Sunnyside Health & Wellbeing Centre
Final Internal Audit Report

August 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance

GIG CYMRU NHS WALES
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Executive Summary

Purpose

The review was undertaken to evaluate the progression and delivery of the project against the key business case objectives (i.e. time, cost and quality), and to assess the adequacy of, and operational compliance with, the Health Boards systems and procedures in place to support its successful delivery.

Overview

Key matters arising concerned:

- The project was reported as delayed by up to 8 weeks at the time of audit. This has yet to be formally assessed (or associated costs determined).
- Key contracts/ agreements require completion as a matter of priority.
- There was a need to enhance monitoring & reporting of the Health Board costs.
- The project would benefit from enhanced risk management.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance Summary

Assurance objectives		Assurance
1	Governance	Reasonable
2	Project Management	Limited
3	Tendering & appointments	Reasonable
4	Approvals	Reasonable

Note: The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion

Key Matters Arising

		Control Design or Operation	Recommendation Priority
1	Effective project governance	Design	Medium
3 - 6	Enhanced cost reporting	Operation	Medium
7 – 8	Enhanced contract monitoring	Operation	Medium
9	Delay control	Operation	Medium
10	Risk management	Operation	Medium
12	Central filing of historic documentation / decisions	Operation	Medium
14	Conclude Pharmacy & G.P. leases	Operation	Medium

1. Introduction

1.1 An Outline Business Case (OBC) for the Sunnyside Health & Wellbeing Centre was submitted to Welsh Government in October 2018 by the former Abertawe Bro Morgannwg University Health Board (ABMUHB). On 1st April 2019 the project was passed to the Cwm Taf Morgannwg University Health Board (CTMUHB) as part of the transfer of services in the Bridgend area.

In September 2020, the Health Board was awarded £10.771m of Welsh Government funding to progress the build.

The health centre is a partnership project with a developer (the current landowner) to build a health and wellbeing centre on part of a wider site proposed for sheltered housing by the developer. The contractual relationships are detailed at **Appendix D**.

The centre will house General Practitioners (G.P.s), dental, sexual health, and community clinics, and provide space for a multi-disciplinary team. It will enable GPs to move from outdated and cramped premises, and for the Health Board to dispose of three community premises that are in poor condition. Payment by the Health Board to the developer will include the value of the building, plus a land swap to include transfer and disposal of the former GP premises. At this point the Health Centre and its land will be transferred to Health Board ownership. Payments made to finance the on-going build, will be protected by a Deed of Cross Rights.

Work on the wider project commenced on site in October 2020, with the Health Centre commencing on 12th March 2021. Contract completion was originally anticipated for the 20th July 2022.

The project remains at an early stage (foundations have yet to be laid). The Health Board have incurred circa £1m to date. A significant portion of costs related to planning pre-contract (design) fees, (**Appendix D**). Only £54k related to construction, and the project remains at an early stage (foundations have yet to be laid, as per project reports to the end of June 2021).

The audit was originally deferred at the request of management, to allow the conclusion of matters such as the development agreement, tender, and planning permission.

Noting the impact of Covid 19, the delivery of this audit has included an increased element of remote working.

1.2 The key potential risk considered in the review was whether project costs/ progress had not been adequately controlled leading to failure to achieve programme/ project objectives.

2. Detailed Audit Findings

Governance: To affirm that there were appropriate accountability structures and allocation of key roles (e.g., SRO, Project Director) – including the identification and engagement of key stakeholders.

2.1 Good governance is the process of decision-making and the process by which decisions are implemented.

2.2 As noted, the project remains at an early stage (foundations have yet to be laid). It is recognised therefore that it is appropriate for governance arrangements to evolve to

reflect the project stage e.g. from greater user requirement input, to more technical oversight of construction costs and issues. Accordingly, observations relating to enhanced scrutiny are in this context.

2.2 The project benefited from a dedicated Project Board, service led Steering Group, site meetings, and routine reporting to an Executive Capital Management Group. These included terms of reference, and provided detailed contractor scrutiny, user engagement, and executive linkage. They also detailed assigned roles, including a Senior Responsible Officer chairing the Project Board, and a lead officer. The project benefitted from key finance, user and estates representation, in accordance with good practice.

2.3 However, arrangements had evolved from those specified at the January 2020 Full Business Case. At the time of the audit, revised terms of reference had been agreed for the various project groups, and the role of the Senior Responsible Officer had recently been re-allocated. There was a need to ensure that the key project roles, accountabilities, and project groups were appropriately aligned as the project transitioned from the design to the construction stage. In particular, noting the lack of detailed cost reports (**MA 3** & **5**), there was a need to ensure appropriate scrutiny of costs at Project Board level (**MA 2**).

2.4 The current project governance arrangements would therefore benefit from a Project Execution Plan (PEP) to define project scrutiny roles and responsibilities and range of contractual arrangements (see **Appendix D**). This included the need to re-focus stakeholder engagement to ensure that delivery effectively meets the specified stakeholder requirements (**MA 1**).

2.5 Noting the general alignment of governance arrangements with good practice and active review, a **reasonable** assurance is presently provided in relation to governance.

Project Management: To affirm that appropriate project management controls are in place, including risk management, cost control, project planning and performance monitoring etc.

2.6 Observations in this section are made in context of project management being managed by the developer, with the Health Board in a monitoring role i.e. to check / sample controls being applied.

Effective cost reporting

2.7 While noting the early stage of site works, the audit sought to ensure clarity in the reported cost position, with the submission and scrutiny of cost reports to relevant bodies, notably the Project Board.

2.8 The project benefitted from contractual rights to separate reporting for the Health Centre together with supporting information, as required (e.g. of project time and cost variations). Valuation reports were provided by the contractor supporting payment requests, including detailed commentary on design issues, progress on site, and provision of contractual documentation. A monthly progress report was also provided by the contractor, including accepted and proposed variations to contract. These were scrutinised by the Project Team (which included the Estates project manager, external project managers and contactor), and summaries were provided to the Project Board.

2.9 Under the Collaboration Agreement, the Health Board are entitled to separate Health Centre reporting. However, while much detail was separated, no overall Health Centre cost

summary was provided by either the contactor, or the developer's project manager. This would ensure that Health Centre costs were understood and not confused with housing costs. Proposed variations of costs were separately allocated but not totalled. There was therefore a requirement for enhanced cost presentation to provide separate Health Centre cost reporting.

2.10 The project groups were also unsighted on the various rates, provisions and allowances within the contract, and therefore, the full liabilities and cost implications of project / design changes e.g., in approving an additional charge of £63,375 for the revised heating system, it was unclear whether a £12,500 provisional sum for heating had been deducted from costs (**MA 4**).

2.11 At the time of the audit, the project was reported by the contractor as being some 8 weeks behind programme. However, Dashboard reporting to the Welsh Government showed the project as remaining on its original payment profile. Financial forecasts and cash flow profiling against budget to the Project Board were not identified. Accordingly, it was difficult to determine the Health Board cost position from existing project reporting. (**MA 3**).

2.12 While project summaries were provided at Welsh Government Dashboards, there was a need to ensure that these were consistent with the evolving project information (e.g., see ***Appendix C - Figure 1****).* Supporting project manager and cost adviser reports were not identified in support of the Welsh Government Dashboard as required (which would additionally detail non-works expenditure). Excepting the Dashboard, the only reporting identified at the project was provided by the contractor (**MA 5**).

2.13 There was also a need for costed and agreed equipment schedules to support reporting of equipment costs (a future action, noting the early phase of the project). (**MA 6**).

Contract management

2.14 The audit sought to understand the effective operation of the defined contractual arrangements to ensure delivery via third parties, and third-party management.

2.15 In accordance with the agreed contract conditions (between the Health Board and the developer), the Health Board is liable for any changes in project costs which they initiate e.g., as a result of changes in design requirements (or as otherwise reasonably arising from the contract). The Health Board should therefore have an active interest in cost control (as the informed client), though it is recognised that such scrutiny and assurance may be selective (noting active third-party management).

2.16 As a contract managed by a third party, various rights and safeguards are included to protect the interests of the client (CTMUHB). However, the Health Board has not yet fully exercised its rights to obtain copies of key documentation defined within the contract e.g. a performance bond (and terms), site inspections, and collateral warranties (which give direct contractual rights against sub-contractors in the event of contractor insolvency). (**MA 7.1**).

2.17 For both the Health Board and third-party appointed advisers, the provision of documents such as adviser activity schedules (within adviser contracts) would facilitate project monitoring e.g. to enabling activity related payments, and enhance performance monitoring based on the same. Monitoring and reporting of adviser costs against contracted sums was not evidenced. (**MAs 7.2** & **7.3**).

2.18 Similarly, noting their liabilities for cost increases, the Health Board were not in receipt of proposed cost variations to the contract in accordance with entitlements to information

detailed at the contract. It is recognised that changes to date have been minimal (**Appendix D**) (excepting the change to the heating network, which was well documented). However, it has been recommended that pending variations are notified, monitored and approved by the Health Board at future project changes (**MA 8**).

Time management

2.19 The audit also sought to examine the mechanisms by which time delivery was managed.

2.20 The project was reported as being 8 weeks behind program at the time of audit. The contactor had reported "claimable delays" (associated with 5.76 weeks of this), which had been increasing across the duration of the project. Accordingly, to avoid later dispute, it has been recommended that the Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames). (**MA 9**).

Risk management

2.21 The active management of project risks via a risk register is a key project control. As a scheme progresses, risks should generally reduce e.g., once groundworks are complete, risk of unforeseen ground conditions is removed etc. Similarly, project contingency may progressively be utilised. A key consideration therefore is the relation between the value of residual risk and residual contingency.

2.22 While a risk register was reported to the Project Board, its risks were not costed, and risks required updating to more accurately reflect current project issues. Risks reported at the Welsh Government Dashboard were also out-dated. Additional to the potential delay in the project's delivery, several key risks were not reflected within the risk register or at risk reporting e.g., confirmation of the contract (and rental) with Ashford surgery, and confirmation of pharmacy income.

There was therefore a need to actively manage and report project risks (profiling top risks to appropriate groups). There was an associated need to actively monitor and report the residual risks versus remaining contingency, informed by the quantified assessment of risks and project costs (**MAs 10.1 – 10.3**). While it was noted that this latter task now included within revised terms of reference for the Finance and Commercial project group, effective review based on current costed risks remained to be evidenced.

2.23 While noting the quantum of project control issues, including present limitations to risk and cost reporting to the Project Board for scrutiny and assurance, a **limited** assurance has presently been determined in relation to project management.

Tendering and appointments: To affirm that processes to appoint the developer and any advisers accord with local and national requirements.

2.24 The developer was the incumbent landowner (a specialist in the development of sheltered housing). As previously noted, the Outline Business Case (OBC) was submitted by the former Abertawe Bro Morgannwg University Health Board and approved by Welsh Government. This proposed an agreement with the owner to develop the land as part of a joint sheltered housing and health care development. Cwm Taf University Health Board inherited this position in April 2019 upon its formation and sought to build on the approved Outline Business Case. Much information relating to early project decisions rested with the former Health Board (ABMUHB) (e.g., in email records). It has been recommended therefore that such information, relating particularly to the choice of location and developer, are retained in a central project file for reference (**MA 12**).

2.25 The Full Business Case was based on budgets reflecting the market tendered construction price. The contracted works costs were in accordance with these tender prices as evaluated by the developer's project manager and detailed at the December 2019 tender report. The full price payable to the developer includes a land swap of existing G.P. premises (values of which have been assessed by the District Valuer, and to be confirmed on sale – as detailed at the FBC). Executive approvals therefore consisted of approval of the FBC, and Executive approval of the resultant contracts.

2.26 A Collaboration Agreement and a Deed of Cross Rights were both complete and protected the interests of the Health Board – the latter of which safeguards the Health Board's rights in the build in the event of developer failure (including the right to Open Book inspection of costs incurred). The Collaboration Agreement with the developer primarily consisted of the "*design and build*" contract with the appointed contractor - including a range of advisers (**Appendix D**).

2.27 Circa a third of adviser costs incurred by the developer were payable by the Health Board in respect of the Health Centre. Health Board rights to documentation under the contract included the right to inspect developer adviser contracts. Accordingly, to appropriately manage the contract, there was a need to obtain all relevant contractual documentation. As of June 2021, the developer's project manager advised that documentation relating to the appointment of the design team remained to be formally completed (**MA 11**).

2.28 The Health Board project manager was selected from a pre-approved framework (SCAPE), and an appropriate contract was in place. The remaining adviser appointments were below £5k (as supported by detailed ledger monitoring) with approvals according with Standing Orders and Standing Financial Instructions.

2.29 Noting the above, a **reasonable** assurance is therefore provided in respect of tendering and appointments.

Approvals: To affirm that appropriate approvals have been obtained at key junctures and that the project has progressed within these approvals.

2.29 As noted previously, the Health Board was awarded £10.771m of Welsh Government funding in September 2020, to progress the development.

2.30 The Full Business Case was signed off by the Board ahead of Welsh Government approval. This included the tendered costs (which were subsequently those contracted). The Health Board's Chief Executive Officer signed the subsequent Collaboration Agreement on this basis (i.e. the contractual agreement for construction).

2.31 UHB Management reviewed the (inherited) design with users prior to entering into formal contractual arrangements with the developer, and ongoing user engagement was evident via the project Steering Group. Subsequent changes have related to completing technical specifications, which were advised as substantially complete, but awaiting formal sign off. (**MA 13**).

2.33 The March 2021 Commissioning Group meeting noted the need to "*clarify GP's expectations*", and to reduce key project risks (notably in relation to the independently owned G.P. surgery). It has been recommended therefore that signed lease agreements are concluded with relevant parties at the earliest opportunity (**MA 14**).

2.34 As noted at **MA 10.1**, this includes the need to confirm pharmacy income (to ensure the ongoing viability of the Health Centre).

2.35 The general aspirations to improve primary care services were documented at the business case, and a time-tabled schedule for each service has since been devised for occupancy. However, specific agreements have yet to be put in place to provide target outcomes for each service (**MA 15.1**).

2.36 Deliverable outcomes at the Dashboard no longer included positive impacts on Hospitals (Accordingly, management should review and confirm the current project objectives based on only measurable outcomes (**MA 15.3**) and ensure that future business cases only included measurable aspirations (**MA 15.2**).

2.37 There was therefore robust engagement with relevant parties, and contractual approvals were in compliance with Standing Orders and Standing Financial Instructions. While noting the need for full design sign-off, and conclusion of leases, a **reasonable** assurance is presently determined in respect of approvals.

Overall Assurance Opinion

An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review. Key to this is an assessment as to whether the project remains within the parameters of time, cost and quality as ascribed at the business case.

The assurance in respect of key objectives areas are covered in detail above, and the performance against time, cost and quality are summarised as:

- Time – the project was stated as 8 weeks delayed at the time of audit. However, while the contractor has reported claimable delays, no formal claims have been made to date (within time frames required at the JCT between the construction company and the developer),. Accordingly, this has not yet been formally assessed by the developer's advisers.
- Cost – four months into the build, a change from a combined heating system with the housing development remained the only significant cost variation (**Appendix C**). Overall, noting that there may be a cost implication of the delay, there remains circa £1.2m contingency on a scheme of circa £11m (see **Appendix C**).
- Quality – The project remains set to deliver the objectives of the business case, notably to upgrade provision from cramped and dilapidated premises, enhancing the estate, and enhancing and concentrating service provision within a community hub set within social housing (this latter to enable re-focus on wellness support and early diagnostics within a local setting, rather than reactive treatments).

Accordingly, noting the positive financial position of the project (i.e. the significant contingency sums remaining), the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the review is **reasonable** assurance.

Note: Subsequent to the conclusion of the audit fieldwork, the developer's appointed contactor entered administration. It should be noted that the Health Board's contractual arrangement is solely with the developer (and therefore the requirement to re-appoint a contractor and associated advisers (if applicable) rests with the developer). Given the timing of these events (i.e., post audit fieldwork) they have not been considered within this review or the opinion. Nonetheless, there is likely to be a delay and associated cost with the appointment of a replacement contractor.

The Health Board should obtain confirmation of the various contracts/ bonds and explore the coverage of the performance bond in respect of the contractor's administration.

Whilst recognising the failure of the main contractor, the issues identified at the current review should be addressed and the associated recommendations applied, on the appointment of a new contractor and through to the project's completion.

Appendix A: Management Action Plan

Matter Arising 1: Project Execution Plan (Operation)	**Impact**
The NHS Wales Capital Investment Manual states: *"A mandatory requirement is the preparation of a Project Execution Plan (PEP) for all projects requiring NHS Executive approval" (A.6.1.1)* Management confirmed that the project does not currently benefit from a Project Execution Plan detailing terms of reference and reporting arrangements. <u>Internal governance</u> The Full Business Case outlined arrangements for effective governance of the project (**Appendix B**). However, arrangements at the project have been revised for the construction phase. General project governance was overseen by a Project Board. Its new terms of reference defined this as, reporting to both: • the Management Board; and • the Executive Capital Management Group. In turn, in accordance with best practice, the above was supported by sub-groups i.e. a: • Primary Care Contracting Group; • Construction Group; • Commissioning Group (including communications); and • Finance / Commercial Group. Each of these groups benefitted from appropriate attendance and leadership at the new terms of reference, and the revised arrangements permitted greater delineation and focus between construction v service / design issues. However, titles at the Welsh Government Dashboard differed from those at the FBC, with the Project Lead being designated Project Director, and the service lead having no assigned role.	Potential risk that: • Effective governance is not operated.

Contractual relationships
There were also a range of contractual relationships e.g., a number of advisers, some contracted to the Health Board, some to the developer (e.g., the "employer's agent"), and some to the construction company (see **Appendix D**). A substantial sum adviser costs were paid as part of "pre-contract costs" (**Appendix D**), and others were to be incurred via the various parties as the contract progresses. Noting these matters, contractual relationships could usefully be summarised at a Project Execution Plan.

Recommendations		**Priority**
1.1 Management should confirm revised governance arrangements via a Project Execution Plan including: • effective cost management; • contractual relationships, values and payment arrangements; • committee reporting of project risks; • scheduled outputs from sub-groups for scrutiny; and • stakeholder engagement.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
1.1 The Health Board will work with the external project manager to develop a Project Execution Plan to be signed off at the Project Board, this will provide a formalised single record of all of the above criteria which have been approved separately by Project Board.	30th September 2021	Head of Capital

Matter Arising 2: Project Board Scrutiny (Design)	**Impact**
The NHS Wales Capital Investment Manual identified best practice principles to be applied at capital investment projects. It identified the Project Board as the accountable body for project delivery. Minutes of the Finance & Commercial Group of May 2021 recorded the critical task to "*Complete the expenditure monitoring and reporting template.*" This group was chaired by the Head of Capital, who also acted as the project lead. However, the Project Board terms of reference did not contain specific oversight of project costs, and the Board was not in receipt of detailed cost reports (**MAs 3** & **5**). For the Project Board therefore to be the accountable body for delivery of the project, there was need for the consistent presentation of time/cost information to enable independent scrutiny. At the time of audit, a revised cost reporting template was in process of approval.	Potential risk that: • Effective governance is not operated.

Recommendations	**Priority**
2.1 Management should ensure that: • sufficient information is provided to the Project Board to enable appropriate scrutiny/ challenge; and • there is appropriate membership / representation at the Project Board to ensure effective scrutiny of project costs at the Project Board. **(D)**	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
2.1 The updated financial reporting spreadsheet will be amended to the standard project Highlight Report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	30th September 2021	Head of Capital

Matter Arising 3: Cost certainty & reporting (Operation)	**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance in its requirements for scheme reporting to the Welsh Government, states that: *"It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations."* The Collaboration Agreement gives the Health Board the right to separate reporting for the Health Centre (i.e., dis-aggregated from the combined project cost reporting of the associated Health Centre and Housing). The following was concluded from inspection of monthly contractor valuation and weekly contractor reports: • Not all items were separated for the Health Centre e.g., there was no account summary or split of provisional sum adjustments; • Cash flow – no variance commentary was provided; and • No financial forecasts were provided. At the time of audit, the project was reported by the contractor as being some 8 weeks behind programme. However, Dashboard reporting to the Welsh Government showed the project as remaining on its original payment (cashflow) profile. Project forecasts and cash flow profiling to the Project Board were not identified. Whilst the internal monitoring profiled expenditure by month, this did not monitor against the budgeted cash flow. This detailed payment and cash flow monitoring was undertaken by the project lead, but not published to project groups. Project reporting therefore lack significant elements, including: • the approved budget from the Full Business Case; • contacted sums; • expenditure to date; • forecast out-turn; and • associated variance commentary. Reporting of the time and cost position was therefore unclear.	Potential risk that: • Management are not appropriately informed. • Management are not provided with appropriate control assurances.

Recommendations		Priority
3.1 Management should ensure appropriate reporting, forecasting and management of project costs and delivery in accordance with its contractual rights and obligations, including overall project reporting of: • Full Business Case approved budget; • contacted sums; • expenditure to date; • forecast out-turn; and • associated variance commentary.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
3.1 The updated financial reporting spreadsheet will be amended to the standard project Highlight report which enables the Board to have more detail on the financial position. This will be supported in completion by regular meetings of the finance and commercial group. It will be proposed to the Senior Responsible Officer that the Capital Finance Manager will be invited to attend Project Board.	30th September 2021	Head of Capital

Matter Arising 4 : Provisional sums (Operation)	**Impact**

The contract includes the following clauses:

Clause 2.1.4:

"The Health Board will pay a fair and reasonable proportion of the proper costs of the Consultants to be agreed between the Health Board and the Developer (acting reasonably)."

Clause 2.1.6:

"The Health Board will pay other reasonable and proper general costs arising from the Health Centre works to be agreed by the Parties acting reasonably."

Given the above, provisional sums should be separately assessed as part of existing contractual obligations.

Excepting the revised heating solution, it is recognised that there have been no adjustments to provisional sums to date. However, with regard the need for future monitoring it was noted that the contract includes significant provisional sums e.g.

Item	**Cost**	**Commentary**
Dental fit out	£220,000	Provisional sum
Acoustic soundproof booths / rooms	£82,500	Provisional sum
Car charge points	£17,047	Not yet instructed
Sub-total (example provisional sums)	**£319,547**	of £386,100 total provisional sums
Distributed heating system	£12,500	A stand-alone system is now to be utilised for the Health Centre. Welsh Government review of the business case (by NWSSP: Specialist Estates Services) commented that there was need to confirm the net increase in heating costs). Management confirmed that points raised at this review remain to be fully addressed. No such responses were available to this audit.

Potential risk that:

- Management are not appropriately informed.

Preliminary costs	£649,120	No breakdown provided, to understand elements which may increase with extended time, or time (cash flow) phased charging.
Mechanical (other costs)	£150,754	Not itemised
Electrical (other costs)	£118,213	Not itemised
Total (of example inclusions)	**£1,250,134**	of £6,651,489 total construction contract price

There was need to ensure that the client was not charged for design changes where provisional sums have been made e.g., whether the additional charge of £63,375 for the revised heating system includes a reduction of £12,500 for the provisional sum for heating (as above). The Health Board should also understand the contractual relation between requests / clarifications and resultant adjustments in provisional sums.

While Health Board monitoring of provisional sums was identified, this did not include the car charge points, or break-down of other sums identified in the table above.

Recommendations	**Priority**
4.1 Management should ensure that individual cost provisions within the works information are reported to understand charges and adjustments to provisional sums.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
4.1 The updated reporting template includes a section detailing provisional sums and contingencies and tracks through the release of provisional sums into actual costs, as well as all contingency items, these will be reported monthly to Project Board as part of the financial template. However there will need to be a further tender and revised provisional sums with the letting of a contract for completion therefore an extended target date is provided to ensure the most up to date information is captured	31st March 2022	Senior Project Manager

Matter Arising 5 : Welsh Government Dashboard (Operation)		**Impact**
NHS Wales Infrastructure Investment Guidance 2018 (043) details: *"To inform the Welsh Government of progress on NHS infrastructure investment projects, all schemes receiving funding are required to report on a monthly basis. Project reports are required to be submitted … each month to the respective Capital Development Manager and the Deputy Head of Capital, Estates and Facilities. It is important for organisations to ensure that these reconcile to the schedules included within the monthly Financial Monitoring Returns".* Project manager and cost adviser reports were not provided in support of the Welsh Government Dashboard as required.		Potential risk that: • Welsh Government are not appropriately informed.
Recommendations		**Priority**
5.1 Management should ensure provision of project manager and cost adviser reports, in support of the Welsh Government Dashboard return.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
5.1 These will be included as required as soon as the project recommences, and a new contractor is appointed. This is likely to take at least a further 3-4 months hence the longer target date.	31st January 2022	Senior Project Manager

Matter Arising 6 : Equipment costs (Operation)		**Impact**
Welsh Health Circular 2018 (043) - NHS Wales Infrastructure Investment Guidance requirements for scheme reporting to the Welsh Government, states that: *"It is essential that organisations ensure that the information from Supply Chain Partners is up to date and contains realistic forecasts in terms of completed works and valuations."* Regarding Health Board supplied equipment, as of April 2021 the Commissioning Group stated: "*leads to agree equipment schedule*". Equipment transfer lists were also required. However, this is recognised as a future action, noting the early phase of the project.		Potential risk that: • Costs are not appropriately controlled.
Recommendations		**Priority**
Future 6.1 Management should confirm agreed and costed equipping schedules (net of transfers) for inclusion within cost reporting.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
6.1 Room data sheets and equipment schedules have been drawn up and are in the process of being analysed for transfer and new purchase.	30th November 2021	Senior Project Manager

Matter Arising 7 : Contract Monitoring (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) states: *"After selection of the appropriate Advisors, Designers and Contractor (if applicable), the LHB or Trust should submit a schedule of their funding requirement …. It should include the priced activity schedules submitted by each successful organisation."* Each party should therefore submit a payment schedule against which payments and activities should be monitored. Both the developer and Health Board Project Manager submitted activity schedules. In support of its contract for £98,000, the Health Board Project Manager schedule included the following:	Potential risk that: • Parties are not appropriately monitored. • Payments are made in excess of duties performed

Item	**Hours**	**Cost**
Attend RIBA Stage 4 Design meetings	48	£4,179
Prepare Project Execution Plan (not provided)	24	£2,089
Attend RIBA Stage 5 Design meetings	110	£9,576
Attend RIBA Stage 5 Progress Meetings & Attend Site to Review Progress	120	£10,447
Attend RIBA Stage 5 Project Delivery Group Meetings	160	£13,929

It was noted that a Project Execution Plan had not been produced, and payment monitoring against activity schedules was not evidenced.

<u>Performance monitoring of the developer and developer advisers</u>

It is recognised that any monitoring undertaken by the Health Board in relation to developer advisers is in the context of project management being managed by the developer, with the Health Board in a monitoring role.

The application of key performance indicators provides an effective tool to manage internal and external resources. Key Performance Indicators to monitor performance were not being applied at the contract.

In the case of the developer, examination of the tender sum breakdown showed a £36,000 charge for a Performance Bond. There were also specific required actions, such as satisfying planning conditions and providing collateral warranties (due within 20 days of award of a sub-contract – Clause 220 – none supplied to date). These give direct rights to the Health Board against sub-contractors.

For advisers contracted to the developer, the Health Board is liable to pay circa 30% of their fees (via developer charges). Extensions of time for the Health Centre, or additional works may therefore give rise to additional fee and should similarly be monitored. While the Full Business Case provides for a directly contracted site Supervisor / Clerk of Works, such role had been vested solely in the developer. However, the Collaboration Agreement provides for client site inspection as required. No such site inspections had been reported to the Health Board. Accordingly, the Health Board have been unsighted as to the performance or thoroughness of on-site records which should record the quality of the completed work and on-site activities (for which they were being charged). These can also be key records in the event of dispute e.g., contractor delay claims v activities on site. There was therefore scope to enhance project management and assurances by additional monitoring of third parties.	

Recommendations	Priority
7.1 Management should obtain documentation to which the client is entitled under the contract, including collateral warranties, and a copy of the construction performance bond, and confirm assurances provided at the latter.	**Medium**
7.2 Payments for both the Health Board's and the developer's adviser activities should be monitored against contracted activity schedules.	**Low**
7.3 Performance of relevant parties should be monitored appropriately.	**Low**

Agreed Management Action	Target Date	Responsible Officer
7.1 These are available and will be supplied by the developer.	30th September 2021	Senior Project Manager
7.2 Schedules are in place and will continue to be monitored at every payment application date.	30th September 2021	Senior Project Manager
7.3 As above although there will be a delay with the appointment of a new contractor.	30th September 2021	Senior Project Manager

Matter Arising 8 : Change control (Operation)	**Impact**
The Collaboration Agreement states that: • a Proposal Cost must be provided within 2 days (3.9.5), outlining the costs to raise a costed Change Request (to be compiled over a maximum of 9 business days); • within 4 days of the Proposal Cost the employer then either instructs to undertake the works, or decides not to progress; • the contractor then within 9 business days, or 19 working days if less than £50,000, upon receipt of the employer's instruction should prepare a change quotation; • the Employer has 20 days to accept the Change Request as costed; • within 10 days into the 20, the Employer may withdraw the request at no cost, or instruct extension of the 20-day time frame, or instruct to proceed; and There were therefore specified time frames within which costs should be appraised and approved. Certain works can also be instructed using "*daywork*" rates (typically for small or urgent works). These may be less economic than assessing an overall sum for a project change. Accordingly, under clause 450 of the Collaboration Agreement, their use should be pre-authorised by the Employers Agent. As previously noted, the contract also includes Clause 2.1.6: *"The Health Board will pay other reasonable and proper general costs arising from the Health Centre works to be agreed by the Parties acting reasonably."* The Health Board are therefore liable for any changes in project costs which they initiate e.g., as a result of changes in design requirements. They should therefore have an active interest (as an informed client), in being informed of, and approving such changes. There have been £171,073 of agreed and pending changes to date (**Appendix C**). However, while these were listed at reports by the contractor, supporting detail was not provided to the Health Board.	Potential risk that: • Contract changes are not appropriately controlled. • Undue time and cost increases are incurred.
Recommendations	**Priority**

Future assurance 8.1 Management should be provided with proposed contact variations and monitoring to facilitate timely Health Board scrutiny, in accordance with entitlements under the contract.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
8.1 This will be provided when the project restarts and all design works are completed.	At future project changes.	Senior Project Manager

Matter Arising 9 : Delay (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the need to monitor "*time, cost and quality*". Delay is separately ascribed to the health centre and housing development via a narrative at the monthly project reports. However, this was not separated at the project summaries provided. The following observations relate only to the health centre. Minutes of the March 2021 site progress meeting stated that the contractor "*are not currently reporting a delay to programme in their report*" but "*it was noted that they are circa 4 weeks behind in their programme*". It also referenced *"claimable"*, weather delays of up to 6 weeks (supported by a separate delay entitlement tracker listing 5.76 weeks *"claimable delay")*. The April 2021 contractor report identified "*potentially*" a 6 week delay due to steel supply. The June 2021 Project Manager report noted that "*the contractor is 8 weeks behind programme* (including steel delay) *but it still looking to maintain the critical path. The contractor stated there are future opportunities to draw this delay back and at this time are not advising on a delay to the Practical Completion date*". It also advised that "*the disruption caused to the overall design programme by involving the contractor in the process of developing an alternative proposal to the Health Centre design could give rise to a claim"*. Health Board management commented that no claims for "Extension of Time" have been received, and no such delay awarded. While there may be aspirations to recover time, there appears to be progressive slippage, and associated increase in the potential liability to incur and fund delays (also noting the early stage of construction works). The contract requires that *"if and whenever it becomes reasonably apparent that the progress of the Works or any Section is being or is likely to be delayed"* the Contractor *"shall as soon as possible, and in any event within 28 days"* give notice of a delay (*Clause 2.24.1*). The contractor has variously referenced "claimable delay" and "potentially claimable delay" within project reporting. However, no formal notice of delays as defined within the JCT contract provisions (e.g., detailing the impact on time and cost and associated contributing events etc.), have been submitted by the main contractor.	Potential risk of: • Late cost increases and delay

Accordingly, to avoid later potential disputes, it has been recommended that the Health Board require the developer to remind the contractor of its contractual obligations in respect of the timely notification and impact of delays.		
Recommendations		**Priority**
9.1 The Health Board require the developer to remind the contractor of its contractual obligations to formally notify of any delays (and their associated time/cost impact within the contractual time frames).		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
9.1 With the original contractor there was confidence that much of the time could be recovered and therefore no formal application had been made. Clearly with the current contractor going into administration there will need to be a new contractor appointment. The Health Board will ensure that the need for a contractual. notification of future delays is communicated to the new contractor.	31st March 2022 (subject to timeline for appointment of new contractor)	Senior Project Manager

Matter Arising 10 : Risk Management (Operation)	**Impact**
Welsh Government guidance on completing project Dashboards, WHC 2021 (011), requires a: "*summary of all potential risks & opportunities that may affect the forecast outturn*." NHS Wales Infrastructure Investment Guidance WHC 2018 (043) more generally states: "*Risk registers for each individual project/programme must be completed, shared and monitored, with reference ..to time, cost and quality*". The risk register is intended to act as a key project management tool. Risks should progressively be managed down as the project progresses, and contingency is utilised to address issues i.e., enabling comparison of residual risk with residual contingency. The responsibility for the same rests with the Finance and Commercial project group, as defined within its agreed terms of reference. A risk register was included within the Full Business Case, compiled in January 2020. An updated risk register (dated April 2021) was presented to the May 2021 Project Board but did not include costs. While valuation of residual risk and contingency were not reported, this requirement was recorded as an action at that meeting. The following current project risks were not reflected within the risk register or in risk reporting: • confirmation of the contract (and rental) with Ashford (privately owned) surgery; • confirmation of pharmacy income; • technical design changes / NHS regulatory compliance (RIBA Stages 4 & 5); • Update of room data sheets / equipment; • Covid-19; and • land swap / sales shortfall. While the top five risks to the project were reported at the Welsh Government Dashboard, these were out-dated, and still included delay to Welsh Government funding (received in September 2020).	Potential risk that: • risks are not appropriately assessed and managed.

Recommendations		Priority
10.1 A costed risk register should be regularly maintained and reported to facilitate monitoring of the build.		**Medium**
10.2 Management should actively monitor and report the value of residual construction cost risks v remaining contingency.		**Medium**
10.3 Risks reported at the Welsh Government Dashboard should be reflective of current project reporting.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
10.1 A fully costed capital risk register is in existence and will continue to be kept up to date as risks are realised or not throughout the project, however this will be revisited with decision on process for and appointment of a new contractor.	31st November 2021	Head of Capital
10.2 This is picked up in the appendix to the standard Highlight Report discussed in action 2.	30th September 2021	Head of Capital
10.3 The project Dashboard will be updated in line with the Project Board reporting – target date in line with reporting dates for the Welsh Government Project Progress (Dashboard) Returns.	17 October 2021	Senior Project Manager

Matter Arising 11 : Contracts (Operation)	**Impact**
The Collaboration Agreement states that: *"The Health Board accepts full responsibility for all design and specification of the Health Centre Works as contained in or referred to in the Health Board requirements (as if it were its own)"* including *"extension of time or additional loss and expense in accordance with the terms and conditions of the building contract". (3.1)* It also includes clause 2.1.4: *"The Health Board will pay a fair and reasonable proportion of the proper costs of the Consultants to be agreed between the Health Board and the Developer (acting reasonably)."* It also gives the Health Board the right to obtain a certified copy of all contracts. Copies of both the signed Deed of Cross Rights (including Welsh Government rights) and Collaboration Agreement (development agreement) were available. The contract for Project Management advice direct to the Health Board was also completed (in December 2020). However, adviser contracts were unavailable for advisers contracted to the developer, to facilitate understanding of the ongoing rights and obligations of the parties. As of June 2021, the developer's project manager also stated that the design team contract remained to be completed (though it is noted that this is a third party agreement and the developer's risk).	Potential risk that: • Contractual liabilities are not appropriately minimised.
Recommendations	**Priority**
11.1 The Health Board should obtain engrossed and signed copies of all relevant developer adviser contracts in accordance with entitlements to inform of potential liabilities and costs, and report relevant implications to appropriate groups/committees.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

11.1 This cannot be fully achieved without the appointment of a new contractor. The Health Board will ensure that all contracts have been received and filed centrally. The new contractor contract will be provided by the developer on signature.	30th September 2021	Project Leader

Matter Arising 12 : Central filing (Operation)		**Impact**
Welsh Government Infrastructure Investment guidance WHC 2021 (011) states that: *"It is considered good practice to publish key project documentation at each stage of approval to ensure a full and final record of the decisions taken by Local Health Boards and NHS Trusts."* Documentation relation to decisions taken in respect of land and developer options rest with the former (ABMUHB) Health Board and informed the Strategic Outline Business Case. While not forming part of the scrutiny of this audit, it is important that such documentation is obtained to retain a full historic record.		Potential risk that: • The Health Board cannot justify decisions taken.
Recommendations		**Priority**
12.1 The Health Board should obtain and retain all historic documentation within a central repository in the event of any future challenge or contractual disputes.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
12.1 All electronic documentation is filed in a central shared file. All papers will be moved to a single central location accessible by all Health Board project officers.	30th September 2021	Senior Project Manager

Matter Arising 13 : Design sign-off (Operation)	**Impact**
The NHS Capital Investment Manual (best practice) identifies the best practice of "*users to finalise and sign off their requirements*" including "room data sheets" in order to reduce the potential for project changes. The design was inherited from Abertawe Bro Morgannwg University Health Board and reviewed with users for suitability. The Steering Group (operated by CTMUHB to date) had additionally engaged heads of service (e.g., Audiology, Dental etc). While the design was therefore reviewed / refreshed, as fit for purpose by the Health Board, it was at an outline level of design (Royal Institute of British Architects – RIBA – Stage 3). Full Business Cases (FBC) are generally required to be at RIBA Stage 4 (technical design) (RIBA Stage 5 detailing the particular requirements at the construction stage), and both the design and room data sheets would be signed off by users to freeze the design. It is usual at the construction stage for a firm cost to be provided including a risk provision for the precise procurement cost of technical items, or other uncertainties. Welsh Government feedback on the business case (FBC) noted that many such aspects, should be included within an Estates Annex, which was not provided in this case. The developer bid on the basis of the outline design, making appropriate cost provisions to cover uncertainties. There is therefore risk of cost increase if a finalised design cannot be assured. A design at such a level did not include "*fit*" of contents, and specific mechanical and electrical items. The Welsh Government Dashboard to March 2021 confirmed that technical design compliance with NHS Wales technical and service standards has been concluded. Since the original review, no significant user changes have been made. Management confirmed therefore that since that date, that the design was progressed only in respect of mechanical and electrical detail, which has also been concluded in respect of all major items. However, documentation and reporting in relation to this was not provided to audit. While the design has been reviewed for functional requirement, there remained a level of detail to be agreed regarding the technical solution e.g. number and location of electrical outlets; IT provision etc. While not the originators of such changes, the users have an interest in such technical provisions being made. The design was therefore substantially complete, but formal sign off awaited full specification of technical provisions.	Potential risk that: • Design changes increase out-turn cost. • The design does not meet the needs of users. • Delivery is delayed
Recommendations	**Priority**

13.1 Management should instigate a process for formal review and sign-off of any further design changes with relevant parties.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
13.1 The Health Board already has in places processes for sign off of design by users and this process will be used in this scheme moving forward (also to be detailed in the Project Execution Plan).	30th November 2021	Senior Project Manager

Matter Arising 14 : Lease agreements (Operation)	**Impact**
As noted at Welsh Government scrutiny of the business case, the various lease agreements with service users, notably the General Practitioners (GPs) remain outstanding. Change in circumstances, especially for the independently owned G.P., sales value, the type and volume of services to be provided can all play a part in desire to commit to a forward lease. It is important therefore that leases with the various parties are signed as soon as possible. The Commissioning Group held in March 2021 stated that there remained a need to "*clarify GP's expectations*". The May 2021 issue log further noted the need to: "*Clarify how the building is to be managed, who will manage the building and what the anticipated costs will be for the GP practice tenant*".	Potential risk that: • The project is un-viable. • The objectives of the business case are not delivered.

Recommendations	**Priority**
14.1 Management should obtain signed lease agreements with relevant parties at the earliest opportunity.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**
14.1 The Primary Care lead will continue to work with NWSSP Specialist Estates Services to ensure that the lease is signed off as soon as possible.	31st January 2022	Primary Care Estates and Development Manager

Matter Arising 15 : Service Model (Operation)	**Impact**
NHS Wales Infrastructure Investment Guidance WHC 2018 (043) outlines the "*requirement*" for the service delivery model to be supported. The need for "*measurable*" benefits was stated at both the Full Business Case, and the Welsh Government Dashboard. While the business case outlined the social housing aspect within the wider scheme, the Health Board will not allocate tenants, and commits only to benefits isolated to primary care (rather than any hospital impacts). While a sessional timetable had been devised, the audit did not evidence room occupancy information including the level of administrative space / peripatetic use. While general efficiencies were anticipated from combining four G.P. practices, specific efficiencies such as joint reception staff / back-office functions have not been outlined. The six top benefits were outlined at the Welsh Government Dashboard return together with means of measurement. However, these contain no reference to the potential positive impact on hospital admissions. Targets at the Full Business (Appendix H) included: *"Reduced unnecessary attendance, referrals or admissions to hospital".* However, project goals did not include an increase in hospital bed turnover. Similarly, it did not include increased hospital discharges into a supported community setting. In discussion with management, the audit was informed that these objectives were not deemed measurable (i.e., would not be capable of attribution to such a single cause). The Dashboard also indicates only overall improvements in overall delivery of Primary Care services, rather than service specific targets (e.g., for Mental Health access or provision).	Potential risk that: • The service model is not agreed. • Service efficiencies are not optimised. • Post occupancy changes result in sub-optimal outcomes and post project costs.
Recommendations	**Priority**
15.1 Management should confirm an agreed service model with measurable outcomes for front line and support services.	**Medium**

Future 15.2 Objectives at the business case should be measurable.	**Medium**
15.3 Management should review and confirm project objectives based on only measurable outcomes within a Benefits Realisation Plan.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
15.1 The Bridgend Integrated Locality Group (ILG) will link with the Primary Care team over the service model and support functions. This will be developed during the construction period for the site and given that the completion is likely to slip to late 2/23 the target is to complete in order that any financial consequences are picked up in Integrated Medium Term Plan (IMTP) planning cycles.	31st March 2022	Bridgend ILG Community Lead
15.2 The approved business case contained a Benefits Realisation Plan. This will be reviewed to ensure that the benefits are measurable and deliverable.	31st January 2022	Head of Capital as lead for the ILG and Primary care teams
15.3 Please see response above .	31st January 2022	Head of Capital as lead for the ILG and Primary care teams

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that that the project achieves its key delivery objectives and that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

Appendix C: Project Cost development & summary

Cost development

The project was co-ordinated with a developer, via Welsh Government funding. The design was at an outline level of detail rather than full design (the implications of which were assessed in the audit). Construction was tendered by the developer, rather than being delivered via the NHS national construction framework (Designed for Life: Building for Wales) as is generally mandated for NHS construction. Tendering for a construction contractor was undertaken in December 2019 and contracted as below ***Figure 1***.

Non-construction costs were developed from budgets as estimated in the Outline Business Case (OBC). These were increased to recognise changes in heat provision (£142k), land valuations, a client Project Manager, extended program, design finalisation, and leased parking costs at the leisure centre. Equipment and planning contingency were also revised to be based on more robust estimates. Costs were further adjusted to include £1.254m of Optimism Bias (a sum not permitted under framework rules, but included to cater for the level of development risk within the outline design).

Cost Summary

Figure 1 *(Audit analysis – agreed with the Health Board)*

The Health Board is to pay the developer:	**Per Contract**	**Per Contract**	**WG Dashboard**	**WG Dashboard**
Health Centre construction	£6,651,489		£6,651,489	
Additional heating works allowance			£142,157*	
Compliance provision requested by WG			£137,500*	
Pre-contract (consultant) costs	£235,499			
Design changes (as of 15/12/20)	£53,420			
Planning	£169,373			
Consultants (contracted to developer)	£0	£7,109,781		£6,931,146
Plus: VAT at 20%		£1,330,298		£1,386,229
		£8,440,079		£8,317,375

Plus non-developer contracted costs:

(from FBC – *above – net of VAT*)	**Per Contracts**		**WG Dashboard**	**WG Dashboard**
Internally contracted fees (£582,245 - £235,499)	£346,746		£582,244	
Non works (less planning *above £367,035 net - £169,373*)	£197,662		£367,035	
Equipping	£353,270		£353,270	
Planning contingency	£882,166		£882,166	
	£1,779,844		£2,184,715	
Plus VAT	£286,619		£269,233	
Total		£2,066,463		£2,453,948
Total costs		£10,506,452		£10,771,323

Funding			
Welsh Government funding	£10,771,000		£10,771,000
Difference	£264,548		-£323

* Allowances made by the Health Board

As of June 2021, there were £169,189 of agreed variations and £1,884 pending variations (relating to temporary hoarding signage).

Variations to date included:

Revised heating solution	£65,375
Mechanical & Electrical NHS compliance changes	£76,744
Associated derogations required from standard guidance	£25,750
Amended fees	£1,320
Total agreed variations to June 2021	£169,189

Audit Cost Conclusions

Funding surplus			£264,548
Planning contingency			£882,000
Currently available contingency			£1,146,548
Internal fee budget		£346,746	
Less:			
Project Manager	-£98,000		
M&E Adviser (circa)	-£5,000		
Supervisor provision	-£25,000		
		-£128,000	
Forecast surplus internal fees			£218,746
			£1,365,294
Less: agreed and pending variations (£169,189 + £1,884)			-£171,073
Total available contingency (based on above)			£1,194,221

Less any additional sums to be spent on equipment etc.

Less additional fees due to the employer's agent / other parties

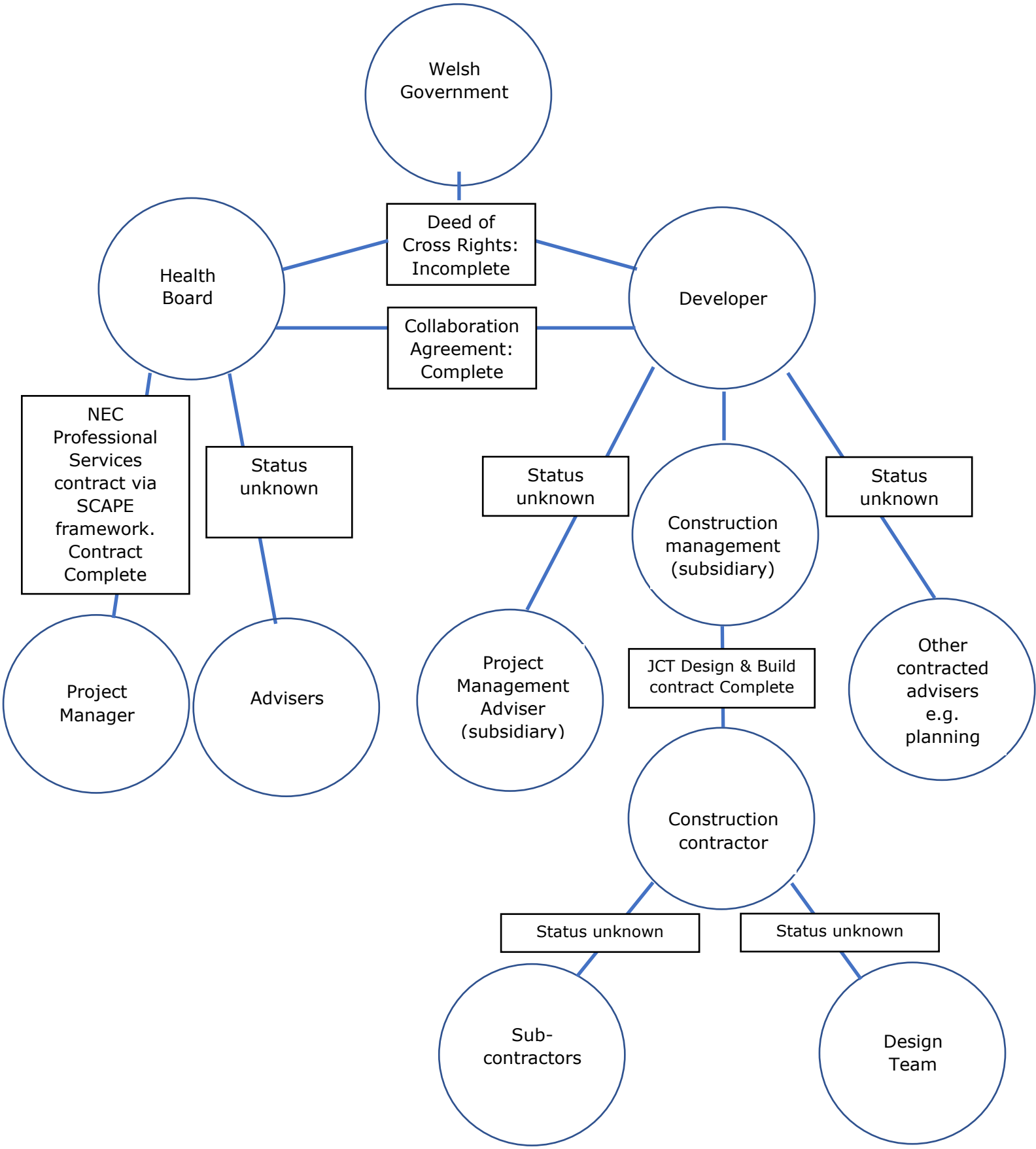
The Health Board have similarly estimated that over £1m of the contingency will remain unspent.

Conclusion – the project presently has adequate contingency & is expected to remain within agreed cost parameters based on current arrangements.

At the time of audit, the development was under construction (contracted duration 12/3/21 – 15/7/22).

Noting the inclusion of Optimism Bias of £1.254m within funding, and the margin between contractually committed costs and funding, there would therefore appear considerable margin for confidence in delivery within budget.

Appendix D: Contractual relationships



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