Group Director of Learning and Workforce Development	JS
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Linda Kennedy	Non-Executive Director, UHBW	LK
Lorraine Francis	Councillor for Eastville	LF
In attendance		
Cath Lewton	Interim Programme Officer, BNSSG ICB (minute taker)	CL
Corry Hartman	Strategic Workforce Lead, BNSSG ICB	CH
Julie Walsh	Associate Director for Workforce, Sirona	JW
Linda Ruse	BNSSG Training Hub Programme Manager	LR
Simon Bailey	Strategy and Planning Co-ordinator, BNSSG ICB	SB
Trisha Quashie-Boney	Associate Director of Strategic People Business Partnering, NBT	TQB
Apologies		
Alex Nestor	Deputy Chief People Officer, UHBW	AN
Domini Harewood	Interim CPO for Sirona	DH
Jan-Baptiste Grant	Non-Executive Director, AWP	JBG
Jeff Farrar	Chair of BNSSG ICB	JF
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Mandy Gardner	CEO, Voluntary Action North Somerset (VANS)	MG
Peter Mitchell	Chief People Officer, NBT	PM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Tim Cooper	Non-Executive Director, Sirona	TC

	Item	Action
01	**Apologies** Apologies listed above.	
01	**Declarations of interest** None were declared.	

	Item	Action
02	**Minutes of the last meeting** Minutes were agreed as an accurate record.	
03	**Action log** The action log was reviewed and updated.	
04	**ICB Updates – Organisational Change and Model Region Update presented by Jo Hicks** JH updated on the following key areas: • Reported that there has been no formal announcement of the BNSSG Gloucestershire cluster Chief Executive due to national delays; all chief executive announcements are on hold nationally. • Explained ongoing work on new ICB functions and possible move to executive layer, but financial pressures and cost of change are unresolved, with decisions pending from region and national teams. • Referenced Health Service Journal coverage of a possible "Plan B" that could extend the change period to 2026/27 or longer, due to cost and national savings requirements. • Noted the detrimental impact of prolonged uncertainty on staff morale, productivity, and life decisions (e.g., mortgages, holidays). • Stated that NHS Employers and trade unions are aware of these issues and are lobbying nationally. AM raised concerns about staff being refused mortgages due to job uncertainty and asked if this is a real issue and how it could be lobbied nationally. JH confirmed it is a real issue, manifesting in both individual choices (holidays, moving house) and financial questions from lenders about future job security. The ICB provides information on where staff can seek financial advice, and that the issue is being raised with NHS Employers and trade unions at a national level. JC expressed support for JH and the team, acknowledging the complexity and uncertainty, and wished for more certainty for staff. **Model Region Discussion** JH presented slides (to be circulated) on the regional blueprint, received the previous day. Key areas highlighted were: • Regions will remain (seven in total), become smaller, and move to a chief executive/non-executive structure, similar to former Strategic Health Authorities (SHAs).	

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	• Timeline for regional change is set for end of 2026/27, with no indication of acceleration. • Outlined the new structure: Department of Health and Social Care (DHSC) headquarters, regions, ICBs (strategic commissioning), and service providers. Regions will provide strategic leadership and oversight and be accountable for health system performance. • Regions will have three core functions: strategic leadership (planning, investment, talent pipelines), performance management (oversight, risk management), and improvement/intervention (direct support to providers or ICBs based on performance). • Noted a shift toward regions engaging directly with providers, not just via ICBs, especially for performance issues. • Highlighted increased freedoms for high-performing providers, with capability ratings now published. • Workforce, training, and education oversight will shift more to region; ambiguity remains about non-clinical training and employee relations. • Regions will assure local staff experience, manage employee relations, and oversee strategic workforce planning, but details are still being worked out. • Emphasised the need for system influence, especially in this region, with roundtables planned for December–February to shape workforce strategy. • Stressed the importance of including primary care, social care, and VCSE voices, as there is a risk smaller voices may be lost in the new structure. JS asked if non-clinical education and training is included, as most references are to clinical training. JH confirmed non-clinical training is yet to be mapped; opportunity exists to influence this area, with more detail expected in the long-term workforce plan. This is in a holding place until November/December. AM stressed the need for clarity on roles and responsibilities and asked if there is genuine opportunity to influence the regional plan. JH affirmed that in this region, there is a real opportunity to influence,	

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	especially after the long-term workforce plan is published. Plans for system-wide roundtables (December–February) to interpret national policies and shape local workforce strategy. Noting national figures suggest one in thirteen acute staff will need to move to community, but local context may require more significant shifts. Stressing the need to build bridges between acute, primary, voluntary, and social care, and to align with the strategic agenda (Healthy 2040). LR voiced concern about ambiguity in regional plans and the risk of smaller voices (primary care, social care, VCSE) being lost. Urged for strong system discussions in Q4 to ensure influence and avoid regression and highlighted the importance of primary care in the neighbourhood model and the need for inclusion in strategic discussions. JC wondered if regional plans are aligning with mayoral areas and larger geographies and stressed the need for clarity and strong advocacy from the committee. JC asked if the ICB People committee should escalate issues to the ICB for stronger representation. JH responded that will take the issue to the People Programme Board, report back on barriers, and advise how the committee can help. **Action:** CL to circulate the model region slides that JH presented. **Action:** JH to take system influence and inclusion issues to the People Programme Board, report back on barriers and committee support needed.	**CL** **JH**
05	**Updates from Provider People Committee Reps** Provider updates in which JC requested key risks faced at the moment as the focus. **General Practice Report presented by Linda Ruse and Bryony Campbell, update included:** • Violence and Aggression: Data remains an issue; recent checks show violence and aggression is not currently worse than before but remains a concern. • Winter Pressures: General practice is busy with vaccination season and increased COVID cases, impacting workload. • Contract Variation: New contract requires online consultations and all access methods to be open during core hours from October. Some practices are concerned, and national collective action is possible, but local appetite is unclear. • Physician Associates/Assistants: Role discussions have quieted; a Southwest community of practice may be established for support.	

	Item	Action
	• Funding Issues: Problems with Additional Roles Reimbursement Scheme (ARRS) payments—some overspend, some underspend—impact PCN cash flow. Reduction in SDF funding affects delivery of new initiatives and fellowships. • Practice Manager Event: Successful BNSSG-wide meeting with over 100 attendees, focusing on challenges, funding, and the 10-year plan/neighbourhood model. Strong appetite for inclusion in strategic discussions. • Succession Planning: Offers for sharing staff across PCNs and agreements for business continuity are in place. **UHBW and NBT (Bristol Hospital Group) update provided by Linda Kennedy, update included:** • Group Formation: Jenny Lewis appointed as Group Chief People and Culture Officer, starting soon. Interim site leadership teams in place; group operating model consultation to begin in October. • Financial Controls: Both trusts face financial challenges; UHBW paused external recruitment for three months, MBT tightened controls. Mars scheme implemented, with 65 staff scheduled to leave by end of October. • Bank Pay: Initial decision not to implement change award is under review due to union pressure; final decision expected soon. • Employee Relations & Industrial Action: Climate remains tense; recent resident doctor strikes and further pay ballots underway. • Physician Associates: Work underway to clarify local responsibilities and consult on contractual changes. • Redeployment Protocol: Both trusts signed BNSSG system protocol to support redeployment and avoid compulsory redundancies. • Violence and Aggression: Strengthening response, aligning to national standards, and holding joint workshops for collaborative approaches. Follow-up meeting scheduled; update to be provided at next committee. • Anti-Racism Programme: Joint work to reinforce commitment, with key themes from RES data to be reported to the board in November.	

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	• Appraisals & Staff Survey: Appraisal window closed with high completion rates; staff survey launched with target response rates and engagement plan. • Collaboration Benefits: Joint induction for 616 new resident doctors improved training and allowed earlier ward duty; leadership development programmes are being aligned. • Awards: Group shortlisted for Nursing Times Workforce Awards and NBT for Employer of the Year. **Sirona Care and Health update provided by Julie Walsh, update included:** • Sickness Absence & Turnover: High levels reported; improvement programmes started in April have made progress, but challenges remain. • Violence and Aggression: Identified as a key factor in retention and absence, especially in inner city areas; additional support and buddying implemented, increasing resource strain. • Sponsorship Restrictions: Home Office changes have reduced access to support worker resource pools, creating future pipeline concerns. • Podiatry Workforce Gaps: National issue impacting Sirona; task and finish groups established to address skill gaps as service demand rises. • Patient Safety Links: Workforce gaps (e.g., podiatry) are being monitored for patient safety risks, highlighted in operational performance meetings. **AWP and VCSE alliance submitted written reports in their absence.**	
06	**Workforce Monthly Monitoring Report presented by Corry Hartman** Areas of focus were: • Staffing Numbers: The system is currently about 500 staff above plan, mainly due to increases in substantive and bank staff. This is viewed positively, as having more staff than planned is preferable to shortages. • Turnover Rates: The overall turnover rate is on a downward trajectory, now at approximately 11%, which is below the planned target. This is seen as a positive development. At the	

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	provider level, UHBW is below 10%, which is considered exceptional, while Sirona's turnover, though higher, has improved from over 15% a year ago to about 13.5%. • Sickness Absence: Sickness rates are at 4.9%, slightly above plan, with a seasonal increase expected as winter approaches. This trend is not considered abnormal but will be monitored. • Vacancies: There are about 1,900 vacancies across the four main providers, equating to a 7.4% vacancy rate. Most providers are at 8–9%, but UHBW stands out with a vacancy rate below 3%. • Temporary Staffing Expenditure: – In August, there was a £2.3 million overspend on temporary staffing, with a notable £1 million increase in bank spend attributed to the impact of industrial action. – Year-to-date, agency spend is on plan, but bank spend is £4 million over, resulting in a total temporary staffing overspend of £3.9 million. – Despite these overspends, the monthly average expenditure on temporary staffing is £2 million less than last year, and 50% less than two years ago, reflecting significant progress in reducing reliance on temporary staff. • **General Practice Workforce:** – 42% of GPs are under 39, which is positive for future workforce sustainability. – 70% of general practice nurses are over 40, raising concerns about succession planning and the need for proactive measures. – Non-clinical staff in general practice also show a high age profile, with 55% over 55, highlighting another succession risk. • Benchmarking: Compared to national averages, the system has more staff per 10,000 population, but is slightly under the regional average except for nursing, where it falls below the health ratio. AM raised the issue of the high proportion of older nurses in general practice and the need for succession planning, suggesting further breakdown of age data to identify hotspots. CH acknowledged the issue, noting it is common across the region and that general practice nursing requires experienced staff. Agreed to further analyse the data and explore succession planning needs	

	Item	Action
	LR confirmed awareness of the age profile issue, especially for non-clinical staff. Noted that while there is a good inflow of new nurses, experience gaps remain. Explained that younger nurses often move to acute settings for better maternity benefits, then return later. Mentioned a retention project and plans to drill further into workforce data, including evaluation and output from ongoing projects. BC stated that the system does not yet know what the ideal age/experience mix should be, but highlighted existing staff-sharing agreements and business continuity measures to support resilience JH noted that temporary staffing is now managed by a cap system, and that regional teams may begin engaging directly with providers where caps are exceeded. Emphasised the importance of monitoring this area as regional oversight increases.	
07	**Healthier Together 2040 – Strategic Intentions presented by Simon Bailey** SB explained Healthier Together 2040 is a long-term system strategy aiming for sustainable health and care, focusing on prevention, hope, and improved outcomes over a 3–15-year horizon. The first targeted cohort is working-age people with multiple health needs (approximately 5,300 individuals), who are high users of NHS and wider services. This group is expected to grow by 50% over 15 years, making current models unsustainable. Highlights included: • Discovery and Evidence Review: Included academic literature, population insights, and engagement with about 80 professionals across the system. Ten design principles were established, such as addressing the "causes of causes" (e.g., mental health first), working relationally, and focusing on what matters to individuals. • Co-Design and Testing: Involved three design events, focus groups, and iterative feedback with professionals and people with lived experience, especially from deprived communities. Clinical Model and Strategic Intentions: • Person-Centered Approach: The model centres on the individual, emphasising relational care, trust-building, and enabling clinicians to work at the top of their skills. There is a focus on addressing mental health first, as evidence shows this can drive benefits for people with multiple health needs. • Health and Wellbeing Plan: Proposes a single, digital care plan shared across organizations, moving away from disease-specific pathways and reducing duplication/conflict. This plan	

	Item	Action
	would be based on what matters to the individual and the professional, providing one version of the truth. • Outcome Measures: Intends to broaden outcomes beyond clinical metrics to include patient experience and patient-reported outcomes, aligning with the 10-year plan. There is recognition that new ways of working, and new metrics will be needed, and that this is a developmental area. • Integrated Care Teams: Envisions shifting expertise from acute to community settings, using MDTs and digital/virtual reviews to deliver care flexibly and efficiently. This includes flexible working, digital enablement, and supporting clinicians to deliver care in new ways. • Workforce Implications**:** Highlights the need for new roles (e.g., care navigators, social prescribers), career pathways, and training for both new and existing staff. There is a focus on supporting staff through change, not just pipeline development, and on engaging education providers and the training hub. • Healthy Workplaces: Suggests engaging employers, expanding occupational health support, and recognising that many in the target cohort work within ICS organisations. There is an opportunity to offer occupational health to carers, volunteers, and small organisations Actions and Next Steps: • Attend People Programme Board to discuss and develop a workforce chapter aligned with Healthier Together 2040 strategic intentions, integrating national frameworks, local pilots, and ongoing transformation. • Further development of outcome measures, digital/AI strategy, and workforce development plans, with ongoing engagement of education providers and system partners. • Ongoing monitoring of workforce implications, including succession planning, training needs, and the impact of role changes on service delivery and staff retention. • Continued engagement with system partners, including voluntary sector, education providers, and employers, to ensure the model is co-designed and responsive to evolving needs. LK asked about data alignment and confidence in measuring progress. SB acknowledged this is a development area, with plans to build on existing outcome measures and expand their use but noted it's a journey into new territory. LK also asked about the role of AI; SB said digital and AI tools are in scope but must support humanistic	

	Item	Action
	care, reflecting public feedback about the importance of trust and human connection. LR Highlighted the critical role of education, training, and workforce development, especially for general practice. She expressed concern about the risk of losing key roles (e.g., social prescribers) due to workforce pressures and asked for assurance that both pipeline and existing staff development are being addressed. SB and JH confirmed that workforce development is a priority, with a workforce "chapter" being developed for the People Programme Board, and that the plan will address both new and existing staff. JC noted 'Shine a light on Care' report has recently been published which has been commissioned by WECA, BCC and others. This would be worth looking at as have a section on what is needed in terms of mental health needs requirement. JC will send the report to SB. **Action:** JC to send the 'Shine a Light on Care' report to SB.	**JC**
08	**Strategic Workforce Oversight Group (SWOG) – a highlight of areas of interest. Noting no People Programme Board has been held since the last committee meeting.** JH noted that SWOG met yesterday, and the notes will be distributed at the next meeting. JH announced merging the Temporary Staffing Group and One Workforce Group to reduce duplication and improve capacity.	
10	**Hot Topics / Risks or Matters for Escalation** AM updated that the transition committee for the new BNSSG-Gloucestershire cluster have met once, focusing on introductions and terms of reference. The next step is for committee chairs to connect and align structures, but progress is limited by the lack of a chief executive appointment. This creates uncertainty and makes it difficult for leaders to plan. There is recognition that some committees across the merging ICBs are already aligned, while others differ in name and function. Work is needed to harmonise these as part of the transition. The absence of a confirmed chief executive for the new cluster is a significant risk, impacting decision-making and the ability to move forward with integration. No new risks were formally escalated.	

	Item	Action
11	**AOB** No Additional items raised.	
	Date of next meeting: Wednesday 26th November 2025, 1500-1700.	

Cath Lewton with the assistance of Copilot
Executive PA and People Support Officer/Interim People Programme Officer
Date: September 2025