Draft Minutes of the Public People and Culture Committee
Held On 12th May 2026
Via MS Teams

Recording (YouTube link) – Click here

Chair:		
Clive Curtis	CC	Independent Member for Local Community / Committee Chair
Present:		
Lorna McCourt	LMC	Independent Member – Trade Union
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Kirsty Williams	KW	CAV UHB Chair
In Attendance:		
Lianne Morse	LM	Deputy Director of People & Culture
Claire Whiles	CW	Assistant Director of OD, Culture & Wellbeing
Rachel Gidman	RG	Executive Director of People & Culture
Rachel Pressley	RP	Head of People Assurance & Experience
Matt Phillips	MP	Director of Corporate Governance
Claire Beynon	CB	Executive Director of Public Health
Ceri Dixon	CD	Senior Business Partner – People Services
Paul Bostock	PB	Chief Operating Officer
David Williams	DW	Head of Communications
Katrina Griffiths	KG	Associate Director of People & Culture
Andy Jones	AJ	Director of Nursing – Children & Women
Abigail Holmes	AH	Clinical Board Director – Children & Women
Emma Cooke	EC	Executive Director
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Observer:		
Louise Blunsdon	LB	People Assurance & Experience Co-ordinator
Apologies:		
Jason Roberts	JR	Executive Director of Nursing

litem no	Agenda Item	Action
P&C 12/05/1.1	**Welcome, Apologies & Introductions (click to view)** The Committee Chair (CC) welcomed everyone to the meeting.	
P&C 12/05/1.2	**Declarations of Interest (click to view)** No declarations of interest were noted.	
P&C 12/05/1.3	**Minutes from meeting on 17th February 2026 (click to view)** The minutes were agreed to be a true reflection of the meeting on 17th February 2026. **The Committee resolved that:** a) The draft minutes of the meeting held on 17th February 2026 were agreed to be a true and accurate record of the meeting.	
P&C 12/05/1.4	**Action Log following 17th February 2026 Meeting (click to view)** All actions were accepted. RG verbalised around the comms of H&S and the training compliance had increased and the message has hit home. **The Committee resolved that:** a) The Action Log was discussed and noted.	
P&C 12/05/1.5	**Chair's Actions (click to view)** There were no chairs actions. **The committee resolved that:** a) There were no chairs actions.	
	Items for Review & Assurance	
P&C 12/05/2.1	**Staff Story** The Executive Director of People & Culture – Rachel Gidman (RG) introduced the staff story by welcoming Rebecca Stringer, a lead nurse in the Health Inclusion Department, and highlighted the story would include key messages about morale, trust, and leadership, which would be relevant to the meeting's agenda. The Committee Chair – Clive Curtis (CC) expressed appreciation for the presentation, stating he would like to ensure the committee's thanks were passed on, emphasising the value of hearing from frontline staff and its importance for independent members to stay connected. The Independent Member for Trade Union – Lorna McCourt (LMC) stated she was the lead rep for PCIC for five years before taking on her current role, was a frequent visitor to HMP Cardiff, and had seen firsthand the difference the teams made. She noted Rebecca had shown true leadership throughout the process. The Chief Executive – Suzanne Rankin (SR) mentioned she was searching for staff survey results to triangulate with Rebecca's story, suspected the prison healthcare team was small and wanted to see if improvements matched the leadership described. She encouraged colleagues, especially independent	

	members, to visit the prison health services, highlighting it as a thought-provoking and challenging environment. She noted that a great deal of healthcare is provided directly to inmates, with the local prison population being particularly young men on remand who present multiple vulnerabilities and challenges, making strong leadership essential in that setting. The CAVUHB Chair – Kirsty Williams (KW) expressed interest in understanding the critical success factors for the team and how these could be replicated across CAVUHB. She questioned whether success was due to luck or if people are appointed to leadership roles with confidence in their skills, and whether staff are being properly equipped and supported when placed in leadership positions. She wanted assurance that recruitment and training for managers at various levels would replicate the positive outcomes seen and sought to understand the wider organisational context. RG responded that she believed the situation was varied, noting that Rebecca is a clinician and sometimes clinicians are promoted for their clinical skills rather than management or leadership abilities. She emphasised that the annual plan for this year prioritises leadership and management, with a focus on conducting a training needs analysis to ensure the right people receive the right training at the right time, aiming to improve development before staff move into leadership roles. The Assistant Director of OD, Culture & Wellbeing – Claire Whiles (CW) noted that the staff survey raised themes such as lack of involvement in decision making, lack of visibility of leadership, and inconsistent experiences. She emphasised this as an important point and mentioned that more would be discussed in the staff survey section. The Executive Director of Public Health – Claire Beynon (CB) she wanted to add a health needs assessment was undertaken in HMP Cardiff recently and it will help improve lives. The health needs assessment has described what's needed and it will give direction for what is needed. **The Committee resolved that:** a) The Staff Story was received.	
P&C 12/05/2.2	**Board Assurance Framework – Workforce** The Deputy Director of People & Culture – Lianne Morse (LM) noted the following points: • The revised BAF now presents a single clear people risk, replacing the previous three separate risks. • The framework was strongly aligned with CAVUHB strategy and deliverables. • It features two aligned domains: workforce sustainability and culture/wellbeing. • There was a clearer definition of causes, controls, and gaps within the framework. • Actions listed in the BAF will be dynamic and updated as things change throughout the year. • The team proposed to bring these actions back to the committee at agreed regular intervals for assurance. • The committee was asked to support and endorse the new format and adopt the revised approach going forward.	

	The Independent Member for Capital & Estates – Rhian Thomas (RT) expressed encouragement about the ongoing review of the BAF documentation. She suggested making the document "a bit punchier," as there was still a lot of text and the actions were described generically. She requested clarity on which domain each action targeted, as it was not clear which actions related to which domains. She asked for more specificity in the descriptions, noting that actions like "continue to reduce reliance on temporary workforce" were too broad and needed detail. She observed that the timescales for actions were long-term (e.g., March 27) and requested information on what interim actions would be taken during the period. LM thanked RT for the feedback and confirmed they will take the BAF back and revise it based on the suggestions. The Independent Member for Local Authority – Susan Lloyd-Selby (SLS) agreed this was a much better approach and thanked LM for the work. She echoed RT's comments, emphasising the need for more specificity in the document. She noted there was a lot of information about causes but very little about impact, stressing the importance of understanding the impact of issues for assurance. She referenced the mention of patient experience, suggesting this could mean waiting times, longer hospital stays, or community services, and requested that these impacts be drawn out in a more specific way. She wanted actions to be targeted to impacts so measurable progress could be seen, especially regarding patients. KW thanked Lianne for the work and emphasised the importance of being specific about what will be achieved. She noted that the BAF mentions limited assurance at various points and stated that the impact of actions should allow an increase in assurance over time. She said being able to link actions to impact and seeing the level of assurance move in the BAF would indicate success. **Action - LM to revise the Board Assurance Framework (BAF) based on feedback for more specificity, clearer impact, and domain-targeted actions, and to bring back updates at regular intervals.** **The Committee resolved that:** a) The revised People BAF format was supported & endorsed, recognising the improvements made to clarity, structure and strategic focus b) The revised approach to reporting was agreed to be adopted, with a greater emphasis on risk, assurance and impact rather than detailed activity c) The revised format was noted and will continue to evolve, particularly as new approaches to workforce insight and cultural monitoring are implemented	
P&C 12/05/2.3	**Key Performance Indicators** The Deputy Director of People & Culture – Lianne Morse (LM) highlighted the following points: • Highlighted performance up to end of March on bank and agency reduction, showed improvement over the last three years. • Focused on the current year and future plans to achieve further agency and bank reduction, noting last year's agency spend was about £5.5m (a 30% reduction), but margins for further reduction were smaller and challenging. • Stressed the need for greater focus on bank spend, working with clinical boards to identify hotspots and opportunities for improvement, using business partners and specialist teams.	

	• Identified key drivers for bank spend, which included: sickness, vacancies, and additional capacity (e.g., extra beds/services not in the establishment). • Committed to bringing regular updates on progress against the plan to reduce variable pay. • Noted a correlation between temporary pay spend and sickness absence, with interventions leading to slow but visible progress in reducing in-month sickness since December. • Acknowledged significant shifts in sickness rates among healthcare support workers, with some clinical boards reducing sickness by more than 3%. • Mentioned ongoing work to analyse sickness drivers and align with staff survey findings. • Stated CAVUHB target is no workforce growth from end of March, with continued reductions over the last 12 months and ongoing reviews of workforce plans. The Chief Operating Officer – Paul Bostock (PB) wanted to understand what was being done about bank staff, noting the slides mentioned a 10% reduction but showed nursing and midwifery spending £8m more, leading to confusion about the gross number the 10% reduction was based on. He questioned whether last year's spend was £12m for nursing and midwifery and asked what number the 10% reduction was being applied to. LM stated she was not aware of a prediction to spend more in nursing and midwifery, explaining the 10% reduction applied to all staff groups based on the 25-26 outturn. She mentioned student streamliners would join from July to December, which would significantly reduce bank spend, and a recruitment campaign for HCSW would further reduce both agency and bank reliance. PB was confident that £8m was put into the plan, referencing a session where it was stated that £16m would be spent on bank for nursing. LM clarified that the figure was based on last year's numbers, explaining in SLT they predicted spending based on what was spent in 25-26, and aimed for a 10% reduction this year. SLS noted the BAF identified a risk that absence control was more focused on case management rather than prevention and asked how this risk was being addressed. She highlighted that the primary reason for staff sickness is anxiety depression, and stress, but only 20% of those off sick for these reasons were accessing Occupational Health (OH) support, expressing concern about this gap and asking what was being done to address it. LM stated she was very focused on the management of sickness absence because it was not where it needed to be, noting there was some drift in terms of applying the policy. CW explained she made significant progress in OH, bringing down waiting times so staff were seen in a timely way, resulting in a sustained service within KPIs and a multifaceted route for staff support. The Employee Wellbeing Service (EWS) is a self-referral service, and managers or OH can recommend staff access it. This was part of ongoing work to strengthen the wellbeing offer. Work around leadership and management aimed to encourage conversations and effective practices within teams to prevent burnout and anxiety. There was a piece of work in OH to provide a triage telephone call system for managers to	

	enable early support and intervention, and recruitment into OH vacancies was underway. SLS asked, since sickness levels were being measured and the primary reasons are understood, what steps are being taken to measure the impact of actions to address these issues, such as improved take-up of Occupational Health, and what measures are in place to understand if steps are addressing the issue. CW stated that in the paper later in the meeting, she would be looking at measures such as sickness absence, number of referrals, and employee relations cases. She considered a broader set of measures, not just lagging indicators like sickness absence, but also team performance and triangulating data to provide insight rather than just data. RT noted that it was apparent that the quality and frequency of data collected wasn't doing enough to aid decision making. She referenced the staff in post table, mentioning staff groups in different categories and specifically that there are 3,000 people in "additional clinical services." She requested clarity and suggested tracking data across Clinical Boards (CBs) and being more specific about what is meant by categories like "additional clinical services." She encouraged clearer future data collection and presentation to provide more context and help with decision making. LM responded that she can show the data by staff group, by band, and by Clinical Board to make it more meaningful. She clarified that "additional clinical services" was predominantly healthcare support workers (HCSW) and is just the staffing group in ESR, and they will change that going forward. SR noted the importance of data reliability and suggested having a RAG rating or indicator to show how reliable the data is. She mentioned she would pick this up with colleagues in the BI team to look at data sets for consistency across CAVUHB. On sickness absence, she pointed out that there were other forms of absence challenging CAVUHB, such as parental leave and unspecified locally agreed absence. She suggested that to give assurance on the whole picture, all forms of absence should be classified and presented together. She highlighted that nursing and midwifery have strong data that allows understanding of these different forms of absence, while other teams may have less confidence in their data due to collection methodology. The Executive Medical Director – David Fluck (DF) thanked LM for the paper and noted that the aim is to monitor total spend in workforce, but the aggregate figure is not clear in the paper. He emphasised that the various components interact with each other and having the total, aggregate picture would be helpful to see the dial that needs to move. KW asked about benchmarking against comparable organisations to see how CAVUHB's statistics look but noted that internal progress across CB's may be more relevant. She questioned whether CB's are aware of others' strong performance and if best practice is being shared to drive consistency. She referenced consultancy work highlighting that current staffing models are not aligned to activity and service delivery. She noted the people and workforce culture strategy plan is ending and the paper does not mention progress on aligning staffing structures, numbers, and roles to future needs. She asked where CAVUHB stands with this alignment work.	

	LM explained that robust data exists for temporary pay in areas using the rostering system, especially for nursing and healthcare support workers, and that more areas are being added to health roster to improve data confidence. She committed to making the data more explicit and clearer in future reports. She stated that business partners share data and discuss initiatives within their clinical boards, focusing on what is working, what is not, and where the focus needs to be, with learning from best practice across boards. RG highlighted that CD&T was noted in the executive reviews for not just low sickness but other positive indicators, calling it exemplar practice to be shared. She emphasised that while financial objectives are paramount, she does not want the focus on finances to overshadow the importance of staff wellbeing and getting people back into work for their own purpose and the economy. She reiterated the need to balance financial priorities with staff wellbeing. SLS noted that Section 3 of the KPIs paper provides information about suspensions but lacks details on expected completion of investigations. She requested that future reports include an indication of timescales for these cases. **Action - LM to provide more granular workforce data (by staff group, band, Clinical Board) and include total workforce spend in future reports.** **Action - LM to bring back data on all forms of absence (sickness, parental leave, etc.) for a fuller picture.** **The Committee resolved to:** a) The committee noted & discussed the content of the report.	
P&C 12/05/2.4	**Staff survey** The Assistant Director of OD, Culture & Wellbeing – Claire Whiles (CW) highlighted the following points: • Participation in the staff survey increased, providing more robust data, but all themes declined and are below the Wales average. • Morale, engagement, and working environment scores are all around or just above 50%, with no theme improving this year and engagement dropping by about 6 percentage points over two years. • The largest gaps compared to the Wales average are in morale, working environment, and engagement, indicating both system pressure and local/organisational factors. • Only 27.6% of staff feel there are enough staff to do their job properly; work pressure is at 38.5%; confidence that concerns will be acted upon has dropped to 54.9%; advocacy score is 53.5%. These represent material workforce, patient safety, and organisational risks. • The issue is not staff commitment, but sustainability and experience of work in the current environment. There is a tension between workforce growth and the perception of insufficient staffing, suggesting the problem is not just numbers but how work is organised and experienced. • Risks identified include retention and turnover, patient safety, reduced engagement, lack of involvement in decision-making, and reputational risk. These are leading indicators for anticipating risk. • Staff voice highlights workforce pressure, burnout, inconsistent leadership, reduced confidence in speaking up, and concerns about fairness, but also strong local team relationships and commitment to patient care.	

	• The response will shift from broad, centrally driven plans to targeted, locally owned action, supporting clinical boards to take ownership and ensuring visible, timely local action. • The approach aims to co-design with teams, focus on psychological safety and leadership behaviour, ensure local ownership of capacity issues, and set clear leadership expectations. • Success will be measured not just by improved survey scores, but by staff being able to see and feel improvement, tracked through absence, turnover, employee relations, pulse feedback, and evidence of local change. The CC noted it was encouraging to see a much higher response rate to the staff survey, reflecting staff's willingness to engage. He highlighted that with this increased engagement comes a risk of disappointment if change is not visible, and asked what will be tangibly different this year to ensure staff feedback leads to real improvement. CW Upon receiving the staff survey results, Claire stated that organisational communications were sent out to acknowledge both concerns and positive aspects, with a message that further work would be undertaken at the Clinical Board (CB) level to ensure localised conversations. She noted that while last year CBs presented actions taken in response to survey results, it is often difficult for staff outside those teams to see or feel the tangible difference unless directly involved. To address this, Claire explained that this year, senior business partners, the OD and Culture team, and others will support more localised action, gathering not just actions but also the actual impact of those actions. She mentioned the use of pulse surveys and other measures to track whether there is an improvement in staff engagement and visible changes in ways of working, such as impacts on sickness absence. She emphasised that a broad range of measures is being developed to quantify and qualify what is happening at a local level, aiming to enable managers to locally own and monitor the impact of their actions. The COO commented that the staff survey results are telling, highlighting a disconnect as 27% of staff feel there are not enough resources. He noted the leadership challenge in managing the message, since more money has gone into Cardiff and Vale UHB to enable more staff, yet staff still feel there are not enough. He expressed concern about how to manage this, as staff may expect more resources, while the organisation needs to redesign services and may end up with fewer staff to be financially viable. He pointed out that despite significant investment and increased staffing, staff still feel beleaguered and do not feel psychological safety. DF thanked CW for the staff survey update and mentioned he has a meeting planned with the consultant body. He noted that a high number of consultants responded to the staff survey, which is unusual in most sectors. He emphasised the need for a shared understanding of the issues across the organisation and stated that activating staff is crucial, as executives cannot make these changes alone. He described the shared reality for staff as being overworked, referencing Don Berwick's comment that staff do not want to be heroes every day but feel they have to be to get their job done. CW noted that fundamental changes to ways of working will be needed, and emphasised that everyone in CAVUHB has a place in responding to the staff survey results and improving both staff experience and patient/community outcomes. RT noted the staff survey was conducted in autumn/winter and questioned why it takes six months to obtain the results and begin working on them. She	

	highlighted that a significant portion of the workforce is not captured by the survey and asked if there is any learning or review material on actions taken in response to last year's staff survey feedback. CW explained that the first organisational report was received at the end of February, after which communications were sent to all staff and work began with HEIW to determine what reports could be pulled. She noted that last Friday, further access to the dashboard was obtained, allowing more detailed results to be shared with executives. She stated there is always a delay in gaining access to results because the survey is externally managed but reassured that work at Clinical Board level had already started. She mentioned a focus group was held prior to this staff survey, where CB's presented the actions they had taken based on last year's survey, and this was used in communications to encourage participation. LMC described being invited to hotspots while working in PCIC, listening and feeding back to management, and then reporting in the Local Partnership Forum (LPF) with a "you said, we listened, and we did" section. She emphasised the need to tap into resources at Clinical Board level, noting that staff on the floor often trust their lead reps more than management, and highlighted the importance of partnership working. She offered to meet with Executive teams and share her experience to help utilise partnership working more effectively. SR discussed the staff survey, supported a more localised targeted approach, and referenced the method of articulating shared realities to address how the organisation feels for colleagues. She stressed the importance of authenticity in recognising colleagues lived experience. She suggested looking at organisations across the UK or Europe that have made substantial improvements in colleague experience to see if there are approaches CAVUHB could adopt. The Executive Director of Therapies – Emma Cooke (EC) agreed with the comments supporting a more local approach to delivery. She cautioned about the language used, noting that "you said, we listened, we did" is not truly co-productive and can feel top-down. She emphasised that people need to be part of the solution, and that solutions should come from those working in the teams, not just senior staff. She highlighted the importance of empowering staff and being mindful of language to encourage accountability and positive culture change. **The Committee resolved to:** a) The headline findings of the 2025 NHS Wales Staff Survey were noted b) The proposed action-focused, locally owned response model was endorsed, which: o prioritises a small number of high-impact local improvements o strengthens Clinical Board accountability for delivery o reduces reliance on large-scale engagement activity in favour of targeted, team-level action o ensures staff feedback leads to visible and timely change c) Support alignment of this approach with wider organisational priorities, including: o leadership and management capability o Values Based Teams o Cultural Early Warning System (CEWS) d) Request ongoing assurance through established governance routes that: o local priorities and actions are being delivered o impact is monitored through leading indicators and CEWS insight o learning and effective practice are shared across the organisation	

P&C 12/05/2.5	**Speaking Up Safely Update** The Director of Corporate Governance – Matt Phillips (MP) noted the following: • The Speaking Up Safely framework was introduced in August 2024, replacing the previous Freedom to Speak Up system, with a focus on a one-stop shop for raising concerns and guaranteeing anonymity for users. • The system uses "connectors"—volunteers from across CAVUHB—who act as trusted points of contact, allowing staff to choose whom they speak to and ensuring representation from various backgrounds. • Anonymity has not resulted in disruptive conduct; most concerns are legitimate, and the system prevents bypassing HR procedures. • The main challenge is extracting data due to the anonymity guarantee, making it difficult to identify early trends or issues from the system itself. • Most issues raised are eventually routed into established processes (e.g., respect and resolution), with connectors building trust before connecting staff to the right support. • How connectors might help complete the feedback process for staff who share concerns, particularly given survey results that show employees feel less confident about speaking up. SLS recalled a previous presentation from a community connector and noted there are now 17 connectors, asking if this number is sufficient and highlighting the need for more non-clinical connectors. She observed and questioned whether spikes in conversations (notably in February and March 2026) were linked to specific events or triggers. MP confirmed that the current number of connectors is sufficient for the workload, but more are desired to improve workforce representation and provide more choice for staff raising concerns. The person raising the concern chooses which connector to approach, with information provided about each connector's profession and location to facilitate this choice. The Speaking Up Safely paper was presented at the Strategic Leadership Team meeting, where increasing the number of connectors was discussed. The recent spikes in conversations were attributed to targeted communications and an in-person briefing in Maternity, which immediately increased engagement with the system. RT acknowledged the importance of recognising the connectors' contribution, time, and energy. She noted the paper reported 76 conversations between December 2024 and April 2026, averaging just under 5 per month, and questioned whether this volume is low, expected, or indicative of an awareness issue. MP stated that with 18 months of data, they will be able to provide better annual comparisons in future committee meetings. He confirmed the volume of conversations is in line with what other health boards experienced in their first year using the system. He mentioned efforts to promote the system through traditional internal communication routes. He encourages leaders to ask staff during walkarounds if they are aware of the system. He highlighted that connectors are motivated individuals who volunteer their time and capacity to support the system. KW expressed gratitude for the individuals acting as connectors. She asked how it feels for people to engage in the process and whether it is successful for	

	those who use it. She wanted to know if people are happy to engage and if there is confidence that the process is useful and resolves issues or provides opportunities for resolution. MP noted that now the system is established, a feedback questionnaire is automatically sent as a follow-up to those who engage with it, and although it started recently, they will be able to build on this data and bring it back to a future committee. He raised the point that if the aim is to provide trust, certainty, and access, he needs to distinguish between the system's functionality and the trust it has, versus what happens once the process is handed over to HR or other established processes. **The Committee resolved that:** a) The work that has been undertaken to date to launch and embed SUS was noted.	
P&C 12/05/2.6	**Developing a Cultural Early Warning System** The Assistant Director of OD, Culture & Wellbeing – Claire Whiles (CW) highlighted the following points: • The system aims to provide earlier identification of workforce pressure, team functioning, and organisational risk, moving from retrospective insight to proactive support and intervention. • It is not just a dashboard; it combines workforce, health and wellbeing, and staff experience intelligence with structured team conversations and targeted action. • The initial phase focuses on a minimum viable workforce insight dashboard using Power BI, integrating workforce, occupational health, wellbeing, and staff experience data, with plans to expand to quality, safety, and operational performance for a balanced scorecard. • Data will inform structured team conversations, local leadership action, escalation, and targeted support, closely linked to values-based teams and staff survey insights. • Mental Health Clinical Board is the pilot site, using the Cultural Compass approach to bring together indicators across workforce, quality, performance, and finance for ward and team-level conversations. • The approach is informed by learning from Welsh Ambulance Services NHS Trust (WAST) and national work through HEIW, with a decision to develop an internal model rather than procure an external platform. • Delivery timelines: phase one dashboard by August, expanded integration and rollout by November, and a fully integrated model with embedded governance and assurance by May next year. 1:37:00 • The goal is to strengthen understanding of culture at team/service level, embed action-focused improvement, enhance leadership capability, and improve organisational oversight and assurance. The Senior Business Partner in People Services – Ceri Dixon (CD) explained that in the Mental Health Clinical Board, they are working with Cardiff University to develop leadership skills across a whole system approach, which led to the development of the cultural compass conversation. Conversations at ward and team level will review all available data and metrics, acting as a data validation exercise and identifying opportunities for proactive action. The approach has been multidisciplinary, involving lead reps and various indicators, focusing on conversations in the appropriate place and considering staff survey results for action and assurance. The process allows for escalations into directorates, Clinical Board, and Exec levels, as well as celebrations of success. They will use a theory of change logic framework to monitor the impact of any interventions in the immediate, short, medium, or long term, tracking effects on metrics and overall staff and patient experience.	

	CB zoomed in on the cultural early warning scores tool from WAST and noted that while collating indicators like staff sickness and turnover in one place is helpful, some indicators may impact teams differently. She highlighted that dealing with performance issues within teams can be positive, even if the tool marks "none" as green, and cautioned that the tool should not disincentivise people from acting on performance issues. She also questioned how data on relationship breakdowns between team members would be collected and whether it relates to pulse surveys, emphasising the need for regular feedback and awareness of other ongoing factors. SR thanked CW & CD for the work, acknowledging it has been ongoing in the background for some time and emphasising that it is a key priority. She raised the point that ownership of the dashboard should not rest with the People and Culture team or the executive, but with individual managers leading their teams, and suggested creating a dynamic around this ownership through engagement and co-production. She asked about the policy or SOP for this work, specifically what the trigger points for escalation are, how managers know when and how to escalate, and how the dashboard will be managed, reported, and understood. She recommended having a clear policy to guide these aspects, possibly drawing from WAST's example. CW agreed with the dashboard being locally owned and emphasised the importance of external support and capacity, noting the positive involvement of Cardiff Business School and the potential for a knowledge partnership transfer in the future. She confirmed that an SOP will be developed for this work, recognising its potential significance for CAVUHB and the need to get it right. She stated that the work will be grown iteratively over time, starting with existing measures and expanding based on lessons learned at the local level. **The Committee Resolved that:** a) **T**he direction of travel for developing an internally led Cultural Early Warning System as part of the wider Values-Based Teams, Leadership and Organisational Insight Programme was noted. b) The alignment with learning from WAST and emerging national work through HEIW was noted. c) **T**he use of Mental Health Clinical Board as the initial test site for the CEWS and Cultural Compass approach was supported. d) Learning from the test site will inform wider organisational rollout, dashboard development and governance arrangements was noted. e) A further update on progress, including early learning, refined indicators and implications for wider implementation was received.	
P&C 12/05/2.7	**Clinical Board Spotlight – Children & Women** The Director of Nursing of the Children & Women Clinical Board – Andy Jones (AJ) presented and highlighted the following points: • **Workforce Profile**: Predominantly clinical workforce, with nursing and midwifery making up almost 60%. Strong mid-career profile, mostly female, leading to higher maternity leave and part-time staff. • Inclusion & Diversity: Active support for inclusion ambassadors across protected characteristics; focus on Welsh language promotion and accessibility. • **Sickness & Turnover**: Sickness scrutiny panels established, resulting in a reduction of long-term sickness cases and overall sickness percentage. Turnover rate reduced from nearly 12% to 6.5%.	

	• **Training & Appraisals**: Statutory and mandatory training slightly below target but improving; value-based appraisals also on an upward trajectory. • **Staff Engagement**: Increased participation in NHS survey; plans for a local engagement group to identify solutions and respond to feedback. Annual staff celebration events and recognition of International Day of the Nurse and Midwife. • **Achievements**: Introduction of skill mix in health visiting and school nursing, improved children's community nursing service, implementation of Maudsley model for eating disorders, midwifery practitioner role development, and band 4 support worker recruitment. • **Communication & Wellbeing**: Enhanced communication through newsletters, vlogs, and sway documents; intentional manager check-ins; sustaining resilience at work practitioners; focus on proactive wellbeing support. • **Recruitment & Retention**: Shift from staff voices to Speaking Up Safely; appreciation initiatives; innovative posts and advanced roles in community and acute child health. • **Digital Transformation**: First Maternity unit in Wales to implement safe care; use of BadgerNet, Maternity and perinatal dashboards, virtual consultations, and Civica for patient experience. • **Hotspots & Challenges**: Neonatal intensive care service restructured as perinatal service; ongoing challenges in obstetrics and gynaecology; improvements in children's community nursing service, including new base and respite provision. • **Good Practice**: Growth of inclusion ambassadors, improved communication, proactive wellbeing, partnership working, and celebration of achievements. • **Patient Voice & Rights**: Launch of Babies, Children, Young People Strategic Plan; focus on children's rights and UN Convention of the Rights of the Child. The COO thanked AJ and the team for the presentation. He noted that 31% of staff in the Clinical Board responded to the staff survey and questioned what the staff said and how the board is responding. He referenced previous pressures in Neonates and acknowledged that a lot of work had been done to address issues there. He asked what staff would say if walked around today, whether hotspots are resolved or remain, and what the timescales are for improvements. AJ acknowledged that the board could come together to help identify improvements, but some hotspots remain and these are challenges they are working with. He indicated there wasn't significant detail available at the time of preparing the presentation. AH stated the staff view would be mixed if asked now, due to inconsistency in experiences. She explained that while staff on the ground feel they need more, the board actually has the largest workforce ever through proactive recruitment. She emphasised the focus on keeping the workforce well, including trauma-informed leadership and management, as staff are experiencing more trauma in the workplace than before. She described that women are having more successful pregnancies, but with increased complexities and adverse outcomes, and admissions to ITU have risen, partly due to more women with severe cardiac disorders having pregnancies. She affirmed that outstanding care is still provided, but the trauma impact on the workforce is significant. She questioned whether the workforce is in the right place and suggested the need to consider different workforce models, such as obstetric nursing, to better align with current service needs. SLS asked how learning from improvements, such as the automated admin process that saved 15 to 34 hours of clinical time daily, was captured and	

	whether it can be applied in other areas. She questioned how hotspots are identified and what support CAVUHB provides to enable this learning. AJ explained that concerns and compliments are monitored through dashboards and regular meetings, helping to identify hotspots and challenges. He noted that some challenges are evolving due to population changes, and progress has been made, but more work remains. He emphasised the importance of maintaining headroom to address ongoing challenges and highlighted that engaging the entire workforce is key to producing effective changes. KW appreciated the focus on patient voice and the importance of a children's rights approach, noting Cardiff's status as the fastest growing area for Welsh speakers. She asked if the directorate uses Welsh essential recruitment policies to grow staff with clinical and linguistic skills to meet population needs. AJ responded that the directorate has not yet implemented Welsh essential recruitment policies, partly because student streamlining processes do not allow for it. He mentioned that they have offered opportunities to students from North Wales and other areas to encourage Welsh language diversity and are promoting Welsh language skills locally, but acknowledged there is more to do. RG stated that the question about making roles Welsh essential has come up before and that it is within the organisation's ability to designate a percentage of roles as Welsh essential, not just in Children and Women, but across CAVUHB. **The Committee Resolved that:** a) The Clinical Board Spotlight on Children & Women was noted.	
P&C 12/05/3.1	**Policies:** **Disciplinary Policy** **All Wales Improving Performance at Work Policy** The Associate Director of People & Culture – Katrina Griffiths (KG) highlighted that the committee was asked to approve the formal adoption of the new All Wales disciplinary policy and the All Wales Improvement Performance at Work policy (previously known as the capability policy). She noted both policies replace the current disciplinary and capability policies and have been approved by the Welsh Partnership Forum, coming to the committee for formal adoption within the UHB. The COO recognised that these are All Wales policies and stated the committee has no choice but to approve them. He raised concerns about moving from a staged capability process to a more supportive improvement focus, noting that previous changes to sickness policies led to increased discretion and inconsistency, and questioned whether the new policy would create similar risks and drive more inconsistency across the organisation. LM noted that the improving performance policy was piloted in Hywel Dda UHB because the capability policy is not used widely in any of the organisations, and positive feedback was received from Hywel Dda UHB that the procedure works and is embedded well there. **The Committee resolved to:** a) The development and approval of the All-Wales Disciplinary Policy and the All-Wales Improving Performance at Work Policy was noted. b) Formally adopt both policies on behalf of the Health Board	

	c) Endorse the proposed next steps to support implementation, including the development of supporting guidance and delivery of training and awareness sessions	
P&C 12/05/3.2	**Committee Annual Report** The CC noted that this was to be endorsed and will be taken to CAV UHB Board on 28th May 2026. **The Committee Resolved that:** a) The Annual Report was noted and endorsed for Board approval.	
P&C 12/05/4.1	**Digital Communications & Analytics** **The Committee Resolved that:** **a)** The Digital Communications & Analytics was noted.	
P&C 12/05/5.1	**Any Other Business** The Head of Equity & Inclusion – Mitchell Jones (MJ) noted the Welsh Language Commissioner has opened a new Welsh Language Standards enforcement investigation against CAVUHB regarding compliance with Standard 96, due to previous failure to comply and a complaint raised by a member of the public. He explained practical challenges, including difficulties with the ESR system, and stated they have worked closely with the Welsh Language Commissioner. He reported positive progress, with 74% of staff now registered for Welsh language skills, up from 61.3% in February, and described several steps taken to improve registration, including making it mandatory and enabling updates via Microsoft Forms. He stated there is nothing they haven't been able to improve, and although the process has been challenging, momentum is building and consistent progress is being made. RT asked if natural review checks are being built in to obtain Welsh language skills data, such as during onboarding or VBAs, and how much reflection has been undertaken to see if these questions are routinely asked within existing processes rather than through separate workarounds. MJ explained that Welsh language skills information should transfer directly from Trac when someone is recruited, and once the data is collected, there is no requirement to update it unless the individual's skills have improved. **Action- MJ to continue fortnightly updates to the Welsh Language Commissioner and provide a progress update at the next committee meeting in July.**	
P&C 12/05/5.1	**Private Agenda**	
P&C 12/05/6.1	**Review & Final Closure** The next meeting was scheduled on 21st July 2026 via MS Teams.	