Nursing Management
Final Internal Audit Report

November 2024

Hywel Dda University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Committee:	Audit & Risk Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To review the systems in place for rostering and absence management.

Overview

We have concluded **limited** assurance overall with three high priority findings relating to:

- Annual leave utilisation outside of the permitted tolerance, reducing contingency for unplanned absence or surge and therefore increasing the likelihood of temporary staff use
- In some cases there was lack of evidence to demonstrate that agency use has been approved in line with the new escalation process implemented in July 2024
- Lack of evidence to demonstrate that sickness absence is being managed in accordance with the requirements of the all-Wales Managing Attendance at Work Policy, which could result in more frequent and prolonged absences, and greater reliance on temporary staffing

We also identified one medium priority finding relating to update policy/supporting guidance to reflect new processes for bank and agency escalation and roster review/approval arrangements.

Full details of matters arising are provided within Appendix A.

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

	Objectives	Assurance
1	The Health Board utilises efficient rostering practices, including appropriate absence planning and management processes, to maximise available resources and minimise use of overtime or temporary staffing.	Limited
2	Absence is managed in accordance with applicable Health Board and national policies and procedures.	Limited
3	Rosters are subject to appropriate review and scrutiny to identify and address issues or areas for improvement.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Matters Arising

	Matters Arising	Objective	Control Design or Operation	Recommendation Priority
1	Policy & Procedures	1 & 3	Design	Medium
2	Annual Leave	1	Operation	High
3	Escalation of Unfilled Shifts	1	Operation	High
4	Sickness Absence Management	2	Operation	High

1. Introduction

1.1 Effective staff rostering processes are fundamental to ensuring that services have appropriate staffing levels and skills mix to maximise the quality of care provided and reduce the risk of harm to patients. The Health Board's Rostering policy provides guidance on the creation and management of staff rosters.

1.2 Effective absence management is key to efficient rostering, to maximise available resources and mitigate the need for reliance on additional staffing through overtime, bank and agency which incur additional costs.

1.3 The associated potential risks considered in this review are:

- Increases workforce and financial pressures
- Detrimental impact on staff wellbeing, patient safety and experience

1.4 Testing undertaken within this audit has focused on a sample of five areas within the Carmarthenshire County Directorate, selected following analysis of key indicators including annual leave utilisation, sickness absence rates and temporary staffing utilisation. Details of sampled wards are provided on the next page.

2. Detailed Audit Findings

Objective 1: The Health Board utilises efficient rostering practices, including appropriate absence planning and management processes, to maximise available resources and minimise use of overtime or temporary staffing

Policies and Procedures

2.1 The Rostering Policy sets out how the Health Board will manage staff rostering to ensure services have safe staffing levels and appropriate skill mix to maximise the quality of patient care and reduce risk. The E-Rostering SharePoint site offers a comprehensive suite of guidance documents and videos to support staff in implementing and adhering to rostering processes and policy requirements.

2.2 Policy and associated guidance require updating to reflect recent process changes – see para 2.9 for further details. **[Matter Arising 1]**

Training

2.3 The E-Rostering team offer regular training sessions to all staff involved in rostering. Corporate Nursing invited all staff with rostering responsibilities to attend a refresher training session on roster management and rostering efficiency during July/August 2024. Weekly training slots were offered, but attendance logs highlighted that only 22% of staff invited had attended. A pre-recorded training session is available on SharePoint so the training is more accessible to staff, although use/access cannot be monitored.

Unless stated otherwise, the remainder of this section and Objective 2 summarises the findings of sample testing undertaken at five wards:

Site	***Ward***
Glangwili	*Dewi*
Glangwili	*Steffan*
Glangwili	*Cilgerran*
Eastgate, Llanelli	*Acute Response Team*
Glangwili	*Coronary Care Unit*

Annual Leave

2.4 Nursing staff submit annual leave requests in advance for the forthcoming year to enable roster planning, prevent the accumulation of leave and reduce the need for additional staffing.

2.5 In line with the Nurse Staffing Act, an additional allowance of 14.6% is built into each roster establishment for wards meeting the criteria of Section 25B of the Act, to ensure that safe staffing levels are not compromised during periods of annual leave. Four of the five sampled wards are S25B wards.

2.6 We reviewed the annual leave booked/taken as at the end of July 2024 to ensure that it was in line with the amount of leave booked/taken for the time of year. All five areas sampled were on or near the target.

2.7 Rostered registered and unregistered annual leave usage was reviewed for the sample of five areas covering the six-week summer holiday period (22/07/24-

01/09/24). No issues were identified with CCU. For the remaining four sampled wards, the rosters had been signed off despite annual leave being outside of the tolerance range for the period tested:

	Dewi		Steffan		Cilgerran		ART	
Week	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
1 22/07/24	15.8%	14.7%	21.6%	21.1%	12.1%	18.2%	18%	15.3%
2 29/07/24	18.7%	16.5%	12.7%	4.5%	15.4%	17%	19.7%	7.6%
3 05/08/24	16.7%	9.8%	14.8%	15.9%	14.6%	11.9%	24.1%	21.2%
4 12/08/24	15.9%	18.9%	14.8%	20%	14.1%	13.6%	12.1%	20.5%
5 19/08/24	14.4%	16.2%	18.8%	10.8%	17.1%	17%	16%	8.7%
6 26/08/24	15.8%	17.2%	17.2%	21.2%	18.6%	15.2%	19.7%	21.1%
	Annual leave outside of tolerance range [<11% or >18%]							

Table 1: Annual leave usage

2.8 Analysis of areas within the Health Board with the highest percentages of unavailability due to annual leave was undertaken and data on additional staff use obtained. For a one-week period over the same holiday period as above, we noted that one ward had used more than 13 WTE to backfill shift by means of bank, agency and overtime usage. Highlighted below are the three wards from our sample utilising the highest bank and agency WTE: **[Matters Arising 2]**

Ward	Week Sampled	RN/ HCSW	Annual Leave %	Other Leave %	Total %	Bank and Agency WTE used in week
GGH Morlais (Afallon)	22/07/2024	RN	27.9	-	27.9	11.06 WTE
		HCSW	28.8	27.5	56.3	
PPH Ward 5	05/08/2024	RN	21.1	1.9	22.9	13.09 WTE
		HCSW	20.9	4.3	25.2	
Pem St Non	19/08/2024	RN	31.8	-	31.8	6.45 WTE
		HCSW	25.5	5.9	31.4	

Table 2: Additional WTE usage for sample of highest Annual Leave % usage.

Escalation of Unfilled Shifts to Bank & Agency

2.9 Effective 1 October 2024, all bank shifts must be booked via the Bank Team. This is yet to be reflected in policies and guidance documents. **[Matter Arising 1]**

2.10 Escalation of shifts to bank are allowable up to 6 weeks in advance. Sample testing of 15 shifts escalated to bank confirmed compliance with this.

2.11 New escalation processes were introduced in July 2024 for the escalation of registered nursing shifts to agency. Wards are RAG rated based on their whole time equivalent (WTE) vacancy rate, which determines the escalation/authorisation process as follows:

Table 3: Agency escalation process effective July 2024

RAG Rating	Vacancy Rate WTE	Escalation Timescale	Approval		
			Planned Care	USC WGH	USC GGH/PPH
Green	0 - 1.5	48hrs*	Head of Nursing**		
Amber	1.6 – 5	48hrs*	Senior Nurse**		Deputy HoN**
Red	5+	7 days	Escalation Automatic		

* where a bank holiday weekend exists escalation will move to 72hrs in advance in Green and Amber Areas.
** or nominated deputy

2.12 Sample testing of 25 shifts escalated to agency, to assess compliance with the escalation and approval process set out above, identified six instances across five wards where there was no evidence (either within or outside of the roster system) that the correct authorisation had been obtained. Four shifts were out of hours so authorisation in line with the existing escalation process would not be possible. Out of hours escalation and approval arrangements are being defined within the new process to be implemented in November 2024. **[Matter Arising 3]**

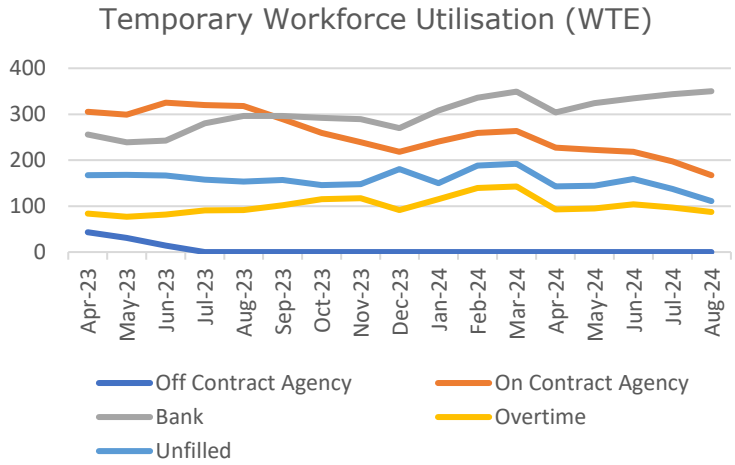
Ward/RAG Rating	Details of Shift	Expected Authorisation	Authorised by
GGH Staffan	Night Shift 4.8.24*	HoN	SNM
GGH Dewi	Late Shift 21.7.24*	HoN	SNM
PPH Ward 1	Late Shift 22.7.24*	DHoN	SNM
PPH Ward 1	Long Day 28.8.24*	DHoN	SNM
GGH Cadog	Night Shift 28.7.24*	HoN	SNM
GGH Preseli	Long Day 28.9.24*	HoN	SNM

*Out of hours shifts (evening / weekend)

2.13 Testing also identified two instances where agency shifts had been booked in accordance with the escalation process for the RAG rating of the ward, but subsequently transferred to a ward with a lower RAG rating. The shifts were transferred during the shift following a decision by Senior Nurse Manager(s) based on service needs. Nonetheless, it has resulted in agency use on wards that has not been approved in line with the escalation process for that ward. The approval requirements in these circumstances are not clear. **[Matters Arising 3]**

2.14 All 25 agency shifts reviewed had been escalated within the appropriate timeframes.

2.15 Recent data demonstrates an improving trend in agency utilisation. Effective 1 November 2024, planned use of nurse agency will cease across all nursing areas, excluding Bronglais which will follow in February 2025. Work is currently undergoing to finalise the Standard Operation Procedure for review and agreement by the Executive Team. This will supersede the escalation process set out in table 3 at para 2.11.



Conclusion:

2.16 There is a comprehensive suite of guidance available to staff to promote and encourage effective rostering practices. However, we identified annual leave utilisation outside of the permitted tolerance range, which reduces contingency resource in the event of unplanned absence or surge, increasing reliance on temporary staffing.

2.17 Whilst there were no issues with escalation of unfilled shifts to bank, testing identified instances where agency use had not been authorised in line with the new process, and the need for clarity of approval requirements where agency shifts are transferred to other wards.

2.18 We have concluded **Limited** assurance for this objective.

Objective 2: Absence is managed in accordance with applicable Health Board and national policies and procedures

2.19 The all-Wales Managing Attendance at Work Policy sets out the arrangements for managing sickness absence, including documentation/evidence requirements and the trigger points prompting further action to be taken.

2.20 Testing was undertaken across the five areas sampled to ensure both long-term and short-term sickness episodes have been managed in accordance with policy. We sampled 20 employees across the five areas, encompassing a total of 60 (five long-term and 55 short-term) sickness absence episodes during the period August 2023 to August 2024. Our findings are summarised in the table below.

2.21 Only six of the 60 episodes reviewed had been properly managed in accordance with policy. We identified a significant lack of evidence to demonstrate that sickness absence is being managed in line with policy requirements, with incomplete documentation to support the periods of absence (e.g. self-certificates and fit notes). Discussions with Ward Managers highlighted that not all were clear on the rules around obtaining a doctors Fit Note to cover sickness from day eight onwards. **[Matter Arising 4]**

2.22 There was limited evidence of action taken where absences breached a formal review point as defined within policy, and we observed one example where a manager correctly identified a sickness episode triggering a formal discussion, but action could not be taken due to poor record keeping. **[Matter Arising 4]**

Observation	LTS (5)	STS (55)
No documentation on file to support episode		11 (20%)
Incomplete documentation to support the absence period i.e. lack of sickness notification, self-certification, return to work documentation	4 (80%)	19 (35%)
No certified doctors Fit Note in place covering the whole of the absence period	2 (40%)	7 (13%)
Dates of sickness/reason differed between Allocate and documentation held		7 (13%)
No documents in place to show that long term sickness interviews had taken place	1 (20%)	
Return to work interview was not timely		15 (27%)
Insufficient action taken (or lack of evidence to confirm) where formal absence review points are met		15 (27%)

2.23 Ward Managers acknowledged weakness in sickness management arrangements and cited examples of steps being taken to improve this, including the use of spreadsheets and whiteboards to monitor and track absences and triggers. We were advised that regular meetings are held with Workforce to review their sickness levels and receive advice on trigger monitoring.

Conclusion:

2.24 Testing identified a significant lack of evidence to demonstrate that sickness absence is being managed in line with policy requirements, with incomplete documentation, delays in completing return to work interviews and failure to take appropriate action where formal review points are met.

2.25 Poor sickness management practices could result in more frequent and prolonged absences, and the need for greater reliance on temporary staffing.

2.26 We have concluded **Limited** assurance for this objective.

Objective 3: Rosters are subject to appropriate review and scrutiny to identify and address issues or areas for improvement

2.19 The Health Board is strengthening roster review and approval processes, with the E-Rostering Team now responsible for final review and sign off of rosters, liaising with Senior Nurse Managers to resolve any issues prior to roster publication. This new arrangement is being trialled within 25 wards effective 16 September 2024, selected based on agency use and variable pay expenditure, and is due to be extended to a further 11 wards for the next roster period.

	Extant Process	New Process
1st Approval	Ward Manager	Ward Manager & Senior Nurse Manager
Final Approval	Senior Nurse Manager	E-Rostering Team

2.20 The Health Board is also trialling a roster efficiency audit tool for use by Senior Nurse Manager / E-Rostering Team for the final review and approval of rosters. We were advised that initial feedback from the two areas participating in the trial (PPH and Critical Care) has been positive, with action ongoing to refine and finalise the audit tool for wider implementation.

2.21 These changes replace the roster audits undertaken by the E-Rostering Team (we have previously highlighted that action is not always taken to address issues identified in these audits), instead allowing for real-time scrutiny and proactive resolution of issues prior to publishing the rosters.

2.22 Policies/procedures require updating to reflect these process changes. **[Matter Arising 1].**

Conclusion:

2.23 We have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)			**Impact**
Amendments to the policy are required to reflect the changes in processes involving roster sign off and the forthcoming changes to the used of agency and escalation of shifts.			Potential risk of: Staff are not aware of current processes resulting in inconsistency / non-compliance with requirements.
Recommendations			**Priority**
1.1a	Update the Roster Policy and supporting guidance to reflect process changes to roster sign off		**Medium**
1.1b	Document the procedure for the escalation of unfilled shifts to bank and agency.		
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	Update Roster Policy and supporting guidance	31 March 2025	Michelle James, Head of Resourcing & Utilisation
1.1b	Clearly define procedure for escalation of unfilled shifts to bank and agency, in the form of a Standard Operating Procedure	31 January 2025	Helen Humphreys, Head of Nursing for Professional Standards & Regulation

Matter Arising 2: Annual Leave (Operation)	**Impact**
Rostered registered and unregistered annual leave usage was reviewed for the sample of five areas covering the six-week summer holiday period (22/07/24-01/09/24). For four sampled wards the rosters had been signed off despite annual leave being outside of the tolerance range (11-18%) for the period tested, with some wards permitting up to 24% of their establishment on annual leave compared to the target 14.6%. We also analysed utilisation of additional staff for areas within the Health Board with high % of annual leave for one week over the same six-week period and noted that wards had used up to 13 WTE to backfill shifts by means of bank and agency.	Inefficient rostering processes potentially resulting in: • Increased workforce pressures and unnecessary use of temporary staff resource • Detrimental impact on staff wellbeing, patient safety and experience

Recommendations		**Priority**
3.1	Roster manager to ensure that annual leave utilisation is within the permittable range of 11-18% for any given period. This should be checked as part of the new roster approval process.	**High**

Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Monthly report, to include annual leave allocation, to be generated for first six months of revised process and circulated to Heads of Nursing. Frequency of report to be reviewed and adjusted in line with satisfactory compliance.	30 November 2024	Michelle James, Head of Resourcing & Utilisation
	Overview of report findings, to include good practice and areas for focus, to be discussed on the Rostering Group agenda.	31 December 2024	Helen Humphreys, Head of Nursing for Professional Standards & Regulation

Matter Arising 3: Escalation of Unfilled Shifts (Operation)			**Impact**
Sample testing of 25 shifts escalated to agency highlighted six shifts that had not been authorised in line with new process implemented in July 2024. We also identified instances where the reallocation of agency shifts resulted in agency use on wards that has not been approved in line with the escalation process for that ward. The approval requirements in these circumstances are not clear.			Non-compliance with escalation and approval processes potentially resulting in inappropriate use of temporary staffing, placing additional financial pressure on the Health Board.
Recommendations			**Priority**
3.1	Ensure that unfilled shifts are escalated to agency in line with the new process effective 1 November 2024 and maintain an audit trail to demonstrate compliance with the standard operating procedure, where approval is obtained outside of the roster system. This could be achieved by including the Roster Team on approval correspondence which would provide oversight and enable a central record of approvals to be maintained. Determine approval requirements for the reallocation of agency shifts and consider whether this needs to be incorporated into the new standard operating procedure.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Standard Operating Procedure to clearly outline approval process for escalation of unfilled shifts, clearly identifying in and out of hours requirements.	31 January 2025	Helen Humphreys, Head of Nursing for Professional Standards & Regulation
	Peer audit to be commenced to monitor roster efficiency and compliance	31 March 2025	Helen Humphreys, Head of Nursing for Professional Standards & Regulation

Matter Arising 4: Sickness Absence Management (Operation)		**Impact**
Only six of the 60 episodes reviewed had been properly managed in accordance with policy. We identified a significant lack of evidence to demonstrate that sickness absence is being managed in line with policy requirements, with incomplete documentation to support the periods of absence (e.g. self-certificates and fit notes). There was limited evidence of action taken where absences breached a formal review point as defined within policy, and we observed one example where a manager correctly identified a sickness episode triggering a formal discussion, but action could not be taken due to poor record keeping.		Poor management of sickness absence and non-compliance with the all-Wales Managing Attendance at Work Policy, potentially resulting in: • Prolonged absences placing additional burden on existing workforce and increasing reliance on temporary staffing • Detrimental impact on staff wellbeing, patient safety and experience
Recommendations		**Priority**
4.1	Staff with administrative responsibilities for absence management should: • be offered refresher training on the NHS Wales Managing Attendance at Work Policy and procedures. • ensure correct documentation is completed/obtained in a timely manner and retained on employee personal files, • monitor sickness absence to identify where review points are met, ensuring escalation and action in line with policy requirements • for each absence episode, maintain a full audit trail demonstrating appropriate management of the absence in accordance with policy	**High**

Agreed Management Action		Target Date	Responsible Officer
4.1	Recording of Managing Attendance at Work Policy training session to be circulated to those with responsibility for nursing absence management.	31 December 2024	Heather Hinkin, Assistant Director of People Management & Helen Humphreys, Head of Nursing for Professional Standards & Regulation
	Bite size training session on return-to-work processes being developed.	30 April 2025	Heather Hinkin, Assistant Director of People Management
	Monitoring and audit process to be agreed jointly between nursing management and operational workforce, to include escalation and appropriate action.	31 May 2025	Heather Hinkin & Helen Humphreys, Head of Nursing for Professional Standards & Regulation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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