**London People Board – Minutes**

**Monday 12th May 2025**

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| **Welcome and apologies** |
| The chair **Nnenna Osuji (NO)** Welcomed Board members to the meeting. |
| **Review minutes from London People Board held on 13th March 2025** |
| Minutes approved |
| **Supreme court ruling on Women’s Rights** |
| The meeting noted the recent supreme court ruling on Women’s Rights.  Ify Okocha (IO) highlighted growing pressure on CYP services and wider staff concern following the Supreme Court ruling. IO noted the need for the NHS response to consider organisational culture as well as external expectations.  Nnenna Osuji (NO) suggested a local message from the Board to supplement national guidance, which would need to be carefully balanced. Board members emphasised current care challenges and proposed involving staff networks to shape a response that resonates with both staff and service users.  Lizzie Smith (LS) also referenced recent listening sessions within NHSE London region that indicated staff would value a dedicated space for reflection.  Kevin Fenton (KF) proposed a short session for Board members to discuss the implications of national guidance. This was supported by LS and NO, who suggested this could be discussed by the LPB EDI Steering Group on the 16th May.  **Actions**   * LPB EDI sub-group to discuss a supplementary message on behalf of the Board, in collaboration with relevant stakeholders. |
| **Collective London Organisational Change Programme** |
| LS provided an update on the pan-London Change Programme, established in response to structural changes including the NHS England and DHSC merger, and the ICB reductions. The programme is being overseen by the London Region Executive Team, with participation from system Chief Executives and key delivery leads.  LS noted People and HR workstreams are being led by system leaders, with Sarah Morgan leading the HR and People Change group.  The group are working to determine a timeline for the people change process which will ensure that ICBs meet their financial running cost targets by the end of the financial year.  Systems face significant challenges, including the absence of a confirmed and fully funded voluntary redundancy (VR) scheme, and tight timelines to submit change plans to the region by 30 May.  LS noted internal change structures are being set up within NHS England (London), with LS as SRO and Caroline Clarke leading implementation.  A future "Regional Health Authority" (RHA) model is being informally referenced, although no formal model has been confirmed. Complexity is heightened by differing timelines between system and NHSE reforms, and various organisations are operating under different severance schemes (e.g. MARS in some cases). |
| **10 Year Plan** |
| Marie Gabriel (MG) reflected on feedback from local government colleagues, who have been supportive but also expressed significant concern about the wider implications of NHS workforce changes. As the largest employer in many areas, the NHS plays a critical anchor role. Local authorities fear that NHS redundancies will increase demand for housing support, welfare, and other public services, particularly if displaced staff cannot find new employment quickly.  MG highlighted a dual impact: while some health professionals are applying for roles in local government (a potential gain), this may not serve long-term NHS workforce needs, especially as these individuals are often those needed to deliver future integrated care ambitions.  The meeting also noted the broader economic and social contribution of the NHS, particularly efforts by ICBs to support people furthest from the labour market into NHS careers. MG expressed concern that this focus may diminish amid workforce reductions and restructuring, reducing opportunities for long-term unemployed individuals to access meaningful NHS employment.  Lorissa Page (LP) highlighted the importance of continuing to support anchor work, particularly initiatives aimed at helping people into entry-level roles. The meeting acknowledged these roles are likely to reduce, particularly in admin and clerical categories. The meeting discussed exploring new entry points, such as digital pathways, to ensure inclusive access to NHS employment remains viable and also noted the challenge of balancing central government policies on employment with shrinking workforce capacity within the NHS.  The meeting agrees the highlights below:   * **Ask** – Support and enable managers to implement workforce changes responsibly and empathetically. * **Safeguard** – Monitor and respond to the disproportionate impact of changes on particular staff groups, especially those who may already face inequalities. * **Keep** – Maintain unity and morale within the workforce during periods of uncertainty, ensuring communication is clear and consistent.   The meeting also emphasised the continued importance of skills development and mentorship to prepare the workforce for future needs, even in times of change. |
| **Staff Survey Results** |
| Chetna Modi (CM) presented a detailed analysis of the 2024-25 NHS staff survey results, with a specific focus on sexual safety. A deep dive into the data revealed particularly negative findings for staff with protected characteristics, and younger staff. This reinforced earlier conversations regarding the urgent need for cultural change and effective guidance and support across NHS organisations.  CM also highlighted concerns in London Ambulance Service, where incidents of bullying, harassment, and sexual misconduct, especially from the public remain high. Despite these challenges, there has been encouraging progress, with notable efforts underway to shift culture and share learning, offering potential for wider application across the system.  The meeting discussed motivation and morale, noting a growing number of staff expressing a desire to leave their roles, coupled with limited job mobility due to ongoing workforce and financial pressures. CM emphasised the need to support staff through these difficulties, linking motivation directly to the quality of patient care. She also commended the work of the community of practice in creating space for peer learning and scaling good practice.  IO stressed that the coming year would be extremely challenging, particularly given the scale of savings required and emphasised the imperative to maintain staff morale and motivation amid difficult financial decisions.  NO closed by highlighting the need to move from discussion to action, asking what must be done "once for London" in response to these insights. She invited colleagues to reflect and share further feedback following circulation of the minutes. The meeting agreed this data should be used to inform EDI work across the region. |
| **Integrated planning for neighbourhood teams** |
| Andrew Bland (AB) presented the pan-London neighbourhood and borough model for integrated working and confirmed that a shared Case for Change and a Target Operating Model (TOM) had been agreed and would be published imminently.  The London model seeks to ‘Londonise’ national policy by adapting it to the capital’s context. AB emphasised that neighbourhoods, defined as populations of approximately 30-50,000 people, are the frontline of integrated care. These are the places where general practice, social care, mental health, community health, and voluntary sector services must come together to respond to cohort-based needs (e.g. children, frailty, long-term conditions) and place-based needs (local populations).  The meeting noted that the infrastructure and workforce planning required to support these teams is most effective when organised at borough scale (typically <250,000 people). The model proposes a borough-level ‘integrator’ - a lead organisation (often a provider trust) with responsibility for coordination, workforce enablement, and service improvement. This integrator would work across all relevant organisations to establish consistent, shared governance and make the most of shared and pooled budgets at borough level.  AB highlighted that success depends on investing in relationships, developing distributed leadership models, and creating flexible career pathways for staff to move across traditional organisational boundaries. The need to align the NHS’s focus on health with local authorities’ wider mandate around wellbeing, and suggested a joint focus on resident experience and outcomes rather than institutional performance.  The model also introduces a shared improvement function at borough level, enabling neighbourhood teams to access quality improvement support and workforce development tools consistently.  AD noted that while place-level integration must reflect local context, a common framework for neighbourhood and borough working is essential to reduce variation, empower frontline staff, and support sustainable service transformation across London.  **Discussion**  Board members noted the model and its alignment with national policies while reflecting London’s unique needs and highlighted the importance of strong clinical leadership within neighbourhood teams, emphasising the need to involve general practice representatives actively to ensure local buy-in and practical delivery.  The meeting discussed the funding arrangements and how pooled budgets would be governed, with concern expressed about potential bureaucracy slowing progress. AB acknowledged these concerns and explained that the model aims to streamline decision-making through clear borough-level integrators and shared governance frameworks but conceded that implementation will require ongoing refinement.  The group discussed the challenges of workforce availability, particularly in primary care and community services, noting that flexible career pathways and cross-organisational roles are promising but need strategic investment and cultural change. There was also interest in how the model would support addressing health inequalities, with AB noting that tailored neighbourhood teams can be more responsive to diverse local populations and social determinants of health.  Board members stressed the importance of data sharing and digital infrastructure to enable integrated working and outcome measurement, suggesting that borough integrators should prioritise investment in IT systems to support this.  The board agreed that the model represents a significant step towards more joined-up care, but it would require sustained collaboration across NHS, local authorities, and voluntary sectors to succeed.  **Actions**   * AB to circulate the final Target Operating Model (TOM) and Case for Change documents to board members once published. * Convene a working group to explore workforce development plans supporting flexible roles across neighbourhood teams, involving HR and education partners. * An INT item will be brought back to the LPB in 4-6 months |
| **Any Other Business** |
| None raised |
| **Close** |