Meeting Date	**7th February 2019**	**Agenda Item**	**4b**
Meeting	Mental Health and Mental Capacity Act Legislative Committee		
Report Title	**Deprivation of Liberty Safeguards (DoLS) Process Update**		
Report Author	Jason Crowl, Nurse Director, Primary and Community Service Delivery Unit		
Report Sponsor	Cathy Dowling, Interim Deputy Director of Nursing and Patient Experience		
Presented by	Gareth Howells, Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This report is to provide the committee with an update in relation to the Deprivation of Liberty Safeguard (DoLS) Process.		
Key Issues	• Internal Audit completed a follow up review and the Health Board Wide DoLS position remains at limited assurance level. • A review into the reasons why delays occur in the system has been undertaken resulting in a clearer understanding of the underlying causes. • The Supervisory Body (Primary Care & Community Services Delivery Unit) is taking a lead role in managing the implementation of the DoLS improvement plan. • Managing Authorities (Singleton, Morriston, Neath Port Talbot, POW, Gorseinon and Maesteg, Mental Health & Learning Disabilities Service Delivery Units) will be working to address some of the issues which lead to delays. The actions to address the issues are detailed within this report.		
Specific Action Required ***(please ✓ one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
			✓	
Recommendations	The Committee is requested to note the continued profile of improvement and risk mitigation outlined within the report.		

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) PROCESS UPDATE

1. INTRODUCTION

This report is to provide the Committee with an update on the Deprivation of Liberty Safeguard (DoLS) Process.

2. BACKGROUND

The Mental Capacity Act Deprivation of Liberty Safeguards provides a legal framework to protect **vulnerable adults,** who may become, or are being deprived of their liberty in a **care home** or **hospital setting.** These safeguards are for people who lack capacity to decide where they need to reside to receive treatment and/or care and need to be deprived of their liberty, in their **best interests,** otherwise than under the Mental Health Act 1983 (MCA Code of Practice). The safeguards came into force in Wales and England on the 1st April 2009.

The Health Board has a statutory responsibility to ensure patients under its care can be assessed within agreed time scales The Corporate Safeguarding Team is working with the Supervisory Body (Primary Care & Community Services Delivery Unit) and the Managing Authorities (Singleton, Morriston, Neath Port Talbot, POW, Gorseinon and Maesteg, Mental Health & Learning Disabilities Service Delivery Units) to address some of the issues which are contributing to the delays.

3. PROCESS REVIEW UDATE

The Supervisory Body (Primary Care and Community SDU) has developed a plan with timescales to improve performance in the DoLS process thus reducing the number of breaches. The Dashboard is operational and will provide a single reference point for the Managing Units. All Units will be able to interrogate their own activity data and report to safeguarding committee utilizing the new dashboard.

Further work has commenced to implement a SharePoint site for the coordination of a central database for access to all Units.

An Internal Audit, focusing on DoLS activity within ABMU HB, was undertaken by NHS Wales Shared Services Partnership (NSSP) in 2017. The result of this audit gave a *Limited* level of assurance. To address this, collaborative working between the Supervisory Body and the Corporate Safeguarding Team is now underway. A follow up Internal Audit is currently ongoing and findings are being reported to the Audit Committee. Follow up Audit is planned for March 2019.

A review of the DoLS process undertaken by Supervisory Body has identified the following underlying causes for the delays in completion of the process.

1. The Supervisory Body does not have sufficient dedicated administration staff to manage the process.
   Action: The Supervisory Body will provide additional temporary administration support whilst it recruits a new dedicated band 4 DoLS coordinating administrator to the team.
   Update: This post has been shortlisted and interview dates are early February. Additional administration support has been arranged through bank/agency team.

2. The Supervisory Body was dependant of staff in the delivery units or contractual staff for necessary assessments. It found that staff could not be released from delivery units in a timely way or the level of productivity was lower than required.
   Action: The Supervisory Body will develop a clear team structure and employ its own Best Interest Assessors (2 Best Interest Assessor Band 6 posts) and increase the administration capacity. DoLS will be managed as part of the Complex Care Team.
   Update: Two full time BIA Assessors have been appointed. Start date 1st March.

3. The Supervisory Body did not have the appropriate level of management information to discharge its duties.
   Action: A dedicated DoLS live dashboard has been developed which enables live case, ward, unit, and organisational level data necessary to discharge the

functions. As the DoLS team develop the correct budget and SIP list arrangement will be configured and aligned in the finance system.
Update: DoLs dashboard is live and used to generate reports

4. The data used to calculate breaches had been based on the English data set and not those agreed for Wales.
   Action: Work has been ongoing to align with the other Health Boards. ABMU will benchmark with other services going forwards and a collaborative approach has been agreed to support mutual development. The revised calculation period for delays starts at the point that assessments have been requested by the Supervisory Body. This is in line with Western Bay policy arrangements.
   Update: Service has linked in with Gwent Supervisory Body managed though ABHB and is evaluating a prioritisation-screening tool to prioritise cases for assessment.

5. The reasons for Urgent and Standard referrals and where they originate is not evenly distributed across the organisation.
   Action: the new management information highlighted the referral trends of several wards and units which need further investigation. This will be part of the role of the ABMU DoLS improvement group going forwards.
   Update: This is part of DoLS improvement group going forwards.

6. There is a need to improve the link with Managing Authorities and strengthen training.
   Action: There has been a crossover of responsibilities between the Supervisory Body and the ABMU Safeguarding Team, resulting in a disconnect between the Supervisory Body and the Managing Authorities. To resolve this the Supervisory Body will now take the lead with the Managing Authorities on the DoLS improvement work stream. This will be supported by Safeguarding. DoLs will continue to report to Safeguarding Committee.
   Update: Complete

Bridgend Boundary Change

The responsibilities of the Supervisory Body and Managing Authority for the population will change. A dedicated joint CTHB and ABMU safeguarding work stream has commenced to manage risk and clarify future arrangements for March 2019. The recruitment of staff for DoLS will apply only to the new Swansea Bay Health Board.

Actions Being Undertaken by Supervisory Body for Quarter 4

To enable the Primary and Community Services Delivery Unit to discharge its functions as the Supervisory Body the following actions have commenced:

- Working through the Internal Audit Action Plan in partnership with Safeguarding Team and all Managing Authorities;
- Complete visits planned with high referral teams to discuss referral threshold;
- Review of DoLS training with the ABMU legal Services team;
- To strengthen the perfomance and governance of the Best Interest Assessors (BIA) role, two Band 6 BIA posts and a dedicated Band 4 DoLs service adminstrator will shortly be recruited;
- It is anticipated that there will be a need to utilise additional BIAs from the Health Board rota to manage the waiting list demands;
- Implement across the organisation the dedicated DoLS Dashboard which will provide real time performance activity relating to the Managing Authorities (All Health Board Service Delivery Units) and the Supervisory Body.
- Established a bench marking arrangement with other HB DoLS Team.

4. FINANCIAL IMPLICATIONS

There is no identified budget for DoLS activity and it is based on cost but does not cover the full actual cost of delivering the service. Work is ongoing to identify costs associated with a revised service model for administration and dedication assessors for the activity. This work will clarify costs associated Bridgend Transfer and also establishing a correct budget and costing structure for the DoLS going forwards.

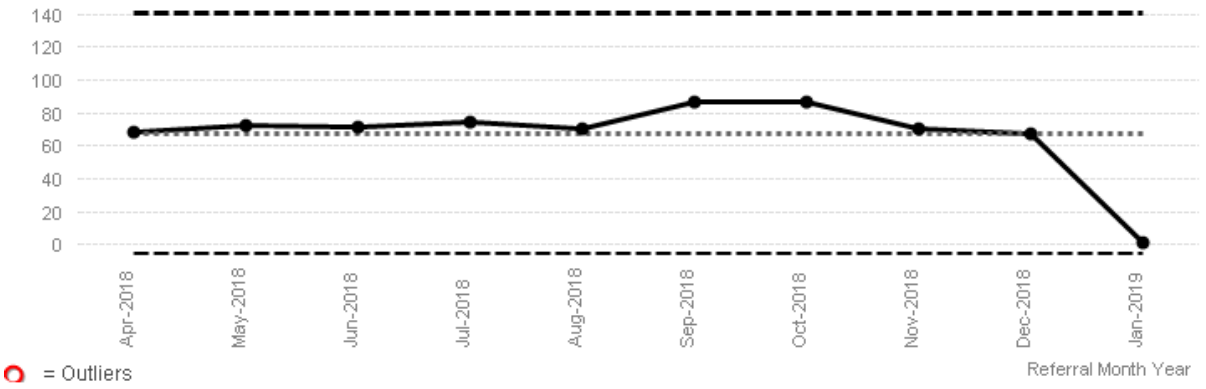
5. RECOMMENDATION

The Committee is requested to note the continued profile of improvement and risk mitigation outlined within the report

DoLS Supervisory Body Dashboard 1st April 2018 – 1st January 2019

DoLs Granted within timescales and those who have breached (01-Apr-18 to 01-Jan-19)

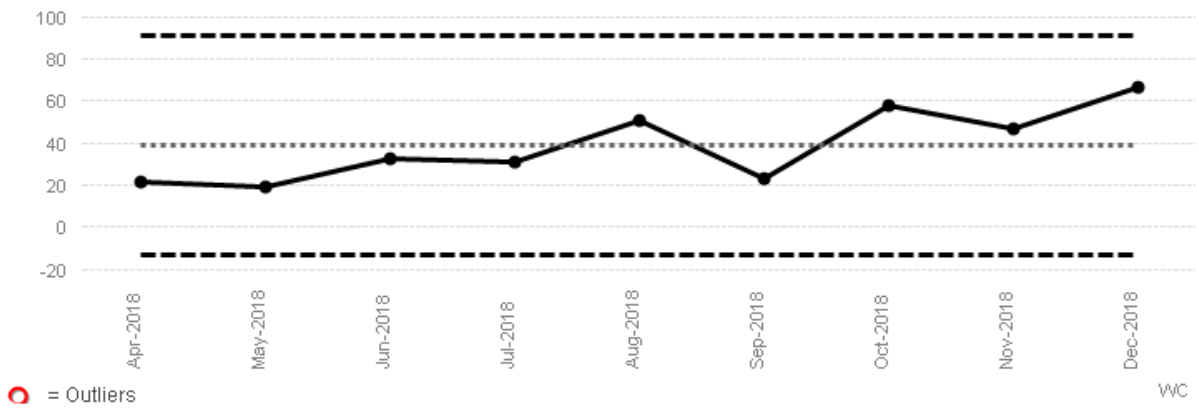
SPC Chart for DOL Referrals over time (01-Apr-18 to 01-Jan-19) 3 Sigmas



Show Line Chart | Show SPC Chart

Referrals	Decisions (sign off)	Section 12	Breaches	Within
673	699	527	351	86

DoL In Month Breaches over time (01-Apr-18 to 01-Jan-19)



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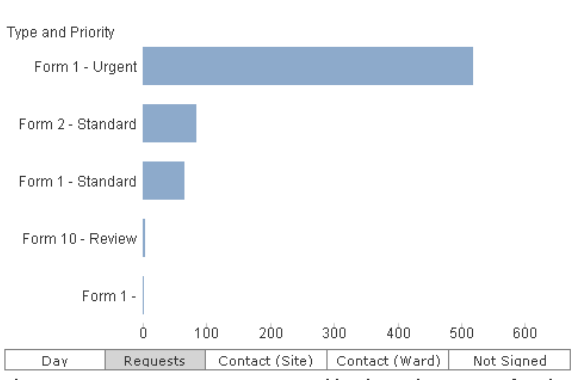

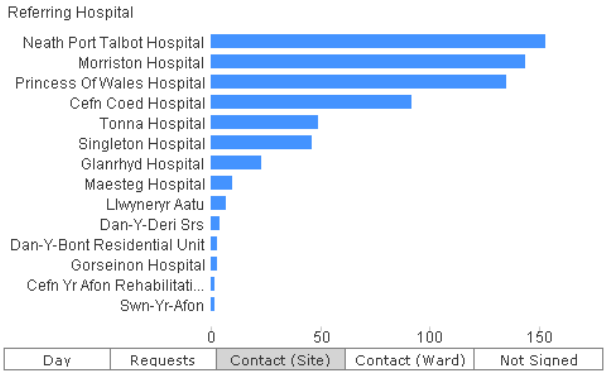

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
		✓			✓		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓	✓				

Quality, Safety and Patient Experience

The dedicated DoLS Dashboard will provide real time performance activity relating to the Managing Authorities (All Health Board Service Delivery Units) and the Supervisory Body.

Financial Implications

To reduce the breaches and any consequential risk of financial loss, the Supervisory Body has developed an action plan. However, there still remains a consequential risk of financial loss and this is identified within the Corporate Risk Register.

Legal Implications (including equality and diversity assessment)

Until the new Liberty Protection Safeguards (LPS) legislation is in place, the Health Board has a statutory responsibility to continue with the DoLS process.

Staffing Implications

Two Band 6 Best Interets Assessors posts and a dedicated Band 4 DoLs service adminstrator will shortly be recruited. The new posts will be co located with the Swansea Local Authority DoLs team which will provide accomodation, development support and the potential for new models to develop in the future

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

Collaboration – Working together ensure safeguarding of patients in a way that does not inappropriately restrict their freedom.

Report History	N/A
Appendices	N/A

Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

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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Appendix A Progress Against Previously Agreed Actions
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Appendix C Responsibility Statement
Appendix D Management Action Plan

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Proposed Receiving Cttee/s: Audit Committee

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Please note:
This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee. Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Abertawe Bro Morgannwg University Local Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

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.

Audit Source:	Internal Audit	Audit Year:	2018/19		**STATUS SUMMARY**	High	Medium	Low	
Report Ref:	ABM-1819-026	Title:	DoLS Follow Up		Completed	2	3	1	
Report Issued:	10/09/2018	Overall Assurance Opinion:	Limited		In Progress	3	2	0	
Lead Executive:	DoN - Gareth Howells	Version:	Final V1.0		Overdue	3	2	0	

Key Finding Ref	Findings	Impact (Internal Audit)	Recommendation	Priority	Management Response	Responsible Officer	Deadline	Completed Date	Status at Report Date	Status as at 18/03/19	Comments
1 (D)	At the time of fieldwork no Multi Agency or ABMU Policy for DoLS had been approved. Internal Audit were informed a new Policy had been issued for approval in the July Safeguarding Committee but the agenda or Committee minutes does not state the document was presented or approved.	Staff may be unclear on their responsibilities.	The Multi Agency guidance should be approved by the Safeguarding Committee as soon as possible. Staff should then be made aware of new policies / guidance and they should be published on ABMU intranet.	M	The existing Multi agency guidance has been agreed by the Western Bay Safeguarding Adults Board (WBSAB) DoLS sub-group and approved by the WBSAB Policy, Practice & Procedures Group on 19th april 2018 whereby it was confirmed that the guidance did not need to go to the WBSAB. This guidance will now be presented to Safeguarding Committee on September 21st 2018 and following this will be distributed to Service Delivery Units and placed on the Intranet DoLS section.	Jodie Denniss, Interim Deputy Head of Safeguarding	31/10/2018	21/09/2018	Completed	Completed	Guidance was presented and accepted at September 2018 safeguarding Committee and is now available on the intranet
2 (D)	All fields were added to the Master database, however it was noted that the database was colour coded to signify if there was any fields incomplete (pink incomplete and white complete). It was noted that the new fields were not always complete. As the master database is the source of information to manage and monitor DoLs and also for reporting to the Safeguarding Committee and Mental Health Legislation Committee there is a risk that management are unable to robustly monitor DoLs and information reported to the committees will be incorrect.	If relevant information is not captured on the P&CS database, it is difficult to identify where the delays and issues are within the application process.	The DoLS administration team should aim to capture all information requested on the DoLS master database to ensure robust management and monitoring and ensure information reported to Safeguarding Committee and Mental Health & Legislative Committee is accurate.	H	Fields are left intentionally blank where the data is no longer required (DOLS position changed/Discharged/Died). The MASTER spreadsheet is accessed through a dedicated SharePoint site and performance data is displayed through the dedicated DOLs dashboard	Jason Crowl, UND PCS	31/10/2018	30/10/2018	Completed	Completed	**October 2018** COMPLETE The master database has been revised and some fields are piuuurposfully left blank whilst data is awaited or data is not required. Other fields have not been given dedicated drop down codes to reference to the dashboard.
3 (O)	Since the previous audit the Health Board has increased the number of BIAs to 32 however the internal BIAs are not being used due to capacity. This has resulted in full use of external BIAs. The current external BIA arrangement is inadequate - there is no a contractual arrangement in place to ensure quality of service.	There is a financial impact on the Health Board due to the over reliance on external BIAs	Internal Audit have been informed that a rota is to be implemented on 1st August 2018 for the internal BIAs. This should be monitored via corporate management to ensure that staff are being released during their rostered time to complete BIA duties when required and ensure the rota system is effective. If the use of external BIAs continue several recommendations are reported below *(See Findings 8, 9 and 10)*.	M	The rota has been up and running since August 1st 2018. Some HB BIAs are now completing assessments. However independent BIAs are still being utilised as some HB BIAs are unable to be released from ABMU HB duties. The utilisation of independent BIAs ensures that the DoLS assessments take place in a timely manner in order to prevent breaches when the HB are unable to utilise their own BIAs due to capacity issues. This rota is currently monitored by the Corporate Safeguarding Team and reported to the Mental Health and MCA Legislative Committee on a quarterly basis.	Jodie Denniss, Interim Deputy Head of Safeguarding	01/09/2018		Overdue	Overdue	**SJC - Email received from Jodie Denniss 14/12/2018** Status should be partially complete not complete. Comment – Rota for internal BIAs being extended until end of March 2019, with 2 substantive BIA posts to be advertised from PCS Delivery Unit. UND and Corporate Safeguarding Team to carry out benchmarking exercise with other areas re: contracts.
4 (O)	A new field was added to the DoLS database to help decrease the delay in authorisation being communicated to the Ward *'Date paperwork was issued to the ward'*. However on analysis this section in not being completed consistently and a delay in communication still exists. A total of 19 out of 236 cases had the section completed between April and July 2018.	Wards are not always aware when an application has been authorised.	The DoLS administration team should look to complete all relevant sections on the master database to help monitor the timeliness of communication to the ward.	M	The field is not used when the DOLS is no longer required and is intentionally left blank	Jason Crowl, UND PCS	30/08/2018	30/08/2018	Completed	Completed	COMPLETE
5 (D)	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 database. It was identified that the information held on the central databases was not reconciling to the master. It was also noted that there were gaps in information for the DoLS cases held on the central databases.	UND's may not have appropriate oversight of DoLS applications within their unit.	The Unit Nurse Directors should review the current process for managing the central databases to ensure that they are maintained and monitored effectively at each Unit.	M	Work with all Units to remove separate local database and allow controlled access to DOLS MASTER database and dedicated Dashboard	Jason Crowl, UND PCS	31/10/2018	03/12/2018	Completed	Completed	**October 2018** IN PROGRESS. The Master Database has been revised and will act as the main database and be accessible from the dashboard. The access to the dashboard will be provided after a workshop which has been arranged for November. Work has started for a dedicated sharepoit site to replace the master database. **SJC: Deadline amended to 30/11/2018** **SJC - Email received from Jodie Denniss 14/12/2018:** Status can be marked as complete – completed date 3/12/18. The implementation of the DoLS dashboard will negate the need for SDUs to have individual databases, they will all be able to access their areas on the dashboard which is expected to be live by February 2018.
6 (O)	A Terms of Reference has been composed for the DoLS Improvement & Support Group and been circulated through the group for comment, no comments were made and the Terms of Reference were sent to the April Safeguarding Committee for approval. Due to lack of attendance the ToRs were not signed off. Internal Audit were informed that the Terms of Reference would be approved in the July Safeguarding Committee however audit did not find any reference in the Agenda or Committee minutes that this happened.	The Group is operating without an approved Terms of Reference, and may not be covering issues with the process.	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 Terms of Reference for the HB DoLS Improvement Group have been presented to the Corporate Safeguarding Committee on March 14 as seen on agenda but this was not evident from the minutes. The terms of reference will now be re presented for ratification at the Corporate Safeguarding Committee on September 21st 2018	Jodie Denniss, Interim Deputy Head of Safeguarding	31/10/2018	21/09/2018	Completed	Completed	Terms of reference were ratified at September safeguarding Committee and this has been minuted.

7 (O)	There are discrepancies in the number of breaches reported within unit reports for the Safeguarding Committee, and the figures reported by P&CS on the master database and DATIX	Under reporting of breaches within units.	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	The DoLS Improvement and Support Group can be utilised to work with the Service Delivery Units to develop a common method for monitoring . There is a S.O.P. flowchart for reporting DoLS breaches as DATIX incidents, this is already incorporated into Level 2 DoLS training. It has been added to the Safeguarding Intranet page to make it accessible to staff . *Lead: Deputy Head of Safeguarding* *Action by: UNDs & Corporate Safeguarding team*	Jodie Denniss, Interim Deputy Head of Safeguarding	31/10/2018	03/12/2018	Completed	Completed	**October 2018** IN PROGRESS- SDUs will be able to monitor breaches via the new DoLS 'dashboard' set up in conjunction with the Supervisory Body – due to go live imminently. Until this is in place it is not possible to accurately cross- check DATIX reported breaches. **Estimated date for completion October 2018** **SJC - Email received from Jodie Denniss 14/12/2018:** Status can be marked as complete – completed date 3/12/18. The implementation of the DoLS dashboard will negate the need for SDUs to have individual databases, they will all be able to access their areas on the dashboard which is expected to be live by February 2018.
8 (O)	The process for adding a new external BIA to the Health Board's BIA list does not include the approval of a senior member of staff with the only requirements to be added to the list being proof of qualification, training and the relevant insurance to conduct the assessments. The BIA is not supplied with any service agreement outlining what is expected from them or how to conduct themselves during the assessment.	No senior approval for new external BIAs to be added to the BIA list. New BIAs are not made aware of what is expected of them that may result in the Quality of service being inadequate.	Management should ensure that a formal procedure is established for adding a new external BIA to the Health Board's BIA list that includes appropriate checks and authorisation. If placed onto the list, the BIA should be required to agree to a Service Agreement that should outline the quality and time requirements.	H	The Health Board's BIA list is currently held by the Corporate Safeguarding Team. Checks are undertaken before external BIAs are added to the list to ensure they have appropriate qualifications that includes DBS checks, insurance, but there is not a formal protocol in place. This will be developed by the Corporate Safeguarding team in conjunction with the Supervisory Body	Jodie Denniss, Interim Deputy Head of Safeguarding	31/10/2018		Overdue	Overdue	**October 2018** IN PROGRESS DoLS project support officer to benchmark with other HBs and LAs if they have formal procedures re: adding external BIAs and draft something similar. **New estimated date December 2018** **SJC: Deadline amended to 31/12/2018**
9 (O)	Internal Audit were informed that external BIAs only accept DoLS assessments if the assessments were issued in batches and single assessments were generally not accepted by the BIAs. At the time of fieldwork a single assessor was completing 11 assessments with a further 13 cases pending assignment to the same assessor. In comparison the new Health Board rota to be implemented in August limits the internal assessors to a maximum of two assessments. On analysis it was identified that over 91% of assessments conducted by external BIAs breached the timescale between April 2017 and March 2018. The DoLS team stated that when assessments are issued to external BIAs there is no timescale or deadline attached with each case so the external BIA is unaware of the actual breach date or what assessment to prioritise.	The Health Board could face financial penalties due to DoLS assessments breaching timescales	There should be a limit on the number of DoLS assessments issued to external BIAs at a given time. All DoLS assessments issued to BIAs should include an expected complete by date or the date in which the DoLS case will breach its given timescale. The Health Board should look at introducing sanctions or financial penalties for consistent breaches from an external BIA.	M	The PCS which provides Supervisory Body function is recruiting 2 dedicated full time BIA roles and dedicated DOLS administration role. The BIA function will be coordinated as a support role to manage demand. The Supervisory Body will review the allocation rules to ensure maximum use of the BIA available.	Jason Crowl, UND PCS	31/10/2018		Overdue	Overdue	**October 2018** IN PROGRESS A review of the BIA list, costing arrangements, allocation , qualificiations and sign off process is underway and will be completed December 2018. The use of BIA will be reduced as a dedicated team of Band 6 BIA will be employed by the DoLS team. Posts out to advert October 2018
10 (O)	For the external BIAs to receive payment they are required to complete a standardised form supplied by the Health Board, that states who the assessment relates to. The form should be signed by the ward sister or senior nurse but audit was informed that this authorisation is not always obtained and the forms are processed for payment regardless of this. It was also noted that several of the external BIAs were also employees of the Health Board and being paid for DoLS assessments completed in their own time (as external BIAs) via accounts payable, instead of payment via payroll.	Payments are being issued without the required authorisation.	All payment forms should be authorised for payment before being processed for payment. All Health Board employees need to be paid via payroll not Accounts Payable.	H	Supervisory Body will review the sing off arrangements and stop payments where appropriate signatures are not available. Units are to ensure forms are signed by ward manager. Supervisory Body will review payment process to ensure correct procedures are followed.	Jason Crowl, UND PCS	31/10/2018		Overdue	Overdue	**October 2018** IN PROGRESS A review of the BIA list, costing arrangements, allocation , qualificiations and sign off process is underway and will be completed December 2018. The use of BIA will be reduced as a dedicated team of Band 6 BIA will be employed by the DoLS team. Posts out to advert October 2018
11 (O)	It was noted by audit that the maintenance of the central database as well as the appointment of BIAs (internal or external) is placed entirely on a single individual without segregation of duties or checking processes. There is no contingency plan in place to cover the individual when absent, resulting in the DoLS not being maintained during their absence. The DoLS Improvement & Support Group of 6.4.2018 Minute reference 6 DoLS Admin support: *DoLS database and admin currently maintained by Susan Hunt/Diane Morgan. DN has previously helped with DOLS admin on an ad-hoc emergency basis to cover sickness/leave however DN/SH/DM were recently all off work at same time.* *CD has been trying to get temporary additional support for SH whilst DM and DN are unavailable, until a sustainable solution can be found. CD has informed group that the situation in recent circumstances was not sustainable or safe.*	Failure to manage DoLS processes during periods of staff absence.	The Director of Nursing for Primary Care & Community Services should review the current staff structure to ensure sufficient resource is available to manage the DoLs process.	H	Supervisory Body will recruit dedicated DOLS administration role and 2 band 6 BIA to create a team. The team will be managed by CHC Lead Manager. Leave support is provided by bank Admin or where necessary agency admins role.	Jason Crowl, UND PCS	31/10/2018		Overdue	Overdue	**October 2018** IN PROGRESS A review of the BIA list, costing arrangements, allocation , qualificiations and sign off process is underway and will be completed December 2018. The use of BIA will be reduced as a dedicated team of Band 6 BIA will be employed by the DoLS team. Posts out to advert October 2018