Report of Internal Audit

Subject: Internal Audit Progress Report

INTRODUCTION

This report provides an update of progress towards delivery of the 2024/25 Internal Audit Annual Plan, as well as a summary of the work undertaken to date.

SUMMARY OF PROGRESS

As per the agreed plan, we have finalised the following reports since the last committee meeting:

- Climate Change & Decarbonisation (01.24/25)
- Equality, Diversity & Inclusion (04.24/25)
- Accident and Incident Reporting & Investigation (05.24/25)
- Follow Up (06.24/25)

The following reports have also been issued in draft:

- Key Financial Controls (07.24/25)

Overall, the status of the internal audit programme is as follows:

Assignment *Reports considered today are shown in italics*	**Status**	**Opinion**	**Recommendations:**		
			High	**Medium**	**Low**
Climate Change & Decarbonisation (01.24/25)	*FINAL*	*Substantial*	*0*	*0*	*2*
Risk Maturity Follow Up (02.24/25)	FINAL	Some	1	2	2
Governance Structures & Processes (03.24/25)	FINAL	Substantial	0	1	1
Equality, Diversity & Inclusion (04.24/25)	*FINAL*	*Substantial*	*0*	*0*	*1*
Accident and Incident Reporting & Investigation (05.24/25)	*FINAL*	*Reasonable*	*0*	*2*	*0*
Follow Up (06.24/25)	*FINAL*	*Reasonable*	*0*	*2*	*1*
Key Financial Controls (07.24/25)	DRAFT				
		TOTAL:	**1**	**7**	**7**

Note: Opinions and recommendations will be included when reports are finalised.

LIAISON WITH MANAGEMENT & EXTERNAL AUDIT

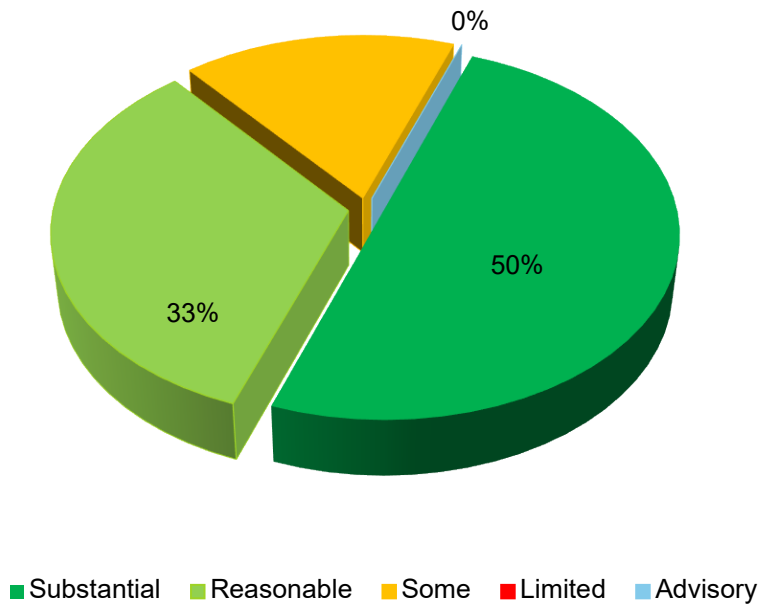
There has been ongoing communication between Internal Audit and Senior Management within the Association in relation to the completion of the audit plan.

INTERNAL AUDIT PLAN CHANGE CONTROL

The following changes have been made to the Internal Audit Annual Plan since it was agreed:

Change	**Date**	**Agreed By**
HSMS: Accident & Incident Reporting and Investigation review was put on hold in January due to a lack of information available to us to undertake the audit during the agreed fieldwork dates. Remainder of fieldwork undertaken in February 2025.	8 January 2025	Chief Executive
Vistor Centres (Generic) review was postponed until the first week of April at the request of management. Initial fieldwork dates agreed fell within a busy period for the centres.	27 January 2025	Chief Executive

ASSURANCE LEVEL TO DATE



WORK IN PROGRESS OR YET TO START

Audit	Start Date	Debrief Date	Draft Report Issued	Planned Audit Committee	Comments
IT Strategy	03/03/2025	11/03/2025		~~May 2025~~ July 2025	Internal quality review stage.
Visitor Centres	31/03/2025	8/04/2025		~~May 2025~~ July 2025	"

ASTARI

Pembrokeshire Coast National Park Authority

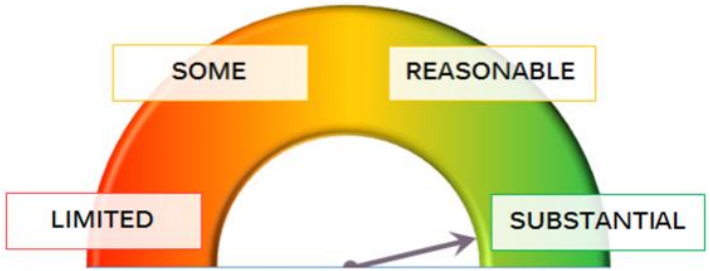
Climate Change & Decarbonisation

Internal Audit Report: PCNPA-2024/25-01

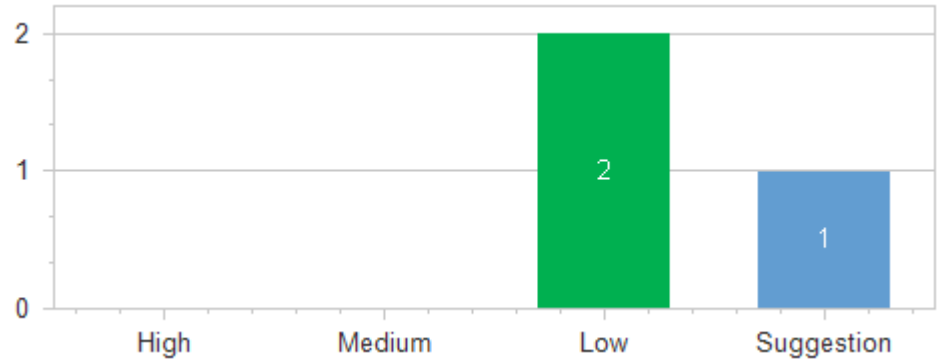
Date: 1 May 2025

1. EXECUTIVE SUMMARY

Level of Assurance

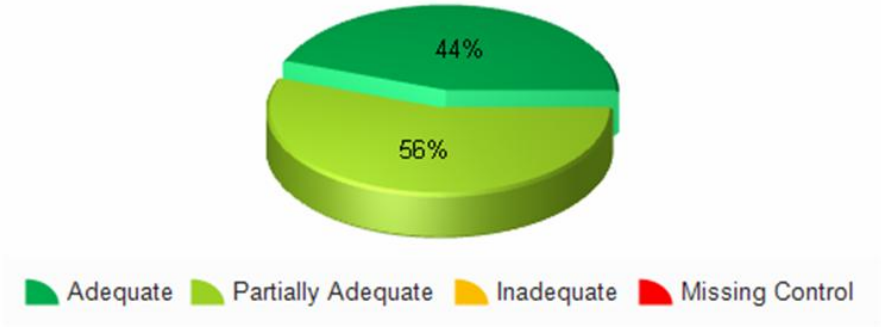


Number & Priority of Recommendations / Suggestions

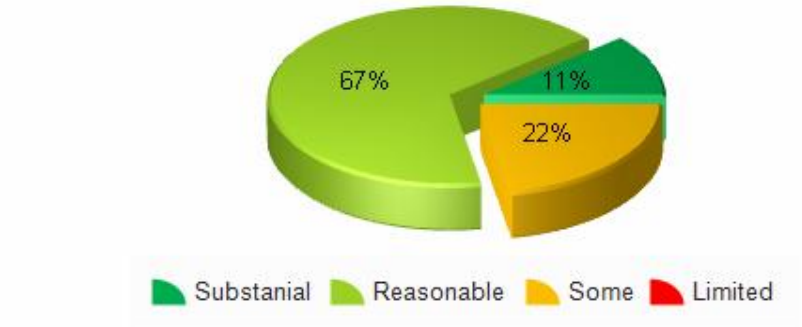


Conclusion:	Taking account of the scope of the review and the issues identified, whilst the Authority can take ***substantial*** assurance that the organisation has identified the key risks in relation to achieving Objective 4 – "The National Park is protected and conserved" and that there has been progress relating to carbon neutrality and travel challenges. Work was ongoing to continue to progress in this challenging area; however, we have not raised recommendations where actions were already underway within the organisation.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- The organisation was in the process of reviewing its Environmental Policy to meet current decarbonisation expectations and had other supporting policies and guidance around elements such as travel and procurement.
- Carbon Literacy training had been provided to relevant staff (including the senior leadership team and Authority Members) and the training slides had been purchased to allow the organisation to deliver the training to the additional staff; however, due to resource challenges this had not yet been completed.
- An informal staff group called the "Eco Champs" was in place to encourage staff suggestions and ideas; although it had not met in recent months. It is positive to note that staff want to be involved in this type of group and continuation of meetings and engagement should be encouraged.
- The organisation contracted with Aquatera in May 2022 to create a baseline carbon performance calculation and provide a draft Carbon Reduction Delivery Plan to aid in achieving the objective of Net Zero Carbon emissions by 2030. From the Aquatera report the organisation's Net Zero Action Plan was created, however through review of the two documents we found that not all elements noted within the Aquatera Plan had been migrated to the Net Zero Action Plan. Further discussion with the organisation noted that the actions identified in this report were now out of date when compared to current Welsh Government requirements and reporting and so we have not raised a recommendation.
- The organisation's Decarbonisation Delivery Plan 2024/25 included four outcomes; three in relation to "Climate" and one in relation to "Communities". Underpinning these outcomes were defined Priority Actions, deliverables, milestones and timescales as well as the resources required to achieve them. Alongside the Delivery Plan there was also a Net Zero Action Plan and a Fleet Decarbonisation Plan that outlined the expectations and constraints in replacing current vehicles with electric vehicle (EV) alternatives.
- The Aquatera report had identified that the organisation's largest contributor to emissions was the supply chain / procurement and we noted that the organisation was in the process of updating its Procurement Strategy in line with new sustainability requirements and training on the new Procurement Act had been sought.
- The organisation provided annual emissions data to the Welsh Government in line with regulations and relied upon the Welsh Public Sector Net Zero Reporting Guide to complete the calculations; however, there was no internal procedure document or guidance to show how the data was gathered to ensure consistency through succession.
- A Teams site had been created to request and store data for emissions and this was used to inform the data submissions to Welsh Government.
- We reviewed the 2023 Cross Year Comparison data set and noted that updates were provided each year to show reduction or increase in the emissions levels; although we identified some areas where clarity of reporting could be improved to ensure prior year comparisons and direction of travel were clear. This was fed back to the organisation during the review and so we have not raised a recommendation or suggestion.
- An annual update was provided to the Authority which detailed works done and reduction in emissions however, as the organisation had not set clear targets for expected outcomes the reporting did not make clear whether the results achieved were in line with expectations and as such, on target to reach net zero by 2030.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	The organisation is considering and adapting for the challenges being presented as part of the environmental impact decarbonisation agenda.
Risk:	**Objective 4 –** The National Park is protected and conserved **Risk Descriptions:** ▪ Biodiversity in the National Park is in decline ▪ The long-term impact of Climate Change changes the nature of the National Park ▪ The special qualities of the National Park deteriorate ▪ A failure to meet targets to become net zero
Engagement objective:	To provide assurance that the organisation is identifying the key risks in relation to achieving objective 4 – "The National Park is protected and conserved" (with particular attention paid to "a failure to meet targets to become net zero") – and that there is clear direction for the organisation in addressing those risks or escalating where risks cannot be managed to the Authority. In terms of detailed testing of progress, the review will specifically focus on actions relating to carbon neutrality and travel challenges, as these are areas where progress has already been made.

2.2. Background to the Engagement

An audit of Climate Change & Decarbonisation was undertaken as part of the approved internal audit periodic plan for 2024/25.

This was a risk-based review that aimed to provide assurance that the organisation was appropriately identifying key risks relevant to the stated objectives and taking appropriate action to mitigate those risks. Through the scoping meeting the organisation communicated that the review would add greater value if it focussed on the areas of carbon neutrality and travel challenges (both of which form part of the delivery plans and objectives). For reference, "travel challenges" refers to the organisation's approach and consideration of electric fleet management, EV charging networks and commuting. The review considered the recording of carbon neutrality and travel challenges within the delivery plans and the accuracy of the recording as well as the effectiveness of the process undertaken to ensure value is added.

The following areas were agreed to be included within this review:

Areas within scope:	Risk identification processes in relation to objective 4 and how those risks, and action taken to mitigate those risks, are communicated through the risk register. Guidance, processes and structures around Delivery Plans with particular attention paid to carbon neutrality and travel challenges;

	Identification, Planning and Implementation of the Carbon Neutrality programme (considered in line with the Public Sector Readiness for Net Zero Carbon by 2030); Identification, Planning and Implementation of the travel challenges (i.e. electronic fleet, commuting, EV charging networks and staff benefits); Accuracy of data sources and outcomes of any gap analysis exercises and / or data mapping exercises; Awareness raising and training for staff on Climate Change and decarbonisation; and Monitoring of compliance with Delivery Plan and regulatory requirements including reporting performance / assurance to the leadership team or National Park Authority.
Performance measures considered in assignment planning:	Milestone completion against any action plans. Accuracy of controls and assurances recorded on the Strategic Risk Register.

2.3. Limitations to the scope of the review

- The review considered the processes the organisation had in place to identify and manage risks relating to climate change and decarbonisation but did not include the undertaking or re-performance of any risk assessments.
- Testing was undertaken on a sample basis only and was limited to operation rather than effectiveness depending on the nature of the control and the information available to us as part of the review.
- We reviewed the process undertaken to calculate carbon footprints; however, cannot provide any guarantee that all such contributors have been identified.
- Site visits were not carried out as part of this review.
- We placed reliance upon assurance provided by other specialists within the last 12 months to avoid duplication.
- The audit recognised that Carbon Neutrality and Travel Challenges were in development, with gap analyses having been undertaken. Our assurance is therefore limited to progress in delivering an effective programme that provides clear oversight and assurance.
- We aimed to provide assurance that there were controls in place to assist in delivering the projects referenced above; however, this was not a detailed project review and we are not providing any guarantee that they will be delivered or that all benefits will be realised.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Last Information Received:	4 November 2024
Draft Report Issued: **Re-issued:** **Re-issued:**	9 December 2024 25 March 2025 30 April 2025
Initial Response Received: **Updated Response Received:** **Final Response Received:**	12 December 2024 14 April 2025 1 May 2025

Auditor:	Rhian Howes, Risk Assurance Consultant
Client Sponsor:	Jessica Morgan, Head of Decarbonisation
Distribution:	Tegryn Jones, Chief Executive

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	The organisation used the Welsh Public Sector Net Zero Reporting Guide to complete the required calculations; however, there was no internal procedure document or guidance that defined how the data should be gathered to ensure consistency or to support any staff changes in the area. Further, the backing data used to complete the calculations was not retained.	Without a clear procedure in place to show how data is gathered the organisation risks different individuals calculating different values. If backing data is not retained then evidence cannot be provided, if required, of the accuracy of the calculations.	The organisation should create an internal procedure(s) to show how data is gathered for each area of reporting required and this should include requirements surrounding retention of data.		Agreed procedures for data collection can be written during the reporting cycle.	**Responsible Person:** Sustainability Officer **Date:** 30 September 2025
R2	The organisation had purchased electric vehicles (EV) and was considering the approach for the replacement of others (following the end of their useful lives or leases) but this had not yet been clarified. Works had not been completed to assess the requirements for all the vehicles they currently held to understand their	Value for money considerations do not sufficiently form part of decision making and monies are not spent in the most effective way possible.	Whilst it is understood that the organisation was considering the purchase of EVs in a like for like manner, the organisation should review the vehicles in use to understand their usage and requirements (telematics my aid in this). The outcome of this assessment may show value for money alternatives		Agreed, review of fleet use across the Authority in order to reduce emissions and ensure value for money.	**Responsible Person:** Sustainability Officer and Head of Decarbonisation **Date:** 31 March 2026

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
	requirements, for example: could they be removed instead of replaced. For the EV vehicles which had been purchased, as they were in use with differing teams and as such in differing teams' budgets, the organisation had not reviewed the potential savings / ongoing expense of these vehicles.		for the organisation. It is acknowledged that cost-savings for existing EV and charging stations sat across multiple budgets; however, the organisation should review EV spend to identify savings made / expenses above budget to improve future purchases.			

Suggestions in line with good practice or processes seen in other organisations

Ref.	Finding	Suggestion	Management Response
S1	A set cycle of regular communications was not used to keep staff informed as to the organisation's expectations, objectives or incentives around climate change, but individual departments did release updates on plans they were delivering which impacted climate change. Whilst these served as prompts, they were not frequent and did not provide continued guidance. Staff are an essential component in ensuring that the organisation achieves its objectives and as office buildings and commutes / travel accounts form a large portion of the carbon footprint, continued communications would aid in reminding staff to reduce the footprint where possible, increase environmental awareness and collective responsibility.	The organisation should consider introducing regular climate change / decarbonisation updates and guidance (this will be of particular importance whilst staff await carbon literacy training). The topics should ensure that staff are well informed as to what is required of them and what the organisation's objectives are to allow them to contribute where possible and be continually mindful. The communications should be in a range of mediums to allow for accessibility of information.	Agree, utilising existing methods of communication such as staff newsletter, staff meetings, Authority Teams Channel, notice boards and groups such as staff reps to communication progress and opportunities for reducing emissions.

ASTARI

Pembrokeshire Coast National Park Authority

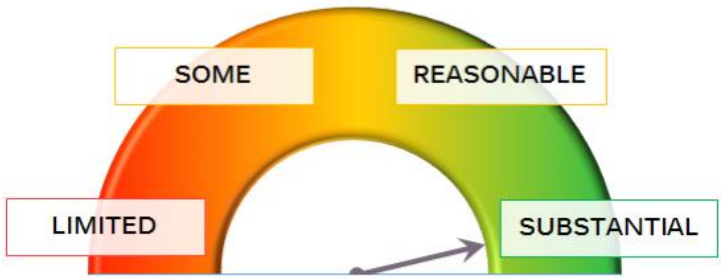
Equality, Diversity & Inclusion

Internal Audit Report: PCNPA-2024/25-04

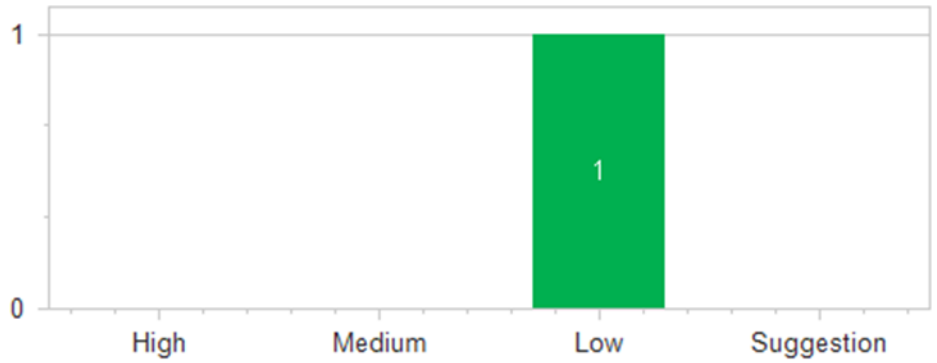
Date: 30 April 2025

1. EXECUTIVE SUMMARY

Level of Assurance

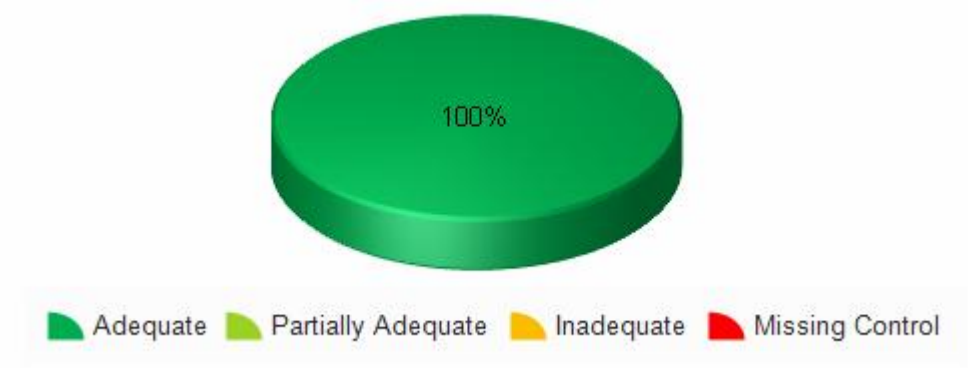


Number & Priority of Recommendations / Suggestions

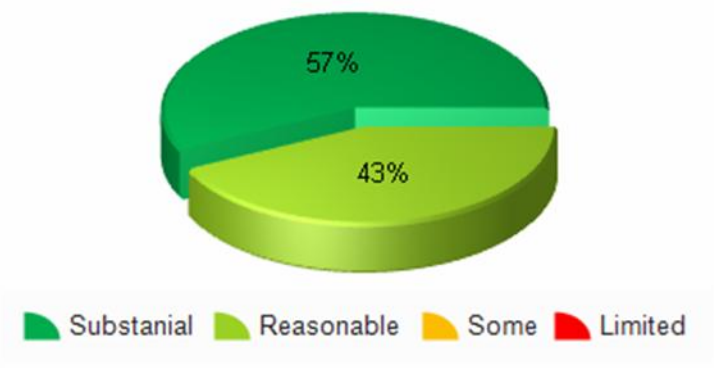


Conclusion:	Taking account of the scope of the review and the issues identified, the Authority can take ***substantial*** assurance that the organisation has robust and monitored processes and plans in place to comply with the Welsh Government Equality requirements and to promote equality, diversity and inclusion across the organisation.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- Through review of the Equality, Diversity and Inclusion Policy, the Strategic Equality Plan 2020-2024 and the draft version for 2025-2029, we found that the documents included a good level of detail on the expectations set by the Public Sector Equality Duty (PSED) Wales. We found that two sessions had been held on EDI for Board Members during 2024 and training records showed that there was 56% attendance at one course and 50% attendance on the other. Four (22%) Board Members had not attended any EDI training during 2024. As noted in the recent Governance Structures and Processes review, Board Member attendance at training was lower than target.
- We noted that there was mandatory training on EDI in place for all staff and at the time of the review 97% of staff had undertaken the course.
- We saw evidence of multiple pieces of documentation and data being considered when developing the Equality Plan 2025-2029 and were informed that there would be consultation on the draft version of the document; we saw that there was a consultation link included on the Authority's website and we saw evidence of some of the consultations undertaken.
- We found that the Authority had set four long-term aims and 11 equality objectives. Through review of these objectives we noted that they, and the associated aims, included defined actions and timescales. We saw that other elements as required in the PSED relating to the objectives and Strategic Equality Plan had been included.
- We obtained and reviewed the Equality, Diversity and Inclusion Policy and found that it was current and included most key information.
- We reviewed a sample of eight actions reported as complete within the 2023/24 annual equality report. Through review of documentation we found that all had been completed.
- Our review of reporting undertaken noted that much of the reporting was on outputs rather than outcomes. It was also not clear in some cases, based on the examples we reviewed, whether the objective had been completed or not or was likely to be achieved by the end of the plan period. The PSED states that objectives should be SMART[1] and outcome-focused which, with the inclusion of data, rather than narrative, to provide further context when reporting on progress would provide greater assurance over delivery. For example: an activity reported as complete in the 2023/24 report was 'Health and Safety cultural survey was carried out in 2023/24"; however, there was no reference to the findings. It would provide more context, information on outcomes and assurance to Members to detail the findings of the survey and comment on any improvement actions required based on those findings. We also noted that a statement on the effectiveness of the steps that the Authority had taken to fulfil each of its equality objectives had not been included in the Annual Equality Report despite it being a requirement of the PSED.
- We found that clear guidance was in place to promote awareness and consistency in the completion of Equality Impact Assessments (EIAs), aligned with the PSED requirements. EIAs were undertaken as part of the Integrated Assessment process; however, we found that an Integrated Assessment had not been completed for all changes and had focused on strategic changes to date. Further guidance had been developed recently to promote understanding of when an Integrated Assessment was required and to create a transparent reasoning of why an assessment was not required, which required review and approval from a member of SMT. This approach demonstrates good practice, although at the time of the review no examples of its use were available.
- Through review of a sample of Integrated Assessments, we found that appropriate information was included and there was evidence of ongoing review and consideration rather than the assessment being undertaken at the end of a proposed change which promotes effectiveness.
- We saw evidence of regular reporting to the NPA on progress against the objectives set in the Equality Plan, noting the limitations above. We noted that the annual reports demonstrated work undertaken thematically against each objective, however, the current format and approach did not present the position against the objective, which is likely due to the objective not being written in a SMART manner which made measurability very difficult.

[1] SMART = Specific, Measurable, Achievable, Relevant &, Time bound.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	To comply with legislative and regulatory requirements and promote an inclusive environment to staff and other stakeholders.
Risk:	A lack of robust structures in place and plans to enhance equality, diversity and inclusion (EDI) across the organisation could lead to reputational damage, not achieving the benefits that good EDI processes present as well as potential non-compliance with the Public Sector Equality Duty and Welsh Government expectations.
Engagement objective:	To provide assurance that the organisation has robust and monitored processes and plans in place to comply with the Welsh Government Equality requirements and to promote equality, diversity and inclusion across the organisation.

2.2. Background to the Engagement

An audit of Equality, Diversity & Inclusion was undertaken as part of the approved internal audit periodic plan for 2024/25.

The organisation had recently developed a new Equality Plan and Policy for the next period and this review included consideration of this update.

The following areas were agreed to be included within this review:

Areas within scope:	Awareness of the organisation's requirements under the Public Sector Equality Duty. Policies and guidance for the organisation in the areas of equality, diversity and inclusion. Review of the organisation's analysis of current arrangements in this area and understanding of areas which need to be enhanced. Review of the Equality Plan including content, development, monitoring and sample checking of outcomes. A review of the Equality Impact Assessment process including sample testing to ensure compliance. Monitoring and reporting to leadership and the National Park Authority.
Performance measures considered in assignment planning:	Progress against the Equality Plan Accuracy in reporting against the Equality Plan
Additional outcomes / value added expected from the review:	Advice from other clients on how they are monitoring compliance with smaller equality monitoring data sets in terms of Workforce and Members.

2.3. Limitations to the scope of the review

- Testing was undertaken on a sample basis only.
- The audit sought to ensure that there were appropriate plans in place to achieve compliance and progress in this area but did not provide assurance that the plans will be achieved.
- The organisation had recently had reviews undertaken by Audit Wales relating to the topic of Equality and Diversity. We have not duplicated this work and have taken assurance from it where possible.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Last Information Received:	8 January 2025	**Auditor:**	Sarah Griffiths, Senior Risk Assurance Consultant
Draft Report Issued: **Draft Report Re-issued:**	19 February 2025 30 April 2025	**Client Sponsor:**	Tegryn Jones, Chief Executive Officer
Initial Responses Received: **Final Responses Received:**	19 March 2025 30 April 2025	**Distribution:**	Mair Thomas, Performance and Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	We noted that the 2023/24 Annual Equality Report included lots of high-level information on related projects and work; however, there was scope to include further information on outcomes and demonstration via data. The Public Sector Equality Duty states that the annual report should include a review of the effectiveness of the work undertaken each year. This was not included in the latest report.	Reduced oversight of progress against objectives and an inability to measure 'success' due to a focus on outputs and not outcomes, which could result in inappropriate resources being assigned to equality objectives and non-compliance with the Public Sector Equality Duty (Wales).	When compiling future Annual Equality Reports, the organisation should ensure that the information presented focuses on outcomes and assesses the effectiveness of work towards the delivery of the equality objectives. Use of data would be beneficial where available to provide additional context as well as a clear position against the objective.		We will include statement on the effectiveness of the steps that the Authority had taken to fulfil each of its equality objectives in the Annual Equality Report 2024/25 and include wider data sets, case impact studies where appropriate.	**Responsible Person:** Performance and Compliance Officer **Date:** 31 March 2026

This engagement was conducted in conformance with Global Internal Audit Standards. The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the strengths and weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regard to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

This report is prepared solely for the use of the Authority and senior management of Pembrokeshire Coast National Park Authority. Details may be made available to specified external agencies, including external auditors, but otherwise the report should not be recited or referred to in whole or in part to other third parties without prior written consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

ASTARI

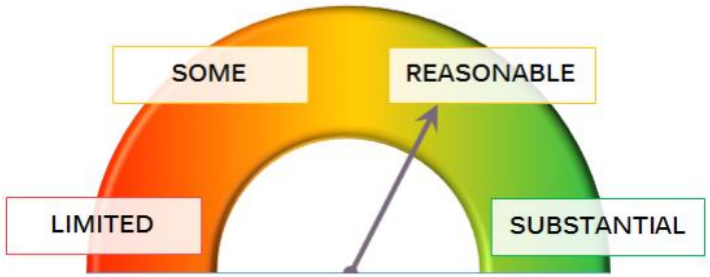
Pembrokeshire Coast National Park Authority

HSMS: Accident, Incident and Near Miss Reporting & Investigation

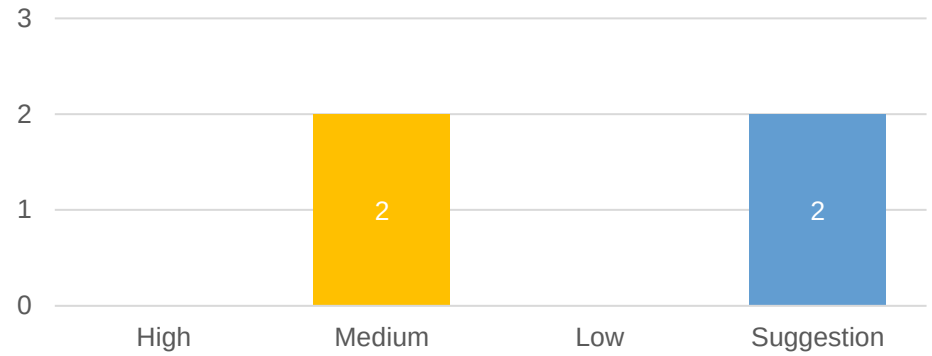
Internal Audit Report: PCNPA-2024/25-05
Date: 30 April 2025

1. EXECUTIVE SUMMARY

Level of Assurance

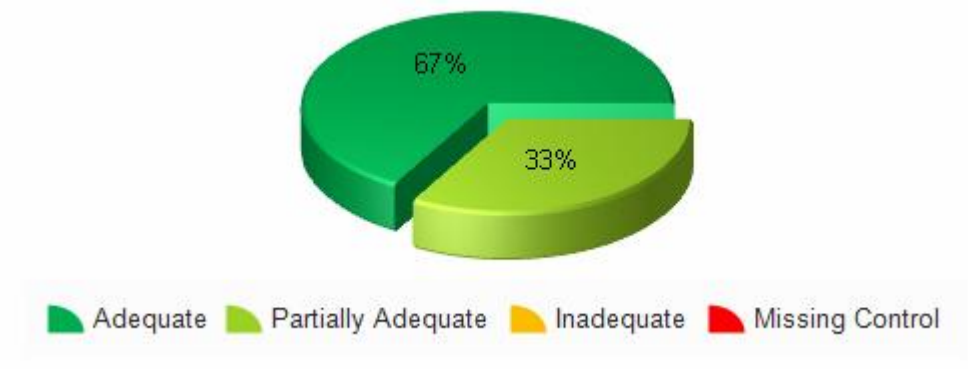


Number & Priority of Recommendations / Suggestions

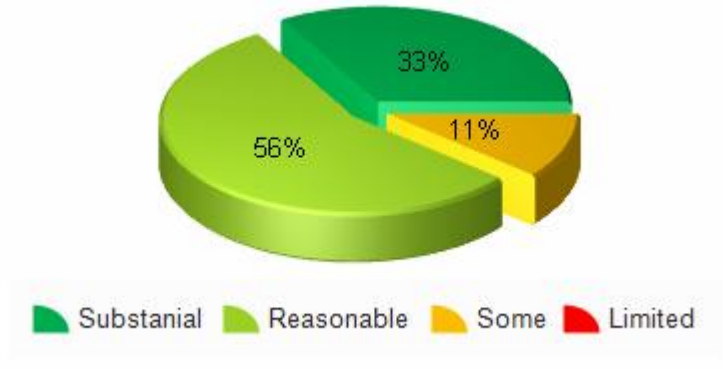


Conclusion:	Taking account of the scope of the review and the issues identified, the National Park Authority can take ***reasonable*** assurance that there are robust procedures in place, and being complied with, to identify and act upon accidents and incidents within a timely manner. However, some control improvements are required to help to ensure the continuous and effective mitigation of the risks in this area.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- An overarching and National Park Authority approved Health & Safety Policy was in place, which included key information expected including roles and responsibilities.
- Guidance was available to staff on the Authority's required approach via the supporting Incident Reporting and Investigations Policy and supporting process maps.
- Information was also available and provided to volunteers via the Volunteer Handbook, which was due to be reviewed and strengthened further to promote accountability.
- H&S training requirements of staff had been identified, and we were informed that H&S training compliance was 98% but we were unable to validate the accuracy of this with the information available to us.
- Training compliance was monitored and reported to the People Services Committee, with escalation processes in place. We noted that managers had not received specific training on the Authority's required approach and investigation procedures but had carried out IOSH Managing Safely training. Feedback from a sample of eight employees interviewed from across the Authority and of various level confirmed that the majority felt they had received sufficient training and guidance to understand their responsibilities.
- Feedback from interviews was positive with all those interviewed confirming that there were no barriers to reporting an incident or near miss however it was noted that volunteers often refused to provide sufficient evidence to enable effective reporting and investigation. We have not raised a recommendation at this time as we confirmed that there were plans in place to help mitigate this risk.
- Staff felt that the method of reporting was accessible and user friendly in 87% of those interviewed. Work had started to make reporting more efficient via the use of a Microsoft Teams form but this had not yet been implemented fully. We endorse this approach and recommend this work be progressed within a timely manner.
- All staff interviewed felt that reports were taken seriously, and that improvement action was taken when they or team members had reported incidents and near misses.
- We were not provided with evidence to confirm that ongoing promotion of reporting was occurring, outside of the Health & Safety Committee, but feedback from staff was generally positive and no significant issues were noted.
- Our testing identified a lack of consistent quality information was captured on incident reports and this subsequently prevented effective oversight over the timeliness of reports and investigations. There was currently no method of tracking when incidents occurred, reports were made and investigations completed for efficient oversight of performance and identification of any poor performance requiring attention.
- On average reports in our sample, which we were able to test, were made 10.8 days after the incident occurred. This jumped to 21 days if we included one report that took 125 days to be reported which related to a volunteer not having reported in a timely manner.
- We were advised of two RIDDOR had occurred since 1 January 2024 and through testing we confirmed that both were reported to the Health and Safety Executive (HSE) within defined timescales.
- Limited progress had been made to establish a robust and formal method of tracking improvement actions arising from reports/investigations centrally through to completion for assurance purposes. We have therefore restated a Medium priority recommendation around this, raised in the Health & Safety (02.23/24) review. We were provided with an example of a recent incident whereby actions had been completed as expected.
- We were advised that the Head of People Services had oversight of this area and monitored a central log of all reported accidents, incidents and near misses. These were also reported and discussed at Health & Safety Committee meetings and were an ongoing agenda item. Employees had opportunities to raise concerns at regular staff representative meetings and Countryside Management meetings.

- An all-staff survey was conducted in early 2024 where the weakest areas reported by staff were in relation to incident reporting. This aligned with feedback from staff we interviewed who said that they felt near misses and incidents in relation to abusive behaviour were under-reported. We confirmed via interview with the Chief Executive and review of relevant documentation that the Authority was aware of this and regularly promoted reporting via relevant groups and committees.
- Our follow up of progress made against three relevant recommendations raised in the Health & Safety (02.23/24) review confirmed that two out of three were fully implemented. One Medium recommendation has been restated in the Action Plan below.

Additional feedback

As part of the review we took into consideration improvements already identified internally and work planned to address this and have not raised additional recommendations where we feel risks would likely be mitigated by action planned.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	Appropriate structures and processes are in place to ensure that accidents and incidents are identified and reported within a timely manner; effective investigations are undertaken where necessary; and opportunities for improvement and prevention of re-occurrence of issues identified and actioned.
Risks:	Strategic Risk 13 – Failure to meeting Health & Safety requirements. Internal Audit identified risk: Incidents are not reported or reported in a timely manner resulting in reduced ability of the Authority to identify hazards and act upon them appropriately, carry out robust investigations and learn lessons to prevent re-occurrence of incidents, resulting in increased likelihood of harm to staff and the public, financial loss and reputational damage.
Engagement objective:	To provide assurance that there are robust procedures in place, and being complied with, to identify and act upon accidents and incidents within a timely manner. The review will consider whether appropriate action is being taken to promote a culture of reporting, to maximise the value of the process and lessons learnt.

2.2. Background to the Engagement

An audit of HSMS: Accident, Incident and Near Miss Reporting & Investigation was undertaken as part of the approved internal audit periodic plan for 2024/25. The organisation requested that Accident and Incident Reporting and Investigation be covered following feedback from the recent staff survey and recent incidents. The following areas were agreed to be included within this review:

Areas within scope:	Policy and procedural guidance, including definition of roles and responsibilities. Training and awareness raising, including proactive promotion of reporting near misses, accidents and incidents and reporting of outcomes. Reporting processes, including access and usability of staff working remotely. Reporting and investigation processes, including timeliness of investigations. Actions arising from investigations, including timeliness of completion and lessons learnt appropriately communicated to staff. Internal (2nd Line) assurance, including performance reporting. Interviews with a sample of staff to confirm their understanding of their responsibilities in line with PCNPA's expectations.

	Follow up on relevant outstanding H&S internal audit recommendations.
Performance measures considered in assignment planning:	Compliance with procedural guidance. Number of RIDDORs since 1 November 2023. Percentage completion actions required arising from investigations.

2.3. Limitations to the scope of the review

- Testing was on a sample basis only from 1 November 2023 and was limited to time and information available to us during the review.
- We did not reperform any accident/incident investigations as part of the review.
- Reliance was placed on our Health & Safety (02.23/24) review where applicable to reduce duplication of work.
- Interviews with staff were dependent on engagement and availability during the review.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Debrief Meeting:	24 February 2025
Draft Report Issued:	18 March 2025
Responses Received:	29 April 2025

Auditor:	Steffan Beange, Risk Assurance Consultant Ceri Kwiecinski, Risk Assurance Manager
Client Sponsor:	Tegryn Jones, Chief Executive Officer
Distribution:	Joy Arkley, Head of People Services Mair Thomas, Performance and Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	The Incident Reporting and Investigation Policy stated that all incidents should be reported at the time they occur. Our testing identified that only 68% of our sample included dates of incident vs date of report for analysis of timeliness. Of those reports with dates, we found that three (18%) reports were made the same day as the incident and the longest took 125 days, which we later found out was a volunteer that had failed to share with management what had happened at the time. Removing the 125 days anomaly report, staff took on average 10.8 days to report an incident to HR. Timeliness of reporting was not collated centrally for assurance and oversight of compliance and to identify poor performance.	Incidents are not reported or reported in a timely manner resulting in reduced ability of the Authority to identify hazards and act upon them appropriately, carry out robust investigations and learn lessons to prevent re-occurrence of incidents, resulting in increased likelihood of harm to staff and the public, financial loss and reputational damage.	To help strengthen oversight and assurance that the risk of staff not reporting incidents in a timely manner is being managed, it should be ensured that all reports include the date the incident occurred and the date it was reported to HR/management for investigation and that this information is centrally captured to enable efficient oversight and insight of performance and to identify and seek to address any poor performance. By capturing this data more effectively, along with the timeliness of investigations, it may be used as an aid in promoting the importance of reporting and holding staff accountable across the Authority and be reviewed regularly by the Health & Safety Committee.		Agreed.	**Responsible Person:** Joy Arkley **Date:** 30 May 2025

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R2	Records were not consistently and centrally recorded and tracked appropriately through to completion for assurance purposes and to maximise the likelihood of the event not recurring. We have therefore restated the recommendation raised in last year's Health & Safety audit as the risk remains.	Appropriate action to learn lessons and prevent reoccurrence of issues is not carried out resulting in further accidents and incidents and potential harm to stakeholders, HSE intervention and financial loss.	**Restated Recommendation – Health & Safety (02.23/24), Ref: 1507** Investigation processes and improvement actions identified following accident, incident and near miss reporting should be centrally captured and monitored through to completion. This will help to strengthen internal assurance processes in place and ensure that lessons are learnt and acted upon appropriately.		Agreed to design and deliver appropriate training as part of the implementation of CSM review May/June 2025.	**Responsible Person:** Joy Arkley **Date:** 30 June 2025

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	Additional feedback from employees interviewed included the desire to understand outcomes from reports made and insight into what the Authority is doing to help prevent re-occurrence of issues.	The Authority may wish to include specific case studies from reports received and investigated, including action taken and lessons learnt as part of ongoing promotion of the importance of reporting incidents and that the Authority takes the safety of stakeholders seriously.	This may be taken forward via the Health and Safety Group in the first instance.

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S2	During our review we noted that training had not been provided to managers on how to conduct a thorough investigation in line with the expectations and defined approach of the Authority. Managers had received IOSH Managing Safety training, which provided overarching guidance on the importance of the process and managers interviewed generally felt they understood their responsibilities sufficiently. It was however noted via our testing that the quality of information submitted by managers required HR to request additional information for assurance that a robust investigation had occurred, and this reduced assurance over the effectiveness the process.	Consideration should be given to providing more detailed training/awareness to managers responsible for conducting investigations specific to the Authority's expected procedures to promote consistency in application.	Accepted, although we are minded to appointing external Investigating Officers in the most serious occurrences.

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Pembrokeshire Coast National Park Authority

Follow Up

Internal Audit Report: PCNPA-2024/25-06

Date: 23 April 2025

Table of Contents

1. EXECUTIVE SUMMARY 3
1.1. Conclusion & number of recommendations 3
1.2. Status of recommendations followed up 4
2. BACKGROUND AND SCOPE 5
2.1. Scope of the review 5
2.2. Limitations to the scope of the review. 5
2.3. Recommendation Tracking 6
3. ACTION PLAN 7
APPENDIX A: DATA SUPPORTING THE OPINION 9

Fieldwork Undertaken:	3-4 February 2025
Last Information Received:	12 February 2025
Draft Report Issued:	14 March 2025
Responses Received:	16 April 2025
Final Report Issued:	23 April 2025
Audit Committee Presentation:	14 May 2025

Auditor:	Rhian Howes, Risk Assurance Consultant
Client Sponsor:	Tegryn Jones, Chief Executive Officer
Distribution:	Mair Thomas, Performance and Compliance Officer

1. EXECUTIVE SUMMARY

1.1. Conclusion & number of recommendations

Progress in implementation recommendations:

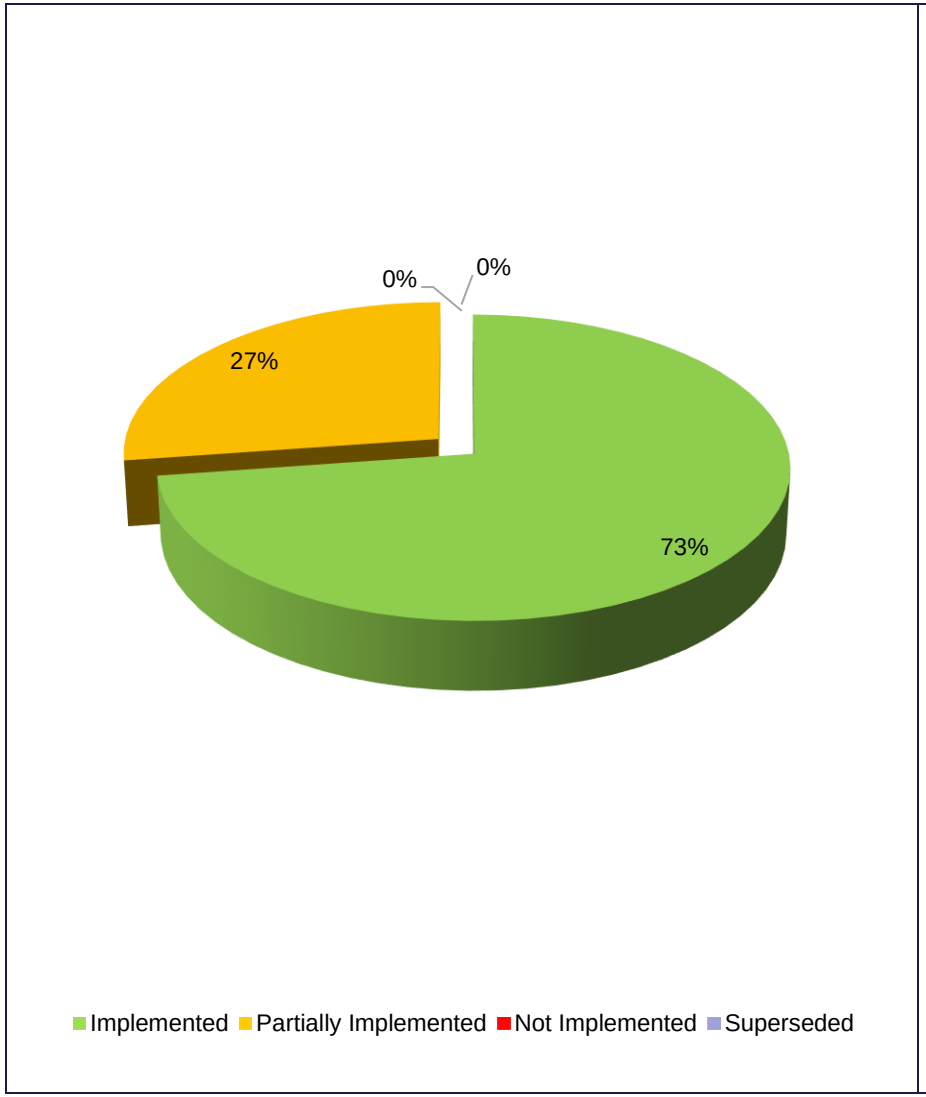
	High	Medium	Low	Suggestion
Recommendations:	0	2	1	0

Conclusion:	
	In our opinion, Pembrokeshire Coast National Park Authority has demonstrated ***Reasonable*** progress towards the implementation of agreed actions to address internal audit recommendations. There had been a significant improvement in the effectiveness of Internal Audit recommendation tracker, allowing the Authority to better monitor its outstanding actions. There are no High or Medium rated recommendations that we consider to be receiving inadequate management attention. We have reiterated recommendations where they have not been implemented and, where further actions are required, have raised new recommendations. These are detailed in the Action Plan.

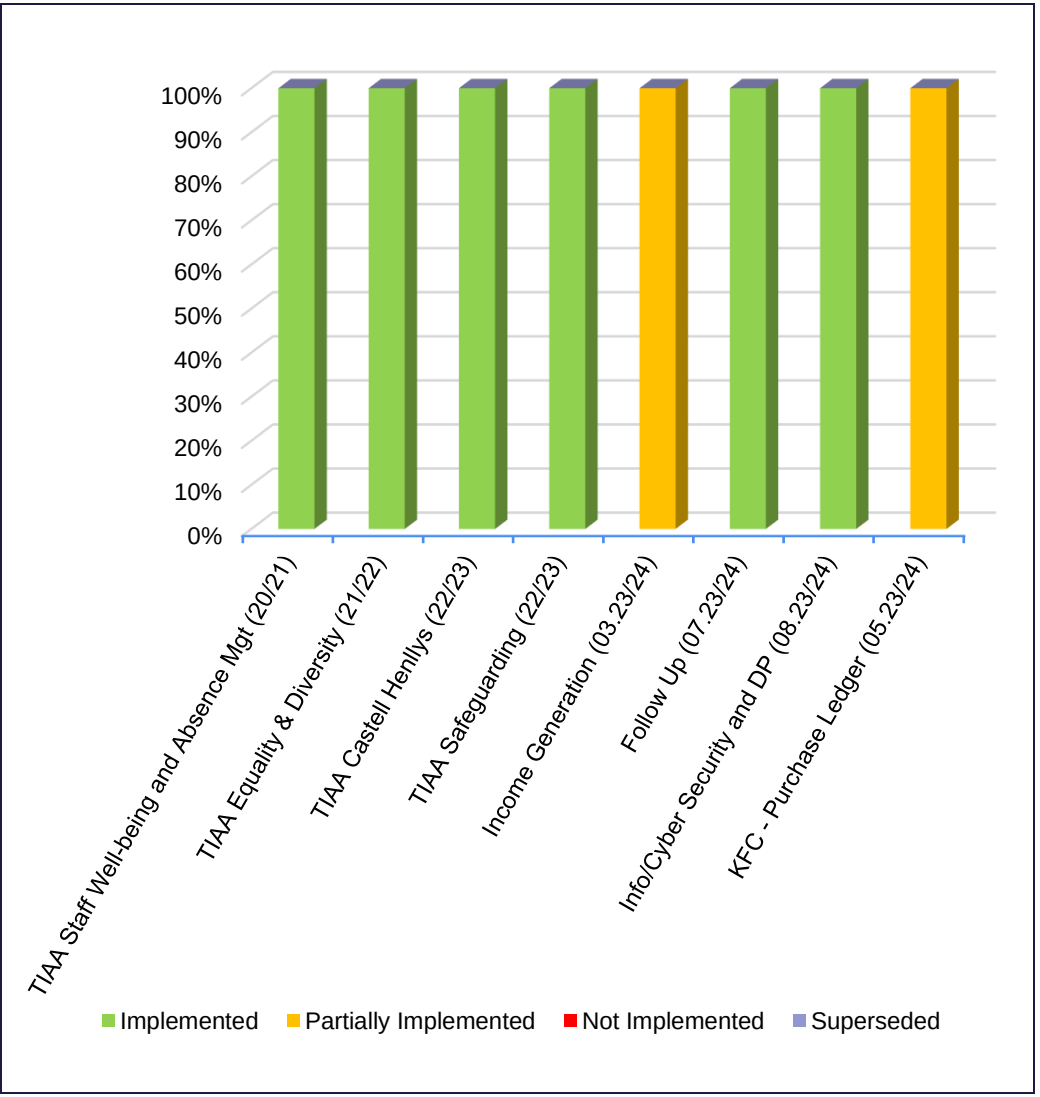
1.2. Status of recommendations followed up

The following charts provide an overview of the status of recommendations that have been followed up as part of this review:

Overview of recommendation status:



Recommendation implementation status by audit:



2. BACKGROUND AND SCOPE

2.1. Scope of the review

As part of the approved internal audit plan for 2024/25 we have undertaken an audit to follow up previous management actions as agreed in response to internal audit recommendations. Recommendations with dates for implementation not yet due will be followed up in future Follow Up audits.

The audits considered as part of this review were:

- Staff Well-being and Absence Management (TIAA.20/21)
- Equality & Diversity (TIAA.21/22)
- Castell Henllys (TIAA.22/23)
- Safeguarding (TIAA.22/23)
- Income Generation (03.23/24)
- Key Financial Controls - Purchase Ledger (05.23/24)
- Follow Up (07.23/24)
- Information & Cyber Security and Data Protection (08.23/24)

As part of our ongoing Internal Audit Plan, we also seek to follow up on relevant outstanding recommendations as part of specific reviews, such as Risk Management and Key Financial Control audits.

In total 11 recommendations were followed up in this review, comprising seven 'Medium' and four 'Low' recommendations. The focus of the review was to provide assurance that appropriate action is being taken to implement agreed actions.

Staff members responsible for the implementation of recommendations were interviewed to determine the status of the agreed action and, where appropriate, audit testing was undertaken to assess the level of compliance with this status and the controls in place.

Performance measures considered in assignment planning:	Percentage of agreed recommendations implemented.

2.2. Limitations to the scope of the review.

- The review focused on recommendations made in the above audits and did not review the whole control framework of the areas listed above. We are therefore not providing assurance on the entire risk and control framework.
- Where possible we placed reliance on our previous work to reduce duplication.
- Testing was undertaken where appropriate to confirm the effectiveness of actions taken to implement the recommendations. Where testing was undertaken, it was undertaken on a sample basis only from the period since actions were implemented or controls enhanced.

- The coverage of the scope was dependent on the availability of information provided to us during the fieldwork stage.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.3. Recommendation Tracking

Recommendation tracking enhances an organisation's risk management and governance processes. It provides management with a method to record the implementation status of recommendations made by assurance providers, whilst allowing the Audit and Corporate Services Review Committee to monitor actions taken by management.

Pembrokeshire Coast National Park Authority's management undertakes tracking of the implementation of recommendations made by internal audit on a regular basis, with an update provided to the Audit and Corporate Services Review Committee at each meeting. As part of our Follow Up review, we have verified this information and completed audit testing to confirm the level of implementation stated and compliance with controls. We have verified the status of implementation of recommendations, as reported to the Audit and Corporate Services Review Committee via the internal recommendation tracking process, is accurate for the majority of recommendations reviewed but limited evidence to support two recommendations prevented full validation.

3. ACTION PLAN

Priority:	= Low	= Medium	= High	= Suggestion

Status	Restated Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
Income Generation (03.23/24)				
Partially Implemented	**Recommendation (Ref: 1723)** The Authority's Income Diversification Checklist should be used to create an action plan with any elements that are to be undertaken formally documented, including specific actions and target timescales for completion. If an action is not intended to be completed, the rationale for this decision should be clearly recorded and the action plan as a whole should be approved at an appropriate level. **Summary of Findings** We confirmed with the Chief Executive that the checklist had since been reviewed and was only relied upon for relevant (larger) projects. Insufficient evidence was provided to us during fieldwork stage for us to confirm how the Authority intended to ensure that all key elements of income diversification would be captured, including any actions required. We have therefore restated the recommendation as in progress.		The focus of the Authority is on generating income and setting a balanced budget. Members and officers have reviewed the Audit Wales framework and considered that it is not-fit for purpose for the majority of our income generating activities. Spending more time on this recommendation will do nothing to identify sources of income and to continue to focus on this recommendation takes our focus away from actually setting a balanced budget and would increase our risk. Therefore it is proposed to close this recommendation.	**Responsible Person:** Chief Executive **Date:** N/A **Audit Note:** The committee is asked to approve the decision to supersede this recommendation.
Key Financial Controls (05.24/25)				

Status	Restated Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
Partially Implemented	**Recommendation (Ref: 1864)** On request or notification of bank detail changes from suppliers, a process whereby verification via a phone call should be undertaken. The obtaining of this number should be either online or via a known number used previously. **Summary of Findings** We confirmed through interview with the Head of Financing that processes were in place to update the system upon identifying bank/supplier changes. We did not receive evidence to confirm that this change of process had been formally documented and that recommended controls had been fully implemented.		We evidence any changes directly on the supplier record on Exchequer, a screen shot example has been provided. Written procedures are in place but are currently out of date as refers to an old finance system - XL. Procedures have not changed. Action: Financial Standards and financial procedures will be updated once new finance system implemented in Spring 2025.	**Responsible Person:** Head of Finance and Fundraising **Date:** 30 April 2026
Partially Implemented	**Recommendation (Ref: 1865)** Periodic regular reviews of suppliers should be undertaken, and those not used within a defined period deactivated. **Summary of Findings** We confirmed with the Head of Finance that the process to deactivate suppliers who had not been used in an 18-month period was underway but had not yet been completed due to the large number of suppliers recorded within the system.		We have 4k registered suppliers on our system. This will be a long process as we do not have capacity to trawl through all. This will be on ongoing process as and when time allows. Authority can review progress through export reports from Exchequer - 27 accounts currently closed. Action: In acknowledgement that this is an ongoing process rather than a one off process, we will run a twice a year report from Sage to identify current number of suppliers who have been deactivated to assess our progress in this area.	**Responsible Person:** Head of Finance and Fundraising **Date:** 30 April 2026

APPENDIX A: DATA SUPPORTING THE OPINION

Recommendation Status by Audit:

Review	Total Number of Recommendations	Recommendation Status				No. of recommendations carried forward (2 + 3)
		Implemented (1)	Partially Implemented (2)	Not Implemented (3)	Superseded (4)	
Staff Well-being and Absence Management (TIAA.20/21)	2	2	0	0	0	0
Equality & Diversity (TIAA.21/22)	1	1	0	0	0	0
Castell Henllys (TIAA.22/23)	1	1	0	0	0	0
Safeguarding (TIAA.22/23)	1	1	0	0	0	0
Income Generation (03.23/24)	1	0	1	0	0	1
Follow Up (07.23/24)	2	2	0	0	0	0
Information & Cyber Security and Data Protection (08.23/24)	1	1	0	0	0	0
Key Financial Controls – Purchase Ledger (05.23/24)	2	0	2	0	0	2
TOTAL:	**11**	**8 73 %**	**3 27 %**	**0 0 %**	**0 0 %**	**3 27 %**

Recommendation Status by Priority:

Review	Total Number of Recs	Recommendation Status				No. of recommendations carried forward (2 + 3)
		Implemented (1)	Partially Implemented (2)	Not Implemented (3)	Superseded (4)	
High	0	0	0	0	0	0
Medium	7	5	2	0	0	2
Low	4	3	1	0	0	1
TOTAL:	**11**	**8**	**3**	**0**	**0**	**3**
		73 %	**27 %**	**0 %**	**0 %**	**27 %**

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Pembrokeshire Coast National Park Authority

DRAFT Strategy Update for Internal Audit

2025/26 -2027/28

To be presented at the Audit & Corporate Services Review Committee meeting of 14 May 2025 and at the National Park Authority meeting of TBC.

Table of Contents

1. Introduction 1

1.1. Approach 1

1.2. The Purpose and Function of Internal Audit 2

2. Developing your Internal Audit Strategy for 2025 / 2028 3

3. Considerations for the National Park Authority 3

4. DETAILED INTERNAL AUDIT PLAN 2025/26 4

Appendix I: Strategy for Internal Audit 2025/26 – 2027/28 7

1. INTRODUCTION

1.1. Approach

This strategy sets out the approach taken to develop your strategy for Internal Audit for 2025 / 2028. It provides the Authority with a three year strategy and a more detailed plan for 2025/26.

The Internal Audit Strategy is reviewed at least annually to take into account any significant events or findings which may impact upon the audit risk assessments and in-year changes are often implemented as the priorities of the organisation change and the risk environment alters. An update on delivery of the Strategy, including any changes, is provided at each meeting of the Audit & Corporate Services Review Committee.

Each year an 'Understanding the Business' exercise is undertaken through which your Internal Audit team considers any changes to the Authority or the operating environment, including reviewing the results of previous audits and other sources of assurance. This, plus your own risk management processes are used to undertake a risk assessment and develop a robust, risk-based audit plan.

An Annual Plan will be prepared prior to the start of each fiscal year and will be presented to the Audit & Corporate Services Review Committee for approval for submission to the National Park Authority.

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1.2. The Purpose and Function of Internal Audit

Our professional responsibilities as internal auditors are set out in the Global Internal Audit Standards (GIAS), published by the Institute of Internal Auditors (IIA), which have been updated and are live from 9 January 2025.

The GIAS state that the purpose of Internal Audit is to "strengthen the organisation's ability to create, protect and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight."

Internal Auditing enhances the organisation's:

- Successful achievement of its objectives;
- Governance, risk management, and control processes;
- Decision-making and oversight;
- Reputation and credibility with its stakeholders; and
- Ability to serve the public interest.

The GIAS state that internal auditing is most effective when:

- It is performed by competent professionals in conformance with the Global Internal Audit Standards, which are set in the public interest;
- The internal audit function is independently positioned with direct accountability to the board; and
- Internal auditors are free from undue influence and committed to making objective assessments.

The updated Standards place particular emphasis on Board ownership, via the Audit & Corporate Services Review Committee, of the Internal Audit Strategy and Annual Plan and that requirement is reflected throughout this document.

2. Developing your Internal Audit Strategy for 2025 / 2028

Understanding Pembrokeshire Coast National Park Authority's objectives and risk profile is the starting point for the development of the strategy for internal audit for the Authority, which is set out at Appendix I to this document.

The following key areas were considered in the update of the 2025/26 plan and three year strategy:

Key Areas considered:	
1	This Strategy is a risk-based Strategy and it is built around the Authority's objectives and risks. Given the work ongoing to update the risk register, we have not included any strategic risk specific reviews in this year's plan. Appendix I provides details of the significant risks from the February 2025 Risk Register and how our audits will provide partial assurance over the risks.
2	Ensuring audits are undertaken "across" teams, considering the integration of teams across the Authority as part of relevant reviews.
3	Knowledge learnt about the Authority so far and the findings of our reviews undertaken in 2023/24 2024/25, to ensure the audit universe (detailed in Appendix 1 – Other internal audit coverage) is accurate and complete.
4	Impacts of the external environment on the Authority and it's potential to achieve its objectives, including but not limited to financial pressures and climate change, have been considered.
5	Feedback from management and the Audit & Corporate Services Review Committee Chair was sought and used to develop the plan to ensure it provides the most value to the Authority.

The detailed plan for 2025/26 is set out in Section 4.

3. Considerations for the National Park Authority

To assist the Authority with its consideration of the Internal Audit Plan, some questions are provided below that could be considered when reviewing the Plan:

- Does the Strategy for Internal Audit (as set out at Appendix I) cover the Authority's key risks as they are recognised by the organisation?
- Is there sufficient alignment between the proposed engagements planned and the rest of the Authority's assurance framework / programme of assurance?
- Does the audit strategy include all those areas that the Authority would expect to be subject to internal audit coverage, both in terms of our professional responsibilities as well as covering areas of concern flagged by management?
- Is the level of audit resource accepted by the Authority and agreed as appropriate, given the level of assurance required?
- Does the detailed internal audit plan for the coming financial year (see Section 4) reflect the areas that the Authority believes should be covered as priority?
- Is there sufficient clarity over the assurance you will be receiving detailed in the plan for the coming financial year?
- Is the level of audit resource accepted by the Committee and agreed as appropriate, given the level of assurance required?
- Is the Authority satisfied that sufficient assurances are being received to effectively monitor its risk profile?

4. DETAILED INTERNAL AUDIT PLAN 2025/26

Audit	Overview of Internal Audit Coverage	Proposed Timing	Days
Risk Management	This review will aim to follow up on the recommendations and suggestions raised in the previous year's risk reviews and that the benefits anticipated from the changed processes are being achieved. The review will cover: ▪ Follow up on four outstanding recommendations raised in the Risk Maturity (01.23/24) review comprising of one High, one Medium and two Low priority recommendations. - Link between strategic objectives and the Authority's strategic risks; - Risk management guidance - Accuracy and clarity of information recorded on the register, including use of "actual" assurance and further actions required.	December 2025	2
Governance: Strategic Planning	To provide assurance that the Authority has implemented robust structures and processes to implement its strategic plan, monitor that implementation and report progress accurately to the National Park Authority. The review will cover: ▪ The content of the corporate strategy and its measurability. ▪ How the corporate strategy has been broken down into deliverable elements. ▪ How the Authority considers external changes and risks and incorporates these into its strategy. ▪ The structures and processes through which the deliverables will be managed and monitored. ▪ Alignment with other processes, such as risk, performance and financial management. ▪ Plans for reviewing annual planning taking into account progress. ▪ Reporting of progress in delivering the plan(s) and the accuracy of that reporting.	October 2025	3

Audit	Overview of Internal Audit Coverage	Proposed Timing	Days
IT Continuity & Disaster Recovery	To provide assurance that there are robust continuity and recovery processes in place within the organisation for responding to an incident impacting on the operation of the organisation's key ICT systems. The review will cover: ▪ ICT Continuity & Disaster Recovery Plans. ▪ Alignment with the organisation's Business Continuity arrangements. ▪ Continuity, resilience and back-up arrangements for key systems and data. ▪ Detailed procedures for recovering key systems should continuity not be possible. ▪ ICT continuity and recovery testing processes. ▪ Maintenance of plans, learning from incidents and assurance processes.	July 2025	4
Key Financial Controls	Review of key financial control areas on a cyclical basis, including the following: General Ledger; Payroll; Creditors; Budgetary Control; Fixed Assets; and Cash & Treasury Management. Coverage of the above areas will be risk-based, taking into account the following: changes to personnel or systems, time since the previous assurance review, changes in the external environment and/or risks identified in the sector. It is likely that the review will include an element of validation of the work undertaken to prevent re-occurrence of errors identified by External Audit.	February 2026	3
Customer Engagement (incl. consultations)	A review of how the customer voice is heard and incorporated into service planning / development as well as in terms of feedback of current services provided. To provide assurance that the organisation is providing appropriate opportunities for customers to engage with the organisation and get involved with elements such as policy / service design and, where appropriate, informing or being part of decision-making processes. The review will cover: ▪ The structures and processes through which customer engagement / involvement is enabled. ▪ Review of how the Authority identifies potential opportunities for customer engagement / involvement. ▪ Verification that outcomes from the engagement / involvement are being achieved. ▪ Consideration of key forms of customer feedback, including compliments and complaints, and how this data is being used to learn lessons and shape services or improvements. Our review will exclude consultations undertaken as part of the planning application process.	September 2025	4

Audit	Overview of Internal Audit Coverage	Proposed Timing	Days
Asset Management – Commercial Management	This review will aim to provide assurance that the Authority is managing its assets in line with the expectations of the Authority and that income is being maximised from its assets. The review will cover: ▪ Asset portfolio management arrangements, including key roles and responsibilities; ▪ Identification and ongoing validation of asset / estates responsible for; ▪ Commercial rent collection and monitoring arrangements, including arrears management; ▪ Income arrangements and methodology utilised to maximise income from estates, such as car parks; and ▪ Budget management and oversight.	November 2025	4
Follow Up	To meet internal auditing standards and to provide management with ongoing assurance regarding implementation of recommendations. In the first year this will include consideration of all outstanding recommendations and an assessment of whether they are still live and their stage of implementation.	December 2025	2
Management	This will include: ▪ Annual planning; ▪ Preparation for, and attendance at, Audit & Corporate Services Review Committee meetings; ▪ Regular liaison and progress updates; ▪ Liaison with external audit; and ▪ Preparation of the annual internal audit opinion.	Ongoing	5
		TOTAL:	**27**

APPENDIX I: Strategy for Internal Audit 2025/26 – 2027/28

Internal Audit Coverage	Source / Rationale	2024/25	2025/26	2026/27	2027/28	Last Audit Date
Risk Management	Annual review of this key area to provide assurance that the Authority's risk management processes are operating effectively and that key risks to its objectives are being identified, managed and monitored.	✓	✓	✓	✓	2024/25
Key Financial Controls	Review of key financial control areas, including the following: ▪ General Ledger ▪ Payroll ▪ Creditors ▪ Budgetary Control ▪ Fixed Assets ▪ Cash & Treasury Management Coverage of the above areas will be risk-based, taking into account the following: changes to personnel or systems, time since the previous assurance review, changes in the external environment and/or risks identified in the sector.	✓	✓	✓	✓	2024/25
Governance	Annual review of governance arrangements in place; areas that may be considered include:					
	▪ Performance Management (Organisational)			✓		2022/23
	▪ Value for Money				✓	2023/24
	▪ Governance Structures & Processes	✓			→[1]	2024/25
	▪ Strategic Planning		✓			-
Business Continuity	A review that aims to provide assurance that the Authority is appropriately prepared for a major incident that could significantly impact on delivery of the Authority's services.			✓		-

[1] This symbol indicates an audit area that is to be covered in years beyond the life of this Strategy.

Internal Audit Coverage	Source / Rationale	2024/25	2025/26	2026/27	2027/28	Last Audit Date
Visitors Centres	A thematic review covering all three of the Visitors Centres is planned for every three years. This will be a cross-cutting, risk-based review of the operation of the Visitors Centre covering such areas as business planning, health and safety, cash handling or other areas as required. The specific scope of the review will be agreed in advance each year.	✓			✓	2024/25
Asset Management	Coverage of asset management areas including the following					
	▪ Commercial Management		✓			-
	▪ Health & Safety			✓		
Countryside Management	Coverage of countryside management areas including the following:					
	▪ Coastal Path				✓	2023/24
	▪ Forestry Management				→	-
Information Technology	Cyclical coverage of IT control areas including the following:					
	▪ Information & Cyber-Security and Data Protection			✓		2023/24
	▪ IT Strategy	✓			✓	2024/25
	▪ IT Continuity & Disaster Recovery		✓			2022/23
Human Resources	Coverage of HR areas including the following:					
	▪ Sickness Absence Management				→	-
	▪ Succession Planning				→	-
	▪ Performance Management (Personnel)			✓		-
	▪ Recruitment & Retention				✓	-
Equality, Diversity and Inclusion	Review of how the Authority ensures that it is complying with equality legislation and is also maximising the benefits that can be achieved through effective inclusion.	✓			→	2024/25
Customer Engagement (incl. consultations)	A review of how the customer voice is heard and incorporated into service planning / development as well as in terms of feedback of current services provided.		✓			-

Internal Audit Coverage	Source / Rationale	2024/25	2025/26	2026/27	2027/28	Last Audit Date
Sustainable Development Fund	Cyclical review of how the Authority distributes the SDF and how it ensures compliance with the requirements of the fund and that deliverables are completed.			✓		-
Climate Change & Decarbonisation	A review to provide assurance that key risks in relation to achieving Objective 4 – "The National Park is protected and conserved" have been identified and are being appropriately managed.	✓			→	2024/25
Conservation & Nature Recovery	A review of how the Authority is monitoring its conservation and nature recovery objectives with the aim of providing assurance that the monitoring is data-led, backed up by evidence and that performance information reported is accurate.				✓	-
Safeguarding	Cyclical review of how the Authority ensures its safeguarding responsibilities are met, including at events and through general use of the Authority's facilities.				→	2022/23
Planning & Development	A review of how the Authority achieves its planning and development goals and ensures efficiencies in the process in support of the Authority's corporate objectives.			✓		-
Fraud	A compliance review to provide assurance that key fraud risks are being identified by the Authority and steps taken to reduce those risks. Fraud will also be considered in each of our reviews.				✓	-
Accessibility & Engagement	Linking with the organisation's Corporate Plan objectives, this review will consider the Authority's activities around enabling accessibility to the National Park's amenities as well as how it engages with stakeholders to achieve its objectives.			✓		-
Income Generation	Follow Up review that considered how the Authority is responding to the recommendations made by the Wales Audit Office in its Income Diversification Report.				→	2023/24
Procurement & Contract Management	This review will aim to provide assurance that the Authority is achieving value for money through its procurement activities and that established contracts are being appropriately managed to achieve the outcomes expected.			✓		-

Internal Audit Coverage	Source / Rationale	2024/25	2025/26	2026/27	2027/28	Last Audit Date
Complaints & Customer Feedback	This review will consider how the organisation seeks feedback from its customers and other stakeholders and acts upon that feedback, along with any complaints received, to address any under-performance or to ensure a culture of continual improvement is operating.				✓	-
Follow Up	To meet the internal auditing standards and to provide management with ongoing assurance regarding implementation of recommendations. In year 1 this will include consideration of all outstanding recommendations and an assessment of whether they are still live and their stage of implementation.	✓	✓	✓	✓	Annual
Added Value Services	We can undertake a number of additional added value services to support the Authority, including: ▪ Project Management Support ▪ Project Assurance – including attendance at project meetings as a 'critical friend' ▪ Workshops on specific areas such as risk, projects or strategic / corporate / operational planning ▪ Training These may form part of the formal Internal Audit Plan or may include, for example, pre-Authority / Audit & Corporate Services Committee training on particular subject areas. These can be requested at any point throughout the year but may be subject to an additional resource allocation.	-	-	-	-	-