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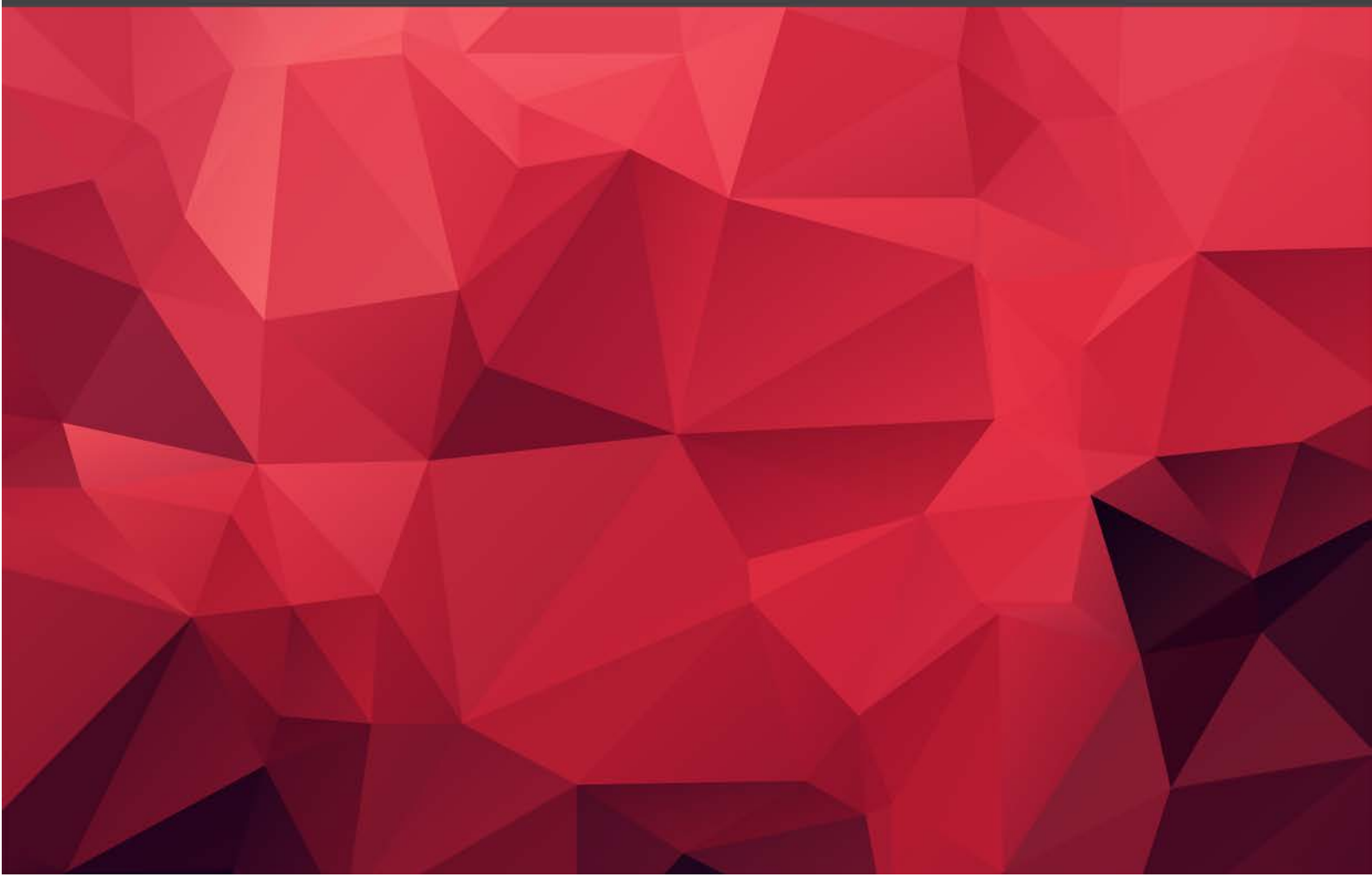

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Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

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Summary report

Introduction

1 The National Health Service in Wales' (NHS Wales) estate exists to support the provision of health care services. Buildings and infrastructure are valuable resources that can directly influence health service performance. They need to be of an appropriate type, condition, and location, but can be costly to run and maintain.

2 Health boards across Wales typically have a diverse estate with numerous buildings, geographically dispersed, and of varying age and condition. Hywel Dda University Health Board (the Health Board) currently has an estates portfolio valued at over
£200 million. Around 60 per cent of the estate is over 30 years old.

3 Successful estate management requires input and effort from health boards, and involves two broad activities:

- Strategic management of the estate – this is important for making sound decisions about current use and future development of estates. The Board, supported by relevant professionals, should determine what estate is needed to support service delivery, approve plans to deliver this, and provide oversight. The Health Board's Integrated Medium Term Plan (IMTP) will be a key influence on this. Without a strategic approach, there is a risk that estate management and service development decisions are not co-ordinated. This creates a further risk that financial investment in the estate may be misdirected.
- Operational management of the estate – this is important for ensuring the estate remains fit for purpose on a day-to-day basis, and that professionals are able to acquire, modify, and dispose of parts of the estate as required.

4 Effective and efficient management of the estate should deliver value for money. But insufficient attention to either strategic or operational matters can result in money being wasted and sometimes substandard service delivery to users.

5 Within the Health Board, estates management is the responsibility of the Facilities Department (the department) which was established in November 2013 following a restructure. The department has locally-based operational teams at each acute hospital, with centrally-based corporate teams providing property and environmental management, capital project delivery, and corporate governance. This department brings together the responsibilities for:

- estates and equipment management, including maintenance, Electro-Biomedical Engineering and compliance – referred to as 'hard' facilities management;
- catering, portering, cleaning, and laundry services – referred to as 'soft' facilities management; and
- Hospital Sterilisation and Decontamination Unit (HSDU).

6 In 2014-15, the Health Board spent around £35 million on facilities management, about four per cent of its total annual spend.

7 Structured Assessment is the Auditor General's annual examination of NHS bodies' arrangements to support good governance and the efficient, effective and economical use of resources. Previous structured assessment work has highlighted issues with the Health Board's estate. The Health Board has the third highest backlog maintenance[1] in Wales on a risk adjusted basis[2]. Of this backlog, around £24 million is categorised as high and significant risk. Compared to other health bodies in Wales, the Health Board's performance is generally better than the average on the Welsh Government's estates indicators. But despite this, the Health Board has consistently failed to meet the Welsh Government's targets for physical condition and statutory and safety compliance. Appendix 1 shows the Health Board's historic performance on the NHS Wales' estates dashboard since 2008.

8 In 2015-16, the Health Board did not set a balanced financial budget, and had an outturn deficit of £31.2 million. With this difficult financial environment and a significant maintenance backlog, it is essential that the Health Board maximises the value for money from its estate and associated resources.

9 Our review has therefore sought to answer the following question: **Is the Health Board managing its estates effectively?** In answering this question, we have considered whether the:

- Health Board's strategic approach to estates management is robust?
- Health Board is delivering an economical, efficient and effective estates service?

10 We have concluded that the Health Board has improved its strategic approach to managing its estate, but needs to underpin this with stronger operational arrangements to show the service is value for money:

- The Health Board's strategic approach to estates management is better than it was, but further improvements are possible:
  - accountability is now clearer, but scrutiny, performance management and business planning need to be stronger;
  - the estates strategy is a good first iteration, but needs further development, some of which is dependent upon an agreed IMTP;
  - improvements in property information are leading to better management of risks like asbestos, and new technology is supporting improvements in space utilisation; and

[1] Maintenance required to bring assets up to an NHS specified physical condition and/or compliance with mandatory fire safety requirements and statutory safety legislation.

[2] NHS Estates, **A risk-based methodology for establishing and managing backlog Gateway reference 4102**, TSO, 2004.

  - there have been improvements to the way that the capital programme is agreed, managed, and monitored, however, the associated future revenue costs are not always being recognised.

- Although there is evidence of some good performance, arrangements are not strong enough to ensure that the estates service is consistently providing value for money:
  - several years of historic budget setting means the current estates budget may not fully reflect the Health Board's ambitions;
  - there is a risk that estates is undertaking too many reactive repairs, which would represent poor value for money;
  - the department has achieved significant cost reductions, however, there are risks that opportunities to improve value for money in the longer term may be missed;
  - performance management is not strong enough to demonstrate an efficient, effective, and customer-focused service; and
  - some aspects of training have improved, but there is no strategic approach to training and workforce planning, and sickness absence is problematic.

Recommendations

11 We make eight recommendations:

Recommendations table

Recommendations	
Strategic approach to estates management	
R1	Strengthen performance management by: • setting clear business objectives; • widening the range of performance measures; • ensuring there is robust data; and • reporting performance regularly.
R2	Create a Capital, Estates and IM&T Sub-Committee forward work plan, that includes regular scrutiny of the estates function.
R3	Improve customer focus and clinical engagement. Do this by introducing a multi-disciplinary forum for discussion of estates matters and/or using suitable existing groups or fora where appropriate.
R4	Develop a second iteration of the estates strategy focused on development of the estate and supporting the IMTP.

Recommendations	
An economical, efficient, and effective estates service	
R5	Develop a zero base estates budget that makes provision for likely revenue costs arising from changes to the health board estate, such as new buildings.
R6	Widen the range of performance management KPI to include: • time; • cost; • productivity; • non-productive time; • quality; • service; and • customer feedback.
R7	Introduce a long-term approach to improving value for money. Do this either as a separate plan, or include it within existing business plans. Ensure this is part of the department's regular business planning mechanisms.
R8	Ensure the right number of people with the right skills are available now and in the future, by developing fully funded plans for workforce and training.

Detailed report

The Health Board's strategic approach to estates management is better than it was, but further improvements are possible

Accountability is now clearer, but scrutiny, performance management, and business planning need to be stronger

12 The restructure of the facilities management function in November 2013 has made the lines of accountability for estates clearer. The Deputy Chief Executive and Director of Operations is the executive lead for facilities management, which includes estates. Reporting to him, the Assistant Director of Estates and Capital Management has day-to-day responsibility for the facilities management function.

13 The Board now has an Independent Member acting as 'lead' member for estates issues. This follows a short period without anyone fulfilling this role, and should help to ensure that estates issues are understood and advocated for at Board level.

14 The Health Board has made changes to its committee structures. Scrutiny of estates matters is now the responsibility of the Capital, Estates and Information Management and Technology (CEIMT) sub-committee. This is a sub-committee of the Business Planning and Performance Assurance Committee (BP&PAC), which reports to the Board.

15 The CEIMT sub-committee's agenda has been unbalanced, although, there are signs of improvement. A sample review of 2015-16 agendas showed no items relating to estates matters or information management and technology. All agenda items related solely to the capital programme, resulting in little scrutiny or challenge of estates matters at a strategic level. A further sample review of 2016-17 agendas shows that this is now improving with some scrutiny of estates and sustainability matters.

16 Scrutiny of operational estates matters also needs to improve. Current performance management arrangements are based around 'one to one' meetings between the Executive Director and Assistant Director. The Assistant Director has regular individual and team meetings with his staff.

17 The current estates strategy outlines some broad intentions to review services and seek efficiencies, but these are predominantly in the soft facilities management area. There is little of the formal business planning and performance management infrastructure expected of high performing organisations. For example, we found no:

- business plan setting out estates' aims, objectives, budgets and targets;
- comprehensive scorecards or dashboards of key metrics covering all the dimensions of performance;

- regular programme of service reviews, or periodic ‘deep dives’ into the performance of individual services; and
- multi-disciplinary estate group, which would provide the main clinical services with a forum to raise and discuss estates related matters, and provide estates with customer feedback and engagement.

The estates strategy is a good first iteration, but needs further development, some of which is dependent upon an agreed IMTP

18 A good strategy should be based on answering three questions. These are:

- Where are we now?
- Where do we want to be?
- How do we get there?

19 The Health Board has an estate strategy covering the period 2015-2017 (the strategy), based on what it considers to be a sound information base. The Health Board recognises that once the IMTP is agreed, the strategy is likely to need further development to reflect this. We have reviewed the Health Board’s strategy with reference to NHS guidance[3]. Exhibit 1 outlines our assessment of the estates strategy against this guidance.

Exhibit 1: Estates strategy assessment

Estates strategy assessment	
Provides a useful baseline assessment of the Health Board’s estate.	There is a lack of quantified objectives.
Some evaluation of the capital delivery team’s capacity is underway. Business case schemes include the revenue implications for estates.	The strategy does not contain an assessment of its ‘deliverability’. That is, whether estates have the capacity and capability to deliver what is set out in the strategy.
The strategy recognises the need to be consistent with the IMTP and support its implementation.	The IMTP was not finalised when the strategy was written. It is not clear how involved estates were in the IMTP development process. It is essential to involve managers and clinicians from across the Health Board, as well as other stakeholders whose services are affected.

[3] NHS Estates, **Developing an estate strategy Gateway reference 4282**, TSO, March 2005.

Estates strategy assessment	
The strategy predicts that annual reviews will ensure it remains consistent with the IMTP.	There is a risk of divergence between the strategy and IMTP. The strategy needs to describe the mechanisms for engaging with the clinical and service leadership.
The Health Board's capital investment plan recognises the uncertainty around capital funding.	The strategy is not fully costed and funded. An outline of the revenue impact of the capital investment programme would be beneficial.
Includes the managed community estate.	More recognition of the independent community estate, which is part of the healthcare system. The condition and tenure of these premises may present risks to the Health Board.
Recognises the high levels of backlog maintenance, and proposes a method for addressing this through property disposals and selective capital investment.	The strategy includes a set of principles to inform investment decisions. But none of the capital funds are ring fenced so could be directed elsewhere.
The strategy has been reviewed by the BP&PAC.	It is important that the whole of the board considers and approves the strategy, and receives annual progress updates.

Source: Wales Audit Office analysis of the Health Board's estates strategy 2015–2017

20 The current strategy provides a good baseline from which to develop the next iteration when the IMTP is finalised. However, it is currently a mixture of two potential strategies:

- a strategy for the Health Board's estate, that is an 'estates strategy'; and
- the development of some parts of the facilities management department, that is a 'strategy for estates'.

21 The latter would be better addressed within the department's business planning and performance management.

Improvements in property information are leading to better management of risks like asbestos, and new technology is supporting improvements in space utilisation

22 The Head of Property Performance is responsible for maintenance backlog, leases, acquisitions and disposal, space utilisation, and property information. Much of this information is established through the use of condition surveys. These are essential tools to provide a full understanding of the condition of the estates. We

were told that in the past, condition surveys might not have been done as frequently or as widely as needed. Estates' recent work on improving property information means the quantity and quality of data are now reasonable, with detailed backlog information held.
The property performance team work closely with colleagues in the maintenance team to capture up to date property information.

23 The approach to key risks such as asbestos and legionella has improved as a result of improved information. The Health Board has implemented a number of improvements:

- A gap analysis exercise highlighted weaknesses in compliance with relevant NHS Health Technical Memoranda (HTM) standards. The estates team report that they are now using the HTM as a framework, supported by detailed working practices, and are now substantially compliant in all key items.
- Establishing the Compliance Team to strengthen risk management within the estate environment. The Compliance Manager is responsible for identifying and monitoring compliance with HTM and mandatory guidance, including training. This helps the Health Board to demonstrate compliance with HTM standards on issues such as policy guidance, management structures, and qualified individuals.
- Key risks are included in the log of high-risk backlog maintenance, which helps maintain visibility and oversight.

24 The property performance team are developing a life cycle for assets on the acute estate. If successful, this will enable them to use forecasts of property condition to feed into future work programmes. The overall aim of the life cycle work is to develop a four-year investment plan to sit alongside the IMTP.

25 The estates team are also experimenting with digital technology to identify potential improvements in space utilisation, which will help support the estate rationalisation programme. Early reports indicate that that this technology has identified space utilisation improvements over and above its cost.

There have been improvements to the way that the capital programme is agreed, managed, and monitored, however, the associated future revenue costs are not being recognised

26 Creating BP&PAC and the CEIMT sub-committee has provided a method for stronger oversight of the capital programme. The committees are supported by the Capital Planning Group and Capital Monitoring Forum. A 'tracker system' now helps to monitor capital schemes. The health board now assigns a senior

responsible owner and project director to each scheme, as recommended in the Managing Successful Programmes methodology.

27 Changes to the risk registers mean they now include information from the HTM gap analysis exercise. The Health Board uses the information from the risk registers to help prioritise capital expenditure. The Assistant Director of Estates and Capital Management considers that there is now a good level of information to help manage and make decisions about the capital programme. Capital programme decisions take account of patient experience and complaint issues. For example, some of the larger schemes have responded to comments about patient and visitor experience, for example car parking improvements and a new coffee shop.

28 Estates capital business cases use whole life costing, which is good practice. This is an investment appraisal technique that assesses the total cost of an asset over its life. It takes account of the initial capital cost, as well as operational, maintenance, repair, upgrade, and eventual disposal costs. However, the sums included in business cases for future maintenance, repair and upgrade are notional figures. That is, they do not feed through into increases in estates' budget. This means that future maintenance budget pressures are not being acknowledged and planned for.

Although there is evidence of some good performance, arrangements are not strong enough to ensure that the estates service is providing value for money

Several years of historic budget setting means the current estates budget may not fully reflect the Health Board's ambitions

29 In 2014-15, the facilities management operational budget was about £35 million including HSDU. The four main budget headings are: operational maintenance, cleaning, catering, and energy. Exhibit 2 provides a breakdown of 2015-16 estates related expenditure.

Exhibit 2: Estates related expenditure 2015-16

Budget area	Expenditure £000s
Estates property	£8,641
Estates operations	£6,276
Estates management	£642
Information and performance	£559

Budget area	Expenditure £000s
Capital support	£112
Totals	**£16,230**

Source: Wales Audit Office analysis of Health Board data 2015-16

30 The department told us that:

- there were previously budget overspends, with the operational maintenance budget the biggest contributor;
- the 2013 Shared Services Partnership report[4] and organisational restructure brought increased budget discipline; and
- there has been a recovery of the budget position, which is now in balance.

31 We have not been able to verify all of these statements because the Health Board's detailed budget information was not available.

32 The Chartered Institute of Building Services Engineers[5] (CIBSE) recommends that budgets should be zero-based. Rather than applying an increment to the previous years' budget, zero-based budgeting starts from a 'zero base' and the budget is built up based on needs and costs. This approach provides a more sustainable budget, reducing the risk of not meeting essential and statutory maintenance needs.

33 The Health Board's estates' budget is not zero-based, but based on a process of rolling forward historic budgets with annual cost improvements. After several years of this practice, there is a risk that activity is matched to the budget constraint and not to actual demand. This is especially important if the estate is subject to significant change, such as new build, disposals, or reconfiguration.

34 For example, the Health Board does not routinely include the future maintenance costs of new buildings into the relevant budget. CIBSE advice is that the belief that newer buildings have less maintenance costs than older buildings, is only partially true. Newer buildings should be less prone to breakdowns, but are more complex than older buildings. Therefore, newer buildings are potentially more expensive to maintain in the long term, and may need some different skills. The failure to make provision for the maintenance costs of new buildings will continue to generate future budget pressures in the long term.

[4] NHS Wales Shared Services Partnership Facilities Service, **Report on maintenance provision for estate services in the NHS in Wales**, October 2013.

[5] Chartered Institution of Building Services Engineers, **Maintenance Engineering and Management Guide M**, November 2014.

There is a risk that estates is undertaking too many reactive repairs, which would represent poor value for money

35 Health boards should have a maintenance strategy that balances workload between reactive and planned work. Reactive repairs, that is unplanned, are generally more expensive than planned maintenance. In the long term, more planned work should lead to less reactive work and to fewer catastrophic faults. However, over maintaining could drain resources unnecessarily and introduce other problems.

36 A good practice estates department should periodically review the levels of reactive and planned work to ensure that there is an efficient balance between the two. Although there is no agreed NHS good practice benchmark, local government maintenance departments generally hold that the split between planned and reactive repairs should be between 70:30 and 60:40 by value.

37 To provide an illustration, we reviewed a sample of data from one site, Prince Philip Hospital for 2014-15. This showed that the split between planned and reactive repairs was 42:58. We recognise that this is only one year's data for one site, but it illustrates that the Health Board may be undertaking too many reactive repairs and needs to monitor this more closely.

The department has achieved significant cost reductions, however, there are risks that opportunities to improve value for money in the longer term may be missed

38 To ensure the estates budget provides value for money, health boards should regularly evaluate the economy, efficiency and effectiveness of the service. This is best done in a long-term planned and sustainable way, looking beyond short-term savings. Typical top-slicing of budgets, or arbitrary cost-cutting, can leave organisations exposed and unprepared for the future and can lead to higher overall costs or the displacement of costs elsewhere. A strategic approach also ensures that any changes align with health board and departmental objectives.

39 The Health Board reports that estates benchmarking has been only marginally useful, because achieving a meaningful sample size of similar organisations is difficult. The Health Board attempts to benchmark its estates performance by:

- completing the NHS Wales Estates and Facilities Performance Management System (EFPMS) returns. However, the sample size is small and there is little similarity between health boards, so the information needs to be treated with some caution; and

- reviewing information in the NHS England's Estates Return Information Collection (ERIC) system for comparative purposes.

40 Neither of these benchmarking exercises provides the Health Board with a completely satisfactory experience, but they do provide some useful approximations.

41 Exhibit 3 is the Health Board's performance on the NHS Wales' estates dashboard. This shows that overall, the Health Board had a reasonably good performance against NHS Wales' requirements, but with some specific areas needing improvement to meet the target.

Exhibit 3: Performance against NHS Wales' estate dashboard 2012-2015

Assessment criteria	2012-13 score	2013-14 score	2014-15 Score	2014-15 RAG rating
Physical condition	87	87	87	Amber
Statutory and safety compliance	86	87	88	Amber
Fire safety compliance	91	91	90	Green
Functional suitability	90	91	92	Green
Space utilisation	96	97	98	Green

RAG ratings – Red up to 75 per cent, Amber 75 per cent – 89 per cent, Green 90 per cent or above
Source: NHS Wales Estate Condition and Performance Report 2014-15

42 Appendix 1 shows the Health Board's historic performance on the NHS Wales' estates dashboard since 2008. This shows that the Health Board has met the target for three of the five indicators.

43 Across Wales, health board estates departments are under increasing pressure to reduce their budgets while continuing to support the delivery of safe clinical services. Senior estate personnel are therefore increasingly focusing on the need to identify efficiency savings.

44 The Health Board's estates department has made significant savings. Some of these savings have come from selling properties and terminating leases, staff reductions, and investing in more energy efficient plant and equipment. Since 2012, the Health Board has reduced its footprint by about 8,300m^2, which provided around £1.3 million in capital receipts and a revenue saving of over £650,000 per

year. However, the addition of new buildings has offset these reductions, leaving a net increase in footprint of around 3,000m^2.

45 The Health Board's own cost analysis shows that:

- On a unit cost basis (£ per m^2), facilities management (including estates) had an average cost of £153 per m^2 in 2014-15, a reduction of eight per cent since 2012-13.
- Building and engineering maintenance costs were £23.16 per m^2 in 2014-15, a reduction of 13 per cent since 2012-13.
- The new facilities management structure has delivered overall cost improvements of around £1.3 million.

46 Apart from the broad measures above, the department does not regularly measure its productivity in any detail. In addition, there is no documented plan that seeks to improve value for money in a co-ordinated, long-term way. Managers have told us they intend to review some services in the future, but there is no plan. Without a planned approach to value for money, there are risks that opportunities may be missed, or short-term cost reductions could be counter-productive in the longer term.

For example:

- The department reports that it does not have a training budget. So meeting the identified £80,000 annual cost of HTM and mandatory training is difficult. However, the department has kept the same training supplier for many years without any market test or competitive tendering.
- Over the last three years, the maintenance team has reduced by 22 staff to a total of 87 operational staff. Staff reductions without compulsory redundancies are less disruptive, but there is a risk that the department may lose some of its most valuable or skilled staff, while less skilled staff remain.
- Estates has four help desks, one for each acute site, while many other NHS organisations have moved to a single help desk system. In addition, there are two other facilities management help desks, making six in total.
- The Health Board has not undertaken any market testing of its estates services. This is important because it has the lowest proportion of contracted out services in Wales at only eight per cent. Many technical staff are paid one grade higher than their counterparts in other health boards.
- The department has introduced the 'POD' system into two wards at Glangwilli Hospital. This local scheme provides two wards with a named semi-skilled staff contact point for dealing with minor repairs. Ward sisters report positively about this scheme. It is responsive, it reportedly improves staff utilisation, and estates are considering a wider rollout. But without the context of a wider plan for value for money, there is no assurance it is targeting the right areas, or this is the right thing to do in a strategic sense.

Performance management is not strong enough to demonstrate an efficient, effective, and customer-focused service

47 The main characteristics of a good performance management system are the setting of meaningful performance targets, and the measuring and reporting of performance against them in a consistent way.

48 Maintenance is one of the larger parts of the Health Board's estates function and is relatively information rich. Therefore, we reviewed this service as a way of evaluating how good performance management is likely to be across the whole of the estates function.

49 There are some maintenance service standards in use, but these are not wide ranging enough to give a full picture of performance. We would expect that a comprehensive set of performance standards would include broad categories such as:

- time;
- cost;
- quality;
- service; and
- customer feedback/user satisfaction.

50 The current service standards are time based only, specifying response times for various categories of planned and reactive repairs. There are six-monthly and annual reports of performance against the service standards. However, there is little evidence that these are subject to robust higher-level scrutiny.

51 Relying on one measure of performance is a weakness. But compounding this weakness are shortcomings in how some of this data is compiled and analysed. The department's RAM4000 IT system records repair jobs and generates the performance data. Because a repair may require new parts and the department holds little stock, this can introduce a delay into the repair process. In these and similar cases, some areas have adopted a protocol that opens a job on the system, closes it, and then re-opens it. In effect, it 'stops the clock', that is the time waiting for parts is not counted. Our sample review was of the Prince Philip Hospital team data, and the Health Board reports that this practice is prevalent only in this team.

52 Estates report that this gives a more accurate reflection of its performance because such delays are outside of its control. While true, this 'stop the clock' practice causes problems because it:

- causes data quality issues because of inconsistency between different areas/teams;
- masks the true repair time as experienced by the customer;
- may give the department, and others, false confidence in its performance; and

- prevents the department analysing the data further, for example to consider what parts or jobs generate the most delays and whether it can do things differently to offset this.

53 Our review of the RAM4000 IT system shows that it has the potential to generate much more detailed information than it currently does, and Appendix 2 provides some examples.

54 Current maintenance performance is reasonable, but it does not meet all of the Health Board's targets. Exhibit 4 shows that over the last three years, performance has deteriorated in three of five categories. However, the 'stop the clock' method may mean this performance is overstated compared to what the customer actually experiences.

Exhibit 4: Reactive and planned maintenance performance 2012-15

Repair category	Target	2014-15	2013-14	2012-13
Planned repairs				
High risk repair completion	75%	79%	84%	76%
General risk repair completion	70%	63%	68%	65%
Reactive repairs				
Priority 1 – complete within one day	85%	82%	82%	82%
Priority 2 – complete within three days	78%	73%	76%	78%
Priority 3 – complete within seven days	65%	67%	67%	74%

Source: Wales Audit Office analysis of Health Board data

55 The department does not have any systems to provide assurance that repair requests are categorised accurately. For example, there is no regular programme of help desk audit, audit of repair requests, or post-repair inspection for planned or reactive repairs. There has also been no recent training for helpdesk staff on the four separate help desks.

56 The repairs system is organised around prioritisation of repair requests, so it is vital that they are categorised accurately. Poorly categorised repair requests could lead to unnecessary expense or higher priority jobs waiting unnecessarily.

57 We have found wide variation in how repair requests are categorised between different acute sites. For example:

- For reactive repairs – one site categorised 68 per cent of its reactive workload as Priority 1, while another site categorised only 32 per cent as Priority 1.
- For planned maintenance – one site categorised 55 per cent of its planned workload as High Risk, while another site categorised only 25 per cent as High Risk.

58 There are likely to be some genuine differences between sites due to local risk factors. For example, drainage at Glangwilli Hospital receives a higher priority compared to Prince Philip Hospital because of differences in site conditions. Managers think that there is probably a good level of consistency within sites, because of the continuity of help desk staff. Managers are less confident that there is consistency across sites. However, without any routine analysis, there is no assurance that this is an accurate picture.

59 An efficient and user-focused estates service will:

- provide services that consistently exceed the expectations of customers; and
- know what customers think of the service.

60 One way to ensure that staff see customer service as essential is to use a code of conduct, service charter or similar. This makes clear what behaviour is expected of staff and provides a way to link together existing policies. In the Health Board, there is no code of conduct or similar, governing the approach to customer care. There are also no user satisfaction surveys in use, which means the department has no reliable data to gauge what its customers think of it.

Some aspects of training have improved, but there is no strategic approach to training and workforce planning, and sickness absence is problematic

61 NHS-wide guidance emphasises the need for clearly designated accountabilities and responsibilities for estate management. This is to ensure that staff managing the estate are suitably qualified.

62 The Health Board's estates department has a training plan that covers mandatory and HTM related training. The compliance manager is responsible for compiling and monitoring the plan, which typically identifies around £80,000 of training. However, there is no dedicated training budget, so managers often have to prioritise training demand and look for appropriate sources of funding.

63 Other professional development or training, ie, not classed as mandatory/HTM, is addressed on an individual basis between the staff member and their manager. Managers assess training requests using a business case approach and record them in the staff member's personal appraisal and development review record (PADR). Estates do not have a training plan covering these training areas, which

may make it difficult to plan staff development on a strategic basis. For example, many new buildings are more complex than older buildings, which may require maintenance staff to develop different skills in future.

64 We have been told that the maintenance team has an ageing staff profile. For example, at Glangwilli Hospital around 57 per cent of fitters are 55 or older. Management have recognised this issue and have started thinking about it, but there is no workforce plan. Without a plan to address the ageing workforce and the possible need for different skills, the estates department may be approaching a future situation where they will be unable to deliver the range of services needed.

65 In October 2013, the Shared Services Partnership report noted that there were high levels of long-term sickness. The department monitor sickness levels as a KPI, but do not routinely break this down into long and short term sickness, each of which should be managed differently. Maintenance staff sickness was 5.93 per cent in 2012-13, and 7.73 per cent in 2014-15. The latter figure equates to 1,832 working days lost, or the work of about nine staff. The Health Board could not easily provide information on other non-productive time such as travelling time. This suggests that it is not regularly monitored

Appendix 1

NHS Wales' estates dashboard performance

The following charts are based on annual estate data returns submitted by health bodies in Wales to the EFPMS. This system was introduced by the Welsh Government in 2002 and is managed by NHS Wales Shared Services Partnership – Facilities Services.

The EFPMS information focuses on the condition and performance of the health estate.
The charts cover the seven year period 2008-09 to 2014-15, and cover five of the six national performance indicators. The sixth, energy performance, is not included because it was outside the scope of our work.

Each chart shows the:

- performance for Hywel Dda University Health Board;
- all-Wales average; and
- Welsh Government target, where applicable.

More information on EFPMS can be found at NHS Wales Shared Services Partnership – Facilities Services

Exhibit 5: Physical condition

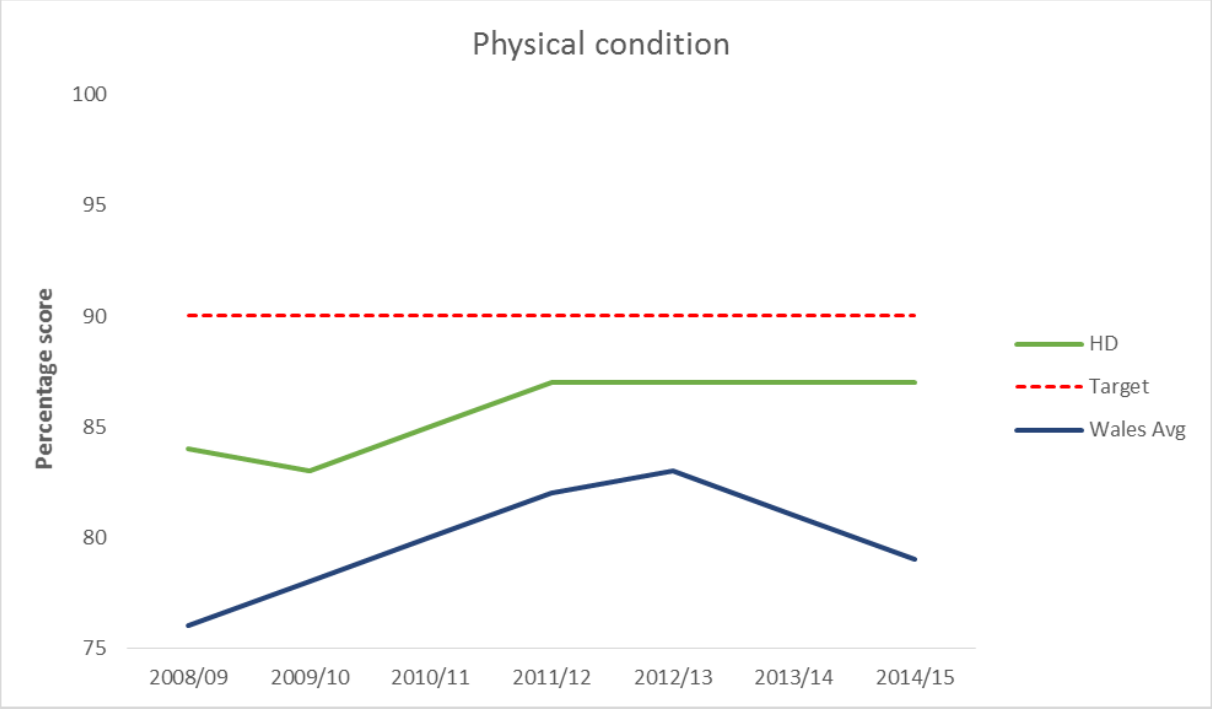


Exhibit 6: Statutory and safety compliance

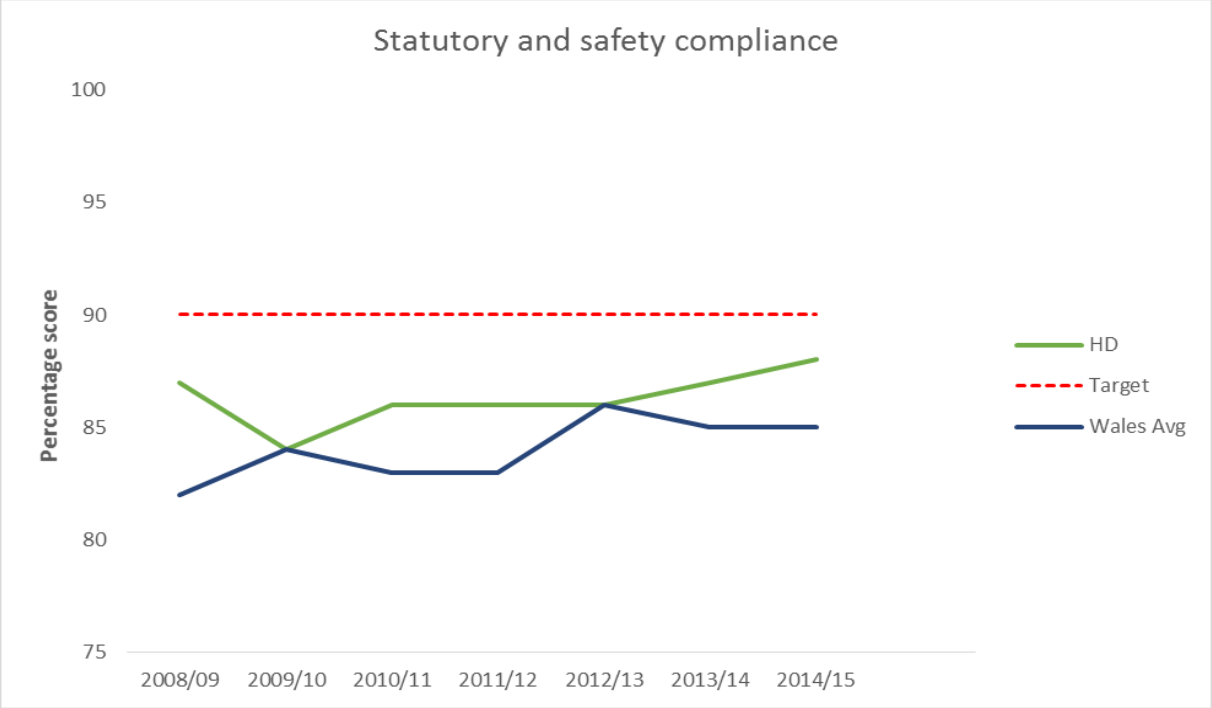


Exhibit 7: Fire safety compliance

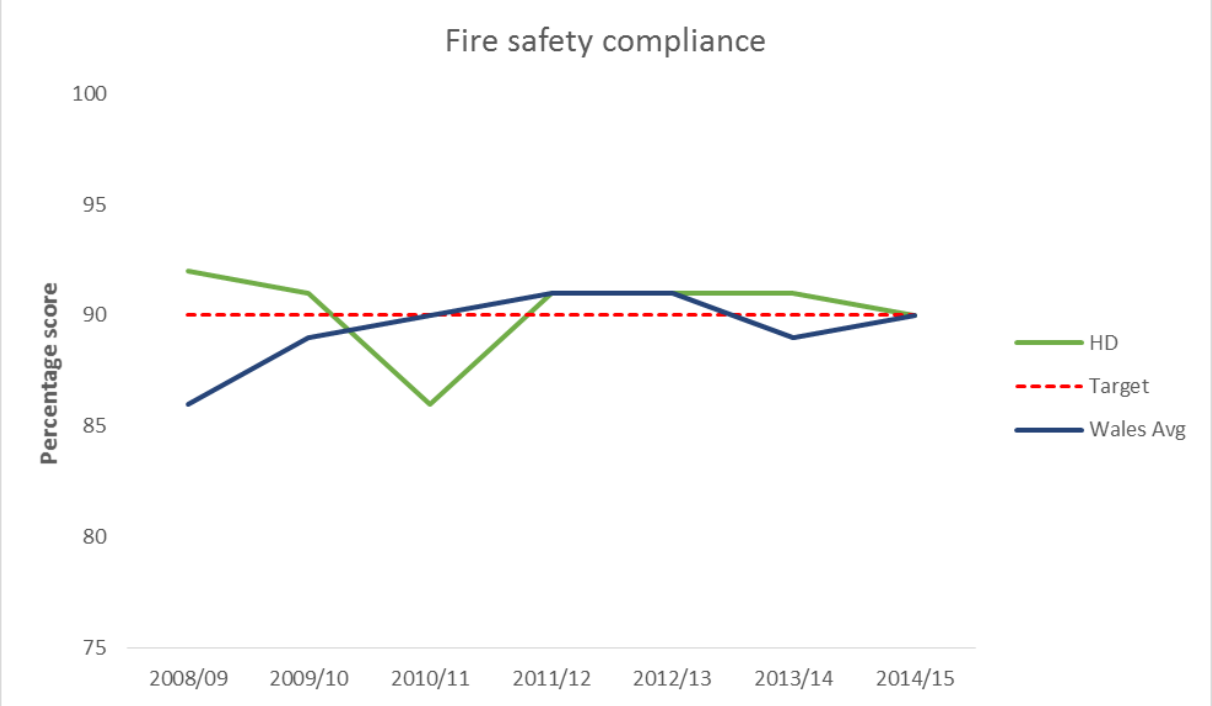


Exhibit 8: Functional suitability

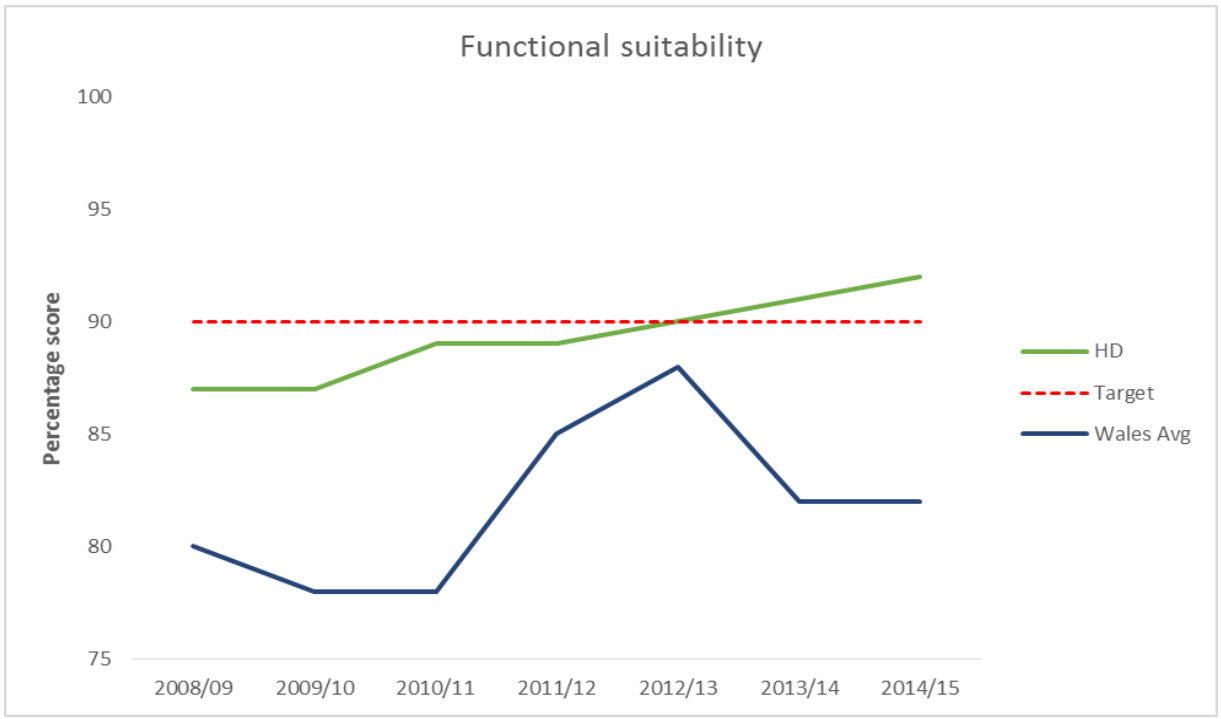
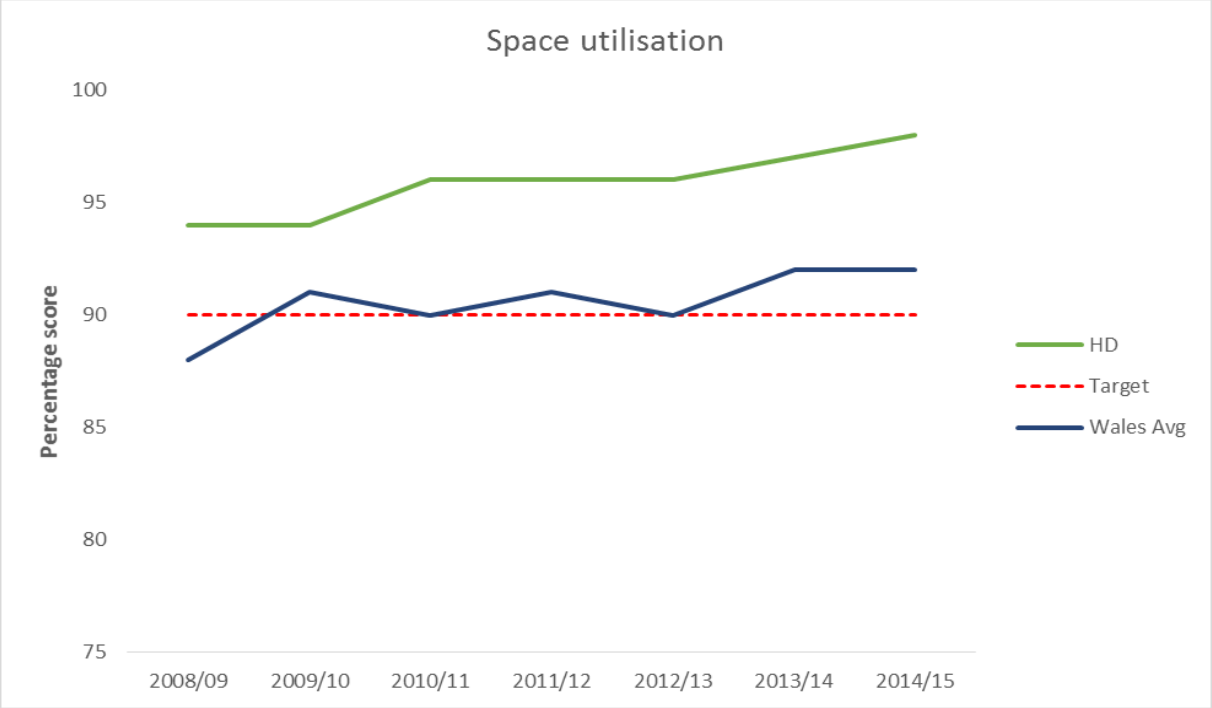


Exhibit 9: Space utilisation



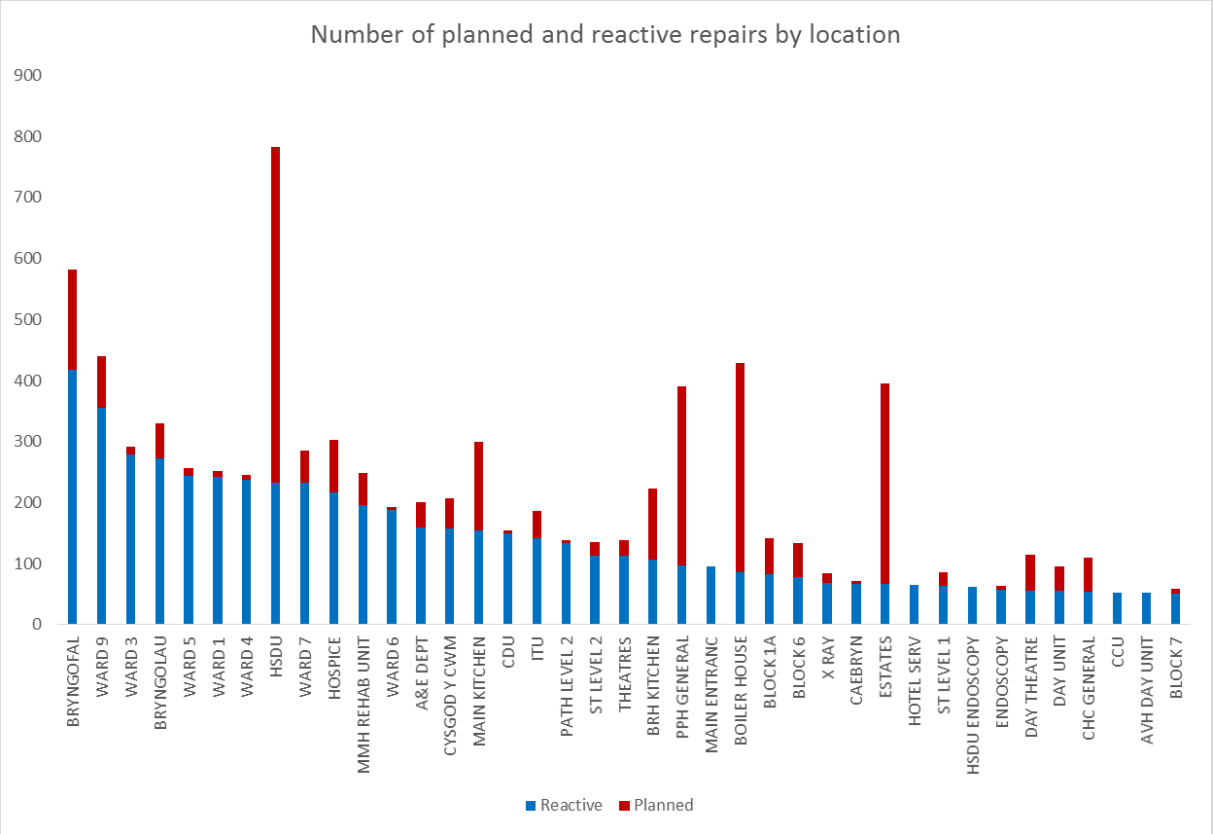
Appendix 2

Estates IT system – illustrative analyses

This section contains a series of analyses based on sample data downloaded from the department's RAM4000 IT system. The sample was for Prince Philip Hospital for the period 2014-15.

These indicators are based on work carried out by the Audit Commission on property maintenance, and show typical ways to analyse data to provide meaningful management information about the repairs service.

Exhibit 10: The number of planned and reactive repairs by location

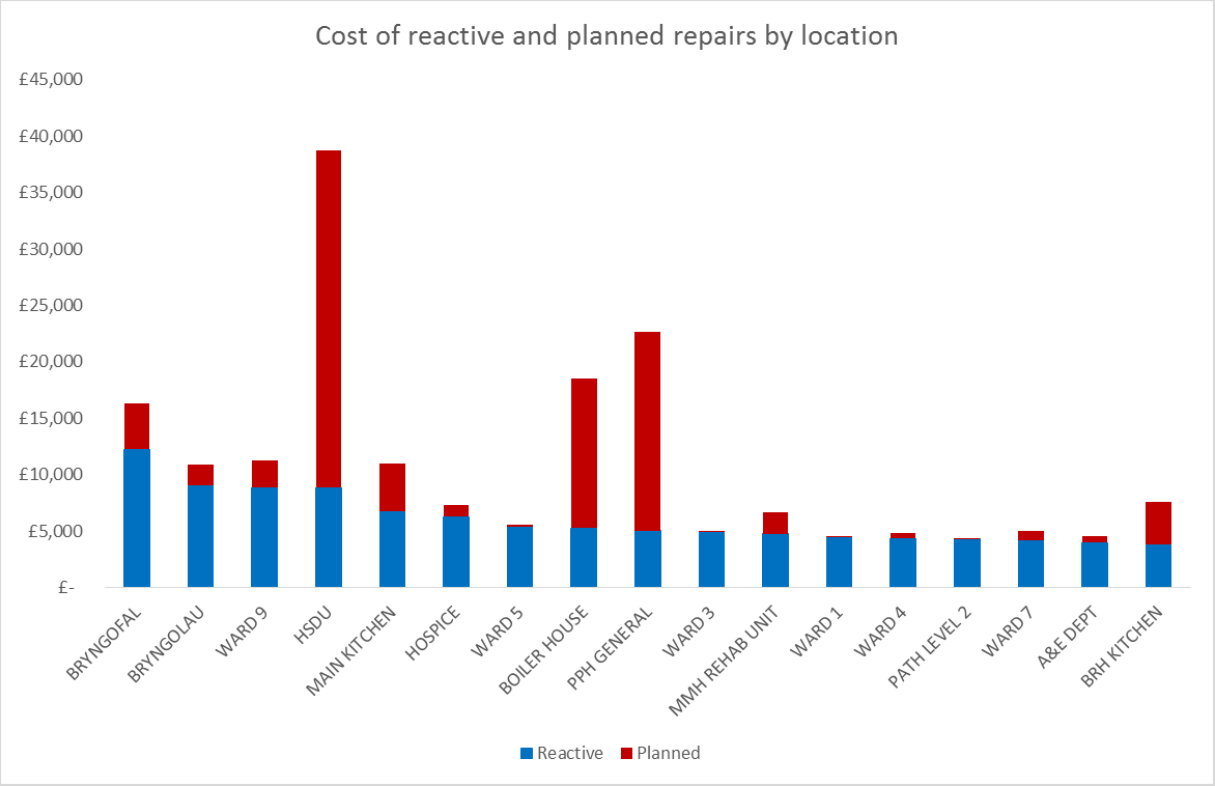


Interpretation

Can all significant differences in workload be explained by the condition of the buildings or equipment, or could differences be explained by differing practices?

Have internal education and awareness raising initiatives been focussed on those locations that form the bulk of the workload?

Exhibit 11: The cost of planned and reactive repairs by location



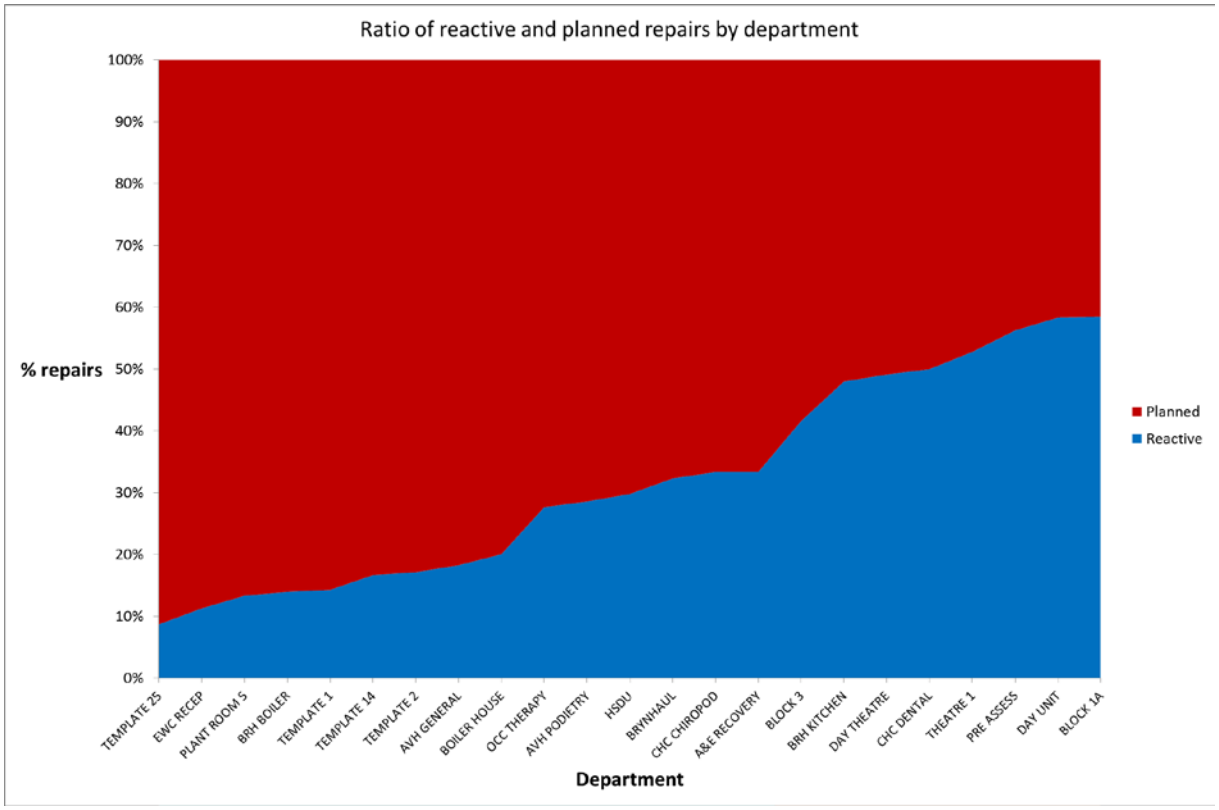
Interpretation

This indicator emphasises the potentially significant use of resources spent on repairs.

Are significant variations in the cost and volume of planned work explained by building or equipment profile?

Significant expenditure in one area may suggest the need to consider alternative solutions, including a more systematic approach to planned maintenance or more radical approaches.

Exhibit 12: Proportion of reactive and planned repairs by department



Interpretation

Has the level of planned maintenance been systematically reviewed recently?

If not, does the organisation have some assurance that the balance between reactive and planned is optimal?

Exhibit 13: number of repairs by trade

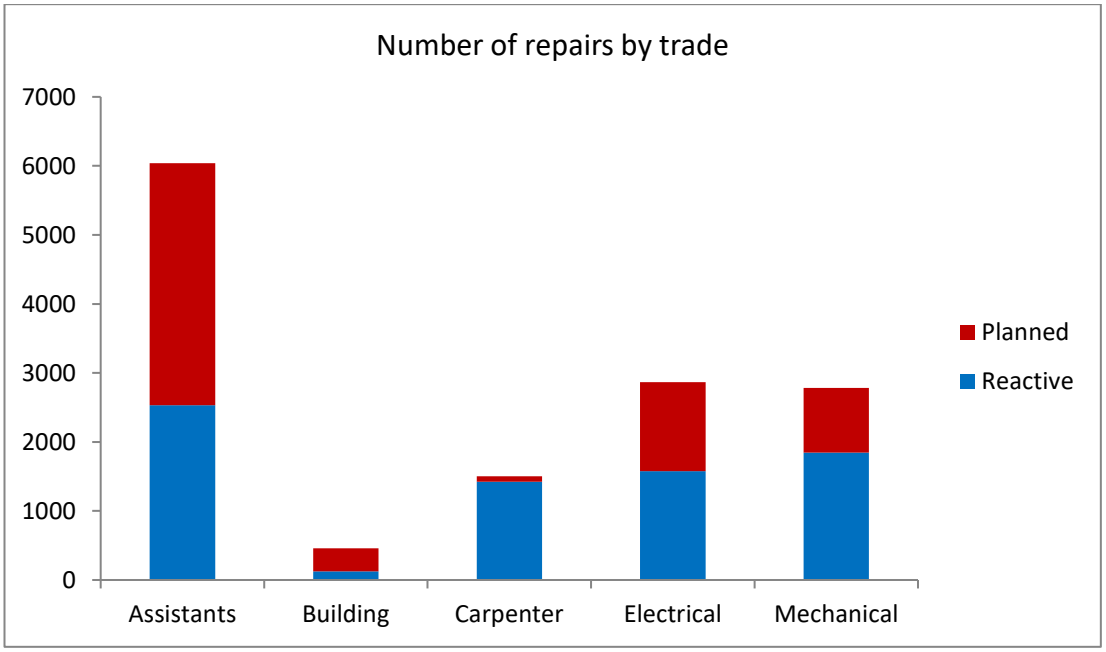
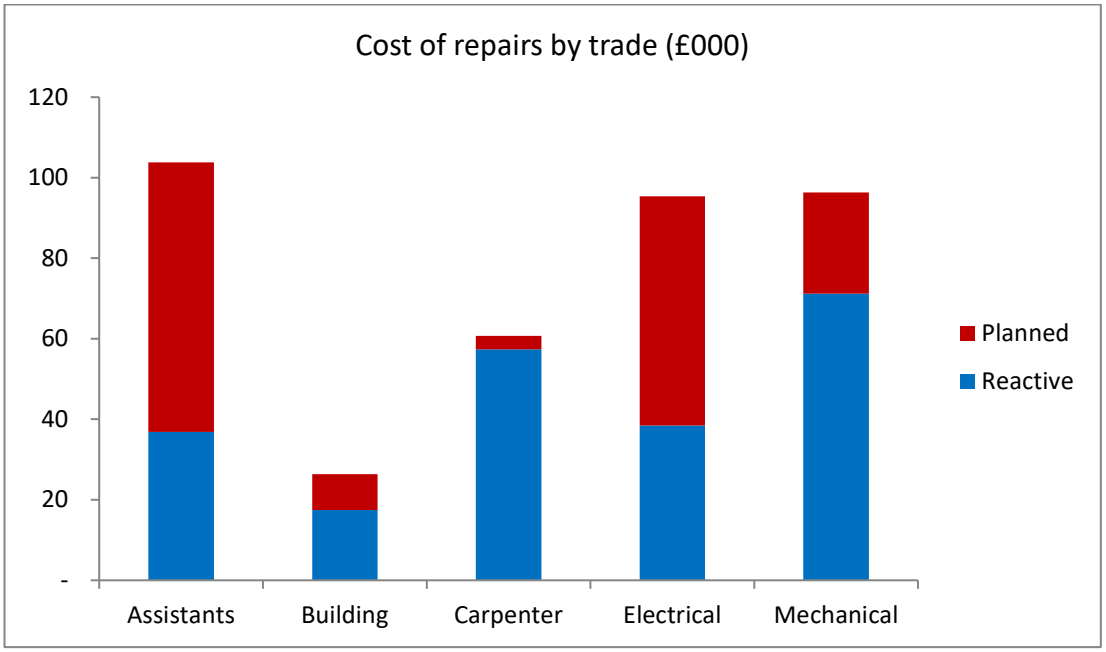


Exhibit 14: cost of repairs by trade

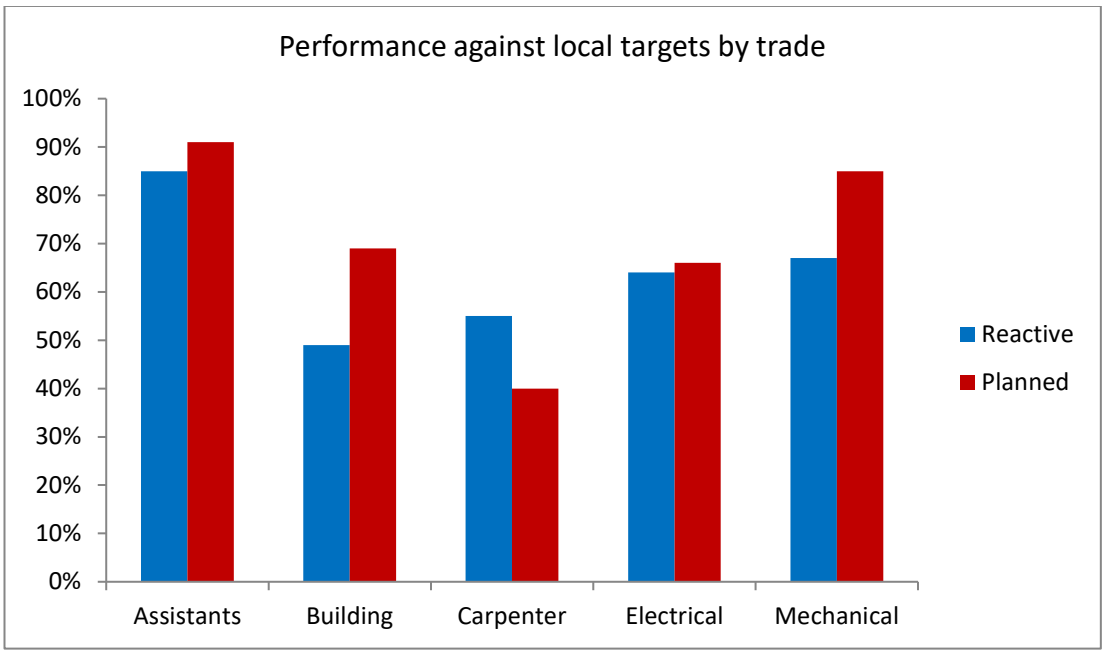


Interpretation

Maintenance staffing may be more influenced by historical factors rather than a systematic determination based on an analysis of existing workload. Has such an analysis been done recently?

Are significant differences between trades easily explained, and how is this related to response times?

Exhibit 15: Performance against local targets by trade



Interpretation

Has an analysis of performance by trade been undertaken?

Are there any reasons for the differences in performance? Is this related to the relative staffing balance between trades?

Differences in performance between sites could point to inconsistencies in service delivery.

Exhibit 16: Most frequent reactive repair requests

Top 20 reactive repairs	Number	Cost £
Heating issues	662	18,058
General fair wear and tear	443	16,900
Fault on lights	711	12,261
Fault on doors	377	11,702
Blockages	597	10,084
Fault on door locks	219	7,677
Hot water issues	141	7,507
Health and Safety	221	5,666
Investigate leaks	92	5,422
Fault on Autoclave	78	5,282
Fault on Endoscope Washers	103	4,678
Fault with electrical equipment	192	3,726
Fault with Electric Bed	166	3,579
Fault on nurse call handsets	319	3,394
Fault on fridge or freezer	139	3,151
Fault on flooring	59	3,063
Fault on Clinimatics	76	2,700
Fault with sinks	78	2,333
Fault with lifts	88	1,751
Fault on dishwashers	37	1,176

Exhibit 17: Most planned repair requests

Top 20 planned repairs	Number	Cost £
1W Autoclave tests	124	13,632
1W Daily boiler house checks	50	8,479
1W Fire Alarm testing	50	3,797
1W Gas installation checks	289	3,343
1W Examine door seals	196	3,312
1W HWS Temp monitoring	201	2,687
1W Kitchen checks	43	2,084
1W AHU maintenance	491	1,891
1W DHW Calorifier Drain down	688	1,878
1W V.I.E. Plant checks	50	1,861
2W External manhole check	37	1,789
1W Boiler House duties	49	1,072
1W Daily Oxy maintenance	49	620
1W Controls Air Comp maintenance	34	387
1W Manifold Plant maintenance	95	340
1W Med Comp Air Plant maintenance	33	337
1W Boiler House checks	40	188
1W Compressor checks	15	173
1W Medical Vac Plant maintenance	32	168
1W CHP Meter readings	8	46

Interpretation

Are the most common jobs those that might reasonably be expected?

Are there any jobs that may reasonably be expected to be done on the ward/department by others?

Are there any jobs that suggest user behaviour that could be influenced?

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