Hywel Dda University Health Board

Estates Directorate Governance Review

Final Internal Audit Report

October 2019

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

Contents **Page**

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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1. Introduction and Background

This assignment originates from the 2019/20 internal audit plan and the subsequent report was submitted to the Chief Executive and Audit & Risk Assurance Committee.

The relevant Executive Director lead for the assignment was the Deputy Chief Executive/ Director of Operations, whilst the Director of Estates, Facilities and Capital Management was the relevant operational lead for the assignment.

2. Scope and Objectives

The overall objective of this audit was to confirm that Directorate governance structures follow the principles set out in the Health Board's system of assurance, and supports the management of key risks and achievement of the Directorate's objectives.

The following objectives were reviewed as part of this audit:

- The Directorate has a clear organisational group structure with approved terms of reference;
- The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance;
- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated.
- Look for assurance that staff in department visited have an awareness of the requirements of the Declarations of Interest, gifts and hospitality policy. Review level and nature of declarations made;
- The directorate division has an appropriate and up to date scheme of delegation in place which is applied accordingly;
- Review divisional / departmental arrangements for financial (including Contract) monitoring and management;
- The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of incidents are concerns raised; and
- Workforce Management – Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy.

3. Associated Risks

The following inherent risks were considered during this audit:

i. Governance structures, roles and responsibilities are not clear;

ii. Risks to achievement of the managed unit or Health Board objectives are not identified, managed or reported appropriately;

iii. Assurance against key areas of Directorate business, performance and compliance not received and acted upon;

iv. Incidents and concerns are not recorded and addressed;

v. Robust arrangements for financial management not in place; and

vi. Staff not managed appropriately.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The 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.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Estates Directorate Governance Review is **Limited** assurance.

RATING	INDICATOR	DEFINITION
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.

The Estates Directorate has an established management group supported by a number of sub-groups and meetings. Performance scrutiny and monitoring are evident within the management and supporting groups/meetings. We can confirm that the directorate is engaged with the Finance Department in delivering services against budget and identifying saving targets, and schemes of delegation were evident.

However, we identified a number of high priority findings that require addressing, including:

- Instances of non-compliance for the management of sickness absence including missing files and inaccurate or incomplete sickness documentation.
- Objectives listed within staff PADRs were not specific, measureable or timely across the departments audited.
- Long-standing risks entered on the registers dating back as far as 2012 were evident with mitigating actions implemented whilst awaiting approval

of a capital bid; however, the inherent risk score and risk treatment status have not been amended to reflect this. In addition, three risks identified on the corporate risk register were not evident on the Directorate or Services risk registers.

In addition, a number of medium priority findings were identified in regard of the Directorate of Facilities Team Meeting terms of reference and declaration of interests.

5. Assurance Summary

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

		Assurance Summary*			
Audit Objective					
1	The Directorate has a clear organisational group structure with approved terms of reference			✓	
2	The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance		✓		
3	A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated		✓		
4	Look for assurance that staff in department visited have an awareness of the requirements of the Declarations of Interest, gifts and hospitality policy. Review level and nature of declarations made			✓	

Audit Objective		Assurance Summary*			
					
5	The directorate division has an appropriate and up to date scheme of delegation in place which is applied accordingly				✓
6	Review divisional / departmental arrangements for financial (including Contract) monitoring and management				✓
7	The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of incidents are concerns raised				✓
8	Workforce Management – Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy		✓		

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

Design of Systems/Controls

The findings from the review have highlighted **four** issues that are classified as weakness in the system control/design for the governance within the Estates Directorate. These are identified in the Management Action Plan as (D).

Operation of System/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the operation of the designed system/control for the governance within the Estates Directorate. These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

OBJECTIVE 1: The Directorate has a clear organisational group structure with approved terms of reference

The Directorate of Facilities Team Meeting (DFTM) has been established as the directorate's management group. We can confirm that a terms of reference (TOR) for the DFTM has been produced that describes its purpose, objectives, membership, attendees and operating arrangements. We also noted that key management positions within the Estates Directorate were all members of the DFTM.

Whilst the DFTM has a TOR in place, the group's operating arrangement have not been annually reviewed and approved by the Operations Business Board since 2017. In addition, the employee named as the Head of Specialist Services within the TOR was not the same individual named in the Health Board's *Directorate Organisational Management Structures* as at March 2019.

We can confirm that key issues such are finance, workforce, quality and performance were being reported and scrutinised at DFTM meetings for the period October 2018 to June 2019, with evidence of actions taken to address areas of risk or concern.

See Finding 1 at Appendix A.

OBJECTIVE 2: The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance

A review was undertaken of the DFTM agendas, minutes and papers since October 2018 to establish whether a work plan/ cycle of business had been established. Whilst no work plan/cycle of business was evident, the standing items of the DFTM included the risk register, performance dashboard, finance and key issue reports.

A review of DFTM agendas for the period October 2018 - June 2019 identified that the following items had not been submitted or discuss at the directorate management meetings:

- Declaration of interests
- Review of terms of reference
- Review of the membership
- Review of other sub-group/committee terms of reference

- Sub-group/committee update reports

The supporting groups and committees of the DFTM do not have a TOR in place with the exception of the Central Compliance & Assurance Audit Group. However, to mitigate the lack of assurance reporting arrangements, we can confirm that at least one member of the DFTM attends these groups and committees. The current reporting arrangements should be noted in the TOR of the DFTM.

We can confirm that key issues such are finance, workforce, quality and performance were being reported and scrutinised at supporting groups and committees with evidence of actions taken to address areas of risk or concern.

See Findings 2 & 3 at Appendix A.

OBJECTIVE 3: A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated

The Estates Directorate risk registers, both Directorate and Services, are submitted to the Central Compliance & Assurance Audit Group for review rather than the DFTM. Issues arising from Central Compliance & Assurance Audit Meetings are reported through to the DFTM by exception. In addition, Capital risks are recorded separately within individual project documentation with update and progress report through to the Capital, Estates and Information Management & Technology Sub-Committee through dashboards.

A risk appetite had not been set by the Central Compliance & Assurance Audit Group with all risk reported at every meeting. A review of the Directorate and Services risk registers confirmed that the information entered for all risks was complete with reviews recently undertaken. However, the following was noted:

- long-standing risks entered on the registers dating back as far as 2012 were evident with mitigating actions implemented whilst awaiting approval of a capital bid; however, the inherent risk score and risk treatment status have not been amended to reflect this
- the 'Target Risk Score' and 'Risk Tolerance Score' for a number of risks did not match, including five risks where the 'Target Risk Score' was higher than the 'Risk Tolerance Score'
- a number of localised risks (i.e. only affecting one site) scored higher or equal to Health Board-wide risks

A review was also undertaken to ensure high priority risks had been submitted for inclusion on the Corporate Risk Register. Whilst we noted that three risks

(Ref. No. 508, 652 & 718) were listed on the Corporate Risk Register, these risks were not evident on the Directorate or Service risk registers.

See Finding 4 at Appendix A.

OBJECTIVE 4: Look for assurance that staff in departments visited have an awareness of the requirements of the Declaration of Interest, gifts and hospitality policy

A review was undertaken to establish assurance that staff within the directorate were aware of the requirements of the declaration of interest, gifts and hospitality policy. Concluding a discussion with the Director of Estates, Facilities & Capital Management, the Estates Directorate does not hold a record of declarations of interests, gifts or hospitality offers. However, we were provided with evidence where Hotel Services management had sought advice from the Human Resources Department when some staff had received gifts from patients/ relatives, whilst the Health Board Register of Sponsorship and Hospitality also has three entries for the Estates Directorate.

See Finding 5 at Appendix A.

OBJECTIVE 5: The directorate division has an appropriate and up to date scheme of delegation in place, which is applied accordingly

We can confirm that the Estates Directorate has an Oracle approved hierarchy in place for 2019/20 that complies with Standing Orders and Scheme of Delegation. All requisitions are input through the Oracle system in line with the *NHS Wales No Purchase Order No Pay Policy* whilst some buildings staff have the ability to use a Health Board credit card to purchase small value items at short notice.

A review of the management of the credit card at Withybush General Hospital ascertained that the Buildings Team Leader retains control of the credit card, whilst purchases listed in the June 2019 statement reconciled to locally held records held by the Budgets Officer.

No matters arising.

OBJECTIVE 6: Review of Estates Directorate arrangements for financial monitoring and management

The Estates Directorate were fully engaged in the budget setting process for 2019/20 that included the adjustments to cost centre budgets based upon historical and workforce information. At Month 4, the directorate's performance

had seen a cumulative adverse variance of £0.127m, whilst the delivery of savings (at 3.7% of the annual budget equating to £1.387m) was on target.

We can confirm that the Estates Directorate has regularly received monthly Finance dashboard reports highlighting key areas of spend and savings, current performance levels and forecasted year-end positions. There was evidence of the Finance dashboard reports being submitted to the DFTM for review and scrutiny during 2019.

Both the Director of Estates, Facilities & Capital Management and Senior Finance Business Partner stated that there was positive engagement between to the functions with regular agenda-driven meetings to address current performance and achievement of the required financial savings. We also noted that finance was reported and discussed at the DFTM and supporting performance groups with actions to address areas of risk or concern evident.

There are three ranges of contracts being monitored and managed by the Health Board - Large Capital Projects, Discretionary Capital Projects and Operational Maintenance Projects. We can confirm that these projects are reported, monitored and managed at the Capital Monitoring Forum, which is chaired by the Director of Estates, Facilities & Capital Management. The Audit & Assurance Specialist Services Unit are currently undertaking a review of the Health Board's discretionary capital projects and maintenance contracts as part of their 2019/20 plan.

No matters arising.

OBJECTIVE 7: The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of incidents are concerns raised

All Estates Directorate incidents are recorded on the Datix reporting system. Following a review of the DFTM papers for the period October 2018 to June 2019, we can confirm that incidents are regularly reported to the DFTM as part of the Performance Dashboard Report, scrutinised and reviewed to ensure management actions mitigate the risks that led to the incident occurring.

No matters arising.

OBJECTIVE 8: Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy.

The Estates Directorate sickness and PADR performance levels at July 2019 were 6.35% and 87.14% respectively. An Electronic Staff Record (ESR) report was obtained from the Workforce Intelligence Team that detailed the PADR compliance levels of organisational cost centres (as at 12th August 2019) and

periods of sickness recorded in 2019. The following departments were selected based on the ESR reports:

- GGH Hotel Services
- GGH Laundry
- PPH Hotel Services
- PPH Portering

Sickness Management

Of the 20 sickness periods selected, two employee files at GGH Laundry could not be located. Of the 18 periods of sickness tested, we noted the following:

- One instance where no 'Notification of Absence' form on file.
- Five instances where absence start and/or finish dates recorded on ESR did not match the absence notification forms and/or medical/self-certificates.
- Two instances where a return to work form was not on file.
- One instance where details recorded on the return to work forms were incorrect/ missing and had not been signed by the employee or manager.
- Two instances where the return to work interview was undertaken 12 days after the employee returned to work.
- One instance where no action was taken after two periods of sickness totalling more than 10 calendar days within a 12-month period.

The findings noted above also reconciled to sickness management audits undertaken by the HR Department during 2019. Whilst the audit reports identified areas of good practice, elements of non-compliance were noted and in the case of Laundry GGH an action plan was subsequently developed.

Performance Appraisal Development Reviews

A sample of 19 PADRs were reviewed across the following four departments - Hotel Services GGH & PPH, Laundry GGH and Portering PPH - to ensure personal objectives set for each employee complied with the SMART (Specific, Measurable, Achievable, Realistic & Timely) principle set out in the *Performance Appraisal and Personal Development Plan Policy*.

Of the 19 PADRs reviewed, 44 personal objectives had been set. Whilst we noted that the majority of objectives were achievable and realistic, there were a large number of objectives across the departments audited that were not specific or measureable – see Table A below for a breakdown of each cost centre tested.

We only noted three instances where an explicit timeframe had been included against objectives. Whilst the Health Board's PADR template specifies the setting

of personal objective to be achieved over the year, in some instances this may take longer to complete, such as a professional qualification, and therefore a designated timeframe should be recorded.

Of the 19 PADRs reviewed during this audit, only one pre-dated the Health Board-wide Internal Audit (Ref: HDUHB-1819-35) report published in May 2019.

See Findings 6 & 7 at Appendix A.

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	H	M	L	Total
Number of recommendations	**3**	**4**	**0**	**7**

Table A – Breakdown of Sampled PADR Reviews

WARD/DEPT	NO. OF PADR REVIEWED	TOTAL OBJECTIVES REVIEWED	SPECIFIC		MEASURABLE		ACHIEVABLE		REALISTIC		TIMELY	
			Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
Laundry GGH	4	6	4	2	1	5	4	2	4	2	0	6
Hotel Services GGH	5	14	1	13	2	12	14	0	14	0	1	13
Portering PPH	4	9	3	6	3	6	9	0	9	0	0	9
Hotel Services PPH	5	15	1	14	5	10	14	1	14	1	0	15
TOTAL	19	44	9	35	11	33	41	3	41	3	1	43

Finding 1 – Terms of Reference (D)	Risk
The Directorate of Facilities Team Meeting (DFTM) operating arrangements and TOR should be reviewed on an annual basis and approved by the Operations Business Board, this has not occurred since 2017. In addition, the Head of Specialist Services noted in the TOR was not the same as per the structure at March 2019.	Governance structures, roles and responsibilities are not clear.
Recommendation 1	**Priority level**
Management should ensure that the Directorate of Facilities Team Meeting terms of reference is reviewed, updated and submitted for approval.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
This has already been updated and approved by the DFTM on the 1st Oct 19. We have also added this to the work plan for the DFTM so that it will be reviewed annually and submitted to the Operations Board.	Director of Estates, Facilities & Capital Management October 2019

Finding 2 – DFTM Work Plan (D)	Risk
We noted that a work plan/cycle of business had not been implemented by the DFTM. No reference to a work plan/cycle of business was evident in the TOR nor agendas, minutes or papers. In addition, we noted that some key items	Governance structures, roles and responsibilities are not clear.

listed in the Health Board and QSEAC work plans had not appear in DFTM agendas for the period October 2018 to June 2019.	
Recommendation 2	**Priority level**
The Directorate of Facilities Team Meeting (DFTM) should establish an annual work plan to ensure organisational business objectives and goals provided by supporting groups, committees and external sources are captured and reported.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
We have now set up a formal work plan. This has been approved at the DFTM on 1st Oct 19. This work plan incorporates key actions raised at all relevant supporting committees.	Director of Estates, Facilities & Capital Management October 2019

Finding 3 – Supporting Groups Reporting Arrangements (D)	**Risk**
Of the supporting groups and meetings within the Estates Directorate, only the Central Compliance & Assurance Audit Group had a TOR in place. Whilst we noted that at least one member of the DFTM attends these groups and committees, the formal accountability and reporting arrangements of these groups and committees have not been made explicit in the TOR of the DFTM.	Governance structures, roles and responsibilities are not clear.
Recommendation 3	**Priority level**

Estates and Facilities Management should ensure that the accountability and reporting arrangements of supporting groups and committees are defined and documented in the Directorate of Facilities Team Meeting terms of reference.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Agreed. The ToRs for the DFTM will now be reviewed to incorporate formal reporting and accountabilities. The other supporting groups will develop their own specific ToRs confirming reporting arrangements. This will be undertaken at the same time as the next review of the ToRs for the DFTM, which is scheduled on the work plan for March 2020.	Director of Estates, Facilities & Capital Management March 2020

Finding 4 – Estates Directorate Risk Register (O)	**Risk**
A review of the Directorate and Services risk registers identified that long-standing risks entered on the registers dating back as far as 2012 were evident with mitigating actions implemented whilst awaiting approval of a capital bid; however, the inherent risk score and risk treatment status have not been amended to reflect this. A review was also undertaken to ensure high priority risks had been submitted for inclusion on the Corporate Risk Register. Whilst we noted that three risks (Ref. No. 508, 652 & 718) were listed on the Corporate Risk Register, these risks were not evident on the Directorate or Service risk registers.	Risks to achievement of the directorate or Health Board objectives are not identified, managed or reported appropriately.

Recommendation 4	Priority level
Estates Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are included on the directorate registers.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
A full review is underway of all Directorate, Corporate and Service Risks within the FM team. It is planned to do this review in line with the agreed work plan by the end of Jan 2020. We intend to work closely with the Governance Team and Internal Audit within this review to ensure clarity on the recommendation.	Director of Estates, Facilities & Capital Management January 2020

Finding 5 – Declarations of Interest (D)	Risk
Whilst we noted evidence of gifts and hospitality being address and recorded, the Estates Directorate does not hold a record of declarations of interest.	Assurance against key areas of Directorate business, performance and compliance not received and acted upon.
Recommendation 5	**Priority level**
Management should ensure declarations of interest, gifts and hospitality are periodically reviewed at the Directorate of Facilities Team Meeting.	**MEDIUM**

Management Response	Responsible Officer/ Deadline
A log will be held centrally to register these interests and will be reported quarterly to the DFTM. This will be added to our work plan.	Director of Estates, Facilities & Capital Management January 2020

Finding 6 – Sickness Management (O)	Risk
Of the 20 periods of sickness chosen within our sample, two employee files at GGH Laundry could not be located. Of the 18 periods of sickness tested, we noted a number of inaccurate and incomplete sickness documentation.	Staff not managed appropriately.
Recommendation 6	**Priority level**
Department managers and leads should ensure that the management of all periods of sickness complies with the NHS Wales Managing Attendance at Work Policy.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Agreed. Regular audits are undertaken by the HR team of sickness management procedures within FM. These have been broadly positive, noting weaknesses in the Laundry Service. A targeted review will be undertaken of all sickness management procedures. We would seek further validation of this using HR as previously.	Director of Estates, Facilities & Capital Management February 2020

Finding 7 – PADR (O)	Risk
Of the 44 personal objectives reviewed, the majority of objectives were achievable and realistic. However, there were a large number of objectives across the departments audited that were not specific or measureable. We also noted that there was three instances where an explicit timeframe had been included against objectives.	Staff not managed appropriately.
Recommendation 7	**Priority level**
Estate Directorate Management should ensure all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Agreed. The FM team have made substantial efforts in delivering a formal PADR process to significant staff numbers (circa 86% of staff). This has been well received by the staff involved and acknowledged internally by members of the Executive team. A review will be needed to ensure the PADR process is consistently applied across all staff. We will work to identify exemplar examples within our workforce and ensure that there is learning delivered throughout our supervisory team to improve standards. This review will be undertaken on each PADR as it becomes due for each member of staff.	Director of Estates, Facilities & Capital Management October 2020

Appendix B - Assurance Opinion and Action Plan Risk Rating

2019/20 Audit Assurance Ratings

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

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

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

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

Prioritisation of Recommendations

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

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

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

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