Report No. 10/23

Audit & Corporate Services Review Committee

REPORT OF THE INTERNAL AUDITOR

SUBJECT: INTERNAL AUDIT REPORT 2022/23

The report is the outcome of work completed against the block two of the 2022/23 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
- Conservation Management Schemes
- Safeguarding
- Performance Report
- ICT Disaster Recovery – to follow

The TIAA Annual Report which contains the Head of Audit opinion will follow.

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.

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

2022/23

April 2023

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 2023.

Review	Year	Date Presented to Audit & Corporate Services Review Committee
Risk Management	2019/20	February 2020
Departmental Review – Education – Block 1 (Follow Up 2021/22)	2020/21	November 2020
Staff Wellbeing and Absence Management	2020/21	November 2020
Planning Application and Fees – Block 2	2020/21	May 2021
Cyber Security	2020/21	May 2021
Business Continuity Plan (Follow-Up 2020/21 – Block 1 – 2019/20)	2020/21	July 2021
Estates Delivery	2021/22	November 2021
IT Strategy	2021/22	November 2021
Resilient and Sustainable Services	2021/22	May 2022
Equality and Diversity	2021/22	May 2022
Risk Management – Mitigating Controls	2021/22	May 2022
Procurement and Creditors	2021/22	May 2022

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	13
Outstanding	17
Considered but not Implemented or Superseded	1
Not Implemented	-

3. The Authority has made some progress with 13 (42%) recommendations implemented. However, 17 (55%) recommendations remain outstanding and details of the progress made to date are provided in the report. One recommendation (3%) has been considered but not implemented and will be closed.

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:	4th April 2023
Date management responses rec'd:	13th April 2023
Date final report issued:	17th April 2023

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. **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)**	30/9/2023
Latest Update	The Spreadsheet was not provided and therefore the recommendation has been assessed as still outstanding and requires a revised target date for implementation.				
New implementation date	TBC	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date needs to be set for implementation	

11. **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)**	31/03/25
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 is expected to be updated by March 2024.				
New implementation date	March 2024	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of March 2024 has been set for implementation	

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)**	31/03/24
Latest Update	As the above recommendation, a review of policies has started. The Policy is to be updated by March 2024				
New implementation date	March 2024	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of March 2024 has been set for implementation	

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)**	31/03/24
Latest Update	The Policy is in a draft format and out for consultation. A revised target date of October 2023 has been set for implementation.				
New implementation date	October 2023	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of October 2023 has been set for implementation	

12. **Cyber Security**

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)**	30/12/23
Latest Update	As of March 2023, the Microsoft 365 project has yet to be fully implemented whilst the reorganisation was being finalised. Sensitivity labelling and Office 365 metadata has been researched and the intention is to implement it at a later date. The existing policy document remains in place				
New implementation date	October 2023	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of October 2023 has been set for implementation	

Audit title	**Cyber Security**	**Audit year**	2020/21	**Priority**	**3**
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**	30/08/21	**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	N/A	**Status**	**Considered but not implemented**	The recommendation is no longer being progressed.	

13. **Business Continuity Plan**

Audit title	**Business Continuity Plan**	**Audit year**	2019/20	**Priority**	**1**
Recommendation	The BCP should 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)**	31/12/2023
Latest Update	Revised Business Continuity Plan drafted but awaiting full implementation of Office 365 before adopting.				
New implementation date	March 2024	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of March 2024 has been set for implementation	

14. **Estates Delivery**

Audit title	**Estates Delivery**	**Audit year**	2021/22	**Priority**	**2**
Recommendation	An Estate Strategy be developed setting out the vision, strategic aims and key priorities of the Estate Management function and including the Authority's approach to meeting the de-carbonisation agenda targets set by Welsh Government.				
Initial management response	We will work to develop an Estate Strategy as recommended. Targets relating to the Authority's buildings that form part of the organisations drive to be carbon neutral by 2030 are also included in the "Responding to the Climate Change Emergency – Delivery Action Plan".				
Responsible Officer/s	Andrew Muskett Building Projects Manager	**Original implementation date**	31/03/24	**Revised implementation date(s)**	N/A
Latest Update	A new Head of Decarbonisation has been in post from February. The Authority is working with Wales Energy services to provide a comprehensive review of the buildings in terms of decarbonisation which will be incorporated into the new Decarbonisation strategy, once this is complete, the Estates strategy will be reviewed accordingly.				
New implementation date	TBC	**Status**	**Outstanding**	The recommendation is still within target date set.	

15. **ICT Strategy**

Audit title	**ICT Security**	**Audit year**	2021/22	**Priority**	2
Recommendation	The IT Strategy be formally approved once it has been completed.				
Initial management response	The IT Strategy will be updated to reflect and support the new priorities agreed during the course of the development of the new Corporate and Resources Plan in line with the response to Recommendation #2.				
Responsible Officer/s	Business Improvement and IT Manager	**Original implementation date**	31/03/2024	**Revised implementation date(s)**	N/A
Latest Update	The IT Strategy has not been formally approved as it does not fall into the category of formal policies. Its overall aims are being followed, with the increased use of Office 365 being the primary driver. A new Digital Transformation and general IT Strategy is being formulated following the internal reorganisation.				
New implementation date		**Status**	**Outstanding**	The recommendation is still within target date set.	

Audit title	**ICT Security**	**Audit year**	2021/22	**Priority**	2
Recommendation	The workstreams identified within the Corporate and Resources Plan be prioritised to enable the best use of the available resources.				
Initial management response	The Authority is currently undertaking work to agree a new high level strategy and also develop a new Corporate and Resources Plan. As part of this process the Authority will be deciding on its priorities and this will include the priorities for IT.				
Responsible Officer/s	The new Corporate and Resources Plan will be agreed by the Authority	**Original implementation date**	31/03/2024	**Revised implementation date(s)**	N/A
Latest Update	Update March 2023 - Authority will be developing a Digital Transformation Delivery Plan which will help prioritise support from IT team against Authority's wider Objectives.				
New implementation date		**Status**	**Outstanding**	The recommendation is still within target date set.	

16. **Resilient and Sustainable Services**

Audit title	**Resilient and Sustainable Services**	**Audit year**	2021/22	**Priority**	3
Recommendation	The Business Continuity Plan be finalised as planned once the Microsoft 365 software has been fully implemented.				
Initial management response	Agreed				
Responsible Officer/s	IT Manager	**Original implementation date**	31/03/24	**Revised implementation date(s)**	N/A
Latest Update	The Plan is to be finalised once Microsoft 365 software has been fully implemented.				
New implementation date	N/A	**Status**	**Outstanding**	The recommendation is still within target date set.	

Audit title	**Resilient and Sustainable Services**	**Audit year**	2021/22	**Priority**	3
Recommendation	The Action in relation to the awareness of the Business Continuity Plan with staff be completed once the Plan has been finalised as planned.				
Initial management response	Agreed				
Responsible Officer/s	Leadership Team	**Original implementation date**	31/03/24	**Revised implementation date(s)**	N/A
Latest Update	As per the above recommendation				
New implementation date	N/A	**Status**	**Outstanding**	The recommendation is still within target date set.	

Audit title	**Resilient and Sustainable Services**	**Audit year**	2021/22	**Priority**	3
Recommendation	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.				
Initial management response	Agreed				
Responsible Officer/s	HR Manager and H&S Group	**Original implementation date**	31/07/22	**Revised implementation date(s)**	N/A
Latest Update	No evidence was provided to confirm that this recommendation has been implemented				
New implementation date	TBC	**Status**	**Outstanding**	A revised target date for implementation needs to be set.	

17. **Equality and Diversity**

Audit title	**Equality and Diversity**	**Audit year**		**Priority**	2
Recommendation	The Code of Conduct for Authority Members be reviewed and updated and include reference to inclusion and inclusivity.				
Initial management response	Agreed				
Responsible Officer/s	Monitoring officer, DS&A manager, PC	**Original implementation date**	31/07/22	**Revised implementation date(s)**	N/A
Latest Update	This is still to be reviewed				
New implementation date	December 2023	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of December 2023 has been set for implementation	

Audit title	**Equality and Diversity**	**Audit year**	2021/22	**Priority**	2
Recommendation	Equality, diversity and inclusion be included as part of the induction process for all new staff with specific signposting to the Equal Opportunities Policy.				
Initial management response	Agreed				
Responsible Officer/s	HR Manager	**Original implementation date**	30./09/22	**Revised implementation date(s)**	N/A
Latest Update	No evidence was provided to confirm that this recommendation has been implemented.				
New implementation date	TBC	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date needs to be set for implementation	

Audit title	**Equality and Diversity**	**Audit year**	2021/22	**Priority**	2
Recommendation	Training and refresher training on equality, diversity and inclusion be completed for all staff as planned				
Initial management response	Agreed				
Responsible Officer/s	HR Manager	**Original implementation date**	31/03/23	**Revised implementation date(s)**	N/A
Latest Update	No evidence was provided to confirm that this recommendation has been implemented.				
New implementation date	March 2024	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of March 2024 has been set for implementation	

Audit title	**Equality and Diversity**	**Audit year**	2021/22	**Priority**	3
Recommendation	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.				
Initial management response	Agreed – however, the Authority will seek to provide clearer guidance on the level of decision making required to undertake an EIA.				
Responsible Officer/s	PC Co-ordinator and Chief Executive	**Original implementation date**	31/03/24	**Revised implementation date(s)**	N/A
Latest Update	Key decisions and plans are being subjected to integrated assessments. The Delivery Plan and Corporate and Resources Plan will be subject to integrated assessments. Wider corporate improvement project on policies will look at the best approach to take around wider corporate policies and procedures that sit outside of strategic plans and decisions.				
New implementation date	N/A	**Status**	**Outstanding**	The recommendation is still within target date set.	

18. **Risk Management – Mitigating Controls**

Audit title	**Risk Management – Mitigating Controls**	**Audit year**	2021/22	**Priority**	3
Recommendation	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.				
Initial management response	Agreed. Leadership team will periodically sample test and evaluate mitigating controls.				
Responsible Officer/s	Leadership Team	**Original implementation date**	01/01/22	**Revised implementation date(s)**	N/A
Latest Update	Accountability meeting not commenced yet				
New implementation date	June 2023	**Status**	**Outstanding**	The recommendation is outstanding and past its due date. A revised target date of June 2023 has been set for implementation	

19. **Procurement and Creditors**

All recommendations have been implemented.

20. The following recommendations have been implemented.

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Risk Management	The Risk Management Strategy be reviewed and updated to reflect current arrangements.	2	Finance Manager	31/01/2020
Planning Application Fees – Block 2	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.	2	Nicola Gandy / Matthew Griffiths	March 2021
Equality and Diversity	All job adverts for the Authority to include a consistent statement in relation to Equality and Diversity	2	HR Manager	30/06/22
Risk Management – Mitigating Controls	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	Finance Manager	31/03/22
Risk Management – Mitigating Controls	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	Chief Executive / Finance Manager	31/03/22
Risk Management – Mitigating Controls	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	Chief Executive / Finance Manager	31/03/22
Planning Application Fees – Block 2	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	3	Nicola Gandy / Matthew Griffiths	June 2021 and half yearly
Resilient and Sustainable Services	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	HR Manager	31/07/22
Risk Management – Mitigating Controls	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	Chief Executive	31/02/22
Risk Management – Mitigating Controls	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	Leadership Team	31/02/22
Risk Management – Mitigating Controls	The Risk Register be proofread including checking arithmetic calculations before being presented to the Audit and Corporate Services Committee.	3	Chief Executive / Finance Manager	Completed at time of review

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Procurement and Creditors	Version control details be added to the Financial Standards and the Sustainable Procurement Policy to clearly state when the documents were last reviewed, approved (and by whom) and are next due to be reviewed.	3	Finance Manager	Immediate
Procurement and Creditors	The wording of paragraph 8 of the Cardholder Agreement Form be updated to include a reference to the Barclaycard Premium Cardholder User Guide which is consistent with current practice.	3	Finance Manager	Immediate

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

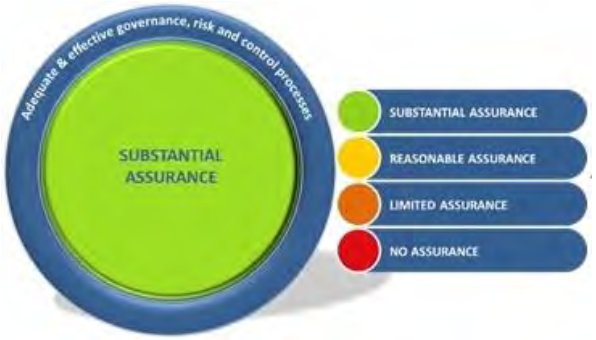
Assurance Review of Conservation Management Schemes

2022/23

April 2023

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

N/A

KEY STRATEGIC FINDINGS

The Authority has clearly defined arrangements in place for the management of Conservation Schemes.

The process for bidding, applying and awarding of funding was discussed and sample testing completed to evidence the process in practice. No issues were identified.

No recommendations have been raised.

GOOD PRACTICE IDENTIFIED

The Authority maintain a comprehensive filing system for each site which was evidenced during the audit.

SCOPE

The review considered the process for the management of conservation schemes and how they link into the National Park Management Plan. The review considered the process for bidding, application and awarding of funding for schemes. The review did not consider the actual benefits of the schemes awarded.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

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)
No recommendations were raised.							

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
No Operational Effectiveness Matters were identified.				

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.	In place	-	-

Other Findings

The Pembrokeshire Coast National Park Management Plan 2020-24 was approved by the Pembrokeshire Coast National Park Authority on 11th December 2019. The Management Plan sets out the National Park purposes of conservation, enjoyment and understanding. The Plan pursues National Park purposes through partnership action across five complementary themes:

- A national asset – A landscape for life and livelihoods;
- Landscapes for everyone – Wellbeing, enjoyment, and discovery;
- A resilient Park – Protecting and restoring biodiversity;
- A place of culture – Celebrating heritage; and
- Global responsibility – Managing natural resources sustainably.

The five themes are based on National Park purposes and are each detailed within the Management Plan under sections two to six. Clear links could be seen between the Management Plan 2020-24 and the management of conservation schemes.

Other Findings

There are two main entry points for landowners wishing to enter the Conserving the Park Scheme; either through information they had read on the Authority's flyers or through information posted on the Authority's website. This is a rolling programme of entry which operates on a wait list on occasions where it becomes oversubscribed. An advisor visit is conducted to assess the applicant's land and to draw up joint objectives for conservation management. To enable entry to the scheme, the objectives must deliver for one or more priority habitat types or species from a list published by the Pembrokeshire Nature Partnership.

The list of priority habitats and species has been taken from the Local Biodiversity Action Plan for Pembrokeshire which provides action plans for European Annex 1 habitats and Annex 2 species and the UK Biodiversity Action Plan habitats and species in Pembrokeshire, as well as those of local concern; this document is available via the Pembrokeshire County Council website. Active sites within the scheme receive a monitoring visit. The aim of the Authority is to visit 50% of schemes per annum; visits are based on risk or the need for continued advice. The schemes are visited and assigned a red, amber, or green category as can be seen in Appendix C of this report.

The Traditional Boundaries Scheme is a grant scheme for the restoration of traditional boundaries in the Pembrokeshire Coast National Park. The scheme exists to provide opportunities for landowners to receive financial support with all aspects of the management and restoration of traditional field boundaries, whilst improving carbon storage in hedgerows. Applications are received through the Authority's website. Once received, a member of the Conservation Land Management Team makes contact with the applicant to arrange a site visit to discuss the proposed works and measure the boundary in question. Works are paid on a metre/percentage basis once the works have been completed and an invoice received. In the event of oversubscribing to the scheme, the following are considered when prioritising applications:

- Wildlife value;
- Proximity to or visibility from public rights of way;
- Contribution to the landscape; and
- Historic Value.

The management of the conservation schemes is undertaken by the Conservation Team. The team is led by the Conservation Team Leader who reports to the Head of Nature Recovery. The Conservation Team Leader maintains a Management Agreements Expenditure sheet which is used to log all of the sites the Authority has management agreements over. Management Agreements are signed by both a Director and the Landowner and annual payments are signed off by the Conservation Team Leader before being made. A redacted copy of the sheet was provided and a review confirmed that it logs all information relating to each individual site including a reference number, dates of payment, end dates and total amounts of funding received each year. The site summary sheet provides information relating to the site including the site type, area (hectares), a background of the site and the management regime. In addition to the Management Agreements Expenditure Sheet, two examples of site summary sheets detailing the site name, location, and information about the management regime were provided. The site summary sheets are site specific, produced for all sites and electronically stored in a site specific folder.

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	-	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
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

Outputs and outcomes for the year are summarised into a Conserving the Park report. The report is publicly available and can be found via the Authority's website. A review of the latest report highlighted information on new agreements is available covering the periods from 2019/20 up to 2021/22. Also included within the reports are case studies demonstrating the work that has been undertaken by the Conservation Land Management Team and the outcomes that have been achieved including increasing ecological resilience, supporting citizen science and new trees and woodlands in the landscape.

A quarterly Performance Report is presented to the Audit and Corporate Services Review Committee. A copy of the latest report up to 31st December 2022 was provided during the audit. The report includes conservation sites and pollinator/habitat improvements carried out in the year to date. An extract is shown in Appendix C of this report and details the actual percentage against the target.

The Pembrokeshire Coast National Park Management Plan is accompanied by three assessments including:

- Sustainability Appraisal (incorporating Strategic Environmental Assessment);
- Equality Impact Assessment; and
- Habitats Regulations Assessment.

The assessments are available on the National Park Authority's website and a summary of the Sustainability Appraisal are included in each section of the Management Plan.

A review of the Authority's website highlighted a section on conservation. This section of the website offers information about the Authority's efforts to conserve the landscape through the work on the coast and inland areas, in building conservation, planning, agriculture, forestry and sustainable development.

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:	3rd February 2023	22nd March 2023
Draft Report:	5th April 2023	13th April 2023
Final Report:	17th April 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Conservation Management Schemes		
Type of Review:	Assurance	**Audit Lead:**	Senior Auditor

Outline scope (per Annual Plan):	The review will consider the process for the management of conservation schemes and how they link into the National Park Management Plan. The review will review the process for bidding, application and awarding of funding for schemes. The review will not consider the actual benefits of the schemes awarded.	
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. Sustainability: The impact on the organisation's sustainability agenda has been considered. 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 review will not consider the actual benefits of the schemes awarded.	

Planned Start Date:	22nd March 2023	**Exit Meeting Date:**	29th March 2023	**Exit Meeting to be held with:**	Biodiversity Officer

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 INFORMATION

Appendix C

Explanation of Monitoring Categories

RED	AMBER	GREEN
A site is judged to be Red if: A serious or repeated breach of management plan has taken place. Damaging activities have taken place or features of interest destroyed/partially destroyed.	A site is judged to be Amber if: Management is considered compliant and effective but the conservation value of the site will take time to improve. There is a positive direction of travel in terms of quality improvement but with minor deviations from the management plan which may slow recovery or improvement of conservation value. Management is compliant but our recommended management is not producing the expected results.	A site is judged to be Green when the management regime is compliant, the management is effective and the site is of high quality and with high ecological integrity. In the green category we are often 'running to stand still' as maintenance of good condition requires continued management. Such sites may slip back to Amber if the land changes hands or the owners' circumstances change.
Our response: The Authority will make a judgement on whether to continue involvement with the site.	**Our response:** In the first case, the positive feedback is provided to the landowner. In the second case we communicate with the landowner regarding ideal management practice and reasons for deviation, perhaps looking for alternatives. In the third case we would work with the landowner to experiment with management. This is standard practice in nature conservation management and is referred to as 'adaptive' management.	**Our response:** Green sites may stay with the scheme requiring smaller amounts of intervention. For example, a site which had capital expenditure such as gates and scrub control may now only need a small amount of on-going assistance with grazing animals. For some sites continued support may be the only option for retaining the conservation interest of the site.

Extract from Performance Report

Measure - Data Available Quarterly	2021/22 Q1 – Q3 (April - Dec) Actual	2022/23 Q1 – Q2 (April - Sep) Actual	2022/23 Current Period: Q1 – Q3 (April – December)					
			Actual	Target	Revised Target	RAG	Trend	Comments
Conservation Sites - % in line with their formal management plan (S6)	100	100	100	100%		Green	→	
Conservation Work Programme: # jobs completed ytd (S6)	122	57	62	Trend				
# Pollinator/ habitat improvements carried out on PROW ytd (S6)	89	249	287	Trend				Including 69 scallop edges cutting jobs ytd and 55 bee bank jobs ytd.

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

Assurance Review of Safeguarding

2022/23

May 2023

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

There are no directly related risks on the PCNPA strategic risk register.

KEY STRATEGIC FINDINGS

Safeguarding procedures operated by Pembrokeshire Coast National Park Authority (PCNPA) are generally sound and fit for purpose.

Safeguarding responsibilities of staff are clearly defined and appropriate arrangements are in place in respect of recruitment and training.

Tier 2 child protection / adult protection training has not been provided to the Safeguarding Lead and Ranger Service Manager since 2015.

GOOD PRACTICE IDENTIFIED

Staff with safeguarding responsibilities meet at least annually to discuss any issues or concerns relating to the Authority's safeguarding procedures.

Discussions are currently ongoing to introduce an annual safeguarding report to the HR Committee or the Audit and Corporate Services Review Committee.

SCOPE

The review considered the effectiveness of the safeguarding arrangements.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	3	0

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	Periodic reports regarding safeguarding activities are not currently made to the Senior Management Team or the Board. The HR Manager indicated that an annual safeguarding report will be introduced going forward. Discussions are currently ongoing with the HR Committee and the Audit and Corporate Services Review Committee as to where such a report will be taken.	The introduction of an annual safeguarding report to a suitable committee of the Board be progressed as a matter of priority.	3	*The Human Resources Manager agreed to take responsibility for providing the report in liaison with the Authority's Safeguarding Lead.*	*30/09/23*	*HR Manager*
2	Directed	The Authority's Safeguarding Statement specifies that '...at least one member of the selection panel will have specialist understanding of effective recruitment within this safeguarding policy', although there is no specific reference to Safer Recruitment training. The Authority's Action Plan 2022/23 specifies that 'when recruitment takes place for roles requiring a DBS (Disclosure and Barring Service) check for safeguarding purposes one of the interview panel members should have undertaken 'Safer Recruitment' training.'	Requirements for Safer Recruitment training for staff undertaking interviews be reviewed with a view that the PCNPA Safeguarding Statement and the PCNPA Action Plan 2022/23 contain a consistent approach. 'Safer Recruitment' training should be specified in the Safeguarding Statement.	3	*The Authority's Managers are 'Safer Recruitment' trained, although it is acknowledged that the Safeguarding Statement should reflect this.*	*30/09/23*	*Graham Peake*

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	It was confirmed that the Safeguarding Lead and the Ranger Service Manager had undertaken appropriate child protection / adult protection Tier 2 training as required by the Safeguarding Statement, although not since 2015. It is acknowledged that refresher training is being organised for 2023.	Tier 2 Child protection / adult protection refresher training be provided to the Safeguarding Lead and Ranger Service Manager more frequently than every seven years. Minimum required frequency of refresher training should be set out within the Safeguarding Statement.	3	*Best practice is to refresh training every 2 – 3 years. The Authority will document and carry out refresher training every 3 years.*	*30/09/23*	*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.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

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	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.	In place	3	-

Other Findings

The Pembrokeshire Coast National Park Authority (PCNPA) Safeguarding Statement was approved by the National Park Authority in December 2019 and was subject to a further informal revision in December 2020. The HR Manager indicated that the next scheduled review will be in 2024 unless legislative changes require an earlier review.

Responsibilities of all staff in relation to safeguarding are clearly set out in the Safeguarding Statement.

Other Findings

Review of the PCNPA Safeguarding Statement and discussion with the HR Manager confirmed that all key areas are covered including:

- Staff responsibilities;
- Definitions of abuse;
- Employment processes;
- Guidance in respect of working safely;
- Treatment of volunteers;
- Guidance in respect of work experience and placements;
- Procedures where staff suspect abuse or mistreatment;
- Procedures where staff have concerns about colleagues; and
- Procedures for making and dealing with allegations.

A designated Safeguarding Lead is identified within the Safeguarding Statement, together with three officers who are responsible for deputising for the Lead. Up to date out of office hours contact details are provided for all officers with safeguarding responsibilities.

Review of job descriptions for staff with specific safeguarding responsibilities confirmed that such responsibilities were included in the documents. Discussion with the HR Manager indicated that staff with safeguarding responsibilities are very clear on their responsibilities. The safeguarding leads meet periodically to discuss safeguarding issues.

The PCNPA Safeguarding Statement specifies that 'as a minimum all staff that work with, or who manage staff who work with, vulnerable groups will undergo the Pembrokeshire Local Operational Group (LOG) Safeguarding Board Tier 1 Training' and 'the Safeguarding Lead and the Ranger Service Manager will undergo appropriate child protection / adult protection Tier 2 Training'.

There are no directly related risks on the PCNPA Strategic Risk Register. The HR Manager indicated that PCNPA is not considered to be a high-risk safeguarding environment.

A review of five roles requiring DBS (Disclosure and Barring Service) checks to be undertaken confirmed that in all cases the correct DBS check (i.e., Basic or Enhanced) was properly recorded as having been completed.

For a sample of three recent recruitment exercises for staff requiring DBS checks, it was confirmed that in all cases a member of the selection panel had completed Safer Recruitment training as required.

Other Findings

A review of a listing of safeguarding training provided to employees indicated that the majority had received online Elms safeguarding training between 2020 and 2022. 46 employees were shown as not having received safeguarding training.

The HR Manager confirmed that the majority of these staff would have received the training when it was provided by Pembrokeshire County Council (PCC). Records of this training were retained by PCC, but PCNPA has so far been unable to obtain them. It is intended that all staff will have completed the online Elms training in the coming months.

It was confirmed that the Safeguarding Lead and the Ranger Service Manager had undertaken appropriate child protection / adult protection Tier 2 training as required by the Safeguarding Statement, although not since 2015. Refresher training is being organised for 2023.

The HR Manager confirmed that there had been no reportable safeguarding incidents in recent years. Procedures for making and dealing with allegations against staff and volunteers are set out within the Authority's Safeguarding Statement. This includes procedures for investigating allegations internally or by referral to the multi-agency Local Operational Group.

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	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
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	
	There are currently no Key Performance Indicators (KPIs) in respect of safeguarding. The HR Manager confirmed, discussions will be held with the HR Committee and the Audit and Corporate Services Review Committee in respect of introducing 'Safeguarding - Reportable Cases' as a HR performance metric going forward. As stated previously, it is intended that an annual safeguarding report to a suitable committee of the Board will be introduced in the coming months.
	There are no directly relevant sustainability implications in respect of Safeguarding, although it was noted that all processes and documentation were electronic rather than paper based.
	Resilience in respect of safeguarding procedures was noted to be strong. Procedures operated as usual during the Covid-19 pandemic, with no relaxation of requirements.

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:	7th October 2022	7th October 2022
Draft Report:	14th December 2022	5th May 2023
Final Report:	5th May 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Safeguarding		
Type of Review:	Assurance	**Audit Lead:**	Senior Auditor

Outline scope (per Annual Plan):	The review will consider the effectiveness of the safeguarding arrangements.	
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. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	None	
Exclusions from scope:	As above.	

Planned Start Date:	19/10/2022	**Exit Meeting Date:**	20/10/2022	**Exit Meeting to be held with:**	HR 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

Internal Audit

FINAL

Pembrokeshire Coast National Park Authority

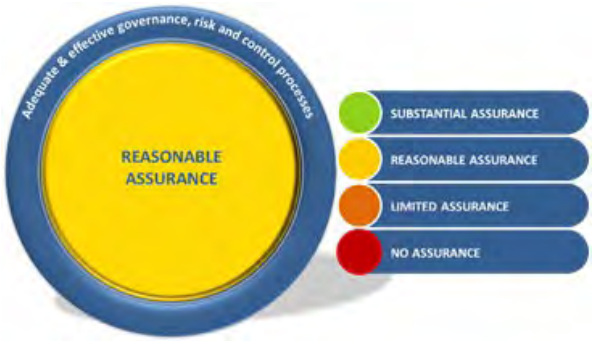
Assurance Review of Performance Management

2022/23

March 2023

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Several risks

KEY STRATEGIC FINDINGS

There is a framework in place that details the performance management arrangements and is linked to the delivery of the organisation's strategic objectives.

Previous quarter data is reported to Committee; the reports do not clearly set out where the data has changed since it was last reported.

Performance Reports are not being presented to the Senior Leadership Team in a timely manner.

Resilience needs to be provided for the in-house Performance Reporting system.

GOOD PRACTICE IDENTIFIED

The Authority has its own in-house performance management database in place to effectively manage performance data.

SCOPE

The review considered the arrangements for providing assurance to the Board and senior management through the use of Key Performance Indicators and the systems that are used to track and manage the attainment of these targets. The scope of the review did not include consideration of the accuracy or completeness of all reports presented to the Authority/Committees or the appropriateness of all decisions taken.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	2	0

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	A sample of ten performance measures from the Performance Report presented to the Audit and Corporate Services Review Committee for November 2022 (September's data) was selected and for seven out of ten the data was verified to the performance database. For the remaining three, the data could not be initially substantiated but evidence was provided later to substantiate the data. The Performance and Compliance Co-ordinator stated that there is often an occurrence when some performance data is updated after the cut off time for reporting to Committee. This means that, in the next quarter's report to Committee in March for December's data, the reporting of the previous quarter's figures (which would then be September's data) would appear different to the actual reported in the November report. For example, in the Conservation area for the measure of "participants in PCNPA's education programme" the data reported for September in November's report was 1,148 but the data in March's report showing the September figures had changed to 1,177. Whilst at year end the overall figure would be accurate, this is misleading for management and members. There is a risk that senior managers are not sufficiently sighted on progress against strategic objectives to take timely and relevant action, which could result in objectives and targets not being addressed.	The reporting of the previous quarters data sets in the Performance Reports to Committees where the data has changed since it was last reported be recorded in brackets to clearly set out the change.	2	*Accepted will put previous data entry where there are changes for quarterly/ monthly stats between Committee reports in brackets within the report. Explanation of this will be put in introduction report and it will explain that data can change between reports due to changes and updates relating to source data. All data is reviewed at end of financial year to double check for accuracy and to reflect changes, amendments and updates for source data captured on other systems/ records.*	*Q2 2023/24*	*Performance and Compliance Officer*

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	Delivery	The Performance and Compliance Co-ordinator confirmed that the performance reports are discussed with the Senior Leadership Team (SLT), but this is infrequent and not minuted due to the timing of the compilation of the reports and time they need to be presented to the Committees thus leaving little time for SLT review. There is a risk that senior managers are not sufficiently sighted on progress against strategic objectives to take timely and relevant action, which could result in objectives and targets not being addressed. The Authority is aware of this issue and is looking to address with this issue by one of the fortnightly meetings focusing on performance management.	Performance Reports be presented to the Senior Leadership Team in a timely manner for review and potential action prior to the reports being presented to the Committees and outcomes be recorded within the SLT minutes.	2	*Performance Reports are shared with officers including SLT in advance of them going to print when timescales allow. CEO has oversight prior to Committee report sign off. However, a degree of flexibility is needed around timings and delays in updates to system by officers or timescales for data sets to be available means that it won't always be possible for performance report itself to go to SLT meetings for discussions in advance of print. SLT members do however attend both Committees and respond to queries from Members.* *It is proposed under new Management Team Structure that one of the management team meetings a month look at performance reporting matters. This will link to wider performance report (however timings may mean that report itself won't be able to be considered).*	*Integration of performance management into new management team meetings – Q1/Q2 2023/24*	*Performance and Compliance Officer / Chief Executive*
5	Delivery	An in-house performance reporting system was developed by an individual within the ICT Department. It was noted that there is risk to the Authority as there is no contingency in place in the event of that individual being absent and any support or modifications to the system are required.	Another member of the ICT Team be trained on the in-house performance reporting system to provide resilience in the event of the designer being absent.	2	*Depending on capacity within IT team another officer will be trained on system and further documentation put in place.*	*Q2/Q3 2023/24*	*IT Team Leader*

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 Corporate and Resource Plan sets out that the Authority has two strands to reporting performance. Operational performance is reported quarterly to the Operational Review Committee and to the Audit and Corporate Services Review Committee. Finance and audit performance is reported quarterly to the Audit and Corporate Services Review Committee. The Committees can recommend the need for further action to the full Authority. It was noted that operational performance is also reported to the Audit and Corporate Services Review Committee. Clarity needs to be identified for the responsibility for monitoring performance.	Clarity be obtained with regards to which committee has responsibility for receiving and monitoring performance reports.	3	*Recommendation not accepted. Taking performance reports to both committees ensures that all members are aware of performance and able to highlight issues of concern.*	*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)
4	Delivery	A review of performance reports highlighted that there are a considerable number of metrics resulting in the performance report currently being 61 pages long. The Authority needs to review performance management reporting with a view to condensing the metrics reported to align more to strategic objectives so that they are more qualitative and quantitative Key Performance Indicators. Many of the indicators could still be measured locally by departments and senior management but not reported to Committee. The Performance and Compliance Co-ordinator stated that this has been recognised but no action has been taken to date.	The Performance Management Framework be reviewed with a view to condensing the report ensuring that qualitative and quantitative key performance indicators are measured.	3	*Authority is reviewing its performance management framework linked to wider development of delivery plans to identify a smaller number of key indicators. The performance framework will be reviewed to reflect this.* *Work will be carried out as indicators are reduced to see if any operational level performance data needs to be recorded – and where this is the case and it is appropriate for them to be recorded on the performance reporting system these will be included on the system. In some cases, it may be decided that teams should use for operational level performance data analysis the analysis tools directly tied to the system – APAS (BI power), Workforce Manager (ArcGIS Insights).* *Some indicators such as planning/ net zero are determined by Welsh Government and others are tied to compliance monitoring. Authority also needs to be mindful of any indicators that may need to be incorporated that are developed in partnership with Welsh Government for National Park Authorities.*	*01/10/23*	*Performance and Compliance Officer.*

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
No Operational Effectiveness Matters were identified.				

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	1	-
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	2	-

Other Findings

The Authority's Management Plan 2020-2024 sets out its vision and "action in pursuit of the National Park purposes of conservation, enjoyment and understanding". The delivery of the actions supporting the Plan is reported on through the Authority's performance management framework. A transition performance measurement framework is currently in place to take into account of activities identified under the steps to delivering the Authorities Well-being Objectives in the Corporate and Resources Plan that has been put in place for 2022/23. This is to help the transition process.

The Performance and Compliance Co-ordinator reporting to the Chief Executive has day-to-day responsibility for performance monitoring and reporting. Each manager has responsibility for each relevant Key Performance Indicator (KPI).

The Authority approved a new high-level strategy for the Authority in July 2021. The Strategy identified four priority areas for 2022-26. The performance report follows the structure of the Corporate and Resources Plan for 2022/23.

The four areas identified are:

- Conservation – Boosting biodiversity and halting its decline.
- Climate – Destination: Net Zero.
- Connection – Natural Health Service.
- Communities – Vibrant Communities.

Other Findings

The Authority utilised the Fynnon system for performance which was funded by Welsh Government, however, funding and support from the software supplier was coming to an end. As a result, the Authority scoured the market to find an alternative system. This proved to be unsuccessful mainly due to costs and licence issues. The Authority decided to develop their own in-house system for performance reporting.

The Performance and Compliance Co-ordinator is the Systems Administrator, along with the ICT Department of the Performance Reporting system and can set up and de-activate users. The users for each KPI populate the data in to the system and data reviewed by the Performance and Compliance Co-ordinator for reasonableness.

The Authority must submit quarterly planning performance data to Welsh Government. This is undertaken by the Planning Department. Deadlines for data for performance reports may fall before the Welsh Government Deadlines and planning department will receive reminders from Performance and Compliance Co-ordinator when this is the case.

The Authority has several individual risks that relate to the KPIs within the Performance framework. Controls are in place to mitigate the risk.

The Authority has implemented a transition performance measurement framework taking account of activities identified to deliver the Well-being Objectives The framework prioritises measures and activities based on the following:

- P1 High risk for Authority if not delivered or progressed in 2022/23 / Wider risks around compliance, funding commitments and reputational risks.
- P2 Moderate risk for Authority if not delivered or progressed in 2022/23 / Likely to be taken forward and further developed through delivery plans.
- P3 Lower risk for Authority if not delivered or progressed in 2022/23 / Likely to be taken forward and further developed through delivery plans.
- C Collaboration/ Strategic Partnership Activity.

The Performance Reporting system has been set up with a Menu for each delivery plan, each of the four each wellbeing objectives, Planning Policy and Delivery and Corporate Areas of Change. There are various tabs for Projects, Measures, Reports, Admin and Users. Each measure has been assigned an owner and a manager.

Each area has a measure which you can select and drill into with a milestone, outcome and various historical data. Data is collected depending on the measure which could be weekly. monthly, quarterly or annually. Users who populate the data provide a RAG (Red, Amber and Green) status and comments for each measure.

The System has a Dashboard functionality where various graphical displays are available for each measure. There is also a Help functionality to assist owners in navigating around the system.

The Performance Framework also includes reporting measure on Well-being Objective – Planning Policy and Service, which includes Change Management, Governance and Collaboration, Finance and Assets and Compliance.

Regular and statutory monitoring undertaken across the organisation is reported separately within the Health, Safety and Wellbeing Quarterly Report that is presented to the Audit and Corporate Services Committee.

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	3, & 4	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Partially in place	5	-

Other Findings

The Finance Manager presents budget performance reports to the Audit and Corporate Services Review Committee. The reports include the Revenue Budget, Quarterly Income Versus Budget & Prior Years, Revenue Forecast, Capital Programme against budget and The Authority's Useable Reserves. The report contains a commentary on the large variances.

The Authority has various performance measures in place that are monitored under the Climate Well-Being Objective as part of the Authority's aim for net zero and a carbon neutral National Park. They also support the Authority's contribution to achieving the Well-being goals within the Well-being of Future Generations (Wales) Act.

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:	17th February 2023	17th February 2023
Draft Report:	15th March 2023	22nd March 2023
Final Report:	23rd March 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Pembrokeshire Coast National Park Authority		
Review:	Performance Management		
Type of Review:	Assurance	**Audit Lead:**	Audit and Fraud Manager

Outline scope (per Annual Plan):	The review considers the arrangements for providing assurance to the Board and senior management through the use of Key Performance Indicators and the systems that are used to track and manage the attainment of these targets. The scope of the review does not include consideration of the accuracy or completeness of all reports presented to the Authority/Committees or the appropriateness of all decisions taken.	
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. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	None As above	
Exclusions from scope:		

Planned Start Date:	27th February 2023	**Exit Meeting Date:**	3rd March 2023	**Exit Meeting to be held with:**	Performance and Compliance Co-ordinator

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

INDICATIVE

Pembrokeshire Coast National Park Authority

Indicative Internal Audit Annual Report

2022/23

May 2023

Internal Audit Annual Report

Introduction

This is the 2022/23 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 Pembrokeshire Coast National Park Authority's framework of governance, risk management and control.

Our approach is based on the International Standards for the Professional Practice of Internal Auditing which have been developed by the Institute of Internal Auditors (IIA) and incorporate the Public Sector Internal Audit Standards (PSIAS). In 2022, TIAA commissioned an External Quality Assessment (EQA) of its internal audit service. The independent EQA assessor was able to conclude that TIAA 'generally conforms to the requirements of the Public Sector Internal Audit Standards and the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF).' 'Generally conforms' is the highest rating that can be achieved using the IIA's EQA assessment model. Ongoing quality assurance work was carried out throughout the year and we continue to comply with ISO 9001:2015 standards.

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. One area, ICT Disaster Recovery, was reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited assurance'. Recommendations were made to further strengthen the control environment in this area and the management responses are under discussion prior to finalising the report.

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 Pembrokeshire Coast National Park Authority from its various sources of assurance.

Internal Audit Planned Coverage and Output

The 2022/23 Annual Audit Plan approved by the Audit and Corporate Services Review Committee was for 25 days of internal audit coverage in the year.

During the year there was one change to the Audit Plan and this change was approved by the Audit and Corporate Services Review Committee. The planned review of the Board Assurance Framework has been deferred to 2023/24.

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 Pembrokeshire Coast National Park 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	3	2
Reasonable Assurance	2	4
Limited Assurance	1	0
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.

The ICT Disaster Recovery report has not been issued at the date of this report and is awaiting final confirmation from management. The indicative grading of 'Limited Assurance' has been included in the table above and in the statistics below. Any changes will be updated prior to finalisation of the Annual Report.

We made the following total number of recommendations on our audit work carried out in 2022/23. The numbers in brackets relate to 2021/22 recommendations.

Urgent	Important	Routine
3 (0)	**12 (10)**	**13 (14)**

Audit Summary

Control weaknesses: There was one area reviewed by internal audit (ICT Disaster Recovery) where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited assurance.' Recommendations were made to further strengthen the control environment in these areas and the management are currently considering their responses.

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

Risk Area	Urgent	Important	Routine
Directed			
Governance Framework	2 (0)	2 (3)	5 (4)
Risk Mitigation	0 (0)	0 (0)	0 (0)
Compliance	0 (0)	8 (7)	7 (7)
Delivery			
Performance Monitoring	0 (0)	1 (0)	1 (2)
Sustainability	0 (0)	0 (0)	0 (0)
Resilience	1 (0)	1 (0)	0 (1)

[1] This excludes the Board Assurance Framework review which did not take place at Management's request.

Operational Effectiveness Opportunities: One of the 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
2 (6)

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%[1]
Audits Completed in Time Allocation	100%	100%
Final report issued within 10 working days of receipt of responses	95%	100%
Compliance with IIA Internal Audit Standards	100%	100%

Release of Report

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

Date Indicative Report issued:	11th May 2023

Annexes

Annex A

Actual against planned Internal Audit Work 2022/23

System	Type	Planned Days	Actual Days	Assurance Assessment	Comments
Board Assurance Framework - Advisory	Advisory	2	0	N/A	Deferred to 2023/24 at the request of Management
ICT Disaster Recovery	Assurance	3	3	Limited	Draft Report Pending
Safeguarding	Assurance	3	3	Substantial	Final Report Issued
Visitor Centres & Cafes - Castell Henllys	Compliance	2	2	Reasonable	Final Report Issued
Performance Management	Assurance	3	3	Reasonable	Final Report Issued
Payroll and Expenses	Assurance	3	3	Substantial	Final Report Issued
Conservation Management Schemes	Assurance	3	3	Substantial	Final Report Issued
Follow-up	Follow up	1	1	N/A	Final Report Issued
Annual Planning	Management	1	1		Final Plan Issued
Annual Report	Planning/Reporting	1	1		Final Report Issued
Audit Management	Planning/Reporting	3	3		
	Total Days	**25**	**23**		