Royal Papworth Hospital
NHS Foundation Trust

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

Held on Thursday 27 March 2025, 11.15-13.15
Via Microsoft Teams

M I N U T E S

Present	Fadero, Amanda	(AF)	Non-Executive Director (Chair)
	Harrison, Sophie	(SH)	Chief Finance Officer
	Howard-Jones, Larraine	(LHJ)	Deputy Director of Workforce and OD
	Leacock, Diane	(DL)	Non-Executive Director
	Mensa-Bonsu, Kwame	(KMB)	Associate Director of Corporate Governance
	McEnroe, Harvey	(HM)	Chief Operating Officer
	Midlane, Eilish	(EM)	Chief Executive Officer
	Oonagh Monkhouse	(OM)	Director of Workforce and OD
	Eilish Midlane	(EM)	Chief Executive Officer
	Norman, Claire	(CN)	Assistant Director of Workforce and OD
	Paddison, Charlotte	(CP)	Non-Executive Director
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
In attendance	Anderson, Zoe	(ZA)	Head of Talent and Career Pathways
	Atkinson, Angie	(AA)	Public Governor
	Brodowski, Naomi	(NB)	Executive Assistant (minutes)
	Davies, Pauline	(PD)	Head of Management and Leadership
	Foltynie, Emma (left 11.50)	(EF)	Professional Nurse Advocate Lead
	Hotchkiss, Marlene	(MH)	Public Governor
	Iles, Steve	(SI)	Recruitment and Temporary Staffing Manager
	Lonsdale, Jon	(JL)	Assistant Director of Clinical Education
	McClean, Josevine	(JM)	Staff Governor
	Radwell, Adam	(AR)	Head of Workforce Information
	Speed, Nicola (left 11.50)	(NS)	PVDU Nurse
	Taylor, Elizabeth	(ET)	Head of Workforce Operations

Agenda Item		Action by Whom	Date
1.	**Apologies for Absence** The Chair opened the meeting and apologies were noted as above.		
2.	**Declarations of Interest** There is a requirement that those attending Board Committees raise any		

Agenda Item		Action by Whom	Date
	specific declarations if these arise during discussions. No specific conflicts were identified in relation to matters on the agenda.		
3.	**Committee Member Concerns** No concerns reported.		
4.	**Minutes of the Previous Meeting – Part 1 – 30 January 2025** The minutes of the previous meeting held on 30 January 2025 were **approved.**		
5.	**Matters Arising and Action Checklist – Part 1 – 30 January 2025** The action checklist was updated.		
6.	**Board Assurance Framework (BAF)** • Risk 1929 – Low level of Staff Engagement – this has been reduced to 12. The Committee **approved** the reduce in risk. • Risk 1853 – Staff turnover in excess of our target level – this will be reviewed at the next meeting. • Risk 3261 – Industrial Relations/Industrial Action – to be reviewed in June.		
7.	**Staff Story** *Given by Emma Foltynie, Lead Professional Nurse Advocate, and Nicola Speed, PDVU Nurse* • EF is the Lead Professional Nurse Advocate for the Trust. It is a restorative supervision role that was introduced a few years ago into the NHS and it is a requirement for all organisations to have. • The roles of Professional Nurse Advocates (PNAs) and Professional Advocates (PAs) are distinguished primarily by the specific training courses they have completed. The PNA role was introduced by NHS England in 2020, while midwives have been utilising a similar model since 2017. This approach offers a flexible method for providing restorative supervision and also supports Allied Health Professionals (AHPs). The training for these roles is at a level 7 course. • These roles support the workforce through four key areas: o Education and Development (formative) o Monitoring, evaluation and quality control (normative) o Clinical supervision (restorative) o Personal action for quality improvement • The normative and formative elements focus on how we learn and develop in our roles, helping to identify areas where staff may need additional training and support. • The primary focus is on the impact on patient care, patient experience, and the methods of delivering that care. Additionally, the emphasis is on personal actions for quality improvement. The		

Agenda Item		Action by Whom	Date
	essence of the RCS model is to encourage staff to bring forward their challenges and concerns. • When NHS England introduced this initiative, they provided guidelines for implementation within trusts. • The original guidance suggested a 1:20 ratio of PAs to nurses. Currently, at Royal Papworth, the ratio is 1:46. • NHS England has recently delegated the programme to the ICS, leading to ongoing discussions about the appropriate ratio. • The Trust has 16 qualified PAs, with 12 available (excluding those on maternity leave). • A significant challenge has been allocating release hours for PAs, as there was no official guidance from NHS England. At CPAC it was agreed that 6 hours per week would be allocated. • As the lead EF's role involves implementing the framework, providing leadership, and being a point of contact for RCS. She supports the team by upskilling members, promoting the role, collecting data, representing the Trust at meetings, and developing resources and an intranet page to aid our work. • Staff often have limited opportunities to reflect while working, so this provides a psychologically safe space to reflect, learn from experiences, build resilience, and develop self-compassion. • There are numerous links for additional support, ensuring confidentiality by not keeping names or records, only sharing feedback themes locally and regionally. The only exception is if there's a concern about harm to oneself or others, which is discussed at the start of the RCS to clarify boundaries. • Participation in RCS is by invitation or self-referral. • Since September, EF has collected 95 pieces of feedback, mostly from nurses. • One piece of feedback indicated a staff member felt both unsupported and supported, suggesting a possible error. Overall, the feedback shows the support has been successful. • Key points include the evidence-based and interactive nature of the support, following a consistent framework with clear role boundaries. • To conclude, 100% of those who experienced the PVDU would reach out again and recommend it to their colleagues. • NS shared her experience working with EF last year after the loss of a colleague. EF's restorative session during the team away day was incredibly helpful, providing a cathartic experience and helping everyone on their feelings and team dynamics. The session was well-received, and there is a plan to have a follow-up session in June. • The confidentiality, safe space, and structured approach have been crucial for the team's recovery and focus. This support has been invaluable, and NS advocates for its wider implementation, though it's not one-size-fits-all. <u>Questions</u> • DL asked if EF had encountered any situations where colleagues have found their first session has not met their needs the first time round and they therefore need to come back for additional support? EF responded that it is not a quick fix, and some staff do		

Agenda Item		Action by Whom	Date
	require ongoing support, especially those off sick due to stress and anxiety. EF is supporting those people with the aim of helping them return to work, and this is not a one-session solution. • DL asked how EF measures her success. EF responded that this is something that is going to be looked at. MS added that when we examine our nursing staff retention rates, sickness levels, and team dynamics, we see that these factors span a broad range. It's not about creating new metrics to measure the impact of EF's role; rather, it's about leveraging existing metrics to understand how her role influences them. This work is essential, though it might sometimes be perceived as the softer aspects that are crucial to staff well-being. • SH asked with considering themes of diversity, such as ethnicity and disability, how might the role evolve over the next year to ensure that staff from various backgrounds, who might not traditionally speak up, can access your services and have the same experience? For example, in critical care, staff from different groups may not always feel they have access to these avenues. EF responded that one of the great aspects of being part of the preceptorship program is meeting our newly qualified staff, including internationally educated staff who have joined Royal Papworth. For instance, one of the nurses from India shared that she felt isolated living away from her family, but through the RCS, she connected with others in similar situations. This highlights the importance of continuing to build these connections and support networks. • AF asked how much time is allocated to undertake the role and EF responded that she has 15 hours per week, which can sometimes be a juggle. • CP inquired about the funding and security of the role. MS explained that the role is financed through the health and wellbeing budget, which is a significant priority in the annual planning for the upcoming year. Additionally, the Trust is cutting back on other costs, such as premium agency, to help support this initiative. • CH asked for assurance on whether there is a return on investment or an economic case that clearly outlines the benefits of this role. MS responded affirmatively, stating that EF presented a selection of slides today, but there is much more detailed information on the outputs of her work. The benefits include staff retention, team collaboration, and sickness rates, along with the reasons behind those rates over time. While it's too early to draw definitive conclusions, EF's work is regularly presented to CPAC every couple of months, ensuring great transparency.		
8.	**Workforce Committee Terms of Reference** • The changes to the terms of reference were **approved**.		

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9.	**Workforce Directors Report** <u>Nurse Career Pathways</u> *Update given by Larraine Howard-Jones* • The original ambition of the programme was to map out pathways, but on top of this with the new nursing profiles that are due to land in the summer, we need to incorporate this in too. • We are working closely with our trade unions to respond to these new profiles. It is essential to shift the focus of our career pathways program immediately to accurately describe the current jobs. This will allow us to quickly map the differences when the new profiles are introduced and identify anyone who may be affected. • Early in phase 2, it became clear that the national NHS Job Evaluation Group would consult on changes to Bands 5-6 nursing profiles in the summer of 2024, with new profiles expected in 2025. This development required the project team to refocus on ambitions a-c to prepare for potential challenges in pay banding accuracy once the national profiles are released. • We estimate that up to 25% of the nursing workforce in bands 4-7 may request a banding review. Handling this volume on a case-by-case basis could overwhelm the evaluation process. To address this, the program pivoted to ensuring all current role profiles are accurate and can be quickly mapped to the new national profiles, allowing the Trust to efficiently identify and address any discrepancies. • As a result, the focus of the Career Pathways Programme has shifted to completing all 165 profile reviews, including job evaluations and development-stage assessments, by the end of April 2025. A dedicated task-and-finish team of workforce professionals and job evaluators, in partnership with trade union colleagues, will manage this high volume. In June, this team will revisit the profiles, mapping them against the new profiles once published. • After finalising the new profiles and addressing discrepancies, the program will return to focusing on ambitions d-h, including ensuring clear development pathways, appropriate training and development, and robust talent management processes. • The next steps are: o By April 2025: Review all nursing profiles and ensure they are correctly banded and do a high-level mapping on individuals to understand whether they are working beyond or within their role profile or whether they are in development. o June/July 2025: Review of roles against newly published national profiles with the task-and-finish team. o Post June/July 2025: Address any banding anomalies or cases requiring back payments in collaboration with trade union partners and local C&P colleagues. o Q4 2025/6: Refocus on ensuring career progression tools, training, and development processes are in place to support staff growth.		

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	Questions • CP asked can you get an education of the planning around the financial impact of this shift recognising that if up to 25% of our nursing staff requested a review, do we understand what that financially means for us as an organisation and do we have a plan for that? LHJ responded that the methodology we implemented is in response to the potential 25% of our workforce requesting a review, which could overwhelm our evaluation service. We are not suggesting that all 25% would have different profiles that would incur additional costs. This estimate was simply to predict the volume of work we might face and to find a better way to address it. Additionally, we've been working closely with our colleagues on the pathways program, particularly in cardiology. We're gaining insights into the roles that have already been evaluated and identifying those that present a risk due to working beyond their band. Many of these individuals are part of a career development and planned development program, but there is a risk for those whose roles have gradually expanded over time. Initially, we estimated this risk at 10%, but we now believe it is less than that. Our finance partners have been engaged in this process, and SH and her team are doing some planning in the background. SH added that the reason we're approaching this work in such a structured manner is to ensure we have a clear understanding of the potential risks. This effort allows us to quantify the risks or understand their profile. Beyond this, the potential national cost implications could be substantial. At the board level, we need to discuss how to align approaches across individual NHS organisations to build consistency. Additionally, we must engage in conversations with the national team about mitigating and managing the financial implications. • DL asked two questions. Firstly, in terms of the recruitment audit do we have an idea of what percentage of hires are currently being audited, and is this providing any insights at the moment? Secondly, regarding the pipeline, we have a healthy pipeline of nurses and support staff, but it is unclear regarding the temporary staffing aspect of the pipeline. For example, the Band 5 pipeline shows 23 + 5 temporary staffing. What does this mean? OM responded that regarding the bank, this means that alongside recruiting for permanent staff, we also have rolling adverts for people to join our bank and do temporary work with us. At any given time, we're recruiting for healthcare support workers, nurses, and admin and clerical staff for our bank. We're also looking to increase the number of AHPs, for instance. These bank recruits go through the same recruitment process: they apply, are interviewed, and are vetted before joining the bank. This includes individuals who may work at other trusts and want to work with our bank, as well as those who only want to do bank work.		

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	Regarding the auditing, we audit 20% of Band 7 roles and above, and this is an ongoing part of our HR and recruitment processes. We are working with Oleeo to streamline the process, which is currently quite manual and time-consuming for both the team and managers. However, we are committed to maintaining transparency in recruitment. • DL asked why e-rostering is not suitable for consultant colleagues and if there is an interest in implementing it for them? IS responded that it was found to be uniquely complex, partly due to the small teams with specialised skill sets. Swapping individuals in and out is challenging. For example, a Band 5 nurse can be moved around within a ward where there is a larger workforce with similar expertise. However, if you need a TAVI operator, you need someone with that specific skill, and we only have four such operators. E-rostering is effective for planning schedules months in advance, but it may not be as useful for rapid, flexible, and responsive changes in the workforce. This has been the challenge when discussing e-rostering with the consultant body. While I haven't personally used e-rostering, this is the perception, and we haven't had anyone advocate strongly for its implementation. OM added that regarding medical staffing, the return on investment for consultants may not justify the effort required. While e-rostering is used for junior doctors due to larger teams and greater flexibility, it has been challenging to implement for consultants. Some areas, like radiology and certain parts of anaesthetics, use e-rostering because their clinical leads prefer this method. We have examined the investment case for e-rostering, which would require software and roster managers in each area. To prove its return on investment, we need clinical leaders to drive standardisation and consistency. Each team currently operates uniquely, and convincing doctors to adopt a standardised approach requires leadership from within the divisions or at a deputy level. The effort and impact of e-rostering need to be evaluated to determine if it will provide the most significant benefit. IS will talk to Stephen Webb and ask him to do a diagnostic on e-rostering for medical staffing to explore the possibilities are and identify any issues.	**IS**	**29/05/25**
10.	**2025/26 Draft Workforce Action Plan** *Update given by Oonagh Monkhouse* • The Trust Workforce Strategy has been extended for a further 12 months to align with the development of the Trust 5-year strategy. • We will develop a workplan for 25/26 to bridge the gap until the development of the new strategy. • The current strategy is based on 6 themes: o Compassionate and collective culture o Belonging and inclusion for all o Developing the workforce o Growing the workforce o Efficient and effective workforce processes		

Agenda Item		Action by Whom	Date
	○ Work with partners • To focus and align with the key priorities of the organisation, we aim to improve efficiencies and productivity, foster inclusive leadership, and enhance workforce planning to reduce agency costs. Embedding and progressing our work on Equality, Diversity, and Inclusion (EDI) remains a central focus. Job evaluation is a significant focus and a key risk for the organisation. Additionally, we need to understand the implications of the upcoming Employment Rights Bill and what it will mean for us. <u>Questions</u> • DL asked if OM and the team have the capacity to undertake all the work and is there a prioritisation of the items in the plan? OM responded that much of the work is already underway or mandated by legislation. There isn't much that we can't undertake, as it aligns with the Trust's objectives. • AF asked if there is anything that could be stopped to help focus on other things and OM responded that this may need to be looked at if we have to reduce our corporate headcount. • CP said that she really welcomed the ambition to achieve Level 3 Disability Confident Employer status, but what are the next steps for the Trust to reach this goal? LT responded that currently the person designated to lead this project is fully occupied with the nurse pathway projects, causing a delay. The first step we need to take is to review the criteria for Level 3, which requires evidence for everything, unlike the self-assessment for Level 2 that we achieved previously. There is still significant work to be done, particularly around recruitment and education. It's crucial to ensure we can meet the Level 3 requirements and maintain them. We are in the very early stages of scoping out what needs to be done, identifying what we are already doing and determining the gaps for timeframe for completion. We aim to be fully prepared and confident when we submit our application, ensuring the organisation is ready to provide the support. • One area that needs looking into is how we support reasonable adjustments being at 24/7 service and how we accommodate employees who may need time off, whilst ensuring that necessary staffing levels are maintained. The Workforce Action Plan final version will come to the May meeting.	**OM**	**29/05/25**
11.	**Equality, Diversity, and Inclusion** *Update given by Oonagh Monkhouse* <u>WRES and WDES 25/26 action plans</u> • We have tried to realistic about the action plans and for them to be aligned with strategic objectives. • The WRES and WDES actions plans were **approved** and **recommended** to the Board by the Committee. <u>EDS2 Report</u>		

Agenda Item		Action by Whom	Date
	• We have made improvements from last year to this year. • The EDS covers workforce equalities, inequalities, and health, with governance around health inequalities being a key focus identified in the review. • The action plan emphasises addressing inequalities and the Board's vision, particularly regarding staff networks. • MS and IS have begun establishing a governance structure around health inequalities, incorporating EDS2 and domains 1 and 2. They are starting with a self-assessment using the NHS Providers self-assessment tool to determine the Board's current position on health inequalities, which will aid in developing the structure. • There is a health inequalities panel which is leading on this work and the work will go to the June Board workshop. • The work and action plan were endorsed by the committee. • The EDS2 report was **approved** and **recommended** to the Board by the committee. <u>Gender Pay Gap Report</u> • The report has the same themes are the last few years. • Most of the pay structures in the NHS are nationally set, so we are looking more at career progression. • Medical staff are a different profile to AfC staff, which does affect the results, particularly with Clinical Excellence Awards. • The Gender Pay Gap report was endorsed by the committee. • The Gender Pay Gap report was **approved** and **recommended** to the Board by the committee.		
12.	**Staff Survey Results** *Update given by Oonagh Monkhouse* • The 2024 survey was undertaken October 2024 to December 2024. We had a response rate of 58% which is an improvement from 2023 (56%) and is above the average for our peer group (57%) and the national response rate (50%). Our results are benchmarked against our peer group of 13 acute specialist hospitals. • The survey questions are organised against nine themes. Our scores improved to a small degree in all nine themes and this builds on the improvement we saw in 2023. In approximately 7% of questions our scores were significantly better than 2023. In 92% of questions there was no significant change (i.e. they will have increased or decreased but this may be normal variation). In one question there was a significant reduction. • Our recommender scores as a place to work and as a place to be treated improved to 71% and 91% respectively. The average scores for these questions for our peer group was 73% and 89% respectively and nationally 61% and 64% respectively. • As in previous years there is wide variation in the results across both Divisions/Directorates and Staff Groups. The results in STA are the most negative across all the Divisions/Directorates and within STA the areas of Critical Care and Theatres are the least positive. Thoracic areas have the most positive of the clinical		

Agenda Item		Action by Whom	Date
	departments. In relation to staff groups, we saw an improvement in the overall results in the Registered Nurse group and Estates and Facilities and Medical staff groups were the least positive. • There have been improvements in a number of areas, including line management and learning and development. • There has also been an improvement in staff believing there are equal opportunities for all, particularly those from a BAME background, which shows in the WRES results, and we are slightly above our peer group. • However, there is a persistent issue around bullying and discrimination. There have been some improvements but not the amount we would like to see. • Pharmacy, Thoracic and Nursing are on an improving trend, but STA, although on an improving trend, have the worst results in the Trust. • We have been sharing the survey results with staff and with managers, staff and staff side colleagues through our normal communication channels and in specific briefings. They will also be shared and discussed with Staff Networks. We will also discuss the results at the second Inclusive Leadership event on 01 April 2025. Last year the Chief Executive and Director of Workforce conducted a number of online sessions to present and discuss the results with staff in online sessions. These were well attended and received positive feedback. We are planning to run similar sessions in early April. • AF asked if one area, for example STA, could attend a committee meeting to present on their results. OM will action, looking for a representative to attend the July meeting.	**OM**	**31.07.25**
13.	**Education and Training** <u>Education Report Q3 2024/25</u> • There were nearly 200 applications for the fellows' post from medical staff. • There is currently no indication through the usual networks regarding the CPD funds from NHSE for 2025/26 and this is on our risk register. Within the Charity strategy a new group has been established to better support CPD through charitable funds. Typically, we are informed in April/May, but this year poses a higher risk due to the disbandment of NHSE. However, we do know have a more robust plan with the Charity to cover any shortfall. • The mandatory training compliance is at 89%. Resuscitation compliance has increased by 7% this quarter, but we still have a 25% DNA rate, primarily due to sickness or staff signing up for sessions during a clinical shift and then not being able to attend due to clinical workload. • Ongoing national work is being undertaken to define what national training compliance should look like. • Our OSCE success rate is significantly higher than the national average, with an improving trend in first-time pass rates. • The Annual Quality Assurance visit was positive, although we have not yet received the formal report. • We have submitted our annual education self-assessment and have		

Agenda Item		Action by Whom	Date
	been invited to meet with NHSE to discuss balancing rosters and rotas to enable staff to access training. • AF asked if the risk around the CPD funds is greater due to the changes to NHSE and if it is something we should be worried about. JL responded that we are in the same position with not knowing until April/May but it is likely that there will be a lower reward and we are also waiting on what the changes to the apprenticeship levy are and how things could be used differently. However, we know have a much stronger strategic direction with the charitable funds to support if there is a reduction in the funding. • DL asked for further detail and an update on the progress for proposals for clinical work and the embedding of CPD roles within clinical areas to supplement the centralised CPD function. JL responded that proposals were initiated during annual planning where several divisions expressed interest in having additional CPD posts embedded within their own clinical divisions. Currently we have such posts in theatres, critical care and thoracic, but most CPD support is provided through the clinical education team. There are benefits and risks to adopting a different model, and the proposals aim to supplement the existing training provision with new posts. We are currently evaluating whether this approach is appropriate, considering factors such as planning, delivery, and the impact on other roles. Initial assessments have been undertaken and we are now exploring potential options to enable this change. • MS raised that there are two areas of mandatory training that are currently vulnerable: Level 3 safeguarding and Cardiac Advanced Life support course (CALS). These two areas are being picked up through various workstreams to develop plans. AF asked that MS and JL bring back an update on the plans to the next meeting. <u>NETS Survey 2024</u> • The National Education Surveys is open to all professions. The Trust's numbers are very small. The survey only came through a couple of weeks ago and it is hard to get the information from it. • Medical Postgrad and Medical Undergrad are where we got the most responses. • MS said that the data needs cross-referencing with our other data sources and surveys. • MS will bring any new gap analysis and recommendations to the May committee to give assurance to the committee.	**MS/JL** **MS**	**29.05.25** **29.05.25**
14.	**PIPR M11 PM&C** • DL said that it's good to see agency use going down, but the use of bank staff is going up. How do we get the bank usage down and what steps are being taken to address this? OM responded that bank staff get paid at the same rate as substantive staff, which means as long as areas are sitting within their establishment it is fine to have say 95% substantive and 5% bank staff. SH responded that there are roster reviews going on, but also as we don't pay enhanced bank rates it means as long as areas are within their establishment then they shouldn't be going over budget.		

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	• OM and MS will do a spotlight on rostering and bank usage as part of PIPR for the next meeting. <u>New metrics for 25/26</u> • The new metrics for PIPR were **approved** by the committee.	**OM/MS**	**29.05.25**
15.	**Policies and Strategies** None to discuss.		
16.	**Sub Committee minutes** <u>EDI Steering Committee</u> For information.		
17.	**Committee dates and business forward planner** For information.		
18.	**Issues for escalation and Emerging Risks** There were no issues for escalation or emergency risks.		
	Date & Time of Next Meeting: **Thursday 29 May 2025, 11.15 to 1.15pm, via MS Teams**		

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Signed

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Date

Royal Papworth Hospital NHS Foundation Trust
Workforce Committee