

Archwilydd Cyffredinol Cymru  
Auditor General for Wales

# Continuing NHS Healthcare – Follow-up Report



WALES AUDIT OFFICE  
SWYDDFA ARCHWILIO CYMRU





I have prepared and published this report in accordance  
with the Government of Wales Acts 1998 and 2006.

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# Summary

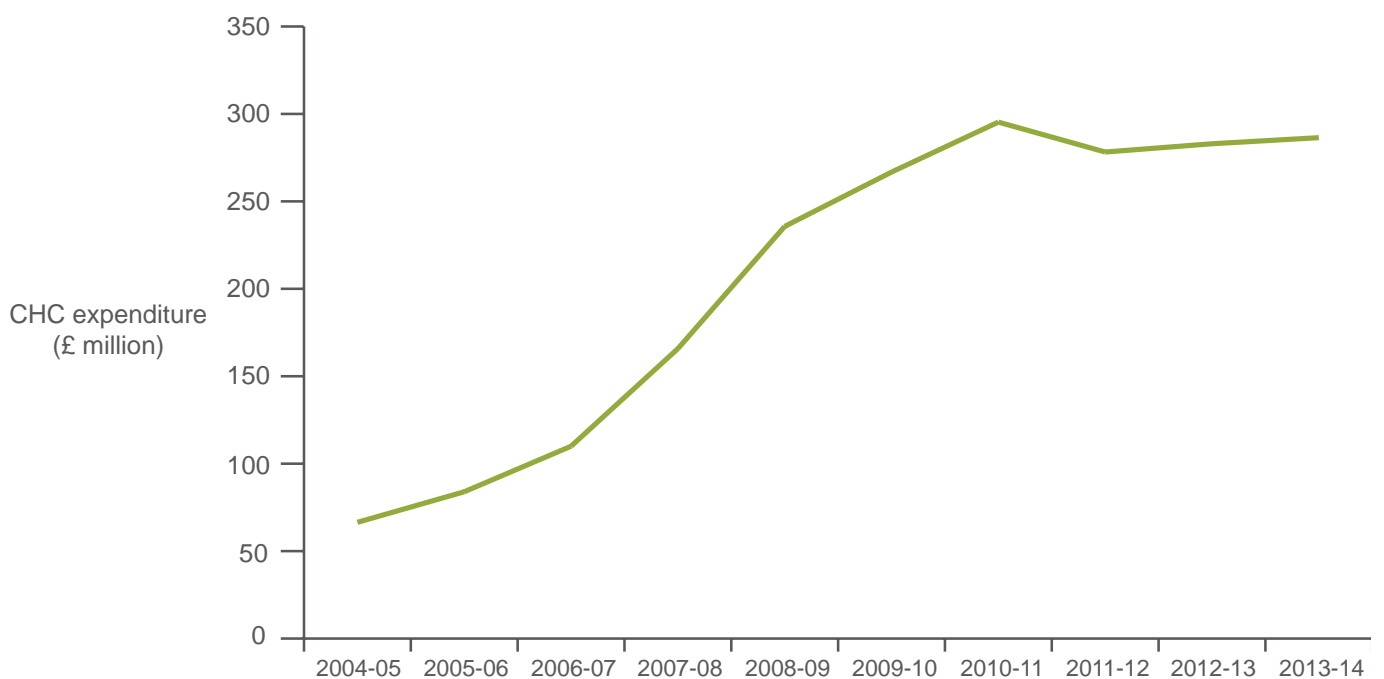
- 1 Some people need care and support over an extended period, as the result of disability, accident or illness. Health services are free to all at the point of delivery, but depending upon a person's needs or financial circumstances, they may be charged for services provided or funded by local authorities.
- 2 When assessed as having a primary health need, people are eligible for Continuing NHS Healthcare (CHC), which is a package of care and support that is provided to meet all of the assessed needs of an individual, including physical, mental health and personal care needs. CHC is often long term, although it can be episodic in nature with some people moving in and out of eligibility. Health boards reported to us that 5,778 people across Wales were in receipt of CHC as at 31 March 2014.
- 3 When someone is eligible for CHC, the NHS has responsibility for funding the full package of health and social care. Where the individual is living at home, the NHS will pay for healthcare and social care, but this does not include the costs of food, accommodation or general household support. Where a person is eligible for CHC and is in a care home, the NHS pays the care home fees, including board and accommodation.
- 4 If an individual is not eligible for CHC, they can still access a range of health and social care services. This can include the NHS paying for the nursing element of care provided to someone in a care home, known as NHS-funded nursing care. Health boards reported to us that 5,229 people across Wales were in receipt of NHS-funded nursing care as at 31 March 2014. However, for any care provided by social services, such as personal care and accommodation in a care home, a charge may be made depending on the person's income, savings and capital assets. Therefore, for some people a decision that they are ineligible for CHC can have a significant financial impact, with care costs being paid from their savings or potentially from the proceeds from the sale of their home.
- 5 In June 2013, the Auditor General published a report on CHC<sup>1</sup>. The report concluded that the CHC Framework in place at that time had delivered some improvements, but that more needed to be done to ensure that people are dealt with consistently and fairly. The Public Accounts Committee issued its own report on this topic in December 2013<sup>2</sup>. The Committee's report concluded that equitable and timely access to CHC had not always been available, and this had led to some patients and their families feeling disenfranchised and let down by the system.

<sup>1</sup> *Implementation of the National Framework for Continuing NHS Healthcare*, Auditor General for Wales, 13 June 2013

<sup>2</sup> *Implementation of the National Framework for Continuing NHS Healthcare*, National Assembly for Wales, Public Accounts Committee, December 2013

- 6 The Welsh Government consulted on a revised CHC Framework between December 2013 and March 2014. The Welsh Government then issued a final version of the Framework in June 2014, for implementation from 1 October 2014.
- 7 The Auditor General's June 2013 report showed that, having risen every year between 2004-05 and 2010-11, CHC expenditure unexpectedly fell back in 2011-12 by 5.8 per cent<sup>3</sup>. Since 2011-12, expenditure has increased slightly but, in 2013-14, remained three per cent below the level reported in 2011-12 (Figure 1).

Figure 1 – CHC expenditure in Wales 2004-05 to 2013-14

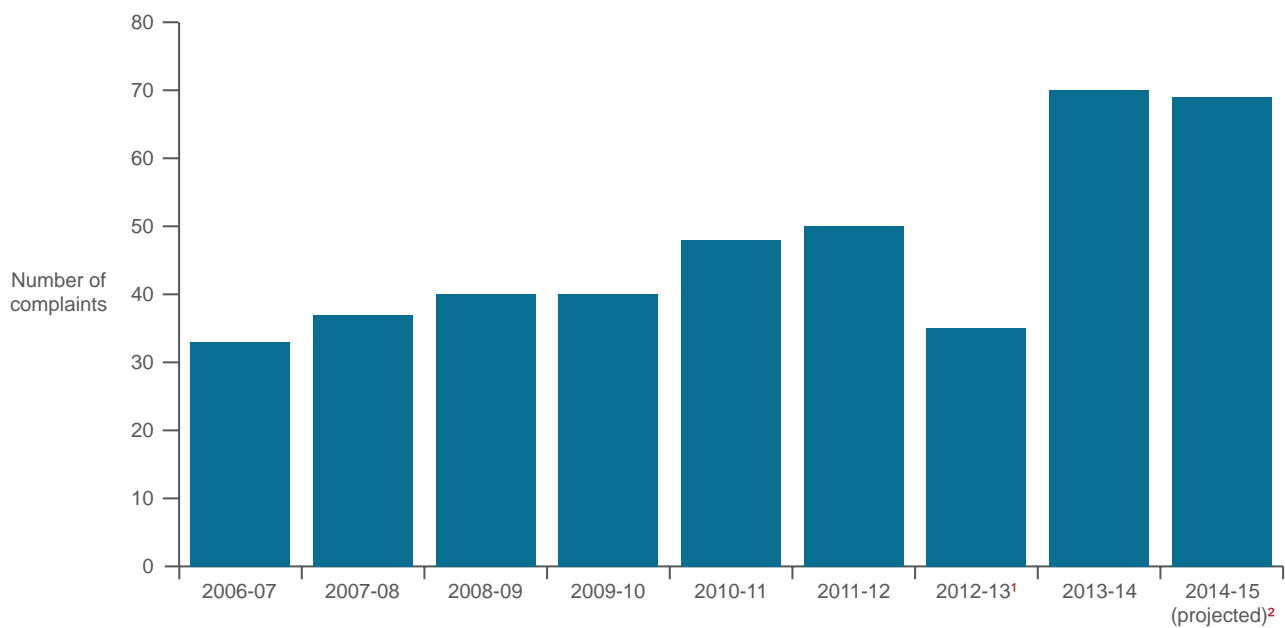


Source: Wales Audit Office analysis of health boards' annual accounts

<sup>3</sup> All CHC expenditure figures in this report exclude any in-year adjustments to the provisions made in annual accounts for the potential liabilities arising from retrospective claims.

8 Having fallen back sharply in 2012-13, the number of CHC-related complaints received by the Public Service Ombudsman for Wales increased to a peak of 70 in 2013-14, with a similar number projected for 2014-15 (Figure 2). The Public Service Ombudsman has confirmed that more recent complaints have tended to focus on the quality of the assessment and decision-making processes rather than on the administration of a claim once eligibility is established.

Figure 2 – CHC complaints received by the Public Service Ombudsman for Wales, 2006-07 to 2014-15



Notes:

- 1 The number of complaints received in 2012-13 at 35 turned out to be lower than the projected 51 complaints as included in the Auditor General's June 2013 report.
- 2 2014-15 projection as at September 2014.

Source: Public Service Ombudsman for Wales



- 9 Prepared by Wales Audit Office staff on behalf of the Auditor General, this follow-up report examines:
- a how the Welsh Government in revising the CHC Framework has responded to the issues raised by the Auditor General and the Public Accounts Committee;
  - b the progress made by the Powys Project<sup>4</sup> in clearing the backlog of retrospective CHC claims<sup>5</sup> received up to 15 August 2010 and the progress made by the Powys Project and health boards in clearing the claims received from 16 August 2010; and
  - c the steps taken to strengthen communication and engagement with individuals and their families about CHC<sup>6</sup>.
- 10 **Overall, we found that there has been a positive response from the Welsh Government to many of the issues raised and recommendations made previously by the Auditor General and the Public Accounts Committee. However, despite some progress, we still have significant concerns over the approach to clearing retrospective claims. In our view, the Welsh Government now needs to take a stronger and more directive role with health boards to improve and speed up the processing of retrospective claims.**
- 11 **The revised CHC Framework addresses many of the weaknesses in the previous version and leadership and oversight are being strengthened.** The revised CHC Framework addresses many of the issues previously raised by the Auditor General and the Public Accounts Committee, and the Welsh Government has improved the guidance within the Framework and the supporting documentation.
- 12 The Welsh Government is strengthening its leadership and oversight through a new Performance Framework for CHC, which includes an annual peer review in each health board (referred to as an annual audit sample) that has the potential to help ensure consistent decision making on CHC eligibility. CHC and the complex care agenda are major challenges for health boards. The Welsh Government and health boards have developed training in the revised Framework. Although substantial numbers of staff have received the training, there is considerable variation in attendance numbers across health boards.

4 Originally, the Welsh Government set up the national Powys Project, hosted by Powys Teaching Health Board, to deal with all retrospective claims received across Wales up to 15 August 2010. It is also now responsible for a share of the claims held by health boards received from 16 August 2010.

5 An individual or their representative may request a retrospective review where they contributed to the cost of their care, but have reason to believe that they may have met the eligibility criteria for CHC, which were applicable at that time.

6 Appendix 3 summarises the audit methods we have used to support our findings and conclusions, including a short survey of all health boards in Wales. We have not undertaken detailed fieldwork in health boards.

- 13 There are more retrospective claims outstanding than ever before, and the response from some health boards has been unsatisfactory. The revised Framework outlines a common process for dealing with retrospective claims, and the Welsh Government has now set deadlines for reviewing all retrospective claims (Appendix 1). However, the deadlines only relate to the internal review of a claim and do not provide an incentive for health boards to complete all parts of the claims process promptly. We and the Public Services Ombudsman are of the opinion that the current approach is flawed as it does not adequately focus upon or monitor what matters most to individuals – the completion and resolution of their claim.
- 14 A national task and finish group has been established by the Welsh Government and health boards to oversee retrospective reviews. Although the task and finish group has delivered on a number of fronts, it has not delivered on its core remit – ensuring claims are processed efficiently within the deadlines set – and attendance and membership has been problematic. The performance monitoring developed by the task and finish group is inadequate and does not identify explicitly whether claims are being reviewed within the deadlines set. Some health boards have also struggled to provide accurate and timely performance data.
- 15 The NHS received 2,525 claims up to 15 August 2010, which were the responsibility of the Powys Project. Since 16 August 2010, the NHS has received a further 4,092 claims, a significant proportion of which were in response to a July 2014 cut-off date announced by the Welsh Government<sup>7</sup>. The majority of the claims received since 16 August 2010 are now the responsibility of the Powys Project, but health boards have retained a significant number of claims. The division of responsibility between health boards and the Powys Project creates added complexity, and this makes it more difficult to ensure consistency.
- 16 The Powys Project reviewed as intended all claims received up to 15 August 2010 by the agreed deadline; this was a significant achievement. Although all claims were not completed by this date, problems establishing independent panels appear now to have been resolved. The Powys Project, although it has demonstrated its ability to deliver, faces an even greater challenge in processing its share of the claims received after 16 August 2010 and has been constrained by IT problems and delays in the transfer of information from some health boards. The Powys Project has been unable to fill vacancies and recruit additional staff whilst it has been developing a business case for its long-term funding and seeking its approval from health boards. The Powys Project issued the business case to health boards in December 2014.

<sup>7</sup> The Welsh Government announced on 30 April 2014, that any claims with a claim period relating to 1 April 2003 and 31 July 2013 needed to be submitted by 31 July 2014. This led to the submission of 2,486 claims.

- 17 We acknowledge that delays in processing can occur due to a slow response from individuals or their representatives to requests for information. Nevertheless, some health boards have not demonstrated that they are able to deal in a timely way with the claims they are responsible for. The performance of two health boards is of particular concern. The other health boards have made variable progress with some making significant inroads into the backlog of claims. As at the end of October 2014, four health boards were projecting to take around two years or more to review all outstanding claims. We have not reviewed progress since the end of October 2014, but we understand that whilst claims continue to be reviewed and completed, there has been no step change in the rate of progress. Health boards have already missed the two-year deadline for a significant number of claims, and unless there is a change of approach, many more claims will breach the two-year deadline.
- 18 Some claimants are being dealt with unreasonably as a result of some health boards not always requesting proof of payment promptly on receiving a claim. Subsequently, and through no fault of the claimant, there is a risk that some health boards may not give priority to some longstanding claims over other claims that are far more recent. Some claimants are being disadvantaged due to unfair demands from health boards over the extent of the proof of payment evidence that they are expected to provide many years after submitting their claim.
- 19 **Public information on CHC has been expanded but needs to be more accessible, there were weaknesses in the publicity of the July 2014 cut-off for some retrospective claims, and access to advocacy services remains a concern for some health boards.** The Welsh Government has developed a range of information leaflets, but could do more to publicise them and make them more accessible. In particular, there is no general information that is widely available, for example in care homes, to raise public awareness of CHC. Although the Welsh Government issued various communications itself, the action taken by health boards to publicise the end of July 2014 cut-off for some retrospective claims appears to have been inconsistent. In addition, some health boards remain concerned about the availability and funding of advocacy services for CHC.

# Recommendations

## Implementation of the revised Framework

- 1 The Performance Framework is key to ensuring the effective implementation of the revised Framework. **We recommend that the Welsh Government:**
  - a monitors closely the quality of health boards' self-assessments, and quarterly and annual reports, requiring health boards to address any deficiencies;
  - b ensures the recent annual audit sample is reported at an individual health board level, requiring health boards to confirm the steps they are taking to address any issues or inconsistencies in their decision making on eligibility;
  - c prioritises the development of the planned customer feedback mechanism; and
  - d ensures that, following the end of the secondment to the role of the national policy and practice lead for CHC, it has appropriate internal capacity to deliver the Performance Framework.

## Retrospective claims processing

- 2 The performance of health boards has been too variable. The national task and finish group for retrospective claims, which is health board led and works on a collaborative basis, has struggled to agree a robust plan and monitoring arrangements. We believe that it is now appropriate for the Welsh Government to take a more directive approach with health boards. We have identified issues with the way targets are set for the processing of retrospective claims, and with the adequacy of performance monitoring. **We recommend that the Welsh Government** within a month of the publication of this report:
  - a Requires all health boards to adopt a common claims register based on the Powys Project version, or as a minimum, confirms the core information that health boards should hold on local registers.
  - b Outlines to health boards the key performance monitoring information they need to provide each month; this should include the number of claims that have, and are at risk of, breaching the processing deadlines and should cover all key steps in the claim process.
  - c Considers setting target times for completing, as well as reviewing, claims.
- 3 To meet the processing deadlines set by the Welsh Government, there needs to be an immediate step change in some health boards. **We recommend that the Welsh Government:**
  - a assures itself that individual health boards are allocating sufficient staff resources to enable processing deadlines to be met, and if this assurance is lacking, take additional steps, such as requiring the Powys Project to take over backlog claims from a health board; and
  - b satisfies itself that the long-term funding provided by health boards for the Powys Project is adequate, including for any additional claims taken over from health boards.

- 4 Health boards are dealing unreasonably with some people who submitted a claim a number of years ago over proof they have paid care home fees. **We recommend that the Welsh Government:**
- a issues guidance covering longstanding claims in which health boards have only recently asked for proof of payment to ensure health boards give appropriate priority to reviewing this type of claim; and
  - b extends the guidance issued in December 2013 to similar claims received after 16 August 2010 to ensure claimants are not disadvantaged by their inability to provide further proof of payment, which they were not made aware of at the outset of their claim.

#### Informing individuals, their families and the public

- 5 To build upon the steps already taken to improve the communication and engagement with individuals, **we recommend that the Welsh Government:**
- a requires health boards to make general information on CHC more widely available, for example through care homes; and
  - b considers whether more needs to be done to publicise the rolling cut-off and the 1 October cut-off date for claims covering the period 1 August 2013 to 30 September 2014.

## Part 1

The revised CHC National Framework addresses many of the weaknesses in the previous version, and leadership and oversight are being strengthened



## The revised Framework addresses many of the issues raised and recommendations made previously by the Auditor General and the Public Accounts Committee

The guidance within the Framework and the supporting documentation have been improved

- 1.1 The Auditor General's June 2013 report identified 13 areas in which the Welsh Government could improve the detailed guidance in the former Framework. These have in the main been addressed, either fully or partially. For example, the revised Framework now includes:
  - a expanded guidance on how CHC should be applied to people with a learning disability or with mental health needs;
  - b more detail on joint funding arrangements between health and social care and on top-ups<sup>8</sup> and direct payments<sup>9</sup>; and
  - c less onerous and more realistic requirements for the frequency of CHC reviews<sup>10</sup>, that are in line with the requirements in England.
- 1.2 The revised Framework also outlines a common process for dealing with retrospective claims and sets deadlines for how long it should take to process a claim (this is covered in more detail in **Part 2** of this report). However, the revised Framework does not specify the maximum target time within which health boards should resolve disputes when an individual challenges a decision on CHC eligibility. The revised Framework continues to state that health boards should 'deal promptly' with a dispute and that health boards should agree and publicise timescales for dealing with disputes.
- 1.3 The Auditor General's report highlighted the scope for the development of more national protocols and documentation, and for greater sharing of local policies and documentation between health boards. The Welsh Government has taken steps to address these issues, and created a new website, the complex care information and support site ([www.cciss.org.uk](http://www.cciss.org.uk)), which supports the revised Framework and contains a range of materials, including examples of a range of documents and policies.
- 1.4 The Welsh Government intends over time to share further examples of documentation and protocols on the website, which will continue to evolve and support the implementation of the revised Framework. The Welsh Government's focus is on sharing protocols and documentation between health boards. The Welsh Government has not developed national documentation for all health boards to use.

<sup>8</sup> Top ups are additional personal contributions to CHC packages such as for additional services or for higher-cost 'premium' accommodation.

<sup>9</sup> Direct payments are made by social services to individuals so that they can buy care services for themselves.

<sup>10</sup> There should be periodic review of CHC cases to determine whether an individual's needs have changed. A change in needs should trigger an appropriate change in the package of care and an assessment of whether the person continues to be eligible for CHC funding.

## The revised Framework promotes the use of a screening tool in specific circumstances but leaves its use to the discretion of health boards

- 1.5 The Auditor General's June 2013 report identified a number of potential benefits from adopting a screening tool to determine whether someone requires a CHC assessment. In its consultation document for the revised Framework, the Welsh Government proposed a mandatory screening tool. However, having considered the consultation responses, the Welsh Government decided not to make the tool mandatory. The rationale for this was that a screening tool:
- a 'risks premature assumptions being made regarding the outcome of reablement and assessment'<sup>11</sup> – there were concerns that practitioners would use the screening tool and trigger a full CHC assessment before rehabilitation or reablement had maximised the individual's level of independence; and
  - b might be used to screen out individuals who were potentially eligible, before a comprehensive assessment had been undertaken – all individuals with complex needs who are likely to require longer-term care and support are entitled to a comprehensive assessment.
- 1.6 The revised Framework does acknowledge that there may be specific circumstances where a screening tool would be useful. Should a health board choose to use a screening tool, the Framework states that this must be the version used in England, and that it should be completed by at least two people, one of whom should be from the relevant local authority. We understand that some health boards have previously requested greater direction from the Welsh Government on the use of the screening tool. However, the Framework does set out the two instances where the Welsh Government believes it may be appropriate to use the screening tool, which are:
- a care home residents whose condition has changed and an earlier-than-planned review is needed; or
  - b to provide a structured rationale where the multidisciplinary team believes a complex care package is clearly not required.

## The revised Framework adopts the decision support tool used in England and, although the Welsh Government has undertaken an initial assessment, the full impact of the new tool will take time to establish

- 1.7 The Auditor General's June 2013 report concluded that because of differences between the decision support tool used in Wales and England, it might be more difficult for some people in Wales, most notably those with dementia, to meet CHC eligibility criteria; whilst for people with some other health conditions, it may be easier. The Welsh Government has adopted the decision support tool used in England as part of the revised Framework, which should help ensure greater consistency.

<sup>11</sup> Consultation – summary of responses, *Continuing NHS Healthcare: The National Framework for implementation in Wales*, Welsh Government, 30 June 2014



- 1.8 The Public Accounts Committee was concerned about the impact of amending the decision support tool upon those people assessed under the previous version, as individuals might have been disadvantaged and therefore potentially able to make a retrospective claim. The Welsh Government arranged for a sample of health boards to assess the potential impact of the new decision support tool on eligibility decisions made under the former version of the tool. The report on this exercise confirms that:
- a two health boards assessed 10 cases each (a third health board withdrew due to a lack of capacity to undertake the assessments);
  - b the results indicated that whilst the new decision support tool may increase some scores, the overall outcomes were not affected; and
  - c because the sample size of the evaluation was smaller than anticipated, the report concluded that there is a need for ongoing monitoring by health boards of the impact of the new tool.
- 1.9 In response to our survey, five health boards raised the potential impact of the new decision support tool as one of their concerns with implementing the revised Framework. Their concerns related to the potential for increased numbers of individuals being assessed as eligible for CHC and the associated cost pressures; and for the potential for increased workload through requests for reviews of cases previously considered ineligible.
- 1.10 The revised Framework also seeks to reduce the demands on practitioners by them avoid duplicating and transcribing information on various records. The Framework makes clear that practitioners must consider every domain in the decision support tool, but that if the assessment and care plan documentation are sufficiently robust there is no requirement to duplicate paperwork by copying information into a decision support tool document. In these circumstances, it will be acceptable to only complete the decision support tool summary sheet; the summary record of the multidisciplinary team decision on eligibility and the rationale; and the equality monitoring form. This takes away duplication from front-line staff, but makes the scrutiny process more time-consuming for CHC managers. Some health boards told us that they would welcome greater direction from the Welsh Government on when it is appropriate not to fully complete the decision support tool. However, the Welsh Government informed us that the annual audit sample did not indicate any problems with accuracy or completeness of the recorded evidence on eligibility and the decision-making process.

## Some important steps are being taken to strengthen leadership and oversight, and although substantial numbers of staff have received training in the revised Framework, there is considerable variation between health boards

The Welsh Government is strengthening its leadership and oversight through a new Performance Framework for CHC which includes annual peer review of CHC eligibility decisions

- 1.11 The previous reports by the Auditor General and the Public Accounts Committee identified the need to strengthen leadership and governance around CHC, both at an all-Wales level and within health boards. The Welsh Government has subsequently agreed revised governance arrangements as part of the revised Framework, with:
  - a health boards having a named executive director responsible for monitoring CHC performance and maintaining strategic oversight; and
  - b each local authority having a named link with 'equivalent organisational status' to liaise with the health board named director and to report to the relevant local authority scrutiny committee.
- 1.12 All health boards confirmed to us that they have agreed an executive lead for CHC. However, Betsi Cadwaladr University Health Board confirmed that it had agreed two executive leads – the Director of Nursing, Midwifery and Patient Services, and the Director of Primary, Community and Mental Health Services. We have not examined lead arrangements within local authorities as part of this follow-up work.
- 1.13 The Welsh Government is establishing a complex care stakeholder reference group to provide policy officials and health boards with access to expertise in CHC and in other areas of long-term care. Representation is likely to include local government, service provider organisations, specialist advisory groups for learning disability, mental health and children's services, and policy leads from relevant parts of the Welsh Government. The group is likely to hold its first meeting in January 2015.
- 1.14 In addition, the Welsh Government has agreed a new Performance Framework with health boards which comprises of four key mechanisms: self-assessment; strengthened performance reporting; annual peer review and sample audit; and service user feedback (Figure 3). The purpose of the Performance Framework is to monitor the implementation of the revised Framework; provide assurance that CHC eligibility decisions are consistent and fair across Wales; and provide opportunities for shared learning and service improvement.

Figure 3 – New Performance Framework for CHC

Mechanism	Details
Organisational self-assessment	Each health board is to undertake an annual self-assessment, using the tool we issued alongside the Auditor General's June 2013 report.
Strengthened reporting arrangements	<p>The named health board director is to present (as a minimum) a quarterly performance report with a prescribed coverage to their board, and copied to the Welsh Government. An annual report is to be prepared by the named health board director (again with a prescribed coverage), and a national publically available report is to be collated by the Welsh Government.</p> <p>Quarterly reporting is due to commence in 2015-16, with annual reports commencing in June 2015 (initially covering the six months from December 2015). Some of the required data is not currently collected, but the Welsh Government expects health boards to address these gaps.</p>
Annual peer review and sample audit	Annual peer review of CHC decision making in all health boards to determine whether there is consistency across Wales. The audit involves reviewing a sample of recent CHC and funded nursing care cases, together with a sample of retrospective claims. The audit assesses whether the health board has followed the correct process and interpreted eligibility criteria appropriately and consistently.
Service-user feedback	<p>To support improved user experiences, the Performance Framework commits to developing feedback arrangements.</p> <p>The Welsh Government is considering the options available for gathering service user feedback, and in particular is looking at developing a questionnaire that health boards would hand out to all people who have a CHC assessment. Individuals would return the questionnaire to an independent body for analysis and reporting.</p>

Source: Welsh Government, *Performance Framework for the Implementation of Continuing NHS Healthcare in Wales, 2014*

- 1.15 Health boards submitted their first self-assessment and action plan to the Welsh Government in February 2014. Feedback from the Welsh Government and health boards on the self-assessment tool has been positive, with them finding it to be clear, concise and not time-consuming whilst successfully identifying key national and local areas for service improvement.
- 1.16 We have not sought to review fully the February 2014 self-assessments, but some aspects appear to be overly positive. For example, five health boards concluded that all relevant health and social services staff had attended initial CHC training. However, we have found that the problems highlighted in the Auditor General's June 2013 report with ensuring all staff are trained are still evident ([paragraph 1.26 to 1.27](#)).

1.17 The Welsh Government co-ordinated the first annual sample audit in October 2014, which involved the Welsh Government national policy and practice lead for CHC, the national director for complex care<sup>12</sup>, and the director of the Powys Project, all of whom have a clinical background. The roll out of the annual audit sample was a significant step forward. At the time of preparing this follow-up report, the Welsh Government was writing up and discussing with individual health boards the results from the annual sample audit. As a result, we are not in a position to confirm the specific outcomes. However, the Welsh Government confirmed to us that the exercise had been very worthwhile and that it had identified:

- a a range of good practice that would be shared across health boards;
- b the need for greater clarity over when people with a learning disability should be eligible for CHC or for joint funding between the health boards and the local authority;
- c generally consistent and appropriate decision making on eligibility, with substantive issues in only one health board; and
- d generally consistent implementation of the national process for retrospective claims, with substantive issues in only one health board (a different health board from the one where the audit identified issues with eligibility decision making).

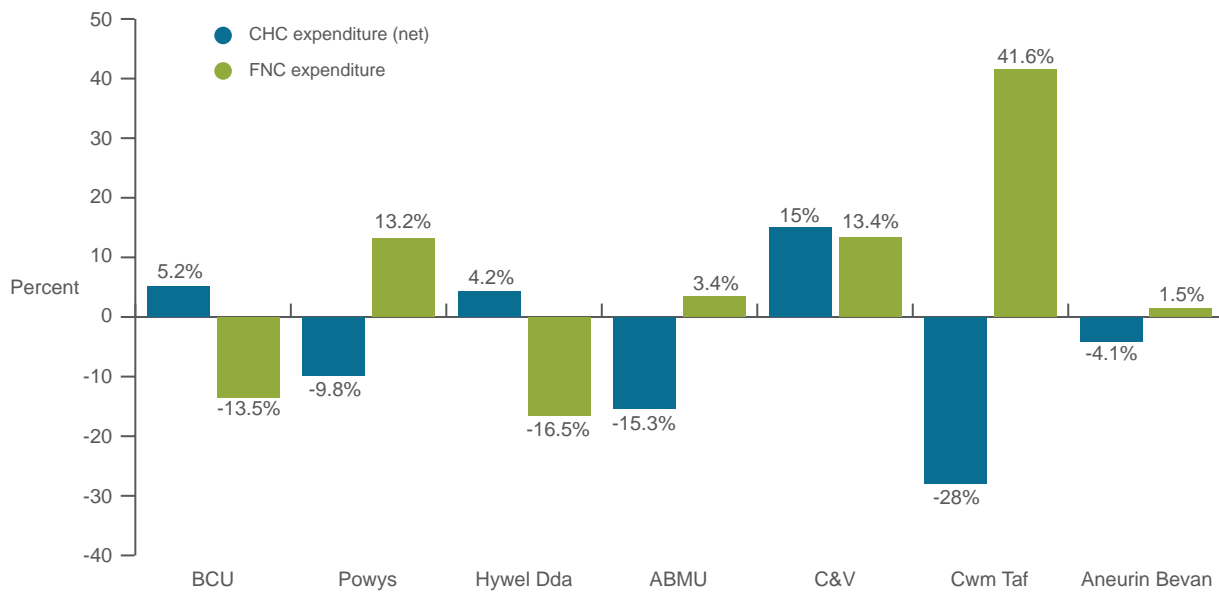
1.18 The revised Framework also stipulates other situations in which health boards should look to use peer review of individual cases, namely:

- a where the multidisciplinary team is unable to reach a consensus view on CHC eligibility, it should escalate the dispute to the appropriate manager and access peer review from within, or outside of, its health board;
- b where the individual or their representative disputes the clinical assessment of the multidisciplinary team, external peer review (from another directorate or health board) should be offered as a matter of course; and
- c as part of their audit and continuous service improvement programmes.

<sup>12</sup> The National Director for Complex Care, a post that became full time in April 2014, has a remit to work across health boards on matters relating to CHC, complex care, and integrated health and social care services.

1.19 CHC and funded nursing care expenditure patterns continue to vary significantly across health boards (Figure 4), and indicate the need for ongoing peer review. As outlined in the Auditor General’s June 2013 report, there are a number of reasons that can explain reductions in CHC expenditure at some health boards, including investment in modernising complex care services; a push to identify savings within CHC budgets; and changes to the nature and extent of some hospital and community services. The Auditor General’s recent report on NHS financial and service performance<sup>13</sup> identified CHC as the fourth largest area of reported savings by health boards, with £24 million of savings identified in 2013-14. However, the Auditor General’s June 2013 report on CHC concluded that it was unclear whether the way health boards were interpreting eligibility for CHC had also contributed to the differing expenditure patterns.

Figure 4 – Percentage change in CHC and NHS-funded nursing care expenditure 2010-11 to 2013-14 (cash terms)



Source: Wales Audit Office analysis of health board final accounts

13 NHS Wales: Overview of Financial and Service Performance 2013-14, Auditor General for Wales, 14 October 2014

1.20 The successful implementation of the Performance Framework will require appropriate capacity within the Welsh Government. The national policy and practice lead for CHC, working on secondment from NHS Wales, currently provides this capacity. However, the secondment is due to end in February 2015. In considering its options, the Welsh Government will need to take into account the resources and skills needed to drive and deliver the Performance Framework, including the annual sample audit.

### CHC and the complex care agenda are major challenges for health boards

1.21 In October 2014, health boards agreed revised governance and accountability arrangements for complex care<sup>14</sup> with the Welsh Government, which included establishing a national complex care board<sup>15</sup> jointly chaired by the lead health board chief executive and the director of social services at the Welsh Government. We understand that the board will have strategic oversight of relevant policy matters and their implementation, along with other key issues such as the retrospective CHC claims process. The board will have no executive decision-making mandate, but it will provide advice, guidance and recommendations to health board chief executives.

1.22 We have not reviewed the governance arrangements within individual health boards as part of this work, but the prominence of CHC and complex care has increased in recent years and health boards will continue to face significant demands and challenges. For example, analysis undertaken by the national director for complex care indicates that NHS Wales now funds as many placements in care homes as it provides inpatient beds.

### Working with health boards, the Welsh Government has developed training in the revised Framework and substantial numbers of staff have received the training although there is considerable variation in attendance levels across health boards

1.23 The Auditor General's June 2013 report found that health boards had rolled out standard training on CHC to mixed effect, and that they needed to provide a broader range of training. Although the Public Accounts Committee welcomed the Welsh Government's commitment to the provision of training, it recommended better monitoring of training and its outcomes.

<sup>14</sup> Complex care services would include long-term care, reablement and recovery services, integrated health and social care, and NHS-funded nursing care as well as CHC.

<sup>15</sup> Health boards and the Welsh Government are also establishing a national complex care performance and operations group. This group would take the lead on performance and operational aspects of complex care, and would provide expertise, advice and information to the national complex care board to enable it to carry out its strategic oversight role.

- 1.24 The Welsh Government has developed with health boards national training modules for health and social services staff. The training modules, which were modified as the result of testing at ‘train the trainer’ workshops, involve:
- a a ‘priority’ module – this covers the key differences in the revised Framework and has been delivered to staff from each health board who are to cascade training locally; and
  - b a ‘foundation’ module – an updated one-day basic training course in the revised Framework with delivery to health board representatives commencing in September 2014, and then cascaded down locally.
- 1.25 In addition, the Welsh Government is planning to develop specialist training on key issues, such as on co-ordinating a package of care or on planning the transition between children and adult services. The specialist training will be provided centrally rather than through cascade arrangements within individual health boards.
- 1.26 In their responses to our survey, all health boards expressed concern about ensuring all appropriate staff receive timely training in the priority or foundation modules. The two jointly developed training modules were finalised at the end of July 2014 (the priority module – this was one month later than planned) and the start of September 2014 (the foundation module). The revised Framework’s implementation date was 1 October 2014, and health boards have been working towards all staff that routinely assess CHC eligibility receiving update training by the end of December 2014. In order to assist health boards, experienced trainers from the Powys Project have provided additional support.
- 1.27 The Performance Framework requires health boards to report on the number of staff who have completed the different training modules. The Welsh Government confirmed to us that at least 1,500 NHS Wales staff have attended the priority module training and over 900 have attended the foundation training. However, the Welsh Government also confirmed that there is considerable variation in attendance numbers across health boards and that it is continuing to monitor the situation.
- 1.28 In addition, the Welsh Government is to re-launch the complex care forum<sup>16</sup> to support practitioners and with the intention that this forum will have a greater focus on shared learning. The Welsh Government is also planning to run an annual conference or learning event on CHC. The first conference, likely to take place in the first quarter of 2015, will include feedback on the annual sample audit results.

<sup>16</sup> The complex care forum, for multidisciplinary teams supporting people with complex needs, facilitated shared learning and provided a forum for debate. It last met in May 2012.

## Part 2

There are more retrospective claims outstanding than ever before, and the response from some health boards has been unsatisfactory

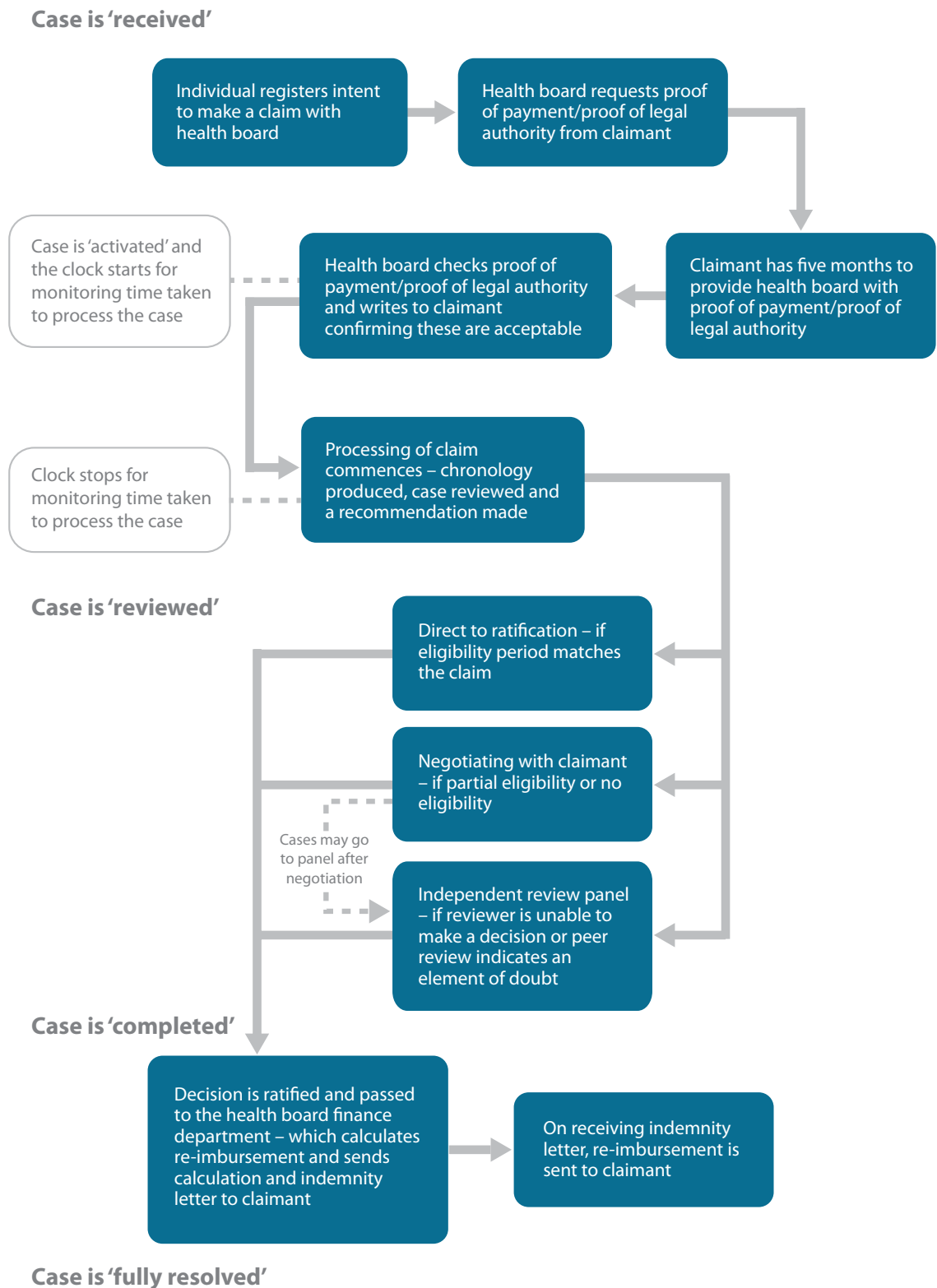




## The revised Framework outlines a common process for dealing with retrospective claims

- 2.1 The Auditor General's June 2013 report identified that there was no common approach across health boards for dealing with retrospective claims. The revised Framework now outlines a common process for health boards to follow, based on the approach used by the Powys Project. The responsibility for processing retrospective claims rests with either the Powys Project or individual health boards ([Appendix 1](#)).
- 2.2 The Auditor General's report highlighted that CHC is a complex topic with its own distinct language. In this report, we have used the following terms to refer to the different steps involved in dealing with a retrospective claim ([Figure 5](#)):
  - a a 'closed' claim refers to where a claimant is unable to provide proof of payment or proof of legal authority, or where they have decided to withdraw their application;
  - b a 'reviewed' claim refers to a claim that has been reviewed and a recommendation made, and there are potentially a number of further steps to be taken including negotiation with the individual or an independent panel hearing;
  - c a 'completed' claim refers to a claim in which a decision has been ratified and which is ready for the re-imburement process to commence (if applicable); and
  - d a 'fully resolved' claim refers to when no further action is required on a claim with the re-imburement made (if applicable).

Figure 5 – Retrospective claims process



Source: Wales Audit Office analysis of various Welsh Government documents

## The Welsh Government has set deadlines for reviewing retrospective claims, but the approach could lead to health boards acting in a way that undermines the timely processing of claims and performance monitoring is inadequate

The revised Framework sets deadlines for the submission of claims and for the maximum processing time which reduces over time from two years to six months

- 2.3 The Auditor General's June 2013 report highlighted that the Welsh Government had not set a timetable for clearing the retrospective claims that were the responsibility of health boards. The Public Accounts Committee considered that all claims should be dealt with within a maximum of two years.
- 2.4 The revised Framework sets out deadlines for people to register and for the NHS to process all current and future retrospective claims ([Appendix 1](#)). The Framework states that the current backlog of claims – those relating to a claim period between 1 April 2003 and 31 July 2013 that have been received between 16 August 2010 and the 31 July 2014 deadline set by the Welsh Government – should take individually no longer than two years to process.
- 2.5 The revised Framework then reduces the maximum processing time for other claims, as follows:
  - a for those relating to a claim period between 1 August 2013 and 30 September 2014 that are received between 1 August 2014 and 1 October 2015, the maximum time taken to process is reduced to 12 months; and
  - b for those relating to a claim period after October 2014, there is a rolling cut-off for people to submit claims (within 12 months of the claim period), and the maximum time to process is reduced to six months.
- 2.6 If a claim spans two periods, then the full claim period is considered at the time the case is first processed. For example, for claims submitted before 31 July 2014, the whole claim period would be considered even if this extended past July 2013. The complexity of the requirements and the reducing timeframes for processing claims is a significant challenge for health boards. This will require health boards to monitor closely progress against these requirements and the adequacy of the resources deployed on claims processing.

Claims are only expected to be reviewed rather than completed within the prescribed deadlines and there is potential for health boards to act in a way that undermines timely processing

- 2.7 Processing a claim commences when an individual registers an intent to make a claim and is fully resolved when the individual receives a re-imbusement (Figure 5). However, the Welsh Government deadlines for dealing with a claim only relate to part of this process. The revised Framework refers to the 'date of application' as the point at which the clock should start in measuring the time to process a claim; and to a claim then being 'processed' within the stated timeframe. The Framework does not define these terms explicitly. However, Welsh Government officials told us that, as outlined in a public leaflet on CHC retrospective cases<sup>17</sup>:
- a the 'date of application' is when a health board issues a letter to the claimant confirming that the proof of payment and proof of legal authority<sup>18</sup> evidence that they have submitted is acceptable, and not the point at which the application is submitted; and
  - b a claim is 'processed' when it has been reviewed and a recommendation made, and not when a final decision is communicated to the claimant or the reimbursement (if applicable) is made.
- 2.8 The Welsh Government's rationale for starting and stopping the clock at these stages is that progress before and after these points becomes more dependent upon the claimant or their representative. Specifically:
- a Before the clock starts:
    - the health board needs to request proof of payment and proof of legal authority from the claimant;
    - the claimant then needs to provide proof of payment and proof of legal authority prior to the claim being processed – claimants are currently given up to five months to provide this; and
    - the health board needs to review the proof of payment and proof of legal authority, and confirm the adequacy of this to the claimant.
  - b After the clock has stopped:
    - the majority of claims require a negotiation phase and/or an independent review panel hearing, this can take three months or longer to complete;
    - health boards are routinely taking two to three months to calculate the reimbursement due, and send out the indemnity letter to the claimant; and
    - on receiving the indemnity letter, health boards have up to 30 days to issue the re-imbusement.

<sup>17</sup> *Continuing NHS Healthcare: Cut-off dates for assessment of eligibility for cases during the period 1 April 2003 to 31 July 2013*, Welsh Government information leaflet, 2014

<sup>18</sup> A key part of the initial process of dealing with a retrospective claim is ensuring that the person making the claim is able to provide proof that they have paid the relevant care home fees and that they have legal authority to pursue the claim.

- 2.9 In practice, a claim that meets the two-year deadline may actually take three years or more to go from the claimant registering an intent to claim to them receiving reimbursement (if applicable). The way the deadlines are set could also lead health boards to not deal with all parts of the process in a timely way. There is a risk that health boards could focus on reviewing outstanding claims and:
- a not devote resources to requesting and reviewing proof of payment and proof of legal authority, or to issuing letters to claimants confirming that these are acceptable – this would also reduce the number of claims that are ‘activated’ with the clock started; and
  - b not prioritise the negotiation and independent review panel process or the calculation and payment of re-imbursements.
- 2.10 As health boards are not necessarily capturing information on, and do not report all key stages in the process (paragraphs 2.17 and 2.19), there is mixed evidence on whether they are taking all steps in the process in a timely way. There is some evidence that they are not always dealing with claims promptly in the early stages of processing. In the past, some health boards have not requested proof of payment in a timely way (paragraphs 2.49 and 2.52). The Welsh Government told us that the sample audit indicated that proof of payment is now generally being requested promptly but that there was variation between health boards.
- 2.11 There is no reporting or evidence on how promptly health boards complete a claim once they have reviewed it. The time they take to fully resolve a claim is, however, being reported. This data shows that in the past there have been problems with health boards taking extended time to reimburse claimants, but that this now seems to have been resolved. By the end of October 2014, all health boards were taking between eight to 12 weeks to calculate the amount to be reimbursed and send the indemnity letter to the claimant; and then, on receipt of the indemnity letter, all health boards were making the reimbursement within 30 days.
- 2.12 We have discussed this issue with the Public Services Ombudsman for Wales, whose views the Welsh Government has regularly sought over the reasonableness of deadlines for dealing with retrospective claims. We and the Public Services Ombudsman are of the opinion that the current approach is flawed as it does not adequately focus upon, or monitor, what matters most to individuals – the completion, rather than the review, of their claim.

**The Welsh Government and health boards have established a national task and finish group with a remit to ensure claims are processed within the deadlines set, but membership and attendance has been problematic**

- 2.13 In January 2014, and in line with a recommendation in the Auditor General's June 2013 report, the Welsh Government and health boards established a national task and finish group to oversee retrospective claims. The Public Accounts Committee also recommended that the Welsh Government should develop a coherent plan for clearing the backlog of claims, and this is the key deliverable for the task and finish group.
- 2.14 A health board chief executive chairs the group with membership from each health board, the NHS national director for complex care, the director for the Powys Project, and the Welsh Government national policy and practice lead for CHC. The task and finish group has been meeting on a quarterly basis. However, attendance at meetings has been problematic, with:
- a only three health boards nominating a representative at director level as required – two health boards have nominated an assistant director and the remaining two health board representatives are at lower grades;
  - b attendance by the nominated representative being highly variable across health boards – two health board nominated representatives failed to make any of the first four meetings; and
  - c only three health boards have sent a representative, whether the nominated member or an alternative, to all four meetings.
- 2.15 Some health boards told us that the lack of videoconferencing facilities has impacted upon attendance at the group meetings. The chair of the national task and finish group is working with health boards to resolve the issues over-representation and attendance at its meetings. In addition, the chair is also working with health boards to improve health board attendance at the business support group, which has also been very variable. The business support group underpins the national task and finish group, and is responsible for drafting detailed proposals and gathering performance monitoring data. Some health boards told us that initially they had lacked clarity over the role of these two groups.
- 2.16 Despite these issues, the national task and finish group reported to us that it has been successful in a number of areas. These include information cleansing to ensure accuracy of the numbers of cases reported by health boards; developing guidance on definitions and practices around retrospective claims processing, instigating training and support, and establishing audit and assurance processes. Nevertheless, as expanded upon in the rest of this section, the national task and finish group has not delivered on its core remit – to ensure all retrospective claims are processed efficiently and to the set deadlines.

The performance monitoring developed by the task and finish group does not identify whether the prescribed deadlines are being met and some health boards have struggled to provide accurate and timely data

2.17 From its establishment in January 2014, the national task and finish group has looked to agree a format for the performance report that it receives for retrospective claims. The Powys Project collates monthly performance data from health boards and then uses this to compile the performance report. By November 2014, there had been three performance reports<sup>19</sup> and the coverage of each report has changed. At no point has the performance report or the supporting data addressed explicitly some fundamental issues of key importance to the Welsh Government, health boards and claimants (Figure 6). Furthermore, from November 2014, as agreed by the task and finish group, health boards will be significantly reducing the information that they provide each month.

Figure 6 – Coverage of performance reports and core data

Key issue	What is covered in the performance report?	What data is provided by health boards?
Are claims being reviewed within the deadlines set?	This is not reported upon (although it is possible to infer that some claims are likely to have missed the deadline – see paragraphs 2.42 to 2.44). There is no reporting of the number of outstanding cases with a two-year or one-year deadline for processing.	Up to October 2014, the number of claims with a review outstanding that had passed their breach date, based on the month the claim was submitted, could be established from the data return. However, the return did not include the date that adequate proof of payment was received – which is the Welsh Government's start point for calculating a breach date. In addition, the data return did not identify whether cases that had been reviewed had met the deadline or not. Health boards no longer provide this data.
How many claims are at risk of breaching the deadline?	Not reported.	Up to October 2014, the number of cases approaching a breach date could be established from the data return, but again only based on the date the claim was submitted. Health boards no longer provide this data.
How many reviewed claims have been completed or fully resolved?	Not reported.	Not captured.
When is each health board projecting to review all claims?	Not reported. However, the projected date that some longstanding claims are likely to be reviewed has been reported. Initially this was by health board, but then on an all-Wales basis, and is no longer to be included in the report.	Up to October 2014, the data return included the number of reviews completed since March 2014. Projections could be based on this data (paragraph 2.45). Health boards no longer provide this data.

Source: Wales Audit Office review of performance report and supporting data

<sup>19</sup> A July 2014 report covered data from March to June 2014, an October 2014 report included data up to and including September 2014, and a November 2014 report included data up to and including October 2014.

- 2.18 The first three performance reports, which have not drawn on all the available supporting information, have focused on the number of claims that the Powys Project and health boards are responsible for and have tracked the number of reviews undertaken and outstanding. The three reports have also outlined:
- a the number of claims with and without proof of payment and proof of legal authority;
  - b the time taken by health boards to calculate the amount to be reimbursed and to send the indemnity letter to the claimant; and
  - c whether claims were being reimbursed within 30 days of the indemnity letter being received from the claimant.
- 2.19 From November 2014, the information provided each month by health boards is being limited to an overall total of the number of cases received up to 30 September 2014 but not reviewed; the total number of active or inactive claims; and the total number of claims with insufficient evidence of proof of payment or proof of legal authority.
- 2.20 Some health boards have struggled to provide timely and accurate monthly data to inform the performance report. Some health boards told us that initially there was a lack of clarity over what the data should cover. This contributed to some health boards questioning the accuracy of the first performance report, despite this reflecting the data that they had provided. Welsh Government and Powys Project staff subsequently held meetings with each health board to clarify the data required and what this should cover. In addition, the chair of the task and finish group requested that either the chief executive or the responsible executive director in each health board sign off the monthly data prior to its submission to the Powys Project team.
- 2.21 However, these problems continued and one health board did not provide all the required data for September 2014; and three health boards did not submit any data for October 2014. Our own review of the data submitted by health boards identified ongoing problems with figures not balancing and inaccurate or differently interpreted submissions.



## The Powys Project reviewed as intended all claims received up to 15 August 2010 by the deadline of 30 June 2014 although all claims were not completed by this date

- 2.22 All claims received up to 15 August 2010 (when the former Framework was implemented) are the responsibility of the Powys Project, which received in total some 2,454 claims. In its response to the Public Accounts Committee report, the Welsh Government has confirmed its intention that all claims were to be reviewed by the end of June 2014. The Powys Project met this deadline, which was a significant achievement. However, as at the end of June 2014, 155 cases (six per cent) were going through negotiation and/or the panel process and had not therefore been completed.
- 2.23 As at the end of October 2014, the number of these claims not completed had fallen to 49, of which 35 were awaiting an independent panel, and 14 were going through the negotiation process. Powys Project staff told us that problems arranging independent panels have slowed down progress with the outstanding claims. Although panel chairs are in place, it has taken time to find health board and local authority representatives. The Powys Project has now appointed and trained members for the three regionally based panels.

## The responsibility for processing the substantial number of claims received since 16 August 2010 now rests with the Powys Project and health boards, and this division of responsibility creates added complexity, and makes it more difficult to ensure consistency

- 2.24 The Welsh Government first confirmed the arrangements for dealing with retrospective claims in September 2011, with the Powys Project responsible for all retrospective claims received up to 15 August 2010 (when the former Framework was implemented). The responsibility for processing any retrospective claim received after this date rested, at that time, with individual health boards.
- 2.25 The Auditor General's June 2013 report expressed concerns about the ability of health boards to deal with the claims received from 16 August 2010. The Public Accounts Committee shared this concern and recommended that the Powys Project was not disbanded until all backlog claims were cleared.

- 2.26 In January 2014, the national task and finish group began to develop a number of options for the claims received from 16 August 2010, including handing all backlog claims over to the Powys Project. In February 2014, health board chief executives agreed that in principle some claims would become the responsibility of the Powys Project whilst health boards would process the remaining claims. Following this decision, the task and finish group discussed and agreed the detailed split of cases between health boards and the Powys Project (Figure 7). The reason for splitting responsibility for the claims received since 16 August 2010 was that:
- a Health boards could not remain responsible for all these claims as they did not have the capacity to deal with all of them in a timely way.
  - b Health boards did not want to pass responsibility for all these claims over to the Powys Project, as:
    - they needed to develop capacity and experience in dealing with retrospective cases on an ongoing basis; and
    - it was not necessarily possible to second staff employed by health boards to process retrospective claims to the Powys Project, as they were not always dedicated to claims processing.

Figure 7 – Responsibility for processing claims received from 16 August 2010

Organisation	Claims responsible for
Powys Project	A proportion of the claims submitted between 16 August 2010 and the end of April 2014. Claims to be received between May and July 2014, in response to a July 2014 cut-off date advertised by the Welsh Government <sup>20</sup> .
Health boards	A proportion of the claims submitted between 16 August 2010 and the end of April 2014. All claims after 1 August 2014.

Source: Wales Audit Office analysis of various Welsh Government documents

<sup>20</sup> The Welsh Government announced on 30 April 2014, that any claims with a claim period relating to 1 April 2003 and 31 July 2013 needed to be submitted by 31 July 2014.

- 2.27 In assessing the progress with clearing the claims received from 16 August 2010, we have relied heavily upon the available performance information, although this proved not to be as robust or comprehensive as we would expect. The available data shows that, as at the end of October 2014, the NHS had received 4,092 claims since 16 August 2010<sup>21</sup> with:
- a 2,486 claims being received between May and July 2014 in response to the July 2014 cut-off announcement; and
  - b the majority of the remaining 1,606 claims being received between 16 August 2010 and the end of April 2014.
- 2.28 The division of responsibility between health boards and the Powys Project makes it more difficult to ensure that claims are dealt with equitably, for example:
- a claims should be dealt with in chronological order but the number of claims and the speed at which health boards process these will determine how long people in similar circumstances have to wait; and
  - b although the Framework now outlines a common process for dealing with retrospective claims, the recent annual audit sample identified that this process was not being applied consistently in one health board ([paragraph 1.17](#)).
- 2.29 Progress is often dependent upon agreement across all health boards, which is a challenge in itself. For example, this report highlights the inadequacy of performance monitoring information, and addressing these shortfalls will require a good degree of consistency between health boards on the information they hold on their local claims registers. Health boards considered, but could not agree, adopting a common claims register based on the version used by the Powys Project.
- 2.30 To allow health boards to generate meaningful and comprehensive performance monitoring information, we have identified some key information that we think should be included for each claim on their local register ([Figure 8](#)). This is very likely to require health boards to update their local claims register. The Powys Project has confirmed that its claims register holds all the key information that we have identified, and the decision by health boards not to adopt this format should be revisited. To ensure consistency and transparency in the way data is reported, we believe that health boards and the Powys Project should routinely share the information held on their claims registers.

<sup>21</sup> This data is partly drawn from health board performance monitoring data as at the end of October 2014; however, we have had to rely upon earlier data from two health boards that only cover the period up to the end of April 2014.

Figure 8 – Some key information needed on claim registers to generate meaningful performance information



2.31 Our discussions with a law firm highlighted that the complexity of the arrangement between health boards and the Powys Project makes it difficult for individuals and their representatives to be clear as to which body they need to deal with. The arrangements have made it harder for individuals and their representatives to navigate an already complicated process.

## The Powys Project faces an even greater challenge in processing its share of the claims received after 16 August 2010, and has been constrained by IT problems and delays in the transfer of information from health boards and the agreement of ongoing funding

- 2.32 The Powys Project has responsibility for the 2,486 claims received between May and July 2014 following the publicity about the July 2014 cut-off date. Claimants had until the end of December 2014 to provide proof of payment and proof of legal authority, and at the time of drafting this report the final number of claims that will proceed was not known. A proportion of these claims are likely in time to be closed (27 per cent of the claims received up to 15 August 2010 were subsequently closed because the claimant was unable to provide proof of payment or proof of legal authority, or decided to withdraw their application).
- 2.33 To meet the Welsh Government's processing deadline, the Powys Project will need to review all the validated claims within two years of confirming receipt of adequate proof of payment or proof of legal authority. The Powys Project told us that it is reviewing the adequacy of the evidence provided by the December 2014 deadline, and expects that in some cases it will need to request further proof from the claimant. As a result, the two-year deadline is likely to be in early 2017 rather than December 2016. Even so, this is a far more challenging target than for the claims received up to 15 August 2010 for which the Powys Project had a similar number of claims (2,454) to process but an additional year to complete all claims.
- 2.34 In addition, the Powys Project had agreed to process a proportion of the other claims received by health boards since 16 August 2010. The original plan was that health boards would pass over all of the agreed claims by the end of June 2014, and that the Powys Project would then review all cases by the end of December 2014. This would release capacity for the Powys Project to review its main bulk of claims (the 2,486 claims received between May and July 2014).
- 2.35 As at the end of October 2014, the Powys Project had reviewed 19 of the 728 claims passed to it from health boards, and the Powys Project has confirmed that it will not be able to review the remainder of the claims by the end of December 2014. This is likely to have a knock-on effect with the processing by the Powys Project of its other claims, and is due to:
- a health boards only handing over to the Powys Project two-thirds of the planned number of claims by the end of June 2014 deadline – this was partly because some health boards had not obtained proof of payment and proof of legal authority on all cases;
  - b continuing delays with some health boards providing the relevant case files to allow the claim to be processed;

- c being unable to fill vacancies and recruit additional staff until health boards have agreed the ongoing funding for the project; and
  - d being without access to an IT network for over a month, following the relocation of all other NHS staff from the building complex – which slowed down the process of chasing records, transferring information, and producing chronologies.
- 2.36 The Welsh Government and health boards have jointly funded the Powys Project to process the claims received up to 15 August 2010. The Welsh Government has also provided £735,000 towards the cost of the Powys Project processing claims received from 16 August 2010, but has confirmed that it will not provide any further funding. The Welsh Government funding was sufficient to cover the costs of the Powys Project up until the end of December 2014, and all Powys Project team member contracts were due to expire at this date. Health boards only agreed the funding for the rest of the 2014-15 financial year at the end of October 2014.
- 2.37 In December 2014, the Powys Project issued a business plan to health boards for the long-term funding required to enable the project to meet the deadlines set by the Welsh Government. The task and finish group has discussed the business case, which is now being considered by health board chief executives. Once a business case is approved, staff contracts can be extended to the expected end of the project's life. However, health boards may well struggle to provide adequate long-term funding. The task and finish group is considering proposing an extension of the deadline for reviewing claims from two to three years. The lack of agreed long-term funding means that the Powys Project cannot fill existing vacancies for special investigators, clinical advisors and administrative staff. There is also a potential risk that experienced staff will leave the Powys Project as their current contracts expire at the end of March 2015.

**Some health boards have not demonstrated that they are able to deal in a timely way with the claims they are responsible for, and some claimants are being dealt with unreasonably**

**Health boards have not always given appropriate priority and resources to dealing with the retrospective claims they have received since 16 August 2010, and two have made little progress**

- 2.38 The Auditor General's June 2013 report found that health boards had made very limited progress in clearing the retrospective claims that they were responsible for at that time (those received from 16 August 2010). The report concluded that most health boards had not given sufficient priority, or allocated appropriate staff resources, to deal with retrospective claims. This remains the case for a number of health boards.

- 2.39 We gathered data in August 2014 on the staff resources allocated to processing retrospective claims, repeating the exercise we originally undertook in May 2012. We found that health boards have not substantially increased the number of staff dealing with retrospective claims. Specifically:
- a there was little or no noticeable change in three health boards;
  - b there had been an increase of between 0.7 and 1.2 whole-time equivalent staff in the remaining four health boards; and
  - c none of the health boards planned to increase further the number of staff – although some health boards have subsequently told us that it may be necessary to consider the adequacy of staff resources.
- 2.40 As at the end of October 2014, health boards retained responsibility for 878 of the 1,606 claims they had received from 16 August 2010. Comprehensive data on the number of claims that health boards have closed (where a claimant is unable to provide proof of payment or proof of legal authority, or where they have decided to withdraw their application) is not readily available. However, the available data indicates that:
- a between 16 August 2010 and the end of October 2014, health boards reviewed 254 claims and closed a further 225 claims; and
  - b as at the end of October 2014, 399 claims had a review outstanding, of which health boards were preparing to close 92 claims due to lack of proof of payment or proof of legal authority.
- 2.41 Based on the October 2014 performance report data, we have analysed the number of claims outstanding and the number of claims reviewed since March 2014 (Figure 9); together with data on the number of claims completed in the 19 months to the end of July 2014 that we gathered directly from health boards. We have not reviewed progress since the end of October 2014, but we understand that whilst claims continue to be reviewed and completed, there has been no step change in the rate of progress. We acknowledge that delays in processing can occur due to a slow response from individuals or their representatives to requests for information. Nevertheless, the number of claims completed and reviewed by each health board has varied, and some have made significant inroads into the backlog of claims. For example, Cardiff and Vale University Health Board, which has allocated the most staff resources to processing claims, is on top of its retrospective claims. However, performance in two health boards has been particularly unsatisfactory.

Figure 9 – Claims reviewed and outstanding by health board (March to October 2014)

Health board	Claims passed to the Powys Project	Claims retained by health boards with a review outstanding (start of March 2014) <sup>1</sup>	Reviews completed (March to end October 2014)	Claims with a review outstanding as at end October 2014
Abertawe Bro Morgannwg	93	90	14 <sup>2</sup>	76
Aneurin Bevan	107	138	37	101
Betsi Cadwaladr	317	13	3	10
Cardiff and Vale	76	33	18	15
Cwm Taf	61	60	0	60
Hywel Dda	62	60	21	39
Powys	12	11	5	6
<b>Total</b>	<b>728</b>	<b>405</b>	<b>98</b>	<b>307</b>

Notes:

1 Claims with a review outstanding exclude cases that were closed or that were about to be closed.

2 Abertawe Bro Morgannwg University Health Board informed us that the actual number of reviews undertaken between March and the end of October 2014 was 21, rather than the 14 reported centrally.

Source: *Performance report for the national task and finish group, November 2014*

2.42 Cwm Taf University Health Board has only reviewed eight of 75 claims it has received since 16 August 2010<sup>22</sup>. As at the end of October 2014, the health board had 32 claims that it had received between two and four years earlier but which they were still to review. The health board has not concluded any review in the eight months to the end of October 2014, and did not complete any claims in the 19 months to July 2014. It has taken the health board up until the summer of 2014 to appoint its first dedicated member of staff to deal with retrospective claims. Compared to other health boards which have received similar numbers of claims, Cwm Taf University Health Board continues to allocate relatively few staff resources to retrospective claims.

22 The health board told us that it has been taking an additional step (seeking individuals' comments on the chronology of the case) before the actual review of the case was undertaken. This is likely, therefore, to extend the time taken to complete the review phase. The Framework does not require this step, and the health board stopped this practice in December 2014.



2.43 Betsi Cadwaladr University Health Board has received the most claims in Wales, but has made very little progress with these over the years. The Auditor General's June 2013 report highlighted the poor progress that the health board had made at that time. By September 2014, the health board had marginally increased the staff allocated to dealing with retrospectives (increasing from 2.0 to 2.4 whole-time equivalent staff reflecting increased administrative and management support). The poor performance of the health board has continued, with only three claims reviewed between March and October 2014, and with only nine claims completed in the 19 months to July 2014. The health board's inability to deal with claims in a timely way led to the Powys Project agreeing, at the request of the health board, to take over virtually all outstanding claims – 317 claims were passed over with the health board retaining just 10 recent claims to process itself.

**Health boards have already missed the two-year processing deadline for a significant number of retrospective claims, plans to review longstanding claims by the end of December 2014 will not be met, and many more claims are likely to breach the two-year deadline**

- 2.44 The performance report provides details of the progress made since March 2014 with 223 longstanding cases relating to claims received between 16 August 2010 and 15 August 2012. However, the number of longstanding claims that health boards have received is likely to be greater than reported. Health boards exclude from the figures longstanding cases in which they have only recently requested and received proof of payment or proof of legal authority (see [paragraphs 2.49 to 2.52](#)).
- 2.45 A significant number of the reported longstanding claims will have already breached the two-year deadline. In September 2014, health boards reported that they had reviewed 87 of the 223 longstanding claims. Based on the date of submission, the remaining 136 claims will therefore have breached the two-year deadline. A significant proportion of the 87 reviewed cases may also have breached the deadline, although data is not available to quantify the numbers involved ([Figure 6](#)).
- 2.46 Health boards set themselves a target of reviewing all the reported longstanding claims by the end of December 2014. However, the November 2014 performance report concludes that, at an all-Wales level, health boards will miss this target. Betsi Cadwaladr University Health Board has passed all of its longstanding cases to the Powys Project, which will also not undertake all the reviews by the end of December 2014 ([paragraphs 2.34 to 2.35](#)). The monthly review rates<sup>23</sup> suggest that four health boards (Hywel Dda, Powys, Cardiff and Vale, and Aneurin Bevan) are likely to miss the December 2014 deadline, but by only a month or two. The two other health boards are likely to miss the end of December 2014 target by a considerable number of months:

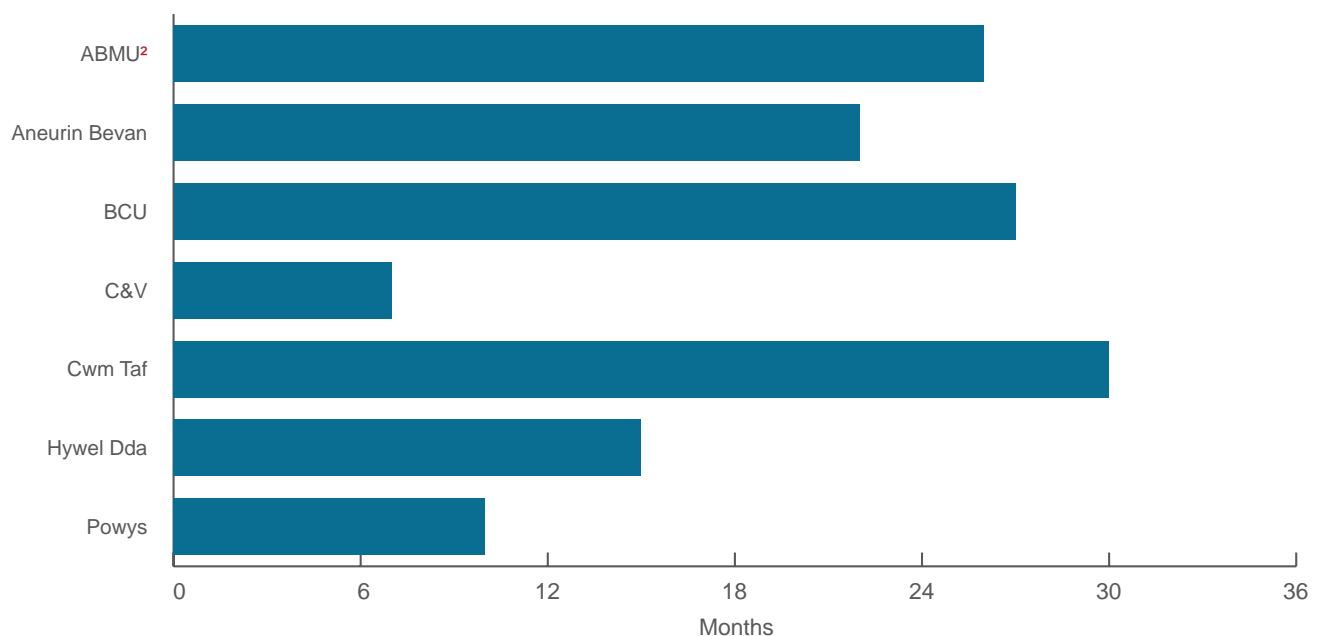
<sup>23</sup> Based on the number of reviews undertaken between March and October 2014.

- a it is likely to take Abertawe Bro Morgannwg University Health Board until the end of May 2015 to undertake all its longstanding reviews; and
- b there is no data available on which to project when the relevant 34 reviews at Cwm Taf University Health Board will be reviewed, but if the health board achieved the average review rate across all health boards it would take until March 2016 to undertake all the longstanding reviews.

2.47 We have also examined how long it might take, at current rates, for health boards to review all of the 307 outstanding claims that they remain responsible for (Figure 10). Our projection is that Powys Teaching Health Board, with relatively few claims, and Cardiff and Vale and Hywel Dda University Health Boards will undertake all their reviews within a year or shortly after. Four health boards will take around two years or more to review all outstanding claims, and a number of breaches of the two-year deadline are therefore likely.

2.48 Health boards will soon be faced with retrospective claims with differing maximum processing times of two years, one year, or six months. Health boards will need to closely monitor and manage these cases, and avoid the risk that more recent claims with a shorter processing deadline do not take precedence over longer-standing claims.

Figure 10 – Projected timescales for health boards to review all outstanding cases received between 16 August 2010 and the end of October 2014<sup>1</sup>



Notes:

- 1 Analysis excludes the 92 claims health boards were preparing to close at that time. The projections used in this table are based on the number of reviews undertaken as reported by each health board for the eight-month period March to October 2014. Cwm Taf projection based on achieving the average review rate of two claims per month.
- 2 Abertawe Bro Morgannwg University Health Board projection is based on 21 reviews being undertaken in this period as reported to us and not the 14 reviews as detailed in the November performance report (Figure 9).

Source: Wales Audit Office analysis of data from November 2014 performance report for national task and finish group

**Some health boards have not always requested proof of payment and proof of legal authority promptly on receiving a claim and the approach taken to processing these claims can be unreasonable to the individuals**

- 2.49 Welsh Government guidance states that health boards should base the deadline for reviewing a claim, and therefore its breach date, on the date that it receives proof of payment and proof of legal authority. This is important, as the breach date could be used to determine the priority given to processing a claim. Health boards are applying this guidance to longstanding claims that they have only recently requested proof of payment and proof of legal authority from the claimant. This is, in our view, unreasonable. It results, through no fault of the claimant, in longstanding claims having a similar or longer breach date than far more recent claims. One health board informed us that once it receives the proof of payment, it gives priority to claims based on the date the claim was submitted rather than the breach date. The position in other health boards is unclear.
- 2.50 For example, if a claim submitted in 2011 only had proof of payment or proof of legal authority requested and provided in 2014, then a breach date would be in 2016. However, a claim received in 2014 with all the necessary evidence (claims since August 2014 are now required to be submitted with proof of payment and proof of legal authority), would have a breach date in 2015, a year earlier than the longstanding claim (claims received after August 2014 are to be reviewed within 12 months).
- 2.51 By applying the guidance to this type of case, health boards are giving themselves a better chance of meeting the two-year deadline for reviewing cases; and have reduced the number of longstanding claims that they intended to review by the end of December 2014.
- 2.52 The Auditor General's June 2013 report found that health boards on receiving proof of payment had not always checked its adequacy, and that on processing the claim many years later were not then accepting the original evidence. Given the substantial passage of time that may have elapsed since the claimant supplied the original proof of payment, it could be difficult or impossible for some claimants to find and provide the additional evidence required.
- 2.53 In response, and following discussions with the Public Service Ombudsman for Wales, the Welsh Government issued supplementary guidance in December 2013 on proof of payment. The guidance outlined that claimants should not be disadvantaged by their inability to provide further proof of payment, which they were not made aware of at the outset of their claim. The guidance outlines that health boards should reimburse the claimant where there is evidence that the individual was resident in a care home for the period of eligibility; and where there is no evidence that any public body or agency paid the fees.

2.54 The guidance was limited to those cases that the Powys Project was dealing with, namely cases received up to 15 August 2010 (these had a claim period between 1996 and 15 August 2010). However, a number of the cases received from 16 August 2010 may also have a claim period that could go back as far as 2003. As health boards have not always requested or checked proof of payment at the outset then individuals will be similarly disadvantaged. The number of such cases is not readily available from health boards. We have discussed this anomaly with the Welsh Government, who is considering extending the supplementary guidance to similar claims received from 16 August 2010.

## Part 3

Public information on CHC has been expanded but needs to be more accessible, there were weaknesses in the publicity of the July 2014 cut-off for some retrospective claims, and access to advocacy services remains a concern for some health boards



## The Welsh Government has developed a range of information leaflets, but could do more to publicise them and make them more accessible

- 3.1 The Auditor General's June 2013 report highlighted a number of concerns about health boards' communication and engagement with individuals and their families about CHC. The Public Accounts Committee expressed similar concerns about the engagement with individuals and their families in the assessment process and about a lack of public awareness about CHC. The Welsh Government accepted the Committee's recommendations, stating that there would be revised guidance and that it would make available a range of plain language public information leaflets through health boards and on a website from June 2014.
- 3.2 One of the seven key messages detailed in the revised CHC Framework is that 'individuals and their families/representatives must be fully involved and informed throughout the assessment process'. The Framework then reflects this key message through, for example, specifying that:
- a health boards have a responsibility to make available national information leaflets to individuals and their families;
  - b involving individuals and their families in the assessment and care planning process is not an optional extra, and that there should be 'no decisions about me without me'; and
  - c health boards must provide the individual and their family/representative with a summary of the decision on eligibility, which includes a clear rationale, setting out the reasons why the decision has been reached.
- 3.3 However, producing clear and simple communication with the public over retrospective claims has become more complicated given the different claim periods, cut-offs for making a claim, and deadlines for the NHS to complete claims processing (Appendix 1). The Welsh Government had made available three information leaflets relating to CHC and the assessment process (including easy-read versions of each leaflet), and a further three leaflets on retrospective claims (Figure 11).
- 3.4 The Welsh Government has clearly taken steps to improve the information that is available to the public, and the leaflets are available on the complex care information and support site ([www.cciss.org.uk](http://www.cciss.org.uk)). However, all of these information leaflets are designed to be accessed once an individual is 'in the system'. There is no general information widely available, for example in care homes, to raise public awareness of CHC and to help the public to be proactive. We believe that the aim should be that anyone in, or about to go into, a care home should be made aware of CHC and funded nursing care. Also more could be done to publicise the website – only one of the six leaflets contain details of the website, although another does contain a link to the Welsh Government website which contains other CHC information leaflets.

Figure 11 – Welsh Government information leaflets – CHC for adults

Title	When the leaflet is intended to be given out	What it covers
Public information leaflet	When NHS staff seek the individual's consent to start arranging the CHC assessment.	CHC and funded nursing care eligibility, consent and assessment process, and what to do if the individual is not happy with the assessment outcome.
Preparing you for a CHC eligibility meeting	When NHS staff invite the individual to the multidisciplinary team to discuss needs and determine eligibility.	How to prepare for the meeting, where the meeting will take place, who will be there, the role of the individual at the meeting, what will happen at the meeting, next steps and rights if the individual disagrees with the decision.
What receiving CHC-funded services means for you	When NHS staff plan care after the individual is found eligible for CHC.	What CHC is and why the individual is receiving a care package, review process and what happens if the individual is no longer found to be eligible.
Cut-off dates for assessment of eligibility for cases during the period 1 April 2003 to 31 July 2014 – Frequently asked questions	On request or when registering an intent to make a retrospective claim.	Details of the July 2014 cut-off date for retrospective claims including details of the process and expected time to process a claim.
CHC retrospective claims – claimant information leaflet and request for information	After the individual has registered their intent to make a retrospective claim.	Details of the retrospective claims process, details of CHC and funded nursing care including case studies demonstrating eligibility, and next steps.
CHC retrospective claims for reimbursement, frequently asked questions, November 2014	On request or when registering an intent to make a retrospective claim.	Details of CHC, who may be eligible, when and how to make a claim, deadlines for submission and processing.

Source: Wales Audit Office review of information leaflets

## Although the Welsh Government issued various communications itself, the action taken by health boards to publicise the end of July 2014 cut-off for some retrospective claims appears to have been inconsistent

- 3.5 Age Cymru has criticised the way the end of July 2014 cut-off date for some retrospective claims was publicised. The Welsh Government informed us that it took the following range of steps to publicise the July 2014 cut-off date:
- a issuing a press release on 30 April 2014;
  - b sending an email on 1 May 2014 to health boards, local authorities, user representative bodies, third sector and care home providers, together with bilingual posters and leaflets – this led to some organisations such as the Citizen’s Advice Bureau and Age Cymru publicising the cut-off on their websites;
  - c re-issuing the email on 18 June 2014 because of the lower-than-expected receipt of claims;
  - d making available leaflets via the national retrospective helpline<sup>24</sup>, and via the national retrospective website which was signposted from the Welsh Government and other health board websites;
  - e publicising via Twitter and requesting that health boards do the same; and
  - f placing adverts in 12 local newspapers during the week beginning 30 June 2014.
- 3.6 The Welsh Government asked health boards to distribute the poster as widely as possible. However, the steps taken by health boards varied significantly. Information gathered by the Welsh Government indicates that Hywel Dda and Aneurin Bevan Health Boards had the most comprehensive distribution covering a broad range of locations. Hywel Dda reported distribution to GP surgeries, main and community hospitals, residential and nursing homes, libraries, leisure centres, local authorities, and local third sector organisations. Aneurin Bevan reported very similar distribution points as well as to the main town supermarkets. In contrast, Abertawe Bro Morgannwg and Betsi Cadwaladr Health Boards only distributed to hospitals and GP practices or community venues. The extent to which posters were then prominently displayed is not clear.
- 3.7 There is a further deadline of the 1 October 2015 for any case with a claim period of 1 August 2013 to 30 September 2014. For claim periods from 1 October 2014, there is now a rolling cut-off. These cut-offs are covered in the leaflet *Retrospective Claims for Reimbursement, Frequently Asked Questions*, November 2014.

<sup>24</sup> The Powys Project operates and advertises a helpline for claimants and potential claimants.



## Some health boards remain concerned about the availability and funding of CHC advocacy services

- 3.8 The Auditor General's June 2013 report highlighted gaps in the availability of advocacy services. The revised Framework states that health boards and local authorities should make individuals aware of local advocacy services that may be able to offer advice and support. The Framework also states that health boards need to consider the adequacy of advocacy services for those who are eligible or potentially eligible for CHC, and whether any action is needed to address any shortfalls.
- 3.9 In response to our survey, three of the seven health boards raised advocacy services as a concern, pointing to an inadequate level of local provision and to uncertainty about the prospect of securing funding to expand services. Concerns also related to the expertise in CHC of those offering advocacy services, although the Welsh Government's view is that the role of an advocate is to help the individual express their views and not to provide expert advice. The Welsh Government also told us that:
- a advocacy can be provided in various forms, and that the annual sample audit indicated that in many cases, family members or carers act as advocates;
  - b the role of the Care Co-ordinator in improving communication and engagement with individuals and their families may also limit any increased demand for advocacy;
  - c it had also worked with advocacy groups to gather information on the available services, and to clarify their role with CHC which will be reinforced in a 'Practitioners Frequently Asked Questions' document to be published early in 2015; and
  - d it held a national training day for advocates in the autumn of 2014 and that officials have presented at several advocacy network meetings.

## Appendices

Appendix 1 - Summary of arrangements for dealing with retrospective claims

Appendix 2 - Action taken in response to the main recommendations made by the Auditor General and the Public Accounts Committee

Appendix 3 - Audit methods



# Appendix 1 - Summary of arrangements for dealing with retrospective claims

This summary relates to claims received from 16 August 2010. The Powys Project is responsible for all claims submitted before this period and was tasked with completing these claims by June 2014.

Period which the claim relates to	Deadline for registering a claim	Deadline for processing a claim	Who is responsible for processing
1 April 2003 to 31 July 2013	31 July 2014	The revised Framework states that backlog 'claims should take no longer than two years to process'.	The Powys Project is responsible for the majority of claims – largely those received between 16 August 2012 and 15 August 2013; and 1 May 2014 and 31 July 2014.  Health boards are responsible for all other claims.
1 August 2013 to 30 September 2014	1 October 2015 (to include proof of payment, proof of legal authority)	The revised Framework states that 'these claims should normally be resolved within 12 months of receipt'.	Health boards
1 October 2014 onwards	Rolling cut-off with a claim period no longer than 12 months from the date of application	The revised Framework states that 'the resolution of claims submitted after 1st October 2014 ... should normally be achieved within six months'.	Health boards

Source: Welsh Government, *Continuing NHS Healthcare National Framework for Implementation in Wales, June 2014*

# Appendix 2 - Action taken in response to the main recommendations made by the Auditor General and the Public Accounts Committee

We have brought together issues and recommendations from both the Auditor General and Public Accounts Committee reports in this appendix. These are summarised under the main sections of this report, and are cross referenced to the relevant paragraphs.

Recommendation	Summary of action taken by the Welsh Government and health boards
<b>Improving the Framework, leadership and oversight</b>	
<p>The Auditor General’s report identified opportunities for making the former Framework clearer or more explicit; for addressing gaps in its coverage; and for ensuring that guidance is realistic and deliverable.</p>	<p>These have, in the main, been addressed by the new Framework (paragraphs 1.1 to 1.2).</p>
<p>To ensure that national policy and guidance supports consistency and fairness, the Welsh Government was recommended to:</p> <ul style="list-style-type: none"> <li>reconsider the benefits of introducing a screening tool to determine whether someone requires a CHC assessment;</li> <li>review the differences between the decision support tool domains in Wales and England, particularly for cognition, to confirm that the Welsh domains are reasonable; and</li> <li>work with health boards to develop national protocols and documentation, and encourage greater sharing of local policies and documentation between health boards.</li> </ul>	<p>The Welsh Government has considered adopting a screening tool, but under the revised Framework, its use is left to the discretion of health boards (paragraphs 1.5 to 1.6).</p> <p>The revised Framework adopts the decision support tool (paragraphs 1.7 to 1.10).</p> <p>A range of materials and good practice examples are now available via the complex care information and support website (paragraphs 1.3 to 1.4).</p>
<p>The Committee recommended that the Welsh Government assessed the impact of amending the decision support tool upon those people scored under the previous decision support tool – this was to establish whether individuals might have been disadvantaged and therefore potentially able to make a retrospective claim.</p>	<p>An initial assessment of the impact of the decision support tool has been undertaken, but the full impact will take time to establish (paragraphs 1.8 to 1.9).</p>

Recommendation	Summary of action taken by the Welsh Government and health boards
<p>The Committee and Auditor General's recommendations to strengthen leadership and governance, nationally and within health boards, involved the Welsh Government:</p> <ul style="list-style-type: none"> <li>strengthening its strategic oversight of the CHC Framework;</li> <li>requiring health boards to allocate overall responsibility for CHC at board director level, with specific responsibility for ensuring consistency in the Framework's application across the health board, the adequacy of staff resources allocated to CHC, and effective joint working with social services;</li> <li>monitoring progress with the provision of training to practitioners and professionals in this area to ensure that this leads to improvement;</li> <li>requiring health boards to establish peer review arrangements of the processes and decision making around CHC eligibility, and a means of sharing the learning from peer reviews;</li> <li>requiring health boards to complete and action the self-assessment and improvement checklist developed by the Wales Audit Office; and</li> <li>monitoring peer review and self-assessment processes to ensure they are achieving their intended outcome.</li> </ul>	<p>A Performance Framework for CHC (paragraphs 1.14 to 1.17) and revised health board governance and accountability arrangements (paragraphs 1.21 to 1.22) have been agreed.</p> <p>As required by the Welsh Government, all health boards have agreed an executive lead (paragraphs 1.11 to 1.12).</p> <p>The Performance Framework includes reporting of numbers of staff receiving training in the revised Framework (paragraph 1.27). Substantial numbers of NHS Wales staff have received training in the revised Framework although there is considerable variation in attendance levels across health boards (paragraphs 1.26 to 1.27).</p> <p>An annual sample audit is part of the Performance Framework and results are to be disseminated in writing and at an annual conference (paragraphs 1.17 to 1.18). The first annual sample audit was undertaken in October 2014.</p> <p>The Performance Framework requires health boards to complete an annual self –assessment using the Wales Audit Office template (paragraphs 1.15 to 1.16). The first self-assessments were carried out in February 2014.</p> <p>The Welsh Government co-ordinates and is responsible for writing up the results of the annual sample audit (paragraph 1.17) and receives the self-assessments undertaken by health boards (paragraph 1.15).</p>
<b>Retrospective claims</b>	
<p>The Auditor General's report recommended that the Welsh Government set a deadline for the completion of all retrospective claims that health boards were processing; and the view of the Committee was that all claims should be dealt with within a maximum of two years.</p>	<p>The revised Framework sets deadlines for the submission of all claims and for the maximum length of time the NHS should take to process the claim which varies from two years to six months depending upon the date the claim is made (paragraphs 2.3 to 2.6).</p>
<p>The Auditor General's report recommended that the Welsh Government establish a task and finish group with executive-level representation from across all health boards and chaired by a health board chief executive, to ensure that all retrospective cases, whether these are being handled by the Powys Project or individual health boards, are processed efficiently and to the set deadlines.</p>	<p>An executive task and finish group has been set up, but there are problems with membership and attendance levels (paragraphs 2.14 to 2.15). The performance monitoring developed by the task and finish group is inadequate (paragraphs 2.17 to 2.21).</p>

Recommendation	Summary of action taken by the Welsh Government and health boards
<p>The Committee was concerned about the arrangements for retrospective claims received after August 2010, and recommended that:</p> <ul style="list-style-type: none"> <li>the Welsh Government either developed a coherent plan for clearing the backlog of cases, or gives further consideration to whether the national project should deal with these; and</li> <li>that the national project was not disbanded until the backlog of all claims was cleared.</li> </ul>	<p>Some health boards have not demonstrated ability to deal in a timely way with the retrospective claims that they are responsible for (paragraphs 2.38 to 2.48).</p> <p>The Powys Project faces an even greater challenge in processing its share of claims received after 16 August 2010 (paragraphs 2.32 to 2.37).</p>
<p>The Auditor General's report recommended that the Welsh Government worked with health boards to agree a detailed and common approach to dealing with the retrospective cases being processed by health boards, and ensured the approach was broadly in line with the approach adopted by the Powys Project team.</p>	<p>The new Framework outlines the process to be followed across health boards, and this is based on the Powys Project approach (paragraph 2.1). The annual audit sample includes retrospective cases, and the first audit found that most health boards were following the correct processes (paragraph 1.17).</p>
<p>The Auditor General's report identified a significant risk that the national project would not clear all retrospective claims by the agreed deadline. The Committee recommended that the Welsh Government reviewed whether staffing levels were adequate and considered whether steps could be taken to improving staff retention in the Powys Project team.</p>	<p>The Powys Project reviewed as intended all claims by the June 2014 deadline, but did not complete 155 of the 2,525 claims (paragraphs 2.22 to 2.23). The long-term funding of the Powys Project has not yet been secured (paragraphs 2.36 to 2.37).</p>
<p><b>Communication and engagement with individuals and their families</b></p>	
<p>The Committee had a number of misgivings about the current approach to engaging individuals and their families in the assessment process, and recommended that:</p> <ul style="list-style-type: none"> <li>a proactive approach was needed to ensure information is provided to those who need it, enabling them to challenge decisions on eligibility; and</li> <li>information should be clear and simple.</li> </ul>	<p>An expanded range of public information leaflets has been developed, although these could be better publicised. The complicated arrangements for cut-off dates and responsibility for processing claims is confusing (paragraph 3.3). Information is not readily available to the public unless they are being assessed for CHC (paragraph 3.4).</p>

## Appendix 3 - Audit methods

We have gathered evidence for the follow-up review from a variety of sources. These included collating data from the Welsh Government, health boards, and the Powys Project; a review of the revised Framework together with a range of supporting documents; and interviews with Welsh Government officials, the Powys Project director, the health board national director for complex care, and staff from Cwm Taf Health Board.

We also undertook a short survey of all health boards that gathered information on the progress with completing retrospective claims, the level of staff allocated to processing retrospective claims, and on any issues or concerns with implementing the revised Framework.

As this is a follow-up review, we have relied heavily upon readily available performance information, which proved on a number of occasions not to be as robust or comprehensive as we would expect. The extent of our fieldwork has been more limited than was the case for the full review as reported in June 2013, with, for example, a far more limited range of interviews and no case file reviews.

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