Royal Papworth Hospital
NHS Foundation Trust

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

Held on Thursday 28 November 2024, 11.15-13.15
Via Microsoft Teams

M I N U T E S

Present	Fadero, Amanda (Chair)	(AF)	Non-Executive Director
	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
	Screaton, Maura	(MS)	Chief Nurse
	Smith, Ian	(IS)	Medical Director
In attendance	Abdoul, Ali	(AA)	Guest
	Atkinson, Angie	(AA)	Public Governor
	Bage, Luke	(LB)	Head of Resourcing
	Bottiglieri, Tony	(TB)	Freedom to Speak Up Guardian
	Brodowski, Naomi	(NB)	Executive Assistant
	Kinoti-Ronoh, Fridah (left 11.45)	(FKR)	Clinical Respiratory Physiologist
	Hotchkiss, Marlene	(MH)	Public Governor
	Hughes, Sarah (left 12.00)	(SH)	Chair of ICB People Committee
	Iton, Claudia (left 12.15)	(CI)	Chief People Officer, C&P ICS
	Lonsdale, Jon	(JL)	Assistant Director Clinical Education
	McClean, Josevine	(JM)	Staff Governor
	Radwell, Adam	(AR)	Head of Workforce Information
	Renwick, Jacqui (left 11.45)	(JR)	Head of Quality Improvement and Transformation
Apologies	Paddison, Charlotte	(CP)	Associate Non-Executive Director
	Taylor, Elizabeth	(ET)	Head of Workforce Operations

Minutes completed by outsourced company.

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**		

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	There is a requirement that those attending Board Committees raise any 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 – 26 September 2024** The minutes of the previous meeting were **approved** with a change to the meeting date at the top of the document, which should have read "September" rather than "July".		
5.	**Matters Arising and Action Checklist – Part 1 – 26 September 2024** • The Committee noted the closed actions and those to be taken at later meetings, or later on the agenda. • Action 046 – Job planning – in progress: IS advised that the job plans were being worked through ready for the paper to the January 2025 meeting, including research and education. The main area of concern was in surgery, with potential new appointments being looked at. The review of the thoracic job plans was going well.		
6.	**Board Assurance Framework (BAF)** • KMB presented the BAF, highlighting BAF 742 and BAF 1854. Due to the strong recruitment timelines, the recommendation was to remove these two from the BAF. AF reminded those present that BAF 742 had only recently been transferred to the Committee and was now being recommended for de-escalation, with the reasons noted. • DL supported the recommendations, cautioning that these would need to be kept under close review, as the situation could change quickly. MS assured the Committee that these would remain on the corporate risk register and monitored via safer staffing. AF also supported the de-escalation, but requested regular updates on this particular risk from the corporate risk register, which MS agreed to provide.	**MS**	
7.	**Staff Story** *Staff story from Fridah Kinoti-Ronoh and Jacqui Renwick* • OM introduced FKR and JR to the meeting. OM had heard FKR speak at a recent event and asked her to share her story with the Committee. FKR and JR had recently graduated from the second cohort of the transformational reciprocal mentoring programme. • FKR introduced herself, saying she had been with RPH for five years and had been told about this programme by a colleague and became interested following conversations with OM and her colleagues. The programme had been well organised and easy to take part in. • JR advised that she had joined RPH the previous year, and had led the response to the staff survey in her previous organisation. JR had been		

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	interested in joining the programme to hear the wide range of experiences across the Trust. • JR and FKR had agreed to meet regularly and work on their partnership, as well as being part of the study days, and have continued to do so since the cohort graduated. JR added that from shadowing FKR, she now understood FKR's role and day-to-day experiences. FKR shared that the team had asked lots of questions about why JR was there, while other members of the team had welcomed the opportunity to talk to JR in addition. FKR commented that she felt that people treated each other differently if they were aware you knew someone like JR. • JR stated that, with being new to RPH, she now had a much greater understanding of what it felt like to work in the Trust, and building relationships with a shared purpose. FKR added that networking and meeting new people was also a key outcome for her. FKR added that it had been a positive experience, and made her feel more secure in that she could talk to JR about anything. FKR felt much more part of the Trust and had been able to move on from experiences with previous employers. JR welcomed the trust that had developed and the ability to discuss a wide range of issues from each other's perspective, some of which had been personal and challenging. JR noted that getting the personal views of working was very different to reading the results of a staff survey, and this programme had helped JR understand how leaders within the Trust could influence change. This programme had helped JR consider inclusion more in working practices and decision-making, and how the corporate roles impacted on clinical areas. • AF thanked JR and FKR for their presentation, and the benefits that both had taken, which was echoed by those present. • DL asked FKR whether she would encourage others to join, or ask about the programme. FKR replied that people had spoken to her and she was encouraging colleagues to be involved. There was more that could be done to increase awareness of the programme. JR added that FKR was now acting as an advocate for others. • TB asked FKR what improvements could be made in teams to address the issues raised, such as isolation and making new starters feel more welcome. FKR suggested that more time listening to colleagues beyond their role in RPH, and how they felt about equality and their experiences. • OM noted that learning from the cohorts showed how important support from managers was, and management of time. There would now be training and expectations for the managers, to ensure there was time set aside to have these discussions. AF asked that the impacts of these changes be reported in future.	**OM**	
8.	**Workforce Directors Report** • OM presented the report, which incorporated the responses to previous actions, but acknowledged that it would be reviewed for content and length. <u>Measures to improve appraisal quality and compliance</u> • From the trend data, appraisal compliance was not increasing. There		

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	were issues with data accuracy, such as people being in the right team, as well as proper recording of appraisals. An improvement plan was being developed from 01 April 2025, with groups looking at the appraisal cycle, documentation, objective-setting, and other areas. • AF expressed concern that some staff had not had an appraisal for two years, which was echoed by DL, with an update requested to the January 2025 meeting.DL asked that the report included a projected timescale for achieving compliance. OM noted that there were legal requirements for appraisals, as well as EDI, career development and wellbeing. The team were looking at digital solutions to help with the recording of appraisals. For medical staff, there was an issue with recording and access to the system. • TB asked how RPH compared to other Trusts, especially for those who had not had an appraisal for some time. OM noted that quality of appraisals were very similar, but a benchmark for overall compliance would be approximately 80%. <u>Nursing recruitment pipeline</u> • OM presented the report, which was produced every month for managers; the current pipeline was very healthy. <u>Time to hire</u> • OM advised that there were some changes within the time-to-hire metric, but the time was not coming down. LB added that a recruitment working group had recently been set up, with a wide membership to hear different perspectives. The team would review engagement with candidates and getting the information required to be able to recruit. • LB advised that RPH would lose approximately five candidates a month, with main reasons being non-disclosure, non-response and no longer being interested in the role. The review was looking at which stages in the process candidates were dropping out, time to do checks, and whether particular Bands were more likely not to start. OM added that for individuals new to the NHS, the checks required could be a surprise when compared to other employers. LB advised that the team were working with the local job centres, so people were aware of the requirements and time to start an NHS job. • TB asked whether the adverts included details of when the shortlisting would take place, as well as the interviews. LB noted that with pressures, these dates could change, and so it may not be useful. The team were working with communications to help, such as the Good Interview Guide on the website. • AF asked about the workforce dashboard, and staff in post and bank usage, noting agency and overtime had increased. OM replied that the change for Bank usage was very small. The agency and overtime use had decreased over the longer-term, and the short-term increase had been discussed at the Performance Committee. MS, SH and OM were working with clinical areas and different drivers, such as shortage of skills or increased establishments. Teams had been asked to consider controls and targets for reducing overtime or agency usage, as it was not safe to completely stop using such cover. The Vacancy Panel would now consider all routes into the Trust, which would strengthen the oversight and scrutiny.	**OM**	

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	• DL asked for more details on why it was not possible to only use Bank healthcare support workers. OM confirmed that this was part of the review, but there was not the capacity in the Bank. The Bank would be the first choice, but there may be an urgent safety need which may mean agency cover, and this would be approved by the Matron. • AF queried how RPH compared against the newly published reference costs. SH replied that this was being reviewed for the right comparators, given the changes at other cardiothoracic hospitals. Due to the specialist workforce required, RPH was usually an outlier. • AF noted the increase in mandatory training, and asked how 90% could be achieved. OM advised that there may be a limit with number of trainers for the specialist face-to-face sessions, although capacity had been increased.		
9.	**Career and Talent Pathways** • LHJ presented the paper, and the project building on the healthcare support workers' programme. This responded to national changes and ensured people were on the correct banding for the role. LHJ reminded those present that this included giving people the opportunity to develop in their current role, as well as progress to another one. • At the start of the programme, there were eight objectives, which had been impacted by changes in the national agenda. The need to talk to staff on what they could do to progress in their role or career would still continue. • A key part of the project was ensuring that the roles and skills were as required for safe patient care, and that people were being paid for the work that they were actually doing. The team had been working on a pilot with the Cardiology department, which had seen better outcomes than expected, which would assist with workforce planning. • It was clear that the small number who were working above their role, were being managed. However, there was still an issue about the length of time for which staff had been routinely working above their role, which would be looked at in detail in the next phase. Phase 2 would look at critical care and administration, as well as going back to cardiology. This was not about performance, but helping people progress and develop within their roles. • SH welcomed the work undertaken, noting that this could be a significant cost pressure for 2025-26, in balancing this with the clinical needs and establishment for the patients being cared for. OM noted that the matter was a national issue, and that several professional groups were calling for job evaluation and banding process to be reviewed. The processes within RPH were good, and that RPH had a higher skill mix and Bands than other Trusts. • AF suggested that this be brought back to the Committee when the work in critical care should be finalised, which was welcomed. OM added that this also linked to BAF Risk 3261, which was being kept under review. LHJ noted that an update would be included in the regular dashboard, and suggested bringing a detailed report at the end of Phase 2, which was welcomed. • SH asked for more details on what other providers were doing, and whether this could have consequences outside the RPH. OM advised that there were national discussions between the Department of Health	**LHJ**	

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	& Social Care, NHS England, trade unions, and other involved parties. Partners across the East of England were trying to work together and share profiles. NHS England's view was that Trusts were responsible for keeping their bandings accurate and so no additional funds were available to cover any increases. LHJ advised that she would be talking to a number of system groups to discuss this work. • OM asked whether this could be a future Board development topic. AF and DL welcomed the suggestion, adding that this needed to include the points raised by SH on the financial planning and alignment with local Trusts.		
10.	**PIPR M06 and M07 24/25** • AF noted that many items had been covered already, and there were no other items to discuss.		
11.	**Education and Training** <u>Q2 Education Report</u> • JL advised that there had been an increase in mandatory training compliance, which was welcomed. The main reasons for not attending were sickness absence or not being released from clinical shifts. There was a national programme to standardise training, which would allow for training to be accepted on transferring into RPH. JL assured the Committee there had been no risks or incidents due to people not having mandatory training. • The main education-related risks were similar to the previous year: CPD funding, specifications, and number of trainers and trainees. JL noted that in previous reports there had been a risk relating to CPD funds, which had been closed as the funds had come through. • DL questioned how the priorities with the EPR project would be balanced with the other training space needs. JL noted that most classroom training space was booked at 90% capacity, with clinical training in 3 North West being well received; although this was a short-term solution. The long-term options were being looked at to ensure training space. <u>Education Annual Self-Assessment</u> • Unfortunately, due to the timing of the submission, this had not come to the Committee for approval before being sent. There were areas of non-compliance, with justifiable reasons why, listed, and action plans in place. JL stated that where clear reasons were given, they were not usually questioned. <u>CUH-RPH Education Collaborations</u> • There were no other items to add to those already discussed.		
12.	**JD working Lives Gap Analysis and survey actions** • IS presented the report, thanking all those involved in the preparation of the paper. IS reminded those present of the background, with the three surveys being aligned. One area highlighted was that locally employed doctors (LEDs) did not feel they had the same training		

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	opportunities, with some improvements having been made. There were concerns about the environment and rest and mess facilities, with a pilot for out-of-hours facilities and report to come to the January 2025 meeting. The junior doctors were involved in designing the new mess facilities, and it was hoped that these could be in place before the end of this financial year. • Reflecting the wider staff experience, there were reports of inappropriate behaviours and bullying. MS had helped with training and understanding of impacts of behaviours, as well as encouraging people to talk to the Freedom to Speak Up Guardian. There would also be a dedicated session at the Resident Doctors' Forum on the new sexual safety national programme. TB added that he submitted articles to Trust-wide communications and attended induction. • IS assured the Committee that actions were underway in response to all items raised, with a review before the next GMC survey. • AF asked about appraisals, and IS replied that additional training sessions had been arranged for LED appraisers, as LEDs had different requirements: this should improve compliance. <u>Guardian of Safe Working report</u> • AF asked if this, and the next Freedom to Speak Up report, had been taken to the Board, so this was for the Committee's information, which was confirmed. IS advised that there was a misunderstanding that LEDs were not able to exception report, which was not true; all resident doctors were able to do this.		
13.	**Freedom to Speak Up Guardian report** • TB advised that future reports would come to this Committee before going to the Board.		
14.	**Policies and Strategies** <u>Workforce Strategic Lifespan</u> • OM advised that the Workforce Strategy was due to expire in 2025, and approval was being sought to extend this for another year, to align with the Trust's overarching strategy. A workplan would be developed for this extension year, with key performance indicators. • The Committee **approved** the one-year extension.		
15.	**Sub Committee Minutes** <u>EDI Steering Committee</u> • The EDI Steering Committee minutes were noted.		
16.	**Committee Dates and Business Forward Planner** The committee dates and forward planner were noted.		

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17.	**Any Other Business** There were no items of any other business.		
18.	**Issues for escalation and Emerging Risks** There were no issues for escalation or emergency risks.		
	Date & Time of Next Meeting: **Thursday 30 January 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