Medical Variable Pay

Final Internal Audit Report

2025/26

Swansea Bay University Health Board

Reasonable Assurance

Contents

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Fieldwork	April 2026 – June 2026
Executive Sign Off	21st July 2026
Audit Committee	10 September 2026
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Executive Summary

Purpose

To assess whether the health board has established effective governance, control and oversight arrangements to manage medical variable pay (MVP), including understanding its drivers and delivering sustained reduction in expenditure.

Overview

Addressing MVP has been a key area of focus for Swansea Bay University Health Board (the 'health board'), supported by external input from Deloitte (July 2025 -June 2026). Our review identified that governance, reporting, and analytical arrangements have strengthened. This includes the introduction of Medical Workforce Control Boards (MWCBs) in October 2025, improved workforce analytics and enhanced organisational-level scrutiny. MVP is now routinely monitored at Executive level, with increased visibility, structured challenge, and strengthened analytical capability through consolidated workforce and financial reporting, enabling improved understanding of drivers and service-level variation.[1]

Local oversight arrangements at Service Group level vary, and there is an opportunity to provide greater consistency in the day-to-day management of MVP activity and the application of organisational controls. While examples of effective local oversight were identified during the review, the maturity and structure of arrangements differ across Service Groups, supporting the need for a more standardised approach as the organisation transitions to the new Care Group model.

There is evidence of targeted action to address MVP, including strengthened approval processes and a reduction in long-term locum posts. However, these improvements have not yet consistently translated into sustained reductions in reliance on temporary staffing. Demand continues to be predominantly driven by structural workforce gaps, limiting the extent to which transactional controls alone can deliver sustained reductions. In the context of the health board's 'Organised for Success' programme and the planned transition from four Service Groups to six Care Groups, there is an opportunity to establish a more standardised approach to MVP processes and oversight.

Notwithstanding the progress made, newly strengthened arrangements will need further embedding to deliver sustained and consistent reductions in MVP expenditure. In particular:

- Procedures have been developed for the booking, approval, and processing of both locum bank, and agency shifts. However, there is no formally approved and integrated control framework for MVP, limiting clarity over roles, approvals, and escalation requirements.
- High levels of retrospective booking of locum bank shifts reduce assurance that activity is authorised in advance and weakens the preventative nature of controls.
- Approval and escalation controls are not applied consistently across Service Groups. Gaps in audit trail and reliance on local agreements or informal processes evident, result in variable application of controls.
- The absence of an updated medical rate card results in routine escalation and high levels of local rate negotiation, limiting the health board's ability to apply consistent challenge and control costs.
- While governance arrangements are established, there is no defined minimum standard for Service Group–level oversight or reporting. Although the MWCB provides a consistent link between Service Groups and Executives, local arrangements vary, resulting in inconsistent monitoring and challenge of MVP activity outside formal organisational forums.

Taken together, while the health board has established strengthened governance, analytical capability, and oversight arrangements for MVP, the issues identified indicate that current controls are largely mitigating, rather than eliminating, reliance on temporary staffing. Whilst continued embedding of the

[1] The review focused primarily on medical variable pay arrangements within secondary care services. Limited testing was undertaken in relation to primary care and community services activity due to the comparatively low levels of medical variable pay expenditure and activity identified within those areas.

revised control framework remains important, sustained reductions in expenditure will ultimately depend on the successful delivery of longer-term workforce solutions that address the underlying causes of medical variable pay utilisation. On this basis, we have concluded **reasonable assurance**.

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

Whilst this review focused specifically on medical variable pay arrangements, the themes identified regarding governance, approval processes, escalation arrangements, oversight and control frameworks may also have relevance to wider variable pay arrangements across other staff groups and should be considered accordingly

Scope & Assurance Summary

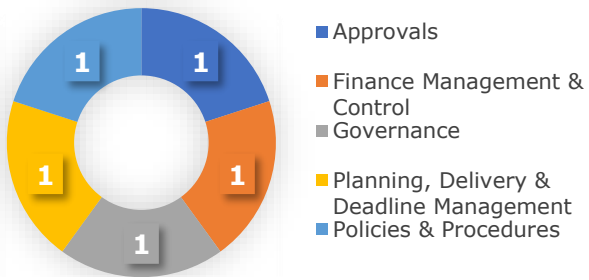
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The health board has appropriate policies and procedures to direct and control the use of medical variable pay.	1	**Limited**
2	There is robust analysis of medical variable pay spend to establish underlying contributing factors behind its use.	1, 2, 4	**Reasonable**
3	Actions and initiatives to address the level of medical variable pay are being progressed to ensure there is sustained reduction in spend.	2, 3, 4	**Reasonable**
4	Monitoring and scrutiny of medical variable pay, and the actions to address expenditure take place within appropriate forums.	5	**Reasonable**

Management Actions

2 High Priority

3 Medium Priority

Themes



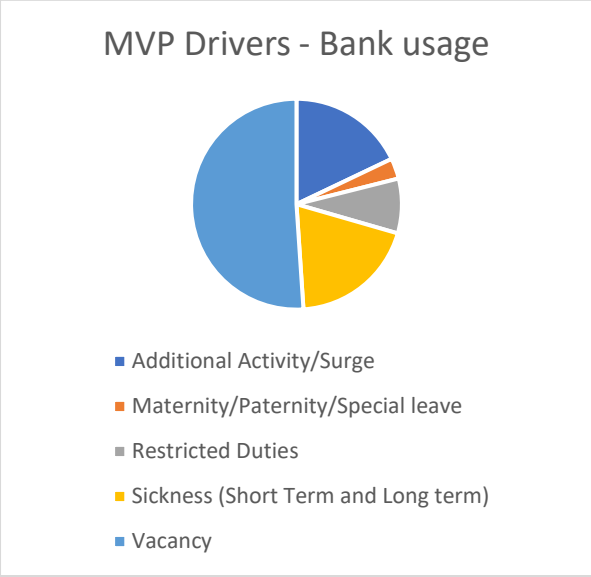
Risk Types

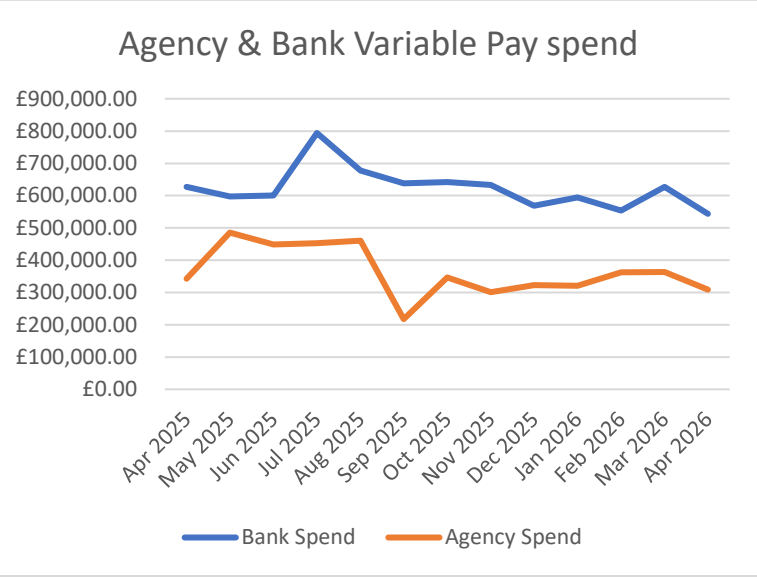
Financial Loss

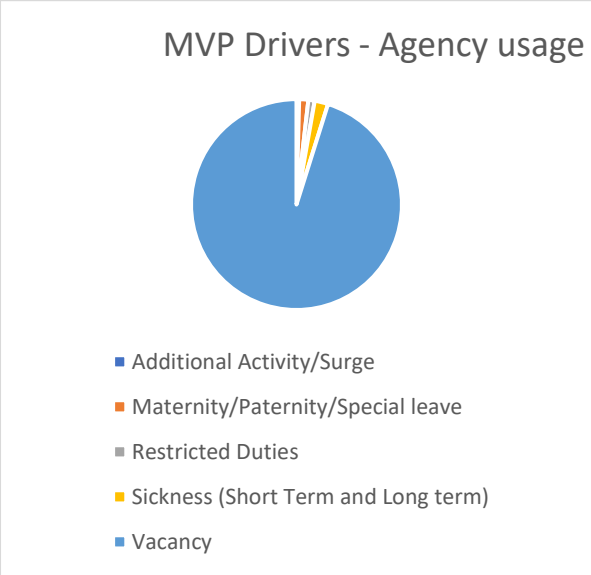
Public Perception & Reputational Risk

Medical Variable Pay – At a Glance

MVP Total Spend April 2025 – April 2026	SBUHB Total Variable Pay Spend April 2025-2026	Monthly Range of MVP spend April 2025 – April 2026	Monthly MVP % of Variable Pay spend
£15.9m	£63.3m	Lowest - £0.970m (April 2026) Highest - £1.488m (July 2025)	Lowest – 19% (April 2026) Highest – 28% (August 2025)







MVP spend totalled £15.9m between April 2025 and April 2026 (c.25% of total variable pay). While spend has varied across the period, there is some indication of improvement by April 2026, which represents the lowest monthly position both in absolute terms and as a proportion of overall variable pay.

Agency utilisation is overwhelmingly vacancy-driven, whereas Bank usage reflects a broader range of factors, with Vacancy (50%) the primary driver alongside Sickness (19%) and Additional Activity/Surge (18%).

Top 7 Directorates	Bank Spend	% of Total Bank spend
Anaesthetics	£1,678,742	21%
Accident & Emergency	£741,775	9%
Obstetrics & Gynaecology	£548,080	7%
Oral Maxo Facial Surgery	£371,936	5%
Medicine	£343,440	4%
Cardiothoracic	£324,322	4%
Trauma & Orthopaedics	£259,151	3%

Top 7 Directorates	Agency Spend	% of Total Agency spend
Adult Mental Health	£723,128	15%
Haematology	£631,353	13%
Rehabilitation & Recovery (Mental Health)	£441,848	9%
Medicine	£371,858	8%
Oncology	£347,002	7%
Pathology	£311,989	7%
Obstetrics & Gynaecology	£300,330	6%

Findings & Agreed Action Plan

Objective 1: The health board has appropriate policies and procedures to direct and control the use of medical variable pay.	**Limited**

Addressing medical variable pay (MVP) has been a key area of focus for the health board, supported by external input from Deloitte over the period July 2025 – June 2026. This work identified a number of control weaknesses, including limited documentation of variable pay arrangements, unclear approval processes, the absence of a fully operational executive approval framework for premium rate shifts, and a lack of clearly defined accountability. In response, the health board has developed a suite of guidance documents to strengthen its control framework.

This includes two draft standard operating procedures (SOPs) developed to reflect the revised internal locum bank and medical agency arrangements; in addition to an extant Waiting List Initiative (WLI) procedure (approved in November 2024). Collectively, these documents set out the processes for requesting, approving and managing MVP activity across key mechanisms, and are supported by process map flowcharts.

The draft SOPs and associated flowcharts provide end-to-end process descriptions and are broadly aligned in structure and content. They identify key roles and responsibilities, define escalation routes (particularly in relation to rate cap compliance and approval above the Welsh Government (WG) cap[2]), and consistently emphasise prior approval and senior oversight. In addition, the internal locum bank SOP explicitly references integration with Allocate, the health board's electronic rostering system.

However, these documents are not formally approved, version controlled, or centrally accessible, limiting assurance that processes are fully governed and consistently applied across the organisation (see **Key Finding 1**). We acknowledge that further organisational and operational changes are underway, including restructuring from Service Groups to Care Groups, anticipated introduction of an updated rate card, consideration of outsourcing locum bank management, and conclusion of external support arrangements. Management has advised that formal approval of SOPs will follow these developments; however, the absence of a defined timeframe limits assurance over when a fully integrated and approved control framework will be established.

Notwithstanding this progress, our review identified a number of weaknesses in the completeness and integration of the overall guidance framework. While individual documents address specific aspects of MVP, they do not collectively form a single, integrated control framework setting out overarching principles, approval thresholds, escalation routes, and monitoring expectations. Benchmarking with a neighbouring health board demonstrates that this can be achieved through adoption of a dedicated Financial Control Procedure (see **Key Finding 1**).

In addition, there is no direct linkage between MVP guidance and the Scheme of Reservation and Delegation (see **Key Finding 1**). Approval thresholds and escalation points are not explicitly mapped to delegated financial authority limits, which may limit clarity over decision-making authority and increase the risk of inconsistent approvals, particularly during organisational change. There is also limited emphasis on proactive workforce planning, specifically the timely population of rotas, which may impact the effectiveness of controls in practice (see **Key Finding 1**).

[2] The Welsh Government (WG) locum rate cap sets maximum allowable hourly rates for medical staff by grade (e.g. up to £97.22 per hour for a consultant role), compared to lower SBU locally set rates (e.g. £77.79 per hour)

Key Findings		Risk & Impact	Agreed Management Action
1	**Absence of a formally approved and integrated medical variable pay control framework** The health board has developed a number of guidance documents to support the management of MVP. However, these arrangements operate as standalone documents and do not form part of a single, formally approved control framework, resulting in fragmented guidance across policy and process levels. In particular: • There is no overarching framework setting out consistent principles, approval thresholds, escalation requirements, and monitoring expectations across MVP activity. • Approval thresholds and escalation routes are not explicitly linked to the Scheme of Reservation and Delegation, limiting clarity over decision-making authority. • Key operational guidance, including the locum bank and medical agency SOPs, is not formally approved, version controlled or centrally accessible, reducing assurance over governance and consistent application. • The WLI procedure operates separately from other MVP arrangements and is subject to ongoing revision, and so will need revision to align with the recently developed SOPs.	Increased risk of inconsistent application of approval processes, reduced transparency and accountability for decision making, and unnecessary or excessive variable pay expenditure due to weakened financial control.	**Agreed Action:** • Establish an approved formal integrated medical variable pay framework which brings together standalone documents, aligns to approval thresholds and includes an escalation route in-line with the health board's decision-making structure. • Review of standalone documents to ensure each one is the most up-to-date version, seeking approval of any which remain in draft. These will then be referenced within the framework. **Expected Evidence of Implementation:** • Framework approved by appropriate forum supported by minutes, published on the health board's intranet with communication to staff of its publication.
		High Priority	**Officer:** Liz Wonnacott, Head of Service, Medical Directorate **Target Implementation Date:** 31st December 2026
	Theme: Policies & Procedures	Control Design	

Objective 2: There is robust analysis of medical variable pay spend to establish underlying contributing factors behind its use.	**Reasonable**

Effective control of MVP requires access to reliable and integrated finance and workforce information to enable the health board to understand the underlying drivers of spend at Service Group and directorate level, and to support timely challenge and intervention.

Following external review and support, the health board has strengthened its analytical arrangements, most notably through the development of a Medical Workforce Dashboard. This consolidates workforce, finance, and temporary staffing data into a single reporting platform and provides structured analysis of MVP spend, volumes, and activity by staffing route, driver category, and service area. This supports regular scrutiny through Medical Workforce Control Boards (MWCBs), which have been established for each Service Group and have met routinely since November 2025.

The MWCBs provide the primary forum for reviewing and challenging MVP analysis (see Objective 4). Evidence reviewed confirms that MVP is consistently analysed by recognised drivers, including vacancies, sickness, rota gaps, unplanned absence, and additional or enhanced activity. This enables the identification of service-level variation and repeat outliers.

However, the effectiveness of analysis is constrained by limitations in the completeness, timeliness and integration of underlying data. In particular, the continued use of retrospective claims (see **Key Finding 2** & Objective 3) and incomplete forward rota entry (see **Key Finding 1**) reduce the accuracy and timeliness of reported MVP drivers, limiting the ability to proactively challenge services ahead of spend being incurred.

In addition, the absence of an updated rate card and reliance on local arrangements (see **Key Finding 4**) complicate interpretation of breach metrics. This requires manual intervention and professional judgement to distinguish genuine non-compliance from locally agreed exceptions. Examples include instances where Senior House Officers undertake shifts at Foundation Year 2 rates without being treated as grade breaches; and historic rate variations within specific specialties, such as anaesthetics, applied within defined timeframes prior to shifts. While these arrangements are understood operationally and are routinely considered within MWCB discussions, they are not explicitly identified within dashboard outputs and therefore rely on narrative explanation and forum-based interpretation.

Taken together, while analytical capability and governance oversight through the MWCBs have materially strengthened, the above factors reduce assurance that MVP analysis consistently provides a complete and timely understanding of underlying drivers across all services. These limitations are driven in part by the absence of a formally approved medical variable pay control framework and the lack of an agreed, up-to-date rate card, as set out in **Key Findings 1** and **4**.

Objective 3: Actions and initiatives to address the level of medical variable pay are being progressed to ensure there is sustained reduction in spend.	**Reasonable**

Sustained reduction in MVP requires not only effective approval and escalation controls, but also delivery of initiatives that address the underlying drivers of temporary staffing reliance, applied consistently across Service Groups.

The health board has implemented a range of actions and initiatives aimed at reducing MVP expenditure, including strengthened approval arrangements for agency and locum bank usage, enhanced scrutiny through MWCBs, and a thematic Recovery and Sustainability (R&S) programme approach focused on addressing underlying workforce pressures. Our review identified examples of local initiatives and oversight arrangements operating within Service Groups to support the proactive management of workforce pressures and temporary staffing requirements. However, the structure and maturity of these arrangements varies across Service Groups and is discussed further under Objective 4.

Long Term Locums Utilisation

There is evidence of meaningful progress in addressing prior reliance on long-term medical locums. Medical HR data confirms that long-term locum posts fell from 34 in February 2025 to 16 by April 2026 (over 50%). However, this has not consistently translated into reduced workforce dependency. Twelve of the original 34 services continue to demonstrate sustained and material reliance on agency and/or bank staffing following the reduction or cessation of long-term locum arrangements, with high volumes of bank shifts (e.g. over 200 in individual services) and associated spend exceeding £100k in some cases.

Agency Utilisation

Agency expenditure remains highly concentrated. Analysis for September 2025 to January 2026[3] shows that Psychiatry, General Medicine, Surgery, Obstetrics & Gynaecology account for approximately 90% (£2.21m) of total spend. Demand within these areas is overwhelmingly driven by structural workforce gaps, with 95% of expenditure attributed to vacancy cover rather than short-term or exceptional pressures. This concentration reinforces that, while approval controls and scrutiny arrangements are generally operating effectively (29 of 30 placements appropriately approved through Executive scrutiny panels or by Service Group Medical Directors), sustained reduction in agency spend is heavily dependent on resolving these underlying workforce shortages.

Locum Bank Utilisation

Locum bank usage shows similar patterns. Of 4,813 shifts analysed between September 2025 and January 2026, approximately 47% were recorded retrospectively, including a significant proportion entered more than 30 days after the shift date (see **Key Finding 2**). Approximately 44% of shifts relate to known and recurring workforce gaps, such as vacancies and less-than-full-time working arrangements, of which around 40% were still entered retrospectively despite the underlying requirement being foreseeable. Additionally, only a small proportion (16%) of shifts were filled at the originally advertised grade or payment rate.

Testing of 70 shifts across the three highest-usage Service Groups (Morriston, Neath Port Talbot Singleton (NPTSSG) and Mental Health & Learning Disabilities (MHLDSG)) confirmed that, while system approval at service manager level is generally recorded within the Allocate rostering system, evidence of formal escalation and use of the mandated approval documentation is inconsistent (see **Key Finding 3**). Escalation is occurring routinely rather than as an exception, limiting its effectiveness as a mechanism for driving ongoing control of expenditure and usage.

[3] Data has been analysed to January 2026 to allow for completeness and accuracy, recognising that shifts may be submitted up to three months in arrears. Fieldwork commenced in April 2026, and more recent data was therefore considered incomplete at the time of testing.

This is further compounded by the absence of an agreed and embedded medical rate card, further reducing the organisation's ability to clearly identify outliers and apply consistent challenge (see **Key Finding 4**).

Workforce configuration also contributes to ongoing reliance on MVP. Analysis identified 150 medical staff working below whole-time equivalent (WTE) in January 2026, the majority (79%) operating between 0.7 and 0.8 WTE, reducing available capacity and contributing to rota gaps.

Overall Impact on MVP utilisation

Overall, MVP spend has fallen from approximately £1.5m–£1.7m per month in 2024 to £0.9m–£1.3m between January and March 2026. While this demonstrates progress, current controls are largely mitigating rather than eliminating reliance on temporary staffing. Further sustained reduction is constrained by structural workforce gaps and the absence of key enablers, such as an updated rate card (see **Key Finding 4**).

In summary, while initiatives are in place to address both control and underlying drivers, further sustained reduction in MVP spend remains dependent on consistent embedding of controls and implementation of structural workforce solutions. Continued reliance on temporary staffing and a lack of systematic alignment between workforce establishment and demand indicate that underlying pressures persist and may constrain the sustainability of current improvements without ongoing scrutiny and intervention.

Key Findings		Risk & Impact	Agreed Management Action
2	**High levels of retrospective booking of locum bank shifts** Analysis of locum bank activity identified a significant level of retrospective booking, with 2,195 of 4,813 shifts (47%) recorded after the shift date, including 23% entered more than 30 days later. This includes activity relating to known and recurring workforce gaps, such as vacancies and less-than-full-time arrangements, where advance planning would be expected.	Increased risk of unauthorised activity, reducing transparency accountability for decision-making and weakening the preventative nature of controls, potentially leading to unnecessary or excessive variable pay expenditure.	**Agreed Action:** • The medical variable pay framework will reinforce the requirement for prospective booking and approval of locum bank shifts, whilst clarifying the exceptional circumstances under which retrospective bookings would be deemed appropriate, and the processes to be followed to accommodate these; • Continued oversight of retrospective booking at medical workforce control boards, including requests for hotspot areas to attend to discuss the reasons for late entries. This requirement will be included in the medical variable pay framework. **Expected Evidence of Implementation:** • Approved medical variable pay framework with relevant section included; • Agenda, minutes and slides for medical workforce control boards showing oversight of retrospective booking, including detail on increases/decreases over time (e.g. since the last report and year-to-date) and escalation of any hotspots.
		Medium Priority	**Officer:** Liz Wonnacott, Head of Service, Medical Directorate **Target Implementation Date:** 31st December 2026
	Theme: Planning, Delivery & Deadline Management	Control Operation	

3	**Inconsistent application of approval and escalation controls** Formal escalation processes are not consistently applied or evidenced. Testing of 70 locum bank shifts across three Service Groups identified that whilst approval within Allocate was generally evidenced, compliance with the broader control framework and associated approval documentation was significantly more variable between Service Groups, limiting assurance that strengthened organisational controls have been embedded consistently in practice. In particular: • In Morriston Service Group, 14 of 30 sampled shifts (47%) had no supporting SharePoint approval form, with a pattern of retrospective entries (30% recorded over one month after the shift date). • In NPTSSG, 22 of 30 shifts (73%) had no evidence of formal approval or use of standard request forms. • While MHLD demonstrated more structured oversight through regular review arrangements; however, these processes did not consistently align with the formal requirements of the Locum bank SOPs approval form.	Increased risk of non-compliant expenditure, reducing transparency, accountability and audit trail assurance. Inconsistent application of approval and escalation controls limits management's ability to apply effective challenge to variable pay utilisation and increases the risk that expenditure reduction initiatives are not implemented consistently across services.	**Agreed Action:** • Medical variable pay framework to set out process for approval and escalation of locum/bank shifts; • Compliance to be monitored through the medical workforce control boards groups. **Expected Evidence of Implementation:** • Approved medical variable pay framework with relevant section included; • Agenda and minutes for medical workforce control boards showing oversight of compliance.
		Medium Priority	**Officer:** Liz Wonnacott, Head of Service, Medical Directorate **Target Implementation Date:** 31st December 2026
	Theme: Approvals	Control Operation	

4	**Absence of an up-to-date medical rate card** The update of the health board's medical rate card, identified as a key control within the Recovery and Sustainability workstream, has not been finalised. Initial plans indicated completion by September 2025, however while it was supported in principle by Management Board in October 2025, a revised rate card is yet to be approved and introduced. As a result, rate setting continues to rely on local negotiation and case-by-case escalation. This not only weakens control over individual payments but also limits the Health Board's ability to establish and monitor recurring savings expectations associated with its wider variable pay reduction programme. Analysis of January 2026 activity indicates that escalated rates and grade adjustments are occurring routinely across high-demand services, reflecting underlying structural workforce pressures: Morriston Service Group (530 shifts reviewed): • 262 (49%) were above SBU rates but within WG cap rates; • 55 (10%) were paid above WG cap rates, including WLI-related payments and approved step-down arrangements; and • 52 (10%) reflected locally agreed arrangements in excess of standard rates, including acute GP cover and grade substitution. • 161 (30%) were at a higher grade than requested but remained within SBU payment rate. NPTSSG (300 shifts reviewed): • 203 (68%) were paid above WG cap rates; • 88 (29%) were within standard WG thresholds; and • Only one shift reflected other local rate arrangements. MHLDSG - A more limited review of MHLD activity did not identify the same patterns in relation to rate escalation, although minor inconsistencies were noted in the recording of shift rationale.	Increased risk of inconsistent rate application, reduced cost control, and continued reliance on local negotiation, limiting transparency and comparability of costs. The absence of an agreed and consistently applied rate structure also constrains the ability to monitor compliance, apply consistent challenge, and demonstrate delivery of sustained reductions in variable pay expenditure.	**Agreed Action:** • Approval and implementation of the rate card including communication with all services; • Service groups will be expected to report any non-compliance to the medical workforce control boards. **Expected Evidence of Implementation:** • Approved rate card circulated to all services • Agenda and minutes of medical workforce control boards to monitor compliance and escalate issues.
	Theme: Finance Management & Control	**High Priority** Control Design	**Officer:** Sharon Vickery, Assistant Director of Workforce **Target Implementation Date:** 31st December 2026

Objective 4: Monitoring and scrutiny of medical variable pay, and the actions to address expenditure take place within appropriate forums.	**Reasonable**

The health board has established a range of governance arrangements to support the monitoring and scrutiny of MVP. At organisational level, this includes the Recovery and Sustainability (R&S) programme, established during 2024/25, and the introduction of the Variable Pay Steering Group in 2025/26, reflecting increased scrutiny in response to the health board's financial position.

These arrangements are supported by MWCBs, chaired by the Interim Executive Medical Director, with standing attendance from Medical HR and finance representatives, and input from Service Group Medical Directors.

There is regular reporting to the Performance and Finance Committee (PFC) and Workforce & Organisational Development Committee (WODC), providing a structured framework for oversight. MVP is consistently reported and discussed at committee level, supported by a central workforce dashboard and standardised MWCB reporting, enabling comparison across Service Groups and identification of higher-risk areas.

At Service Group level, oversight arrangements are in place but vary in structure and maturity. MHLDSG operates a structured two-tier governance approach, combining a weekly MVP group with a broader workforce forum that provides both operational and strategic oversight. Morriston Service Group has implemented a daily MVP site call supported by a forward-looking three-day forecast reviewed by the Service Group Medical Director, although its effectiveness is impacted by the retrospective entry of shifts. In contrast, NPTSSG does not operate a dedicated MVP forum, with oversight incorporated within broader workforce meetings where MVP is not a routine or explicit focus. As a result, there is no consistent approach to maintaining a comprehensive and routine view of MVP activity and associated risks outside MWCB cycles. This limits continuous visibility and reduces the consistency of challenge and scrutiny across Service Groups (see **Key Finding 5**).

Organisational reporting provides good visibility of MVP expenditure, trends and performance. WODC reporting includes consistent categorisation of MVP, while PFC reporting links MVP to the wider financial position. Rotational presentations from Service Groups to PFC further oversight by analysing financial performance, and highlighting key cost drivers, variable pay utilisation, risks and mitigating actions. This provides a clear line of sight between operational pressures, workforce drivers and financial impact at Service Group level. However, the role and outputs of the MWCBs are not consistently reflected within the established committee reporting.

Progress in delivering the health board's Variable Pay Plan 2026/27 was shared with the WODC in June 2026. This confirmed that delivery of required savings remains challenging, with continued reliance on variable pay driven by hard-to-recruit specialist roles, the need to maintain safe staffing levels, and variability in the availability of substantive staff. The update also confirmed that Service Groups are being supported to develop more detailed delivery plans, which will be subject to monitoring through the R&S programme.

Key Findings		Risk & Impact	Agreed Management Action
5	**Absence of defined minimum standards for medical variable pay oversight** The health board has established governance arrangements for monitoring MVP, including structured organisational-level oversight through MWCBs and committee reporting. However, there is no clearly defined minimum standard for Service Group oversight. This results in variation in local arrangements, where some Service Groups have implemented structured and well-documented arrangements, while others rely on informal mechanisms, individual roles, or broader workforce forums rather than dedicated, consistently evidenced MVP oversight processes. This reflects previously identified issues raised by Deloitte regarding fragmented accountability at Service Group level, and indicates that while governance has strengthened, consistent embedding of local oversight arrangements remains incomplete.	Increased risk that emerging cost pressures, underlying workforce drivers, and opportunities for intervention are not identified or challenged in a timely manner, limiting effective control over MVP expenditure.	**Agreed Action:** *Re-emphasise the requirement for each service group to have a forum in which medical variable pay is discussed on a regular basis.* *Ensure that Service Group Medical Directors present to Medical Workforce Control Boards, clearly setting out the arrangements they have in place for Service/Care Group reporting and oversight of MVP, to include as a minimum:* • *Confirmation of the forum(s)* • *Confirmation that reports will be in writing* • *Frequency of reporting* • *Minimum standard/content of reports* • *Internal escalation criteria and route* *Section to be added to the Medical Workforce Control Board agendas for service group medical directors to provide notes/minutes from their forums for noting.*
			Expected Evidence of Implementation: *Example evidence could include:* • *Approved guidance or framework setting out minimum MVP oversight standards.* • *Documented Service/Care Group governance arrangements aligned to the standard (e.g. terms of reference, meeting structures).* • *Evidence of routine MVP oversight taking place (e.g. meeting agendas, minutes, reporting packs).* • *Monitoring reports demonstrating compliance with defined oversight requirements.*
		Medium Priority	**Officer:** Liz Wonnacott, Head of Service, Medical Directorate **Target Implementation Date:** 31st December 2026
	Theme: Governance	Control Operation	

Appendix A: Assurance Opinion and 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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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 Swansea Bay 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

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