Report No. 18/25

Audit & Corporate Services Review Committee

Report of the Internal Auditor, Astari

Subject: Internal Audit Reports

The report is the outcome of the remainder of the work completed against the Internal Audit Strategy / Annual Plan approved by the Audit & Corporate Services Review Committee on the 31 July 2024, together with the Internal Audit Annual Report for the same time period.

Reports are presented in respect of the following area:

- Key Financial Controls (Fixed Assets)
- IT and Digital Transformation Strategy
- Visitor Centres
- Internal Audit Annual Report 2024/25

Recommendation: Members are asked to NOTE and COMMENT on these reports.

Pembrokeshire Coast National Park Authority

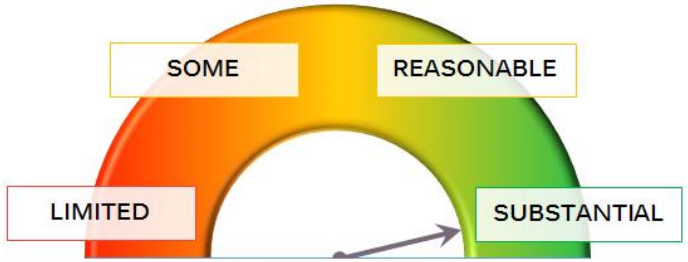
Key Financial Controls – Fixed Assets

Internal Audit Report: PCNPA-2024/25-07

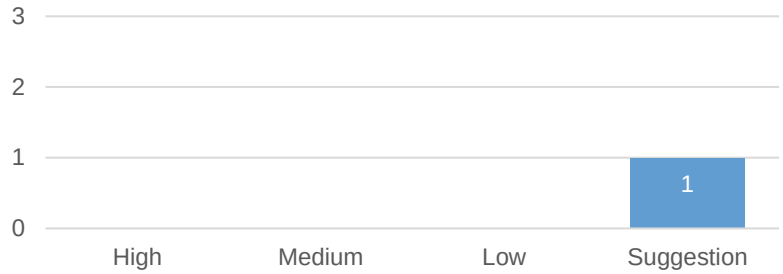
Date: 2 July 2025

1. EXECUTIVE SUMMARY

Level of Assurance

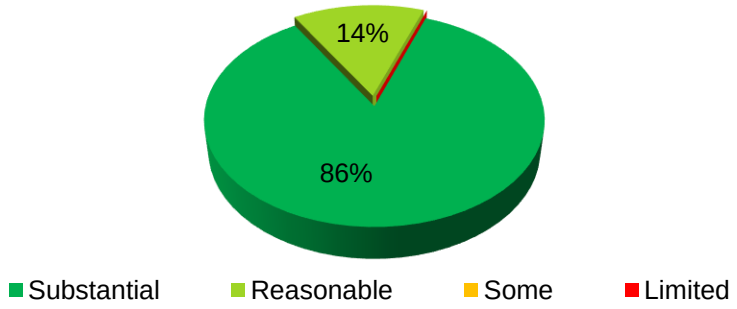


Number & Priority of Recommendations / Suggestions

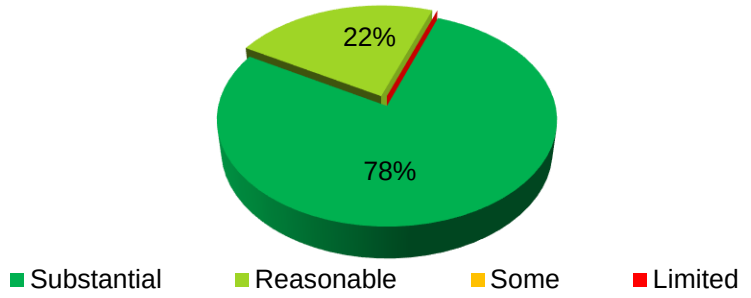


Conclusion:	Taking account of the scope of the review and the issues identified, the Board can take ***substantial*** assurance that that key financial controls in the area of fixed asset management are in place and are effective.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

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

- A Schedule of Delegated Authority (SoDA), Financial Regulations and Standing Orders were present and were in line with expectations for the size of the Authority.
- Internal (2nd Line) assurance checks were in place, including regular reconciliations and reporting.
- Capitalisation procedures were covered as part of the Financial Regulations and classification and useful economic lives were defined in the Annual Accounts.
- Fixed and intangible assets were appropriately recorded within a spreadsheet. Given the size and complexity of PCNPA, this was appropriate. Access was limited to the Finance Team.
- We tested a sample of 15 assets within the Fixed Asset Register to confirm that they were in line with capitalisation processes. Through testing we found that all (100%) had been accurately recorded, with amounts matching supporting data sources.
- Whilst the Finance Team had internal processes for when capital assets were identified, there was limited guidance in place for the wider organisation in relation to identifying and reporting assets in their areas.
- Depreciation periods were defined and had been approved by the Board, as per the sign off of the Annual Accounts. We tested ten assets and confirmed that all (100%) had depreciation periods in line with expectations.
- Guidance relating to disposals was made available within the Financial Regulations and SoDA. There were processes in place within the Finance Team in relation to the disposal of assets, however documented guidance was limited to the wider organisation. We understood through interview with key staff that the organisation had not recently disposed of many assets.
- We were advised that a verification exercise and audit of the Asset Register was undertaken annually.
- Maintenance of the fixed asset register was done annually, while this fit the needs of the business currently, future consideration should be given to increasing this if the level of assets increases.
- As full cost was recognised any links to grant funding was on the purchase and did not offset the depreciation of the assets.

Additional Feedback

We would like to thank the members of the finance team and the Head of Finance & Fundraising for their engagement with the review and cooperation throughout, this enabled us to obtain all required evidence and complete the review in a timely fashion.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	The organisation has robust key financial controls in place to ensure that transactions are recorded accurately, in a timely basis and that any discrepancies are identified, investigated, and addressed.
Risk(s):	Financial loss, inability to achieve the organisation's objectives or inability to take advantage of arising opportunities due to a lack of effective fixed asset management.
Engagement objective:	To provide assurance that key financial controls in the area of fixed asset management are in place and are effective.

2.2. Background to the Engagement

An audit of Key Financial Controls was undertaken as part of the approved internal audit periodic plan for 2024/25.

The scope of this review was risk-based and areas had been selected on the basis of increased risk as a result of one or more of the following:

- Significant changes in systems or personnel.
- An incident or perceived potential for an incident to occur.
- Significant changes to structures or processes that mean that new or altered controls have been established.

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

Areas within scope:	Fixed Asset Management ▪ Maintenance of the fixed asset register; ▪ Additions and disposals; ▪ Asset capitalisation; ▪ Depreciation; ▪ Reconciliations to the general ledger; and ▪ Link back to grant funding.
Performance measures considered in assignment planning:	Compliance with authorisation limits and SODA. Compliance with key controls and policies / procedures. Compliance with Accounting Standards.

2.3. Limitations to the scope of the review

- Testing was undertaken on a sample basis only.
- The review was limited to the key controls operating within each of the areas identified above and focused primarily on the roles of the Finance team.
- We did not seek to assess the appropriateness of expenditure or income received, only of the financial treatment of those transactions and adherence with the organisation's policies and procedures.
- Where staff or changes had occurred, we only provided assurance over the processes since the changes occurred.
- We did not seek to assess the appropriateness of organisational decisions, for example on the structure of the fixed asset register or on management decisions, only that there was appropriate monitoring of the effectiveness of the structures in place to ensure they meet the organisation's needs.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Last Information Received:	25 February 2025
Draft Report Issued:	7 April 2025
Responses Received:	26 June 2025

Auditor:	Tom Wilkinson, Risk Assurance Supervisor
Client Sponsor:	Catrin Evans, Head of Finance & Fundraising
Distribution:	Tegryn Jones, Chief Executive Mair Thomas, Performance and Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
No recommendations were raised as part of this review.						

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	Whilst the Finance Team had internal processes for when capital assets were identified, there was limited guidance in place for the wider organisation in relation to identifying and reporting assets in their areas.	Consideration should be given to developing a guide or raise awareness of what constitutes an asset and therefore ensuring the rest of the business assists the Finance Team with the identification and capitalisation of assets. This could also include how to notify Finance upon the disposal of an asset.	Financial procedure 4 on procedures for the disposal of assets is available to staff. This provides guidance when disposing assets. Other guidance is provided in the Financial Standards which is currently due for review. Tenders for major contracts are notified to finance in all cases.

ASTARI

Pembrokeshire Coast National Park Authority

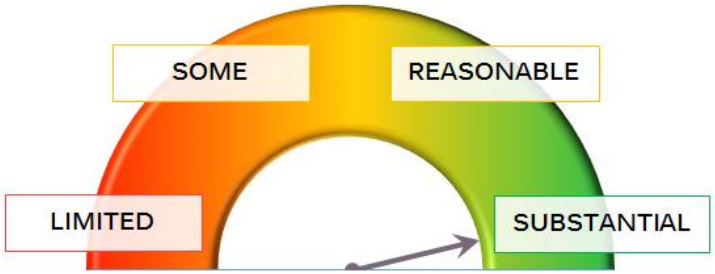
IT & Digital Transformation Strategy

Internal Audit Report: PCNPA-2024/25-08

Date: 2 July 2025

1. EXECUTIVE SUMMARY

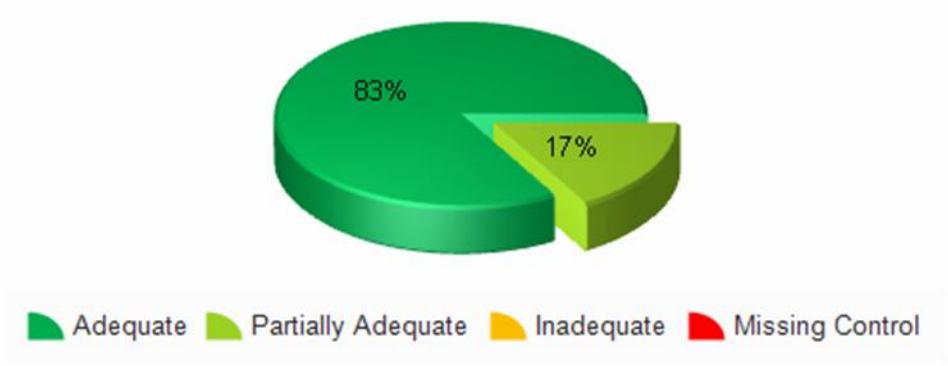
Level of Assurance



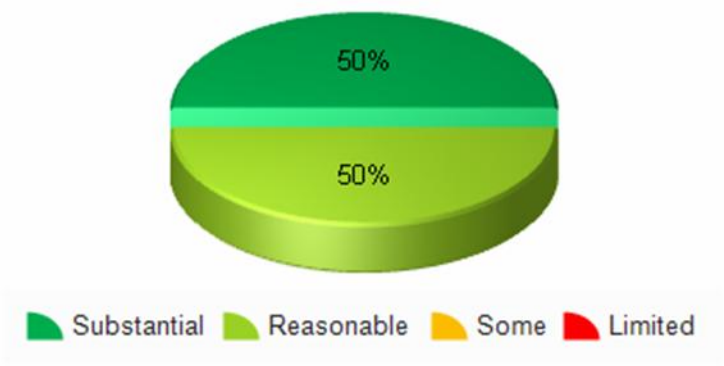
Number & Priority of Recommendations / Suggestions

Conclusion:	Taking account of the scope of the review and the issues identified, the Board can take ***substantial*** assurance that the organisation's technology investments align with business needs and have clear direction, avoiding low buy-in, inefficiencies, and poor risk management that prevent IT from supporting the organisation's goals.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

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

- Our review of the Information Technology and Digital Transformation Strategy (ITDTS) that was approved in 2024 and the aligned Delivery Plan of the Authority noted that they included many of the key elements expected in relation to organisational IT strategies including: the current position of the organisation, a future vision of IT, priorities for the next three years and a high-level action plan for implementation.
- We confirmed that there was an action plan outlining the projects required to achieve the objectives of the ITDTS, with responsibility and deadlines listed. Monthly meetings were held to review progress and issues were escalated if specific concerns, such as funding, arose. However, at the time of review some project deadlines had passed with no escalation. A “Priority” column was included in the action plan but had not been completed at the time of the review, meaning that it was not clear which were high priority (and therefore should potentially be escalated).
- Through discussions and review of the documentation we confirmed that engagement had occurred in relation to the overall Delivery Plans and there was also additional engagement with stakeholders regarding elements such as the organisation’s IT user Policy, training and learning; however, we could only evidence limited engagement for the creation of the ITDTS itself, which increases the risk that key priorities for the organisation may have not been included, but also that a key opportunity for getting buy-in to IT and digital priorities may have been missed. As this was only a strategy for implementing the overall Delivery Plan we do not consider this to be a significant gap; however, there could be additional benefits from more enhanced stakeholder engagement, particularly around buy-in to delivering the ITDTS.
- The IT Team had not completed a formal skills analysis at the time of our review; however, it was planning on enhancing its skill set by completing additional training later in 2025. A skills assessment against the requirements of the ITDTS would help to ensure that staff development is in line with what is required by the organisation and should also help to reduce future costs, by increasing in-house skills and therefore reducing reliance on external (and usually more expensive) support.
- We confirmed that the IT Team had used external support on an ad hoc basis as required, such as for exchange server issues and setup of new switches to assist the delivery of the project. We understand that external support is expected to be required to deliver elements of the organisation’s ITDTS.
- We reviewed example reports and noted that the organisation’s Assurance Monitoring Report included a dashboard tracking key compliance elements such as cybersecurity training (92.12% in Q3, up from 88.88% in Q2) and sign-up to the ICT user policy (92% in February 2025, against a target of 98%). This also provided an update on some key actions such as developing an IT Action Plan and the implementation of Microsoft 365.
- We confirmed that achievement of the overall ITDTS was planned to be monitored annually; however, due to the lack of measures included in the Strategy it was not clear how this was going to be undertaken in a robust or quantifiable way. The recommendations raised in this report should help to ensure that the Strategy is more measurable and that it will be a value-adding tool that will help the Authority achieve its overall objectives in the most efficient way.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	The organisation's Information Technology (IT) and digital arrangements support the achievement of the organisation's objectives in a robust and cost-effective way.
Risk:	If the organisation's investment in technology or digital initiatives doesn't align with business needs, lacks coordination, or lacks a clear strategic direction, it could result in low buy-in for achieving desired outcomes. This misalignment could lead to inefficiencies, an inability to manage key risks effectively, and ICT not fully supporting the organisation's goals.
Engagement objective:	To ensure the organisation's technology investments align with business needs and have clear direction, avoiding low buy-in, inefficiencies, and poor risk management that prevent IT from supporting the organisation's goals.

2.2. Background to the Engagement

An audit of IT & Digital Transformation Strategy was undertaken as part of the approved internal audit periodic plan for 2024/25.

In such a fast-changing IT environment at the current time, this periodic review was aimed at providing assurance that the Authority was looking ahead and identifying potential risks and opportunities to enhance its IT infrastructure, ensure its systems are fit for the future and that opportunities to improve customer services are acted upon. It links directly to the Authority's strategic technology objectives.

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

Areas within scope:	Review the current IT & Digital Transformation Strategy to ensure it aligns with the organisation's corporate objectives and includes key elements that follow best practices. Review of progress in delivering IT and digital projects Consideration of stakeholder engagement and the organisation's buy-in to the elements within the Strategy. Resourcing delivery of the organisation's IT & digital initiatives, including skills, training and external support. Performance monitoring and reporting, including to the senior management team and National Park Authority.
Performance measures considered in assignment planning:	Accuracy of reporting to senior management team and the National Park Authority as appropriate. If the organisation's investment in technology or digital initiatives doesn't align with business needs, lacks coordination, or lacks a clear strategic direction, it could result in low buy-in for achieving desired outcomes. This misalignment could lead to inefficiencies, an inability to manage key risks effectively, and ICT not fully supporting the organisation's goals. If the organisation's investment in technology or digital initiatives doesn't align with business needs, lacks coordination, or lacks a clear strategic direction, it could result in low buy-in for achieving desired outcomes. This misalignment could lead to inefficiencies, an inability to manage key risks effectively, and ICT not fully supporting the organisation's goals.

2.3. Limitations to the scope of the review

- The amount of testing was limited by the time available and this was therefore a high-level review of this area. We provide no guarantee regarding the successful implementation of the Strategy or any linked projects.
- Our role was not to assess the contents or objectives of the Strategy for appropriateness, only to review them for alignment with the organisation's objectives and for clarity. We are therefore not providing any assurance over whether they are the correct objectives and priorities or not.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Debrief Meeting:	11 March 2025
Draft Report Issued:	11 June 2025
Responses Received:	1 July 2025

Auditor:	Emma Bailey, Senior Technology Consultant
Client Sponsor:	Jessica Morgan, Head of Decarbonisation
Distribution:	Mair Thomas, Performance and Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	We confirmed that there was an action plan outlining the projects planned to deliver the Strategy, with responsibility and deadlines listed. Monthly meetings were held to review progress; however, we noted that issues were only escalated if specific concerns, such as funding, arose. At the time of our review we noted that some project deadlines had passed with no escalation.	If there is no clear direction on priorities of projects there is a risk that projects with higher priorities are not escalated in a timely manner leading to delayed completion of the projects and delivery of the Strategy itself.	The organisation should ensure that the action plan is sufficiently prioritised and that there are clear guidelines for escalation to ensure that projects / actions are escalated when required, which will avoid any knock-on impacts to other projects or objectives of the organisation.		We will include a priority column on the implementation plan. Guidelines for escalation will be drawn up.	**Responsible Person:** Head of Decarbonisation **Date:** 31 March 2026

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	We identified some additional opportunities that the organisation may want to consider when updating its IT & Digital Information Strategy in the future.	The organisation's IT & Digital Information Strategy, combined with the detail in the relevant Delivery Plan, should define how the organisation will utilise technology to achieve its objectives. We suggest that the organisation considers enhancing the structure of the next version by including more detailed information on IT risks (both organisational and related to the delivery of the IT strategy), resources (including financial, staffing / skills) and the role of IT in driving digital innovation within the organisation. Other good practice elements of such a strategy include: ▪ Keys roles and responsibilities; ▪ Monitoring / review processes; and ▪ Reporting to stakeholders. By including the above in the IT & Digital Information Strategy the business should have a clearer understanding of how IT will facilitate the organisation achieving its strategic objectives.	Happy to consider suggestion during the next strategy review.
S2	The IT Team had not completed a formal skills analysis. The Team was planning on enhancing its skill set by completing additional training later in 2025. It was confirmed that the IT Team had used external help on an ad hoc basis, such as for exchange server issues and setup of new switches, to assist the delivery of key projects.	The organisation should consider conducting a comprehensive skills review of the team against the IT & Digital Information Strategy to effectively manage, plan, and monitor both current and required skills. This should include establishing training plans and qualifications to support the achievement of objectives and promote staff development.	This is a good suggestion, would be happy to organise a skills audit, however consideration of limited funds for training must be taken into account. IT team training needs are discussed annually during the wellbeing review and annual appraisal.

Pembrokeshire Coast National Park Authority

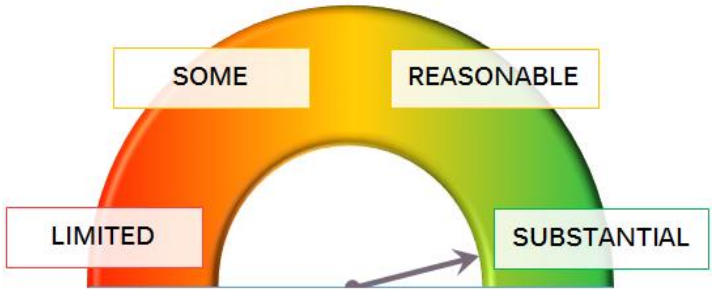
Visitors Centres

Internal Audit Report: PCNPA 2024/25-08

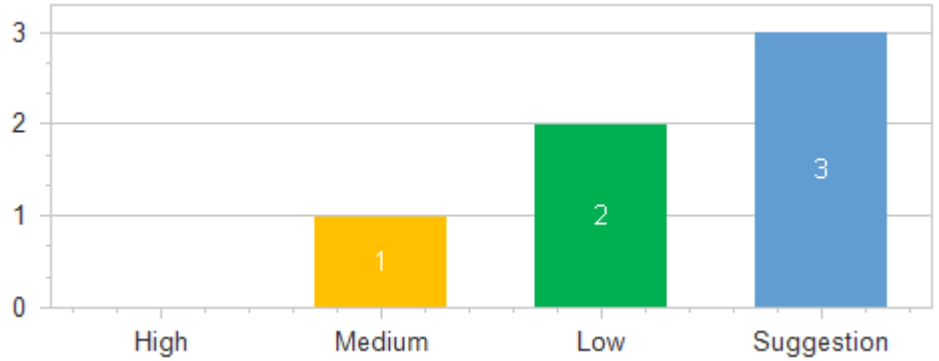
Date: 18 June 2025

1. EXECUTIVE SUMMARY

Level of Assurance

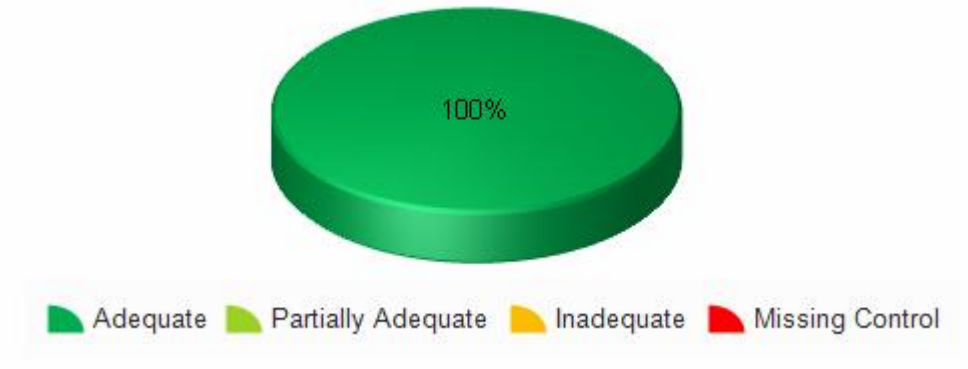


Number & Priority of Recommendations / Suggestions

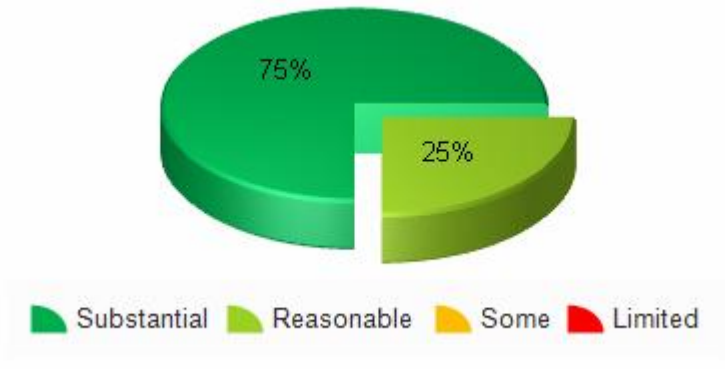


Conclusion:	Taking account of the scope of the review and the issues identified, the National Park Authority can take ***substantial*** assurance that there are robust processes in place to ensure that health and safety is managed consistently across the three visitor centres to minimise the risks to staff and visitors, with action taken to address any under-performance or issues identified.

Assessment of Control Design



Assessment of Control Application / Compliance



Summary of findings

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review.

- We obtained and reviewed staff guidance in place and confirmed that it was up to date and clearly detailed key roles and responsibilities for the management and oversight of the visitor centres. Our site visits and interviews with staff confirmed that guidance was understood and generally aligned with current working practice.
- Our review of site risk assessments confirmed that they were up to date and detailed but were conducted using various templates, which prevented ease of comparison and consistency in approach.
- We saw examples of regular site safety inspections and walk arounds of the centres completed by staff, although these were not consistently recorded across all sites. Some key checks were not always documented at Oriel y Parc and Castell Henllys, such as playground and high wind checks, preventing management oversight.
- Our testing of key compliance elements during the review identified the following:
  - We confirmed that up to date electrical tests were in place for all three sites, with remedial work identified during the tests having been rectified.
  - Gas service records were on file for all sites, although Oriel y Parc was not dated therefore limiting our assurance over whether it was in date. This has been communicated to the Authority.
  - Fire risk assessments were in place for all sites but remedial actions from them not centrally tracked and there had been a lack of progress noted in picking these actions up and addressing them since the Project H&S Manager had left. Work was in progress within the Authority to review its approach with the use of a specialist consultant and therefore we have limited our assurance and review of this area.
  - Servicing was undertaken periodically of the goods and passenger lifts at Oriel y Parc but the Authority could not evidence that it was compliant with the thorough inspection element required under Lifting Operations and Equipment Regulations 1998 (LOLER) at the time of the review.
  - Legionella risk assessments were in place and up to date for all sites, with frequent legionella management tasks completed in by staff in line with expectations. External assurance was sought regularly by Vector, the Authority's legionella management specialist contractor, to validate accuracy and appropriateness of water temperature readings to ensure that risks are managed.
  - We confirmed that relevant staff had been provided with first aid training and processes were in place to monitor and replenish stock.
  - Food safety checks and paperwork was completed daily, weekly and monthly in line with expectations.
  - Fire suppression systems in Oriel y Parc was up to date with its specialist annual testing regime.
  - Playground inspections were conducted periodically across relevant sites but were not consistently documented in Castell Henllys.
- The Authority worked with various expert groups to keep up to date with key legislation and changes. Examples were observed whereby information provided by partners was used to self-assess, implement change in line with good practice and was shared with wider teams.
- We confirmed that there were internal (2nd line) assurance checks in place, to ensure that work was undertaken at the centres in line with expectations, this included internal audits conducted of key H&S tasks such as fire safety checks, compliance with risk assessments and internal expectations and improvement plans where relevant.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	The Authority has robust key controls in place to ensure that the health and safety of staff and visitors within the visitor centres (Carew Castle, Castell Henllys and Oriel Y Parc) are managed appropriately, consistently and in line with relevant legislation.
Risks:	**Objective 7 –** The Well-being and safety of people across the Authority are ensured. **Risk Descriptions:** ▪ The Authority fails to meet health and safety requirements ▪ Staff are subject to inappropriate working conditions
Engagement objective:	To provide assurance that there are robust processes in place to ensure that health and safety is managed consistently across the three visitor centres to minimise the risks to staff and visitors, with action taken to address any under-performance or issues identified.

2.2. Background to the Engagement

An audit of Visitors Centres was undertaken as part of the approved internal audit periodic plan for 2024/25.
A review of the structures and processes in place to identify, risk assess and take action to mitigate key health and safety risks to staff and visitors. The review will include risks relating to normal working practices and working remotely (lone working) and the risks relating to visitor attendance at the sites. The scope of this review was agreed with the Head of Regenerative Tourism on the basis of increased risk as a result of changes in personnel and structures, which have led to new or altered controls.

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

Areas within scope:	½ day visit to Carew Castle and Castell Henllys Visitor Centre, and remote meeting to review Oriel y Parc arrangements (if time allows), and review of the following areas for compliance and consistency: ▪ Risk identification and assessment processes. ▪ Roles and responsibilities for site management and oversight. ▪ Adherence and oversight of key compliance elements including first aid, fire, legionella, electric, gas and/or LOLER (where applicable). ▪ Monitoring, reporting and escalation of H&S risks. Membership of expert groups such as Visitor Safety and identification of legislation changes and their implementation.

Performance measures considered in assignment planning:	Number and severity of accidents and/or incidents reported. Alignment and consistency of key controls across all visitor sites.

2.3. Limitations to the scope of the review

- The scope of the review was limited to the Authority's three visitor centres: Carew Castle, Castell Henllys and Oriel Y Parc.
- Reliance was placed on previous work where possible to avoid duplication including the following audits: Health & Safety (23/24-02) and HSMS: Accident, Incident and Near Miss Reporting (24/25-05). Similarly, we placed reliance upon any third-party specialist works undertaken where this is made available to us.
- We have limited the assurance we are providing over fire safety as the Authority had a specialist consultant currently reviewing its approach.
- Due to the limited time available the review:
  - Focused on how each Visitor Centre identified, assessed and managed its health and safety risks; we did not have sufficient time to test all areas and therefore focused on reviewing how the Authority gets this assurance internally or via third parties.
  - Did not include an independent risk assessment of each site; it was dependent on the information available to us or immediately visible based on the visits undertaken and information reviewed.
  - Only included testing on a sample basis only. Whether testing was undertaken as a desktop exercise or through site visits will be dependent on the timeliness of the information provided and / or identified need for testing via observation.
- Interviews with staff were dependent on engagement and availability during the review.
- The audit recognises that an action plan was being compiled to identify further areas of improvement to aid in the consistency of processes across all three visitor centres. Our assurance will consider if this plan has accurately identified any areas of concerns and provided clear oversight of actions required to ensure staff and visitor safety.
- This review did not include roles and responsibilities and risk assessments undertaken by organisations which lease café space within the centres.
- Where changes to staff or processes have occurred, we have only provided assurance over the processes since the changes occurred.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Debrief Meeting:	8 April 2025
Draft Report Issued:	13 May 2025
Responses Received:	18 June 2025

Auditor:	Steffan Beange, Risk Assurance Consultant
Client Sponsor:	James Parkin, Director (Nature Recovery & Tourism)
Distribution:	Claire Bates, Head of Regenerative Tourism Mair Thomas, Performance & Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	We were provided with evidence that the goods and passenger lifts at Oriel y Parc were frequently serviced in line with expectations but there was limited evidence of thorough inspections being undertaken, in line with Lifting Operations and Equipment Regulations 1998 (LOLER) requirements. We were advised that the Authority's insurers may be carrying out these checks, but we were not provided with evidence that these were being tracked and that the Authority had assurance that they were compliant.	Non-compliance with LOLER may result in harm to stakeholders, reputational damage and financial loss.	Assurance should be sought that the Authority is appropriately complying with LOLER and that thorough inspections are being undertaken within required timescales. It should be ensured that going forward, these inspections are tracked centrally for assurance purposes over compliance with regulations.		Appropriate additional goods lift check to be added to lift servicing contract at Oriel y Parc.	**Responsible Person:** Building Projects Manager **Date:** 31 December 2025
R2	Up to date site risk assessments were in place for the three centres but there was no consistency in templates used, with various risk matrices used, including a 3x3 matrix for Oriel y Parc, a 5x5 matrix for Castell Henllys and no matrix for Carew Castle. This may result in the risk identification and assessment process being inconsistent and not aligned with the Authority's expectations.	Risk assessments may not be undertaken consistently and in line with organisational expectations, reducing the effectiveness of them and comparability.	A review of the Visitor Centre risk assessments should be undertaken and aligned with the Authority's standard template, to ensure consistency in approach and promote comparability.		Visitor Centre Risk Assessment Matrix to be standardised across the site risk assessments at next review. Note: The site risk assessments have been updated for 2025 season, therefore the suggestion is that the matrix is standardised at the next review.	**Responsible Person:** Visitor Services Manager **Date:** 31 March 2026

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R3	There was an inconsistent approach noted in how H&S inspections conducted by staff were recorded and evidenced across the three centres. There were limited records available in Castell Henllys and Oriel y Parc, for expected checks as detailed in the site risk assessments and procedures, such as playgrounds checks, high wind checks and general H&S walk arounds.	Checks are not undertaken in line with expectations, H&S risks are not identified and addressed appropriately resulting in potential harm to stakeholders and inability for the Authority to protect itself in the event of a claim.	All internally required inspections undertaken by visitor centre staff should be documented and stored centrally, including all expected fire related checks, playground checks, high wind checks, general walk arounds and any other checks completed. The Authority may consider utilising the approach applied at Carew Castle, with use of Google Sheets, for efficiency and effective management oversight.		Standardisation of H&S site checks across all visitor centres (where appropriate), ensuring checks highlighted in site risk assessments are documented.	**Responsible Person:** Head of Regenerative Tourism **Date:** 31 March 2026

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	Given time available we were unable to review this area in detail but during our review of Oriel y Parc, staff advised us that they had not received sufficient training to enable them to use the Evacuation Chair in the event of an incident/fire.	The Authority may find it beneficial to review staff awareness and training at Oriel y Parc to ensure that they are appropriately equipped to use the Evacuation Chair.	Organise Evac Chair training for key Oriel y Parc staff. By end of March 2026. Visitor Services Manager (West). The risk assessment will be updated to state that the small open passenger lift can be used to evacuate the gallery if required. The lift has been tested and does not shut down in the event of a fire alarm. The use of an evac chair is not required.

Ref.	Finding	Suggestion	Management Response
S2	Through review of accident and incident data provided for the Authority, we noted that there were no incidents in 2024 or 2025 for Castell Henllys. Our interviews with a sample of site staff, we were advised that they had reported a number of incidents to the former Health and Safety Manager but the incident log did not reference these. We were unable to test this area in detail given the limited time available.	Consideration should be given to investigation potential missing incident reports for Castell Henllys to ensure that any gaps are identified and controls put in place to prevent re-occurrence of issues where relevant.	Visitor Services Manager (North) to investigate and to remind the team regarding the importance of reporting incidents and near misses. By end of September 2025. Visitor Services Manager (North).
S3	A review was in the process of being conducted for fire risk assessment processes by a specialist at the time of our audit. Information available to us at the time identified that there was limited collation and tracking of actions arising out of fire risk assessments for effective tracking and oversight of performance in addressing risks. This also prevented oversight whereby decisions had been taken to not action a certain recommendation, with no central decision log / record maintained to evidence appropriate consideration.	Once updated structures are in place for fire risk assessments across the Authority, consideration should be given to establishing centralised tracking of all recommendations arising from fire risk assessments. This may help in assurance reporting to management and relevant committees as well as to retain a record of decisions made to not action certain recommendations and why in the event of a fire or legal challenge.	Authority commissioned a specialist consultant (last year) who is looking at all our buildings (Llanion completed) and providing a Fire risk AP for us/ site managers to work through. This work takes into account new regulations regarding fire. Once the consultant has compiled the FRA Risk and Action Plan our existing action plan will be updated to track recommendations arising as a result of the consultants work. Progress against this action plan to be monitored by Health and Safety Group

Pembrokeshire Coast National Park Authority

Internal Audit Annual Report

Date of Issue: 8 July 2025

Presented at the meeting of the Audit & Corporate Services Review Committee: 23 July 2025

Contents

EXECUTIVE SUMMARY

Background

The purpose of this report is to present the results of our internal audit work for Pembrokeshire Coast National Park Authority's system of governance, risk management and control. This report forms part of the framework designed to inform the Statement on Internal Control and is therefore a key part of Pembrokeshire Coast National Park Authority's assurance cycle. The outcomes of this report should be used to inform and update the organisation's risk profile; however, there are a number of other important sources to which the Audit & Corporate Services Review Committee should look for assurance.

This report does not supplant the Audit & Corporate Services Review Committee's responsibility for forming its own view on governance, risk management and control.

Scope

Our findings are based on the Internal Audit work performed as set out in the Internal Audit Strategy / Annual Plan approved by the Audit & Corporate Services Review Committee on the 31 July 2024.

In addition, the following have also been taken into account in arriving at our opinion:

- The results of follow up action undertaken in respect of audits from previous years;
- The acceptance of recommendations by management;
- The effects of any material changes in the organisation's objectives or activities;
- Matters arising from previous reports or other assurance providers to the Audit & Corporate Services Review Committee and/or National Park Authority;
- Whether or not any limitations have been placed on the scope of internal audit; and
- Whether there have been any resource constraints imposed upon us which may have affected our ability to meet the full internal audit needs of the organisation.

In giving our opinion it should be noted that assurance can never be absolute; the most that the internal audit service can provide to the National Park Authority is a reasonable assurance that there are no major weaknesses in risk management, governance and control processes. The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

Internal Audit Assurance Statement

The annual Head of Internal Audit opinion is provided to Pembrokeshire Coast National Park Authority by Astari Limited. We are satisfied that sufficient internal audit work has been undertaken during 2024/25 to enable us to draw a reasonable conclusion on the adequacy and effectiveness of Pembrokeshire Coast National Park Authority's governance, risk management and internal control arrangements. For the 12 months ended 31 March 2025, based on the work we have undertaken and subject to the areas for improvement identified in our internal audit reports, our opinion is that the organisation has adequate and effective governance and control arrangements. In the area of risk management, we provided a Some assurance opinion in the Risk Maturity Follow Up, focused on progress made to implement previously raised internal audit recommendations to strengthen the risk management framework. These recommendations have all been accepted and we are aware of work being undertaken to progress this area, which we endorse and will continue to support the Authority to maximise the value that can be gained from the risk management framework as a valuable tool and source of assurance.

Conflicts of Interest

We have not undertaken any work or activity during 2024/25 that would lead us to declare any conflict of interests.

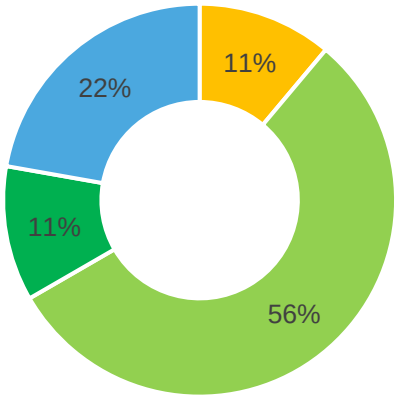
SUMMARY OF WORK UNDERTAKEN

We completed nine reviews at Pembrokeshire Coast National Park Authority during 2024/25. Of these, all were assurance reviews and no advisory reviews were undertaken. Our Follow Up review indicated that ***Reasonable*** progress had been made in implementing recommendations. The outcomes of these reviews are summarised below and more detail is provided in our Assurance Map in Appendix A on page 8.

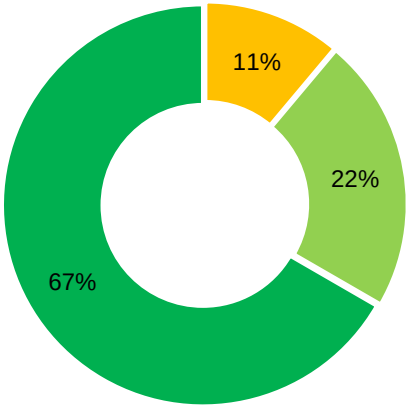
All of the recommendations made during the year were accepted by management.

Assurance Provided Compared to Previous Year

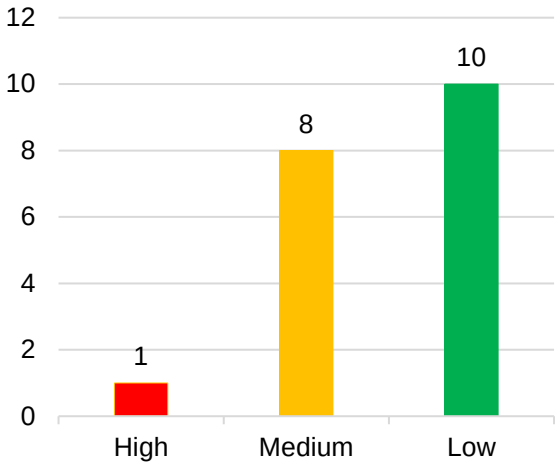
2023/24 Assurance:



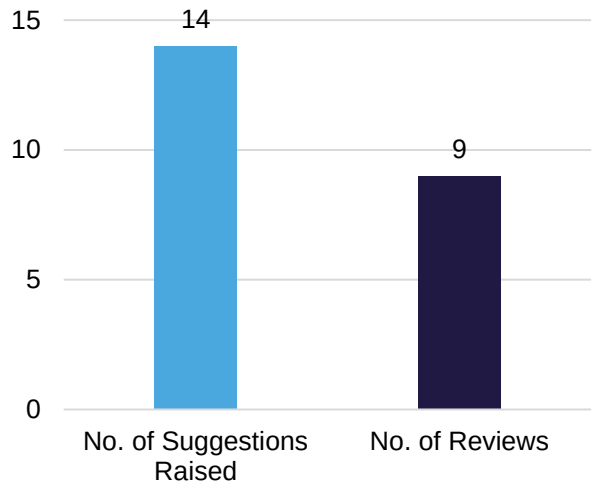
2024/25 Assurance:



Number of recommendations:



Number of suggestions compared to number reports:



Internal Audit Performance 2024/25

The following statistics[1] provide information on the performance of Astari Ltd across all our clients. This information is reported on a quarterly basis throughout the year to the Astari Ltd National Park Authority. In addition, we have included specific statistics for Pembrokeshire Coast National Park Authority for comparison.

PERFORMANCE	BARCUD GROUP (incl Astari Ltd)	PCNPA
Terms of Engagement issued at least two weeks in advance of fieldwork commencing.	**97%**	**89%**
Draft reports issued at least three weeks prior to the relevant committee.	**98%**	**100%**
Final Report within one week of management response.	**97%**	**100%**
% clients that agree that Internal Audit provides a positive value adding service.	**100%**	**100%**

[1] Where delays were requested or caused by the client this has not affected the results.

Good Practice Sharing and Value for Money

All our reports are designed to offer value for money through the provision of:

- Assurance that internal processes are operating effectively and efficiently to mitigate identified risks;
- Recommendations and Suggestions based on good practice from within and external to the sector; and
- Benchmarking / comparative information from other organisations where practicable and time allows.

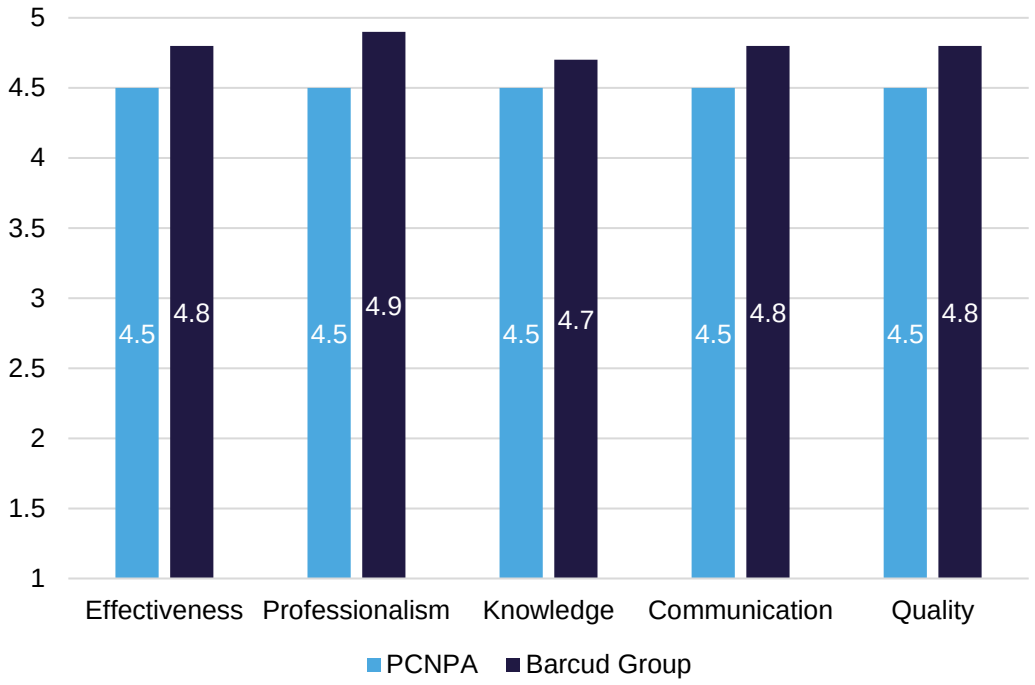
In addition, the following were provided in 2024/25:

- Circulated a notification from the Cabinet Office regarding the delayed implementation of the Procurement Act.
- Guidance was provided on Value for Money (VfM) strategies and examples of potential methodologies and measures were shared.
- Guidance was provided regarding good practice structure to utilise for the strategic risk register.

Client Satisfaction

145 satisfaction surveys were issued across the service in 2024/25 and 96 responses were received (a response rate of 66%). For Pembrokeshire Coast National Park Authority, four surveys were issued and two (50%) responses were received. The average scores are provided below.

Survey responses range from 1 (very dissatisfied) to 5 (very satisfied). Exact question wording can be provided upon request.



Update on Our Quality Assurance and Improvement Programme (QAIP)

Our latest External Quality Assessment (EQA), undertaken in June 2020, concluded that “Barcud Shared Services (incorporating Astari Ltd) is delivering internal audit services to a standard that generally conforms with the International Professional Practices Framework (IPPF)”, the highest rating achievable.

In addition, the assessor identified 13 opportunities for us to improve our service to our clients categorised as “Enhance”, “Review” or “Consider”. All 13 opportunities have now been fully actioned and signed off by the Barcud Shared Services National Park Authority.

We are planning our next EQA for the summer of 2025 and will report on the outcome to the Audit & Corporate Services Review Committee.

HIGH-LEVEL SUMMARY OF EMERGING AND KEY RISKS

As part of our work, we have access to multiple organisations' risk registers as well as broader risk information and risk guidance. Through regular review of this information, and our own assessments of risks, we have detailed below the key risk areas (in no particular order) we believe are facing the sector at the current time and may become more significant over the next year for consideration:

- **Cyber and information / data security** – continuing to be one of the top risks in the majority of risk publications, cyber-security, particularly ransomware, remains a risk that all organisations should be regularly considering. Proactive measures are vital to prevent successful attacks where possible or minimise their impact should they occur. A recent case investigated by the Information Commissioners Office saw an organisation fined £60,000 following a cyber-attack which led to their customer's sensitive information being published. Whilst the firm was not responsible for the cyber-attack, it was found that they failed to put appropriate measures in place to ensure security was managed electronically, such as muti-factor authentication (MFA) on all accounts. Similarly, the ransomware attack on the NHS in 2022 resulted in the IT security provider being fined £3.07 million as they did not have multi factor authentication across all accounts, as well as a lack of regular vulnerability scanning and patch management. In addition to the above, organisations must consider the risk of sharing customer data with third parties due to data ownership rules.
- **Artificial Intelligence –** a clear threat but also opportunity, Artificial Intelligence (AI) is becoming increasingly used across all sectors and many are looking to exploit it for benefits for customers and efficiency savings. Ensuring there is clear understanding of 'how' AI is being used and data ownership are vital to ensure that the organisation is not incidentally breaching data protection legislation or relinquishing commercially sensitive data to competitors or people that will use the data for malicious purposes. The 'black box' nature of AI applications along with a general lack of understanding regarding how they work, increases these risks to organisations and may also result in results being relied on for decision making that are based on flawed or inaccurate assumptions.
- **Data integrity –** accuracy and reliability of data continues to be fundamental to organisations, affecting almost every National Park Authority decision made. Quality data provides the foundation on which organisations can make good quality decisions, effectively plan for the future and respond to challenges. Data integrity can be impacted by multiple risks such as: manual data entry; differing and incompatible systems / applications; and minimal internal assurance checks. Without ensuring data integrity National Park Authority decision making may be undermined and regulatory intervention may occur if organisations cannot provide backing evidence (either numerical or other) to confirm regulatory submissions.
- **Changes in laws and regulations** – The UK Government has announced a new 'failure to prevent fraud' offence which is expected to become legislation in September 2025. The new offence falls under the Economic Crime and Corporate Transparency Act 2023 and joins similar 'failure to prevent' offences such as bribery and tax evasion. The new offence holds large organisations (both private and public) accountable for fraudulent activities committed by their employees. The legislation suggests that an organisation will be able to avoid prosecution if it is able to prove that it had 'reasonable procedures' in place to prevent fraud from occurring.

  Changes to employment legislation also came into force in April 2025 which included Neonatal Care (Leave and Pay), National Minimum Wage, National Insurance increases and Statutory payment increases. In addition, the new Procurement Act has been live since February 2025.

  The amount of new legislation and regulations will put increased pressure on organisations to implement changes, ensure compliance but also to ensure that systems and staff are set up to maintain compliance on an ongoing basis. This, plus the challenges from the economic situation, global unrest and political change, mean that organisations are in a permanent state of change that needs to be closely managed.
- **Fraud** –the current economic climate, which has seen high interest rates and levels of inflation coupled with low levels of economic growth, has put added pressure on organisations and individuals to simply stay afloat and pressures such as these often create incentives to commit fraud. Further, a new 'failure to prevent fraud' offence will become legislation in September 2025 creating an increased potential for an organisation to face financial loss and reputational damage.
- **Strategic direction –** With competing demands and constrained resources, clear strategic direction and a clarity of purpose become key issues and help to guide the National Park Authority (NPA) to ensure that they protect stakeholders and the organisation. In line with this, a clear understanding of the inherent risk of decisions made and processes in place go towards ensuring that outcomes are aligned to the purpose and priorities of the organisation. Without a clear strategic direction understood by staff and the NPA the organisation risks differing individuals working towards different goals and objectives failing to be met. A clear strategic direction also enables

more effective risk management and therefore the allocation of resources (to manage risks to within risk appetite), increasing efficiency as well as the likelihood of being able to respond positively to opportunities.

- **Skills shortage, talent management and retention** – this area of risk remains in the top 5 reported by organisations globally for the third year in a row. Balancing shifting demographic trends with skills and budgetary shortages at a time of increased digitalisation is a challenge. Although seen as a reducing risk over the last year, there remain significant challenges around recruiting and retaining quality staff and the changing needs and expectations of employees. With many organisations now trialling initiatives such as 4-day working weeks or 9-day fortnights, organisations risk losing staff to other organisations if they do not regularly review their offering and ensure they are keeping up with market expectations.
- **Global unrest & political change –** there remains significant uncertainty, unrest and ongoing conflicts in many areas but also changes in governments and therefore political direction. These changes have caused economic instability, volatile markets and supply chain risks. Significant changes to British / Welsh political standing have also been evident, with a shift across devolved and local government showing an increased voting percentage for more of the right of centre parties such as Reform UK. This shift to the right has been noted across many European countries, with change in direction often resulting in changes to funding, legislation and commitments (such as Net Zero and Environmental Policies). There may also be specific changes in Wales as we look ahead to significant changes in Welsh politics and upcoming Senedd elections.

APPENDIX A – INTERNAL AUDIT ASSURANCE MAP

The table below summarises the internal audit work undertaken during the year 2024/25 including the level of assurance and number of recommendations:

Assignment	Opinion	Recommendations:		
		High	Medium	Low
Climate Change & Decarbonisation	Substantial	0	0	2
Risk Maturity Follow Up	Some	1	2	2
Governance: Structures & Processes	Substantial	0	1	1
Equality, Diversity and Inclusion	Substantial	0	0	1
Accident and Incident Reporting and Investigation	Reasonable	0	2	0
Follow Up	Reasonable	0	2	1
Key Financial Controls	Substantial	0	0	0
Visitor Centres	Substantial	0	1	2
IT Strategy	Substantial	0	0	1
	TOTAL:	**1**	**8**	**10**