

**Meeting of the Workforce Committee (Part 1)**  
**(Sub Committee of the Board of Directors)**

**Held on Thursday 29 January 2026, 11.15-13.15**  
**Via Microsoft Teams**

**MINUTES**

<b>Present</b>	Elwood, Jonathan	(JE)	Associate Director of Corporate Governance
	Fadero, Amanda	(AF)	Non-Executive Director (Chair)
	Howard-Jones, Lorraine	(LHJ)	Deputy Director of Workforce and OD
	Leacock, Diane	(DL)	Non-Executive Director
	Midlane, Eilish	(EM)	Chief Executive Officer
	Monkhouse, Oonagh	(OM)	Director of Workforce and OD
	Robinson, Zoe	(ZR)	Deputy Chief Operating Officer
	Sanford, Liz	(LS)	Interim Chief Finance Officer
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
<b>In attendance</b>	Bage, Luke	(LB)	Head of Resourcing
	Butler, Jade	(JB)	Assistant Director of Workforce Operations
	Davidson, Bill	(BD)	Public Governor
	LeWinton, Holly (left 11.50)	(HL)	Senior Clinical Physiologist
	Lonsdale, Jon	(JL)	Assistant Director of Clinical Education
	Patrick-Redhead, Onika	(OPR)	Assistant Director of OD
	Radwell, Adam	(AR)	Head of Workforce Information
<b>Apologies</b>	Atkinson, Angie	(AA)	Public Governor
	Brodowski, Naomi	(NB)	Executive Assistant (minutes)
	McEnroe, Harvey	(HM)	Chief Operating Officer
	Paddison, Charlotte	(CP)	Non-Executive Director
	Taylor, Elizabeth	(ET)	Head of Employee Relations

Agenda Item		Action by Whom	Date
<b>1.</b>	<b>Apologies for Absence</b> The Chair opened the meeting and apologies were noted as above.		
<b>2.</b>	<b>Declarations of Interest</b> There is a requirement that those attending Board Committees raise any specific declarations if these arise during discussions.		

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3.	<p><b>Committee Member Concerns</b></p> <p>No concerns raised.</p>		
4.	<p><b>Minutes of the Previous Meeting – Part 1 – 27 November 2025</b></p> <p>The minutes of the previous meeting held 27 November 2025 were <b>approved</b>.</p>		
5.	<p><b>Matters Arising and Action Checklist – Part 1 – 27 November 2025</b></p> <p>The action checklist was updated.</p>		
6.	<p><b>Board Assurance Framework (BAF)</b>  <i>Update given by Oonagh Monkhouse</i></p> <ul style="list-style-type: none"> <li>• There are currently 2 risks that fall within this committee’s remit, and the paper highlights risk 3733 in particular.</li> <li>• Due to workforce spend and workforce planning being closely tied to the organisation’s financial position—and both the operational and financial plans for the year are still being finalised—it is proposed that the likelihood score for this risk is temporarily increased.</li> <li>• Once the operational plan is agreed and there is confidence that the workforce plan is sustainable, affordable, and aligned with operational needs, the score can be reviewed and potentially reduced.</li> <li>• The committee is asked to consider and discuss this proposal before making a recommendation to the Board.</li> <li>• DL asked what has been done to ensure the controls on pay spend are adequate and robust.</li> <li>• OM responded that the pay overspend is mainly driven by temporary staffing, not by increases in the substantive workforce. Establishment levels match the plan, and any workforce growth reflects planned investment rather than unplanned expansion.</li> <li>• Agency use is now minimal, limited to a few specialist or project-specific posts. Overtime has significantly reduced, now mostly linked to PSIs. Bank spend is the main pressure, largely due to maintaining safe staffing during short-term or unplanned absences, with some variation across services.</li> <li>• A weekly vacancy control panel continues to review all requests. A new divisional-level vacancy panel adds an extra layer of scrutiny before requests reach the central panel – this is still embedding. Overall, there is strong control over vacancies, recruitment and temporary staffing, particularly within clinical areas.</li> <li>• MS added that the oversight of temporary staffing has strengthened, with weekly nursing reviews comparing planned and actual bookings and assessing upcoming needs. This has helped stabilise usage but has not fully resolved the issue.</li> <li>• The main pressures now stem from short-notice absence and higher sickness levels in some areas, which exceed what rosters can absorb and push headroom above the intended level, increasing reliance on bank staff.</li> </ul>		

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	<ul style="list-style-type: none"> <li>• Work is underway to reduce sickness and improve the ability to manage short-notice absence within budget.</li> <li>• Fixed and flexible working patterns also limit the ability to redeploy staff quickly, adding to the challenge. Some inconsistencies in how temporary staffing costs are recorded are being addressed with finance colleagues to improve accuracy.</li> <li>• Controls remain strong, including cancelling temporary shifts at short notice when they are no longer required, supported by continuous assessment of staffing needs.</li> <li>• OM added that there are two main areas of focus for medical staffing. The first is clarifying Health Education England trainee funding flows, with recent discussions held with HEE to understand how funding is allocated. Once this is clearer, stronger controls and better visibility will be introduced, particularly around requests to increase trainee numbers, which is currently a recognised risk.</li> <li>• The second priority is reviewing the size and configuration of the medical workforce, including ensuring the organisation correctly reclaims income when medical staff work elsewhere under SLAs. Finance teams have already identified cases where income was not being received, and this is now being addressed. These areas form the core of the current medical staffing work.</li> <li>• The committee accepted the temporary increase to 16 for risk 3733 and this will be reviewed as part of the annual plan.</li> </ul>		
7.	<p><b>Staff Story</b>  <i>Presented by Holly LeWinton, Senior Clinical Physiologist</i></p> <ul style="list-style-type: none"> <li>• HL was genuinely grateful and surprised to receive the Leadership Award at the 2025 Staff Awards. She had never seen herself as a traditional leader, especially without a senior title, and much of her development has happened alongside a heavy clinical workload. That experience has shaped how she support others and how she's grown into a leadership role within her department.</li> <li>• HL is a respiratory physiologist in outpatients and has been at Royal Papworth for nearly six years, progressing through the bandings during that time.</li> <li>• Leading in a busy clinical environment means supporting people under pressure, whether that's helping colleagues develop or guiding students who are adapting to a new NHS setting. Many arrive with limited clinical experience and face emotional and academic challenges, so leadership often means being a teacher, a source of reassurance, and someone who helps them build confidence.</li> <li>• A recent example is the introduction of new equipment and software in our department. Initially, no one felt confident using it. HL took time to understand the system, not because she had all the answers, but because staff were coming to her with questions. HL was open about what she didn't know and worked through the problems together with the team. That helped the team feel more comfortable, and over time solved issues collectively and rebuilt confidence.</li> <li>• Supporting apprentice students has been another important part of</li> </ul>		

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	<p>her role. Many arrive overwhelmed—new job, new environment, academic pressures, and often far from home. HL realised they needed more than clinical guidance; they needed emotional support, encouragement, and someone to help them grow into confident physiologists. Watching that transformation has been incredibly rewarding.</p> <ul style="list-style-type: none"> <li>• Balancing this with her own clinical workload hasn't always been easy. There are moments when time is tight, but HL tries to stay calm and make space for people, even if it's just saying, "give me two seconds and we'll work it out together." That small pause can make a big difference.</li> <li>• HL has also learned that leadership isn't defined by banding. Some junior staff naturally take charge in difficult situations, while more experienced colleagues may need support when learning something new. Good leadership means recognising individual strengths and adapting to different needs.</li> <li>• For HL, being a good leader involves acknowledging that none of us are perfect, being honest when she don't know something, and creating an environment where people feel respected, able to speak up, and confident that their ideas matter. HL tries to identify strengths in others that they may not see in themselves and give them opportunities to use those skills.</li> <li>• HL advocates for the team in senior meetings, bringing forward their ideas and ensuring their voices are heard. To support this, HL introduced junior staff meetings where they can discuss what's working and what isn't, and we feed their insights into wider departmental discussions. This has given them a stronger voice and helped us understand what's happening day to day on the ground.</li> <li>• DL asked what support HL had for herself, particularly when helping so many others and helping manage their feelings of overwhelm, as taking on all the emotional load of others can be overwhelming for a leader too.</li> <li>• HL responded that initially she didn't vocalise to anyone about what she was taking on but now has people she can approach and speak to about it.</li> <li>• AF that the three qualities that stood out were humanity, compassion and humility. Humility, in particular, is such an important leadership trait, and you've shown it in abundance. It creates psychological safety, and from what you've described, you've clearly built an environment where people feel safe to speak up. The fact that junior staff feel able to escalate concerns and know they'll be heard is incredibly powerful.</li> </ul>		
8.	<p><b>Workforce Directors Report</b>  <i>Updates given by Oonagh Monkhouse, Adam Radwell, Jade Butler, Maura Screatton and Onika Patrick-Redhead</i></p> <p><u>ESR update</u></p> <ul style="list-style-type: none"> <li>• The update moves managers from static, end-of-month spreadsheets to live, accessible data, giving them real-time visibility of key workforce information. The system now shows appraisal and mandatory training compliance, including whether</li> </ul>		

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	<p>items are due, outstanding, or linked to new starters, and all of this can be exported for managers to work through offline.</p> <ul style="list-style-type: none"> <li>• Additional features include: <ul style="list-style-type: none"> <li>○ A staff list with key details such as salary points to support payroll processes.</li> <li>○ Flexible working requests, which teams are beginning to record so future reporting can be developed.</li> <li>○ Declarations of interest and fit-testing information, both visible to managers and staff.</li> <li>○ Links to key reports, such as the latest OEG report.</li> </ul> </li> <li>• The team have also been working on new Qlik dashboards, including: <ul style="list-style-type: none"> <li>○ A staff survey dashboard showing four years of results, comparisons with previous years, colour-coded changes, and the ability to deep-dive into individual questions.</li> <li>○ Views by trust, division, and sub-division, plus WRES and WDES data with trend lines against trust averages.</li> <li>○ A temporary staffing dashboard showing bank, agency and overtime usage against vacancies, currently for nursing and HCSWs, with plans to expand trust-wide.</li> </ul> </li> <li>• The overall aim is to make workforce data more accessible, timely and useful, with ongoing development based on feedback and ideas from teams across the Trust.</li> </ul> <p><u>Attendance Management</u></p> <ul style="list-style-type: none"> <li>• OM and MS met with the critical care leadership team last week to check in on progress and, in particular, to gain assurance around leadership ownership and governance. What stood out was a clear shift in how the senior nursing team, especially the matrons, were taking responsibility for the work. They had prepared the information themselves rather than relying on the Workforce Strategic Business Partner and there was noticeably more energetic and engaged in the discussion.</li> <li>• They were honest about still having concerns about how things will work in practice but compared with our pre-Christmas meeting—where they contributed very little and the workforce team led most of the conversation—the change was significant. It felt like a genuine step forward in ownership. They also reflected that the band 7 ward sister roles are beginning to embed well and are providing the day-to-day leadership that was intended.</li> <li>• There has been a clear shift in accountability and confidence within the team, which is really encouraging. The business partners and the ER team have now been able to get much closer to the root causes of the issues critical care has been facing. Two main workstreams are progressing: attendance and flexible working, where we're now seeing real traction in identifying gaps and exploring different approaches.</li> <li>• We're also seeing stronger collaborative working with trade union colleagues, helping them understand the direction of travel and the support required. Overall, the progress has been very positive, and it's great to see the improvements taking shape.</li> </ul>		

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	<p><u>Leadership Development Programme</u></p> <ul style="list-style-type: none"> <li>• The programme launching in February will introduce the new Line Manager Series, which currently includes five confirmed workshops covering attendance management, appraisal skills, building strong recruitment outcomes, inclusive working relationships, and holding effective conversations. A sixth workshop will be added following the organisation-wide bullying and harassment session taking place next month, once those materials have been developed.</li> <li>• For medical staff, the series will mirror the same structure with one adjustment: the appraisal skills workshop will be replaced with job planning, reflecting their specific requirements.</li> <li>• A question was raised yesterday about the start date, and the agreed position is that the programme should begin in Q3 of 2026–27, meaning it will commence by September. In the meantime, medical colleagues can still take part in the other four workshops.</li> <li>• The revised Leadership and Management Development Programme will be launching in April, and this will be made up of 7 modules, with 3 action learning sets applied to those modules: <ul style="list-style-type: none"> <li>○ Module 1: Leading with compassion,</li> <li>○ Module 2: Influence and impact,</li> <li>○ Module 3: Inspiring performance,</li> <li>○ Module 4: Growth and Conversation,</li> <li>○ Module 5: Change and Cultural Intelligence,</li> <li>○ Module 6: Operation Excellence,</li> <li>○ Module 7: Towards a sustainable future.</li> </ul> </li> <li>• We are developing a passport-style approach to show how people progress through the different development programmes. One option is that completing the Line Manager Series becomes a prerequisite before moving onto the Leadership and Management Development Programme.</li> <li>• Another option is that staff who join from another Trust, or who can clearly demonstrate equivalent skills and experience, could move straight into the leadership and management offer without repeating content they already meet. This gives us a consistent structure, while still allowing flexibility for people with prior experience.</li> <li>• AF asked if this has all be costed and OM responded that these programmes will be resourced by the OD team.</li> <li>• There are three other programmes – Liberating Your Talents, Leading for Inclusion and Transformational Reciprocal Mentoring Programme, which are all charity funded.</li> <li>• DL asked how we ensure this gets embedded into the organisation, for example will there be sessions after the formal training where participants can meet up and share ideas.</li> <li>• OPR responded that the OD team do have follow up sessions and we will make sure sessions are in place for all programmes.</li> <li>• LHJ added that in the leadership programme we've included a 360-degree feedback process. This will give us a baseline of where participants are when they enter the training, and we'll repeat it at the end of the programme, and again six to twelve months later, to assess progress and how well the learning is</li> </ul>		

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	<p>being applied.</p> <ul style="list-style-type: none"> <li>We're also looking at how to incorporate action learning sets, which weren't part of the original LMDP. These will provide opportunities for shared learning with peers. We've already built these into the People Management Development Programme, and we're exploring how we might adapt them for the Line Management Series as well. We haven't finalised that approach yet, but it's something we're actively working on.</li> </ul>		
<p><b>9.</b></p>	<p><b>Internal Audit – Workforce (Job Evaluation)</b>  <i>Update given by Lorraine Howard-Jones</i></p> <ul style="list-style-type: none"> <li>Hopefully the committee is reassured by this audit. It provides moderate assurance on the design of controls – actions which we have already taken forward and are actively working on – and substantial assurance on operational effectiveness.</li> <li>In practical terms, this means that the system is functioning well, decisions are being made appropriately, and outcomes are consistent with national guidance.</li> <li>Crucially, there is no evidence of unfair or inconsistent banding outcomes, which is exactly what the process is intended to safeguard.</li> <li>The committee can be assured that the job evaluation process at the Trust is robust.</li> </ul>		
<p><b>10.</b></p>	<p><b>Guardian of Safe Working report</b></p> <p>Report not received in time – moved to the next meeting.</p>		
<p><b>11.</b></p>	<p><b>Resident Doctor 10-point plan</b>  <i>Update given by Ian Smith</i></p> <ul style="list-style-type: none"> <li>This has already been presented to the Board, partly due to national requirements for it to be formally escalated. We therefore took the decision not to wait, and Luke Williams was able to support the presentation to the Board.</li> <li>There are actions still underway, including conducting a survey of the residents. As this was only initiated three weeks ago, there are no further updates at this stage. As soon as we have new information, we will bring it back to the committee.</li> <li>OM added an issue around Resident Doctor overpayments was reviewed at last week's Audit Committee, following the Board's concern about overpayments to resident doctors.</li> <li>AR provided detailed information, which showed that only three overpayments occurred in the past year. Although any overpayment can feel significant to the individual—regardless of when it happened—the Audit Committee's deep dive found no wider concerns and no need for further action beyond what is already in progress.</li> <li>Audit has therefore addressed the matter raised by the Board, and no additional steps were recommended.</li> </ul>		

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12.	<p><b>Medical Revalidation Annual report</b> <i>Update given by Ian Smith</i></p> <ul style="list-style-type: none"> <li>• The report sets out the regulatory requirements and how we are meeting them, including the structure we have in place for revalidation, the regularity and format of appraisals, and the evidence we collect. It's also important to highlight that we build dedicated job-planned time into consultants' schedules—up to four hours per week—not only for assembling their portfolio but also for undertaking quality improvement, audit, and other mandatory activities. So, structurally, all the necessary elements are in place.</li> <li>• A question was raised about the quality of what we deliver, given that the staff survey—though not broken down by staff group—indicates that many staff do not find their appraisals valuable. In contrast, the feedback we receive directly from appraisees is much more positive. Although the responder group is a subset, the staff survey is also a subset, so the comparison is fair.</li> <li>• Among the doctors who provided appraisal feedback—19 individuals—94% reported that their appraisal supported their personal and professional development, that they found it useful, and that they would be happy to have the same appraiser again.</li> <li>• This suggests that, for those participating in the process, it is working very effectively.</li> </ul>		
13.	<p><b>Education</b> <i>Update given by Jon Lonsdale</i></p> <p><u>Annual NHSE self-assessment</u></p> <ul style="list-style-type: none"> <li>• This self-assessment dates back to the submission made in November last year, and it is provided to this group for information. Overall, the report is a positive assessment, building on the progress made in previous years, addressing earlier improvement actions, and placing us in a strong position.</li> <li>• Included is a summary page, followed by the underlying data that has been lifted directly from the submission. The only point to highlight, rated as a low-level risk, is one area where we declared that we were not meeting the required standard. Because the assessment is binary (you either meet the standard or you don't), we chose to be transparent and mark it as “not met,” even though we are close. This relates to the availability of an IT suite.</li> <li>• While we do not have a dedicated IT suite, the impact is largely mitigated by the wide availability of devices across the Trust. However, these are accessed within clinical environments rather than a dedicated training space, which is why we reported it as non-compliant.</li> <li>• Aside from that, the report reflects a number of strong areas of performance.</li> <li>• Normally, we would expect to meet with NHSE around December to review our submission and discuss their findings. We have not been invited to such a meeting this year, recognising that NHSE is undergoing internal restructuring and may have shifted priorities.</li> <li>• Overall, the assessment places us in a good position, particularly as we look to build further on financial transparency for</li> </ul>		

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	<p>non-medical staff—a natural next step following the strong work completed for medical staff. In summary, it is a positive outcome.</p> <p><u>Oliver McGowan training</u></p> <ul style="list-style-type: none"> <li>• This position statement updates the committee on progress with learning disability and autism training. Since 2020, all CQC registered organisations have been required to deliver this training, with most—around 99%—using the Oliver McGowan programme. We follow the same approach.</li> <li>• Compliance with the initial e-learning element is just over 90%, similar to other organisations. Staff are assigned to either Tier 1 (mainly non-patient-facing; ~160 staff) or Tier 2 (mainly patient-facing; ~1,800 staff). Both tiers require e-learning plus a face-to-face session, which is strictly specified and therefore delivered via external partners, coordinated locally through CPFT.</li> <li>• NHSE currently funds this training, but the funding ends at the close of this financial year, creating a significant financial risk. Regional discussions on future options are underway, but no solution has been identified.</li> <li>• Compliance with the face-to-face element is low (under 5%), though this reflects the broader regional picture. Despite this, the need for training remains critical, as evidence shows that people with learning disability or autism often experience poorer healthcare outcomes, and training improves care.</li> <li>• The paper sets out the financial implications and current position. The associated risks are included on the risk register, including both the training compliance risk and the impact of not having an employed learning disability specialist—two issues that overlap.</li> <li>• LHJ added that this has been added to our cost pressures for the year. Delivering and administering the training—even assuming the required training capacity is available, which remains uncertain—creates a minimum annual cost pressure of around £60,000. This figure does not include the additional £500,000 per year that would be required if we were to backfill staff time. Releasing this level of workforce capacity is therefore a substantial resource impact, with significant financial implications if backfill were needed.</li> <li>• We also need to consider whether the Oliver McGowan approach, while recognised as the gold standard, is financially sustainable for us. This is an important piece of work, and whatever solution we pursue, it would be far more effective to do this collectively as a sector rather than each Trust acting independently.</li> <li>• This morning’s regional meeting was very informative, and it’s clear that all organisations are facing the same challenges.</li> <li>• AF added that we can’t leave this as a non-compliance, but it does come down to balancing the risks. We know that patient care improves when this training is completed, yet we also have other areas of mandatory training where we are non-compliant, and which similarly affect care. It becomes an overall organisational risk assessment.</li> <li>• AF agreed that this isn’t something we can tackle in isolation as a single Trust — it needs a coordinated sector-wide approach.</li> <li>• DL asked if there are alternatives to Oliver McGowan training and</li> </ul>		

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	<p>have other Trusts started to consider having hybrid training.</p> <ul style="list-style-type: none"> <li>• JL responded that across the ICB, no organisations are on track to meet the NHS target of 30% training completion by year-end, highlighting a system-wide challenge rather than an isolated issue. Although various delivery models were explored when the training was first introduced, most ICBs have ultimately returned to the collaborative Oliver McGowan approach, which is well-developed, quality-assured, and supported by established administrative structures.</li> <li>• There is strong regional support for continuing with the CPFT-coordinated model, though this is complicated by the forthcoming merger of three ICBs with different training approaches. A stabilisation period of around six months is anticipated, provided organisations contribute to the shared delivery model.</li> <li>• Overall costs are broadly similar regardless of the model chosen, but the Oliver McGowan collaborative approach remains the most efficient. The key challenge remains balancing significant financial and workforce pressures with the clear need to improve care for people with learning disability and autism.</li> <li>• MS added that the Board should be aware that this is a risk and there is a request to continue and explore training options.</li> <li>• MS and JL to bring back a plan in 2 months' time.</li> </ul>		
<p><b>14.</b></p>	<p><b>Policies and Strategies</b>  <i>Update given by Oonagh Monkhouse</i></p> <p><u>Development of the Workforce Strategy 2026-31</u></p> <ul style="list-style-type: none"> <li>• We're currently awaiting a discussion with Kaleidoscope to help shape the next steps. The link with Kaleidoscope is important, as we'll want to ensure that the workforce strategy aligns with the newly published Trust strategy. A significant amount of information and feedback was gathered during that process, and we want to draw on that to inform the workforce strategy for the next three to five years.</li> <li>• We've offered some dates for a meeting next week and, assuming that goes ahead, we should be in a position to report back around March. That said, there are only so many ways to structure a workforce strategy, and I don't anticipate a radical departure from the priorities we've focused on over recent years—the six strategic aims covering inclusion, compassion, effective and cost-efficient workforce processes, and maintaining compliance with key workforce metrics.</li> <li>• The timeline may also need some reconsideration, given OM is leaving the Trust at the end of February.</li> <li>• A further update will come back in May.</li> </ul>		
<p><b>15.</b></p>	<p><b>PIPR M09 2526 PM&amp;C</b></p> <p>For information.</p>		

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16.	<b>Sub Committee Minutes</b> For information.		
17.	<b>Committee dates and business forward planner</b> For information.		
18.	<b>Any other business</b> No other business.		
19.	<b>Issues for escalation and Emerging Risks</b> There were no issues for escalation or emerging risks.		
	<b>Date &amp; Time of Next Meeting:</b> <b>Thursday 26 March 2026, 11.15 to 1.15pm, via MS Teams</b>		

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Signed

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Date

**Royal Papworth Hospital NHS Foundation Trust  
Workforce Committee**