

Draft Minutes of the Public People and Culture Committee
Held On 17th February 2026
Via MS Teams

Recording (YouTube link) – [Click here](#)

Chair:		
Clive Curtis	CC	Independent Member for Local Community / Committee Chair
Present:		
Judi Rhys	JR	Independent Member – Third Sector
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
Robert Warren	RW	Assistant Director of Health & Safety
Rachel Pressley	RP	Head of People Assurance & Experience
Matt Phillips	MP	Director of Corporate Governance
Claire Beynon	CB	Executive Director of Public Health
Jason Roberts	JR	Executive Director of Nursing
Ceri Dixon	CD	Senior Business Partner – People Services
Paul Bostock	PB	Chief Operating Officer
Jo Brandon	JB	Director of Communications
Jonathan Pritchard	JP	Assistant Director of People Resourcing
Jessica Castle	JC	Director of Operations – Specialist Services
Catherine Twamley	CT	Interim Director of Nursing – Specialist Services
Maisy Provan	MP	Armed Forces Lead
Shajneen Abedean	SA	Equity & Inclusion Manager
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Susan Lloyd-Selby	SLS	Independent Member for Local Council
Mitchell Jones	MJ	Head of Equality & Inclusion
Rhian Thomas	RT	Independent Member for Capital & Estates
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Suzanne Rankin	SR	Chief Executive
Mark Dunford	MD	Head of Occupational Health

Item no	Agenda Item	Action
P&C 17/02/1.1	<p>Welcome, Apologies & Introductions (click to view)</p> <p>The Committee Chair (CC) welcomed everyone to the meeting.</p>	
P&C 17/02/1.2	<p>Declarations of Interest (click to view)</p> <p>No declarations of interest were noted.</p>	
P&C 17/02/1.3	<p>Minutes from meeting on 25th November 2025 (click to view)</p> <p>The minutes were agreed to be a true reflection of the meeting on 25th November 2025.</p> <p>The Committee resolved that:</p> <p>a) The draft minutes of the meeting held on 25th November 2025 were agreed to be a true and accurate record of the meeting.</p>	
P&C 17/02/1.4	<p>Action Log following 25th November 2025 Meeting (click to view)</p> <p>All actions were accepted.</p> <p>The Committee resolved that:</p> <p>a) The Action Log was discussed and noted.</p>	
P&C 17/02/1.5	<p>Chair's Actions (click to view)</p> <p>There were no chairs actions.</p> <p>The committee resolved that:</p> <p>a) There were no chairs actions.</p>	
Items for Review & Assurance		
P&C 17/02/2.1	<p>Staff Story</p> <p>The Executive Director of People & Culture – Rachel Gidman (RG) introduced the staff story, mentioning the importance of patient-centred care and therapeutic activity, and introduced Katie Turner, deputy ward manager in Alder Ward, Hafan-y-Coed (HYC), noting the Christmas theme and its relevance to patient and team wellbeing</p> <p>Th Executive Nurse Director - Jason Roberts (JR) walked around HYC on Christmas Eve as a judge for the best decorated ward, where he saw and heard the Christmas video for the first time, met the patient, and expressed thanks to the nursing staff and leadership. He noted the uplifting atmosphere, with staff and patients singing together, and highlighted the sense of joy experienced, especially given the challenging environment.</p> <p>The independent Member – Third Sector - Judi Rhys (JRH) commented that the music and approach would benefit other patient groups, especially those with dementia, and asked if the story would be shared more widely in CAV UHB, as it was a positive example of engagement across wards.</p>	

	<p>The CAV UHB Chair - Kirsty Williams (KW) referenced an Arts Council for Wales report showing the cost-effectiveness of arts as preventative engagement, noted that CAV UHB previously had a strong reputation in this area but the programme ended due to financial issues, and asked about the scope for working with the third sector to promote opportunities for patients to be prescribed art and the arts as part of their treatment and support.</p> <p>The Director of Communications & Engagement - Joanne Brandon (JB) explained that although the Arts in Health programme no longer existed, related work continued across CAV UHB, including partnerships with Rubicon Dance and Music in Hospitals, and involvement with the Parkinson's Disease Choir and Royal Welsh College of Music and Drama. Herself and Emma Cooke worked on these initiatives and recently won funding from the Bearings Foundation for youth therapy projects. She highlighted a strong evidence base supporting arts in health, which helped with funding bids, and stated that these activities were widely promoted across all channels, with positive patient feedback. She offered to send examples of this promotion and feedback.</p> <p>RG mentioned that a great story was shared at the last meeting and that a bank of stories was created for use in different forums, including the website, with plans for broader awareness and training aspects.</p> <p>The Committee Chair - Clive Curtis (CC) requested for thanks to be passed on to the team for the inspiring staff story, emphasising its value as a learning experience for everyone and its importance for the wider public to understand the impactful work happening across CAV UHB, benefiting both staff and patients.</p> <p>The Committee resolved that:</p> <p>a) The Staff Story was received.</p>	
<p>P&C 17/02/2.2</p>	<p>Board Assurance Framework – Workforce</p> <p>The Assistant Director of People Resourcing - Jonathan Pritchard (JP) presented the Board Assurance Framework on Culture and highlighted the following points:</p> <ul style="list-style-type: none"> • CAV UHB spends over £1b annually on workforce; there was a reduction of 304 staff in the past 12 months, attributed to measures like vacancy freeze, recruitment scrutiny panels, and voluntary release schemes. • Variable pay (bank, agency, overtime) represented about 5.7% of workforce spend; efforts focused on reducing temporary spend, specifically agency and overtime. • Agency spend reduced significantly from £12.6m to £3.8m in the first nine months of the year (excluding medical and dental staff). • Overtime spends reduced from £8.2m to £800k, mainly due to stopping overtime and replacing it with bank shifts; one clinical board still relied on overtime, but further reductions were expected. • Bank spend increased by £4.9m, as expected, due to the shift from agency and overtime, but WG expected further reductions. • Implementation of health roster enabled detailed staffing information, safer ward staffing, and better performance management, contributing to reduced temporary pay. • Combined reduction in bank, overtime, and agency spend totalled £11.3m over two years (nine-month period comparison). 	

- CAV UHB used less than a quarter of the agency nurse shifts used by Cwm Taf UHB, which reflected strong performance in managing temporary staffing.

RG explained that overtime was part of the T&C's and was still paid when staff overrun their shift or for emergencies, but it was previously over-utilized. Restrictions were put in place, and there was confidence it was being used appropriately. She added that if new workforce cannot be brought into the model, the team were working on creating a unified workforce story, which would be brought back to the committee for collective ownership.

KW thanked the team for their work and acknowledged the significant effort and results achieved. She highlighted that this was also a patient quality and experience issue, not just a financial one, noting that staff in permanent roles provide the safest care. She questioned what more can be done, as considerable money was spent on variable pay, and asked if temporary pay was used to account for patient acuity, cover annual leave, sickness, or facilitate CPD/training. She asked about the realistic scale of further reductions and what was driving the continued use of variable pay, even as it shifts more to bank rather than overtime or agency.

RG explained that the nursing overhead included a percentage for annual leave (AL), continuing professional development (CPD), and other factors, but currently some areas were exceeding this percentage. She highlighted that sickness was a major issue, with about 1k staff off sick per day, and emphasised the need to address this further. She stated they were working with clinical boards to delve deeper into the causes and management of sickness, combining process improvements and behavioural interventions.

The Deputy Director of People & Culture - Lianne Morse (LM) said extensive work was done in preparation for the annual plan for 2026/27. She noted JP's report did not include medical and dental staff, but agency spend for these groups was about £1.7m, which had significantly reduced over the last three years. She explained that bank staff usage covered sickness, vacancies, and varied by staff group; CAV UHB was committed to reducing bank costs (currently close to £42m) by 10% next year. She stated agency spend was around £6–6.5m, with a target to reduce by 30%, and aimed to reduce waiting list initiatives for medical and dental workforce (currently £2.8m). She described these as ambitious targets, balancing cost reduction with safety and risk.

JR explained that the staffing act allowed for a headroom of 26.9%, which was established about 12 years ago and was considered outdated. He stated that annual leave (AL) is within CAV UHB's control and was managed well, with improvements in flattening leave across the year to avoid spikes that require bank or agency cover. He highlighted that nurses required more professional development than any other health professional, averaging 52 hours per year. The headroom calculation allowed for about 1.5% for professional development, which was insufficient for current needs. He noted that maternity leave was outside CAV UHB's control and, due to nursing being a female-dominated profession, the rate was higher than anticipated when the headroom was originally set.

The Executive Medical Director – David Fluck (DF) stated that there wasn't an overhead built into much of the medical workforce, which was a historical issue that needed review, especially with the rise of less than full-time working. He acknowledged there would always be gaps and emphasised that bank or temporary staff cannot be completely removed because flexibility was essential

	<p>in workforce planning. He explained that bank staff were preferred due to thorough checks and familiarity with CAV UHB, making them safer and more cost-effective than agency staff. He stressed the need to determine the appropriate level of temporary staff and modernise workforce planning to account for holidays, maternity, and other life events. He mentioned a push to roster resident doctors using an allocated system like nurses, which was seen as a significant step forward in modernising the medical workforce.</p> <p>KW agreed with DF that CAV UHB would always require a level of temporary staffing and cannot operate without it. She noted that CAV UHB has more nurses than ever before, and the staffing act provides for headroom, yet variable pay remained high. She questioned what the benchmark should be for variable pay, why the figures were as they are despite increased staffing, and whether CAV UHB has a clear understanding of the reasons behind these numbers. She suggested that the committee should monitor progress on the expected reductions in variable pay throughout the year.</p> <p>The Committee resolved that:</p> <p>a) The information included within the paper was discussed, noted and accepted as assurance</p>	
<p>P&C 17/02/2.3</p>	<p>Key Performance Indicators</p> <p>The Deputy Director of People & Culture - Lianne Morse (LM) highlighted the following points:</p> <ul style="list-style-type: none"> • Turnover: Turnover continued to fall each month, now just above 8% in January, which was seen as a positive trend. • Job Planning: Compliance with job planning had improved, now close to 83%, with a target of 90%. • Value-Based Appraisals (VBAs): Slight improvement to 73% compliance, but more focus and work were needed in this area. • Healthcare Support Worker Compliance: Increased to 83% last month, attributed to validation of skill set meetings in clinical boards. • Sickness Absence: Reducing sickness absence remained a challenge; ongoing support for managers to proactively manage absence, with a focus on policy, guidance, and proactive management of return to work and staff wellbeing. • Priority for 26-27: Continued focus on proactive management of sickness absence and staff wellbeing as a key priority for the next year. <p>KW thanked LM for the clarity and helpfulness of the KPI update, noting it was clear where CAV UHB stood. She observed that several KPIs were not being met, though some were trending positively. She highlighted the strong reliance on CB's for delivering on these KPIs. She referenced a recent audit at Audit Committee, which identified limitations in capacity, capability, and skills within CBs, and noted this was not unique to one board. She asked executive colleagues if there was a programme in place to support clinical boards in fulfilling their responsibilities, specifically in managing sickness and ensuring value-based appraisals (VBAs) were completed, and what plans exist to better equip CBs for these tasks.</p> <p>RG stated she asked the leadership and management team to review the entire offering for managers, including decision-making and the financial side of work. She noted that there was currently no triumvirate programme, and the plan was to work with senior leaders to identify what support was needed for individuals, then cascade this support throughout CAV UHB. She mentioned sickness was recently reviewed and staff availability data, which highlighted</p>	

gaps in managerial actions, such as basic return-to-work documentation. She emphasised there was more work to do in upskilling staff on the basics of managerial activity. She described VBAs as an important opportunity to check in with staff and discussed the need to streamline the process and make objectives clearer, including stronger documentation around availability and sickness. She confirmed that this review work had started and would be cascaded once completed, with updates to be brought back to the committee

The Chief Operating Officer - Paul Bostock (PB) referenced a recent conversation about the tricordent redesign and the need to determine what support would be required for implementation. He stated there were current deficits in capability, which was down to not enough people with the necessary skills for required roles. He questioned what support would be needed at the top level and how to equip everyone in leadership positions, estimating that approx. 2k–3k people in such roles. He suggested a training needs analysis and emphasised the need for board support to agree on how to deliver this, as it cannot be achieved with limited resources. He stressed the importance of a proper programme of equipping managers and ensuring consistency across the CBs, noting current struggles with consistent application of policies and procedures.

KW highlighted that CAV UHB was placing significant emphasis on the new operating model, which involved devolving decision-making to lower levels. She expressed concerns about the capability to manage the current model and stressed the need for confidence in the future system's ability to deliver, especially as decision-making is devolved.

CC agreed that the board needs to be made aware of the issue, stating it is crucial to good governance of the board.

The Deputy Director of Health & Safety – Robert Warren (RW) highlighted:

- The main KPIs for health and safety were related to RIDDOR incidents, which must be reported to the HSE.
- Most incidents were due to the seven-day absence configuration, not necessarily serious injuries.
- Only six staff incidents were specified injuries; the rest were reported because of the seven-day injured reporting figure, indicating a cultural issue regarding recovery time.
- The high percentage (approx. 90%) of RIDDOR reports due to seven-day absence was a concern, compared to the UK average of 70%.
- There was ongoing work with People Services and trade unions to address the length of recovery and to reduce the number.
- Health and safety training compliance had improved since the COVID pandemic, with CBs now more engaged in ensuring staff were trained and compliant with statutory requirements.

RG stated that health and safety was equivalent to quality and safety, emphasising it was the safety of staff. She highlighted that fire risk training was a statutory requirement, current compliance was just over 70%, and this needed to increase; training can be virtual, not just face-to-face. She mentioned violence and aggression incidents had increased, and the ESR information was not accurate, so a cleansing process was underway to correct staff modules. She reiterated the importance of understanding and reporting RIDDORs, noting educational work was done and stressed the need for everyone to take health and safety as seriously as patient safety moving forward.

	<p>KW thanked RG and RW for the clarity about the risks in the health and safety report. She asked RG what was practically needed for the committee to take health and safety seriously, expressing concern that the conversation might repeat without concrete action. She specifically questioned what action should arise from the information received today.</p> <p>RG said health and safety was taken to executive reviews, but the desired conversations and trajectory were not happening. She asked PB how to engage and ensure accountability, so everyone takes health and safety seriously, including both CBs and corporate areas.</p> <p>PB said they need to ramp up health and safety at the executive reviews and give it the same focus as VBAs, making it a bigger priority for everyone to get behind. He admitted he hadn't appreciated that health and safety had reached this level of concern.</p> <p>DF supported RG's points about mandatory training and health and safety, noting that non-compliance exposes staff, the organisation, and patients to risk. He discussed the need to consider consequences for non-compliance, questioning whether there comes a point when it is unsafe for individuals to carry out their work if they are not compliant. He stressed the importance of communicating these risks to staff, highlighting the need to make staff aware of the risks to themselves, CAV UHB, and patients.</p> <p>RG stated the team would put together communication and gather names of those in CBs and corporate areas who were not compliant, then cascade this information to the relevant areas and follow up at executive reviews.</p> <p>Action – RG to pull communication together, obtain names of non-compliant staff in clinical boards and corporate areas, cascade to relevant teams, and review actions at executive reviews.</p> <p>The Committee resolved to:</p> <p>a) The committee noted & discussed the content of the report.</p>	
<p>P&C 17/02/2.4</p>	<p>Equity & Inclusion including staff networks review</p> <p>The Assistant Director of OD, Culture & Wellbeing - Claire Whiles (CW) introduced the Equity & Inclusion Manager - Shajneen Abedean (SA) to the committee and highlighted the following points:</p> <ul style="list-style-type: none"> • The paper focuses on improving governance and structures around staff networks at Cardiff and Vale UHB. • Claire explained the need for a staff networks reset due to inconsistencies in governance, sustainability, and clarity of purpose, with some networks active and others struggling. • Proposed actions include standardised terms of reference for all networks, clarifying scope, governance, and reporting arrangements, and defining advocacy as systemic (not individual cases). • Establishment of the Adborth Advisory Group is planned to provide structured advisory input to senior discussions, without decision-making authority or duplicating formal consultation. • A formal relaunch of all staff networks is planned for April 2026, prioritising sustainability and governance before speed. <p>JRH expressed interest in the paper and questioned who decided on the staff networks. She also asked whether the number of networks was typical, seeking to understand the wider landscape across health boards.</p>	

	<p>CW stated they make an active choice not to force staff networks, preferring them to emerge organically. She mentioned networks also emerge in different CBs. She emphasised the importance of supporting networks with the right governance to keep staff safe and enable organisational listening. She noted that networks had experienced peaks and troughs in activity.</p> <p>SA noted that currently network activity happens "as and when," serving as a platform for addressing the sense of belonging, but without strategic direction. She said that developing terms of reference and direction would benefit both the staff network and CAV UHB.</p> <p>KW welcomed the work, saying intentionality and purposefulness, along with governance, were valuable and a step forward for CAV UHB. She added that these networks could provide information to the committee and board about what it feels like to work in CAV UHB.</p> <p>The Committee resolved to:</p> <ol style="list-style-type: none"> a) Note the challenges currently faced by Staff Networks were noted. b) The proposed governance review and standardised Terms of Reference were supported. c) The formal relaunch of all staff networks in April 2026 was endorsed. d) The establishment of the Adborth Advisory Group as a mechanism for senior-level insight, accountability, and staff voice was supported. e) Promote staff participation by encouraging line managers to enable release time for network engagement. 	
<p>P&C 17/02/2.5</p>	<p>Occupational Health / Wellbeing Services KPI</p> <p>CW highlighted the following points on the occupational health / wellbeing services KPI:</p> <ul style="list-style-type: none"> • Occupational Health (OH) service was performing strongly and consistently against key measures, with high timeliness for case management, pre-employment clearances, and physiotherapy referrals, reflecting sustained improvement. • The service was stable, clinically safe, and managed demand well, including work under service level agreements, without compromising core responsibilities. • Data demonstrated that absence duration was more influenced by early management action and quality of referrals than by OH capacity. • OH was responding well and timely; variation in absence duration was often linked to early conversations and manager confidence in handling attendance issues. • Strengthening early management action was likely to have more impact than simply increasing clinical capacity; a pilot was being explored to support managers with earlier advice before formal referral. • Employee Wellbeing Service remained clinically safe, delivering counselling and trauma-informed support; accreditation, governance, and digital improvements were progressing. • There was pressure in trauma pathways, with waiting times around six months, and longer waits for counselling, still within KPIs but not considered acceptable for staff. • Increased demand and complexity were driving these waits; a wider Wellbeing model review was underway, focusing on keeping the service stable and understanding demand before changes. • Key areas for committee support: improving how managers handle attendance/absence, monitoring access and waiting times, and receiving updates as the Wellbeing Review develops. 	

	<ul style="list-style-type: none"> • Clarified abbreviations: CQOS (Safe, Effective, Quality Occupational Health Service Industry Standards), EMDR (eye movement desensitization and reprocessing), and others used in the papers. <p>JRH thanked the team for the paper. She asked about the longer waits for counselling, noting it was counterproductive, and questioned how long the waits were and whether they were due to increased demand or staff numbers.</p> <p>CW explained the current wait for counselling was approx. 20 weeks and the Employee Wellbeing Service operates as a self-referral service. Staff receive a resource appointment within 7 days to assess the best means of support. The service signposts staff to Canopi if their waiting lists are shorter. She noted increasing demand and complexity in cases, with some programmes required more sessions than standard counselling. She stated the team was not content with current waiting lists, which was why they were reviewing the whole employee health and wellbeing model.</p> <p>PB asked how CAV UHB can help people get ready for the world of work, noting that some reasons for referrals seem unjust but acknowledging that work was tough and employers pay people to work hard. He stressed the need to ensure the right people were in the right place.</p> <p>CW noted the need to look at accountability, induction processes, and whether staff were being appropriately prepared for their roles. She mentioned reviewing job descriptions to ensure expectations were clear. She described this as a large area to address, emphasising the importance of focusing on prevention and wellbeing to better prepare and support people.</p> <p>Action – CW to lead a review of the employee wellbeing model, focusing on prevention, access, and timeliness, and bring updates to the committee.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> The continued delivery and development of the Occupational Health collaborative model (CAV–CTM) was noted. Assurance was received on strong and improving performance across case management, preplacement, and physiotherapy pathways. The emerging themes relating to manager capability and referral quality and the steps being taken to address these was noted. The positive impact of OPAS and sickness panels in improving referral quality and management consistency was noted. Ongoing work with People Services and OD to strengthen manager capability in attendance management was supported. The development and piloting of a rapid access, prereferral sickness management support offer for managers (capacity dependent) was supported. The risks relating to service capacity, SEQOHS, health surveillance and vaccination expansion, and the mitigations in place was noted. Request a future update on: <ul style="list-style-type: none"> o performance o SEQOHS progress o health surveillance rollout o vaccination collaboration o pilot outcomes and impact 	
<p>P&C 17/02/2.6</p>	<p>RADON Update</p> <p>RW highlighted the following points on RADON:</p>	

	<ul style="list-style-type: none"> • Elevated levels of radon were detected in CAV UHB during recent monitoring; previous checks in 2015 showed no concerns. • Two areas of concern were found: the basement of Denbigh House and the basement tunnel area of Pembroke House, which were not working areas but transit routes. • These areas were closed off due to health and safety risks, with relevant signage, locked access, and a signing procedure for inspection purposes. • The risk to staff was extremely low, as exposure would require working in those areas for extended periods, which does not occur. • Trade union partners were consulted and raised no concerns about the approach. • Further monitoring was ongoing and would not wait another 10 years; baseline readings would be checked again in three months. • Access to these areas was now strictly controlled and prohibited except by approved procedures. <p>DF questioned whether affirmative action on radon was taken quickly enough, asking if earlier action should have been taken since it was first detected.</p> <p>RW clarified that 10 years ago, no areas of concern or elevated radon levels were detected; the current issues have occurred since then.</p> <p>KW thanked RW for the report and asked about the tunnels in UHW, noting that although doors were supposed to be restricted, they were often open and people are seen wandering through, raising concerns about actual access control.</p> <p>RW explained that significant investment has been made in TDSi card access for tunnel infrastructure, and for the specific area in question, the doors are physically locked with a key and have a thumb wheel on the inside for exit, ensuring controlled access.</p> <p>PB noted that many tunnels are a thoroughfare, and there is a need to move patients through what is essentially a service area, which is why tunnels near A&E have been refurbished. He highlighted the challenge of dual purposes for the tunnels and confirmed the existence of a tunnel safety group that meets regularly.</p> <p>RW confirmed that there is a Tunnel Safety Group, which he chairs. He mentioned ongoing challenges such as illicit dumping of waste, including by clinical staff, and emphasized the need for education about the dangers and risks the tunnels present to the UHB, particularly from a fire safety perspective.</p> <p>The Committee Resolved that:</p> <p>a) The course of action detailed was agreed.</p>	
<p>P&C 17/02/2.7</p>	<p>Clinical Board Spotlight – Specialist Services</p> <p>The Director of Operations for Specialist Services - Jessica Castle (JC) presented and highlighted the following points:</p> <ul style="list-style-type: none"> • Specialist Services Clinical Board has 7 directorates, provides a wide range of services across South Wales, and spends about £290 million annually with over 2000 whole time equivalent staff. • Workforce profile is heavily frontline, mainly nursing/midwifery and additional clinical services; small changes in workforce (e.g., sickness, turnover) have significant operational impact. • National changes like the band 2 to 3 healthcare support worker review have material cost and planning impact due to the board's staff profile. 	

- Age profile shows a stable but maturing workforce, with most staff aged 31-55; succession planning is needed to address future retirement risk, especially in specialist/hard-to-recruit roles.
- Workforce is predominantly female and has many part-time staff; high maternity leave and less-than-full-time staff in resident doctor workforce have led to improved rota design and reduced locum use.
- Ethnicity data shows mostly white British staff, but targeted inclusion work is underway; efforts to improve ESR data completeness for better workforce understanding.
- Disability reporting is low, with high unspecified rates, suggesting possible underreporting and hidden needs; proactive wellbeing support and early intervention are priorities.
- Welsh language skills are being recorded and targeted for improvement in ESR.
- Sickness rate is 6.8%, with targeted sickness panels in hotspot areas; turnover is low overall but higher in lower banded staff in Artificial Limb and Appliance Service, prompting career framework development.
- Statutory/mandatory training compliance is close to target (81%), but fire training is low and being targeted; medical staff compliance is being linked to annual job plan review.
- Value-based appraisal (VBA) compliance is just over 72%, with nursing/midwifery leading; admin/clerical and healthcare scientists are focus areas for improvement.
- Inclusion work, partnership forums, and local ownership of KPIs are emphasized.

The Interim Director of Nursing for Specialist Services - Catherine Twamley (CT) presented and highlighted the following points:

- The Clinical Board actively promotes staff achievements through platforms like Viva Engagement, Colleague Shout Out, and features in Ask Suzanne; positive reinforcement of values and behaviours is a proactive focus.
- Cultural initiatives such as “Civility Saves Lives” are being rolled out across all areas as a back-to-basics approach, not due to specific issues but to reinforce positive culture.
- Annual Clinical Board celebration events are held to recognize staff, with increasing participation and engagement in events like the Nursing and Midwifery Conference.
- Strong partnership working exists with trade unions and people services; the board has managed complex HR situations and organisational change processes (OCP) effectively, including service realignments.
- Rotational posts are encouraged, especially in critical care and cardiac services, to aid recruitment, retention, and provide diverse opportunities; similar models are being explored in other directorates.
- Cardiac surgery workforce models are being reviewed to expand the role of surgical care practitioners for consistent, high-quality care.
- Band 4 system practice practitioner roles were successfully implemented in spinal rehab, addressing high vacancy rates and supporting new ways of working; many have since progressed to qualified staff.
- Staff engagement is supported through newsletters and magazines, with ambassadors for learning, inclusion, and learning difficulties; specialist funding streams have enabled innovative roles.
- Wellbeing is prioritized, with bespoke psychological support provided after bereavements and high-profile cases; critical care has a dedicated clinical psychologist.

- Recruitment and retention are strong in some areas (e.g., critical care has no nursing vacancies and a waiting list); the board aims to replicate this success elsewhere.
- Digital readiness is high, with safe care, health roster, and EPMA (electronic prescribing) fully embedded; early adoption allowed feedback and smoother rollout.
- Bespoke induction and strong PDN (Practice Development Nurse) teams support new starters with specialized skills; cross-directorate training and a clinical skills suite are being developed.
- Leadership development has included targeted cultural and service reviews, leading to specific improvement actions.
- Vacancy scrutiny panels and skill mix reviews are routine; targeted interventions have reduced sickness rates significantly in areas like Haematology.
- Recruitment, retention, and workforce redesign are ongoing, with new roles and funding streams supporting service needs; QSE (Quality, Safety, Experience) roles have been expanded to address gaps.
- Innovative solutions, such as newer pharmacist roles and a legal advice service, have addressed workforce and service delivery challenges; new posts have been secured in response to national inquiries and compensation schemes.
- The board celebrates achievements through awards and recognition, highlighting national successes and internal spotlights.

CC thanked the team for their comprehensive and interesting presentation, stating he was encouraged to hear about a stable and mature workforce, which is an asset to the Clinical Board. He noted the challenge of losing expertise when retirements occur and asked whether retirements were staggered and managed properly or if there was a risk of losing many skilled staff in a short timeframe.

JC explained that within the Artificial Limb and Appliance Service (ALAS), there had been a noticeable instance where several scientific and professional staff retired at the same time. To address this, the team now focuses on developing people from the apprentice level, mapping out career frameworks so individuals can see their progression within the service, which helps with succession planning and readiness to step into roles when needed.

RG thanked the team for their presentation and asked, after hearing the discussion about health and safety and fire compliance, if there was anything further they could do to take action at the exec reviews, since progress on fire compliance has stalled.

CT stated that the Fire Manager attends their Clinical Board monthly meetings and planned to offer different training platforms, including options beyond face-to-face sessions, to improve fire training compliance among staff.

PB noted it was good to hear Jessica talk about the career framework, mentioning that with no definitive retirement age and various flexible retirement options, succession planning is tricky. He added that some staff may get offended if asked about their retirement plans and suggested managers could use help navigating these conversations.

KW thanked the team for their comprehensive presentation and asked about lessons learned from the two specialist services that had undergone cultural reviews, specifically whether those lessons have been implemented or are shaping the work of the Clinical Board and other service areas.

JC stated that the main lesson from the reviews is the need for early interventions and being more proactive, taking early actions with individuals

	<p>when issues arise. She mentioned that in the Artificial Limb and Appliance Service (ALAS), things have improved but they are still on the journey. She described it as a long journey and noted that in Cardiology, issues should have been tackled earlier. Jessica emphasized that when noise first appears in the system, it is important to deep dive and intervene quickly.</p> <p>PB noted that there are two reviews within this Clinical Board and two in other clinical boards. He explained that the process of conducting reviews and sharing recommendations is becoming more consistent. He clarified that they are not just finding their way but have been trying to be consistent in how reviews are done and how learning is shared across the organisation.</p> <p>Action – RG to provide names of non-compliant staff on fire training to JC and CT for targeted follow-up between meetings.</p> <p>The Committee Resolved that:</p> <p>a) The Clinical Board Spotlight on Specialist Services was noted.</p>	
P&C 17/02/3.1	<p>Health & Safety Policies</p> <p>There were no policies to review.</p> <p>The Committee Resolved that:</p> <p>a) There were no H&S policies.</p>	
P&C 17/02/3.2	<p>Annual Equality Report</p> <p>CW highlighted the following points on the annual equality report:</p> <ul style="list-style-type: none"> • The annual equality report for 2024-25 is a statutory requirement under the public sector equality duty. • The full report was included in the committee pack for review; after approval, it will be translated and finalized for accessibility and visual engagement before publication. • Examples in the report mainly reference two clinical boards, reflecting responses received during the Welsh Government assessment; not all areas submitted information on time. • Actions are being taken to support clinical boards in contributing to future reports and to minimize duplication in data requests. • The reporting lag is recognized and will be addressed in the next cycle, with the 25-26 report coming to committee in June 2026. • WG is amending the reporting framework; once confirmed, clinical boards will be asked for required information, aligning data collection with other workforce reporting to reduce duplication. • Committee approval of the report as presented is requested. <p>The Committee resolved to:</p> <p>a) The Annual Equality Report was approved.</p>	
P&C 17/02/3.3	<p>Putting People First Portfolio</p> <p>RG explained this is about strategic direction, with a portfolio governance structure implemented. There are two key objectives: people feeling valued, developed, supported, and engaged (measured through engagement score), and becoming an inclusive culture representing the local population. The programme content was outlined in the paper. The request is to note the terms of reference and approve.</p> <p>The Committee Resolved that:</p> <p>a) The Terms of Reference for the Shaping Our Future People and Culture Portfolio Board was approved.</p>	

<p>P&C 17/02/3.4</p>	<p>All Wales Reserve Forces Mobilisation Policy</p> <p>The Armed Forces Lead - Maisy Provan (MP) highlighted the following points on the All Wales Reserve Forces Mobilisation Policy:</p> <ul style="list-style-type: none"> • The policy was last updated in 2020 and needed review due to shorter, more frequent military deployments, especially for medical reservists. • Recognition of shorter and more frequent deployments is now included; deployments can be less than three months. • Emphasis on early discussion and capacity planning with line managers before reservists are mobilised, to allow services to plan for absences. • Pension arrangements are now highlighted earlier in the policy for clarity, following issues in Aneurin Bevan. • The policy ensures compliance with the Armed Forces Covenant, fair and consistent treatment of reservists across Wales, and improved assurance for managers. • There is a small number of reservists currently, but numbers may increase due to strategic review targets. <p>The Committee Resolved that:</p> <ol style="list-style-type: none"> a) The all-Wales Reserve force mobilisation policy was approved and b) Noted some of the offerings available by the MoD 	
<p>P&C 17/02/5.1</p>	<p>Any Other Business</p>	
<p>P&C 17/02/5.1</p>	<p><u>Private Agenda</u></p>	
<p>P&C 17/02/6.1</p>	<p><u>Review & Final Closure</u></p>	