APPENDIX E

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

Executive Lead – Chief Operating Officer				
SBU 2122-013 **Planned Care Recovery Arrangements** **Report Issued February 2022** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1.1	The Outpatient Redesign and Recovery group includes the review and discussion of advice and guidance tools which support pathway and referral management alongside receipt of service level recovery plans. We note that the January 2022 meeting minutes and the groups highlight report to PCPB indicate that Service Group engagement, particularly from clinical leads, could be improved. Morriston has provided no medical representation in the period April 2021 – January 2022, but has designated a lead Outpatients sister to attend, whilst Singleton Neath Port Talbot has had clinical representation at just two meetings. Outpatients Redesign and Recovery group membership and attendance requirements should be reviewed with consideration given to mechanisms for highlighting any consistent gaps in attendance.	It is recognised that staff are under significant pressures currently, and that is likely to continue for the foreseeable future, whilst also recognising the need to move forward with the outpatient recovery & sustainability plans. A review will be undertaken to compare the attendance of the outpatient redesign & recovery meetings over the last 12 months with the membership outlined within the terms of reference - compliance with then be discussed with members of the Group. In the first instance the Group will consider whether or not we have the right nominations and secondly for those individuals to appoint a deputy who can attend if they are unable to do so themselves. The review will continue quarterly, and the compliance with the terms of reference escalated to the Group if required.	**April 2022:** A review was undertaken to compare the attendance of the outpatient redesign & recovery meetings over the last 12 months, this has highlighted the lack of clinical attendance at the meeting. Service Groups have been asked to identify suitable clinical staff for future meetings and to ensure that appropriate deputies are available for the meetings. Based on the foregoing, the deadline date has been extended to 30/06/2022 **June 2022:** As a result of the recommendation made in the Audit, a review of attendance is undertaken every quarter, and the findings presented back to the Outpatients Recovery & Redesign Group - escalation is via service groups.
	2.1	Review of the Diagnostics Recovery Group agendas and minutes note that the primary focus of the group has been on the development and monitoring of recovery plans. However, we were unable to identify any discussion at the group of the GMO requirement to 'Undertake a review of diagnostic access to primary care practitioners and develop a plan with Primary Care Clusters to enable better prevention and early intervention with urgent conditions created.' The DRG at present does not have agreed terms of reference We recommend that the Diagnostics Recovery Group receive and approve terms of reference	As highlighted in the audit, the focus of the diagnostic group during 2021/22 has been to develop and implement recovery plans to support improvements in waiting times. However, with the 2022/23 recovery & sustainability plan now agreed, the group will work strategically on the achievement of the Goals, Methods and Outcomes. The terms of reference have been drafted with this in mind, and will be reviewed and agreed at the next diagnostics meeting on the 17th February. Plans are in draft with each service on the GMOs they plan to deliver for 2022/23, and a highlight report will be developed for monthly reporting and review by the Planned Care Board.	**April 2022:** Terms of Reference for the Diagnostics Group have been developed and include representation from the PCS Service Group, as a result of the review findings. The updated terms of reference were discussed at the meeting on the 17th March, however due to a change in leadership of the Group the TOR were not approved. **June 2022:** The terms of reference were agreed for the Diagnostics Recovery Group meeting on the 16th June 2022. Membership on the group has also been accepted by PCS, and they are in the process of identifying a named representative.
	2.2	Review of the Diagnostics Recovery Group agendas and minutes note that the primary focus of the group has been on the development and monitoring of recovery plans. However, we were unable to identify any discussion at the group of the GMO requirement to 'Undertake a review of diagnostic access to primary care practitioners and develop a plan with Primary Care Clusters to enable better prevention and early intervention with urgent conditions created.' The DRG at present does not have agreed terms of reference When considering objectives within the terms of reference for the Diagnostics Recovery Group, there should be identification of whether the group is responsible for the review of diagnostic access and development of any plans with Primary Care Clusters or representatives.	As stated above the terms of reference are now in draft and will be finalised by the end of February. How diagnostic services work with primary care will be discussed as part of the development of the terms of reference. As a minimum, a representative from PCS or a cluster representative will be secured as part of the terms of reference.	**June 2022:** The terms of reference were agreed for the Diagnostics Recovery Group meeting on the 16th June 2022. Membership on the group has also been accepted by PCS, and they are in the process of identifying a named representative.

	4.1	The health board outpatient clinic information page contains contact links for a number of active services and current arrangements reflecting the constraints and impact of COVID-19. There is no detail to outline the validation exercises underway, or information on the alternative pathways being established as a result of health board review of these areas. We recommend the health board ensures there is supporting information available to patients which outlines the outcomes of validation exercises such as movement to see on symptom and patient initiated follow up pathways. It would also allow the health board to highlight the number of initiatives underway to support waiting list management.	Validation of waiting lists is recognised as a priority for the Health Board and the Welsh Government's National Planned Care Board. In line with local guidance on validation, patients who have been waiting for longer than 52 weeks will receive a letter from the Health Board, which asks the patient to confirm that they would like to remain on the waiting list and outlines next steps. It is recognised that this should potentially be undertaken earlier than 52 weeks, and the Health Board are currently considering writing to patients at 36 weeks, and as part of that review the narrative provided to patients will also be reviewed. An outpatient dashboard has already been developed via outpatient's transformation, and action is being taken to allow the dashboard to be accessible to those working in primary care. For example, when GPs refer a patient they will be able to advice patients how long they are likely to wait for an appointment.	**June 2022:** Monthly administrative validation of the longest waiting patients on the stage 1 and follow waiting lists continues. In addition to letter validation, the Dr Doctor system is being used for text validation to improve efficiency where possible. Additional validation posts have been requested through the Welsh Government Outpatient Transformation fund. An external validation company have been recruited for a 3 month period in the interim to focus initially on stage 1 patients waiting over 36 weeks. Validation of waiting list is a continuous exercise and patients are communicated with by letter, text and telephone. Any patient removed from the waiting list receives a letter, as does their GP. The outpatient dashboard for GPs advising them of waiting times has been finalised and is now available for viewing – Action Complete

Executive Lead – Director of Digital				
SBU 2122-021 **ITIL Service Management Review** **Report Issued October 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	2.1 (b)	The health board has configured ServicePoint with pre-defined summaries for calls for operators to select from drop down lists. This was intended to remove the requirement for operators to specify if the call logged was an incident or a request. However, from our sample testing we established that this was not a 'fool proof' resolution for categorising incidents and requests for action correctly as we noted inconsistencies in classification of calls between incidents and requests. We also identified that the classification, categorisation and prioritisation terminology used in service point drop down lists is not consistent with the standard operating procedures. We recommend the Board emphasise to service desk operators the importance of ensuring calls are logged correctly.	The second element of this to ensure service desk staff enter accurate information is aligned to the service desk accreditation courses being undertaken by all service desk staff. These Service Desk Institute courses are being run from October 2021 – March 2022 and a group will be formed to specifically address data quality.	**April 2022:** Two final members of staff are scheduled to undertake the training on the 17th and 19th May 2022. This action can then be closed. **June 2022:** All staff have now undertaken the training. This action can be closed.
SBU 2122-005 **Network & Information Systems (NIS) Directive** **Report Issued April 2022** **Assurance Rating Reasonable**	**2**	Whilst we were informed that a formal improvement action plan is not yet in place due to the health board receiving advice from the CRU to await the outcome of the CAF, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement. We noted that improvement objectives have been identified following the completion of the self-assessment, however, an improvement action plan has not yet been developed Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation	Agreed. This is being worked on	**June 2022:** A NIS Improvement Plan has been written and submitted to the CRU for review. Completed.

Executive Lead – Director of Finance				
SBU 2122-015 **Procurement & Tendering STA / SQA** **Report Issued October 2021** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	7.1	Our review noted that the Declaration of Interest section for three of the 15 STA forms sampled were complete, but had not signed off by the person completing the form. We also noted the forms were inconsistent regarding who should complete this section. The single tender action request form for the sample reviewed typically only required a declaration from the budget holder. It does not request the same from others who may be involved in selecting or procuring the supplier and the budget holder may not have satisfied themselves that those involved had appropriately declared any interests. Declarations of interests will be completed and signed for all individuals involved in each single tender action / quotation.	Consideration should be given to how we use existing HB declarations of interest as part of this process. It would be preferable to use existing information that is available as opposed to further increasing the administrative burden on procurement. Procurement will work with Corporate Governance to establish if this is viable.	**April 2022 (Keir Warner):** The proposed approach is impractical and will cause a significant administrative issue for both the Procurement team and the Health Board. An alternative approach is being proposed; that the STA/SQA form will be amended to require that all signatories complete a check box confirming that they have no interests to declare in relation to the goods/services/company being purchased. This form is nationally agreed and the amendments will be proposed to the All Wales procedure review group for consideration. Completion by June 2022 but is subject to All Wales agreement and may not be approved. Based on the foregoing, the deadline has been extended to 30/06/2022 for update. **June 2022:** The new SQA/STA form has now been agreed and is in use. The new form has been issued to all requestors and includes the need for declarations of interest for all signatories.
SBU 2021-007 **Control of Contractors** **Report Issued April 2021** **Assurance Rating Limited**	**4**	Management advised that there were plans to introduce a more formal competency procedure within Estates. A spreadsheet template had been created, with pre-determined questions to ensure that contractor information in key areas such as H&S policies, competencies, cub-contractor arrangements, risk assessments, insurances etc. has been checked. However, this was not in use at the time of fieldwork. Estates should finalise and apply the new contractor evaluation spreadsheet at all appropriate new appointments	Agreed. The evaluation spreadsheet will be introduced for use in Financial Year 20/21.	**Follow-up: Estates Assurance SSU-SBUHB-2122-004: Closed** Work has been undertaken in conjunction with Procurement to issue a checklist for members of staff to follow when looking to appoint contractors.

Executive Lead – Director of Finance				
ABM 1617-012 **Neath Port Talbot Operational PFI** **Report Issued July 2017** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	4.1.1 (a)	Whilst it is noted that a significant element of the risk is transferred to the partner in PFI deals, it is imperative that there are arrangements in place to monitor those risks. A risk register will be prepared to monitor Trust/ partner/ shared risks.	Agreed **Updated Response – July 2017** The outcome of the legal services review by NWSSP Legal & Risk Services will inform future requirements.	**Follow-up: Estates Assurance (SSU-SBUHB-2122-04): Closed** As has been reported in previous follow up reports, management advised that whilst a risk register is currently not in use, health and safety risks / issues are discussed at the Liaison Group meetings and any significant risks are dealt with promptly. Review of the agenda and minutes of the Liaison Group has confirmed that risks / issues are raised accordingly, with an action plan reviewed and updated at each meeting
	4.1.1 (b)	Whilst it is noted that a significant element of the risk is transferred to the partner in PFI deals, it is imperative that there are arrangements in place to monitor those risks. Clause 55.10 of the risk matrix requires that a risk sub-group be established that is accountable to the Liaison Group. We were advised that such monitoring would best be undertaken as a standing item at the Liaison Group as the attendance for both would be the same. Noting the above, the terms of reference for the Liaison group have yet to be revised. Additionally, there is no evidence of a risk register having been presented to the liaison group. The Liaison Group or Risk Sub Group will be responsible for monitoring the risks as standard agenda items.	Agreed. To be reviewed quarterly as a standing agenda item. **Updated Response – July 2017** The outcome of the legal services review by NWSSP Legal & Risk Services will inform future requirements.	**Follow-up: Estates Assurance (SSU-SBUHB-2122-04): Closed** As has been reported in previous follow up reports, management advised that whilst a risk register is currently not in use, health and safety risks / issues are discussed at the Liaison Group meetings and any significant risks are dealt with promptly. Review of the agenda and minutes of the Liaison Group has confirmed that risks / issues are raised accordingly, with an action plan reviewed and updated at each meeting

Executive Lead – Director of Finance				
SBU 1718-011 **Control of Substances Hazardous to Health (COSHH)** **Report Issued February 2019** **Assurance Rating Limited**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	4	Monitoring and reporting arrangements in relation to COSHH were not defined. However, good practice was noted at the annual Health and Safety report which outlined a process of "periodic audits" of each aspect of Health & Safety. External audits were undertaken of departmental practices by parties such as the Health & Safety executive, and Health Inspectorate Wales. Additional to these, reports were also noted by the "Authorised Engineer" (role provided by NWSSP: Specialist Estates Services) relating to specific areas e.g. medical gases. However, such a formalised approach to the "periodic audits" as outlined at the Health and Safety report was not evidenced. Operation of COSHH systems will be audited and reported in accordance with the requirements outlined within the annual Health and Safety report.	Agreed	**Follow-up: Estates Assurance (SSU-SBUHB-2122-004): CLOSED** Risk assessments have been completed at a number of locations across the HB sites. The risk assessments address the chemicals involved in the process/area and the requirements to keep them appropriately safeguarded. Whilst it is recognised that not all sites/processes have been reviewed at the date of fieldwork, recognition is provided for the process to address requirements.

Executive Lead – Director of Workforce & Organisational Development				
SBU 1920-032 **WOD Directorate** **Report Issued August 2020** **Assurance Rating Reasonable**	**Rec Ref** **1**	**Findings & Recommendation** We were provided with details of WOD directorate staff PADR status. Performance to October 2019 indicated the directorate was 14% below the Health Board average of 67%. Analysis against directorate staff individual status highlighted that the majority listed as expired were overdue by only a few months - 85% of staff were either in date or with 3 months of expiry. Whilst management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit). We recommend management should ensure PADRs are completed & recorded in ESR for these soon, focus should be given to those employees overdue by more than a year (there were 8 recorded at the time of audit).	**Original Response / Agreed Action** It is noted that the Trade Union Officers PADR is not completed by the WOD function. Following the audit targeted work began to ensure all WOD PADRs were completed. This meant that compliance rose to 73% in January 2020. Due to the COVID-19 pandemic it is recognised that the WOD PADR compliance has fallen to 55%. The funding to ensure that WOD are able to continue to function which was agreed early 2020 has been on hold meaning that gaps remain in management structure. Due to the uncertainty of the situation, the redeployment of people and reassignment of tasks PADRs may not take place at due dates. Management can reassure that discussions around wellbeing and tasks are continuing. The completion of PADRs will be dependent on no second wave of the pandemic, a return to a more normal way of working and recruitment into posts.	**Update/Comment** **June 2022:** The Director of Workforce and OD has set up a plan to monitor the PADR Compliance within the WOD directorate on a fortnightly basis. This has included Assistant Directors producing action plans to reach the 85% target and reporting back to the Director of Workforce and OD on progress. At the 22/06/2022 the PADR compliance excluding Trade Union Representatives and Kick Start Programme is 68%. PADR compliance was discussed during a deep dive at June WOD Committee, PADR data will continue to be reviewed and monitored by the WOD committee as part of the HB Assurance. Action Closed
SBU 2122-024 **Staff Wellbeing & Occupational Health** **Report Issued September 2021** **Assurance Rating Reasonable**	**5.1**	The majority of OH referrals are made via management. However, an individual can also self-refer, to seek advice before becoming ill and absent from work. On referral to the service the individual is triaged to assess and determine the appropriate clinical support before an appointment is offered. Following this appointment, the OH team issues a report to the individual and/or manager with their findings and recommendations for reasonable adjustments as required. The Occupational Health Team maintain monthly figures on the number of referrals received, the specialty assigned after triage and the average number of working days for triage and the first appointment. However, the team informed us they do not typically hear back from staff and managers once reports are issued. Therefore, they do not receive feedback from stakeholders on the effectiveness of the service and in order to identify areas for improvement and development The OH team should seek to evaluate the effectiveness of the service from various stakeholder's perspectives, including line-managers, employees in receipt of the service and HR colleagues/Business Partners, to identify areas for improvement and service development. The team could explore working with the Workforce and Organisational Development Service to see if OH is having a positive effect to reduce sickness absences.	The OH team will seek to evaluate the service from various stakeholder's perspectives, including line-managers, employees in receipt of the service and HR colleagues/Business Partner's. This may help identify areas for service development and improve the effectiveness of the service. OH&WB representative will be gained at the monthly Workforce sickness strategy meeting where a review of the Service Group sickness action plans is undertaken.	**June 2022:** An MS Forms evaluation has been developed in order to receive feedback from managers and service users to inform the effectiveness of Occupational Health management referrals. A link to the evaluation is sent as a hyperlink to each manager and service user in the email containing Occupational Health Report.

Executive Lead – 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**
	2.1	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. The Group otherwise had sufficient coverage of subject areas against its ToR, but we were informed that due to the large agenda there can be challenges in keeping the meeting within its timings whilst allowing contributors adequate scope to present reports and highlight key issues. A number of other objectives including monitoring of licensing standards, agreement of Patient Experience Plan and review implications of confidential enquiry reports could also be considered if still appropriate as objectives for the group. 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. Consideration should be given to the purpose and focus of the group against the large number of objectives contained within its terms of reference.	Agreed - Following the Q&S Workshops a review of the Terms of Reference, role and function of the QSGG will be completed and as well as appropriately updating and revising the document, mapping of the QSGG sub-groups and reporting groups and scoping its place within the governance structure. This will also include ensuring the expectations contained within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 are included.	Quality and Safety structures revised. First meeting of new Quality Safety Patient Services Group to be held 21st June 2022
	3.1	We note the QSGG has not been quorate on six occasions due to a lack of attendance from the Chairs of the group: The Director of Nursing & Patient Experience and Executive Medical Director. Additionally, wider membership of the group as outlined within the ToR could also use consideration as some listed members have not attended and we note there is no requirement for a representative from the COO to attend despite the agenda featuring service group performance and reporting. QSGG membership and chairing arrangements should be reviewed with consideration given to ensuring Executive Director presence outside of that of the Director of Nursing & Patient Experience.	Agreed - Membership of the Q&SGG will be considered following the Q&S workshops as part of the review of the Terms of Reference of the Group. This will include confirming the joint chairmanship and ensuring consistent Executive Director attendance.	New chairing arrangements include wider representation from Executive team

Executive Lead – Director of Strategy				
SBU 2021-004 **Environmental Infrastructure Modernisation Programme (S2P2)** **Report Issued August 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) – states: “Boards .. will need to identify a Senior Responsible Owner (SRO) for each project with the capacity and expertise to lead and challenge.” There is particular need therefore for the SRO to be able to exercise scrutiny and challenge at the project informed by appropriate project information. The Service Director (Morriston Hospital Service Delivery Units) was the allocated SRO for this project (as defined at the Project Execution Plan). An email trail was supplied in June 2021 of the Project Director obtaining SRO approval of Compensation Events (contractual changes) at the project. She was also copied minutes of the July Project Board (by the Project Director), requesting her approval to items approved within the meeting. However, the most recent attendance of the SRO to project meetings was to part of a Feb 2021 Project Board meeting. A prior Project Execution Plan (PEP) had indicated the operation of a Programme Board. This no longer operated and was not defined at the current Project Execution Plan. There was therefore particular need to ensure effective linkage of the Project Board to senior committees via its summary reports accountable officers (as designed at the PEP). While summary financial reporting was provided to the Capital Monitoring Group, the SRO did not attend this group. Formal information linkage to the Executive via the SRO was therefore not identified. It is recognised that technical issues at the Project Board may not involve the SRO. However, there was need to define any such delineation as to notifications and approval by the SRO e.g. partial attendance, or approval of action or decision logs. There was therefore a need for linkage to the Senior Responsible Office and Executive team to be defined at the Project Execution Plan. The Project Execution Plan (as approved by the Project Board) should define monitoring and reporting arrangements for both the Senior Responsible Officer, Project Board, and Executive Team via the project and committee structures (particularly where the SRO is unable to attend key meetings).	Agreed. We will look to utilise action / decision logs, potentially delineating user related actions requiring SRO approval, and look to better define SRO and executive interactions at the Project Execution Plan.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** The Project Execution plan has been updated accordingly for the approach to be taken for Project Board meetings on the occasions when the SRO is unable to attend

	2	Welsh Government Guidance "Guide to developing the Programme Business Case" states: "The Programme Business Case is a working document which must be revisited and updated upon completion of each tranche of the programme, prior to obtaining approval to commence a further tranche". A Programme Business Case was originally produced in 2013 and updated in 2018. The project phases have developed considerably as the programme has progressed. There was a need therefore to re-appraise the Programme Business Case alongside the revised business case for this stage. Any such revision will need to be factored into timing and costings of the phase. In this case management stated any revision to the Program Business Case would need to reflect the Site Strategy, Clinical Service Plan and Estates Strategy (all of which are in process of revision). For this reason, this has not presently been factored in as a required task for approval of the business case. Management should confirm the waiver to refresh the Programme Business Case at the Welsh Government Capital Review Meetings, else factor in appropriate time and cost to the project for this task.	Agreed. We will look to confirm the need for a refreshed Programme Business Case potentially at the Welsh Government Capital Review Meeting in order to obtain Welsh Government funding.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** It was confirmed at the Welsh Government Capital Review meeting (September 2021) that the Programme Business Case would not be refreshed until the development of the UHB Estates Strategy was sufficiently advanced for the two to be aligned.
	3	The Supply Chain Partner contract prepared for the construction stage includes the requirement to create a project bank account, operated via a Trust Deed and Joining Deed. This is to be used exclusively for payments to the Supply Chain Partner and its supply chain (to protect and facilitate timely payments). Evidence of a Project Bank Account is to be provided by the Supply Chain Partner to the Health Board. While not required at the current stage, at Stage 4 (construction), this should be set up within three weeks of the contract date. Noting that Welsh Government require such accounts to operate, it is recognised that there may be significant lead time in setting up such new and complex arrangements. There is a need therefore for the parties to ensure that arrangements will be in place in timely manner. This is denoted for future action, noting that the "start on site" was not scheduled until April 2022. Future Assurance: Management will ensure that a Project Bank account will be set up in timely manner, as required by the contracts.	Agreed. We recognise the lead times involved and will advise the Supply Chain Partner of the need for timely set-up in liaison with the Health Board.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** Management is aware of the need for a project bank account to be in place and discussions are ongoing to achieve this in accordance with the project programme.

	6	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires up to date financial monitoring of projects. Project cost reporting presently suffers from certain anomalies and limitations: – Non-works costs were provided only in total – While the capital monitoring report showed in-year expenditure, the "Level 2" cost report also showed prior year expenditure but labelled the combined total as a forecast. Neither report therefore provided a forecast i.e. including future expenditures. – The capital monitoring report showed in-year variance against expected spend. However, noting a lack of priced activity schedules by the Supply Chain Partner and advisers, the basis of this expected spend profile was not clear. – The Supply Chain Partner report monitored actual and forecast expenditure against their own contact sum, but there was not similar monitoring of the overall project (including Health Board, non-works, and adviser sums). – No reporting against contracted sums or approved funds allocated was identified for the project. It is recognised that there was detailed in-year monitoring of expenditure, including reporting to the Capital Monitoring Group. It is also recognised that this was in context of final assessment and agreement of budgets for the current phase with Welsh Government only being concluded in July 2021 (the point of audit conclusion). However, there was a particular need for reporting against budget, and forecast out-turn. Cost reporting should include forecasts to the end of the project stage, including current and forecast variance to contracted sums and funding.	Agreed. Cost reporting will be developed with the health board cost advisor and will report against contract and budget, including forecast outturns.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** Review of the latest cost report, prepared by the appointed Cost Advisor, confirms the reporting of forecasts, outturn and variances.

	7.1	The Project Execution Plan states that the Project Board is the body "responsible for the overall direction and management of the project through to completion." While project changes were authorised via correspondence between the Project Director and the Senior Responsible Officer, the Project Board had no defined role scrutiny or challenge of project changes. Testing was undertaken as follows: **Authorisation** While approval by the Senior Responsible Officer was obtained for one recent Compensation Event, Project Board approval was not evidenced. Neither the Senior Responsible Officer, nor the Project Board had a defined role in approving Compensation Events at the Project Execution Plan (the Project Board being the accountable body for project control). Signed approval at the Supply Chain Partner Compensation Events was only provided by the external Cost Adviser. This was contrary to the requirements of the Project Execution Plan, which requires Health Board approval. In all 9 cases sampled, Compensation Events were well substantiated by calculations of time and resource. (Observations relating to the need to align resource charged to project tasks has made at MA 6). For the 6 sampled changes in respect of the advisers, they were signed by both the requesting adviser and the Health Board Capital Planning lead in accordance with his delegated limits (£25,000 as specified at the Project Execution Plan). The Project Execution Plan should define the role of the Project Board in scrutiny and approval of project changes.	Agreed. We will update the role of the Project Board in respect of approval of Compensation Events.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** The Project Execution Plan defines the role of the Project Board in relation to compensation events: and further defines the project team roles and responsibilities for contract variation approvals and/or changes to employer scope/brief.

	Total Compensation Event's	Total no. of Compensation Events to date	Sample value	Sample no	Substantiated	Appropriately Authorised?	Timely approval?
Supply Chain Partner	£282,696	8	£178,239	3	Yes	See comments	Yes
Adviser	£65,570	6	£65,570	6	Yes	Yes	See comments

	7.2	The Project Execution Plan states that the Project Board is the body "responsible for the overall direction and management of the project through to completion." While project changes were authorised via correspondence between the Project Director and the Senior Responsible Officer, the Project Board had no defined role scrutiny or challenge of project changes. Testing was undertaken as follows: **Timeliness** The Project Execution Plan reflects the contract in requiring agreement within stipulated time frames (response to Compensation Event requests within two weeks). This is required to avoid agreement by default due to breach of these time limits. All three Supply Chain Partner Compensation Events were agreed within the required time frames, but similar monitoring was not found for agreement of adviser Compensation Events. Only four of the six adviser Compensation Events to date were provided (hence sample size. Of the remaining two (which could not therefore be sampled), one was raised two months earlier, and the date the other was raised was not recorded. There was a need therefore to monitor timely approval, additional to appropriate authorisation. There was also a need to monitor timely response for Requests for Information (RFI) from the Supply Chain Partner, to avoid compensation claim for delay. Timely agreement of Compensation Events and Requests for Information should be monitored and reported.	Agreed. We will ensure that both Compensation Events and Requests for Information are monitored for timely approval.	**Follow-Up: Capital Assurance (SSU-SBUHB-2122-002) – Closed** Change control is reported to Project Board through the cost reports; and review of the dates recorded for the changes applied to date note agreement within a reasonable timeframe.

	Total Compensation Event's	Total no. of Compensation Events to date	Sample value	Sample no	Substantiated	Appropriately Authorised?	Timely approval?
Supply Chain Partner	£282,696	8	£178,239	3	Yes	See comments	Yes
Adviser	£65,570	6	£65,570	6	Yes	Yes	See comments

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**
	3.1	The Project Initiation Document details that the Project Manager will provide monthly highlight reports to the recently refreshed Steering Group. The new terms of reference for the refreshed Steering Group additionally confirm that the Steering Group will report monthly to the Planned Care Delivery Board. Recognising the recent implementation of the refreshed governance arrangements, only one formal highlight report had been produced for the new Steering Group, for its initial meeting in September 21, with Flash reports produced in the last two months for the Planned Care Delivery Board. The content of reporting included: – high level detail of key risks; – progress to date; – planned actions for the coming period; and – an overall 'RAG' (red/amber/green) rating of the project (which had been assessed as 'Red' at the reports reviewed). However, the reports did not provide supporting detail as to how this RAG rating had been determined. The reports also did not provide narrative of progress against timeline. It is understood that whilst early expectations for delivery timescales were communicated, a formal delivery programme has not yet been defined. Whilst recognising a detailed programme will be prepared once approval is received, highlight reports should be clear on overall progress against original expected timescales, to ensure group members are adequately informed on any slippage (which may affect key matters such as achievement of expected benefits). Highlight / Flash reporting to the Steering Group & Planned Care Delivery Board should be enhanced to include: – Reporting of progress against expected timelines, including any slippage incurred to date against original targets, and ongoing reporting against a more detailed delivery programme once this has been agreed; and – A clear summary of the factors influencing the overarching RAG rating.	Agreed. Over the past few months, we have hoped that we have demonstrated that we have significantly strengthened the governance arrangements around this project. Audit's recommendations have been noted and will be implemented going forward.	**June 2022: Update from NWSSP A&A** Copies of the capital highlight reports, the external PM reports and a highlight report prepared by the Transformation team [December 2021] provided and reviewed. Review of the latter notes reference to the RAG rating - not included in the other reports. For the report that has been provided there is an explanation (albeit brief) for the slippage i.e., red, due to slippage. This is more than was provided previously therefore meets the expectation as per the recommendation. Since the date of the previous report, an external Project Manager has been appointed to the project and the content of those reports sets out the progress against programme, explanations for deviation from programme, costs, change requests, risk register etc as would normally be expected to be reported. Further, capital highlight reports are prepared by the Capital team which reports on the key achievements to date and the key activities for the next period, key risks and actions required by the Project Steering Group.**The detail of the reporting reviewed addresses the recommendation raised, therefore it can be closed.**

	4.1	UHB submitted a bid to the Welsh Government COVID Recovery Fund on 7 September 2021, setting out the capital funding requirements for the project as follows: – A total capital requirement of £6.3m, for enabling works and equipping; – £5.928 to be expended in 2021/22, and a further £0.410m in 2022/23. The capital submission also indicated that an additional funding bid would be submitted to Welsh Government for revenue support, with the covering letter indicating the revenue needs as follows: – An initial revenue requirement of £20.522m in 2022/23, including building and operational costs; – An estimated recurring revenue requirement for annual running costs at £20.099m (primarily comprising staffing costs). The letter indicated that these were maximum costs and further work was ongoing to refine and confirm actual costs. Welsh Government approval for £5.928m capital funding was received on 23 September 2021. At the time of the audit, the funding of the recurring revenue requirement had not yet been confirmed. The UHB remained in dialogue with Welsh Government to clarify the position. It is noted that, on presentation of the long-term revenue solution to the Board in August 2021, the Chair stated that the level of recurrent revenue expenditure would not be affordable to the UHB without external support. The UHB should confirm the funding route/s for the recurring revenue requirement across the life of the modular unit, prior to any procurement commitment being made.	Agreed. Subsequent to Audit undertaking their fieldwork on this project, the Health Board received an email from Welsh Government [13 October 2021] stating that the Minister has endorsed this project and we will receive a formal letter within the next few days confirming the funding. This email has been shared with Audit.	**May 2022:** WG funding has been received. Recommend this action can be closed. Basis for closure reviewed and agreed with NWSSP colleagues.

	5.1	At the time of reporting, the Strategic Outline Case (SOC), presenting options for a permanent capital solution, was awaiting approval by the Welsh Government. The SOC also confirmed that an interim 'service bridging' revenue solution, to address immediate needs, was being developed. Following SOC submission, options for the 'service bridging' solution had been further refined with the potential for a long-term (10 years+) revenue solution, via leased modular build on the Neath Port Talbot site, being assessed. Whilst noting the 'service bridging' solution was referenced in the SOC, a longer-term revenue solution was not presented as one of the delivery options considered within the Case and as approved by the UHB Board. A paper was presented to the UHB Board in August 2021 setting out the costs associated with the long-term revenue solution, the proposed procurement approach (which may potentially include a direct award from the modular build framework) and the anticipated timeline. The paper did not however highlight the deviation from the business case requirements set out in the NHS Wales Infrastructure Investment Guidance and UHB SFIs. The paper was noted by Members, with an agreement that a case could be submitted to Welsh Government for project funding. Welsh Government has now awarded the required capital funding to support the enabling works and equipping elements of the project, from the COVID Recovery fund. However, confirmation of the recurring revenue requirement (and any associated business case requirements) remained outstanding at the time of reporting. Whilst acknowledging the Welsh Government has not (to date) provided any indication of business case requirements, the full details of the project should be presented to the Board, including the value for money provided by the preferred option, to enable an informed approval to be granted before the project progresses to the procurement stage. A paper should be submitted to the UHB Board, setting out: – Any deviation from the NHS Wales Infrastructure Investment Guidance and the UHB's SOs/SFIs in the business case / approvals route taken; and – The case for the preferred option, including the value for money provided, and assurance that procurement regulations will be applied.	Agreed. This is a unique project which has not been developed in our usual way. The project is continuing to evolve and therefore we acknowledge that our usual processes that we follow are not in place. Discussions have been held with the Project Director and it has been agreed that once further clarity is known, a paper will be prepared and submitted to the Health Board which will detail any deviation from the NHS Wales Infrastructure Investment Guidance and the UHB's SOs/SFIs in the business case / approvals route taken. Additionally, the paper will include the case for the preferred option including the value for money provided and assurance that procurement regulations will be applied.	**May 2022:** The paper was prepared by the Director of Finance and submitted to the Health Board, which detailed any deviation from the NHS Wales Infrastructure Investment Guidance and the UHB's SOs/SFIs in the business case / approval routes taken. The paper also included the preferred option and the value for money provided and assurance that procurement regulations were applied. Health Board gave approvals to proceed with this procurement approach on the 25th November 2021. Therefore, recommend this action is closed. Basis for closure reviewed and agreed with NWSSP colleagues.

	6.1	The development of a potential long-term revenue solution has progressed through the investigation of the feasibility of a number of options following the initial reference to a temporary bridging solution within the SOC. Key changes to the original proposed solution include: – Location of the modular build: from the Morriston site to the Neath Port Talbot site; – Duration of the lease arrangements: from a three year 'bridging' solution until the capital solution was developed, to a longer-term 10+ years model, which may negate the need to progress the capital investment set out in the SOC; – The number of theatres to be provided by the modular solution: from two to four; and – The preferred model of supply: from a company which would provide both the building and staffing, to a company with a supply only model, following concerns raised by UHB clinicians. It is recognised that it is normal practice to investigate the feasibility of a range of options before selecting the best fit for the UHB's needs. However, a clear audit trail has not been identified to support the directions given or decisions made during this process to date, which have influenced the development of a preferred solution. Whilst a RAID (Risks, Actions, Issues, Decisions) log had been maintained during 2020, no issues/decisions had been logged for the period January to July 2021; reflecting the period in which the above changes in project direction occurred. As part of the refreshed governance structure initiated from September 2021 onwards, a new Decisions Log has been implemented. This will be supported by the minutes of formal Steering Group meetings held going forward. The Decisions Log should be backdated to provide a clear audit trail of decision points in the direction of the revenue solution, including where formal instruction was given to pursue a particular option.	Agreed. Audit have acknowledged that there is evidence from email trails and minutes that demonstrate that issues have been escalated to the appropriate people and that decisions have been taken in suitable ways; however, this information has not been captured on a formalised decisions log. The Project Manager is to, as is reasonably possible, go through the backlog of emails / minutes relating to this project and capture the decisions and reasons as to why made.	**June 2022: Update from NWSSP A&A** A Teams channel is in place for the project with a sub-folder entitled 'Decisions'. Management has confirmed that emails etc., supporting the decisions taken are logged here to maintain the required audit trail. **Recommendation can be recorded as closed.**

	8.2	The development of the SOC was led by the Business Planning Manager (Capital Planning) and the Project Manager, with discussions held via the project Steering Group. In accordance with standard UHB practice at this stage, formal governance arrangements (including a project board) had not yet been implemented. Whilst recognising this standard approach, a TOR for the Steering Group, and minutes of discussions held, have not been identified – reducing the audit trail of the business case development and sign-off process. Whilst a number of email communications have been reviewed to support the involvement of key stakeholders (including clinicians, Finance, Capital Planning) in the development and finalisation of the SOC, specific sign-offs / agreements from these parties have not been evidenced. Noting the potential difficulties in maintaining a central audit trail when documents are retained within email systems, a central log would be beneficial to summarise the process at this project, including the issue of the various iterations of the business case and confirmation of sign off received from the key parties. A central log should be maintained of the SOC development process, recording the issue of each iteration and where final sign-offs have been received from key stakeholders; with reference to related email evidence as appropriate.	Agreed. Audit's recommendation has been noted and is deemed to be both reasonable and achievable.	**June 2022: Update from NWSSP A&A** Discussion held with the Business Planning Manager confirmed that the central log is solely for the SOC / business case development. Noting the final route of approval for this project i.e. COVID recovery fund for enabling works / equipment and revenue for the lease commitments, the requirement as per the recommendation is no longer applicable. As is referenced in MA5.1, a paper has been presented to Board which provides the required detail of the trail from initiation to conclusion (of decision). **Recommendation can be recorded as closed.**

Executive Lead – Director of Strategy				
SBU-2122-001 **Singleton Hospital Replacement Cladding 21/22** **Report Issued October 2021** **Assurance Rating Reasonable**	**Rec Ref**	**Findings & Recommendation**	**Original Response / Agreed Action**	**Update/Comment**
	4.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires up to date financial monitoring of projects. This project formed part of a joint business case together with enabling works to the car park. However, these were separately funded and contracted relating to a separate building, with associated works concluding in June 2021. Individually funded projects within a wider programme of works are typically monitored separately. The requirement at Welsh Government returns is to require outcomes to be monitored against funding approvals. However, reporting continues to include enabling works in respect of the car park. August project Board minutes reported the project as "£400k underspent, minus the £55k (car park) overspend totals £360k underspend which is the total contingency for Cladding." However, the car park continued to be integrated to reporting at the August 2021 Project report, with a joint under-spend. Exclusion of these costs would facilitate understanding the position as relating to the main façade project. Indeed car park reporting would now be static figures, and both separate and combined reporting would show both completed, ongoing and total performance. The audit was not able to reconcile the main scheme cash flow at the Welsh Government Project Progress Dashboard with supporting project cost reports (reconciliation to supporting project reports being a requirement of the Welsh Government return). Project reports should include separate reporting of the car park and main scheme, in addition to combined summary reporting.	Agreed	**June 2022: Update from NWSSP A&A** Reviewed and am comfortable with the summary reporting [reference has been made to the May 2022 PPR report]. There are separate cost reports prepared and the PM report references, only the current work noting that the car park work has concluded. The WG PPR is a consolidated report [enabling works i.e. car park and main works i.e. main façade] with the separate cost reports / funding approvals embedded within the return for information. **Recommendation can be recorded as closed.**

	5.1	NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires effective financial monitoring of projects. The project benefited from detailed cash flow reporting and forecast out-turn against budget, together with monthly monitoring of expenditure against a time profiled budget. Associated variances were discussed at the Project Board. The project was subject to ongoing assessment of the time and cost impact of expert witnessing of cladding replacement (to inform any legal claim in respect of the prior cladding). These visits had yet to be assessed and costed into the programme. The first such event caused a one-week impact to the programme. Circa 26 such events scheduled which have been estimated at £750k based on this experience. However, the approach and number of visits remain under assessment to determine if efficiencies can be derived (such as use of remote CCTV monitoring). Similarly, there were other “high risk” / likely events including stoppage due to high winds, and additional discoveries relating to the building fabric. Some of these may also escalate costs, while delay impacts may slow cash flow. The net effect on cash flow may therefore be difficult to predict. Capital Cash Resource Limits should be finalised with Welsh Government in October each year, with monies spent by the end of the financial year. Accordingly, the forward position has been subject to detailed estimation (as above). However, while Welsh Government Project Progress Dashboards highlighted project risks, they did not highlight uncertainties regarding cash flows. Cash flow reporting to both Welsh Government and internally should highlight uncertainties relating to in-year forecasts.	Agreed. A meeting was held in September with the Contractor and the Health Board to review the spend profile for the current financial year which highlighted any uncertainties relating to in year forecasts and was reported in October’s Project Board meeting. Regular financial meetings are held with WG in addition to them receiving the monthly Cash Resource Limit reports. A financial report is received at Project Board for additional assurance and scrutiny. Any anticipated cash flow variances will be highlighted (within “Notes”) at future dashboards.	**June 2022: Update from NWSSP A&A** Review of the latest PM report does not identify any further potential uncertainties that would need to be flagged. The point relating to the 'expert witness' has been included in the dashboard notes as recommended. **Recommendation can now be recorded as closed.**

	7.1	As previously noted, NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires that: “Risk Registers for each individual project/programme must be completed....and monitored,”. Key risks identified at the Project Manager’s Report corresponded with those listed at the Welsh Government Project Progress Dashboard. However, these differed from those at the Risk Register. Of only 4 "red" risks at the Risk Register, one related to the potential for the neo-natal strategy to change (e.g. due to noise, or service pressures and availability of decant areas – which were no longer available as of July 2021). However, this risk did not feature at either the Project Manager’s Report, or the Supply Chain Partner Client listings of risks. The Risk Register (version 18 - 6/9/21) also included an early warning risk in relation to car park surveys, though that project was completed in June 2021. The Project Manager’s Report also identified "quality of surveys", and the need for major structural repairs as “high” risks. However, these featured as a "low" and "medium" risk respectively at the Risk Register. Risks at the Risk Register should be regularly appraised for currency and magnitude.	Agreed. Whilst the car park is being completed, there is still Japanese knotweed external works etc which are still being undertaken. Tree planting is continuing and Japanese knotweed is an ongoing treatment regime for five years. However, all car park risks have now been removed from v19 of the Risk Register.	**June 2022: Update from NWSSP A&A** The agreed management action as per the report was that the car park related risks would be removed from the risk register. Have reviewed the latest version of the risk register and can confirm that there are no car park related risks included. **Recommendation can be recorded as closed.**
	7.2	As previously noted, NHS Wales Infrastructure Investment Guidance WHC 2018 (043) requires that: “Risk Registers for each individual project/programme must be completed....and monitored,”. Key risks identified at the Project Manager’s Report corresponded with those listed at the Welsh Government Project Progress Dashboard. However, these differed from those at the Risk Register. Of only 4 "red" risks at the Risk Register, one related to the potential for the neo-natal strategy to change (e.g. due to noise, or service pressures and availability of decant areas – which were no longer available as of July 2021). However, this risk did not feature at either the Project Manager’s Report, or the Supply Chain Partner Client listings of risks. The Risk Register (version 18 - 6/9/21) also included an early warning risk in relation to car park surveys, though that project was completed in June 2021. The Project Manager’s Report also identified "quality of surveys", and the need for major structural repairs as “high” risks. However, these featured as a "low" and "medium" risk respectively at the Risk Register. Risk reporting should accord with the current Risk Register.	Agreed. Neo natal risk is sensitive to noise & dust & lot of services running along inner façade. This was perceived as being a red .risk, but not was not covered in PM report as such as there are ongoing discussions as to how to approach this. We are currently in the process of formulating a plan as to how best to deal with it e.g. whether to fully or partial decant. However, we will look to align reporting to the Risk Register.	**June 2022: Update from NWSSP A&A** Have reviewed the relevant supporting reports (PM report/WG dashboard) and the risk register. Details of the high risks at each report reconcile. **Recommendation can be recorded as closed.**