

Bundle BCU Audit Committee 17 February 2026

AC26.14 Internal Audit Progress report - supporting papers for reference

AC26.14c BCU 2526 07 Final Internal Audit Report Value and Sustainability

AC26.14d BCU-2526-22 Final Internal Audit Report - Primary Care CAF

AC26.14e BCU-2526-31 Final Internal Audit Report - Estates and Facilities Alerts

Value and Sustainability – Delivering Quality Improvements

Internal Audit Report 2025/26

Betsi Cadwaladr University Health Board



Limited Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2526-07

June - September 2025

29 January 2026

17 February 2026

Russell Caldicott, Executive Director of Finance

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Executive Summary

Purpose

To review the effectiveness of established processes and governance arrangements to support the Value and Sustainability approach to savings identification, reporting, monitoring, and delivery.

Overview

The Health Board has established robust systems and controls to monitor and report the delivery of financial cost savings, reporting positive progress in delivering its savings requirement as it strives to achieve a forecast balanced year-end financial position.

However, there is no formal process in place to track and manage the non-financial factors / benefits (i.e. quality, patient outcomes, efficiency, access, patient/staff experience etc) of implementing and delivering the Value and Sustainability saving schemes in line with a key delivery priority stated in the Integrated Medium Term Plan (IMTP) 2025-28 – 2E.1 that states '*Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.*'

We recognise the process followed for recording the savings is compliant with Welsh Government reporting requirements.

We have concluded limited assurance on this area. The matters requiring management attention include:

- The Health Board’s Guidance for Savings 2025-26 provides comprehensive support for the finance and costs aspect of savings applications and reporting, however, does not reference non-financial, wider value and sustainability measures.
- There is no provision in the Savings Submission Document (SSD) to record or evaluate the impact of implementation on non-financial factors.
- We reviewed a sample of twenty-two (22) approved SSDs and found that the quality and comprehensiveness of Supporting Financial Analysis was not consistent across schemes. For six (6) schemes reviewed we were unable to confirm how the savings had been determined or whether costings were robust from the information / data supporting the SSDs.
- We found two (2) instances whereby the reported actual savings delivered did not reconcile to the supporting backing documentation.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	Robust process and governance arrangements are in place to manage and support implementation / delivery of the Value and Sustainability workstreams. All approved initiatives adhere to the principles of Value and Sustainability with a clear focus on improving quality and outcomes.	1	Limited
2	There is evidence to demonstrate that approved initiatives are progressing and delivering the purported savings and quality improvements – this will include the implementation and delivery of Value and Sustainability initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board.	2, 3	Limited

Management Actions



High Priority



Medium Priority

Themes



■ Finance Management & Control

Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Robust process and governance arrangements are in place to manage and support implementation / delivery of the Value and Sustainability workstreams. All approved initiatives adhere to the principles of Value and Sustainability with a clear focus on improving quality and outcomes.

Limited

The Health Board is utilising the Value and Sustainability approach to deliver its savings target of £40m for the 2025/26 financial year. Consistent with the national approach, the Health Board have developed transactional and transformational schemes aligned to the five workstreams / thematic areas agreed by the national Value and Sustainability Board.

We acknowledge that Value Based Health Care was incorporated as a sixth workstream during the time of review, however we have focused solely on the processes and arrangements supporting delivery of the five established workstreams, consistent with the Health Board Integrated Medium Term Plan 2025-28 and approved review brief. The five workstreams are:

- Workforce.
- Medicines Management.
- Continuing Health Care (CHC) / Funded Nursing Care (FNC).
- Procurement and non-pay, and
- Clinical Variation / Service Configuration.

To support operational processes and ensure consistency across workstreams, the Health Board has established formal processes supported by relevant guidance for staff. We confirmed that the guidance document outlines the requirements, expectations, application criteria, reporting requirements, and provides access to relevant supporting documentation. All saving scheme applications must be fully documented, assigned a senior responsible officer, and submitted formally via a standard Savings Submission Document (SSD). Submitted SSDs are reviewed, verified, and approved prior to inclusion in the Health Board savings plan. Following approval, the saving schemes are added to a centrally managed and controlled tracker which is updated monthly and used to support monitoring and reporting purposes. Whilst robust, we noted that the established processes and controls focus solely on the financial cost saving aspect of implementation / delivery of the Value and Sustainability schemes.

Governance, oversight and scrutiny comprise of the following arrangements. Each workstream has a dedicated local and national Value and Sustainability Project Board which report to a local and national Value and Sustainability Programme Board. The Health Board’s Value and Sustainability Programme Board is accountable to the Integrated Performance Executive Delivery Group (IPEDG) and is required to provide updates to the Health Board Performance, Finance, and Information Governance (PFIG) Committee on request. Delivery performance is reported monthly to Welsh Government as part of the Health Board’s Monitoring Return, and savings are routinely reported to the Performance, Finance and Information Governance (PFIG) Committee. We were advised that savings delivery is also monitored and discussed at the weekly Finance meeting and the monthly CFO meetings but have not corroborated this assertion. Value and Sustainability is also one of four BCU Major Change Programmes and is embedded into the Integrated Medium Term Plan 2025-28 (2E: Developing and delivering Value and Sustainability).

Key Findings		Risk & Impact	Agreed Management Action
1	Value and Sustainability		Agreed Action:

The Health Board Guidance for Savings 2025-26 provides comprehensive support for the finance and costs aspect of savings applications and reporting, however, does not reference non-financial, wider value and sustainability factors. Furthermore, there is no provision in the Savings Submission Document (SSD) to record or evaluate the impact of implementation on non-financial measures such as quality and outcomes.

Whilst we recognise there is no formal national policy/guide outlining specific requirements regarding the inclusion and consideration of non-financial factors in the development, implementation, and reporting of Value and Sustainability saving plans, the principle that Value and Sustainability is broader than financial cost savings is outlined in the Health Board Integrated Medium-Term Plan 2025-28 2E.1 that states *'Design and deliver a refreshed value and sustainability programme for 2025/26, which has clear outcomes based on broader measures of value, to deliver qualitative, performance and financial improvement.'*

We confirmed that work has commenced on developing the monitoring and reporting of Value and Sustainability schemes to provide oversight of delivery against a wide portfolio of benefits and quality measures. A draft Value Benefits Realisation framework has been developed which includes defined benefits, measurement methods, and example metrics; a Value and Sustainability Deep Dive was presented to the IPEDG which included completed benefits framework for three of the five workstreams; and provision to record non-financial benefits has been added to the monthly Highlight Report.

However, the work was ongoing at the time of review, and we were unable to confirm the extent to which current Value and Sustainability saving schemes were underpinned by improvements in quality and outcomes.

Failure to consider non-financial benefits / costs.

Adverse impact on quality and patient outcomes.

1.0 Combine Clinical Variation & Value-Based Health Care into a merged workstream which will act as the primary driver for quality-led clinical improvement initiatives within the V&S framework. This newly formed workstream will be operational in Q4 (with priority areas of focus agreed by end Feb-26).

1.1 A comprehensive 'Value' benefits framework is already in development based on the HFMA value definition: Outcomes + Experience / Cost (developed in conjunction with BCU's Benefits Lead). This will provide a more holistic (quality) view of programme delivery, over and above savings. The final version will be presented for ratification at Programme Board Feb-26. Any future initiatives will be prioritised against this wider framework.

1.2 Work has commenced with the PMO to refine and utilise the Portal as the vehicle to capture and report benefits realisation for 'non-transactional' value schemes that deliver against multiple metrics of value. This will sit alongside the existing national monitoring return, which focuses exclusively on cost savings. This will be completed by end of March-26 and be operational for delivery against our agreed programme of work for 26-27

1.3 Programme reporting (particularly highlight reports and reports into IPEDG and PFIG) will cover the wider set of value metrics included in the benefits framework. This will be in place for end of March-26 and will provide greater assurance around the quality outcomes of the V&S programme for 26-27.

Expected Evidence of Implementation:

- Non-financial benefits and quality measures are defined / quantified at the outset and are key considerations in the approval of V&S saving schemes.
- Robust benefits realisation process in place to monitor and track delivery and impact of implementation.

High Priority

Officer: Programme Director for Value & Sustainability

Target Implementation Date: 31st of March 2026

Theme: Finance Management & Control

Control Design

Objective 2: There is evidence to demonstrate that approved initiatives are progressing and delivering the purported savings and quality improvements – this will include the implementation and delivery of Value and Sustainability initiatives identified internally, by other Health Boards, or through the national Value and Sustainability Board.

Limited

Savings data is managed via a centrally controlled tracker document. The tracker is updated monthly with actual achieved savings data, and forecasts are revised as necessary. Saving schemes are Red/Amber/Green (RAG) rated based on the progress of submissions, with fully developed and approved schemes assigned a “Green” RAG rating and included in monthly reporting updates. At the outset of this review the Health Board had two hundred and twenty-five (225) “Green” RAG rated saving schemes (based on Month 3 tracker), from which we chose a sample of twenty-two (10%) schemes for review. The sample was primarily based on the highest value schemes from each area, and comprised a total planned in-year savings value of £10.7m (£11m full year effect).

We confirmed that each of the twenty-two schemes in our review sample was supported by an approved Savings Submission Document (SSD) per the guidance, and that the planned savings had been recorded accurately on the tracker. In each instance the SSD had been completed and approved appropriately including the Financials and Supporting Financial Analysis sheets. However, we noted that the level of detail included in the Supporting Financial Analysis sheets was variable – in several instances we were unable to confirm how the savings had been determined, or whether the identified savings /costings were robust.

At Month 6 (September 2025) our sample schemes had delivered a reported £5.8m savings against a planned target of £4.6m. Evidence/backing documentation was provided for seventeen (17) of the twenty-two (22) sample schemes – we reconciled these to the actual savings achieved data recorded on the tracker. The total savings verified was £5.3m (17/22 sample schemes).

In addition to monitoring delivery, the tracker is also used to support reporting requirements. Savings performance is routinely reported to the Performance, Finance and Information Governance (PFIG) Committee via the Health Board Finance Report. We reviewed the Finance Report (Month 6) presented at the October 2025 PFIG and were able to reconcile the reported savings to the tracker data.






Key Findings	Risk & Impact	Agreed Management Action
<p>2 Saving Submission Documents</p> <p>We reviewed the approved Saving Submission Documents (SSDs) for each of the 22 saving schemes in our review sample and noted that the quality and comprehensiveness of Supporting Financial Analysis was not consistent across schemes.</p> <p>For 6/22 schemes reviewed we were unable to confirm how the savings had been determined or whether costings were robust from the information / data supporting the SSDs.</p>	<p>Lack of transparency.</p> <p>Failure to comply with Guidance requirements.</p>	<p>Agreed Action:</p> <p>2.1 Reinstatement of the submission deadline to ensure that all SSDs are submitted with sufficient time to fully evaluate the supporting documentation.</p> <p>2.2 Review of the narrative in the ‘BCU Guidance for Savings’ to allow planned savings information to be contained within a specialist system (e.g., in this case the meds management system), with the output from the system being sufficient to demonstrate the estimate provided for the saving value is reasonable. (Avoiding duplication of systems and ensuring one source of information).</p>

		<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> All SSDs supported with robust financial analysis / backing documentation in compliance with BCU Guidance for Savings (2025-26).
<p>Theme: Finance Management & Control</p>	<p style="background-color: red; color: white; text-align: center;">High Priority</p> <p>Control Operation</p>	<p>Officer: Head of Financial Reporting</p> <p>Target Implementation Date: 31st of March 2026</p>
<p>3 Actual Savings Reconciliation</p> <p>We requested evidence of actual savings delivery at Month 6 for each of the 22 schemes reviewed – this was provided for 17/22 schemes. We reviewed the supporting documentation and reconciled the working documents to the tracker. We found the following limitations:</p> <p><u>Cancer Services</u></p> <ul style="list-style-type: none"> The reported savings for one (of two) Cancer Services Medicines Management scheme in our review sample was less than the actual saving achieved per the backing documentation. We were advised that the reported figure was an adjustment for a prior over-reporting of a different Cancer Services Medicines Management scheme - the over-reporting was not corrected against the relevant scheme as the accepted practice is that negative values should not be reported on the tracker. Cancer Services has six Medicines Management saving schemes. We confirmed that the aggregate reported savings (for the six schemes) reconciled to the total savings per the backing document. However, due to the adjustments the reported savings on the tracker was inaccurate for four of the six schemes. <p><u>Mental Health and Learning Disabilities</u></p> <ul style="list-style-type: none"> Scheme MHL25004-01 (Reduction in Out of Area Beds) delivered actual savings of £96,235 in June 2025 – we reconciled this to the backing documentation. In July, August, and September, the scheme delivered £0 savings per the tracker. However, the backing documentation showed that actual costs had increased significantly over this period (due to service pressures) 	<p>Lack of transparency.</p> <p>Inaccurate reporting.</p>	<p>Agreed Action:</p> <p>3.1 The guidance on how to adjust future savings values to correct estimates, where actual information is not available at the point of submission is not clear. Advice will be taken from WG, as potentially limiting over estimates to one scheme may result in over reporting for some months. When guidance is received, we will strengthen the internal guidance to incorporate the WG views and advice.</p> <p>3.2 WG have confirmed the Mental Health and Learning Disabilities scheme has been recorded correctly and in accordance with their requirements. However, it is recognised that neither the WG or BCU internal guidance specifically document the process, and the internal guidance will be strengthened to ensure this scenario is covered.</p> <p>Expected Evidence of Implementation:</p>

<p>resulting in a total year to date savings deficit of £624,335 at Month 6. -</p> <p>Whilst the full year savings forecast had been adjusted to reflect the costs pressure incurred July - September, we queried whether the current reported delivery of £96,235 saving provided a true and accurate reflection of scheme performance. Management stated that the recording and accounting treatment was consistent with Welsh Government requirements – this was verified and confirmed by Welsh Government Senior Finance colleagues.</p>	<p style="text-align: center;">High Priority</p>	<ul style="list-style-type: none"> All reported savings supported with robust backing documentation demonstrating actual delivery. <p>Officer: Head of Financial Reporting Target Implementation Date: 31st of March 2026</p>
<p>Theme: Finance Management & Control</p>	<p>Control Operation</p>	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Primary Care – Contract Assurance Framework Internal Audit Report 2025/26

Betsi Cadwaladr University Health Board



Reasonable Assurance

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BCU-2425-22
August – October 2025
8 January 2026
February 2026
Tehmeena Amjal, Chief Operating Officer
Dave Harries, Head of Internal Audit
Nicola Jones, Deputy Head of Internal Audit



Executive Summary

Purpose

To review the arrangements in place for the management of primary medical care contracts through the Contract Assurance Framework process.

Overview

The Contract Assurance Framework (CAF) was introduced in October 2023. The Health Board are in the process of implementing this and aligning with existing quality governance processes across Primary Care. We have reviewed how this has been implemented to date.

We have concluded reasonable assurance on this area. There has been positive progress in implementing the CAF, with learning being fed back to the national forum. The matters requiring management attention include:

- The CAF includes review of agreed national measures, and guidance states that local priorities should be agreed between Health Boards and General Practitioners (GP) practices. We are advised there have not yet been discussions to agree local priorities.
- There is a significant reliance on self-assessments provided by practices, with few requests for supporting evidence. We acknowledge that submissions from practices are made under a trusted contract and align with national guidelines. However, when issues arise and actions are agreed upon after a Health Board review, evidence supporting completion should be requested based on a documented risk assessment.
- There are several groups within Primary Care where information relating to practice compliance with the GMS contract are reported and discussed, however there is no onward reporting / assurance provided to the Health Board.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified and are highlighted for management information:

- There were some omissions in documentation reviewed, however we were satisfied that documents had been reviewed by those required; management should ensure full completion of all sections of documentation.
- A local standard operating procedure (SOP) has been developed – management should ensure this is completed and approved.

Scope & Assurance Summary

Objectives <small>The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.</small>	Related Findings	Assurance
1 There is a documented process / procedure in place within the Health Board to ensure General Practices are meeting the requirements of the GMS contract. This includes clear roles / responsibilities and timescales.	1	Reasonable
2 All GPs (including those managed by the Health Board) provide information required to evidence compliance with the GMS contract. Information is complete, reviewed (as appropriate), and where performance issues are identified, actions are taken to address these.	2	Reasonable
3 There is appropriate assurance provided to the Health Board on GP Services, with performance information / data reported to an appropriate forum.	3	Reasonable

Management Actions

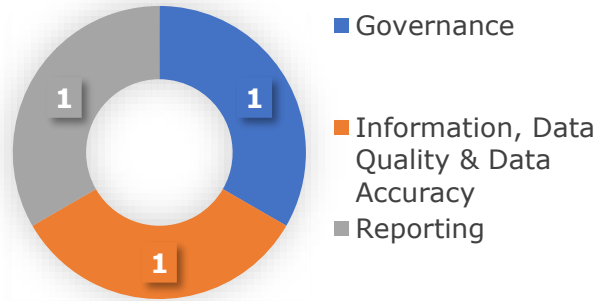


High Priority



Medium Priority

Themes



Risk Types

Quality or Safety Issues
Public Perception & Reputational Risk

GP Practices

There are ninety-six (96) practices within the Health Board area, twelve (12) of these are managed by the Health Board.

Each practice is assessed annually against the requirements of the GMS contract, with an assurance rating given. The ratings for 2023/24 and 2024/25 are summarised below. These figures show an increase in positive assurance (substantial/reasonable) from 60% to 70% over the year:

Assurance rating	2023/24	2024/25
Substantial	11 (11%)	6 (6%)
Reasonable	47 (49%)	61 (64%)
Limited	36 (38)	28 (29%)
No assurance	2 (2%)	1 (1%)

Findings & Agreed Action Plan

Objective 1: There is a documented process / procedure in place within the Health Board to ensure General Practices are meeting the requirements of the GMS contract. This includes clear roles, responsibilities and timescales. **Reasonable**

Overview / Summary of Observations

The Welsh Unified General Medical Services (GMS) Contract, introduced in October 2023, standardised expectations to improve quality across general practice in Wales. To support its delivery, a national Contract Assurance Framework (CAF) was developed to provide consistent oversight and assurance. The CAF involves structured annual submissions from practices via the Primary Care Information Portal (PCIP), including self-declarations and practice data.

While national guidance is in place, Health Boards are expected to develop local procedures and agree on local priorities with Local Medical Committees. *'Annual Contract Assurance Return – this will consist of two parts, with a national template on the primary care portal and a second part for local priorities (this will supplement the national template and not duplicate information available or asked for elsewhere). The Health Board must agree local information requirements in the second part with the Local Medical Committee.'* We are advised there are no local priorities included at present, and this has not been an area that has been discussed. We are advised that through the desktop review process noted below, information / assurance can be requested for any areas of priority / concern.

A standardised desktop review process—led by the Primary Care Contracting Team—evaluates these submissions against nationally agreed criteria, with input from multidisciplinary teams across Integrated Health Communities (IHCs). Each review results in an assurance rating and may trigger further action such as focused visits or improvement plans.

We recognise this is a new process that is being implemented, which is in addition to work already undertaken by the contracting team. Work is continuing to align the process with quality governance processes across Primary Care, as the workload to meet timescales for the CAF is a pressure on the contracting team. The team have drafted a standard operating procedure and identified some duplication in the documents used, and continue to reflect on the process and feedback nationally.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Local priorities</p> <p>The Unified CAF guidance for Health Boards references local priorities:</p> <p><i>'Annual Contract Assurance Return – this will consist of two parts, with a national template on the primary care portal and a second part for local priorities (this will supplement the national template and not duplicate information available or asked for elsewhere). The Health Board must agree local information requirements in the second part with the Local Medical Committee.'</i></p> <p>We are advised there are no local priorities included at present, and this has not been an area that has been discussed. We are</p>	<p>There is a risk that the strategic Health Board objectives / priorities relating to primary care practices have not been formally considered and included in the CAF. This may result in the Health Board being unable to achieve related</p>	<p>Agreed Action:</p> <p>The wording of the National Guidance implies that local priorities are expected to be part of the CAF process. The negotiated national position was that the process should be as standardised as possible to ensure consistency of the “ask” of practices across Wales. However, where there are specific additional local information requirements that are not available through other processes or systems, this can be facilitated as part of the CAF process. It was not mandated that this should be in place and feedback has been provided to WG to clarify the requirement in the guidance. There was a national delay in publishing CAF and therefore the initial cycle was condensed into a shorter period of time, with the</p>

<p>advised that through the desktop review process noted below, information / assurance can be requested for any areas of priority / concern.</p>	<p>objective(s) if this is not agreed with practices.</p>	<p>second cycle following very closely behind. The approach taken within BCUHB was to introduce and implement only the national template for the first 2 assessment cycles. We are now at a point where we can reflect on the learning from those initial cycles and consider any additional local requirements we may now wish to implement. The Primary Care Contract Management Group will consider whether any local priorities now require to be added to the process and this will be discussed further with the LMC.</p>
<p>Theme: Information, Data Quality & Data Accuracy</p>	<p>Medium Priority</p> <p>Control Design</p>	<p>Expected Evidence of Implementation:</p> <p>Evidence of discussions at an appropriate level relating to local priorities.</p> <p>Details of local priorities agreed with Local Medical Committee (if applicable).</p> <p>Officer: Head of Primary Care Contracting</p> <p>Target Implementation Date: 30 June 2026</p>

Objective 2: All GPs (including those managed by the Health Board) provide information required to evidence compliance with the GMS contract. Information is complete, reviewed (as appropriate), and where performance issues are identified, actions are taken to address these. **Reasonable**

Overview / Summary of Observations

To demonstrate compliance with the requirements of the GMS contract, the team undertake desktop reviews of the information submitted by practices via the Primary Care Information Portal, as detailed in objective 1 above. Data from declarations is downloaded from the portal which provides detailed information for each area of the contract, and is used to inform the desktop review.

The Primary Care Contracting Team hold data on all practices within the Health Board area, which includes the Assurance levels from the desktop review process, for the current and previous years, and also the outcomes of each review i.e. action plan/visit.

All ninety-six (96) practices have been reviewed in 2025. As noted above, the ratings demonstrate an increase in positive assurance (substantial/reasonable) from 60% to 70% over the year. There are seventeen (17) practices that were either rated limited/no assurance in 2023/24 and 2024/25. We confirmed that sixteen (16) of these have either had a visit the previous year or have had (or are scheduled) one this year. The one exception identified had justification as to why there was no visit (some clinical indicators only referred to a small number of patients).

For a sample of ten (10) practices we reviewed the 2024/25 desktop review documentation, and the action plans and/or visit details (where applicable). We were also provided with 2023/24 information for comparison. We observed the following:

- Completed desktop review reports were provided for all those within the sample, and the assurance outcomes are considered appropriate (based on the information provided in the desktop report and annual /CAF returns).
- Action plans reflected the areas of concern within desktop reports.
- The desktop report includes sections for comments by Health Board officers, such as Primary Care Medical Director (PMCD), Clinical Governance, Nursing etc. These sections were not routinely completed; however we confirmed that comments were included in the assessments reviewed.

There is a reliance on the information submitted by practices, with no request for evidence to support declarations made. We recognise that this is a national approach, and that areas of concern will be identified / taken forward through the desktop review process and action plan or a visit.

There is also no evidence requested to confirm actions raised following a desktop review. If practices are visited evidence would be viewed at this point, however where no visit is required, requested evidence for completed actions plans is not currently sought – we consider this should be risk based to ensure that issues raised have been addressed.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 Evidence of completed actions</p> <p>There is a reliance on self-assessments / declarations submitted by practices. We recognise this is a national approach, however there is also no evidence requested to demonstrate completion of actions following desktop reviews (except where visits are undertaken).</p>	<p>There is a risk that there is no evidence to support actions that have been completed by practices following desktop review. This may result in issues that have been identified not being adequately resolved.</p>	<p>Agreed Action:</p> <p>The GMS contract is frequently described as a “high trust” contract and as noted within the report, the agreed national CAF process is very heavily weighted towards self-declaration. The Primary Care Contracting Team will develop a risk-based approach to requesting evidence from practices regarding completion of actions following a desktop review. This will also need to be agreed with the LMC.</p> <p>Expected Evidence of Implementation:</p> <p>An agreed risk based approach to requesting evidence from practices to support completion of actions following a desktop review.</p> <p>Examples of action plans and supporting evidence provided by practices.</p>
<p>Theme: Governance</p>	<p>Medium Priority</p> <p>Control Design</p>	<p>Officer: Head of Primary Care Contracting</p> <p>Target Implementation Date: 30 June 2026</p>

Objective 3: There is appropriate assurance provided to the Health Board on GP services, with performance data / information reported to an appropriate forum.

Reasonable

Overview / Summary of Observations

There is an established governance structure within Primary Care. Detailed information on practice performance is reported and then filtered through the groups below to the Primary Care Board, which has received reporting throughout the year. These groups include:

- CAF Desktop Review Group
- Primary Care Contract Management Group
- Primary Care Panel
- Primary Care Quality Delivery Group

The Contracts Management Group receives detailed information, which includes Annual Return Reports that provides detail of annual returns and exceptions identified with practices across IHC areas. We note there have been some gaps in reporting due to the introduction of the CAF process, as this becomes aligned with the annual return reporting, however, there has been a recent report (November 2025) on the annual return for 2024/25. It has been agreed that CAF will be monitored through the Primary Care Quality Delivery Group and the outcomes of the desktop assessments and proposed visiting programme for 204/25 was discussed by the Group on 5th August 2025. The CAF process for 2024/25 has recently been completed, with reporting due in January 2026.





Whilst we recognise there is an established reporting structure within Primary Care, there is no information or assurance provided to the Board, via its Committees, on practice compliance with the GMS contract.

Key Findings	Risk & Impact	Agreed Management Action
<p>3 Committee reporting</p> <p>Whilst there is regular review and reporting of contractor compliance with the GMS contract within Primary Care, there is a lack of assurance reported to the Health Board or its Committees.</p>	<p>There is a risk that the Health Board is not receiving adequate assurance relating to practice compliance with the GMS contract. This may result in the Board being unaware of potential issues that will affect patients.</p>	<p>Agreed Action:</p> <p>It has been agreed that the CAF process and outcomes will be monitored through the Pan-BCU Primary Care Quality Delivery Group, which in turn reports to the Primary Care Board. This is outlined in the report.</p> <p>The 2025/26 Annual Delivery Plan identified an action for the Director of Performance and Commissioning to ensure greater visibility of Primary Care information at Board level, however, this has been delayed due to the Director retiring. The performance portfolio now sits with the Executive Director of Finance.</p> <p>The Primary Care Contracting Team will provide information on GMS compliance as directed by the Executive Team.</p>

		<p>Expected Evidence of Implementation:</p> <p>An agreed reporting structure to provide assurance to the Board on practice compliance with the GMS contract, and any issues identified.</p> <p>Agendas/minutes of relevant committee.</p>
	<p>Medium Priority</p> <p>Control Design</p>	<p>Officer: Primary Care Contracting</p> <p>Target Implementation Date: 30 June 2026</p>
<p>Theme: Reporting</p>		

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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Estate Management – Estates and Facilities Alerts

Final Internal Audit Report 2025/26

Betsi Cadwaladr University Health Board



Limited Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

BCU-2526-31

October 2025 – December 2025

January 2026

February 2026

Stuart Keen, Director of Environment and Estates

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Ossama Lotfy, Principal Auditor

Executive Summary

Purpose

To review action taken to address and implement Estates and Facilities (E&F) Alerts within the Health Board.

Overview

We have concluded **limited** assurance on this area. The matters requiring management attention include:

- There is no evidence of consistent oversight or assurance that all Alerts are reviewed and acted upon. We are advised that this is due to no overarching governance group within Estates responsible for reviewing all safety alerts and ensuring compliance across the Health Board.
- There is no Standard Operating Procedure (SOP) for the management of (E&F) Alerts. Although a central register exists to record (E&F) Alerts received, actions taken in response are not routinely updated or tracked to completion. Our sample of eight (25%) recent alerts showed that three (37.5%) had no evidence of implementation, suggesting incomplete follow-up.

Full details of matters arising are detailed within the Findings and Agreed Action Plan.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion. **Related Findings** **Assurance**

1	There are effective governance arrangements and internal processes for receiving, reviewing, and disseminating Estates and Facilities (E&F) Alerts within the Health Board.	1	Limited
2	Adequate arrangements are in place to evidence actions taken in response to E&F Alerts, including risk assessments, implementation of required measures, and monitoring of compliance or closure.	2	Limited

Management Actions

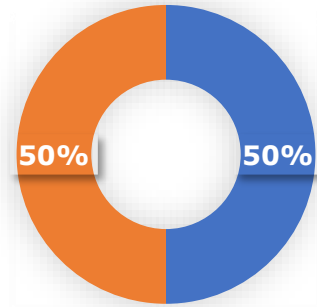


High Priority



Medium Priority

Themes



■ Governance

■ Performance Monitoring

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: Governance & Oversight - to review the governance arrangements and internal processes for receiving, reviewing, and disseminating Estates and Facilities (E&F) Alerts within the Health Board.

Limited

The Deputy Director / Specialist Estates Services (SES), within NHS Wales Shared Services Partnership, acts as the NHS Wales representative on the UK Safety Partnership Group, which agrees draft Estates and Facilities Alerts. SES provided a Quality Assurance process outlining the steps followed prior to publication of a UK-wide alert.

Alerts are published on both the SES and Public Health Wales (PHW) websites, and PHW circulates them to Chief Executives and other designated recipients within Health Boards. It is then the responsibility of individual Health Boards and Trusts to disseminate and act on these alerts.

Estates & Facilities (E&F) Alerts are received by the Head of Estates and the Senior Estates Officer – Policy and Technical Compliance, who disseminate them to Operational Estates Managers (East, Central, West) and other Senior Estates Officers for review and action. There is no Standard Operating Procedure (SOP) currently in place for the management of E&F Alerts.

Whilst a central register is maintained to record Alerts received, it was noted that actions taken to implement these are not routinely updated. Estates advised that this is due to the absence of an overarching governance group within Estates to review Safety Alerts. Existing arrangements include:

- Electrical Safety Alerts – overseen by the Electrical Safety Group.
- Reinforced Autoclaved Aerated Concrete (RAAC) – escalated to the Strategic Occupational Health and Safety Group.
- Medical Gases – overseen by the Health Board Medical Gas Group.
- All other alerts – aligned with the Estates Health and Safety Meeting.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Governance and Oversight of Estates and Facilities Alerts</p> <p>Operational Estates Alerts are received by the Head of Estates and Senior Estates Officer – Policy and Technical Compliance, however there is no evidence of consistent oversight or assurance that all alerts are reviewed and acted upon.</p> <p>Although a central register exists to record (E&F) Alerts, actions taken in response are not routinely updated or tracked to completion.</p> <p>There is currently no overarching governance group within Estates responsible for reviewing all safety alerts and ensuring compliance.</p> <p>There is no Standard Operating Procedure (SOP) for the management of (E&F) Alerts.</p>	<p>The absence of formal governance and procedural oversight increases the risk that safety-critical alerts may not be consistently reviewed, acted upon, or recorded.</p> <p>Incomplete central records could lead to delayed or missed implementation of essential safety measures.</p>	<p>Agreed Action:</p> <ul style="list-style-type: none"> • Interim measure has been implemented with a SOP to include a single point of access to all alerts so all parties can access the information. This includes a monitoring spreadsheet. • Review the full directorate reporting structure and how that relates to the other groups within the organisation to ensure clarity and accountability. This is driven by other factors and will include additional roles to support responses such as this. • Define a directorate governance structure to encompass all statutory reporting and the management of Alerts and record such in a SOP. • Finalise a reporting route to ensure organisational assurance and the potential for an annual Estates compliance report.

		<p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> • Interim measure: Minutes of review meeting, interim SOP and implementation of central resource. • Formal governance framework for the receipt, review, and monitoring of all (E&F) Alerts. • Standard Operating Procedure (SOP) for managing (E&F) Alerts. • Routinely updated central register that tracks the status of alerts, assigned actions, and completion dates. • Periodic assurance reports to relevant governance committees on the status of E&F Alerts.
<p>Theme: Governance</p>	<p style="text-align: center;">High Priority</p> <p>Control Design</p>	<p>Officer: Director of Environment and Estates</p> <p>Target Implementation Date: Interim measure: 28/02/2026. 31/07/2026 for the finalisation of the structure given the wider organisation restructure and approval of governance.</p>

<p>Objective 2: Monitoring and Reporting – to assess the adequacy, timeliness, and evidence of actions taken in response to E&F alerts, including risk assessments, implementation of required measures, and monitoring of compliance or closure.</p>	<p>Limited</p>
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As outlined in Objective 1 above, a central register is held to record (E&F) Alerts received by the Health Board. However, Estates management advised that follow-up actions are not consistently updated on this register due to the absence of an overarching governance group within Estates to review, track, and ensure compliance with all safety alerts. This gap may result in fragmented ownership and inconsistent assurance regarding the Health Board’s response to national E&F Alerts.

Audit testing was undertaken to assess the adequacy and effectiveness of arrangements for receiving, recording, reviewing, and implementing (E&F) Alerts across the Health Board.

We reviewed eight (25%) of the most recent alerts published on the SES intranet site and action taken to implement these. We observed the following:






- Five out of eight (62.5%) of alerts were fully implemented, with evidence of actions taken and monitoring systems in place.
- Three out of eight (37.5%) had no evidence of implementation, suggesting incomplete follow-up.

This presents an increased risk to safety and operational resilience if alerts are not addressed consistently across Health Board sites.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 Monitoring implementation</p> <p>A central register exists to record (E&F) Alerts, but follow-up actions are not consistently updated.</p> <p>A review of eight (25%) recent alerts showed that three out of the eight (37.5%) had no evidence of implementation, suggesting incomplete follow-up.</p>	<p>Alerts that are not actioned or tracked may compromise safety or operational effectiveness.</p> <p>Limited assurance that Estates actions are appropriately reviewed, evidenced, and monitored.</p>	<p>Agreed Action:</p> <ul style="list-style-type: none"> The SOP will include the development of a tracker to include information such as: Description, Risk Rating, Owner, Target Implementation Date, Implementation Evidence, Link to Corporate Risk Register, etc. As an interim measure, a tracker will be developed to collate the current Alerts and form the basis of a transition mitigation pending the SOP. <p>Expected Evidence of Implementation:</p> <ul style="list-style-type: none"> Routinely updated central register that tracks the status of alerts, assigned actions, and completion dates. Periodic assurance reports to relevant governance committees on the status of E&F Alerts.
<p>Theme: Performance Monitoring</p>	<p>High Priority</p> <p>Control Operation</p>	<p>Officer: Director of Environment and Estates & Head of Operational Estates</p> <p>Target Implementation Date:</p> <p>Interim tracker – 28/02/2026 Full tracker – 31/07/2026.</p>

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Assurance Opinion

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