Archwilio Cymru
Audit Wales

Continuing Healthcare Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2019-20

Date issued: November 2020

Document reference: 2016A2020-21

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Summary report

Background

1 Continuing NHS Healthcare (CHC) is a package of care provided by the NHS for those individuals with primary health needs[1]. Health boards are responsible for ensuring that CHC is provided to eligible adults and Continuing Care is provided for eligible children and young people[2].

2 The Welsh Government provides guidance and advice for Health Boards on CHC. The National Framework for Continuing NHS Healthcare (The National Framework) sets out a mandatory process for the NHS, working together with local authority partners, to assess health needs, decide on eligibility and provide appropriate care. Several resources have also been developed to support the delivery of the National Framework, for example a Decision Support Tool which supports the CHC assessment process.

3 The National Framework sets out its expectations of Local Health Boards in managing CHC, as shown in **Exhibit 1**.

Exhibit 1: Organisational Expectations for CHC

Local Health Boards are responsible for:

- ensuring consistency in the application of the National Framework for CHC;
- promoting awareness of CHC;
- implementing and maintaining good practice, ensuring quality standards are met and sustained;
- providing necessary training and development opportunities for practitioners; identifying and acting on issues arising in the provision of CHC;
- informing commissioning arrangements, both on a strategic and individual basis;
- ensuring best practice in assessment and record keeping; and
- provision of strategic leadership and organisational and workforce development, and ensuring local systems operate effectively and deliver improved performance.

(The National Framework for Continuing NHS Healthcare)

4 In 2019-20, Betsi Cadwaladr University Health Board (the Health Board) spent £106.2 million on CHC. This was an increase of around 8% compared to the previous year. CHC costs per head of population in the Health Board were the

[1] CHC is different from 'Funded Nursing Care' provided for people in nursing homes that require nursing support but are not considered to be eligible for CHC

[2] For the purposes of this review the use of the term CHC refers to both Continuing Healthcare for adults and Continuing Care for children and young people.

second highest of any health board in Wales in 2018-19 and CHC expenditure continues to create significant financial pressures for the Health Board.

5 This review assessed the Health Board's management arrangements for CHC at the corporate and operational level and included an examination of financial management and performance management arrangements and supporting information systems. The quality of the Multi-Disciplinary Team (MDT) decision making process and the NHS CHC panels i.e. whether decisions reached are appropriate sat outside of the scope of our review.

6 Our review was undertaken during January and February 2020 and therefore took place ahead of the declaration of the COVID-19 pandemic. We acknowledge that the Health Board has made several short-term changes to its CHC processes in response in line with Welsh Government guidance. This included implementation of a new Discharge to Recover and Assess process. The Discharge to Recover and Assess process means that patients that may be eligible for CHC have their care fully funded by the Health Board due to normal CHC assessments and processes being suspended. At the time of writing the Health Board was awaiting a national decision on when the usual CHC process should resume. We anticipate that this review can provide helpful reflections and valuable learning for the Health Board as it starts to reinstate normal CHC processes.

7 Audit Wales has also recently undertaken reviews of Social Services Budgetary and Cost Pressures at Denbighshire County Council and Conwy County Borough Council.[3] These reviews looked at how the Councils commission and administer residential and nursing home care placements and so may provide further context on some of the issues raised in this report. In addition, we are intending to undertake a further review of residential and nursing home commissioning during 2020-21 which will involve the Health Board and all six north Wales councils.

Key messages

8 Overall, our work has found that weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of CHC. But the Health Board has been developing an ambitious plan for improvement.

9 Prior to 2018 the Health Board managed CHC through a single health board-wide team. However, it was recognised that this structure did not adequately foster ownership of the CHC processes by operational staff, particularly in relation to budgetary management. Therefore, in 2018 the Health Board altered the structure of its CHC team, creating six sub-teams covering geographical areas, specialities and corporate aspects of CHC management. However, while solving one issue, the new structure weakened the capacity for central coordination and management of continuing healthcare. These weaknesses have meant that the management of

[3] Both 'Social Services Budgetary and Cost Pressures' reviews are due to be published to the Audit Wales website in October 2020.

CHC since 2018 evolved in an unplanned way and has led to some inefficiencies and occasional tensions between different CHC teams.

10 We also found that the Health Board's wider corporate arrangements are not yet effectively supporting the devolved CHC teams. There are opportunities to develop more consistent financial reporting, better utilise the IT systems and improve performance measurement and management. Staff raised significant concerns around weaknesses in the fee setting for care homes which has been causing tensions between partners, care homes and patients and their families. The Health Board has recently agreed to increase the fees paid to care homes to address this issue.

11 Lastly, we found varying performance across the CHC area teams and mental health division.[4] However, we did identify that since the autumn of 2019, the Health Board has been developing an ambitious improvement programme. This improvement programme, if it can be given sufficient momentum, should help to address many of the issues identified in this report.

12 Recommendations arising from this audit are detailed in **Exhibit 2**. The Health Board's management response to these recommendations are summarised in **Appendix 1**.

Recommendations

Exhibit 2: recommendations

The table below sets out the eight recommendations from our review.

Recommendations
The Health Board should develop a range of relevant and accessible governance documents for its management of CHC
R1 Building on the new national Framework (when published) and supporting tools, the Health Board should develop a set of key guidance documents to ensure consistent management of CHC across its teams. In addition, the Health Board should develop standard operating procedures that guide team members in the use of certain CHC tools such as the checklist.

[4] We do not comment on the quality of contracted and commissioned CHC services which sat outside the scope of this review.

Recommendations

The Health Board should introduce a consistent and accessible training programme for CHC team members and those that engage with CHC

R2 Following development of new guidance detailed in **R1** the Health Board should develop a consistent and accessible training programme for CHC team members and those that routinely engage with CHC (ie members of the MDT). In developing the programme, the Health Board could usefully engage with key partners such as local authorities and providers.

The Health Board should increase consistency of its CHC team structures and ensure roles are clearly articulated and understood

R3 The Health Board's work to drive consistency in the structure of its operational CHC area / divisional teams and divisions should include work to ensure job descriptions reflect the roles required. These should be clearly articulated and understood by existing and new CHC area/divisional team members.

The Health Board should introduce a formalised escalation procedure to resolve CHC disputes between its teams

R4 The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients.

The Health Board should seek to invest and develop its CHC contracting and commissioning team

R5 The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.

The Health Board should have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities

R6 The finance team provides a range of different reports for each operational CHC area team and division which produces different insights on performance and expenditure. This makes it difficult to identify areas of good practice or

Recommendations

learning opportunities between teams. Quality metrics for CHC are also underdeveloped. With central co-ordination and oversight, Operational CHC teams and divisions should work together to explore and agree on a set of quality, financial and performance metrics to manage CHC effectively and consistently across the Health Board.

The Health Board should ensure its CHC teams use the BroadCare IT system effectively and consistently

R7 The BroadCare IT system for managing CHC patients is not yet operating effectively at the Health Board due to weaknesses in its implementation, lack of training and lack of administrative support. In order to maximise the value of the system in managing CHC, the Health Board should:

- address the backlog of incomplete records through additional short-term capacity;
- ensure the system is set-up correctly for the Health Board, with system terminology matching that of the CHC process;
- ensure CHC teams are sufficiently trained on the use of the system; and
- ensure the corporate finance team use the system effectively.

The Health Board should formalise leadership within the corporate CHC team

R8 While the Health Board took steps to strengthen leadership within its corporate CHC team during 2019, arrangements are currently temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.

Exhibit source: Audit Wales

Detailed report

Weaknesses in the governance and oversight of CHC has led to inefficiencies, variation and tensions in its management, but the Health Board has been developing an ambitious plan for improvement

While the restructuring of CHC teams in 2018 had some benefit, the lack of central co-ordination and management impacted the CHC teams' ability to operate effectively

CHC restructuring in 2018 created improved divisional ownership for continuing healthcare

13 In 2018, the Health Board altered the structure of its CHC team, creating six sub-teams covering both corporate and operational aspects of CHC management. Prior to this, the Health Board managed CHC through a single team, which was hosted by one of its three geographical 'areas'. However, this structure caused concerns that operational CHC staff did not take ownership over the process, particularly in terms of the budget. This was leading to significant cost growth.

14 The CHC teams are currently structured as follows:

- three operational 'area' teams covering the geographic areas of east, central and west north Wales with responsibility for both general and elderly mental health CHC patients;
- a mental health operational team which covers all of North Wales;
- a children's services operational team which covers all of North Wales; and
- a corporate team, which covers aspects such as training and retrospective claim reviews.

15 Those we spoke to as part of our fieldwork were generally of the view that devolving the management of CHC to more local teams has been positive. For example, there is a consensus of views that the operational team staff take greater ownership over the CHC process and budget under the new structure. Operational teams also have the benefit of having a greater understanding of the services available within their area and can make effective use of locally developed relationships between partners, such as local authorities and care homes.

Limited central coordination has allowed unnecessary variation in processes and duplication of effort

16 From the point of restructure in 2018, the Health Board intended that the corporate CHC team would have a vital role in establishing robust arrangements that enables effective management of CHC across the Health Board. The corporate CHC

team's responsibilities include developing and monitoring the use of Health Board guidance, providing necessary training materials and courses; overseeing and managing the appeals process and managing retrospective claims for CHC.

17 Despite these intentions, the corporate team is small, and its capacity has recently been further strained due to staff secondments, long-term sickness absence and ongoing vacancies. Its lack of capacity has limited its ability to support and co-ordinate the operational teams. The team has been focussing on managing retrospective reviews and on identifying learning themes from appeals and complaints, which led to the recent development of a new appeals process.

18 The Health Board recognises that there are several areas where CHC processes and management should be strengthened. For example, use of the CHC checklist[5] is inconsistent which can have a direct consequence for patients. This includes variation in the period for which teams will fund care between a patient's positive checklist result (ie care is required) and the point at which the Decision Support Tool and CHC panel formally agrees a CHC package. Standard operating procedures could helpfully provide guidance in this way.

19 We are aware that some operational teams have taken steps to strengthen their own governance, such as the mental health CHC team strengthening controls by developing its operational framework. While such steps may lead to more effective working for individual teams, the absence of governance across teams is a cause for concern. This may allow undesirable variability and practice across the organisation (**Recommendation 1**).

Operational teams have developed in an ad hoc way and now vary in terms of size, seniority and experience, reflecting differing levels of investment across areas

20 Each of the operational CHC teams were small following changes to the CHC structure in 2018. Since that time each division has taken steps to increase the size and alter the structures of their teams.

21 While some teams were able to secure investment from within their divisions quickly and with relative ease, others have taken a more gradual approach and utilised temporary funding such as Invest to Save Fund and the Integrated Care Fund. This has resulted in notable differences between operational CHC teams, for example:

- teams have significantly varied numbers of substantive and temporary roles including managers, care facilitators and nurse reviewers;
- some teams have developed structures wherein the members specialise in different types of CHC patients where others have not; and

[5] In addition to the National Framework and the Decision Support Tools that Health Boards are required to use, the Welsh Government also recommends the use of the CHC checklist

- the mental health team has developed a Right Care and Assurance Programme (RCAP) function to manage high-cost care cases within their cohort of patients.

There was no central coordination of these changes and as a result the individual team structures have evolved independently of one another.

22 The Health Board has traditionally recruited CHC staff by attracting candidates with a nursing background. However, some of those we spoke to explained that the expectations of CHC staff are more specific. For example, staff should also be able to demonstrate higher levels of resilience and be skilled at managing difficult conversations. In addition, following the structural changes in 2018 there was no formal evaluation of job descriptions to reflect the differences of working in localised teams. Several of those we spoke to told us that their roles had altered significantly but that their job descriptions had not been updated to reflect the changes. Given the complexity and sensitivity surrounding the CHC process, there is a risk that current arrangements require staff to undertake roles and discharge responsibilities that go beyond the expectations formally set out by the Health Board.

23 As part of the Health Board's developing improvement plans for CHC (discussed further in **paragraphs 71-75**), it intends to develop workforce plans and re-evaluate the operational structure of its CHC teams. At the time of our fieldwork the Health Board was conducting workshops to develop a model team structure for CHC, utilising service demand and productivity benchmarks. This work is important in supporting decision-makers to ensure appropriate capacity, capability and consistency of the Health Board's CHC teams (**Recommendation** 3).

24 The resilience and stability of the Health Board's CHC teams is a further key concern. The rates of sickness absence and turnover within the Health Board's CHC teams are comparatively high which impacts on the capacity and resilience of teams. For one of the area operational teams the longest serving member of the team had been in post for two years. This is a further risk for the Health Board in ensuring it can ensure its ability to discharge its responsibilities in respect of CHC over the long-term. Increasing the stability and resilience of its CHC area teams and divisions should be a key consideration of the Health Board's work to develop CHC workforce plans.

The Health Board's CHC training is not yet fit for purpose

25 The national framework for CHC requires partners to provide access to appropriate training for staff involved in CHC. Following the publication of the National Framework in 2014, the Health Board was engaged in a regional CHC training and education group with local authority representatives, but this is no longer in operation. Subsequently, the corporate team developed a training package for CHC team members. However, capacity constraints and workload pressures have limited access to this training. As a result, different operational teams have developed their own training and induction programmes, which include a mixture of shadowing, observing and practicing with anonymised packages and mock panels.

The length of time teams provide for new recruits to train varies from a few days to three months. This inevitably makes it challenging to drive consistency and effectiveness in the management of CHC across the Health Board.

26 In addition, patients can be referred for CHC from a range of professional staff and various environments. There is currently no general training on CHC available for staff that are outside of CHC teams, such as ward nurses, although there is an information leaflet on the role of the Care Co-ordinator. CHC staff members we spoke to feel that there is a long-standing confusion across the Health Board regarding the role of CHC, particularly in terms of how it fits into the wider picture of patient flow, discharge planning and reablement. Inability to access training presents a missed opportunity to more fully inform and educate members of staff who, while sitting outside the direct CHC teams, impact on the CHC process through their involvement with patients (**Recommendation** 2).

27 While there is currently no training strategy for CHC, at the time of our fieldwork the Health Board had an ambition to develop such a strategy and was considering how to progress this work. For example, it may work with its partner local authorities to reinstate a joint training group following the publication of the new national Framework. The publication of the new Framework has been delayed as a result of the pandemic. In light of changes created by the COVID-19 pandemic there is now an even greater opportunity for the Health Board to reflect on any changes it saw as beneficial and implement a formal and accessible training programme that supports the Health Board in improving its CHC processes.

While there is good engagement between the corporate and operational teams, there are examples of significant tensions between operational CHC teams

28 Those we spoke to told us of how the relationship between the corporate and operational CHC teams work well. Although limited by its capacity, the corporate CHC team attempts to make itself available to support the operational teams with ad hoc queries and to provide learning points such as from retrospective reviews, appeals and Welsh Government guidance.

29 However, we heard examples of significant tensions between operational teams that can lead to internal disputes. These are mainly caused by a disagreement over which operational team should take primary ownership and financial responsibility for an eligible CHC patient. The differing budgets and organisational structures for each team, along with separate CHC panels has caused disagreements over which team/s should fund patients either with multiple needs, ie mental health and physical health, high-cost or complex needs.

30 Internal disputes have in the past become significant and protracted. While staff we spoke to were confident that this does not impact on quality of care, it causes significant frustration between staff. The corporate CHC team is often aware of the ongoing issues, however they do not have the power to arbitrate disputes, as they must be resolved between divisions (which hold the specific budgets for each team). The absence of policies such as pathways for specific care needs means

there is little to guide staff in the event of a dispute. At the time of our fieldwork the Health Board were developing a set of principles for dispute resolution. To add to this, the Health Board should develop a formal escalation process that staff can access and apply to reduce tensions and delays in the management of CHC (**Recommendation 4**).

Wider arrangements to support effective continuing healthcare management are underdeveloped

Multidisciplinary team decision making processes are starting to strengthen with the aim of improving the quality of their recommendations

31 A fundamental part of the CHC process is the work of the multidisciplinary team. The multidisciplinary team can draw on members from several professional disciplines such as doctors, nurses, therapists and social workers. The multidisciplinary team assesses the eligibility of a patient for CHC, develops a care package to meet the needs identified and presents a recommendation to the CHC panel to approve or challenge the recommendation. The multidisciplinary teams are led by care co-ordinators who coordinate the whole process of assessment for longer-term care, including gathering evidence to inform the decision on CHC eligibility.

32 It is crucial that multidisciplinary teams have the capacity and capability to undertake these roles effectively to ensure eligible patients can receive the right care in the right place and at the right time. Multidisciplinary team recommendations can be challenged and rejected by the CHC panel if they are judged to be incomplete or at odds with the National Framework. The National Framework states, 'Only in exceptional circumstances and for clearly articulated reasons should the LHB not accept the multidisciplinary team's expert advice on CHC eligibility'. Although there is a mechanism to appeal such judgements and to submit retrospective claims, this can cause distress for the patient and family and is costly and time-consuming for the Health Board. Therefore, the focus should be on getting the right decision made first time. Members of staff from the Health Board told us that a significant number of CHC applications submitted by multidisciplinary teams are regularly challenged or rejected by CHC panels. This suggests there may be room for improvement in the quality of multidisciplinary team recommendations to the CHC panel as well as potentially the application of the CHC eligibility criteria by the panel.

33 The Health Board has increasingly recognised that it must provide greater support to its multidisciplinary team to ensure that they fully understand the CHC process, which, in turn will ensure greater quality of applications received by the CHC panel. Some operational teams have acted by placing one of the CHC team members to act as an expert to guide multidisciplinary team discussions, helping them to navigate the national Framework and other legal frameworks. The Health Board

has a CHC improvement group (see **paragraph 71**) which, at the time of fieldwork, was evaluating this approach with a view to implementing it more broadly across each operational area team.

34 We also found that some divisional CHC operational teams are seeking to better engage with staff that are likely to be called upon as care co-ordinators by inviting them to observe multidisciplinary team discussions and CHC panel decisions. Those we spoke to said these steps were improving the quality of CHC applications while also managing the expectations of patients and families more effectively and appropriately than before. However, as detailed earlier in this report there are capacity restraints within the CHC teams which limits the availability of staff to provide support.

There is scope to improve partnership working between the Health Board and local authorities in the management of CHC

35 The National Framework for CHC makes clear the expectation that Health Boards and Local Authorities work effectively in partnership for specific elements of managing CHC, such as appointing jointly funded care packages, dealing with formal disputes and commissioning for residential and nursing homes. Effective management of CHC is, in many cases, dependent on effective communication between the Health Board and Local Authority, for example where a patient requires a housing adaptation before they can be discharged from hospital.

36 As described in **paragraph 7**, as part of our wider audit work programme, we have recently undertaken a review of social services financial pressures in Denbighshire County Council and Conwy County Borough Council. Both reviews indicate some weaknesses in partnership working which can cause delays in managing a patients' care and tensions between partners, providers and patients, including lack of communication regarding:

- the outcome of CHC panel decisions;
- changes to the nursing home rates previously agreed between partners; and
- the next steps for patients who, following review, are found to no longer be eligible for CHC packages.

These examples are largely a result of poor or slow communication between partners. We are aware that the urgent issues caused by the COVID-19 pandemic resulted in partners engaging in proactive and rapid communication to ensure patients had appropriate and timely access to CHC. The Health Board should build on this work with partners to reflect on how they can improve communication arrangements in the long-term. Again, this is an area where consistent guidance and accessible training (as referenced in **Recommendations 1 and 2**) could prove beneficial.

Commissioning and finance support for CHC teams is under-developed

37 The National Framework advises Health Boards to adopt an integrated approach of working with local authorities to commission CHC services to 'exercise maximum influence over the development of provision.' The Health Board does not currently commission services through a planned, collective approach, relying instead on spot purchasing. Spot purchasing refers to the practice of buying to meet an immediate need. The practice of spot purchasing means that the Health Board is engaged in a resource intensive practice which does not guarantee best value for money. The Health Board has, however, recently sought the support of the National Collaborative Commissioning Unit (NCCU) to identify ways to support it in terms of commissioning, planning and working with providers. In addition, the Health Board is in the process of developing a commissioning team and business support hub, which it intends will be able to further progress its commissioning capacity and experience.

38 In June 2019 the Health Board utilised Invest to Save funding to recruit a Head of Commissioning based within the corporate CHC team. The intention was to subsequently establish a commissioning team. However, due to pressures with the Health Board's management of CHC previously discussed in this report such as teams needing ad hoc support and advice, the appointed Head of Commissioning was asked to undertake an interim management role for the corporate team. This represents a poor use of resources as the Health Board are not using their resources as planned to make improvements but are instead having to focus on managing operational issues in a reactive way. The Health Board should resume plans to develop a skilled and dedicated commissioning capacity and capability (**Recommendation 5**).

39 There is a dedicated finance resource to support the Health Boards management of CHC, however, its capacity has been stretched since the expansion to six CHC teams in 2018. Operational CHC teams indicate that in general they receive good support from the finance team. The finance team collates CHC activity and cost data into weekly, monthly and quarterly reports but has developed different reporting content for different teams focussing on different aspects of financial performance and improvement. This results in lost opportunities that would arise from consistent reporting approaches across teams, for example:

- benchmarking and performance can be shared to support learning; and
- a smaller number of standardised reports would make better use of finance team capacity. This in turn could enable finance staff to better support service development.

The Health Board should therefore have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities (**Recommendation 6**).

The process of fee setting for CHC is a cause of tension

40 In addition to support from the finance team, the operational CHC teams also receive support from a contract management function. This has helped set agreed standards of service, monitoring agreements and escalating procedures with local authorities and care homes. Not all nursing homes are signed up to the agreement and in these instances, the contracting team will have a funding letter in its place.

41 Several staff we interviewed also raised concerns about the process of fee setting with care providers. While there's been a focus on CHC savings by the Health Board, there is a growing discontent amongst care home and domiciliary care providers with the current arrangement for setting fees. This is due to factors such as:

- the income from the Health Board for care homes hasn't increased with the rate of inflation for several years;
- rates for CHC, albeit often requiring intensive care services, being lower than the rates of Funded Nursing Care which are paid by the Local Authority. This has the potential to impact on the quality and sustainability of services; and
- some care homes have raised fees for some elements of their service, commonly referred to as 'top-up fees' which have not been agreed with the Health Board.

42 These issues have caused significant tension between the Health Board, some CHC providers and their patients and families which also sometimes inappropriately draws in ward staff to help manage this issue on a case by case basis.

43 At the time of fieldwork, we were aware that the Health Board had increased engagement with partners to agree a way forward which provides a clear and fair fee setting arrangement that all partners can sign up to and uphold. The Health Board has recently taken significant steps to address this issue. In response to pressures caused by the first phase of the pandemic, the Health Board agreed uplifts to care home fees. In 2020-21 the Health Board's broader financial planning also included long-term uplifts to care home fees.

The IT system for CHC is not yet being utilised effectively, leading to a reliance on less resilient systems

44 The Health Board uses an IT system called BroadCare to manage CHC. The system acts as a database which holds information on the patients in the CHC process. The BroadCare system was introduced at the Health Board in 2018. However, there were some weaknesses in the way the system was implemented within the Health Board which continue to affect its utility.

45 The BroadCare system was originally developed for NHS England and is widely used by NHS Trusts in England. There were therefore some features of BroadCare that were not well-suited to the Health Board due to differences between working practices and CHC processes between NHS England and NHS Wales. There was

limited recognition of these issues when the system was originally implemented, and the support to implement the system within the Health Board, including opportunities for training staff was not sufficient, being limited to a one-day training package and access to a test system for three months. The Health Board attempted to adopt a train the trainer approach, involving developing two super users of BroadCare within each operational team. However, this had limited success as those we spoke to said there was a lack of capacity for people to learn through using the system. As a result, many staff have developed their own approaches to using the system, which has created inconsistencies.

46 The purpose of implementing BroadCare was to provide a single file repository and reporting system. Prior to BroadCare, information regarding CHC activity and spend was stored on Microsoft Excel spreadsheets. However, while the BroadCare system had been in place for over two years at the time of our review, data relating to activity and cost continues to be managed through Microsoft Excel spreadsheets. This is due to incomplete records within BroadCare which undermines the reliability and usability of the system for accurate reporting and payments. The contracting team has had issues due to patient records within the BroadCare IT system being incomplete which has caused delays in payments being made to providers.

47 Those we spoke to attributed the gaps in information within the BroadCare system to factors such as:

- some staff do not fully understand how to use the system;
- the system is not intuitive or compatible with their working practices; or
- lack of administrative capacity to complete current and past records.

48 There is a need to both correct and cleanse the historic data and ensure effective use of the system by staff so that the issues relating to data quality do not recur. The CHC Operational Group and Improvement Group are aware of and exploring ways to address these issues in order to maximise the use of BroadCare across its CHC function. As part of this process, the Health Board is also exploring ways to integrate BroadCare with other Health Board data systems. The Health Board should seek to address these issues urgently to improve the robustness of its patient records for CHC (**Recommendation 7**).

CHC performance is variable, and information on quality is insufficient, however, the Health Board is developing an ambitious improvement programme

Performance management and measures are limited and the Board does not regularly oversee CHC performance, but the Health Board is exploring opportunities for richer data

49 There are mechanisms for monitoring and reporting on CHC at local, operational levels. The various teams of CHC have their own mechanisms to monitor and

report their performance. Some information is also reported to various groups and sub-committees of the Board through different performance reports. Performance measures for CHC at the Health Board have mainly focussed on:

- Activity: number of cases, number of out of area placements, number of reviews, those overdue and breaches;
- Cost: per package, movement since last period and changes to annual forecasted spend against budget (including efficiencies); and
- Risks: including cases under dispute or not yet reviewed by panel.

50 The national CHC Framework states that at Board level, each Board should receive information, including relevant escalated actions relating to CHC and that performance reports should be shared with any local partnership board with local authorities. Our review has found that CHC does not currently feature strongly within the routine performance monitoring by the Board.

51 The Health Board has started to develop its performance monitoring of CHC to provide richer data that can drive improvement. For example, the corporate CHC team is looking at good practice English CHC key performance indicators to help strengthen its performance measurement and management information.

52 In addition, the BroadCare IT system has the functionality to provide business intelligence reports. At the time of our fieldwork the Health Board's performance team was starting to develop a dashboard which draws on activity, spend and quality data from BroadCare, though this will be dependent on BroadCare having reliable and complete records. The Health Board recognises that its information regarding patient experience remains absent, and that such qualitative information is a challenge to capture and present.

CHC spending continues to increase year-on-year

53 As **Exhibit 3** shows, spending on CHC increased each year since 2016-17. This level of growth is unlikely to be sustainable in the long-term.

Exhibit 3: annual Health Board spend on CHC

The below exhibit shows the annual Health Board spend on CHC between 2016-17 and 2019-20.

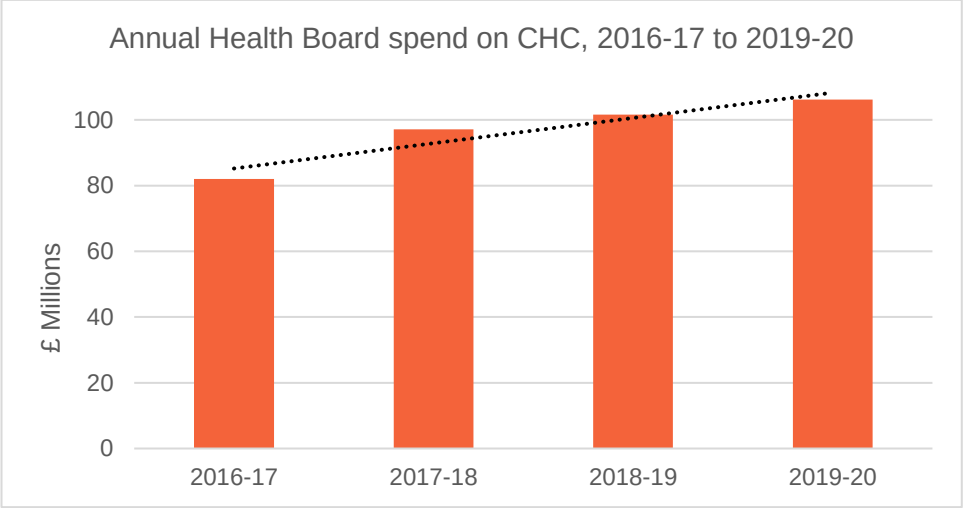

Exhibit source: Health Board data

54 An NHS benchmarking network exercise compared the spend and activity of CHC for each Health Board in Wales between 2016-17 and 2018-19. The benchmarking exercise suggested that the Health Board has the highest number of patients per 100,000 of population in 2018-19, calculated at 389. It is worth noting that some staff we spoke to felt that the benchmarking exercise was not meaningful due to perceived differences in the way Health Boards measure and record activity for CHC.

55 CHC teams have been required to deliver against savings targets to address the increasing spend of the function. Given the organisational structure for CHC, operational teams have their own savings targets, and performance and movement in expenditure varies significantly between operational area teams from one financial year to another, shown in **Exhibit 4**. The Health Board recognises that there is a benefit in reporting savings in a collective way and is now identifying common themes that areas can compare and learn from one another.

Exhibit 4: operational area movement in expenditure, 2017-2020

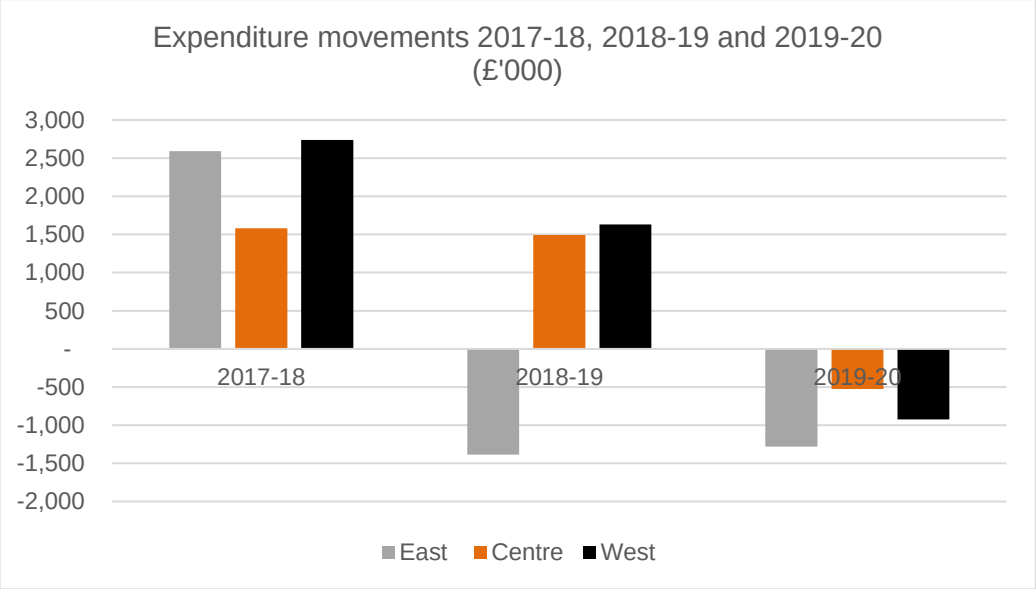

Exhibit source: Health Board data

56 Although CHC teams have individual savings targets, those savings are not subsequently available for the CHC teams to invest in the service, but rather are counted as savings within their broader respective divisions. This could be a barrier in terms of incentivising teams to make savings and pursue improvements, particularly if their divisions are not on board with the improvement agenda for CHC.

The Health Board regularly has overdue CHC reviews due to stretched capacity and external factors but has been making good progress with retrospective reviews

57 The National Framework sets specific performance expectations in terms of timeliness within the CHC process. For example, the time between a CHC assessment and agreeing a care package should be no longer than eight-weeks, or two days for a fast-track patient; and the time between first receiving CHC care and having a review of your care needs should be no longer than three months and annually thereafter.

58 While most of the Health Board's CHC work is completed in accordance with the expectations of the National Framework, it regularly sees breaches for a minority of cases. For example, since the introduction of the checklist there has been some instances of delays in CHC team members following up on the findings of the checklist which has led to patients waiting ten weeks which is beyond the eight-week limit.

59 We also heard examples of funding packages that had been agreed but not formally sent through to the CHC finance team, meaning providers had not been

paid for weeks, or even months following the placement of a patient within a care home. Given the lack of central co-ordination it is difficult for the Health Board to manage and mitigate this issue.

60 The Health Board regularly has a small number of overdue reviews. Overdue reviews can be protracted due to factors such as lack of capacity within CHC teams, difficulties in the patient's care such as movements in and out of hospital, and access to social workers.

61 During the pandemic the Health Board was required to suspend its usual arrangements for reviewing patients in receipt of CHC, although it did undertake light-touch safe and well checks. These checks, which were done remotely, provided assurance that patients were still receiving the right care.

62 Under a previous arrangement each Health Boards retrospective reviews were managed through a national project hosted in Powys. When this project came to an end in March 2019 each Health Board took back responsibility for retrospective claims in their area. The Health Board re-inherited 41 retrospective claims at that time. The Health Board has since made good progress with retrospective claims which can take a significant amount of time to progress due to the need for peer review, independent review or legal advice. At the time of fieldwork, the Health Board was anticipating having completed its investigations into all retrospective claims by the end of 2020.

Quality assurance arrangements are insufficient

63 The national framework states that the Health Board has a responsibility to monitor the quality of services provided through CHC in the context of provider performance as it would for all service contracts. It details that this includes making clear arrangements within purchasing and contracting processes on respective responsibilities.

64 The Pre-Placement Agreement (PPA) for nursing homes includes the providers' responsibilities regarding quality assurance, which includes the submission of a quarterly self-assessment survey of nursing homes which require providers to report against a set of indicators including falls and any submissions to Care Inspectorate Wales. The information from the survey is provided to the Health Board's contract management team and is discussed in quality meetings between contract management and operational teams. The information from the survey is also used to inform a rolling annual inspection programme. Inspections are undertaken between contracting representatives, practice development nurses and sometimes social service staff. These inspections look at a range of information including the care homes' insurance and training of staff.

65 However, not all the care homes contracted by the Health Board have signed up to the PPA and it is unclear whether the arrangements outlined above apply equally to those not signed up. While these arrangements partially cover care homes, the Health Board does not currently have established quality assurance arrangements for domiciliary care. The Health Board does not receive assurance on what domiciliary care providers are delivering and is currently unable to monitor them. At

the time of fieldwork, the Health Board was working on developing data drawn from and within the Health Board and from external sources such as Care Inspectorate Wales and partner Local Authorities. While this will support the Health Board to monitor providers to an extent it can only provide a limited level of assurance about the quality of care services provide for the its patients. The Health Board should work to develop quality metrics for CHC to support performance monitoring and reporting (**Recommendation 6**).

66 Since the start of the pandemic, there have been some changes to CHC quality assurance arrangements for CHC. This includes introduction of an escalation and support tool and a formal system for daily contact between care home providers, the Health Board and local authorities to rapidly identify issues and offer support. The Executive Director of Primary and Community Care's portfolio for CHC has also recently strengthened with clearer responsibility for quality assurance and oversight. As part of this, the Health Board is currently developing underpinning governance arrangements with operational groups and reporting lines.

There are greater opportunities to invest CHC expenditure in reablement to promote patient independence

67 The National Framework (for CHC) is supportive of the Welsh Government's wider aims of prevention and promoting independence. It states that 'CHC should not necessarily be viewed as a permanent arrangement. Care provision should be needs-led and designed to maximise ability and independence' (CHC guidance). There is an expectation that partners should work together to ensure that there is sufficient access to services which promote and support independent living and prevent needs from deteriorating. It is therefore vital that partners have a good and comprehensive range of core services to provide for needs of the current and future population.

68 However, many of those we spoke to at the Health Board felt several patients are in receipt of CHC because a core service provision is not available to them due to issues such as lack of funding or workforce shortages. Gaps in core services impact negatively on the ability and/or independence of some patients and makes their needs greater, and potentially needing CHC. One example cited frequently was a lack of access to district nurses. District nursing can provide substantial support to patients to enable them to stay healthy in their communities. In addition, gaps in services for children mean that children with primary health needs must go 'out of area' to receive the care they need, which negatively impacts the patient and incurs substantial costs to the Health Board.

69 Strengthening access to core services has the potential to prevent escalated health needs. This has benefits in terms of patient care and experience and produces efficiencies as there is less demand for more intensive CHC services. As part of the community transformation programme, area teams have been working to develop a wider range of core services which can support people to maximise their independence. This has on occasion included the block purchasing of discharge to assess beds in care homes. The Health Board recognises that there is scope for

greater investment into core services which will deliver longer term benefits for patients as well as the health and care system

The Health Board is developing an ambitious improvement programme for its CHC arrangements but needs to ensure there is a sustainable approach to the leadership of this important function

70 In September 2019, the Health Board appointed an Assistant Director for Primary and Community Services on a fixed-term contract to oversee CHC improvement. This appointment was made to strengthen leadership and oversight of CHC and we have noted a positive direction of travel since the appointment, albeit that we expect the additional capacity will be required over a number of years. The Health Board should formalise the leadership within the corporate CHC team to maintain long-term improvement and oversight (**Recommendation 8**).

71 The Health Board also introduced a CHC improvement group during 2019. The group is chaired by the Assistant Director for Primary and Community services and meets monthly. The aim of the group is to drive continuous improvement and support longer-term transformation, though its focus is also on achieving financial savings targets. Attendance at the CHC improvement group is variable although the membership has evolved to include a broader range of key representatives including finance and local authority representatives.

72 During our fieldwork, some of those we spoke to suggested that the improvement group is currently too financially focussed and a need for greater emphasis on quality and safety of services. Our observation and review of previous meetings' minutes showed an increasing improvement in the balance of the agenda.

73 In addition to the Improvement Group there is a CHC Operational Group which also meets monthly. Its purpose is to gather key members of staff to discuss broad issues including learning from past cases and appeals, discussing any common problems such as IT systems and discussing performance including financial performance. Some of those we spoke to indicated that the operational group was helpful in bringing teams together to think collectively, however the membership of the group could be more inclusive because some staff do not always hear the outcomes from meetings. This issue could be addressed by revisiting the membership of the group or ensuring a better information cascade from the discussions and decisions at that meeting.

74 At the time of our fieldwork, the Health Board was developing an ambitious plan for improving its management of CHC, overseen and driven by its CHC improvement and operational groups. This included the development of two business cases for CHC which combine to cover three key elements, namely:

- increased grip and control; this will see the Health Board identifying and applying a consistent approach across the Health Board in the management of CHC. This will include developing standard operating procedures.

- development of a business support unit; this team would be responsible for procurement, contracting and performance monitoring. This hub will manage relationships with providers in a more planned and proactive way.
- development of a complex case team: this additional team will manage CHC on behalf of complex and high-cost patients. This will provide a single, experienced panel to manage the cohort of complex patients which occasionally causes tensions between area teams and operational divisions.

75 It is worth noting that during the pandemic, the Health Board implemented a command structure to enable rapid and effective decision making for urgent matters related to COVID-19. This included a care home cell, with members comprised form a range of key partners including local authorities. We understand that this arrangement was unique and has been commended as good practice by Welsh Government. In relation to the points above, the Health Board has indicated that it has made good progress in relation to establishing its business support function with the creation of a virtual management team and improved partnership working to support contracting of care home services. We are aware that the Health Board is still committed to plans in the other two areas, but that progress has been delayed due to the pandemic and the delayed publication of the new National Framework.

Appendix 1

Action plan

Our recommendations are set out below to improve the operational management arrangements which support the administration of continuing healthcare. We have not made any recommendations relating to the post-COVID-19 environment. The Health Board should compete this table and ensure that recommendations are logged on the corporate recommendation tracking system, to enable audit committee to monitor progress.

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
18	**The Health Board should develop a range of relevant and accessible governance documents for its management of CHC** R1 Building on the new national Framework (when published) and supporting tools, the Health Board should develop a set of key guidance documents to ensure consistent management of CHC across its teams. In addition, the Health Board should develop standard operating procedures that guide team members in the use of certain CHC tools such as the checklist.	Staff have access to necessary and relevant local guidance	Yes	**Head of CHC Commissioning** A set of key local guidance documents will be finalised by November 2020 and a work programme will be signed off. Key documents will be completed by March 2021 with full completion by June 2021. All the documents will be available on the Health Board Intranet site and where appropriate on the dedicated pages of the Health Boards' website. Documentation will be	June 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
				reviewed and refreshed when the new national CHC Framework is published.	
25	**The Health Board should introduce a consistent and accessible training programme for CHC team members and those that engage with CHC** R2 Following development of new guidance detailed in R1 the Health Board should develop a consistent and accessible training programme for CHC team members and those that routinely engage with CHC (ie members of the MDT). In developing the programme, the Health Board could usefully engage with key partners such as local authorities and providers.	Staff that feel informed and educated about the CHC process and how to apply it effectively	Yes	**Head of CHC Commissioning** A tiered training programme will be designed by 31 March 2021. This will provide the foundations for a rolling training programme reflecting competency levels required for different roles associated the CHC process on a 1-4 tier system. The design of the programme will be discussed with partners including those representing providers. Level 1 will be a core on-line training for all CHC active staff. Level 2 will include additional CHC support for key CHC	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
				staff such as CHC coordinators. Level 3 will be a focused programme of training for clinical staff in CHC teams including an in-team induction programme and corporate supported training events. Level 4 will be focused on sharing learning between CHC staff from corporate and area teams, including case reflection and themed learning integrated into practice such as learning from appeals and retrospective cases.	
22	**The Health Board should increase consistency of its CHC teams and ensure roles are clearly articulated and understood** R3 The Health Board's current work to drive consistency in the structure of its CHC teams should include work to ensure job descriptions reflect the roles required. These should be	Operational teams with the right capacity and seniority to work effectively.	Yes	The CHC corporate team will lead the design of core structures for operational teams at Area and divisional level. This will include standardised job descriptions and structures on teams can work towards locally as	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
	clearly articulated and understood by current and new CHC team members.			opportunities allow within employment law.	
29	**The Health Board should introduce a formalised escalation procedure to resolve CHC disputes between its teams** R4 The Health Board should formalise and implement escalation arrangements for CHC disputes at pace. There should be a clear procedure which is widely understood by relevant staff and can be used to quickly resolve internal disputes, for example, which team should take the budgetary responsibility for specific CHC patients.	Reduced tensions between teams as staff can resolve disputes quickly and easily through an agreed escalation process.	Yes	**Head of CHC Commissioning in partnership with Area / MHLD Directors of Finance** The Health Board will develop an internal disputes process mirroring the three stages in the PPA agreement used with external providers. This will be health board wide covering Area teams and the MHLD division.	April 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
39	**The Health Board should seek to invest and develop its CHC contracting and commissioning team** R5 The Health Board's role as a contractor and commissioner of CHC is underdeveloped which causes inefficiencies and tensions amongst its staff and its providers. The Health Board should resume the work it began in 2019 to develop a CHC contracting and commissioning team with the capacity and capability to plan and deliver CHC more effectively and efficiently.	A dedicated contracting and commissioning resource to undertake planned commissioning of CHC care that is efficient and effective.	Yes	**Associate Director of HealthCare Contracting and Finance** The Health Board accepts the need for the development of a new 'Commissioning Unit' with the responsibility for the strategic commissioning and performance management of all CHC and ICP placements. The HB has agreed in principle to adopt a 'Business Hub' model that will build on these principles, work has commenced to develop an outline business case.	April 2021
40	**The Health Board should have consistent reports across its CHC teams to enable the identification of good practice and learning opportunities** R6 The finance team provides a range of different reports for each operational CHC area team and division which produces different insights on performance and expenditure. This makes it difficult	Oversight of performance across a range of metrics for various CHC teams that informs ongoing management and the Health Board's wider improvement plans.	Yes	**Head of CHC commissioning** CHC quality and performance tools are in development to support CHC delivery. They build on the learning during pandemic and the changes implemented in pathways of care. Quality metrics will be explicit in the revised PPA which providers will be	March 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
	to identify areas of good practice or learning opportunities between teams. Quality metrics for CHC are also underdeveloped. With central co-ordination and oversight, Operational CHC teams and divisions should work together to explore and agree on a set of quality, financial and performance metrics to manage CHC effectively and consistently across the Health Board.			required to sign as a core component of the contractual arrangements. **Chief Finance Lead for CHC in partnership with Head of CHC Commissioning** Finance Metrics – with the full adoption of the BroadCare system, the opportunity is recognised to improve reporting efficiency and agree a standardised set of Financial metrics reports. Work on this through the Health Boards CHC Operational Group has already commenced and any requests for non-standard reports to support the different Operational requirements will be evaluated by that Group to see if they should be adopted and add value to all Divisions.	February 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
48	**The Health Board should make arrangements to ensure its CHC teams use the BroadCare IT system effectively and consistently** R7 The BroadCare IT system for managing CHC patients is not yet operating effectively at the Health Board due to weaknesses in its implementation, lack of training and lack of administrative support. In order to maximise the value of the system in managing CHC, the Health Board should: • address the identified backlog of incomplete records through additional short-term capacity; • ensure the system is set-up correctly for the Health Board, with system terminology matching that of the CHC process • ensure CHC teams are sufficiently trained on the use of the system. • Ensure the corporate finance team use the system effectively.	A reliable patient record system for CHC that staff can use to inform its plans, performance monitoring and decisions	Yes	**Chief Finance Lead for CHC in partnership with Head of CHC Commissioning supported by the Senior Systems analyst Informatics.** The Health Board accepts this recommendation and is implementing a BroadCare optimisation programme. The optimisation programme will ensure: a) Consistent case management documentation, a peer support programme and improved data quality in CHC operational teams. b) Financial reconciliation and transfer to BroadCare software case management for authorisation and payment of care packages.	February 2021

Para	Recommendation	Intended outcome/ benefit	Agreed	Responsible officer and actions	Completion date
69	**The Health Board should formalise leadership within the corporate CHC team** R8 While the Health Board strengthened leadership within its corporate CHC team during 2019, arrangements are currently ad hoc and temporary. The Health Board should seek to develop longer-term leadership to ensure improvement and robust central oversight of its CHC management.	Strengthened long-term oversight and management	Yes	**Assistant Director for Primary and Community Services.** A transition plan has been agreed to consolidate the corporate CHC leadership team. This team will now oversee CHC and the care home sector reporting into a substantive Assistant Director of Primary and Community services from 1 January 2021.	January 2021

Exhibit source: Audit Wales

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