Nursing Management

Final Internal Audit Report

2025/26

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2526-04
Fieldwork	June 2025
Executive Sign Off	29 July 2025
Audit Committee	August 2025
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Executive Summary

Purpose

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* sets the standard for the creation and management of staff rosters. 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.

In November 2024, a Nursing Management audit (HDU-2425-16) was undertaken to provide assurance on the adequacy of systems in place for rostering and absence management, concluding Limited assurance overall. This review is a further full audit of the systems and controls covered in the previous review, together with expanded coverage across the Health Board.

Overview

The findings of this review are broadly consistent with the 2024/25 review. We observed an improving trend in rostering controls and practices, although compliance with the NHS Wales Managing Attendance at Work Policy deteriorated. Our findings in relation to sickness management are consistent with the wider Staff Sickness Management review (ref HDU-2526-08), emphasising that the issues identified are not specific to nursing and that the management of sickness absence remains a significant challenge for the Health Board.

We have concluded **Limited** assurance overall. The significant matters requiring management attention include:

- widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, with missing and/or late documentation and failure to act on review prompts for frequent absences
- further improvement required in the management of annual leave utilisation
- clarification and refinement of the agency escalation approval requirements

Full details of matters arising are detailed within the Findings & Agreed Action Plan on page 3.

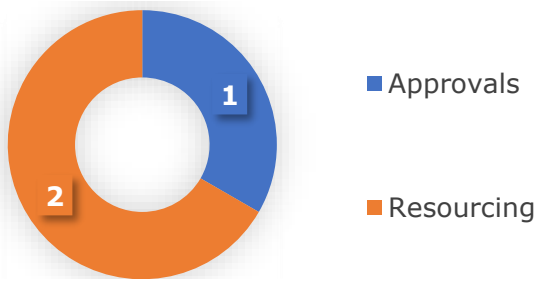
Scope & Assurance Summary

	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	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.	1,2	**Reasonable**
2	Absence is managed in accordance with applicable Health Board and national policies and procedures.	3	**Limited**
3	Rosters are subject to appropriate review and scrutiny to identify and address issues or areas for improvement.	-	**Substantial**

Management Actions

1	2
High Priority	Medium Priority

Themes



Risk Types

Financial Loss

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

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	Reasonable

Overview / Summary of Observations

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. Heads of Nursing, Senior Nurse Managers and Roster Managers participated in a series of training sessions undertaken in July/August 2024. A pre-recorded training session is also available on SharePoint.

Analysis of rostered annual leave usage instances where rosters had been signed off despite annual leave being outside of the tolerance range, reducing contingency for unplanned absence or surge. In some cases, agency/bank/overtime had been utilised to backfill shifts where annual leave exceeded the 18% upper tolerance. **[Finding 1]** Whilst this finding is consistent with the previous audit undertaken in 2025, the number of instances identified has significantly reduced (despite a larger sample size) and there was notably less reliance on temporary staff solutions (and in particular agency) to backfill – suggestive of greater stability in establishments and an improving trend in rostering practices.

A standard operating procedure setting out the escalation process for *Booking Registered Nurse or Health Care Support Workers Additional Hours, Bank Overtime & Agency* was issued in April 2025. The order of priority for additional staffing requirements and authorisation is summarised in Table 3 in Appendix A. Escalation to agency requires approval by the Head of Service/Nursing. Sample testing identified that only 16% of agency shifts reviewed had been escalated to agency in Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy' but is not clear on who the nominated deputy should be. **[Finding 2]**

	Key Findings	Risk & Impact	Agreed Management Action
1	**Annual Leave Utilisation** Analysis of rostered registered and unregistered annual leave usage for the four-week period 19 May – 15 June 2025 identified that rosters for six of the eight sampled wards had been signed off despite annual leave being outside of the tolerance range [see Table 1 in Appendix A]. Extending the analysis to include additional staff usage for the same wards and period identified instances where agency/bank/overtime had been utilised to backfill shifts where annual leave exceeded the 18% upper tolerance [see Table 2 in Appendix A].	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	**Agreed Action:** Completion and implementation of the Unavailability Dashboard (due to be launched August 2025) which will enable greater oversight and monitoring of annual leave utilisation in the context of staff unavailability due to sickness absence, study leave, parental leave etc. **Expected Evidence of Implementation:** Launch of Unavailability Dashboard; improved compliance with AL utilisation tolerance

		Medium Priority	**Officers:** Sharon Daniel - Director of Nursing, Quality & Patient Experience; Helen Humphreys, Head of Nursing for Professional Standards & Regulation **Target Implementation Date:** 30 September 2025
	Theme: Resourcing	Control Operation	
2	**Escalation / Approval of Agency Requests** Escalation to agency requires approval by the Head of Service/Nursing. Sample testing of 25 shifts escalated to agency since implementation of the new SOP in April 2025 identified that only 16% of agency shifts reviewed had been escalated to agency on Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy,' although there is ambiguity about which role(s) this could or should be, and it contradicts the intention of the SOP which is to ensure tight grip and control over agency use through senior management approval. In keeping with this it would be prudent to escalate rather than delegate approval, in the absence of the Head of Nursing.	Non-compliance with escalation and approval processes, potentially resulting in inappropriate use of temporary staffing, placing additional financial pressure on the Health Board.	**Agreed Action:** The SOP will be updated to require, in the absence of the Head of Nursing, delegated approval by the Deputy Head of Nursing or escalation to the Assistant Director of Nursing, Quality & Patient Experience, emphasising that this should be the exception rather than the norm. The feasibility of restricting the system permissions to escalate shifts to agency to only the Deputy/Head of Nursing and Assistant Director of Nursing, Quality & Patient Experience to enforce compliance with this will be explored.
			Expected Evidence of Implementation: Updated SOP; restricted system permissions to escalate shifts to agency
		Medium Priority	**Officer:** Janice Cole-Williams - Assistant Director of Nursing, Quality & Patient Experience; Helen Humphreys, Head of Nursing for Professional Standards & Regulation **Target Implementation Date:** 30 September 2025
	Theme: Approvals	Control Design	

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

Overview / Summary of Observations

The NHS Wales Managing Attendance at Work Policy ('the Policy') provides guidance to staff on managing staff sickness absence. It is available via the staff intranet, and we confirmed that staff working in the areas visited during the audit were aware of the policy and how to access it.

Sample testing was undertaken to test compliance with the key requirements of the Policy. Our sample comprised 183 long and short-term absence episodes for 32 employees during the period 1 April 2024 – 31 May 2025. No documentation was available for 35 episodes. The findings of our review of the remaining 148 episodes are outlined below. **[Finding 3]**

For any period of sickness absence between 1-7 calendar days an employee must complete a self-certification form, and submit doctors fit note certificates from the 8th calendar day of absence onwards. 22% of absences did not have sufficient evidence of self-certification and/or fit notes.

The Return-to-Work meeting is fundamental to the management of sickness absence and policy states that it should be conducted on the first day of return or as early as possible after return. 76% had a Return to Work completed, although 41% had not been completed within a week of the return to work and in many cases the associated documentation was dated several months later.

Managers are required to proactively manage absence where the pattern or frequency gives rise to concern, with the Policy outlining three review prompts. 50% of the sickness episodes triggering a review prompt did not have evidence of appropriate action and escalation in line with Policy. In some cases this was due to managers discretion although the rationale for this was not clear.

Notably, only three employees (15 episodes) sampled were fully compliant with the key controls tested - all were within Ward 9 PPH, where we also observed good practice with a simple, organised approach to record keeping.

Workforce representatives engage with Heads of Nursing to support and advise on sickness management practices, and there are examples of Workforce-led ad hoc deep-dive reviews of sickness management within hot spot areas, although resource and capacity is limited so there is no planned programme of reviews. During our Ward visits staff demonstrated a clear understanding of the requirements of the Policy, indicating that non-compliance may be due to lack of capacity/service pressures or in some cases potentially related to culture. **[Finding 3]**

Key Findings		Risk & Impact	Agreed Management Action
3	**Absence Management** Sample testing identified widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, including: • Absence of any documentation in support of some episodes • Failure to undertake Return to Work interviews, or significant delays in completion • Absence of sufficient self-certificates and/or fit notes covering the whole of the absence • Failure to identify and act on review prompts	• Increased workforce and financial pressure. • Detrimental impact on staff wellbeing, patient safety and experiences.	**Agreed Action:** The good practice identified at PPH Ward 9 will be process-mapped into a guidance document and shared with all Heads of Service/Nursing for implementation within their respective areas. Development of a planned programme of sickness absence reviews, led by service areas with appropriate support from Workforce, to assess compliance with policy requirements and understand and address the root causes of non-compliance. Ward / Department Managers will be held

			accountable for non-compliance, with overall responsibility escalating through Senior Nurse Managers to Heads of Nursing.
			Expected Evidence of Implementation: Process map / guidance document for best practice in sickness management record keeping, and evidence of sharing across the Health Board. Planned programme of sickness absence reviews. Evidence of completion, remedial actions and follow up demonstrating improvement.
		High Priority	**Officer:** Sharon Daniel - Director of Nursing, Quality & Patient Experience; Lisa Gostling – Director of Workforce & OD
	Theme: Resourcing	Control Operation	**Target Implementation Date:** 30 September 2025

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

Overview / Summary of Observations

Rosters are reviewed and approved by the Ward Manager and Senior Nurse Manager. For areas with high variable pay, the E-Rostering Team are responsible for final review and approval of rosters, liaising with Senior Nurse Managers to resolve any issues prior to roster publication. A review checklist is completed for each roster and responsibility for final approval is only returned to the ward when there is improvement in rostering practices/efficiency. Sample testing of roster approval identified no significant issues.

Appendix A

Table 1: Annual leave utilisation outside of tolerance

Week	Y Banwy		Dewi		PPH Ward 9		WGH Ward 8		WGH Ward 12		BGH Dyfi		GGH Theatres		WGH Ward 7	
	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW	RN	HCSW
1 19/05/2025	7.70%	23.80%	14.00%	12.70%	15.40%	12.40%	13.40%	5.70%	13.70%	14.80%	24.40%	0.00%	13.90%	9.20%	14.60%	20.00%
2 26/05/2025	14.70%	17.60%	14.00%	12.70%	14.00%	14.00%	15.90%	11.00%	13.20%	15.30%	13.20%	15.30%	17.40%	12.70%	15.10%	20.20%
3 02/06/2025	14.70%	4.10%	14.00%	13.50%	13.80%	10.30%	7.10%	3.40%	11.30%	15.00%	0.00%	6.40%	16.30%	11.60%	13.10%	13.60%
4 09/06/2025	15.30%	10.20%	14.00%	14.60%	12.10%	12.00%	10.40%	8.60%	11.70%	15.00%	22.20%	18.70%	9.70%	10.20%	13.90%	11.50%
	Annual leave outside of tolerance range [<11% or >18%]															

Table 2: Additional staff utilisation where annual leave exceeds 18% upper tolerance

Ward	Week	RN / HCSW	AL %	Total %	WTE Used			
					Agency	Bank	Overtime	Total
BGH Dyfi	19/05/2025	RN	24.4	37.6	5.74	0.2	0.29	6.23
WGH Ward 7	26/05/2025	RN	15.1	12.6	0	1.33	1.86	3.19
		HCSW	20.2	15.2				
BGH Dyfi	09/06/2025	RN	22.2	39.1	3.39	2.93	0	6.32
		HCSW	18.7	28.2				

Table 3: order of priority for additional staffing requirements and authorisation requirements

Source *(priority order)*	**Timeline**	**Authorisation**
Bank	6 weeks before shift	Ward Manager
Additional Hours	6 weeks before shift	
Overtime	5 days before shift	Senior Nurse Manager or Equivalent
Agency - sickness	Up to 72hrs before shift	Head of Service/Nursing or nominated deputy
Agency – other	Up to 24hrs before shift	
Agency – out of hours	Up to 24hrs before shift	Site Manager (acute & community hospitals); Out of Hours Team (MH inpatient wards)

Appendix B

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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