Mental Health Legislative Compliance Final Internal Audit Report

February 2022

Swansea Bay University Health Board

NWSSP Audit and Assurance

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Committee:	Audit Committee

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Executive Summary

Purpose

To review arrangements in place to provide assurance to the Board over compliance with mental health legislation.

Overview of findings

Key matters arising concerned:

- Mapping exercise against legislation requirement to demonstrate compliance
- Inconsistent reporting of training compliance and gaps in training needs

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	No prior audit in this area

Assurance summary[1]

Assurance objectives		Assurance
1	Appropriate governance arrangements	Reasonable
2	Roles and responsibilities	Limited
3	Policies and procedures	Reasonable
4	Risk management	Reasonable
5	Issue escalation	Substantial

Matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Completeness of compliance reporting	1	Design	Medium
2	Training Assurance	2	Design	High
3	Policies	3	Operation	Low

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

1. Introduction

1.1 The Board has delegated the responsibility for monitoring compliance with mental health legislation across the health board to the Mental Health Legislation Committee, in particular; the Mental Health Act 1983 (revised 2007), the Mental Capacity Act 2005/Deprivation of Liberty Safeguards and Mental Health (Wales) Measure 2010.

1.2 The Mental Health Act was legislated in 1983 and outlines requirements in relation to Hospital Managers' scheme of delegated duties, ensuring that patients are only detained as the Act allows and that patients' care and treatment fully comply with the Act. Hospital managers are also responsible for ensuring that patients' cases are dealt with in line with the Mental capacity Act 2005 which is designed to protect vulnerable people who are unable to make all or some decisions for themselves. Other legislation includes the Human Rights Act 1998 and the Mental Health (Wales) Measure 2010 which helps to ensure that appropriate care is in place across all healthcare settings and at home, ensuring that the mental health needs of each individual patient is met.

1.3 The following inherent risks are associated with this subject area:

- Non-compliance with legislation could result in patient harm, reputational damage and financial implications.

1.4 This audit excluded the assessment of Children and Adolescent Mental Health Services (CAMHS) as a result of the separate audit undertaken over the commissioning arrangements.

2. Detailed Audit Findings

Audit objective 1: Appropriate governance arrangements are in place to ensure that the health board satisfies the requirements of relevant legislation

2.1 In line with SBUHB Standing Orders and scheme of delegation, the Board has delegated responsibility for the management of compliance with mental health legislation to the Mental Health Legislation Committee (MHLCommittee). The purpose of the committee is to 'consider and monitor the use of the Mental Health Act 1983 (MHA), as amended, the Mental Capacity Act 2005 (MCA) (which includes the Deprivation of Liberty Safeguards (DoLS)) and the Mental Health (Wales) Measure 2010 (the measure/MHM).' The committee meets quarterly and reports are presented to provide an update on operational performance, governance and risk in relation to each piece of legislation.

2.2 Both the MHA and MHM compliance reports are initially taken to the MH&LD operational legislative group which sits within the MH&LD service group. The governance structure for the service group was provided.

2.3 The MHA compliance report separates out sections of the Act that have been identified as areas that would present the most risk to the health board if not complied with. We note that while part 3 of the Act is noted within the key to the report, compliance against this area is not detailed within the report**. See Finding 1.**

2.4 The MHM compliance report structure mirrors the four parts of the Measure and provides an assessment of the health boards performance against national targets. The most recent report showed that targets were met by the health board within the previous 12 months except for 1 month for Part 2, whereby performance dipped below by only 1%.

2.5 The MCA compliance report is presented to the MHL Committee and at the Safeguarding Committee and captures performance information and data across the health board. The DoLS Team (acting as the Supervisory Body) also collate data in relation to DoLS referrals, best interest assessments and timescale breaches. The report also includes updates in relation to the MCA, Independent Mental Capacity Advocates and Court of Protection, all of which align with areas of the legislation. We note that non-compliance with DoLS breaches is clearly reported and that this currently sits as a risk within the health board risk register.

2.6 We note that while the above reports provide a broad coverage of compliance against legislation, not all areas are reported upon. We recognise that some sections within the legislation do not place statutory duties on health boards and that reporting is undertaken by exception. The Codes of Practice provide guidance to health boards to enable them to practically implement the legislation, however, we were unable to obtain assurance on the completeness of mental health legislative compliance across the health board. **See Finding 1.**

2.7 The Terms of Reference (ToR) of the MHL Committee, MHLD operational legislative group and Safeguarding Committee were reviewed and meetings were found to be generally well attended, quorate and met in line with planned frequency. We note for management attention that all three ToRs are slightly out of date however we recognise the pressures placed on the health board as a result of Covid-19.

Conclusion:

2.8 There are appropriate governance arrangements in place for the management of compliance with mental health legislation. Noting this, we have assessed this objective as **Reasonable assurance**.

Audit objective 2: Roles and responsibilities are clearly defined ensuring accountability of staff in relation to mental health legislation

2.9 The MHA Code of Practice establishes responsibilities of some key roles in relation to the MHA, including those of professionals in charge of patient care, Approved Mental Health Professionals (AMHP), Independent Mental Health Advocates and Hospital Managers. In addition, the health board has developed a policy for the 'Hospital Managers Scheme of Delegation' which establishes the delegated role of the MHA Team. The Team is authorised on behalf of the health board to undertake statutory administrative responsibilities including the scrutiny and review of statutory documentation relating to detention of patients. The MHA Department is also responsible for ensuring the work complies with the Mental Health Act and the Wales Code of Practice. A team structure and job descriptions of the MHA Team were obtained as part of the review which provided additional information in relation to the team. There are also several policies in place that outline roles and responsibilities in relation to specific parts/sections of the MHA and Code of Practice.

2.10 The MHM Code of Practice (part 2&3) establishes the role of the care coordinator which is a key front line role in the patient's journey, including the statutory duty on mental health services on the completion of care and treatment plans. In addition, the Part 1 Scheme for 'Local Primary Mental Health Support Services' establishes responsibilities for other roles such as Therapists, Consultant Psychiatrists and Primary Care Support Workers. Divisional structures were provided along with the job description of the MHM Lead.

2.11 The MCA Code of Practice establish responsibilities in relation to the Court of Protection and court appointed deputies, Independent Mental Capacity Advocates, while the DoLS Code of Practice also establishes the role of mental health and best interest assessors. While awaiting the introduction of 'Liberty Protection Safeguards' to the MCA, a West Glamorgan Regional Safeguarding policy has been developed. This provides interim guidance for the health board and outlines additional responsibilities for role of the Managing Authority and Supervisory Body. A team structure was provided for the DoLS team who act as the Supervisory Body and we note that there is currently no direct lead role to manage MCA compliance across the health board.

2.12 There is no formal mandatory MHA or MHM training within the health board training framework. Training is delivered on an ad-hoc basis when requested locally. MHA training is delivered within the Undergraduate Mental Health Speciality Attachment with SBUHB Medical School. Care and Treatment Plan training is also available through lunch and learn events provided within the MH&LD service group. We note that mandatory training compliance is periodically reported to the MH&LD service group board and the most recent report showed statutory and mandatory compliance at 84.78%.

2.13 Our review of papers taken to MHLCommittee has shown that there have been instances identified whereby invalid detentions under the Act have been completed by health board staff resulting in non-compliance with legislation. We note that these numbers are low and that the MHA Team have taken action to deliver additional training in order to overcome these issues. **See Finding 2.**

2.14 There are clear mandatory training requirements in relation to MCA, DoLS and Safeguarding within the health board training programme and some additional training requirements for specific staff. Training compliance is reported quarterly within service groups performance reports to the Safeguarding Committee. A review of these reports has shown that while the fields for completion within the template report are the same, they are not consistently reported by all. Of the four reports reviewed (MH&LD, NPT & Singleton, PTCS and Morriston) only Morriston appears to be reporting against specific staff numbers, while the remaining three report against whole service group staff numbers. There are three main areas of training covered that are specific to the MCA/DoLS:

Mandatory

- MCA Level 1&2 – current compliance 32% (figures not included in PCTS)

Specific

- MCA Level 3 – current compliance 26% (figures not included in PCTS or MHLD)
- DoLS Level 2 – current compliance 16% (figures not included in PCTS)

See Finding 2.

Conclusion:

2.15 Roles and responsibilities in relation to mental health are laid out in local policy and/or respective codes of practice. A review of training arrangements has established that training in relation to the MHA and MHM is delivered on an ad-hoc basis and that MCA/DoLS training is inconsistently reported. Noting this, we have assessed this objective as **Limited assurance**.

Audit objective 3: Operational policies and procedures are in place which clearly describe expected processes and methods

2.16 There are several local policies in place that provide guidance on specific parts and sections within the MHA which are all available on the Clinical Online Information Network (COIN) within the SBUHB intranet. We note that two of these policies, the 'Mental Health Act 1983 Withholding correspondence of detained patients' and 'Policy for the Locking of Doors in Inpatient Units and Its Associated Safeguards' were due for review in May 2020. Discussion with the Mental Health Act Team Manager has confirmed that while these policies were updated alongside other policies earlier this year, clinical input is required prior to finalisation and ratification which has been impacted by Covid-19. **See Finding 3.**

2.17 The MHM Code of Practice provides detailed guidance in relation to Part 2 and 3 of the Measure. Only one local policy was provided in relation to the Measure which was the Part 1 scheme 'Local Primary Mental Health Support Services'. We note that this is not a policy per se, but that it was developed in January 2018 and has not since been updated.

2.18 There is one key policy that has historically provided guidance to staff in relation to the MCA and DoLS, the 'MCA Multi-agency guidance - Deprivation of Liberty Safeguards'. This policy has recently been superseded by the West Glamorgan Safeguarding Board - 'Interim DOLS Guidance pending LPS' which mirrors the previous guidance but is now up to date. We also note that there are several guidance documents and flowcharts available on the MCA/DoLS intranet page and some Safeguarding policies that cross over with MCA legislation are available on COIN.

Conclusion:

2.19 Our review has shown that there are local policies and procedures in place that provide guidance to staff in relation to mental health legislation. Policies are generally up to date with the exception of two MHA policies which are in the process of being updated. Noting this, we have assessed this objective as **Reasonable assurance**.

Audit objective 4: Appropriate mechanisms are in place to ensure risk areas are identified, effectively managed and reduction/mitigation arrangements are put in place

2.20 Risks in relation to the MHA and the Measure are identified at a divisional level within the Mental Health and Learning Disabilities (MHLD) service group. Risk register review meetings are held periodically within the service group, where risks are discussed and reviewed in order to establish progress or developments that impact on risk scoring and monitor implementation of the mitigating actions required to reduce to an acceptable level. Risks scoring above 16 are reported to the service group board.

2.21 A similar process exists in relation to MCA and DoLS in that risks are identified at service group level and appear within service group risk registers. In addition, each service group reports to the Safeguarding Committee which is responsible for assisting the health board in delivering its' responsibilities in relation to the safeguarding agenda. Service group performance reports capture risks in relation to DoLS breaches, which are escalated to the Quality and Safety Governance Group and Quality and Safety Committee as required.

2.22 Each update report taken to the MHLCommittee includes a section for risks which provide opportunity for risk identification and scrutiny against each piece of legislation.

2.23 Where required, risks are further escalated to the health board risk register (HBRR). There is currently only one relevant risk on the HBRR (omitting those in relation to CAMHS), which relates to timely completion of DoLS assessments.

Conclusion:

2.24 There are arrangements in place to ensure risks are identified and effectively managed in relation to mental health legislation. Noting this, we have assessed this objective as **Reasonable assurance**.

Audit objective 5: Arrangements are in place for the escalation of issues.

2.25 There are clear pathways within the MH&LD reporting structures to provide opportunity for issue escalation. In addition, the MHA Team provide a layer of review and scrutiny for the MHA and regular meetings between key operational staff and the MHM Lead provide sufficient opportunity for the escalation of issues within the service group.

2.26 The MCA has wider considerations across the whole of the health board and pathways exist within service group reporting structures for the escalation of issues, with best interest assessors and the DoLS team providing an additional layer of support for queries and the escalation of potential issues. In addition, each service group performance report feeds into the Safeguarding Committee, including updates in relation to DoLS breaches and training.

Conclusion:

2.27 There are clear pathways in place for staff to escalate issues in relation to mental health legislation. Noting this, we have assessed this objective as **Substantial assurance**.

Appendix A: Management Action Plan

Matter arising 1: Completeness of compliance reporting (Design)	Impact
Reports presented to the MHLCommittee provide a broad coverage of compliance against legislation. We recognise that some sections within legislation do not place statutory duties on health boards and that reporting is undertaken by exception, however assurance on the completeness of compliance cannot be demonstrated in the absence of a compliance map.	Potential risk of: • All statutory duties are not complied with

	Recommendations	Priority
1.1	We recommend that an exercise is undertaken to map the legislation and/or the Codes of Practice to the arrangements the health board has in place, in order to provide assurance on compliance against legislation, that arrangements are monitored and that there are no omissions.	Medium

	Management response	Target Date	Responsible Officer
1.1	An exercise will be undertaken to match the legislation and/or the Code of Practice to the regular reports made to the Mental Health Legislative Committee.	1st April 2022	Executive Leads: Gareth Howells (Interim Director of Nursing and Patient Experience) and Inese Robotham (Chief Operating Officer) Responsible Officers: MHA: David Roberts (Service Director, MH&LD) MHM: Malcolm Jones (Divisional Manager for Mental Health) MCA: Tanya Spriggs (Nurse Director – Primary, Communities and Therapy)

Matter arising 2: Training Assurance (Design)	Impact
As reported to the MHLComittee, there have been 3 invalid detentions identified by the MHA Team in the first half of this financial year. We note that there is no formal MHA training provided to staff within the MHLD service group on a cyclical basis but that guidance in relation to form completion is available within patient dashboards. A review of service group performance reports taken to Safeguarding Committee has shown inconsistent levels of reporting of MCA and DoLS training and that in some instances, compliance is measured against all staff while some training is specific to certain staff levels. There was one report that did not record compliance against MCA and DoLS training. We recognise that this finding has wider implications across the health board and is not specific to MCA and DoLS	Potential risk of: • Potential action taken against HB with financial and reputational impact • Non-compliance with training requirements could lead to staff error

Recommendations		Priority
2.1	Regular training on the Mental Health Act and Mental Health Measure is provided to relevant staff to ensure adequate provision.	**High**
2.2	Consideration should be given to undertake service group training needs analysis to establish which staff levels require which level of training, in order to effectively manage compliance across the health board.	

Management response		Target Date	Responsible Officer
2.1	A revised programme for MHA & MHM training will be put in place. A range of literature and guidance notes are also available for reference.	1st April 2022	Executive Leads: Inese Robotham (Chief Operating Officer) and Debbie Eyitayo (Director of Workforce & OD) Responsible Officer: David Roberts (Service Director, MH&LD)

2.2	The Learning & Development team will put processes in place to ensure that the training available is targeted at the correct staff groups.	1st April 2022	Executive Leads: Inese Robotham (Chief Operating Officer) and Debbie Eyitayo (Director of Workforce & OD) Responsible Officers: MHA: David Roberts (Service Director, MH&LD) MHM: Malcolm Jones (Divisional Manager for Mental Health) MCA: Tanya Spriggs (Nurse Director – Primary, Communities and Therapy)

Matter arising 3: Policies (Operation)	Impact
There are two policies in relation to Mental Health Act legislation that were due to be reviewed December 2020 and remain extant. The MHA Team have reviewed the policies but clinical input is required in order to finalise their review, which has been impacted by the operational pressures of Covid-19. We were advised that the policies are in the process of being finalised in readiness for ratification.	Potential risk of: • Staff error due to out of date guidance

Recommendations		Priority
3.1	Policies should be reviewed in line with stated review dates.	Low

Management response		Target Date	Responsible Officer
3.1	The following policies: *Mental Health Act 1983 Withholding correspondence of detained patients* & *Policy for the Locking of Doors in Inpatient Units and Its Associated Safeguards* Have been extended on COIN until 30th April 2022 and remain extant.	Complete	Executive Leads: Gareth Howells (Interim Director of Nursing and Patient Experience) and Inese Robotham (Chief Operating Officer) Responsible Officer: David Roberts (Service Director, MH&LD)

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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