Financial Sustainability – Temporary Staffing Controls

Final Internal Audit Report

2025/26

Cardiff & Vale University Health Board

Reasonable Assurance

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Review Reference	CVU-2526-10
Fieldwork	August – November 2025
Executive Sign Off	December 2025
Audit Committee	February 2026
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Executive Summary

Purpose

The overall objective of the audit was to review how the Health Board deploys its workforce to ensure effective and efficient utilisation of the substantive resource, and limitation of the use of temporary staffing, including overtime, bank and agency costs.

Financial sustainability is a critical pillar of effective governance and long-term service delivery in the NHS. For the Health Board, the ability to maintain financial balance while meeting the complex and evolving health needs of its population is both a statutory obligation and a strategic imperative. In the current climate of constrained public finances, rising demand, and increasing operational costs, the importance of robust financial planning, control, and assurance mechanisms cannot be overstated.

The Health Board is currently forecasting a deficit of £56.2 million for 2025/26, significantly above the Welsh Government’s control total of £9.1 million. This position reflects a combination of structural financial challenges, including an underlying deficit, inflationary pressures, and the need to deliver substantial recurrent savings. The Health Board’s Corporate Risk Register and Board Assurance Framework both highlight financial sustainability as a red-rated risk, underscoring the urgency of effective mitigation and oversight. Despite the implementation of enhanced controls, including a themed savings programme and a daily Programme Management Office the scale of the challenge remains significant.

The underlying deficit remains a critical concern and is projected to worsen in 2026/27 without the delivery of recurrent savings. Key operational cost pressures include:

- Mental health out-of-area placements,
- Underperformance in cardiac and critical care contracts,
- Banding arrears for resident doctors,
- Continuing Healthcare (CHC) costs,
- National Insurance underfunding (15% impact, approx. £1.4 million),
- Risk Pool liabilities (approx. £6.6 million exposure),
- Band 2–3 corrective payments (potential £5.8 million risk).

To mitigate these pressures, the Board approved a vacancy freeze from August 2025, with only service critical posts being approved aligned to level of risk, with potential in-year savings of up to £4.2 million.

Overview

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

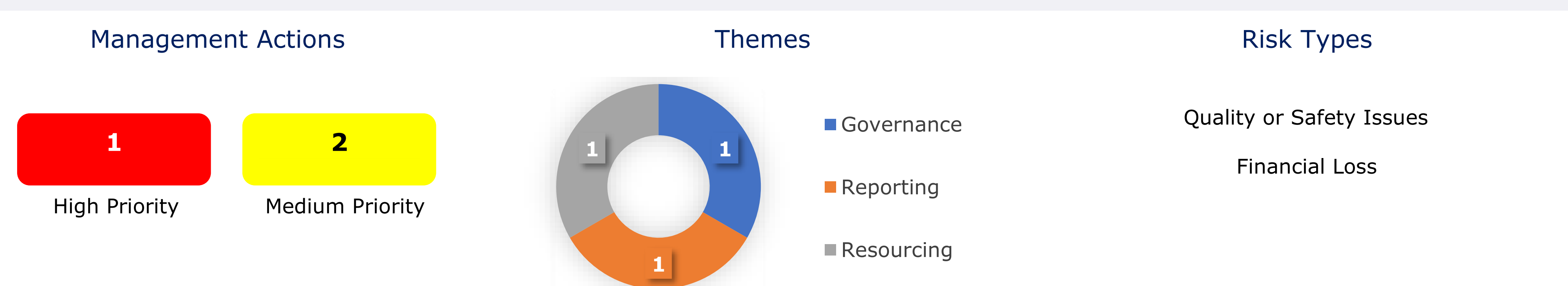
- Medical & Dental Bank - Patchwork system data analysis revealed issues in medical and dental bank shift usage, including long lead times and concentrated approval patterns, indicating potential weaknesses in resource/operational workforce planning and governance.
- The Programme Management Office (PMO) was implemented from January to April 2025, its role in cost containment was unclear, with no demonstrable financial impact.
- Reporting structures are well-established, but data limitations hinder full visibility and operational workforce planning.

While controls are generally well-designed and operating with some effectiveness, further improvements are needed in medical and dental workforce planning and governance to fully realise financial sustainability objectives.

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

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	Effective controls are in place over temporary staffing expenditure, including agency, bank, and overtime usage	1	**Reasonable**
2	Comprehensive governance and oversight arrangements in place to monitor temporary pay trends and cost drivers	3	**Reasonable**
3	The temporary financial control measures introduced in 2025 were effective and had a positive impact on workforce deployment, agency spend, and overall cost containment	2,3	**Reasonable**
4	Comprehensive and timely reports on bank, agency and overtime expenditure are produced and disseminated to relevant staff and groups across the Health Board. These reports are actively monitored and challenged to support informed decision-making and ensure effective financial oversight	2	**Reasonable**



Findings & Agreed Action Plan

Objective 1: Effective controls are in place over temporary staffing expenditure, including agency, bank, and overtime usage	**Reasonable**

Overview / Summary of Observations

The Health Board has made substantial progress in embedding effective controls over temporary staffing expenditure, underpinned by a clear strategic and policy framework. Key documents such as the Workforce Sustainability Roadmap, People and Culture Plan 2022–25, and the Workforce Sustainability Scheme of Delegation articulate the phased approach taken to reducing reliance on temporary staffing, supported by formalised approval processes and prioritisation of bank over agency usage.

Operationally, the Health Roster system has strengthened controls for departments/areas on the system, e.g. Nursing, Midwifery, HCSW, Capital, Estates and Facilities (CEF), laboratories and some administrative staff through advance roster planning, shift verification, and payroll accuracy. Fieldwork did not identify any significant control weaknesses in these areas, and the systems in place were found to be operating effectively. However, the medical workforce remains outside this system, limiting automation and standardisation. The Patchwork system partially addresses this gap by enabling digital tracking and dual approval of medical and dental bank shifts, though its effectiveness was constrained by the lack of professional medical workforce scrutiny by the PMO from January to April 2025. The approval process now sits with the Clinical Board Directors (CBDs) who are leading the Clinical Boards.

The Executive Vacancy Scrutiny Panel meets weekly to consider requests to advertise vacancies, engage medical agency workers, overtime and monitors the use of bank, overtime and agency. The panel uses a master spreadsheet that is downloaded from the TRAC recruitment system to record decision making for approved or declined vacancies. This mechanism ensures accountability and supports pro-active vacancy management and mitigates unnecessary temporary staffing. At the time of writing the report the Executive Vacancy Scrutiny panel has been stood down with accountability passed back to Clinical Boards.

Fieldwork confirmed that while the dual approval mechanism (Clinical Boards and PMO) functioned procedurally, the PMO in its original form did not exist after April 2025 but the oversight role by the Executive team remains. Furthermore, analysis of the Medical and Dental Staff Bank (Patchwork system) data revealed systemic issues, including long lead times for medical bank shift requests and concentrated approval activity, particularly within the Medicine Clinical Board, suggesting deeper resource/operational workforce planning challenges.

Overall, while the Health Board has established a strong control environment, inconsistent system coverage and operational behaviours continue to undermine the full realisation of financial sustainability objectives in temporary staffing.

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Agreed Management Action</th></tr>
<tr><td rowspan="3">1</td><td rowspan="3">Medical and Dental Staff Bank – Patchwork system data validation

As part of our review, we obtained and analysed a dataset of medical and dental bank shifts from the Patchwork system to assess whether temporary staffing practices align with the Health Board’s financial sustainability objectives. The analysis revealed systemic issues that undermine the intended cost-control measures.

Firstly, we identified significant lead times between request and shift dates, with some shifts requested up to 181 days in advance. This practice contradicts the principle that bank shifts should provide short-term flexibility to cover unforeseen gaps. Instead, it suggests that bank shifts are being used as a substitute for resource/operational workforce planning, which is neither cost-efficient nor sustainable.

Secondly, the Medicine Clinical Board accounted for the majority of bank shifts, indicating structural workforce gaps that drive recurring temporary staffing costs. Additionally, approval activity is highly concentrated among a small number of approvers, creating governance and oversight risks.</td><td rowspan="2">Increase cost pressures and reduce the effectiveness of resource/operational workforce planning.</td><td>Agreed Action:
The Health Board will:
Implement system alerts for requests made more than 14 days in advance within the Patchwork system, requiring escalation and justification.
Conduct a resource workforce planning review for Medicine Clinical Board to address structural gaps and reduce dependency on temporary staffing.
Introduce monitoring monthly reports to track long-lead requests and approver concentration. This report will form part of the monthly data review and will be shared with Clinical Board operational leads for their review and action.</td></tr>
<tr><td>Expected Evidence of Implementation:
A request will be submitted to Patchwork to introduce a control mechanism that escalates any shift requests made more than 14 days in advance. As this is not considered a critical system enhancement by Patchwork, implementation will not be immediate.
The Medicine Clinical Board will lead the workforce planning review, supported by the Senior Business Partner and the Medical Workforce team.
A monthly report will be produced to identify shifts scheduled more than 14 days ahead.</td></tr>
<tr><td>High Priority</td><td rowspan="2">Officer: Lianne Morse, Deputy Director of People & Culture and Mike Stephens, AMD for Medical Workforce

Target Implementation Date: 31 March 2026</td></tr>
<tr><td></td><td>Theme: Reporting</td><td>Control Operation</td></tr>
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Objective 2: Comprehensive governance and oversight arrangements in place to monitor temporary pay trends and cost drivers **Reasonable**

Overview / Summary of Observations

The Health Board has established a multi-layered governance framework to monitor temporary pay trends and cost drivers, with structures operating at operational, strategic, and corporate levels. At the foundation, Clinical Boards lead scrutiny through Senior Management Teams and monthly sickness panels, using dashboards and deep dives to identify cost pressures such as long-term sickness and rota gaps. In nursing, the Nursing Productivity Group (NPG) provides a mature forum for reviewing KPIs which include Bank and Agency usage, vacancy rates etc and implementing corrective actions.

The Programme Management Office (PMO) was introduced in early 2025 to provide a second layer of scrutiny over medical temporary staffing. Initially composed of senior leaders across workforce, finance, and clinical domains, the PMO aimed to ensure consistency, challenge, and strategic alignment. However, its role has since diminished, with reduced meeting frequency, weakened clinical input, and a shift toward administrative rather than challenge-based review.

The Medical Workforce Advisory Group (MWAG) is a dedicated workstream within the Workforce Sustainability Programme, which forms part of the wider Financial Sustainability Board (FSB) chaired by the CEO. The role of the MWAG is to provide strategic oversight, while the Medical Workforce Implementation Group (MWIG) offers operational scrutiny of medical workforce deployment and temporary spend. Although MWIG minutes were not available, assurance was obtained through discussions with senior stakeholders confirming regular meetings and data-driven reviews. At the corporate level, the Finance and Performance Committee receives regular updates on workforce expenditure as part of the Integrated Performance Report.

While systems like Patchwork support data-driven oversight, limitations in data integration, job planning, and medical rostering constrain the Health Board's ability to fully model workforce needs. Despite these challenges, the governance framework is broadly sound. As stated in objective 1, the PMO is no longer in situ but there is a weekly Executive meeting where medical agency requests are considered and a Medical bank/agency and Nursing dashboard are presented to provide the Executives with assurance. We will review these issues in more detail as part of the separate Medical Staff Deployment audit which we are currently undertaking.

Objective 3: The temporary financial control measures introduced in 2025 were effective and had a positive impact on workforce deployment, agency spend, and overall cost containment	**Reasonable**

Overview / Summary of Observations

In January 2025, the Health Board introduced two key financial control measures aimed at curbing temporary staffing expenditure: the transfer of approval responsibilities from directorates to Clinical Board senior leadership, and the establishment of a Project Management Office (PMO) to provide an additional layer of scrutiny. These changes were aligned with the Welsh Government's Agency Workforce Reduction Programme and intended to strengthen governance, promote cost-effective deployment, and reduce reliance on agency staffing.

These improvements reflect the maturity of nursing workforce controls, supported by HealthRoster and strong governance via the Nursing Productivity Group. However, for the medical workforce, the evidence is less compelling. Analysis of dashboards generated from the Medical and Dental Staff Bank (Patchwork system) shows no significant reduction in medical bank costs post-PMO implementation.

Within our sample testing, we focused on temporary workforce arrangements including Banke and Agency across the Surgery, Medicine, and Children & Women Clinical Boards. This targeted approach highlighted systemic reliance on temporary staffing to maintain service delivery especially in areas with high patient demand that required high volume of medical bank shifts—particularly in A&E and General Medicine. This points to persistent gaps in substantive resource/operational workforce planning. The absence of a unified electronic rostering system for medics further limits proactive deployment and cost control.

While the 2025 controls improved procedural rigour, their impact on medical workforce cost containment remains inconclusive. As stated within objective 1, the PMO has not been in place since April 2025, and approvals are now undertaken by the Clinical Board Directors.

Key Findings		Risk & Impact	Agreed Management Action
2	**Improve Rota Forecasting and Leave Management to Optimise Substantive Staff Utilisation** Analysis of the Medical and Dental Workforce Bank & Agency Dashboard (Jan–Aug 2025) shows a high reliance on bank staff, with 19,576 shifts filled by the medical staff bank, compared to 215 by agency and 756 unfilled. This suggests gaps in substantive resource/operational workforce planning. The A&E department recorded the highest bank shift volume, with other high-cost areas including General Medicine, Anaesthetics, and Paediatrics. The most frequent reasons for temporary staffing were vacant posts, extra capacity, and sickness, indicating that deployment is often reactive. The absence of a unified electronic rostering system for medical and dental staff limits proactive planning. These patterns point	Continued reliance on temporary staffing increases financial pressure. Reactive deployment may compromise service continuity and staff wellbeing. Lack of planning may lead to avoidable unfilled shifts and clinical risk.	**Agreed Action:** The Health Board will procure and commence implementation of a unified E-Rostering system, starting with foundation Doctors working through to Consultants. In the interim we will continue to use dashboard data to identify high-risk areas and proactively schedule substantive cover. **Expected Evidence of Implementation:** • Paper presented to SLT in Jan 26. • Procure e-rostering system in February • Commence planning and implementation from March 2026.

	to inefficiencies in rota design and leave management, which may be contributing to avoidable temporary staffing costs and operational strain.	**Medium Priority**	**Officer:** Lianne Morse, Deputy Director of People & Culture and Mike Stephens, Assistant Medical Director for Medical Workforce **Target Implementation Date:** Commence March 2026
	Theme: Resourcing	Control Design	
3	**PMO Value Proposition – Medical and Dental workforce** The Project Management Office (PMO) was introduced in January 2025 to enhance scrutiny over temporary staffing requests. It was intended to complement the shift of approval responsibility from directorates to Clinical Board senior leadership, creating a dual-layered governance model. However, following a review of temporary staffing expenditure data before and after the PMO's inception, there is no clear evidence of financial impact attributable to the PMO for the medical and dental workforce. However, the Health Board did see an impact of the Nursing Hub will successfully saw a reduction in overtime which was replace by Bank staff. Analysis of the Medical and Dental Bank & Agency Dashboards shows that: • Pre-PMO (Sept–Dec 2024): Monthly temporary staffing spend for medical workforce ranged from £1.23M to £1.45M, totalling £5.55M over four months. • Post-PMO (Jan–Aug 2025): Monthly spend remained broadly consistent, ranging from £1.08M to £1.41M, totalling £10.36M over eight months. While some month-to-month variation is expected, the data does not support a significant downward trend or cost avoidance that could be directly linked to the PMO's oversight. Furthermore, feedback from the Associate Medical Director (AMD) suggests that Clinical Boards are already well-positioned to assess the necessity of temporary staffing, and that there is the risk that the PMO may have introduced unnecessary complexity without adding strategic value.	Inefficient use of resources if the PMO adds administrative burden without improving outcomes. Dilution of accountability due to overlapping governance layers. Reduced engagement from senior medical leaders if governance is perceived as bureaucratic or ineffective.	**Agreed Action:** • A decision was made by the Medical Director to remove the dual tier approval process for medical and dental bank shift requests – instead the approval process has been handed back to the Clinical Board Directors. • Medical agency requests are still considered by the Executives on a weekly basis. **Expected Evidence of Implementation:** N/a
		Medium Priority	**Officer:** Complete **Target Implementation Date:** Complete
	Theme: Governance	Control Design	

Objective 4: Comprehensive and timely reports on bank, agency and overtime expenditure are produced and disseminated to relevant staff and groups across the Health Board. These reports are actively monitored and challenged to support informed decision-making and ensure effective financial oversight	**Reasonable**

Overview / Summary of Observations

The Health Board has developed a structured and timely reporting framework for temporary staffing expenditure, led by the Finance Department. Monthly reports are produced within 10 working days of month-end and disseminated to Clinical Boards, People and Culture, Medical Workforce, Finance Business Partners, and the Executive Team. These reports feed into the overarching monthly finance report presented to the Finance and Performance Committee (F&PC), ensuring corporate-level scrutiny.

Reports include detailed breakdowns of actual vs budgeted spend, trend analysis, and staffing type (bank, agency, overtime), supported by narrative commentary from Finance Business Partners. In high-risk areas such as medical staffing, weekly flash reports provide near real-time visibility of agency usage, enabling early intervention.

Oversight is embedded across multiple forums, including Medical Workforce Advisory Group (MWAG) (for medical workforce), Nursing Productivity Group (NPG) and Clinical Board Performance Reviews. These groups ensure triangulation between finance, workforce, and operational leads, supporting informed decision-making and accountability.

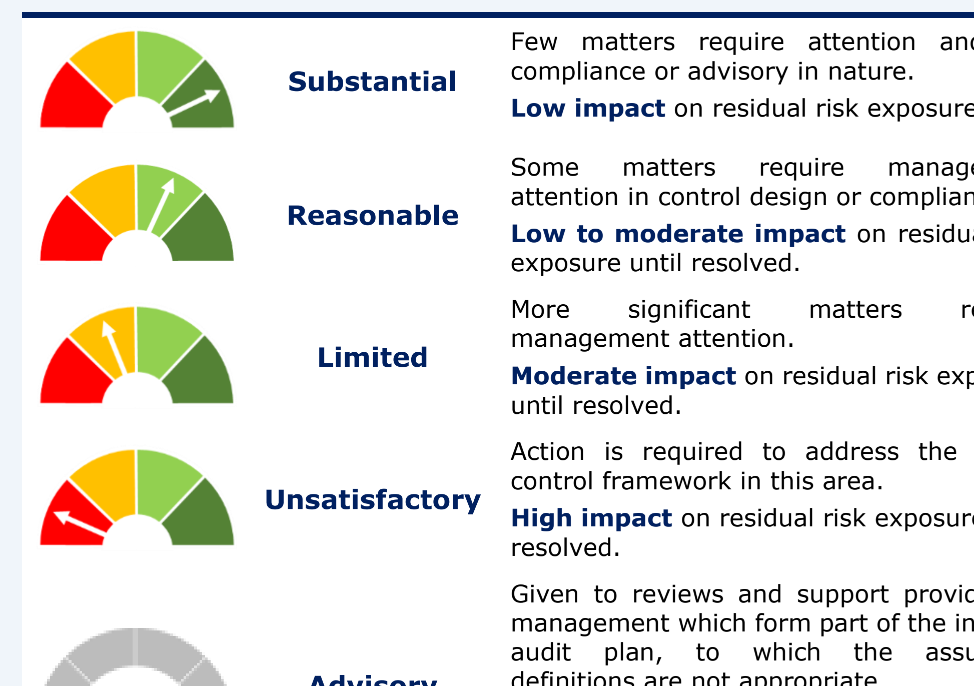
However, limitations persist. The absence of a dedicated unified electronic rostering system for the medical and dental workforce restricts data granularity and automation.

From a nursing perspective, the Health Board is currently over its funded establishment for registered nurses and midwives, due in part to historic education commissioning decisions (submitted 3-4 years in advance) and a significant improvement in turnover (2%). Forecasting is ongoing to manage this surplus, including offering reduced-hour contracts to new graduates and reviewing headroom requirements for the coming year.

Overall, while the reporting framework is comprehensive and well-utilised, system limitations and inconsistent local practices present ongoing challenges to achieving full visibility and control over temporary staffing expenditure.

Appendix A

Assurance Opinion



	Opinion	Description
	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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