Continuing Health Care and Funded Nursing Care

Final Internal Audit Report

February 2022

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To provide assurance over the arrangements the Health Board has in place for managing Continuing Health Care and Funded Nursing Care.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- Lack of Health Board wide CHC and FNC monitoring data.
- The current inefficiencies of maintaining two databases for CHC information.
- A reliance on one person to authorise higher value cases.

Other recommendations and advisory points are within the detail of the report.

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ 2018/19

Assurance summary[1]

Assurance objectives		Assurance
1	Documented procedures	Reasonable
2	Initial assessment for funding	Reasonable
3	Approved of funding	Reasonable
4	Database accuracy	Reasonable
5	Safe keeping of records	Reasonable
6	Queried invoices investigated	Reasonable
7	Monitoring and reporting	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Documented procedures to be updated	1	Operation	Medium
2	FNC assessment process	2	Operation	Medium
3	CHC assessment process	2	Operation	Medium
4	CHC approval process	3	Operation	Medium
5	Database accuracy	4	Operation	Medium
6	Monitoring invoice queries	6	Design	Medium
7	Information storage and accessibility	5	Operation	Medium
8	Monitoring and reporting	7	Operation	High

1. Introduction

1.1 Our review of Continuing Health Care (CHC) and Funded Nursing Care (FNC) was completed in addition to the 2021/22 approved Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Continuing Healthcare is a package of care that is arranged and funded solely by the NHS for individuals who have been assessed as having a primary health need. CHC can be received in any setting, including a patient's home, where costs such as that of a community nurse or specialist therapist will be paid. In a care home, if the individual is eligible for CHC, the NHS will pay the care home fees.

1.3 The request to undertake an assessment of a patient to determine eligibility for CHC funding can be made by the patient themselves, a family member, or a health care professional. The Health Board should have processes in place to assess and approve applications in line with '*Continuing NHS Healthcare: The National Framework for Implementation in Wales'.* Once approved, all recipients of CHC are recorded on the All-Wales National Complex Case Database that is used for monitoring and financial forecasting. In 2020/21 the Continuing Care spend by the Health Board was in excess of £46m.

1.4 People receive FNC if they live in a care home and are not eligible for CHC but have been assessed as requiring the services of a registered nurse. Each year, the health care needs of people receiving FNC are reviewed against specific criteria. If their needs have changed, they may be entitled to CHC if they have a primary health care need. People may move between criteria levels as their health needs change.

1.5 Local authorities cannot provide clinical services because the NHS is responsible for care provided by a registered nurse. For people in care homes with nursing needs, registered nurses are usually employed directly by the care home and the NHS makes a contribution to the costs of nursing care for each individual. In 2020/21 the FNC spend by the Health Board was in excess of £7m.

1.6 The Covid-19 pandemic has seen many of the resources used to oversee the CHC and FNC processes in the Health Board re-deployed.

1.7 The potential risks considered in the review were as follows:

- Non-compliance with the national framework guidance.
- Incorrect payments made where records are maintained in a timely manner.
- Financial loss due to inability to adequately forecast CHC and FNC costs.
- Missed opportunities to utilise funds differently where management information is not available.
- Breach of General Data Protection Regulations (GDPR) if file management system does not protect data.

2. Detailed Audit Findings

Objective 1: There are appropriate documented Health Board procedures in place for CHC and FNC that align to the National Framework and detail the processes to be followed in relation to areas including undertaking assessments, approval by panel, input onto the National Complex Case Database and the roles and responsibilities of individuals, teams and ILGs.

2.1 The Health Board has chosen not to develop its own CHC policy. Instead, it uses the 2014 Welsh Government (WG) *'Continuing NHS Healthcare: The National Framework for Implementation in Wales'* and the appended Decision Support Toolkit as its framework for processing applications. WG has recently updated the framework. The revised version will come into effect from April 2022.

2.2 Applications are initially scrutinised at a Clinical Service Group (CSG) panel specific to the category of application (adults, mental health or children). They are then reviewed at one of three Integrated Locality Group (ILG) panels. Each ILG is responsible for certain categories of CHC applications, and so can be responsible for the approval of CHC packages for individuals who are not resident in their geographical area. The Health Board's scheme of delegation has been updated to align to the new arrangements.

2.3 The Financial Control Procedure for CHC has not been updated since 2017. While some of the principles around process remain relevant, more detailed information on the organisational arrangements within the Health Board need to be included. **(Matter arising 1)**

2.4 In September 2020 a Panel Process Group was set up to map processes and create flowcharts for staff to use, and to develop a terms of reference (ToR), for both the CSG and ILG panels. The CSG Panel ToR has been drafted but has yet to be approved. We understand that the ILG Panel ToR will be created following approval of the CSG Panel ToR. **(Matter arising 1)**

2.5 The CHC application process flowchart and the process for new FNC applications have been drafted. Each of these documents cover the fundamentals of how to undertake the assessments, the approval process by panel, when to enter the data on to the National Complex Case database and what the roles and responsibilities are for the individuals and teams. However, in light of the revised WG framework that will take from April 2022, Health Board documents need to be reviewed and aligned to this before finalising. **(Matter arising 1)**

2.6 Once all documents have been approved, the CHC team need to ensure that the relevant staff are aware of them and know where to find them. **(Matter arising 1)**

2.7 Staff that are involved in the FNC and CHC process are undertaking refresher training.

Conclusion:

2.8 There has been progress mapping and documenting the FNC and CHC processes. However, the anticipated publication of the revised all Wales CHC framework means existing documents will need to be reviewed to ensure that they reflect the new guidance. We have provided reasonable assurance for this area.

Objective 2: Initial assessments for funding are undertaken in line with agreed process including completion of relevant documentation such as the decision support toolkit, the involvement of relevant professionals, timelines are adhered to and appropriate scrutiny and challenges is given to the process.

2.9 Applications require a nursing assessment form. Assessments are then reviewed for potential approval in line with the respective FNC or CHC frameworks.

2.10 All of the FNC case files that we tested contained complete nurse assessment forms that had been approved prior to the care package starting. We identified a small number of cases where the care package took up to eight weeks to be approved after the assessment had been completed. We also saw delays of up to seven weeks between the funding approval being granted and the CHC team being informed so that they could update the National Complex Case database and finance records, which could impact financial reporting. **(Matter arising 2)**

2.11 For the CHC case files that we reviewed where nursing assessment forms were present, we saw evidence of: the decision support tool being used to assist the application; a multi-disciplinary team being involved in the assessment; family members being involved; and a named care co-ordinator or professional lead in place. However, not all of the information was in place as we would expect. For example, some nursing assessment forms were incomplete, or case files did not confirm that, where applicable, a Best Interest Form had been sighted. **(Matter arising 3)**

2.12 The CHC Quality Assurance template should be used for new applications. However, we saw instances where it was used during case reviews. Given the need to ensure quality, the template should be used for both new cases and during the case review process. **(Matter arising 3)**

2.13 CHC applications are first scrutinised at a CSG panel relevant to the speciality of the application (adult, mental health or children). Financial approval is then sought at the relevant ILG panel. The timing of the panel can cause delays in the approval process. Nearly all of the care packages in our sample had started between two and six weeks prior to the ILG panel meeting, but in most cases, the CSG panel had reviewed the proposed care package ahead of it starting. **(Matter arising 3)**

Conclusion:

2.14 Most of the applications that we tested had correct documentation in place, but there were some inconsistencies in practice across the CHC categories that need to be resolved. Whilst there were delays in the approval process, and some placements started before approval, in some cases this was necessary to ensure

the patient's needs were met. We have provided reasonable assurance for this area.

Objective 3: Where CHC and FNC funding has been approved, the agreed process has been followed including adherence to relevant Financial Control Procedures and the Health Board's Scheme of Delegation. In addition, for 'Fast Tracked' cases the relevant process has been followed.

2.15 The draft CHC process documents outline the stages an application goes through for approval. These stages are aligned to the Health Board's scheme of delegation. Applications and the associated care package are scrutinised by a CSG panel, relevant to the category of application (adult, mental health, children), before being reviewed by one of three ILG panels for financial approval. If the annual cost of the package exceeds £50k, approval is obtained from the Director of Nursing for Bridgend ILG. For care packages above £150k, the Chief Executive and Director of Finance must approve.

2.16 FNC cases do not require panel approval as weekly rates are in place and the decision to support funding is made by the District Liaison Nurse.

2.17 While we have identified some instances where full information was not presented to the decision panels, in the main, our testing confirmed that cases complied with the CHC process and approvals were in line with the scheme of delegation, although the FCP needs to be updated. However, where the process relies on one individual to approve high value cases, there have been delays obtaining approval. **(Matter arising 4)**

2.18 We did not look at 'Fast-track' cases as our sample did not include any specific fast track cases.

Conclusion:

2.19 There was compliance with the scheme of delegation and cases were largely managed in line with the draft CHC process documents. To strengthen the controls, the FCP needs to be updated. Management needs to consider how to avoid delays in the approval of high value cases. We have provided reasonable assurance for this area.

Objective 4: Where there are new cases or have been changes to care packages or funding of existing cases, the National Complex Case Database is accurately updated in a timely manner.

2.20 The National Complex Case (NCC) database covers all health boards in Wales. The NCC is a record of CHC and FNC packages and is used to produce data for WG reporting. Whilst some financial information is recorded, the database does not have the wider functionality needed for financial monitoring. As a consequence, the Health Board maintains a separate finance database for CHC costs. It is therefore key that the information on both databases is consistent, and that both are updated promptly following approval or changes to care packages.

2.21 We were unable to test the timeliness of updates to the databases following the decisions made by the ILG panels as neither database contains an evidence trail to show when records were added or updated.

2.22 Our testing of the accuracy of the information contained in both databases to the information held in the panel approval documents identified a number of minor errors. For example, care package start dates or marginal differences in costs, meaning that an invoice may not be paid promptly until the query has been resolved. **(Matter arising 5)**

2.23 Cases with annual costs above £50k require a higher level of authorisation. We have identified that the databases are not updated until approval for all cases assessed at a panel has been granted. As a consequence, low value cases from the same panel meeting that have been approved, are not updated on the finance database. As noted in 2.17 above (matter arising 4), we have seen instances of delays to these approvals taking place. In turn this could mean more invoices are being put on hold unnecessarily. **(Matter arising 5)**

2.24 Whilst we acknowledge the reasons for the two databases and appreciate the constraints surrounding the NCC database, it is apparent that there are inefficiencies when maintaining two databases. **(Matter arising 5)**

Conclusion:

2.25 Some improvements could be made to the accuracy of the information presented and approved at the ILG panel meetings, and subsequently transferred to the NCC and finance databases. Consideration also needs to be given to a timelier process for updating the databases in relation to lower value cases that are approved at panel meetings where there are also higher value cases that need onward approval. We have provided reasonable assurance for this area.

Objective 5: An effective file management system is in place to ensure the safe keeping of CHC and FNC records.

2.26 Since our last review of the CHC process, there has been a move away from paper records and physical files. All CHC and FNC patient records are now held electronically and accessed via SharePoint.

2.27 Nursing assessments are completed electronically by the District Liaison Nurse or Nurse Assessors, but assessments in hospital settings are still manually recorded.

2.28 Nursing assessments are emailed to the relevant team (adults, mental health or children). While a generic team email account had been set up for children's assessments, the email account is not used and forms are sent to the email account of one team member, creating a risk of delays in processing if that person were to be absent from work. **(Matter arising 7)** The adult and mental health teams were using generic accounts to receive assessment forms.

2.29 At the time of our fieldwork, the CHC team were unable to provide a definitive list of who has access to their SharePoint folders. We note several generic staffing

group accounts with access to these files, but it was not clear who was in each group, and therefore if access was appropriate. (**Matter arising 7)**

2.30 In some instances, email correspondence or notification emails relating to cases were not saved within the electronic personal folders, but remained in the email account of the CHC team members. (**Matter arising 7)**

Conclusion:

2.31 In the move to more electronic ways of working, progress has been made to become more efficient. However, consideration needs to be given to the security and accessibility of information held. We have provided reasonable assurance for this area.

Objective 6: Invoices identified as not reconciling to the National Complex Case Database are investigated in a timely manner. Analysis of queried invoices is undertaken to identify trends and potential training requirements.

2.32 At the start of the pandemic an 'Invoice Query Log' was created so that the CHC and Finance teams could remotely access a central record of the invoices that had been placed 'on hold' and not paid as they did not reconcile to the information on the finance database. However, we have identified that the level of detail recorded on the query log is basic and mostly narrative, so analysing timeliness of resolution, trends and themes is not possible**. (Matter arising 6)**

2.33 Invoice queries can arise due to differences in rates, if the end date of care packages vary, if cases have not yet been presented at panel, or if the databases have not been updated before the invoice has been received.

2.34 Invoices are reconciled to the finance database by the CHC team before being passed for payment. However, the finance database is not a 'live' document. It is updated at month end with the panel decisions made in that month. As such, each month some invoices have to be put on hold until the next month end update. **(Matter arising 5)**

2.35 Delays can also occur if the financial sign off form is not completed to show the split in funding between the Health Board and Local Authority, which of the two is the 'lead', or what category the care package falls under. **(Matter arising 6)**

Conclusion:

2.36 Whilst the invoice query log is not be used to identify trends or patterns, it appears that queries could be grouped into common themes of causes. Some of these causes could be avoided if the key documentation was completed more comprehensively and the databases more timely. We have provided reasonable assurance in this area.

Objective 7: Periodic reports on CHC are produced and submitted to management and appropriate groups for monitoring purposes.

2.37 The mental health service team request reports from the finance team in relation to CHC mental health cases.

2.38 Previously, quarterly monitoring reports were submitted to WG and the Health Board. This was stopped due to the pandemic and has not restarted. It is not clear if there is Health Board wide monitoring of CHC, both in terms of financial expenditure and case numbers. **(Matter arising 8)**

Conclusion:

2.39 We have seen some instances of financial information monitoring, but this has not been consistent across the specialities. In addition, we have not seen evidence of overarching Health Board reporting and monitoring. As such, we are providing limited assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Updates to documented procedures (Operation)	**Potential Impact**
The introduction of the Health Board's operating model in April 2020 changed the way CHC applications were processed. While there is a structure in place for managing applications and approvals, the process is complex, and has resulted in some ILG panels approving CHC applications for individuals who are not resident in their locality. For example, Bridgend ILG panel approves all adult CHC cases. In September 2020 a Panel Process Group was set up to look at the application and approval processes as a result of the new operating model. At the time of our review the following documents remained in draft: • CHC Application Process flowchart; • process document for new FNC applications; and • Terms of Reference (ToR) for the CSG panel. Other documents, such as the Nursing Assessment form and Decisions Support Tool for CHC/FNC applications are in place. However, the ILG panel ToR, that will set out the responsibility of the ILG panels when approving care packages for individuals who are not resident in their locality, have not been drafted. Welsh Government is in the process of finalising a revised CHC Framework and Decision Support Tool (DST). This will take effect from April 2022. Therefore, the documents previously created will need to be reviewed to ensure they capture changes being introduced within the revised framework. There is a Financial Control Procedure (FCP) in relation to CHC, although this was due for review in February 2021. The FCP still refers to previous processes and authorisation levels and does not reflect the current set up in the Health Board. In addition, there are appendices to the FCP that the CHC team do not use. In our 2018 audit of CHC we recommended revising the FCP, but the same version remains in place.	Incorrect decisions made and potential financial loss where there is non-compliance with the national framework and local processes. Potential patient harm if decisions are based on incomplete information.

Recommendations	Priority
1.1a Existing procedure documents and assessment forms, including those that are in draft format, should be reviewed and updated to reflect the revised WG CHC framework and any changes as a result of the new operating model in place within the Health Board. 1.1b Once finalised, management should ensure that they are accessible to all relevant staff and that staff are using the most up to date versions of the forms.	**Medium**
1.2 A terms of reference for the Clinical Service Group Panels and Integrated Locality Groups panels should be put in place to set out the roles of each panel, their decision-making responsibilities and membership and quoracy arrangements. When developing the ILG panels terms of reference, consideration should be given to decision making powers of the panel when they are making funding decisions on behalf of another ILG for cases where the induvial does not reside in their ILG area.	**Medium**
1.3 The CHC Financial Control Procedure should be reviewed by the finance team in conjunction with the CHC team and updated to reflect current processes and set up within the Health Board.	**Medium**

Agreed Management Action	Target Date	Responsible Officer

1.1a The CHC team are awaiting the release of the new Welsh Government CHC Framework, launch date due in February 2022 with an implementation date of 01.04.2022. All existing documentation and assessment forms will be reviewed and updated to reflect the revised WG CHC Framework, in readiness for implementation. 1.1b The CHC team will ensure that all reviewed, updated documents, following the implementation of the WG CHC framework in April 2022, will be accessible for all staff via the designated CHC page on the CTMUHB intranet site, to ensure staff are using the most current version of the forms.	APRIL 2022 APRIL 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
1.2 • Clinical Service Group Terms of Reference are in draft and are to be finalised by March 31st 2022, to include decision-making responsibilities, membership and quoracy arrangements. • Integrated Locality Group Unit Panel Group Terms of Reference will be reviewed and updated in line with the CSG ToR above and will be approved by March 31st 2022.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
1.3 The Finance Team will review the Financial Control Procedure (FCP) in line with any changes identified in the new CHC Framework. The updated FCP will be an agenda item at the Audit Committee and a further review date agreed.	MAY 2022	Julie Hayward-Finance Manager CHC / Katie Games – Finance Manager Commissioning and Contracting

Matter Arising 2: FNC assessment process (Operation)	**Potential Impact**
We tested a sample of ten FNC cases to confirm that the initial assessments had been carried out in line with the agreed process and in a timely manner. We found that: • For eight cases within the sample that should have been reviewed after three months, five had not been reviewed, the longest being five months overdue. At certain times during the pandemic the team were not permitted to undertake review visits at care homes, although we understand that there was ongoing communication with care homes about the residents during these periods. • Our detailed testing in relation to the assessment process was limited to seven cases. Of the other three, two were not available and valid reasons existed for their absence. In the third case a different person's information was held on the file we sampled. Both patients had the same name, so it appears that the records had been misfiled. • For 2/7 cases approval of the nurse assessment took between seven and eight weeks, though this did not impact the placement starting. The FNC guidance refers to a two-week timeframe for approval. • For 2/7 it took between four and seven weeks after a placement had started for the CHC team to be informed of the approval and therefore the National Complex Case database to be updated. Delays in updating the database have an impact on being able to produce accurate financial information for reporting purposes. • We identified a small number of other one-off issues such as the retention of authorisation and confirmation emails not being retained on file.	Incorrect decisions made and potential financial loss if decisions are not made in a timely manner and based on complete information.
Recommendations	**Priority**
2.1a Where possible, and in line with the FNC framework, management should ensure that case reviews take place three months after the placement has started and evidence of this should be retained on the case file.	**Medium**

2.1b The review of nursing assessments should take place promptly to ensure, where possible, funding is agreed ahead of placements commencing. Once agreed, the CHC team should be informed as soon as possible in order for records to be updated and payments to be made.	
2.2 Care should be taken when scanning and filing information to ensure that patient information is saved to the correct files to avoid possible GDPR breaches.	**Low**

Agreed Management Action	Target Date	Responsible Officer
2.1a The CHC Management Team will enhance current practice to ensure that all NHS Funded Nursing Care placements in a care home setting will be completed within a three month period in line with the National Policy (Covid restrictions may need to be taken into account) This will include: • Annual timetable and monthly review lists which will be shared with all nurse assessors for action. • Audit cross check of the monthly review lists will take place at the end of every month, by the FNC administrator and the Nurse assessor team, prioritising any breaches.	FEBRUARY 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
2.1b The CHC Admin Team will ensure that all NHS FNC applications are scrutinised by a Registered Nurse for approval prior to admission.	31.03.22	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
Process to be developed with the Responsible Individual (RI) of each independent Care home, to ensure weekly return forms are completed and returned in a timely manner to notify of all new admissions, to enable timely payments.	28.02.22	Sharon Irwin- NHS Nursing Homes Co-Ordinator
2.2 Quarterly audits of the electronic patient folders have been implemented in response to the internal audit findings, to minimise the risk of any GDPR breaches.	31.01.22	Sharon Irwin- NHS Nursing Homes Co-Ordinator

Matter Arising 3: CHC assessment process (Operation)	**Potential Impact**
We tested a sample of ten CHC cases to confirm that the initial assessments had been carried out in line with agreed process and in a timely manner. We found that: • 1/6 cases, where a nursing assessment was required, the form was not on file so we could not confirm that consent had been given. • For 3/5 cases where a nursing assessment was available, the consent section had not been completed. • 2/4 cases where a 'Best Interest Form' was required, a copy was not on file. We acknowledge that the original form may be retained in the care home, but records held centrally should indicate that the Best Interest form has been sighted. • The Quality Assurance Form was not used consistently. For mental health cases a form is used for new applications, but for adult cases they are used for both new and review cases. • 2/8 cases the Quality Assurance form was not on file, and for a further two cases the form had not been fully completed.	Incorrect decisions made and potential financial loss if decisions are not based on complete information.
Recommendations	**Priority**
3.1 Key documents, such as the nursing assessment form, should be fully completed, and copies of forms should be retained on file. Where forms need to be retained by the care home, the CHC file should include information that confirms the relevant forms have been completed and seen by the team.	**Medium**
3.2 Consideration should be given to the purpose of the Quality Assurance form and then a decision made regarding its use in new applications and review cases. Where possible a consistent approach should be applied. The approach adopted should be reflected in the CHC process documents.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
3.1 All funding applications will be reviewed for quality assurance and evidence of any referenced documentation that is kept within the care home records will be noted and documented on the Nursing Assessment. All documentation will be stored in Patient Folders at initial point of funding application. This has been reinforced with all departments in monthly admin meetings.	28.03.22	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
3.2 The Quality Assurance document and process will be discussed, reviewed and amended accordingly in February 2022, in line with the new CHC Framework, and recent Audit findings.	31.03.22	▪ Victoria Edwards - Senior Nurse Continuing Health Care and FNC ▪ Sharon Irwin- NHS Nursing Homes Co-Ordinator

Matter Arising 4: CHC approval process (Operation)	**Potential Impact**
As part of our testing of CHC applications, we reviewed the case files and the information presented to the panels to ensure that the process had been followed, including retention of information and compliance with the scheme of delegation. We identified the following: • Panel documentation packs are prepared by the CHC team that embed the relevant paperwork, which is obtained from the central CHC team files. However, for mental health cases, documents used by the panel to make a decision are held by the mental health team and not centrally by the CHC team. This is due to the mental health team setting up patient folders on their network drives and not in the central CHC file as outlined in the process flowchart. This approach is not consistent with the other categories of CHC applications and means the CHC team are often unable to access all of the necessary information for these patients • The level of scrutiny or challenge undertaken by the panel for each case is not minuted or recorded. Previously the mental health CGS panel had been capturing this information. • Four of the cases in our sample were presented to the Rhondda Taf Ely (RTE) ILG panel meeting in August 2021. Whilst they were agreed within the meeting, there was no record on file of the appropriate authorisation by the RTE Nurse Director. Two cases over £150k were identified, but we could not see on file the authorisation by the Chief Executive and Director of Finance. • We have noted that final versions of approvals are saved as Word documents, meaning changes could be made after approval has been granted. • We saw instances where there were delays getting care packages that exceeded £50k approved in a timely manner by the Bridgend Nurse Director. There is no clear process if the Nurse Director is unavailable. Currently, during any periods of absence by Bridgend Nurse Director, cases are not progressed. Our testing in finding 3, identified that in many cases, the care package will have already commenced prior to the full levels of authorisation being granted. However, the time delays in obtaining the higher levels of approval have implications on financial reporting as the NCC and finance databases are not updated until the approval is granted. As such the Health Board	Costs incurred by the Health Board that have not been appropriately authorised. Missed opportunities to utilise funds differently if scrutiny of applications does not take place.

cannot start accruing for the costs and any invoices received from the care providers are not paid and have to be put on hold until agreement for the care package is obtained.	
Recommendations	**Priority**
4.1 All relevant documentation for each case should be held centrally to allow access by all relevant parties and for inclusion in the packs of information that are used at panel meetings.	**Medium**
4.2 Records of the discussion held at CSG panel around each case should be maintained to demonstrate there has been an appropriate level of scrutiny.	**Medium**
4.3 Evidence of approval should be retained with the approved panel document converted to a PDF format to prevent changes post approval.	**Medium**
4.4 As the authorisation to approve cases between £50k to £150k has been delegated down from Executive Director of Nursing, it should be established if during periods of absence by the Bridgend Nursing Director, can cases be escalated back to the Executive Director of Nursing. If the scheme of delegation does not allow this, alternative arrangements should be put in place.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 All Patient folders are stored centrally and now via electronic means. We will develop simple flowcharts to provide staff with clear guidance in how to store and access the relevant information within the central Patient Folders.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
4.2 As of December 2021 detailed minutes are now recorded at both CSG and ILG unit panel meetings and stored electronically.	COMPLETED	Sian Lewis - Lead Nurse for CHC and NHS Funded Care

4.3 Financial Scheme of Delegation for all cases will be saved in PDF Format to email for authorisation. The team will be provided access to edit PDF Documents to achieve this.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
4.4 All approved signatories will need to identify a delegated representative to cover annual leave and sickness, and register these individuals with the central CHC team for completion of the CHC process and financial sign off, in line with the scheme of delegation.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care

Matter Arising 5: NCC & Finance Databases (Operation)	**Potential Impact**
<u>NCC - Accuracy of information</u> The all-Wales NCC database is used for WG reporting. Whilst we could not undertake specific testing to confirm the NCC database was being updated promptly after care package approvals were granted or amendments made, we tested the accuracy of the update and completeness of the database. We tested a sample of 15 cases across the three ILG panels. We identified the following: • 3/15 approved cases were not on the NCC database. • 5/12 had minor differences in the costs on the NCC database to that agreed at panel. • 3/12 had different care package start dates on the NCC database to the information contained in the panel documents. <u>Finance - Timeliness of updates</u> The finance database is used by the CHC team to reconcile invoices for payment. However, this is not a 'live' record, instead it is updated by finance at month end based on the cases that have been agreed by the panels in that month, and a copy is sent to the CHC team. As such, for the purpose of reconciling invoices, the finance database is only accurate at a point in time. Invoices for new or amended cases that have not yet been captured on the database are 'put on hold'. Furthermore, if one or more cases that are presented to an ILG panel exceed the £50k limit and need higher approval, then the NCC and finance databases are not updated with the information in relation to the other cases that went to the same panel meeting, despite them being approved. Only when the higher value approvals have been granted, will the database be updated with all the cases. We have seen an example where queries were raised in relation to a higher value case that went to a panel meeting in mid-September. These were not resolved, and therefore the case not authorised, until mid-November, thus impacting the timeliness of updating of the databases in relation to all other cases that went to the same panel meeting.	Incorrect payments where inaccurate information is held. Delays in payments being made impacting on the Health Board achieving its 30-day payment target. Inability to provide accurate data from the NCC database for WG reporting.

Inefficiencies In addition to the above points around being able to accurately maintain two databases in a timely way, we have identified other inefficiencies. For example, where there are deaths or discharges of patients. This information is currently shared with the CHC team from care homes and local authorities, and they update the NCC database accordingly. The finance team then run reports from the NCC database and due to the limited functionality of the system, have to interrogate the data to determine the changes that have occurred, ahead of them separately updating the finance database. It is clear that the two databases in operation serve different purposes and, to an extent the Health Board is constrained by the limitations in functionality of the NCC database. However there appears to be inefficiencies in the current arrangements including the working arrangements between the CHC and finance teams.	
Recommendations	**Priority**
5.1 The importance of accurately capturing information and decisions within panel documentation and then accurately transferring that information to the NCC and finance databases should be re-iterated to all staff.	**Medium**
5.2 The process should be amended when the finance and NCC databases are updated following panel meetings to ensure that cases are updated in good time and not held back due to additional approval of certain cases in the same batch.	**Medium**
5.3 More collaborative working between the CHC and finance teams should be explored in order to try and remove some of the inefficiencies in the current working practices. For example, if the finance database was updated more regularly and became a live document, that would negate the need for some invoices to placed on hold each month. Also, if the CHC team shared the deaths and discharges data with the finance team, this would negate the need for the finance team to have to search for this information within the NCC database.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
5.1 Review and amend processes to ensure the information from Panel is accurately reflected and transcribed to both the NCCD and Finance Database. The FNC administrator will perform quarterly random sampling to demonstrate compliance.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
5.2 Amend current process to ensure any applications presented to panel where additional information is required by the panel chair, prior to approval, will be deferred to next panel to prevent any delays with remaining panel cases.	COMPLETED	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
5.3 Introduce quarterly Finance Meetings with the CHC team to discuss and resolve presenting issues and improve working practice for all parties. Death Reports to be added to ILG Panel Sheets on a monthly basis to enable financial records to be updated in a timely manner.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care

Matter Arising 6: Invoice queries (Design)	**Potential Impact**
It was our intention to review the invoice query log to identify any patterns or trends. However, the invoice information collated is a basic record of what the query was, what updates had occurred, and if it had been resolved. Information on the database is narrative, with no common identifier fields, or clear date information. Queries are not categorised with a recurring cause, and the date the query is resolved is not documented. The database is not used by finance or the CHC team to identify trends, and we could not undertake any detailed analysis. Despite not being able to analyse the query log, we have been informed that most invoice queries arise from differences between the invoice and what is recorded on the NCC or finance database. This highlights the importance of accurate and timely updates to the NCC and finance databases following panel decisions. (see matter arising 5) We understand that there can be delays in payments if the Financial Sign Off (FSO) document is not fully completed. We reviewed 15 FSO documents and found instances of: • Two different forms were being used, the format of each was slightly different. • The 'lead' (Health Board or Local Authority) organisation was not always identified on the form, so it was unclear if it should be the Health Board to invoice the Local Authority, or vice versa. • The split in funding between the Health Board and Local Authority was not always being recorded. • The criteria that identifies the category of each case was not always completed.	Financial loss due to inability to adequately forecast CHC and FNC costs. Additional staff resource used to resolve recurrent issues.
Recommendations	**Priority**
6.1 The Invoice Query Log should be developed further so that is becomes a more effective document for the CHC team to use. It could be used to help identify what the key themes and trends are and escalating common reasons will help prevent them reoccurring. This could be reported and	**Medium**

discussed at the fortnightly 'Query Log' meeting that takes place with the CHC team, procurement, and finance.	
6.2 Management should feedback to staff the importance of completing the Financial Signoff Form in full, particularly around identification of the lead (Health Board or Local Authority), the agreed split of costs between those parties, and the categorisation of the case.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
6.1 Review and develop the Invoice Query Log with Finance and Procurement teams to ensure that the log provides evidence of effectively resolving and reducing queries.	APRIL 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
6.2 Completion and use of the FSO will be reviewed, providing necessary training, in line with the new CHC framework to ensure that the NCCD and the Financial Database reflect accurate details to enable timely payment of invoices, reduce queries and minimise payment delays.	MARCH 2022	Sian Lewis - Lead Nurse for CHC and NHS Funded Care

Matter Arising 7: Information storage and accessibility (Operation)	**Potential Impact**
At the time of our fieldwork the CHC team did not have a clear list of staff who have access to CHC SharePoint folders. Our analysis identified several user groups that have access, but the individuals who form these groups was not clear. We also identified an individual with access who has since left the organisation. During our fieldwork we saw instances where emails relating to individuals remained with staff members individual email accounts or the team generic email account. Information was not consistently saved within the personal electronic folders that have been set up for each patient. The CHC process flowchart states that Nursing Assessment applications should be forwarded to a generic email account for adult applications, however personal accounts are listed for mental health and children's applications. We understand that since writing the process flowchart, a generic email account is now in use for mental health applications. A generic account has also been set up for children's applications, but it is not yet being used, meaning all applications still go to a nominated persons email account. Should they be absent from work, the ability to access the assessments and process them in a timely manner could be compromised.	Breach of General Data Protection Regulations (GDPR) and potential fines if file management systems do not protect data. Time delays in processing applications or resolving queries where information is held in personal email accounts.
Recommendations	**Priority**
7.1a A review of the access to the CHC patient folders saved on SharePoint should be undertaken to confirm only those requiring access have it. 7.1b Periodic reviews should take place going forward to ensure access levels remain accurate, especially in relation to staff who may no longer work in this area.	**Medium**
7.2 Management should ensure that all email correspondence is saved within the individual's personal files.	**Low**

7.3 The generic email account set up for children's CHC cases should be activated and the CHC process documents updated to reflect the generic email account addresses.	**Low**

Agreed Management Action	Target Date	Responsible Officer
7.1a The team will develop a process with IT advice to review and amend access to the CHC shared drive by designated named staff, on a bi annually basis.	28.02.22	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
7.1b See 7.1a	28.02.22	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
7.2 CHC Team to develop an enhanced process around recording accurate decision making of Out of Panel Virtual Approvals and outcomes.	31.03.22	Sian Lewis - Lead Nurse for CHC and NHS Funded Care
7.3 Children's CHC generic email inbox is now activated. Documentation will be amended to include generic email address for easy access for all staff.	Completed	Sharon Irwin- NHS Nursing Homes Co-Ordinator

Matter Arising 8: Monitoring and reporting (Design)	**Potential Impact**
We looked at monitoring and reporting of CHC data. We found: • Previously the CHC team provided quarterly monitoring reports to WG, copies of which were also presented at Health Board meetings. This reporting requirement was paused due to the pandemic and has yet to restart. • The CHC team is part of the Bridgend ILG Primary & Community Care CSG. While CHC / FNC data is reported to CSG Performance review meetings, it does not appear to be comprehensive. For example, there is information about M&C and RTE ILGs but not Bridgend and it is not clear what the split between FNC and CHC spend is. • The finance team provides detailed information to Merthyr Cynon ILG in relation to mental health cases as they host the service on behalf of the Health Board. We understand that similar information will be provided to appropriate ILGs for adult and children cases. However, we note that this data is taken from finance database, which is not 'live', as there can be delays in adding information from recent panels. The complex way in which the CHC process has been set up within the Health Board means there are multiple budget holders across the ILGs and the categories (adult, mental health, children), with authorisation of spend often taking place across ILG boundaries, highlighting the importance of accurate and timely information being made available. While we can see reporting and monitoring happening in part, we did not see if information is available, or if any reports are produced, that would allow corporate oversight of CHC in terms of expenditure and details around case numbers.	Missed opportunities to use funds differently where management information is not available.

Recommendation		Priority
A formalised reporting structure should be put in place that allows the monitoring and scrutiny of CHC data to take place at varying levels within the Health Board, and to facilitate management in being able to make informed decisions around the delivery of the service and care packages provided.		**High**
Agreed Management Action	**Target Date**	**Responsible Officer**
CURRENT REPORTING MECHANISMS • In light of the current review of the Health Board's operating model, it is agreed that CHC reporting and monitoring will be included as part of this review and will incorporate any reporting management tool identified by Welsh Government in the new framework. • Prior to the review of the operating model, CHC / FNC will be a standing agenda item on monthly Community Service Group performance meeting agendas. Reporting to Health Board Quality and Safety Committee and Planning, Performance and Finance Committee will commence.	3 MONTHS 3 MONTHS	Sian Lewis - Lead Nurse for CHC and NHS Funded Care Sian Lewis - Lead Nurse for CHC and NHS Funded Care

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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