Archwilydd Cyffredinol Cymru
Auditor General for Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Review of progress on previous Wales Audit Office recommendations

Betsi Cadwaladr University Health Board

Audit year: 2014-15

Issued: January 2015

Document reference: 479A2014

Status of report

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The team who delivered the work comprised Mandy Townsend, Sara Utley and Stephen Pittey.

Contents

The Health Board shows signs of progress across each of the reviewed areas, but there remains a significant amount of work to do and significant organisational barriers to overcome. The Health Board is not demonstrating the outcomes from its programmes of work.

Summary report

1. Between 2010 and 2012, the Wales Audit Office delivered three service reviews across Betsi Cadwaladr University Health Board (the Health Board) as part of our agreed programme of national and local audit work. These were:

- Ward Staffing Benchmarking Review (2010)
- Follow Up Review of Outpatient Services (2011)
- Use of Locum Doctors (2012)

2. Ward nurses are pivotal to the delivery of high-quality patient care. Insufficient ward staff and the wrong skill mix can adversely affect the quality of patient care. Nevertheless, with ward-staffing costs consuming up to a third of the annual pay budget and health boards facing significant financial pressures, it is vital that health bodies achieve value for money from their ward staff.

3. Outpatient services perform a critical role in the operation of patient pathways across the Health Board. They see around 700,000 patients a year, in 28 locations around North Wales. Outpatients are a complex and multi-faceted range of services requiring co-ordination to work effectively. They form a critical first impression for many patients, and their successful operation is crucial in the delivery of services to patients.

4. NHS Health Boards need a flexible approach for meeting staffing needs. It is not acceptable or desirable to close or stop health services because of shortages of medical staff. Health Boards respond to this need by employing a mix of permanent, contracted and agency staff. This approach, if well managed, is an appropriate way of ensuring that the public health need is met. However, this approach if not well managed is costly, inefficient and could create safety or quality of care risks. To meet the flexible staffing needs, the Health Board employs locum doctors (locums). A locum is one who is standing in for an absent doctor, or temporarily covering a vacancy for an established post. Locum appointments can be short or long term, supplied by an agency or the NHS.

5. Our work identified a number of opportunities for improvement across these reviews and presented the Health Board with a series of recommendations for action. In this report, we follow up those recommendations to determine where the Health Board has made progress, identify any barriers to progress, and highlight areas that require more development and focus going forward.

6. This follow-up review is timely for a number of reasons:

- Across the three service areas, the Audit Committee only tracks the action plan from one of our three reviews: *Use of locum doctors.* A level of assurance that progress has been made against our ward staffing and outpatient services recommendations is overdue.
- Since the Francis Inquiry Report published in February 2013[1], and subsequent responses from the Welsh Government, Chief Nursing Officer (CNO) and Royal College of Nursing, health boards have fallen under increasing scrutiny to ensure that their hospitals comply with safe levels of nursing staff.

[1] Report: *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, (2013). The Stationery Office.

- In June 2013, the Health Board published the second stage of its outpatient services review to help inform the ongoing modernisation of outpatient care across North Wales. The backlog of patients waiting for a follow-up appointment remains an issue for the Health Board and a Follow-up Programme Board has been put in place to strategically tackle referrals and backlog.
- The Health Board relies on the use of locum doctors to maintain service delivery, but the approach offers poor value for money, introduces a risk to the quality of service and does not offer a more strategic solution. The Health Board's locum costs continue to rise. The recent appointment of a permanent Executive Medical Director provides an opportunity for the Health Board to develop its strategy towards efficient locum use and implement change management programmes to reduce the dependency on locum support.

7. To help focus our review we asked the following question. Is the Health Board making sufficient progress in addressing the issues identified in our previous audits?
Our methodology for this review centred around self-assessments completed by the Health Board for each of the three topic areas along with a review of evidence provided by the Health Board to support those assessments.

8. Our conclusion is: The Health Board shows some signs of progress across each of the reviewed areas, but there remains a significant amount of work to do and substantial organisational barriers to overcome. The Health Board has yet to demonstrate significant and sustainable positive outcomes from its actions.

9. The summary below draws together key findings that emerged from our follow up work. Our recommendations are set out in Appendix 1. Additional narrative against each of the recommendations from our original studies can be found in Appendix 2 (Ward Staffing), Appendix 3 (Outpatient Services) and Appendix 4 (Use of Locums).

The Health Board shows signs of progress across each of the reviewed areas, with more than 20 per cent of recommendations complete

10. Table 1 summarises the findings from our follow-up work.

Table 1: Progress against recommendations

	Number of recommendations in original review:				
Review	**Completed**	**Partially complete**	**Limited evidence**	**No longer relevant**	**TOTAL**
Ward Staffing (2010)	1	3	0	1	5
Outpatient Services (2011)	2	6	1	0	9

Review	Number of recommendations in original review:				
	Completed	Partially complete	Limited evidence	No longer relevant	TOTAL
Use of Locum Doctors (2012)	3	9	2	0	14
TOTAL (Percentage)	6 (21%)	18 (64%)	3 (11%)	1 (4%)	28 (100%)

Source: Follow-up of recommendations fieldwork, June/July 2014.

11. The Health Board shows some progress against our action plans from the original reviews, with six recommendations assessed as completed (21 per cent). We judged 18 recommendations (64 per cent) to be 'partially complete' where the evidence demonstrated that processes were underway but work had not progressed sufficiently to show that all required actions were in place. This category covers a broad range, and a more detailed narrative of progress against individual recommendations can be found in Appendices 2 to 4 within this report.

12. The Health Board did not provide sufficient evidence for us to reach a judgement against three recommendations (11 per cent). One recommendation from our 2010 ward staffing review was no longer directly relevant due to the Health Board's revised focus on CNO guidelines.

13. Organisations perform well when they exhibit strong leadership and effective governance. Among the building blocks for healthy leadership and governance is the scrutiny and challenge of performance information[2]. This provides an assurance of progress towards strategic goals and the opportunity to take action when that assurance is lacking.

14. The Health Board exhibits stronger progress across our three reviewed service areas where there has been active leadership and governance over the issues being addressed, and closer scrutiny of performance information:

- The Office of the Medical Director provides a focus for assurance in the management of locum use and promotes engagement with Clinical Programme Groups (CPGs) to review their reliance on locum support. The Health Board's Audit Committee offers a further level of scrutiny by tracking progress in the use of locums.
- Management information to monitor ward staffing and vacancies is now more focused under the requirements of CNO safe staffing principles. The Health Board monitors nursing ratios through its workforce intelligence dashboard and tracks vacancies and recruitment timelines more thoroughly. The Health Board has demonstrated a more strategic engagement with the issues it faces in ward staffing since the arrival of the new Director of Nursing.

[2] Source: *The Good Governance Guide for NHS Wales Boards – Doing it right, Doing it better*, Academi Wales (2014), Welsh Government.

- Progress against our recommendations in the review of outpatient services is beginning to emerge with the Health Board's commitment to its outpatient services review and the development of a Follow-up Programme Board to tackle backlog.

A significant amount of work remains to be done in order to provide assurance of full implementation of our recommendations

15. The Health Board shows varying levels of progress across the recommendations that we assessed as partially complete:

- In some cases, we confirmed the presence of mechanisms to deliver on the recommendations, but crucial evidence to demonstrate their progression to successful implementation was lacking.
- Some actions were not sufficiently embedded to be regarded as complete. They showed only a 'pilot' status or discrete application to a limited part of the service being reviewed.
- In other cases, the Health Board provided evidence that carried conflicting detail, and we were unable to gain assurance of a structured approach to addressing the key issues.

16. Many examples of evidence reflect ongoing work. We recognise that the Health Board is pressing to develop change programmes and new ways of working that will improve the effectiveness and efficiency of its services for the benefit of the people of North Wales. It would be appropriate for the Health Board to ensure that it has clear programme and project management arrangements in place to ensure that these initiatives remain active, focused and monitored through to completion.

The Health Board has significant organisational barriers to overcome in order to fully evidence progress and embed change across the organisation

17. The Health Board's organisational structure restricts its pace of change and the ability to demonstrate assurances clearly across all service areas. Our review of submitted evidence highlighted limited progress in reducing some of the historical differences between sites, services and sub-regions. As an example, the Health Board reports a staffing ratio in compliance with CNO guidelines. However, variation between CPGs, sub-regions and individual wards confirms that some areas remain outside of target. These imbalances must be resolved to ensure that the Health Board is fully compliant with its commitment to the programme.

18. Aside from the content of the workforce intelligence dashboard, the Health Board offered little evidence that CPGs follow consistent and routine mechanisms to contribute to an overarching corporate profile. Our review of evidence submitted by individual CPGs to develop a picture of the Health Board's strategic approach proved extremely difficult:

- we noted variation in the level of content and detail across CPGs, offering little assurance of the Health Board's true position;
- some documents were incomplete and their active status could not be confirmed;
- many documents were undated, offering limited value to demonstrate a CPG's direction of travel; and
- separate pieces of evidence provided conflicting detail.

19. The requirement for CPGs to focus on their operational priorities is fully understood and some inconsistency across documentation can be expected. The Health Board has told us that the CPG model will be changed in the near future, and there are plans to develop some key performance indicators to improve its monitoring over critical service areas.

20. Going forward, the Health Board needs to provide and enforce standards and principles through a clinical services strategy that cuts across specialty silos and brings consistency into the corporate picture.

21. The application of an overarching clinical services strategy to set out agreed and sustainable service patterns would facilitate progress across a number of fronts relating to our review areas:

- service patterns could be accurately modelled and set to inform medical and nursing rotas in light of demands and pressures;
- the use of locum doctors and bank nurses could be re-appraised against modelled service patterns, potentially reducing the Health Board's reliance on agency usage to provide interim staffing solutions;
- the establishment of a sustainable framework for service provision would facilitate the adoption of new outpatient models and new ways of working; and
- the Health Board can gain assurance that its services are aligned to a researched and planned service model.

The Health Board is not measuring the outcomes from its programmes of work and using this evidence to drive further change or disseminate learning across the organisation

22. The Health Board's self-assessments show how it is tackling many of the issues raised in our original reviews, and the evidence identifies encouraging signs of progress through those initiatives. However, there is a general lack of empirical detail or evaluation to show positive outcomes resulting from the Health Board's programmes of work, particularly in reducing the pressures of demand across service areas and issues of resourcing.

23. We provide some examples below:

- Evidence of the Health Board's 'Lifestyle' programme is most positive: patients entering the programme report on it favourably in terms of benefits to their general health and wellbeing. However, as an example of a gateway to managing the pressure of referrals into the service, the Health Board has not been able to demonstrate how the implementation of 'Lifestyle' has reduced the demand placed on its clinics.
- Similarly, the enhanced packages of care offered by the Wales Eye Care Service (WECS) also represent positive progress towards alternative therapeutic intervention, but it is not evident that the facility has eased referral pressures on the Health Board's Ophthalmology service, and follow-up backlog remains high.
- Both the Office of the Medical Director and the Nursing team undertook considerable work programmes to reduce the Health Board's reliance on locum doctors and bank and agency nursing staff. Nevertheless, reliance on locums remains high, agency spend on nursing staff is above target and increasing, and the nurse bank shows high levels of recruitment, turnover and expenditure.

24. We recognise that many initiatives are in their early planning stages in draft/pilot form, and accept that the full impact of some programmes of work have yet to be identified. It is essential that the Health Board makes sure that targets are set, measured and monitored as these initiatives are rolled out to provide an assurance that progress is being made.

Recommendations

25. Our follow-up review of the three service areas identifies five key strategic actions for the Health Board to take forward. These are set out below. Appendix 1 provides an Action Plan for the Health Board to complete.

The Health Board is reviewing its CPG structure and developing clinical service strategies across a wide range of its services

R1 Decide and implement a cohesive and overarching clinical services strategy that:

- clearly drives the three-year plan;
- utilises cohesive management information to inform service development and provide assurance across the Health Board;
- sets out how service provision will be structured to meet demand;
- supports a structured approach in the management of CPGs or their replacement units;
- is supported by corporate standards and processes; and
- promotes equity of service across the Health Board's catchment.

Where scrutiny has not been strong, there is less evidence of progress against our recommendations

R2 Implement tracking arrangements across all review areas to promote effective governance over actions and ensure that managers have a clear responsibility to account for progress. The Wales Audit Office will support this by providing clear action plans within all our future reports.

Much of the progress we saw remained ongoing or applied to discreet service areas, and programmes of work could not be evidenced as complete

R3 Ensure that service developments are supported by clear programme and project management arrangements to keep initiatives active, focused and monitored. Apply SMART objectives to goals.

The Health Board does not evidence that its work programmes are improving service efficiency or effectiveness

R4 Evaluate the impact of changes made to service structures. Monitor outcomes to confirm that initiatives are producing the desired results.

Many of our previous recommendations are not fully complete

R5 Where appropriate, revisit the recommendations of the ward staffing, outpatients and locum service reviews to complete any outstanding actions.

Appendix 1

Action Plan

Paragraph	Recommendation	Intended outcomes/ benefits	Agreed	Health Board responsibility and actions	Completion date
Summary Report Paragraph 16	R1 Develop a cohesive and overarching clinical services strategy.	To provide a structure that: • clearly drives the three year plan; • utilises cohesive management information to inform service development and provide assurance across the Health Board; • sets out how service provision will be structured to meet demand; • supports a structured approach in the management of CPGs or their replacement units; • is supported by corporate standards and processes; and • promotes equity of service across the Health Board's catchment.	Yes	**Lead Executive Director of Strategy Actions**	
				• First draft reviewed by core group.	October 2014
				• Editorial panel established with independent members.	November 2014
				• Stakeholder workshops to test emerging themes.	December 2014 and January2015
				• Full board engagement sessions.	December 2014 and January2015
				• External peer review and feedback	December 2014
				• Initial submission to welsh government	31 January 2015
				• Wider stakeholder communication and engagement	January – March 2015
				• Consideration of feedback. Plan finalised/approved	March 2015
				• Adoption by the board	

Paragraph	Recommendation	Intended outcomes/ benefits	Agreed	Health Board responsibility and actions	Completion date
Summary Report Paragraph 11	R2 Implement tracking arrangements across all audit review areas.	To promote effective governance over actions. To ensure that managers have a clear responsibility to account for progress.	Yes	**Lead** **Board secretary**	
				Actions: A tracker tool has been established which will now routinely include recommendations from all internal and external audit reports. To assist in the process WAO now routinely include management action plans. Summary and exception reports are then brought to the Audit committee at each meeting.	Completed

Paragraph	Recommendation	Intended outcomes/ benefits	Agreed	Health Board responsibility and actions	Completion date
Summary Report Paragraph 13	R3 Ensure that major service developments are supported by clear programme and project management arrangements.	To set a structure that ensures initiatives remain active, focused and monitored. To provide assurance that progress is actively monitored against agreed criteria and timescales.	Yes	**Lead** **Executive director of strategy**	
				• Commission independent review and audit of current arrangements for capital projects.	November 2014
				• Establish new project governance and management arrangements for all major capital projects.	January 2015
				• Establish new programme management arrangements for tracking and reporting on progress of major service changes with clear lines of accountability and escalation.	April 2015
				• Establish programme management office.	December 2014

Paragraph	Recommendation	Intended outcomes/ benefits	Agreed	Health Board responsibility and actions	Completion date
Summary Report Paragraph 19	R4 Have in place robust mechanisms to evaluate the impact of changes made to service structures and monitor outcomes.	To provide timely information to inform any changes that may be required in order to deliver the required outcomes. To confirm that initiatives are producing the desired results.	Yes	**Lead Chief operating officer** **Actions** A new programme management office has been established with external support which will track delivery of service change through the operational management structures. Revised performance and accountability arrangements are in place which will be further strengthened by the changes to the operational management structure and the programme of escalation and reporting including IMTP and annual operating plan. Ensure Board decisions are guided by expectations and evaluation methods specified at the outset.	March 2015
Appendix 2 Appendix 3 Appendix 4	R5 Where appropriate, revisit the recommendations of the ward staffing, outpatients and locum service reviews to complete any outstanding actions.	To ensure that agreed actions are carried through to completion and to set the position on which to build services for the future.	Yes	**Lead** **Executive director nursing and midwifery** **Executive medical director** **Chief operating officer** **Actions** All outstanding actions have now been added to the health board's tracker tool. They will be managed and monitored via the board's existing systems for reporting and escalation.	Completed

Appendix 2

Follow-up of Ward Staffing Benchmarking Review (2010)

Has the Health Board made sufficient progress to implement our recommendations?

From the follow-up of our 2010 review of Ward Staffing we assessed one of our recommendations as complete, three as partially complete, and one as no longer relevant to current circumstances

Evidence of tangible progress against our recommendations is fragmented. Individual Clinical Programme Groups (CPGs) returned self-assessments. These varied in detail and focus, making it difficult to pull together a cohesive corporate picture.

The Health Board provided a wealth of documentary evidence covering the past four years, in addition to files embedded within the self-assessments. Reviewing this evidence has been a significant task: the majority of documents were not linked to specific recommendations and no supporting information was given about their content, impact or relevance to those recommendations.

To address this, we mapped documents to their appropriate follow-up recommendations. We encountered some difficulties. For example;

- Many documents carried no date, limiting their significance and value as credible pieces of evidence. Others were incomplete or in draft form with no indication of their impact or follow-up.
- Some documents carried little direct relevance to the original recommendations, others had to be mapped across several recommendations.
- Across documents, evidence could be conflicting and confusing (eg, details about vacancies, recruitment, shortfalls).
- Most documents were CPG-specific, so several documents had to be reviewed concurrently to draw out a corporate profile. Differences in style, focus, content and completeness made this task extremely difficult.

The following narrative identifies our key findings for each of the previous Wales Audit Office recommendations.

Overall staffing levels within the acute sector were lower than average and there were variations between divisions which were not clearly explained. Are staffing levels still low? Can you now explain variations?

Our assessment: Partially complete

The Health Board's workforce comprises a higher proportion of nurses than its peers across Wales. Historical increases in nursing levels have turned to a reduction over the past 12 months, and the Health Board has promoted recruitment while relying heavily on bank and agency nursing to support safe staffing levels.

CPGs continue to monitor their workforce in isolation from each other. The mechanism for a more strategic review of nursing levels is not clearly evidenced. The 2013 nursing strategy sets out high-level service objectives only and contains no assurance that demand and activity have been modelled to inform the required nurse staffing levels. Individual CPGs compile annual workforce plans which contain a section to identify how workforce and skill mix is to be changed to meet service needs. This section was incomplete in the workforce plans we reviewed.

There is evidence that staffing levels are scrutinised at ward level against standards of planned professional judgement, and that vacancies are monitored. The Health Board offers no wider evidence to show how variations between divisions have been addressed. Each CPG profiles its service in isolation.

The 2013 corporate nursing workforce strategy is an overarching statement of ideals and carries little strategic detail specific to the requirements of the Health Board and its population. The May 2012 update to the 2011-12 Nursing and Midwifery Strategy cites the establishment of a Nursing and Midwifery Workforce Development and Workload Monitoring Group. Part of the group's remit is to assess changes in workload and be 'fit for purpose when deciding on future nursing and midwifery commissioning numbers'.

The pilot and rollout of an acuity and dependency tool may provide information to move service profiling forward. At the time of our review, it was too early to determine the exact mechanism for this.

The Health Board had a higher proportion of qualified staff than many other health bodies with scope to use more Band 2 staff to act as Healthcare Support Workers (HCSW). Has the proportion of HCSWs increased?

Our assessment: No longer relevant

The Health Board demonstrates that both nursing skillmix and nurse:patient ratios are reviewed in response to RCN and CNO safe staffing guidelines. Evidence of a review of HCSW levels is generally referred to in the context of qualified:unqualified nursing ratios.

Since the Wales Audit Office review of Ward Staffing, the Health Board's primary focus has been on RCN and CNO guidance of safe staffing levels (see later in this review).
Our recommendation relating to HCSW levels and utilisation is superseded by this new focus.

Evidence of HCSW analysis provided for this follow-up is limited to one CPG, which records a surplus of approximately 46 Whole Time Equivalent (WTE) HCSWs. This is counter-intuitive to our original findings.

CPGs have access to skillmix data through the workforce intelligence dashboard and they review variation between individual wards. The Health Board cites plans to develop key performance indicators that will improve its understanding of staffing levels (not yet evidenced).

Whilst the cost per whole-time equivalent for Betsi Cadwaladr was higher than average because of its skill mix and stable workforce, the cost per available bed was around average. Does the Health Board know what its costs are now? What impact have the VERS schemes had on skill mix and proportion of staff at top of band?

Our assessment: Partially complete

The Health Board confirms that nursing staff costs are reported but provides no direct evidence of a recent comparison of nursing staff costs or cost-per-bed indicators. VERS forecasts have been compiled for 2014-17, although the impact of VERS to date is not known.

The Health Board recognises its skillmix and relatively high proportion of senior staff. Three-year staff profile scenarios are based on retirement and turnover assumptions. Nurse non-age related turnover is sub-three per cent. With the inclusion of retiring staff, this rises to just under five per cent overall. Data suggests that retirements and non-age related turnover by 2018 would total 14 per cent (Band 5), 16 per cent (Band 6) and 19 per cent (Band 7) from a pool of 3,135 Full Time Equivalent (FTE) nurses. It is unclear how this document has been utilised since publication.

The workforce intelligence dashboard reports information on staff costs (budget, actual, contract, overtime and bank/agency spend). However, commentary on the dashboard examples focuses on staffing levels rather than cost and there are no indicators relating resourcing to acuity/activity levels. Evidence of cost improvement programmes date back to 2010. It is not clear how these were followed up or what actions were taken as a result of resizing proposals.

Although there was a low level of temporary staff usage, there were inconsistencies in the way staff were deployed and managed. Is there now a standard process for temporary staff? How much has usage increased?

Our assessment: Partially complete

The Health Board relies heavily on its bank nurse database. Despite an active nurse bank, dependence on agency staff is increasing and exceeds the national target. A process is in place to review staffing requirements at ward level and take action to maintain safe staffing levels. The Health Board demonstrates active recruitment into the nurse bank, although reported recruitment levels differ across the evidence provided.

It is not clear why agency rates would be so high in view of such an active nurse bank. The workforce intelligence dashboard (Q3 2013-14) shows that the use of agency staff is increasing, and is 1.54 per cent over the national target of 0.8 per cent.

The Health Board has a Bank and Agency group but offers no terms of reference and only limited information about its activities. The stated intention of the group is 'to maintain an optimum number of staff on the bank to respond to the needs of the organisation'. There is a bank/agency Best Practice framework in place which tracks the status of actions through a red-amber-green rating. Target dates for specific actions in this June 2013 document have now passed. The Health Board has told us that these remain ongoing.

There is conflicting information between documents about the number of nurses and HCAs successfully brought into the bank as a result of recruitment drives held between July and September 2013.

The time taken to get staff into substantive posts is an issue for the Health Board and impacts on its use of bank staff. At January 2014, lead-time for recruitment was 149 days.

Since our 2010 report The Chief Nursing Officer has issued ward staffing guidelines (with some additional funds). Has the Health Board now got a clear understanding of any gaps, and a clear plan to achieve these guidelines? Did the Health Board use the benchmark data alongside other available tools that assess patient acuity and workload and quality of care?

Our assessment: Complete

Overall staff requirements against CNO principles and funding have been scrutinised and plans put in place to prioritise and recruit in order to minimise risk to patients. The Health Board is aware of its staffing levels in terms of skillmix and nurse:patient ratio. It has processes for reviewing staffing levels to ensure that they are safe. Although assessed as complete, some elements of our original recommendation remain in progress and will need to be evidenced more thoroughly going forward.

The nursing workforce intelligence dashboard is the strongest evidence of corporate monitoring of staffing levels, although evidence of strategic decisions arising from its use are lacking.

Operationally, each CPG compiles a staffing proforma and vacancies report. These state the percentage of wards where funded and actual establishment levels meet with planned professional judgement and track recruitment into substantive posts. CPGs also highlight their staff-per-bed and skillmix ratios on the staffing proformae.

It is difficult to draw comparison between CPGs from these individual documents. The Health Board states that the nurse:patient ratio overall is 1:1.03 and skillmix is 65:35 but there is considerable variation across wards and between CPGs and locations. The Quality and Safety Committee has plans to seek assurance over safe staffing levels in 2014.

The Health Board now undertakes recruitment from overseas to help ease staffing pressures.

Appendix 3

Follow Up Review of Outpatient Services (2011)

Has the Health Board made sufficient progress to implement our recommendations?

From the follow-up of our 2011 review of Outpatient Services we assessed two of our recommendations as complete and six as partially complete. One further recommendation was insufficiently evidenced for us to reach an informed judgement.

The Health Board's progress against our recommendations is mixed. With some exceptions, progress has been well evidenced within the self-assessment. However, both the self-assessment narrative and supporting evidence lack many of the definitive outcomes that would demonstrate the successful completion of the original recommendations.

The following narrative identifies our key findings for each of the previous Wales Audit Office recommendations.

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by developing a shared vision of what a successful outpatient service looks like.

Our assessment: Complete

The Health Board has made a significant amount of progress against this recommendation through its Outpatient Services Review. It now faces the challenge of implementing change across outpatient services. The structure for managing this is beginning to emerge.

The 2013 Outpatient Services Review (OPSR) draws from academic research and examples of good practice to offer a template for effective outpatient services. Although it is not a definitive model, it makes recommendations to inform the modernisation and redesign of outpatient care. The specific needs of local service users are also reflected. The document has been widely publicised across the Health Board, but it is not clear that other stakeholders and partners are equally sighted.

A key recommendation of the review is to offer a single model of outpatient service management to replace the disparate arrangements inherited on the formation of the Health Board.

A financial modelling tool has been drafted as part of the review. It is expected that this will be refined and applied at specialty level to inform service redesign.

Given the considerable scale of this project and the individual needs of CPGs, the reshaping of outpatient services will be an iterative process requiring close monitoring and control.

The Health Board demonstrates a commitment to embed this work in its plans for the future: a Strategic Outpatient Board formed in October 2013 and the Health Board has recently appointed a lead to follow up on recommendations.

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by spreading the examples of good practice by building the new system around these models

Our assessment: Partially complete

The Health Board has established a number of principles of good practice through its OPSR. However, these reflect generic ideals and they have yet to be applied and demonstrated as working models of good practice across the Health Board's outpatient services.

Supporting evidence specifically cited against this recommendation within the Health Board's self-assessment is limited.

The OPSR confirms a strategic review of the Health Board's outpatient service structure and references examples of good practice that have been implemented elsewhere.

The Health Board employs 'intentional rounding' to log adverse events causing delay and disruption to outpatient clinics and the actions taken to mitigate those events. The Therapies and Clinical Services CPG has loosely costed the impact of cancelled clinics.

One area where the Health Board demonstrates a good structure for sharing examples of best practice is through its network of Link Nurses at both service and specialty level. North Wales also has Lead Sisters for risk management, clinical audit, smoking cessation, Welsh language, safeguarding and cardio-pulmonary resuscitation.

Outcomes with a positive impact have yet to be broadly evidenced. Some initiatives have been brought in to streamline outpatient services (for example: photo triage in dermatology and cardiology consultation by email) but no evidence is offered to demonstrate how these have helped to ease service demand for face-to-face outpatient consultations within these specialties.

The newly formed Outpatient Services Improving Service User Experience Forum sits within the Therapies and Clinical Support CPG and is charged with sharing good practice and identifying opportunities for joint service improvements. Terms of reference for this group are currently in draft form.

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by improving communication and shared learning by establishing an outpatient user group and ensure primary care are represented

Our assessment: Complete

Although the tenor of this recommendation is complete, the Health Board is at a very early stage in being able to demonstrate that primary care and service user representation is embedded within formal user groups, or that these groups are functioning effectively.

The Outpatient Services Clinical and Operational Management Group was formed in December 2012 and carries GP and Practice Manager representation. Progress of the group has not been swift.

More recently, terms of reference have been drafted for an Outpatient Services Improving Service User Experience Forum under the Therapies and Clinical Support CPG (February 2014). Membership includes one public member, but representation from primary care is notably absent.

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by ensuring duplication with primary care is eliminated

Our assessment: Partially complete

There is some indirect evidence of progress towards reducing duplication with primary care through the application of structured care pathways. Empirical evidence to demonstrate positive impact is scarce. Overall backlog remains high.

The Health Board's target of seven per cent demand reduction across outpatient services depends on the successful implementation of entry and exit pathways with Primary Care. The Clinical Musculoskeletal Assessment Triage Services (CMATs) and Wales Eye Care Services (WECS) are cited as evidence where referrals can be triaged and diverted, but their positive impact on referral patterns into the Health Board's outpatient services has not been directly evidenced.

Together for Health – the five-year vision for the NHS in Wales – places the development of community services as a key priority for the delivery of new models of care. This features within the GP Development Domain Network.

Quality and productivity (QP) indicators for GPs (2012-13) carry a strong focus on care pathways, although only two are mandated (paediatrics ENT and atrial fibrillation), with a third pathway to be chosen at locality level. (QP Indicators for 2014-15 not available at the time of review.)

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by eliminating follow-up backlog

Our assessment: Partially complete

The Health Board established a Follow-up Programme Board to take charge of co-ordinating, progressing and monitoring work around follow-up backlog. A reduction trajectory was signed off in June 2014 and is being monitored by specialty on a monthly basis.

The Follow-up Programme Board recently formed to *'develop a reduction trajectory for each specialty aligned to the clerical validation, LES and pathway development work'*. Focus has been on both backlog and *'front of list'* patients. The Health Board provides good evidence that sign-up to clerical validation has progressed across GP surgeries.

The July 2014 update to the reduction trajectory indicates that progress is being made to reduce waiting list pressures through clerical validation, although the Health Board is currently behind on its projections for backlog reduction.

Work remains ongoing within the Wales Eye Care Service (WECS) to allow patients to receive enhanced care services from optometrists.

Outpatient services must be a priority, and urgent steps must be taken to resolve the issues by – Implementing our earlier recommendations on referral, particularly:

- **further develop and implement gateways, pathways and guidelines; and**
- **develop a model for clinical assessment across North Wales, which clinically triages the patient.**

Our assessment: Partially complete

The Health Board demonstrates that it is making progress against this recommendation through the implementation of clinical gateways, pathways and guidelines.

The Health Board cites its Lifestyle programme for arthroplasty patients as one example of the successful implementation of a gateway/pathway programme. The benefit of this service to eligible patients is acknowledged, but outcomes in terms of the number of patients entering the scheme and the impact on subsequent referral rates to Orthopaedics are not evidenced.

The Health Board also provided evidence about some other referral pathways that are now in place. These include the adult hearing loss pathway, which offers hearing assessments without the need for referral to ENT. Other pathways cover conditions such as dyspepsia, stroke, thrombosis/embolism, and chronic obstructive pulmonary disease (COPD). Further pathways are under development.

The Follow Up Programme Board has identified gastroenterology and urology as priority areas of focus for care pathway design. These have been targeted because of patient volume and high levels of clinical risk. No evidence is offered against these initiatives to confirm progress.

Strategic leadership is required to deliver change:

- **all CPGs need to take ownership of how their staff use outpatients;**
- **formal adoption of outpatient strategy at top level; and**
- **clinical ownership of follow-up backlog, and changes in pathways.**

Our assessment: Partially complete

Recent developments confirm that the Health Board is beginning to take a more strategic lead to restructure outpatient service provision and make it more effective.

The structure of Boards, groups and task/finish projects is beginning to emerge at BCUHB, and representation across CPGs is increasing. Key groups include:

- the Outpatient Services Review Project Board;
- the Outpatient Services Clinical and Operational Management Group; and
- the Follow-up Programme Board.

Task and finish projects sit within the control of these groups. Most notable is the work of the Follow-up Programme Board, which is bringing together a series of projects to address backlog and to develop Local Enhanced Services and care pathways.

Recent evidence provided by the Health Board demonstrates Programme Management Office (PMO) involvement in the development of an outpatients improvement strategy. The PMO project has a broad scope, utilising key performance metrics and data analysis to assess the Health Board's current position and monitor progress against improvement initiatives going forward. Project delivery is timetabled and monitored, and work remains ongoing.

Patient pathway/efficiency improvements will require:

- **clear plan for locality clinics and shared care;**
- **clinical triage of referrals to include diagnostic tests; and**
- **one stop, SOS, and therapist/nurse-led clinics must be widely adopted.**

Our assessment: Partially complete

No specific evidence has been offered against this recommendation. However, the development of Local Enhanced Services, care pathways and associated triage has been put forward elsewhere in the Health Board's self-assessment. These need to be developed further to encompass more specialties, and embedded across the organisation.

Improve co-ordination across all CPGs. Ensure outpatient sessions included in consultant job plans, including:

- **activity and outcome measures;**
- **reward adoption of new ways of working; and**
- **ensure medical records/informatics are integrated into modernisation.**

Our assessment: Limited evidence

A common approach across CPGs is difficult to attain for some elements of provision due to clinical requirements unique to the service. A higher level of focus to gather workload profile information and monitor capacity, activity and outcomes is poorly evidenced.

A recommendation of the OPSR has been to develop a specialist/generalist structure to support CPGs with a consistent overarching configuration while allowing specialties to shape their services in response to clinical factors and patient needs.

Administrative features to support this overarching structure are provided as evidence against this recommendation. They include a document repository system, an Electronic Patient Flow System (Patient Kiosk), and appointment reminder system for patients. The status of these initiatives and the impact of their implementation are not reported.

Evidence offered to support capacity planning and work profiling is limited and incomplete, so it is not clear how the Health Board gets an assurance of consistency between CPGs about their resourcing, activity and outcome measures. A more strategic focus and greater consistency in reporting would help provide this assurance. Outpatient service review through the PMO and Follow-up Programme Board is beginning to clarify these issues. An overarching Clinical Services Strategy would bring this focus forward.

Appendix 4

Use of Locum Doctors (2012)

From the follow-up of our 2012 review *Use of Locum Doctors* we assessed three of our recommendations as complete and nine as partially complete. A further two recommendations were insufficiently evidenced for us to reach a judgement

Has the Health Board made sufficient progress to implement our recommendations?

There is evidence of progress against our recommendations. The Medical Director takes an active role in addressing issues of locum use. The Health Board makes good use of Master Vend suppliers, and a robust infrastructure to administer locum payment is now in place.

Discussions are ongoing with the Deanery regarding training placements and the Health Board is working towards accommodating more multi-site flexibility.

The Health Board cites change management programmes among its plans and intends to focus on care pathways as part of service redesign for the future. It is expected that these will improve the management of both capacity and demand and have a positive impact on the Health Board's reliance on locum support.

The following narrative identifies our key findings for each of the previous Wales Audit Office recommendations.

Develop networks across North Wales and the North West to establish a professional pathway for medical workforce placements.
Our assessment: Partially complete
The Health Board told us that progress is ongoing to develop professional pathways for medical workforce placement. At CPG level, reconfiguration plans are underway that are considering the best placement of medical staff to meet the needs of the local population. The Health Board cites some examples of where changes have already been implemented but offers no outcomes. A Programme Management Office is being developed to oversee and monitor the progress of change processes.

Develop approaches with Wales Deanery and Mersey Deanery to develop training pathways across North Wales and the North West.

Our assessment: Partially complete

The Health Board told us that the development of training pathways remains a priority and will be focused to reflect changes to the structure of medical education in England.

Work is ongoing. The Deanery intends to optimise the educational opportunities for placements in Wales. The Health Board plans to conduct recruitment fairs to promote opportunities for doctors in North Wales. Examples are provided where network links with the North West are utilised to provide educational placements for Children and Young People, Mental Health and Learning Disabilities, and Radiology CPGs.

Future progress against this recommendation will need to reflect and accommodate changes to the structure of medical education and ensure that training opportunities within Wales are commensurate with these changes.

Develop a partnership approach with a Master Vend agency to act as a recruitment partner as well as a short-term supplier of staff.

Our assessment: Completed

The Health Board makes good use of agency support to secure locums and promote recruitment.

The Health Board utilises a Master Vend supplier for its locum needs. Medacs and other agencies provide interim staffing solutions from a pool of locums.

The Health Board told us that agencies also support recruitment into substantive posts as they become available in an effort to reduce the organisation's reliance on locum cover in the long term. This is not directly evidenced.

Create a workforce design model to ensure that medical staff are not restricted to single site working to ensure that the Health Board has appropriate flexibility in meeting staffing needs.

Our assessment: Partially complete

The Health Board demonstrates some progress, although significant and sustainable changes to workforce design have yet to be evidenced. The Health Board has plans for change programmes that will influence the way locums are utilised.

A draft Sustainable Services Strategy is due before the Board in July 2014. It is intended that this will set the framework within which future services can be structured.

The Health Board plans to implement change programmes encompassing service redesign and care pathway development alongside a more radical transformation of whole systems.

The process is likely to take some time: until changes are embedded and the impact on individual CPGs has been assessed, it is unlikely that the Health Board will be able to progress with a cohesive Medical Workforce strategy. Some steps have been taken – through contract changes and the widening of visa access – to move towards a structure that favours multi-site working.

Develop an approach to management of locum demand, which does not focus on short-term gain at the expense of long-term efficiency.

Our assessment: Partially complete

The Health Board told us that locum usage and spend are reviewed monthly. Work is underway to provide formal structure to the approach through a *Policy of principles*.

The Health Board's *Policy of principles* is under development and not evidenced in draft form. The Health Board needs to ensure that the document is ratified and adopted, ensuring that it is commensurate with the requirements of any proposed change management programmes.

Expand existing approaches to reduce demand for medical staff such as expansion of advanced nurse and therapies practitioners.

Our assessment: Limited evidence

The Health Board provides no evidence to show how it is reducing its demand for medical staff through the expansion of nurse-led and therapist services.

Whole-service redesign needs to reflect the contribution of all staff groups and the potential to provide enhanced nurse-led or therapist-led services as an alternative to direct care from doctors. The Health Board's self-assessment against this recommendation makes no reference to the inclusion/involvement of non-medical staff as a means of easing workload pressures on them (and any resulting reliance on locum support).

Profiling of workload, resourcing (all clinical staff groups) and demand needs to be evidenced to inform the opportunities for redesign. An overarching Clinical Services Strategy would cement this approach.

Reduce requirement for agency staff that fills gaps owing to pace of recruitment and trainee placements:

- **commence the recruitment as soon as vacancy becomes known;**
- **remove avoidable gaps between different stages of recruitment, undertake tasks concurrently; and**
- **increase speed and efficacy of medical trainee placement.**

Our assessment: Partially complete

The Health Board has reacted to ensure that gaps in junior doctor training placements can be covered. A clinical services strategy needs to be developed to fully assess wider resourcing and recruitment needs.

The Health Board has reacted positively to the reduction in junior doctor placements from the Deanery and has a contingency plan in place to cover training gaps. Longer-term strategic plans to assess medical resourcing requirements and address recruitment gaps are not set out.

Capacity Activity Management (CAM) software is currently being piloted as a rostering solution for the Health Board. Significant outcomes have yet to be demonstrated.

Deanery constraints on trainee ratios place pressure on the Health Board, particularly during the annual changeover. The Health Board actively manages this process with the Deanery to ensure compliance. No evidence has been offered to show improvements to the recruitment timeline for substantive posts.

Develop and implement corporate policy and procedures on:

- **appointment and use of locums;**
- **vetting requirements;**
- **induction;**
- **performance management;**
- **use of agency locums, beyond 12 weeks (where agency worker regulations apply); and**

Our assessment: Limited evidence

The Health Board will need to revisit its supporting policies and procedures relating to the use of locums. This will ensure that they are consistent with change management plans and service reconfigurations.

There is no direct evidence to show that policies/procedures around locum recruitment and use are in place. The Health Board told us that principles would be brought in to support this within the partnership work programme.

Progress against this recommendation should follow from initiatives of organisational change that will affect the recruitment, placement and use of locum support. The Health Board needs to ensure that policy applied to locums in the future is commensurate with any new ways of working that may be introduced.

Improve cost and quality through rota management by:

- **risk assessing rota ratios to ensure that they provide service resilience and, where relevant, can support medical training requirements;**
- **implementing rota management software across the Health Board.**

Our assessment: Partially complete

The Health Board told us that it is identifying the lines of responsibility within CPGs for the management of medical staff.

The Health Board provides no evidence to demonstrate how rota management is implemented, or how rotas are risk assessed to ensure that they offer service resilience. However, the lines of responsibility for medical staffing within CPGs have been clarified, and accountability for reviewing, reporting and securing safe staffing ratios is now subject to a higher degree of scrutiny.

The Health Board faces pressure to maintain the Deanery training ratio. Enhanced rota planning may result from the implementation of Capacity Activity Management (CAM) software, which is currently being piloted.

Implement the Medical Agency Staffing Data and Accrual (MASDA) system across all sites and train CPGs to ensure that agency locums are processed efficiently and financial controls are in place.

Our assessment: Complete

Medical agency spend is now authorised through the MASDA system, offering tighter financial controls over payment processes. Although not fully implemented, the infrastructure for MASDA and the Health Board's commitment to 'No MASDA, No Pay' warrants a judgement of 'Complete' against this recommendation.

The MASDA system offers electronic support for the process of locum assignment.
The Health Board's roll-out of the MASDA system has targeted CPGs with high reliance upon locum support in the first instance: the initial wave of roll-out covers the CPGs that accounted for 75 per cent of locum spend last year.

There have been some delays in the adoption of the system and seven CPGs have yet to confirm go-live dates. However, requests passing through the MASDA system are increasing and the system is being utilised 'end-to-end' from request through to invoice payment.
The Health Board's principle of 'No MASDA, No pay' confirms a commitment to the system.

Develop corporate-wide information to a sufficient level so that the long-term drivers of locum doctor demand are appropriately responded to.

Our assessment: Partially complete

The Health Board uses a corporate workforce intelligence dashboard to monitor its workforce information on a quarterly basis. The Health Board told us that work is progressing to make data available in real time. The Finance department tracks locum spend and trends within its own reporting framework.

The workforce intelligence dashboard provides a detailed retrospective profile of staffing levels. The facility allows the Health Board to anticipate and plan for seasonal trends based on historical information.

There are limitations with the dashboard in the form it was received as evidence against this recommendation. It does not report locum costs and relates primarily to nursing staff numbers and cost (including agency cost). In addition, activity statistics are not superimposed against staffing levels and therefore focus on supply rather than demand.

These issues need to be addressed if the Health Board is to fully understand the dynamics of supply and demand across its services. This will become more imperative as and when change management initiatives are introduced. The planning process for the development of a Clinical Services Strategy (see Recommendation 1 of this report) will provide the focus to draw service demand against resourcing requirements.

Ensure a single line of accountability is in place for the oversight of locum doctor demand and use.

Our assessment: Complete

The Health Board told us that Finance and the Performance Group (Chief Operating Officer, Director of Finance and ACOS ops) contribute to the monitoring process. Locum use is discussed at CPG level as a function of financial performance and budgetary control.

Although assessed as 'Complete', work is ongoing to clarify lines of accountability further:

- the Medical Director is leading on change management initiatives which will inform demand for locum support;
- the Health Board is proposing to re-establish the Medical Workforce Strategy group; and
- a policy of principles (not viewed) has been drafted to clarify the management arrangements for locum support.

The importance of financial monitoring should not be underplayed, but other factors need to be drawn into decision-making processes in the use and placement of locums. Decisions should be primarily based on clinical decision rather than constrained by budgetary control. Accountable medical leads will need to maintain tight fiscal control, but there is an opportunity for them to review their budgets in light of changes (and efficiency improvements) arising from changes to clinical service structure.

Develop information so that the finances relating to locum doctor use are corporately understood, and that decisions can be based on cost/benefit analyses.

Our assessment: Partially complete

The Health Board told us that the medical workforce intelligence dashboard, financial reporting, and plans for a real-time performance monitoring facility provide evidence to support this recommendation.

The Health Board tracks locum spend and the medical workforce intelligence dashboard provides retrospective profiles of staffing. Although many of the elements for monitoring are in place, more work needs to be done to bring these together as a suite of meaningful indicators to clearly track locum cost against delivery/benefits. In the form it was received:

- the evidence does not isolate locum costs or headcount from those of other staff groups;
- there are no outcome-related performance indicators within either the dashboard or the agency costs briefing; and
- there is no indication of how the information has been taken forward to support decision-making.

Develop arrangements to monitor the effectiveness and safety of the use of locum doctors which includes incident reporting.

Our assessment: Partially complete

The Health Board told us that locum assessments are routinely performed at the end of each placement. The draft principles policy will emphasise the importance of submitting completed assessments.

A proforma for locum assessment is in place, but no evidence is provided to show the completion rates for locum assessments. The Health Board's response does not show how incident reporting is drawn into the review of locum effectiveness and safety.

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