Report No. 13/22

Audit & Corporate Services Review Committee

REPORT OF THE INTERNAL AUDITOR

SUBJECT: INTERNAL AUDIT REPORT 2021/22

The report is the outcome of work completed against the block two of the 2021/22 operational audit plan previously approved by the Authority's Audit and Corporate Services Review Committee

The internal audit service reviewed the following area:

- Follow Up Review
- Equality and Diversity
- Risk Management – Mitigating Controls
- Review of Resilient and Sustainable Services

From these examinations, taking into account the relative risk of the business areas the internal audit service formed generally very positive conclusions regarding the policies, procedures and operations in place.

The TIAA report also includes the summary 2021/22 Annual Audit Report which contains their audit opinion.

Recommendation: Members are asked to NOTE and COMMENT on this report

(For further information, please contact Richard Griffiths, extension 4815
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Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

Follow Up Review

2021/22

April 2022

Executive Summary

Introduction

1. This follow up review by TIAA established the management action that has been taken in respect of all recommendations arising from the internal audit reviews listed below at Pembrokeshire Coast National Park Authority. The review was carried out in March 2022.

Review	Year	Date Presented to Audit & Corporate Services Review Committee
Key Financial Controls – General Ledger and Budgetary Control	2020/21	November 2020
Departmental Review – Education – Block 1	2020/21	November 2020
Staff Wellbeing and Absence Management	2020/21	November 2020
Governance – Strategic Planning	2020/21	November 2020
Planning Application & Fees – Block 2	2020/21	May 2021
Cyber-Security	2020/21	May 2021
Follow-Up 2020/21 – Block 1 – 2019/20	2020/21	July 2021
Follow-Up 2020/21 - Block 2 – 2019/20	2020/21	July 2021
Follow Up 2020/21 – Risk Management	2020/21	July 2021
Follow Up 2019/20 (Risk Management 2018/19)	2020/21	July 2021

Key Findings & Action Points

2. The follow up review considered whether the management action taken addresses the control issues that gave rise to the recommendations. The implementation of these recommendations can only provide reasonable and not absolute assurance against misstatement or loss. From the work carried out the following evaluations of the progress of the management actions taken to date have been identified.

Evaluation	Number of Recommendations
Implemented	11
Outstanding	10
Considered but not Implemented or Superseded	2
Not Implemented	-

3. The Authority has made reasonable progress with 11 (48%) recommendations implemented. 10 (43%) recommendations remain outstanding and details of the progress made to date are provided in the report. Two further recommendations have been superseded following the internal audit review of Risk Management and a subsequent training session in 2021/22 which have resulted in two new, albeit similar recommendations.

Scope and Limitations of the Review

4. The review considered the progress made in implementing the recommendations made in the previous internal audit reports and established the extent to which management has taken the necessary actions to address the control issues that gave rise to the internal audit recommendations.

5. The responsibility for a sound system of internal controls rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses that may exist. Neither should internal audit work be relied upon to identify all circumstances of fraud or irregularity, should there be any, although the audit procedures have been designed so that any material irregularity has a reasonable probability of discovery. Even sound systems of internal control may not be proof against collusive fraud.

6. For the purposes of this review reliance was placed on management to provide internal audit with full access to staff and to accounting records and transactions and to ensure the authenticity of these documents.

Disclaimer

7. The matters raised in this report are only those that came to the attention of the auditor during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our 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. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Release of Report

8. The table below sets out the history of this report.

Date draft report issued:	8th April 2022
Date management responses rec'd:	26th April 2022
Date final report issued:	27th April 2022

Executive Summary

Follow Up

9. Management representations were obtained on the action taken to address the recommendations and limited testing has been carried out to confirm these management representations. The following matters were identified in considering the recommendations that have not been fully implemented:

10. **Key Financial Controls - General Ledger and Budgetary Control**

All recommendations have been implemented.

11. **Departmental Review – Education**

Audit title	**Departmental Review - Education**	**Audit year**	2020/21	**Priority**	**2**
Recommendation	It be ensured that all staff complete their Safeguarding Training module as appropriate and the spreadsheet is updated to record that training has been completed.				
Initial management response	The headings requested is already documented on the accreditation spreadsheet. Missing information is in the process of being updated. As pointed out, the management of the DBS check process has only recently been taken on by the HR Department following a period of personnel change. We will review the processes highlighted, including data management, with oversight provided by the Authority's Safeguarding group which includes the Safeguarding Lead for PCNPA, the Chief Executive Officer and the HR Manager				
Responsible Officer/s	HR Manager	**Original implementation date**	30/11/2020	**Revised implementation date(s)**	N/A
Latest Update	Spreadsheet updated				
New implementation date	31/05/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

12. **Staff Wellbeing and Absence Management**

Audit title	**Staff Wellbeing and Absence Management**	**Audit year**	2020/21	**Priority**	**2**
Recommendation	The Employee Health and Wellbeing policy be updated.				
Initial management response	It was made known to TIAA that the HR department are in the process of a wholesale review of all HR policies.				
Responsible Officer/s	**HR Manager**	**Original implementation date**	01/02/2021	**Revised implementation date(s)**	N/A
Latest Update	A review of policies has started. The Employee Health and Wellbeing Policy was not a priority as higher risks, for example First Aid and HAVS policies were. The Employee Health and Wellbeing Policy will be updated in Q2 2022. Currently this is programmed for May 2022.				
New implementation date	31/05/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

Audit title	**Staff Wellbeing and Absence Management**	**Audit year**	2020/21	**Priority**	**2**
Recommendation	The Managing Pressure and Reducing Stress Policy be updated.				
Initial management response	It was made known to TIAA that the HR department are in the process of a wholesale review of all HR policies.				
Responsible Officer/s	**HR Manager**	**Original implementation date**	01/02/2021	**Revised implementation date(s)**	N/A
Latest Update	A review of policies has started. The Employee Health and Wellbeing Policy was not a priority as higher risks, for example First Aid and HAVS policies were. The Employee Health and Wellbeing Policy will be updated in Q2 2022. Currently this is programmed for May 2022.				
New implementation date	01/06/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

Audit title	**Staff Wellbeing and Absence Management**	**Audit year**	**2020/21**	**Priority**	**3**
Recommendation	Line Managers to undertake Absence Management Training.				
Initial management response	Line Manager training should be wider than Occupational Health referrals. It was advised that upon approval of the revised policies on managing short term and managing long term absence, Line Manager training would be developed and delivered by HR.				
Responsible Officer/s	**HR Manager**	**Original implementation date**	01/03/2021	**Revised implementation date(s)**	N/A
Latest Update	This is scheduled for May 2022 and was delayed due to other priorities last year.				
New implementation date	31/052022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

13. **Governance - Strategic Planning**

All recommendations have been implemented.

14. **Planning Application and Fees – Block 2**

Audit title	**Planning Application Fees – Block 2**	**Audit year**	**2020/21**	**Priority**	**2**
Recommendation	All invalid letters be sent to Applicants where their Planning Application has been rejected in a timely manner in accordance with the Development Management Manual.				
Initial management response	To hold a validation session with planning officers and admin staff to review the current processes and implement new processes to reduce the timing for validation and automate the process as much as possible.				
Responsible Officer/s	Nicola Gandy / Matthew Griffiths	**Original implementation date**	March 2021	**Revised implementation date(s)**	N/A
Latest Update	A session has been held with the organisation's back office IT provider who is looking to develop a module to automate validation. This is something that the organisation has fed into and will be looking to utilise once it is developed. The organisation has offered to be a test authoriser for the developer. Action completed				
New implementation date	30/09/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

Audit title	**Planning Application Fees – Block 2**	**Audit year**	**2020/21**	**Priority**	**3**
Recommendation	A Quality Assurance process be put in place to assess the performance of the Planning Application process and to ensure compliance with the Development Management Manual				
Initial management response	Director and Team Leader to run half-yearly checks on a sample of 10 applications and feedback to team on findings.				
Responsible Officer/s	Nicola Gandy / Matthew Griffiths	**Original implementation date**	June 2021 and half yearly	**Revised implementation date(s)**	N/A
Latest Update	The recommendation is in the process of being implemented. A session was held between the Team Leader and the Director to quality check applications, this has not yet been fed back to the officers. An officer has been away on long-term sickness but has only just returned.				
New implementation date	30/06/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

15. **Cyber-Security**

Audit title	**Cyber-Security**	**Audit year**	**2020/21**	**Priority**	**2**
Recommendation	The Information and Data Security Policy be amended to state that sensitive data is never saved onto an unencrypted laptop or any other portable storage device.				
Initial management response	Recommendation accepted, the Information and Data Security Policy will be amended.				
Responsible Officer/s	Business Improvement and IT Manager	**Original implementation date**	30/04/2021	**Revised implementation date(s)**	N/A
Latest Update	Whilst the original recommendation was accepted, this was replaced by a decision to delay the policy update because of the Authority's decision to move to Microsoft 365. Microsoft 365 provides the ability to implement central security and sensitivity controls through system configuration, thereby providing greater security rather than relying on the adherence to a policy statement. The Microsoft 365 Project is underway and security controls are being configured, the Information and Data Security Policy will be substantially updated as result. It is expected that the reflective updates to the policy will be carried out during the summer of 2022.				
New implementation date	31/08/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

Audit title	**Cyber-Security**	**Audit year**	**2020/21**	**Priority**	**2**
Recommendation	ICT need to introduce controls to prevent users from accessing personal webmail through the Authority's network, encouraging users to use their own mobile phone, tablet or other device in order to access their e-mail through the public Wi-Fi.				
Initial management response	Recommendation to be reviewed with Authority Leadership team – under consideration will be the following implications – risk of not preventing access to personal email accounts, the practicalities of preventing access and the potential impact on staff members who do not have the financial resources available for personal devices. Note: Timetable lengthy as, should the recommendation be accepted: • An update to the ICT Policy, approval and subsequent welsh translation will be required prior to publication. • Controls will need to be put in place on all Authority devices to prevent access to both webmail and mail applications.				
Responsible Officer/s	Business Improvement and IT Manager	**Original implementation date**	30/08/2021	**Revised implementation date(s)**	N/A
Latest Update	Following a review and taking into account the initial management response, the recommendation will not be adopted. Users will continue to be expected to adhere to the ICT policy with regard to the appropriate use of Authority equipment and resources				
New implementation date	30/08/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

16. **Follow Up 2020/21 - Block 1 – 2019/20**

Audit title	**Business Continuity Plan**	**Audit year**	2019/20	**Priority**	**1**
Recommendation	The BCP should to be re-written to ensure that it reflects the current processes required to ensure that the organisation can continue operationally in recovering from a disaster, mishap or other event. Additionally, once the BCP has been agreed all nominated personnel should be made aware of their responsibilities and trained accordingly. The plan should be tested on an annual basis and updated accordingly.				
Initial management response	Recommendations accepted. A new BCP will be created with an annual test schedule and all staff will be provided with appropriate training. Update at 2020/21 Follow Up "Delayed due to Covid-19 however, a new BCP will be created with an annual test schedule. All staff will be provided with appropriate training".				
Responsible Officer/s	Business Improvement and IT Manager	**Original implementation date**	31/12/2019	**Revised implementation date(s)**	31/12/2022
Latest Update	Revised Business Continuity Plan drafted but awaiting full implementation of Office 365 before adopting				
New implementation date	30/11/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

17. **Follow Up 2020/21 - Block 2 – 2019/20**

Audit title	**Risk Management**	**Audit year**	2019/20	**Priority**	**2**
Recommendation	The Risk Management Strategy be reviewed and updated to reflect current arrangements.				
Initial management response	Agreed. The Strategy will be updated to reflect the 4 x4 scoring introduced in 2018. Update at 2020/21 Follow Up Discussion with the Finance Manager confirmed that the Risk Management Strategy has not been updated. It is proposed that the Risk Register be included in the 2021/22 internal audit work undertaken by TIAA				
Responsible Officer/s	Finance Manager	**Original implementation date**	31/01/2020	**Revised implementation date(s)**	30/11/22
Latest Update	Discussion with the Finance Manager confirmed that the Risk Management Strategy has been updated to reflect the changes to the 4 x 4 matrix but a further review is required following the TIAA review of Risk Management and the workshop with Authority Members in 2021/22. .				
New implementation date	09/2022	**Status**	**Outstanding**	The recommendation is outstanding and past its due date.	

Audit title	**Risk Management**	**Audit year**	2019/20	**Priority**	**2**
Recommendation	The narrative in the Mitigation and Controls/Monitoring columns be expanded upon, where applicable, to provide greater assurance to the Authority Members that the risks are being mitigated.				
Initial management response	Agreed. We will explore expanding the narrative in the mitigation and control/ monitoring columns Update at 2020/21 Follow Up Discussion with the Finance Manager confirmed that this recommendation has not yet been implemented. It is proposed that the Risk Register be included in the 2021/22 internal audit work undertaken by TIAA.				
Responsible Officer/s	Finance Manager	**Original implementation date**	31/01/2020	**Revised implementation date(s)**	30/11/22
Latest Update	This recommendation has now been superseded by a similar recommendation in the 2021/22 review of Risk Management.				
New implementation date	30/11/22	**Status**	**Superseded**	N/A	

Audit title	**Follow Up 2019/20 (Risk Management 2018/19)**	**Audit year**	2019/20	**Priority**	**2**
Recommendation	The Authority should recognise risk at an inherent level and align this analysis with its business plan to ensure that all stakeholders recognise the risks which are critical to the Authority's success.				
Initial management response	We will investigate the practicality of incorporating this suggestion into departmental business plans Update at 2020/21 Follow Up Discussion with the Finance Manager confirmed that this is ongoing but has not yet been completed. It is proposed that the Risk Register be included in the 2021/22 internal audit work undertaken by TIAA.				
Responsible Officer/s	Finance Manager	**Original implementation date**	31/03/2019	**Revised implementation date(s)**	30/11/22
Latest Update	Discussion with the Finance Manager confirmed that this is ongoing but has not yet been completed. It is proposed that the Risk Register be included in the 2021/22 internal audit work undertaken by TIAA. This recommendation has now been superseded by a similar recommendation in the 2021/22 review of Risk Management.				
New implementation date	30/11/2022	**Status**	**Superseded**	N/A	

18. The following recommendations have been implemented.

Audit Title	Recommendation	Priority	Responsible Officer	Status	Due Date
Key Financial Controls - General Ledger and Budgetary Control	Out of date Financial Control procedures be reviewed and updated.	3	Finance Manager	Implemented	31/12/2020
Key Financial Controls - General Ledger and Budgetary Control	The General Ledger Suspense account be reviewed and old balances cleared.	3	Finance Manager	Implemented	31/08/2020
Departmental Review – Education	The Data Barring Service (DBS) accreditation spreadsheet be reviewed and completed to include up to date information such as the DBS Category, DBS Number, Date of Issue and Disclosure result for all staff that require this to be completed.	2	HR Manager	Implemented	30/11/2020
Staff Wellbeing and Absence Management	Line Managers need to monitor the three trigger points stated in the Handling Attendance and Absence Policy in order to take further action on employees who hit the trigger points	2	HR Manager/HR Advisor	Implemented	01/03/2021
Staff Wellbeing and Absence Management	Medical Certificates be recorded on Pobl y Parc in accordance with the Handling Attendance and Absence Policy and missing certificates chased up on a regular basis.	2	HR Advisor	Implemented	01/10/2020
Staff Wellbeing and Absence Management	Line Managers to ensure they complete return to work interviews when staff members return from their absence in accordance with the Handling Attendance and absence Policy	2	HR Advisor / HR Manager	Implemented	01/10/2020
Staff Wellbeing and Absence Management	Staff absences be reported to the Leadership Team on a monthly basis	2	HR Manager	Implemented	01/01/2021
Governance - Strategic Planning	An action plan be developed to prioritise short term Work Areas to be delivered and those that can be carried forward to next year if income streams are continually affected by Covid-19 pandemic.	3	Chief Executive and Performance and Compliance Officer in consultation with Leadership Team	Implemented	31/12/2020

Audit Title	Recommendation	Priority	Responsible Officer	Status	Due Date
Planning Application Fees – Block 2	The reason and rationale for requesting an extension for decision making on Planning Applications be recorded on the Agile system to provide a full audit trail of the process and as an example of good case management practice.	3	Matthew Griffiths	Implemented	31/03/2021
Cyber-Security	The Data Protection Policy be re-written to provide a concise and clear explanation of how the Data Protection Act impacts on the Pembrokeshire Coast National Park Authority.	3	Data Protection Officer	Implemented	*To be determined – post currently vacant*
Cyber-Security	The possibility of carrying out a simulated attack on the Authority's systems using the approach that a likely attacker would be further investigated.	3	Business Improvement and IT Manager	Implemented	30/10/21

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

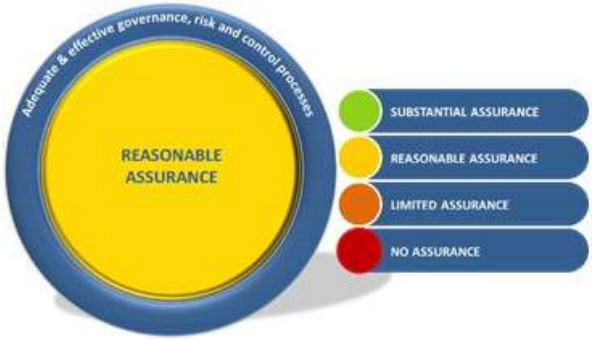
Assurance Review of Block 2-Equality and Diversity

2021/22

April 2022

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Risk 5 - "Failure to meet diversity requirements in Authority Membership"; and Risk 7 "Risk of NPA activities having a negative impact on socio economic well-being of the area"

KEY STRATEGIC FINDINGS

Equality, diversity and inclusion expectations are not included as part of the induction process for new staff.

The organisation has not undertaken training and/or refresher training for staff on Equality, Diversity and Inclusion, but has recognised this.

The Members' Code of Conduct is overdue a review and needs to be updated to include reference to inclusion.

There is an inconsistent approach to the wording on job adverts in relation to equality and diversity.

GOOD PRACTICE IDENTIFIED

The Authority promotes equality and diversity via the website under the themes of Wheelchair Walks- Access for All, Beaches for Everybody - Easy Access Beaches and See for Yourself - Easy Access Viewpoints.

The Authority's Procurement Policy refers to Equality arrangements.

SCOPE

The review considered the arrangements which the organisation has put into place which demonstrate that the organisation operates fairly and equally in its operations. The scope of the review did not include providing assurance that the equal opportunities arrangements cover all the activities of the organisation or that the arrangements identified by the organisation are operating continuously and effectively.

ACTION POINTS

Urgent	Important	Routine	Operational
0	4	2	1

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	The Code of Conduct for Authority Members includes a statement that members must "carry out your duties and responsibilities with due regard to the principle that there should be equality of opportunity for all people, regardless of their gender, race, disability, sexual orientation, age or religion". The Code of Conduct, was last reviewed in 2016 and is overdue a review. The review should include reference to inclusivity, an inclusive culture that enhances employee engagement and creates a sense of belonging with everyone treated fairly and equally.	The Code of Conduct for Authority Members be reviewed and updated and include reference to inclusion and inclusivity.	2	*Agreed.*	*31/07/22*	*Monitoring officer, DS&A manager, PC*
3	Directed	The organisation does not include equality, diversity and inclusion as part of the induction process for new staff but is aware that this work needs to be done and is detailed in the HR Strategy.	Equality, diversity and inclusion be included as part of the induction process for all new staff with specific signposting to the Equal Opportunities Policy.	2	*Agreed.*	*30/09/22*	*HR Manager*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	The organisation has not undertaken training and refresher training for staff but has recognised this within the Performance Report as an action to "Integrate equality training and awareness into the Training and Development Plan for the Authority". The progress status in the report states "Training to be rolled out late February amongst staff and RAG (Red. Amber Green) rated as green. A 35 minute Equality in the Workplace training course in the process of being developed and is to be made available on ELMS, which is an e-learning software package."	Training and refresher training on equality, diversity and inclusion be completed for all staff as planned	2	*Agreed.*	*31/03/23*	*HR Manager*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	A review of a sample of Job Adverts revealed an inconsistent in approach with regards the wording in relation to equality and diversity. For example the adverts for the Administration and Events Coordinator - Oriel and Seasonal Assistant Ranger stated "We are committed to improving the diversity of our workforce and therefore guarantee an interview to disabled candidates, who meet the essential job criteria and opt to apply via our Disability Confident Employers Scheme". Whereas the adverts for the Education and Events Contributor, Seasonal Heritage Interpreter and Planning Assistant / Planning Officer stated "We are committed to equality of opportunity for all staff and applications from individuals are encouraged regardless of age, disability, sex, gender reassignment, sexual orientation, pregnancy and maternity, race, religion or belief and marriage and civil partnerships". The adverts for the Customer Services Assistant did not include any statement in respect of Equality and Diversity.	All job adverts for the Authority to include a consistent statement in relation to Equality and Diversity.	2	*Agreed.*	*30/06/22*	*HR Manager*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The organisation has carried out Equality Impact Assessments (EIA) on key strategies. This was evident from examples provided as part of this review such as the Local Development Plan, the National Park Management Plan (Review) 2020 - 2024 and an Integrated Assessment for the Corporate Plan 2020/21.	The remaining policies and procedures requiring an Equality Impact Assessment (EIA) to be completed to be identified and the EIA prepared as they fall due for review, with a target completion date for the exercise to be determined.	3	*Agreed – however, the Authority will seek to provide clearer guidance on the level of decision making required to undertake an EIA.*	*30/09/22*	*PC Co-ordinator and Chief Executive*
6	Directed	Job descriptions do not consistently include reference to Equality, Diversity and Inclusivity and the organisation's expectations of behaviour. Other organisations audited by TIAA have included appropriate wording within general responsibilities to demonstrate the organisation's commitment to equality and diversity and to clearly set out the expectation of its employees. The job descriptions for the Education and Events Contributor and the Planning Assistant/Planning Officer included the same statement as the job advert whereas there was no statement on the job descriptions for the Administration and Events Coordinator - Oriel, Seasonal Assistant Warden and Seasonal Heritage Interpreter.	Appropriate wording be included within Job Descriptions to demonstrate the Authority's commitment to equality, diversity and inclusivity.	3	*HR Manager: I do not agree that this should be in the Job Description. I would prefer this to be part of our Values.* *Values will drive behaviours but Job Descriptions are not looked at by employees other than at their appointment.*	*N/A*	*N/A*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Directed	The HR Manager presents quarterly Health, Safety & Wellbeing Progress Reports to the Audit and Corporate Services Committee. The report format has been changed from previous reports and also included updated data specifically requested by the Committee The most recent Health, Safety & Wellbeing Progress Report - October to December 2021 was presented to the Committee in March 2022. The report included statistical data on equality and diversity which included Age Distribution, Gender Distribution, Ethnicity, BAME (Black, Asian, Minority Ethnic) Benchmark (Pembrokeshire). The report does not provide any information on sexual orientation or religion/belief which is generally reported upon by other organisations. KD says: I am unable to see the benefit of providing this information (at present) although I do see its value in a wider sense. With between 79 and 89% of staff not completing any EDI data, the statistical importance is questionable.	Statistical data on sexual orientation and religion/belief be considered for inclusion within future Equality, Diversity and Inclusivity reporting. KD says: Suggested Action should be to raise awareness and increase the number of staff declaring EDI information.	*MT: I support KD statement above. The challenge at the moment is increasing the number of staff declaring EDI information and explaining why this information is needed, why it is important and how it can be used to support the Authority in improving its practices. At the moment the gaps in the data means statistically it won't give a true picture. Staff may have more concerns around providing data on sexual orientation and religion so it is important that we provide the reassurance to them in terms of how data will be used etc. while also ensuring we are doing what we can to promote a workforce and recruitment process that provides an inclusive and positive experience for staff. The aim should be to increase the data held to support our annual reporting (and to make the data reported meaningful) that is a legal requirement under the Welsh Specific duty rather than quarterly reporting.* *One issue is that not reporting it quarterly alongside other characteristics, is that it gives religion and sexual orientation a lower profile than the other characteristics. So if it is not included we need to make sure that issues relating to sexual orientation and religion in terms of best practice in terms of inclusive recruitment and workforce are brought to attention of HR Committee.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, & 2	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	3, 4, 5, & 6	1

Other Findings

The organisation's Equality Plan and Objectives 2020-24 was approved by the Authority in February 2020. The Plan sets out reference to the Equality Act 2010 and the nine protected characteristics of the Act. The Plan also states that "PCNPA as a National Park Authority is a listed body under the Equality Act 2010. This means we are required under the general equality duty to consider how we can positively contribute to a fairer society through advancing equality and good relations in our day-to-day activities".

The Plan sets out four Long Term Aims:

- The Park – A Landscape for Everyone - Long Term Aim 1: "Create a Park that is a Landscape for Everyone";
- Our Services – Accessible and Inclusive - Long Term Aim 2: "Our services are accessible and inclusive by default and our projects are contributing to addressing inequality";
- Our Workforce – Diverse, Supportive and Inclusive - Long Term Aim 3: "Our workforce is diverse, we are an employer of choice and staff feel supported within an inclusive and fair work environment"; and
- Governance and Engagement – Increased Participation - Long Term Aim 4: "A diverse range of people are able to influence the work of the Authority and decisions that affect the Park area".

Each long term aim has two or three Equality Objectives.

Other Findings

The organisation's Equal Opportunities Policy was approved by the Authority in September 2019. The Policy also refers to the protected characteristics of the Equality Act which detailed definitions of each characteristic. The National Park as a public sector body carrying out a public function are required to follow the Public Sector Equality Duty Wales.

The Performance and Compliance Officer is responsible for assisting staff with the completion of Equality Impact Assessments on strategies and policies.

The Authority published an Annual Report on Meeting Well-being Objectives (Improvement Plan Part 2) – 2020/21 to the Authority in July 2021. The report includes a section on "Working Towards Long Term Objectives", one of which is Equality. There are two sections relating to Equality "Well-being Objective Equality - Journey Checker" and Well-being Objective Equality - Work Streams".

The organisation has recognised that there is an imbalance in the diversity of the membership of the National Party Authority Board, however the organisation has 18 Members, 12 of whom are nominated by Pembrokeshire County Council and the remaining six Members are appointed by the Welsh Government following an interview process. This has been initially discussed with Welsh Government with a view to improving diversity, however elections are not for another two years.

The organisation has identified two risks within the Risk Register, Risk 5 - "Failure to meet diversity requirements in Authority Membership"; and Risk 7 "Risk of NPA activities having a negative impact on socio economic well-being of the area". In relation to Risk 5 there is one mitigating control/monitoring that has been identified which is "Engagement with Welsh Government to seek to attract diverse candidates for future vacancies". There are currently no vacancies and the next expected opportunity for vacancies to be become available is in two years' time but discussions have taken place with Welsh Government with a view to addressing this issue.

The organisation is working with National Resources Wales (NRW), environmental non-Governmental Organisations in Wales and other National Parks in Wales to develop a proposal for an engagement project that will potentially look at collaborating with organisations or individuals with expertise and experience of working alongside Black Asian and Minority Ethnic networks and groups in Wales. The aim is to build understanding of what is already happening and to explore where people would welcome support to access, connect with and take action in nature. The Performance and Compliance Co-ordinator stated that "The intention is to move beyond just identifying barriers created by the sector to actively dismantling them. If there are opportunities to collaborate or types of support that minority-led groups would welcome, then there is potential that this proposal/ project will provide opportunities to then match-make this with what environmental organisations could offer, and identify future phases of work where we could co-create relevant exciting and relevant projects with ethnic minority communities in Wales. It is very much still in the development phase and currently this work is being led by NRW".

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
FC	**Financial Constraint**	The process operates within the agreed financial budget for the year.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings
The organisation monitors progress of the Aims and Objectives of the Equality Plan with a section on performance in relation to the Equality Well-being Objective, where work streams and actions link to each of the aims and objectives. There are other activities that support delivery under other well-being objectives due to cross cutting nature of some of the projects, especially the health and well-being projects which link in with 'A Landscape for Everyone'. It is important to note that in 2020/21 the Authority was having to respond to the impact of COVID 19 pandemic which had a significant impact on what the organisation could deliver.
The Authority promotes equality and diversity via the website under the themes of Wheelchair Walks- Access for All, Beaches for Everybody - Easy Access Beaches and See for Yourself - Easy Access Viewpoints.
The Authority's Procurement Policy refers to Equality and states that "The Authority is committed to promoting equality of access. The Authority will treat all people equally including those contracting to supply goods or services. It will not discriminate on the grounds of a protected characteristic within the means of the Equality Act 2010 or on any other unjustifiable grounds. Suppliers or contractors appointed for the provision of goods, services or works will have to comply with these criteria".

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our 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. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	28th January 2022	28th January 2022
Draft Report:	17th March 2022	26th April 2022
Final Report:	27th April 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Block 2-Equality and Diversity		
Type of Review:	Assurance	**Audit Lead:**	Audit and Fraud Manager

Outline scope (per Annual Plan):	The review considers the arrangements which the organisation has put into which demonstrate that the organisation operates fairly and equally in its operations. The scope of the review does not include providing assurance that the equal opportunities covers all the activities of the organisation or that the arrangements identified by the organisation are operating continuously and effectively.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Financial constraint: The process operates with the agreed financial budget for the year. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	As above	
Exclusions from scope:	The scope of the review does not include providing assurance that the equal opportunities covers all the activities of the organisation or that the arrangements identified by the organisation are operating continuously and effectively.	

Planned Start Date:	3rd March 2022	**Exit Meeting Date:**	11th March 2022	**Exit Meeting to be held with:**	Chief Executive

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

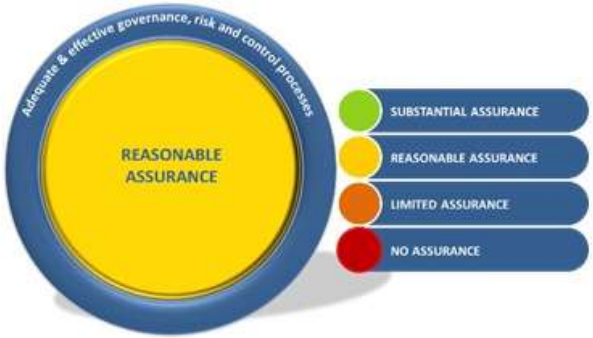
Assurance Review of Risk Management – Mitigating Controls

2021/22

April 2022

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

N/A All Risks

KEY STRATEGIC FINDINGS

The Risk Management Strategy defines the arrangements in place to manage the organisation's risks.

The Risk Register has too many risks and needs to be split into Strategic and Operational Risk Registers to facilitate management review and oversight.

The Register includes controls/monitoring to mitigate the risk which are not actual controls but planned actions which have not yet been completed and therefore cannot be relied upon.

Controls/monitoring recorded against some risks appear to be vague and not clear enough to provide the necessary assurance.

GOOD PRACTICE IDENTIFIED

Risk Management processes have continued to operate throughout the pandemic. The Risk Register includes a risk in respect of the Impact of Covid-19.

SCOPE

The review considered the organisation's arrangements for identifying and monitoring the mitigating controls with regards to the organisation's business significant risk map. Three risks currently included in the organisation's business significant risk map were selected and the effectiveness of the identified controls were reviewed. The scope of the review did not include consideration of all potential mitigating arrangements or their effectiveness in minimising the opportunities for the identified risks to occur.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	6	2

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	There appears to be too many risks to manage by the Authority and Management Team. Best practice utilised by many organisations is to have a Strategic Risk Register setting out an average of approximately ten key strategic risks that could fundamentally impact on the strategic objectives of the organisation and a separate Operational Risk Register. Each strategic risk is linked to a strategic objective. The risks on the current Risk Register could be split into two separate Risk Registers. Categorisation of risks can be defined as: • Strategic risks are risks that affect or are created by an organisation's business strategy and strategic objectives. • Operational risks are major risks that affect an organisation's ability to execute its strategic plan. • Financial risks include areas such as financial reporting, valuation, market, liquidity, and credit risks. • Compliance risks relate to legal and regulatory compliance.	The risks in the current Risk Register be split into two Risk Registers, one for the key strategic risks and one for operational risks.	2	*Partially Accept. We acknowledge there is an excessive number of risks and we will work to reduce them.* *At the November Member Workshop it was agreed to keep one register and but only to report to members risks recorded in the RED category.*	*31/03/22*	*Finance Manager*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	A review of the Risk Register revealed that some of the controls/monitoring recorded to mitigate the risk are not actual controls but planned actions which have not yet been completed and which do not currently provide mitigation against the risk. The table in Appendix C provides examples.	The documented controls/monitoring that have been identified as addressing the inherent risks in the Risk Register be reviewed and any actions which have not yet been completed but which have been included as controls be removed and recorded as Progress Update (actions to be undertaken).	2	*Agreed. A review of the recorded mitigations will be undertaken.*	*31/03/22*	*Chief Executive / Finance Manager*
5	Directed	The review of the Risk Register highlighted that the wording in relation to the controls/monitoring in respect of some risks appeared to be vague and not clear enough to provide assurance that the controls actually mitigate the risks.	Greater clarity be provided with the wording of risks to provide greater assurance to Authority Members on the controls/monitoring in place to mitigate the risks.	2	*Agreed. A review of wording in some of the controls measures will be undertaken.*	*31/03/22*	*Chief Executive / Finance Manager*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	*Directed*	*Risks are currently being considered and reviewed by the Audit and Corporate Services Review Committee and the Operational Review Committee. This can lead to duplication of effort and could lead to different views and outcomes by different members leading to difficult situations for management in updating the Risk Register. Best practice in other organisations is that the Board has overall responsibility for the key strategic risks and delegate's responsibility to a sub-committee to review and consider the Risk Register. This is invariably the Audit Committee (also known as Audit and Risk Committee or Audit, Risk and Assurance Committee in various organisations). The Board (Authority) should still have sight of the Risk Register including the key strategic risks and would also have the minutes of the Audit Committee noting any actions arising from the committee's minutes. The Authority should also review the risk register at least bi-annually.*	*The delegated responsibility for reviewing and considering the organisation's Risk Register be delegated to one committee preferably the Audit and Corporate Services Review Committee.*	*3*	*Although members did agree that the Risk Register should in future only go to the Audit & Corporate Services Review Committee the term of reference of the Operational Review Committee also stipulates that the register be considered. Changing the terms of reference of the Operational Review Committee will be considered at the earliest opportunity.*	*31/03/22*	*Chief Executive*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	The recommendation disagreed with from the previous review was "Each risk be allocated to a named individual to ensure accountability and clarity of ownership". Management stated that "this has been tried in the past, including allocating risks to Members as well as staff. We consider that the current process of review will be more effective". Having a risk owner provides accountability and authority to manage risks appropriately. Risks to the organisation is everyone's' responsibility and lack of ownership can lead to risk falling between the cracks or the responsibility being picked up by the Finance Manager or Chief Executive Officer. Risk ownership is widely practised by all TIAA clients in all sectors.	Reconsideration be given to providing ownership of risks to individuals who can then share the responsibility with their respective service area and team members.	3	*Recommendation rejected.*	*N/A*	*N/A*
6	Directed	There is no clear process in place on how risks are fed into the Risk Register especially from any issues identified by management, Authority Members, Internal Audit, External Audit or external advisors/consultants. An example of this could be any Internal Audit reports that have been given Limited Assurance (Health and Safety 2019/20).	A process be put in place to ensure risks identified by management, Authority Members, Internal and External Audit and extremal advisors/consultants are captured and fed into the Risk Register.	3	*Recommendation rejected.*	*N/A*	*N/A*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
7	Delivery	The Risk Register is reviewed regularly by the Leadership Team. This was verified to the agendas for February, April and June 2021. The Risk Register is presented to the Operational Review Committee and to the Audit and Scrutiny Review Committee. Decisions are made by both Committees to amend the scoring and to sometimes remove risks. There is no mechanism in place to record risks removed from the Risk Register for future reference and to ensure they are not lost sight of as they could re-emerge as risks in the future. It is best practice where there is no risk to remove the risk from the register to ensure that it remains manageable in size and easy to review. The inclusion of a closed risk tab on the Detailed Risk Register would enable such risks to be removed from the current register while not being lost. This would reduce the current risk register in size without losing the history.	Risks removed for the Risk Register be transferred to a Closed Risk tab on the current Register and for this to be reviewed annually.	3	*Agreed. The review of the Risk Register by Leadership Team will also focus on removing closed risks to a separate register.*	*31/03/22*	*Leadership team*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
8	Delivery	Risk is considered as a standing agenda item at each Audit and Corporate Services Review Committee Meeting. A risk summary report is prepared by the Finance Manager which provides a list of proposed changes to risks. The Risk Register is considered in full by the Committee. A Review of the papers presented to the Committee over the past year confirmed that a risk report had been presented to each meeting along with the Register. As part of the discussions between TIAA and Committee Members it was stated that there have been issues with mathematical and typographical errors within the Risk Register in the last three meetings. There is a risk that if the calculations are incorrect then the risk rating / colour could be incorrect and the risk is not given adequate consideration.	The Risk Register be proof read including checking arithmetic calculations before being presented to the Audit and Corporate Services Committee.	3	*Agreed.*	*Already actioned*	*Chief Executive / Finance Manager*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
9	Delivery	Good practice identified in other organisations is to undertake deep dives into selected risks to review the mitigating controls in place that minimise risks to ensure they remain timely, are still in place and still mitigate the risk. This can provide assurance to the Senior Leadership Team and to the Authority. This review should include a review of risks where the biggest differential between the inherent risk score and the residual risk score as the controls mitigating those risks are relied upon most heavily given the big differential and if these controls fail then this would have greatest impact.	The Senior Leadership Team be required to select random risks on a quarterly basis at meetings to perform a deep dive review of the mitigating controls in place.	3	*Agreed. Leadership team will periodically sample test and evaluate mitigating controls.*	*01/01/22*	*Leadership team*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Directed	The Risk Management Strategy does not set out the Authority's risk appetite. Recommended best practice and good risk management guidelines recommend including a section on the risk appetite and stresses the importance of demonstrating good practice and good governance and to set out the approach to identify, assess and manage risks with appropriate action taken to eliminate risks where possible. Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives An example of categories of risk appetite and their definitions is provided as Appendix C.	Consideration be given to developing the Authority's risk appetite for inclusion within the next review of the Risk Management Strategy	*The Risk Management Strategy will be amended to include a section on Risk Appetite.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Ref	Risk Area	Finding	Suggested Action	Management Comments
2	Directed	There is increased focus on Risk Management and its effectiveness in various sectors, especially where organisations have failed. The responsibility of the Leadership Team is to ensure the organisation's risks are managed effectively and one way this can be achieved is by implementing a formal Board Assurance Framework (BAF). Many sectors have introduced a BAF and TIAA has been instrumental in rolling this out in our clients in sectors which did not ordinarily have this type of assurance.	Consideration be given to introducing a Board Assurance Framework to provide Authority Members with greater assurance in the management of risk.	*Consideration will be given to implementing a formal Board Assurance Framework.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, & 2	1
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	2
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	3, 4, 5, & 6	-

Other Findings

The Authority's Risk Management Strategy was last reviewed and updated in December 2019.

The Risk Register is set out in an Excel spreadsheet format. Each risk is pre-numbered with an Inherent Score based on likelihood multiplied by Impact. The scoring mechanism is based on a 4x4 matrix as follows: 1 = Minor; 2 = Moderate; 3 = Major and 4 = Critical.

Each risk is categorised as Strategic, Operational, Financial, Reputational or a combination of any of these. Each risk is provided with a mitigation and then a residual risk score based on the same scoring mechanism as above. A control/monitoring column is then applied to each risk and a column to record the trend for the quarter and a final column for a Progress Update. The overall inherent and residual risk scores are colour coded based on the following:

- Light green – Score between 1 – 2: Acceptable level of risk subject to regular monitoring;
- Dark Green – Score between 3 - 4: Acceptable level of risk subject to regular monitoring;
- Amber – Score between 6 - 9: Risk management measures need to be put in place and monitored; and
- Red – Score 12+: Unacceptable level of risk exposure, which requires extensive management.

Other Findings

The strategy sets out the roles and responsibilities for risk management which includes the following groups/individuals: National Park Authority, Individual Members, Audit and Corporate Services Review Committee and the Operational Review Committee, Management Team, Managers and Employees.

A previous review of risk management was undertaken by TIAA in October 2019. The review identified two priority two and two priority three recommendations. Three recommendations have been identified as implemented as part of the follow up process but one priority three recommendation was disagreed with and not implemented (Recommendation 2 refers). The recommendation is considered best practice and has been reiterated.

At the time of the review the Authority had 42 risks on the Risk Register with no residual risks coloured as red. There was one risk, "Medium to Long Term Risk of significant reduction of funding from WG, other public sector funders, or grant schemes" which had an inherent red risk. However, the residual risk was coloured amber after applying the mitigating controls.

The Risk Management Strategy does not set out the Authority's risk appetite. Recommended best practice and good risk management guidelines include a section on the risk appetite and stresses the importance of demonstrating good practice and good governance and to set out the approach to identify, assess and manage risks with appropriate action taken to eliminate risks where possible. Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives. Organisations will have different risk appetites depending on their culture and objectives and a range of appetites may exist for different risks and these may change over time. The aim of a risk strategy is not to remove all risk but to recognise that some level of risk will always exist. It is recognised that taking risks in a controlled manner is fundamental to innovation and the building of a can do culture which is fundamental to the continued success of The Authority. Risk appetite is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. Risk appetite can be expressed as a boundary, above which the organisation will not tolerate the level of risk and further actions must be taken. A recent Government Finance Function publication, 'Risk Appetite – Guidance Note' published in October 2020 provides advice on defining risk appetite. An example of definitions relating to specific risk areas is provided as Appendix D. Best practice suggests that risk appetite should then be reviewed annually to ensure it accurately reflects the current position of the organisation. (Operational Effectiveness Matter 1 refers).

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	7, & 8	-
FC	**Financial Constraint**	The process operates within the agreed financial budget for the year.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	9	-

Other Findings

Risk Management processes have continued to operate throughout the pandemic. The Risk Register includes a risk in respect of the Impact of Covid-19.

There is increased focus on Risk Management and its effectiveness in various sectors, especially where organisations have failed. The responsibility of the Leadership Team is to ensure the organisation's risks are managed effectively and one way this can be achieved is by implementing a formal Board Assurance Framework (BAF). Many sectors have introduced a BAF and TIAA has been instrumental in rolling this out in our clients in sectors which did not ordinarily have this type of assurance. A BAF is defined as follows:

"An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect".

A BAF is a key mechanism which boards' (Authority's) governing bodies should be using to reinforce strategic focus and better management of risk. The Treasury defines a BAF as ""an effective and efficient framework … to give sufficient, continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services.". TIAA can assist in introducing a BAF to the Authority Members as part of our added value to the Authority. A typical Board Assurance Framework contains:

- Roles and Responsibilities - this would include the roles for all staff with the Leadership Academy and the Board and Committees with oversight responsibilities;
- Risk Management strategy within the organisation – this would set out the risk management processes including details of the Risk Register template;
- Risk Appetite – this would include the risk area and risk level (Adverse, Cautious. open and Minimalist);
- Risk Scoring Matrix - setting out the description and scoring mechanism for the Probability and Impact of risks; and
- Assurance Mapping – this provides an improved ability to understand and confirm that there are assurances in place over key controls. It also highlights where control gaps exist and therefore allows an organisation to address those gaps. Assurance provides confidence, evidence and certainty.

The Framework needs to be clear and concise easy to view and not prohibitive in length. Further information and examples of Assurance Mapping, a BAF can be found at Appendices D and E. Examples of layouts of BAFs were provided separately to the Chief Executive.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our 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. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	22nd July 2021	22nd July 2021
Draft Report:	8th September 2021	26th April 2022
Final Report:	27th April 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Block 1-Risk Management – Mitigating Controls		
Type of Review:	Assurance	**Audit Lead:**	Audit and Fraud Manager

Outline scope (per Annual Plan):	The review considers the organisation's arrangements for identifying and monitoring the mitigating controls with regards to the organisation's business significant risk map. Three risks currently included in the organisation's business significant risk map will be selected and the effectiveness of the identified controls will be reviewed. The scope of the review does not include consideration of all potential mitigating arrangements or their effectiveness in minimising the opportunities for the identified risks to occur.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Financial constraint: The process operates with the agreed financial budget for the year. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	As above	
Exclusions from scope:	As above	

Planned Start Date:	2nd August 2021	**Exit Meeting Date:**	4th August 2021	**Exit Meeting to be held with:**	Chief Executive and Finance Manager

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Risk Appetite Definitions

Appendix C

The table below provides example appetite levels defined by Risk Categories.

Source publication: Government Finance Function – Risk Appetite – Guidance Note (October 2020)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929385/Risk_Appetite_Guidance_Note_v1.0_FINAL.pdf

			Risk Appetite		
	Averse	**Minimal**	**Cautious**	**Open**	**Eager**
Financial	Avoidance of any financial impact or loss, is a key objective.	Only prepared to accept the possibility of very limited financial impact if essential to delivery.	Seek safe delivery options with little residual financial loss only if it could yield upside opportunities.	Prepared to invest for benefit and to minimise the possibility of financial loss by managing the risks to tolerable levels.	Prepared to invest for best possible benefit and accept possibility of financial loss (controls must be in place).
Operations	Defensive approach to operational delivery -aim to maintain/protect, rather than create or innovate. Priority for close management controls and oversight with limited devolved authority	Innovations largely avoided unless essential. Decision making authority held by senior management.	Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	Innovation supported, with clear demonstration of benefit / improvement in management control. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust /lagging indicators rather than close control.
Reputational	Zero appetite for any decisions with high chance of repercussion for organisations' reputation.	Appetite for risk taking limited to those events where there is no chance of any significant repercussion for the organisation.	Appetite for risk taking limited to those events where there is little chance of any significant repercussion for the organisation.	Appetite to take decisions with potential to expose organisation to additional scrutiny, but only where appropriate steps are taken to minimise exposure.	Appetite to take decisions which are likely to bring additional governmental / organisational scrutiny only where potential benefits outweigh risks.
Legal	Play safe and avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge.	Want to be reasonably sure we would win any challenge.	Challenge will be problematic; we are likely to win and the gain will outweigh the adverse impact.	Chances of losing are high but exceptional benefits could be realised.
Commercial	Zero appetite for untested commercial agreements. Priority for close management controls and oversight with limited devolved authority.	Appetite for risk taking limited to low scale procurement activity. Decision making authority held by senior management.	Tendency to stick to the status quo, innovations generally avoided unless necessary. Decision making authority generally held by senior management. Management through leading indicators.	Innovation supported, with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. High levels of devolved authority – management by trust /lagging indicators rather than close control.

Assurance Mapping Example

Appendix D

The primary objective of the BAF is to ensure that appropriate arrangements are established for the purpose of providing the Board with assurance that the controls put in place to mitigate the organisation's exposure to risk is in place. A BAF would build upon the organisation's current risk management process by providing assurance to the Authority in the form of three lines of defence. These lines of defence can be described as:-

- First Line - Operational Internal Controls: the way risks are managed and controlled day-to-day. Assurance comes directly from those responsible for delivering specific objectives or processes. Although this line of defence may lack independence, its value is that it comes from those who know the business, culture and day-to-day challenges to ensure objectives are being met and risks managed;
- Second line - Management and Oversight: the way the organisation oversees the control framework so that it operates effectively. The assurance provided is separate from those responsible for delivery, but not independent of the management chain, such as risk and compliance functions, corporate oversight and compliance functions; and
- Third line - Periodic Audit checks/tests: objective and independent assurance, e.g. internal/external audit, providing reasonable (not absolute) assurance of the overall effectiveness of governance, risk management and controls. This also includes Board reports, external consultants or tenant/stakeholder feedback.

The three lines of defence model can be used as the primary means to demonstrate and structure roles, responsibilities and accountabilities for decision making, risk and control to achieve effective governance risk management and assurance.

There are various benefits in assurance mapping, these can include:

- Gaining a clear understanding of activities and the assurance gained – and whether it is effective and efficient;
- Identifying any gaps in assurance or where it is insufficient;
- Highlighting duplication or where assurance is disproportionate – possible savings;
- Identifying where controls are failing and risks more likely to materialise;
- Providing the ability to better focus resources; and
- Providing evidence to inform the Annual Governance Statement

An Organisation – Assurance Mapping

Assurance Map: _____

Last Update: _____

Areas for Action: Highlighted (see separate action monitoring log)

Substantial assurance from most recent independent report/audit/assurance activity

Reasonable assurance from most recent independent report/audit/assurance activity

Limited assurance from most recent independent report/audit/assurance activity

No assurance from the most recent independent report/audit/assurance activity

Audit due/assurance activity planned in near future

No 3rd line assurance in place or planned, situation is acceptable

			LINES OF DEFENCE			Tag						
	RISK	CONTROLS	LINE 1 Operational	LINE 2 Corporate Oversight/Strategic	LINE 3 Assurance Providers	Reputation	H&S	Finance	IT	Info Security	Training	
A												
B												
C												
D												

Board Assurance Framework

Objectives of Assurance Activity

Governance **Financial Stability** **Health & Safety** **Welsh Language**

Service Standards **Data Integrity** **Planning**

Lines of Defence

1st Operational Management	2nd Internal Compliance Functions	3rd External & Independent Challenge
Operational Performance Reporting	Management/Improvement Review	Stakeholder Feedback
Operational Risk Management	Specialist Functions	Internal Audit
Internal Controls	Cross Business Working Groups	External Audit
Financial Planning	Leadership Team Reporting	Awards & Accreditations
Operational Financial Reporting	Self-Evaluation / Co-Regulation	Regulator / Welsh Government
Staff Supervision and Development	Committees & Board	ICO/ H&S Executive

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

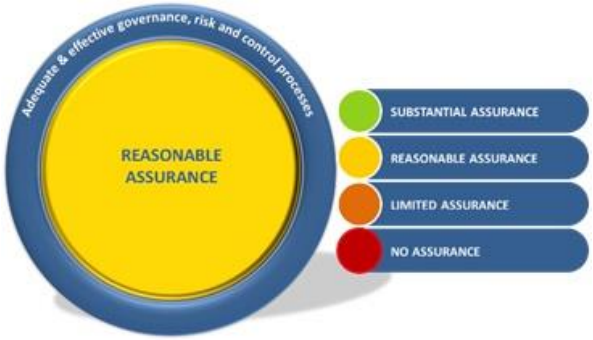
Assurance Review of Resilient and Sustainable Services

2021/22

April 2022

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Risk 38 "Impact of Covid-19". Basic controls/monitoring are in place to mitigate the risk".

KEY STRATEGIC FINDINGS

The Authority has made positive progress in implementing the 'Proposals for Improvement' raised in the Audit Wales report on the Review of Resilience.

A number of low priority recommendations have been raised in relation to the outstanding actions that are yet to be completed.

GOOD PRACTICE IDENTIFIED

The development and monitoring of an action plan to address the "Proposal for Improvements" raised in the Audit Wales report is evidence of best practice.

SCOPE

The review considered the outcomes of the Audit Wales report on resilient and sustainable services at the organisation and reviewed the progress of the action plan developed to address any issues.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	4	1

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The review of the Action Plan revealed that under the heading Organisational Resilience – Business Continuity, the Business Continuity Plan has been prepared but is still in a draft format. The Authority is in the process of implementing Microsoft 365 and this will impact on the ICT arrangements and will therefore impact on the ICT Disaster recovery part of the Plan.	The Business Continuity Plan be finalised as planned once the Microsoft 365 software has been fully implemented.	3	*Agreed.*	*30/09/22*	*IT Manager*
2	Directed	Also under the Organisational Resilience – Business Continuity heading, the other action "P1 (b) Awareness raising activities with staff and members of business continuity approach once new approach in place" has also not commenced as the Plan is not yet finalised.	The Action in relation to the awareness of the Business Continuity Plan with staff be completed once the Plan has been finalised as planned.	3	*Agreed.*	*30/09/22*	*Leadership Team*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	The review of the Action Plan revealed that under the Workforce Resilience section, the Action P2 "Information collated through Work and Well-being forms to inform the development of Training and Development Plan and Annual Health and Safety Plan (re Staff Well-being element)" it was noted that the Work and Wellbeing reviews are being completed with an 81% completion rate at the time of the audit. A Training Matrix has been set up but very little reference is made to Work and Wellbeing reviews. Where they are referenced, the matrix includes the wording "No W & W Review". The HR Manager confirmed that the Training Matrix has not been updated to reflect the Work and Wellbeing reviews that have identified and completed.	The Training Matrix be updated to reflect the Work and Wellbeing reviews that have been identified and completed in relation to the Workforce Resilience Action P2 (a).	3	*Agreed.*	*31/07/22*	*HR manager*
4	Directed	The review of the Action Plan also revealed that under the Workforce Resilience section, the Action P2 (a) "Information collated through Work and Well-being forms to inform the development of Training and Development Plan and Annual Health and Safety Plan (re Staff Well-being element)" the review of the Annual Health and Safety Plan has commenced but has not been completed due to resource issues within the HR Department.	The review of the Annual Health and Safety Plan as set out under the Workforce Resilience action P2 (a) be completed and finalised as planned.	3	*Agreed.*	*31/07/22*	*HR Manager and H&S Group*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Directed	As part of the review, the draft Business Continuity Plan (BCP) was reviewed at the request of the Chief Executive to establish if there were any gaps. The BCP was compared to other organisations in various sectors and the following identified: • There is no reference to when the Chair of the National Park Authority is to be informed when the plan is evoked; • The Contingency Planning - Staffing does not include contact numbers of individuals; • How often the plan will be tested; and • Details of key suppliers and contractors.	The points raised in the findings in relation to gaps identified in the draft Business Continuity Plan be considered for inclusion before it is finalised.	*Noted.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1, 2, 3, & 4	1

Other Findings
Audit Wales published a Review of Resilience – Pembrokeshire Coast National Park Authority in April 2021. The review was part of work performed under Section 17 of the Public Audit (Wales) Act 2004 and Section 15 of the Well-being of Future Generations Act (Wales) 2015.
The report, which was presented to the Audit and Corporate Services Review Committee in July 2021, concluded that "The Authority has proved to be an adaptable and resilient organisation in the face of immediate disruptive threats but further work is needed to ensure this continues over the longer term". The report set out three "Proposals for Improvement", which are detailed in Appendix C.
The Authority has developed an Action Plan to address the 'Proposals for Improvements' identified by Audit Wales in their report. The Action Plan is monitored by the Senior Leadership Team and updated by the Performance and Compliance Co-ordinator.

Other Findings

	The Authority has one risk in relation to Resilience and Sustainable Services, which is Risk 38 "Impact of Covid-19". Basic controls/monitoring are in place to mitigate the risk.
	The Performance and Compliance Co-ordinator updates the Action Plan based on relevant updates provided within the performance reporting system or relevant committee papers. This is then reviewed by relevant staff and any additions or further amendments applied.
	A review of the Action Plan was undertaken as part of the review to confirm that the Authority has addressed the actions as stated within the Action Plan, where applicable. The findings are set out in Appendix C.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Out of scope	-	-
FC	**Financial Constraint**	The process operates within the agreed financial budget for the year.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings
The development and monitoring of an action plan to address the proposal for improvements raised in the Audit Wales report on the Review of Resilience – Pembrokeshire Coast National Park Authority is evidence of best practice.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our 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. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	28th January 2022	28th January 2022
Draft Report:	25th March 2022	27th April 2022
Final Report:	27th April 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Block 2-Resilient and Sustainable Services		
Type of Review:	Assurance	**Audit Lead:**	Audit and Fraud Manager

Outline scope (per Annual Plan):	The review will review the outcomes of the Audit Wales report on resilient and sustainable services at the organisation and will review the progress of the action plan developed to address any issues.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Financial constraint: The process operates with the agreed financial budget for the year. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	As above	
Exclusions from scope:	As above	

Planned Start Date:	28th February 2022	**Exit Meeting Date:**	8th March 2022	**Exit Meeting to be held with:**	Chief Executive

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Additional Findings

Appendix C

The table below is the Action Plan with Updates to address the 'Proposal for Improvements' and audit findings;

Organisational Resilience – Business Continuity

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Findings
P1 (a) Develop renewed business continuity approach informed by our COVID 19 response experience	2021-2022	IT and Business Improvement Manager	Lead Officer time. Officer time from other teams to feed into review process.	Underway	Draft Business Continuity Plan has been prepared	The Business Continuity Plan has been prepared but is still in a draft format. The Authority is in the process of implementing Microsoft 365 and this will impact on the ICT arrangements and will therefore impact on the ICT Disaster recovery part of the Plan.
P1 (b) Awareness raising activities with staff and members of business continuity approach once new approach in place	2021-2023 (Dependent on when above action is complete)	IT and Business Improvement Manager	Lead Officer time.	Not Started		As above
P1 (c) Report to Members on ICT Business Continuity arrangements	2021-2023 (Dependent on when above action is complete)	IT and Business Improvement Manager	Lead Officer time.	Not Started		As above

Workforce Resilience

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Finding
P2 (a) Work and Well-being Forms completed by all staff and line mangers as part of annual performance review process, including discussion with staff on future work place preferences.	Completion of forms by May 31	HR Manager	Line Managers time. Staff Time. HR time – reviewing completed forms.	Underway	As of February 2022, the majority of reviews had been completed and returned to HR. A small proportion have been completed, but not yet returned.	The Work and Wellbeing forms have been completed, this was verified to some examples. At the time of the review it was reported in the Health and Safety Policy and Arrangements presented to the Audit and Corporate Services Review Committee that 81% had been completed.
P2 (a) Information collated through Work and Well-being forms to inform the development of Training and Development Plan and Annual Health and Safety Plan (re Staff Well-being element).	2021-2022	HR Manager	Lead Officer Time. Line Manager Time. Training Budget.	Underway	Training Matrix completed to include Work & Wellbeing Reviews received to date. Annual Health & Safety Plan underway, with priority on statutory and mandatory training, following a gap in face-to-face training as a result of the forced government lockdown.	A Training Matrix has been set up but very little reference was made to Work and Wellbeing reviews, where they are referenced the matrix includes the wording “No W & W Review”. Also the review of the Annual Health and Safety Plan has commenced but has not been completed.
P2 (a) To develop and pilot an intensive training and coaching programme to help build personal capacity enabling staff to cope with stress and additional pressure more effectively.	Pilot programme introduced by May 2021 with evaluation of the pilot programme to develop a wider programme for all staff and managers by September 2021.	HR Manager	Lead Officer Time. Staff Time engaged with training process. Cost of Training.	Underway	Building Resilience Coaching Programme presented to Leadership Team. Resilience Coaching Programme rolled out through Line Managers. Resilience coaching was delivered during January and has had very positive staff feedback. The full training programme will be extended to other staff following the initial pilot.	The Building Resilience Coaching Programme has been presented to Leadership Team and rolled out to line managers.

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Finding
P2 (a) Development of future options for remote working for staff and revised flexible working policy, co-produced with Employee Forum in consultation with wider staff.	2021-2022	HR Manager	Lead Officer time. Employee Forum members time. External expert/ legal advice if needed.	Underway	At the Employee Forum Meeting dated 10 March 2021, Staff Representatives asked Members for their views on the 'future of work in the 21st Century' in light of how workplaces are responding to 1) the Work/Life Balance agenda and 2) learnings from the Government's measures to encourage home working during the continued Covid-19 Pandemic. PCNPA's Human Resources Manager was tasked with consulting staff and managers across the Authority with a view to reviewing and amending the existing Flexible Working Policy. Following wide consultation, an amended Flexible Working Policy was adopted at the Leadership Team Meeting on 14 September 2021. However, in light of the complexities of home working (which is only one of many approaches to flexible working), it was agreed that a standalone Home Working Policy was required in addition to the flexible working policy. The new Home Working and Hybrid working policy was approved by NPA 9/2/22.	An Employee Forum Meeting occurred on 10th March 2021 as set out in the Home Working & Hybrid Working Policy. T The Home Working & Hybrid Working Policy was presented to and approved by the Authority at the February 2022 meeting.

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Finding
P2 (b) Review of Health and Safety Policies and Procedures to reflect changes to flexible working policy and potential increased number of staff home working in the longer term.	2021-2022 (Dependent on when above action is complete)	HR Manager	Lead Officer time. External expert/ Health and Safety advice if needed.	Underway	The Homeworking and Hybrid working policy was drafted to mitigate against a range of risks related to home working, including Health and Safety. Manger guidance was issued on supporting staff through home working.	This was verified to the Home Working & Hybrid Working Policy

Governance and decision making

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Findings
P3 Carry out activities to support the move to potential hybrid or face to face meetings or continued virtual meetings.	2021-22	Admin and Democratic Services Manager	Lead Officer time. Business Improvement and IT Manager time Financial Costs – relating to potentially physical infrastructure, IT equipment and Systems	Underway	Report on *Means of Holding Committee Meetings in the Future* presented to NPA on 16th June 2021. Potential options discussed by Members with outcome that future meetings in term of location to all be hosted in Green room. However video conferencing is likely to remain for the rest of the year. Members of smaller committee meetings (not DM/ NPA) may decide to continue holding committees virtually but this will be dependent on specific Committee Members. A report was presented to NPA on 15 September 2021 setting out a way forward for the replacement of the current meeting room to enable multi-locational meetings to take place in accordance with Welsh Government legislation. Funding has been allocated from the Authority's reserves and a Project Group has been established to take this forward. Activities to support migration to Microsoft teams underway.	The report was verified to the Agenda and minutes of the June 2021 meeting and also to the agenda and minutes of the September 2021 meeting. The Authority is The report on the Green Room Redevelopment – Budget and Next Steps was presented to the Authority and this was verified to the agenda and minutes of the September 2021 meeting. The minutes stated that "It was resolved that: a) Replacement of the Green Room as set out in the report be agreed. b) £500K be allocated from reserves to fund the project. c) A "Green Room Development Group" be set up to oversee the delivery of the project and that Councillors P Baker and P Morgan be appointed as Member representatives".
P3 Relevant delegations are sought and in place.	Ongoing	Admin and Democratic Services Manager	Lead Officer time.	Ongoing	Extended delegated powers working well. Due to ongoing COVID-19 restrictions, an extension of delegated powers has been agreed by the Authority until 31 December 2022.	This was verified to the minutes of the December 2021 meeting.

Action	Timescales	Lead	Resources	Status	Activity 2021/22	Audit Findings
P3 Review the Authority's Public (DM) Speaking Procedures	2021-2022	Director of Planning and Park Direction	Lead Officer time. Monitoring Officer time.	Complete	Workshop held with Members 19/5/21. The amendments to public participation at Development Management Committees was approved at the National Park Authority meeting on 16th June 2021.	This was verified to the minutes of the June 2021 meeting where "It was RESOLVED that: a) an individual who had addressed the Committee on a particular application at a previous meeting shall be permitted to address the Committee again if the application was deferred for any reason to subsequent meetings, for a maximum of three minutes, provided only new material was to be presented; b) the guidance document in respect of public participation at Development Management Committee meetings be re-drafted, taking account of Members' comments, and presented to a future meeting of the Authority"

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

Summary Internal Controls Assurance (SICA) Report

2021/22

April 2022

Summary Internal Controls Assurance

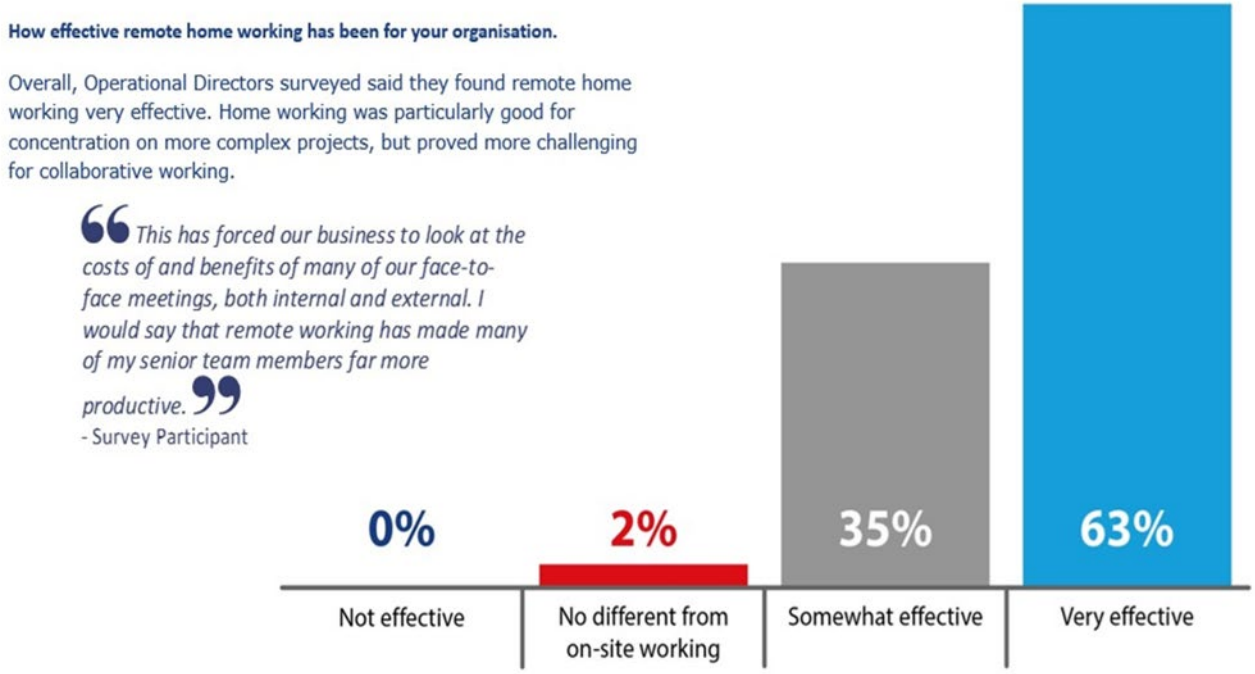
Introduction

1. This summary controls assurance report provides the Audit and Corporate Services Review Committee with an update on the emerging Governance, Risk and Internal Control related issues and the progress of our work at Pembrokeshire Coast National Park Authority as at 28th April 2022.

Emerging Governance, Risk and Internal Control Related Issues

2. In our recent 'Post-Lockdown Working Practices Briefing', we explored the results of our survey of clients to ascertain how organisations are planning to deliver some of their functions going forward. We asked a number of questions regarding home working and its effectiveness since the pandemic started.

Effectiveness of home working



Audits completed since the last SICA report to the Audit and Corporate Services Review Committee

3. The table below sets out details of audits finalised since the previous meeting of the Audit and Corporate Services Review Committee.

Audits completed since previous SICA report

		Key Dates			Number of Recommendations			
Review	**Evaluation**	**Draft issued**	**Responses Received**	**Final issued**	**1**	**2**	**3**	**OEM**
Procurement and Creditors	Substantial	18th March 2022	18th March 2022	18th March 2022	-	-	2	1
Risk Management – Mitigating Controls	Reasonable	6th September 2021	26th April 2022	27th April 2022	-	3	6	2
Equality and Diversity	Reasonable	17th March 2022	26th April 2022	27th April 2022	-	4	2	1
Follow Up	N/A	8th April 2022	26th April 2022	27th April 2022	-	-	-	-
Resilience and Sustainable Services	Reasonable	25th March 2022	27th April 2022	28th April 2022	-	-	4	1

4. There are no issues arising from these findings which would require the annual Head of Audit Opinion to be qualified.

Progress against the 2021/22 Annual Plan

5. Our progress against the Annual Plan for 2021/22 is set out in Appendix A.

Changes to the Annual Plan 2021/22

6. There were no areas where areas where further internal audit work is recommended to enable an unqualified Head of Audit Opinion to be provided for 2021/22.

Progress in actioning priority 1 recommendations

7. We have made no Priority 1 recommendations (i.e. fundamental control issue on which action should be taken immediately) since the previous SICA. More information is provided in Appendix B.

Root Cause Indicators

8. The Root Cause Indicators (RCI) have been developed by TIAA to provide a strategic rolling direction of travel governance, risk and control assessment for Pembrokeshire Coast National Park Authority. Each recommendation made is analysed to establish the underlying cause of the issue giving rise to the recommendation (RCI). The analysis needs to be considered over a sustained period, rather than on an individual quarter basis. Percentages, rather than actual number of reviews/recommendations made permits more effective identification of the direction of travel. A downward arrow signifies a positive reduction in risk in relation to the specific RCI.

RCI – Direction of Travel Assessment

Root Cause Indicator	Qtr 1 (2021/22)	Qtr 2 (2021/22)	Qtr 3 (2021/22)	Qtr 4 (2021/22)	Medium term Direction of Travel	Audit Observation
Directed						
Governance Framework	N/A	67% (2)	N/A	19% (4)		
Risk Mitigation	-				N/A	
Control Compliance	-	33 (1)		67% (14)		The majority of recommendations raised relate to compliance
Delivery						
Performance Monitoring	-	-		10% (2)		
Financial Constraint	-	-			N/A	
Resilience	-	-		4% (1)		

Frauds/Irregularities

9. We have not been advised of any frauds or irregularities in the period since the last SICA report was issued.

Other Matters

10. We have issued a number of briefing notes and fraud digests, shown in Appendix C, since the previous SICA report.

Alerts issued by TIAA

Briefing Note
Fraudulent Emails and Purchase Orders
Guidance to Prevent use of Vehicles as Weapons in Terror Attacks
Protect Duty; Public places to ensure preparedness for and protection from terrorist attacks.
Amazon to Change Payment Methods
Amazon Postpones Changes to Payment Methods
Employing Someone from Outside the UK
HMRC Review into VAT Charges on EVs
Amazon and VISA Settle Dispute
Guidance to public bodies in Wales
Increased Cyber Security Risks
Deadline for Withdrawal of Old Style £20 and £50 Notes
More than 75% of larger charities targeted by cyber-criminals since last year

Fraud Alert
Fraud Alert Fake Omicron Email Scam
An Increase in Scams During the Festive Season
Remote Employees Working Two Jobs
Call 159 to Check if a Call From Your Bank is Genuine
National Cyber Security Centre: SMS & Telephone Best Practice Guidance
Scam texts and phone number cloning for COVID tests
Cyber-Attack Threat Heightened.

Security Alert
Change to UK Terror Threat Level
Increase in People Sheltering in Waste Containers

Responsibility/Disclaimer

11. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. The matters raised in this report not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Progress against Annual Plan

System	Planned Quarter	Current Status	Comments
Risk Management – Mitigating Controls	2	Final report issued	
ICT Strategy	2	Final report issued	
Estates Delivery	2	Final report issued	
Procurement and Creditor Payments	4	Final report issued	
Equality and Diversity	4	Final report issued	
Resilient and Sustainable Services	4	Final report issued	
Follow-up	4	Final report issued	
Annual Planning	1	Final plan issued	
Annual Report	4	Final report issued	
Audit Management	1-4		

KEY:

	To be commenced		Site work commenced		Draft report issued		Final report issued

Priority 1 Recommendations - Progress update

Recommendation	Priority	Management Comments	Implementation Timetable	Responsible Officer	Action taken to date (and any extant risk exposure)	Risk Mitigated
There are no Priority 1 Recommendations.						

KEY:

Priority Gradings

1	URGENT	Fundamental control issue on which action should be taken immediately.

Risk Mitigation

	CLEARED	Internal audit work confirms action taken addresses the risk exposure.
	ON TARGET	Control issue on which action should be taken at the earliest opportunity.
	EXPOSED	Target date not met & risk exposure still extant

Briefings on developments in Governance, Risk and Control

TIAA produces regular briefing notes to summarise new developments in Governance, Risk, Control and Counter Fraud which may have an impact on our clients. These are shared with clients and made available through our Online Client Portal. A summary list of those CBNs and Fraud Alerts issued in the last three months which may be of relevance to Pembrokeshire Coast National Park Authority is given below. Copies of any CBNs are available on request from your local TIAA team.

Summary of recent Client Briefing Notes (CBNs)

CBN Ref	Subject	Status	TIAA Comments
CBN-21042	Fraudulent Emails and Purchase Orders		**Action Required** Procurement teams and suppliers to your organisation should be made aware of this scam.
CBN-21044	Guidance to Prevent use of Vehicles as Weapons in Terror Attacks		**Action Required Where Applicable** Audit Committees and Boards/Governing Bodies are advised to assess their arrangements in light of the risks if applicable and take appropriate remedial action.
CBN-21047	Protect Duty; Public places to ensure preparedness for and protection from terrorist attacks.		**Action Required** Organisations are advised to review their security arrangements in line with their legal requirements and take appropriate remedial action**.**
CBN-21048	Amazon to Change Payment Methods		**Potential Urgent Action Required** Clients are advised to establish whether they make any online purchases from Amazon and if so, whether these purchases currently use a Visa credit and/or procurement card. If this type of card is in use, then clients are advised to put alternative arrangements in place before 19th January 2022.
CBN-22001	Amazon Postpones Changes to Payment Methods		**Potential Urgent Action Required** Following on from the previous related CBN in December 2021, clients are advised to establish what internal process changes were made as a result, and whether there is merit in continuing to use Visa credit cards.

CBN Ref	Subject	Status	TIAA Comments
CBN-22002	Employing Someone from Outside the UK		**Information Only**
CBN-22006	HMRC Review into VAT Charges on EVs		**Action Required Not Urgent** Organisations are advised to ensure that the appropriate HMRC compliant arrangements are in place.
CBN-22007	Amazon and VISA Settle Dispute		**Potential Urgent Action Required** Following on from the previous related CBN in January 2022, clients are advised to establish what internal process changes were made as a result of the previous announcements and consider whether there is merit in continuing to use Visa credit cards.
CBN-22009	Guidance to public bodies in Wales		**Action Required - Not Urgent** Audit Committees and Boards/Governing Bodies are advised to consider the principles within their own systems of control and operational practices.
CBN-22010	Increased Cyber Security Risks		**Action Required - Urgent** Organisations are advised to review their key operational Cybersecurity arrangements and take appropriate remedial action
CBN -22014	Deadline for Withdrawal of Old Style £20 and £50 Notes		**For Information Only** This is for information purposes. All staff within affected service lines such as cashiers, retail assistants and other should be made aware of the process for handling withdrawn notes. All relevant notes held should be banked before 30th September 2022.

CBN Ref	Subject	Status	TIAA Comments
CBN -22015	More than 75% of larger charities targeted by cyber-criminals since last year		**Action Required** Audit Committees and Boards are recommended to seek assurance that IT security remains on the agenda, and to seek assurances checked that systems are patched, monitored, and backed up. IT Disaster Recovery plans should be regularly reviewed to keep up to date, and subject to table-top exercise testing, ideally using a malware incident scenario such as the NCSC's "Exercise in a box".

Summary of recent Fraud Alerts

Ref	Subject	Status	TIAA Comments
December 2021	Fraud Alert Fake Omicron Email Scam		**Action Required** The alert provides information and advice about fraud and economic crime, and the risks associated with it. If you have fallen victim to fraud you should report it to Action Fraud by calling 0300 123 2040, or visit: https:// www.actionfraud. police.uk/ reporting-fraud-and-cyber-crime If you have given your bank details and think you may have lost money, contact your bank immediately.
December 2021	An Increase in Scams During the Festive Season		**Action Required** The alert provides information and advice about fraud and economic crime, and the risks associated with it. If you have fallen victim to fraud you should report it to Action Fraud by calling 0300 123 2040, or visit: https:// www.actionfraud. police.uk/ reporting-fraud-and-cyber-crime.
December 2021	Remote Employees Working Two Jobs		**For Information**
January 2022	Call 159 to Check if a Call From Your Bank is Genuine		**Action Required** This alert provides information and advice to employees about fraud and economic crime, and the risks associated with it. If you have fallen victim to fraud or cyber-crime you should report it to Action Fraud by calling 0300 123 2040, or visit: www.actionfraud.police.uk If you have given out your bank details and think that you may have lost money, contact your bank immediately by dialling 159 if your bank is listed on the left, or using a known contact number for your bank.

Ref	Subject	Status	TIAA Comments
February 2022	National Cyber Security Centre: SMS & Telephone Best Practice Guidance		**Action Required** This alert provides information and advice to employees about fraud and economic crime, and the risks associated with it. If you have fallen victim to fraud or cyber-crime you should report it to Action Fraud by calling 0300 123 2040, or visit: www.actionfraud.police.uk If you have given out your bank details and think that you may have lost money, contact your bank immediately by using a known contact number for your bank, or using the new 159 service.
February 2022	Scam texts and phone number cloning for COVID tests		**Action Required** This alert provides information and advice to employees about fraud and economic crime, and the risks associated with it. If you have fallen victim to fraud or cyber-crime you should report it to Action Fraud by calling 0300 123 2040 or visit: https://actionfraud.police.uk / reporting-fraud-and-cybercrime If you have given your bank details and think that you may have lost money, contact your bank immediately by dialling 159 or using the number on the back of your bank card.
March 2022	Cyber-Attack Threat Heightened.		**Action Required** This alert provides information and advice to organisations regarding the current heightened threat of a cyber-attack. The alert should be shared with senior management and IT Security Specialists who should read the guidance produced by the NCSC and take action as required.

Summary of recent Security Alerts

Ref	Subject	Status	TIAA Comments
November 2021	Change to UK Terror Threat Level		**Action Required** The This Security Alert is designed to inform and protect organisations during the current COVID-19 emergency. To arrange an urgent Security Risk Assessment or request further assistance, please contact: Jonathan Gladwin, Director of Anti-Crime Services; or your Security Management Specialist.
December 2021	Increase in People Sheltering in Waste Containers		**Action Required** Organisations concerned about someone sleeping rough should contact StreetLink on 0300 500 0914 or visit www.streetlink.org.uk. Anti-social behaviour or associated criminal activity should be reported to the Police. To discuss this issue or request any further assistance and support please contact: Jonathan Gladwin, Director of Anti-Crime Services; or you're nominated Anti-Crime Specialist.

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

Internal Audit Annual Report

2021/22

April 2022

Internal Audit Annual Report

Introduction

This is the 2021/22 Annual Report by TIAA on the internal control environment at Pembrokeshire Coast National Park Authority .The annual internal audit report summarises the outcomes of the reviews we have carried out on the organisation's framework of governance, risk management and control. This report, which incorporates CIPFA guidance on the potential limitation of scope brought about by the impact of COVID-19, is designed to assist Authority in making its annual governance statement.

Limitations on our opinion arising from Covid-19

The impact of COVID-19 on many organisations has continued to be felt throughout 2021/22 with restrictions continuing to be applied. This has been compounded by the emergence of new variants which has required the vaccination and booster programme to be accelerated. These have impacted staff availability and organisational capacity. It is acknowledged that this has affected some sectors more than others.

For internal audit the question remains as to whether sufficient internal audit work has been undertaken to gain assurance during 2021/22. This is a key consideration to fulfil the requirement of the Public Sector Internal Audit Standards (PSIAS) for the Head of Internal Audit (HIA) when issuing their annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This opinion is in turn one of the sources of assurance that the organisation relies on for its Annual Governance Statement. Factors that need to be taken in to account in reaching a conclusion include:

- Has any reduction in coverage compared to what was planned resulted in insufficient assurance work?
- Have any limitations in the scope of individual assignments resulted in it only being possible to place partial assurance on the outcome?
- Have changes in ways of working led to gaps in the governance, risk management and control arrangements?

TIAA understands the considerable challenges and the difficult decisions that organisations are having to deal with, however, the professional and regulatory expectations on public bodies to ensure that their internal audit arrangements conform with PSIAS have not changed. In this difficult situation, heads of internal audit will need to consider whether they can still issue the annual opinion or whether there will need to be a limitation of scope.

A limitation of scope arises where the HIA is unable to draw on sufficient assurance to issue a complete annual opinion in accordance with the professional standards. This is an issue not only for the HIA but also for the leadership team and the audit committee who normally rely on that opinion. It may also have wider consequences for stakeholder assessments of the organisation.

What this means for Pembrokeshire Coast National Park Authority

There has been minimal or no impact on the delivery of the internal audit work for 2021/22 as a result of the COVID-19 pandemic. Whilst there was an impact on delivery of the work in the early part of the year during the initial lockdown, we are able to deliver the planned work by year-end (or shortly thereafter). There have been no changes to the planned work as a result of COVID-19; any changes to the plan were based on purely on business/operational need.

HEAD OF INTERNAL AUDIT'S ANNUAL OPINION

TIAA is satisfied that, for the areas reviewed during the year, Pembrokeshire Coast National Park Authority has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by the Pembrokeshire Coast National Park Authority from its various sources of assurance.

Internal Audit Planned Coverage and Output

The 2021/22 Annual Audit Plan approved by the Audit and Corporate Services Review Committee was for 24 days of internal audit coverage in the year.

During the year there were no changes to the Audit Plan.

The planned work that has been carried out against the plan and the status of work not completed is set out at Annex A.

No extra work was carried out which was in addition to that set out in the Annual Audit Plan.

Assurance

TIAA carried out seven reviews, six of which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Authority's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. Details of these are provided in Annex A and a summary is set out below.

Assurance Assessments	Number of Reviews	Previous Year
Substantial Assurance	2	3
Reasonable Assurance	4	3
Limited Assurance	0	1
No Assurance	0	0

The areas on which the assurance assessments have been provided can only provide reasonable and not absolute assurance against misstatement or loss and their effectiveness is reduced if the internal audit recommendations made during the year have not been fully implemented.

We made the following total number of recommendations on our audit work carried out in 2021/22. The numbers in brackets relate to 2020/21 recommendations

Urgent	Important	Routine
0 (0)	10 (11)	14 (8)

Audit Summary

Control weaknesses: There were no areas reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited' or 'no assurance'.

Recommendations Made: We have analysed our findings/recommendations by risk area and these are summarised below.

Risk Area	Urgent	Important	Routine
Directed			
Governance Framework	0 (0)	3 (3)	4 (4)
Risk Mitigation	0 (0)	0 (0)	0 (1)
Compliance	0 (0)	7 (7)	7 (3)
Delivery			
Performance Monitoring	0 (0)	0 (1)	2 (0)
Financial Constraint	0 (0)	0 (0)	0 (0)
Resilience	0 (0)	0 (0)	1 (0)

Operational Effectiveness Opportunities: One of 0the roles of internal audit is to add value and during the financial year we provided advice on opportunities to enhance the operational effectiveness of the areas reviewed and the number of these opportunities is summarised below.

Operational
6 (4)

Independence and Objectivity of Internal Audit

There were no limitations or restrictions placed on the internal audit service which impaired either the independence or objectivity of the service provided.

Performance and Quality Assurance

The following Performance Targets were used to measure the performance of internal audit in delivering the Annual Plan.

Performance Measure	Target	Attained
Completion of Planned Audits	100%	100%
Audits Completed in Time Allocation	100%	100%
Final report issued within 10 working days of receipt of responses	95%	100%
Compliance with Public Sector Internal Audit Standards	100%	100%

Ongoing quality assurance work was carried out throughout the year and we continue to comply with ISO 9001:2015 standards. An independent external review was carried out of our compliance of the Public Sector Internal Audit Standards (PSIAS) in 2017 and in particular to meet the requirement of an independent 5 year review, the outcome confirmed full compliance with all the standards. Our work also complies with the IIA-UK Professional Standards.

Release of Report

The table below sets out the history of this Annual Report.

Date Report issued:	28th April 2022

Annexes

Annex A

Actual against planned Internal Audit Work 2021/22

System	Type	Planned Days	Actual Days	Assurance Assessment	Comments
Risk Management – Mitigating Controls	Assurance	3	3	Reasonable	Final Report Issued
ICT Strategy	Assurance	3	3	Reasonable	Final Report Issued
Estates Delivery	Assurance	3	3	Substantial	Final Report Issued
Procurement and Creditor Payments	Assurance	3	3	Substantial	Final Report Issued
Equality and Diversity	Assurance	3	3	Reasonable	Final Report Issued
Resilient and Sustainable Services	Assurance	3	3	Reasonable	Final Report Issued
Follow-up	Follow Up	1	1	N/A	Final Report Issued
Annual Planning		1	1		Final Plan Issued
Annual Report		1	1		Final Report Issued
Audit Management		3	3		
	Total Days	**24**	**24**		