APPENDIX D

AUDIT TRACKER UPDATE
NWSSP AUDIT & ASSURANCE
AGREED ACTIONS COMPLETED SINCE LAST REPORT

Executive Lead – Director of Finance				
SBU 1819-007 **Systems: DOI & Risk Management** **Report Issued October 2018** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	14	Management were able to explain how the capital allocations from the 2018/19 discretionary programme were determined, based on risk, however no audit trail was available to verify the use of OAKLEAF to drive this process. It was also noted that the Estates Operating Procedures were out of date, and the funding allocation procedure described by management was not formally documented. Estates Operating Procedures should be updated, to set out the required processes associated with the recording of identified risks, and in the risk prioritised allocation of discretionary capital.	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002): Outstanding** No evidence was provided by the UHB as to the action taken to address the agreed recommendation. Estates Operating Procedures should be updated, to set out the required process associated with the recording of identified risks, and in the risk-prioritised allocation of discretionary capital. **October 2022:** Re-written procedures will be produced by the end of November 2022. **December 2022:** The requirement of the recommendation has been met in the development of an operating procedure, which is also referenced in communication with finance colleagues. Closure agreed during discussions with NWSSP A&A colleagues.
ABM 1920-007 **Capital Systems Financial Safeguarding** **Report Issued November 2019** **Assurance Rating Limited**	**3**	Estates procurement activity was reviewed for the period April 2018 to July 2019, including an examination of all relevant Estates cost centres to determine patterns of unusual activity. This identified a significant number of individual orders below £5,000 in value placed with certain contractors. These were reviewed in more detail and discussed with Estates managers, and it was confirmed that: – The above relate primarily to maintenance/repairs – No formal competitive exercises had been undertaken to confirm that these contractors provided best value; – No competency vetting (including, e.g. appropriate industry accreditation checks, health and safety policies etc.) could be demonstrated – Mgmt. advised that the refrigeration contractor's qualifications should be held within an online portal, however evidence was not provided. – Declarations of interest proforma had not been completed (see also the Capital Systems report 2018/19). Appropriate procurement controls should be implemented for contractors employed below current quotation thresholds	Agreed. Appropriate procurement controls will be developed for utilisation within the estates department. These will specifically consider repeat/multiple orders with key contractors/suppliers.	**December 2022:** Excepted procurement controls have been communicated. Closure agreed during discussions with NWSSP A&A colleagues.
	8	We sought to confirm that financial vetting had been undertaken where appropriate (i.e. for contractual arrangements over £25k in value). Financial vetting had not been undertaken at any of the 8 procurement exercises reviewed over the £25k threshold requirement. Financial vetting should be undertaken prior to entering into any contractual arrangement above £25k in value (in accordance with Standing Financial Instructions). Estates should liaise with Finance and Capital Planning to establish requirements for financial vetting at the Local Framework.	Agreed. Advice will be sought from UHB Finance and Capital Planning, together with NWSSP Procurement Services colleagues to determine an appropriate way forward.	**December 2022:** The use of Frameworks ensures that the financial vetting has been undertaken to enable the contractor to join in the first place. Closure agreed during discussions with NWSSP A&A colleagues.

Executive Lead – Director of Finance				
SBU 2122-007 **Waste Management** **Report Issued February 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	7	There was minimal evidence of waste management issues being reported to the Health & Safety Committee during the period reviewed (April 2020 onwards), aside from a brief reference to waste risks within the Health & Safety Operational Group Key Highlights Report. There was no formal reporting evidenced from Estates. a) The Environmental Report (or alternative appropriate report) should be enhanced to widen the scope of reporting of waste management issues. (see also recommendation 6.1.b). b) The relevant Board-level Committee should receive periodic waste management updates. (see also recommendation 1.1.a).	a) Agreed. See also management comments above at 6.1.b regarding widening the scope of reporting outside the Estates Board to ensure Service Unit Directors are appropriately sighted on issues arising within their areas of responsibility. Further, from January 2022, waste is now included within the Estates update to the Health & Safety Operational Group. b) Agreed. We will incorporate a summary on waste management into the next Estates report to the H&S Committee, which is due before April 2022.	**December 2022:** Confirmed that exception report was taken to the last Estates Board [November meeting addressing October data] setting out the details as required. Also, update on waste procedures, noting many have recently been finalised. Closure agreed during discussions with NWSSP A&A colleagues.
SBU 2223-016 **Health & Safety** **Report Issued September 2022** **Assurance Rating Limited**	**1.1**	Section 3.1 within the health and safety policy notes that the Policy will be supported by a number of other health board wide policies. It refers to a later appendix, however this contains reference to legislation, regulations and sources of information but it does not contain a listing of the health boards own supporting policies The health board should complete the identification of which policies relate to and support the overall health and safety policy. This could include capturing policy ownership, oversight group and review dates. Once complete the overarching health and safety policy should include detail on supporting policies.	The H&S Policy was recently reviewed following the change of executive lead for H&S and is a statement of intent of the organisation of which it does. The policy does outline additional policies and it is an oversight of not including a link to other health & safety related policies. The policy will be amended to include the link.	**December 2022:** The revised Health & Safety Policy was approved by the Health & Safety Ops group, and presented to the Health & Safety Committee in October 2022. A non-exhaustive list of supporting policies is provided at Appendix D, with a hyperlink to the policy section on the Health Board's updated SharePoint intranet site. As such, this action is considered closed.

Executive Lead – Executive Director of Nursing & Patient Experience				
SBU-2122-002 **Quality & Safety Framework** **Report Issued January 2022** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2.2	Established just prior to the onset of the pandemic, the QSGG has modified its approach and agenda to compensate and support reporting and escalation to the QSC. The QSGG Terms of Reference include 42 objectives (including one duplicate objective). Our review identified that the group has not met all of these, with those related to monitoring the QSPF and receipt of terms of reference/annual plans from subgroups representing an ongoing gap. The supporting structure of the QSGG indicating reporting groups and subgroups remains outstanding. We recommend that there is mapping of the QSGG sub-groups and reporting groups. Following this there should be a work programme/business cycle created to ensure all relevant information and reporting are addressed and distributed throughout the year.	Agreed	**December 2023:** Patient Safety Group subgroups/reporting groups have been mapped and set out as part of the Terms of Reference. Work programme/plan established and in place. As such, this action is now considered to be complete
	2.3	The QSPF includes that the QSGG 'acts as the first layer of corporate oversight, which exists to provide appropriate oversight to the devolved Service Delivery Units own quality and safety meetings, together with other formed groups and sub committees.' The current exception report in use provides coverage of performance but does not prompt information on the operation of service group quality and safety groups. We recommend that the exception report include reporting on service group quality and safety group operation. The QSGG attendance tracker could be shared to support good practice in this area	Agreed - The exception report from Q&SGG to Q&S Committee will be reviewed following the Q&S workshops and a revised reporting template agreed by the Q&S Committee	**December 2023:** Service Group patient safety groups reporting into the subgroups which support the HB Patient Safety Group, with PSG currently receiving verbal updates. Revised reporting template in place. Service Group quality and safety structures have been mapped to Health Board quality & safety structures and process. As such, this action is now considered to be complete.
ABM 1920-020 **Falls** **Report Issued September 2019** **Assurance Rating Reasonable**	**5**	There are a number of "Gold Command" focus Groups active within the Health Board but there are no gold command policies or protocols in place that are linked to the performance management framework. Consideration should be given to establishing an operating protocol for "gold command" focus groups which is aligned to the performance management framework to ensure that these groups are effective and can demonstrate improvement.	Agreed. The policy provides details of management responsibility for key policy areas e.g. Security, asbestos, transport etc. however it will be reviewed for adequacy in light of the recommendation.	**December 2022:** 'Gold Command' forms part of the command, control and coordination structure which would be put in place in response to a major incident. The decision to convene a Health Board Gold Command will be made by the Executive on Call at the time of the incident, following a review of the details. Gold Command objectives and reporting arrangements are clearly set out within the Health Board's Major Incident Procedure Overarching Plan. The Health Board's Performance Management Framework sets out a clear process for managing performance within the Health Board, which includes a robust escalation process for managing issues as they arise. As such, 'Gold Command' arrangements would not form part of this process. Noting the foregoing, this issue is considered to be closed

Executive Lead – Director of Strategy				
SBU-2122-003 **Elective Orthopaedic Unit** **Report Issued October 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	10.1(a)	Advisers have been appointed from the UHB's Local Framework, to provide architectural, cost and mechanical and electrical advisory services to the project to date. Contracts were in place at the time of review, covering work on both the SOC and revenue solution, and had been appropriately completed and executed. However, the following issues were noted: • The Architect contract ('temporary bridging solution') was capped at £10,000, but payments to date totalled £23,584, exceeding the delegated authority provided by the contract signatories; and • All contracts had been executed after adviser duties commenced; with delays ranging from only one week to seven months (from the date first payment was made). Sufficient contractual cover should be in place to cover the value of works instructed.	Agreed. Within the Capital Planning Department, we strive to ensure that contracts are in place in a timely manner, as demonstrated within this instance. The contractors that we work with are selected from an existing framework which has already undergone competitive compliant procurement exercises that ensures that the Health Board is receiving Value for Money. We place a cap on the contracts to ensure that we are not financially exposed. We accept and agree with your comments. With regards to this particular instance as we have already iterated the project is evolving and progressing at pace and as a result the costs had escalated quickly. We are aware of it and will look to revise the contract to reflect these changes.	**December 2022:** Confirmed that a new contract [£50k] has been prepared for the Architectural Consultant Service and Technical Advisor role. Discussions held on 12/12, with the Capital team, note that Strides Treglown signed the contract on 02/12/2022. It is now awaiting signature by the HB. On the basis that the contract is awaiting signature, it has been agreed with NWSSP A&A colleagues that the recommendation has been addressed and can be closed.
SBU 2122-018 **CAMHS Commissioning Arrangements** **Report Issued December 2021** **Assurance Rating Limited**	**1.1**	The health board commissions Child and Adolescent Mental Health Services (CAMHS) from Cwm Taf Morgannwg University Health Board (CTMUHB). There is no Service Level Agreement (SLA) / service specification in place detailing the CAMHS commissioning arrangement. The health board were unable to provide a definitive answer as to what CTMUHB's responsibilities are, and what remains the responsibility of the health board in respect of CAMHS. The health board should ensure that there is an appropriate SLA or service specification in place for the commissioning arrangement between the health board and CTMUHB that covers all key areas of the CAMHS commissioned.	As stated, the Health Board had already identified that developing a service specification for CAMHS would be included in the 2021-22 work programme. However the postholder supporting this work transferred to a new role in July 2021, and the backfill post was appointed to, but the candidate then withdrew, there has been no cover for this role since this time. This post is currently out to advert but it is unlikely that it will be filled until early 2022 which impacts on the target date for this. There will also need to be careful consideration for the Health Board of the financial implications of implementing a service specification to meet all national requirements which will need to be prioritised as part of the Annual Plan and resourcing requirements agreed for 2023-24 onwards.	**August 2022:** Service Specification now finalised, with update paper to be presented to management board in August. Final Specification will be approved between CTM and SB at the September Commissioning meeting. **December 2022:** Service specification agreed and signed-off. Action complete

Executive Lead – Director of Strategy				
SBU 2223-006 **Stakeholder Communication & Engagement** **Report Issued August 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.1	The health board's 'Framework for Engagement & Consultation' document covers the principles in determining the level of engagement a service change should employ and describes in narrative form the processes that should be followed. We have noted an example of another health board having practical guides and flowcharts for staff to follow in the application and implementation of the process to service change proposals, and that it would be beneficial for the health board to have its own set. We recommend that the health board consider developing documentation to provide service change programme leads with a practical user guide to undertaking public engagement / consultation. This could include the following elements: • process flowcharts in a chronological workflow; • workflow task roles and responsibilities; • typical workflow step timescales; • reference to relevant templates that should be completed; • approval requirements; • decision points and criteria (e.g. assessing the engagement level to be adopted, triggers for stage 2 formal consultation).	A flowchart will be developed as suggested to aid Delivery Groups in clarifying the extant process with elements suggested above included.	**December 2022:** Flowchart developed and tested with one Delivery Group to test approach and benefit. Now issued to all Delivery Groups.
	4	We noted that Stakeholder Reference Group (SRG) meetings had been paused during the pandemic period, although we were advised that key documents were still circulated and distributed out to the membership via email. Whilst these meetings resumed in 2021, we noted the following issues: • Meetings have not reached the groups bi-monthly frequency recorded in its terms of reference and achieved pre-pandemic, and the July 2022 had been cancelled; • Chair and Vice-Chair posts have been vacant for some time, and remain vacant; • We were unable to establish with certainty that meetings that did take place were attended by the appropriate people (we noted some meetings pre-pandemic recorded low attendance and in several cases were inquorate); • The group does not maintain a work programme. We recommend that the SRG address the governance weaknesses identified and resume its activities in full.	A workshop is planned in Autumn 2022 to restart the work of the SRG and also to consider different ways of ensuring consistent Chairing of the SRG. This will include a work programme which used to be in place but which had lapsed over recent years.	**December 2022:** Workshop held on 17th October and forward plan agreed for SRG as well as amended way of working. Meetings now scheduled for shorter length of time from January on a bimonthly basis.

Executive Lead – Director of Strategy				
SBU 2223-007 **Singleton Hospital Cladding Replacement** **Report Issued August 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.1	Meetings between January and June 2022 were reviewed; and the following issues noted: • The Project Board Terms of Reference does not distinguish between decision-makers and advisers. Noting standard practice would not include advisers in the quorum, on this basis two of the six Project Board meetings (February & March 2022) were not quorate. It is recognised however that no decisions were taken at these meetings. • Five Project Board members did not attend any of the six meetings reviewed. There may be opportunity to remove members who are no longer required based on the current stage of the programme or list them separately to attend “as required”. • The Senior Responsible Officer (SRO) attended four of the six meetings reviewed. Whilst the SRO was briefed by the Project Director following the meetings, and included in circulation of papers, the Terms of Reference did not detail these reporting / accountability arrangements. The Project Board terms of reference should be reviewed to consider the following: a) Project Board quorum requirements should be clarified, to ensure only members with decision-making authority are included. b) Project Board minutes should record whether quorum has been achieved, and therefore whether decisions can be taken. c) Noting routine non-attendance by a number of Project Board members, the membership should be reviewed to ensure it remains appropriate. d) Project Board members should be reminded of their responsibilities to attend if required; and e) Monitoring and reporting arrangements for the SRO should be defined (particularly where they are unable to attend Project Board meetings).	Agreed. Terms of reference will be tabled at the next Project Board, with a target ratification by 31 October 2022.	**December 2022:** Updated Terms of Reference (TOR) for the Singleton Cladding Project Board have been received by NWSSP Audit & Assurance colleagues, and reviewed. Following discussion, it has been agreed that this recommendation can be closed
	1.2	The Health & Safety role at Project Board was still being fulfilled by the prior Assistant Director of Health & Safety (now the Assistant Director of Strategy – Capital), noting the post had not yet been filled. Following appointment, the new Assistant Director of Health & Safety should be invited to attend Project Board.	Agreed. On successful appointment, the new Assistant Director of Health & Safety will be invited to attend Project Board.	**December 2022:** The Assistant Director of Strategy (Capital) noted that no appointment has been made and that he will still pick up on this role as part of the Project Board. Following discussions with NWSSP A&A colleagues it has been agreed that rather than leave this as a recommendation that will not be achieved, based on the current structure, but acknowledging this will be addressed should the appointment be made in the remaining period of the project, this recommendation is closed.

	2.1	The Project Director is due to leave the UHB in March 2023; and a successor has been appointed (Assistant Director of Strategy – Capital). Management advise there are some documents managed by the current Project Director which are not more widely available within the UHB (e.g., in relation to the legal action / early progression of the project). Noting the forthcoming departure of the current Project Director, a full audit trail of the historical management of the legal action and early progression of the project should be centrally retained for access by appropriate personnel.	Agreed. Discussions and meetings have commenced between current Project Director (PD) and new PD, to ensure appropriate documentation is stored appropriately to be available following departure of the current PD.	**December 2022:** Discussions held noted that the Project Director is remaining at the HB for at least another 9 months, post his current interim position [which is scheduled to end 31st March 2023]. Noting that the project is scheduled to be completed in April 2024, theoretically, he will still be at the HB in December 2023. Noting the recommendation was raised to finalise all handover it is recognised that if anything required further discussion, in relation to the earlier stages of the project, the knowledge will still be within the HB. Following discussions with NWSSP A&A colleagues, it has been agreed that this action is closed.
	5.1	The latest façade cost report (no. 15, issued June 2022) presented a total anticipated underspend of £163,359 against the approved funding envelope, with a balance of UHB contingency of £278,606. The risk register (revision 29) separately recorded risks valued at £356,256, therefore exceeding remaining contingency. The risk of insufficient funds to deliver the project to completion has been discussed at Project Board, and flagged at the Welsh Government Project Progress Reports. However, as above this is not currently reflected in the cost reporting, which presents an anticipated underspend. Cost reports should incorporate the value of costed risks against available contingency when considering the forecast over/ underspend position.	Agreed. The forecast position will be incorporated into the cost reports from now on. The UHB will endeavour to reclaim the Expert Witness and COVID-19 costs at completion, and if successful, the scheme is currently affordable. SES attend Project Board, and are aware of the current situation, but have said that all contingencies and any gain share has to be accounted for before any funding is allocated.	**December 2022:** Confirmed with the Cost Advisor that the recommended updates would be made to the cost report. Confirmed this is the case [reviewed the October report]. Following discussions with NWSSP A&A colleagues, it has been agreed that this action can be closed.
ABM 1819-005 **Environmental Infrastructure Modernisation Programme** **Report Issued June 2019** **Assurance Rating Reasonable**	**4**	All changes to the contract prices and or completion dates should be enacted via the contractual compensation event mechanism (as provided within the NEC suite of contracts). The final elements of the Environmental Infrastructure Modernisation (BJC1) Programme of work were completed in March 2018 i.e. outside of the original Business Justification Case delivery programme target completion date of December 2017. Within the same, significant delays were evidenced in the delivery of a number of the individual contracts. The UHB attributed the most notable delays to the presence of asbestos within Singleton Hospital, together with equipment supplier performance at the Princess of Wales scheme. No delay damages were applied at the respective contracts examined. Noting the foregoing, the completion of compensation events/formal acceptance of revised contract programmes (amending the respective contract completion dates) was not evidenced in all instances. The schemes included within the Environmental Infrastructure Modernisation Programme will be reviewed to ensure all contract documentation (incl. compensation events) is complete	Agreed, all documentation will be reviewed on close of the project. Final accounts have been agreed and signed off for all schemes except the BMS at PoWH and the Fire Alarms at Singleton Hospital. These are currently being reviewed with a view to achieving sign off by the end of the current financial year.	**December 2022:** Noting the original recommendation was linked to previous projects [which have been completed] it was agreed that the essence of the recommendation would be considered for a current project. The latest copy of the change register for Sub Station 6 has been provided and reviewed. This register includes the changes requested by the contractor, the PM and the Cost Advisor. Following discussions with NWSSP A&A colleagues, it has been agreed that the recommendation has been addressed and can be closed.