Report of Astari (Internal Auditors)

Subject: Internal Audit Progress Report

INTRODUCTION

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

SUMMARY OF PROGRESS

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

- Risk Maturity Follow Up (02.24/25); and
- Governance Structures & Processes (03.24/25).

The following reports have also been issued in draft:

- Climate Change & Decarbonisation (01.24/25)

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

Assignment *Reports considered today are shown in italics*	**Status**	**Opinion**	**Recommendations:**		
			High	**Medium**	**Low**
Climate Change & Decarbonisation (01.24/25)	DRAFT				
Risk Maturity Follow Up (02.24/25)	*FINAL*	*Some*	*1*	*2*	*2*
Governance Structures & Processes (03.24/25)	*FINAL*	*Substantial*	*0*	*1*	*1*
		TOTAL:	**1**	**3**	**3**

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

LIAISON WITH MANAGEMENT & EXTERNAL AUDIT

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

INTERNAL AUDIT PLAN CHANGE CONTROL

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

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

WORK IN PROGRESS OR YET TO START

Audit	Start Date	Debrief Date	Draft Report Issued	Planned Audit Committee	Comments
Climate Change & Decarbonisation	15/10/2024	04/11/2024	09/12/2024	~~February 2025~~ May 2025	Query resolution stage.
HSMS: Accident, Incident and Near Miss Reporting & Investigation	06/01/2025			May 2025	
Equality, Diversity & Inclusion	09/12/2024	18/12/2024		May 2025	
Follow Up	03/02/2025			May 2025	
IT Strategy	03/03/2025			May 2025	
Visitor Centres	31/03/2025			May 2025	

Pembrokeshire Coast National Park Authority

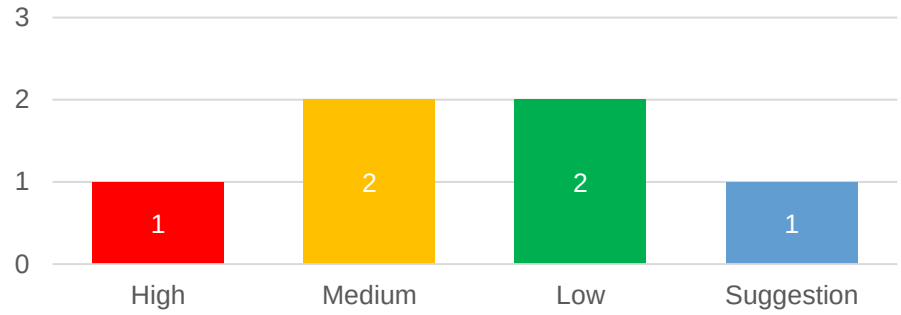
Risk Maturity Follow Up

Internal Audit Report: PCNPA-2024/25-02

Date: 28 January 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 ***some*** assurance that that the five recommendations raised in the 2023/24 Risk Maturity review and the one accepted recommendation from TIIA's Risk Mitigation 2021 review have been implemented as agreed. Work is still required to fully implement five of the six recommendations followed up and these have been updated and restated in the Action Plan in this report. No new recommendations have been raised.

Additional Feedback

To ensure that we are able to effectively provide assurance over this area as well as how the organisation's risk register is used in informing the Authority's assurance plans, both for Internal Audit and other assurance providers, the Authority needs to be clear on what the purpose of its risk management process is. The current Risk Management Strategy defines risk as "*any event or possible event that threatens the Authority's ability to deliver its strategic objectives*", yet the organisation's strategic risk register is not linked to the strategic objectives. There is therefore a disconnect between the Authority's definition of risk and the information the National Park Authority (NPA) and Audit & Corporate Services Review Committee are presented with formally on the risks Management consider to be key at the current time and how well those risks are being managed. As a result, it is not clear how the risk management process is maximising value and avoiding being an overly bureaucratic task.

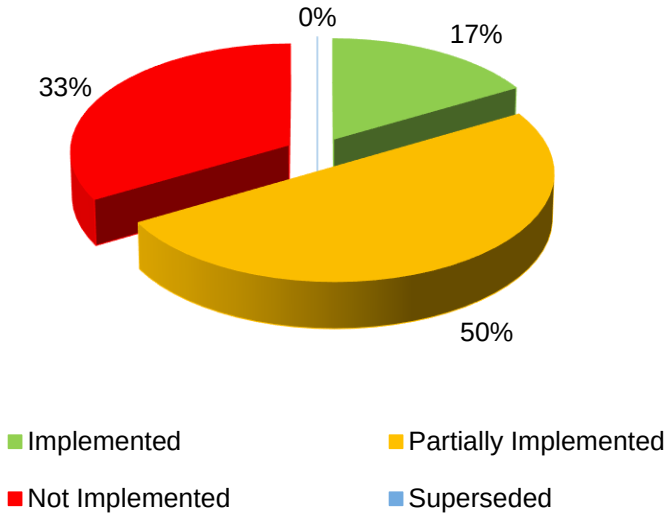
Whatever the Authority's responses are to the recommendations raised in this report, we are keen to support organisation in implementing a risk management process that is a valuable tool to both:

- Management – providing a formal mechanism to support effective, evidence-based decision making and to enable measurable consideration of whether risks are sufficiently managed or not; and
- The NPA – providing assurance that strategic objectives will be achieved, key risks to its strategic objectives are being appropriately identified, assessed and managed, and that resources are being used efficiently by the organisation.

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 one High, two Medium and two Low priority recommendations from the 2023/24 Risk Maturity review (01.2023/24), all of which had been reported to the Audit and Corporate Services Review Committee (ACSRC) as complete. We also followed up on the outstanding recommendation from TIIA's Risk Mitigation review from 2021. Through testing we concluded that one (17%) recommendation had been fully implemented, three (50%) recommendations had been partially implemented and the remaining two (33%) had not been implemented, as shown in the graph and table below:



Recommendation Priority	Status
High	Partially Implemented
Medium	Partially Implemented
Medium	Partially Implemented
Low	Not Implemented
Low	Not Implemented
TIIA (3)	Implemented

- We obtained and reviewed the current risk register (November 2024) and found that objectives had been included. However, when comparing against the organisation's strategic objectives, the objectives in the risk register did not align. The Authority defines risk as "*any event or possible event that threatens the Authority ability to deliver its strategic objectives*"[1]; therefore, by using objectives other than the strategic objectives in the risk register it is not clear how the risk register achieves its aim of providing evidence that risks to the organisation's ability to deliver its strategic objectives are being appropriately identified, assessed and subsequently mitigated.

[1] PCNPA Risk Management Strategy, November 2023

- Where strategic objectives are not included risks become overly generic and the risk assessment processes become less consistent, which in turn makes resource allocation for mitigation activities less efficient. It also reduces the Authority's ability to undertake gap analysis to ensure that risks have been identified against all objectives. Through testing we noted that the objectives included in the risk register did not make any reference to three (75%) of the four strategic objectives:
    - To create a Park that is a natural health service that supports people to be healthier, happier and more connected to the landscape, nature and heritage.
    - To create vibrant, sustainable and prosperous communities in the Park that are places people can live, work and enjoy.
    - To deliver nature recovery and connectivity at scale, so nature is flourishing in the Park, contributing to the protection of 30% of our land and seas for nature by 2030.
- We noted that the way risks were written did not include a "cause → risk → effect" structure. Using such an approach would enable the organisation to better understand the cause(s) of the risks which the organisation faces against the achievement of its objectives and would therefore make the process of identifying appropriate controls easier. Further guidance on this is included in Appendix A.
- We saw evidence of the risk register being updated to remove the secondary 'control/monitoring' column. As the risks were not written in a cause → risk → effect format, the ability to independently determine how the controls reduced either the impact or likelihood of the risk was limited. We could see that there were thematic links in place between the controls and risks listed but we also noted examples of where sources of assurance had been included as controls.

  It would be beneficial to provide some context for each control to detail how the control reduces either the impact or the likelihood of the risk. For example, providing additional context to the control of "code of Conduct for Members and officers" against the risk of "The conduct of Members and officers undermines the reputation of the Authority" could include detail such as: "code of conduct for members and officers informs them of expectations and promotes accountability and compliance". This is useful for those writing the controls (to understand 'why' it is a control and to enable more effective assessment of its impact) and for those reviewing the risk register as this additional context explains the rationale behind the inclusion of the control and maximises the likelihood of common understanding.
- We found that the risk register had been updated to include assurance columns which had been split into internal (2nd Line) assurance and independent (3rd Line) assurance. We reviewed the content of the assurance element of the register and found that there were instances where internal and independent assurance had been incorrectly categorised and all the assurances recorded were sources of assurance rather than actual assurances. To enable the Authority, ACSRC and leadership to understand the assurance in place, the assurance should be reflective of the latest position, for example: rather than including 'monitoring of HR metrics' detailing what the metric is, the latest result and a date would provide 'actual' assurance in the register and would therefore inform the reader of the current risk management situation. Similarly, rather than 'internal audit reports' inclusion of the name of the report, the date and the assurance opinion takes the assurance from a 'source' or assurance to 'actual' assurance.
- Through review of the risk register we found that a 'gaps in control or assurance column' had not been included in the risk register. The recommendation has therefore been restated.
- Through conversations with the Chief Executive Officer we were informed that there had been no progress towards provide guidance on risk identification, controls and assurances as previously recommended. The guidance was planned but was to be undertaken within another piece of work which had not yet progressed. The recommendation has therefore been restated.
- We were informed that the programme of deep dives was due to commence the week after the audit took place. As such, we have closed the recommendation; however, we are unable to provide comment of the content or quality of the exercises as they could not be reviewed.

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:	Key risks to the organisation's objectives are not identified, assessed or appropriately mitigated, which increases the likelihood of not achieving the organisation's objectives, of breaching applicable legislation or of reputational damage.
Engagement objective:	To provide assurance that the five recommendations raised in the 2023/24 Risk Maturity review and the one recommendation raised in TIIA's Risk Mitigation 2021 review, that was accepted, have been implemented as agreed.

2.2. Background to the Engagement

An audit of Risk Maturity Follow Up was undertaken as part of the approved internal audit periodic plan for 2024/25.

Our 2023/24 Risk Maturity review (01.23/24) provided an assessment of the organisation's risk maturity linked to six key areas: governance, risk identification, risk assessment, risk mitigation, assurance and monitoring & reporting. Along with this assessment we raised recommendations and suggestions to move the organisation forward towards the Risk Enabled position. The 2023/24 report included one High, two Medium and two Low priority recommendations, along with three suggestions. We were also made aware of one outstanding recommendation, raised in the 2021 Risk Mitigation review, from the Authority's previous Internal Audit provider that was also followed up on.

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

Areas within scope:	Follow up of the one High, two Medium and two Low priority recommendations as raised in the Risk Maturity review (01.2023/24). Follow up on the one outstanding recommendation from the Risk Mitigation review undertaken by TIIA in 2021.
Performance measures considered in assignment planning:	Percentage of recommendations implemented within defined timescales.

2.3. Limitations to the scope of the review

- The review did not include 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 undertaken 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:

Last Information Received:	11 December 2024
Draft Report Issued:	3 January 2025
Responses Received:	25 January 2025

Auditor:	Sarah Griffiths, Senior Risk Assurance Consultant.
Client Sponsor:	Tegryn Jones, Chief Executive Officer
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	The risk register had been updated to include objectives; however, the objectives included were not the Authority's strategic objectives. The wording of the risks did not follow the cause-risk-effect model which did not enable a clear understanding of the likelihood or impact of the risk on the Authority's objectives.	Risks become more generic and risk assessment processes become less consistent, which in turn makes resource allocation for mitigation activities less efficient.	**Restated Recommendation:** 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.		Accept the recommendation. However, the Objectives were agreed by Members of the Authority therefore we will need to get the agreement of Members to change the Objectives. Initial disucssions in the Audit Committee then consultation and agreement with Members of the Authority. In aligning risk objectives more closely to our Well-being Objectives we will still need to consider risk re Governance and compliance failure linked to our Public duties.	**Responsible Person:** Tegryn Jones, Chief Executive (in consultation with Members of the Authority) **Date:** 31 May 2025

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R2	The risk register had been updated to include one 'control' column; however, there was a lack of visibility of how the controls mitigated the risk and we noted examples of assurances being recorded as controls.	A lack of clarity regarding what should be recorded in which column; duplication of information; creating a document that is significantly larger than it needs to be for the amount of information included; reduced ability to consider the 'strength' of controlling activities.	**Restated Recommendation:** 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.		Agreed – the column will be reviewed and updated in line with any changes to the Objectives and presented to the next Audit Committee after a change in Objectives.	**Responsible Person:** Tegryn Jones, Chief Executive **Date:** 31 July 2025
R3	The Authority had included columns within the risk register for internal and independent assurance; however, the items included were 'sources' of assurance rather than 'actual' assurance.	The Risk Register does not include specific, meaningful information and is not a useful 'tool' for the organisation. It therefore becomes a tick-box exercise that does not add value and wastes resources, rather than helping the organisation achieve its objectives.	**Restated Recommendation:** The assurance columns in the risk register should be used to record specific, actual assurance that risk management activities are having the intended effect.		Agree - Review and identify process for gathering data from assurance sources to provide quarterly assurance within the Risk register 2/3 line columns (this could be linked to our wider assurance reporting). We will then test to see how effective approach is in terms of helping populate the " Gaps on control or Assurance" Column.	**Responsible Person:** Mair Thomas, Performance & Compliance Officer **Date:** 31 July 2025

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R4	There was no "gaps in control or assurance" or equivalent column on the Risk Register, although there was a "Progress Update" column where additional comments were made and we noted that some of these were information on what additional work was being undertaken to further reduce the risk; therefore, essentially they were gaps in control.	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:** 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.		Agreed – "Progress Update" column to be replaced with a Gaps on control or Assurance" subject to agreement of Members.	**Responsible Person:** Tegryn Jones, Chief Executive (in consultation with Members of the Authority) **Date:** 31 May 2025
R5	We noted some key areas of guidance that were missing and would likely mean that there was either a lack of understanding regarding those areas or a lack of consistency in the application of those areas.	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:** 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.		Agreed – Guidance documents prepared following changes agreed by the Authority.	**Responsible Person:** Tegryn Jones, Chief Executive **Date:** 30 September 2025

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	The Authority did not include context when writing controls, which made it difficult to understand 'how' the control would assist in managing the impact or likelihood of a risk.	The Authority should consider enhancing the recording of controls through the inclusion of further context to detail how the control reduces the impact and/or likelihood of the risk.	Noted with consideration to the issue being given when re-drafting Risk Register.

Appendix A: Use of strategic objectives and cause → risk → effect approach

The one strategic objective thematically referenced in the risk register was related to climate. The organisation's strategic objective in this area reads: *"To achieve a carbon neutral Authority by 2030 and support the Park to achieve carbon neutrality and adapt to the impact of climate change."* This is a SMART objective which clearly informs the reader as to what should be achieved.

Below is an extract from the November 2024 Risk Register including elements related to this objective:

	Objective	Risk Controls				Key Controls in Place				Assurance that we are achieving objective				Risk Appetite
		Risk Description	Inherent Risk				Residual Risk			Assurance Level required	Internal assurance (2nd Line)	Independent Assurance (3rd Line)	Assurance level achieved	
4	The National Park is protected and conserved	Biodiversity in the National Park is in decline The long-term impact of Climate Change changes the nature of the National Park The special qualities of the National Park deteriorate A failure to meet targets to become net zero	4	4	16	Delivery Plans, Performance Management process, Management team agendas and minutes Partnerships at local and national level. Involvement in PSB Climate Change work and Pembrokeshire Nature Partnership. Work undertaken to prepare for a new Farming in Designated Landscapes scheme.	2	3	6	Medium	Reports to ACSRC and OR Committees Independently Commissioned baseline study State of Nature Reports Advice from experts	Partnership reports at PSB Reports to Welsh Government, e.g. carbon calculator		6 – Medium X Cautious

As you can see, the objective included in the risk register is not the organisation's strategic objective, but is a higher level, more generic aim. As a result of the lack of clarity in the objective the risks which have been identified against it are similarly very general / broad and are not within the control of the Authority.

Climate change is a global issue which cannot be reduced by the National Park alone. If the organisation's strategic objective had been used here the organisation would be focusing on the risks which could prevent the achievement of carbon neutrality by 2030 and not adapting to the impacts of climate change. These risks could then be written using the cause → risk → effect approach to provide enhanced understanding of what 'causes' the organisation feels it is control of and what outstanding elements still need further risk management. We have provided some examples below for demonstration purposes only (they are not intended to accurately reflect the current risks facing the Authority).

Cause	Risk	Effect	Outcome of this approach:
A funding gap of XXX against anticipated requirements…	…is expected to delay our ability to achieve carbon neutrality by 2030…	…resulting in a missed target by c.5 years and lead to reputational damage and potential consequences with Welsh Government.	Future decisions around funding are better informed by the risk information and therefore could be made to prioritise funding for carbon neutrality, bringing the target back towards 2030; or Noting the other objectives the organisation also needs to prioritise, a formal decision could be made to accept this risk and that the target will likely be missed by up to 5 years, along with the consequences that brings.
A lack of expertise within the organisation…	...may impact on us being able to become fully carbon neutral by 2030…	…leading to an inability to appropriately adapt to climate change, reputational damage and potential consequences with Welsh Government.	Management may be able to demonstrate (through controls and assurances over those controls) that this risk is managed to a reasonable level by making funding available for training staff or buying in external support; thereby demonstrating good risk management. If it is considered to remain a risk, further controls may need to be implemented to reduce the risk further.
The implementation of other projects and initiatives may increase our carbon footprint inappropriately…	…which will inhibit our ability to become fully carbon neutral by 2030 or increase our reliance on less appropriate approaches such as carbon offsetting…	…resulting in increased costs to achieve carbon neutrality, a less positive impact on climate change and/or less positive reputational gain.	This shows the interconnectedness of risks and would help inform other projects / initiatives of the importance of remembering the Authority's carbon neutrality ambitions. It would also inform the organisation that implementing formal controls in projects around considering their carbon impact would be a useful control and could be used to inform the Authority of how well it is managing this risk.

As stated above, these are not intended to accurately reflect the specific risks the Authority is facing; merely examples of risks that *could* be considered when identifying risks against the organisation carbon neutrality objective and writing them in the format cause → risk → effect.

ASTARI

Pembrokeshire Coast National Park Authority

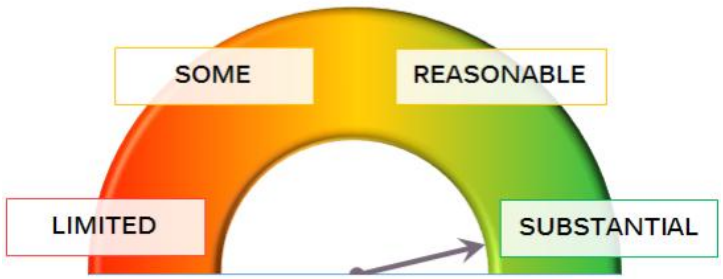
Governance Structures & Processes

Internal Audit Report: PCNPA-2024/25-03

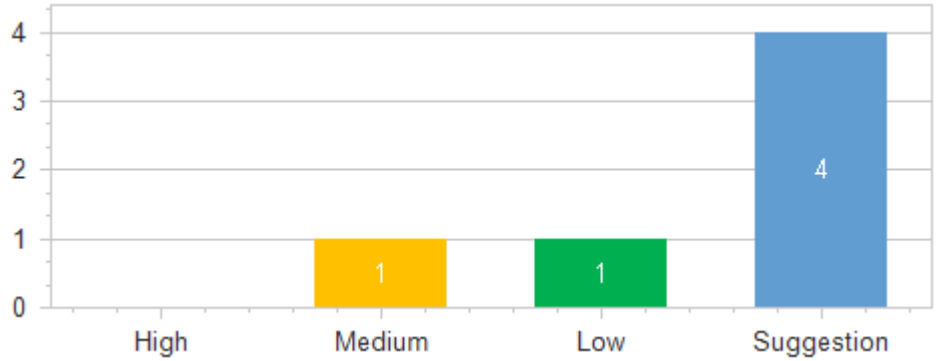
Date: 6 February 2025

1. EXECUTIVE SUMMARY

Level of Assurance

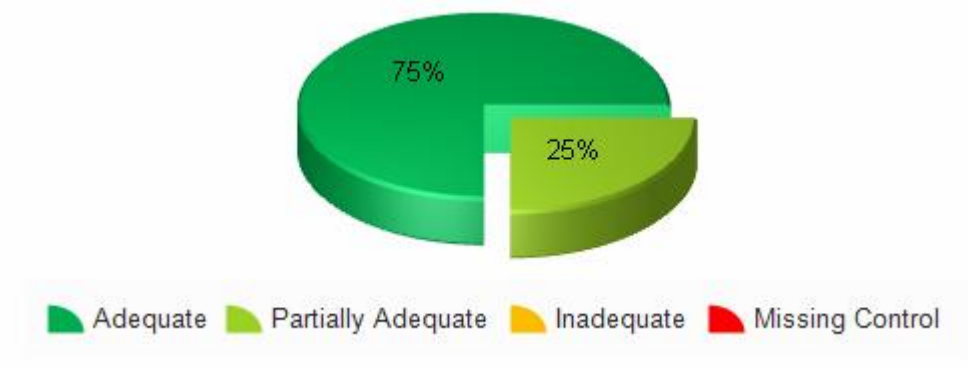


Number & Priority of Recommendations / Suggestions

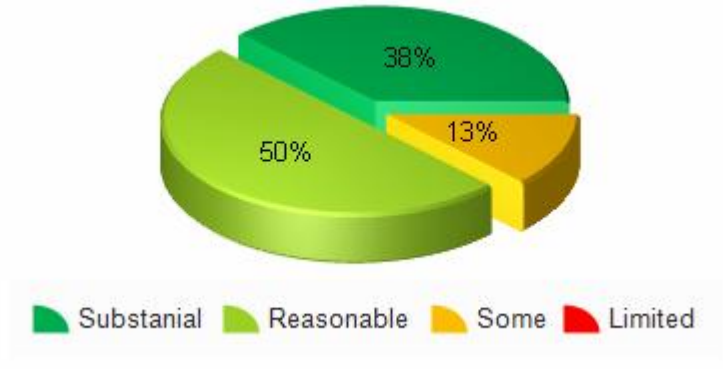


Conclusion:	Taking account of the scope of the review and the issues identified, the Authority can take ***substantial*** assurance that the governance structure of the Authority is in line with good practice and that key governance processes are fit for purpose and align with key expectations.

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 organisation's Code of Corporate Governance and found it to be current, include key expected information, aligned with good practice and had been appropriately approved.
- Our review of the Authority's governance structure found that key expected Committees were included along with a range of other committees and groups that had been established to oversee delivery of objectives and for decision making purposes. However, when comparing the Terms of References (ToR) for the various groups and the Code, we noted a difference in committee structure. We were informed that there had been several mergers in committees but these changes had not been reflected in the Code or in the ToR documentation. Our review also noted that there were likely opportunities improve the efficiency of the organisation through removing duplication between committees / groups.
- Through review of the Terms of References in place we noted that several formats had been used which did not promote consistency and some key information was missing from some of the Terms of References reviewed, which could limit awareness and accountability within the committee structure and could lead to duplication.
- We reviewed the skills mix of the Authority and found that the organisation was reliant upon the Local Authority to nominate members but were involved in the appointment of Welsh Government Members. We were informed that there had been discussion around the requirement of members and the skills required; however, this had not been formalised and assessed against. It may be beneficial for the NPA to work with the Welsh Government to formally identify the required skills and qualities required to effectively contribute to the Authority and help it to achieve its objectives.
- Members last had full Personal Development Reviews (PDRs) in 2023. We were informed that based on feedback from Members, the approach was changed last year to allow for a skills self-assessment, to which only eight (44%) members responded with varying degrees of information. We were informed that PDRs were to be undertaken again in 2025 and have therefore not raised a recommendation.
- We were informed that member training programmes were shaped by the organisation due to the limited information available from PDRs and skills assessments and that training attendance was lower than target, sitting at 58% in September. The data was presented to the People Services Committee for monitoring. The organisation could look to strengthen the wording in the Code of Conduct to ensure that Members are aware that they are expected to attend training to promote accountability.
- We found that there was no centralised programme of reporting in place to detail what information should be presented to each committee or the NPA or the timing of that information; although, we noted that the reporting structure was very transparent and records of what was reported when was clearly available from the organisation's website. A single record of reporting would likely still be a helpful document to ensure that information is provided appropriately and would assist the organisation should a member of the Governance Team be absent. Organisations commonly use this programme to ensure that meetings are not overloaded as well as to identify any duplication and potential streamlining opportunities.
- We saw evidence of a Code of Conduct being in place which included most expected information. We were informed that members should sign at the beginning of their term and, for the 18 members in place at the time of our review we saw evidence of signed declarations being in place for 17 (94%). It was thought that the missing form had been deleted in error and we have therefore considered this to be an anomaly and have not raised a recommendation. We saw evidence of regular reminders and refresher sessions being held on the content of the Code to promote awareness and compliance.
- We saw evidence of all members having had completed a declaration of interest (DoI) in 2024 and these forms were published on the PCNPA website. We also saw evidence of declarations being requested at the start of each meeting and observed this during meetings we attended. Member declarations were recorded on a central register; however, we noted that this document only included declarations made at meetings and not the interests declared within the annual DoI exercise.

- We were informed that emails were sent to all staff annually to request them to declare any interests but there was no need to respond should it be deemed that there is no interest to be declared. During 2024, 10 staff had made declarations. The centralised Officer Interest Register was in place but did not include details of the interest in a transparent or consistent manner.
- We saw that an Annual Governance Statement ("Governance Statement") was produced and reported to the NPA. We saw that the 2023/24 Governance Statement included a satisfied position relating to the Authority's governance arrangements. Through review of the document we noted that there was opportunity to include data and outcomes within the assessment to provide further, evidence-based assurance. We saw that actions were tracked within the Assurance Report; however, the action plan within the Governance Statement could be updated to provide a final status such as implemented, partially implemented or fully implemented.

2. BACKGROUND AND SCOPE

2.1. Objectives and risks

Client's objective:	There is a robust combination of structures and process in place to inform, direct and monitor the activities of the Authority toward the achievement of its objectives.
Risks:	**Strategic Risk 6 -** The Authority fails to meet its statutory governance requirements; The Authority receives critical audit reports from External and/or Internal Auditors; The Authority fails to follow relevant policies in its work and decisions making; and Information and data are not secure. **Internal Audit identified risk:** A lack of clear group / committee roles and responsibilities leads to an increased risk of key duties not being discharged as well as inefficient processes and duplication of efforts.
Engagement objective:	To provide assurance that the governance structure of the Authority is in line with good practice and that key governance processes are fit for purpose, align with key expectations and avoid duplication.

2.2. Background to the Engagement

An audit of Governance Structures & Processes was undertaken as part of the approved internal audit periodic plan for 2024/25.

This was a review of the governance structure of the Authority to provide assurance that it is in line with good practice. This included a review of key committees' and groups' Terms of Reference and other key documentation to provide assurance that the Authority is complying with these and sought to identify any opportunities for enhancing the processes and structures already in place.

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

Areas within scope:	High-level review of the governance structure of the organisation to ensure that it is robust and transparent and that roles are clearly defined and understood, including: ▪ Review of the Agreed Code of Corporate Governance and other governance policies; ▪ Review of key governance documentation, such as the National Park Authority's (NPA) and its committees' Terms of Reference (ToR); ▪ NPA and sub-committee composition and skills mix; ▪ The flow of information between sub-committees and the NPA; and ▪ Key documentation including, for example, declarations of interest and codes of conduct.
Performance measures considered in assignment planning:	Compliance with internal policies and procedures. Alignment of governance structures and processes with good practice.

2.3. Limitations to the scope of the review

- Testing was undertaken on a sample basis only and may be limited by time available and evidence provided within the field work stage.
- We have not commented on whether there is the correct mix of skills and experience on the NPA, only that the organisation had defined what it required and had taken appropriate action to achieve this.
- We have placed reliance upon assurance provided by other specialists within the last 12 months to avoid duplication.
- 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:	13 December 2024
Draft Report Issued:	2 January 2025
Responses Received:	6 February 2025

Auditor:	Sarah Griffiths, Senior Risk Assurance Consultant
Client Sponsor:	Tegryn Jones, Chief Executive
Distribution:	Caroline Llewellyn, Democratic Services Manager

3. ACTION PLAN

Priority:	= Low	= Medium	= High

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R1	We noted that the Code of Corporate Governance and the Terms of References in place were not fully reflective of the current governance structure as some changes had occurred since it was last updated. We also found that key information was not included consistently in committee Terms of References and that multiple formats had been used which all included different information.	Lack of appropriate Terms of Reference could lead to a lack of awareness, consistency and accountability, which could reduce the effectiveness of the governance structure.	The Authority should review its Terms of Reference document to ensure that it is standardised and all current committees and, where appropriate, groups have appropriate Terms of References in place and the Governance Structure is reflective of current arrangements in the Code of Corporate Governance document. We further suggest that the following information should be included as standard in Terms of References: ▪ Purpose; ▪ Roles and responsibility; ▪ Membership and quorum levels; ▪ Frequency of meetings; and ▪ Reporting and escalation.		Agreed – however, since we have all Terms of Reference in place there is limited benefit in having them all in the same format. We have been undertaking a project to move our policies to a standard template and therefore we will undertake a similar project to move all Terms of Reference to the same format.	**Responsible Person:** Caroline Llewellyn, Democratic Services Manager **Date:** 31 March 2026

Ref.	Summary of Finding	Risk	Recommendation	Priority	Agreed Action	Responsible Person & Date for Implementation
R2	The organisation did not require a regular declaration of interests, including nil-returns, to be made by Officers. We noted that the Officer Interests Register was not completed in a consistent manner to promote a good level of understanding of the interests declared.	Undisclosed interests could lead to an inability to ensure unbiased input which could lead to inappropriate decision making, reputational damage and reduce ability to deliver objectives.	The organisation should ensure that any declarations of interests from Officers are recorded in a consistent manner within the Register with appropriate information to promote understanding of the interest so that any conflict in working practices can be avoided. Consideration should be given to requesting 'nil return' declarations where no interests are to be declared to maintain a comprehensive record. There is also scope to use technology to ease the capture of this data such as by using Microsoft Forms.		Partly agree – Current Register acts as an index to more detailed information contained on forms submitted by officers. The nature of the interest can be recorded in the Register going forward. The work required to receive nil-returns by all staff is disproportionate to the risk and benefit. However, the Authority will consider whether there is a benefit in identifying a small number of Senior Managers who should provide a nil-return.	**Responsible Person:** Caroline Llewellyn, Democratic Services Manager **Date:** 31 March 2025

Suggestions in line with good practice or processes seen in other organisations			
Ref.	**Finding**	**Suggestion**	**Management Response**
S1	We noted that Member training attendance was below target at 58% in September 2024. The Code of Conduct signed by Members did not specifically state that Members should attend training and the inclusion of this could help to promote accountability.	The Authority should consider updating the Member Code of Conduct to include reference to the expectation of Members to attend training sessions to promote understanding and accountability.	The Authority has adopted the Model Code of Conduct and will update its Code of Conduct when the Model is revised. An expectation for Members to attend training is set out in the Member Development Strategy and this can be strengthened when that document is reviewed in the coming year.

S2	We found that there was no centralised programme of reporting in place to detail what information should be presented to each committee or the NPA or the timing of that information; although, we noted that the reporting structure was very transparent and records of what was reported when was clearly available from the organisation's website.	The organisation should consider introducing a Programme of Reporting to help manage the flow of information, help to ensure that meetings are not overloaded as well as to identify any duplication and potential streamlining opportunities.	Disagree – there is limited benefit in doing this.
S3	Through review of the Annual Governance Statement we found that the content of the report was very narrative and there was scope to include data such as attendance at training sessions to enhance the assurance in the report. We also saw that the updates against the action plan were narrative and it was difficult to understand whether actions were complete or ongoing.	The organisation should consider the inclusion of further data and outcomes within the Annual Governance Statement to demonstrate the work undertaken to deliver effective governance as well as to provide assurance to the Authority. It would also be advisable to include a current status against action plan actions to allow Members to understand whether the action is complete or not.	We will consider this when reviewing the AGS.
S4	Whilst we accept that current arrangements have not allowed the NPA to define the skill mix of nominated Councillors and Welsh Government Members, understanding these skills and the needs of the NPA for when appointing or nominating members would add value in ensuring that the NPA is effective as possible in overseeing the achievement of the organisation's objectives. This could also be used within the Members' appraisals to determine areas of development required.	Consideration should be given to documenting the skills and knowledge the Authority requires from its members to maximise the effectiveness of the NPA and maximise the value provided to the organisation in achieving its objectives. This could be communicated to the Welsh Government and Local Authority for them to consider and also used during appraisals to identify gaps in skills or knowledge and help to shape the training plan.	Member role descriptions already outline some of the skills and knowledge expected from Members. In addition our training plan identifies training and development needs of members.