Sandwell and West Birmingham Hospitals NHS
NHS Trust

PEOPLE & OD COMMITTEE - MINUTES

Venue: Meeting via WebEx **Date:** 25th June 2021, 9:30 - 11:00

Members			**In Attendance:**		
Mick Laverty	(ML)	Non-Executive Director (Chair)	Johanne Newens	(JN)	Deputy COO
			Susan Rudd	(SR)	Assoc. Director of Corp. Governance
Kate Thomas	(KT)	Non-Executive Director	Di Eltringham	(DE)	Deputy Chief Nurse
Frieza Mahmood	(FM)	Chief People Officer	Tom Mytton	Obs.	The Value Circle
David Carruthers	(DG)	Medical Director			
Mel Roberts	(MR)	Acting Chief Nurse	**Apologies:**		
Dave Baker	(DB)	Director of Partnerships & Innovation	Richard Beeken	(RB)	Interim Chief Executive
			Liam Kennedy	(LK)	Chief Operating Officer

Minutes	**Reference**
1. Introductions (for the purpose of the audio recorder)	**Verbal**
Chair Mick Laverty (ML) welcomed Committee members and attendees to the meeting.	
2. Apologies for absence	**Verbal**
Apologies were received from Richard Beeken and Liam Kennedy.	
3. Minutes from the meeting held on 30th April 2021	**POD (06/21) 001**
The Committee reviewed the minutes of the meeting held on 30th April 2021. The minutes were **ACCEPTED** as a true and accurate record of the meeting.	
4. Action log and matters arising from previous meeting	**POD (06/21) 002**
ML requested an update on the rostering system, Allocate. MR reported that the Allocate system had just been transferred to me from FM. They had a meeting scheduled to progress things ASAP on Tuesday and she had a meeting with Allocate planned. ML queried the state of the business case progress. It was clarified that they had the finances and the approval to proceed. A progress update would be provided with a paper at the next meeting. The Committee reviewed the action log. The following updates were made: • *POD (06/20) 003 - Provide a draft 3-5-year workforce plan to the Committee for discussion.* FM reported that she had put an MMUH workforce update on the agenda as requested – see item 6. It was noted that the following four actions would be presented as part of the agenda: • *POD (02/21) 007 - Incorporate monthly leavers and joiners, including a yearly trajectory, into recruitment reports.*	

Monthly leavers and joiners were presented in Recruitment Scorecard: iii. Vacancy Review Process – see item 5. **Closed.**

- *POD (02/21) 007 - Define the strategic goals for retention and the options at retirement age. Feed back the Committee's exit interview comments with the executives.*

  Exit interview comments were covered in Recruitment Scorecard: iii. Vacancy Review Process – see item 5.

  Retirement options were covered in the 'retaining our staff' retention plan update – see item 7. **Closed.**

- *POD (02/21) 003 - Ask the team to define how to gain full assurance that managers were having the recommended wellbeing and supportive recovery conversations with all staff, and report back to tell the Committee how this would be done.*

  A report was presented on Wellbeing Conversations – see item 8. **Closed.**

- *POD (04/21) 003 - Include levels of turnover in future vacancy reports utilising a traffic light system to identify problem areas.*

  A rag-rated system was shown in the People and OD Draft Dashboard – see item 10. **Closed.**

- *POD (02/21) 005 - Provide a trajectory illustrating the Trust's gender pay gap over time for discussion at the next meeting.*

  FM reported this had not been completed this month as expected, owing to workforce capacity issues. She requested that the topic be deferred until the next meeting.

Action: FM/MR to present an update paper on the new Allocate rostering system.

5. Recruitment Scorecard: **i. Scorecard: Vacancy Management** **ii. International Recruitment** **iii. Vacancy Review Process**	**POD (06/21) 003** **POD (06/21) 004** **POD (06/21) 005**

i. <u>Scorecard: Vacancy Management:</u>

FM referred Committee members to the paper and reported the following key points:

- At the end of May, there were 572 vacancies against an establishment of 7180. That brought them down to an 8% vacancy factor.
- There were just over 300 posts in active recruitment at various stages of the recruitment cycle.
- A new vacancy approval process had been implemented in April. The purpose was to support delivery of CIP and their effectiveness agenda. The impact was covered in the review - see part iii. below.
- They continued to target recruitment hotspots as shown in the report. They had further improved their 'time to hire' in May, which was reduced to 81 days against a KPI of 106 days.

ML queried how last time they had been down to 74 days against a KPI of 96. FM reported that they

had substantially increased recruitment and they realised that they hadn't included the over-recruitment that they were doing for doctors and nurses within the figures. Compared to the last figures, time to hire had gone up a little but they were now including bank into the process, which had previously been decentralised and managed by the Trust bank.

ML commented that last time, the vacancy rate had been 7%, so it had gone up rather than down. FM reported that they had also increased the establishment. They had a new tool that was specifically looking at vacancies versus attrition levels and trying to establish if recruitment plans were going to deliver against the expected reduction and gap. She suggested that they did a demonstration of the tool at a future P&OD Committee to help to provide assurance on vacancies and time to hire reducing rather than it just being the result of introducing a new system.

ML queried where the hotspots were in terms of teams, Directorates, and Groups and where the real issues were, in which parts of the process. FM reported that this could be seen in the heat map for Directorates. The main hotspot for recruitment was in Medicine due to the time it took to get a post advertised, from the moment they knew someone was expected to leave. It also took a long time to shortlist. If HR did the central recruitment for them, the problem was in the time it took to get their approval, which was blamed on operational pressures. This impacted on their dropout rate for candidates in a specialty difficult to recruit within. ML queried whether DC thought that was a fair reflection. DC commented that it was shown in the figures in table 9 and that it seemed like a reasonable explanation. They needed to think about how staff could be supported to prioritise those processes to reduce drop out, if that was a significant problem.

FM added that they had found a partner agency to work with who were willing to come in for free for three days a week to support Medicine with an account management approach. They hadn't been able to find that agreement for nurses. Lower-level junior administrative support was what she thought was really required from a coordination perspective. DC reported progress they had made in streamlining the process and the application forms, which previously people had said put them off in applying. They were working on the process after appointments were made and the support provided in their first six months. He hoped this would help the application process for recruiting senior medical staff.

ML commented that not being able to recruit was one thing. Having them drop out after they had accepted due to the recruitment process was another, which warranted greater focus. He asked FM to look at how they would tackle that at the next meeting or the time after that.

KT queried what the explanation was for how page 2, table 1 showed that in May, the number of posts in active recruitment seemed a lot less than the number of vacant posts, whereas in March and April, they were actively recruiting more posts than there were vacancies. FM explained that they had implemented their new vacancy control management process as part of CIP plans for the Trust. They went into a holding period on a weekly basis where they were reviewed by Finance, clinical, and HR colleagues, to determine whether they met the criteria to be recruited. A significant number of posts were held back because they were deemed to be extra capacity rather than funded vacancies. There had been misinterpretations around the definition of vacancy. Cases were then made linked to Acuity or the delivery of MMUH but unfortunately that took a while to work through. Part of the issue was centralising bank recruitment and what was classified as either an existing or new post. Until May, recruitment hadn't happened in a central place. The report ML had requested would explain further the effects of the transition to the new system for comparison purposes.

ML queried whether they measured time to hire by department. FM reported that they had a very detailed report by department and hiring manager. She offered to anonymise the report but explained

that there were individual managers who drastically increased the time to hire. ML agreed this would be helpful to see in order to find the issues they needed to focus on, hidden within the global figure.

ii. <u>International Recruitment:</u>

DE presented the international nurse recruitment update and made the following key points:

- They had been working with HR, the two recruitment agencies HealthSectorTalent and Morgan McKinley, and the Clinical Fellowship Programme at Wolverhampton, to fill over 200 Band 5 nursing vacancies they had at the beginning of June. They had reduced the 200 down to 187.57.
- Over the next three months, they were in the process of having 150 internationally recruited nurses join and 76 locally recruited nurses.
- By September, they anticipated filling all Band 5 vacancies, based on a retention rate of 10%.
- The red list countries' travel ban was beginning to open up. They had 20 nurses arriving from India and Nepal who would start in the second week of July, after their government isolation.
- They had centralised recruitment with a team of nurses to speed up the appointment process.
- Morgan McKinley had a turnaround rate of four to six weeks.
- They had put in pastoral support from a Band 7 post who could put in more ongoing support.
- They had been working well with universities to provide on-site university accommodation.
- The induction period was being shortened to a full week induction 'boot camp' which prepared them for OSCE as well, starting on the wards over the following four weeks in a Band 4 role.
- The 20 vacancies in ED were hoped to be filled by September. Nine staff had been placed into critical care that week.

KT queried the meaning of OSCE. DE explained that this was the strongly regulated clinical assessment that all their international nurses had to complete. Through Morgan McKinley, they came OSCE-ready. Nurses had to apply and go through an IELTS assessment on literacy and numeracy, which was done before they arrived. They had previously had difficulties accessing OSCE but they were now able to block book 30 places per month to speed up the process. Boot camp helped them to prepare. Some of the nurses had already been working for 5 to 10 years, so they arrived with a good clinical background.

MR added that their strategic direction was to develop their own form of Wolverhampton's Fellowship Programme at an academy at MMUH, which would be more cost-effective. At PMC on Tuesday, they had agreed to over-establish for Band 5s, giving them more nursing support across the organisation.

DC queried the expected dropout rate for people who didn't settle or have the expected clinical ability. FM explained that the only previous comparative rates they had were from Australian recruiting two years ago. They had 9% failing to settle because they were recruiting newly qualified nurses. They had learnt the lesson of recruiting experienced nurses from India who represented the diverse nature of the community with longer-term aspirations to settle in the UK. They expected a reduction in the dropout rate and they had mitigated OSCE failures with added support. DE added that the pastoral support would make a difference. They helped them to find accommodation and paid for their first few weeks.

DC queried the benefits of running their own academy, for discussion off-line. FM reported that they worked with other lead providers in addition to Wolverhampton. Their report on a detailed leavers analysis would better help them track people wanting to leave.

iii. Vacancy Review Process:

FM reported that the Committee had asked for assurance that the new vacancy review process that had been implemented had not impacted adversely on vacancy management processes. The paper outlined the aims, the scale of the efficiency and productivity savings of £13 million, a detailed breakdown of turnaround times, and which posts were excluded from the review process. A related action was also incorporated into the report, showing the number of leavers that were expected to be increasing as a result of the pandemic, addressed within the recruitment plan. She outlined the following key points:

- Posts like band 5 and 6 nurses and band 4 Associate Nurse Practitioners were excluded.
- 94% of all posts, equating to 104 of 111 posts reviewed in May, had been turned around on the same day or within one working day. 5% had been turned around within two working days. One admin post had taken in excess of six working days due to leave issues.
- FM, LK, and MR would be reviewing this on a weekly basis.
- Annex 1 showed 371 expected leavers during the last six months. This had reduced compared to 407 for the same period in 2019/20. Previously they had been at 390 for 2018/19. This showed that the number of leavers [FTE] was stabilising and had reduced within the past six months.
- A breakdown was shown by Directorate and staff groups within each Directorate.
- The main reason for 322 staff leaving the organisation was voluntary resignation, followed by 103 leaving for retirement.
- The highest number of leavers by band was band 5 and 6 nurses and band 2 and 3 HCAs.
- A chart showed leavers by length of service. Over 40% of leavers left after less than two years. This required a targeted focus around onboarding, local induction processes, and giving people a realistic job preview, which was essential for their MMUH ambitions.
- Detailed analysis of the reasons for leaving included a break down by ethnicity.
- Annex 2 showed the requested detailed report showing exit interview responses by Group and destination upon leaving, addressing concerns about staff going to other providers.

DB queried whether there was a correlation between the four feedback areas that had mixed responses and the exit survey answers, which made him wonder if they were too busy to care enough. FM reported that they wanted to do a deep dive into the culture locally in the departments because it wasn't reflective of their aspirations for leadership. She thought the split was more reflective of people feeling confident to share concerns about leadership behaviour because it was reflective of the number of cases they had where there had been a formal process in relation to concerns and where they knew informally that people were reluctant to share in case it had an impact on their career progression.

DB queried whether it was possible to benchmark the exit survey to Wolverhampton's. FM reported that their previous exit survey was over 20 years old. It asked very limited questions with multiple choice options. She suggested benchmarking with Wolverhampton on the core indicators. The new staff survey they were introducing from next week would also assist in looking at this, which they were looking at on a quarterly basis.

KT observed that 9% of leavers were from YHP, which seemed like a high turnover for general practice. She queried whether that was from settling in. FM reported that YHP was sometimes still referred to as not being part of their organisation, despite joining 16 months ago. They needed to do some integration

work to make them feel more supported and more part of the organisation.

ML queried when the time to hire period was counted from. FM reported that this included the vacancy review period. After that authorisation, recruitment had it for up to 48 hours. If everything worked well after the advertisement, the total potential time could take a week. They needed to consider this.

ML commented that it was good that they were getting more detailed leavers information but he queried how this would be fed back in to try to avert people from leaving. FM explained that within the Retention Strategic Goals report, they explained a retention tool that would help with tracking and improvement to achieve their retention goals.

Action: FM to demonstrate the recruitment management tool to provide assurance that vacancies and time to hire were reducing, and showing the impact of the new CIP vacancy review process.

Action: FM to report on reducing the dropout rate for Medical staff who left after roles were accepted.

Action: FM to present the detailed time to hire report.

6. MMUH: Workforce update	**POD (06/21) 006**

FM reported that they were in stage 2 of their planning process for MMUH, which meant that all the services they had potentially identified as being able to continue in the 'as is' state at MMUH had been reviewed with workforce modelling processes in place. They had made minor amendments to the modelling. The pick and drop process was about 44% with an additional 15% from the adjustments.

They had embarked on the process with Groups to do bottom-up modelling for the rest of the services that would work differently, where they needed detailed bespoke work on particular professional Groups like the Medical leadership model. They were introducing a new acute care model, seven day working, and different approaches to multi-disciplinary working.

FM referred Committee members to the paper and highlighted the following points:

- They were on track for delivering a paper to the Board in September on the affordability of their workforce plan moving into MMUH and their activity planning assumptions.
- Over the next two months, they needed to do an intensive piece of work in order to achieve that. She was concerned about the pressures on colleagues in Nursing, Therapies, and Community, because they hadn't benefitted from the same dedicated funding that they had been able to get for the Medical modelling, which was supported by HR and external support. The sheer scale of the task was a challenge. There was the additional difficulty of delivering the restoration agenda and supporting staff recovery aims.

MR reported that the Nursing model changes in relation to the timescales was the topic of conversation at the Senior Nursing Forum, mainly because there were still too many pathway meetings going on that were not timed to meet the workforce models. Those models had to be completed to get an accurate workforce and the model timing had slipped. They needed to have a conversation quickly in their MMUH Executive group about some of the timescales.

FM commented that the timings had been based on moving into MMUH in June 2022. Work they would have done last year had been delayed by the pandemic and squeezed in from February, whilst still delivering supports to the pandemic. She reported that they were trying to keep to the original timescale but whether that was realistic would be seen based on subsequent conversations.

DB commented on how comprehensive the seven workstreams were and how it read almost like the whole people plan. He suggested that there might be an 80/20 within it to focus on to make it more achievable. FM commented on the aspirations to fix a lot of things within the move to the new hospital. Some of these things would take a long time with a lot of concerted effort to fix. They needed to show the same degree of realism to the people aspirations that they had shown around the way in which they worked, about what their core priorities would be, and the model of care. A lot of these were interdependent with the introduction of new systems, change in the culture, and a refreshed focus on leadership. She would welcome a future discussion on how they were to focus their efforts and get the right resources to be able to deliver the MMUH programme of activity as one of the top three Trust priorities, with all the things they needed to work on.

DB commented on the need to prioritise and offered his help.

ML commented on the status of the workforce workstream being rated red. He queried what additional resources FM needed to do this properly so as not to miss opportunities, where else they needed resource, and how they could help to make the case to Executive colleagues that this needed to be resourced properly. He suggested that this and recruitment were the top two Trust priorities.

FM reported that they had an indication of what skills they thought they would require because a lot of this was very specialist workforce planning work, including analytical skills, modelling skills, and more programme management coordination. Normally, they would get that from their own improvement team and PMO, their own performance and insights and workforce information teams but they were so significantly spread on other projects and with supporting the pandemic, that this was difficult.

They also needed to build in capacity to support their operational and clinical colleagues. She had requested PMO and improvement team support but they had been told that they weren't a priority because their focus was on getting the building into a state of readiness and doing logistical aspects. She voiced concerns about having a beautiful building and having everything in its place apart from the people knowing what they needed to do and having sufficient numbers. She offered to work on this with DP, MR, and DC to describe what that looked like for the other professional Groups. ML agreed.

ML undertook to feed concerns that the people side wasn't resourced sufficiently back to EMPA and suggested that they fed this back to the Board.

Action: FM to work with DP, MR, and DC to define what additional resource was required to make a business case for help in achieving their MMUH planning and preparation.

7. Retention: Strategic Goals	**POD (06/21) 007**

FM reported that this paper was an update on ongoing retention work since the previous paper presented in February to P&OD and to the Board in December. She outlined the following elements of the paper:

- The Trust turnover rates in April were 14.12%. These were impacted by the pandemic and TUPE transfers. Turnover rates had reduced in May.
- They had revised the detailed analysis they did on leavers.
- They implemented a new exit survey and leavers process, including a pre-leaver process and 'stay conversations' before people decided to leave. This included an anticipatory response to encourage them to remain and to share their concerns more freely.

- Detailed work had been done with the corporate nursing team in particular on retention-focused sub-groups to take forward actions in local areas.
- They had developed the first draft of a retention analysis tool that assessed retention trends across a two-year period of time and apportioned a negative scoring system to those Directorates and departments that were consistently failing on being able to deliver a quality experience that impacted on retention, for example, the extent to which they adopted flexible working practices, levels of sickness absence and incidents, and other quality and safety indicators triangulated with workforce and KPIs.
- A previous action had been to report on what they were specifically working on in order to deliver their commitments to reduce the number of expected retirees. They had revised the first draft of their retirement policy so that the ethos was on supporting people and providing more flexible retirement options rather than it being an exception to allow them to stay.
- A detailed plan had been developed to retain colleagues later in their career, who may be planning to leave sooner as a result of the pandemic and changes to the NHS pension scheme. Staff would be actively supported to get access to complex financial advice.
- They had engaged with NHSE/I as part of a collaborative approach to addressing this within their ICS and nationally to benefit from some additional tools and funding to pursue that.
- They were also looking into supporting staff with things like menopause.
- The new PDR process would focus more on wellbeing and understanding staff's longer-term career aspirations. A lot of meaningful engagement had been derived from that in terms of future retention approaches, alongside looking at their wider flexible working offer.
- They had signed up to the Black Country and West Birmingham ICS flexible working pledge. They would advertise all roles on a fully flexible basis.
- They were in the process of signing a memorandum of understanding across the organisation to allow a fluidity of movement so staff didn't need to leave the NHS altogether.
- Work to improve their recruitment and onboarding experience was underway.
- Tracking improvement on a regular basis would be enabled through the new retention tool. This would evolve into a cultural barometer dashboard. Together with the deep dive into culture, this would make retention a greater part of their people offering and less standalone.

MR commented that despite all the work they had been doing on wellbeing, the work life balance percentages [as a reason for leaving] were 13% to 17% across the 2 to 10 years [length of employment]. She queried whether they had the right level of detail on that to make sure their health and wellbeing offer was the right one, especially picking up on staff experience and flexible working. FM reported that they could provide richer information on the work life balance detail and through the focus groups and the exit survey. They didn't have anything that cross-checked that against whether their health and wellbeing offer was sufficient. What was done at local level could also be tracked back. They needed to make the health and wellbeing and retention workstreams more integrated to assess the impact.

MR queried whether there were specific bands or areas where the work-life balance was reported as an issue. FM reported that it was predominantly nursing, AHPs, and sections of the medical workforce. Some were more personal work-life balance reasons but the majority were the working hours flexibility

and demands that were placed. They could get better on that in the stay conversations.

ML queried how they would know that some of these things were having an impact or had an impact. FM reported that the scoring system in the retention tool would be adjusted to show improvements at a departmental level. The quarterly staff survey pulse checks would also provide feedback on staff experience to reflect the changes that were made and whether the desire to stay score was improving.

ML queried the impact of opening the new hospital would have on retention and whether people were excited about working in a new facility. FM reported that a significant number of staff, particularly consultants and senior nurses, were waiting for MMUH to open so they could be part of the first cohort of people to retire afterwards so they could see that through in their careers. It was attracting younger people who were excited by the innovative, dynamic environment, and people were excited by the teaching and research abilities.

DC added that from a senior medical staff point of view, tax and pension rules were having a national impact on decision-making. Looking at the retire and return option was a good thing to be doing now. Retaining senior medical staff flexibly would need to be balanced against attracting new people.

KT supported flexible working but queried whether the rostering situation would become more difficult. FM reported that flexibility was controversial. People were requesting flexible contracts, not just flexible hours. She suggested moving to team-based rostering and annualised sessions and linking this to productive outcomes, describing what to achieve rather than the hours people had to work.

ML commented that it was looking like they were getting to the point where they could start triangulating the data to be able to focus on making improvements in the right areas.

JN commented that MMUH was motivational for staff but about a third of their employees wouldn't be moving there. It was important to provide all those incentives and the motivational retention focus also on the staff who would continue to work at City and Sandwell, and in the community. Something motivational specifically for staff not moving should be considered.

8. Wellbeing Conversations	**POD (06/21) 008**

FM reported on how many wellbeing conversations occurred that were expected to take place as part of the PDR process, bearing in mind that the PDR cycle wouldn't be completed until the end of July.

- 25.9% had recorded the wellbeing conversation as having happened, for 1578 employees.
- 25.5% had completed their full PDR process, i.e., most of the 1578.

ML queried whether they were sticking with a hard deadline for completion. FM reported that they had originally intended to extend this to August but the Executive decision was to avoid delaying the wellbeing conversations. She suggested that the deadline should be extended and estimated that 60% of conversations would be completed by the end of July based on how things were currently tracking.

9. Revised Absence Target – Trajectory for Improvement	**POD (06/21) 009**

FM reported that they had agreed at the last meeting that sickness absence targets would be adjusted from 3% to 4%, which was still challenging. Plans were in place to achieve this. A trajectory was included in the annexes, with targeted actions to be taken at a Group level, supported by the HR team.

They had reduced sickness absence from its peak of 5.7% in March, down in April, and to 5.34% in May.

ML queried whether they would be better to have a disaggregated stretch target that was more realistic and more achievable per Group or Directorate. FM reported that the Groups had requested this at their last Group Review. Their workforce information manager, with the support of DB's team, had worked out the best possible position Groups could hope for, based on their last eight years of data.

ML requested views on a Group versus organisational target. The following opinions were shared:

- DB commented that 4% was still 9 sick days per 220-working-day year, which seemed like a lot. He suggested that they wouldn't be able to break historical cultures if they adjusted the target.
- MR suggested triangulating the information and doing deep dives into the areas where absence was an issue before setting them a realistic target as a better way of approaching it, without changing the overall target. Deep dives would include conversations with the staff to give them end targets so that everything else was taken into consideration rather than just sickness.
- DC commented on the risk of creep. Some people regarded sick leave as an additional aspect of leave. That level just went up and up. Taking a global Trust-wide picture about the influences on the areas was more important than looking at single numbers and was easier to do.
- FM suggested that having assessed 37% of people's mental health through the mental health assessment process, they knew that reservists and people trying to support the pandemic in critical care from surgery, theatres, and ophthalmology were experiencing abnormally high levels of stress, anxiety, and depression. Although they weren't off sick yet, they were likely to be over the next 6 to 12 months because of the ongoing impact of that if their health and wellbeing plans didn't work. This should be factored into realistic assumptions for absence rates in those areas. The same thing was true in PCCTS, where they had a challenging level of acuity for the pandemic patients they cared for, suffering post-traumatic stress disorder as a result. She queried whether they could target absence in a more compassionate way to recognise this.
- KT supported MR's idea of targeted interventions. There were pockets of culture where it became normalised to be off sick. Trying to unpick what was actually going on was important.

ML suggested that they had a broad consensus that it would be sensible to have something that was fair and bespoke, that might be the result of doing deep dive information gathering and triangulation. He requested that FM looked into this with colleagues to consider a proposal.

DB commented that the entries on the right-hand side of the table in Annex B, particularly for Women and Children's and to some extent for Medicine, were more strategic and leadership based than the other more tactical responses. He endorsed the approach Women and Children were taking and queried whether the other Groups should look to address this more strategically by using these ideas.

ML agreed and queried how this could be shared. FM reported that before the pandemic, they had local sickness absence meetings that were taken to ward, matron, and departmental level with a shared sense of ownership. A lot of sickness absence processes were subsequently centralised and managers were asking HR what was going on with their staff, which didn't make for lasting improvements because staff had a different relationship with HR than with their own teams, who they were letting down.

Action: FM to consider deep dives to gather information and triangulation to propose more fair, bespoke sickness absence targets.

10. People and OD Dashboard	**POD (06/21) 010**

FM described the background of the action at the last meeting to create a new dashboard to replace all the papers that needed to be read to understand what was happening with people in the organisation. She referred Committee members to the colour-coded dashboard and highlighted the following points:

- This visual tool highlighted areas that were struggling, shown in a graphical depiction, and a detailed table providing an analysis of the red areas with a correlation of the indicators.
- They would continue to develop this draft with indicators like safe staffing and speak up issues.

ML asked DC and MR how useful the dashboard would be to them in managing their people.

MR stated that it would be really useful. She would like to see more metrics on quality. Allocate would give them the right staffing metrics to let them hone in on the right things and have an overall picture.

DC agreed that it was a good start. It was useful to be able to look across at the clinical and corporate Groups to identify areas where they needed to focus.

ML identified mandatory training as the missing element, given its importance to things like CQC. He suggested that she collected people's suggestions and then decided which ones to include. The more that was added, the more complicated the view at a glance became. Rag rating ought to make it clear what was unacceptable and marginal. They had been asking for this for a while. If she kept polishing and refining it, it could be very useful.

FM suggested the idea of two pages with the one table showing safety measures that could cause people to leave, sickness absence, incidents, and the ability to speak up, and another table that described what the culture was like. They were trying to separate the people plan vision into things that drove dissatisfaction and destabilisation versus what motivated people and caused satisfaction.

ML suggested grouping things under headings by retention, recruitment, and wellbeing measures. Things like time to hire wasn't there, yet the temptation to keep adding metrics needed to be avoided.

DB suggested that they looked at the triangulation to drive focused interventions. Attrition rates above the onboarding rates in conjunction with the staff survey results could show things like people leaving affecting team morale. ML agreed that the aim was to define where the hotspots were. Being able to look horizontally at which teams to address and vertically to find underlying process or culture issues would be key to identifying things like speeding up parts of the hiring process.

FM confirmed that she would keep looking at this and it would become a regular agenda item. ML thanked her for a good piece of work.

11. National Staff Survey: Trust Actions	**POD (06/21) 011**

FM explained that there were four key areas the Committee, CLE, and Trust Board had wanted to focus on improving from the annual national staff survey results:

1. Health and wellbeing
2. Equality, diversity, and inclusion
3. Team communication
4. Line manager development.

The paper set out an update on what actions had been taken as a result of that locally and centrally coordinated, and what actions had been taken forward. A new quarterly pulse check survey starting in

July was being launched by NHSE/I to help with more regular tracking than the annual survey. They had been given the liberty to change the questions. They were asking staff to assess the extent to which the Trust was delivering the six NHS National People Promises, asking what people wanted to see the Trust focus on from a values basis. This would provide them with some rich information and would support the development of their Leadership Framework and values.

Ruth Wilkins had sent a paper that FM offered to circulate on where they thought they were going to get to in improving their staff survey response rates over the next few years. They wanted to be more proactive about thinking about what was achievable and what good looked like because that was more aligned to their business focus to be outstanding.

DB queried whether the Pulse Survey went any deeper than at the Directorate level. FM reported that she was in active conversations with them to get a more detailed analysis from the previous annual staff survey because they had originally asked for a higher level.

ML queried how they were feeding back to staff what they were doing about what staff told them. FM reported that they had planned a series of WebEx-type events similar to Team Talk and Team Brief where they would invite people and share what they thought those differences were to get a collective conversation going. They were also looking at using the QIHD process for that and to collect feedback. They recognised that they needed to do something about this and Ruth Wilkins was working on it.

DC reported that the monthly consultant forums he had started to improve engagement would provide feedback on the surveys and information from consultants they had received from other sources.

12. Pay Progression 2021/22	**POD (06/21) 012**

FM explained that this report had to do with the requirements for national pay progression changes to be implemented within the organisation from Annex 23 of the Agenda for Change.

Prior to the pandemic, people had not progressed automatically through the pay gateways. They went through a rigorous process of demonstrating that they had performed well, which led to progression.

Because of the pandemic, all Trusts made the decision that with the exception of there being any live disciplinary warnings or formal conduct processes that would impact a decision about that person's fitness to perform their duties, that they should progress people through the pay step review gateways for that financial year and revisit it for next year.

FM had checked with the ICS and national HR colleagues and only one Foundation Trust was considering a slightly adapted approach this year.

The paper set out the 1156 employees by Group this affected, who were going through a gateway in their pay and receiving a routine pay enhancement from May 2021 to March 2022.

In response to ML's query, SR confirmed from the P&OD Committee's terms of reference that they were quorate and that they could make a decision about this. They needed to notify the Board. FM assured the Committee that they were financially funded for it.

The P&OD Committee **APPROVED** the recommendations outlined in the paper.

a. For the Trust to implement the national requirements around Pay Progression as set out within Agenda for Change terms and conditions (Annex 23)

b. Due to the impact of the Trust's response to the COVID pandemic, to agree a variation to the national approach i.e., to allow all employees who are due a Pay Step Review during year 2021/22 to progress

provided that they undertake a PDR review by the end of the PDR cycle (July 2021); they have no live disciplinary sanctions on file and are compliant with their 100Club Mandatory /Statutory training requirements within one month of their pay review date. We suggest not to consider capability performance or absence /attendance at this time and to review in 12 months.

c. Pay Progression Policy to be developed and implemented along with associated communication and guidance for staff and line managers of staff (initially impacted) on how to process pay progression on ESR.

MATTERS FOR INFORMATION/NOTING	
13. Matters to raise to the Trust Board	**Verbal**

It was suggested that the following topics were raised at the Trust Board:

- The P&OD Committee felt that they had insufficient resources to do the workforce planning for the MMUH move. They needed additional resource to do this properly and fully and so that they didn't miss any of the potential benefits of the move.
- The P&OD Dashboard was coming together and providing a good indication of where the hotspots were in terms of Directorates, staff Groups, and even process pressure points.
- The Pay Progression Policy recommendations were agreed by the P&OD Committee.

14. Any other business	**Verbal**

ML thanked everyone for their contributions. There was no other business.

Details of Next Meeting:

The next meeting will be held on **27th August** 2021, **9:30 to 11:00** via WebEx.

Signed …….

Print …….

Date ……