People & Culture Committee

21st July 2026
9am
Via MS Teams
Public Agenda

09:00	**1**	**Standing Items**	
5 mins	1.1	Welcome, Introductions & Apologies	Susan Lloyd-Selby
	1.2	Declarations of Interest	Susan Lloyd-Selby
	1.3	Minutes from the previous meeting – 12th May 2026	Susan Lloyd-Selby
	1.4	Action Log following the previous meeting – 12th May 2026	Susan Lloyd-Selby
	1.5	Committee Chair's Actions	Susan Lloyd-Selby
09:05	**2**	**Items for Review & Assurance - (09:05 –10:50)**	
15 mins	2.1	Staff Story – Speech & Language Therapy	Rachel Gidman
20 Mins	2.2	Board Assurance Framework - Welsh Resident Doctor Contract and Medical e-rostering	Martyn Cappell / Mike Stephens
15 Mins	2.3	Key Performance Indicators	Lianne Morse
15 Mins	2.4	Task & Finish Group – Representation & Progression (Equity & Inclusion)	Mitchell Jones
10 Mins	2.5	Welsh Language Skills and Commissioner	Mitchell Jones
5 Mins	2.6	People & Reputational Risks	Matt Phillips
25 Mins	2.7	Clinical Board Spotlight – CD&T	Sarah Lloyd / Alicia Christopher / Helen Luton / Ally Doherty
10:50	**3**	**Items for Approval - (10:50-10:55)**	
5 Mins	3.1	Policies: No Items	
10:55	**4**	**Items for Information & Noting**	
0 Mins	4.1	Digital Communications & Analytics	Jo Brandon
10:55	**5**	**Any Other Business**	
10:55	**6**	**Private Agenda Items:**	
	6.1	• *People & Culture Updates* • *Employee Relation Cases*	
10:55	**7**	**Review & Final Closure** (to include any actions from the meeting)	
	7.1	Items to be deferred to Board	Susan Lloyd-Selby
	7.2	To note the date & time of the next meeting: **Tuesday 08th September 2026 at 9am via MS Teams**	Susan Lloyd-Selby

"To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960"

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.	

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
PEOPLE & CULTURE	Board Assurance Framework - Culture	P&C 14/10/2.2	To develop a cultural picture dashboard, with support from local universities and postgraduate students, aiming for placements in 2026.	Rachel Gidman	Claire Whiles	14/10/2025	21/07/2026	ON FORWARD PLAN	Complete and added to the forward plan for 21st July 2026.
PEOPLE & CULTURE	Strategic Equality Plan	P&C 14/10/2.4	For the results and analysis of the gender pay gap deep dive to come back to the committee next year once the information is available and has been analysed	Rachel Gidman	Mitchell Jones	14/10/2025	08/09/2026	ON FORWARD PLAN	added to the forward plan for 08th September 2026.
PEOPLE & CULTURE	People & Culture Plan Refresh	P&C 25/11/2.3	Engagement with staff in the New Year to determine whether to refresh or create a new People and Culture Plan, with a focus on digital, AI, and regional working.	Rachel Gidman	Rachel Gidman	25/11/2025	08/09/2026	ON FORWARD PLAN	added to the forward plan for 08th September 2026
PEOPLE & CULTURE	Clinical Board Spotlight - Specialist Services	P&C 17/02/2.7	Rachel Gidman to provide names of non-compliant staff on fire training to JC and CT for targeted follow-up between meetings.	Rachel Gidman	Rachel Gidman	17/02/2026	21/07/2026	ON FORWARD PLAN	This has been added to the forward plan for 21st July 2026.
PEOPLE & CULTURE	Board Assurance Framework	12/05/2.2	Lianne Morse 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.	Rachel Gidman	Lianne Morse	12/05/2026	21/07/2026	ON FORWARD PLAN	Added to the forward plan for 21st July 2026.
PEOPLE & CULTURE	Key Performance Indicators	12/05/2.3	Lianne Morse to provide more granular workforce data (by staff group, band, Clinical Board) and include total workforce spend in future reports.	Rachel Gidman	Lianne Morse	12/05/2026	21/07/2026	ON FORWARD PLAN	This has been added to the forward plan for 21st July 2026.
PEOPLE & CULTURE	Key Performance Indicators	12/05/2.3	Lianne Morse to bring back data on all forms of absence (sickness, parental leave, etc.) for a fuller picture.	Rachel Gidman	Lianne Morse	12/05/2026	21/07/2026	ON FORWARD PLAN	This has been added to the forward plan for 21st July 2026.
PEOPLE & CULTURE	Welsh Language Standards	12/05/5.1	Mitchell Jones to continue fortnightly updates to the Welsh Language Commissioner and provide a progress update at the next committee meeting in July.	Rachel Gidman	Mitchell Jones	12/05/2026	21/07/2026	ON FORWARD PLAN	This has been added to the forward plan for 21st July 2026.

Report Title:	Welsh Resident Doctor Contract 2026				Agenda Item No:	2.2	
Meeting:	People & Culture Committee	Public	X		Meeting Date:	21.7.26	
		Private					
Status **(please only tick one)**	Assurance		Approval		Information/Noting		
Lead Executive Title:	Medical Director						
Report Author Title:	Associate Director of Medical Workforce & Resourcing						

Main Report
Background and Current Situation:

Presentation Attached (2.2a) to be presented and discussed at the People & Culture committee meeting.

Executive Director Opinion & Key Issues to bring to the attention of the Board/Committee/SLT (delete as appropriate)

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Recommendations:

a) The presentation is to be discussed and noted.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*		

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Welsh Resident Doctor Contract 2026

21st July 2026

Agenda

1. Overview
2. Phased Transition Plan
3. Terms & Conditions Variations
4. Pay Scales/Spines
5. Procurement of E-Systems
6. Impact Rota Assessment
7. Finance Assessment & Additionality
8. Introduction to the Guardian of Safe & Flexible Working
9. Next Steps

Overview

Following negotiations between the BMA and NHS Wales Employers, resident doctors and final-year medical students in Wales voted to accept a reformed resident doctor contract, with 83% supporting the offer in a referendum.

The new contract provides an additional 4% recurrent investment in the resident doctor workforce and introduces significant improvements to pay, working conditions, safe working protections, study leave arrangements, and career development opportunities.

Phased Transition Plan

Date	Transition
August 2026	2002 Contract to Close
	New appointment at all levels
	Existing residents at foundation level
	Residents in unbanded rota
August 2027	Remaining residents within the Core training level
	Transition opens to residents in higher training level
August 2028	All remaining residents with more than 12 months to CCT or residents meeting exception criteria

A multidisciplinary Project Board has been established to lead the implementation of the Welsh Resident Doctor Contract across Cardiff and Vale UHB. The Board is overseeing the programme of work required to support a successful transition, including workforce, rostering, payroll, finance, governance and operational readiness, in advance of the August 2026 implementation date

Terms & Conditions Variations

Area	2002 Terms & Conditions	2026 Welsh Resident Doctor Contract
Pay Structure	Based on basic salary plus banding supplements linked to rota intensity and working patterns.	New hours-based pay model with a simplified pay scale. Doctors are paid for all contracted hours worked above a 40-hour week.
Additional Hours	Remuneration primarily achieved through banding arrangements.	Additional contracted hours are paid directly, providing a clearer relationship between hours worked and pay received.
Enhanced Hours	Complex banding arrangements applied to unsocial working patterns.	Hours worked outside 7am–7pm Monday to Friday attract enhanced pay at 1.5 times the basic hourly rate.
Rota Monitoring	Reliance on periodic rota monitoring exercises to assess compliance and workload.	Introduction of a simplified overtime system and formal exception reporting process.
Exception Reporting	No formal exception reporting mechanism.	Doctors can report breaches relating to safe working, staffing levels, education and training opportunities, and job plan compliance.
Job Planning	No requirement for individualised job plans.	Individual job plans for all resident doctors setting out working patterns, training objectives, Educational Development Time (EDT) and staffing requirements.
Fatigue & Safe Working	Limited contractual protection regarding fatigue and rest facilities.	Fatigue and Facilities Charter incorporated into contractual arrangements, including rest requirements, night-working protections and access to welfare facilities.
Safe Working Oversight	No equivalent independent oversight role.	Guardian of Safe and Flexible Working introduced to oversee compliance, exception reporting and safe working practices.
Study Leave & Study Budget	More variable and restrictive access to study leave and reimbursement	Increased study budgets, Greater flexibility in accessing study leave, Reimbursement at the point costs are incurred.

Pay Scales/Spines

Grade	Payscale and Grade Step	Year	Spine	Pay Value	Uplifted 2026/27 Pay Award (3.5%)
F1	MF01-01		1	£40,000	£41,400
F2	MF02-01		1	£50,000	£51,750
Registrar	MF03-01	1	1	£55,000	£56,925
	MF03-02	2			
	MF03-03	3	2	£62,000	£64,170
	MF03-04	4			
	MF03-05	5	3	£68,000	£70,380
	MF03-06	6			
	MF03-07	7	4	£74,000	£76,590
	MF03-08	8			
	MF03-09	9	5	£78,000	£80,730
	MF03-10	10			

Procurement of E-Rostering System

As part of the implementation of the Welsh Resident Doctor Contract, NHS Wales Shared Services Partnership (NWSSP) has undertaken an all-Wales procurement of the Allocate/RLDatix e-Rostering solution to support compliance with the new contractual requirements and workforce management arrangements. The contract has been awarded on a 4+2+2-year basis, with a total contract value of £1.12 million across the full term, equivalent to an average annual cost of approximately £140,000.

Cardiff and Vale UHB currently operates four separate medical e-rostering systems: HealthRota, MediRota (RotaMap), Momentum (Bio-Optronics) and CLW (MediRota). These systems incur a combined annual cost of approximately £124,000. Subject to implementation of the all-Wales solution, the Health Board will seek to decommission these existing platforms, resulting in a largely cost-neutral position while delivering the benefits of a single standardised rostering system aligned to national contract requirements.

Impact Rota Assessment

Initial assessment carried out in April 26, of the 87 OOH rotas identified 37.93% (33 rotas) being compliant with the new 2026 contract. Progressive work between April and now has been taken which has elevated our compliance position to 87.36% (76 rotas) which leaves a balance of 11 rotas requiring action, this action is workforce gaps.

An initial assessment in April 2026 identified that 33 of 87 rotas (37.9%) were compliant with the new standards. Through focused engagement with services and progressive rota redesign, compliance has increased to 76 of 87 rotas (87.4%). The remaining 11 rotas require further action to achieve compliance, with workforce capacity gaps identified as the primary constraint. Targeted work is ongoing with affected specialties to address these challenge.

Finance Assessment

A detailed financial impact assessment is currently being undertaken to evaluate the implications of transitioning from the 2002 Terms and Conditions of Service to the 2026 Welsh Resident Doctor Contract.

Initial analysis indicates that the new contractual arrangements are likely to result in additional workforce costs for the Health Board, driven principally by changes to out-of-hours working arrangements and remuneration structures.

Additionality (Locally Employed Doctors)

Specialty/Level	Grade	No of Gaps	Salary Scale
Neonates Tier 2	SAS	2	£54,137 - £100,950
Neonates Tier 1	Clinical Fellow	2	£56-925 - £64,170
Haematology SpR	SAS	2	£54,137 - £100,950
ENT Junior	Clinical Fellow	2	£56-925 - £64,170
ENT Senior	Clinical Fellow	2	£70,380 - £80,730
Max Fax SpR (Tier 2)	Clinical Fellow	1	£70,380 - £80,730
Urology Junior	Clinical Fellow	4	£56-925 - £64,170
PICU	TBC	1	£70,380 - £80,730
IUT Junior	Clinical Fellow	1	£56-925 - £64,170
Nephrology Junior	Clinical Fellow	1	£56-925 - £64,170
Total		18	

Estimated cost inclusive of on costs (28.8%) if all posts are appointed at bottom of scale - **£1.42M**

Estimated cost inclusive of on costs (28.8%) if all posts are appointed at bottom of scale - **£1.77M**

Introduction of the Guardian of Safe & Flexible Working

The primary purpose of the Guardian of Safe and Flexible Working is to provide independent oversight of resident doctors' working patterns, ensuring that safe working hours, appropriate rest, training opportunities and contractual protections are upheld under the new contract. The Guardian acts as a key assurance mechanism for both doctors and employers by monitoring compliance with the contract and addressing concerns where working arrangements fall outside agreed standards.

From an employer perspective, the Guardian role introduces a new level of workforce governance and assurance. It provides independent scrutiny of:

- Rota design and compliance
- Fatigue and safe-working risks
- Access to training and Educational Development Time (EDT)
- Exception reporting outcomes
- Organisational compliance with the Fatigue and Facilities Charter
- Fines

Next Steps

- Focus on the remaining 11 rotas
- Complete full financial assessment
- Progress e-rostering rollout
- Validate additionality requirements
- Define the Guardian operating model
- Prepare communication and engagement documents

Report Title:	Key Workforce Performance Indicators			Agenda Item no.	2.3
Meeting:	People & Culture Committee	Public	X	Meeting Date:	21/07/26
		Private			
Status *(please tick one only):*	Assurance	X	Approval	Information	
Lead Executive Title:	Executive Director of People and Culture				
Report Author (Title):	People Assurance and Experience Manager				

Main Report Background and current situation:

Overview

This report, provides the People and Culture Committee with an update on key workforce performance indicators and progress against the three priority actions for 2026/27 outlined in the Annual Plan:

- Improve workforce health, wellbeing and availability
- Strengthen system leadership and management capability to create consistent, compassionate and accountable cultures
- Develop workforce planning capability and capacity whilst using workforce data and insights to drive informed decision-making and future workforce sustainability.

The paper also aims to provide assurance on workforce risks, provides updates on wider people and culture activity, and highlights specific areas of focus from across the organisation.

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At a Glance – Report Structure

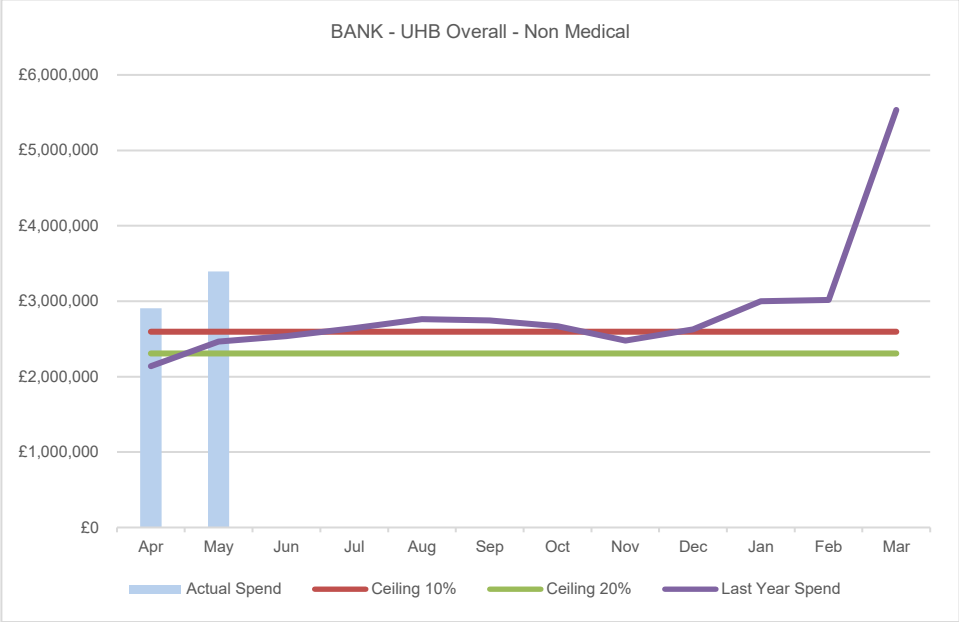
- **Section 1 - KPI Highlights -** Including Welsh Government enabling actions and workforce productivity recommendations with the Ministerial Advisory Group (MAG) Report.
- **Section 2 - People & Culture Priorities -** Update on progress and delivery of the actions.
- **Section 3 – Employee Suspensions -** Overview of current suspension/exclusion cases, duration, reasons, and review processes.
- **Section 4 - Spotlight:** (*Each month we will focus on a different performance related deliverable*). **Absence/ Sickness**
- **Section 5 - Clinical Board Update -** High-level KPIs and workforce insights from **Clinical Diagnostics and Therapeutics (CD&T) Clinical Board**

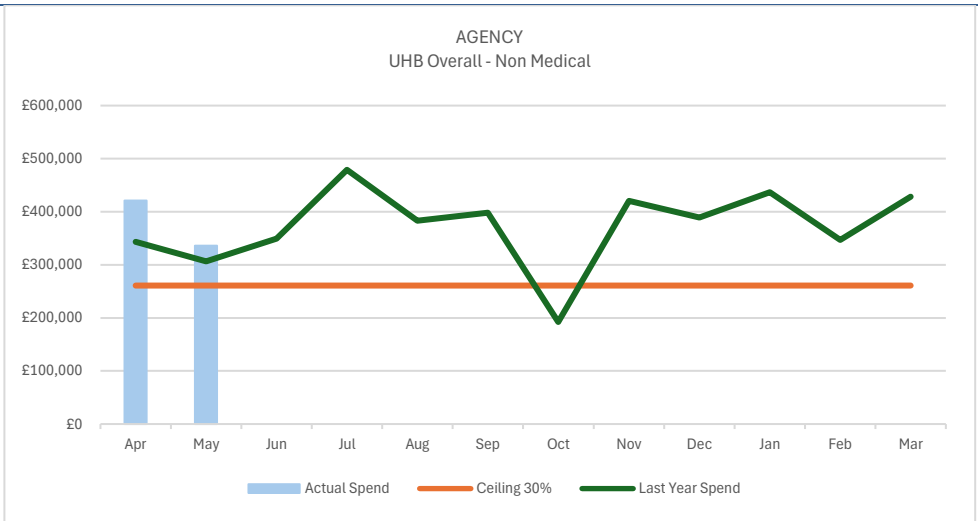
Section 1 - KPI Highlights

Highlights to bring to the Committee's attention include:

Reducing the reliance on bank and agency continues to be a key focus, aligned to the WG Enabling actions for 2026/27. The graphs below show the overall bank and agency costs for non-medical staff groups, highlighting performance against the 30% reduction set by WG and the >10% reduction in bank set by the UHB. Performance is monitored monthly and is reported into . Executive Performance Reviews (EPR) and recently established internal turnaround meetings.

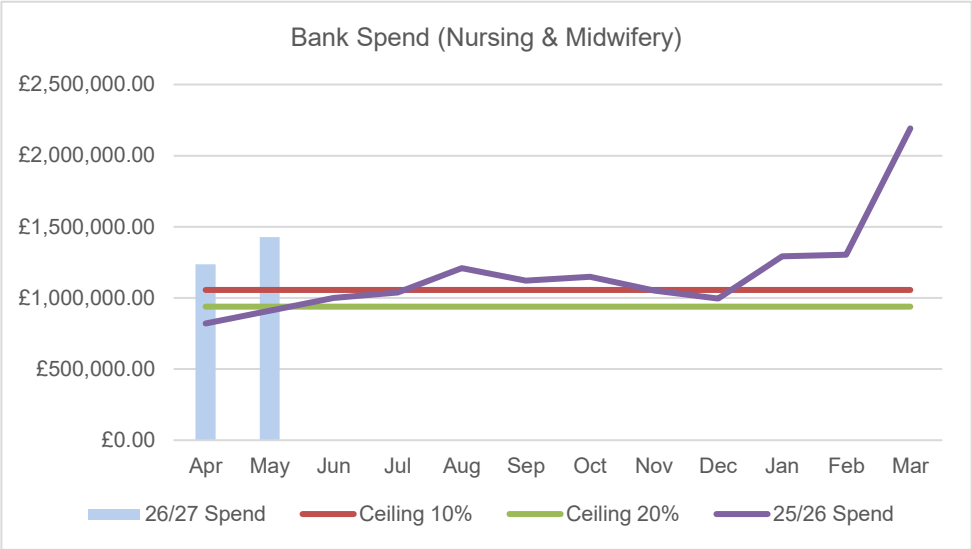
Bank and agency spend shows a mixed position between April and May 2026. Bank expenditure increased by £333k, rising from £4.19m to £4.53m, indicating continued operational reliance on temporary staffing to support service delivery. In contrast, agency spend reduced by £111k, falling from £623k to £513k, which demonstrates positive progress against the agency reduction agenda and Welsh Government enabling actions.

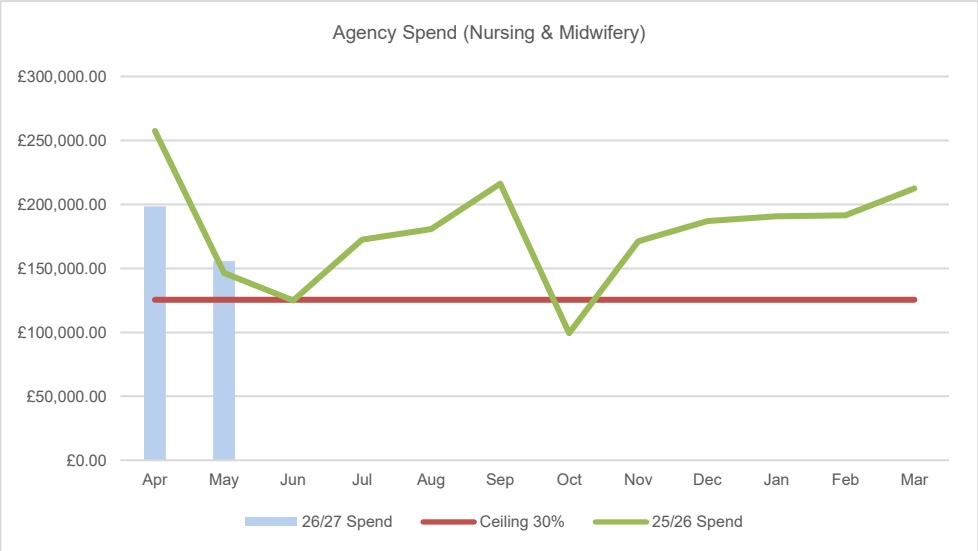




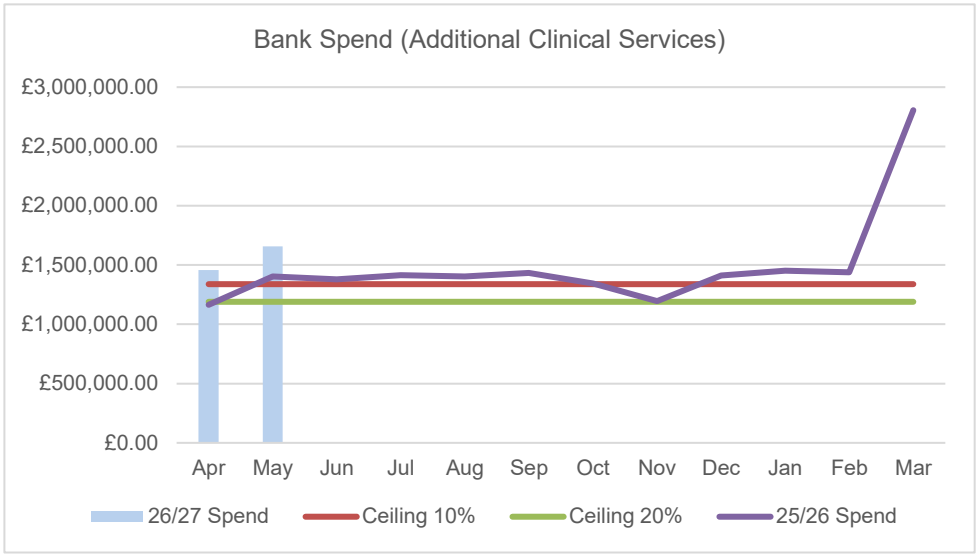
The graphs below show the breakdown by staff group:

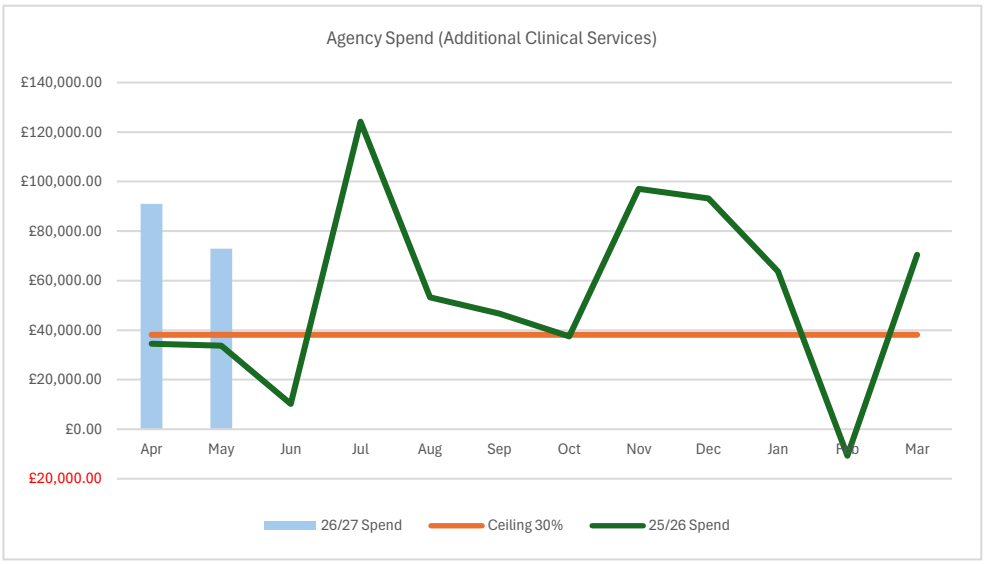
Nursing & Midwifery:





Additional Clinical Services:



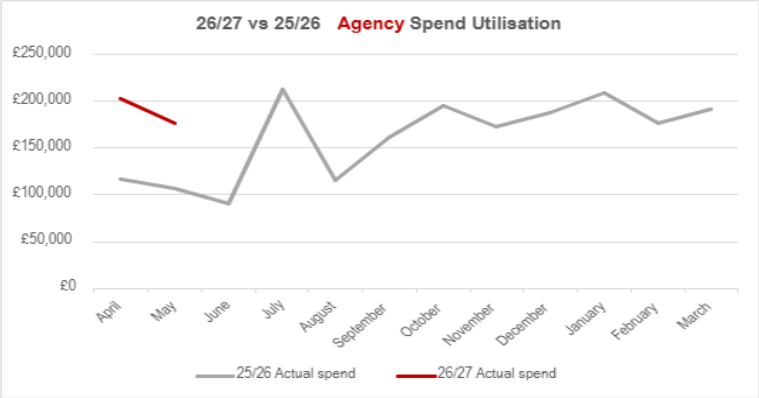


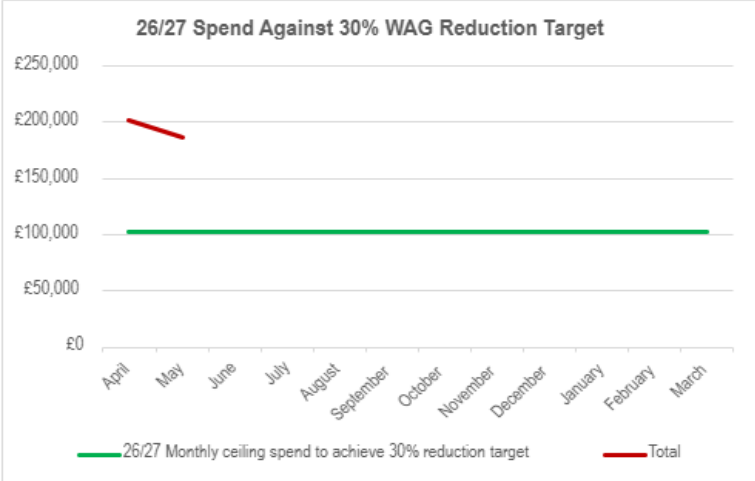
Medical & Dental

Delivery of the Welsh Government enabling action to achieve a further 30% year-on-year reduction in agency expenditure presents a significant challenge. This is primarily due to the over-delivery achieved in 2025/26, where a 35% reduction was realised, resulting in a comparatively low baseline for the current financial year.

As a consequence, the remaining savings requirement of £527k represents a material delivery risk against a reduced starting position. We are currently tracking £173K above ceiling plan within the first 2 months of the year.

Mitigating actions have been implemented to address this position. These include the re-establishment of an Executive Agency Scrutiny Panel to strengthen oversight and challenge, alongside targeted engagement with existing agency workers to support conversion to bank or substantive employment where appropriate.



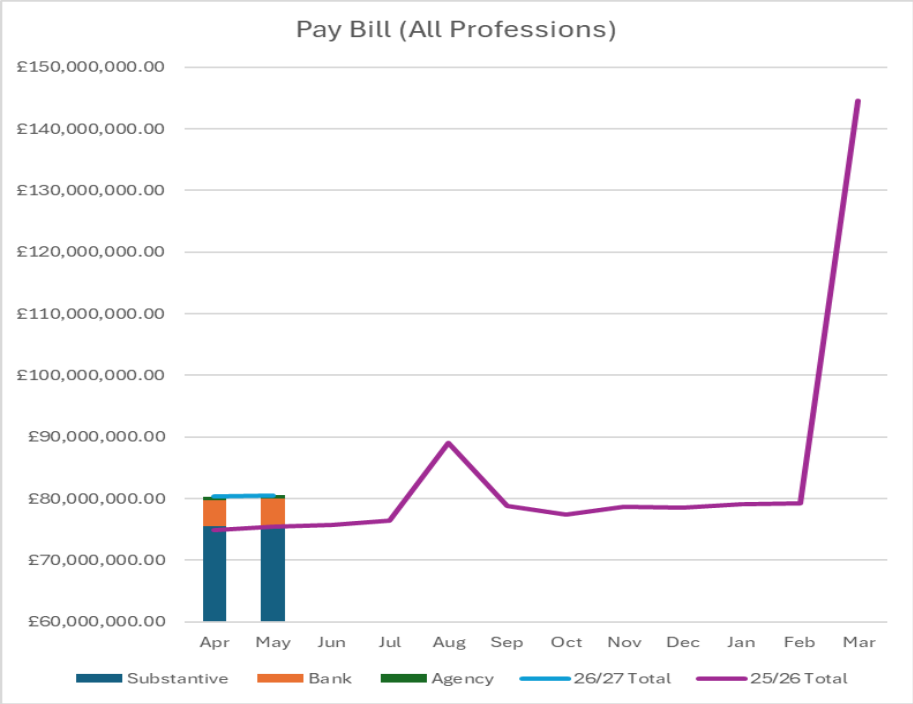


The organisation is currently utilising ten medical agency workers. Robust exit strategies have been identified for three individuals, with ongoing engagement in place for the remainder. A step-change approach is being adopted to facilitate conversion to bank or, where feasible, substantive employment.

In parallel, strengthened controls are being applied at the point of engagement. This includes proactive negotiation with agencies to ensure that agency workers are remunerated in line with PAYE and Working Time Regulations rates equivalent to bank workers. As a result, agency utilisation is limited to the agency commission as the only additional on-cost.

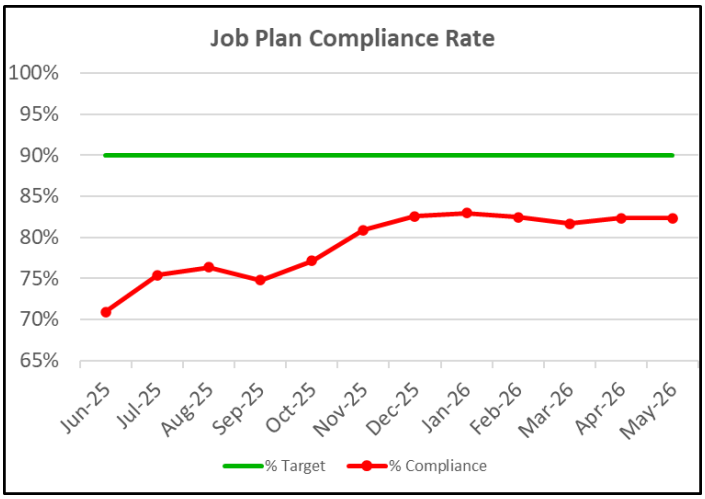
Overall Pay Bill all staff groups

	Apr-26	**May-26**
Substantive	£75,518,983.44	£75,515,282.94
Bank	£4,193,019.05	£4,526,108.75
Agency	£623,319.51	£512,633.75
26/27 Total	**£80,335,322.00**	**£80,554,025.44**
25/26 Total	**£74,902,202.86**	**£75,473,763.65**
Variance YOY	£5,433,119.14	£5,080,261.79

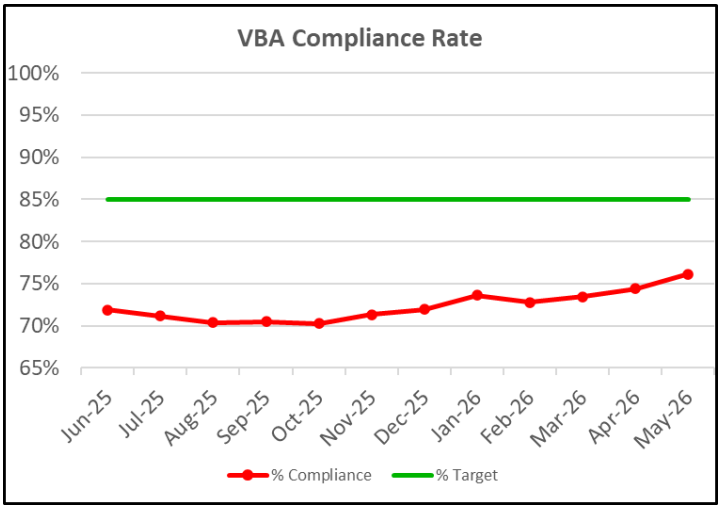


Overall pay costs increased slightly between April and May 2026, rising by £218,703 from £80.34m to £80.55m. Substantive pay remained broadly stable, reducing marginally by £3,701, while bank spend increased by £333,090, indicating continued reliance on temporary staffing. Agency expenditure reduced by £110,686, from £623,320 in April to £512,634 in May, demonstrating positive progress against the agency reduction agenda. However, total pay costs remain significantly above the same period in 2025/26, with a year-on-year variance of £5.43m in April and £5.08m in May. While the reduction in agency spend is encouraging, the overall pay bill continues to reflect wider workforce cost pressures, particularly in relation to bank usage.

Job Planning – Management teams continue to prioritise job planning, with targeted attention on areas showing lower levels of compliance. Following recent communication from the Medical Director, compliance is steadily progressing towards the Welsh Government's 90% target, with the current rate at 82%. A further increase of 8% is required to reach 90% compliance – this equates to approx. 90 clinicians. The quality of job plan content has also noticeably strengthened. Our focus now is to maintain this positive momentum, achieving the 90% target while sustaining the high standard of job plan content.

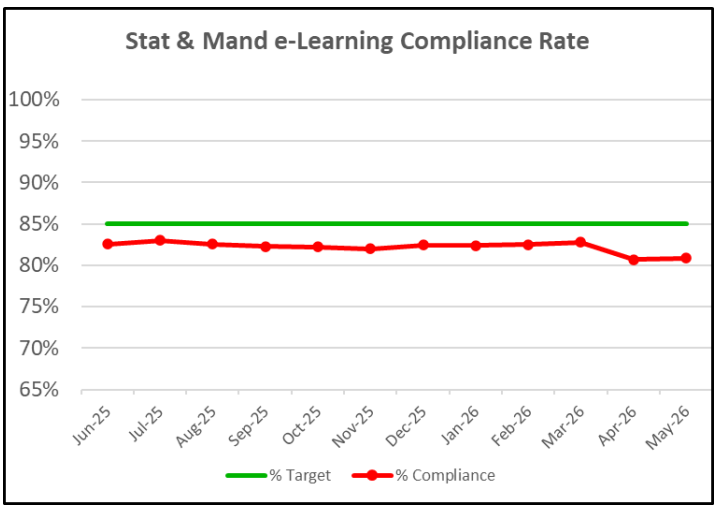


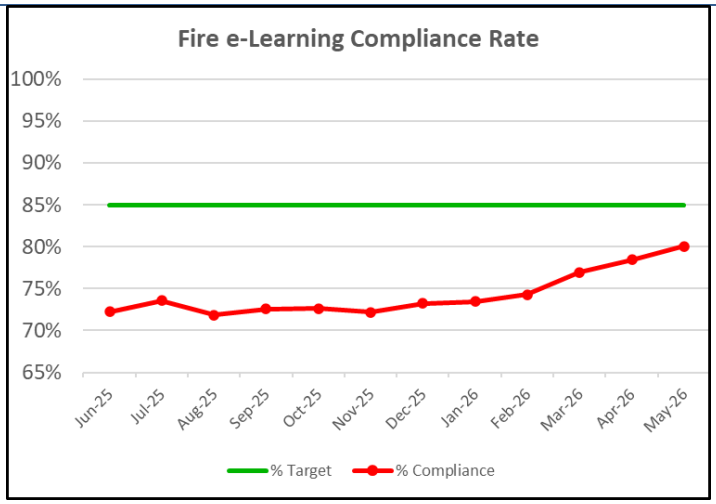
The **Values-Based Appraisal** compliance rate remains below the 85% target. In May 2026 the compliance rate was 76.15%, which has increased since February 2026, and is higher when compared to May 2025 (71.79%). VBA compliance continues to be a focus of Clinical Board Reviews, and more work is needed on identifying deliverable improvement trajectories. To support this, Business Partners are monitoring on a weekly basis, with lists of non-compliant staff being shared with CBs. A review of the VBA template is underway to ensure improvements in compliance, quality, and measurable outcomes.



The overall **Statutory & Mandatory** compliance rate is slightly below the 85% target. As of May 2026, the compliance rate was 80.85%. The step decrease in compliance from April is due to the requirement to record Welsh language skills being added as a mandatory requirement.

Compliance with **Fire** Learning is lower; 80.04% in May 2026. Fire learning compliance is being monitored weekly, with non-compliant staff being identified for the Clinical Boards. Face to face fire training is now being offered via Teams, which will make it easier for individuals to attend. The increase in compliance between February 2026 and May 2026 of 5.77% is shown in the graph below. Forthcoming changes will allow the Health & Safety team to put on fire safety training weeks as in previous years where back-to-back sessions will be provided.

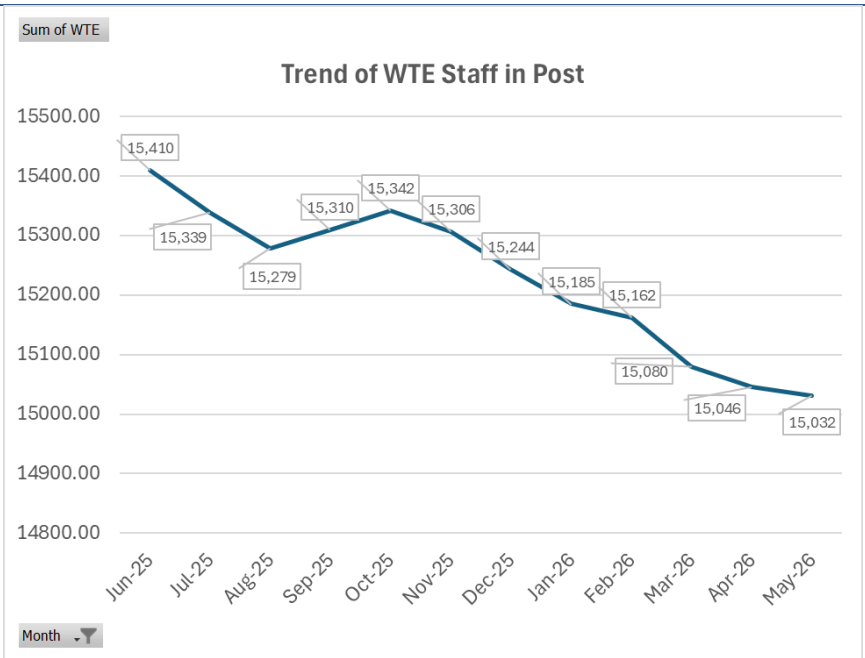




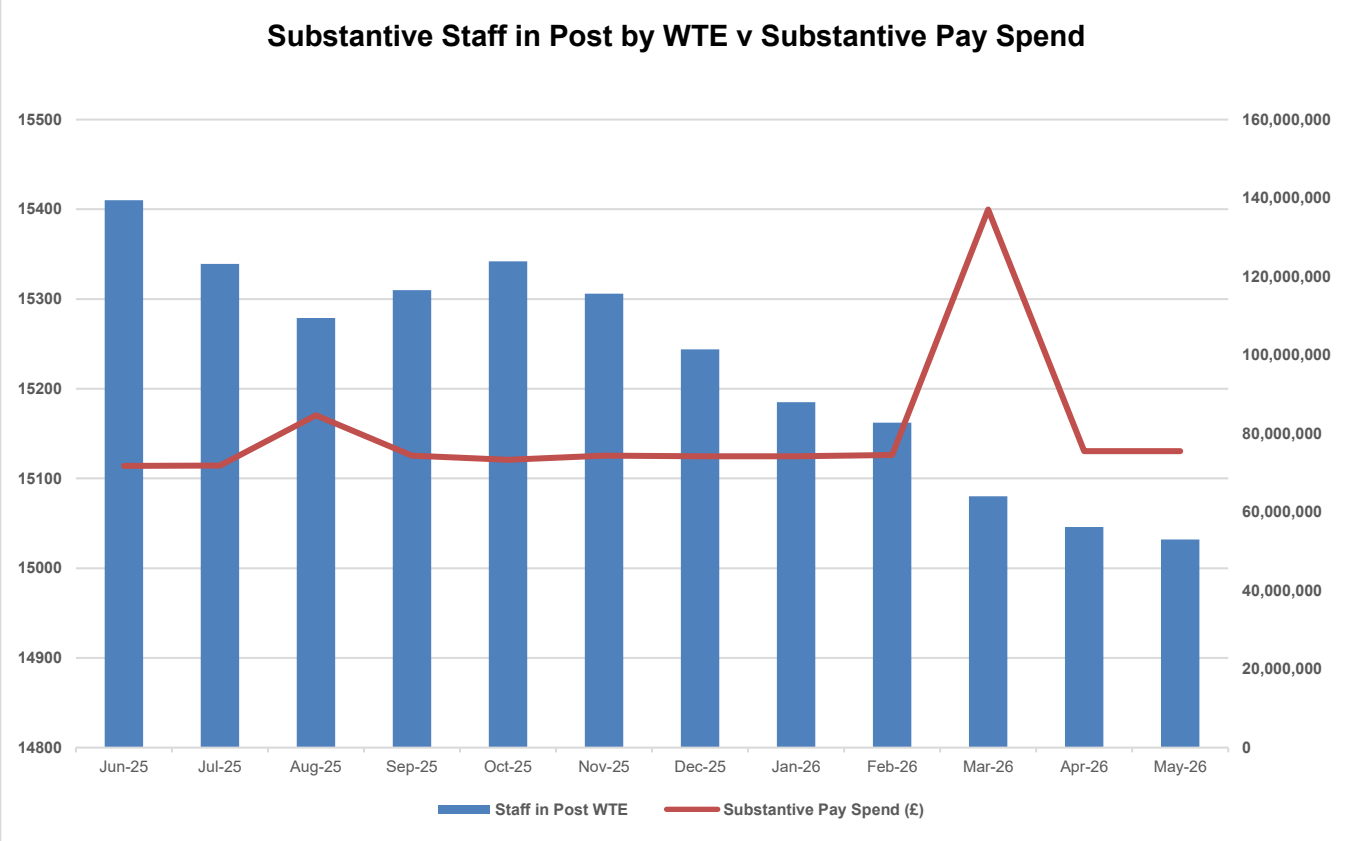
The **WTE Staff in Post** has fallen from 15,410 WTE in June 2025 to 15,032 WTE at May 2026. The increases during September and October 2025 reflects the commitment to take new graduate nurses and therapists – which was forecast and approved. Despite this increase however, the staff in post reduced from November onwards and has reduced each month since in line with the UHB's plan to stop workforce growth.

Staff Group	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	12-Month Change
Add Prof Scientific and Technic	598	600	601	597	605	605	604	602	603	603	598	597	0
Additional Clinical Services	3007	2990	2969	2943	2918	2898	2875	2859	2842	2819	2809	2813	-194
Administrative and Clerical	2640	2663	2644	2643	2595	2582	2573	2581	2580	2557	2554	2555	-85
Allied Health Professionals	1267	1258	1268	1283	1301	1307	1302	1293	1292	1287	1281	1271	4
Estates and Ancillary	1203	1193	1184	1185	1215	1210	1198	1181	1181	1179	1190	1188	-15
Healthcare Scientists	565	562	554	562	568	571	572	574	576	574	574	575	11
Medical and Dental	1160	1150	1139	1152	1150	1150	1151	1150	1159	1157	1160	1159	-1
Nursing and Midwifery Registered	4944	4901	4897	4929	4965	4959	4945	4927	4911	4886	4859	4856	-88
Students	26	24	23	17	25	25	25	20	20	19	20	17	-9
Grand Total	**15410**	**15339**	**15279**	**15310**	**15342**	**15306**	**15244**	**15185**	**15162**	**15080**	**15046**	**15032**	**-378**

Clinical Board	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	12-Month Change
All Wales Genomics Service	336	333	329	332	335	343	341	345	347	330	339	338	2
Capital, Estates & Facilities	1249	1242	1232	1236	1229	1224	1213	1214	1213	1206	1218	1214	-36
Children & Women	2056	2025	2016	2003	1951	1901	1889	1875	1872	1859	1865	1866	-190
Clinical Diagnostics & Therapeutics	2399	2390	2395	2397	2477	2513	2501	2481	2479	2468	2444	2436	36
Corporate Executives	945	969	964	971	973	953	948	954	956	952	954	957	12
Medicine	1883	1876	1860	1848	1834	1818	1817	1806	1801	1793	1576	1582	-301
Mental Health	1399	1382	1375	1379	1384	1380	1370	1371	1370	1367	1358	1358	-40
Primary, Community Intermediate Care	898	902	903	913	910	927	922	916	912	903	1008	1002	104
Specialist Services	2051	2030	2017	2031	2033	2035	2031	2027	2025	2019	2108	2104	52
Surgical Services	2194	2191	2187	2201	2216	2211	2212	2194	2187	2183	2176	2175	-18
Grand Total	**15410**	**15339**	**15279**	**15310**	**15342**	**15306**	**15244**	**15185**	**15162**	**15080**	**15046**	**15032**	**-378**



The reduction of 378 WTE in the last year has been achieved following a number of measures implemented, including the executive level scrutiny of vacancy requests, a recruitment freeze and a review of the skill mix within some Clinical Boards.

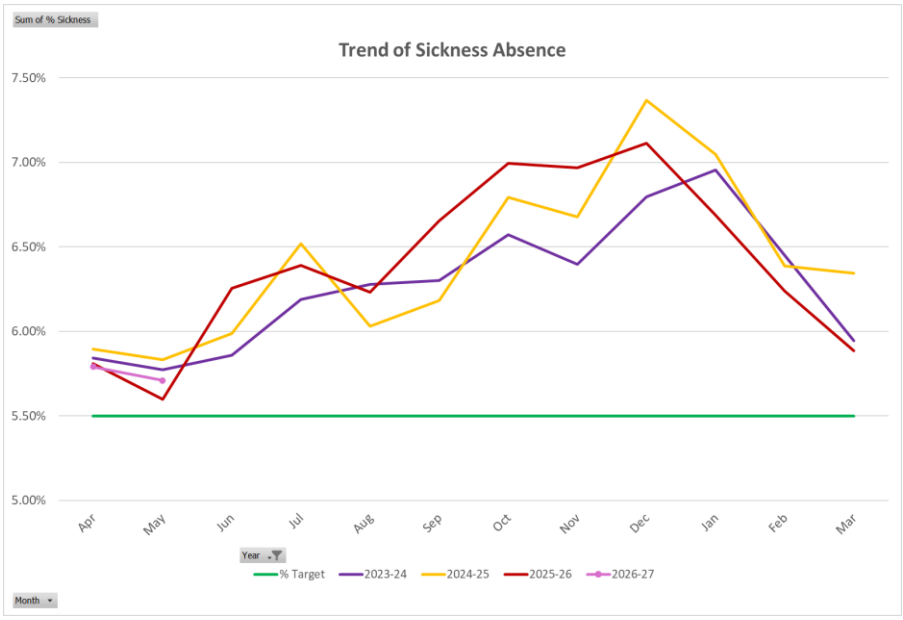


The WTE substantive staff in post peaked at 15,410 in June 2025 and was at its lowest level in May 2026 with 378 WTE less in post. The total pay spend for substantive staff increased in March due to year-end adjustments including the additional superannuation charge but has reduced again in May 2026. The increase in August 2025 was due to the annual pay award..

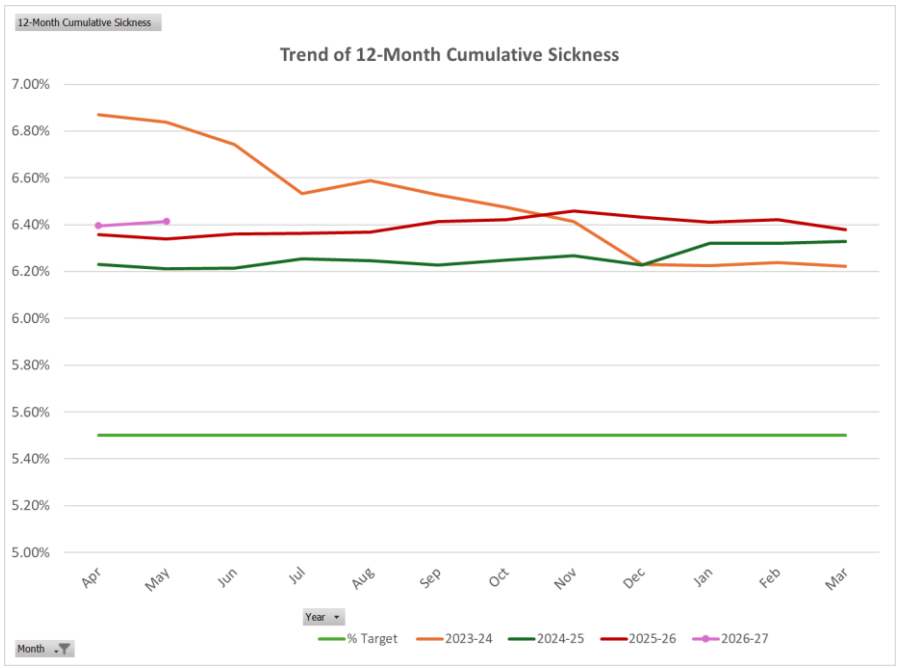
Section 2 – People & Culture Priorities

Improving Wellbeing and Attendance

The Health Board's target for **Sickness** is <5.50%. The monthly sickness rate at May 2026 was 5.71%. The in-month sickness rates in 2026 were broadly lower than those for the previous 2 years, as can be seen in the chart below.



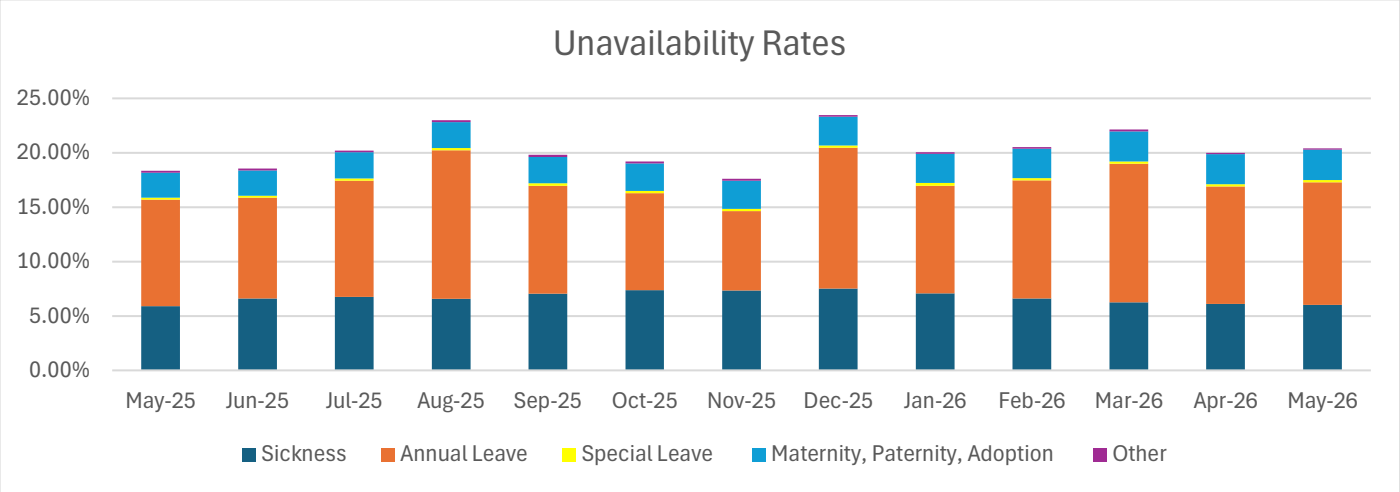
The graph below shows the 12-month cumulative sickness rates over the past three years. The target for 2026/27 remains at <5.5% The 12-month cumulative rate for May 2026 has increased slightly since April 2026 but remains broadly the same over the last 6 months.



The primary reason for absence continues to be Anxiety, Stress and Depression with a cumulative rate of 34.8% – targeted wellbeing interventions and preventive methods are being utilised to reduce impact and support sustained attendance.

Unavailability Rates

The combined absence rate for non-medical staff in April was 20.39%. The majority of this absence is annual leave followed by sickness absence. Other leave includes study leave and medical suspension and equates to an average of 0.15% every month.



Culture – Position and Next Steps (Q1 2026/27)

To support oversight and provide a concise assessment of progress, the table below summarises key workforce indicators across culture, staff experience, wellbeing and leadership. It reflects the position this quarter, drawing on emerging organisational insight, programme delivery and staff survey findings.

The indicators demonstrate progress from development to early implementation across priority areas, with a consistent approach to assessing delivery, risk and impact.

KPI Area	RAG	Narrative
Culture & Organisational Insight (CEWS)	🟡	Progressing from design to early delivery. CEWS has moved into development with a Phase 1 dashboard and cultural heatmap in build, and initial application within MHCB. This represents a step change from fragmented, retrospective data to a more integrated and continuous insight approach. Further work

		required to complete integration and demonstrate impact at scale.
Values-Based Teams (Team Functioning & Culture)	🟡	Early implementation underway. The Values-Based Team approach is being introduced to support team functioning, psychological safety and locally owned improvement. Initial deployment is aligned to areas of highest need; impact will strengthen as rollout and consistency increase.
Staff Experience & Engagement	🟡	Transition from survey to continuous insight and action. Staff Survey 2025 findings have been analysed, confirming key risks (workload, morale, variation between teams). The approach is shifting to local, team-level action supported by CEWS and VBT. Impact on staff experience indicators is not yet evidenced and will be tracked through emerging insight.
Wellbeing & Workforce Sustainability	🟡	Model under review and alignment phase. The wellbeing model review is progressing, with a clearer focus on prevention and early intervention linked to organisational insight. Delivery of a refreshed model is required before measurable improvement can be demonstrated.
Leadership & Management Capability	🟡	Delivery underway with strengthening evidence base. Audit complete and TNA in development to identify capability gaps and target support. Delivery activity in place (e.g. Leadership Conference; Optimising Ops Programme completed with evaluation in progress), with strengthened alignment to HEIW framework and organisational priorities. Impact on leadership capability and organisational outcomes will be demonstrated through evaluation and ongoing insight.

Overall, the RAG position is Amber, reflecting clear progress in establishing the approach and initiating delivery, alongside recognised dependencies associated with early implementation.

There has been a shift this quarter from concept and design to early delivery, including development of an integrated organisational insight model (CEWS), initial implementation of Values-Based Teams and active delivery of leadership and management interventions.

Further work is required to:

- complete integration of workforce and organisational insight
- scale implementation across services
- demonstrate measurable impact on workforce and organisational outcomes

The current position therefore reflects positive trajectory with delivery risk typical of this stage, rather than deterioration in performance.

Building Workforce Planning Expertise

Workforce Planning

- **Building workforce planning capability** - 46 Managers have now completed the HEIW Introduction to Strategic Workforce Planning Online training module. Completion of this training is a pre-requisite for the majority of leadership and management programmes and is actively promoted across the Health Board at every opportunity. It is a people priority as part of the 2026/27 annual plan, and compliance will be monitored every quarter.

Further detailed work has been undertaken to refresh the Minimum Data Set submitted to Welsh Government as part of the Health Board 2026/27 Annual Plan, to identify reasons for projected/planned workforce growth. Outcome of this more forensic analysis showed we are anticipating planned workforce growth predominantly in the following areas:

- Health Care Support Worker (HCSW) recruitment was paused to support the implementation of the nationally agreed HCSW band 2/3 role re-definition. HCSW turnover is higher than other staff groups which resulted in vacancies accumulating during this period which will be recruited to the professionally agreed substantive establishment of 95%.

- We have committed with HEIW to recruit 90 student streamliners (which includes our flexi-route students), this number is significantly less that those commissioned through the education commissioning process. Demand has been modelled on recruiting up to 95%.

- JCC funded roles also contribute to the workforce growth. With regard to the nursing workforce, agreement has been made to substantively recruit to 95% professionally agreed establishments. This does not mean we are reducing our professionally agreed establishment from 100%, it allows us to use the remaining 5% flexibly for temporary staffing.

- A Senior People & Culture Business Partner has successfully completed the Chartered Institute of People & Development (CIPD) Strategic Workforce Planning Programme. These roles are key in building workforce planning capability across the Health Board and also in supporting managers to develop more effective workforce plans.

Voluntary Early Release Update -

21 applications have been approved in 2025/26 with the financial analysis below: -

Category	Amount (£)
Total compensatory Payment costs (to individual)	**£750,996**
Total Compensatory Payment including 15% on costs	**£802,444**
Recurrent Saving from 26/27 onwards	**-£1,059,980**

No further applications have been completed to date.

Section 3 – Suspensions

The UHB currently has twelve staff suspended/excluded from work as a result of allegations that potentially amount to gross misconduct. Of these twelve:

- Three individuals have been suspended/excluded for less than one month: one individual is being formally investigated in accordance with the Upholding Professional Standards in Wales Procedure (UPSW), and this remains ongoing, whilst the internal processes for the remaining two individuals are currently on hold due to an ongoing criminal investigation.

- Three individuals have been suspended/excluded for three months: one individual is being formally investigated in accordance with the All Wales Disciplinary Policy and remains ongoing, whilst the internal processes for the remaining two individuals are currently on hold due to an ongoing criminal investigation.

- Three individuals have been suspended/excluded for six months. Two cases are progressing and nearing completion, one under the All Wales Disciplinary Policy and Procedure and the other under the UPSW Procedure, while the third remains on hold due to an ongoing criminal investigation.

- One individual has been suspended for eight months: the internal process is currently on hold due to an ongoing criminal investigation.

- Two individuals have been excluded for eleven months: in one case, the internal process was initially on hold due to a criminal investigation but has since progressed and is currently being formally investigated under the UPSW Procedure, which remains ongoing; in the other case, the internal process remains on hold due to an ongoing criminal investigation.

The majority of cases exceeding four months in duration are subject to external criminal investigations and, as a consequence, internal processes have been placed on hold. In these circumstances, the UHB is unable to determine definitive timescales for completion, as progression is dependent on external agencies. Notwithstanding this, all cases continue to be subject to regular review to ensure that suspension/ exclusion remains appropriate and proportionate in the circumstances.

Of the six cases that have exceeded four months, three are now progressing through internal processes: two under the UPSW Procedure and one under the All Wales Disciplinary Policy. The case being investigated in accordance with the All Wales Disciplinary Policy has now concluded and is progressing to a formal disciplinary hearing, which is currently being scheduled. It should be noted that all staff are provided with hearing documentation at least 21 days in advance; this requirement inevitably impacts overall timescales. However, this case is anticipated to be concluded within the next six weeks.

Of the two UPSW cases, one is likely to go through the Extended Process and to an Inquiry Panel. It is likely that this will conclude within 4-6 months. This prediction is based on the scheduling of the Inquiry Panel (which can be prolonged due to the composition of the Panel).
The other remaining UPSW investigation is still in its infancy. It is anticipated that this will likely conclude within 7-8 months (given the right to appeal at every stage of the UPSW process, following completion of the investigation).

Section 4 – Spotlight – Absence/ Sickness Update

The UHB has set a sickness absence target of <5.5% for 2026-27, with measures in place to support the achievement of this goal. The UHB's Sickness absence rates have reduced month on month since December 25 (7.11%) to 5.71% in May 26. A reduction of 1.40%. April 26 is the lowest rate in month for April for the last 4 years. However, the sickness rate for May was higher than the rate for May in 2025. The UHBs usual sickness trend increass over the summer months. The People and Culture team are working with the Clinical/Services Boards /Corporate areas to review any themes and trends from previous years to put targeted intervention in place to minimise this anticipated increase. The cumulative sickness rate remains broadly the same at 6.41%, if in month sickness rates continue to decrease the cumulative rate will follow.

Over the past 18 months, the UHB has observed a notable increase in sickness absence attributed to Anxiety/stress/depression/other psychiatric illnesses and it continues to be the top reason for sickness with a cumulative rate of 34.80% (May 2026). The results of the Staff Survey describe increased workloads, operational pressures which may be contributing factors and organisational change. Anxiety/stress/depression/other psychiatric illnesses is a broad absence category on ESR and captures many causes such as Bereavement, Personal Stress (Family Issues, Relationship Breakdown/Divorce etc.) as well as work related stress. People Services continue to analyse this data and the detailed reasons for absence in order to support staff to return to work and to help with absence prevention, where possible.

In April 2025, the UHB had 450 members of staff on long term sick leave. This has reduced over the last 12 months and as of June 2026, there are 363 members of staff on long term sickness absence, a slight improvement but there is still lots more to do.

Themes and interventions to support the reduction of sickness absence:

- Shift from reactive to proactive management, improving early intervention and prevention

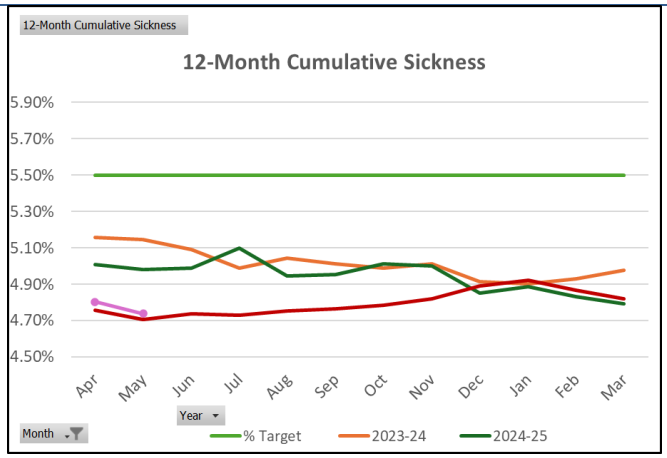
- Recognition of seasonality and service pressures
- Targeted, data-driven interventions at Clinical Board level
- Strengthening attendance management processes and enhancing management capability
- Driving accountability at Clinical Board level
- Promoting staff wellbeing and sustainable attendance

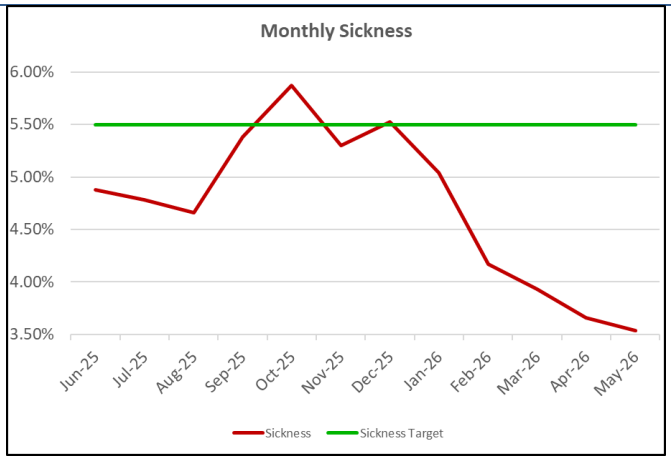
Key Incentives and Interventions to Reduce Sickness Absence:

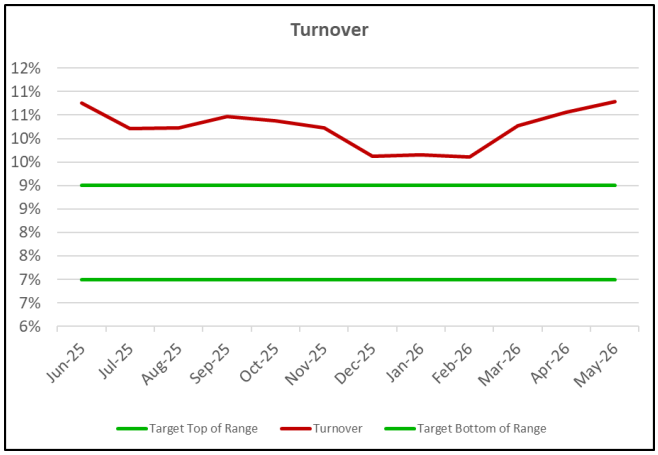
- Sickness Panels – A review and reset of sickness panels across all Clinical Boards to improve attendance management consistency and oversight. Current position includes a review of panel effectiveness, shifting focus from individual case management to identification of themes, trends, and systemic issues. Clinical Boards are adopting targeted approaches, focusing on high-risk areas (e.g. specific departments or staff groups). Learning from panels is being fed into Clinical Board action plans, with follow-up through Business Partner engagement and governance structures.
- Increased focus on earlier identification of absence trends (e.g. seasonal increases). Proactive management of emerging risks such as summer and winter increases and top reasons for absence.
- Transformation of digitalised absence related documentation including return to work form and absence notification with specific links to support and ensuring the recording and reasoning for any discretion applied.
- Alignment with policy approach supporting rapid referral to Occupational Health and wellbeing services, and earlier management engagement.
- Training Needs Analysis (TNA) to identify gaps in management capability.
- Development of targeted workshops for managers, focusing on, application of policy, early intervention conversations, managing stress-related absence.
- A range of wellbeing interventions underpin absence reduction, including access to Employee Wellbeing Services and Occupational Health and support for mental health, stress and MSK conditions.
- Increased focus on communication around, importance of planning and utilising annual leave, managing fatigue and preventing burnout and promotion of flexible working.
- Nationally the Managing Attendance at Work (MAAW) Policy is being reviewed, and sickness absence is a priority for the Value & Sustainability Board.

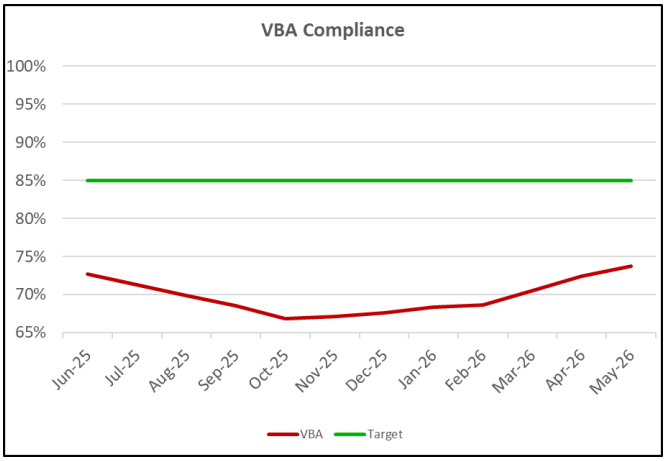
Section 5 – Clinical Board Update

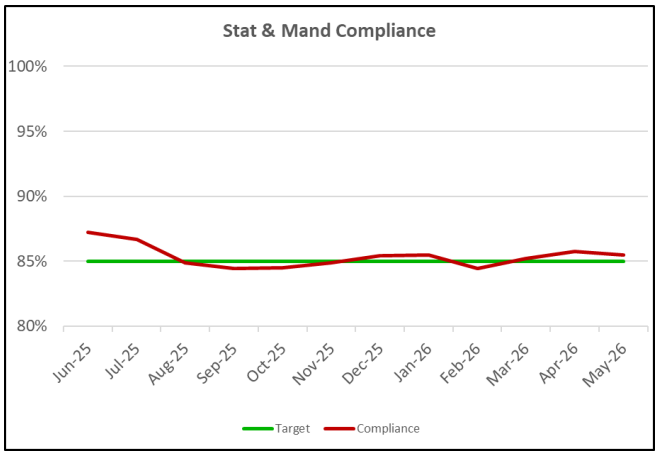
The Clinical Board Spotlight for this month is being presented by the **Clinical Diagnostics and Therapeutics (CD&T) Clinical Board**. Below are the high level KPIs to support the discussion.











Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

This report aims to provide the People and Culture Committee with assurance on key workforce performance measures and progress against the organisation's People and Culture priorities. Regular reporting in this format strengthens governance by enabling the Committee to monitor workforce risks, scrutinise performance trends, and ensure accountability for delivery against agreed objectives. At the same time, it highlights the direct impact of our workforce agenda on the wellbeing, development and engagement of our staff, recognising that a supported and skilled workforce is fundamental to delivering safe, high-quality care for patients.

Recommendation:

The People & Culture Committee is requested to:

- **Note** and **discuss** the contents of the report

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the below boxes as relevant.*		
Putting People First 1. **Click the objective above to view more detail.**		Providing Outstandi 2. **Click the objective above to view more detail.**
Delivering in the Right Places 3. **Click the objective above to view more detail.**		Acting for the Futu 4. **Click the objective above to view more detail.**

Five Ways of Working (Sustainable Development Principles) considered *Please place an "**X**" in the below boxes as relevant*								
Prevention		Long term		Integration		Collaboration		Involvement

Quality Impact Assessment Completed?: *Please place an "**X**" in the below boxes as relevant. A blank QIA and guidance on how to complete a QIA can be found by clicking the link here:* ***Quality Impact Assessment Information***				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***	×	The majority of categories carry some workforce-related risks or implications, and these are addressed within the body of this report through updates on KPIs, key priorities, suspensions, and specific programme areas. Where marked "No" (Socio-Economic and Decarbonisation), the paper itself does not introduce new risks, though broader workforce activity may have indirect benefits. References to relevant sections are included below.

Impact Assessment: *Please state **yes** or **no** for each category.* ***If yes please provide further details.***
Risk: Yes/~~No~~
Workforce risks around turnover, appraisal compliance, training compliance, and recruitment timelines.
Safety: Yes/~~No~~

Indirect safety implications from low Fire safety training compliance and staffing gaps.
Financial: Yes/~~No~~
Recruitment delays and workforce pressures could increase agency/locum spend; mitigations in progress.
Workforce: Yes/~~No~~
Direct implications through wellbeing, leadership development, workforce planning, and OD.
Legal: Yes/~~No~~
Suspensions and disciplinary processes managed under All-Wales policies and employment law.
Reputational: Yes/~~No~~
Risks if priorities (wellbeing, training compliance, Welsh language milestones) are not achieved.
Socio Economic: ~~Yes~~/No - *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES*
Equality and Health: Yes/~~No~~ - *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)*
Decarbonisation: ~~Yes~~/No
No direct impact identified in this paper; workforce planning remains aligned to sustainability commitments.
Welsh Language: Yes/~~No~~
Progress improving, but risks remain if 2025/26 milestones are not achieved.
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*

Committee/Group/Exec	Date:

Report Title:	Workforce Race Equality Standard and new Workforce Equality Standard				Agenda Item No:	2.4	
Meeting:	People & Culture Committee		Public	X	Meeting Date:	21 July 2026	
			Private				
Status **(please only tick one)**	Assurance	X	Approval		Information/Noting		
Lead Executive Title:	Executive Director of People & Culture						
Report Author Title:	Head of Equity & Inclusion						

Main Report

Background and Current Situation:

The Workforce Race Equality Standard (WRES) provides Cardiff and Vale University Health Board with a structured evidence base for understanding workforce race equality across representation, progression, recruitment, professional development, disciplinary and capability processes, and staff experience. The 2025 organisational report is the Health Board's second WRES report and tracks movement since the 2024 dataset, with data drawn from workforce systems, recruitment data and the NHS Wales Staff Survey. It identifies four key areas requiring continued organisational focus: inequitable progression of ethnic minority staff to senior grades, reduced likelihood of appointment after shortlisting, absence or underrepresentation in Board/senior leadership reporting, and persistent gaps in ethnicity declaration, particularly at senior levels.

The 2025 report also shows important contextual progress. The proportion of Black, Asian and minority ethnic staff increased from 14.5% to 16.0%, representing a 10.3% increase, and there has been a small improvement in representation above Band 5, rising from 9.0% in 2024 to 9.8%. However, the report is clear that the Band 5 progression bottleneck remains, that disparity ratios have not materially improved, and that minoritised applicants remain approximately half as likely to be appointed after shortlisting when compared with White applicants. At the same time, staff survey indicators show improvement in some experience measures, including reductions in bullying, harassment and discrimination, although minoritised staff continue to report poorer experience than White colleagues in some areas.

The Health Board has used the WRES findings to move beyond compliance reporting and into a more evidence-led programme of improvement. This has included workforce data deep dives, targeted staff voice activity, community engagement, review of leadership and development routes, inclusive recruitment interventions, strengthened governance, and preparation for the transition to the new Workforce Equality Standard (WES). WES should be understood as an evolution of WRES rather than a replacement: it broadens the approach across protected characteristics while retaining race equality as a visible and important strand within the wider workforce equality framework.

Executive Director Opinion & Key Issues to bring to the attention of the Committee

Strategic assessment

The 2025 WRES report provides both assurance and challenge. It shows a stronger evidence base and early progress in overall ethnic minority workforce representation, representation above Band 5, staff survey response and some staff experience indicators. However, the key issue remains structural: the Health Board attracts a diverse workforce, but this is not yet translating consistently into progression, senior representation or equitable appointment outcomes. This is most evident in the continued bottleneck beyond Band 5, the drop-off through Bands 6 and 7, and the appointment likelihood ratio of 0.51 following shortlisting.

The internal Access to Opportunities analysis reinforces this assessment, identifying the Band 5–6 and Band 6–7 progression points, a fall in ethnically diverse representation to 6.8% by Band 7, and continued disparity in post-shortlisting outcomes. The issue should therefore be understood as a combined progression, recruitment, transparency and systems challenge requiring sustained focus over more than one reporting cycle.

There are important caveats, including reliance on staff survey response rates, limitations on further disaggregation due to small numbers and information governance, and recruitment data exclusions for some medical and non-NWSSP appointments. These do not change the direction of travel, but they reinforce the need for triangulated assurance using ESR data, recruitment data, staff survey findings, targeted feedback and lived experience insight.

Work undertaken since the WRES report

Since receipt of the WRES findings, the Equity and Inclusion Team has used the WRES Working Group to strengthen data-led understanding of representation, progression and recruitment. This has included deep-dive analytics, localised Clinical and Service Board analysis, diagnostic tools and monitoring approaches to identify hotspots, track progress and support evidence-based decisions.

The Access to Opportunities analysis has also informed development and recruitment practice. It highlights the need to improve transparency of opportunities, reduce reliance on informal or *"in the know"* progression routes, strengthen recruiting manager capability, and ensure progression-related development reaches the staff groups and bands where it is most needed.

Community engagement, including engagement with Somali community stakeholders, has helped connect workforce access and widening participation with community insight. This supports the WRES recommendation to target areas of Cardiff with higher minoritised populations and strengthens understanding of barriers, relationships and opportunities.

Staff voice has been central to the response. The *"Your Career, Your Voice"* survey generated over 550 responses and provided insight into progression, retention and confidence in fair access to opportunity. While some findings were positive, free-text feedback highlighted a persistent theme of *"a face that fits"* influencing perceptions of progression. This suggests that confidence in transparent and equitable career pathways requires further strengthening.

Actions are also moving into recruitment practice. Six short inclusive recruitment videos are being developed to support recruiting managers with fair, bias-aware practice, covering unconscious bias, Welsh language, inclusive adverts, reasonable adjustments, values-based recruitment and alignment with equality objectives. This is proportionate to the WRES findings on post-shortlisting disparity and the internal analysis of selection processes.

Leadership and development routes have also been reviewed through the lens of progression. Current interventions include inclusive recruitment resources, leadership and management training review, values-based appraisal and revised Equity and Inclusion content covering ArWAP, the Strategic Equality Plan, anti-racism, unconscious bias and microaggressions. This is important because the WRES findings indicate that the challenge is not simply access to generic training, but access to progression-enabling development at the points where representation drops away.

Corporate induction has been strengthened to provide a more consistent baseline of inclusion from the point of entry. Materials now cover the Strategic Equality Objectives, inclusive culture, Respect, Communication and Engagement, Accessibility, Data, Welsh language, staff networks and equality data completion. This provides an early touchpoint for culture, data quality and staff awareness.

The mandatory All-Wales anti-racism eLearning module provides a further foundation for shared language, baseline awareness and alignment with ArWAP expectations.

Staff networks have been refreshed and relaunched with clearer purpose, governance and alignment to People & Culture and the Strategic Equality Plan. The introduction of Adborth as a flexible advisory model should further widen staff voice and bring lived experience into decision-making. Sustained leadership support, capacity and feedback loops will be needed to ensure this insight consistently influences decisions.

Governance and transitional oversight
In governance terms, the WRES Working Group has been discontinued while the Health Board awaits its first organisation-level WES report. During this transition period, oversight of race equality priorities will continue through existing People and Culture governance arrangements, with responsibility held through the Equity and Inclusion work programme, relevant People and Culture leadership routes, and future reporting through the SEP/WES assurance cycle. This will help ensure there is no gap in ownership, escalation or oversight while the organisation moves from WRES-specific reporting to the broader WES framework.

Transition to WES and future assurance
The transition to WES is a significant shift in the national accountability landscape. It broadens the WRES approach across protected characteristics and supports a more intersectional understanding of workforce experience. The Health Board will increasingly be expected to explain not only what the data says, but how it is shaping decisions, priorities and measurable improvement.

The Welsh Government WES roundtable on 6 July 2026 also confirmed that the Strategic Equality Plan assurance process is moving towards stronger organisational insight, leadership ownership, outcome-focused action and measurable impact. This is consistent with the Health Board's direction of travel, but raises the bar for future reporting to the Committee, Welsh Government and NHS Wales assurance mechanisms.

National SEP maturity guidance reinforces this shift. NHS organisations are expected to report progress biannually, with an interim submission on 31 October and an end-of-year report on 30 April. The process is intended to provide Board assurance, support self-reflection, identify disparities, risks and mitigations, and raise the profile of equality and inclusion at Board and Executive level.

The Committee should therefore view WES as part of a broader shift from activity reporting to assurance on measurable impact. The Health Board has participated in the national WES discussions and is awaiting the organisation-level WES report to enable the next phase of analysis and action planning. Continued engagement through the October 2026 SEP/WES assurance cycle will be important.

Overall, the Health Board can take assurance from the breadth and direction of the work underway. The response is evidence-led, connected to staff voice and community insight, and increasingly embedded into recruitment, leadership development, induction, training, staff networks and governance. However, the Health Board should not

overstate progress. Persistent structural barriers remain in progression and appointment outcomes, and WES will require a more mature approach to intersectional analysis, data quality, leadership accountability and measurable impact. Sustained focus will be required to ensure the move to WES strengthens, rather than obscures, race equality action.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Recommendations:

a) Note the key findings of the 2025 WRES report, including the need for continued focus on progression beyond Band 5, senior representation, recruitment fairness and ethnicity data quality.
b) Note the transition from WRES to WES, which broadens workforce equality monitoring across protected characteristics and places greater emphasis on intersectionality, measurable impact, leadership accountability and strategic assurance.
c) Support the proposed shift from activity-based reporting to evidence-led assurance, using workforce data, staff voice and community insight to target interventions, demonstrate impact and strengthen accountability across the Health Board.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

1. Putting People First	X	2. Providing Outstanding Quality	X
3. Delivering in the Right Places	X	4. Acting for the Future	X

Five Ways of Working (Sustainable Development Principles) considered:
Please place an "x" in the below boxes where relevant

Prevention	X	Long Term	X	Integration	X	Collaboration	X	Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	X	Not required

Impact Assessment
Please place an "x" in the below boxes where relevant

Risk: Yes

The 2025 WRES report identifies several workforce equality risks requiring continued organisational focus, particularly the underrepresentation of ethnically diverse staff in senior roles, barriers to progression beyond Band 5, disparities in recruitment and appointment outcomes, and incomplete ethnicity data recording. If these issues are not effectively addressed, there is a risk that existing inequalities become further embedded within workforce systems and processes, limiting the Health Board's ability to attract, retain and develop a diverse workforce. There is also a risk that decision-making is undermined by poor data quality, reducing the organisation's ability to identify

inequalities, target interventions and demonstrate improvement. The actions outlined within the report, including enhanced workforce intelligence, targeted interventions and governance oversight, are intended to mitigate these risks.
Safety: Yes
There are potential safety implications associated with workforce inequality. Research consistently demonstrates that inclusive workplaces with high levels of psychological safety are associated with improved staff wellbeing, engagement, speaking-up cultures and patient outcomes. Conversely, if staff from ethnically diverse backgrounds experience barriers to progression, discrimination or exclusion, there is a risk of reduced engagement, increased stress, lower morale and reduced confidence in organisational processes. These factors may indirectly impact team effectiveness, staff retention and the quality and safety of care provided. The report's recommendations seek to strengthen inclusion, fairness and organisational culture, helping to mitigate these risks.
Financial: Yes
There are no immediate financial implications requiring Committee approval. However, failure to address the inequalities identified through WRES may result in longer-term financial impacts associated with higher staff turnover, increased recruitment costs, sickness absence, reduced productivity and lost organisational talent. There may also be costs associated with employment disputes, grievances and the implementation of reactive rather than preventative interventions. The proposed approach seeks to reduce these risks through evidence-led workforce planning, targeted development opportunities and improved recruitment practices.
Workforce: Yes
The report has significant workforce implications. The findings highlight inequalities in representation, career progression, recruitment outcomes and staff experience that directly affect workforce sustainability and organisational effectiveness. Without continued intervention, the Health Board may struggle to fully utilise existing talent, develop future leaders from underrepresented groups and create a workforce that reflects the diverse communities it serves. The programme of work described within the report is intended to improve fairness, strengthen career development pathways, enhance recruitment practices and increase confidence among staff that opportunities are accessible and equitable.
Legal: Yes
The matters addressed within this report are directly relevant to the Health Board's obligations under the Equality Act 2010, Public Sector Equality Duty, Human Rights Act 1998 and commitments arising from the Anti-racist Wales Action Plan. Failure to identify, monitor and appropriately respond to evidence of workforce inequality could increase the risk of legal challenge, discrimination claims, regulatory scrutiny or adverse findings against the organisation. The WRES and emerging WES frameworks provide an important mechanism for evidencing compliance, demonstrating due regard and supporting continuous improvement in equality outcomes.
Reputational: Yes
The report identifies issues that may impact organisational reputation if tangible improvement is not demonstrated over time. As workforce equality data is routinely scrutinised by Welsh Government, partner organisations, staff, trade unions and communities, failure to address identified disparities could adversely affect confidence in the Health Board's commitment to equity, inclusion and anti-racism. Continued disparities in senior representation, progression or recruitment outcomes may undermine the organisation's credibility and ability to position itself as an inclusive employer. The programme of work outlined within the report demonstrates a proactive commitment to improvement and provides assurance regarding organisational accountability and transparency.
Socio Economic: Yes

The proposals support the requirements of the Socio-economic Duty by seeking to address barriers that may disproportionately affect individuals from ethnic minority communities who may also experience socio-economic disadvantage. Improved access to recruitment opportunities, fair progression processes, leadership development and targeted community engagement can contribute to reducing inequality of outcome by improving access to employment, career advancement and economic opportunity. The use of workforce intelligence, community insight and targeted interventions will help ensure actions are directed towards areas of greatest need and disadvantage.
Equality & Health: Yes
The report is fundamentally concerned with equality outcomes and organisational progress towards reducing race inequality within the workforce. Failure to address the issues identified has the potential to perpetuate unequal opportunities, reduce workforce diversity and limit the organisation's ability to benefit from a broad range of experiences and perspectives. There is also evidence that improving workforce equality contributes positively to staff wellbeing, organisational culture and patient experience. As this report provides assurance and monitoring information rather than introducing a new policy, service or strategic change, a separate Equality and Health Impact Assessment is not required at this stage. Any future policies or interventions arising from this work will be subject to appropriate impact assessment processes.
Decarbonisation: No
N/A
Welsh Language: Yes
Whilst the report principally focuses on workforce race equality, the themes of representation, inclusion, fairness, accessibility and data quality are equally relevant to Welsh language considerations. Failure to consider Welsh language needs within wider workforce equality activity could limit the Health Board's ability to ensure equitable employment experiences for Welsh-speaking staff and its capacity to deliver bilingual services in line with the Welsh Language Standards and Mwy na geiriau. The transition to the Workforce Equality Standard (WES) provides an opportunity to strengthen intersectional analysis and ensure Welsh language considerations are incorporated into broader equality assurance and workforce planning arrangements.

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Report Title:	Welsh Language Skills and Commissioner					Agenda Item No:	2.5
Meeting:	People & Culture Committee		Public	X		Meeting Date:	21 July 2026
			Private				
Status **(please only tick one)**	Assurance	X	Approval			Information/Noting	
Lead Executive Title:	Executive Director of People & Culture						
Report Author Title:	Head of Equity & Inclusion						

Main Report
Background and Current Situation:

The Welsh Language Commissioner issued a decision notice on 11 June 2026 following Standards Enforcement Investigation CS1436. The Commissioner determined that the Health Board had failed to comply with Standard 96 of the Welsh Language Standards, relating to the requirement to assess and maintain records of employees' Welsh language skills, and had also failed to implement within the required timescales the previous enforcement action issued following investigation CS1063.

As part of the decision notice, the Commissioner has required the Health Board to:

- Record the Welsh language skills of at least 85% of employees by 31 July 2026.
- Fully record the Welsh language skills of all employees by 31 December 2026 (the feasibility of this requirement is being raised with the Commissioner).
- Maintain mandatory arrangements requiring employees to record their Welsh language skills.
- Embed this requirement within recruitment, induction and performance review processes.
- Address systemic barriers associated with ESR and ensure alternative recording methods are available.
- Provide evidence and ongoing progress updates to the Welsh Language Commissioner.

The Health Board has continued to make progress against these requirements. Compliance has increased from 55.47% in June 2025 to 77.13% in June 2026, with the most recent position reported to senior leaders on 9 July 2026 showing compliance at 77.14%. Whilst this represents a significant improvement over the last twelve months, the Health Board remains below the Commissioner's required target of 85% by 31 July 2026.

Performance continues to vary across the organisation. As of June 2026, All Wales Genomics Service (93.72%), Clinical Diagnostics & Therapeutics (88.00%), Capital, Estates & Facilities (87.43%) and Corporate Executives (85.78%) have all achieved or exceeded the Commissioner's target. Other areas, including Primary, Community and Intermediate Care (82.24%), Children & Women (77.62%) and Specialist Services (77.33%), are making good progress but remain below the required threshold. Medicine (64.53%), Surgical Services (64.92%) and Mental Health (67.31%) continue to have the largest gaps and therefore represent the greatest opportunity for further organisational improvement.

The table below summarises current trends and provides further detail on the position across the Health Board:

Sum of % Welsh	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
All Wales Genomics Service	82.66%	82.07%	82.14%	81.87%	82.58%	83.84%	85.67%	85.79%	88.62%	90.03%	92.41%	92.66%	93.72%
Capital, Estates & Facilities	28.90%	28.60%	28.74%	28.32%	62.39%	62.76%	62.98%	63.55%	68.71%	82.42%	85.57%	86.70%	87.43%
Children & Women	59.98%	56.83%	56.85%	56.55%	55.25%	55.76%	58.19%	58.20%	63.24%	67.96%	71.72%	75.65%	77.62%
Clinical Diagnostics & Therapeutics	71.52%	69.74%	70.08%	70.11%	76.44%	77.53%	78.99%	78.91%	81.93%	84.19%	85.58%	86.90%	88.00%
Corporate Executives	65.51%	64.27%	64.28%	63.70%	65.61%	66.70%	69.39%	71.80%	76.89%	79.81%	82.03%	83.96%	85.78%
Medicine	46.62%	45.83%	45.69%	45.09%	45.42%	45.99%	46.99%	46.74%	51.68%	55.88%	60.76%	62.88%	64.53%
Mental Health	53.63%	50.87%	51.02%	49.87%	51.21%	51.66%	52.92%	53.27%	57.60%	60.35%	62.74%	65.07%	67.31%
Primary, Community Intermediate Care	75.37%	69.28%	69.57%	69.80%	70.30%	71.13%	72.89%	73.54%	78.23%	80.41%	77.56%	79.81%	82.24%
Specialist Services	51.79%	50.39%	50.50%	49.91%	58.65%	58.42%	60.06%	60.16%	64.38%	69.53%	72.42%	74.71%	77.33%
Surgical Services	43.58%	42.26%	42.53%	43.10%	44.30%	45.07%	46.86%	47.49%	51.60%	55.86%	59.84%	62.70%	64.92%
Grand Total	**55.47%**	**53.56%**	**53.70%**	**53.38%**	**58.70%**	**59.41%**	**60.98%**	**61.32%**	**65.67%**	**70.14%**	**73.04%**	**75.28%**	**77.13%**

This report provides the Committee with an update on the Health Board's response to the Commissioner's requirements, progress made to date and the risks and opportunities associated with the current position.

Executive Director Opinion & Key Issues to bring to the attention of the Committee

The Commissioner's determination represents a significant regulatory matter for the Health Board. Whilst the finding of non-compliance is disappointing, it is important to recognise that the decision notice acknowledges the significant progress made since the previous investigation and the considerable amount of work undertaken to strengthen the Health Board's arrangements for recording Welsh language skills. The challenge facing the organisation is not an absence of action, but the pace at which improvements have translated into organisational compliance.

The Health Board has increased compliance from 55.47% in June 2025 to 77.13% in June 2026 and 77.14% as of the most recent position reported to senior leaders. This represents a substantial improvement within a relatively short period and reflects a significant organisational effort. Notably, four organisational areas now exceed the Commissioner's 85% requirement and several others are within relatively close reach of the target. However, progress is not consistent across the organisation and there remains considerable variation between Clinical and Service Boards. Whilst some areas have embedded ownership and accountability for Welsh language skills registration, others continue to experience lower levels of engagement and therefore remain significantly below the required threshold.

Appropriate measures have now been established to address many of the barriers previously identified by both the Health Board and the Welsh Language Commissioner. Learning has been gathered from across NHS Wales and incorporated into the Health Board's approach. Mandatory registration arrangements were introduced in February 2026; alternative recording routes have been developed to reduce reliance on ESR approval processes; Welsh language skills registration is promoted through induction arrangements; paper-based solutions remain available for staff without digital access; and dedicated resource has been deployed to manually process and upload records in order to provide a more accurate reflection of workforce compliance. Detailed information has also been made available to Clinical and Service Boards to support local ownership and targeted intervention.

Despite these improvements, there is concern about the likelihood of achieving the Commissioner's requirement of 85% by 31 July 2026. Registration rates have slowed in recent weeks and the remaining unregistered staff are increasingly concentrated within areas that have

historically been more difficult to engage. Whilst further improvement is anticipated before the deadline, the current trajectory suggests that achieving the required threshold will be challenging without a renewed organisational focus and visible leadership intervention across those areas furthest from compliance.

The Executive Director of People and Culture will write to each area currently below the required compliance threshold to request confirmation of the actions being taken, the support required, and clear timelines for achieving compliance with the Commissioner's 85% requirement.

It should be emphasised that this work should not be viewed solely through a compliance lens. The collection of Welsh language skills data is a means to an end rather than an end in itself. For the first time, the Health Board is approaching a position where it will hold sufficiently robust workforce data to support meaningful strategic planning. Accurate information regarding Welsh language capability is fundamental to understanding where Welsh-speaking staff are located, where gaps exist, and where investment in workforce planning and development may be required. This is particularly important in the context of the Welsh Language Standards relating to recruitment, the Active Offer, the Welsh Government's *Mwy na geiriau / More than just words* strategy, and the long-term ambition set out within *Cymraeg 2050*.

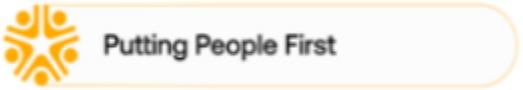
A positive outcome of the work undertaken to date has been the increased organisational conversation around the Welsh language more broadly. The Commissioner's own report notes increased interest in Welsh language learning opportunities, growing demand for Welsh language development programmes and wider engagement with initiatives such as Rhwyd-Iaith. As the Health Board moves beyond the immediate compliance challenge, there is an opportunity to capitalise on this momentum and shift the focus from data collection towards cultural and workforce transformation.

In summary, meaningful progress has been achieved, robust arrangements are now in place and the Health Board has established a credible route towards compliance. However, assurance can currently only be provided with caution. Until the Commissioner's 85% target has been achieved and sustained, and until the Health Board can demonstrate the effective use of this information to support workforce planning and service delivery, a residual regulatory, legal and reputational risk remains. Continued scrutiny through People & Culture Committee and sustained attention from senior leaders across the organisation will be required during the remainder of the enforcement period.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Recommendations:

a) Note 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.
b) Note the Health Board's current Welsh language skills registration position of 77.14% as of the latest internal update, against the Commissioner's required 85% target by 31 July 2026.
c) Recognise the significant progress made over the past year, 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.

Link to Strategic Objectives of Shaping our Future Wellbeing: Please place an "x" in the below boxes where relevant – *Click each item for further information.*			
1. 	X	2. 	X
3. 	X	4. 	X

Five Waves of Working (Sustainable Development Principles) considered: Please place an "x" in the below boxes where relevant											
Prevention	X	Long Term	X	Integration	X	Collaboration	X	Involvement			

Quality Impact Assessment Completed? Please place an "x" in the below boxes where relevant				
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	X	Not required

Impact Assessment Please place an "x" in the below boxes where relevant
Risk: Yes
The Health Board remains subject to formal regulatory action following the Welsh Language Commissioner's determination that Cardiff and Vale University Health Board has failed to comply with Standard 96 of the Welsh Language Standards and previous enforcement action issued under investigation CS1063. The Commissioner has subsequently imposed further enforcement steps requiring the Health Board to achieve 85% Welsh language skills registration by 31 July 2026 and to fully record workforce Welsh language skills by 31 December 2026. Failure to comply with these requirements may result in further regulatory intervention under the Welsh Language (Wales) Measure 2011. The Welsh Language Commissioner has powers to require specific remedial actions, require action plans, require an organisation to publicise its non-compliance, publicise failures to comply, impose civil penalties of up to £5,000, and apply for an order requiring compliance with a decision notice or enforcement step. Continued non-compliance therefore presents regulatory, legal, financial and reputational risks to the Health Board.
Safety: Yes
Welsh language skills data supports the organisation's ability to understand workforce capability and plan services that can deliver bilingual care and the Active Offer. The template specifically recognises the relevance of Welsh language to patient understanding, dignity, accessibility and safety.
Financial: Yes
Whilst no direct financial implications arise from the report itself, failure to comply with the Welsh Language Commissioner's requirements may expose the Health Board to financial penalties. Under the Welsh Language (Wales) Measure 2011, the Commissioner may impose civil penalties of up to £5,000 where an organisation fails to comply with Welsh Language Standards or associated enforcement requirements. Continued non-compliance may also result in

additional costs associated with regulatory intervention, legal proceedings and the implementation of corrective actions.
Workforce: Yes
The issue is directly workforce-related, as it concerns the recording of staff Welsh language skills, the use of that data for workforce planning, and the future alignment of recruitment, induction and performance review processes with Welsh Language Standards requirements
Legal: Yes
The Health Board has been formally determined by the Welsh Language Commissioner to have failed to comply with Standard 96 and previous enforcement action issued under investigation CS1063. The Commissioner has imposed further statutory requirements and associated reporting arrangements. Failure to comply with these requirements may lead to further enforcement action under the Welsh Language (Wales) Measure 2011, including the Commissioner applying to the County Court for an order requiring compliance with the decision notice.
Reputational: Yes
There is a reputational risk associated with continued non-compliance with the Welsh Language Standards, particularly as this matter follows previous enforcement action and has resulted in a second formal determination by the Welsh Language Commissioner. The Commissioner has powers to publicise failures to comply and, in some circumstances, require organisations to publicise their own failures. Failure to demonstrate sustained improvement may therefore impact stakeholder confidence, public perception and the Health Board's reputation as a public body committed to delivering bilingual services and meeting its statutory obligations.
Socio Economic: No
Equality & Health: Yes
The matter has implications for both equality and health outcomes. Welsh language skills data enables the Health Board to understand the capacity of its workforce to provide services through the medium of Welsh and support delivery of the Active Offer in accordance with the Welsh Language Standards and the principles of Mwy na geiriau / More than just words. Incomplete workforce data limits the Health Board's ability to identify service gaps, plan appropriately for Welsh-speaking communities, and ensure equitable access to services for Welsh speakers. Improving compliance with Standard 96 will strengthen workforce planning, support the recruitment and development of Welsh-speaking staff, and contribute to ensuring that patients are able to receive care in their preferred language where required
Decarbonisation: No
Welsh Language: Yes
This report relates directly to the Health Board's compliance with the Welsh Language Standards and the Welsh Language Commissioner's Standards Enforcement Investigation (CS1436). The subject matter, associated risks and proposed actions are intrinsically linked to the Welsh language, including the Health Board's statutory obligations to assess and record workforce Welsh language skills, its ability to plan and deliver bilingual services, and its wider contribution to Welsh Government policy objectives. Accurate Welsh language skills data is essential to supporting delivery of the Active Offer, informing workforce planning and recruitment decisions, identifying Welsh language development opportunities, and enabling compliance with both the Welsh Language Standards and the principles set out within Mwy na geiriau / More than just words. Failure to achieve compliance may adversely affect the Health Board's ability to evidence

and deliver Welsh language services, as well as exposing the organisation to the legal, regulatory, financial and reputational risks outlined elsewhere within this report.

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Report Title: *(needs to match agenda)*	People & Reputational Risks (Scoring 20 - 25)		Agenda Item No:		2.6
Meeting:	P&C Committee	Public	☒	Meeting Date:	21st July 2026
		Private			
Lead Executive Title:	Director of Corporate Governance				
Report Author/s Title:	Corporate Archivist & Records Management Manager				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

A consistent, organisation-wide approach to committee oversight of high-scoring risks is not yet fully established. Current reporting arrangements have not provided Committees with full visibility of risks within their remit.

There are currently 188 high scoring risks of 20 – 25 on the Risk Register, all of which are reported to the Board through one singular report. Through the digital implementation of AMaT, all risks have been assigned a Primary Risk Category by the Risk Owner and their team. These categories have now enabled the 188 risks to be split across our five Committees, with 8 risks identified by the risk owners as People and Reputational and submitted to the P&C Committee in the attached appendices.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information/Noting**	☒

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

The Committee is asked to:

1. Note the approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits.

2. Support the development of a consistent, organisation-wide approach to risk reporting and discussion within Committees, including integration into forward plans and routine agenda items.

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	
***When** it went:*	

***What** decision was made:*	

Main Report
Background & Current Situation

Work is underway to strengthen the alignment between organisational risk register and Committee oversight to support improved governance, visibility and assurance.

The proposed model aligns AMaT risk categories to Committee structures, enabling clearer oversight of key risks within each Committee's remit. These are broadly structured as:

Quality – Quality and Operational risks (96 risks)
P&C – People and Reputational risks (8 risks)
F&P – Finance, Commercial and Sustainability risks (13 risks)
D&I – Digital, Cyber and Infrastructure risks (63 risks)
Audit – Legal and Regulatory risks (8 risks)

Initial implementation will focus on risks with a score of 20+, which will be extracted from AMaT and presented to the relevant Committees in a consistent format.

This approach provides coverage of the majority of high-scoring risks and introduces a structured mechanism for ensuring that Committees have visibility of risks aligned to their remit.

The first phase of implementation will involve presenting these risks to Committees supported by Corporate Governance engagement with Committee Chairs in advance.

At present, Committee approaches to risk discussion are not standardised and will require further development. A programme of engagement and forward planning is being progressed to establish a consistent approach to risk discussion and integration into Committee agendas over time.

This includes updating Committee forward plans, briefing Chairs, and introducing risk as a recurring agenda item, with the intention to develop the approach iteratively based on Committee feedback and use.

Appendices:
(List any appendices that will accompany this report).

- **Risk Register**

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	☒	Providing Outstanding Quality	☒
Delivering in the Right Places	☒	Acting for the Future	☒

Impact Assessment
Risk: Yes
The management and maintenance of the Health Board's Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No

Financial: No
Workforce: No
Legal: No
Reputational: Yes
Socio Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

People Reputational Risks
July 2026

Risk title	Date raised	Risk event	Risk cause	Risk effect	Division	Business unit	Speciality	Risk category	Risk theme	Initial rating score	Current rating score	Target rating score	Response (Status)	Key controls	Assurance on controls	Gaps in controls	Barriers
Lack of dedicated staff resource to effectivly embed business continuity planning within the organisation.	03/02/2025	There is a risk that business continuity planning within the organisation will not be effectivly embed.	The team consists of only 2 whole time equivelants. Business continuity is one componenet of a far reaching portfolio, and represents 1 of the 7 statuatiry responsibilities under the Civil Contingencies Act (2004). Do not have the capacity to ensure BC is absolutely embedded within the UHB.	The organisation fails to comply with its statury duties under the Civil Contingencies Act 2004	Corporate	EPRR		People risks	HIW Governance, Leadership and Accountability Staffing Statutory Compliance Use of Resources Workforce	20	20	4	Tolerate	Dedicated regular traing is delivered to clinical and service boards. Bespoke BC leads training package to uskill clinical board and service leads. Business Continuity Strategic Oversight group meets bi monthly Delivery of BC table top exercise Has document: No Simon Dring 21/04/2026 13:09	Training records. Exercise reports Incident debriefs Joint operational learning Has document: No Simon Dring 21/04/2026 13:10	Organisations of a similar size and complexity would have a dedicated BC manager who is appropriatly trained and qualified. The BC manager should be an integral member of the core EPRR team Has document: No Simon Dring 21/04/2026 13:11	Lack of financial investment within EPRR team Status: Current Simon Dring 21/04/2026 13:12
New contract	04/03/2026	There is a risk that the new contract expected August 2026 will impact compliance of all residents rotas	This is caused by WG / BMA	Which could lead to unsafe staffing unless additional posts are funded	Surgical	General Surgery	General Surgery	People risks	Patient Experience Patient Safety Staffing Statutory Compliance Workforce	20	20	4	Treat	Continue with discussions with Medical Workforce Has document: No Laura Jones 04/03/2026 14:31	Ongoing discussions to esnure compliance Has document: No Laura Jones 04/03/2026 14:30	New contract details not currently agreed Has document: No Laura Jones 04/03/2026 14:31	
Safety risks associated with Main Reception at Hafan Y Coed	09/03/2026	There is a risk that patients or staff may come to harm due to the current lack control around building access. There have been safety incidents in the building, resulting in a need to improve building security, particularly in the evening.	This is caused by lack of adequate CCTV, doors that dont provide robust security, and open access to the vast corridor spaces throughout the building. Main hazards: -Patients or visitors entering clinical areas unsupervised. -Aggression or absconding risk in open reception zone. -Reduced observation at night with minimal staffing	This has and can have an impact on staff and patient safety, especially with reduced staffing at night. People most at risk: -Reception staff -Clinical staff accessing wards -Patients — including individuals with cognitive impairment, agitation, or high risk behaviours	Mental Health			People risks	Environment/Estates Patient Safety	20	20	4	Treat	https://nhswales365.sharepoint.com/sites/CAV_mentalhealthdepartment/SitePages/Building-Works-at-Hafan-Y-Coed-Hospital.aspx Link on MHCB Sharepoint page to demonstrate the Capital works plan for making the Reception area safer Has document: No Joanne Wilson 09/03/2026 16:04	Capital Works plan has been carefully considered and consulted upon. Whilst the preferable option was to have concierge security on site 24/7, this plan is feasible currently, and will be supported by any future opportunities to base Security staff on site Has document: No Joanne Wilson 09/03/2026 16:05	Deadline of financial year end. Plans are in place and a plan of works meeting has been held. All safety aspects, including anti-ligature boardings, site security etc have been documented Has document: No Joanne Wilson 09/03/2026 16:07	
Staff Shortage	03/02/2025	There is a significant risk of staff abscence severly impacting service provision	Extremely small critical mass of specialist staff. EPRR team consists of only 2 whole time equivelants. Both have in excess of 40 years expert knowledge and experience across the NHS / HM Forces / Blue light organisations. Both post holders are close to retirement, however there is no sucsession planning. Highly specialist role which is not replicated by any other postholder within the UHB. Neighbouring UHBs has a larger establishment which affords a greater degree of security and resilience. Business cases to enhance establishment, promote resillience , facilitate sucession planning, have been repeatidly declined from 2014 - 2023 due to a stated lack of financial resources.	Which would lead to the Health Board failing to meet and comply with its statatury duties	Corporate	EPRR		People risks	Staffing	20	20	6	Tolerate	There are no current controls Has document: No Simon Dring 21/04/2026 12:48	There is sufficient trained people that would apply for a post when recruitment is sanctioned Has document: No Simon Dring 21/04/2026 12:49	There are no controls without financial investment in EPRR Has document: No Simon Dring 21/04/2026 12:53	Lack of investment within EPRR by the Health Board Status: Current Simon Dring 21/04/2026 12:50
Delays to treatment of lung cancer patients due to cancelled Theatres	01/04/2025	There is a risk that due to amount of theatre lists cancelled due to lack of available theatre staff, cancer waiting times will breach and increase in length due to the lack of available theatre allocation to Thoracic Surgery.	This is caused by the lack of retention of Theatre Staff and recruitment into vacancies within Theatres to allow sufficient staffing across Cardiothoracic Surgery	Which w/could lead to an impact/effect on increased waiting list demand, more cancer breached patients and delays to cancer treatment.	Specialist Services	Cardiothoracic	Thoracic Surgery	People risks Operational risks Quality risks Reputational risks Strategic risks	Bed Management Communication Cost Pressures Managing Demand Patient Experience Patient Safety Risk Management Staffing Treatment/Procedure Use of Resources Workforce	20	20	10	Treat	Weekly validation of thoracic waiting list by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly theatre scheduling meeting to discuss cancellations, late starts, overruns and staffing constraints. Weekly attendance at wider UHB cancer tracking meeting. Has document: No Lewis Whitehorn 16/10/2025 14:09	Forward planning for thoracic surgery undertaken weekly through key stake holders. Recruitment and retention of theatre personnel. Has document: No Lewis Whitehorn 16/10/2025 14:09	Limited assurance due to significant establishment gaps in theatre scrub staff. Mitigation with overtime payment for current theatre staff is no longer supported, so can no longer guarentee backfill of lists or lists not being cancelled at short notice. Has document: No Lewis Whitehorn 16/10/2025 14:10	Reliant on communication from Theatres Status: Current Lewis Whitehorn 16/10/2025 14:12
Regulation 18 Area - UHW Boiler House	22/12/2025	There is a risk that the asbestos identified on the mezzanine floor and high level gantries may affect general pre-planned maintenance of equipment accessible from these areas. In the case of an emergency any works necessary would need to be undertaken by a licensed contractor or using internal Category B trained staff working with an Asbestos Permit.	This is caused by the identification of loose iinsulation materials in the grid floor and framework of the mezzanine floor and within cables trays and on surfaces below the grid leading to the area being restricted.	The current restriction will lead to delays or additional complexity / costs in undertaking works in a critical area. If the works were to be done without the necessary precuations in place there is a risk that the staff involved or others in the vicinity (either on the mezzanine or in the boiler house below) could be exposed to airbourne asbestos fibres, potentially in excess of the 0.1f/ml control limit. This puts the individuals at risk of developing asbestos related diseases.	Capital Estates and Facilities	Capital Estates and Facilities	CEF - Asbestos	People risks	Environment/Estates Workforce	20	20	5	Treat	Initially the key control will be restricting access to the affected area through physical barriers, signage, training via tool box talks and asbestos information provided on MiCAD (Asbestos register). The longer term plan would be to remediate the boiler room using Licensed Asbestos Removal Contractors. Any work required in this area in the interim, would need to be undertaken by a LARC or a Cat B trained member of staff (working for less than 60mins per week under an Asbestos Permit). Has document: No Owen Davies 22/12/2025 09:30	None specified. Has document: No Adrian Griffin 24/12/2025 11:06	None specified. Has document: No Adrian Griffin 24/12/2025 11:06	There would be a significant cost to remediating the asbestos within the boiler room. This is partly because of the size and complexity of the area but also because the boilers run all the time so the work would need to be phased to reduce the temperature of the asbestos enclosures. Status: Current Owen Davies 22/12/2025 09:34
Patient Safety risk due to severe planned maintenance backlog due to workforce shortages in Clinical Engineering	03/02/2026	There is a risk that patient safety could be compromised due to severe planned maintenance backlogs in Clinical Engineering.	This is caused by staff shortages.	Which w/could lead to an impact/effect on ceasing services.	Clinical Diagnostics & Therapeutics	RMPCE	Medical Physics/Clinical Engineering	People risks	Patient Safety Workforce	20	20	4	Treat	Vacancy requests submitted Has document: No Helen Jenkins 03/02/2026 14:40	Trac forms working through the authorisation process. Has document: No Helen Jenkins 03/02/2026 14:40	Current vacancy process asks for internal recuitment first, which effectively delays the process further. Has document: No Helen Jenkins 03/02/2026 14:40	
Lengthy Outpatient Waiting Lists not meeting WG Outpatient Waiting Standards (OG32)	24/09/2024	There is a risk of patient harm	This is caused by lengthy outpatient waiting lists not meeting WG outpatient waiting standards	Which w/could lead to an impact/effect on patient outcomes and patient experience	Children & Women	Gynaecology		People risks	Clinical Outcomes HIW Standard 3.1 Safe and Clinically Effective Care HIW Standard 5.1 Timely Access Managing Demand Statutory Compliance	25	20	10	Treat	Validation is undertaken by the UHB validation team. All clinics are booked as appropriate in respect of expected activity and trainees allocated to clinics where possible to increase throughout Has document: No Kirsty Hook 10/09/2025 13:40	Ongoing monitoring and escalation of concerns regarding increasing number of patients for an inpatient and daycase procedure to the Clinical Board Has document: No Kirsty Hook 10/09/2025 13:41	Waiting list continues to increase with no clear plan or timescale regarding address of demand/capacity gap Has document: No Kirsty Hook 10/09/2025 13:42 Nil funding to support/address of demand/capacity gap Has document: No Kirsty Hook 10/09/2025 13:42	Waiting times will increase as referrals needing vetting increasing Status: Current Victoria Titshall 12/05/2026 09:59 As of 1 May 2026 1118 unvetted referrals, 353 urgent referrals going back to 4/3/26 submission Status: Current Victoria Titshall 12/05/2026 10:02

Shaping Our Future
Workforce

Clinical Diagnostics and Therapeutics Clinical Board Spotlight

People & Culture Committee

July 2026

Sarah Lloyd – Director of Operations – CD&T

Helen Luton – Director of Nursing and Multi-Professional Teams – CD&T

Ally Doherty – Senior People and Culture Business Partner – CD&T

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CD&T Workforce and Organisational Culture: Strategic Context

Workforce sustainability remains a strategic priority

National workforce shortages continue across several specialist professional groups.

Demand for diagnostic and therapeutic services continues to increase.

Long-term workforce planning is critical to future service resilience.

Staff experience is a key determinant of service quality

Staff survey findings have informed local workforce priorities.

Focus remains on leadership visibility, engagement, wellbeing and recognition.

Improving staff experience supports retention, attendance and organisational performance.

Workforce transformation is supporting future sustainability

Development of new workforce models and career pathways.

Increased focus on workforce redesign and digital innovation.

The Clinical Board remains focused on continuous improvement

Delivering workforce priorities aligned to Shaping Our Future Wellbeing.

Strengthening organisational culture.

Supporting a sustainable, engaged and high-performing workforce.

CD&T is not a support service on the edge of care. It is the diagnostic and therapeutic engine that enables care to happen.

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Understanding CD&T

Supporting every patient pathway

The Clinical Board underpins almost every aspect of clinical activity in the UHB
From sample to scan, medicines to therapies, outpatients to medical illustration: CD&T converts clinical questions into decisions and recovery.

Five directorates providing diagnostic and therapeutic services

Pharmacy
- Inpatient services
- Medicine management
- Aseptic Services
- Home care
- Procurement

Radiology & PIER
- Medical Physics
- Clinical Engineering
- Medical Illustration
- Point of care testing
- Interventional radiology

Laboratory Medicine
- Mortuary services
- Cellular Pathology
- Blood transfusion Laboratory
- Toxicology Lab including Wedinos Service
- Biochemistry

Therapies
- Rehabilitation Model
- Optimization
- Specialist Rehabilitation

Outpatients, Patient Administration, Clinical Coding
- Medical records
- Outpatient nursing

CD&T workforce challenges are fundamentally different to many other Clinical Boards due to the breath and specialist nature of professions.

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Building on the foundations established in 2024

2024 Foundations

- Workforce redesign and new roles
- Staff engagement and wellbeing
- Inclusion and partnership working
- Digital workforce development
- Leadership development
- Workforce governance

2026 Focus

Aligned to Cardiff & Vale People & Culture Plan

- Workforce sustainability
- Recruitment & retention
- Healthy & engaged workforce
- Leadership & succession
- Education & learning
- Digital workforce

Building on established foundations, moving from activity to impact, assurance and long-term workforce sustainability.

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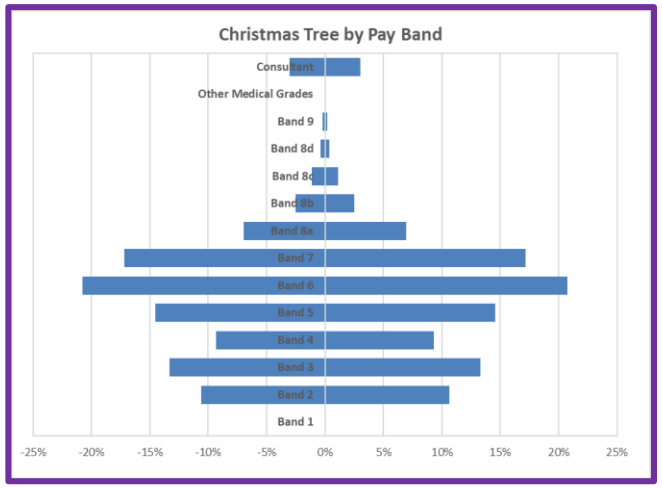
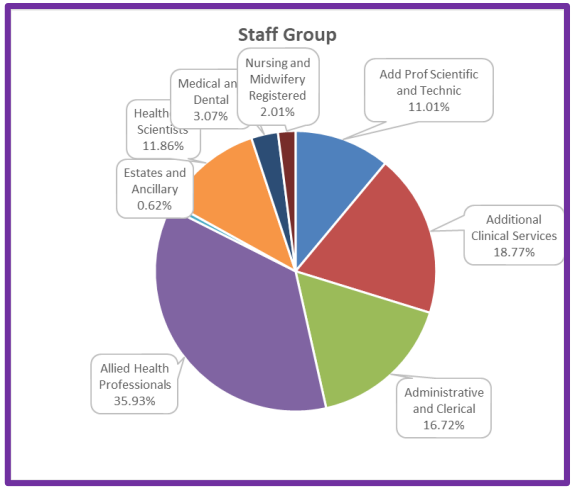
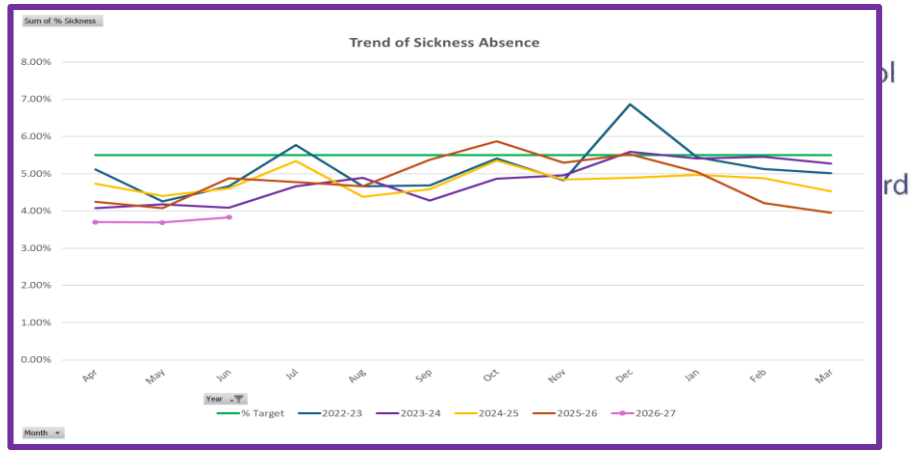
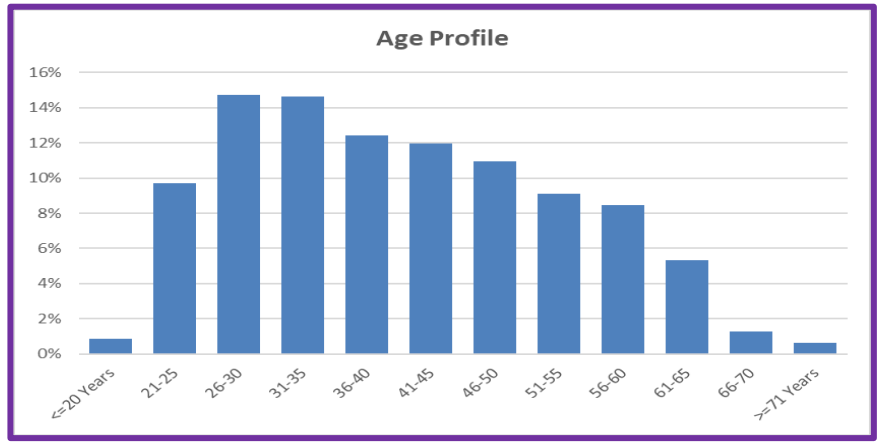
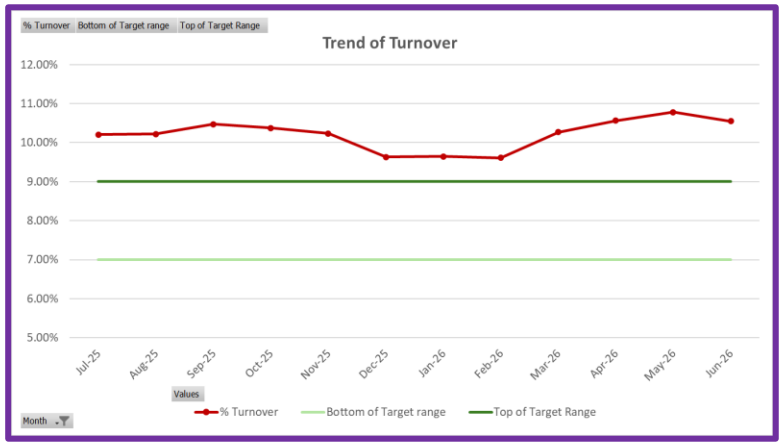
Workforce profile

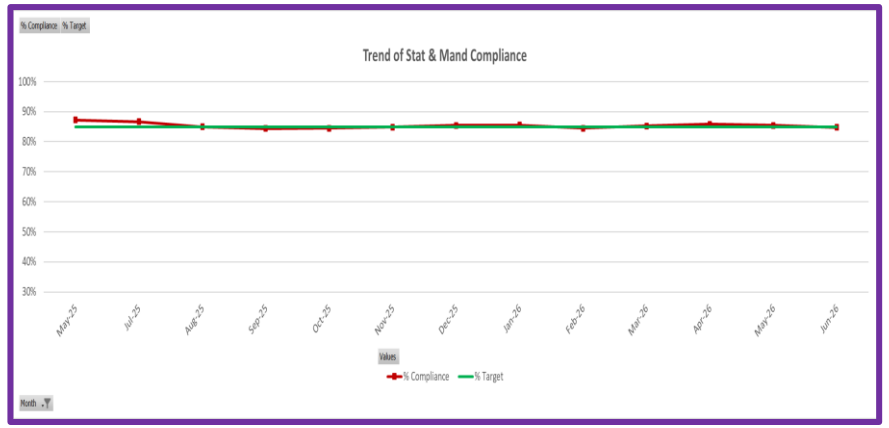












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Interpreting the workforce position

Workforce signal

absence, turnover, compliance

Service effect

capacity, turnaround, flow, quality continuity

People response

support, redesign, leadership, learning

Assurance evidence

trajectory, staff voice, patient impact

Workforce metrics are reviewed through the lens of service resilience

Key message:
The Clinical Board is using workforce data to identify whether risk is emerging, where action is required and whether further assurance is needed.

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CD&T Approach to People and Culture

Aligning local priorities with organisational ambitions

Workforce Sustainability

Workforce redesign

Career pathways

Succession planning

Attract, Recruit & Retain

Recruitment

Development

Recognition

Engaged, Healthy & Motivated

Survey actions

Wellbeing

Engagement

Leadership & Succession

Leadership capability

Talent pipelines

Education & Learning

Advanced practice

Apprenticeships

Digital Workforce

Digital transformation- EPMA roll out, LIMS and RISP programmes

Communication

Key Message: CD&T priorities align to the People & Culture Plan and support workforce sustainability, staff experience and service resilience

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What staff told us and what we are doing

1,163 colleagues shared their views through the 2025 NHS Staff Survey

Three priorities emerged consistently across CD&T

PRIORITY 1
WORKFORCE PRESSURE

25.8%
Enough staff to do job properly

WHAT THIS MEANS

Pressure on teams and wellbeing is affecting staff experience.

OUR RESPONSE

- Attendance focus
- Sickness panels
- Manager support
- Workforce scrutiny

EXPECTED IMPACT

Healthier workforce and improved service resilience

PRIORITY 2
LEARNING & DEVELOPMENT

Declining scores
Development opportunities

WHAT THIS MEANS

Development is critical to retention and future workforce sustainability.

OUR RESPONSE

- Stronger VBAs
- Career pathways
- Learning access
- Succession planning

EXPECTED IMPACT

Improved retention, capability and workforce supply

PRIORITY 3
FEEDBACK MATTERS

Opportunity to strengthen trust

WHAT THIS MEANS

Staff want confidence that feedback results in visible action.

OUR RESPONSE

- Action planning
- Team conversations
- Survey toolkit
- CD&Talks updates

EXPECTED IMPACT

Increased trust, engagement and staff voice

Key Message: The survey findings have been translated into three Board priorities aligned to the Cardiff & Vale People & Culture Plan.

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CD&Talks: A New Approach to Engagement

CD&Talks

Episodes of CD&Talks can be accessed here: CD&TALKS

CD&Talks

These are podcasts designed for all our colleagues that form part of CD&T. They cover a v
topics, sharing important updates and key messages from the Clinical Board.

They will highlight great work, innovations and bright spots from across our directorates and we'll explore the challenges and priorities shaping our work, and how we respond.

We hope you will listen and take part.

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Challenges to Sustaining Progress

Maintaining Momentum

Sustaining engagement and ensuring staff continue to see visible progress and meaningful outcomes from the actions we are taking.

Balancing Ambition with Operational Capability

Maintaining the focus on People and Culture priorities whilst responding to sustained service demand, workforce pressures and competing operational priorities.

Consistency Across a Diverse Clinical Board

Embedding a consistent strategic approach whilst recognising that local solutions are required across different professions, services, sites and workforce groups/

Turning Compliance into Quality

Improving metrics such as VBAs, statutory and mandatory training and attendance management whilst maintaining a focus on meaningful conversations, leadership practice and staff experience.

Evidencing Impact

Demonstrating how People and Culture initiatives are improving staff experience, workforce sustainability, organisation culture and service resilience.

Key Message:The challenge is not a lack of activity. The challenge is sustaining focus, prioritising where we can have the greatest impact and demonstrating that improvement is experienced by staff across all areas of CD&T

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Inclusion, EDI & Wellbeing

- CRI therapy team, silver award for diverse Cymru cultural competence programme
- Embedded EDI leadership roles and Speaking Up Safely Connectors
- Project Search, lived experience roles, supervision and appraisal
- Champion Network development and benefits realisation
- EDI competency framework and training impact
- Support for internationally trained staff and staff with additional needs
- Accessible communication resources
- Community engagement and storytelling

Menopause CHAMPION CD&T
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SUPPORT EMPOWER THRIVE

Improving menopause support

- Promoting more inclusive workplace
- Improving staff well-being
- Supporting managers
- Menopause champions training
- Online resources