Draft Minutes of the Public People and Culture Committee
Held On 21st July 2026
Via MS Teams

Recording (YouTube link) – Click here

Chair:		
Susan Lloyd-Selby	SLS	Independent Member – Local Authority / Committee Chair
Present:		
Lorna McCourt	LMC	Independent Member – Trade Union
Clive Curtis	CC	Independent Member for Local Community
Kirsty Williams	KW	CAV UHB Chair
Rhian Thomas	RT	Independent Member – Capital & Estates
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
Martyn Capel	MC	Associate Director of Medical Workforce
Paul Bostock	PB	Chief Operating Officer
Mitchell Jones	MJ	Head of Equity & Inclusion
Sarah Lloyd	SL	Director of Operations – Clinical Diagnostics & Therapies
Helen Luton	HL	Interim Director of Nursing – Clinical Diagnostics & Therapeutics
Ally Doherty	AD	Head of People & Culture
Alicia Christopher	AC	Interim Deputy Director of Operations – Clinical Diagnostics & Therapeutics
David Fluck	DF	Executive Medical Director
Rachel Pressley	RP	Head of People Assurance & Experience
Jason Roberts	JR	Executive Director of Nursing
Katrina Griffiths	KG	Associate Director of People & Culture
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		

Item no	Agenda Item	Action
P&C 21/07/1.1	**Welcome, Apologies & Introductions (click to view)** The Committee Chair (CC) welcomed everyone to the meeting.	
P&C 21/07/1.2	**Declarations of Interest (click to view)** No declarations of interest were noted.	
P&C 21/07/1.3	**Minutes from meeting on 12th May 2026 (click to view)** The minutes were agreed to be a true reflection of the meeting on 12th May 2026. **The Committee resolved that:** a) The draft minutes of the meeting held on 12th May 2026 were agreed to be a true and accurate record of the meeting.	
P&C 21/07/1.4	**Action Log following 12th May 2026 Meeting (click to view)** All actions have been addressed on the agenda today or added to a future meeting on the forward plan. **The Committee resolved that:** a) The Action Log was discussed and noted.	
P&C 21/07/1.5	**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 21/07/2.1	**Staff Story** Rachel Gidman – Executive Director of People & Culture (EDPC) introduced the staff story about speech and language therapy, highlighting Sarah Clement's role as equity and inclusion lead, emphasising the importance of turning policy into practice and volunteering as a champion and ally. The CC asked what support was offered to E&I champions across CAVUHB to enable them in their role. Mitchell Jones – Head of Equity & Inclusion (HEI) noted that Sarah was doing amazing work in equity and inclusion, highlighted capacity challenges, mentioned that inclusion ambassadors were previously considered but did not work as hoped and need to be reviewed, and emphasised the need to drive this work forward with more people like Sarah. The committee thanked Sarah for her work. **Action – The EDPC & HEI to review and update support for E&I champions and inclusion ambassadors, with progress to be reported in future meetings.**	

	The Committee resolved that: a) The Staff Story was received.	
P&C 21/07/2.2	**Board Assurance Framework - Welsh Resident Doctor Contract and Medical e-rostering** Martyn Capel – The Associate Director of Medical Workforce (ADMW) presented and highlighted the following: • The Welsh Resident Doctor contract was discussed, covering its implementation timeline, transition plan, terms and conditions changes, pay structure, e-rostering system procurement, financial assessment, workforce gaps, and the introduction of the Guardian of Safe and Flexible Working. • The phased transition from the 2002 contract to the 2026 contract, automatic transition for certain groups, and the project board established to guide implementation. • The new pay model, exception reporting process, job planning requirements, fatigue and safe working compliance, and increased study leave budget were detailed. • The uplift in pay scales were noted along with cost pressures, and the ongoing financial assessment and additionality requirements was discussed. • The procurement and rollout of the new e-rostering system was described, its benefits for workforce management, and the transition from multiple platforms to a centralised solution. • Workforce gaps were highlighted, business cases for additional posts, and the financial impact of filling these gaps. • The Guardian of Safe and Flexible Working role was explained, exception reporting, and associated fines for breaches, as well as the importance of timely job schedule submissions. • Next steps were summarised: reviewing remaining rotas, completing financial assessment, progressing e-rostering rollout, validating additionality, defining the guardian role, and preparing communications. Kirsty Williams – The CAVUHB Chair asked if the cost pressures from the new contract were currently factored into CAVUHB's budget for the year or if they were already included on a ballpark figure. The ADMW confirmed that a ballpark figure was estimated and included in the financial accrual for the contract, though the exact numbers were not yet finalised due to late system access. Rhian Thomas – the Independent Member Capital & Estates (IMCE) asked when the magnitude of the increase in costs would be known and requested a more definitive timeline for receiving the final numbers. The ADMW noted that the project board meets every Friday, and he expects to have more information in two to three weeks, after which he can share the numbers comparing the old and new costs. The EDPC stated she would ensure the information comes through to Board, aiming to bring it to the next Board meeting if available, and will make sure the loop is closed on this piece of work. The IMCE suggested that the information could be taken to Finance and Performance (F&P) as a paper for noting or further clarification, to expedite things between Board meetings.	

	Lianne Morse – Deputy Director of People & Culture (DDPC) clarified that some of the 18 workforce gaps existed before the new resident doctor contract, such as in urology and ENT, and wanted members to understand that not all costs are being driven by the new contract. The ADMW confirmed this, stating the gaps were consolidated but predate the contract. The CC asked about the implications of continued non-compliance with rotas and how the board can receive assurance that compliance will be achieved within required timescales. The ADMW responded that the rotas were compliant in essence, but the challenge is filling workforce gaps; compliance depends on meeting the new contract parameters, with the main issue being workforce fulfilment. Claire Beynon – Executive Director of Public Health (EDPH) referenced the risk register, noting the new contract was listed as a risk of level 20 due to potential unsafe staffing unless additional posts are funded. She asked if, now that documentation was available, the risk would decrease or if additional posts were still needed. David Fluck - Executive Medical Director (EMD) stated that additional posts were needed to make the rotas compliant and that, while the financial impact needs to be worked out, he believed the risk was reducing due to the team's work. The CAVUHB Chair wondered why the additional needs for posts and what the process was for reviewing the risks. How do we systematically review the risk scores in areas of work to ensure there is a proper process and how that is triangulated with other information. The EMD acknowledged there was conflict due to the direction of travel but emphasised this was a new contract and running rotas safely and in compliance would require some additional posts. He noted there were benefits, such as savings from the banding scheme and better deployment of resident doctors, and he does not think the financial shift would be significant, though more work was needed to determine the actual risk to CAVUHB. The DDPC confirmed that the people BAF was recently revised, with a commitment to review and update it each month to ensure risk levels remain appropriate and were revised as needed. **Action – The ADMW to provide definitive figures on the financial impact of the new contract within 2-3 weeks, with EDPC ensuring this is reported to the Board and Finance & Performance Committee.** **The Committee resolved that:** a) The Welsh Resident Doctor Contract 2026 was discussed and noted.	
P&C 21/07/2.3	**Key Performance Indicators** Lianne Morse – Deputy Director of People & Culture (DDPC) highlighted the following points: • The focus was on several key performance indicators, highlighting areas where targets are not being met, including reliance on bank and agency staff, sickness absence levels, appraisals, and statutory and mandatory training compliance. • Bank and agency spend was higher than last year, prompting discussions about tighter controls and interventions with clinical boards and corporate areas.	

	• Ongoing efforts to reduce sickness absence, mentioning small reductions and the focus on robust management, manager capability, and prevention. • The appraisals had risen to 76% but were still off target, and statutory and mandatory training compliance has increased to 80% in June, just below the target. These areas will be discussed with clinical boards for improvement trajectories. The CC noted that the pace and reliance on agency and bank workers was clearly affecting the trajectory of financial spend. She referenced previous committee advice that work was being done with clinical boards to identify hotspots and expressed concern that CAVUHB was off plan. She specifically asked where CAVUHB stood in terms of the work being done with clinical boards and questioned how the current position was reached despite that work. The DDPC confirmed the work with clinical boards to identify hotspots was done and stated the main drivers for agency and bank spend were vacancy, sickness, and additional capacity. She noted that despite this work, CAUHB showed higher spend on bank and agency compared to last year. The CAV Chair acknowledged there was an understanding of what was driving the spend and asked if, in conversations with SLT and clinical boards, there were specific guidance, actions, or expectations for each driving factor, or if the approach is generic. She questioned whether there are specific asks and expectations, emphasising that a generic approach ("we all need to do better") would not be effective. The COO stated that the number of substantive posts reduced because posts were held, but were being backfilled with temporary pay. He emphasised that this issue was being addressed through the turnaround meetings, mentioning that they were on their third round of these meetings and needed to understand whether posts were being permanently removed or just held and backfilled with temporary staff. The CC acknowledged that the committee has had this conversation for a considerable period, stating that holding posts and simply backfilling with temporary staff is not a sustainable solution going forward. The IMCE asked for more granular data to make conclusions, questioning whether the improvement in sickness levels was specific to a category of illness or seasonal, and whether trends were monitored to see if interventions led to better outcomes. The DDPC stated that their data shows year-on-year seasonal trends, with sickness increasing during the summer months. She noted that the current sickness trend is following the same pattern as previous years but was slightly less than it was in the last two years. The IMCE asked how, at the Clinical Board level and corporately, they will know that the sickness prevention interventions implemented were working to bring and keep sickness rates down, rather than just temporarily reducing them. The DDPC noted that Clinical Boards and corporate teams were monitoring their hotspots monthly, and sickness was reviewed through executive performance reviews to track whether rates are going up or down. The EDPH stated that they look at sickness levels through executive performance reviews and noted last year that Clinical Boards with higher vaccination rates had lower sickness rates. She observed a big variation in both vaccination and sickness	

	rates by Clinical Board and emphasised the importance of increasing vaccination rates, mentioning that work on next year's winter plan had started to address this. **Action – to bring a more detailed report on sickness and absenteeism, including granular data and intervention tracking, to the next committee meeting.** **The Committee resolved to:** a) The committee noted & discussed the content of the report.	
P&C 21/07/2.4	**Workforce Race Equality Standard and new Workforce Equality Standard** The HEI highlighted the following points: • **WRES Findings and Progress**: • Diverse workforce representation increased from 14.5% to 16%; representation above band 5 increased from 9% to 9.8%. Staff survey rates improved, and no racial inequality was found in access to non-mandatory training and CPD. • Persistent challenges include a bottleneck between band 5 and band 6 progression, a reduction in representation between band 6 and band 7, and ethnic minority applicants being about half as likely to be appointed after shortlisting. • Ethnicity declaration rates improved slightly, with undeclared ethnicity dropping from 11.7% to 10.7%. • The organisation is attracting a diverse workforce, but diversity is not translating into equitable progression to senior leadership roles. Recruitment disparities remain a barrier. • **Actions Taken**: • Conducted a detailed workforce data deep dive into representation, progression, and recruitment, identifying loss of ethnically diverse representation between bands 5 and 7, and highlighting allied healthcare professionals as a group with greater disparity. • Launched a "Your Career Your Voice" survey with over 550 responses to gather qualitative insight into staff perceptions of fairness and progression. • Developed inclusive recruitment videos covering unconscious bias, inclusive adverts, job descriptions, equality objectives, Welsh language, and reasonable adjustments to improve recruitment manager confidence and consistency. • Reviewed leadership and management development through an equality lens, strengthened values-based appraisals, and engaged with the Somali community in Cardiff. • **Transition to WES**: • WES is an evolution of RES, broadening workforce equality monitoring beyond race to include multiple protected characteristics and experiences such as menopause, paid carers, and socioeconomic backgrounds. • WES focuses on intersectionality, increased leadership ownership, stronger links between findings and strategic quality plan delivery, and moves from reporting activity to measuring organisational impact. • Next steps include maintaining focus on RES-identified issues, developing a focused action plan around WES, and strengthening workforce data and analytical capability. • WES aims to provide a stronger evidence base, targeting areas where change is most needed, strengthening accountability, leadership ownership, and measurable impact. Progression, recruitment, and senior representation will likely remain long-term structural challenges. The IMC expressed concern about the bottleneck affecting minority staff progression between bands 5 and 7, asking what was understood about its causes and what targeted actions are planned to address it.	

	The HEI explained the bottleneck was primarily at the shortlisting stage, where ethnically diverse applicants were less likely to progress. Targeted actions included developing inclusive recruitment videos to strengthen recruiting managers' awareness, guard against unconscious bias, improve job adverts and descriptions, and enhance the interview process. CAVUHB was waiting for WES findings before implementing further actions to ensure alignment with new priorities. The IMC asked what changes the committee can expect in assurance and risk identification as the transition occurs. The HEI responded that WES will be embedded more broadly across CAVUHB, including in the IMTP, and WG was focused on ensuring boards have the knowledge to scrutinise this work. The structure and reporting will be clearer once the WES report is received, but the direction is toward better governance and integration, not just reporting through people and culture or EDI teams. **The Committee resolved to:** a) The key findings of the 2025 WRES report was noted, including the need for continued focus on progression beyond Band 5, senior representation, recruitment fairness and ethnicity data quality. b) The transition from WRES to WES was noted, which broadens workforce equality monitoring across protected characteristics and places greater emphasis on intersectionality, measurable impact, leadership accountability and strategic assurance. c) The proposed shift from activity-based reporting to evidence-led assurance was supported, using workforce data, staff voice and community insight to target interventions, demonstrate impact and strengthen accountability across the Health Board.	
P&C 21/07/2.5	Welsh Language Skills and Commissioner The HEI highlighted the following points under the Welsh Language Skills and Commissioner item: • **Previous Issue and Requirement**: • A previous standards enforcement investigation was opened by the Welsh Language Commissioner's Office due to failure to comply with Standard 96, which requires assessment of Welsh language skills in the workforce. • Failure to meet the action set led to another investigation earlier this year, again focused on compliance with Welsh language skills assessment. • **Progress and Current Position**: • Since June 2025, progress has been made, with Welsh language skills registration increasing to 78%, but still 7% below the 85% target set by the Commissioner. • Four areas have met the target: All Wales Genomics Service, CDT, Capital Estates and Facilities, and Corporate Executives. • Registration growth has slowed, and remaining staff are concentrated in areas where engagement is historically difficult. • **Actions Taken**: • Welsh language skills registration became mandatory in February this year. • A simplified Microsoft form and paper versions were introduced to facilitate registration, not just through ESR. • Monitoring, reporting, and accountability were strengthened through Clinical Boards, with regular updates and breakdowns sent to departments. • Linked in with other NHS Wales colleagues to learn from their approaches and implemented all suggested steps. • **Challenges and Focus**:	

	• The challenge is now less about process and more about leadership, engagement, and delivery of compliance. • Medicine, Surgical Services, and Mental Health are below target and remain a focus for CAVUHB. • Next steps include targeted focus on these areas, seeking action plans and timelines, and continuing evidence provision to the Commissioner. • The goal is to use the data to build a more bilingual culture and improve services for Welsh-speaking patients. The EDPH highlighted the significant improvement in Capital Estates and Facilities (CEF), which saw an increase of more than 30% in Welsh language skills reporting between September and October 2025, moving from the lowest uptake to reaching the target in record time. She suggested that the work done in CEF should be replicated in other clinical boards with lower rates. The IMCE echoed the praise for CEF, noting their ability to deliver on missions and recognised their achievement. She applauded the improvement in the relationship with the Welsh Language Commissioner, describing it as a significant achievement compared to previous years. She pointed out that Welsh language standards apply to other Welsh public sector organisations, such as universities, and suggested reflecting on how these organisations progress this work, not just within NHS Wales. The IMC acknowledged the huge amount of work undertaken to improve Welsh language skills recording compared to previous years. He asked, once compliance was reached, how will Welsh language skills recording become part of business as usual within the Health Board, rather than a one-off push. The HEI explained that once Welsh language skills are recorded, they do not need to be recorded again, so once compliance is reached, it will remain. The ADODWC briefly noted that moving away from just measuring compliance (for Welsh language, VBAs, statutory and mandatory training) is key; these should become routine workforce practice and part of leadership, accountability, and team focus. She emphasised people need to understand the difference this can make and why it matters for patient outcomes. **Action - to focus targeted action plans for areas below compliance and refer risk to Board if 85% target is not met by deadline.** **The Committee resolved that:** a) The Welsh Language Commissioner's decision notice in relation to CS1436 and the finding of non-compliance with Standard 96 and the previous CS1063 enforcement action was noted. b) The Health Board's current Welsh language skills registration position of 77.14% as of the latest internal update was noted, against the Commissioner's required 85% target by 31 July 2026. c) The significant progress made over the past year was recognised, including the increase from 55.47% in June 2025 to 77.13% in June 2026, and the achievement of the 85% threshold by All Wales Genomics Service, Capital, Estates & Facilities, Clinical Diagnostics & Therapeutics, and Corporate Executives.	
P&C 21/07/2.6	People & Reputational Risks	

	Matt Phillips - Director of Corporate Governance (DCG) highlighted the following points on People & Reputational Risks: • The AAA reporting format was being used and will be rolled out to other committees, noting this was an initial demonstration and more work was needed on content and approach. • He described the transition from siloed spreadsheets to a single risk system, now offered visibility to all CAVUHB risks, with approx.1400 risks transferred. • The report was advisory, not assurance, as more work was needed on risk scoring maturity and categorisation for committee alignment. • He outlined ongoing moderation and review processes with clinical boards to ensure consistency, including a new organisational risk management group for standardising practices. • The database's usefulness for data-driven insights was highlighted, such as capital prioritisation, and its role in informing planning and people & culture strategies. • He stressed the need for executive and CBD overview to identify themes and create a more useful corporate risk register for board reporting. • Individual risks may not be helpful alone, but the focus should be on fragile services due to workforce gaps, training, and financial decisions, using the data for organisational improvement. The IMC noted that aligning high scoring organisational risks to committee structures is a helpful step forward. He observed that, of the eight people and reputational risks visible to the committee, three relate to premises and equipment (primarily health and safety), and questioned whether they are correctly aligned to this committee or should sit with the quality committee. **The Committee Resolved that:** a) The approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits was noted. b) The development of a consistent, organisation-wide approach to risk reporting and discussion within Committees was supported, including integration into forward plans and routine agenda items.	
P&C 21/07/2.7	**Clinical Board Spotlight – CD&T** Sarah Lloyd – Director of Operations CD&T (DOCD&T) introduced the Clinical Board spotlight and outlined the presentation focus: unique workforce challenges, staff engagement, actions to strengthen workforce sustainability and culture, and priorities for the year: • The importance of workforce sustainability was emphasised, staff experience, new workforce models, and continuous improvement, framing these as key themes for the committee to take away. • She provided context on CDT's professional diversity and complexity in workforce planning, highlighting national shortages, limited education pipelines, and the need for succession planning and skills development. • She summarised how the board has built on its previous position, moving from individual initiatives to a more integrated people and culture approach, aligning local priorities with wider organisational themes. Ally Doherty - Head of People & Culture (HPC) presented the current workforce position for CDT, highlighting workforce sustainability as a major challenge and emphasised the importance of having the right skills and people in place now and for the future. She highlighted the following points: • The workforce profile: largest group is allied health professionals (AHP), followed by additional clinical services, admin/clerical, and healthcare scientists, noting the board's professional diversity and the need for career development and succession planning.	

	• The age profile, turnover, statutory/mandatory training compliance, value-based appraisals, and sickness absence was discussed, stressing that headline metrics must be interpreted carefully, especially for small specialist teams. • It was explained that the board's focus on understanding underlying causes behind metrics, targeting interventions, and viewing workforce sustainability as a quality issue as much as a workforce issue. • It was outlined how workforce metrics are used for decision-making, describing four stages: workforce signalling, service effect, people response, and assurance, and detailed practical interventions for sickness, training, and appraisals. • CDT's workforce priorities align with the wider People and Culture Plan, emphasising a coherent strategy rather than isolated initiatives. • Staff survey feedback was used to inform actions, the engagement campaign, and the phased approach to implementing improvements at board, directorate, and team levels. Helen Luton noted: • The CD&T Talks podcast initiative, designed to improve engagement and communication across the diverse clinical board, providing staff with direct access to leaders, stories, and examples of innovation and good practice. • The podcast's role in complementing formal engagement routes was emphasised, aiming to create a stronger sense of connection and visibility for staff voice. • The challenges in sustaining progress was highlighted, prioritising effort, and evidencing improvements in staff experience, noting the need to spread inclusion work and support for menopause through trained champions. • The menopause support initiative led by Suzanne Rees was noted, focusing on creating an inclusive workplace, supporting managers, and helping colleagues access information, with 13 menopause champions trained and potential for wider adoption. **The Committee Resolved that:** a) The Clinical Board Spotlight on CD&T was noted.	
P&C 21/07/3.1	**Policies:** No Policies **The Committee resolved to:** a)	
P&C 21/07/5.1	**Any Other Business** No further business was noted.	
P&C 21/07/5.1	**Private Agenda**	
P&C 21/07/6.1	**Review & Final Closure** The next meeting is scheduled on 08th September 2026 via MS Teams.	