

## ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD - BRIEFING FOR CLINICAL COMMISSIONING GROUPS

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### BACKGROUND

The planning guidance for 2018/19 stated that:

“Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall published programme funding. CCGs’ auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.”

This paper outlines how the validation process should be commissioned and carried out. The scope of the review will cover the MHIS performance only (**excluding** expenditure on learning disabilities and dementia) and will not cover for example the reporting of spend against individual service lines or the degree of provider triangulation. The review will be completed following on from the year-end accounts process.

### STATEMENT OF COMPLIANCE

CCGs will be required to publish a statement after the end of the financial year to state whether they consider that they have met their obligations with regard to the mental health investment standard, that is to say that their investment in mental health for the financial year either has or has not increased by a greater percentage than has their overall published programme allocation. The CCG compliance statement must be published in a prominent position e.g. alongside the CCG’s Annual Report, on the CCG’s website, and should read as follows:

“The planning guidance for 2018/19 stated that each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall published programme funding.

As the Accountable Officer of [name of CCG] I am responsible for the preparation of the Mental Health Investment Standard Compliance Statement (the “Statement”) for the year ended 31 March 2019 and for the financial information that forms the basis of the calculation on which the Statement is derived. This includes the design, implementation and maintenance of internal control relevant to the preparation of the Statement to ensure that mental health expenditure is correctly classified and included in the calculations and that the Statement is free from material misstatement, whether due to fraud or error.

To the best of my knowledge and belief I have properly discharged my responsibilities, with regard to reporting against the Mental Health Investment Standard.

NHS [Name] CCG considers that it has [not] complied with the requirements of the mental health investment standard for 2018/19. (Note – if the CCG has not complied the CCG should set out brief reasons for non-compliance)

[Name]  
Accountable Officer  
NHS [Name] CCG

## **AGREEMENT OF REVIEW ENGAGEMENT**

Each CCG's Governing Body will need to agree a separate engagement with an independent appropriately qualified reporting accountant to carry out a 'reasonable assurance review' to specifically cover the MHIS compliance statement. We recommend that CCGs engage their existing external audit firm, who will have experience of the CCG's systems and processes, though the reporting accountant will need to be sure they can accept the assignment, and CCGs should be mindful of their own procurement and other governance requirements.

Whilst NHS England requires the CCG to appoint an independent reporting accountant to carry out a reasonable assurance engagement on the MHIS compliance statement for the CCG, the engagement is a bi-partite engagement between the reporting accountant and the CCG, and NHS England does not require a duty of care from the reporting accountant. Whilst NHS England requires the CCG to publish a copy of the reporting accountant's report to show that the CCG has complied with the requirements contained in the 2018/19 planning guidance in respect of the appointment of a reporting accountant, the provision of the reporting accountant's report by the CCG does not create a duty of care between the reporting accountant and NHS England.

The review will be conducted according to a standard scope that has been agreed by NHS England and is appended to this paper. CCGs should plan to fund the cost of the review.

Each CCG's reporting accountant will be required to confirm whether, in their view, the statement made by the CCG has been properly prepared based on the specified criteria for the statement set out below. This will provide assurance as to whether the statement is a reasonable reflection of the CCG's performance against the standard. The report will be addressed to the CCG governing body and should be published on the CCG website alongside the CCG's compliance statement.

## **SUPPORTING INFORMATION**

CCGs will need to provide their reporting accountants with details of the headline calculation showing the percentage allocation increase (which is published information) and the percentage change in mental health expenditure. Backing detail will be required to show how the expenditure on mental health has been arrived at. This will be checked against the criteria to be used for the preparation of the statement and the relevant NHS England guidance (as set out below). CCGs should set out a summary of expenditure in the form shown in Annex 1 (which should reconcile to the non-ISFE mental health submission) and should prepare supporting papers to evidence the expenditure incurred. Reporting accountants should then be able to validate the expenditure as being eligible Mental Health Investment Standard spend.

A CCG Expenditure Summary Template in the format of annex 1 is below.



## THE CRITERIA TO BE USED FOR THE STATEMENT

The figures included in the headline calculation on which the statement is derived should be calculated as per the non-ISFE mental health submission that includes the calculation of the MHIS for each CCG, as follows:

- Increase in spending on mental health in 2018/19 (%) = (eligible mental health spend in the year ended 31 March 2019 less eligible mental health spend in the year ended 31 March 2018 adjusted for any non-recurrent spend) / eligible mental health spend in the year ended 31 March 2018 adjusted for any non-recurrent spend) x 100, rounded to 2 decimal places CCG allocation increase in 2018/19 (%), rounded to 2 decimal places.
- The CCG allocation to be used is to the published CCG allocation for the year (please note, a link to 2018/19 can be found here, column 10 refers <https://www.england.nhs.uk/publication/revised-ccg-allocations-2018-19/>).

If the % increase in spend on mental health is greater than the % allocation increase the CCG should state in the statement that it has complied with the requirements of the mental health investment standard for 2018/19.

If the % increase in spend on mental health is not greater than the % allocation increase the CCG should state in the statement that it has not complied with the requirements of the mental health investment standard for 2018/19.

For the purposes of the mental health investment standard, eligible mental health expenditure (which for this purpose excludes expenditure on learning disabilities and dementia) is expenditure on mental health correctly reflected in the financial ledger for the financial year (under the normal financial reporting requirements) which is consistent with the definitions used for programme budgeting, as set out in more detail below. Spend in both years should be adjusted for any spend against non-recurrent allocations as detailed in the planning and non ISFE submissions, this will ensure both years are on a consistent basis. The 2017/18 detail should be obtained from the 2018/19 planning template (final submission) and the 2018/19 detail should be obtained from the final non ISFE submission for that year.

CCGs should include all identifiable mental health programme spend across all their contracts. This should include mental health related spend with their main mental health provider contracts as well as mental health related spend, where separately identifiable, in other contracts i.e. smaller mental health providers, non-mental health providers and non-NHS providers.

Relevant staff costs can also be included e.g. a CCG's mental health lead, but only when the staff member is charged to programme budgets. The treatment must also be consistent between years.

### **Children & Young People's Mental Health (excluding Learning Disabilities)**

Expenditure to include services for children and young people's mental health across the whole care pathway, from early year's settings through to crisis care and intensive support as well as including the CYP IAPT programme. CCGs should include expenditure for services in

primary and community settings, including acute hospitals. As well as expenditure in NHS services, CCGs should include CYP MH services commissioned or co-commissioned from or delivered in local authorities, schools, further education Colleges and the voluntary sector. This should include both new resources allocated to CYP mental health as a result of the “Future in Mind” investment from the spring budget 2015 which will rise each year to 2020, and existing resources spent on community and primary services and resources allocated in year such as for acceleration of crisis services.

### **Children & Young People's Eating Disorders**

Expenditure on eating disorders for children and young people and their families/carers is for delivery of dedicated community eating disorder services in line with the evidence-based treatment pathway for ED (2015). They should be multidisciplinary teams that include medical and non-medical staff resourced to meet a range of presenting need from early to severe stage of illness and support advice, consultations, treatment and prevention work with universal services (GP, School, voluntary sector) and more intensive outpatient services (e.g. crisis, home treatment, day patient care).

From 2015-16 £30 million has been allocated recurrently to CCGs to contribute to pre-existing expenditure on eating disorders for children and young people to enhancing the development of the community eating disorder teams in order to achieve and maintain the referral to treatment standard.

### **Perinatal Mental Health (Community)**

Expenditure on perinatal mental health treatment and care in a community setting to include services for detection, pre-conception counselling, proactive management, assessment, advice, intensive support and treatment for childbearing women experiencing, with a history, and/or at high risk of serious mental ill health who cannot be managed effectively by primary care services alone. Expenditure on services should include advice, training and assistance to primary care, maternity and other mental health services on the treatment and management of serious perinatal mental illness.

CCGs should include expenditure on multi-disciplinary specialised perinatal community mental health teams including medical, psychological, nursing, occupational therapy and social care and support. CCGs should include expenditure on perinatal specialist mental health support services when they work with partners including other NHS services, local authorities, and the voluntary sector and community sector. The wave 1 Community Services Development Fund announced in November 2016 provides new resources for CCGs to collaborate in specialised perinatal mental health community services and wave 2 provides further investment in 18/19.

CCGs accessing this funding who are working in partnership with a lead CCG should identify the relative proportion of its expenditure from the total allocation and record the associated amount to demonstrate distribution of investment. The ‘perinatal’ period refers to the time of conception until 12 months after the birth of the child.

## **Improved access to psychological therapies for people with common mental health problems (adult and older adult)**

Expenditure against Improving Access to Psychological Therapies (IAPT) only includes expenditure for these services. All activity paid for under this line should be returned to the IAPT minimum data set.

## **A&E and Ward Liaison mental health services (adult and older adult)**

Expenditure on distinct mental health liaison ('liaison psychiatry') specialist teams based on-site at acute hospitals with 24/7 A&E departments.

The specialist teams provide urgent and emergency mental health assessment and treatment to general hospital emergency departments and inpatient wards for adults of all ages.

We are aware that some mental health liaison teams also work in outpatient departments as part of 'planned care' pathways – however this is not in the scope of this request and planned care should therefore not be included in this tracker. Where the same liaison mental health team provides both planned (outpatient) and unplanned (A&E and inpatient) care, best estimates should be made about expenditure on unplanned care pathways and CCGs will need to provide their rationale for the estimates used. \*

Some liaison teams are commissioned from mental health providers; some from acute providers and some from a combination of both. Expenditure on all these different types of liaison contracts should be included.

This expenditure does not include community-based crisis resolution home treatment teams that provide in-reach mental health crisis care to general hospitals. This expenditure is included in a separate expenditure category on crisis resolution home treatment.

- *Subsequent FAQ raised - Please disregard the reference to excluding "planned care" and report all expenditure on mental health liaison teams in the **A & E and Ward Liaison mental health services (adult and older adult)** category.*

## **Early intervention in psychosis 'EIP' team (14 - 65)**

This expenditure relates only to specialist EIP teams that have been commissioned to provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. Early Intervention in Psychosis services also triage, assess and treat people with an 'at risk mental state' (people at high risk of developing psychosis), as well as help those not triaged to access appropriate treatment and support. Expenditure on 'EIP activity' in generic community mental health services should not be included.

## **Crisis resolution home treatment team (adult and older adult, excluding dementia)**

This expenditure is associated with crisis home resolution treatment teams (CRHTTs) that exist in all areas providing the functions of initial urgent and emergency mental health response in communities, usually to people's homes – as well as intensive home treatment for a time limited period as an alternative to inpatient mental health admission. In most cases, one team provides both functions of community crisis response and ongoing home treatment.

However, in some areas these functions will be separated – with separate teams providing the urgent and emergency mental health response (immediate assessment and treatment) and the ongoing home treatment. In these instances, the expenditure on the teams providing both of these functions should be combined.

This expenditure relates only to specialist CRHTT services. Expenditure on ‘CRHTT activity’ in generic community mental health services should not be included. This expenditure should be included in the “**Other community-based crisis and acute adult mental health services (non-inpatient) (Excluding dementia)**” category.

### **Community Mental Health (adult and older adult, excluding dementia)**

Community mental health services comprise multi-disciplinary teams offering specialist assessment, treatment and care to adults with mental health problems in their own homes and in the community.

Expenditure under this category should include expenditure on:

- Assessment and brief intervention teams;
- Recovery teams;
- Community rehabilitation teams;
- Assertive outreach teams;
- Community mental health teams – for adults and older adults;
- Embedded employment support such as Individual Placement and Support for people under the care of the CMHT;
- Specialist primary care mental health provision for people with mental health problems (excluding IAPT for common mental health problems);
- Psychological therapies for people with severe mental illness;
- Community mental health care and support commissioned from the voluntary / independent / third sector;
- Section 117 – CCG expenditure on long term care for clients following detention under the Mental Health Act 1983.
- Please note, this list is not exhaustive.

### **SMI Physical Health (adult and older adult, excluding dementia)**

This category of expenditure is intended to cover CCG commissioned activity to deliver a comprehensive, NICE recommended physical health assessment and follow up intervention (as required), for people with severe mental illness (SMI), across both primary and secondary care settings:

- the proportion of expenditure across inpatient and community mental health settings designated for physical health assessments and follow up interventions for people with SMI;
- specific clinics or services for delivering physical health checks and follow up interventions for people with SMI, whether based in primary or secondary care settings. For example, this service may be delivered via an enhanced primary care service commissioned by the CCG;
- outreach and peer support to ensure people with SMI are supported to engage with physical health care services and support;
- workforce development and training of teams across primary and secondary care.

This category of expenditure is not intended to cover the entirety of the provision to improve physical health care for people with SMI. For example, it should not include local authority expenditure on preventative and public health services such as smoking cessation support for reducing premature mortality amongst people with SMI.

### **Secure Care Pathway**

National guidance is not currently available for spend on Secure Care Pathways, please refer to local guidance, there should be minimal expenditure recorded here.

### **Suicide Prevention**

This expenditure to include:

- Specific NHS-based suicide prevention initiatives relating to mental health patient safety in primary care, inpatient or community settings;
- Any expenditure contributed by CCGs to wider local suicide prevention work led by public health teams in local authorities.
- Please note, this list is not exhaustive

### **Other adult and older adult - inpatient mental health (excluding dementia)**

This expenditure to include:

- Acute inpatient services – defined as acute beds for male and female adults to provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness;
- Psychiatric intensive care units (PICU) - psychiatric intensive care for compulsorily detained patients of adult working age who are in an acutely disturbed phase of a serious mental disorder. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on an acute inpatient ward, usually multi-disciplinary and sometimes with 1:1 nursing staffing ratios;
- Longer-term complex care/continuing care units - For patients with high levels of disability including those with co-morbidity who have limited potential for future improvement and continue to pose significant risk to their own health or safety, or to that of others. Such units can be community or hospital based and domestic services are provided;
- Older adult inpatient services - for the psychiatric care of older patients on older adult mental health wards who are living with frailty alongside a functional mental illness (for example psychosis, affective and behavioural disorders) including complex co-morbidities. This expenditure should not include care and treatment for adults with dementia;
- Any CCG commissioned independent sector provision for adult mental health services, including expenditure on Out of Area Placements (OAPs).

### **Other community-based crisis and acute adult mental health services (non-inpatient) (Excluding dementia)**

This expenditure to include:

- Psychiatric decision units – short term assessment and observation units intended to continue assessment, consider alternatives to admission;

- Crisis houses – usually used as an alternative to admission, often run by voluntary sector;
- Crisis cafes / sanctuaries / havens – often used as an alternative to A&E for people experiencing crisis / pre-crisis;
- Acute day care Services – these usually act as a step up/down service from inpatient care as part of the acute mental health pathway. The services usually offer assessment, treatment activities and care planning for a time-limited period;
- s.136 suites – for assessment of people detained under s.136 of the Mental Health Act;
- Street triage – CCG expenditure on services jointly commissioned with blue light services – e.g. mental health nurses in control rooms, police cars, ambulances.

### **Mental health prescribing**

Expenditure on prescribing on mental health drugs should be in line with NICE guidance, or (where available and appropriate) in line with recommendations from regional medicines optimisation committees. We ask CCGs to specify whether expenditure is NHSBA EPACT system actual costs or NIC (net ingredient costs).

Expenditure to include the following therapeutic areas where total expenditure is the sum of:

- 1) Hypnotics and anxiolytics (BNF legacy 4.1 or equivalent therapeutic class defined by the BNF) (excludes pregabalin)
  - a. Include an estimate of expenditure for pregabalin when used as an anxiolytic only
- 2) Drugs used in psychosis and related disorder
  - a. Oral antipsychotic drugs (BNF legacy 4.2.1 or equivalent therapeutic class defined by the BNF) (excluding prochlorperazine)
  - b. Depot /long acting antipsychotic drug (BNF legacy 4.2.2 or equivalent therapeutic class defined by the BNF)
  - c. Drugs used for mania & hypomania (BNF Legacy 4.2.3 or equivalent therapeutic class defined by the BNF) (excluding carbamazepine and sodium valproate)
  - d. Include an estimate for carbamazepine and sodium valproate when used for mania /hypomania (excludes use in other conditions)
- 3) Antidepressant drugs (BNF Legacy 4.3 or equivalent therapeutic class defined by the BNF) Excluding amitriptyline and nortriptyline
  - a. Include an estimate of expenditure for amitriptyline/nortriptyline when used as an antidepressant
- 4) CNS stimulants and drugs used in the management of hyperactivity disorder (BNF Legacy 4.4 or equivalent therapeutic class defined by the BNF)
- 5) Drugs used in the management of dementia (BNF legacy 4.11 or equivalent therapeutic class defined by the BNF)

NHSE recognise that the identification of MH prescribing costs is complex particularly re multi use drugs etc.

All CCGs should use their best endeavours using local data to establish MH prescribing spend, including multi-use drugs. Enquiries we have made with pharmacy professionals in CCGs and central NHS England concur that best practice would require the use of clinical data from GP practices, but it is recognised that some CCGs may not have the resource or capacity to facilitate this work.

CCGs will need to provide their rationale any estimates used.

### **Mental Health in continuing healthcare**

Any expenditure coded to continuing health care cost centres which relates to mental health conditions should be included in this category as non-core mental health expenditure.

Please also see guidance references for dementia and learning disabilities below:

**Please note, dementia and Learning Disability spend is not to be counted against the Mental Health Investment Standard expenditure, descriptions are included for completeness.**

### **Dementia**

Expenditure on people living with dementia and their carers to include activities that correspond to a range of presenting needs from early stage intervention to more intensive support in primary care, community, outpatient and inpatient settings. Expenditure to include services against the five elements of the well-pathway preventing well, diagnosing well, supporting well, living well and dying well.

- For preventing well this would include activities such as health checks, prevention awareness raising and risk reduction.
- For diagnosing well this would include memory assessment services, regardless of how delivered i.e. primary, secondary, community care, activities to screen people for potential dementia assessment, and activities to set up an initial care plan.
- For supporting well this would include appropriate post-diagnostic support such as follow-up care plan reviews, psychological therapies for both the person with dementia and their carers where appropriate.
- For living well this should include carers' support e.g. respite; community engagement e.g. dementia friends.
- For dying well this should include palliative care and pain management.

We ask CCGs to include expenditure where CCGs work with partners in the community to deliver services including the voluntary sector.

### **Learning Disabilities**

All expenditure that is categorised as learning disabilities (LD) for programme budgeting purposes should be included here.

### **Supporting Guidance**

The expenditure included for the purposes of assessing performance against the Mental Health Investment Standard must comply with the following guidance:

- Technical Guidance - NHS England Guidance for completion of commissioner finance templates, published by NHS England, found on SharePoint;
- Mental Health Financial Planning – Additional Guidance December 2017, issued to CCGs by NHS England; and

- Mental Health Financial Planning – Frequently Asked Questions February 2018, issued to CCGs by NHS England.

### **System Evidence**

In assessing their mental health investment, we would expect CCGs to reference information and reports provided by third parties, for example;

- The BSA
- NHS Providers
- Local Authorities and other third parties

We would expect the CCG to review the data for reasonableness, but we would NOT expect the CCG to test the source systems.

### **CCG MERGERS**

Where the existing CCG is the result of a merger of a number of CCGs on 1<sup>st</sup> April 2018, the CCG will need to combine the relevant financial information from the constituent CCGs for 2017/18 and ensure that relevant supporting information is available for all predecessor bodies.

### **SCOPE OF WORK**

The reporting accountants will be required to verify the calculations and gain assurance that the spend included in them is in line with the published and other supporting guidance, has been properly incurred, and where relevant that any estimates or apportionments have been calculated reasonably, and in line with national guidance where relevant. Reporting accountants will be required to check that assumptions made by each CCG are consistent between years. This is as per guidance distributed to CCGs.

This will require substantive testing which means that reporting accountants will need to be able to trace numbers back through to the financial accounts system, and then to original source documentation e.g. invoices/contracts.

In the first year the reporting accountants will need to test both 2017/18 and 2018/19. The testing of 2017/18 spend should be completed prior to the year-end which will save time during the year-end process. Expenditure will need to be adjusted to take account of spend against non-recurrent allocations and its associated spend so that the expenditure figures are presented on a like basis and based on the same guidance. 2017/18 details can be found within the CCG's final plan submission for 2018/19. 2018/19 details can be found within the final non ISFE submission for that year. 2017/18 and 2018/19 will need to be tested in the first assurance engagement to validate the increase in spend. In future years, only the current year spend will need to be tested.

Reporting accountants will not be required to comment on whether assumptions are consistent between CCGs.

For the purposes of giving their reasonable assurance opinion, reporting accountants are not required to undertake any testing on the underlying information or systems maintained by third parties, such as the BSA, NHS providers and local authorities. Testing of the third-party information provided by CCGs is, therefore, outside the scope of the reasonable assurance engagement.

## **CONSEQUENCES OF NON-COMPLIANCE**

If a CCG makes a positive compliance statement and the reporting accountant's assessment considers that this is not accurate, the CCG will be asked to correct its statement.

If the statement is not corrected, we will expect the reporting accountant to issue a report stating that in their view the statement has not been properly prepared based on the specified criteria, with details of the reasons why. For example, the figures included in the statement have not been calculated correctly in line with the criteria. The CCG will send a copy of this report to the Regional team. The CCG should explain how the error occurred and the steps they are taking to ensure the error is not repeated.

## **FAQs**

FAQs published at the link below should also be considered as a supplementary part of this briefing note;

<https://www.england.nhs.uk/publication/assurance-engagement-of-the-mental-health-investment-standard-briefing-for-clinical-commissioning-groups/>

**Annex 1**  
**Suggested Form of Expenditure Summary**

	2017/18			2018/19			Apportionment notes (usually non-core)
	Core	Non-Core	Total MHIS	Core	Non-Core	Total MHIS	
	£'000	£'000	£'000	£'000	£'000	£'000	
Category 1 - Children & Young People's Mental Health (excluding LD)	X	X	Y	X	X	Y	
Category 2 - Children & Young People's Eating Disorders	X	X	Y	X	X	Y	1
Category 3 - Perinatal Mental Health (Community)	X	X	Y	X	X	Y	2
Category 4 - Improved access to psychological therapies (adult)	X	X	Y	X	X	Y	3
Category 5 - A and E and Ward Liaison mental health services (adult)	X	X	Y	X	X	Y	
Category 6 - Early intervention in psychosis 'EIP' team (14 - 65)	X	X	Y	X	X	Y	
Category 7 - Crisis resolution home treatment team (adult)	X	X	Y	X	X	Y	4
Category 8 - Community Mental Health	X	X	Y	X	X	Y	
Category 9 - SMI Physical Health	X	X	Y	X	X	Y	
Category 10 - Secure Care Pathway	X	X	Y	X	X	Y	
Category 11 - Suicide Prevention	X	X	Y	X	X	Y	
Category 12 - Other adult and older adult - inpatient mental health (excluding dementia)	X	X	Y	X	X	Y	6
Category 13 - Other adult and older adult mental health - non-inpatient (excluding dementia)	X	X	Y	X	X	Y	
Category 14 - Mental health prescribing	X	X	Y	X	X	Y	7
Category 15 - Mental health in continuing care	X	X	Y	X	X	Y	
<b>Total</b>			<b>X</b>			<b>Y</b>	

## Notes

1. [Explanation of basis of apportionment]
2. [Explanation of basis of apportionment]
3. [Explanation of basis of apportionment]
4. [Explanation of basis of apportionment]
5. [Explanation of basis of apportionment]
6. 2017/18 outturn source is from 2018/19 plan templates and is outturn excluding spend against non-recurrent allocations

2018/19 Outturn source can be obtained from the closing non ISFE returns which exclude spend against non-recurrent allocations.

## Annex 2

### Mental Health Investment Standard reporting accountant specification November 2018

#### Context

CCGs have a specified requirement set by NHS England (NHSE) to increase their mental health investment spend. The planning guidance for 2018/19 stated that:

“Each CCG must meet the Mental Health Investment Standard (MHIS) by which their 2018/19 investment in mental health rises at a faster rate than their overall published programme funding. CCGs’ auditors will be required to validate their 2018/19 year-end position on meeting the MHIS.”

From 2018/19 all CCGs will be required to publish a statement after the end of the financial year to state whether they have met their obligations with regard to the mental health investment standard, i.e. whether their investment in mental health for the financial year either has or has not increased by a greater percentage than has their overall allocation. We have referred to this statement below as the “Mental Health Investment Standard Statement of Compliance”).

The format and content of this statement, the criteria on which it is based and the publication requirements are set out in the “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS” issued by NHS England.

This guidance also outlines how the validation process should be commissioned and carried out. It states that each CCG will need to agree a separate engagement with an independent appropriately qualified auditor to carry out a ‘reasonable assurance review’ on the MHIS compliance statement.

#### The format of the reasonable assurance review

This reasonable assurance review would be carried out under *ISAE 3000 (Revised): Assurance Engagements Other than Audits or Reviews of Historical Financial Information* (ISAE 3000).

Under ISAE 3000 the reporting accountant would assess whether the subject matter information used in the preparation of the statement is free from material misstatement and expresses a conclusion on this through a written report. As NHS England have asked for reasonable assurance review this would be a positive opinion which would provide reasonable, but not absolute, assurance, in all material respects.

The reporting accountant’s report should convey their opinion on the outcome of the measurement or evaluation of *subject matter information* against the published *Criteria* set out in this guidance, where the *Criteria* are the benchmarks applied by the CCG to the underlying *subject matter* in the preparation of the *subject matter information*.

For this engagement the terms in italics should be applied as follows:

- Subject matter information = the Mental Health Investment Standard Statement of Compliance

- *Subject matter* = all the information that forms part of the disclosures in the Mental Health Investment Standard Statement of Compliance and the headline calculations on which they are derived, including mental health spend and published programme allocations.
- *Criteria* = Calculations and definitions specified by NHSE in their “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS”, which specifies what figures should be used to derive the headline calculations which support the CCG’s Mental Health Investment Standard Statement of Compliance and how they should be calculated.

To make it clear to the CCG and readers of the opinion how the reporting accountant has reached their conclusion the Criteria would be clearly referenced in both the reporting accountant’s engagement letter and reports.

### **Proposed approach**

1. Ascertain the method of compilation of the Mental Health Investment Standard Statement of Compliance (as reported in the CCG’s non ISFE template) and the headline calculations on which it is based.
2. Consider the internal controls applied by the CCG over the preparation of the statement and the headline calculations, evaluate the design of those controls relevant to the engagement to determine whether they have been implemented.
3. Identify and assess the risks of material misstatement in the Mental Health Investment Standard Statement of Compliance as a basis for designing and performing procedures to respond to the assessed risks.
4. Verify the percentage increase spending on mental health in 2018/19 included in the headline calculations, where increase =  $(A-B)/B\%$ . Where A is expenditure on mental health correctly reflected in the 2018/19 financial ledger which is consistent with the definitions set out in the “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS” and B is expenditure on mental health correctly reflected in the 2017/18 financial ledger, as amended for the 2018/19 planning process, which is consistent with the definitions set out in the “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS”.
5. Verify the percentage increase in the CCG’s allocation included in the headline calculations and check that it is per published CCG allocations.
6. Carry out procedures on the mental health expenditure included in the headline calculations and supporting schedules to check whether it meets the definition of mental health expenditure properly incurred as set out in the relevant Group Accounting Manual and the “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS” issued by NHS England.
7. Verify the factual accuracy of the compliance statement based on the procedures set out above

Where:

1. Documented through enquiry.
2. Documented through enquiry and walkthrough, with reference to the reporting accountant's prior knowledge where they are the CCG's external auditor.
3. Considered by the reporting accountant auditor based on 1 and 2 above.
4. Verified as follows:

Check calculation has been calculated in line with the criteria set out in the "ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS"

A – agree expenditure to CCG financial records and calculations

B - agree expenditure in the headline calculations to CCG financial records and supporting schedules, checking to see that the figures have been amended as necessary to reflect the 2018/19 planning process.

5. Check calculation has been calculated in line with the criteria set out in the "ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS" and agree to audited accounts
6. The procedures will include:
  - Sample checks of 2017/18 expenditure included in the calculations and supporting schedules to the financial ledger and the NHSE eligibility requirements set out in "ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS" (using normal audit principles and assertions). To be carried out under phase 1 of the work.
  - Sample checks of 2018/19 expenditure included in the calculations and supporting schedules to the financial ledger and the NHSE eligibility requirements set out in "ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS" (using normal audit principles and assertions). To be carried out under phase 2 of the work

This checking would consider for example if the expenditure:

- relates to the CCG
- relates to the correct financial year
- meets NHSE's definition of Mental Health Investment Standard spend for the purposes of the statement
- has been correctly reflected in the financial ledger for the financial year (under the normal financial reporting requirements)

When planning and performing the engagement the reporting accountant is required to be professionally skeptical, recognising that circumstances may exist that cause the Mental Health Investment Standard Statement of Compliance to be materially misstated and to consider materiality.

For example, the reporting accountant should recognise that there is a risk of understatement of mental health expenditure in the calculations in 2017/18 and overstatement in 2018/19. The reporting accountant should therefore use analytical procedures to identify any unusual variances between the two years that require further investigation during the testing.

The reporting accountant will request written representations from the CCG as part of the engagement, including:

- that it has provided the reporting accountant with all the information relevant to the engagement
- confirming their measurement of the underlying subject matter against the applicable criteria and their preparation of the headline calculation on which the statement is based, including confirmation that all relevant matters are included in the Mental Health Investment Standard Statement of Compliance and supporting calculations.

### **Assurance that would be provided under the engagement**

Under ISAE 3000 the reporting accountant expresses an opinion on whether the *subject matter information* is prepared, in all material respects, in accordance with applicable criteria.

The wording for the opinion would therefore be:

“In our opinion, the Mental Health Investment Standard Statement of Compliance is properly prepared, in all material respects, based on the Criteria set out in the “ASSURANCE ENGAGEMENT OF THE MENTAL HEALTH INVESTMENT STANDARD BRIEFING FOR CLINICAL COMMISSIONING GROUPS” published by NHS England.

### **Correction of errors**

If during our testing the reporting accountant find errors in the Mental Health Investment Standard Statement of Compliance (or the headline calculations on which it is derived) the reporting accountant should ask the CCG to amend the statement (and where necessary the calculations on which the statement is derived) for the errors identified. The reporting accountant may then need to carry out further testing to confirm the material accuracy of the revised figures.

If the statement is not amended the reporting accountant would give a qualified opinion on the Mental Health Investment Standard Statement of Compliance. This qualified opinion is likely to state that the statement has not been properly prepared based on the specified criteria, setting out details of the reasons why this is the case.

The CCG will send a copy of this report to the Regional team.

### **Annex 3**

#### **MHIS Statement of the Accountable Officer's Responsibilities**

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Accountable Officer to be the Accountable Officer of NHS [entity name].

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable,
- keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group),

In the Mental Health Investment Standard compliance statement, the Accountable Officer will be required to make the following declaration to acknowledge their responsibilities.

As the Accountable Officer of [name of CCG] I am responsible for the preparation of the Mental Health Investment Standard Compliance Statement (the "Statement") for the year ended 31 March 2019 and for the financial information that forms the basis of the calculations on which the Statement is derived. This includes the design, implementation and maintenance of internal control relevant to the preparation of the Statement to ensure that mental health expenditure is correctly classified and included in the calculations and that the Statement is free from material misstatement, whether due to fraud or error.

To the best of my knowledge and belief I have properly discharged my responsibilities, with regard to reporting against the Mental Health Investment Standard.

In preparing the Statement, the Accountable Officer is required to comply with the requirements of the NHS England planning and "in year" "non ISFE" guidance and the Criteria specified by NHS England for the preparation of the statement and the headline calculations on which it has been based.