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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

FINAL INTERNAL AUDIT REPORT 2018/19

ABM University Health Board

Deprivation of Liberty Safeguards (Follow Up)

(ABM-1819-026)

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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

1 EXECUTIVE SUMMARY

1.1 Introduction and Background

In accordance with the 2018/19 internal audit plan agreed with the Audit Committee in March 2018, a follow up review has been undertaken in respect of Deprivation of Liberty Safeguards.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provide protection for vulnerable people in care homes or hospitals who lack capacity to consent to the care of treatment they need. Within ABMU DoLS apply to those who are considered to be deprived of their liberty within an inpatient hospital setting.

An internal audit review of Health Board arrangements undertaken in 2017/18 derived a *Limited* level of assurance. Action was agreed to address issues raised.

1.2 Scope and Objectives

The overall objective of this audit was to review progress made by management to implement action agreed to address key issues identified during the previous audit.

This is a follow up audit and as such the audit scope focused on progress made in those areas highlighted previously as requiring management action only.

1.3 Associated Risks

The following inherent risks were considered during this audit:

- Policies, procedures and responsibilities relating to DoLS are not clear;
- DoLS applications are not logged and actioned promptly;
- Information used for monitoring DoLS application is not up to date, accurate and complete;
- Issues identified with the process are not being actively managed.

2 CONCLUSION

2.1 Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and

objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Deprivation of Liberty Safeguarding is **Limited Assurance**

RATING	INDICATOR	DEFINITION
Limited assurance	 - + Amber	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

3 KEY FINDINGS & RECOMMENDATIONS

3.1 Key Findings

The previous audit made ten recommendations, of which three were high priority and six were medium priority, with one low priority. Concluding testing, we can confirm that five recommendations had been addressed, whilst five were partially addressed. It should be noted that the Unit Nurse Director in Primary Care & Community Services and Corporate Safeguarding Team confirmed that they had been monitoring progress against implementation of agreed action and shared the information with Internal Audit at the outset, recognising that at that point not all actions were complete.

The following key findings were noted:

- Although the master DoLS database had been enhanced to include the dates of key actions taken in the process and reason for breaches, Audit noted that the field 'date paperwork sent to ward' is not being consistently completed on all DoLS cases, this has resulted in a delay in communication to the ward.

- Staff within the Units are not reporting breaches via Datixweb. There are large inconsistencies between the number of DoLS breaches reported on DatixWeb and the number of breaches reported on the master DoLS database. A report run from Datixweb identified 15 breaches between April and June 2018 whilst in the same period the master DoLS database recorded 172 breaches.
- During 2017/18 984 DoLS applications were processed, 70% of these applications used external BIAs at a cost of £82,800. The use of BIAs in 2018/19 continues to be high. Further enquiries confirmed that the control and management of the services provided by external BIAs is not via a Service Agreement/Contract therefore the quality of service provided cannot be guaranteed. Of the 70% of assessment undertaken by external BIAs 91% breached the time target.
- In May 2018 the Mental Health Legislation Committee were informed that "The Health Board has now introduced a BIA rota" – audit were advised that the BIA rota was prepared but was not introduced until 1st August 2018 as per the improvement plan. The Health Board now has 21 BIAs ready to be deployed with a further 11 BIAs trained and awaiting shadowing before being eligible for deployment however of these four had not had an enhanced CRB/DBS check which deems them ineligible to undertake any Deprivation of Liberty Safeguarding assessments.
- The information held within the central databases at Morriston, Singleton and Neath Port Talbot were compared for a period against the information held on the master DoLS database. It was identified that the information held on the unit databases do not reconcile. It was also evident that with the DoLS cases held on the units' database were not always fully completed.

3.2 Design of System / Controls

The findings from the review have highlighted 3 issues that are classified as weaknesses in the system/control design. These are identified in Appendix D as *(D).*

3.3 Operation of System / Controls

The findings from the review have highlighted 8 issues that are classified as weaknesses in the operation of the designed system/control. These are identified in Appendix D as *(O).*

3.4 Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**5**	**5**	**1**	**11**

PROGRESS AGAINST PREVIOUSLY RECOMMENDED ACTIONS APPENDIX A

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
1 (D)	There is multi agency guidance that is currently under review. There is no ABMU policy clarifying expectations of units. Staff would also benefit from further guidance on timescales / escalation and reporting breaches to ensure ward staff are taking appropriate action.	The Multi Agency guidance should be reviewed, and an ABMU policy should clarify the expectations of units and governance arrangements. Consideration should be given to short guidance for staff on wards that identifies action they should be taking and clarifies timescales. Staff should then be made aware of new policies / guidance and they should be published on ABMU intranet.	**M**	The existing multi agency guidance is under review and will be reissued as a Health Board Policy in order to fulfil the recommendations made by this audit. The policy will be circulated for comment and ratified by the Health Board Safeguarding Committee. When ratified, the Policy will be updated on the safeguarding intranet page – and will be circulated to all Unit Nurse Directors via a newsletter from the Director of Nursing and Patient Experience. **Lead: Head of Safeguarding** **Target: 31/01/2018**	**PARTIALLY ADDRESSED:** A new policy was received at the DoLS Improvement and Support Group 29th June 2018. Internal Audit were informed that it was going for approval to the Safeguarding Committee in July but the Agenda for July 2018 does not include this document. Committee papers also did not mention approval of the Policy.	**See Finding 1 at Appendix D**
2 (D)	The database maintained by P&CS does not include: - The date the application was processed; - The dates the application was sent to the Supervising Body representatives to	We would recommend that the following information be captured on the database: - date application is entered into the database; - date application sent for sign off to approve booking of assessments;	**M**	The Primary Care and Community Services Delivery Unit will develop the required database to capture the information identified as part of audit process.	**PARTIALLY ADDRESSED:** Audit were supplied with access to the DoLS database, analysis showed all recommended fields have now been added to the data base, however based on a test sample audit found that 'date paperwork sent to ward' was currently not being completed for all DoLS cases.	**See Finding 2 at Appendix D**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
	approve the booking of assessments; - The timescales between approval to book and the successful booking of assessors; - The timescales between the booking of assessors and the receipt of their assessments; - The reasons against all applications that have breached (records are inconsistent).	-dates of assessment booked; - dates of assessment received; - date authorisation is communicated to ward; - reasons for breached entered for each breach.		**Lead: Unit Nurse Director Primary Care and Community Services** **Target: 01/11/2017**	It was noted that the DoLS were colour coded on the database to signify if there were any fields incomplete (White incomplete & pink complete). It is essential that all relevant fields are completed and the database is kept up to date.	
3a (O)	The lack of BIA's is impacting upon the timescales for DoLS applications. Whilst this has been identified in some Unit risk registers, and agreed for escalation it has not been recorded within the corporate risk register yet.	It was agreed in the Safeguarding Committee that Units are to identify staff who will undertake assessments (for training in October 2017), and establish a system to ensure those staff will be released to ensure sufficient assessors are available. This should be monitored via corporate management arrangements or the safeguarding committee to ensure a sufficient number of assessors are available.	**H**	Additional staff have been identified to undertake BIA training. The Corporate Safeguarding team are working with SDU's to establish a system within each area to ensure that the appropriate staff are released when required. **Lead: Head of Safeguarding** **Target: 30/11/2017**	**PARTIALLY ADDRESSED:** Additional Best Interest Assessors (BIAs) have been trained with a total of 32 (1 approaching retirement) assessors currently available; however only 21 of these BIAs are ready to be deployed and 11 are waiting to shadow an experienced BIA. Evidence of training is evident within the DoLS Improvement & Support Group minutes as well as the Safeguarding Committee papers. In addition, Internal Audit were informed that external BIAs were being used on a regular basis to improve timeliness. However the list of BIAs available to the Health Board is currently 20 but of those 20 only 11 are being utilised. Internal Audit were informed that only external BIAs are being used at present due to Health Board BIAs not having the	**See Finding 3 at Appendix D.** **See also Findings 8, 9, 10 and 11 at Appendix D in respect of control of external BIAs and cover for admin support.**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
					capacity to be released from their current role. Further audit enquiries regarding the control and management over the external BIA's identified an absence of key controls that need to be addressed as a priority. However, the new Nurse Director for Primary Care & Community Service informed Internal Audit that there is an intention to recruit two full time BIAs dedicated to the role.	
3b (O)	The lack of BIA's is impacting upon the timescales for DoLS applications. Whilst this has been identified in some Unit risk registers, and agreed for escalation it has not been recorded within the corporate risk register yet.	We would recommend that the risk of financial penalties arising due to the delays in undertaking DOLS assessments be included, with action planned, in the corporate risk register.	**M**	The risk of financial penalties arising due to the delays in undertaking DOLS assessments will be included with actions plans in the corporate risk register as recommended. **Lead: Head of Safeguarding** **Target: 31/10/2017**	**ADDRESSED:** Audit were sent a screenshot of the current Corporate Risk Register which showed the financial risk penalties arising from breaches of DoLS have been added to the Corporate Risk Register. However, the Head of Safeguarding informed audit that the Risk Register entry will be updated in the near future. The volume of best interest assessments in breach presents additional risk of legal claims for the Health Board. The Unit Nurse Director for Primary Care & Community Services informed Audit that two had already been received and there was a growing interest being shown by Solicitors in Wales.	No further action required
4 (O)	Wards are not consistently informed promptly following authorisation of DoLS applications.	PCCS Unit Management should ensure that adequate arrangements are in place to ensure the prompt communication of authorisation to applicants.	**M**	Feedback system to the relevant managing authorities notifying them of authorisation date to be developed by PC&CSDU and included in new database.	**ADDRESSED – FURTHER ACTIONS REQUIRED:** Field added to the database '*date paperwork sent to ward*'. This was added shortly after the previous Audit Report was issued (Aug 2017). On analysis of	**See Finding 4 at Appendix D**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
				Lead: Unit Nurse Director Primary Care and Community Services **Target: 01/11/2017**	this function, Audit found that for a sample tested this field was not consistently completed.	
5 (O)	There is a delay in the review of assessments received and sign off of the authorisation forms.	PCCS Unit Management should ensure that adequate arrangements are in place to ensure the prompt authorisation of applications following receipt of assessments.	**M**	PCCS admin support and appropriately trained Supervisory Body Sign off to be reviewed and actions to improve process and timescales to be implemented. **Lead: Unit Nurse Director Primary Care and Community Services** **Target: 01/01/2018**	**ADDRESSED:** Unit Nurse Director for Primary Care & Community Service informed audit that the number of individuals trained in Supervisory Body Sign off has increased to 8 to address this issue.	No further action required
6 (D)	Some Units do not keep central databases for DoLS applications / monitoring purposes.	We recommend that Morriston, Singleton and NPT Units should maintain a central database for DoLS applications, to support effective monitoring.	**M**	MSDU have created a central database and the information is recorded and disseminated on a weekly basis. **Lead: Head of Nursing, Medicine Morriston Service Delivery Unit** **Target: 31/10/2017** Singleton SDU will develop a central database for DoLS monitoring and reporting	**ADDRESSED – FURTHER ACTIONS REQUIRED:** All units have implemented a central database however there was an issue with all the databases not reconciling with the master database, all having inconsistencies with less DoLS cases recorded on the central databases in comparison to the master database. All central databases also had the issue of cases not having all the information included in the central databases. The DoLS Improvement & Support Group met on 6th April 2018 and the minutes	**See Finding 5 at Appendix D**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
				Lead: Senior Matron Singleton Service Delivery Unit **Target: 30/11/2017** The Medical Wards within NPTH maintain a record of DoLS application made. Central database being set up by the Senior Management Team to ensure accurate monitoring of applications and ongoing progress. **Lead: NPT Service Delivery Unit** **Target: 30/11/2017**	reflect that Units were encountering difficulty in managing and monitoring the databases. .	
7 (O)	The DoLS Improvement & Support Group does not have an approved Terms of Reference and there is currently no agenda for the meeting.	The Terms of Reference for the group should be approved by members and the Safeguarding Committee to which it is accountable, and consideration should be given to a regular agenda to ensure areas of concern for the group are discussed and addressed.	**L**	The ToR has been drafted and will be presented at the Safeguarding Committee in Q3 2017. The ToR include the specific requirements of an Agenda for the Group which would be agreed and managed by the Group Chair. **Lead: Head of Safeguarding** **Target: 31/12/2017**	**PARTIALLY ADDRESSED:** A Terms of Reference has been produced for the DoLS Improvement & Support Group. The Head of Safeguarding advised that the Safeguarding Committee would sign off the terms of reference in July 2018. However, the Agenda for July 2018 Committee does not include this document. Committee papers also did not mention approval of the Terms of Reference.	**See Finding 6 at Appendix D**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
8 (O)	There are discrepancies in the number of breaches reported within unit reports for the Safeguarding Committee, and the figures reported by P&CS and Datix	UNDs should undertake a check of DoLS cases and monitoring records within their Units to establish whether breaches are being reported promptly. Staff should be reminded that all breaches are to be reported via Datix (with appropriate CCS code.)	**H**	Within Morriston SDU there is an up to date and regularly reviewed spreadsheet in place that will support accurate reporting of information. This is sent weekly to senior nursing team to review and update. **Lead: Head of Nursing Medicine Morriston Delivery Unit** **Target: 31/10/2017** Singleton SDU developed database will cross reference with Datix incident reporting of breaches to provide assurances in compliance. **Lead: Senior Matron Singleton Delivery Unit** **Target: 30/11/17** NPT SDU will develop a central database to ensure accurate reporting and monitoring of breaches. **Lead: Senior Matron NPT Service Delivery Unit** **Target: 3110/2017** Lead Nurse will ensure	**PARTIALLY ADDRESSED:** Audit ran a DATIX report to determine the amount of breaches raised by Units between April & June and compared these breaches to the master database. From the report, only 15 breaches had been input onto DATIX with 171 breaches shown during the same period on the master database. Audit then compared these with the figures reported to the Safeguarding Committee. There are still large discrepancies between the numbers of breaches that are being reported by the units and those reported in the master database – for example in May Safeguarding Committee breaches reported between March and April were as follows: Morriston – 1 breach (11 on database) Singleton – 1 breach (7 on database) NPT – 1 breach (26 on database) POW – 1 breach (24 on database) Audit were informed that breaches being incurred by an external BIA are not being entered onto DATIX by the admin team that maintain the master DoLS database. This would contribute to the low numbers in the DATIX report. Also Units are not recording all breaches in their central databases or DATIX to ensure accurate breach figure reporting bimonthly to the Safeguarding Committee.	**See Finding 7 at Appendix D**

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
				compliance with DoLS process in Gorseinon and Maesteg Community Hospitals. Attended a meeting on 25/09/2017 outlining the requirements for the Managing Authority in the DoLS process. **Lead: Unit Nurse Director Primary Care and Community Services** **Target: 25/09/2017** POW delivery unit (unit DON) will undertake a review of all DoLS cases reported since April 2017 in order to establish if monitoring records and associated Datix reports are reconciled. POW delivery unit (Unit DON) will email staff to remind them that all breaches are to be reported via Datix and that if staff would like additional training in respect of reporting incidents related to this topic i.e. safeguarding the POW DU governance team are able to facilitate this. POW delivery unit (Unit DON) will remind staff via documented Matrons and		

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
				ward sisters/charge nurse meetings that all breaches are to be reported via Datix and that if staff would like additional training in respect of reporting incidents related to this topic i.e. Safeguarding the POW DU governance team are able to facilitate this. **Lead: Senior Matron Princess of Wales Service Delivery Unit** **Target: 31/12/2017** MH & LD are collating information from the wards with regards to breaches and comparing this to the incidents reported in Datix to identify discrepancies. A senior Clinical Nurse has lead on DoLS and reports the outcomes to Patient Experience Group who are able to support with remedial action. **Lead: Senior Clinical Nurse MH & LD Service Delivery Unit** **Target: 31/10/2017**		

Prev Ref	Previous Audit Finding	Previous Audit Recommendation	Priority	Management Response and Agreed Action	Progress on Implementation	Further Actions Required
9 (O)	The CSSIW submission for DoLS data was due on 30/06/2017. However, we were informed that the data was not complete and this had not been actioned at the time of audit (July). Arrangement to submit data were unclear in absence of the MCA/DoLS Manager.	The CSSIW submission should be completed and reviewed by management as a priority.	**H**	Information submitted to Welsh Government 21/08/2017 **Lead: Unit Nurse Director Primary Care and Community Services** **Target: 21/08/2017**	**ADDRESSED:** Information required for the CSSIW national report was submitted to CSSIW in August 2017. Information is being gathered for the CSSIW national report for 2018, information has been requested as soon as possible after the financial year-end but Welsh Government have given a deadline of end of July, a deadline ABMU believe they can achieve.	No further action required

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever.

Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.