Estates Directorate -

Management Arrangements

Internal Audit Report

Cwm Taf Morgannwg University Health Board

2020/21

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NHS Wales Shared Services Partnership

Audit and Assurance Services

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1. Introduction and Background

Our review of the Management Arrangements within the Estates Directorate has been completed in line with the 2020/21 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation').

Over the past three years, as part of the Internal Audit programme, we have reviewed the management arrangements in a number of the Health Board's directorates. The current year's programme continues with this theme, with our focus now around the new operating model and the clinical service groups and supporting corporate functions.

In addition to this review of management arrangements within Estates, we have undertaken a separate audit within the Directorate to establish the level of compliance with the Scheme of Delegation and a number of the most relevant / highest risk Financial Control Procedures applicable to Estates. As such, we have produced two reports, one focusing on compliance with financial governance arrangements, and one focusing on management arrangements.

The Health Board's estate is one of its largest assets and is an asset that grew following the merger with Bridgend in April 2019. As such, the Health Board now manages three district general hospitals, six community hospitals, one mental health site and 35 other health centres, clinics and support facilities. An Estates strategy is in place that describes the current condition of the estate and is used to inform work required. Furthermore, a number of the service change plans outlined in the Health Board's IMTP will have a significant impact on the estate. As such the proper management of the Health Board's estate, is essential in enabling the provision of healthcare to the Cwm Taf Morgannwg population.

During the audit planning phase of this review, we met with the Director of Finance, Assistant Director of Capital and Estates and a number of the business partners in order to confirm the relevance of audit objectives listed in section 2, below.

The relevant lead for the assignment is the Director of Finance.

2. Scope and Objectives

The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within Estates, in order to provide assurance to the Health Board's Audit and Risk Committee that risks material to the achievement of the system's objectives are managed appropriately.

The areas we sought to provide assurance on were:

- Governance arrangements
- Risk management

- Workforce management
- Planning and performance

Our detailed scope and objectives are set out in Appendix C.

3. Associated Risks

The potential risks considered in the review were as follows:

- The service is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Services are not effectively planned.
- Risks materialise as they have not been identified and / or addressed.
- Reduced service provision / additional costs due to inappropriate or unauthorised absence.
- Staff performance is not effectively assessed and addressed.
- Directorate objectives are not achieved as a result of demand and capacity data failing to be properly used and monitored.

OPINIONS AND KEY FINDINGS

4. Assurance Opinions

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. This review, focussing on management arrangements, covers risk management and governance, performance and planning, and workforce, giving three separate opinions relating to the relevant domain areas.

The opinions are based on the work performed as set out in the scope and objectives within this report. An 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 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.

Governance and Risk Management

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with risk management and governance is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

Governance Arrangements

The directorate has a number of groups and committees in place to oversee their governance arrangements. The scope, responsibilities and inter relationships between these groups are outlined within the Terms of Reference (ToR) of the groups and mapped within a committee structure diagram. The Health, Safety and Risk Group ToR had passed its review date and requires a refresh to take into account the boundary change and greater clarity on quoracy arrangements.

While the Covid-19 pandemic has had an impact on the directorate's ability to hold face to face formal meetings, some meetings have continued, and we understand that there have been weekly informal Senior Management Team catch up meetings. Prior to the pandemic, most meetings took place

in line with the frequency recorded in their ToRs and a schedule mapping out all meetings over the course of the year was in existence.

The directorate has continued to liaise with the Finance Business partners throughout the pandemic. However, during this period, the directorate has relied on its own workforce database for monitoring workforce information as it has not received regular reports from the Workforce & OD Business Partner.

Our testing identified two Estate specific policies that had passed their review date. One of these had recently become the responsibility of the directorate. At the time of our fieldwork the directorate had stated to review these policies.

Risk Management

At the time of our fieldwork the directorate was not using Datix to record risks. While attempts have been made to use the system in the past, the directorate's management felt that the system did not meet their requirements. In recent months, much work has taken place within the Health Board on a revised Risk Management Strategy, which includes the use of Datix to allow the flow of risks up through risk registers to the organisational risk register if necessary. The directorate have been working with the Assistant Director of Governance and Risk to review their current approach to recording and scoring risks in line with the Health Board strategy, including adopting Datix.

The directorate's risk register is monitored at the Capital and Estates Governance Board. Currently, the register is focussed on the outstanding maintenance backlog and statutory compliance work, with only a small number of risks that directly affect the directorate.

Workforce Management

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with workforce is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

We tested workforce information across five CTM sites. The staff were from the three main sites of Royal Glamorgan Hospital (RGH), Prince Charles Hospital (PCH) and Princess of Wales Hospital (PoW), and the two smaller sites of Ysbty Cwm Rhonnda (YCR) and Ysbty Cwm Cynon (YCC).

Our testing was split into five key areas: annual leave; flexi-time and Time off in Lieu (TOIL); sickness management; PDRs; and mandatory training. We looked at the data held on ESR and also the information the Directorate maintains on its own staff database.

It was clear that the Covid-19 pandemic has had an impact in relation to overall PDR compliance rates and some of the mandatory training module compliance rates. PDR rates fell from 96% to 40% between January and September 2020 due to work pressures, the inability to hold face to face meetings and the lack of IT equipment for this group of staff. Whilst overall the mandatory training compliance rate remained above 75%, the compliance rate for the fire safety module was only 49%. This is the only training module that is delivered face to face as opposed to online and as a result of the pandemic, courses have not been available for staff to attend. We note that this is a Health Board wide problem.

Our testing of sickness absence records established that the record keeping for the day to day management of absence was, in the main, good. Though we did note a few instances where there were time delays in completing some documents. However, the documentation and recording of Long-Term Sickness (LTS) interviews and informal absence review meetings needs improving. We have been informed that due to the Covid-19 pandemic, some LTS took place via phone calls as opposed to face to face meetings, management agreed that there should still be records of these meeting retained.

We identified a number of discrepancies when testing annual leave information. These included variances between the directorate's own records and ESR records for staff that had carried forward leave into 2020/21, and for staff that transferred from former Abertawe Bro Morgannwg Health Board. In both cases the directorate's own records were accurate. In contrast ESR recorded higher entitlement balances than the directorate's own records for the staff who had entered into the fifth or tenth year service. This highlights the importance of regular reconciliations between data sets when more than one system is used.

We also identified some minor discrepancies around the authorisation of annual leave. Some leave request forms had not been signed as approved and some approvals were not in advance of the leave being taken.

The number of staff that carried forward annual leave into 2020/21 was higher than in the previous year, and in some instances appears to be due to the pandemic.

Annual leave carry forward appears to be a regular occurrence, coupled with the increased carry forward of leave due to the pandemic there is a risk that this may create greater problems in future years and may have a negative impact on staff wellbeing when staff cannot take leave as planned.

TOIL is used by a small number of staff in the areas that we tested, and it was evident that a suitable process is in place to manage it. Similarly, there is a minimal requirement for rosters as most staff work set hours. Where rosters are used, they were prepared well in advance and we did not identify any issues.

Planning and Performance

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with planning and performance is reasonable assurance.

RATING	INDICATOR	DEFINITION
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.

As part of our planning and performance work we look at a directorate's IMTP. We note that due to key staff absence and the onset of the pandemic at year end the IMTP for 2020/23 was not finalised. However, draft versions of the IMTP and associated appendices, that we would have expected to have been developed prior to the pandemic, were not available.

Whilst we did not have a copy of an IMTP to identify any current year non-financial KPIs, Service Change plans or key priorities, we did obtain the previous IMTP and did see evidence of KPI monitoring taking place in relation to areas such as job completion rates. Evidence of monitoring has also been seen in the past as part of the Directorates annual report and other update reports being taken to the Health Board's Finance, Planning and Workforce (now Planning, Performance and Finance) committee.

We also note that performance monitoring in relation to workforce matters takes place in a number of the governance meetings. Though for a number of months the directorate has been reliant on using information from its own database, as opposed to information drawn from ESR by the Workforce and OD Business Partner.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance arrangements			✓	
2	Risk management			✓	
3	Workforce management			✓	
4	Planning and performance			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from our review did not identify any issues classified as a weakness in the system control/design of the management arrangements within Estates.

Operation of System/Controls

The findings from our review have highlighted eleven issues that were classified as weaknesses in the operation of the designed system/control of management arrangements within Estates.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Governance Arrangements

We note the following areas of good practice:

- The Estates Directorate management structure is aligned to the Health Board's new operating model, with staff working and overseeing each of the three Integrated Locality Groups (ILGs).
- The key governance groups within Estates have a clearly mapped out relationship showing the flow of information between groups. The management groups exist to ensure information is disseminated to the staff working within the ILGs. A series of specialist compliance and

safety groups are in place for areas such as Water Safety, Asbestos, Energy and Medical Gases.

- There is a timetable of meetings mapped out for the year for all key groups within the Directorate (although we note that due to Covid-19, not all meetings took place as planned).
- The Estates team has a working relationship, formalised through a SLA, with the Facilities Directorate for providing legislation updates.
- A dedicated member of Estates management, the Head of Assets, Governance and Technical Services Estates, is responsible for overseeing policies and procedures. All Estates policies and procedures are available on Sharepoint.
- All staff with key responsibilities in ordering and requisitioning stock have signed a declaration of interest form. This is a wider coverage compared to the Health Board's Standards of Behaviour Policy requirement.

We identified the following findings:

- The Terms of Reference (ToR) of the Directorate's Health, Safety and Risk Group have passed their review date. The current ToR make no reference to the Bridgend sites.

  The monthly SMT meetings paused during the first Covid-19 peak and recommenced in the summer, however meetings have not been taking place as frequently as expected. (Finding 1)
- The Health Board wide ceasing of CBMs has meant that we have not been able evidence the provision of any Estates workforce data for monitoring. There have been changes to the Workforce & OD business partner during the year, which may have contributed to this. Estates last received a Workforce & OD pack in January 2020. (Finding 2)
- Two of thirteen procedures had passed their review dates. One review was ongoing as at the time of our work. However, the 'Service Testing of Electrical Equipment Procedure' was due for review in July 2018. (Finding 3)
- Declaration of Interest forms were not in place for a small number of staff. (Finding 4)

Objective 2: Risk Management

We note the following areas of good practice:

- There are dedicated leads with the responsibility for overseeing the risk register.
- Risks are discussed at the various safety and compliance groups within the Directorate. They are also monitored at the Health, Safety and Risk

Group with escalation up to the Directorate's Governance Board if necessary.

- The risk register is updated quarterly in line with the timings of the Governance Board meetings.

We identified the following finding:

- The Directorate has chosen to maintain its risk register on an Excel spreadsheet as opposed to Datix. The register mostly contains items which relate to the Health Board's backlog of maintenance and statutory compliance work, as opposed to risks that directly affect the Estates. (Finding 5)

Objective 3: Workforce Management

We note the following areas of good practice:

- There is a central administration team which manages Estates workforce information. They update the Estates workforce database and are responsible for entering all relevant information into ESR, monitoring areas such as absence and compliance rates for mandatory and statutory training and PDRs. They liaise with mangers to encourage completion.
- There is an Estates department annual leave procedure and whilst this is still awaiting workforce sign off, it has been approved internally and used as a reference document. Staff are aware of the Health Board annual leave policy and Estates departmental procedure.
- There is a standardised approach across all sites for the management of sickness absence.
- For our sample of sickness episodes that required medical/ fitness to work certificate, in all instances they were in place and covered the relevant periods of absence.
- A test was undertaken to review TOIL and all records sampled were adequately approved.
- For those areas where rosters are used, the roster was compiled well in advance and ensured the required combination of skilled staff.

We identified the following findings:

- We identified a number of discrepancies between the annual leave entitlement balances on ESR and on the Estates database. (Finding 6)
- In a small number of cases 'Return to Work' forms had not been completed in a timely manner.

  Furthermore, evidence of carrying out Long Term Sickness meetings or informal meetings once absence prompts had been hit, could not be provided. (Finding 7)

- The Directorate's PDR compliance rate is currently low, although we are aware the ability to complete PDRs during the Covid-19 pandemic has been hampered. (Finding 8)
- Whilst the mandatory training target has been achieved, compliance with the Fire Safety module is particularly low. We acknowledge that this has already been raised as a corporate issue as the course is a 'face to face' module and Covid-19 has impacted the ability for this type of training to take place. (Finding 9)

Objective 4: Planning and Performance

We note the following areas of good practice:

- On a monthly basis finance meetings are held between the Senior Management Team and the finance business partner. These meetings continued through the pandemic.

  Ahead of each meeting the monthly reports pack are sent to the budget holders for review. Although the meetings are not formally minuted, all follow ups and actions are documented as a part of the finance pack.
- The Directorate undertakes performance monitoring in a number of ways including the use of the Tabs FM / Planet FM system to capture all planned preventative maintenance jobs.

We identified the following findings:

- Whilst we acknowledge that IMTPs were stood down this year due to the pandemic, we were unable to see evidence any draft versions of the narrative IMTP document and the associated appendix, which should have been prepared prior to the pandemic. As such we have not been able to carry out elements of our testing as intended. (Finding 10)
- The need to have an appropriate workforce plan is an essential component of any directorate's long-term planning. While this has been evident in previous years, the lack of a current year IMTP means that we have been unable to confirm that the directorate continues to develop its workforce plans. (Finding 11)

7. Summary of Recommendations

The audit findings and 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	Rating	H	M	L	Total
Risk and governance		0	4	1	**5**
Workforce		0	4	0	**4**
Planning and Performance		2	0	0	**2**
Total number of recommendations	**-**	**2**	**8**	**1**	**11**

Governance and Risk Management

Finding 1 – Directorate meetings (Operating Effectiveness)	Risk
The Directorate has a number of groups and committees in place to support its governance arrangements. These are mapped out diagrammatically in the Directorate annual report. During the first wave of the pandemic the activities of many of these groups paused. We reviewed the terms of reference (ToR), agendas and minutes of the key groups. Our review identified: • The ToR for the Health, Safety and Risk Group (HSRG) was due for review in March 2019, before the merger with Bridgend, but this did not happen so the ToR also have no reference do not consider members of staff in the Bridgend area. • The ToR for the HSRG require 40% of members to be in attendance to make the meeting quorate. Requiring a percentage quoracy makes it difficult to determine if the quoracy has been achieved. While the ToR includes a membership list it is not definitive and in some cases reference is made to more than one representative from a department, for example Estates Officers. The October 2020 meeting did not appear to be quorate, with 39% of required attendees present and there did not appear to be a discussion recorded within the minutes to confirm quoracy. • The monthly SMT (Senior Management Team) meeting is a key meeting within the directorate to ensure governance. It is a medium through which the Head of Estates meets with Estates' four senior managers. Following a pause due to Covid-19, the SMT meeting re-commenced in June 2020.	Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.

However, at the point of undertaking our audit testing in November there have been no further meetings.	
Recommendation	**Priority level**
1. Management should ensure that the ToR for the Health Safety and Risk Group are reviewed for relevance and brought up to date to reflect all changes especially those relating to the merger with the Bridgend area. 2. The ToR should give greater clarity on the quoracy arrangements. If a percentage quoracy continues to be used, the ToR should more clearly state expected membership. 3. Management should ensure that where possible, in order to maintain continuity, groups such as the SMT continue to meet frequently as they previously did. They should take advantage of the various IT platforms and tools available such as Microsoft teams. This system has been adopted across other groups in the Directorate.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. It is agreed that the TOR should be amended but please note that Bridgend officers have attended the Health Safety and Risk Group. 2. Agreed, will be reflected in the amended TOR. 3. Agreed, meetings will be held at frequencies determined by the TOR, but please note the Senior team met more often during 20/21 (albeit not minuted) to enable the department to respond to the dynamic challenges of Covid 19.	Head of Estates- May 2021 Group Chair – From April 2021

Finding 2 – Workforce data (Operating Effectiveness)	Risk
Following the introduction of the new operating model CBMs have been replaced with new ILG governance arrangements, but as a corporate function, Estates does not align with these arrangements. The directorate considers that matters that were previously covered in CBMs are now captured via other groups. For example, dedicated finance meetings are held with the Finance Business Partner, and risk matters are captured within the Estates and Capital Governance Board. Key workforce information is discussed during the SMT and Operational Management Team (OMT) meetings and disseminated to the relevant teams. While we saw detailed workforce information within meeting papers, the report presented at the March 2020 meeting was based on January data, so some months out of date. However, since the move to the new operating model the directorate does not appear to have received a workforce data pack from the Workforce and OD business partner. We note that at the September 2020 OMT meeting a workforce monitoring report produced by Estates was used. We acknowledge that while there have not been documented scheduled meetings with the Workforce Business Partner in recent months, management consider that the support from the business partner is available if necessary.	Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.

Recommendation	Priority level
A strong relationship with the Workforce & OD Business Partner team should be maintained. In the absence of CBMs, the Business Partner should have a proactive participation with the Directorate through the most relevant group or meeting. Whilst the Directorate is able to produce its own workforce data, the previously provided data packs should be used for discussion at meetings and for reconciling to Estates held data, as it is this corporately produced data that will be used in wider Health Board reporting.	**Medium**
Management Response	**Responsible Officer/ Deadline**
PDR and training data has been provided by the training department on a monthly basis since January 2021 and has subsequently been reported at the Senior operational management team meetings, and will continue to do so. The directorate is not receiving sickness or other work force data consequently the Workforce and OD Business partner will be invited to the monthly meetings that are currently held with the Finance Business partner. If they are not available to attend the meetings the Head of Assets, Technical services and Governance will request the Workforce data pack on a monthly basis and if received will reconcile it to the directorate records.	Head of Operational Estates- On a monthly basis. Head of Assets, Technical Services and Governance – From April 2021 then on a monthly basis.

Finding 3 - Policies and procedures (Operating Effectiveness)	Risk
Policies and procedures (P&P) should be reviewed to confirm relevance either when they reach their review date or when there are changes in legislation. Within Estates, all updates to P&P are approved by the Estates & Capital Governance Board. We reviewed the 13 Estates P&Ps on SharePoint to ensure they were up to date. While the asbestos policy was out of date as it was scheduled for review in November 2020, we note that work has started to update this policy. We also identified that the Service Testing of Electrical Equipment Procedure (STEEP) was due for review in July 2018. However, we acknowledge that up until September 2020, this was the responsibility of another directorate. We acknowledge that Estates has begun the process of review.	Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
Management should ensure that the Asbestos Policy and Service Testing of Electrical Equipment Procedure (STEEP) are updated as soon as possible and all P&Ps which are soon due for review are updated in a timely manner.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The asbestos policy and STEEP will be updated and endorsed at the next meeting of the relevant group.	Head of Assets, Technical Services and Governance – STEEP- September 2021 Asbestos -May 2021

Finding 4 – Declarations of interest (Operating effectiveness)	Risk
The Health Board requires a declaration of interest (DOI) or nil return is completed by band 8a and above staff. In the months prior to this audit, the corporate team had contacted all relevant managers and staff requesting completion on their on-line 2020/21 returns. Our review looked to ensure that the eight relevant members of staff had an up to date DOI or a nil return. We found that: • 1/8 of the staff had not submitted their online 2020/21 DOI return, nor had they completed the previous return in 2019/20. • 2/8 were new starters, but has not completed a DOI at the time of their induction. While the forms have now been completed by both staff as a part of the current exercise, one of the forms was yet to be signed and dated.	Directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
Recommendation	**Priority level**
1. Management should ensure that relevant staff are reminded to complete a DOI or nil return on an annual basis or when changes effect earlier declarations. 2. All new staff at band 8a and above should complete a DOI as a part of Estate's induction process.	**Low**

Management Response	Responsible Officer/ Deadline
1. Agreed 2. Agreed	Action complete The appointing officer as and when.

Risk Management

Finding 5 – Risk register (Operating effectiveness)	Risk
The risk register is a standing agenda item for the Capital & Estates Governance Board and as such regular monitoring takes place. However, the risk register is in a different format to that which we have seen in other directorates. The register in use, consists of a list of outstanding jobs from the maintenance backlog and statutory compliance work. As such, the majority of risks on the register relate to the Estate's corporate responsibility to other departments within the Health Board, as opposed to risks that emanate from and directly affect the Estates department themselves. The register is collated on Excel and not Datix. Information such as risk rate target, last review date, next review date and risk owner, which are data fields within Datix are not included in Estate's register. As such, we have been unable to undertake detailed testing on the risk register. We identified two risks contained on the register that relate directly to the Estates team, namely: • retention and recruitment of staff and • lack of ongoing support for an IT system used. Through our meetings with Directorate staff and the Workforce and OD Business Partner, other risks were mentioned, such as the ageing workforce and ensuring suitable mentors within the team to support apprentices. While we acknowledge that these could be considered under the umbrella 'retention and recruitment' of staff risk, they appear to be risks in their own right that require specific attention.	Risks materialise as they have not been identified and / or addressed.

We understand that meetings have already taken place between the Estates management team and the Assistant Director of Governance and Risk to discuss how the current register can be aligned to the Health Board's revised Risk Management Strategy.	
Recommendation	**Priority level**
1. The Directorate should review their approach to risk management in line with any advice they have been provided by the Assistant Director of Governance and Risk. This should include the use of Datix as the organisational platform for capturing risk thus allowing the flow of risks up to the Organisational Risk Register as necessary. 2. Work should be carried out to review the content of the register to ensure it captures risks specifically relating to the Estates Directorate (not limited to, but including) operational and staff concerns. The items on the current register that are deemed as an issue and not a risk could continue to be maintained in their current format. 3. Where deemed necessary, the Directorate should request further support and training on the application of the Risk Management Strategy and use of Datix to capture risks applicable to them.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. This recommendation has been actioned through meetings with Assistant Director of Governance & Risk, regular communication is ongoing by emails between the Assistant Director and the Estates team to transfer high scoring risks into the Organisational Risk Register (Datix).	Head of Assets, Technical Services and Governance - September 2021

2. This recommendation will be picked up by the Directorate's Health, Safety and Risk group at the next meeting scheduled for May 13th. Following discussions, group members will be requested to manage general departmental risks through the same Estates Risk Register spreadsheet. 3. Meetings have been held with the Health and Safety team and Datix support meetings with officers from CTM UHB - Information Systems. Training and support has been requested from the Health and Safety team for the updates to Datix, and for the new layout and standard reports.	

Workforce Management

Finding 6 – Annual Leave (Operating Effectiveness)	Risk
We tested a sample of 20 annual leave occurrences of staff from the three main hospital sites of RGH, PCH & POW, and the two smaller sites of YCR and YCC. Our review identified the following points: • The Directorate has manual leave records (as not all staff have access to a computer), its own database that includes leave information, and ESR. Our testing of the systems identified the following discrepancies between the recording systems: ➢ 5/20 staff, who were based at POW, had incorrect leave entitlement on ESR as the migration date of April 2019 had been used to calculate their leave entitlement as opposed to their actual NHS start date. ➢ 7/20 had carried over leave from 2019/20, but the entitlement in ESR did not include the carried forward balance. ➢ 3/20 had their entitlement miscalculated on the manual records. This was due to staff entering their 5th or 10th year of service. The pro-rated additional days had been included in the ESR balance but were not included in the Directorate's own records. This error was rectified during the course of the audit. • For 1/7 cases of carried forward leave, the request form was incomplete and not signed. For the 3/6, the forms were not approved by the relevant manager in line with Directorate's annual leave policy and the scheme of delegation.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.

We also note that many of the requests and authorisation dates were between mid-March and mid-April, though we acknowledge that the late submission of requests may be Covid-19 related if staff had to cancel leave late in the year. • For 2/20 there were discrepancies between the leave dates recorded on the annual leave form and database and what was recorded on ESR. • 1/20 had leave approved and recorded on their annual request form, however it was not recorded on ESR. • 3/20 the annual leave request form had not been signed off as approved. • 3/20 the annual leave request form was submitted on or after the leave was taken and in three other instances the timeliness of submission could not be determined because the submission date was not recorded on the form. • In one case we identified that the member of staff had taken too much leave in the prior year and their balance had to be adjusted at the start of 2020/21. As part of our testing we obtained a report of staff that had carried forward leave into 2020/21. A total of 63 staff and 1362 hours were listed from across Capital and Estates. Our testing of a sample of these, as noted above, established that the Covid-19 pandemic was cited on a number of occasions as the reason for being unable to take leave at year end and therefore the need to carry it forward. However, there appears to be a high number of staff and hours to be carried forward, suggesting leave had not been taken evenly throughout the year. The Directorate's annual leave policy is clear that leave should only be carried forward in extenuating circumstances.	

Recommendation	Priority level
1. Management should ensure that reconciliations and checks are done periodically, especially at the start of the financial year, between their departmental records and ESR. Contact should be made with workforce colleagues to ensure the correct NHS start date is recorded for staff that have transferred into the Health Board, in order for ESR to properly calculate staff's annual leave entitlement. 2. Requests to carry forward annual leave into future years should be kept to a minimum. Where there is an operational demand and leave cannot be taken, requests and authorisation to carry forward leave should be made in a timely manner and where possible in line with the Directorate's annual leave policy. Authorisation to carry forward leave should be granted in line with the Scheme of Delegation. 3. Annual leave requests should be submitted, approved and dated in a timely manner, as stated in Estate's annual leave procedure and approved leave accurately input on ESR.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. Agreed. Checks are currently made and this will be reinforced to the management/ admin team. 2. Agreed 3. Agreed	1.Head of Operational Estates and Head of Assets, Technical Services and Governance – April 2021 2. Throughout the year 3. Throughout the year

Finding 7 – Sickness Absence Review (Operating Effectiveness)	Risk
We tested a sample of 20 sickness occurrences of staff from the three main hospital sites of RGH, PCH & POW, and the two smaller sites of YCR and YCC. Our testing included ensuring accurate information is recorded on the various forms and systems used, adequate documents are maintained to support sickness episodes, and monitoring and follow up of prompts and long-term sickness takes place. We identified the following points: • 3/20 of the return to work forms were not completed in a timely manner following the individuals return. Two took over two months to complete. • For 5/6 of the sample who required a Long-Term Sickness interview, documentation was not available. • For 3/5 of the sample who required an informal absence monitoring discussion to be undertaken, documentation was not available to confirm that the discussion had taken place or if management discretion had been applied to not hold the informal discussion.	Reduced service provision / additional costs due to inappropriate or unauthorised absence.
Recommendation	**Priority level**
1. Management should ensure there is an adequate structure in place regarding the prompt monitoring of sickness prompts, the follow up of sickness interviews and maintenance of required documentation as stated in the NHS Wales Managing Attendance at Work policy.	**Medium**

2. Where a manager exercises their discretion and chooses not to undertake an informal or formal warning, this decision should be documented on the individuals file.	
Management Response	**Responsible Officer/ Deadline**
1)+2) An adequate supervisory structure and process is in place to ensure the recommendations are adhered to, supervisory/ management staff will instructed accordingly, a review will be carried out in September 2021.	Head of Operational Estates - April 2021 followed by a 6 month review

Finding 8 – PDR compliance (Operating Effectiveness)	Risk
We reviewed a directorate PDR compliance report from the September OMT meeting. This showed that over 40% of PDRs were overdue. The pandemic has had a major impact on undertaking PDRs in recent months, as in January 2020 the Directorate had a compliance rate of 96%.	Staff performance is not effectively assessed and addressed.
Recommendation	**Priority level**
1. In addition to being an important component of staff wellbeing, the timely completion of PDRs will be an essential part of the NHS Wales Pay progression policy, as such managers and supervisors should be reminded of the requirement to complete PDRs in a timely manner. 2. Ongoing monitoring of compliance rates should continue within the OMT meetings and reports should be requested from Workforce to support the departments own records and allow plans to be developed to return the Directorate to their previously high compliance rate.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. The impact of Covid undoubtedly affected compliance rates during the year. The directorate prides itself on performance which is confirmed by the 96% compliance rate in January 2020. A concerted effort has been made and the current compliance rate is circa 76%. 2. Agreed- Existing practices will continue.	Head of Operational Estates - Ongoing

Finding 9 – Mandatory training (Operating Effectiveness)	Risk
The directorate has not received a workforce data pack since March 2020. We obtained a mandatory training compliance report from the learning and development team and note that as at November 2020 the overall compliance rate was 75% which is in line with the Welsh Government target. However, only 49% of staff have up to date fire training. We acknowledge that this is a Health Board wide problem as this is a face-to-face course, and there has been difficulty in staff accessing this course at the current time. Our review of the detailed compliance list, where individual staff compliance rates were stated, identified that of the 169 staff, six members of staff had a compliance rate of less than 10%, three of which had a 0% compliance rate. We understand that some of the staff are new starters and have not yet undertaken their mandatory training modules.	Staff performance is not effectively assessed and addressed.
Recommendation	**Priority level**
1. Management should liaise with the corporate Health and Safety team and establish an action plan for how fire safety training can be delivered safely to all relevant staff.	**Medium**

2. Regular workforce data reports should be obtained via the Workforce Business Partner and reconciled to the directorate's own records to ensure accuracy. 3. Management should continue to remind staff of the importance of undertaking their mandatory training in line with Welsh Government requirements. For new starters, completion of the mandatory WG modules should be carried out as soon as possible after commencing employment.	
Management Response	**Responsible Officer/ Deadline**
1. Online training module is now available, and staff will be requested to complete it. 2. On the basis that the information is provided by the Workforce Business Partner the Directorate records will be reconciled. 3. Compliance will be monitored on a monthly basis through the Senior team meetings to ensure staff are compliant.	Head of Operational Staff – To coincide with the individual's annual training plan Continual monthly monitoring

Performance and Planning

Finding 10– IMTP planning (Operating Effectiveness)	Risk
The 2020/21 Local Planning Framework that was issued to all directorates and clinical service groups within the Health Board. The framework sets out the timeframe for delivery and the areas that each section of the 2020/23 IMTP should include. Final submission of draft plans and associated appendices was in February 2020. Directorate's needed to submit an appendix containing their priorities based on the completion of the Strengths, Weaknesses, Opportunities and Threats (SWOT) model by October 2019. We understand that illness within the senior management team and the onset of the pandemic meant that a final draft version of the Estates' IMTP was not completed. We acknowledge that as a result of the pandemic the Health Board paused the IMTP approval process and switched to a quarterly operating framework model. However, we have not seen evidence of the draft IMTP document, the associated appendices, or the earlier SWOT analysis that should have been completed prior to the onset of the pandemic. As such, we have been unable to test the development of the plan.	Services are not effectively planned.
Recommendation	**Priority level**
Acknowledging that this has been an unprecedented year in the Health Board and IMTPs were superseded, going forward, management should ensure they follow the timeframes and content set out in the Health Board's Local Planning Framework when developing future IMTPs. Evidence should be retained of the work carried out on draft versions of the document.	**High**

Management Response	Responsible Officer/ Deadline
Agreed- Timescales will be followed, and draft versions retained.	Assistant Director of Capital and Estates- April 2021

Finding 11– Workforce planning (Operating Effectiveness)	Risk
Workforce planning is key to the directorate. We note that in previous iterations of the IMTP the directorate management and the Workforce and OD Business Partner considered the workforce profile and had developed projects to consider future workforce needs such as the apprenticeship scheme and the management trainee programme. However, as we have not been able to see a copy of the 2020/23 IMTP we have been unable to confirm what workforce planning arrangements are being developed.	Services are not effectively planned.
Recommendation	**Priority level**
While the IMTP programme has been paused, the need to continue to plan for future workforce needs continues. Management should ensure that future planning continues to give consideration to anticipated workforce pressures.	**High**
Management Response	**Responsible Officer/ Deadline**
Workforce planning is a continual process and discussed regularly at senior team meetings, the outcome of this will be included in the IMTP submission.	Assistant Director of Capital and Estates - April 2021

Appendix B - Assurance opinion and action plan risk rating

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 can take **no 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 **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.

Appendix C – Detailed Scope and Objectives

Governance arrangements

- Appropriate governance structures, committees and groups are in place with clear reporting lines that support the key operational functions of finance, workforce, planning and performance.
- Business partners provide appropriate support for the service's key operational functions.
- There are appropriate mechanisms in place to ensure new legislative and regulatory information received is disseminated and actioned on a timely basis, with policies and procedures owned and kept up to date.
- Declarations of interest (or nil returns) are submitted for all relevant staff and the service's management are aware of the declarations made.

Risk management

- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded, monitored and reported on. Risk owners are identified for each risk and mitigation plans are in place where appropriate.
- Risks associated with the Health Board's estate that have any impact on quality and patient safety are appropriately captured.

Workforce management

- Annual leave is appropriately planned, requested, recorded and authorised.
- Flexi time and Time off in Lieu (TOIL) is appropriately recorded, monitored and managed in accordance with local procedures and processes.
- Sickness absence is appropriately recorded, monitored and managed in accordance with the All Wales Managing Attendance at Work policy.
- Staff and management appropriately complete PDRs in good time.
- Staff complete mandatory training in line with specified timeframes.
- Staff rosters are planned and approved in line with agreed templates to ensure optimum workforce deployment and minimum use of overtime or agency staff to achieve safe staffing levels.

Planning and performance

- The Directorate has appropriate arrangements in place to ensure that its Integrated Medium-Term Plan (IMTP) is developed in accordance with the Health Board's corporate planning framework.

- Budget holders and other relevant staff are appropriately engaged in the development of the Directorate's IMTP.
- Workforce planning arrangements exist to establish and plan for known future changes to the service. For example, key staff due to retire within three years.
- Budget holders within the service monitor budgets and agreed Cash Releasing Efficiency Scheme (CRES) targets. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- The Directorate has appropriate non-financial performance measures and key performance indicators in place that cover relevant service delivery and cross-cutting themes such as workforce. These are formally reviewed and reported on a regular basis. Appropriate action and recovery plans are in place where required, should targets begin to show an adverse variance.
- The Directorate has arrangements in place to generate and capture performance data as a means of identifying areas for improvement.
- The Directorate is in communication with the Integrated Locality Groups to identify plans they have that have an impact on the service. Plans are in place and used as 'day to day' business planning tools for managing the service and are monitored and reported on to ensure they remain relevant.

Directorate specific objective

- We will consider how good practice is captured and communicated between the Estates Service and other corporate teams so that shared improvements to services can be made where appropriate.