COMMITTEE	**GOVERNANCE AND AUDIT COMMITTEE**
DATE	**10 OCTOBER 2024**
TITLE	**OUTPUT OF THE INTERNAL AUDIT SECTION**
PURPOSE OF REPORT	**TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 30 SEPTEMBER 2024**
AUTHOR	**LUNED FÔN JONES – AUDIT MANAGER**
ACTION	**TO RECEIVE THE REPORT, COMMENT ON THE CONTENTS AND SUPPORT THE ACTIONS THAT HAVE ALREADY BEEN AGREED WITH THE RELEVANT SERVICES**

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1. CYFLWYNIAD

1.1 The following report summarises the work of Internal Audit for the period from 1 April 2024 to 30 September 2024.

2. WORK COMPLETED DURING THE PERIOD

2.1 The following work was completed on the 2024-25 plan in the period to 30 September 2024:

Description	Number
Reports on Audits from the Operational Plan	11

Further details regarding this work are found in the body of this report and in the enclosed appendices.

2.2 Audit Reports

2.2.1 The following table shows the audits completed in the period up to September 30, 2024, indicating the relevant assurance level and a reference to the relevant appendix.

TITLE	DEPARTMENT	SERVICE	ASSURANCE LEVEL	APPENDIX
Post-16 Provision in Schools Grant	Education	Schools	High	Appendix 1
Car Parks	Environment	Transport	Satisfactory	Appendix 2
Staff Protection Register	Corporate Support	Support	Satisfactory	Appendix 3
Managing Absences and Referrals Arrangements (Part 1)	Corporate	Support	Satisfactory	Appendix 4
Freedom of Information Requests	Corporate	Research and Information	Limited	Appendix 5
Harbours Statement of Accounts 2023-24	Finance	Accountancy	High	Appendix 6
Welsh Church Fund	Economy and Community	Community Regeneration	High	Appendix 7
Lloyd George Museum Accounts	Economy and Community	Museums and Arts	High	Appendix 8
Plas Pengwaith	Adults, Health and Well-being	Adults	Limited	Appendix 9
Llys Cadfan	Adults, Health and Well-being	Adults	Limited	Appendix 10
Plas Hafan	Adults, Health and Well-being	Adults	Limited	Appendix 11

2.2.2 The general assurance levels of audits fall into one of four categories as shown in the table below.

LEVEL OF ASSURANCE	**HIGH**	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.
	SATISFACTORY	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.
	LIMITED	Although controls are in place, compliance with the controls needs to be improved and / or introduces new controls to reduce the risks to which the service is exposed.
	NO ASSURANCE	Controls in place are considered to be inadequate, with objectives failing to be achieved.

3. WORK IN PROGRESS

3.1 The following work was in progress as at 30 September 2024:

- Education Digital Standards *(Education)*
- General Schools *(Education)*
- School Transport *(Education)*
- School Transport Project Management *(Environment)*
- Car Parks *(Economy and Community)*
- Category Management Follow-up *(Corporate Support)*
- Absence Management and Referral Arrangements Part 2 *(Corporate Support)*
- Advice & Consultancy and Supporting Ffordd Gwynedd Reviews *(Corporate)*
- Safeguarding Arrangements - Establishments *(Corporate)*
- Proactive Prevention of Fraud and Corruption and the National Fraud Initiative *(Corporate)*
- Whistleblowing *(Corporate)*
- Use of External Meeting Rooms *(Corporate)*
- Mobile Phones *(Finance)*
- Creditors System – Key Controls *(Finance)*
- Public Toilets *(Highways, Engineering and YGC)*
- Street Cleaning *(Highways, Engineering and YGC)*
- Smallholdings – Follow-up *(Housing and Property)*
- Housing Waiting Register *(Housing and Property)*
- Gwynedd Homebuy *(Housing and Property)*
- Housing Support Grant *(Housing and Property)*
- Elections Act Wales *(Corporate Leadership Team)*

4. RECOMMENDATION

4.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 1 April 2024 to 30 September 2024, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

Appendix 1

POST-16 PROVISION IN SCHOOLS GRANT 2022-23

1. Background

1.1 Cyngor Gwynedd was allocated over £4m by the Welsh Government to provide post-16 education in mainstream schools. In addition, over £200k was allocated for the provision of adult learning.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to review the 'Sixth Form and Adult Learning in the Community' allocation certificate for the year 2023-24, ensuring that clear accounting records have been kept indicating that Welsh Government funding has been received and then distributed to schools and the Community Learning Service, for the purposes as stated in the award letter(s).

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
HIGH	**Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.**

4. Main Findings

4.1 Assurance can be given that the 'Sixth Form and Adult Learning in the Community' allocation certificate for the year 2023-24 is appropriate. Based on the tests carried out, an appropriate audit trail for the figures was seen and the internal controls in place can be relied upon to achieve objectives.

Appendix 2

CAR PARKS (ENVIRONMENT)

1. Background

1.1 The Council has 55 chargeable car parking sites under the care of the Environment Department with 89 parking fee collection machines. The Department has begun the process of upgrading their machines to be able to accept cards as well as cash. As an alternative, the Department has an agreement to collect fees over the internet with Pay By Phone, a company that accepts credit and debit cards over the internet. The Council has additional car parks that are managed by the Economy and Community Department who have separate arrangements to that of the Environment Department.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place to collect income from car parks, review a sample of new parking sites to ensure proper processes are in place for collection of monies, the prompt recovery of investment costs, identify any obstacles and /or ability to resolve promptly. To achieve this, the audit encompassed reviewing a list of chargeable car parks and ensuring that income was properly collected, review new car parks established to ensure proper processes were in place for timely collection of fees. The audit was limited to Council assets only i.e. the audit did not include private car parks under the Council's management agreements.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	2
LOW	0

5. Main Findings

5.1 During the audit (May 2024), the Environment Street Parking and Works Manager reported that the Service had begun to replace existing Pay and Display machines. At the time, it was reported that 10 machines were accepting credit cards as well as cash. An additional 15 machines with new 'card readers' were ordered. It was explained that there is no specific budget available for the replacing parking machines and that the Service uses the parking works budget to cover the costs (around £4,200 per machine), and therefore it will probably take a few years to upgrade every machine. Meanwhile, the "Paybyphone" app is available for people to use across the County. However, it was recognised under the Council's IT Digital Plan that one of its objectives is to improve customer engagement by providing payment machines. There is a possibility that the machines may be eligible for consideration to receive funding under the IT Digital Scheme.

5.2 A sample of contracts were reviewed and found to be appropriate.

5.3 In addition to a three-year maintenance agreement paid on a quarterly basis, the Department has an agreement for a web-based system for monitoring car park use. The Street and Parking Manager explained that the system was able to generate reports from simple data e.g. for reviewing fees, identifying times visitors were staying, which car parks were being used and how much visitors were willing to pay. The system also allows live verification of information, such as the ability to flag which ones are full/ with spaces and can change the tariff themselves for summer and winter months on the machines instead of relying on the company to physically change the software of the machines twice a year.

5.4 However, the Council does not appear to be reconciling charges against the number of tickets being issued. The Street and Parking Manager explained that the data can be collected to carry out a reconciliation, but it is not reasonable to do so with the current resource. Tickets are only reconciled for third party car park agreements so that charges can be calculated.

5.5 Two new car parks that have recently been established namely, Y Glyn in Llanberis and the car park by the beach in Dinas Dinlle have been reviewed to ensure that cash collection machines have been installed promptly and that appropriate cash collection arrangements are in place. It was discovered during the audit that these car parks were managed by the Economy and Community Department which was outside the scope of this audit.

5.6 A Parking Strategy (effective from 1st April 2021) was found to be in place for car parks under the care of the Environment Department. It is set out under section 9.1 of the strategy

'Car park assets in other sections:

9.1 The Council clearly owns a number of car parks in Country Parks, Leisure Centres etc. And obviously the management procedures of different Departments in the Council differ from each other in terms of how they deal with the assets.

9.2 As the Council is seen by the public as one single entity, it is considered worthwhile to adopt the proposals outlined in this review for all parking assets owned by the Council. It is also considered that it would be much more practical if the management of all assets sat under the Environment Department. This can ensure consistent management of the assets.

9.3 It is proposed that the Economy and Community Department transfer their assets under the management of the Environment Department and working together to ensure that an adequate income stream goes towards the Economy and Community Department's savings targets.'

5.7 As of June 2024 the assets do not appear to have been transferred. The Assistant Head of Economy and Community explained that there has been limited discussion since the strategy was adopted between the departments but some of the management aspects from the Environment Department such as acting on enforcement arrangements may be of advantage to them.

6. <u>Actions</u>

The relevant Services are committed to implementing the following steps to mitigate the risks highlighted:

- **Check whether pay and display machines can be funded through the IT Digital Strategy Plan to ensure Gwynedd car park machines are promptly refurbished.**
- **Continue to implement towards the strategy to offer options to collaborate/transfer assets for managing car parks with the Economy and Community Department to improve the Council's car park management processes where possible.**

Appendix 3

STAFF SAFETY REGISTER

1. Background

1.1 The Staff Safety Register contains information about individuals, animals or locations that may pose a risk to Cyngor Gwynedd staff members. It is available to any members of staff dealing with the public, or visiting domestic, private, or public settings, to identify any risks before meeting/visiting.

2. Purpose and Scope of Audit

2.1 The scope of the audit was to ensure that suitable arrangements were in place for identifying and mitigating the risks faced by Council staff working with the public. In addition, ensuring that relevant staff have access to the information in a timely manner, and that appropriate arrangements are in place for protecting staff wellbeing. To achieve this, the audit entailed reviewing arrangements for reporting and recording events, as well as selecting a sample of different risks recorded on the Staff Safety Register, ensuring that the expected documentation was present, and the record was detailed, up to date, and accurate.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	2
LOW	1

5. Main Findings

5.1 The Staff Safety Register is maintained on the Health and Safety Database, and an application must be made to gain access. On August 1st, 2024, there were 54 entries on the register, a mix of incidents involving individuals, animals, and locations. A sample of 50% were selected for a detailed review, a total of 27 entries. It was observed that the time taken between the date of the event and the date of entry on the register varied between 0 and 282 days. The Health and Safety Team Leader explained that there are reasons why an event can take some time to be registered, such as:

- The original event does not reach the register criteria, but further events or patterns trigger an entry further on. Previous events continue to be included to show escalation or a pattern.
- A serious incident means that the department has looked back at the history and asked for evidence of a historical event for the record (perhaps from different departments), which can be time-consuming.
- Waiting for legal advice (e.g. because someone is under 18, an individual working for or with a close contact to the Council, sensitive information).
- Moved from the old system, so unmodified input date at the time.
- HS11 (incident reporting form) late arrival.

5.2 Event review/retention periods on the register are based on the risk category and commence from the date the entry is created on the register. For 3 out of 27 of the sample, it was found that the review date did not match the risk category or creation date, with the review date of 1 other event calculated using the HS11 date, not the date of creation of the event on the register. The Health and Safety Team Leader explained that records received reviews much more frequently when using the old system, and those review periods were transferred to the Health and Safety database, where the current register is maintained. As such, the staff responsible for updating the register have to adjust the review date themselves, with the wrong dates inputted for 4 in the sample. They were immediately corrected.

5.3 During the audit, 5 entries were found on the register with the date of review having expired, with one over 6 months old. It has been confirmed that the time taken to review records is dependent on Managers responding, and the amount of information that needs to be processed. The service works closely with and reports regularly to the Data Protection Team, who are satisfied with the service's data retention and disposal arrangements.

5.4 Following an application to the Information Technology service, a list of all staff with access to the register was received along with their access rights. It is possible to obtain the following rights:

- 'Search', which allows only to search for specific persons or locations.
- 'User', which allows access to the full register with key information only.
- An 'Administrator', who has full access to the register with all information, which is limited to service staff, and Health and Safety Forum staff members.

5.5 A sample of 32 staff members (5%) were selected from the system to be verified further. 6 were not considered as they had now left their employment with the Council. Of the remaining 26, given the nature of their posts, it is deemed acceptable for them to access the register, 25 of whom also have reasonable rights. However, there was 1 member of staff with 'Administrator' rights, despite not working for the service nor being a member of the Health and Safety Forum. The Health and Safety Team Leader confirmed that the member of staff involved had previously been a member of the Forum and would amend their rights immediately.

5.6 It was confirmed during the audit that the Information Technology service was in the process of creating a new system for the Health and Safety service, including the Staff Safety Register. The new system will enable definite review periods to be set and reminders sent when review dates are approaching. The Health and Safety Team Leader stated that staff awareness of the register was low, with a number of staff unaware of its existence, and others having forgotten that they had access.

5.7 It was found that face-to-face 'Personal Safety' training has not been offered to members of staff since 2018, but that an E-module of the same name is available on the E-learning Portal. Of the 26 users in the sample, their training records were reviewed and none had completed the 'Personal Safety' E-module. 12 have completed face-to-face training between 2013-2018, with 8 having completed some form of relevant training. 6 were not found to have completed any relevant training.

6. Actions

The Health and Safety Team Leader is committed to implementing the following steps to mitigate the risks highlighted:

- **Continue to collaborate with IT for the creation of a new system that will enable creating firm review dates, and send reminders when review dates are approaching, and in the meantime, remind administration staff to ensure review dates are calculated correctly.**
- **Continue to collaborate with IT for the creation of a new system that will enable the export of data in relation to users.**
- **Encourage department representatives in the Health and Safety Forum to arrange suitable training for any staff working with the public.**

Appendix 4

MANAGING ABSENCES AND REFERRAL ARRANGEMENTS

1. Background

1.1 Cyngor Gwynedd has developed a managing absences module on the Council's self-service system which will replace the current paper regime of services completing SA1, SA2 and SA3 forms along with keeping a record of the absence on a separate document. It will abolish the administrative work within Services where administrators have to collect information from Team Managers and Leaders as well as having to submit an absence report on an Excel spreadsheet to the Support Service on a monthly basis.

1.2 The new policy - Managing Sickness Absences will come into force on 1st June 2024 and the new recording system will be in effect from 10th June 2024. Following a request from the Support Service Manager, it was agreed to conduct the audit in two parts. Part-one reviewing the processes of building and developing the system controls and the second part to measure the performance of the system when the system becomes operational.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that key controls had been established during the development of the management absences module on the self-service system. To achieve this, the audit included checking and reviewing the internal controls established during the development of the module.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
SATISFACTORY	**There are controls in place to achieve objectives but there are aspects of the arrangements that need tightening to further mitigate the risks.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	4
LOW	0

5. Main Findings

5.1 The Auditor tested the staff sickness absence management test system and found the system to be operationally appropriate for recording staff sickness absences, completing the return-to-work form and referrals to Occupational Health.

5.2 New policies have been established, staff have been notified and comprehensive training provided on the new sickness management procedures along with information circulated to all Council staff.

5.3 The system has been developed in-house by the Council's IT Service. A project officer was responsible for coordinating the project with accountable officers responsible for development, testing and training.

5.4 Controls for confirming individuals' work patterns, entering mandatory information and 'triggers' on the system were in place to notify management of the next steps required/remind managers to update/ implement the next step on the system.

5.5 During the training on the new procedures and the use of the system, it was reported that users could export information and create reports, this was not tested during the audit. In addition, no confirmation has been received of the reminder emails that will be sent to staff and management to remind them/inform them of updating illness records. The Project Officer explained that the system currently allows the export of the sickness record document for recording only, the ability to create and run reports has not been built into the system by the IT developers but this is in the pipeline. The Project Officer reported that an audit trail existed for managing the risk of misuse e.g. exporting excess paper copies for recording sickness occurring unnecessarily.

5.6 The risk register was reviewed and confirmed that main risks / controls have been considered such as data protection regulations, sickness data record retention period including "fit notes" on iGwynedd, an audit trail for identifying personnel entering sickness data, delegation to officers down the management tree only with the confirmation emails to continue to be sent to the attention of the line manager. In addition, the system demonstrated that mandated boxes need to be completed and it was reported that individuals are unable to input sickness themselves.

5.7 The sickness recording system is based on the core data from the “System Swyddi Gwynedd (SSG) which is updated by the Payroll Service regularly through Cyborg. SSG operates on job numbers and therefore the permission rights on the sickness recording system have been set against job numbers designated for each officer. As a result, any adjustments by Payroll e.g. new starters, leavers etc. results in immediate updating of the sickness recording system. The Project Officer reported that the following departments/services are responsible as follows:

- Support Service responsible for receiving staff queries regarding the system's operation.
- Human Resources for any query regarding the sickness policy.
- Service Managers to report on their service's sickness statistics.
- HR with the role for monitoring compliance.

5.8 It was expressed that while the Support Service deals with system enquiries, the officers don't have any permission rights on the system to allow them to make changes on the system which means requests to implement changes on the system will then need to be forwarded to the system developers for implementation. A request from the Support Services Manager has been made for these rights to be permitted to the Support staff so that there is no reliance placed on the developer and their team to provide support to Managers/Leaders, and that Support Service can deal with these requests without reliance on the developers. Until this is operational, the team will need to manage the risk of sensitive data falling to the wrong departments/officers, i.e. ensure the support staff refer all requests directly to the developers and not the IT Helpdesk.

5.9 The base for the module appears to be functional but consideration should be given to the following key controls:

- Certainty over backup arrangements and data recovery.
- The ability to create reports, manage data and extraction of information is restricted to specific officer(s).

5.10 In addition, it was found adequate project management arrangements were in place based on the Agile methodology.

6. Actions

The Project Officer has committed to implementing the following steps to mitigate the risks highlighted:

- **Receive assurances from IT that information is successfully saved or that unsuccessful backups can be identified.**
- **Conduct a recovery test of backup data on the module and ensure that the data has been correctly recovered by confirmation with relevant service/s.**
- **Check compliance with Data Protection Regulations i.e. review a privacy statement.**
- **That an audit trail exists for identifying the person running reports and exporting forms.**
- **Communicate contact details for main officers that will be responsible for handling enquiries/operations in the system.**
- **Monitor system usage and compliance.**
- **Continue to develop and test the system to ensure bespoke sickness absence management reports can be generated.**

Appendix 5

FREEDOM OF INFORMATION REQUESTS

1. Background

The Freedom of Information Act 2000 came into full force in January 2005. The Act gives the right to individuals to grant a request for a variety of information from a public authority and set the guidelines for how those requests should be responded to. The Act also outlines what kind of information is exempt from availability. The Act (Section 10) states that applicants have the right to expect a response by the twentieth working day after the application is received.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place for administrating and processing requests for information through the Freedom of Information Act 2000. To achieve this, the audit encompassed reviewing the arrangements in place for receiving, distributing, collecting, and responding to requests under the Act, together with the recording of requests to produce statistics and performance assessment.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**Although controls are in place, compliance with the controls needs to be improved and / or introduce new controls to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	2
LOW	0

5. Main Findings

5.1 In accordance with the Freedom of Information Act 2000, the target date for a response is 20 working days, but if it appears that the Council will not be able to respond within the target date, the applicant should be notified and the reason for the delay explained.

5.2 The Support Service has an information request system on a SharePoint system which was developed internally and purposefully for recording and tracking requests for information received. A dedicated officer has been appointed for tracking the applications on the central system and to forward the applications to the correct departments.

5.3 According to the UK Government's freedom of information statistics, in 2023, across all monitoring bodies, 81% of requests were responded to on time, which is down from 86% in 2022. It has been seen that Gwynedd's performance is slightly lower than these statistics with a timeliness rate of 77%. There were 1,160 applications received during the financial year 2023-24, and 267 of these applications did not receive a response within the permitted timeframe. These statistics are reported to the Governance Information Group and are reported to the performance challenging meeting of the Corporate Support Department.

5.4 The 'WhatDoTheyKnow' website facilitates requesting information from UK public authorities and publishes the applications online. A sample of 20 applications made through the website were reviewed, cross-referencing them with the Council's internal system, and it was found that only 1/20 of the applications received their response within the timeframe allowed by the Act. Of the 20 applications, 12/20 were found where the applications have been sent to specific officers but no response has been given, 1/20 are waiting for an internal review to be completed (where the applicant is unhappy with a response), 2/20 received a reply but there are follow-up questions from the applicant and no responses further given. There is no record of 3/20 being recorded on the Council's internal system, and one of the requests was not a freedom of information request but referred to the relevant service. One of the applications was found to date back to 2019, and no response has been given.

5.5 From the sample checked, it was seen that the Council refused to provide any answers that would be contrary to the General Data Protection Regulation and requests that are beyond the act, as well as not providing a full response if they do not have the data.

5.6 The Freedom of Information Act 2000 requires all public authorities to maintain a Publication Scheme approved by the Information Commissioner. The Publication Scheme describes the information the Council publishes or intends to publish. It was seen that Cyngor Gwynedd's Publication Scheme is on the Council's website. The Publication Scheme contains a list of the different areas of information that has been published and is available for public viewing, as well as points of contact for the different areas of information. It was found that the Scheme has not been updated but there are plans to do this.

6. Actions

The Research and Information Service has committed to implementing the following steps to mitigate the risks highlighted.

- **Continue to encourage departments to respond within the statutory timeframe.**
- **Maintain the departmental contact point network.**
- **Be proactive by providing more datasets on the website (open data).**
- **Update the Publication Scheme and keep it up to date on the Council's website.**
- **Ensure officers within departments respond to requests within the statutory requirements.**

Appendix 6

HARBOURS' ACCOUNTING STATEMENT

1. Background

1.1 The Harbours Act 1964 requires that Gwynedd, as a harbour authority, prepares an annual statement of accounts relating to Pwllheli, Porthmadog, Abermaw and Aberdyfi harbour activities.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to confirm the accounts on the Harbours' annual accounting statement for the 2023/24 financial year, as well as to confirm that appropriate internal controls were in place.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
HIGH	**Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.**

4. Main Findings

4.1 Assurance can be given that the Harbours' accounting statement for the 2023/24 financial year was appropriate. Based on the tests carried out, it was seen that there was an appropriate audit trail for the figures and that the internal controls could be relied upon to achieve their objectives. Appropriate accounts have been kept and bank reconciliations are made as part of Council wide bank reconciling.

4.2 Based on the tests carried out it was found that a sample of payments were supported with appropriate invoices or receipts, and that VAT had been properly treated. There was also an appropriate trail for a sample of other transactions, such as internal transfers.

4.3 Staff costs are administered through Cyngor Gwynedd's Payroll Unit where PAYE and National Insurance requirements have been appropriately applied. These staffing costs are appropriately recorded in the statement.

4.4 The fixed asset figure on the accounting statements is supported by an asset register.

Appendix 7

WELSH CHURCH FUND

1. Background

1.1 The Welsh Church Fund derives from the Welsh Church Act 1914. Cyngor Gwynedd administrates the fund and allocates the interest as annual grants to registered charities in Gwynedd to promote and support activities which will benefit the people of Gwynedd and enrich the local communities. Organisations such as local Eisteddfodau, activities within the arts, education, leisure and sports, conservation, and charities that support sick or disabled individuals can apply for the grant. It's possible to apply for any amount, but individual grants will tend to be between £100 and £3,000.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to conduct the independent examination of the Welsh Church Fund accounts for the 2023/24 financial year, in accordance with the requirements of the Charity Commission.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
HIGH	**Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.**

4. Main Findings

4.1 In accordance with the requirements of the Charity Commission, an independent audit of the accounts must be carried out if the fund's annual income is over £25,000. Fund money was invested in order to attract interest, so the income threshold was exceeded in the 2023/24 financial year.

4.2 Assurance can be given that the Welsh Church Fund accounts for the 2023/24 financial year are appropriate. Based on the tests carried out, an appropriate audit trail for the figures were seen.

Appendix 8

LLOYD GEORGE MUSEUM ACCOUNTS

1. Background

The Lloyd George Museum and his childhood home, Highgate, Llanystumdwy, traces the life of the former Prime Minister of the UK. The museum is a registered charity and is administrated by Cyngor Gwynedd with help from Friends of the Museum who support and assist with the development of the museum and its educational use. Because the museum's income exceeded the threshold of £25,000, the trustees' account and annual report for 2023-24 must be submitted to the Charities Commission, including an independent examiner's report of the accounts.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to complete the independent examiner's report on the museum's 2023-24 accounts, giving assurance that what is presented to the Charities Commission is correct. This was done by reconciling the accounts with the Council's main accounting system, ensuring that all transactions were relevant to the Museum.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
HIGH	**Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	0
MEDIUM	0
LOW	1

5. Main Findings

5.1 The accounts for 2023-24 were found to be appropriate and the independent examiner's report was completed to state this.

5.2 Despite their efforts, the Museums and Arts Service has not been able to upload the 2022-23 accounts to the Charity Commission website, which currently indicates that they are late, as the deadline of 31 January 2024 has passed. The Service plans to revisit this.

6. Actions

The Service has committed to implementing the following steps to mitigate the risks highlighted.

- **Submit the charity's financial statements to the Charity Commission website.**

PLAS PENGWAITH

1. Background

Plas Pengwaith is located in Llanberis and provides care for up to 31 residents over the age of 18, specializing in supporting people living with dementia.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place for the proper management and maintenance of the home in accordance with applicable regulations and standards. To achieve this, the audit reviewed that the home's arrangements were adequate in terms of administration and staffing, budgetary control, procurement of goods and receipt of income, health and safety, performance monitoring along with ensuring that the service users and their properties were protected.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**Although controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	3
MEDIUM	2
LOW	0

5. Main Findings

5.1 A sample of 10 invoices were reviewed, but as the home did not keep a record of the dates that orders were placed, it could not be confirmed that they had been placed before receiving the invoice. The Clerk confirmed that she receives several invoices to pay without an order to support them, but that on similar occasions, she asks the Manager or the kitchen staff (who have authority to raise an order) about the invoice before paying. It was agreed from now on to record the dates orders were raised.

5.2 During the visit it was seen that several fire alarms, emergency lights, escape routes, and fire extinguishers tests were missed. The Manager confirmed that she had recently delegated the duty of reviewing the Fire Log Book to a specific member of staff, in an effort to identify when tests are missed in the future.

5.3 The quantity of medicines did not reconcile with the records of the home on every occasion. A sample of 5 residents' medicines were reviewed during the visit, 7 different medicines in total. For one, there were 10 more Paracetamol tablets present which had not been recorded on the stock checks. The Assistant who was present at the time confirmed that this would be noted in the 'hand-over' notes. The Manager confirmed at our closing meeting that the records would be updated immediately.

5.4 Homes receive several Quality Assurance Inspections annually, carried out internally by the Adults, Health and Wellbeing Department, as well as Health and Safety Inspections from the Property Service, and Medicine Inspections from the NHS and the local pharmacy. If any element of the Internal Audit had already been checked recently as part of the Quality Assurance, Health and Safety, or Medicine Audits, it was decided to rely on the reports, accepting their assurance.

5.5 However, it appears that recommendations arising from Quality Assurance Audits or Medicine Audits are not implemented on every occasion. Checks on the temperature of the fridge and medicine room continue are not carried out on a daily basis, although the pharmacy highlighted this in their inspection dated January 10th 2024. In addition, staff supervision and appraisals continue not to be completed in a timely manner since a Quality Assurance Audit on 5th February 2024. The Manager explained that arrangements are already in place for holding supervisory meetings. Following the visit to the home, it was confirmed that all members of staff have received an appraisal.

5.6 Medicines are not kept at the correct temperature. The temperature of the medicine room is expected to be kept below 25°C, and the fridge between 2°C-8°C. On the day of the visit the room was 25.7°C, and the fridge 12.8°C. The records maintained confirmed that the temperatures were too high on several occasions. In addition, it was seen that the thermometer for measuring the temperature of the room was located in a different room to where the medicine is kept. Arrangements were made during the visit to move the thermometer to the correct room. Following the visit, the Manager discovered that the fridge had been switched off and since it was switched on, the temperature of the fridge has been within the correct range.

5.7 The Manager stated that she receives budgetary control reports from the Finance Department on a regular basis, but believes that due to a lack of appropriate training, further support is needed to understand them, and expressed an interest in receiving budgetary monitoring training.

6. Actions

The Manager and Clerk has committed to implementing the following actions to mitigate the risks highlighted.

- **Ensure that an order is raised on every occasion when ordering goods, keeping a record of the date.**
- **Ensure that fire tests are carried out in a timely manner.**
- **Ensure that correct medication stock checks are carried out weekly, as well as monthly checks when ordering stock.**
- **Remind night staff to check and record the temperature of the fridge and medicine room daily, and to monitor for a period after the thermometer was moved and consider options for controlling the temperature if it is not within the expected ranges.**
- **Strive to act on the recommendations of external audits promptly, in particular staff supervision.**

LLYS CADFAN

1. Background

Llys Cadfan is located in the town of Tywyn and provides care for up to 33 residents over the age of 18, specialising in supporting people living with dementia.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place for the proper management and maintenance of the home in accordance with applicable regulations and standards. To achieve this, the audit reviewed that the home's arrangements were adequate in terms of administration and staffing, budgetary control, procurement of goods and receipt of income, health and safety, performance monitoring along with ensuring that the service users and their properties were protected.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**While controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	6
LOW	1

5. Main Findings

5.1 Homes receive several Quality Assurance Audits annually, carried out in-house by the Adults, Health and Wellbeing Department, as well as Health and Safety Audits by the Property Service, and medicines inspections by the NHS and the local pharmacy. If any element of the Internal Audit had already been reviewed recently as part of the Quality Assurance Audit, Health and Safety Audit, or Medicine Audit, it was decided to rely on the reports, accepting their assurance.

5.2 A Quality Assurance Audit was carried out on staff files at Llys Cadfan Home in March 2024, where general training, Social Care Wales memberships, supervision and appraisal records, as well as employment agreements were reviewed. Although not everything was present and correct at the time, it was found that the recommendations from the Quality Assurance Audit had been implemented by the time the home was visited, and the staff files were complete.

5.3 A Medicine Audit was conducted by the local pharmacy in January 2024. It was noted that the home kept proper records, and that suitable arrangements were in place for the ordering, storing, administration, and disposal of medicines. It was confirmed in the report that staff training was up to date, and all staff had adopted the Medication Policy. However, during the visit, it was observed that the door to the medication room was unlocked. It was immediately closed by the Manager. It was noticed that there was already a note on the door reminding staff to lock it on all occasions.

5.4 It was found that the amounts of medications did not agree with home's records on all occasions. Medications for 6 residents were checked, 9 different medications overall. For one resident, records at the home confirmed 125 'Paracetamol' tablets for them, with only 121 in the box. Following the visit, the Manager confirmed that the discrepancy was due to the failure of one member of staff to identify the correct number of tablets on the records, but the records have now been corrected.

5.5 There was no 'Safeguarding' poster displayed at the home. However, 'Safeguarding' cards were kept near the visitors' book. The Manager confirmed that she would arrange for a poster to be displayed.

5.6 It was observed that visitors did not sign the visitors' book on all occasions when leaving the home. The Manager indicated that she would arrange for a poster to be placed next to the visitors' book reminding everyone to sign out.

5.7 Some of the home's generic risk assessments have not been reviewed since 2022 but are in the process of being updated.

5.8 It was found that the home's Asset Register was not up to date. However, the Manager confirmed that arrangements were already in place for night staff to update it.

5.9 A sample of 4 staff members' leave cards were checked during the visit, to ensure that the annual leave entitlement agreed with the formula. For one member of staff, the formula confirmed a leave entitlement of 270.1 hours, but the leave card stated only 240. The Manager confirmed that this was an error and corrected it immediately. She expressed that there was a risk of errors when calculating leave entitlement because the original formula document was received back in 2021, but since then, any modifications are being received through emails from the Human Resources Adviser, with the Manager having to update the original document.

The formula document was seen during the visit, and it was noticed that several formulas had been crossed out and new formulas added by hand. It is thought it would be easier if one official document is circulated along with clear guidelines.

5.10 It was observed that the Home has a comprehensive Statement of Purpose, but its quality is not up to the standard expected by the Authority, with font size and style varying throughout the document, capital letters in the middle of sentences, unhighlighted headings, and instructions on how to complete the document not deleted.

5.11 The Manager stated that she receives budgetary reports from the Finance Unit on a regular basis, and although she conducts a basic check, she has not received any relevant training. She expressed an interest in budgetary monitoring training.

6. Actions

The Manager is committed to implementing the following actions to mitigate the risks highlighted.

- **Staff have been reminded of the need to keep the door to the medication room locked.**
- **Ensure medication stock records are accurate and reconcile.**
- **Display a 'Safeguarding' poster in an appropriate place, where all staff can see it.**
- **Arrange for a poster to be placed next to the visitors' book reminding everyone to sign when leaving.**
- **Ensure risk assessments are up to date and receive regular review.**
- **Ensure that the Asset Register is updated and reviewed annually.**
- **Ensure accuracy in calculating staff leave entitlement.**
- **Review the standard of the Statement of Purpose.**

Appendix 11

PLAS HAFAN

1. Background

Plas Hafan is located in Nefyn and provides care for up to 30 residents over the age of 18, and is under the management of a new Manager since February 2024.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place for the proper management and maintenance of the home in accordance with applicable regulations and standards. To achieve this, the audit reviewed that the home's arrangements were adequate in terms of administration and staffing, budgetary control, procurement of goods and receipt of income, health and safety, performance monitoring along with ensuring that the service users and their properties were protected.

3. Audit Level of Assurance

3.1 The controls for risk mitigation were examined. The auditor's assessment concludes that the level of assurance of the audit is as follows:

Assurance Level	Description
LIMITED	**While controls are in place, compliance with the controls needs to be improved and/or new controls introduced to reduce the risks to which the service is exposed.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	5
LOW	1

5. Main Findings

5.1 Homes receive several Quality Assurance Audits annually, carried out in-house by the Adults, Health and Wellbeing Department, as well as Health and Safety Audits by the Property Service, and medicines inspections by the NHS and the local pharmacy. If any element of the Internal Audit had already been reviewed recently as part of the Quality Assurance Audit, Health and Safety Audit, or Medicine Audit, it was decided to rely on the reports, accepting their assurance.

A Quality Assurance Audit was carried out on the staff files of Plas Hafan in February 2024 where general training, Social Care Wales membership, supervision and appraisal records, as well as employment contracts were reviewed. It was noted that everything was present and up to date in their inspection.

5.2 The home has a comprehensive Statement of Purpose, but it has not been presented to the standard expected by the Authority, with the size and style of the font varying throughout the document, headings not highlighted, and guidelines on how to complete the document not deleted.

5.3 Resident care plans are not kept in a secure location. The plans have been kept in cupboards in the hallway. Although the cupboards are locked, the keys are kept on a hook above, where all visitors to the home have access. The Manager agreed to consider different options for better safe storage of the keys.

5.4 Residential homes have now disposed of staff time sheets, with the Managers recording their staff's hours in a spreadsheet to be submitted to the Payroll Service. A sample of 4 members of staff was selected, ensuring that their hours for April 2024 on the work 'rota' agreed with the spreadsheet. Of the sample, 3 out of 4 reconciled, with a discrepancy of 6 hours for one member of staff. The 'rota' for the week ending April 27th confirmed that 45 hours had been worked, with 51 hours recorded on the spreadsheet. The Manager suggested that the discrepancy arose from an error in the spreadsheet in March 2024, which has been corrected in April. However, no audit trail or supporting records were found for the adjustment.

5.5 The home’s asset register is not reviewed annually. Several receipts were seen in the file for new items that had been purchased but had not been added to the register. The Manager explained that a review would be carried out in the near future.

5.6 A 'Safeguarding' poster was not displayed in the home. The Manager confirmed that it had only been received. Following the visit, a confirmation was received that the poster was now displayed.

5.7 For some medicines, a stock check had not been conducted for two weeks from the date of the visit, where they are expected to be carried out weekly. In addition, it was seen that several medicines did not reconcile with the records of the home on every occasion. 5 residents' medication was reviewed, 9 different medications in total. For one resident, there were 2 more 'Paracetamol' tablets than what had been recorded by the home, with another resident's 'Apixaban' tablets short by 28 compared to their records.

5.8 A sample of 10 members of staff was selected to review their training records, specifically, Fire, First Aid, Safeguarding, Movement and Handling, and Medicine training. Several members of staff training had either ended or had no relevant training at all. The Manager confirmed that she is aware of this and maintains a record of those staff for organizing training soon.

5.9 The Manager stated that budgetary control reports are received from the Finance Department on a regular basis, but believes that due to a lack of appropriate training, further support is needed to understand them, and expressed an interest in receiving budgetary monitoring training.

6. Actions

The Manager has committed to implementing the following actions to mitigate the risks highlighted.

- **Review the standard of presentation of the Statement of Purpose.**
- **Ensure that keys to the cupboards where care plans are kept, are kept in a safe place, out of reach of visitors, where only staff have access.**
- **That any adjustments to the hours of the work 'rota' are recorded, either on the 'rota' or on the payroll spreadsheet, so that any adjustments/discrepancies can be explained.**
- **Ensure that the Asset Register is updated and reviewed annually.**
- **Display a 'Safeguarding' poster in an appropriate place, where all staff members will see it.**
- **Ensure that medication stock checks are carried out weekly.**
- **Organize Fire, First Aid, Safeguarding, Movement and Handling, and medicine training, for the relevant staff members, ensuring that the training is regularly renewed.**