Agenda Item 13b

Internal Audit

FINAL

PCC Cumbria & Cumbria Constabulary

Assurance Review of Estates – Buildings Health and Safety

2022/23

November 2022

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Included in Audit Plan 2022/23

KEY STRATEGIC FINDINGS

Although policy and procedures are in place, the audit identified gaps in content and some inconsistency with current operations.

Some remedial works were identified as remaining outstanding for several years. An improved tracking and monitoring process has recently been adopted.

It was established that there is no routine reporting schedule regarding the status of Estates compliance to the PCC as the legal owner of the estate.

Inconsistency was identified within weekly fire alarm testing records, with data for four locations showing under 50% of tests being recorded during 2022.

GOOD PRACTICE IDENTIFIED

Tracking and monitoring of routine maintenance and health and safety tasks has been improved recently, with online records retained and central oversight.

A new staff member during 2022 was asked to review operations based on good practice seen elsewhere. This has led to improved practice in several areas.

SCOPE

The review considered how the organisation monitors and meets its health and safety obligations in relation to: water hygiene; fire risk assessments; asbestos; and periodic electrical testing. An additional focus was requested on health and safety in relation to buildings that have had reduced use during the Pandemic.

ACTION POINTS

Urgent	Important	Routine	Operational
0	4	7	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	A sample of eight water risk assessments from 2019 was selected and all high priority actions were investigated. Most of these were routine monthly, quarterly and annual activities such as sampling, testing, flushing, and temperature checking, all of which were found to be in place and monitored through a robust and detailed tracking process. Only one high priority recommendation from the sample involved Estates works - the removal of dead ends identified at the HQ Stable Block, noted for action within 28 days. The Estates Maintenance Officer confirmed following a visual inspection during the audit that this action had not been carried out. No record was available for why this was not actioned when raised in 2019. The Estates Maintenance Officer stated that it will now be addressed. Management confirmed that a more robust process will be introduced to track the outcomes of the scheduled 2022 risk assessments, whereby all recommendations will be reviewed and assessed for incorporation into the annual maintenance plan as appropriate based on the level of risk and priority.	All recommendations arising from the upcoming Legionella risk assessments be subject to the intended robust monitoring and tracking process through to their implementation. Any items identified as remaining unaddressed from the 2019 risk assessments should be given particular attention. The monitoring process should include a record of any items where it is decided not to take the recommended action, along with the justification.	2	*An action plan is in place capturing the outstanding actions from the current risk assessment review. Actions from the commissioned risk assessments will be added to this plan to be tracked to completion.* *There were delays on the completions of the previous outstanding actions as a result of Covid preventing contractors entering sites for a considerable period of time.* *A robust Action tracker was introduced prior to the audit being in place. The department has an effective monitoring regime implemented and fully actioned as evidenced by the combined tracking sheet.* *In our opinion this would be a Routine (3) classification.*	*Closure of action findings* *31/3/2023 (depending on the findings identified)*	*Estates Officer*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
7	Directed	Routine fire safety checks, tests and evacuation drills are undertaken by nominated individuals for each location. Central monitoring processes are in place and were demonstrated via video call, with records indicating that most regular checks are generally carried out with the expected frequency. Management stated that regular missed actions prompt further investigation to address underlying issues. A dedicated monitoring system is in place for weekly fire alarm testing. Responsible staff are required to enter details of the weekly tests via an online form, which is monitored centrally. A review of the submitted data found that four properties (Appleby, Barrow Island, Kendal Main Building and Kirkby Stephen) had recorded fewer than 50% of the expected tests during 2022. No details were available to explain the reasons for these missed tests and there was no investigation outcome regarding these data gaps. The Head of Fleet and Estates noted that some staff may have issues using the online form and that the figures provided may not accurately reflect the true extent of testing.	The procedure for carrying out and recording weekly fire alarm tests be re-communicated with training provided to staff having difficulty using the system, so that the data collected can be relied upon as a true reflection of the extent of testing. Where individuals or locations are identified with regular non-compliance, these should be prioritised for investigation as to the root causes.	2	*Unfortunately, due to unforeseen circumstances the Audit did not allow adequate time to supply these at time of the audit.* *We accept that some records were missing on the online tracker but upon investigation it was identified that the majority of the tests had been completed and logged in the paper records on site. Copies of these can be provided if required.* *We will recommunicate the procedure and update any training. We are also reviewing the recording of our fire alarm tests and whether this will be in paper format or electronic.* *In light of the above it should be considered for a Routine (3) classification.*	*31/12/22*	*Estates Officer*

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8	Directed	The Asbestos Management Plan specifies that "all buildings, constructed before 2000, will be surveyed annually". Management confirmed that these annual surveys are not carried out, as they are not considered feasible in terms of resourcing, nor seen as proportionate to the risk. Estates staff undertake general observations of known areas of risk during their regular activities, but that this does not represent a formal comprehensive inspection programme. Building users, when aware of the presence of asbestos, are also known to report any concerns about the condition of these areas through the estates helpdesk. It was confirmed that surveys are undertaken in advance of refurbishment works or other significant activity, in order to address the most significant risks.	The Asbestos Management Plan be reviewed and updated, to ensure the survey and/or inspection frequency is proportionate to the risk profile of the estate. Once these standards have been established and approved, compliance with the new Management Plan be monitored and reported.	2	*This finding is based on what is set out in a policy and whilst it is accepted the practice differs from that set out in the policy there is adherence to statutory requirements. The technical team have an embedded practice of regularly observing when visiting individual sites.* *As confirmed within the audit asbestos surveys are undertaken prior to any work commencing on buildings.* *Annual monitoring isn't a mandatory requirement and we feel, at least in part, that our practice satisfies the 'best practice' criteria.* *As such we feel this category would best be reflected as 3 score as no gaps in compliance is present, it is variation to policy only, similar to a later finding in this audit.*	*28/02/2023*	*Senior Estates Officer*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
11	Delivery	The estate includes a combination of owned, leased and PFI buildings. The force monitors the management of these buildings in a variety of ways, based on the risk associated with the workforce based there. For leased buildings, management stated that an annual check is conducted of the key health and safety areas. No record could be provided of examples of this check, however, which had been conducted by a former staff member. The compliance of these properties could not therefore be verified. The PFI site at Workington has similar arrangements, including regular meetings and the provision of status updates, although again no evidence was available of an overall annual check or review to verify that all key elements are in place. The PFI site contact commented in correspondence that this is common practice among their other clients.	Arrangements be formalised and documented for the provision and formal recording of assurance around estates compliance and health and safety from third parties providing PFI or leased buildings housing constabulary staff, such as an annual assurance review of all relevant activity. Records be retained in an accessible location, as these may be required in the event of an incident involving force staff, to demonstrate that reasonable care had been taken.	2	*In part this finding is accepted but due to the short timescale and limited notice of the scope of the audit the team did not have sufficient time to find the relevant documentation.* *The post holder who had these duties has left the team. It is correct that some records were held locally to the post holder and this is something we have now changed and a new method of recording is in place.* *Regular inspections of the lease hold property is undertaken and can be demonstrated through diary entries, work orders and requests for work being made to suppliers and landlords. Active management and inspections are undertaken. An annual inspection of landlord's compliance with H&S is undertaken but records could not be found and measures are being introduced to explore holding this information on the asset management system.* *The new post holder has these duties captured within their role and is actively managing this wok, including data recording.*	*31/3/2022*	*Head of Estates and Fleet / Senior Estates Officer*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Legionella Management Plan does not specify the required frequency for professional external Legionella risk assessments to be conducted. The HSE L8 ACOP no longer details a required statutory timeframe, but common practice is to continue with the previous requirement of a two yearly cycle. The force is due to obtain new risk assessments at the end of 2022, following the previous review in April 2019.	The Legionella Management Plan be updated to include the expected frequency for conducting Legionella Risk Assessments.	3	*There are no designated time frames for the frequency of risk assessments. They should however be reviewed as and when the risks change which is normally as a result of any changes to the H&C water system.* *We will update the current Legionella Management Plan to reflect the current review frequency.* *Our current frequency for assessments is 3 years and as no issues have been identified in recent decades, we see no reason to deviate from this practice with no discernible benefit or enhanced risks to the building users. The next cycle of risk assessments is due to be carried out and the team will be developing an action plan to close out any findings from this exercise.*	*Completion of assessments* *31/01/23* *Closure of action findings* *31/3/2023 (depending on the findings identified)*	*Estates Officer*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	Fire Safety is currently included within the overarching Health and Safety Policy, with supporting guidance for staff available via the intranet. Given the breadth and variety of activities required in the realm of fire safety, which involve a range of staff within different functions (including Health and Safety, Estates, on-site managers and fire wardens), there is a need to set out clear roles, responsibilities and expectations. It is therefore good practice to have a dedicated Fire Safety Policy, where all of the expected standards can be fully detailed. Management stated that a plan is in place to develop such a policy.	A dedicated Fire Safety policy be developed and introduced, covering all relevant activities, roles and responsibilities, and the standards required to comply with legal obligations and approved practice.	3	*A full overarching Fire Safety Policy is in development and the Estates team will review and align our internal fire management procedures to this document once published.*	*31/03/2023*	*Health & Safety Adviser*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	The Fire Safety guidance provided for the audit did not indicate how often professional external fire risk assessments should be carried out. Management stated that these are done on a three-yearly cycle, although most assessments completed during 2022 referred to the previous version dating from 2017. While this is not an unreasonable gap for the nature of the force's estate and workforce, the required timescale should be established and documented within the dedicated Fire Safety Policy (currently in development). Management confirmed that fire risk assessments are reviewed whenever the Estates or Health and Safety team become aware of a change in the building or its use. For some properties, such changes may be rare, or central teams may not be made aware of changes in use. It is therefore highly recommended to undertake an annual review of each risk assessment, which may include a desktop review and floor walk with key building users, to ensure that any issues are captured and appropriately addressed. A record of this annual review should be retained.	The required frequency of fire risk assessments and inspections be explicitly stated within the relevant policy. This should include both the schedule for full external reviews and also a requirement for an annual internal review with key building users of existing risk assessments.	3	*We accept the recommendation and will confirm the frequency of the audits by the end of January 2023 after the Force Health and Safety Committee Board where we will agree the frequency of both the external reviews and the internal reviews.*	*31/03/2023*	*Health & Safety Adviser*

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4	Directed	Throughout the Force's fire risk assessments, there are frequent comments from the assessor stating "as per previous assessment", where no change was identified since the 2017 assessment. Where there are no hazards or significant observations this may be reasonable, but the 2022 assessment for Longtown Police Station point 4.1 notes that Housekeeping and Maintenance are "not adequate" and that deficiencies are "all as per previous assessment". The 2022 assessment does not re-state the deficiencies and later notes that all previous recommendations have been satisfactorily addressed, which appears to contradict the earlier "not adequate" statement. Failure to clearly state all deficiencies within the latest risk assessment increases the risk of confusion or misunderstanding, along with the potential for deficiencies to not be properly addressed.	The provider of future fire risk assessments be instructed that all deficiencies be clearly identified within each new risk assessment, rather than referencing a previous document.	3	*We accept the recommendation and will have implemented within the force by the end of January 2023. Even though these assessments are completed externally we will as a force add the requirement to our policy that there is to be a summary sheet included at the time of each new assessment outlining all the previous findings so that we can refer back as in when required.*	*30/01/2023*	*Health and Safety Officer*

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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
6	Directed	Recommendations from fire risk assessments are recorded on a central tracker. One tracker was created for the last set of risk assessments from 2017, with a new one established for the new assessments in 2022. Within a sample of 10 2022 fire risk assessments reviewed, 21 actions had been identified by the external assessor as not having been implemented following recommendation in 2017. 10 of these related to regular checks and policy actions overseen by Health and Safety, some of which were required across multiple sites. All have now been addressed during 2022, but there was no record of why they were not addressed in 2017. Of the 11 Estates recommendations within the sample noted as not implemented between 2017 and 2022, four were recorded on the 2017 Action Plan as "reviewed and found unreasonable". Management confirmed that this would be on the basis of a risk assessment, considering the nature of the risk and of building usage. There was no record of why the remaining seven items had remained outstanding since 2017. All actions arising from the 2022 risk assessments were found to be accurately recorded with their current status on the new tracker, which appears to be considerably more robust. As the 2022 actions are recent, many remain in progress.	The recommendations arising from the 2022 fire risk assessments continue to be monitored and tracked closely, until all are either implemented or a clear justification is agreed and documented for not doing so. Particular attention should be given to those items that were previously identified in 2017 and have not yet been addressed.	3	*We accept the recommendation in relation to the 2017 risk assessments.* *However, a robust tracker has been in place prior to the audit and is being monitored for closure on all open items from the 2017 and 2022 risk assessment reviews as evidenced during the audit.* *The audit finds that all 2022 risk assessments are completed with actions agreed demonstrating effective current practices.*	*Closure of action findings* *31/3/2023 (depending on the findings identified)*	*Estates Officer* *Health & Safety Adviser*

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9	Directed	Details of asbestos containing materials (ACMs) identified through surveys are held within the "OakLeaf" database, along with any recommended actions. Where an ACM is removed as part of any Estates upgrade works or similar, the record is updated to reflect this. The current database does not have the facility to record any actions or mitigations short of removal. In one example reviewed, a label was required to be applied to the ACM to alert building users. As there was no way of recording whether this had been done, assurance could not be gained on this point. Management stated that they are currently in discussions with the software provided regarding the adoption of an updated version of Oakleaf, so this represents an opportunity to request additional functionality.	The facility to record the implementation of recommended actions to address or mitigate the risks of ACMs (short of removal) be explored and implemented if possible in the next version of the Oakleaf database.	3	*Fully accept the recommendation.* *We are currently in the process of completing a trial with the new version of OakLeaf and will have made a decision on the future use of it by the end of the 2022 financial year.*	*31/03/2023*	*Senior Estates Officer*

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10	Delivery	Management reporting for this area is managed separately for Health and Safety and Estates matters, with Health and Safety issues reported to the quarterly Health and Safety Committee. The Head of Fleet and Estates confirmed that routine reports on Estates matters used to be presented to the Office of the PCC (which owns the estate), but that this ceased during the COVID disruption and has not recommenced. Given the broad range of areas of compliance and the associated costs involved, it is important that at least periodic reporting is reintroduced, such as an annual overview of key metrics to ensure accountability and to allow for appropriate review and challenge.	Reporting to the Office of the PCC on Estates and related compliance matters be re-introduced. This should be at a frequency and level of detail to be agreed, but should ideally incorporate at least an annual summary of key activity.	3	*Accept the recommendation and it was the Head of Estates and Fleet who raised this as he considers this is a gap and raised it as an area he would like to strengthened / reintroduced. I* *It is noted this is graded yellow (routine), however, the control is not in place. Earlier findings for which controls and actions are in place are graded important, it does not appear consistent with the gradings set out earlier in the document and strengthens the comments made within this document around the grading of the findings.*	*31/03/2023*	*Head of Estates and Fleet*

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Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
There were no operational effectiveness matters identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, 2, 3, & 4	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	5, 6, 7, 8, & 9	-

Other Findings
Arrangements for the appointment of contractors were discussed with management. The Head of Fleet and Estates provided assurances that these were all subject to the Force's standard procurement rules, while the staff member responsible for each area was able to confirm the requirements and standards required for the relevant contractors covering that aspect of the estate. A review of the contractors in place according to recent certificates and documentation confirmed that these are all well-established within their fields.
The Health and Safety Adviser confirmed that mandatory annual Fire Safety Awareness training has been reintroduced for all staff in 2022/23. The completion rate is being regularly monitored and reported, although staff have until March 2023 to complete the training.
The Health and Safety Adviser confirmed that personal emergency evacuation plans are in the process of being prepared for all relevant staff, so support the fire arrangements in their work locations. Constabulary response – These are already in place.

Other Findings

It was confirmed that EICR electrical inspections are carried out on a five year cycle for all boards across the estate. A review of a sample of eight certificates provided evidence that they were all within the required five year limit. The future schedule for the planned date of re-inspection for this sample also indicated that their next inspection would be within a five-year timeframe. The Estates Engineering Officer noted that a small number of historical EICR certificates for Kendal could not currently be located. If they cannot be found promptly, copies will be requested from the contractor.

All observations graded as C2 (urgent) from the sample of EICR test certificates were reviewed for appropriate remedial action. There were no C1 (dangerous) items among the sample. All of these remedial works were found to be being monitored. Evidence was available in most cases of the item having been rectified or quotations received with the works pending. For several other items, details were provided of thorough risk assessments of the nature and usage of the area of the building, along with a review of the relevant regulatory standards and detailed discussion with the contractor, before a decision was made that implementation was not appropriate or necessary.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	10, & 11	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings
Upon appointment in early 2022, the new Estates Maintenance Officer was asked to review key management arrangements within Estates, based on their experience of good practice elsewhere. Recommendations arising from that report were confirmed during this audit to have been introduced, including improved record keeping and monitoring on recommendations from external inspections and risk assessments.
Across the various areas of Estates health and safety work, a move from paper-based records to shared electronic documents was identified. As well as being more sustainable in terms of use of resources, this should also provide longer-term efficiencies in the need for space for physical filing and storage.
Through interviews with various members of the Estates team, it was established that there is a strong understanding among the group of each colleagues' role and expertise, with increasingly standardised monitoring processes in place. This provides greater resilience for the overall Estates Health and Safety activity through the ability to cover absences.
Management confirmed that there had been no reduction in compliance or health and safety activity during the pandemic, and that routine tasks had continued irrespective of any reduced rates of occupancy during lockdowns. The evidence reviewed during the audit supported this assertion, as no significant variation in delivery was identified in this respect.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	26th September 2022	26th September 2022
Draft Report:	19th October 2022	11th November 2022
Final Report:	14th November 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Estates – Buildings Health and Safety		
Type of Review:	Assurance	**Audit Lead:**	Stuart Whittingham

Outline scope (per Annual Plan):	The review considers how the organisation monitors and meets its health and safety obligations in relation to: water hygiene; fire risk assessments; asbestos; and periodic electrical testing. |There will be an additional focus on health and safety in relation to buildings that have had reduced use during the Pandemic.
Detailed scope will consider:	The review will set out to provide assurance to the Joint Audit Committee that the organisation has robust arrangements in place and operating for Estates – Property Compliance. • The organisation has robust policies and procedures in place to ensure that compliance with statutory and regulatory requirements is met and can be demonstrated. • The organisation has considered the risks associated with (non-)compliance and appropriate mitigating controls are identified and operated. • Robust records are maintained to evidence that the required assessments and monitoring activities are carried out with timely action to address issues identified. • Performance is reported in sufficient detail to senior management allowing for appropriate challenge and scrutiny on non-performing areas of the service. • Budgets are set for the service and regularly monitored throughout the year.

Planned Start Date:	28/09/2022	**Exit Meeting Date:**	13/10/2022	**Exit Meeting to be held with:**	Head of Estates and Fleet; Health and Safety Manager; Senior Estates & Facilities Maintenance Manager

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc.?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N