Medical Staff Deployment

Final Advisory Report

2025/26

Cardiff and Vale University NHS Health Board

Contents

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Executive Sign Off	March 2026
Audit Committee	May 2026
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Executive Summary

Purpose

The advisory review of Medical Staff Deployment was completed in line with the 2025/26 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

The effective deployment and management of the medical workforce is critical to the delivery of safe, timely, and high-quality care across the Health Board. In recognition of this, the Health Board has committed to strengthening its systems and processes for medical job planning, e-rostering, annual leave and sickness absence management. These functions are essential not only for operational efficiency but also for workforce wellbeing, regulatory compliance, and financial sustainability.

The advisory review considered the Health Board's plans for alignment of job planning with demand and capacity modelling, the integration and interoperability of rostering systems, and the visibility and accuracy of annual leave and sickness absence data. We examined the plans for allocation and accountability of Supporting Professional Activities (SPA), which represent a significant proportion of consultant time and cost. We also assessed the role of leadership, communication, and workforce support in embedding sustainable change.

The job planning component of the audit specifically focussed on Consultants and SAS Doctors, while the annual leave sickness and rostering aspects extended to all medical personnel.

Overview

This advisory review assessed the robustness of Cardiff and Vale University Health Board's arrangements for deploying its medical workforce, focusing on four core areas: overarching job planning, rostering, and the management of medical annual leave and sickness. Evidence gathered through detailed fieldwork, interviews with senior medical and workforce leaders, review of Medical Workforce Advisory Group (MWAG) governance papers, and analysis of job planning and rota datasets highlighted clear strategic intent and meaningful progress in some areas, particularly job planning compliance, which improved steadily through 2025. However, several controls are not yet fully effective. Rostering remains fragmented across multiple systems, job plans are not routinely informed by demand and capacity modelling, and sickness and annual leave data are dispersed across a number of Health Board systems such as Electronic Staff Record (ESR), Codi/Intrepid and local trackers, limiting visibility and assurance. Governance structures are strong, but their effectiveness is reduced by inconsistent data quality and system integration.

As this is an advisory review no assurance rating is provided. We have made the following observations and identified opportunities that the Health Board may wish to take forward to strengthen processes, these are detailed further within Appendix A: Opportunities for improvement and development:

- The Medical & Dental Workforce Workplan provides a strong foundation but lacks defined risks, interdependencies and realistic delivery metrics.
- Annual leave does not feature as a standalone workstream within the 2025/26 Medical & Dental Workplan, resulting in no defined milestones, ownership or measures to address known variation and visibility gaps.
- Rostering arrangements remain fragmented across multiple systems, resulting in inconsistent practices and limited visibility of medical deployment.
- Significant variation and non-compliance across 115 rota templates creates operational burden and impacts the Health Board's readiness for implementation of the national e-roster solution.
- Sickness and annual leave processes are under-developed and fragmented across systems, leading to incomplete visibility of medical workforce availability.
- Job planning compliance is improving but remains misaligned with service need due to limited modelling and lack of integration with rostering systems.
- The terms of reference for MWAG are out of date and would benefit from a review and update.

- MWAG's ability to scrutinise sickness and annual leave is restricted by the absence of consolidated datasets and inconsistent reporting.
- Engagement and communication challenges across clinical and corporate teams reduce the effectiveness and pace of governance oversight.

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

Scope & Actions Summary

Objectives		Related Actions
1	Plans are in place to take forward and improve the recording of job planning, rostering, annual leave and sickness management within the Health Board, with clearly defined actions, timescales and outcomes, and these are monitored and updated regularly.	1,2,3,4,5, 6 and 7
2	There are effective governance and monitoring arrangements in place to oversee the delivery and progression of medical job planning, rostering, annual leave and sickness management, to ensure achievement of the anticipated improvements.	7,8 and 9

Management Actions

9

Themes

Risk Types

Quality or Safety Issues

Findings & Agreed Actions

Objective 1: Plans are in place to take forward and improve the recording of job planning, rostering, annual leave and sickness management within the Health Board, with clearly defined actions, timescales and outcomes, and these are monitored and updated regularly.

Medical and Dental Workplan 2025/26

The 2025/26 Medical & Dental Workforce Workplan (the 'Workplan') provides a comprehensive and clearly structured framework for strengthening medical workforce deployment across the organisation. Our fieldwork confirmed that the workplan provides a strong and well structured foundation across job planning, unified e-rostering and sickness recording.

We note that whilst the workplan captures important elements to drive improvements forward, it does not fully define risks, interdependencies or delivery metrics **(Finding 1)** furthermore, it does not include annual leave as a standalone workstream. **(Finding 2)**

For each theme, the Workplan identifies expected outcomes, baseline positions, named leads and enabling functions, along with quarterly milestones that span procurement activity, stakeholder engagement, data scoping, training readiness and system configuration. The Workplan also embeds alignment with national programmes such as the Welsh Resident Doctor Contract (WRDC) and the All-Wales resident doctor E-Rostering solution.

Actions, Timescales and Outcomes Across the Four Key Themes

The Workplan sets out defined actions, quarterly milestones and expected outcomes across three major improvement themes: job planning, e-rostering, sickness management. We noted that progress has been mixed, with several milestones only partially achieved to date as detailed below:

Job planning

The Workplan sets a clear expectation that job planning should be embedded consistently across all Clinical Boards, supported by robust standards, annual reviews and improved SPA (Supporting Professional Activity) justification through the review of Welsh Government job planning guidance. The Welsh Government originally set a requirement for 90% of Consultant and SAS job plans to be compliant and in-date by September 2025, a milestone the Health Board did not achieve. This deadline was subsequently extended to March 2026, reflecting challenges experienced across Wales. Despite these pressures, the Health Board has made strong and sustained progress, with compliance increasing steadily throughout 2025 and reaching 82% as reported to the People and Culture Committee in February 2026, leaving the Health Board close to achieving the revised national target.

However, several underlying issues remain. Job plans are not consistently underpinned by demand and capacity modelling, meaning Direct Clinical Care (DCC) allocations often reflect historic practice rather than current clinical need. SPAs justification is variable, with many plans lacking clarity on deliverables or agreed outputs. Most importantly, job plans do not reconcile with rota patterns because job planning and rostering systems (Allocate, HealthRota, MediRota, Momentum, Excel) operate in isolation. This limits the ability of job plans to influence deployment or provide reliable assurance over activity. **(Finding 6)**

E-Rostering

The Workplan sets out a structured sequence of actions across Q1–Q4 to deliver a unified medical e-rostering solution, beginning with procurement confirmation, system scoping, rota template reviews, engagement with key stakeholders, and preparatory training. The original target was to begin implementation for Resident Doctors by January 2026, later revised to August 2026 following national procurement delays and the introduction of the Welsh Resident Doctor Contract.

The Health Board currently operates multiple rostering systems—including HealthRota, MediRota, Momentum and CLW—alongside numerous Excel rotas. Each system is configured differently, with local rules, bespoke workarounds and inconsistent data definitions. The rota compliance database demonstrates 115

separate rota templates, many requiring redesign due to Working Time Directive breaches or non-alignment with WRDC rules. This fragmentation creates substantial variation in rota cycles, weekend frequencies, and out-of-hours commitments, increasing the administrative burden and widening risk exposure.

These factors have delayed preparatory milestones and present a major challenge for safe configuration of the e-roster solution. The lack of standardisation, together with incomplete scoping outputs, means foundational work must be prioritised before unified rostering can deliver the intended improvements. **(Finding 3 and 4 refers)**

Sickness Management

The Workplan sets expectations for improved accuracy and visibility of sickness absence recognising the impact on rota stability and workforce deployment. However, sickness data visibility remains under-developed and highly fragmented, with similar system limitations and operational challenges affecting their delivery.

Sickness data for medical workforce is dispersed across numerous Health Board systems including ESR, Codi/Intrepid and also the Single Lead Employer (SLE) contract, leading to inconsistent visibility of absences. Return-to-Work (RTW) compliance for Resident Doctors remains very low due to SLE processes that fall outside direct Health Board control. Annual leave data shows the same fragmentation pattern, split across ESR, Codi and local spreadsheets, with Clinical Boards applying varied processes for recording, approval and reconciliation. In both areas, no consolidated Health Board wide dataset has been produced, limiting the Health Board's ability to identify trends, quantify demand gaps, or assess the impact of absence on rota fragility.

These weaknesses mean that the Health Board does not yet have a reliable operational picture of medical workforce availability. This reduces the effectiveness of capacity planning, complicates rota modelling, and could impact the Health Board's readiness for the All-Wales resident doctors e-rostering system. **(Finding 5)**

Workplan monitoring and updates

Progress against the Workplan is discussed regularly within the Medical Workforce Advisory Group (MWAG) and updates are shared through established senior forums. However, the way progress is monitored in relation to sickness and annual leave remains more narrative-focused than data-driven, with updates often relying on verbal or written summaries from workstream leads rather than consistent dashboard reporting. At present, consolidated datasets for sickness and annual leave are still being developed, which means visibility of progress varies across the different themes. As a result, it can be more challenging to assess delivery against milestones or to understand how workstreams are progressing relative to expectations. These gaps do not diminish the commitment to improvement, but they do indicate that further development of the supporting data infrastructure would strengthen the overall assurance available. **(Finding 8)**

Objective 2: There are effective governance and monitoring arrangements in place to oversee the delivery and progression of medical job planning, rostering, annual leave and sickness management, to ensure achievement of the anticipated improvements.

Governance structures and defined roles

The Workplan is sponsored by the Executive Medical Director (Senior Responsible Officer-SRO) who provides strategic leadership, accountability and direction for the overarching Medical Workforce Programme. Supporting the SRO are designated workstream leads, including the Associate Medical Director for Workforce, the senior workforce systems leads (e.g., Medical Resourcing, Workforce Systems), and key operational managers such as the Job Planning Lead and Operational Rostering Lead.

Governance of the Workplan is supported by a clear and structured set of committees and workstream leads. The MWAG sits at the centre of this framework and provides the primary strategic oversight. MWAG meets monthly, operates to a defined Terms of Reference, and reviews progress across all of the four key medical workforce themes. We reviewed agendas, minutes and action logs spanning 2024–26 which demonstrated consistent review of risks, workstream progress and operational challenges.

Alongside MWAG, the Medical Workforce Implementation Group (MWIG) supports operational coordination by progressing scoping work, collating data, and preparing specialties for system and process changes. Corporate committees also play a significant role: the People & Culture Committee (PCC) receives thematic workforce reporting including sickness deep-dives, while the Strategic Leadership Team (SLT) receives strategic workforce papers such as job planning strategies, digital workforce proposals and ESR data improvement updates. Together, these forums ensure organisational visibility, escalation and alignment across the workstreams. However, the Terms of Reference (ToR) for MWAG are out of date and no longer reflect the Health Board's current governance structure. **(Finding 7)**

Despite having a well-established governance framework, a number of operational challenges identified under Objective 1 have influenced the delivery and pace of the medical workforce workstreams. These constraints—particularly fragmented datasets for sickness, annual leave and rota compliance—have limited the level of insight available to MWAG and, in turn, its ability to fully scrutinise progress or test whether improvements are being realised. MWAG continues to provide broad strategic oversight and receives regular updates on job planning, rostering readiness and national workforce programmes; however, the absence of consolidated sickness and leave data until early 2026 has meant that oversight in these areas is largely narrative and less supported by consistent, system-wide reporting. **(Finding 8)**

Our fieldwork identified several engagement-related factors that may be influencing how effectively these arrangements operate in practice. Interviews with senior clinical and workforce leaders highlighted examples where some medical staff felt somewhat distanced from corporate workforce processes, while corporate colleagues described challenges securing consistent clinical involvement in activities such as sickness reporting, rota scoping and job planning quality reviews. Participation across task-and-finish groups and workforce forums was also described as variable, particularly among Resident Doctors and certain pressured specialties, which can limit opportunities for shared understanding and collaborative problem-solving. These engagement dynamics do not undermine the governance structure itself; however, they may reduce the operational depth of discussions and slow the pace of progress in areas where successful delivery depends on sustained clinical input and consistent behavioural adoption. **(Finding 9)**

Appendix A: Opportunities for improvement and development

Finding 1: Workplan Structure Limitations		Residual Risk
The 2025/26 Medical & Dental Workforce Workplan provides a strong structural foundation, setting out priorities across job planning, rostering and sickness. However, the Workplan does not articulate key risks, interdependencies or mitigations, despite several dependencies being well-known through operational evidence. Performance measures focus largely on headline percentages rather than quality, timeliness or outcome-based indicators. Several milestones appear aspirational when compared to actual delivery progress, limiting the Workplan's value as a realistic operational tool. Without greater definition, the Workplan risks setting direction without providing the mechanisms required to drive consistent improvement across Clinical Boards.		The Health Board may continue to operate with gaps between strategic aims and operational reality, reducing the likelihood of timely and sustainable improvement.
Opportunity 1		**Priority**
Strengthen the Workplan for 2026/27 by adding explicit risks, dependencies, realistic milestones and broader KPIs to improve deliverability and clarity.		**N/A - Advisory Review**
Management Response 1	**Target Date**	**Responsible Officer**
The Workplan was developed at pace to ensure that our strategic priorities were captured alongside the National Programmes of Work that are led by NHSWE. The intention was to use it as a live document to track progress, unfortunately this hasn't worked due to the information being captured in other places, e.g. WG Enabling Actions, WRDC implementation, etc. We accept that the Workplan needs to be strengthened for 26/27 focusing on a few key strategic priorities, e.g. implementation of E-Rostering system, WRDC, improvement in job planning, implementation of All Wales Job Planning Policy.	May 2026	Mike Stephens, Assistant Medical Director for Workforce & Lianne Morse, Deputy Director of People & Culture

Finding 2: Annual Leave not defined as a standalone workstream in the Workplan	Residual Risk
Although the 2025/26 Medical & Dental Workforce Workplan references annual leave as an important dependency for the e-rostering programme, it does not set out a standalone annual-leave workstream with defined actions, milestones, leads, success measures or deliverables. Our fieldwork confirmed that annual leave remains fragmented across ESR, Codi/Intrepid and local spreadsheets, with inconsistent recording practices across Clinical Boards and no consolidated Health Board-wide dataset. Despite these operational issues being well-known, no specific milestones have been included in the Workplan to address variation, standardise processes, or improve visibility. The absence of a clear annual-leave improvement workstream contrasts with the Workplan's more fully articulated areas such as sickness recording, job planning and unified rostering, each of which includes baseline data, key actions and quarterly milestones. Without equivalent structure for annual leave, progress is not formally monitored, and the Health Board lacks assurance that this area is developing at the pace required to support accurate deployment, capacity planning and readiness for unified rostering implementation.	Limited oversight and fragmented leave data may result in incomplete visibility of workforce availability, inaccurate capacity planning, and increased operational pressure on rota stability and service delivery.

Opportunity 2	Priority
Introduce a defined annual-leave workstream within the Medical & Dental Workforce Workplan for 2026/27, setting out clear actions, ownership, milestones and expected outputs.	**N/A - Advisory Review**

Management Response 2	Target Date	Responsible Officer
Annual Leave management hasn't been identified by the senior medical and P&C team as an area that is problematic, so it didn't feature on our 25/26 workplan as a priority. All medical staff use the Codi system (previously Intrepid) for booking annual leave which is managed by HEIW. Other staff groups either use HealthRoster or ESR MSS for recording annual leave.		Mike Stephens, Assistant Medical Director for Workforce & Martyn Capel, Associate Director for Medical Workforce

There is a facility in the Medical HealthRoster system to record annual leave, but we'll need to understand whether there is an interface with Codi and how this would be managed. We will scope this out as part of the e-rostering implementation plan.	To commence April 2026	Karl Davis, Assistant Medical Director, Medical Education Undergraduate Teaching

Finding 3: Fragmented Rostering Arrangements	**Residual Risk**
Rostering arrangements across the Health Board remain highly fragmented, with Clinical Boards relying on a diverse mixture of systems, including HealthRota, MediRota, Momentum, CLW and bespoke spreadsheets. This variation has led to inconsistent rota-build practices, differing approaches to sickness and annual leave recording, and limited standardisation in how deployment information is captured. Our interviews confirmed the resulting heavy manual workload and the limited real-time assurance available to operational teams. In addition, discussions at the January 2026 MWAG highlighted significant risks arising from rota fragility and inconsistencies linked to the new Resident Doctor Contract. The original intention was to implement a single medical e-rostering system in January 2026 for the Health Board; however, this timeline was revised to August 2026 to align with the requirements and implementation demands of the new Resident Doctor Contract. This delay extends the period during which fragmented practices remain in place. The ongoing variation in systems, templates and local business rules also limits the organisation's readiness for medical e-rostering system implementation, as inconsistent data and unclear configuration requirements pose material risks to safe and accurate migration.	Continued fragmentation will limit safe system transition and inhibit visibility of workforce deployment, increasing compliance and service-delivery risks
Opportunity 3	**Priority**
Introduce a standard set of rostering rules and minimum data requirements across all Clinical Boards to reduce variation and support safe preparation for medical e-rostering system. This should include consistent rota-build standards, clear processes for recording sickness and annual leave, and a basic data-validation exercise to check existing templates before migration. Taking this approach will improve data quality, reduce manual workload, and help ensure the Health Board is ready for the planned August 2026 implementation of the unified medical e-rostering system.	**N/A - Advisory Review**

Management Response 3	**Target Date**	**Responsible Officer**

As part of the implementation of Medical HealthRoster, rostering principles will be developed for Resident Doctors initially and then for other grades including Consultants: • Resident Doctors - Foundation, Unbanded Rotas and New Hires (locally Employed) • Resident Doctors – All Other Grades • Consultants & SAS	August 2026 August 2027 TBC	Mike Stephens, Assistant Medical Director for Workforce & Martyn Capel, Associate Director for Medical Workforce Karl Davis, Assistant Medical Director, Medical Education Undergraduate Teaching

Finding 4: Variation and compliance of medical rotas	**Residual Risk**
Rota-compliance monitoring remains a manual and labour-intensive process led by the Operational Rostering Lead, who maintains and updates the rota-compliance dataset. The dataset currently contains 115 templates—87 banded and 28 unbanded—each of which is assessed individually against Working Time Directive (WTD) and contractual requirements. Compliance checks are completed using a manually populated spreadsheet that reviews weekly hours, rest periods, weekend frequency, consecutive shift patterns, on-call commitments and pattern rotations. Extensive narrative notes within the dataset highlight the scale of variation across templates, including rotas requiring redesign of on-call duties, inconsistent shift sequences and unclear compliance assumptions. Over 54% of the templates exceed the WTD 48-hour average limit, and many require bespoke adjustments to achieve compliance. This level of variation creates significant operational burden, reduces consistency and adds complexity to the preparation work required for migration to the planned medical e-rostering system. Reliance on a single individual to complete these assessments further reinforces the need for a more standardised, systematic and sustainable approach to rota design and compliance monitoring	If unaddressed, rota risks—including non-compliance, inequitable patterns and configuration failures—will persist, reducing workforce safety and sustainability.
Opportunity 4	**Priority**
Take a phased, minimum-standard approach by prioritising core rota elements required for medical e-rostering system's configuration—cycle length, weekend frequency, on-call rules, and rest requirements—while addressing high-risk templates first. Establish simple validation checks and provide central coordination support to Clinical Boards to ensure rotas meet contractual and WTD requirements prior to system upload. This avoids wholesale redesign, reduces workload and accelerates readiness for system migration.	**N/A - Advisory Review**

Management Response 4	Target Date	Responsible Officer
As part of the implementation of the WRDC a working group has been established to review current rotas and work towards setting 'establishments' for resident doctors. During the implementation rota monitoring has ceased to enable teams to focus on rota compliance in readiness for August 2026. Within the WRDC, monitoring is replaced by a Guardian of Safe & Flexible Working (GOSFW) and exception reporting. Again, this will be achieved through using a unified E-Rostering system, where regular reports can be produced.	Commence August 2026	Mike Stephens, Assistant Medical Director for Workforce & Martyn Capel, Associate Director for Medical Workforce Karl Davis, Assistant Medical Director, Medical Education Undergraduate Teaching

Finding 5: Weaknesses in absence data visibility	Residual Risk
The Workplan includes sickness absence as a defined improvement priority with a baseline (1.77%), target (<4%), named leads and specific actions to improve ESR recording and reinforce MAAW requirements. However, sickness data visibility remains under-developed and fragmented across ESR, Codi/Intrepid and Single Lead Employer (SLE) systems, limiting the completeness and reliability of information on medical workforce absence. Return-to-Work compliance for Resident Doctors remains very low due to processes outside the Health Board's direct control, further reducing visibility of end-to-end sickness management. Annual leave shows the same fragmentation pattern across ESR, Codi and local spreadsheets, but unlike sickness, it is not supported by a standalone Workplan workstream or defined improvement actions. The absence of annual-leave milestones, ownership or performance expectations further hinders the ability to progress with actions aimed at consolidating suitable annual leave data across the Health Board. The combined weaknesses across sickness and annual leave mean the Health Board does not yet have a reliable operational picture of medical workforce availability, reducing the effectiveness of capacity planning, complicating rota modelling and increasing the risk of instability ahead of the planned e-rostering implementation.	The Health Board may continue to experience incomplete visibility of workforce availability, leading to operational inefficiencies, inaccurate capacity planning and greater pressure on rota stability.
Opportunity 5	**Priority**

Consolidate sickness and annual-leave data into a single Health Board-wide dataset and standardise ESR-based processes across Clinical Boards. This will strengthen visibility of medical workforce availability, enable consistent capacity planning, and support safe preparation for the All-Wales resident doctors e-rostering implementation.	**N/A - Advisory Review**

Management Response 5	Target Date	Responsible Officer
The unified E-Rostering system will require all sickness absence to be recorded in the system. This will ensure that the Single Lead Employer (SLE) receives accurate information for Resident Doctors employed by them.	Commence August 2026	Mike Stephens, Assistant Medical Director for Workforce & Martyn Capel, Associate Director for Medical Workforce
There is a facility in the Medical HealthRoster system to record annual leave, but we'll need to understand whether there is an interface with Codi and how this would be managed. We will scope this out as part of the e-rostering implementation plan.	Commence April 2026	Karl Davis, Assistant Medical Director, Medical Education Undergraduate Teaching
The system will also enable us to develop dashboards using the data for locally employed doctors (LEDs), R/D employed by SLE, along with SAS and Consultants.	Commence December 2026	

Finding 6: Job planning not linked to medical workforce modelling/deployment	Residual Risk
Job planning performance within the Health Board has improved significantly over recent years, with compliance with the requirement for signed-off consultant job plans rising steadily throughout 2025 and reaching 82% as reported to the People and Culture Committee in February 2026, placing the organisation close to the Welsh Government's 90% target. This reflects considerable operational effort from clinical and workforce teams and shows that the Health Board is within reach of full compliance. However, despite this progress, several underlying elements limit the effectiveness of job planning as a workforce deployment tool. "Directorates produce demand and capacity (D&C) modelling on a yearly basis for RTT specialities only. They do not produce a comprehensive activity baseline for all activity. There is no formal link between the D&C and job planning. Direct Clinical Care (DCC) allocations are often based on historic arrangements rather than evidenced service need.. SPA allocations lack consistent justification, and there is little routine monitoring of outputs. Critically, job plans do not reconcile with rota patterns because job planning and rostering systems operate independently across Allocate, HealthRota, MediRota, Momentum and Excel. Allocate is used largely as a static repository, with	If modelling is not embedded and systems remain disconnected, job plans may continue to misrepresent actual activity, leading to capacity gaps, inefficiencies, and misalignment between planned and delivered clinical services.

limited use of its structured fields or modelling functions. These limitations mean that even as compliance improves, job plans still struggle to shape, influence or align with actual deployment.	

Opportunity 6	Priority
The Health Board may wish to introduce simple, easy-to-complete activity and demand templates for core services (such as clinics, theatres and hot-week patterns) to support the next round of job plan reviews. Minimum mandatory fields could be required within Allocate (e.g., SPA justification, DCC categories and prospective cover) to strengthen the consistency of inputs. During the medical e-rostering system's configuration, only the most material elements — including DCC totals and out-of-hours commitments — may need to be mapped initially, with more detailed functionality introduced gradually over time. This approach would improve alignment between planned and delivered activity while keeping workloads manageable across Clinical Boards.	**N/A - Advisory Review**

Management Response 6	Target Date	Responsible Officer
Demand and capacity planning in 2026 will be underpinned by more detail baseline activity analysis. This will provide the opportunity for job planning to be more closely aligned to service need. Clinical Boards will utilise the functionality in the e-job planning (R L Datix) system to produce reports on all activity as part of their yearly job planning cycle.	Commence July 2026	Clinical Board Directors & Director of Operations

Finding 7: Out of date MWAG's Terms of Reference	Residual Risk
The Terms of Reference (ToR) for the MWAG have not been updated since 2024 and no longer reflect the Health Board's current governance arrangements or reporting lines. The ToR state that MWAG reports issues to the Strategy & Delivery Committee, a forum that is no longer operational, and make no reference to the People & Culture Committee (PCC), which now receives key medical workforce reporting including job planning, sickness deep-dives and strategic workforce updates. The ToR therefore do not accurately describe the current flow of assurance or escalation routes. Additionally, the scope and responsibilities outlined within the ToR have not been updated to reflect new workforce	Terms of Reference remain outdated, there is a risk that governance responsibilities, reporting lines and escalation routes are not clearly defined or understood.

programmes and operational priorities, including the All-Wales resident doctor e-rostering programme and MWAG's broader oversight role.	
Opportunity 7	**Priority**
Review and update the MWAG Terms of Reference to reflect current reporting lines (including the People & Culture Committee), revised governance expectations, and the updated scope of MWAG's strategic and operational responsibilities.	**N/A - Advisory Review**

Management Response 7	Target Date	Responsible Officer
The terms of reference will be reviewed, amended and approved	May 2026	Lianne Morse

Finding 8: Gaps in MWAG's Oversight of Sickness and Annual Leave	**Residual Risk**
MWAG provides broad strategic oversight and routinely reviews job planning, rostering readiness and national workforce programmes. However, its ability to scrutinise sickness and annual leave is limited by the absence of consolidated datasets. Until early 2026, MWAG did not receive a unified sickness report / annual leave report, despite persistent concerns such as under-recorded consultant sickness and low RTW compliance for Resident Doctors. This restricts MWAG's ability to triangulate data, identify underlying causes or monitor trends in workforce availability. As a result, oversight remains partly narrative and lacks the operational depth required for early intervention or assurance over compliance with policy expectations.	Incomplete datasets reduce MWAG's ability to validate workforce risks, monitor improvement trajectories, or identify inaccuracies in sickness/leave reporting.
Opportunity 8	**Priority**
Introduce a single monthly dashboard covering sickness (ESR + SLE feeds), and annual leave utilisation, using simple metrics and RAG ratings to improve visibility without creating administrative burden.	**N/A - Advisory Review**

Management Response 8	Target Date	Responsible Officer

Once the e-rostering system has been implemented for the Resident Doctors, a dashboard will be developed using data from the systems available to us, in a similar way to other staff groups.	Commence October 2026	Martyn Capel, Associate Director for Medical Workforce & Paul Jones, E-Rostering Manager

Finding 9: Clinical engagement across workstreams	**Residual Risk**
Our fieldwork evidence suggests that engagement across some medical workforce workstreams varies significantly and may influence the consistency of governance oversight. Interviews with senior medical and workforce leaders highlighted challenges securing sustained engagement from certain clinical groups, with several noting that participation in relevant forums and task-and-finish groups can be uneven. For example, interviewees referenced low traction in some engagement sessions, variable attendance from Resident Doctors and pressured specialties, and difficulties progressing activities requiring cross-specialty input. Communication pathways between corporate functions and clinical teams were reported to be inconsistent, with examples of important messages not cascading fully or being interpreted differently across Clinical Boards. MWAG papers also include repeated prompts for improved clinical input into sickness, annual leave and rota data, suggesting that gaps in engagement are affecting the completeness of reporting and the pace of progress across workstreams. Taken together, these observations indicate that engagement and communication dynamics may be limiting the operational impact of otherwise well-structured governance arrangements.	Variable engagement reduces the effectiveness of governance routines, slows progress on actions requiring clinical involvement, and limits the completeness of information presented for senior oversight.
Opportunity 9	**Priority**
Strengthen engagement by using short, focused clinical–corporate workshops, appointing clinical champions for each workstream, and issuing regular "you said → we did" updates to build visibility and trust.	**N/A - Advisory Review**

Management Response 9	**Target Date**	**Responsible Officer**
The Medical & Dental senior leadership team and the Executive team, supported by the People & Culture team will continue to improve the communication and engagement across the UHB, via the LNC and SMSC. • A new Clinical Director and peer support programme is in development which will support improved engagement. • A Health Care Professional Forum is also being scoped out.	May 2026 December 2026	David Fluck, Medical Director & Mike Stephens, Assistant Medical Director for Workforce

• Corporate Induction is being strengthened along with a dedicated induction for Consultants.	TBC	Karl Davis, Assistant Medical Director, Medical Education Undergraduate Teaching

Appendix B: Assurance Opinion & Prioritisation of Findings

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.

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