WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

European Working Time Directive compliance for junior doctors in training - follow up

Betsi Cadwaladr University Health Board

Audit year: 2011

Issued: October 2011

Document reference: 278A2011

Status of report

The team who delivered the work comprised Mandy Townsend and Tom Haslam.

Contents

The Health Board has made good progress with the implementation of European Working Time Directive (EWTD) compliant rotas but needs to strengthen current arrangements to maintain levels of compliance and patient care.

Summary report

Introduction

1. In March 2009, we published an all-Wales report on compliance with the EWTD for junior doctors in training. The local audit work that preceded that report considered the arrangements that the then NHS trusts had put in place to secure compliance by August 2009. We focused on the requirement for junior doctors to be working no more than an average of 48 hours a week.

2. Our all-Wales report concluded that, based on the rate of progress over the previous two years and the challenges that still lay ahead, the 48-hour target was unlikely to be met on time across NHS Wales as a whole. That was, at least, without either a substantial investment of effort and resources or, in some areas, the possible temporary extension of the August 2009 deadline.

3. Betsi Cadwaladr University Health Board (the Health Board) was created in October 2009. It encompasses:

- Two former NHS Trusts, North West Wales NHS Trust and North Wales NHS Trust. The latter was the result of a previous merger in April 2009 of Conwy and Denbighshire NHS Trust and North East Wales NHS Trust.
- Six former Local Health Boards: Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham.

4. It is organised into 11 Clinical Programme Groups (CPGs) and provides services across three main hospital sites: Ysbyty Gwynedd (West), Ysbyty Glan Clwyd (Central) and Wrexham Maelor (East).

5. Our local reports to the predecessor trusts in October 2008 (North West Wales) and January 2009 (North Wales) concluded that both had put a number of arrangements in place to ensure EWTD compliance. However, significant challenges still existed and clear leadership and plans were required to support compliance.

6. A number of health boards in Wales applied to the Welsh Government for temporary derogations in clinical specialties where compliance against the 48-hour maximum working week was unlikely to be achieved by the August 2009 deadline. These derogations do not apply to all junior doctors but rather to those working on specific rotas. Where derogations were granted, health boards were expected to reduce average weekly working time on these rotas to 52 hours a week or less. In addition, derogations only apply until August 2011 or, in exceptional cases, extensions may be granted until August 2012. The Health Board obtained derogations for 13 separate rotas spread across each of its three main hospital sites (Ysbyty Gwynedd – West; Ysbyty Glan Clwyd – Central; Wrexham Maelor – East).

7. Our all-Wales report, in 2009, also emphasised that planned changes to achieve compliance might prove difficult to sustain in practice. Potential issues affecting progress included: a lack of funding for additional posts or problems with recruitment; staff resistance to new ways of working; or concerns about the impact of a reduction in working time on the quality of professional training. The report also highlighted the risk that, while compliant in principle, reported rota patterns may not reflect actual working patterns.

8. With these issues in mind, we decided to undertake some follow-up to examine whether the Health Board is now well placed to sustain, and where necessary improve, compliance with the EWTD for junior doctors. We undertook our fieldwork over the early part of 2011.

9. Our overall conclusion is that the Health Board has made good progress with the implementation of EWTD compliant rotas but needs to strengthen current arrangements to maintain levels of compliance and patient care. More specifically:

- New rotas and other changes in working practice are supporting compliance but there are concerns about the impact of current arrangements and rotas may not reflect actual hours worked. Because:
  - while there are inconsistencies in the approach to rota management, all of the Health Board's junior doctor rotas are, in principle, now EWTD compliant;
  - new rota patterns have been supported by other changes in working practice but there are concerns about whether some of these changes can be sustained and the impact on patient care; and
  - monitoring arrangements do not provide sufficient assurance that junior doctors' rota patterns reflect the actual hours they work.
- Governance and performance arrangements for EWTD compliance are unclear, although the Health Board is now taking action to clarify core responsibilities and accountabilities.

10. During our recent consultant contract review, we interviewed a range of consultants from the three major hospitals in the Health Board. We asked them for their views on the implications of the EWTD for junior doctor and also included related questions in the online survey of all consultants (to which we received 125 responses, 30 per cent). Appendix 1 provides the EWTD related survey results.

11. The Health Board's Internal Audit service is concurrently reviewing EWTD compliance of junior doctors in detail. Although the scope of both pieces of work is different, we have worked closely together to ensure that they are coordinated and present maximum value to the Health Board.

Recommendations

R1 Develop and document a standardised model for EWTD compliance to ensure junior doctors' working time is managed in a consistent fashion across the Health Board. Use this to ensure that:

- it is clear who is leading, and therefore ultimately responsible, for delivery of EWTD compliance across the Health Board;
- rota development, management and monitoring is consistent across the Health Board;
- define a network of relevant staff involved in rota development, management and monitoring and provide an appropriate cross CPG forum and software tools to enable these staff to standardise good practice, share innovation and learning;
- implement a training programme for all new staff involved in rota development, management, and monitoring, as the pool of staff changes;
- those involved in ensuring EWTD compliance have relevant personal objectives, and are held to account for delivering them; and
- risks are properly identified and mitigated.

R2 Develop and implement a robust rota monitoring strategy and in doing so:

- ensure that all necessary information is gathered together in good time and accessible to all parties;
- agree coordinated timetables for monitoring exercises, with responsibility clearly assigned;
- implement and audit clear standards of record keeping for monitoring records, which ensure records are kept and stored for statutory timescales;
- put in place arrangements to check compliance with monitoring, perhaps by using the MRM Live system more extensively;
- put a documented mechanism in place to assure itself that junior doctors are not breaching EWTD regulations by working as locums, and where they are providing internal cover have opted-out; and
- ensure performance is regularly reported through the performance management framework to appropriate fora, including CPGs, the Board, and Board of Directors.

R3 To ensure patient safety and long-term sustainability of rotas, the Health Board must:

- Complete service reviews as soon as practicable.
- Extend the audit of handover processes to Glan Clwyd and Ysbyty Gwynedd, and to ensure that:
  - they are operating as intended;
  - and best practice on handover is applied across the Health Board; and
  - or benchmark against the recommendations identified at East, to demonstrate comparable practice across all three sites.
- Develop capacity and succession plans for 'new' roles, such as advanced nurse and midwifery practitioners.

New rotas and other changes in working practice are supporting compliance but there are concerns about the impact of current arrangements and rotas may not reflect actual hours worked

While there are inconsistencies in the approach to rota management, all of the Health Board's junior doctor rotas are, in principle, now EWTD compliant

12. Our October 2008 and January 2009 local reports examined whether the predecessor trusts were progressing towards meeting the August 2009 requirements for junior doctor EWTD. Both reports included four recommendations for improvement. There is evidence that both former trusts were making reasonable progress in addressing our recommendations and adopting new ways of working. The trusts' Medical Directors took a lead role on EWTD compliance and both trust boards monitored implementation closely up to the August 2009 deadline.

13. The Health Board inherited temporary derogations from the 48 hour working limit for 13 rotas. By early February 2011, the Health Board had made good progress in making 11 of the 12 derogated rotas nominally compliant with the 48 hour limit (Exhibit 1). The final senior paediatric rota in Glan Clwyd is compliant from August 2011.

Exhibit 1 Changes in rota compliance August 2009 – February 2011

Hospital	Rota	Compliant at August 2009	Nominally compliant with the 48 hour week limit at February 2011
Ysbyty Gwynedd	Anaesthetics - junior	No	Yes
	Anaesthetics - senior	No	Yes
	Obstetrics & Gynaecology - senior	No	Yes
	Paediatrics/Neo Natal - junior	No	Yes
	Paediatrics/Neo Natal - senior	No	Yes
Wrexham Maelor	Obstetrics & Gynaecology - senior	No	Yes
	Obstetrics & Gynaecology - junior	No	Yes
	Paediatrics - junior	No	Yes
	Paediatrics - senior	No	Yes
Glan Clwyd	Obstetrics & Gynaecology - senior	No	Yes
	Obstetrics & Gynaecology - junior	No	Yes
	Paediatrics - junior	No	Yes
	Paediatrics - senior	No	No

Source: Betsi Cadwaladr University Health Board and Welsh Government

14. The majority of rotas have been set at or near to the 48-hour maximum and inevitably it will be more challenging to ensure these rotas remain compliant in practice. There are a large number of rotas that are currently set very close to the 48 hour limit. In February 2010:

- four in 10 junior doctors were working on rotas set to within an hour of the threshold; and
- one in 12 junior doctors was working on rotas set to within 10 minutes of the threshold.

15. The Health Board acknowledges that there are still some distinct differences in the arrangements for the management of junior doctors' rotas, it inherited from the predecessor trusts. There is no network or mechanism to disseminate good practice, standardise procedures or provide a forum for discussion and training. The current approach is for individuals to rely heavily on informal requests for assistance from a limited number of 'expert' staff.

16. Although rota preparation is done on the Zircadian e rota software, day to day management is manual adjustments of standalone spreadsheets. This represents a large commitment of staff time (staff varying from admin staff to consultants) across the Health Board. Electronic rota management (e-rostering) is available as an add-on module to the current all Wales MRM system, but is offered at extra cost. However, the medical director's office reports that Zircadian (the MRM software provider) are keen to engage in a mutually beneficial 'pilot' of the e roster software.

17. Any pilot should be linked to e Locum and focus on reducing locum use, alongside the more efficient administration and monitoring of rotas. The Health Board currently spends £3.5 million on junior locums annually, so this project has the potential to deliver a cost saving to the Health Board for a relatively small investment[1]. Zircadian[2] report an average 27 per cent savings on locum costs, with some users saving up to 44 per cent.

18. Overall, if more efficient rota management is adopted across the Health Board and produces the expected returns, the Health Board could save approximately £1 million on locum expenditure, alongside freeing administrative staff for other tasks. The Health Board is in the process of discussing the options with the Local Negotiating Committee and plans to present the perceived benefits to the board of directors in due course.

New rota patterns have been supported by other changes in working practice but there are concerns about whether some of these changes can be sustained, and the impact on patient care

19. The Health Board and its predecessor trusts have employed a variety of initiatives and changes to working practice to assist with EWTD compliance. These have included additional medical staff, new roles for non-medical staff, and new ways of working. However, both our interviews and consultant survey raised concerns about the impact of these changes on patient care, and about whether these changes can be sustained in the current financial climate. The impact of financial pressures has been raised by assistant medical directors at the board of directors, but at the time of our review no tangible way forward had been agreed.

[1] The Zircadian pilot will cost around three thousand pounds (ex Vat) for a four month trial, and in October 2011 the Welsh Government agreed in principle to fund a pilot project.

[2] Zircadian is the name of both the system, and the company providing the system.

20. The reduction in junior doctor hours can be offset by increasing consultant working. The Health Board is exploring its approach to medical workforce planning, through recruitment of extra consultants and benchmarking with other parts of the UK. Overall, 38 per cent of consultants pointed to the use of extended consultant cover over the previous 18 months in their specialty/department to support EWTD compliance. The Health Board also benefits from extra training posts supported by both its own funding and the Deanery. However, Deanery posts are not guaranteed as the Deanery plans to reduce, by 18, its surgical training posts in North Wales between 2011 and 2013. The Health Board anticipates further reduction in training posts across other CPGs, but in May 2011 the extent (if any) of these reductions are not yet clear. The Health Board is also aware of a recent modelling exercise to establish if Wales is training enough Higher Speciality Trainees compared the NHS Wales future requirement for consultants.

21. Without the financial freedom to simply recruit more doctors, even assuming that extra posts could be filled, achieving EWTD compliance has inevitably necessitated changes in the way core clinical activity is undertaken. Overall, 73 per cent of consultants responding to our survey indicated that the main specialty/department in which they worked had seen the redesign of junior doctor rotas over the previous 18 months in order to support EWTD compliance. Just over one quarter (27 per cent) pointed to service reconfiguration as an important factor in delivering compliance.

22. The redesign of nursing roles has also been an important factor in work to achieve EWTD compliance. Clinical specialties benefiting from the development of nurse practitioner roles include Obstetrics & Gynaecology and Orthopaedics. In these specialities, nurse/midwifery practitioners are undertaking some of the core clinical activity previously delivered by junior doctors. While there is evidence of good practice, a number of specialties have not developed extended nursing roles. Indeed, in some areas there has been resistance to developing alternative methods of delivering clinical services. Just over one third (35 per cent) of consultants responding to our survey pointed to the greater use being made of nurse practitioners in their main specialty/department.

23. To support the delivery of care out of hours, the Health Board is sustaining Hospital @ Night[3] (H@N) arrangements across all three of its major hospital sites. We reported on the early development of H@N in our 2008 and 2009 reports. We did not review H@N in operation in detail. H@N has been subject to internal audit review at Wrexham and this review may be extended to the other sites. We noted further progress has been made to develop and refine H@N operation, with some variation for local circumstances. While some local variation is necessary and beneficial, it is important that common systems of working are in place, which enables junior doctors and nurse practitioners to be clear about their respective roles.

[3] The H@N concept is based on the notion of only having in work those who need to be at work by introducing generic multi-professional teams. These teams would have the competences required to meet patients' immediate needs.

24. Now all three acute sites use nurse or advanced nurse practitioners (ANPs) to cover evenings, nights and weekends in a structured and standardised manner. A pilot is due to start at Wrexham which extends this ANP working practice 24/7 with the aim of demonstrating improved core continuity across teams. The ANP's also provided out of hours clinical care, with cross cover during day time hours as part Ysbyty Gwynedd Acute Care Team where three ANPs were recruited using funding from vacant junior doctor posts, in August 2009. In August 2010 the vacancies were filled, and the ANP posts funding was discontinued.

25. There are positive examples of multi disciplinary working, as demonstrated by the obstetrics teams in Ysbyty Gwynedd and Ysbyty Wrexham Maelor, with the continued use of senior midwives to cover slots on the SHO rota. This has not been without its problems, as long term absence for maternity and sick leave meant that SHO cover was required on occasion at Ysbyty Gwynedd. The use of Senior Midwifery Care Practitioners on a combined rota with junior doctors, preserves daytime opportunities for juniors as well as exposure to out of hours to expand their experience building their confidence as they progress to middle grades.

26. Given the Deanery's planned reduction of trainee posts and the advantage of stability generally offered by ANPs, succession planning is vital for these roles within the multidisciplinary teams.

27. The Health Board is considering further plans to change ways of working. For example, a pilot of a 24/7 emergency physician on the acute sites. This model would allow a dedicated medical physician to be present on the wards each day while other physicians continue with their outpatient work. The Health Board is pursuing this because elsewhere in the UK, such an increase in senior decision-making capacity has improved EWTD compliance of junior doctor rotas by reducing their call-outs. It has also had positive impacts on patient care, including reduced lengths of stay, as well as improving training opportunities.

28. Service reviews are expected to find long-term sustainable solutions to EWTD compliance, as well as ensuring services meet national standards and the needs of the local population. The development of plans for further changes to ways of working, and the location of services form part of these reviews. The wider children's service review includes the particular issues around paediatrics, as the senior paediatrics rota at Ysbyty Glan Clwyd, only became EWTD compliant in August 2011. However, some consultants when we discussed EWTD with them in December 2010, cited problems with recruitment, concerns about the sustainability of proposed solutions (particularly given the Deanery's future plans to reduce the numbers of training posts), and the ongoing uncertainty caused by organisational change. All of which will impact on the decisions take in light of the service reviews.

29. With junior doctors working less hours, continuity of care can be more difficult to deliver. When asked about the overall impact of the EWTD in their specialty /department, around three quarters of consultants (75 per cent) pointed to a negative impact on the quantity of service provision. A slightly smaller proportion (62 per cent) pointed to the negative impact on the quality and safety of service provision. Many consultants commented that quality and safety was reduced because continuity of care

was limited. They felt junior doctors had less experience of treating patients throughout their inpatient stay and opportunities to gain experience in ward, theatre and outpatient environments were more limited. The move to team working away from the traditional 'firm' emphasises the need for good medical records and handover between shifts. While both these issues were outside the scope of this review, there were also mixed views on effectiveness of handover from all of those we spoke to, suggesting a clinical audit of the effectiveness of handover arrangements across the Health Board may be appropriate.

30. When reviewing rotas, the Health Board will also need to consider the Royal College of Physicians recommendation of larger rota sizes of 12 or more participants, to support training and development. Overall, the Health Board's average rota size is of around seven participants, with less than a quarter (22 per cent of rotas) involving 12 participants or more. Of the 43 consultants who provided additional comments in our survey, over half raised concerns about the time available for junior doctors' training. They pointed to a slower acquisition of skills among junior doctors than had been achieved previously, due to extensive out of hours working with limited supervision and without the support of a team infrastructure.

31. When asked about the impact of EWTD compliance on junior doctors' health and well being, the responses were more mixed. While 26 per cent thought there had been a positive impact, 27 per cent pointed to a negative impact and 28 per cent thought it had no impact (the remaining 19 per cent indicated that they did not know).

Monitoring arrangements do not provide sufficient assurance that junior doctors' rota patterns reflect the actual hours they work

32. Although rotas are compliant in principle, there is a risk that these rotas are not sustainable when subjected to the vagaries of day to day working practice, and taking into account any additional internal cover requirements. Only 58 per cent of consultants responding to our survey could state categorically that junior doctors did not have to regularly work over and above the hours set out in rotas in order to meet the demands of the job. Recruitment issues, resulting in vacant slots on rotas were frequently cited by consultants as a barrier to nominally compliant rotas being put into practice. In these situations, and for quality (and cost) reasons, the Health Board prefers to use internal cover wherever possible rather than locum doctors.

33. Devising a compliant rota is only a first step in the process. In order to provide sufficient assurance, the rota should be monitored to ensure that it is put into practice as intended. The Health Board is required under the New Deal to ensure all rotas are monitored twice every 12 months, and that any new/amended rotas are monitored within six weeks of implementation. We did not examine this area in detail, as Internal Audit were reviewing monitoring arrangements in 2011.

34. Historically, rota monitoring and assurance was the responsibility of the medical staffing office in each of the predecessor trusts. This model has not been adopted by the Health Board. Instead, monitoring and tracking of New Deal and the EWTR's is the responsibility of the CPGs, supported by the medical director's office and medical workforce. From the evidence we have seen, it is more realistic to state that the medical director's office undertakes the monitoring with varying degrees of assistance from CPGs, and not all CPGs are fully aware of their responsibilities. This is not sustainable because there is not sufficient capacity in the medical director's office. Moreover, there is, as a consequence limited ownership and accountability of the effective management of the doctors the CPG employs, and the potential financial risks this creates.

35. Current monitoring exercises use of the MRM Live system, yet still require a major effort from staff to track and notify participants. The Health Board reports that robust monitoring is difficult and there is no simple, systematic method for obtaining the necessary personal information to notify doctors, because staff do not have routine access to the information.

36. Rota monitoring is based on a self assessment by junior doctors. The outcome of this monitoring determines what intensity payments they may be entitled to. This is potentially a conflict of interest. In the past this was mitigated by the 'hands on' nature of the medical staffing offices and their detailed knowledge of working patterns, and now relies on the office of the medical director to manage and mitigate financial risk for CPG's.

37. Under EWTD an employer is not only obliged to keep records that are adequate but also records must be retained for a minimum of two years. A recent Welsh Government request for a full audit trail at Ysbyty Gwynedd back to 2004 could not be fulfilled because the information was not available. This may well be a consequence of the merger, and loss of 'organisational memory' of where records are stored, but the Health Board must assure itself that record keeping is now adequate.

38. The Health Board acknowledged that in December 2010 it could not state with confidence that all rotas were monitored as required. Most rotas only achieved annual monitoring. It should be noted that in May 2011, the medical director's office was in the process of catching-up with monitoring requirements, as some capacity was temporarily devoted to this task. In May, 75 per cent of the rotas had been monitored within the last six months, with plans to monitor the remaining 25 per cent over the following two months to ensure full compliance. This was achieved. The medical director's office will also undertake the next round of monitoring to allow the CPGs to take over an up to date position in April 2012. However, as most junior doctors on the rotas change twice per annum, any lack of monitoring presents a risk that the Health Board may not fulfil its obligations under the New Deal. The CPGs will have to maintain this monitoring in future to manage this risk.

39. The following example is illustrative of past difficulties in the Health Board's monitoring arrangements:

- one specialty failed to collect junior doctors' personal email addresses on induction;
- the medical director's office required these email addresses so that junior doctors could participate in the EWTD monitoring exercise;
- the Workforce and Organisational Development directorate held junior doctor applications on file that contained the required email addresses;
- one staff member spent almost four weeks trying to obtain the addresses from workforce and organisational development, which couldn't be released because of concerns over data protection; and
- with a deadline looming, the monitoring exercise was conducted using Health Board email addresses, knowing that not all doctors use their accounts, with a correspondingly poor 18 per cent response rate for that speciality, casting doubt on the validity of the result.

40. In addition, in December 2010, we came across one rota that had not been monitored in 18 months, the combined medical and surgical F1 rota in Ysbyty Gwynedd. The Health Board reports that this was because of a lack of capacity, and no rotas were monitored in the west. The relevant junior doctors have raised their concerns with the medical director's office and the British Medical Association. The rota has now been monitored; however despite concerns being raised the doctor return rate was 61 per cent, and the duty return rate of 53 per cent. The medical director's office reports that foundation trainees were more concerned at how the rota was being operationally managed day to day.

41. Health Board policy does not allow its junior doctors to work locally as agency locums. The assistant medical director explained that oversight of the policy is the responsibility of the medical director's office. However, he acknowledged that potential breaches of this policy could not be discounted. Some consultants reported through our consultants survey in December 2010 that they have seen juniors working as locum cover. Within the scope of our review, it was not possible to verify whether what they had witnessed was in fact an internal cover arrangement. In addition, despite the Health Board planning its own rotas to give adequate rest, if juniors work elsewhere between shifts, they may not get adequate rest. This could present a serious medico-legal risk if an untoward incident occurred.

Governance and performance arrangements for EWTD compliance are unclear, although the Health Board is now taking action to clarify core responsibilities and accountabilities

42. Leadership on medical staffing issues within the predecessor trusts lay with their medical directors, and different approaches to rota management in the predecessor bodies led to a wide variation between rotas. However, the formation of the Health Board in October 2009 and the consequent reorganisation resulted in a new organisational environment where CPGs are supported by a smaller corporate centre. This is taking time to embed, and in the interim, leadership on EWTD has been unclear, and we found little evidence that CPGs are yet providing the necessary leadership and ownership on junior doctor EWTD compliance.

43. Within the Health Board's organisational structure, the CPGs have formal responsibility for rota planning, and monitoring with Chiefs of Staff and their clinical directors expected to take a lead role. At the time of the audit, not all tier four posts in the CPGs had been permanently filled which meant that interim management arrangements were in place below the level of Associate Chief of Staff. This may in part explain the fact that some CPGs have made slow progress with inherited rota issues. As with most new leadership models, further work is going to be needed to ensure clinicians understand how the new lines of accountability will work.

44. 'Expert' staff who worked in predecessor trusts' medical staffing departments are now split between the Medical Director's office, and the workforce and organisational development directorate. The role and remit of the workforce and organisational development directorate on junior doctor EWTD also needs more definition.

45. Within CPGs, varying grades of staff are responsible for rota planning and management. Correspondingly they have varying levels of awareness and understanding of EWTD requirements. No recent training has been provided and most of these staff also have other responsibilities. Consequently, there is still a lot of demand for assistance from the 'expert' staff. There has been reluctance at CPG level to explore EWTD compliance and rota issues in the detail needed to ensure robust and realistic solutions. There were a number of rotas with long standing issues where monitoring identified that junior doctors are working more hours than on the rota or juniors regularly raise concerns. In May, the problem areas included orthopaedics and medicine (East), surgery and orthopaedics (Central) and paediatrics (West). Many of these issues could result in higher intensity payments becoming due, which carries a significant financial risk. The medical director's office reports that all issues are now being worked through with CPG clinical and managerial staff, and only one orthopaedic and one surgical rota have outstanding issues.

46. This variation at CPG level was compounded by the unforeseeable long-term absence of the Medical Director in 2010. Since the return of the Medical Director, progress is evident, particularly on collaborative working with CPGs to progress the rota issues. Health Board staff report that good progress is being made to resolve these issues. The Medical Director asked CPGs for formal assurance that long-standing issues were resolved. As lower tier CPG and medical workforce management structures are confirmed, roles and responsibilities are being more clearly defined.

47. At the corporate level, EWTD issues are reported to the board of directors via the director of workforce and organisational development. Assistant medical directors report that EWTD does feature in discussion at the board of directors, but only in the context of wider junior doctor discussions. However, this forum is not a statutory Board committee, and not strictly part of the Health Board's performance management framework. This means that EWTD compliance issues were not consistently included in formal Board reporting. For example the Board discussed the Wrexham ANP pilot, but not the impact of freezing ANP posts. The effects of such decisions on the overall sustainability of rotas and service provision merit closer scrutiny.

48. The EWTD appears in the Health Board risk register as a risk, with management and mitigation assigned to the medical director. However, CPGs have the operational responsibility for delivering and managing EWTD compliance. And the new Health Board-wide risk management arrangements are not yet fully embedded in CPGs. Until CPG risk management arrangements are sufficiently robust, the medical director plans to formally write regularly to CPGs for assurance on their progress.

49. The Medical Director has plans to formally report to the Board on his areas of responsibility. In addition, the performance management framework (including performance measures reported) are under review by the Health Board, and workforce issues including EWTD will form part of this new holistic framework.

Appendix 1

Consultants' opinions about the impact of the European Working Time Directive

The information set out below is from a survey of NHS employed consultants across Wales which we conducted in 2010 as part of audit work on the consultant contract. We received a total of 580 responses across Wales, of which 125 were from the Health Board.

Has the specialty/department in which you undertake most of your work undergone specific changes over the past 18 months in order to support compliance with the European Working Time Directive for junior doctors?	Percentage		Count	
	BCU LHB	Wales	BCU LHB	Wales
	answered yes	answered yes	answered yes	answered yes
Redesign of junior doctor rotas	69.6%	68.1%	87	395
Greater use of advanced nurse practitioners	32.0%	30.9%	40	179
Extended levels of consultant cover	38.4%	41.0%	48	238
Other workforce remodelling	14.4%	14.7%	18	85
Extended use of Hospital at Night / Hospital at Day / Hospital at Weekend approaches	27.2%	24.0%	34	139
Service reconfiguration	19.2%	21.0%	24	122
Other	7.2%	10.2%	9	59

Has the specialty/department in which you undertake most of your work been granted a temporary derogation from the 48 hour average working time limit for junior doctors?	BCU LHB	Wales		BCU LHB	Wales
Yes	11.9%	6.5%		14	36
No	65.3%	65.2%		77	362
Don't know	22.9%	28.3%		27	157

In your experience, are junior doctors still having to regularly work over and above the hours set out in agreed rotas to meet the demands of the job?	BCU LHB	Wales		BCU LHB	Wales
Yes	20.3%	21.3%		24	118
No	57.6%	54.1%		68	300
Don't know	22.0%	24.7%		26	137

Thinking about the specialty/department in which you undertake most of your work, how would you describe the impact of the European Working Time Directive on: Junior doctors' training and skills development?	BCU LHB	Wales		BCU LHB	Wales
Positive impact	2.5%	1.4%		3	8
No impact	14.3%	13.4%		17	75
Negative impact	77.3%	78.5%		92	438
Don't know	5.9%	6.6%		7	37

Thinking about the specialty/department in which you undertake most of your work, how would you describe the impact of the European Working Time Directive on: The quantity of service provision in your specialty?	BCU LHB	Wales		BCU LHB	Wales
Positive impact	2.5%	1.6%		3	9
No impact	18.5%	19.7%		22	110
Negative impact	74.8%	72.0%		89	401
Don't know	4.2%	6.6%		5	37

Thinking about the specialty/department in which you undertake most of your work, how would you describe the impact of the European Working Time Directive on: The quality and safety of service provision in your specialty/department?	BCU LHB	Wales		BCU LHB	Wales
Positive impact	4.2%	2.7%		5	15
No impact	29.7%	25.8%		35	143
Negative impact	61.9%	63.4%		73	351
Don't know	4.2%	8.1%		5	45

Thinking about the specialty/department in which you undertake most of your work, how would you describe the impact of the European Working Time Directive on: Junior doctors' health and well-being?	BCU LHB	Wales		BCU LHB	Wales
Positive impact	26.3%	19.0%		31	106
No impact	28.0%	32.3%		33	180
Negative impact	27.1%	28.9%		32	161
Don't know	18.6%	19.7%		22	110

WALES AUDIT OFFICE

SWYDDFA ARCHWILIO CYMRU

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@wao.gov.uk

Website: www.wao.gov.uk

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500

Ffacs: 029 2032 0600

Ffôn Testun: 029 2032 0660

E-bost: info@wao.gov.uk

Gwefan: www.wao.gov.uk