BNSSG Integrated Care Board (ICB) People Committee Meeting

1. Minutes of the meeting held on 12th February 2026 at 15:00 – 17:00, 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
Dave Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Ellen Donovan	Non-Executive Member – Quality and Performance, BNSSG ICB	ED
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
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
Jeff Farrar	Chair of the BNSSG ICB	JF
Jo Medhurst	Chief Medical Officer, BNSSG ICB	JM
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 23rd October 2025 were recorded as an accurate record.	
03	**Action Log** Actions were updated.	
04	**Update from the Staff Partnership Forum (3rd February) presented by Neil Turney** NT provided a concise update on recent SPF activity, noting that engagement remains consistently strong despite the pressures of organisational change. SPF continues to function as a constructive forum for raising staff concerns and maintaining open dialogue between management and trade union representatives. He highlighted that SPF participation has expanded through the inclusion of Managers in Partnership (MiP), represented by RS, whose involvement brings broader national insight from working across ten ICB areas. SPF discussions have focused heavily on voluntary redundancy (VR) and wider organisational change. NT reported strong appreciation for the support and guidance provided by JH and the HR team, particularly in relation to drop-in sessions, VR queries, and maintaining clear communication with staff. He emphasised that staff feel well supported during what is an emotionally and operationally challenging period. NT noted an emerging concern: the impact on staff who are not applying for VR, particularly once outcomes are announced and workloads begin to shift. Staff are anxious about potential increases in responsibility, changes in team composition, and the risk of inheriting unfamiliar or additional tasks. He also described a “wave pattern” of stress and uncertainty among staff as each stage of the change process unfolds.	

	Item	Action
	SPF has reviewed the consultation outcome for VR and will engage with forthcoming documents relating to the next phase of organisational change. ED thanked Neil for his update, noting that SPF feedback aligns closely with themes emerging across the committee's earlier discussions, offering reassurance about organisational self-awareness and transparency. JC echoed this, thanking Neil and emphasising the continuing importance of SPF as a source of honest staff insight during transition.	
05	**Update from the Inclusion Council (IC) (22nd January) presented by Jo Hicks** JH explained that a key topic at the Inclusion Council was the future status of staff networks as the organisation moves into the new cluster arrangements. • There is clear intention to continue all existing staff networks through the transition • The aspiration is not simply to maintain them, but ideally to broaden membership as BNSSG merges into a wider cluster workforce • Preserving staff networks is seen as essential to: – Maintaining safe spaces for minoritised groups – Supporting cultural continuity – Providing ongoing peer support – Offering insight and challenge to the workforce agenda She emphasised that inclusion and lived experience voice must remain embedded in the new governance structure, not treated as an "add-on" during organisational change. The second priority discussed at the Inclusion Council related to the Time to Talk Team, a peer-based internal support offer. • The team provides additional emotional, wellbeing and reflective support for staff. • However, many staff remain either unaware of the service or unclear on how to access it. • The IC identified the need for greater visibility, including: – More consistent signposting – Showcasing who the Time to Talk ambassadors are – Embedding referral reminders into manager conversations – Using staff networks as channels to increase awareness	

	Item	Action
	She noted that this theme strongly echoed the staff survey findings and the wellbeing discussions earlier in the People Committee, demonstrating good triangulation across organisational intelligence sources. JH advised the committee that beyond these two priority areas, there were no additional concerns requiring escalation. The IC remains stable, constructive, and actively engaged, despite the organisational turbulence. She reiterated that staff networks and the IC are important cultural anchors and would play a meaningful role in supporting staff as the organisation enters its next structural phase.	
06	**Workforce KPI Metrics (Q3) presented by Lara Reading** LR presented the Workforce KPI metrics for Quarter 3 (1 October – 31 December 2025). She noted that the period reflects ongoing national organisational change, voluntary redundancy applications, and high levels of uncertainty, all of which influence workforce patterns and must be considered when interpreting the data. Key areas were: • The overall headcount remained stable at 461, with very little movement • 4 starters in total • 3 on fixed-term contracts (primarily maternity cover) and 1 substantive nurse assessor • There were 6 leavers in total, 2 due to fixed-term contract completion and others for promotion or work-life balance reasons • 1 dismissal on ill-health capability, following an extended period of support LR explained that managing leavers during VR windows is highly sensitive, especially when individuals on long-term absence are also applying for VR. Turnover figures were presented as: • 9.9% rolling turnover (12-month period) • 6.8% when fixed-term contracts are excluded Lara noted that turnover remains suppressed due to: • Staff awaiting VR outcomes • Reduced availability of NHS vacancies nationally	

	Item	Action

	• A general preference for stability during a complex organisational landscape
	
	Sickness absence was identified as the most significant area of concern.
	• Quarter end absence rate: 4.29% (target = 3%)
	• Early January ESR snapshot: improved to ~3.29%
	• Long-Term Sickness
	• Makes up almost 3% of the workforce
	• Primary causes:
	  – Stress and anxiety
	  – Bereavement
	  – Chronic medical conditions
	• Cases remain complex and resource-intensive to manage
	• Short-Term Sickness
	• Predominantly seasonal:
	  – Cold, cough, flu
	  – Other respiratory illnesses
	
	BNSSG's position mirrors Gloucestershire ICB, which also reported around 4.2% absence at quarter end.
	
	• Stress, anxiety, and depression remain the leading causes of long-term absence.
	• This matches patterns reflected in:
	  – The Staff Survey
	  – The PSED report
	  – SPF feedback
	• Pressure is expected to increase as organisational change enters panel and selection phases.
	Some positive signs were also noted:
	• Several staff returned quickly following brief stress-related absences
	• Managers are signposting wellbeing resources effectively
	
	EAP utilisation remains high and is viewed as positive.
	Most common themes:
	• Anxiety
	• Low mood
	• Relationship pressures
	Lara attributed the high usage to:
	• Effective promotion
	• Staff comfort in accessing support
	• Heightened emotional impact of organisational change
	
	Statutory and Mandatory Training compliance levels remained steady at approximately 87%.	

	Item	Action
	LR provided an update on casework: • 1 active grievance • Several long-term sickness cases ongoing • Two tribunal cases now scheduled for January 2027 (postponed from 2026) The tribunal hearings will require witness preparation and support during peak transition activity adding to pressure on HR and operational managers. Raj Uppal from the HR team, has been delivering: • Line management training • Change-related support sessions These have been delivered across both BNSSG and Gloucestershire ICB. Feedback has been positive, with line managers valuing practical guidance during a difficult period. AM asked whether the tribunal cases pose additional organisational or reputational risk. LR confirmed that no significant new risks are identified but the main concern is capacity, given tribunal work overlaps with organisational change timelines JH raised a significant risk area: • South Central & West CSU is running its own VR programme, with pressure to release staff by the end of the financial year • This may destabilise business-critical services BNSSG relies on, especially HR and transactional support Actions underway: • A dedicated transition workstream is monitoring risk • TUPE planning is progressing for CSU staff whose work is dedicated to BNSSG functions JH emphasised the need to protect HR capacity during change, describing it as a “priority risk”. Ellen asked how the HR team was coping. JH acknowledged the team is extremely stretched but holding up through mutual support. RS reinforced the stretch, noting: • HR has been exceptional, particularly LR’s work • BAU will need to pause • Transition work is not short-term • Significant effort will be required through to November, even after April’s cluster formation	

	Item	Action
07	**Organisational Change presented by Jo Hicks** JH provided an update on organisational change, focusing on the need to update recruitment guidance as the programme moves into a more complex phase involving VR outcomes, matching, panel decisions, and forthcoming cluster arrangements. She reminded the committee that recruitment restrictions have been in place since March to protect fairness and ensure staff at risk have priority access to roles. With VR windows now closed and significant workforce movement imminent, the guidance needs strengthening to ensure: • No external recruitment blocks redeployment opportunities • Vacancies remain available for staff displaced through organisational change • Recruitment processes remain legally compliant and aligned with cluster transition • Managers receive clear, consistent direction She confirmed the revised guidance will likely extend elements of the recruitment freeze, add clarity on exceptions, and act as a tool to manage workforce sequencing during transition. The guidance will be shared with SPF and Inclusion Council, then implemented by the executive team, given that no further People Committee meetings will occur before cluster formation. JC asked whether the guidance would work for both pre- and post-cluster phases. Jo confirmed it must, as structural realignment continues through November. AM emphasised the need to manage expectations for staff and managers already fatigued by prolonged change and stressed that clarity and fairness must be at the forefront. ED raised concerns about HR capacity to manage enhanced recruitment controls alongside VR, tribunal work, and casework. JH acknowledged the pressure but confirmed HR will maintain oversight. RS highlighted the extreme workload on HR, confirming that BAU will need to be paused and that the transition period will be a “six-month marathon,” not a short-term intervention.	
08	**Reports presented by Calais Hutchins:** • **Gender Pay Gap** CH began with the Gender Pay Gap, reporting a snapshot workforce of 497 staff as of 31 March 2025, comprising 371 females and 126 males. This year’s results showed: • Mean gender pay gap: equivalent to £5.79 per hour • Median gender pay gap: £3.40 per hour, and the preferred metric for interpretation	

	Item	Action
	She explained that the pay gap continues to be shaped by structural workforce patterns, particularly: • Women being significantly overrepresented in lower pay quartiles • 83.6% of part-time roles held by women • Only 6.04% of males working part-time • Women representing 82.91% of Quartile 1 (lowest paid) but 58.82% of Quartile 4 (highest paid) She noted positive movement: improved female representation in upper quartiles and alignment of actions to existing Equality, Diversity and Inclusion (EDI) objectives. • Associated Actions • Reduce the gender pay gap year-on-year • Increase female representation in upper quartiles • Improve inclusive recruitment • Strengthen flexible/hybrid working policies • Upskill managers in inclusive practice • **Disability Pay Gap** CH presented the Disability Pay Gap, noting that although not mandated nationally, the ICB chose to publish voluntarily. Findings included: • Mean pay gap: 17.39% (£4.80 per hour) • Median pay gap: 8.92% (£2.46 per hour) Key concerns: • 4.66% of staff with a declared disability were concentrated in the lowest quartile • Only 1.27% were represented in the highest quartile • **Ethnicity Pay Gap** CH noted that this is the second year the ICB has published its ethnicity pay gap. Headline findings: • Mean pay gap: 5.25% (£1.44 per hour) • Median pay gap: 7.34% (£1.82 per hour) Contextual challenges: • Small sample sizes impact stability of the data • Staff from racialised communities are disproportionately represented in the lowest quartile (15%) • In the highest quartile, representation for BME and “unknown” categories were both 8% Linked organisational objectives: • Increase representation of racialised communities in Bands AA and above to 12% by April 2028 • Build an in-house development offer to improve progression pathways	

	Item	Action
	• Strengthen reporting mechanisms related to discrimination and harassment ED asked for clarification on the starting point for the 12% ethnicity representation target. She wanted to assess how ambitious the target truly is and what interventions would be required to achieve it. CH confirmed that the equality objectives were set prior to this year's reporting cycle (2024–25 data) and she is currently mapping year-on-year progress. She committed to returning with full baseline data once this work is complete. JH added that because the equality objectives were set before the organisational change programme was announced, all EDI objectives—including pay gap action plans—will require re-baselining once the cluster is formed and the new organisation takes shape. AM highlighted that the organisation is in a period of significant instability and recommended: • Distinguishing short-term, medium-term, and long-term actions • Prioritising only those actions that must not be lost during transition • Managing expectations for the Board so that commitments are realistic JH agreed and confirmed this would be incorporated into future iterations of the report. JH noted persistent issues in the recruitment funnel, particularly the conversion rate from applicants to successful candidates from racialised communities. JH asked whether intersectional data such as caring responsibilities or parenting status was held. CH confirmed that intersectionality data is currently "patchy" but improving, and is a recognised area for development AM suggested benchmarking comparable organisations to identify best practice for faster improvement. JC confirmed that the committee was satisfied with the reports and associated action plans, subject to the refinements discussed. **All three pay gap reports approved for submission to the ICB Board.**	

	Item	Action
	• **Public Sector Equality Duty (PSED)** CH presented the Public Sector Equality Duty (PSED) report, explaining that it summarises how the ICB meets its statutory responsibilities under the Equality Act 2010 across workforce equality, protected characteristic data, and system-wide EDI activity. She highlighted that the PSED complements, but is distinct from, the Health Inequalities Duty. Key findings included: • **EDS Domain 1 (Population Health):** – Targeted work underway to improve maternity outcomes for ethnically minoritised and high-deprivation groups. – Cardiovascular programmes require stronger outreach and signposting. – A robust Accessible Information Standard (AIS) network and shared platform is needed to improve communication support across the system. • **Workforce trends:** – Workforce diversity is improving slowly, with higher disclosure levels. – Gender, disability, and ethnicity pay gaps persist. – Reports of bullying and harassment have increased significantly, though current reporting methods combine bullying with violence/aggression, limiting clarity. • **Equality objectives:** – Existing objectives will need to be re-baselined following organisational change. ED sought clarity on the rise in bullying/harassment. CH confirmed reports have almost doubled but require deeper analysis to distinguish internal issues from patient-driven aggression. AM emphasised the need for clearer explanation before the report goes to Board. JH noted limitations in national reporting tools and confirmed additional triangulation would be added. **Action:** CH to highlight on slide deck the priority areas, showing short and medium term.	**CH**
09	**Staff Survey presented by Lara Reading** LR presented the results of the 2025 local staff survey, undertaken jointly with Gloucestershire ICB, but reported separately for BNSSG. She explained that this was the first year not using the national Picker	

	Item	Action
	methodology, due to the organisation's state of organisational change. This decision allowed: • Faster turnaround of results • Questions tailored specifically to the change programme • A more direct insight into staff sentiment during a period of high uncertainty The survey ran 10 November – 5 December 2025 and achieved a 52.9% response rate, lower than previous years under Picker but still considered a strong and representative return. LR emphasised that despite unprecedented organisational turbulence, responses showed: • Strong resilience • Pride and commitment to the ICB • Evidence that staff remained anchored to the organisation's values • Improvements across several core questions compared with 2024 Staff most commonly cited: • Workload pressure • Health and wellbeing strain • Uncertainty related to organisational change • A need for continued clear communication She noted that the response period coincided with the height of executive consultation, meaning staff were still unclear about future structures or VR opportunities. Significant improvements were recorded in several areas, albeit with the caveat that neutral options were removed from some questions: • 92.3% felt able to do their job well • 60.8% felt able to meet the demands of their workload — a 22% increase, though influenced by respondents being forced to select agree/disagree • 70% felt supported in balancing home and work commitments Directly comparable questions (including neutral options) showed: • Slight fall in staff feeling enthusiastic about their role • Improvements in staff reporting that working relationships were not strained	

	Item	Action
	• Reduction in staff feeling burnt out, despite pressures Staff reported significantly positive views regarding their managers: • 85% said they receive clear feedback • 91.1% agreed managers take a positive interest in wellbeing • 88.6% felt managers listen to challenges they raise This reinforced the impact of line-manager capability building and wellbeing initiatives. Notable findings included: • 75.5% felt recognised for their work • 73.8% felt valued by the organisation • 76.9% felt safe to speak up (up from 66.8% the previous year) • 69.3% believed action would be taken if they spoke up LR emphasised that this should still be higher and will be a focus area LR highlighted the following year-on-year comparisons: • Bullying/harassment from patients: slight decline in staff reporting "never" experiencing it • Bullying/harassment from managers: improved (96.3% reporting "never") • Bullying/harassment from colleagues: broadly unchanged • Discrimination from managers/colleagues: improvement She stressed these findings must be triangulated with PSED data, which shows rising reports overall—emphasising different definitions used across surveys and system reporting. CH noted that pay gap and PSED analyses reveal different experiences for specific protected groups. Staff reporting never experiencing unwanted sexual behaviour: • From the public: dropped from 98.9% → 92.2% • From colleagues: 98.9% → 98.8% Although absolute numbers remain low, any decline is concerning. LR noted no such cases were reported through internal anonymous mechanisms, and further review is required to understand the discrepancy. Two areas of concern saw significant negative movement: • Musculoskeletal issues: sharp increase in staff experiencing MSK problems linked to work	

	Item	Action
	• Work-related stress: 5.2% decline in those reporting they had not felt unwell due to stress These were flagged as priorities requiring deeper triangulation with: • Sickness data • Workload metrics • Organisational change pressures However, staff do not feel pressure to attend work while unwell, which is a positive indicator of culture. The survey included bespoke questions about the national transition programme. Staff generally agreed that: • They were receiving information in a timely and transparent way • Their managers were supporting their wellbeing through the change • The organisation is committed to staff wellbeing However, free-text comments highlighted: • High anxiety about the lack of clarity on future roles • Concerns about unsustainable workloads • Difficulty finding time to attend wellbeing sessions • Frustration about information being published externally (e.g., HSJ) before reaching staff • Appreciation for the leadership tone, but sadness about the expected loss of colleagues LR presented data showing strong awareness of: • “Have We Got News for You?” updates • HR drop-ins • NHS “Changes” hub • All-staff webinars Lower awareness existed for: • Time to Talk Team • Some wellbeing or coaching offers JH suggested more proactive signposting of Time to Talk, especially during return-to-work conversations or when staff present with stress symptoms.	

	Item	Action
	ED noted that directorate response rates vary considerably and may skew findings. She asked whether the survey team would analyse directorate-level differences. LR confirmed this, though noting capacity constraints. JC raised the risk of acquiescence bias, which may artificially inflate agreement rates. LR acknowledged this and confirmed the approach would be reviewed. AM stressed that MSK and stress declines were "too significant to ignore" and must inform future mitigation. **Action:** JH to ensure more proactive signposting of Time to Talk, especially during return-to-work conversations or when staff present with stress symptoms.	**JH**
10	**New Committee Structure for the Cluster presented by Jo Hicks** JH provided an update on the development of the new governance and committee structure that will come into effect as the organisation transitions into the cluster model and, subsequently, towards full merger. She noted that the work is ongoing and has not yet reached a finalised state. Jo explained that she is expecting a further detailed discussion with Tracey Cox regarding the design and parameters of the Transformation, OD and People Committee, which will replace the current ICB People Committee under the new arrangements. At present, she has had less direct input into the design of the governance structure than some other executive and non-executive colleagues but remains closely involved as the People Directorate lead. JH outlined the emerging expectations for the new committee's remit. She anticipates that its primary focus for the next 12 months will be: • Managing and overseeing the transition from cluster to merger • Ensuring that all staff receive appropriate support throughout organisational change • Maintaining oversight of OD (Organisational Development) work required to stabilise and develop the newly formed cluster • Monitoring workforce risks, wellbeing, and culture through the transition period • Ensuring the organisation is able to "go live" safely and coherently under the new governance framework • Embedding and maturing the new structures in a way that supports staff retention, cohesion, and performance	

	Item	Action
	Jo described this as a "getting us off the ground, good and healthy" remit emphasising that it will be a period of settling, supporting, and stabilising, rather than strategic transformation. JH noted that some elements of the current People Committee remit will continue into the new structure, including: • Workforce assurance • Culture and wellbeing monitoring • Oversight of equality, diversity and inclusion (EDI) commitments • Organisational development and leadership • Workforce metrics and reporting However, she explained that the governance framework is being redesigned, and therefore some responsibilities may: • Move to cluster-level working groups • Shift to the Transformation Directorate • Be rationalised or combined with system-wide functions Final decisions are pending further conversations and finalisation of the cluster governance map. JH emphasised that: • The exact terms of reference are not yet agreed • The structure of reporting lines is still being negotiated • Non-executive involvement is still being determined • Several final design elements will depend on the next meeting with Tracey Cox • More detail to be shared once these discussions are complete	
11	**Hot topics/Risks/ Matters for Escalation or Communication** JH escalated a significant organisational risk regarding recruitment controls during organisational change. The organisation urgently needs updated recruitment guidance due to organisational change and VR impacts. • The current recruitment guidance (in place since March) is no longer adequate for the next phase of organisational change. • With VR decisions, panel assessments, and staff movement imminent, the organisation must tighten recruitment controls to: – Prevent recruitment into posts that may be needed for redeployment – Ensure internal at-risk staff are prioritised – Avoid creating unintended redundancy risks – Maintain consistency and fairness across directorates • New guidance will therefore likely include:	

	Item	Action
	- Extended or strengthened recruitment freeze - Clearer definitions of what roles can/cannot be recruited to - A framework for exceptions - Explicit alignment with cluster transition needs This is urgent because the People Committee will not meet again before the cluster goes live, meaning executive governance must carry the risk forward. The organisation risks destabilising the workforce unless recruitment guidance is updated immediately to protect redeployment opportunities and manage organisational change safely. She emphasised this was a critical risk, not a routine update.	
12	**Any Other Business** None were raised.	

Cath Lewton with the assistance of Copilot
Executive PA to CPO and People Support Officer
February 2026

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 28th January 15:00 - 17:00, via MS Teams

Minutes

Present		
Jaya Chakrabarti	Non-Executive Member, BNSSG ICB (Chair)	JC
Ellen Donovan	Non-Executive Director, BNSSG ICB	ED
Linda Ruse	BNSSG Training Hub Programme Manager, BNSSG ICB	LR
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Linda Kennedy	Non-Executive Director, UHBW	LK
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	
In attendance		
Cath Lewton	Interim Programme Officer, BNSSG ICB (minute taker)	CL
Corry Hartman	Strategic Workforce Lead, BNSSG ICB	CH
Domini Harewood	Chief People Officer for Sirona	DH
Holly Hardy	GP Fellows Lead, BNSSG ICB	HH
Lorraine Francis	Councillor for Eastville	LF
Toria Wrangham	Head of Strategic Workforce, BNSSG ICB	TW
Apologies		
Jan-Baptiste Grant	Non-Executive Director, AWP	JBG
Jean Scrase	Group Director of Learning and Workforce Development	JS
Jeff Farrar	Chair of BNSSG ICB	JF
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Tim Cooper	Non-Executive Director, Sirona	TC

	Item	Action
01	**Apologies** Apologies listed above.	
01	**Declarations of interest** None were declared.	
02	**Minutes of the last meeting** Minutes were agreed as an accurate record.	
03	**Action log** The action log was reviewed and updated.	

	Item	Action
04	**ICB Updates – Organisational Change presented by Jo Hicks** JH gave a detailed update on the organisational change programme currently underway across the ICB. JH explained that the system is in a significant period of transition, with multiple change processes occurring simultaneously. She confirmed that the Executive Directors have now completed their formal consultation period as part of the restructuring process. Alongside this, the associated recruitment exercises have also taken place, and some members present may have been engaged in those interview panels. JH advised that the appointment decisions are now finalised, and the organisation is expecting to issue internal staff communications the following day announcing the newly confirmed Chief roles for the emerging clustered ICB. External communications will follow as appropriate. In parallel with the executive recruitment, JH reported that the governance review required by the organisational change programme is progressing. A new governance model is being developed to support the temporary "cluster year" covering 2026–27. This includes the creation of a Joint Cluster Board, which will function as a formal subcommittee of the two existing ICB Boards during the cluster period. Beneath this, a revised committee structure will be established to align with the new organisational functions and leadership portfolios. JH confirmed that the next meeting of the Committee will be the final formal meeting of the People Committee in its current BNSSG form, and an update on the future governance arrangements will be presented at that time. She also noted that recruitment of the Non-Executive Directors for the new Cluster Board is underway, and this process is ongoing. LK offered supportive comments, acknowledging the heavy workload and pressure faced by executives and Non-Executive Directors during the transition. She expressed appreciation for the work happening "behind the scenes" and recognised that staff at all levels were navigating challenging circumstances. JC echoed this sentiment, offering thanks on behalf of the Committee, and confirmed that members stand ready to assist if needed. **Action: JH to Present the new governance structure for the cluster ICB at the March meeting, including People-related committees.**	**JH**

	Item	Action
05	**Updates from Provider People Committee Reps** Provider updates in which JC requested key risks faced at the moment as the focus. **Bristol Hospital Group update presented by Linda Kennedy, update included:** LK began by noting that the timing of this meeting was challenging, as the Group's own People Committee was scheduled for the following day, meaning many areas were still in flux and subject to imminent refresh. Nevertheless, she highlighted key points from the Integrated Quality and Performance Report (IQPR). She reported that turnover at UHBW continued to decrease, which was positive, but sickness levels had risen slightly due to an increase in flu across the workforce. She also drew attention to statutory and mandatory training compliance: while UHBW was above target, NBT continued to experience difficulty meeting requirements, particularly due to the scale of the Oliver McGowan training programme. This remains a significant area of focus across both Trusts to ensure full delivery. LK then proceeded to outline the six emerging "People Strategic Priorities" that will shape the future direction of the merged Bristol NHS Group. She emphasised that these were not yet a full joint strategy but foundational pillars to guide the work until the merger formally concludes and priorities become clearer. The pillars include: (1) Communities and Partners – reflecting the ongoing shift from hospital-centric care to community-based models; (2) Inclusion, Belonging and Diversity – embedding EDI principles within all organisational practice; (3) "Looking After Our People" – promoting staff wellbeing, speaking up, and kindness as core behaviours; (4) Developing a Future-Focused Workforce – preparing for technological change, digital transformation, and reconfigured corporate services; (5) Leading Change – ensuring clarity and shared purpose during transformation; and (6) "Right Skills, Right Place" – ensuring effective workforce deployment aligned to organisational and population needs. All pillars, LK noted, align strongly with the "four Ps": people, patients, population and the public purse. She also highlighted two final updates: embargoed staff survey results would be shared the following day, with early indications described as broadly positive given the scale of current change; and NBT had	

	Item	Action
	recently received a national award for Best UK Employer of the Year, recognising collaboration between nursing and HR teams. JH noted the importance of ensuring alignment between the Group's evolving workforce priorities, the developing ICB strategic commissioning model, and regional structures. She emphasised that the "three shifts" work would heavily influence workforce requirements and that all partners needed to remain closely connected during organisational change to avoid gaps or duplication. LK agreed, highlighting the challenge of maintaining clarity and line of sight across multiple layers of system activity, particularly as terminology around "place", "neighbourhood", "locality" and "community" remained inconsistent. She emphasised the need for clear definitions and shared understanding to avoid fragmentation. TW reinforced this point, noting that while the system already has strong place-based partnerships, inconsistent language risks undermining engagement and creating confusion. JC asked whether there was a risk of partners assuming others were covering key areas of work, to which TW responded that those already embedded in place-based arrangements understood the structures, but others may struggle to navigate them. Further questions raised included concerns from RL, who reported similar uncertainty among GPs and practice managers about terminology and boundaries. She referenced emerging views that neighbourhoods should be understood as models rather than fixed population sizes, although formal guidance was still awaited. CLF raised the need to ensure social care is not overlooked in community-based workforce planning. JH responded that while the ICB does not commission social care, the system must continue to work collaboratively with local authorities and VCSE partners, especially in preparing for the three shifts. She acknowledged the uncertainty created by changes to the ICB's "system convener" role but stressed the need for joined-up planning. **General Practice Report presented by Linda Ruse update included:** LR provided an overview of current primary care workforce issues and emerging risks, particularly in the context of developing neighbourhood models. LR began by building on the earlier discussion regarding system terminology and neighbourhood design, noting that recent workforce data highlights several trends with significant	

	Item	Action
	strategic implications. She reported that roles funded through the Additional Roles Reimbursement Scheme (ARRS) are increasingly being directed toward GPs and nurses, who were relatively recent additions to the scheme. While this expansion supports core clinical capacity, she cautioned that it is occurring at the expense of personalised care roles, which are declining almost in direct proportion. She stressed that personalised care roles—such as care coordinators, social prescribing link workers and health coaches—are essential to future neighbourhood models and the broader focus on prevention, continuity and community-based care. As such, she emphasised that system partners must remain mindful of maintaining balance within the ARRS workforce mix as longer-term planning evolves. LR also highlighted reductions in pharmacy technician numbers and in the much-discussed GP Associate (GPA) role, noting the influence of national media attention and ongoing uncertainty across the country. Turning to wider system issues, she advised that general practices and Primary Care Networks (PCNs) remain anxious due to the continued delay in confirmation of their 2026/27 contracts. While it is not unusual for contracts to be confirmed late in the financial year, the prevailing financial pressures mean practices feel particularly vulnerable, and she stressed the need for ongoing communication and reassurance. A significant portion of the update focused on the Oliver McGowan mandatory training, where BNSSG remains one of the highest-performing areas nationally. However, acute-sector winter pressures have led to higher 'did not attend' rates and lower forward bookings for February and March, creating a risk to achieving year-end targets. In response to a question asked she explained that "Plan B" involves more targeted outreach, particularly to dentistry and other sectors with historically low uptake and potentially offering places to social care staff where helpful. She noted that this would not improve finances but would support target achievement and ensure training capacity is used effectively. JC, provided an example highlighting lived experience of access barriers for neurodivergent individuals, reinforcing the need for inclusive approaches to training and patient engagement. In response to a question from ED on the implications of not meeting targets, LR clarified that the Code of Practice requires full delivery,	

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	and alternative "light touch" approaches would not be acceptable unless providers could evidence equivalence. She confirmed that any financial impact would be minimal due to reserves and emphasised that the priority is maintaining high performance and system reputation. LR concluded by updating the Committee on the Promising Primary Care programme, Sexual Safety Charter communications and findings from the GP Staff Survey, which will shape training hub priorities around wellbeing, appraisals and leadership development. **AWP submitted a written report in their absence.** **Sirona did not provide a written response and were not able to attend the meeting.**	
06	**Workforce Monthly Monitoring Report presented by Corry Hartman** CH presented a selection of key workforce metrics drawn from the circulated performance report. He began by outlining the overall staffing position across the system, confirming that total staff in post—encompassing substantive, bank and agency roles—was above plan in December, with approximately 550 WTE over the planned level, of which around 400 WTE were attributed to increased bank usage. This trend was linked directly to heightened sickness absence during Quarter 3, driven primarily by flu and influenza classified under code S13. He noted that sickness levels were higher than the same period last year, and although turnover had continued to fall to historically low levels of around 10.5%, turnover would no longer appear as a monitored metric in future NHS England operating plans. Turning to vacancies, he reported that the system continued to hold approximately 2,000 WTE vacancies across Sirona, NBT, UHBW and AWP combined, and that this figure had remained broadly static. General practice workforce levels were described as reassuring, with BNSSG maintaining higher numbers of GPs and nurses per 10,000 weighted population than both regional and national averages, an indicator of comparative strength in primary care workforce supply. He then provided a granular overview of temporary staffing performance, noting that AWP was performing strongly against both agency and bank plans, recovering well after early challenges earlier in the year. UHBW continued to manage agency expenditure	

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	effectively, though bank spend remained more difficult. In contrast, NBT faced significant pressures, sitting £5.5m above plan, with analysis suggesting that this position was unlikely to be recovered by year-end given winter demand, industrial action, and ongoing sickness pressures. CH emphasised that NHS England does not permit systems to plan for industrial action, meaning that providers must absorb its financial impact retrospectively. During the presentation, RS asked whether the significant variance in temporary staffing spend could be partly attributed to the need to run temporary escalation spaces, citing a recent period in which acute providers were caring for 1,000 patients with only 800 beds, effectively requiring staffing for an additional 200 patients. She highlighted that this context must form part of internal and regional scrutiny so that providers are not unduly penalised for pressures outside their control. JC endorsed this point, stressing the importance of understanding how much temporary staffing expenditure would have been unavoidable under any model, and how much would have been spent on agency alone if bank staffing did not exist. ED asked whether earlier spikes in being over plan—in August, September and October—had created a deficit that could not now be recovered, and whether the ICB could absorb the overspend. CH responded that spikes must be balanced across the full financial year, but industrial action distortions complicate this. JH expanded on this, explaining that providers work closely with finance colleagues to mitigate variance across twelve months, but noted that the traditional levers used to reduce bank and agency usage were “drying up”, making the forthcoming national requirement for a 30% reduction in agency spend in 2026/27 extremely challenging. TW added that temporary staffing should not be viewed solely as a financial problem, but as a necessary operational solution, particularly in the context of winter escalation, vacancies, and the need to flex the workforce rapidly. RS echoed this, stressing that hidden system costs—such as running beds for patients in the wrong care setting—should be surfaced to inform system design. The discussion concluded with CH confirming that he and TW were developing a revised workforce insights model, which would move beyond traditional KPIs and align with the future commissioning	

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	requirements of the restructured ICB. This will be presented at the final meeting of the Committee. **Action: CH to present draft Workforce Intelligence Model at March committee meeting.**	**CH**
07	**Violence and Aggression towards staff update on Board discussion and provider actions presented by Jaya Chakrabarti** The Committee received a substantive update on violence and aggression towards staff, introduced by JC, who reminded members that this item followed a significant discussion at a recent Board meeting and a subsequent verbal update to the ICB. JC recapped the national context underpinning the issue, including alarming data showing approximately 200 racist assaults per day nationally and 14.4% of NHS staff experiencing physical violence. She highlighted that GP practices hold important data on individuals known to pose risks, but this information has historically not been routinely shared across the system, limiting opportunities for coordinated risk management. She emphasised that the Committee had a responsibility to consider how system partners could collectively strengthen prevention, management and deterrence of abusive behaviour toward staff. RS was invited to summarise the detailed follow-up discussion held with JC and JH. She explained that a fundamental challenge for clinicians and staff is determining whether a person's behaviour is a symptom of illness—something frontline workers encounter daily—or whether it constitutes abusive or discriminatory conduct that requires escalation and consequence. This distinction, she noted, is often difficult to judge in real time. RS stressed that ultimate responsibility for staff safety sits with each employer, and she welcomed the reflection triggered at Board level on whether all employers are doing everything required to protect their workforce. She noted that Deputy Chief Nurses across the system are reviewing "red-carding" processes—where care may be withdrawn after repeated or extreme abusive behaviour—but that policies are inconsistent and require alignment. She stressed the need for system agreement to prevent situations where one provider withdraws care, and another is left to manage the risk without support. She also highlighted the potential	

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	need for multi-agency planning, including police and social care colleagues, for the highest-risk individuals. RS further updated members that national bodies such as the RCN are increasing their focus on racism and aggression, with forthcoming summits offering opportunities for system representation. JC added that data-sharing approaches must be legally robust, compliant with Caldicott principles, but also pragmatic enough to support frontline safety. She noted that thresholds for determining when behaviour "crosses the line" remain variable and contextual. Members provided several important reflections. TW emphasised that personalised care and community roles—particularly within VCSE organisations—are expanding rapidly, often in small organisations without robust HR or safeguarding structures, meaning these staff may be particularly vulnerable. HH highlighted operational challenges in primary care, where practices lack security and work in small, enclosed environments, making red-card approaches difficult to apply despite high levels of exposure to unsafe behaviours. RS responded that while many cases involve individuals with mental health, substance misuse or emotional crisis, capacity does not grant licence to abuse staff, and primary care colleagues will be fully included in system work. CLF offered powerful insight from a local authority and equalities perspective. She emphasised that behaviours linked to enduring mental ill-health should be distinguished from entrenched discriminatory behaviour, as the latter requires far stronger system responses. She raised concerns based on lived experience that black and brown staff are too often expected to tolerate racist behaviour or allocated to service users known to be discriminatory. She also described the risks faced by social care staff entering homes marked with behavioural "flags", stressing that social care must not be overlooked within the system approach. TW added that while unacceptable behaviour must be addressed, staff also require strengthened capability in early de-escalation and recognising triggers where patients feel unheard or distressed. This reinforced the need for a holistic approach that spans prevention, training, reporting and consequences. JC summarised the discussion, emphasising that protecting staff must remain a system priority throughout the organisational transition and that partners should	

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	reflect on what action and oversight must carry over into the new governance arrangements. The Committee agreed that violence and aggression would remain on the agenda for the final meeting and that further work was required to ensure system alignment, support for employers, inclusion of VCSE and social care, and clear data-sharing pathways. **Action: Ensure Violence & Aggression remains a standing agenda item for the final Committee meeting (25 March) and transfer the Violence & Aggression system workstream into the new ICB governance structure as a legacy action, ensuring no loss of momentum across transition.**	**JH**
08	**Update on People Response to Healthier Together 2040 and next steps presented by Toria Wrangham** JC reminded members that the purpose of this item was to confirm whether the Committee was satisfied with the next steps proposed and assured about the direction of travel. TW presented the item, noting that the People Response had been shared previously. She explained that the HT2040 framework sets out the strategic ambitions for the next decade, with the People Response focusing on how the system workforce must evolve to meet those ambitions. TW described two key approaches underpinning the People Response. The first was the One Workforce approach, which aims to create a unified health and social care workforce capable of working across boundaries and driven by a skills-based, rather than sector-based, model of development. The second approach centred on Work, Health and Good Employment, recognising the role of employment in population health and proposing interventions to strengthen economic participation, health equity and community resilience. To translate these ambitions into operational delivery, she outlined two enabling mechanisms: 1. the development of an Integrated Workforce Development Framework (IWDF), designed to create a clear link between strategic priorities and workforce development activity across nine domains including skills, behaviours, service development, inclusion, and wellbeing; and	

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	2. a proposed Faculty Model, intended to preserve and strengthen clinical and professional voice across disciplines and sectors. She described the recent system roundtable, which brought together representatives from education providers, VCSE partners, local authorities, NHS providers and primary care. The purpose was both to build shared ownership of the People Response and to test the IWDF and Faculty Model. She reported that feedback on the IWDF was overwhelmingly positive. Participants valued the structure and discipline it introduced, particularly its ability to join up individual, service and system-level development needs. A test exercise applying the framework to the challenge of designing systemwide skills pathways demonstrated its potential for real-world use and confirmed appetite for further development. On the Faculty Model, she reported more mixed but constructive feedback. While participants strongly supported maintaining professional voice, there was uncertainty about whether the model should be profession-specific, cross-professional or organised by sector. Some sectors expressed concern about siloing, while others felt strongly that profession-specific identity needed protection. Further development work is therefore required. The roundtable also identified a major and urgent issue: placement capacity across the system. TW explained that demand for placements now significantly exceeds supply, affecting the system's ability to train and grow the workforce required for future models of care. In response, a Placement Group has been established at pace to design a hub-and-spoke model capable of supporting cross-sector placements, aligning with the IWDF and future workforce needs. TW also highlighted the potential role of the Integrated Care Academy (ICA) at the University of the West of England. Discussions with ICA leadership suggest strong interest in helping to shape and host aspects of the Faculty Model and wider workforce development infrastructure. A subgroup has been formed to explore this further. LK asked what the biggest blockers were to moving the proposals forward. TW confirmed that capacity across system partners was a key constraint, as organisations were managing significant change simultaneously. She also said the Faculty Model required further work to resolve issues around structure and funding. JH added that the intention was to embed this work as foundational infrastructure to be	

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	carried into the new ICB arrangements, ensuring continuity across the transition. JC confirmed that the Committee endorsed continued development and proof-of-concept testing of the IWDF and further scoping of the Faculty Model, with updated proposals to return to the Committee and the People Programme Board in March.	
09	**Strategic Workforce Oversight Group (SWOG) and People Programme Board – a highlight of areas of interest.** • **People Programme Board (PPB):** JH began by confirming that there were no new issues requiring escalation from the PPB, noting that the majority of matters discussed at that forum had already been addressed through items earlier on the Committee's agenda. She highlighted that the meeting papers included the PPB minutes for reference and assured members that there were no additional points requiring Committee action at this stage. • **Strategic Workforce Oversight Group (SWOG):** JH set out two key areas of strategic significance currently under consideration at system level. The first concerned long-term workforce supply, with regional workforce intelligence indicating a potential supply shortfall emerging within the next 18 months. She emphasised that this was not solely a BNSSG issue but reflected a wider regional pattern, with indicators pointing to challenges in securing sufficient workforce capacity to meet projected service demands. She stressed the importance of addressing this proactively to avoid "sleepwalking" into a workforce deficit. The group is therefore beginning early discussions about how the system can better influence national bodies, including the need to shape national recruitment strategies, enhance local education pipelines, and strengthen mechanisms for securing a sustainable, home-grown workforce. JK acknowledged this point, signalling agreement with the need for forward planning. The second issue she highlighted related to the cessation of the Trusted Assessor model, a framework previously used to improve discharge flows and support effective use of workforce skills across care pathways. While the programme has formally concluded, she emphasised that there is considerable learning that must be captured and carried forward, particularly as the system moves into the "three shifts" approach and seeks to redesign models of care that support a greater focus on community-based provision. She confirmed that she, alongside colleagues in nursing, social care and workforce leadership, will continue to examine the insights arising from the Trusted Assessor pilots to ensure that the system retains valuable knowledge about	

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	skill-mix optimisation, decision-making at interfaces, and the relationship between acute and community staffing. **Action: JH to feed SWOG's workforce supply risk analysis into March Committee and future People Operating Model work.**	
10	**Hot Topics / Risks or Matters for Escalation** LK brought forward a significant risk which she noted had also been discussed within the Bristol Hospital Group's own governance structures. She explained that the volume, pace and scale of organisational change across the system represented a substantial and growing concern. LK highlighted that this encompassed multiple simultaneous processes, including organisational consultations, restructuring activities, cultural change programmes, the merger within the Bristol Hospital Group, and broader shifts at national and regional levels. She stressed that the system is experiencing "many moving parts" and that the interaction of these various strands of change increases operational and workforce risk, particularly relating to staff anxiety, continuity of service, and organisational resilience. She confirmed that the risk had been added to the Group's risk register and suggested that the People Committee should remain mindful of it. JC agreed that the risk was both obvious and material, acknowledging the intense change pressures experienced across the estate and the importance of naming such risks explicitly to ensure they are effectively managed. JH responded to LK's contribution by confirming that this risk already features across multiple BNSSG risk registers, including the transition risk register, the people risk register, and the Board-level corporate risk register. She emphasised that while mitigations were in place, they could not wholly eliminate the pressures caused by concurrent large-scale change programmes. JH noted that, beyond the transactional and structural aspects of change, the system must also consider the "softer" impacts on staff—such as uncertainty, fatigue, and the cumulative emotional strain of prolonged transformation. She agreed that ongoing visibility of this risk was essential. JC added that as the system moves further into transition, the intensity of these pressures is likely to increase before stability is restored. She emphasised that mitigations alone are insufficient and that Committee members, particularly Non-Executive Directors, stand ready to support the executive team wherever needed. No new risks were formally escalated.	
11	**AOB** No Additional items raised.	

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12	**Final Committee Meeting 25th March – proposed agenda and close down** The Committee received a closing update from JC regarding preparation for the final formal meeting of the People Committee, scheduled for 25th March. JC explained that this meeting will serve two core purposes: first, to complete all remaining business required under the current BNSSG ICB governance arrangements; and second, to ensure a smooth transition of ongoing work into the governance structures of the new ICS entity. She reminded members that several items—such as the violence and aggression programme, monthly workforce monitoring, and routine partner updates—would continue to require oversight at the March meeting, both to meet statutory expectations and to ensure continuity into the post-transition environment. JC invited members to propose any additional items that must be finalised or handed over before the Committee disbands. JH responded by identifying two substantive items that should be added to the March agenda. First, she confirmed that the emerging Workforce Intelligence Model, developed by CH and TW, will be ready for initial presentation. This model is intended to replace the traditional monthly monitoring process and provide a future-focused approach aligned with the strategic commissioning requirements of the new ICB. Second, she confirmed that the Committee will receive the new governance structure for the incoming ICS, including clarity on where People-related functions, responsibilities and decision-making will sit going forward. She highlighted that the new ICB organisational consultation is due to open on 23rd March, meaning some detail will still be evolving, but sufficient high-level material should be available for Committee assurance. LK welcomed these additions, emphasising the need for as much clarity as possible. She stressed that while change is inevitable, Committee members and system partners must understand how the future governance model will operate in order to remain aligned during the transition. She urged the team to share any emerging details—however preliminary—that may assist partners in planning for the new landscape. JC reiterated the importance of ensuring that all critical People Committee workstreams—particularly those involving cross-system collaboration—retain visibility and traction during the transition. She reminded members that although governance forums will change, many of the same partners around the table today will continue to work together in different configurations, and therefore maintaining continuity is essential.	

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	The Committee agreed the proposed agenda direction and confirmed that any additional items arising in February or March should be raised promptly to ensure they can be included.	
	Date of next meeting: Wednesday 25th March 2026, 1500-1700	

Cath Lewton with the assistance of Copilot
Executive PA and People Support Officer/Interim People Programme Officer
Date: January 2026