Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Deep Dive - Medical
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Carly Hill, Assistant Director, Medical Directorate

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board is currently incurring significant and sustained financial pressure driven by medical workforce spend, with a substantial proportion of predictable activity delivered through variable pay (locum, agency, additional sessions) rather than substantive job plans.

This creates:

- Reduced financial control
- Ongoing cost escalation
- Misalignment between workforce capacity and service demand

Current position:

- Variable pay is being used to sustain core, recurring activity
- Workforce models are not consistently aligned to demand
- Medical staffing remains a primary driver of financial pressure

The recent All-Wales Agency and Locum and Variable Pay Expenditure Analysis 2025/26 undertake by NHS Performance and Improvement has reported that Hywel Dda University Health Board (HDdUHB) is less reliant on agency locums than some Health Boards however this is negated by the Health Board having one of the highest levels of internal medical variable pay in Wales.

Cefndir / Background

Medical workforce spend continues to be a significant driver of the Health Board's financial position, with ongoing reliance on locum, agency, and additional session payments to sustain

core services. This has arisen not solely from workforce shortages, but from how services are configured and job planned, with predictable activity frequently delivered through variable pay rather than substantive capacity.

A targeted deep dive has therefore been undertaken to understand the structural drivers of this position and identify opportunities to shift to a more planned, cost-controlled workforce model.

The focus is on enabling financial recovery and sustainable service delivery through better alignment of workforce capacity to demand.

Asesiad / Assessment

Current Position

- Workforce configuration does not consistently match demand patterns
- Predictable activity (for example, Collaborative Effort for Patient Outcome Development (CEPOD) Theatre work, elective work) is delivered as additional paid activity rather than core contracted work
- Certain specialties and sites (for example the Bronglais Hospital (BGH) anaesthetics services) show systematic reliance on variable pay models

This results in:

- Higher cost for activity (hidden cost)
- Limited transparency of true workforce requirement
- Persistent overspend driven by structural factors

£1.1m medical agency expenditure incurred to end of May (P02), with full year forecast of c.£6.5m.

- Forecast represents a £1.9m increase (+41%) compared to 2025/26 baseline
- Current trajectory is £3.3m above the 30% reduction target for agency spend

Overall position masks variation across services:

- Planned and Specialist Care: forecast 30% reduction (on target)
- Pathology (Operational Allied Health Professions and Health Science): +38% increase
- Community and Integrated Medicine: +128% (+£1.9m), driven primarily by Pembrokeshire rota gaps and front-door pressures

Monthly run rate expected to stabilise at ~£0.5m per month, with only marginal reduction from early-year levels

Key Drivers (Appendix 1)

Job planning misalignment

- Recurrent work not embedded in job plans
- Dependence on additional sessions to deliver planned activity

Job planning for medical staff in NHS Wales is a contractual requirement and a core mechanism for aligning workforce capacity with service demand. Consultant job plans are agreed on an annual basis, with interim reviews where service needs change, and must comply with national terms and conditions.

The process is explicitly a mutual and collaborative one between the consultant and the employer, setting out agreed programmed activities (PAs) across direct clinical care, supporting professional activities, and any additional responsibilities. Health Boards are required to ensure that job plans are up to date, reflect actual activity, and are consistent with organisational priorities, including service delivery, waiting list recovery, and financial sustainability.

Compliance therefore requires full annual completion, clear documentation of all activity (including any additional or variable sessions), and active management of job plans through governance arrangements within the Medical Directorate. Robust job planning is a key lever for reducing unwarranted variation, ensuring equity, and supporting the shift from variable pay to substantive contracted activity.

Workforce model design issues

- Annualised/flexible job plans leading to elective work being paid variably
- On-call models enabling high earnings without corresponding throughput

Variable pay embedded as default

- Locum and agency used to deliver known demand, not just gaps

Metric	Benchmark	Current position	Variance (midpoint)	Opportunity
Agency spend (% of total pay)	<2-3%	4.2%	+1.7%	Indicates a reliance on external staffing & provides an opportunity to strengthen workforce planning
Total temporary staffing (% of workforce cost)	<5-8%	17.2%	+10.7%	Suggests structural workforce gap and over reliance on variable pay
Consultant variable pay (% of consultant spend)	<10-15%	26.5%	+14.0%	Indicates misalignment of job plans and recurrent activity not embedded in core contracts

The Health Board rate card is a key control to standardise payments for additional clinical activity and reduce unwarranted variation. Embedding requires clear expectations and alignment with Allocate e-rostering so all additional sessions are approved and paid at agreed rates.

Negotiated rates continue to be used where there are service-critical gaps, workforce shortages, or urgent cover requirements.

The full rollout of Allocate is now complete and correct use by services will strengthen compliance through improved visibility, controls, and monitoring; however, full implementation is limited in anaesthetics, where the CLW rota remain in use. Addressing this is essential to achieving consistent application and financial control.

Consistent use of the rate card will improve financial control, equity, and transparency, supporting better forecasting and oversight via the Medical Directorate. Failure to embed it risks continued reliance on negotiated rates, cost escalation, inequity, and reduced visibility, undermining financial recovery.

Impact

If unchanged, the current model will:

- Sustain structural overspend
- Prevent delivery of financial recovery plans
- Limit ability to invest in substantive workforce solutions

Internal Audit – Variable pay (Appendix 2)

The recent internal audit concluded reasonable assurance over the management of medical variable pay within the Medical Workforce Stabilisation programme, with substantial assurance over reporting and governance.

Strong oversight arrangements are in place, supported by comprehensive reporting, implementation of the Allocate rostering system, and introduction of a standardised medical rate card, all of which have improved transparency and control.

However, key control weaknesses remain at an operational level, including retrospective recording of shifts, inconsistent approval practices, and variable justification of additional shifts. These issues are primarily driven by the absence of a dedicated medical variable pay policy/procedure, resulting in inconsistent application of controls across services. A high-priority action has been agreed to implement a formal policy and strengthen compliance, to ensure a consistent, timely, and well-controlled approach to managing medical workforce costs.

Financial Opportunity

Analysis indicates that a material proportion of the £31.8m variable pay spend in 2025/26 relates to recurrent, predictable activity, particularly within:

- Planned Care (e.g. elective delivery, non-resident on-call rotas)
- Diagnostic services (e.g. Radiology, Pathology)
- Integrated Medicine models across counties

Below are the potential opportunities to be worked through with the Clinical Care Groups (CCGs):

Quarter	Action	Potential Impact (£m)
Q2 2026/27	**Immediate Grip** Rate card enforcement Allocate compliance, rota scheduling (6-4-2) Reduction of retrospective shift approvals	1-2m
Q3 2026/27	**Stabilisation** Job planning Recruitment into known gaps Reduction in temporary agency	2-4m
Q4 2026/27	**Structural Changes** Workforce redesign NROC review Embed new models	3-5m
FY End Position	Sustained reduction in variable pay and agency	6-11m

Clinical Care Group	Variable pay (£m)	Vacancy %	Key issues	Opportunity type
Planned Care & Specialist Services	13.1	28%	Service design Elective delivery Job planning	Workforce re-design Establishment control group Job Planning Structural opportunities International recruitment Portfolio pathway
Mental Health & Learning Disabilities	1.5	31%	Premium spend on agency due to service fragility and recruitment gaps	
Community & Integrated Medicine	8.7	36%	Rota fragility in ED, recruitment gaps	
Operational Allied Health & Health Science	2.3	14%	Premium spend on agency due to service fragility and recruitment gaps	

Immediate actions within organisational control:

- Rate card enforcement
- Job planning compliance
- Rota review vs Royal College standards

Actions requiring service-led change:

- Targeted recruitment in high-vacancy specialties
- Sickness management and Occupational Health restrictions
- Service redesign and alternative workforce models

Not all variable pay is releasable:

- A proportion remains required to manage service fragility, recruitment gaps, and demand instability
- Delivery plans therefore need to focus on the achievable element of conversion, not total elimination
- Service design doesn't align with the current budget / funded posts

Based on current modelling:

- Targeted reduction focus is on high-spend areas (particularly across CIM and Planned Care)
- Initial trajectory assumes phased reduction through job planning, workforce redesign, and agency control
- Residual spend will be actively aligned to justified service risk

This approach enables a targeted response, focusing immediate controls for releasable opportunity, while addressing the structural gap. Service redesign will be required in some areas to achieve sustainable improvement, particularly where current workforce models do not align with demand or represent value for money.

Action Plan (Appendix 3)

The financial trajectory set out in this report is directly aligned to the Action Plan (**Appendix 3**) and reflects a phased delivery of the interventions identified through the deep dive.

The trajectory has been developed by mapping each action to its specific impact on the underlying drivers of variable pay, as identified within the assessment and supporting appendices (for example, job planning misalignment, workforce model design, and reliance on agency for core service delivery).

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** the current position;
- **ENDORSE** the priority actions and trajectory to shift from variable pay to planned workforce models;
- **ENDORSE** an annual medical workforce review, that feeds into the annual planning cycle;
- **AGREE** that future reporting will focus on delivery of measurable outcomes, specifically:
    - Reduction in variable pay
    - Reduction in agency spend
    - Improved alignment between workforce capacity and demand; and
- **REQUIRE** routine monitoring of progress against defined metrics and trajectory

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.15 Seek assurance on the development and implementation of a comprehensive approach to performance delivery and quality management, to incorporate all performance requirements set by the Board, WG, regulators and inspectors, that enables all staff with managerial responsibility to strive for excellence whilst effectively delivering the basics. 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1978 'Risk of insufficiently skilled workforce to deliver services due to limited labour market', which includes medical workforce. 2326 'Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding'
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 2 Financial recovery and route map 6 Clinical services plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Not Applicable
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Medical Pay and Rostering

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Context

- Ongoing medical workforce instability driven by inconsistent rostering practices, rota gaps, and reliance on variable pay
- Limited standardisation across care groups and fragmented rota coordination
- Current processes (incl. paper-based additional duties claims) create delay, cost risk and lack of oversight
- Allocate e-rostering system not fully embedded, limiting visibility and control

Decision

- Mandate use of Allocate rostering system
- Standardise rota coordination through a 6–4–2 model across all care groups
- Establish centralised rota coordination function to support delivery and compliance
- Move to fully electronic pay processes via Loop (eliminate paper-based claims)

Next Steps

- Mandate 6–4–2 model:
  - 6 weeks – rota publication
  - 4 weeks – leave finalisation
  - 2 weeks – gap closure/escalation
- Identify and deploy central rota coordinators (cross-site support where required)
- Identify Full transition to Allocate (decision required on CLW for Anaesthetics due to service fragility):
- Enforce compliance across all specialties
- Training and rapid implementation support
- Cease paper forms for additional duties:
- All claims via Loop electronic system only

Position

- This is a non-negotiable stabilisation programme to improve safety, cost control and workforce sustainability
- Standardisation and digital adoption are essential to reduce reliance on premium pay and temporary staffing
- Care groups will be held to account for compliance, with central support provided to enable delivery
- Forms part of wider Medical Stabilisation and workforce programme

Agency Workforce

- Significant dependency on agency across acute and specialist services
- Immediate exit possible in limited cases only
- Multiple services at risk of unsafe staffing if agency removed

Risk Rating and Definition

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

RAG Rating	Number	Definition of risk of exit	Common themes
Red	19	• Compromise patient safety • Create rota gaps or service instability • Risk service closure or failure to deliver core activity • Inability to deliver statutory services	• Recruitment unsuccessful or stalled • Consultant-led service dependency • Recurrent “unsafe service” statements
Amber	10	• Exit is possible but only once replacements are fully inducted • Requires time-limited extension • Risk is transitional, not structural	• Recruitment underway or offers made • Onboarding delays (visa, notice periods) • Known replacement but not yet in post
Green	3	• Replacement is confirmed and starting / started • Role is naturally ending • Service has confirmed safe withdrawal	

Conclusion

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Position	Opportunity / Risk
3 workers safe to exit	Immediate cost reduction opportunity Minimal risk Quick wins, but limited
10 workers can be exited with conditions	Exit achievable but delayed Requires recruitment completion Dependent on onboarding timescales
19 workers are deemed unsafe to exit due to service delivery	Core service dependant on agency Consultant-level risk within acute, Emergency Department (ED), Haematology and Mental Health and Learning Disabilities (MHLD)

Agency workforce is sustaining core service delivery. Large scale immediate reduction is unsafe if we continue to deliver services in the same way, but targeted and controlled reduction is achievable

Anaesthetics Rate Card – Temporary Extension

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

Context

- Weekend emergency theatre cover not embedded in job plans; reliant on voluntary cover (longstanding issue)
- Rate card changes have exposed fragility in weekend provision
- Immediate risk highlighted due to unplanned sickness

Decision

- Agreed time-limited derogation from rate card to maintain safe emergency service cover
- Decision taken to mitigate patient safety risk in the immediate term

Next Steps

- Confirm rota coverage for upcoming period (focus: next weekend gaps)
- Provide timeline to embed weekend emergency work into core job plans (no extensions expected)
- Set out workforce deficit position across emergency & elective pathways
  - Include plan to reduce reliance on variable pay
  - Outline sustainable workforce model and delivery timeline

Position

- This is an interim measure only
- Future decisions (including Bank Holiday) dependent on receipt of above

Acute Medical Workforce Review (RCP-Aligned)

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Context

- An Acute Medical Workforce Review has been completed in line with Royal College of Physicians (RCP) guidance, providing a benchmarked assessment of consultant capacity, job planning, and service demand
- Review confirms misalignment between current workforce configuration and predicted demand patterns
- Variation exists in programmed activity (PA) allocation, with reliance on variable pay mechanisms to sustain delivery
- Output has been validated and shared with Finance for costing against current variable pay expenditure

Decision

- Note findings of the review and endorse use as the baseline for workforce redesign and financial planning
- Support transition from reactive variable pay models to planned, substantive workforce capacity aligned to demand

Next Steps

- Complete financial modelling to quantify gap between substantive workforce capacity and required activity
- Identify opportunities to reduce variable pay where activity is recurrent and predictable
- Develop aligned workforce plans to rebalance PA allocation and reduce reliance on non-substantive staffing
- Integrate findings into wider medical workforce planning and IMTP processes

Position

- This provides a validated, evidence-based foundation for workforce and financial planning
- Establishes a clear link between workforce capacity, demand, and variable pay expenditure
- Represents a key step toward a more sustainable, planned workforce model, though further work is required to translate findings into delivery

Understanding Key Drivers of Variable Pay

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

Context

- Analysis of variable pay identifies key service areas where expenditure is driven by structural job planning issues rather than unplanned demand
- **Anaesthetics – Carmarthenshire:**
  - Emergency CEPOD and Trauma lists delivered as additional activity attracting variable pay
  - Activity is predictable and recurrent but not embedded within core job plans
- **Anaesthetics – Bronglais:**
  - Annualised job plans cover emergency/on-call work only
  - All elective activity delivered as additional work via variable pay
  - Fully consultant-delivered model increases exposure to higher individual earnings

Decision

- Acknowledge that current variable pay reflects misalignment between job planning and known demand rather than true demand volatility
- Support re-job planning approach to embed predictable activity into substantive workforce capacity

Next Steps

- Undertake re-job planning across both sites to align contracted activity with actual service delivery
- Embed recurrent emergency and elective activity within core job plans
- Reassess workforce model following changes to determine:
  - Whether a genuine workforce deficit exists
  - Or whether current activity can be delivered within existing establishment
- Use findings to inform wider work on reducing variable pay and improving cost control

Position

- Current variable pay is artificially inflated due to structural job planning arrangements
- Significant opportunity exists to reduce spend and improve transparency through realignment of workforce capacity
- Re-job planning is a critical enabler to understanding true workforce requirements and delivering a sustainable model

High Earners and Service Dynamics

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

Context

- Analysis of high earners shows concentration in:
  - Trauma and Orthopaedics
  - Paediatrics
  - Obstetrics
  - Predominantly within Bronglais Hospital
- Services operate within a low-intensity demand environment, with relatively limited activity pressures
- Consultants can undertake:
  - Multiple non-resident on-call (NROC) shifts
  - Additional paid activity alongside core roles
- Limited waiting list or demand pressure reduces the requirement to expand substantive workforce

Decision

- Acknowledge that high earnings are not driven by service demand, but by workforce model design and job planning flexibility
- Support review of on-call arrangements and job planning structures to improve alignment between pay, activity, and demand

Next Steps

- Review NROC arrangements and utilisation to assess alignment with actual service demand
- Assess opportunities to rebalance job plans and reduce layering of additional paid activity
- Evaluate whether current workforce models deliver value in terms of throughput and outcomes
- Incorporate findings into broader work on variable pay reduction and workforce optimisation
- Consider alternative workforce models where appropriate to improve efficiency and transparency

Position

- High levels of earnings reflect structural and contractual arrangements rather than demand pressures
- Current model presents a financial inefficiency, with limited correlation between spend and service output
- Creates complexity in workforce planning, where expenditure remains high despite low demand indicators
- Targeted redesign of job plans and on-call structures represents a key opportunity to improve value and sustainability

Conclusion

The deep-dive highlights a consistent theme:

Variable pay is often being used to deliver predictable, recurring activity that should be job planned and costed within substantive workforce models.

Key next steps:

1. Complete financial modelling of the RCP-aligned workforce review.
2. Undertake systematic job plan redesign, prioritising:
    - Anaesthetics (Carmarthenshire and Bronglais)
    - High variable-pay specialties
3. Reduce structural reliance on variable pay, shifting to:
    - Transparent, planned activity,
    - Improved cost control,
    - Better alignment between workforce and demand.
4. Review NROC models in low-intensity services, ensuring value for money and equity.

This work provides a clear opportunity to:

- Improve financial grip and control,
- Enhance workforce sustainability,
- And ensure equitable and efficient use of consultant capacity.

While some underlying workforce gaps may remain, a significant proportion of current expenditure is likely to be releasing efficiency rather than requiring new investment, contingent on effective job planning reform.

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Medical Workforce Stabilisation (Variable Pay)

Draft Internal Audit Report

2025/26

Hywel Dda University Health Board

Reasonable Assurance

Contents

Review Reference	HDU-2526-06
Fieldwork	April - May 2026
Executive Sign Off	
Audit Committee	June 2026
Executive Lead	Mark Henwood, Medical Director
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

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

Executive Summary

Purpose

The overall objective of this audit was to provide assurance of the key controls of managing medical variable pay as part of the Medical Workforce Stabilisation programme.

Overview

The reporting and scrutiny of medical variable pay has been embedded within the governance arrangements of the Health Board from budget holders viewing live financial information on the Qlik system through to the Clinical Care Groups and statutory committee of the Board. A Medical Workforce Planning Steering Group has also been established as part of the Medical Workforce Stabilisation programme to review the organisation's medical workforce position and performance, including variable pay through the triangulation of data.

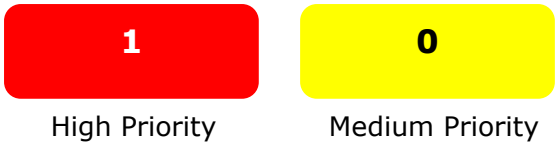
We also noted the implementation of the Allocate rostering system across all wards and specialties (as part of the Medical Workforce Stabilisation programme) to capture shifts that have incurred variable pay, whilst a new rate card was introduced in March 2026 to ensure consistency in pay arrangements across all medical shifts. The matter requiring management attention include is the lack of a dedicated policy or procedure for use and management of medical variable pay that was evident in the inconsistent approaches within wards and specialties that has led to instances of retrospective recording of requests and approval of shifts, no segregation of the requesting and approving officer, incorrect reasoning of requested shifts, whilst some approvers were not always the budget holders.

We have concluded **reasonable** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

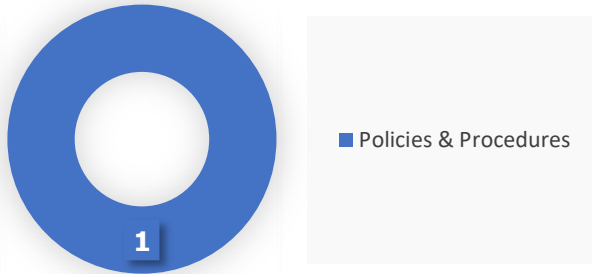
Scope & Assurance Summary

	Objectives[1]	Related Findings	Assurance
1	The use of medical variable pay is scrutinised and challenged with actions taken to address any areas of concern	1	**Reasonable**
2	Medical variable pay is regularly reported through to the Health Board	-	**Substantial**

Management Actions



Themes



Risk Types

Financial Loss

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

Findings & Agreed Action Plan

Objective 1: The use of medical variable pay is scrutinised and challenged with actions taken to address any areas of concern	**Reasonable**

Overview / Summary of Observations

Testing of 100 shifts worked during 2025-26 across five cost centres (Glangwili General Hospital – A&E, Anaesthetics, Ophthalmology, General Surgery & Withybush General Hospital – A&E) was selected from the Allocate rostering system.

In March 2026, a Finance Report submitted to the Health Board identified that "*there is a concerning trend that not all shifts are reported promptly on the Allocate rostering system and monthly spend is showing month on month variations due to retrospective shifts*". Testing during this review corroborated this issue with 47% of the shifts retrospectively submitted to bank and approved/ finalised by an officer taking 10 days or more to be recorded on Allocate after the shift had been worked.

Instances were also identified where there was no segregation of duties between the requesting and approving/ finalising officers, whilst many of the approving/ finalising officers were not the budget holders. Discussion with the various rota coordinators and service delivery managers noted due circumstances (e.g. vacancies, sickness, annual leave, etc.) it was not always possible to have that separation of duties. In addition, instances were noted of staff approving/ finalising shifts on behalf of the budget holder and incorrect reasoning for some shifts were identified.

The Health Board has several policies and procedures that support elements of medical variable pay such as the *Budgetary Control Procedure* and *Study Leave Policy for Medical and Dental Staff*. However, there is no explicit policy or procedure in place dedicated to medical variable pay. The lack of a policy or procedural document has contributed to the inconsistent approaches taken by staff within wards and specialties that have been identified above. To ensure a clear and consistent approach is embedded within Hywel Dda, the Health Board should consider introducing a financial control and/ or standard operating procedure as noted with another NHS Wales Health Board that provides an overview of the controls and processes for the use and management of variable pay for medical and dental staff. **[Finding 1]**

The Finance Department provide regular reports to the Clinical Care Groups (CCGs) that outline key elements relating to variable pay such as monthly and year-end budget and trends, end of year forecast, pay analysis and summary narrative for each county and directorate within the CCG portfolio (including the categorisation of medical and dental variable pay breakdowns), actions, savings plans and targets.

All additional duty hours (ADH) or bank shifts are set in line with the medical rate card 2017 unless a negotiate rate had been agreed between the individual medical employee and the ward/ specialty management, with many rates historically agreed. Testing of 100 shifts worked during 2025-26 noted that only 11 shifts were set against the medical rate card, whilst 89 were negotiated between the individual and management.

A new medical rate card was developed by the Health Board with engagement from the British Medical Association (BMA) representatives as part of the Medical Workforce Stabilisation programme. The new medical rate card was implemented in March 2026 that covers all specialties and grades with clear definitions for in hours, out of hours, resident and non-resident rates. Any requests for negotiated rates are required to be submitted to the Medical Workforce Planning Steering Group for consideration and approval rather than dealt with locally. This new internal control mitigates the variable and inconsistent approach to negotiated rates identified in our testing above.

Key Findings		Risk & Impact	Agreed Management Action
1	**Medical Variable Pay Policy and Procedure** Whilst there are policies and procedures in place that impact on medical variable pay, there is no explicit policy or procedure in place on the use and management of medical variable pay. This should include the prompt submission and approval of shift requests (to mitigate retrospective actions when possible), segregation of duties, the correct assignment of reasoning for the requested shift and the assignment of approval on behalf of budget holders.	Inaccurate or inconsistent approaches taken by staff impacting medical variable pay due to the lack of a dedicated policy or procedure	**Agreed Action:** Develop, approve and implement a Medical Variable Pay Policy and Procedure which clearly defines: • Governance and accountability for requesting, approving and recording medical variable pay • Requirements for prospective approval of shifts (with clear escalation where retrospective approval is unavoidable) • Segregation of duties to ensure appropriate separation between requestor and approver • Standardised categories for reasoning/justification of additional shifts • Defined approval hierarchy, including delegated authority arrangements on behalf of budget holders • Timely submission and processing expectations • Monitoring, reporting and audit arrangements The policy will be developed in line with organisational policy frameworks and subject to appropriate stakeholder consultation prior to formal approval through governance committees. **Expected Evidence of Implementation:** Approved Medical Variable Pay Policy and Procedure document Evidence of consultation (e.g. tracked changes, stakeholder Sample audit demonstrating: • prospective approvals in place • correct use of justification categories • appropriate authorisation levels applied Monitoring report or dashboard showing compliance
		High Priority	**Officer:** Carly Hill – Assistant Director **Target Implementation Date:** October 2026
	Theme: Policies & Procedures	Control Design	

Objective 2: Medical variable pay is regularly reported through to the Health Board — **Substantial**

Overview / Summary of Observations

A key element of the Medical Workforce Stabilisation programme was the full implementation of the Allocate rostering system to all wards and specialties. Allocate allows teams to plan individuals working arrangements and identify any gaps in the rota that are filled through additional duty hours (ADH) or by bank staff.

Budget holders have access to their live financial information via the All-Wales Qlik system that allows users to access a personalised dashboard with the ability to drill down on various financial elements including medical variable pay.

A review of Clinical Care Group (CCG) and statutory committees of the Board for the period 2025-26 confirmed the regular reporting of medical variable pay including breakdowns of current performance and year-end forecast positions. Medical variable pay was also identified as a 'top priority alert' within the financial reports submitted to the Finance and Performance Committee.

The Medical Workforce Planning Steering Group has been established to review the organisation's medical workforce position and performance, including variable pay. The aim of the group is to triangulate key data including (but not limited to) as the financial performance of cost centres, establishment WTE positions, job plans and sickness absence rates. The group is chaired by the Assistant Director Medical Directorate.

The Medical Workforce Planning Steering Group also review ward and specialty rotas on a weekly basis to ensure rosters have been planned six weeks in advance to identify unfilled shifts. In addition, all wards and specialties are required to adhere to the new medical rate card introduced in March 2026. Any negotiation of medical rates is now required to go via the Medical Workforce Planning Steering Group rather than be agreed locally by management.

Appendix A

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.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

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

Appendix 3 – Action Plan

Opportunity	Actions	Outcome	Measure of success	Trajectory	Delivery ownership	Governance method
Job plan redesign (priority specialties: anaesthetics, high-spend areas)	Undertake systematic job plan reviews in priority specialties Benchmark PAs against activity and demand Shift appropriate activity from additional sessions into core contracts Standardise job planning principles across CCGs	Alignment of workforce capacity with service demand and improved cost control	Reduction in additional session spend (£ and %) % of job plans reviewed Increase in activity delivered within core contracts	6 months from start of review Anaesthetics – Oct 2026	Clinical Directors General Managers Service Delivery Managers	Medical Director oversight Monthly review via Medical Workforce Planning Group Monthly job planning escalation meetings
Embed predictable activity into baseline workforce	Identify recurrent activity currently delivered via variable pay Convert into substantive roles, expanded PAs, or annualised job plans Align workforce establishment to demand projections	Improved workforce-demand alignment and reduced reliance on variable pay	% reduction in variable pay for recurrent activity Increase in substantive workforce capacity Reduction in ad hoc sessions	Progressive reduction across financial year	Clinical Directors CCG Directors General Managers Service Delivery Managers Clinical Leads	Deputy Medical Director oversight Bi-monthly monitoring through Medical Workforce Planning Group
Reduce agency reliance via internal bank and control processes	Expand internal bank utilisation Strengthen agency approval controls Improve forward rostering (6-4-2	Lower cost delivery of care while maintaining safe staffing	Reduction in agency spend (£ and %) Improved internal bank fill rates	Immediate and ongoing	General Managers Rostering Leads Service Delivery Managers	Monthly reporting and exception escalation via Medical Workforce Planning Group

	scheduling) Enforce compliance with agency caps		Compliance with agency controls			
Review and standardise high-cost workforce models (e.g. non-resident on-call)	Review NROC and other premium pay arrangements Benchmark across services and against best practice Standardise frameworks where appropriate Address high-earning outliers via job planning	Equitable and sustainable pay aligned with workload and demand	Reduction in high-earning outliers Standardisation of pay models Improved cost predictability	Review Q1, plan for reduction Q2, implementation from Q3	CCG Directors Clinical Directors General Managers Service Delivery Managers Clinical Leads	Medical Director oversight Medical Workforce Planning Group Exception approval for deviations
Apply RCP workforce modelling to planning decisions	Apply RCP modelling tools across key specialties Quantify required vs funded vs actual workforce Use outputs to inform recruitment, job planning, and service redesign Integrate into annual planning processes	Evidence-based workforce planning aligned to population need	Reduction in workforce gap (required vs funded) Improved planning accuracy Alignment between workforce and activity demand	Q1 modelling, Q2–Q4 application and refinement	AMD's Clinical Directors Clinical Leads General Managers Service Delivery Managers	Medical Director oversight Quarterly reporting Finance & Performance Committee