

**National Assembly for Wales**  
Public Accounts Committee

# Implementation of the National Framework for Continuing NHS Healthcare: Follow-up Report

March 2015

Cynulliad  
Cenedlaethol  
Cymru

National  
Assembly for  
Wales



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Framework for Continuing NHS  
Healthcare: Follow-up Report**

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# Public Accounts Committee

The Committee was established on 22 June 2011. The role of the Public Accounts Committee is to ensure that proper and thorough scrutiny is given to Welsh Government expenditure. The specific functions of the Committee are set out in Standing Order 18. The Committee will consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

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## Current Committee membership:



**Darren Millar (Chair)**  
Welsh Conservatives  
Clwyd West



**William Graham**  
Welsh Conservatives  
South Wales East



**Mike Hedges**  
Welsh Labour  
Swansea East



**Jocelyn Davies**  
Plaid Cymru  
South Wales East



**Sandy Mewies**  
Welsh Labour  
Delyn



**Julie Morgan**  
Welsh Labour  
Cardiff North



**Jenny Rathbone**  
Welsh Labour  
Cardiff Central



**Aled Roberts**  
Welsh Liberal Democrats  
North Wales

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## Chair's foreword

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In December 2013, the Public Accounts Committee published a report into continuing NHS healthcare. At the time, we concluded that some patients and their families had been left feeling disenfranchised and let down by the system as timely access to continuing healthcare had not always been available.

In January 2015, the Auditor General published a follow-up report on the Welsh Government's National Framework, which seeks to ensure a consistent approach for assessing continuing healthcare. It found that whilst the Framework had delivered some benefits more needed to be done.

Having considered the Auditor General's report and taken further evidence, the Committee recognises that in the past months improvements have been made since 2013. However, we remain concerned about delays and potential inconsistencies in Health Board decision-making and feel that more must be done to ensure that patients and their families are treated fairly and are made aware of their options and provided with more information on how decisions will be made about the care they receive.

In addition to the above, the number of retrospective claims that are outstanding is still disappointing as is the time taken to process and resolve these claims.

We trust that the recommendations in this report will be helpful for the Welsh Government to show the necessary leadership to drive forward improvements to the continuing NHS healthcare system so that patients and their loved ones can be confident that it is fair, transparent and consistent across Wales.

Darren Millar AM  
Chair

## Recommendations

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**Recommendation 1.** The Committee recommends that, to ensure confidence in the quality and consistency of decisions on continuing healthcare funding awards, the annual audit samples of all Health Boards should be undertaken independently, by the same team.

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**Recommendation 2.** The Welsh Government should provide the Committee with details of the outcomes and findings from the on-going review of cases with learning disabilities, which is concluding in March 2015.

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**Recommendation 3.** The Committee recommends that the Welsh Government continues to monitor Health Boards' progress in processing retrospective claims and if necessary, refer claims not processed within the prescribed deadline to the Powys Project and provides the Committee with an update before the summer recess.

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**Recommendation 4.** The Committee recommends that the Welsh Government reports to the Committee before the summer recess on the expansion of the local and national recruitment programme and whether this has led to improvements in the time taken to process current and future claims.

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**Recommendation 5.** The Committee recommends that the Welsh Government monitors Health Boards to ensure that the shorter processing deadline for more recent claims does not result in unintended consequences of longer resolution times for long-standing claims which are unresolved.

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**Recommendation 6.** The Committee recommends that the Welsh Government ensures that governance arrangements are clear and well understood in relation to complex care. This will include monitoring the effectiveness of such arrangements and the engagement of members of the National Complex Care Board and any task and finish groups which support its work.

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**Recommendation 7.** In addition to the current leaflets that are designed to be accessed once an individual is ‘in the system’, the Committee recommends that the Welsh Government publishes a general public information leaflet on continuing health care. These leaflets should be shared with health and social care professionals and distributed widely, including being made available in doctors’ surgeries. (Page 23)

**Recommendation 8.** The Committee recommends that mandatory guidance is issued to Health Boards and social care providers on where information in relation to continuing health care should be made available. This should include the provision of information to individuals (and/or their family members) who are in, or prior to admission into a care home, including details of how the Decision Support Tool is applied to individuals being assessed for Continuing Healthcare. (Page 23)

**Recommendation 9.** The Committee remains concerned about the awareness, quality and level of provision of advocacy services provided by different Health Boards and is supportive of patients and carers understanding their options and the decision-making process as well as healthcare professionals. The Committee recommends the Welsh Government reports to the Committee before the summer recess, on how it intends to improve the consistency, quality and awareness of advocacy services. (Page 23)

## Introduction

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1. 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.
2. 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 health care and social care, but this does not include the cost of food, accommodation or general household support. Where a person is eligible for CHC and is already in a care home, the NHS pays the care home fees, including board and accommodation. The Welsh Government's Framework sets out the arrangements for the delivery of Continuing NHS Healthcare in Wales.
3. In June 2013, the Auditor General for Wales published a report [Implementation of the National Framework for Continuing NHS Healthcare](#). The Auditor General's report found that whilst the [previous] Framework had delivered some benefits, more needed to be done to ensure that people were dealt with fairly and consistently. The report noted that there was a significant risk that the national project to process retrospective claims would not be complete by the agreed deadline, and that new backlogs of retrospective claims had developed in health boards.
4. The Committee published its own [report](#)<sup>1</sup> on this topic in December 2013. The Committee concluded that equitable and timely access to continuing NHS healthcare had not always been available, and this had led to some patients and their families feeling disenfranchised and let down by the system.
5. The [Welsh Government response](#) to the Committee's report was published on 31 January 2014. It accepted seven of the recommendations in full and three in part. When considering the Welsh Government's response in March 2014, the Committee took up the Auditor General's offer to follow up the progress made on reducing the backlog claims' deficit and the launch of the revised framework.

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<sup>1</sup> Public Accounts Committee, Implementation of the National Framework for Continuing NHS Healthcare, December 2013 Healthcare

6. Taking into account the findings from that follow up work, the Auditor General published [Continuing NHS Healthcare - Follow-up Report](#) in January 2015. The Auditor General's follow-up report found that:

- the revised CHC National Framework addressed many of the weaknesses in the previous version, and leadership and oversight were being strengthened;
- there were more outstanding retrospective claims than ever before, and the response from some health boards had been unsatisfactory; and
- public information on CHC had been expanded but needed 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 remained a concern for some health boards.

7. On 3 February 2015, the Committee considered the Auditor General's follow-up report, and took evidence from the Welsh Government:

- Dr Andrew Goodall, Director General, Health and Social Services and Chief Executive of NHS Wales;
- Albert Heaney, Director of Social Services and Integration, Welsh Government; and
- Lisa Dunsford, Deputy Director, Integration Policy and Delivery Division, Welsh Government.

### ***Our view***

8. The Committee is pleased to note the Welsh Government has accepted<sup>2</sup> the recommendations made in the Auditor General's report. The Committee agreed to set out its views on this matter in this report.

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<sup>2</sup> [Letter from Director General, dated 27 January 2015](#)

# **1. Implementation of the revised CHC Framework**

## **Background**

9. The Welsh Government consulted on a revised CHC Framework between 13 December 2013 and 13 March 2014. A final version of the Framework was issued in June 2014 with an implementation date of 1 October 2014.

## **The revised Framework and new Decision Support Tool (DST)**

10. The revised framework now includes:

- expanded guidance on how CHC should be applied to people with a learning disability or with mental health needs;
- more detail on joint funding arrangements between health and social care and top-ups and direct payments; and
- less onerous and more realistic requirements for the frequency of CHC reviews, that are in line with the requirements in England.

11. The guidance within the Framework and supporting documentation has also been improved, with the use of a screening tool being left to the discretion of health boards. The Welsh Government has adopted the Decision Support Tool (DST) used in England.

12. The Committee had previously raised concerns about the impact of amending the DST, as those individuals assessed under the previous version may have been disadvantaged and therefore potentially able to make a retrospective claim.

13. The Welsh Government arranged a pilot to examine outcomes under the DST against the previous version. Two health boards (Cardiff & Vale University Health Board and Hywel Dda University Health Board) were involved in the pilot to assess ten cases each; a third health board (Betsi Cadwaladr UHB) withdrew due to lack of capacity to undertake the assessments.

14. The Director of Social Services and Integration confirmed the pilots showed that for those individuals with dementia “there was no

marked difference”.<sup>3</sup> In a follow-up letter from the Director General, dated 13 February 2015, he confirmed the pilots related to individuals with dementia. Their needs were assessed against the 2010 Welsh DST and the proposed DST as issued by the Department of Health in England and in all cases “there was no difference in outcome for CHC eligibility”.<sup>4</sup>

15. However, for those with learning disabilities “the evidence pointed to a potential difference”.<sup>5</sup> The pilot tested 20 cases relating to dementia and a further three cases relating to learning disability. Of the three cases tested relating to learning disability, one individual who would have been determined as not eligible for CHC using the old DST was found to be eligible using the new tool.

16. The Committee was concerned that the small sample size was potentially not sufficient to determine definitively whether retrospective claims made against the old DST would disadvantage claimants. The report of the pilot study,<sup>6</sup> concluded that:

“The sample size of the evaluation was smaller than anticipated and the findings do not replace the need for the ongoing monitoring of implementation from an equalities perspective.

“It does provide some assurance to Welsh Government that it does not appear likely that significant numbers of people with a dementia have been disadvantaged by the application of the Welsh DST issued with the 2010 Framework.

“The exercise has raised some query regarding the application of the DST to individuals with a learning disability, and this requires further exploration with the relevant expert groups.”<sup>7</sup>

## **Sample Audit**

17. The Welsh Government has also agreed a new Performance Framework with local health boards, which the Welsh Government says will support continued improvement and shared learning. As part of

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<sup>3</sup> RoP, paragraph 21, 3 February 2015

<sup>4</sup> [Letter from the Director General, dated 13 February 2015](#)

<sup>5</sup> RoP, paragraph 22, 3 February 2015

<sup>6</sup> Review of the Framework for the Implementation of Continuing NHS Healthcare in Wales 2014

<sup>7</sup> [Letter from the Director General, dated 13 February 2015](#)

the Performance Framework the Welsh Government has undertaken a sample audit (peer review) of CHC eligibility decisions.

18. The audit involves reviewing a sample of recent CHC cases, together with a sample of retrospective claims. The audit assesses whether a health board has followed the correct process and interpreted eligibility criteria consistently.

19. The Performance Framework also sets out arrangements for health boards to produce quarterly and annual performance reports on CHC, and for the Welsh Government to compile an annual publically available report.

20. The Committee questioned the Welsh Government on the annual sample and what was being done to improve poor performance. The Deputy Director said:

“I think, in relation to the sample audits, what we are finding across a range of areas is that there is variation between health boards. Now, some may be doing very well on training, some may have been struggling with retrospectives, but, in terms of the mechanisms that we are putting in place, we are gathering the information from the self-assessments, which were undertaken in February last year. The sample audits were undertaken in September and October and they were sample audits by a central team, rather than by peer review, but we would want to move to peer review in the future.”<sup>8</sup>

21. In a follow-up letter, the Director General confirmed that the sample audit examined seven recent cases and three retrospective claims in each of the seven health boards. Of the 42 recent cases, nine related to individuals with dementia and seven to individuals with learning disabilities. He stated:

“The reviewers agreed that, in at least two of those seven learning disability cases, the assessed need should have led to an outcome of eligibility for CHC.

“The findings of these small studies indicate to Welsh Government that ongoing monitoring is needed to ensure equity for older people with mental health needs (e.g dementia)

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<sup>8</sup> RoP, paragraph 24, 3 February 2015

and that closer examination is required of jointly funded cases for individuals with learning disability. We are currently working with the Local Health Boards to undertake that exercise.”<sup>9</sup>

22. The Director of Social Services and Integration confirmed that local health boards would review all of the cases that are jointly packaged between local authorities and health, to ensure that there are no discriminatory features by March 2015.

23. The sample audit was more persuasive than the DST assessment pilots that claimants had not been disadvantaged if they suffered with dementia but re-iterated the concerns relating to cases involving individuals with learning disability.

### *Our view*

**The Committee recommends that, to ensure confidence in the quality and consistency of decisions on continuing healthcare funding awards, the annual audit samples of all Health Boards should be undertaken independently, by the same team.**

**The Welsh Government should provide the Committee with details of the outcomes and findings from the on-going review of cases with learning disabilities, which is concluding in March 2015.**

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<sup>9</sup> [Letter from the Director General, dated 13 February 2015](#)

## 2. Retrospective claims

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### Background

24. 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.

### Responsibility for retrospective claims

25. 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 prior to 15 August 2010. The Auditor General's follow-up report explains that responsibility for retrospective claims received since 16 August 2010 rested with either the Powys Project or individual health boards. However, the Powys Project had been responsible for all claims received between 1 May 2014 and 31 July 2014 and health boards had been responsible for all claims received since 1 August 2014.

26. The Auditor General's follow-up report highlighted that some health boards had not always given appropriate priority and resources to dealing with the retrospective claims they had received since 16 August 2010.

27. Figure 10 of the Auditor General's follow-up report showed that two health boards in particular, Betsi Cadwaladr and Cwm Taf, were likely to breach the two-year deadline for reviewing all outstanding cases.

28. The Deputy Director noted:

“...we were monitoring the responses by each of the local health boards to the retrospectives and, as I've said before, there was quite a big variability. Some local health boards wouldn't have been far off missing the numbers that they'd expected to deliver by December just gone, others were a long way off. I think someone referred to the issue with Betsi



Cadwaladr, and they asked very early on for Powys to take on dealing with their retrospectives.”<sup>10</sup>

29. The Auditor General recommended in his follow-up report that:

“The Welsh Government 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.”<sup>11</sup>

30. In response to this recommendation, the Welsh Government confirmed that it had been agreed that all ‘phase 2’ claims would now transfer to the Powys Project.<sup>12</sup> The Director General said:

“I think, in respect of the current progress being made with the numbers of cases, and referring to the graphs that the WAO set out, that partly drove, actually, the reason for intervention, and having the discussion amongst the chief executives in a different way, that said, actually, rather than wait until the end and acknowledge that there was a problem looking backwards, it’s actually to say that, if we don’t intervene differently, there will be a problem in actually keeping up with these numbers of cases going forward. Hence, the decision to actually move the phase 2 cohort to the Powys programme: it’s to allow us, actually, to ensure that we will go through the appropriate numbers per month, in order to meet the requisite timescales at this stage.”

31. The Committee noted that because of this decision the majority of retrospective cases are now the responsibility of the Powys Project; that this was to ensure that the prescribed deadlines are met, and that health boards have ongoing responsibility for more recent and future retrospective claims.

32. The Director General explained what the Welsh Government was doing to improve health boards who were not engaging with the process. He said:

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<sup>10</sup> RoP, paragraph 90, 3 February 2015

<sup>11</sup> Auditor General’s follow-up report

<sup>12</sup> [Letter from Director General, dated 27 January 2015](#)

“...I’ve just written out to all of the leads, and I’ll explain what my expectations are other than that, but, obviously, we are monitoring the progress that is being made.”<sup>13</sup>

33. The Director General acknowledged that there was a legitimate question of why the decision to give the Powys Project responsibility for all phase 2 claims had not been taken previously. The Auditor General’s follow-up report explains some of the rationale for the previous division of responsibility.<sup>14</sup>

34. From his perspective as a former health board Chief Executive, the Director General noted that he had personal responsibility to make sure there was the necessary progress with retrospective claims. The Director General added that he didn’t “want to distribute the expertise to a national programme”<sup>15</sup> and felt that local health boards should take responsibility and build up their knowledge and expertise to deal with new claims in future. Commenting on the transfer of phase 2 claims to the Powys Project, the Deputy Director noted that:

“What we are continuing to do, though, is to try and, through the knowledge of the Powys team, share that amongst the health boards, so they need to ensure that they do develop their own capacity.”<sup>16</sup>

35. The Director General confirmed that funding to deal with the backlog of claims of £5.6 million over two and a half years would be shared across the health boards. The Deputy Director said:

“What we need to go through in more detail is the contribution that each health board should make, because, again, I think, where some have put in capacity and have been delivering, their efforts should be recognised and those who probably haven’t done what they should have done need to make sure that they provide that additional contribution.”<sup>17</sup>

36. The Director General concluded:

“...it does not take away any of the responsibility for the ongoing processing of continuing healthcare—not claims, but

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<sup>13</sup> RoP, paragraph 156, 3 February 2015

<sup>14</sup> Auditor General’s follow-up report, paragraph 2.26

<sup>15</sup> RoP, paragraph 27, 3 February 2015

<sup>16</sup> RoP, paragraph 109, 3 February 2015

<sup>17</sup> RoP, paragraph 90, 3 February 2015

actually current patients who are being placed within packages of care.”<sup>18</sup>

## Recruitment

37. The Committee raised concerns about the staffing levels and difficulties with recruitment some health boards had faced, in particular at Betsi Cadwaladr UHB, which had one of the higher levels of claims to clear.

38. In response, the Deputy Director confirmed that recruitment issues had not been considered as part of any review and he agreed to provide further information on the difficulties Betsi Cadwaladr UHB had faced in recruiting to professional roles.

39. In a follow-up letter, the Director General said that Betsi Cadwaladr UHB were in the process of reviewing its approach to managing CHC across the health boards, which would involve a re-assessment of staffing levels to manage prospective caseload. However, the letter did not clearly clarify the number of staff employed to deal with retrospective claims, and instead focused on nurse assessors and administrative staff who are involved in assessing and reviewing current CHC/Funded Nursing Care cases.<sup>19</sup>

40. Subsequently, the Committee wrote to Betsi Cadwaladr UHB to ask for clarification on the number of staff employed to deal with the retrospective claims and the number of staff dealing with current cases.

41. The Chief Executive, Professor Trevor Purt, replied on 16 March 2005, stating:

“1. The Health Board has not employed staff specifically to deal with retrospective CHC claims. The Health Board took the view that retrospective claims would best be managed by Powys Teaching Local Health Board, which is the current practice.

2. No additional staff have been employed to deal with current retrospective claims. This is kept under review. As part of an internal re-organisation of management structures in the Health Board we will be reviewing our overall CHC capacity,

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<sup>18</sup> RoP, paragraph 95, 3 February 2015

<sup>19</sup> [Letter from the Director General, dated 13 February 2015](#)

including the impact of retrospectives. This will be completed by the end of June.”<sup>20</sup>

42. The Director General confirmed that health boards were already progressing with “the expansion of the recruitment that is necessary, both on a local and on a national mechanism through the Powys programme at this stage”. He said:

“...the authorisation had already been given to Powys to get on with their increased recruitment, because, although they’ve got their core establishments, obviously, now, they were taking on these additional cases.”<sup>21</sup>

### **Task and Finish Group**

43. The Welsh Government and health boards have established a national task and finish group with a remit to oversee retrospective reviews and ensure claims are processed within the deadlines set.

44. The Auditor General’s 2015 report highlights that:

“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 deadline set – and attendance and membership has been problematic.”<sup>22</sup>

45. During the evidence session, it appeared that the National Complex Care Board would assume the responsibilities of the task and finish group, although this was unclear.<sup>23</sup> The Committee sought clarity on this issue and the Director of Social Services and Integration said:

“One will be the board, Chair, and the other is a stakeholder reference group with key stakeholders able to challenge and scrutinise the process but also the performance information, and we had a very helpful discussion last week that really started that.”<sup>24</sup>

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<sup>20</sup> Letter from the Chief Executive, Betsi Cadwaladr UHB, 16 March 2015

<sup>21</sup> RoP, paragraph 95, 3 February 2015

<sup>22</sup> Auditor General’s follow-up report

<sup>23</sup> RoP, paragraphs 133 - 139, 3 February 2015

<sup>24</sup> RoP, paragraph 139, 3 February 2015

46. Given the poor attendance at meetings of the task and finish group, the Committee asked if in future minutes of meeting would be published. The Director General said:

“...Yes, we can make sure that people are aware where there’s been a problem about local attendance and those issues as necessary. But, I would also suggest that we can act differently in terms of the way in which I would be looking to intervene along with the team anyway, and it would not to be tolerating the fact that people would not attend in the first place.”<sup>25</sup>

### **Claim processing times**

47. In the Committee’s 2013 report, it recommended that all claims should be dealt with within a maximum of two years. The Framework now sets deadlines for the submission of all claims and for the maximum processing time, which will come down over time from two years to six months.

48. The Auditor General’s follow-up report raises concerns that health boards will soon be faced with retrospective claims with differing maximum processing times of two years, one year, or six months and claims are only expected to be reviewed within the prescribed deadlines, and there are usually a number of further steps that need to be taken before the claim is completed.

### ***Our view***

49. The Committee was content with the decision taken to move the phase 2 cohort of claims to the Powys programme, although this could have been done sooner.

**The Committee recommends that the Welsh Government continues to monitor Health Boards’ progress in processing retrospective claims and if necessary, refer claims not processed within the prescribed deadline to the Powys Project and provides the Committee with an update before the summer recess.**

**The Committee recommends that the Welsh Government reports to the Committee before the summer recess on the expansion of the local and national recruitment programme and whether this has**

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<sup>25</sup> RoP, paragraph 146, 3 February 2015

**led to improvements in the time taken to process current and future claims.**

**The Committee recommends that the Welsh Government monitors Health Boards to ensure that the shorter processing deadline for more recent claims does not result in unintended consequences of longer resolution times for long-standing claims which are unresolved.**

**The Committee recommends that the Welsh Government ensures that governance arrangements are clear and well understood in relation to complex care. This will include monitoring the effectiveness of such arrangements and the engagement of members of the National Complex Care Board and any task and finish groups which support its work.**

### 3. Public Information and Advocacy Services

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#### Public Information

50. The Auditor General's report states that public information on CHC had been expanded but needs to be more accessible and that in particular advocacy services remain a concern for some health boards.

51. In a follow-up letter, the Director General said that:

“...a key aim of the revised CHC Framework was to make the process more user-friendly and focussed on the need of the individual.”<sup>26</sup>

52. He said that to support improved communications the Welsh Government had “provided detailed guidance on the role of the Care Co-ordinator” and had “developed and distributed a range of public information leaflets, which are also available in Easy Read formats”.<sup>27</sup>

53. The Welsh Government has produced three information leaflets relating to CHC and the assessment process, and a further three leaflets on retrospective claims.

54. The Auditor General's 2015 report highlights that all of these information leaflets were designed to be accessed once an individual is ‘in the system’ but there was no general information widely available, for example in care homes.

55. In evidence, the Welsh Government informed the Committee that it had recognised the variation in the distribution of information and that it would be more “prescriptive in terms of where they should be available”.<sup>28</sup>

#### Advocacy Services

56. The Auditor General's 2015 report also highlights that some health boards remain concerned about the availability and funding of CHC advocacy services.

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<sup>26</sup> [Letter from the Director General, dated 13 February 2015](#)

<sup>27</sup> *ibid*

<sup>28</sup> RoP, paragraph 129, 3 February 2015

57. The revised Framework 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 shortfalls.

58. During evidence, the Director of Social Services and Integration said that some individuals would have a statutory entitlement to advocacy under the [Mental Capacity Act 2005](#) and for others the Welsh Government had been working with the Wales Council for Voluntary Action (WCVA) to ensure that services are available.

59. In a follow-up letter, the Director General said that at present health boards are focusing on the provision of statutory advocacy for individuals who lack mental capacity. He said:

“Welsh Government is aware that further work is required with Health Boards to ensure that they implement the requirements of the 2014 Framework.”<sup>29</sup>

60. The Committee sought clarity on how the Welsh Government intends to monitor the access and quality of advocacy services. The Deputy Director said that as part of the monitoring arrangements, a customer feedback mechanism would be introduced.<sup>30</sup>

61. The Committee was concerned that whilst the customer feedback would be able to monitor the quality of service received, there was still no mechanism for monitoring those individuals who may not have been made aware of the service. By depending on feedback, the visibility of advocacy services cannot be gauged.

62. When questioned further on how the quality of those advocacy service would be monitored the Deputy Director said they would raise the issue again with their stakeholder group to gather more views.<sup>31</sup>

63. The Committee also explored whether there was a role for community health councils in providing advocacy service to individuals wishing to challenge a CHC decision. The Director General said he would make sure “the complaints process itself wouldn’t preclude

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<sup>29</sup> [Letter from the Director General, dated 13 February 2015](#)

<sup>30</sup> RoP, paragraph 183, 3 February 2015

<sup>31</sup> *ibid*



them from at least raising it with the [Community Health Council] in the first place”.<sup>32</sup>

### *Our view*

64. The Committee believes that an individual in, or about to go into, a care home should be made aware of CHC and funded nursing care and be offered the necessary advocacy services.

65. The Committee notes that public information has been expanded but needs to be more accessible.

**In addition to the current leaflets that are designed to be accessed once an individual is ‘in the system’, the Committee recommends that the Welsh Government publishes a general public information leaflet on continuing health care. These leaflets should be shared with health and social care professionals and distributed widely, including being made available in doctors’ surgeries.**

**The Committee recommends that mandatory guidance is issued to Health Boards and social care providers on where information in relation to continuing health care should be made available. This should include the provision of information to individuals (and/or their family members) who are in, or prior to admission into a care home, including details of how the Decision Support Tool is applied to individuals being assessed for Continuing Healthcare.**

**The Committee remains concerned about the awareness, quality and level of provision of advocacy services provided by different Health Boards and is supportive of patients and carers understanding their options and the decision-making process as well as healthcare professionals. The Committee recommends the Welsh Government reports to the Committee before the summer recess, on how it intends to improve the consistency, quality and awareness of advocacy services.**

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<sup>32</sup> RoP, paragraph 199, 3 February 2015