Minutes of the Public People and Culture Committee
Held On 25th November 2025
Via MS Teams

Recording (YouTube link) – Click here

Chair:		
Clive Curtis	CC	Independent Member for Local Community / Committee Chair
Present:		
Rhian Thomas	RT	Independent Member for Capital & Estates
Mike Jones	MJ	Independent Member for Trade Union
In Attendance:		
Lianne Morse	LM	Deputy Director of People & Culture
Matt Phillips	MP	Director of Corporate Governance
Rachel Gidman	RG	Executive Director of People & Culture
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Robert Warren	RW	Assistant Director of Health & Safety
Rachel Pressley	RP	Head of People Assurance & Experience
Matt Temby	MT	Managing Director of University Hospital of Llandough
Tara Robinson	TR	Director of Nursing – Mental Health Clinical Board
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
Leanne Morris	LM	Head of People Services
Katrina Griffiths	KG	Associate Director of People & Culture
Martyn Capel	MC	Associate Director of Medical Workforce Resourcing
Mike Stephens	MS	Assistant Medical Director
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Susan Lloyd-Selby	SLS	Independent Member for Local Council
Mitchell Jones	MJ	Head of Equality & Inclusion
Claire Whiles	CW	Assistant Director of OD, Culture & Wellbeing

Item no	Agenda Item	Action
P&C 25/11/1.1	**Welcome, Apologies & Introductions (click to view)** The Committee Chair (CC) welcomed everyone to the meeting.	
P&C 25/11/1.2	**Declarations of Interest (click to view)** No declarations of interest were noted.	
P&C 25/11/1.3	**Minutes from meeting on 14th October 2025 (click to view)** The minutes were agreed to be a true reflection of the meeting on 14th October 2025 (following some minor amendments). **The Committee resolved that:** a) The draft minutes of the meeting held on 14th October 2025 were agreed to be a true and accurate record of the meeting.	
P&C 25/11/1.4	**Action Log following 14th October 2025 Meeting (click to view)** All actions were accepted. **The Committee resolved that:** a) The Action Log was discussed and noted.	
P&C 25/11/1.5	**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 25/11/2.1	**Staff Story** The Executive Director of People & Culture - Rachel Gidman (RG) introduced the staff story, providing context about the corporate parenting charter (2023) in Wales and CAV UHB's responsibility towards young adults brought up in care. CAV UHB submitted a bid to widen access, aiming to go beyond work experience by conducting research with universities and collaborating with local authorities and HEIW, who supported the funding. The featured story was about Chloe, a participant in the "Bright Starts" programme, which supported care-experienced young people. RG noted Chloe's significant personal growth from being initially very reserved to confidently sharing her story. The Director of Nursing for Mental Health - Tara Robinson (TR) praised the staff story, stating she was inspired and expressed interest in learning more about the Bright Starts programme. The UHB Chair - Kirsty Williams expressed strong support, saying she wanted to "cheer" for the initiative, emphasizing the importance of providing opportunities for care-experienced individuals and commending the organisation for fulfilling its civic mission and making a positive impact. She thanked everyone involved for their efforts and highlighted the significance of the scheme.	

	RG confirmed the programme's broader aims, included involving care-experienced individuals in service design and quality/safety work, and committed to sharing more about the Bright Starts programme and its impact. The committee expressed appreciation for Chloe's story and the programme and noted its inspirational impact and requested that thanks be passed on to Chloe and those involved. **The Committee resolved that:** a) The Staff Story was received.	
P&C 25/11/2.2	**Board Assurance Framework – Wellbeing** The Deputy Director of People & Culture - Lianne Morse (LM) provided an update on the Board Assurance Framework and highlighted the following: • Staff well-being was a high organisational risk, noting a slight rise in cumulative sickness absence (6.4%) and that the UHB's target of 5.5% would not be achieved. • Stress, anxiety, and depression remained the leading causes of absence, consistent with national trends, and referenced ongoing interventions to support staff. • The need to move from reactive to preventative approaches was noted and emphasized that well-being was everyone's responsibility and mentioned the development of an early warning system to integrate data for leaders. • Efforts to strengthen leadership and management training, collaboration with public health, and the importance of the staff survey to assess changes and support needs were all noted. • The committee was asked to note the sustained risk, endorse the shift to prevention, support data integration for assurance, and request an updated well-being outcomes framework in the next quarter. The Executive Director of Public Health – Claire Beynon (CB) clarified that the vaccination rate was 37% across the Health Board, which was better than last year, but the aspiration was to reach 60% or higher. **The Committee resolved that:** a) The sustained level of risk and the limited improvement to date in absence and staff survey indicators was noted. b) The shift toward a system-wide, preventative model of wellbeing aligned to organisational redesign and leadership development was endorsed. c) The integration of wellbeing, workforce and operational data to strengthen assurance and align with the Culture Dashboard was supported. d) An updated wellbeing outcomes framework by Q1 2026 was requested.	
P&C 25/11/2.3	**People & Culture Plan Refresh** RG highlighted the following points on the People & Culture Plan Refresh: • The People and Culture Plan, originally launched in 2022 as a three-year plan, would have its refresh intentionally delayed aligning with the upcoming clinical service plan and organisational redesign work. • Staff engagement on the new or refreshed plan would begin in the new year, with a focus on whether to refresh or fully renew the plan. • Digital, AI, automation, and digital literacy would be more prominent themes in the next plan.	

	• All current themes remain relevant, with retention and regional working (especially with local authorities) continuing as priorities, and that Welsh language and inclusion will remain golden threads. • The committee was asked to note and support the proposed approach for developing the 2026–2030 People and Culture Plan. RT stated the People and Culture Plan was a helpful framework for aligning thinking, discussions, topics, and themes over the last few years, and welcomed the methodology of pausing for now. She noted there was good material in the existing plan and asked RG what should be brought forward into the next phase. RG responded that all the themes from the current plan were still relevant, noting the All-Wales strategy runs to 2030 and shared the same themes. She highlighted that retention was added to their plan. She said the next plan would likely continue much of the same work but with a bigger focus on regional working (especially seamless working with local authorities) and on automation and AI. She emphasized that Welsh language and inclusion would remain, but digital aspects and regional working would be more prominent. **Action – RG to engage 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.** **The Committee resolved to:** a) The proposed approach to developing the People and Culture Plan 2026–2030 was noted and supported.	
P&C 25/11/2.4	**Key Performance Indicators** LM highlighted the following points on the key performance indicators: • **VBA (Values Based Appraisal):** Reviews took place with clinical boards, and all areas were asked for an improvement trajectory to reach 85% by the end of March. • **Job Planning:** Currently at 77%, with significant work ongoing and further details to be presented by the Associate Director of Medical Workforce Resourcing - Martyn Capel (MC) and the Assistant Medical Director - Mike Stephens (MS). • **Workforce Planning Capability:** The team was reviewing and improving the education commissioning process, running workshops with clinical boards, and encouraging managers to undertake workforce planning training, including embedding it in the general manager leadership programme. • **Employee Relations:** There were 51 formal investigations, which was higher than desired. The main issue was the length of time investigations take, not the appropriateness of the cases. The team was looking at investigation training, durations, and options for dedicated investigating officers to speed up the process. The Independent Member for Trade Union – Mike Jones (MJ) noted there was excellent work going on within the People & Culture teams. He agreed with LM about the need to improve the timeliness of investigations, referencing past success when dedicated investigating officers were employed and suggested revisiting that approach. He stated that prolonged investigations harmed individuals and raised sickness levels within teams, and he expressed full support for efforts to address this issue moving forward. RG stated they would be bringing a proposal regarding the involvement of psychology in supporting tribunals and coroner's courts, referencing the concept of an organisational development (OD) unit and the use of investigators. She	

	mentioned they were looking at how to redesign some of the services they provide. **The Committee resolved to:** a) The contents of the report was discussed and noted.	
P&C 25/11/2.5	**Sickness Absence** KG presented the sickness absence and highlighted the following: • The UHB sickness absence target was 5.5%, with September 2025 rate at 6.41%. • Anxiety, stress, depression, and other psychiatric illnesses were identified as the top reason for sickness absence, followed by cough/cold/flu/influenza and gastro-related issues. • Contributing factors included increased workload, operational pressures, personal circumstances, financial pressures, caring responsibilities, and bereavement. • Mental health was highlighted as the clinical board with the highest proportion of absence related to stress, anxiety, and depression (44.86%), and nursing/midwifery registered staff at 37.46%. • Monthly sickness panels were held within clinical boards to identify hotspots and provide targeted interventions. • Enhanced occupational health support was mentioned as well as, fast-track referrals, access to counselling, and training for line managers to recognize and support staff experiencing stress. • Proactive completion of stress risk assessments, introduction of mindfulness sessions, and promotion of flexible working arrangements was described. • Next steps were outlined: continued monitoring, targeted interventions, maintaining sickness panels, further education, guidance on reasonable adjustments, early intervention, and further analysis of causes. RG acknowledged the increase in mental health issues across the UK and emphasized the importance of supporting and upskilling managers, as they interact with their teams daily and can notice changes in individuals. She highlighted that empowering managers was crucial due to the large workforce. **The Committee resolved that:** a) The content of the report was discussed and noted.	
P&C 25/11/2.6	**Health & Safety including Tracker** RW highlighted the following points on the Health & Safety Tracker: • A paper on the plus sized patient's pathway was ready to go to the next Quality meeting, aiming to transfer governance of this issue to a clinical risk register. • An incident involving the transfer of a patient with a medical gas cylinder was highlighted, which resulted in staff injury due to improper use of brackets. • Work on the health and safety culture plan was ongoing, which had guided departmental focus and was being integrated with the people and culture plan for the next phase, with collaboration underway to define the future approach. RG clarified that there were concerns about the plus sized patients pathway, which RW identified as a risk for the organization. She stated it should not be led solely by health and safety but should be part of the quality conversation, and that the related paper was being referred to the Quality Committee for further handling.	

	Action – The Bariatric Patient pathway and medical gases paper to be referred to the Quality Committee. **The Committee Resolved that:** a) The content of the report was discussed and noted.	
P&C 25/11/2.7	**Medical & Dental Deep dive** MC highlighted the following points on the Medical & Dental deep dives: • **Staffing Levels & Vacancies:** Data on whole time equivalent staffing, showed growth trends and current consultant vacancies (52 WTE), with 16 pending starters and a 4.2% vacancy rate. The need to revisit successful past recruitment initiatives was emphasized, including overseas recruitment and working with partners. • **Flexible Working Trends:** Showed a significant increase (420%) in flexible working applications among resident doctors from 2021 to 2025, impacting operational delivery and variable pay. • **Variable Pay & Bank Expenditure:** A reduction in bank variable pay was noted (23% lower than prior year, or 10% lower excluding industrial action), with vacant posts being the largest driver of spend. • **Waiting List Initiatives (WLI):** Increased spend on WLI year-on-year, driven by patient demand, ongoing work to reduce reliance on WLIs, which included increased substantive consultant workforce and exploring in-source models. • **Agency Spend:** A major reduction in agency spend (66% less than previous year), with only nine active agency workers, mainly in areas with national recruitment challenges (psychiatry, gastro). Discussed ongoing efforts to convert agency roles to substantive posts. MS highlighted the following points: • **Job Planning Compliance:** Reported job planning at 80% completion, with an additional 10% in process, showing significant improvement over two years. Stressed commitment to reaching and maintaining 90% compliance, and noted improved quality of job plans. • **Sickness Absence:** Shared that medical staff sickness absence is very low (1.87%), though actual rates may be closer to 3% due to underreporting. Noted that sickness cover spend is about 4.9% of the medical budget. • **Statutory & Mandatory Training:** Identified underperformance in statutory and mandatory training among medical staff compared to the rest of the organization. Outlined ongoing interventions and referenced national discussions about reducing the number of required modules. • **SAS Doctors & Rostering:** Mentioned efforts to improve representation and support for SAS doctors, active management of fatigue and fertility requirements, and ongoing work on e-rostering, which may be accelerated by the new resident doctor contract. • **New Resident Doctor Contract:** Explained that the proposed contract would require job planning for resident doctors, likely driving further adoption of e-rostering and operational changes. • **Summary of Performance:** Concluded that vacancies and sickness are low, appraisals are over 90%, extra contractual hours are decreasing, but statutory/mandatory training remains the main area needing improvement. RT acknowledged the presentation of many positive figures in the medical and dental deep dive. She asked about the underreporting of sickness, specifically what was driving the issue.	

	MS responded that underreporting was historically due to doctors reporting sickness to local supervisors but not to clinical directors or managers, and a culture of covering each other's work without formal reporting unless out-of-hours cover was needed. He noted recent efforts to improve reporting for better support. RT referenced ongoing issues with mandatory training compliance and asked about the realistic ability to change this, noting it as a long-standing cultural legacy issue. MS explained that improvement efforts include simplifying the process, ensuring appropriate modules for each area, and introducing a "stick" approach by linking mandatory training completion to study leave approval. He also mentioned the excessive number of modules and the need to update requirements. RG stated that the team is cleansing mandatory training data to ensure it is appropriate for each doctor, noting that this process is complex due to consultants being grouped together. She mentioned that they are considering the All-Wales approach, but progress is slower than desired, so they may proceed independently. RG highlighted that the statutory requirement for fire training is important due to infrastructure risks and emphasized the need to reframe this work. She asserted that people safety should be framed at the same level as health, quality and safety, and that mandatory training is essential for quality and safety. **The Committee Resolved that:** a) The content of the report was discussed and noted.	
P&C 25/11/2.8	**Mental Health Clinical Board Spotlight** The Managing Director UHL - Matt Temby (MT) introduced the Mental Health Clinical Board and highlighted the following: • The Mental Health Clinical Board consists of three directorates: adult services, mental health services for older people, and psychology/psychological therapies. • The board was undertaking a large programme to response to WG's mental health strategy and strategic programme requirements. • CAV UHB were working with an external company (36°) to review and support the model of care across both community and hospital-based services. • Secondary care services are mainly based at Llandough Hospital, with a wide range of community services across CAV UHB, highlighting the complexity and spread of services. • A revised governance structure was being implemented, including new groups for people and performance, and finance, to improve engagement and shared planning across directorates. • The performance group focuses on metrics related to people and culture, aiming for better planning and accountability. The Senior Business People & Culture Business Partner for Mental Health – Ceri Dixon (CD) Ceri Dixon highlighted the following points: • Focus on improving staff engagement and communication, including structured feedback and collaboration with staff side. • Undertaking MBTI exercises to enhance individual and team communication preferences. • Promoting staff health and well-being, with deep dives into sickness absence and targeted positive initiatives. • Strengthened governance structure for strategic workforce planning and clearer decision-making frameworks.	

	• Collaboration with HEIW and others on roles such as CAPS and strategic workforce planning. • Initiatives to reduce avoidable harm and improve staffing practices, with consistent themes of performance and quality. • Exploring opportunities to optimize mental health estate and provision for staffing efficiencies. • Advancing digital improvements and automation in work processes. • Workforce size is 1,384, with adult services as the largest directorate; focus on consistency, capability, and capacity sharing. • Majority of workforce are nursing staff and healthcare support workers, with ongoing work on banding and role validation. • Workforce planning considers current demographics and future needs, aligning with strategic planning. • Reviewing correlation between employee relations cases and sickness absence, and working with safeguarding colleagues to improve investigation processes. • Introducing avoidable harm conversations and checklists to ensure appropriate actions in employee relations cases. • Enhancing welfare support for staff undergoing processes, and maximizing use of digital database systems for data analysis, including protected characteristics. • Stress, anxiety, and depression are significant contributors to sickness absence, with focused work to prevent or mitigate these issues. • Emphasis on early intervention, reasonable adjustments, and wraparound support for staff returning to work. RG questioned whether the straight line trajectory on the VBA data was helpful, suggesting a need for a more mature representation. She noted that with sickness absence just over 6%, this equates to about 1,000 individuals off sick every day, and asked what assurance exists that actions will be taken to reduce this figure. CD explained that the culture within the Clinical Board is being examined, emphasizing that it's not just about what actions are taken but how they are implemented. She stated that data is interrogated to identify if certain wards or areas are experiencing issues, and that understanding patient acuity and related factors helps explain increased sickness absence. Weekly planner and tracking provide clear indications of wards and areas under particular stress, allowing for targeted interventions. Conversations are ongoing to implement reasonable or temporary adjustments and provide wraparound support for staff returning to work, in collaboration with colleagues across clinical boards. MJ highlighted the high headcount (527 staff) off due to cold, cough, flu, and influenza, and asked if the percentage of staff who have taken the flu vaccine is known, suggesting this would correlate with the high number of staff taking sick leave for these reasons. CD responded that she did not have the information at that moment but would obtain and share the exact figures. The Director of Nursing for Mental Health Clinical Board - Tara Robinson (TR) – highlighted the following: • Ward staffing reviews were conducted weekly and monthly, which involved people services and finance, using a live ward dashboard to scrutinize local and temporary staffing levels and reasons for temporary staff use. • Regular meetings with finance and people services reviewed sickness trends, roster efficiencies, annual leave, headcount, and financial	

	positions, aiming to maintain budgets and ensure rosters were signed off in time. • The introduction of streamliners and the "grow your own" programme has helped reduce temporary staffing and improve care quality, with staff progressing from healthcare support worker to band 5 roles. • Staff side colleagues lead initiatives to connect with ward and community areas, sharing challenges and opportunities, and supported staff through preventative measures and post-incident meetings. • The nursing team promoted interprofessional training opportunities, not just limited to nursing. • There were ongoing efforts to improve flu vaccine promotion and uptake. • The Clinical Board held shared learning events with the recovery college and people with lived experience to embed learning from incidents and good practice and is expanding recovery college activities. • Challenges included the recruitment freeze, prioritizing posts for safety, adapting to recent changes in the clinical board, work-related stress, reports of poor behaviour, variable communication, and overdue inspections. • Next steps would focus on embedding governance, improved communication, workforce reshaping, stabilizing staffing, re-establishing the Partnership Forum, and ongoing work with external partners on the model of care. • Good news included staff recognition awards, significant investment in staff training, and recognition of high-quality care in specific teams. PB thanked the Mental Health Clinical Board (MHCB) and informed the committee about the significant change and turbulence within the board, noting that the team is leading a major workforce redesign process with many moving parts. He highlighted that there are long-standing and cultural issues being addressed, with the support of 36 Degrees, and commended the team for tackling difficult challenges. He cautioned that as these issues are managed, there might be a temporary spike in sickness and employee relations cases but emphasized that this is part of the necessary process and praised the hard work being done by the MHCB. He wanted to set this context for the committee, acknowledging the bumpy period but expressing confidence that things will improve due to the team's efforts. The UHB Chair expressed gratitude for the opportunity to visit facilities at Llandough (HYC) on 24.11.25 and meet staff and patients. She acknowledged the significant amount of activity underway and asked about the timescales for the various pieces of work, noting that some are ongoing while others are more discrete. She questioned whether metrics have been set to measure progress and impact, specifically how the board will know that all activities are delivering results for patients and staff. She referenced flow issues at Llandough (UHL), highlighting the challenging decisions clinicians face regarding discharge and the impact on patient admissions. She asked how the board will measure the impact of these activities. TR responded that there are a number of different metrics being used, including those related to flow (such as outliers), staff experience (like the staff survey), sickness rates, VBA compliance, and qualitative feedback from staff. She mentioned that scheduled walkabouts with all services, both community and inpatient, are planned because the current metrics tend to focus on inpatient services, and the board wants to ensure a broader perspective. She emphasized the importance of gathering feedback through these walkabouts and working with staff side and people services to provide detailed plans and evidence of progress.	

	RG shared that she was recently asked how culture is measured formally and has been researching this nationally and UK-wide. She found that many organizations use staff surveys but discovered that WAST was doing notable work in this area. She planned to visit WAST to learn about their approach and intends to cascade these findings throughout the organization to improve how cultural signals are identified and escalated. CB raised a question about the long waits for addiction services and asked what plans are in place to address this issue. MT explained that they are prioritising vacancies for addiction services because they recognise there is a real challenge with waiting times. He mentioned that this was discussed with the Adult Directorate. He expressed hope that with increased leadership focus and prioritisation of vacancies, they can start to turn around some of the waiting times. **The Committee Resolved that:** a) The Mental Health Clinical Board spotlight was discussed and noted.	
P&C 25/11/3.2	**Policies** **All Wales Flexible Working Policy** RP stated that the flexible working policy has been in place for a while, but there is a small amendment regarding the timescales for appeals, which now need to be completed within two months to comply with legislation. She noted that the committee has been asked to adopt this amended version of the policy. **The Committee resolved to:** a) The All-Wales Flexible Working Policy was approved.	
P&C 25/11/4.1	**Digital Communications & Analytics** This paper was for noting. **The Committee Resolved that:** a) The Digital Communications & Analytics was noted.	
P&C 25/11/5.1	**Private Agenda**	
P&C 25/11/6.1	**Review & Final Closure**	