Report No. 02/26

Audit & Corporate Services Review Committee

Report of the Internal Auditor, Astari

Subject: Internal Audit Reports

Reports are presented in respect of the following areas identified in the 2025/26 Internal Audit Annual Plan:

- Asset Management – Commercial Management
- Customer and Stakeholder Engagement
- Risk Management
- Strategic Planning
- Follow-up Report

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

Pembrokeshire Coast National Park Authority

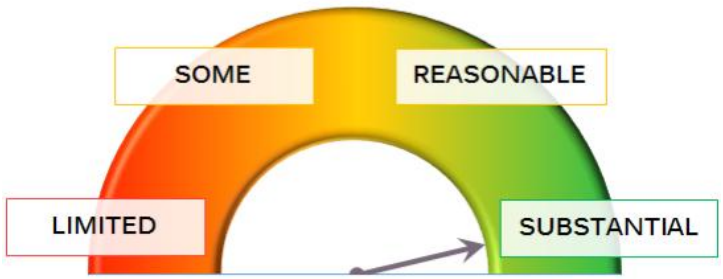
Asset Management – Commercial Management

Internal Audit Report: PNCPA-2025/26-03

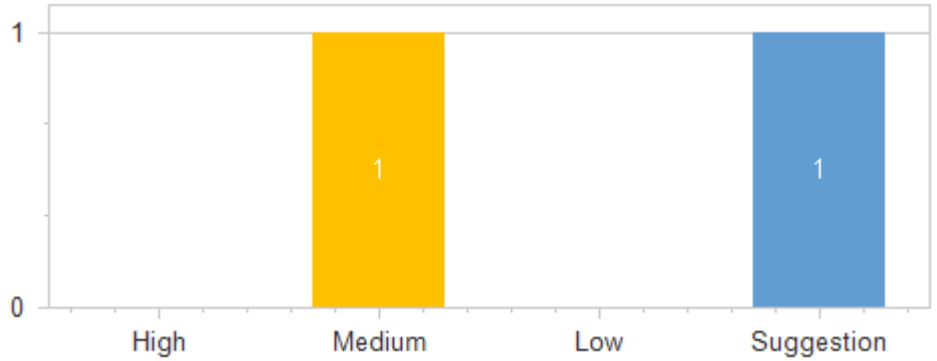
Date: 26 January 2026

1. EXECUTIVE SUMMARY

Level of Assurance

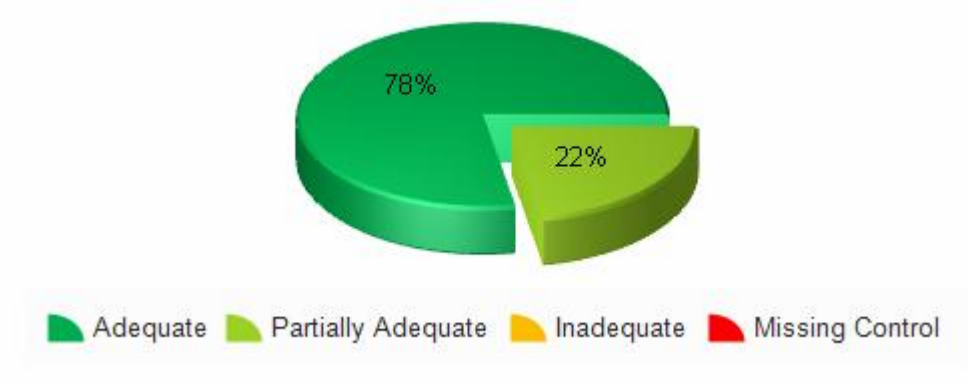


Number & Priority of Recommendations / Suggestions

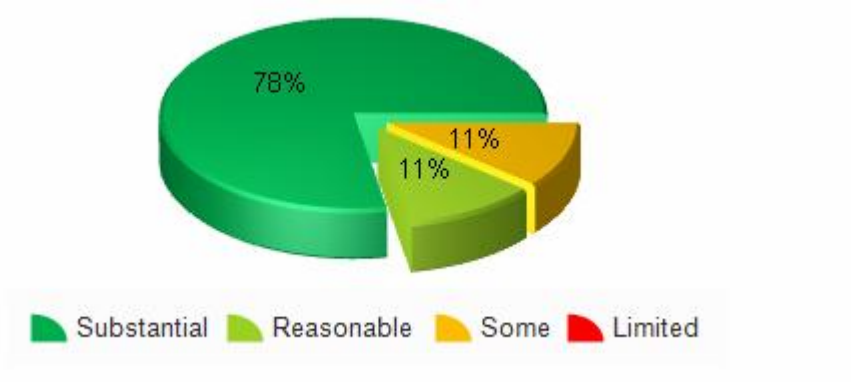


Conclusion:	Taking account of the scope of the review and the issues identified, the Board can take ***substantial*** assurance that the commercial portfolio is being managed in line with the Authority's expectations and that income is being maximised from those assets.

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:

- We obtained and reviewed the 2025-2030 Asset Management Strategy and supporting Asset Management Policy and confirmed that they were appropriately approved by the National Park Authority (NPA), provided overarching direction to the Authority regarding its income generating ambitions from its assets. We also confirmed that the objectives set aligned with and supported the overarching purpose of the Park.
- Through interview and review of relevant documentation, we confirmed that the Estates Officer had significant experience and knowledge of the Authority's estates and commercial portfolio. We observed opportunities to reduce liabilities / enhance income to the Park being identified, aligned with the Park's overarching purpose, and taken to the Asset Management Group for consideration by the Estates Officer .
- Our testing confirmed that the Authority had identified the assets that it had a legal interest in and tracked those assets generating income via leases on Excel Spreadsheets. Sample testing of the data back to source evidence did not identify any issues. We also confirmed that income from concessions and licences was centrally recorded and tracked.
- Our review of the rent collection and monitoring processes confirmed that invoices were generally raised in a timely manner, but that there had been no formal arrears recovery processes undertaken since the move to Sage Accounting at the end of March 2025. This had resulted in circa £46,898 payments being overdue across three (18%) leaseholders, with one exceeding 200 days. We were advised that limited resources and pressures on the team had been the cause of this. We confirmed that statements had been set up and sent out the week prior to the audit and the Head of Finance advised us, following the audit, that they had added the aged debtor process to be undertaken as part of month end, with chaser phone calls made in lieu of letters set up in Sage. We have not raised a recommendation with the caveat that this work is undertaken as intended. We also confirmed that action was taken immediately to resolve outstanding rent identified during our testing at the time of the audit.
- We confirmed that car pack charges and proposed increases were appropriately approved by NPA. Our review of the charge increases proposal report presented in the October 2025 meeting confirmed that it included evidence of benchmarking against other similar parks and the local area and there was clear consideration of any changes in charges against current strategic priorities of the park. Our testing of current charges to date, for the past two seasons, confirmed that those applied to the PaybyPhone app and cash machines aligned with levels approved by NPA. No issues were noted.
- We confirmed that the Authority had controls in place to reduce the length of downtime and lost revenue in the event of a car park machine being broken, including an alternative payment method via the PaybyPhone app.
- A walkthrough of the cash handling processes in place confirmed that there was some segregation of duties in place between the collection of cash and banking of the cash, with physical controls also in place to protect from theft; however, due to the current process lacking independent checks of variances in cash banked versus collected there was an increased opportunity for fraud to be undertaken and go undetected. Due to the new ‘failure to prevent fraud offence’ under the Economic Crime and Corporate Transparency Act 2023, this now has greater implications for the organisation.
- Our sample testing of ten bank transfers received from Loomis since 1 April 2024 identified that 60% were higher than expected and of the 40% that were in deficit, these did not exceed -£4.30. We confirmed that those with materially higher levels of cash received than recorded on the machine tickets were due to machine errors or the method of splitting monies across cash collection bags for Loomis. Similarly, small deficits occurred due to the machine not reading coins fully. As noted above, there was no formal process for investigating variances, in particular to help identify any material variances of less cash banked than expected.
- We confirmed that cost versus benefit of the Authority's assets, including commercial portfolio, was reviewed recently to ensure that the portfolio supports the achievement of the Authority's strategic properties. We confirmed that the Estates Officer was tasked with progressing actions arising from that latest review with Executive Team in October. We were provided with multiple examples where opportunities to maximise income from the Authority’s assets had been appropriately considered and approved.

- We confirmed that there was regular monitoring and oversight of commercial portfolio decisions and financial performance at Asset Management Group, Executive Team and National Park Authority level to help identify and address any under performance and ensure risks are appropriately considered and managed. No significant issues were noted.

Additional feedback

We would like to thank the Estates Officer and colleagues involved in the audit for their excellent engagement prior to and during the audit.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	To manage the national park's assets in a commercially responsible and sustainable manner to support conservation, promote equitable access, and ensure value for money for both the authority and stakeholders.
Risk:	Lack of clear commercial strategy and/or ineffective management and oversight of commercial portfolio performance, resulting in potential misalignment between commercial management activity and the Authority's strategic priorities, financial loss and reputational damage.
Engagement objective:	To provide assurance that the commercial portfolio is being managed in line with the Authority's expectations and that income is being maximised from those assets.

2.2. Background to the Engagement

An audit of Asset Management - Commercial Management was undertaken as part of the approved internal audit periodic plan for 2025/26.

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

Areas within scope:	Asset portfolio management arrangements, including key roles and responsibilities. Identification and ongoing validation of asset / estates responsible for. Commercial rent collection and monitoring arrangements, including arrears management. Income arrangements and methodology utilised to maximise income from estates, such as car parks. Budget management and oversight.
Performance measures considered in assignment planning:	Compliance with policies and procedures. Financial performance.

2.3. Limitations to the scope of the review

- Our testing was on a sample basis only.
- We reviewed the process undertaken by the authority to identify its commercial assets and the terms of each lease / agreement in place but are not providing assurance that this assessment identified all relevant assets, only that the process undertaken aligned with expectations.
- We have not commented on the appropriateness of commercial activity, only that decisions taken by the authority have been appropriately approved.
- Our testing and assessment of whether income was being maximised was based on what the authority has defined to be appropriate.
- This review did not cover asset management from a maintenance or health and safety perspective, as they will be covered in a separate review. This review focused on the commercial assets owned/leased and how the authority ensures that it receives the relevant income associated with them.

- 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:	18 November 2025
Draft Report Issued:	22 December 2025
Responses Received:	19 January 2026

Auditor:	Ceri Kwiecinski, Risk Assurance Manager
Client Sponsor:	Sara Morris, Director of Placemaking, Decarbonisation and Engagement
Distribution:	Jessica Morgan, Head of Decarbonisation Catrin Evans, Head of Finance Gary Meopham, Estates Officer 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	Our testing of the Authority's cash handling process for car park income established that the Car Park Supervisor, responsible for collection / managing those who collected the cash boxes from the car park machines, recorded receipt of the cash and handled storage of cash until collection of it by an external company – Loomis – which counted the cash. When statements, along with the cash in the bank, were received by Finance each week they only reviewed the detail to journal entries to the correct car park cost centre. Interviews during the review identified that there was no scrutiny of the variances highlighted on statements by Loomis and supporting evidence of cash collected versus cash received in bank was not reviewed by Finance. Sample testing of ten statements received by Loomis since 1 April 2024 identified 60% included more cash than that recorded on the original car park machine ticket and 40% was under, but at most by £4.30. We confirmed that machine faults often caused variances in totals where more / less money was receipted than recorded. However, these variances had not been independently checked and there was potential for more	Lack of appropriate segregation of duties and scrutiny over cash collected versus cash received in bank increases the risk of fraud going unidentified, non-compliance with legal requirements, financial loss and reputational damage.	The Authority should review the current car park cash handling process to ensure that there is appropriate segregation of duties and independent checks involved to manage potential risk of fraud. An example process could include cash collection records maintained by the Car Park Team being stored centrally and independently checked by Finance. Where material variances are identified from the statements received by Loomis, these should be appropriately investigated. Given the new 'failure to prevent fraud offence' under the Economic Crime and Corporate Transparency Act 2023, that became live on 1 September 2025, it is more imperative than ever that organisations can evidence that it has "reasonable procedures" in place to prevent fraud occurring an to also reduce the risk of successful legal prosecution should a fraud occur.		The cash is not counted by staff before being bagged to Loomis. Checks should happen at this point as this is the ideal time to be identifying/investigating variances. This procedure is historical. However, as this procedure is not undertaken, variances are reported by Loomis on weekly statements when they count the cash. The statements with the variances are sent to finance and the car park supervisor. Finance as from Dec 25 will now highlight variances over £5 so that the car park supervisor can investigate.	**Responsible Person:** Head of Finance & Fundraising **Date:** Complete (December 2025) (*Bribery Policy to be reviewed by 31 March 2026*)

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
	material deficits to have gone unchecked and not investigated. Given the level of cash collected each year through this method being around £500,000, it is a key area of risk.					

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

Ref.	Finding	Suggestion	Management Response
S1	Our testing established that prior to issuing an invoice it must be approved at director level. We confirmed that rental invoices were generally raised two weeks prior to the invoice being required to be issued but saw instances where there were sometimes delays in issuing invoices within a timely manner due to this process.	The Authority may find it beneficial to review the current schedule of delegated approval limits to help promote efficiency and proportionality in approval processes, while ensuring there remains appropriate segregation of duties in the raising and approval of invoices.	This is noted and will be reviewed by March 2026. This appears to have been the procedure for many years.

ASTARI

Pembrokeshire Coast National Park Authority

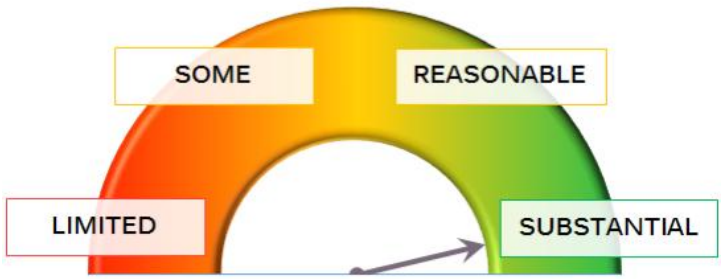
Customer & Stakeholder Engagement

Internal Audit Report: PCNPA-2025/26-02

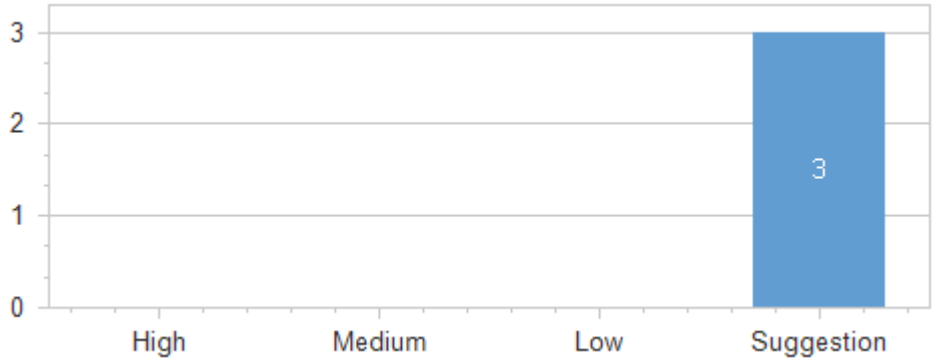
Date: 19 November 2025

1. EXECUTIVE SUMMARY

Level of Assurance

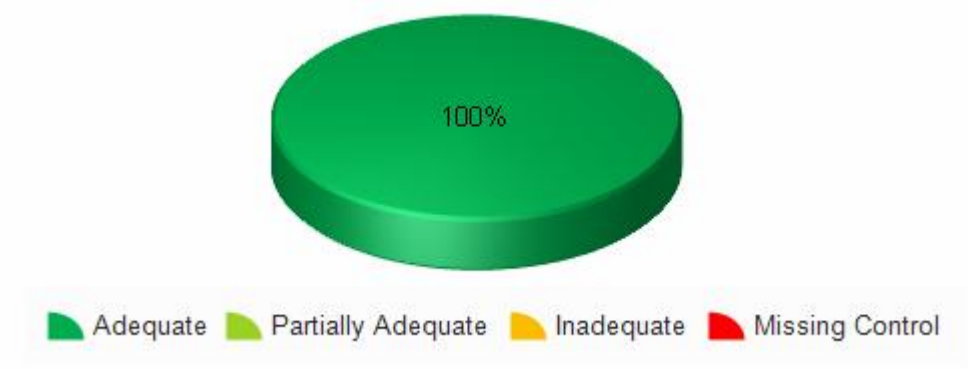


Number & Priority of Recommendations / Suggestions

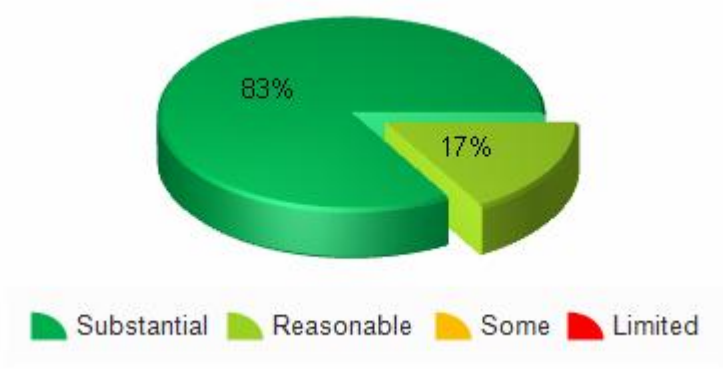


Conclusion:	Taking account of the scope of the review and the issues identified, the Board can take ***substantial*** assurance that the organisation is providing appropriate opportunities for customers and stakeholders to engage with the organisation and get involved with informing or being part of the decision-making processes in the establishment of its core plans.

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:

- We confirmed through interview and review of relevant documentation that the Authority had defined its specific stakeholder engagement principals and provided supporting direction within its Code of Governance. It was also clear that staff understood the Authority's duties to comply with relevant legislation and Natural Resource Wales' (NRW) specific guidance for consultation on the establishment of core plans.
- Testing undertaken during this audit confirmed that statutory consultation requirements were complied with as part of the development of the Partnership Plan.
- Through interview and review of relevant documentation we confirmed that the Authority had a clear understanding of who its core stakeholders were and that these were appropriately considered in the consultation process of its Partnership Plan.
- We confirmed that there was regular promotion of the opportunity to engage and consult on the Partnership Plan through various mediums, with the intention to maximise stakeholder reach and awareness.
- Through interview and review of relevant documentation we confirmed that mechanisms were in place to enable stakeholders to sign up to be on the contact list for ongoing notification of consultations on key strategic plans and policies.
- We confirmed that sufficient time was provided to customers and stakeholders to consult on the Authority's Partnership Plan and that the activities undertaken to promote and invite stakeholders to consult this year focused on inclusivity and obtaining feedback from a representative demographic of the park's stakeholders.
- The success / outcomes achieved from engagement activity undertaken to promote the consultation process were not formally measured to obtain insight into what engagement mediums provided the greatest return (formal consultations received), to help promote effective allocation of resources going forward for future consultation processes across the Authority.
- Our testing confirmed that the Authority appropriately considered and utilised the feedback received through its consultation processes to help shape the Partnership Plan, to maximise the likelihood of it meeting the needs of customers and stakeholders.
- Good practice was noted in the recent establishment of the Partnership Group, for the promotion of ongoing meaningful engagement, consultation and collaboration with key stakeholder groups in the delivery and review processes of the Partnership Plan.
- We confirmed that, following the Partnership Plan consultation process and action taken to update the plan as a result, emails of thanks were sent to those parties / persons involved in consultation directly. We also endorse the intention to establish a video to publish online and promote how the Authority listened to and used the opinions / feedback received from its customers / stakeholders to establish the latest Partnership Plan.

Additional feedback

We would like to thank the team involved for their excellent engagement and support prior to and during the audit.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	The Authority ensures that diverse, effective, and meaningful routes and mechanisms for consultation are used to capture and embrace the views of all parties and that these views are acted upon in the shaping of new plans and services.
Risk:	Core strategic plans set by the Authority do not adequately take into account the views of customers and stakeholders as part of the setting process of its core strategic plans, leading to inefficient or ineffective services, customer disengagement and/or reputational damage.
Engagement objective:	To provide assurance that the organisation is providing appropriate opportunities for customers and stakeholders to engage with the organisation and get involved with informing or being part of the decision-making processes in the establishment of its core plans.

2.2. Background to the Engagement

An audit of Customer & Stakeholder Engagement was undertaken as part of the approved internal audit periodic plan for 2025/26.

During the scoping meeting of this review, management requested that the scope of this audit be narrowed to focus on the recent stakeholder engagement of its Partnership Plan, with a view of helping to identify opportunities for improvement to take on board for the Local Development Plan (LDP) setting process, helping to maximise the effectiveness and value of engagements undertaken.

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

Areas within scope:	The structures and processes through which customer and stakeholder engagement / involvement is enabled in the Partnership Plan setting process. Review of how the Authority identifies potential opportunities for customer and stakeholder engagement / involvement. Verification that desired outcomes from the engagement / involvement are being achieved. Provision of good practice guidance regarding identification of potential opportunities for improvement in the customer engagement process in preparing for the next key plan setting process, the Local Development Plan.
Performance measures considered in assignment planning:	Achievement against defined outcomes. Customer/stakeholder satisfaction levels. Evidence of improvements resulting from customer/stakeholder feedback.

2.3. Limitations to the scope of the review

- We are not providing assurance over the organisation's overall customer engagement control framework. At the request of management, our scope was focused on the structures and processes by which customer engagement is maximised through the setting of core business plans only: Partnership Plan / Local Development Plan.
- The review is limited by the scope documented and the time available and we did not review the entirety of methods employed to engage with customers.
- The success or not of particular involvement / engagement techniques was not a specific focus of this review; although it may be commented upon if the data is available. We sought to provide assurance that the organisation had mechanisms in place to measure outcomes and success of engagements only.
- We did not get in touch with stakeholders of the organisation for their feedback on this area and relied on information available internally within the organisation.
- Planning application consultation process was not covered within the scope of this review.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.4. Key dates & personnel involved:

Debrief Meeting:	18 September 2025
Draft Report Issued:	10 November 2025
Responses Received:	14 November 2025

Auditor:	Ceri Kwiecinski, Risk Assurance Manager
Client Sponsor:	Sara Morris, Director of Placemaking, Decarbonisation and Engagement
Distribution:	Emma Gladstone, Strategic Policy Officer Michel Regelous, Strategic Policy Officer Mair Thomas, Performance & Compliance Officer

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	A significant amount of work was undertaken to promote engagement and undertake consultation events / meetings during the consultation process of the Partnership Plan, but the Authority did not formally measure how successfully or value adding each activity undertaken was (which ones may have resulted in the most formal consultations being submitted as a result / obtained the greatest engagement). With resource constraints a key challenge for the Authority, understanding what methods of working produce the best results and outcomes may aid in effective allocation of resources and promotion of value for money for all types of future consultation processes.	To seek to maximise engagement with the resources available, consideration should be given to reviewing the success of engagement activities and the value they achieve to help inform future consultation processes across the Authority. An opportunity to consider in helping to maximising value obtained from resources available includes filming and publishing presentations which invite customers / stakeholders to consult, rather than holding multiple online events, which (based on the information available to us) have limited attendance rates.	Accept. The Authority will consider reviewing the cost-benefit of engagement methods (recognising however that benefits vary on a case-by-case basis and that engagement outcomes may not be comparable on a pure cost basis). We will keep record of what methods of engagement receive the highest level of response and consider making more use of media / recordings to raise awareness and participation, including as a means of increasing participation in events the Authority may subsequently hold.
S2	The Authority did not currently have insight from its customers and stakeholders on how well they felt the Authority enabled engagement and consultation, including stakeholder awareness of opportunities and methods available to consult.	Consideration should be given to whether undertaking a wider piece of work to understand whether current arrangements in place around how the Authority enables customer / stakeholder engagement may be beneficial, to help identify opportunities for improvement and ensure alignment of practices with stakeholder expectations.	Accept. In terms of the Partnership Plan process, the Authority is establishing a Partnership Forum. A date for the inaugural Fforwm Partneriaeth Arfordir Penfro / Pembrokeshire Coast Partnership Forum (the Partnership Group) has been set for 25th November 2025. Functions of the Forum, which will meet quarterly, include fostering collaboration, reporting progress and contributing to all aspects of Plan review. This will enable and encourage an ongoing conversation with partners and their stakeholders. With regard to the Local Development Plan process, the Authority undertook consultation on a draft Delivery

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
			Agreement which invited comments on the Community Involvement Scheme, detailing how and when we will engage and involve stakeholders, the public and any interested parties in the preparation of the plan. The Authority's Management Team will discuss whether there is an opportunity to obtain engagement feedback through the publication of Coast to Coast or other suitable methods.
S3	During our review we established that the officers responsible for this area understood the consultation processes expected but that this was not formally defined anywhere. Completion of key stages and tracking of progress relied heavily on their knowledge and personal tracking of progress through calendars. There was no central checklist / tracking mechanism to aid in cover for the area in the event of staff unavailability. The lack of central tracker also prevented efficient assurance to be obtained that timely stakeholder engagement will / has occurred.	Consideration should be given to establishing a formally documented checklist / tracker for consultation processes that cover key stages and which can be tailored and added to, dependent on what was being consulted on, and used as a method of tracking progress centrally for each individual policy / strategic plan consultation process.	Accept. This approach would assist in contingency / succession planning, and could be supplemented by narrative on lessons learned etc.

ASTARI

Pembrokeshire Coast National Park Authority

Risk Management

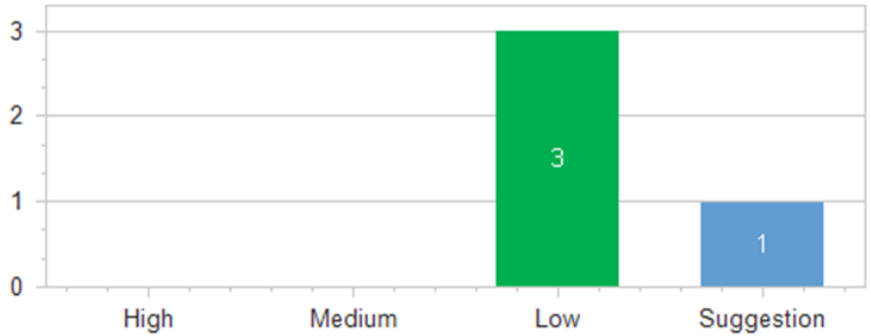
Internal Audit Report: PCNPA-2025/26-04

Date: 12 January 2026

1. EXECUTIVE SUMMARY

Level of Assurance

Number & Priority of Recommendations / Suggestions



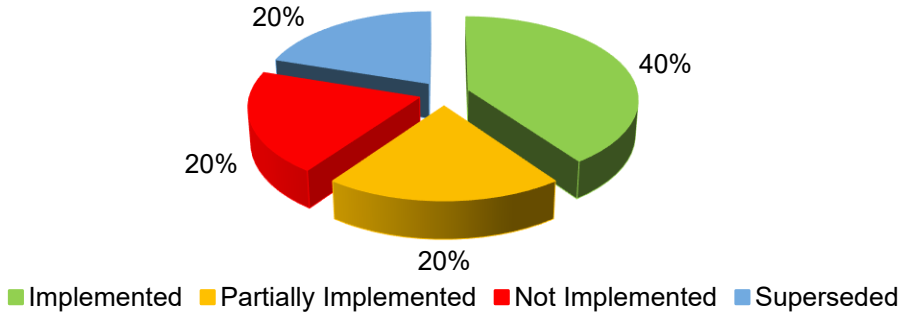
Conclusion:	Taking account of the scope of the review and the issues identified, the Authority can take ***reasonable*** assurance that the recommendations raised in the Risk Maturity (01.23/24) review have been appropriately acted upon.

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:

- We followed up on the five recommendations restated in the 2024/25 Risk Maturity Follow Up, which consisted of one 'High', two 'Medium' and two 'Low' priority recommendations. The graph and table below show the implementation status of the recommendations. Any which were partially or not completed are included in the action plan below.

Ref.	Recommendation Priority	Status
1	High	Implemented
2	Medium	Superseded
3	Medium	Implemented
4	Low	Not implemented
5	Low	Partially implemented



Detailed Findings

Recommendation	Priority	Work Undertaken	Conclusion
Risk Maturity (01.23/24) – ref. 1459 Management should agree with the National Park Authority what objectives should be used on the Strategic Risk Register to ensure that the register adds most value and achieves its aim of informing the Authority of how management are identifying and acting upon "any event or possible event that threatens the Authority ability to deliver its strategic objectives". Once agreed, a review of the risks should then be undertaken to identify any risks to the objectives that haven't yet been considered and also to ensure that current risks are re-worded to make it clear what the cause of the risk is and what the effect is on the objective to which the risk is linked.	High	We reviewed the minutes of the June 2025 National Park Authority Meeting and found that the risk register had been discussed and risks reviewed. The register had been updated to include a column detailing the failure of an agreed objective, to which we found that wellbeing objectives aligned. We assessed that as sufficiently implementing the recommendation, which was to agree what objectives should be used on the register to ensure that it adds most value and achieves its aim of informing the Authority on the organisation's risk management activities.	Implemented
Risk Maturity (01.23/24) – ref. 1464 The assurance columns in the risk register should be used to record specific, actual assurance that risk management activities are having the intended effect.	Medium	We sampled 12 assurances (one from each risk) listed on the risk register and sought to verify the assurance listed through review of backing evidence. Of the 12, we found that evidence was provided for all (100%). Although we confirmed that action had been taken in line with the recommendation, through discussion we found that the wording of assurances was not clear in three cases and there was one example where there was an overstatement of assurance with the 'internal audit of ICT and BCP' being stated; however, the audit only covered disaster recovery from an IT perspective, which could be misleading. Through discussion we were informed that the organisation had decided not to go more specific on the register in relation to assurances and that the current level of detail was sufficient. We saw evidence that additional information on assurance and the current position was reported to the Audit and Corporate Services Review Committee and was planned to be included in packs at future meetings, which enabled actual assurance to be obtained and scrutinised. We have therefore agreed, based on the work undertaken to date, the recommendation as 'superseded'; however, recommend review of the wording of assurances to ensure clarity.	Superseded

Recommendation	Priority	Work Undertaken	Conclusion
Risk Maturity (01.23/24) – ref. 1462 The content of the "Key Controls in Place" column should be reviewed to ensure that each is a tangible, key control that is in place to reduce either the impact or the likelihood of risk occurring.	Medium	Through review of the risk register we could see that controls listed were thematically aligned with the risk and therefore considered this recommendation to be complete.	Implemented
Risk Maturity (01.23/24) – ref. 1463 Either in addition to or instead of the "Progress Update" column, a "Gaps in control or Assurance" column should be added and this should be used to record planned further action to reduce the risk (controls) or planned assurance to be gained that controls are operating effectively (assurance). For ease of understanding, consideration should be given to recording this with either an "(c)" for gaps in control or "(a)" for gaps in assurance.	Low	Our review of the register showed that the recommended inclusion of a column to record any gaps in control or assurance or record required actions had not been undertaken. The November 2025 risk register showed seven risks sat above their target score, six (86%) of which did not include further actions which limits visibility. We therefore concluded that this recommendation had not been implemented and have restated it.	Not Implemented
Risk Maturity (01.23/24) – ref. 1458 Guidance on the following areas should be made available and this could be achieved through the existing Risk Strategy or a separate guidance document: ▪ Risk identification; ▪ Controls, including the different types of control (preventative, directive, corrective and detective); and ▪ Assurance, including the different types of assurance and the difference between potential assurance and actual assurance.	Low	We obtained and reviewed the Risk Management Strategy and Guidance (April 2025) and found that some recommended changes had been implemented. Further guidance on the process of risk identification would be beneficial, and the risk controls section requires update to ensure that this is accurate. We therefore consider this recommendation to be partially implemented and have restated it.	Partially Implemented

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	Key risks to the achievement of the organisation's objectives are identified, assessed and appropriate action taken to mitigate the risk's impact and / or likelihood.
Risk:	Risk management is not undertaken robustly throughout the organisation, leading to risks not being identified or appropriately mitigated and therefore increasing the likelihood of an event having a detrimental impact on the achievement of the organisation's objectives.
Engagement objective:	To provide assurance that the recommendations raised in the Risk Maturity (01.23/24) review have been appropriately acted upon.

2.2. Background to the Engagement

An audit of Risk Management was undertaken as part of the approved internal audit periodic plan for 2025/26.

This review aimed to follow up on the recommendations and suggestions raised in the previous year's risk reviews and provide assurance that the benefits anticipated from the changed processes were being achieved. During the last Risk Maturity Follow Up (02.24/25) a Some assurance opinion was provided over progress made.

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

Areas within scope:	Follow up on five outstanding recommendations raised in the Risk Maturity (01.23/24) review comprising of one High, two Medium and two Low priority recommendations. ▪ Link between strategic objectives and the Authority's strategic risks; ▪ Risk management guidance, including risk identification, controls and assurances information; and ▪ Accuracy and clarity of information recorded on the register, including the recording of clear controls and use of "actual" assurance and further actions required.
Performance measures considered in assignment planning:	Percentage of recommendations implemented within defined timescales.

2.3. Limitations to the scope of the review

- This audit did not review the whole control framework of the areas listed above and we are therefore not providing assurance on the entire risk and control framework.
- Testing was undertaken where appropriate to confirm the effectiveness of actions taken to implement the recommendations. Where testing was undertaken it was done so on a sample basis only from the period since actions were implemented or controls enhanced.
- Risk management remains the responsibility of the National Park Authority and senior management to agree, manage information needs and to determine what works most effectively for the organisation.
- 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:	18 December 2025	**Auditor:**	Sarah Griffiths, Senior Risk Management Consultant
Draft Report Issued:	23 December 2025	**Client Sponsor:**	Tegryn Jones, Chief Executive
Responses Received:	8 January 2026	**Distribution:**	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	A review of the risk register showed that there were examples of a lack of clarity in the wording of assurances meaning that Members may find it hard to understand what the assurance is and to be clear on whether it was an assurance or a control.	Lack of clarity in the wording of assurances or the inclusion of controls can lead to the organisation perceiving a higher level of assurance being in place resulting in a risk of inappropriate decision making.	Assurances within the risk register should be assessed as to whether they are assurances or controls and once defined, wording should be reviewed to ensure that there is clarity as to what is in place.		Text on assurances and controls will be reviewed for the next Audit and Corporate Services Review Committee.	**Responsible Person:** Tegryn Jones, Chief Executive **Date:** 31 March 2026
R2	Our review of the register showed that the recommended inclusion of a column to record any gaps in control or assurance or record required actions had not been undertaken. The November 2025 risk register showed seven risks sat above their target score, six (86%) of which did not include further actions which limits visibility. We therefore concluded that this recommendation had not been implemented and have restated it.	The Risk Register is not useful as an action plan to clearly communicate either (1) what further action is planned to reduce the risk to within the organisation's risk appetite; or (2) what further assurance is required to evidence that controls are operating effectively.	**Restated recommendation (1463)**: Either in addition to or instead of the "Progress Update" column, a "Gaps in control or Assurance" column should be added, and this should be used to record planned further action to reduce the risk (controls) or planned assurance to be gained that controls are operating effectively (assurance). For ease of understanding,		Agreed, however, rather than including another column on the Risk Register a Future Actions section will be included on the Cover Report. This will be updated when it has been completed.	**Responsible Person:** Tegryn Jones, Chief Executive **Date:** 31 March 2026

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
			consideration should be given to recording this with either an "(c)" for gaps in control or "(a)" for gaps in assurance.			
R3	Through review of the Risk Management Strategy and guidance, we found that there was a lack of clarity relating the identification of risks and the information included relating to types of controls did not align with good practice.	Risk management may not be undertaken as efficiently as it could be, or, in the worst case, key risks may be missed due to a lack of understanding, leading to a range of impacts including injuries, loss of finance or damage to reputation.	**Restated recommendation (1458)**: Guidance on the following areas should be made available, and this could be achieved through the existing Risk Strategy or a separate guidance document: ▪ Risk identification, and ▪ Controls, including the different types of control (preventative, directive, corrective and detective).		Agreed – document will be updated next time it is reviewed to include section on risk identification and controls (including the different types).	**Responsible Person:** Tegryn Jones, Chief Executive **Date:** 31 December 2026

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	We noted that the controls detailed in the risk register could be enhanced by providing further context.	The organisation should consider adding further clarity to the controls documented in the risk register to ensure that the audience can understand the effect that the control is having to reduce either the impact or likelihood of the risk. This will help with assessing whether the risk is sufficiently managed.	Information will be added as part of the review of papers for future meetings.

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Pembrokeshire Coast National Park Authority

Follow Up

Internal Audit Report: PCNPA-2025/26-05

Date: 6 January 2026

Table of Contents

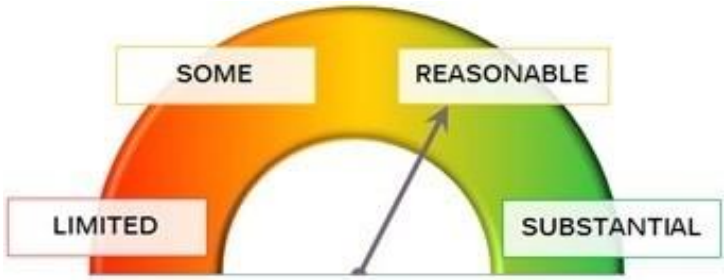
Fieldwork Undertaken:	15 December 2025
Last Information Received:	17 December 2025
Draft Report Issued: **Re-issued:**	23 December 2025 5 January 2026
Initial Responses Received: **Final Responses Received:**	2 January 2026 5 January 2026
Final Report Issued:	6 January 2026

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

1. EXECUTIVE SUMMARY

1.1. Conclusion & number of recommendations

Progress in implementation recommendations:



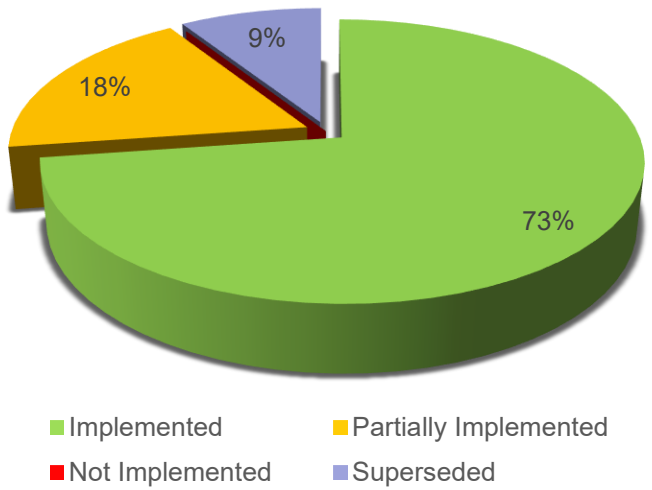
	High	Medium	Low	Suggestion
Recommendations:	1	1	0	1

Conclusion:	In our opinion Pembrokeshire Coast National Park Authority has demonstrated ***Reasonable*** progress towards the implementation of agreed actions to address internal audit recommendations. We have restated recommendations where they have not been implemented and, where further actions are required, have raised new recommendations. These are detailed in the Action Plan.

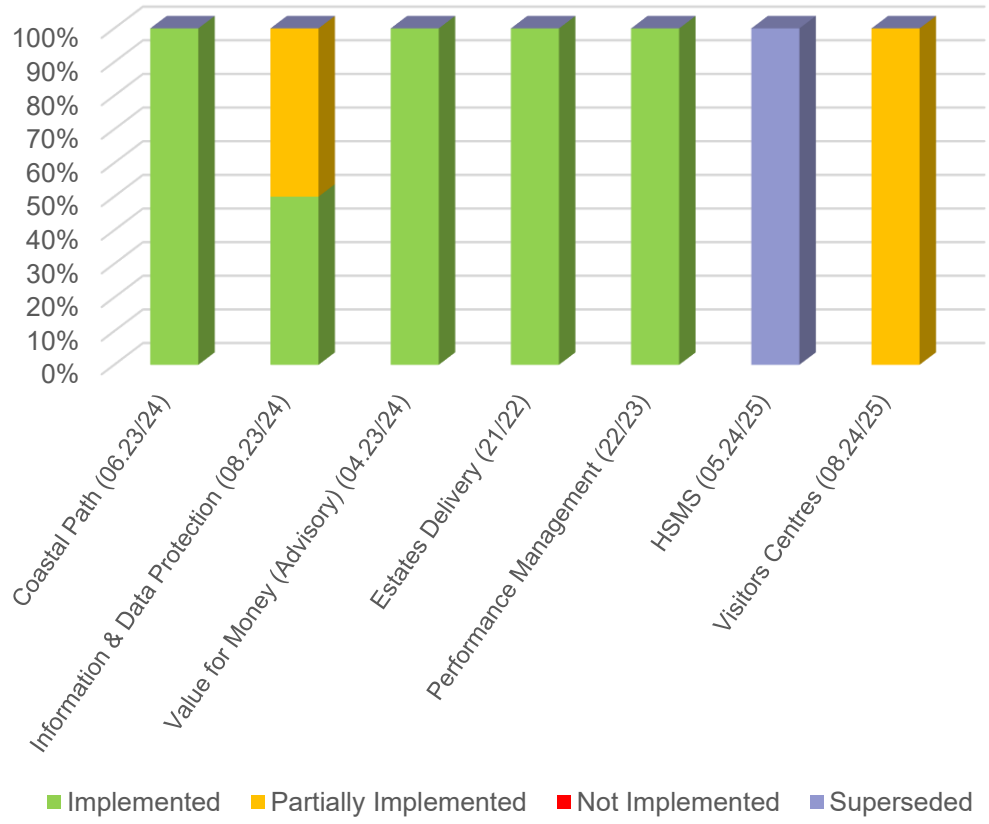
1.2. Status of recommendations followed up

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

Overview of recommendation status:



Recommendation implementation status by audit:



2. BACKGROUND AND SCOPE

2.1. Scope of the review

As part of the approved internal audit plan for 2025/26 we have undertaken an audit to follow up previous management actions as agreed in response to internal audit recommendations. Recommendations with dates for implementation not yet due will be followed up in future Follow Up audits and we have not included the results of recommendations followed up as part of separate reviews. The audits considered as part of this review were:

- Estates Delivery (TIAA.21/22)
- Performance Management (TIAA.22/23)
- Health & Safety (02.23/24)
- Value for Money (Advisory) (04.23/24)
- Countryside Management – Coastal Path (06.23/24)
- Information & Cyber Security & Data Protection (08.23/24)
- HSMS: Accident, Incident and Near Miss Reporting & Investigation (05.24/25)
- Visitors Centres (08.24/25)

In total 11 recommendations were followed up in this review, comprising one ‘High’ and 10 ‘Medium’ priority recommendations. The focus of the review was to provide assurance that appropriate action is being taken to implement agreed actions.

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

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

2.2. Limitations to the scope of the review

- Due to the time available, the review was limited to High and Medium recommendations, reported as complete to us, raised in the above audits and did not review the whole control framework of the areas listed above. We are therefore not providing assurance on the entire risk and control framework.
- Where possible we placed reliance on our previous work to reduce duplication.
- Testing was undertaken where appropriate to confirm that the actions agreed by management in response to recommendations raised had been fully implemented. Where testing was undertaken, it was undertaken on a sample basis only from the period since actions were implemented or controls enhanced.
- The coverage of the scope was dependent on the availability of information provided to us during the fieldwork stage and within the agreed time available for this review.
- Our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

2.3. Recommendation Tracking

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

Pembrokeshire Coast National Park Authority's management undertakes tracking of the implementation of actions agreed by management in response to recommendations made by internal audit. This tracking is based on an assessment by the staff responsible for implementing those actions and is subsequently validated by Internal Audit. We identified two instances where we concluded that the status of the agreed actions was not fully complete and these specifically related to the following audits:

- Information & Cyber Security & Data Protection (08.23/24)
- Visitors Centres (08.24/25)

As our testing confirmed that the remaining eight (73%) recommendations were accurately reported to the Audit & Corporate Services Review Committee via the internal tracking process, our opinion is that the Audit & Corporate Services Review Committee can place reasonable reliance on the tracking reports provided by management. We have made a suggestion to allow the organisation to distinguish between internally 'complete' recommendations and internal audit 'closed' recommendations going forward, as it is important to note that until a recommendation is fully implemented and confirmed as 'closed', the organisation may still be exposed to an unacceptable level of risk.

3. ACTION PLAN

Priority:	= Low	= Medium	= High	= Suggestion

Status	Restated Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
Information & Cyber Security & Data Protection (08.23/24)				
Partially Implemented	**Recommendation (Ref: 1900):** The organisation should review the asset register and confirm that the inventory is held and that the correct data (serial number and user etc) has been recorded. This exercise might be completed in line with a financial asset verification exercise and it would be beneficial if the findings of the asset verification register were compared to the asset list within Intune to ensure all devices are listed and up to date to provide assurance of information and cyber security. **Management Response:** Update the starter and leaver processes to take account of ICT permissions and assets. Following update of above ICT asset register to be updated. **Summary of Findings** While the asset register was in place and was being updated as changes to equipment were made and as the organisation worked towards enrolling all equipment in InTune, there had not yet been a review of the existing historic inventory listed within the asset register to confirm that it was accurate. We therefore considered the recommendation to be partially implemented.		Review to be carried out of existing historic inventory listed within the central asset register to confirm this information is correct.	**Responsible Person:** IT Team Leader **Date:** 31 March 2026

Status	Restated Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
Visitors Centres (08.24/25)				
Partially Implemented	**Recommendation (Ref: 2879):** Assurance should be sought that the Authority is appropriately complying with Lifting Operations and Lifting Equipment Regulations (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. **Management Response:** Appropriate additional goods lift check to be added to lift servicing contract at Oriel y Parc. **Summary of Findings** Whilst the organisation had ensured the goods and passenger lifts at Oriel y Parc underwent regular inspections with clear tracking of these, the organisation had not yet confirmed whether the passenger lifts required LOLER testing and as such, whether the Authority was complying with the LOLER regulations.		The OYP inspection took place on 04/08/2025 and is part of M&E inspection & testing programme moving forward. The follow up audit asked wider questions relating to Authority lifts at other sites. In response to this: Agreed Action - Buildings team will audit sites to identify how many appliances fall under LOLER testing requirements and where required add these to the M&E inspection & testing programme moving forward.	**Responsible Person:** Buildings Project Manager **Date:** 31 March 2026

The table below summarises any new suggestions that we have raised as part of this Follow Up review:

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	While the organisation tracked agreed management actions for recommendations through the Internal Audit Action Log Tracker and separated these into actions outstanding and actions completed, for those completed they did not identify the date completed or whether the action and associated recommendation had been confirmed as "complete" and therefore closed by Internal Audit. This created a difficulty in identifying which recommendations should be included in our independent Follow Up assessment.	The organisation might consider adding additional information to the Action Log Tracker to increase clarity over the status of recommendations and timelines. For example, categorising actions completed by management as "complete" (and including the date of when this occurred) and, once confirmed as complete by Internal Audit the status could be changed to "closed". This distinction could also be incorporated into the reports provided to the Audit and Corporate Services Review Committee.	An additional column will be added to the tracker spreadsheet to note when an action and associated recommendation has been closed (or reinstated) after the completed action (as identified as complete by staff) has been subject to follow up audit by internal auditors. Noting also the year of the follow up audit where the completed action was considered. Where staff have noted that action has been completed we will look to note the month of completion – reflecting entry note for item on the performance system. We will review the columns and classifications against those used by the internal auditors on their system to help ensure consistency in approach. No change is proposed for the action log that goes to Audit and Corporate Services Committee apart from making it clearer that this action log relates to staff assessment of action being completed and that these completed actions will be subject to further quality assurance/ testing as part of the follow up audit. It is viewed that the follow up audit is the appropriate place to report to Members any issues found of staff assessed completed actions and the need for them to be reinstated or new action implemented (if this is the case they will be added back into the action log). Keeping a staff assessed completed action on the monitoring action log for Members until they have been subject to follow up audit has potential to cause confusion and lead to increase in length of the document.

APPENDIX A: DATA SUPPORTING THE OPINION

Recommendation Status by Audit:

Review	Total Number of Recommendations	Recommendation Status				No. of recommendations carried forward (2 + 3)
		Implemented (1)	Partially Implemented (2)	Not Implemented (3)	Superseded (4)	
Estates Delivery (TIAA.21/22)	1	1	0	0	0	0
Performance Management (TIAA.22/23)	1	1	0	0	0	0
Health & Safety (02.23/24)	1	1	0	0	0	0
Value for Money (Advisory) (04.23/24)	1	1	0	0	0	0
Countryside Management – Coastal Path (06.23/24)	3	3	0	0	0	0
Information & Cyber Security & Data Protection (08.23/24)	2	1	1	0	0	1
HSMS: Accident, Incident and Near Miss Reporting & Investigation (05.24/25)	1	0	0	0	1	0
Visitors Centres (08.24/25)	1	0	1	0	0	1
TOTAL:	**11**	**8 73%**	**2 18%**	**0 0%**	**1 9%**	**2 18%**

Recommendation Status by Priority:

Priority	Total Number of Recs	Recommendation Status				No. of recommendations carried forward (2 + 3)
		Implemented (1)	Partially Implemented (2)	Not Implemented (3)	Superseded (4)	
High	1	0	1	0	0	1
Medium	10	8	1	0	1	1
Low	0	0	0	0	0	0
TOTAL:	**11**	**8**	**2**	**0**	**1**	**2**
		73%	**18%**	**0%**	**9%**	**18%**

ASTARI

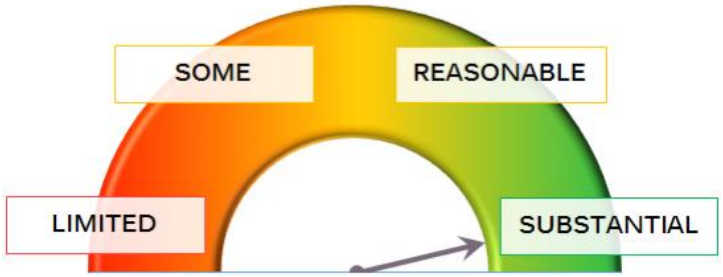
Pembrokeshire Coast National Park Authority

Governance: Strategic Planning

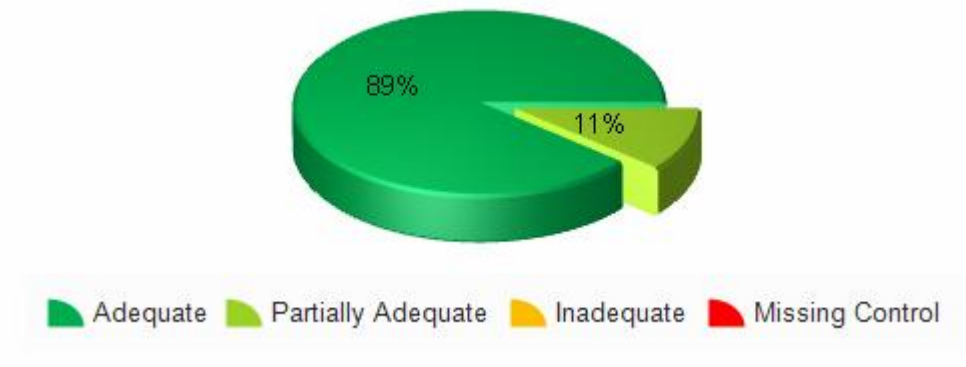
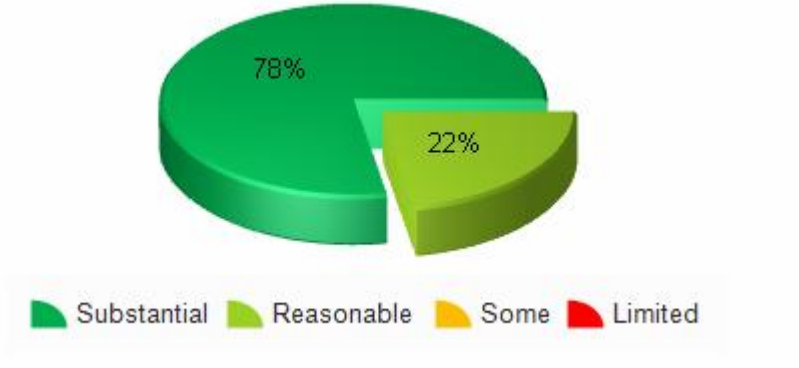
Internal Audit Report: PCNPA-2025/26-06

Date: 15 December 2025

1. EXECUTIVE SUMMARY

Level of Assurance	Number & Priority of Recommendations / Suggestions
	No recommendations or suggestions were raised in this review.

Conclusion:	Taking account of the scope of the review and the issues identified, the Authority can take ***substantial*** assurance that robust structures and processes have been implemented to achieve its strategic plans, monitor that implementation and report progress accurately to the National Park Authority.

Assessment of Control Design	Assessment of Control Application / Compliance
	

Summary of findings

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

- Through interview and review of evidence provided by the organisation we concluded that the organisation had good processes in place to identify external requirements, changes and risks to ensure that any additional requirements would be brought into the Authority's plans and actions. This included the Key Controls recorded on the organisation's risk register against risk 7: "Not meeting the legal and Governance Requirements of the Authority, not mainstreaming requirements in areas such as Equality and Well-being Objectives."
- We reviewed the Authority's Equality Plan 2025-2029 and Well-being Objectives (incorporated into the Corporate and Resources Plan (2025 revision) and found that they were clearly described and included either clear objectives or links to Delivery Plans where the objectives were further defined and measured included. We did not identify any gaps from applicable statutory requirements in our testing and noted that, where possible, they included measurable objectives / targets to enable effective monitoring and oversight.
- Our assessment of the objectives / targets in the Corporate and Resources Plan found that 89% were explicitly measurable, as long as a baseline was in place for objectives that were based on words such as "improve" or "increase", and that there was justification for why the other 11% were not explicitly measurable, for example: where further work was being undertaken to establish a baseline / set of measures to ensure that the targets / measures set were most meaningful and outcome-focused.
- Through all our documentation reviews, including of meeting papers and minutes of various groups, it was evident that the requirements of stakeholders had been considered as part of the development of the Authority's strategic plans and that the feedback from stakeholders had been incorporated. The Partnership Plan was a particular example of how the organisation was seeking to work with partners and stakeholders to deliver significantly more for the Park than could be achieved alone.
- We confirmed that, although there was a complex relationship and inter-linking between the organisation's various obligations, strategies, plans and Delivery Plans, there was a good understanding of how they fit together and the Corporate and Resources Plan specifically included information on how they were coordinated and fit together.
- We undertook a high-level review of the organisation's Delivery Plans to check whether there was alignment between the "Deliverables" in those plans with the more strategic plans and strategies. We were able to trace through key objectives to the Delivery Plans and that further detail was then added on how they were to be achieved, specific timescales, resources required and progress to date. No issues were noted.
- We reviewed a sample of objectives from the Corporate and Resources Plan through to the Delivery Plans and tracking / measures within the organisation's Performance Reporting system. In all cases we were satisfied that there was effective monitoring of those objectives sampled, noting that further work was occurring in a range of areas to further develop monitoring and reporting processes. We also noted clear alignment with other strategies and plans, such as the Partnership Plan and Well-being Objectives.
- The process was effectively supported by a new (September 2025) Corporate Performance Framework Operational Procedure and Guidance that we concluded provided a robust guide to how the organisation monitors performance and also will likely aid in improving information and data management generally.
- We reviewed a range of reports to various groups in this review, including reports to: the Management Team, Audit & Corporate Services Review Committee, Operational Review Committee, Standards Committee and the National Park Authority. It was evident that there was a clear hierarchy in place of reporting routes for performance against the various strategies and plans and that escalation routes for any issues or significant under-performance had been considered.
- Our review of the accuracy of reporting was limited by the changes that had been recently made to the organisation's priorities as a result of the new Welsh Government Indicators; however, based on the information we reviewed and from a comparison of data reported in performance reports against information available in the organisation's Performance Reporting system, we did not identify any concerns with the reporting provided.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	To meet legal and governance requirements of the Authority as well as providing direction to staff.
Risks:	**Risk 7:** Not meeting the legal and Governance Requirements of the Authority, not mainstreaming requirements in areas such as Equality and Well-being Objectives. If the organisation does not have a clear strategic plan that is monitored, the organisation may not deliver what is required and internal delivery may be inefficient.
Engagement objective:	To provide assurance that the Authority has implemented robust structures and processes to implement its strategic plan, monitor that implementation and report progress accurately to the National Park Authority.

2.2. Background to the Engagement

An audit of Governance: Strategic Planning was undertaken as part of the approved internal audit periodic plan for 2025/26.

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

Areas within scope:	How the Authority has defined its corporate objectives / priorities and how performance can be measured. How strategies have been broken down into deliverable elements. How the Authority considered external changes and risks and incorporates these into its strategies. The structures and processes through which the deliverables will be managed and monitored. Alignment with other processes, such as risk, performance and financial management. Reporting of progress in delivering the plan(s) and the accuracy of that reporting.
Performance measures considered in assignment planning:	Accuracy of reporting of progress against evidence available of performance.

2.3. Limitations to the scope of the review

- Delivery Plans and Operational Department Level Plans were excluded from this review, although we reserved the right to consider how they supported delivery of more strategic plans where that was appropriate. Joint Strategic Plans were also outside the scope of this review due to the limited time available.
- The review considered how the organisation was meeting its statutory responsibilities through its Plans; however, testing of compliance was on a sample basis and we did not test every aspect of every statutory responsibility. We are also not legal experts in all the areas of the Authority's operations and therefore are not providing any guarantee regarding legal compliance.
- 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:

Fieldwork End Date:	4 December 2025	**Auditor:**	Nigel Ireland, Chief Audit Executive
Draft Report Issued:	9 December 2025	**Client Sponsor:**	Tegryn Jones, Chief Executive
Responses Received:	9 December 2025	**Distribution:**	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
No recommendations or suggestions were raised as part of this review.						

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

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