COMMITTEE	**GOVERNANCE AND AUDIT COMMITTEE**
DATE	**9 OCTOBER 2025**
TITLE	**OUTPUT OF THE INTERNAL AUDIT SECTION**
PURPOSE OF REPORT	**TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 28 SEPTEMBER 2025**
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. INTRODUCTION

1.1 The Global Internal Audit Standards, Standard 11.3, Communicating Results state *"the chief audit executive must communicate the results of internal audit services to the board and senior management periodically and for each engagement as appropriate."*

1.2 Furthermore, Standard 15.1, Final Engagement Communication states *"the chief audit executive must disseminate the final communication to parties who can ensure that the results are given due consideration."*

1.3 The following report summarises the work of Internal Audit for the period from 12 May 2025 to 28 September 2025.

2. WORK COMPLETED DURING THE PERIOD

2.1 The following work was completed in the period from 12 May 2025 to 28 September 2025:

Description	Number
Reports on Audits from the Operational Plan 2024-25	3
Reports on Audits from the Operational Plan 2025-26	6

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 from 12 May 2025 to 28 September 2025, indicating the relevant assurance level and a reference to the relevant appendix.

TITLE	DEPARTMENT	SERVICE	ASSURANCE LEVEL	APPENDIX
School Funds (2024-25)	Education	Schools	Satisfactory	Appendix 1
Breakfast Clubs (2024-25)	Education	Schools	Limited	Appendix 2
Field Workers' Awareness of the Safeguarding Policy (2024-25)	Corporate	-	Limited	Appendix 3
Post-16 Provision in Schools Grant 2024-25	Education	Schools	High	Appendix 4
Harbours Accounting Statement	Finance	Accountancy	High	Appendix 5
Welsh Church Fund	Economy and Community	Community Regeneration	High	Appendix 6
Plas Hedd	Adults, Health and Wellbeing	Residential and Day	Limited	Appendix 7
Plas y Don	Adults, Health and Wellbeing	Residential and Day	Limited	Appendix 8
Ash Dieback Disease	Highways, Engineering and YGC	_	Limited	Appendix 9

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 29 September 2025:

- Commercial Waste Collection *(Environment)*
- School Transportation Follow-up *(Environment)*
- Arrangements for the Distribution of Bins Follow-up *(Environment)*
- Field Workers' Awareness of the Safeguarding Policy *(Corporate)*
- Income – Recovery Arrangements *(Finance)*
- Lloyd George Museum *(Economy and Community)*
- Y Frondeg Home *(Adults, Health and Wellbeing)*
- Follow-up Llys Cadfan *(Adults, Health and Wellbeing)*
- Follow-up Plas Hafan *(Adults, Health and Wellbeing)*
- Direct Payments *(Adults, Health and Wellbeing)*
- Falling Trees *(Highways, Engineering and YGC)*
- Business Continuity Planning/Emergency Planning *(Highways, Engineering and YGC)*
- Homelessness Prevention Grant *(Housing and Property)*
- Housing Support Grant *(Housing and Property)*

4. RECOMMENDATION

4.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 12 May 2025 to 28 September 2025, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

Appendix 1

SCHOOL FUNDS

1. Background

1.1 Paragraph 16.22.1 of the Council's constitution states:

Where an officer of the Council is, by virtue of his official position, responsible for money or goods which are the property of a fund connected with a Council establishment, the purpose of which are analogous to the service provided by the Council:

(a) The officer shall keep all monies or goods, the property of the unofficial fund, separate from those of the Council.

(b) Proper records of account shall be maintained and be kept separately from those of the Council.

(c) The fund's controlling body shall appoint a competent person as auditor, to audit the fund's activities annually and report to the fund's controlling body or in the case of schools and colleges the Board of Governors.

(d) Such annual reports shall be held available for inspection by the Internal Auditors if requested.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that appropriate management and administrative arrangements were in place for school funds. To achieve this, a sample of schools was selected and a full audit of the accounts was carried out.

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 Score Risk

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 Following the distribution of a questionnaire in 2021/22 to gain an overview of school accounts in Gwynedd, this report is the third consecutive full audit of a sample of school funds. The schools will not receive individual reports following this audit, but they have been informed of the relevant weaknesses in their funds.

5.2 It was found that 3 out of the 4 schools were using the 'Guidelines for Governors and Headteachers on the Management of School Funds 2010', with the fourth school planning to include it on the agenda of the next Governing Board meeting. Although these guidelines were updated in 2022, they do not cover processes that are more common today, such as online payments and the use of bank cards, as well as the procedure for closing funds. Several elements need to be reviewed, and this has already been reported to the Education Department in the past, but it appears that no action has been taken so far.

5.3 One school in the sample was using online banking and appeared to have appropriate arrangements in place to mitigate the risk of fraud. The other Headteachers expressed that they were considering starting to use online banking.

5.4 Overall, there was good awareness among the sample of the need to audit accounts. This person should be experienced, with appropriate qualifications, and independent, and the auditor should not take any part in the day-to-day activities of the fund. Despite this, inconsistencies were found in the financial records.

5.5 Paragraph 19.1 of the Financial Regulations for Schools with Delegated Budgets states; *"Where a Council officer, by virtue of their position, is responsible for money or goods belonging to an unofficial fund associated with the school and for a purpose equivalent to the service provided by the Council":*

(ch) "Such reports must be submitted, certified by the auditor, along with a copy of the relevant committee record acknowledging receipt of the audited accounts, to the Internal Audit Department of Gwynedd Council annually."

In general, this does not happen. During the audit, some schools noted that they had not received a request to send the documents, and therefore had not done so, while others were unaware of the requirement. In fairness, the Financial Regulations for Schools with Delegated Budgets document is dated, and the Guidelines for Governors and Headteachers on the Management of School Funds do not refer to the need to send them. Sending the audited accounts to the Internal Audit Service would serve as proof that the accounts have been subject to independent audit, as well as scrutiny by the Governing Body, with the aim of strengthening quality.

6. <u>Actions</u>

The officers have committed to implementing the following steps to mitigate the risks highlighted.

- **Update the guidelines for governors and headteachers on the management of school funds**

Appendix 2

BREAKFAST CLUBS

1. Background

1.1 In 2004 the Welsh Government introduced a Free Breakfast Initiative in primary schools, with the aim of improving children's health and their ability to concentrate, thereby raising learning standards. On the 25th of September 2024, 79 primary schools in Gwynedd were running a breakfast club through the initiative. The clubs are divided into 2 sessions, a care session, which is subject to fees, and a breakfast session, which is free.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that appropriate arrangements were in place for the running of breakfast clubs, as well as the administration of income from the care element during the sessions. To achieve this, the audit included selecting a sample of breakfast clubs to confirm staffing arrangements, and the management of pupils' dietary requirements and/or allergies, as well as ensuring that there were appropriate arrangements for managing and monitoring the budget.

3. Audit Assurance Level

3.1 The controls were checked for risk mitigation. 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 the service is exposed to.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	1
MEDIUM	3
LOW	1

5. Main Findings

5.1 Of the 79 primary schools hosting a breakfast club in September 2024, only 33 of them had a child attending with an allergy. In order to check allergy handling arrangements, a sample of 4 schools was selected. However, the Auditor was unable to visit one school because the school was not available during the duration of the audit.

5.2 Prior to the visits, a copy of the Allergy Folder was received from the Catering and Cleaning Service Manager, which is a handbook shared with each kitchen containing information and arrangements in relation to running a breakfast club, menus, risk assessments, and a copy of the Allergy Policy. It was found that the Folder was not up to date, with the 2023/24 menus included, and risk assessments not reviewed since 2023. It was discovered during the audit that the Catering and Cleaning Service Manager was no longer in his role, and that the Education Modernisation Officer had meanwhile been working with the Health and Safety Service to review the risk assessments. It was noted that the assessments, as well as current menus, would be shared with the schools during the summer.

5.3 From the sample of breakfast clubs checked, one Headteacher expressed that they had not received any guidance/details of their duties in relation to breakfast clubs during their 5 years in his role. The Assistant Head -Education Services explained that it was very likely that no information had been shared since the COVID period, and that they would arrange for any new headteachers to receive guidance in the future.

5.4 The Allergy Policy sets out clear actions on how to collect information, record, and report any child with allergies. It was found during the visits that the schools do not follow the guidelines on all occasions, with many of the actions, such as holding specific meetings with the Headteacher, parents, and the cook, as well as drawing up personal risk assessments for each child, being missed altogether.

5.5 Similarly, it was found that records of children with allergies were not promptly shared with the Catering Team, nor were they constant from one entry to another. The name of each child with an allergy is stated on an Allergy Alert Form, with a copy kept in the Allergy File in the kitchen, and a copy sent for the attention of the Catering Team. A Pupil's Allergy Form is also prepared, one for each child, which includes a picture of the child, and is displayed on the kitchen wall. In 2 of the 3 schools visited, it was found that the list of names within the Folder was inconsistent with what was sent to the Catering Team, and with the forms/pictures on the kitchen wall, with children who had left unremoved, and new children with allergies not yet included. The Assistant Head - Education Services expressed great concern that the schools were not providing the information to the Catering Team in a timely manner.

5.6 The Allergy Policy states that children with allergies receive purple utensils (plate and bowl), as to distinguish them, and that those utensils must be kept separate from the other utensils in the kitchen to avoid cross-contamination. However, during the visits it was found that one school did not yet possess purple bowls, and that one child with a nut allergy had received breakfast on an ordinary plate. The Cook noted that a purple plate did not have to be given at that time, as there were no nuts in the breakfast, noting that the pupil received a purple plate on all lunchtime occasions. It was found that the plate for lunchtime was kept among the ordinary plates, unseparated.

5.7 It was found that the Policy did not specify the need for separate eating utensils for children with allergies. On several occasions during the visits, children were seen putting spoons on the table, where it would be close enough and easy for the child next to them to pick it up. It was suggested to the Catering Team that there is a risk of cross-contamination, this was agreed to be considered, in discussion with the Health and Safety Service.

5.8 As for the content of the breakfast, the foods provided are set by the Government. There are four categories, and one option must be provided from each category. The categories are: Milk or yogurt-based beverages, Cereals, Fruit and Vegetables, and Bread. Several Headteachers expressed concern that fresh fruit was not being offered, however, it was found that all schools provided juice (orange or apple), and that this met the requirement of the Government. The Assistant Head - Education Services confirmed that food choices will change soon, with the Government banning juice due to its high sugar levels.

5.9 None of the staff members present during the visits, supervisory staff (under the responsibility of the school), nor kitchen staff (under the responsibility of the Catering Team) appear to have completed Fire training, nor any of the Council's mandatory E-learning modules.

6. Actions

The relevant Officers are committed to implementing the following actions to mitigate the risks identified:

- **Continue to work with the Health and Safety service to review catering-related risk assessments.**
- **Ensure that each kitchen's Allergy manuals/folders are current, and up-to-date for the new educational year.**
- **For any new headteachers, ensure that guidance is shared in relation to the running of a Breakfast Club, setting out clear duties.**
- **Arrange a meeting with headteachers to reintroduce the content of the Allergy Policy, emphasising the need to provide information in relation to allergies accurately, and promptly, to the Catering Team.**
- **Remind kitchen staff to keep accurate, up-to-date records of allergies, with the Catering Team, during their visits, carrying out checks.**
- **Remind staff of the guidance in relation to the provision of purple equipment to all children with allergies, with the Catering Team to conduct checks during visits.**
- **Identify any schools that lack the appropriate equipment, ensuring that an order is placed immediately.**
- **Consider the need to provide separate eating utensils to children with allergies to avoid cross-contamination.**
- **As Site Managers, consider adapting fire drill arrangements/times to include kitchen staff.**

Appendix 3

FIELD WORKERS' AWARENESS OF THE CORPORATE SAFEGUARDING POLICY

1. Background

1.1 Safeguarding children and adults is the responsibility of everyone who represents or works on behalf of the Council, and a Corporate Safeguarding Policy is in place to explain how to fulfil that responsibility.

2. Purpose and Scope of Audit

2.1 Following a request from the Safeguarding Executive Group, the purpose of the audit was to evaluate the Council's field workers' awareness of the corporate Safeguarding Policy by distributing questionnaires to the workers.

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	2
MEDIUM	0
LOW	0

5. Main Findings

5.1 The statistics of the number of staff who have completed the mandatory 'Safeguarding' training up to 03/06/25 were received. These statistics include office workers and field workers, but exclude the Education department, as school staff follow a different Policy.

Number of unique individuals in the Council	3,772
Number of unique individuals having completed Mandatory Safeguarding Training	2,632
	70%

5.2 Statistics by department were also received, again including office workers and field workers. The statistics duplicate individuals who have more than one job

Department	Number of Staff	% Completed the Safeguarding Training
Environment	407	33%
Finance	219	99%
Economy and Community	249	71%
Corporate Services	182	93%
Adults, Health and Wellbeing	1,241	86%
Children and Supporting Families	651	67%
Highways, Engineering and YGC	434	34%
Housing and Property	270	44%
Corporate Management Team	111	73%

5.3 A specific audit was carried out on field workers' awareness of the Corporate Safeguarding Policy as it was already known that the Council's communication arrangements with these workers were not as effective when compared to office staff. Unfortunately, these same communication challenges arise in carrying out an audit that is dependent on the input of the field workers, who often do not have ready access to emails, the intranet and the mandatory training modules, but these are challenges that need to be overcome as these workers carry out the Council's frontline work.

5.4 As Internal Audit, by virtue of undertaking the annual audit plan, visit a number of work locations outside the main offices, it is then possible to share and collect questionnaires with staff who are present at the same time, as well as leaving a pack of questionnaires for other staff to complete when available. When the Safeguarding Executive Group asked Internal Audit to conduct an audit of fieldworkers' awareness, resource constraints prevented dedicated external visits. However, 67 responses were received through a combination of visits to Highways, Engineering and YGC Depot as part of scheduled audits, and the Business Development Manager's effort to circulate the questionnaire among 160 department staff. Not all departments have field workers.

5.5 The 67 responses from Highways, Engineering and YGC staff varied by place of work, with an average of half the staff being aware of the Policy, a quarter are aware of the content, 21% have received training (which is less than the department average) and 60% recognising that they have a responsibility to report concerns, with 84% willing to do so. Only 18% expressed that they knew who their Designated Safeguarding Manager was, but no one named the correct officer.

5.6 At the request of the Safeguarding Strategic Panel, the sample was expanded to include school staff, excluding teaching staff. Teaching staff follow the school's Safeguarding policy, which is based on the 'Keeping Learners Safe' National Guidance. Ancillary staff, including cleaning and kitchen staff are accountable to the corporate policy, but are subject to the school's safeguarding policy when dealing with pupils. They are expected to undertake Safeguarding refresher training annually under the control of the school's Designated Safeguarding Person. This refresher training does not refer to the corporate policy as the Safeguarding policy of the schools is slightly different, but the principles are the same.

5.7 The Safeguarding presentation provided by the Education department for schools includes a QR code at the end for staff to register that they have received the training. As it is the school's responsibility to maintain the register of everyone who has attended, some choose to use their own form to register – so the complete attendance statistics were not available. However, as a means of verifying the training arrangements of the schools, the Education department expressed that annual quality visits are carried out, which include reviewing that the school is providing the training to all members of staff.

5.8 According to statistics from the Education department's Safeguarding and Wellbeing Quality Leader, 1,180 staff have registered via the QR code to have completed the Safeguarding, and the Prevention training at the beginning of September 2024. Not all schools use the QR code. From the responses, all schools expressed that they have adopted a Safeguarding Policy during 2024/25. Also,

- 94% of the Designated Safeguarding Persons in schools have received specific safeguarding training in the last two years;
- 85% of Schools' Governors have also received the relevant training for their role in the last two years;
- 97% of schools have delivered basic Safeguarding training to all staff before the end of the Winter Term;
- 100% of schools have indicated that they are confident that all school staff and volunteers know what to do if a child discloses information about abuse.

5.9 The questionnaire for this audit refers to the Corporate Policy, but it cannot be assured that the responses given by the 125 ancillary staff (out of 569) across 17 of the 94 schools enquired refer to the Corporate Policy, or the School's Policy. However, the results are consistent with statistics from the Education Department.

6. Actions

The Safeguarding Executive Group has committed to implementing the following steps to mitigate the risks highlighted.

- **Continue to seek to raise awareness of the Corporate Safeguarding Policy among field workers.**
- **Share and display posters with details of Designated Safeguarding Officers.**

Appendix 4

POST-16 PROVISION IN SCHOOLS GRANT 2024-25

1. Background

1.1 Cyngor Gwynedd was allocated over £4.5m 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 'Local Authority Sixth Form' and 'Adult Community Learning' Allocation Certificate for 2024-25, ensuring that clear accounting records have been kept to indicate 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 letters.

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 allocation certificates for 2024-25 are 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 5

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 2024/25 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 2024/25 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 6

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 2024/25 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. The fund is invested to attract interest, so the income threshold was exceeded in the 2024/25 financial year.

4.2 Assurance can be given that the Welsh Church fund accounts for the 2024/25 year are appropriate. Based on the tests carried out, an appropriate audit trail for the figures were seen.

4.3 Despite the statement of assurance, the Charity Commission's website incorrectly states that the accounts for the last 4 years have been qualified. However, Internal Audit has contacted the Charity Commission to rectify this.

Appendix 7

PLAS HEDD

1. Background

1.1 Plas Hedd Care Home is located in the city of Bangor and is registered to provide a service for up to 28 residents over the age of 18, who find it difficult to live independently within the community, or who have been assessed as needing support.

2. Purpose and Scope of the 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 relevant regulations and standards. To achieve this, the audit covered verifying that the home's arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and income receipts, health and safety, and performance monitoring as well as ensuring that the service users and their property were protected.

3. Audit Assurance Level

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 the service is exposed to.**

4. Current Risk Score

4.1 The audit's risks are as follows:

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

5. Main Findings

5.1 Care 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 Medication Audits by the NHS and the local pharmacy. If any element of the Internal Audit had already been recently reviewed as part of the Quality, Health and Safety Assurance, or Medicine Audits, it was decided to rely on the reports, accepting their assurance.

5.2 However, it has been found that recommendations derived from Quality Assurance Audits are not implemented on all occasions. A sample of care plans were checked as part of the Quality Assurance Audit of 24th March 2025, where it was identified that staff did not sign the relevant sections when completing the Daily Notes. The home was visited to carry out an Internal Audit on the 16th of July, where a sample of 3 care plans were reviewed. It was found that the Daily Notes of the three residents for the previous two weeks remained unsigned. Following the publication of the draft report it was confirmed that a staff meeting had been arranged to discuss this.

5.3 For the 4 residents whose pocket money records were checked, it was found that receipts for expenditure were missing on two occasions, for two different residents. The Manager and Deputy Manager immediately investigated this, finding the receipts among other residents' records. They noted that they would remind staff to be more careful when retaining receipts in the future. It was also found that the Manager did not sign or confirm a date when reconciling the pocket money, making it impossible to identify when the reconciliation was last held. By the time the final report was published evidence had been received showing that each resident's pocket money had been reconciled, with a proper record kept, and that monthly reconciliations were to be held henceforth.

5.4 It was found that visitors did not sign the visitors' book on all occasions when leaving the home, nor confirm the time of departure. The Manager stated that she would arrange for a poster to be placed at the visitor book to remind everyone to sign when leaving. Following the publication of the draft report, a copy of the poster was received, confirming that it had been displayed at the visitors' book.

5.5 During the visit, it was seen that monthly tests on the fire extinguishers and escape routes are being conducted, where they are expected to be carried out on a weekly basis. The Manager noted that although the tests were conducted and recorded monthly, they were checked on a regular basis.

5.6 A 'Safeguarding' poster was not seen displayed in the home. The Manager confirmed that she would arrange to get a poster soon. By the time the final report was published, it was seen that a poster had been received and displayed.

5.7 It is not possible to confirm how many members of staff have read the Safeguarding Policy or completed mandatory E-learning modules. The home has a laptop available to enable staff access to policies as well as the modules. However, the laptop has a generic 'log in', which allows you to view/read only the documents/modules. Staff cannot log in individually so that the system can identify who has read/completed which policies or modules. Enabling care home staff access to the Policy Centre and the E-learning Portal has been a challenge over recent years, with the generic laptop having enabled that. In order for a record to be available, and for monitoring purposes, the Manager agreed to ask staff to identify any policies read or completed modules in the future, recording these on the in-house training spreadsheet.

5.8 Not all staff members who dispense medication appear to have up-to-date training. A sample of 10 staff members was randomly selected to review their training records. 3 were disregarded because they do not provide medication. Of the remaining 7, training for 2 has expired, with only 1 having completed a competency test in the past year, where they are expected to be conducted annually. The Deputy Manager stated that she would arrange training as soon as possible. It was explained that staffing problems made it difficult to release staff to attend training. The Cook as well as the Assistant Cook were found to be on long-term sick leave, with the sole remaining staff member in the kitchen resigning in August 2025. For some months now care staff have had to work shifts in the kitchen to ensure residents are fed. Although several posts were advertised, it was noted that attracting applicants was difficult, and that deadlines often had to be extended.

5.9 Since October 2022 adult care home workers are required to register with Social Care Wales. For the sample of 10 staff members who's training records were reviewed, 2 were not found to have registered. This was brought to the attention of the Manager. By the time the final report was released, one had registered, and the other was about to start the process.

6. Actions

The relevant officers are committed to implementing the following actions to mitigate the risks identified:

- **Endeavour to act promptly on external audit recommendations, in particular, Daily Notes, carrying out random checks to ensure staff sign off on completing tasks, and remind underperforming staff of their duties.**
- **Keep appropriate records of pocket money reconciliations, stating the date, and signing.**
- **Arrange for a poster to be placed next to the visitor book reminding everyone to sign and confirm time when leaving, reminding staff to also state this to visitors when they are admitted to the home.**
- **Display a 'Safeguarding' poster in an appropriate area, where all members of staff will see it.**
- **Keep appropriate records of any training policies/modules staff completed on the generic home laptop and send the information to the Learning and Organisational Development Service to update the individual records**
- **Ensure that all members of staff providing medication complete relevant training as soon as possible, including competency testing.**

Appendix 8

PLAS Y DON

1. Background

1.1 Plas Y Don Care Home is located in the town of Pwllheli and is registered to provide a service for up to 28 residents over the age of 18 who find it difficult to live independently within the community, or who have been assessed as needing support.

2. Purpose and Scope of the 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 and in accordance with relevant regulations and standards. To achieve this, the audit covered verifying that the home's arrangements were adequate in terms of administration and staffing, budgetary control, procurement of goods and income receipts, health and safety, and performance monitoring as well as ensuring that the service users and their property were protected.

3. Audit Assurance Level

3.1 The controls were checked for risk mitigation. 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 the service is exposed to.**

4. Current Risk Score

4.1 The audit's risks are as follows:

Risk Level	Number
VERY HIGH	0
HIGH	2
MEDIUM	7
LOW	0

5. Main Findings

5.1 Care 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 Medication Audits by the NHS and the local pharmacy. If any element of the Internal Audit had already been recently reviewed as part of the Quality, Health and Safety Assurance, or Medicine Audits, it was decided to rely on the reports, accepting their assurance.

5.2 However, it has been found that recommendations derived from Quality Assurance Audits are not implemented on all occasions. A sample of 3 care plans were checked as part of the Quality Assurance Audit of January 21st, 2025, where it was noted that documents in 2 plans were not reviewed every three months as expected. Of the 3 care plans reviewed as part of the Internal Audit, although recently reviewed, they had not been reviewed every three months beforehand, with monthly assessments on 'oral care' being missed on several occasions. 'Oral care assessment' has not been completed for 1 resident since 2024. Similarly, it was found that the residents' 'Daily Notes' were not complete on all occasions for July 2025, with days missed, and staff having not dated or signed when completing tasks.

5.3 On one occasion, it was found that no record of a resident's personal items was present in their care plan.

5.4 Since October 2022 adult care home workers are required to register with Social Care Wales. For the sample of 10 staff members who's training records were reviewed, 2 were not found to have registered. This was brought to the attention of the Manager. It was confirmed she would register the 2 members of staff as soon as possible.

5.5 Of the 4 members of staff selected to review their staff files, it was found that 3 had not been supervised for over four months, where they are expected to be held every three months. The appraisal records of the home were not reviewed following confirmation from the Manager that she had not conducted an annual appraisal for some years. Following release of the Draft Report, it was seen that a supervision rota had been created.

5.6 For 1 staff member, the workings hours claimed for the week ending 24/05/25 did not agree with those noted on the work rota, resulting in a 42-minute overpayment. The Manager suggested that this was a mistake on her part in entering the details of the rota on the payroll spreadsheet, or that the staff member may not have been able to take a brake during a shift, and that the Manager had therefore arranged for her to be paid for it. She noted that this happened frequently, but that she did not record it anywhere.

5.7 The Asset Register of the home was not reviewed following confirmation from the Manager that it had not been reviewed for over 2 years. She confirmed that a complete, current register would be completed in the near future.

5.8 For the 4 residents whose pocket money records were reviewed, it was found that receipts for expenditure were missing on three occasions, for three different residents. It was confirmed that the residents on occasions were spending on "bingo" at the day centre, but that receipts were not being provided. It was agreed to request receipts from now on. These were found to be small amounts, no more than £2.

5.9 It was found that visitors did not sign the visitors' book on all occasions when leaving the home, nor confirming the time of departure. It is noted that a poster is already located above the book asking visitors to sign in. The Manager confirmed that she would create a new poster stating the need to sign and confirm the time of departure.

5.10 It was seen that tests had not been carried out on the fire extinguishers, or escape routes for a month from the date of the visit, where they are expected to be carried out weekly. The Auditor visited the home 24/07/25. The Manager stated that she was confident that these were being carried out, but that staff were not recording them on every occasions.

5.11 Individual risk assessments of residents are expected to be reviewed monthly. Of the 3 residents whose records were reviewed, their risk assessments had not been reviewed for over 4 months, although Quality Assurance highlighted the failure in their report dated 21/01/25. By the release of the Final Report, it was confirmed that arrangements were in place to audit the Care Plans every 3 months.

5.12 It was found that 31 incidents as a result of medication error occurred between February and July 2025. These are documented and reported to the Area Manager, NHS, and Quality Assurance. As a result, 3 members of staff have now been temporarily suspended from dispensing medication, with a meeting already scheduled for the 4th of September to discuss further, where Area Managers, Heads of Department, Quality Assurance, as well as a member of the Safeguarding Team will be among the attendees.

6. Actions

The Manager is committed to implementing the following actions to mitigate the risks identified:

- **Strive to act promptly on external audit recommendations, in particular, reviewing care plans, conducting random checks, and reminding underperforming staff of their duties.**
- **Ensure that an up-to-date record of residents' properties, in the form of a list or photographs, is kept in their care plans.**
- **Draw up a supervision and appraisal rota, ensuring that all staff members receive supervision every 3 months, and an annual appraisal.**
- **Ensure accuracy in entering staff hours on the payroll spreadsheet and recording any brakes that may not be taken on the work rota.**
- **Ensure that the home has an up-to-date record of all its belongings, arranging an annual review, or when purchasing/disposing of items.**
- **Create a new poster for display near the visitors' book clearly stating the need to confirm arrival and departure times, as well as signing.**
- **Ensure that fire tests are carried out in a timely manner, and appropriate records are maintained.**
- **Hold a meeting with relevant staff to remind them of their duties in relation to reviewing residents' risk assessments, carrying out regular checks to identify any missed reviews.**
- **Remind staff to be vigilant when dispensing medication.**

Appendix 9

ASH DIEBACK DISEASE

1. Background

1.1 Ash Dieback disease causes a range of symptoms and has a detrimental effect on the structural stability of most trees it infects. It is expected that the majority of ash trees in Gwynedd will die from the disease over the coming years, leading to environmental, economic, and health and safety risks due to falling trees or branches.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that appropriate arrangements were in place to manage and mitigate the risks of Ash Dieback Disease, by reviewing planning and risk management procedures, training, reviewing the inspection records for a sample of trees and the actions taken. A more general audit entitled 'Falling Trees' has also been included in the current year's audit plan.

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	2
MEDIUM	1
LOW	0

5. Main Findings

5.1 The Council acknowledges that Ash Dieback Disease poses corporate risks to the Council, and as a result, it has been included on the corporate risk register. Not only are there clear environmental risks, but also economic and health and safety risks from trees or branches falling on individuals, buildings, roads, and vehicles.

5.2 Following ash trees data collection work within the county, in September 2021 the authority approved the Department's request to establish a specialist team to manage the disease on its roads and lands. At the same time, a permanent budget of £100k was allocated to the team to carry out operational work such as inspecting, pruning, and felling infected trees. Within the 25% of roads, parks, cemeteries, and schools in Gwynedd that have been inspected since 2020, approximately 25,000 ash trees have been examined, with around 8,000 of them identified as being in the high-risk category. The Service has cut or pruned around 3,000 of the ash trees so far, following a re-verification of the data within the system during the audit. 75% of the roads and paths remain to be inspected.

5.3 Due to a lack of resources, the team prioritises based on likelihood of an event and its impact and therefore inspects trees that are on or near main roads, schools, cemeteries, and other public open spaces. As a result, many quieter roads and lands have yet to receive planned inspections, with revisits to high-risk sites prioritised to determine if tree conditions have deteriorated.

5.4 The Council is aware of the resource shortfall, but several bids for additional budget to employ arborists have been unsuccessful. A successful bid enables more of the work program to be undertaken, along with supplementary work such as raising awareness among private landowners. Nevertheless, a website has been created that includes useful information for the public and private landowners about the disease.

5.5 A Tree Risk Management Strategy is being drafted at the time of the audit, and the Ash Dieback Plan will be updated accordingly. However, the challenging resource situation means there is a risk that trees will not be inspected and treated as frequently as outlined in the planned program.

5.6 A sample of specific ash trees in areas of varying priority was selected, and the Service's inspection records for them were obtained from the Ezytreev system. The sample showed that the selected trees, and those nearby, had been inspected, the ones beside a section of the A4085 and Parc y Dre Caernarfon within the last year, trees beside a section of the A4871 in 2022 and ones by Lon Eifion in 2020. Most of the trees assessed as high-risk remain standing without further action despite being recommended for felling. The hope is that trees will be inspected at least every two years, and vulnerable trees annually until they are pruned, but the lack of resources creates a risk of not being able to achieve this. Despite the relatively low likelihood of a tree or branch falling and causing injury or death, it is difficult to prove whether the current inspection and felling program is sufficient in the event of a legal case against the Council.

5.7 There are restrictions on felling trees during the Spring and Summer nesting season. When the nesting season is over, the results of the recent inspections are analysed and a work programme for cutting trees is created. However, the work is limited to areas of high priority, and other factors such as the weather, the need to close roads etc can lead to additional time and costs, further limiting the number of trees felled.

5.8 The Service faces several other challenges, such as, assessing crown dieback (loss of leaves from the top down due to the disease) in winter when trees naturally shed leaves, storms and strong winds that can weaken or break branches across a wide area overnight, and deciding what to do with the felled wood, which has some monetary value. It is expected that the Ash Dieback Plan will address these.

6. Actions

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

- **Publish a Tree Risk Management Strategy and update the Ash Dieback Plan**
- **Submit another bid for more resources**
- **Cutting the trees that have been designated as high risk in high priority areas, within the resource limits of the Service**