COMMITTEE	**GOVERNANCE AND AUDIT COMMITTEE**
DATE	**3 FEBRUARY 2026**
TITLE	**OUTPUT OF THE INTERNAL AUDIT SECTION**
PURPOSE OF REPORT	**TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 25 JANUARY 2026**
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**

---

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 29 September 2025 to 25 January 2026.

2. WORK COMPLETED DURING THE PERIOD

2.1 The following work was completed in the period from 29 September 2025 to 25 January 2026:

Description	Number
Reports on Audits from the Operational Plan 2025-26	21

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 29 September 2025 to 25 January 2026, indicating the relevant assurance level and a reference to the relevant appendix.

TITLE	DEPARTMENT	SERVICE	ASSURANCE LEVEL	APPENDIX
Commercial Waste Collection	Environment	Waste Collection	Limited	Appendix 1
Follow-up - Arrangements for the Distribution of Bins	Environment	Waste Collection	Limited	Appendix 2
Animal Health	Environment	Trading Standards	Satisfactory	Appendix 3
Follow-up – Freedom of Information Requests	Corporate	-	Satisfactory	Appendix 4
Income – Recovery Arrangements	Finance	Income/Debtors	Limited	Appendix 5
Precepts	Finance	Accountancy	High	Appendix 6
Lloyd George Museum	Economy and Community	Museums and Arts	High	Appendix 7
Tan y Marian	Adults, Health and Wellbeing	Learning Disabilities	Limited	Appendix 8
Y Frondeg	Adults, Health and Wellbeing	Learning Disabilities	Satisfactory	Appendix 9
Follow-up – Plas Pengwaith	Adults, Health and Wellbeing	Residential and Day-Care	Limited	Appendix 10
Follow-up – Llys Cadfan	Adults, Health and Wellbeing	Residential and Day-Care	Satisfactory	Appendix 11
Follow-up – Plas Hafan	Adults, Health and Wellbeing	Residential and Day-Care	Satisfactory	Appendix 12

TITLE	DEPARTMENT	SERVICE	ASSURANCE LEVEL	APPENDIX
Direct Payments	Corporate Leadership Team Adults, Health and Wellbeing	Business Service and Care Commissioning	Satisfactory	Appendix 13
Cegin Arfon	Adults, Health and Wellbeing	Learning Disabilities	Limited	Appendix 14
Siop Galwch Acw	Adults, Health and Wellbeing	Learning Disabilities	Limited	Appendix 15
Canolfan y Gwystl	Adults, Health and Wellbeing	Learning Disabilities	Limited	Appendix 16
Succession Planning YGC	Highways, Engineering and YGC	YGC	Satisfactory	Appendix 17
Business Continuity Planning	Highways, Engineering and YGC	Across the Department	Satisfactory	Appendix 18
Falling Trees	Highways, Engineering and YGC	Management	Limited	Appendix 19
Homelessness Prevention Grant	Housing and Property	Housing	Limited	Appendix 20
Housing Support Grant	Housing and Property	Housing	Satisfactory	Appendix 21

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 25 January 2026:

- Education Outside Schools *(Education)*
- School Transportation Follow Up *(Education/Environment)*
- Breakfast Clubs Follow up *(Education)*
- School Transportation Follow-up *(Environment)*
- Building Control *(Environment)*
- Mandatory Training *(Corporate Services)*
- Fire Arrangements *(Corporate Services)*
- Information Management and Data Protection *(Corporate)*
- Field Workers' Awareness of the Protection Policy *(Corporate)*
- CoLS/LPS *(Adults, Health and Wellbeing)*
- Out-of-County Payments *(Children and Family Support)*
- Crematorium *(Highways, Engineering and YGC)*
- Fleet Management *(Highways, Engineering and YGC)*
- Follow-up – Environment Category Management *(Highways, Engineering and YGC)*
- Emergency Accommodation Costs *(Housing and Property)*
- Crematorium *(Highways, Engineering and YGC)*

4. RECOMMENDATION

4.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 29 September 2025 to 25 January 2026, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

Appendix 1

COMMERCIAL WASTE COLLECTION

1. Background

1.1 The Council provides a commercial waste collection service to around 2,000 businesses across Gwynedd. In April 2024, new recycling legislation came into force. This requires that every workplace, such as businesses, the public sector, and charities, must separate their recyclable items by type before they are collected. The implications of the law meant that Cyngor Gwynedd, as a waste operator, also had to collect waste and recyclable materials separately.

1.2 Ensuring a source of income from commercial waste and holiday lets is fundamental to the service and is identified as a key risk on the department's risk register.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that there were adequate and effective internal controls in place for managing and administering the Council's Commercial Waste collection service. As the Service was in the process of transferring to a new system, the audit did not encompass the internal controls within the current system but rather focused on holding discussions with relevant staff to identify any obstacles to performing their work effectively and ensuring that the new system addressed these weaknesses.

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 Score Risk

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 At the time of the audit, the Commercial Waste service was in the process of moving towards a new administrative and management system, Bartec. For this purpose, no audit tests were carried out on the current system, with the original intention of reviewing how the features of Bartec would impact and facilitate work arrangements and mitigate risks to the service. Bartec is already being used by the domestic waste service, but unfortunately from the audit's perspective, the adoption timeline for the system has slipped, and is now expected to be operational sometime in 2026/27. It was therefore not practical to conduct an audit of the new system, but this is expected to be the subject of a further internal audit once it becomes operational.

5.2 Bartec offers more than the current simple Microsoft Access database system that records business details and requires teams to print a daily collection list from it. Bartec's intention is to facilitate and simplify waste collection by optimising collection routes, managing bins and contracts, tracking collection vehicles and providing real-time updates to staff and customers. Bartec can also facilitate financial arrangements, such as invoicing. The service is seizing this opportunity to review their working arrangements, and a Ffordd Gwynedd workshop held at the end of 2024 highlighted different perspectives and barriers in the current arrangements that need to be overcome.

5.3 The effectiveness of any system depends entirely on the quality of the data it contains. It appears that the data in the current commercial waste service system is unreliable, which can lead to the creation of incorrect collection lists to the collection teams and the issuing of incorrect bills to customers. This would mean that it is not appropriate to transfer the data directly to Bartec, and this has contributed significantly to the delay in its adoption. There is an intention for officers to join the collection teams and re-document which bins each business has, and to generate a new database from that. Commercial waste bins do not have official stickers indicating their owner, as per the domestic garden waste scheme, which can create obstacles for the officers. It is therefore essential to have a system that ensures that the data remains accurate after this exercise.

5.4 Unreliable data create a risk that bin collectors have collected more, or less, than what businesses have paid for, and therefore that incorrect bills have been issued to customers. Creating a new database based on the exact number of different bins the businesses have is likely to change the service's income levels.

5.5 The role of the back office in the current process includes administration, advising customers, and supporting commercial waste collection teams. Currently, all requests, enquiries, or complaints go through the office, or directly to the collection team, but there is no certainty that the current communication arrangements allow every case to receive the appropriate attention and action.

While this arrangement will continue with the new system, Bartec will enable the customer to submit service requests directly through it, reducing the administrative burden on the back office, and updating the database within the system immediately.

5.6 Bartec can also respond to certain complaints using its live data, such as delays with the lorry. Teams will be expected to record every collection in Bartec via iPads, noting any reason for not collecting (bin not presented, mixed or contaminated recycling waste, etc.).

5.7 As a result of the budget, the commercial waste service is expected to generate a profit for the Council. Arrangements for advertising the service were reviewed, but no proactive marketing is being carried out. The Waste and Recycling Manager confirmed that they began work on this last year in collaboration with experts from 'Local Partnerships', a public body that supports local authorities with various aspects, such as marketing, but no further work has been done. Fees are also intended to be reviewed considering the competition with the private sector.

6. Actions

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

- **Create a new commercial waste database by joining the collection teams, documenting which bins are to be collected, and ensuring that the data remains accurate and up to date.**
- **The Commercial Waste Service is planned to be restructured in 2026.**
- **Promote the service through proactive marketing and review fees.**

Appendix 2

ARRANGEMENTS FOR THE DISTRIBUTION OF BINS FOLLOW UP

1. Background

1.1 An Internal Audit of Arrangements of the Distribution of Bins was carried out as part of the 2024/25 plan, to ensure that suitable arrangements were in place for the distribution of bins to Gwynedd residents and businesses, taking into account the costs involved. A limited level of assurance was given to the audit, that is, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To achieve this, the audit encompassed reviewing supporting records and documentation, as well as conducting a site visit.

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 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	2
LOW	0

5. Main Findings

5.1 Of the 8 actions agreed upon from the original audit, only 2 were found to have been implemented, the conclusions are reported below.

5.2 The Assistant Head of Environment confirmed that the service is facing a £200,000 savings plan. One of the considerations to achieve the saving is to relocate the Bin Delivery Service. As such, there will be no expenditure on improving the condition of the warehouse. During a visit to Llwyn Isaf on the 2nd of October, 2025, rain was observed to be collecting in places within the building due to the roof leaking, with rotting cardboard boxes holding the equipment. The items inside were in acceptable condition, and the warehouse was neat and orderly. It was noted that since the full audit, the warehouse is regularly cleaned and organised.

5.3 It is noted that although there is a lock on the gates of the depot, all staff members, as well as staff from the 'Biogen' company, (which shares the site) have a key.

5.4 Since June 2025, 'Contenur UK Limited' has been recycling old bins on behalf of the Council, paying £250 per tonne. Although there have been 3 collections since then, an invoice hasn't been raised. In addition, no invoice has been raised for collections made by 'Indigo Environmental' for the period 07/02/25-20/06/25, valued at £1,701.00. The Waste and Recycling Manager – Quality Assurance, explained that invoices would be raised shortly, and that in the future there were plans to invoice every 6 months.

5.5 No monitoring of stock levels, nor stock checks are conducted. It was confirmed that the service is in the process of procuring a new system ('Bartec'), which would enable not only effective stock monitoring, but also to optimise journeys, with the hope of being able to reduce the use of hire vehicles. However, it has been confirmed that the timetable has slipped, and that the system is not expected to be operational for Bin Delivery Service until February 2026.

5.6 It was found that the service is considering alternative options to enable manual staff, who do not have access to the E-learning Portal or the Policy Centre, to complete the Council's mandatory modules and policies.

6. Actions

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

- **That stock checks are carried out regularly and effectively.**
- **That income from the sale of old bins is promptly claimed.**
- **That all drivers complete the Council's mandatory E-learning modules.**
- **That all drivers accept mandatory policies, such as Safeguarding.**

Appendix 3

ANIMAL HEALTH

1. Background

1.1 Local Authorities in Wales have statutory duties to work with local communities to help them comply with the law that has been introduced to protect animal welfare and to prevent the spread of animal diseases. Local Authorities help farmers and businesses comply with the Animal Health Act 2006 and are also responsible for taking action when the laws are broken.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that appropriate arrangements were in place by the service to operate in accordance with the requirements of the Animal Welfare Act 2006, and that high standards of animal health and welfare are maintained. To achieve this, the audit encompassed assessing the effectiveness of the for monitoring and responding to emergencies, planning and visit arrangements, staff member training, and reviewing the complaints procedure.

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 The Council has the right to take possession of any animal where their health and welfare are suffering from unnecessary pain or stress on agricultural land, and animals kept and raised in conditions that do not comply with the Animal Health Act 2006.

A recent case was seen where the Council had to take possession of animals from a farmer in the area due to poor conditions and neglect of the animals, constituting animal welfare offences. The Council was expected to respond to this case within days and find contractors to carry out the urgent work. No paperwork was available, and no formal contract with the contractors had been created, nor had a tender process been followed. The Trading Standards and Licensing Manager explained that this was a case of emergency, and no similar case had occurred in the past.

5.2 Another case was seen where the Council had to step in to ensure that the animals on a farm had food and water. It is not the responsibility of Trading Standards officers to feed and look after the animals, so the Council had to find someone at short notice to do the work. It was seen that options were limited in this situation and there were concerns about the health and welfare of animals, so the Council only had a verbal agreement with those willing to do the work. It was noted that each case is different, and that the Council has connections with the Animal and Plant Health Agency (APHA), the Police, and veterinary surgeons to carry out the work.

5.3 A copy of the 2011 Trading Standards policy was received, and the Manager explained that the main principles are still being followed, although it is an old policy. No other clear guidance from the service was seen specifying arrangements, procedures, points of contact etc. The Manager agreed that the policy needs updating, and guidance and a list of contractors would also be beneficial, but due to limited capacity and scarce resources within the service, it is difficult to find time to do this as their priority is to ensure animal health and welfare.

5.4 The 'Tascomi' system is used to record case details. Over 720 complaints have been recorded in the system, and a random sample of 20 complaints was reviewed. From the sample selected, 14 complaints had been closed and 6 were 'in progress'. Of the complaints that had been closed and completed, on average, it was observed that the service sent a first response to the complaints within 1.18 days and resolved them within 4.73 days.

5.5 It was found that the service does not receive additional funding if the Council need to take possession of animals. The Manager explained that there is a national consensus that the Animal Health Act 2006 is no longer fit for purpose, and an example was seen of one Authority that spent over a million pounds following the need to take possession of animals.

6. Actions

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

- **Update the policies and procedures that are in place.**
- **Looking to establish a list of contractors and having a procedure in place to set up an agreement with contractors as soon as possible after the work begins.**

Appendix 4

FREEDOM OF INFORMATION ACT – FOLLOW UP

1. Background

1.1 A Freedom of Information Internal Audit was conducted as part of the 2024/25 plan, to ensure that appropriate arrangements were in place for administering and processing requests for information under the Freedom of Information Act 2000. As part of the original audit, arrangements for receiving, distributing, collecting and responding to requests under the Act were reviewed.

2. Purpose and Scope of Audit

2.1 The audit was intended to ensure that agreed actions resulting from the most recent full audit were implemented in a timely manner to mitigate the risks. To achieve this, the audit included reviewing records or supporting documentation.

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 Five actions were agreed in the original audit in September 2024, all with a risk rating of 5. The actions have been implemented and the conclusion is reported below, but there is still ongoing work in place to encourage departments and officers to respond within the statutory timeline and to be proactive in making more data sets available on the website (open data).

5.2 Since the internal audit was conducted, the Information Commissioner's Office (ICO) was commissioned to conduct an external audit of the Council's Freedom of Information procedures. The external audit was conducted during April 2025, and the report on the findings was published in May 2025. The findings included a 'Reasonable' assurance rating in terms of responses to the requirements of the Act but indicated that there is some room to improve current arrangements in order to reduce the risk of non-compliance with the Act.

5.3 One of the risks highlighted in the original internal audit was the failure to update the Publication Scheme regularly in accordance with Section 19 of the Freedom of Information Act. The scheme has now been updated on the website to include the current information.

5.4 The original internal audit found that there was a lack of arrangements for processing applications, which therefore caused the Council to fail to respond to applications within the permissible timeframe. Gwynedd's performance was slightly below the UK Government's 2023 Freedom of Information statistics, with Gwynedd's timeliness rate at 77%, compared to a rate of 81% across all monitored bodies. By now, the response rate of Cyngor Gwynedd has improved significantly in 2025/26, rising to 89% for quarter 1, and up to 92.1% in quarter 2.

5.5 The Senior Statutory Data Protection Officer confirmed that a work programme has been created, which includes recommendations from the Information Commissioner's Office, and progress on the work programme is reported to the Governance and Audit Committee and to the Response Programme Board.

5.6 It was seen that communication had improved with the department coordinators as the support team are communicating with them through Teams to remind them and to ask for responses. In addition, a training session was held for the department coordinators in June 2025, and another session is being held in September to share good practices. Nevertheless, one of the recommendations from the Information Commissioner's Office was that the Council should provide mandatory Freedom of Information training to all staff across the Council, and confirmation was received that a new e-learning module has been created.

5.7 It was found that the Senior Statutory Data Protection Officer has shared an email with Council managers containing some guidance on freedom of information requests. A bulletin was included in the email, which is a document outlining how to identify a request for information, a link to the open data page on the website, which includes datasets published on the Council's website, as well as a link to the Freedom of Information Policy and the Publication Scheme. It was observed that more 'open data' sets have been made available on the website since the original audit.

6. Actions

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

- **Continue to encourage departments and officers to respond to requests within the statutory timeframe.**
- **Ensure that recommendations from the Information Commissioner's Office are given attention and completed in accordance with the schedule.**

Appendix 5

INCOME RECOVERY

1. Background

1.1 The Council has raised over £9 million of invoices through the debtor system (from February 2025 to August 2025) and £8.7million worth of aged debts over 6 months old (before 1 February 2025) are still outstanding. The Income Service is responsible for the recovery of debts in compliance with the Council's Constitution together with the Council's Recovery Policy 2024. The average collection rate was reported in August 2025 to be 68.56% within the month with the remainder of the non-recoverable debt accumulating over time.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place to collect, recover and write off the Council's debts and ensure compliance with the Council's Recovery Policy. To achieve this, the audit encompassed reviewing a sample of debts that have been raised, recovered and those that have been written off to ensure that there are appropriate and timely arrangements for identifying and dealing with arrears.

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 Score Risk

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 As part of the audit, the Income Service presented two reports, a report of invoices with the Council's total debts up to 31 August 2025 and a report on each debtor to analyse the number of invoices and debt on the system per debtor, as well as identifying the debtors with the highest debts.

5.2 A sample of 40 invoices raised through the Council's debtor system was reviewed to ensure that recovery arrangements had been implemented in accordance with the Council's Recovery policy. In addition, 16 debtors with a high amount of accumulated debt were reviewed against their account. From the checks, it was confirmed that the debts have been promptly recovered, in the first stages, in all cases i.e. a reminder after 28 days from the invoice due date or that arrangements have been put in place to recover a debt such as direct debit, instalment scheme, referral to a responsible officer etc.

5.3 Regarding the write-off of debts, for a sample of debts submitted to the Head of Finance for write off in June 2025, appropriate action was seen taken in accordance with the Council's Recovery policy.

5.4 Some officers within other departments had rights on the debtor system to allow them to set up invoices themselves. It appears that an audit trail for the recovery procedure exists and that access to the system is properly controlled by administrators' systems with rights set/restricted for all users. The Income Manager demonstrated that there is an audit trail on the system to identify who has also authorised the invoice along with raising it on the system.

5.5 However, failures and risks were identified as set out below in several operations or where formal arrangements were not in place for the purposes of recovering the Council's debts.

5.6 No guidelines exist for the Income Service, nor instructions for users of the system on setting up and approving invoices. The response received was that officers receive training within each other's departments, as well as instructions that are available on the system's website if officers need assistance. However, with high staff turnover, there is a risk of placing reliance on staff with the experience and expertise to train new staff, which can be challenging in the current climate, with limited resources.

5.7 Reviewing a sample of debts found that 75% of debts amounting to around £13.4million had been suspended for various reasons which are identified on the system through different flags. It was analysed that 11% of the debts that have been suspended, amounting to £1.7million, were due to the services requesting suspension or the debt being directed to the relevant service/department (Flags D, E, F). The lack of formal arrangements for following up on the debts mean that there is a high risk that recovery arrangements are placed on hold for the long term without further intervention by the service which delays the recovery process, increases the possibility of bad debts not being collected within the statutory period, and ultimately being written off. 1% of these are accounts that need to be written off exist on the system (worth around £89,600).

5.8 In addition to this, cases were referred to the Legal Service by the Income Service in May 2025 but recognition was not received by Legal until the 8th of October 2025 which delays the opportunity for prompt recovery.

5.9 There is no service agreement/guidance which identifies responsibilities between the services and the Income Service, which means that there is a lack of accountability within the services to ensure that recovery actions are implemented promptly.

5.10 From a sample reviewed, some debtors were found to have received service from the Council despite the fact that they have pre-existing debts which inflates the amount of irrecoverable debts. This is likely to happen especially when services do not check their debts or do not have access to the system to verify them.

5.11 Services may not be aware of the bad debts until the Income Service applies to write off the debt which ultimately has an impact on their budget. Once an invoice has been created, it will appear as income in the accounts unless it is deleted or written off, so there is no incentive for the services to provide assistance in collecting the debt promptly. It also means that there is a risk for services to be able to inflate their budget income by introducing invoices in advance on the system. To avoid this, the Senior Recovery Officer reported that some councils reverse the income if the income has not been received/recovered after 2 or 3 months from the date of the invoice.

5.12 The Income Manager expressed that historically all departments received a list of their outstanding debts but the exercise has not taken place for a long time. However, the Income Manager believes that the exercise should be reintroduced on a quarterly basis with the aim of services reviewing and taking action.

5.13 Following a meeting with the Income Manager and the Senior Recovery Officer, it was reported that only one report is used monthly for identifying all the debts from the debtor system but that the data is extracted manually rather than being generated on 'schedule' from the system. Following further enquiries, it was found that failures in the system hinder the Income Service from being able to work more effectively and efficiently, such as by identifying and creating a report of bad debtors, the ability to put in place dates on the system that needs to be followed up, placing debt on hold with an expiry date so that the debt is not permanently suspended.

5.14 The statistics for monitoring the performance of the Income Service were obtained and it was found that the performance measure is the value of various debts over 6 months of age and monthly collection rate. However, while conducting the audit, it was found that some invoices are not recovered by the Income Service as the debt management is out of their hands and hence the responsibility of verifying and going after these debts falls on other departments which distort this data. Examples identified as exceptions and out of the Income Service's debt collection control include:

Debtor/Flag	Balance (31/08/25)	Responsibility
Prefix 'i'	£1,471,548.75	Trunk Road
Legal charge/estate litigation (S,S1,S2,SL)	£3,629,549.44	Care Finance
Betsi Cadwaladr University	£2,625,867.33	Adults

5.15 However, it is understood that there are no formalised recovery arrangements for the remaining debt (47%), for identifying who is liable for the collection, recovery and reporting of the remaining debts. This means that the Recovery Service has by default accepted responsibility for the debts even though they have no control over the verification procedures or recovery of the debts.

6. Actions

The Income Service with the support of the Ffordd Gwynedd Senior Consultant is committed to implementing the following actions to mitigate the risks highlighted:

- **Establish a service level agreement setting out service responsibilities together with Income responsibilities to ensure that the Council recovers debts in a timely manner.**
- **Automating the processes that are currently being implemented manually e.g. introducing new bill formats, distributing bills, setting up new payment receipt arrangements and creating reports to facilitate the recovery procedure.**
- **Review invoices with relevant Services to verify debts on the system.**
- **A request to the Management Team to consider changing the income recording/identification procedure so that the Service can decide to reverse the income if the income has not been received/recovered after a specified period.**
- **Request to the Management Team to re-review the responsibilities of reporting recovery statistics which are beyond the control of the Recovery Service.**

Appendix 6

PRECEPTS

1. Background

1.1 Precept is the tax set by Community Councils and charged on households within their area. Cyngor Gwynedd is responsible for collecting this tax through Council Tax bills, taking into account the number of households within the community, and their band. The money is transferred in instalments to the Community Councils within the year. The precept is used to fund a wide range of work that goes beyond the work done by the Local Authority, such as maintaining cemeteries, repairing bus shelters, or cutting grass and maintaining footpaths.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that the precepts of Town and Community Councils were being administered appropriately. To achieve this, the audit covered verifying the procedure for administering the precepts for 2025/26, by reviewing the information received from the Councils to ensure that the Council Tax system was producing accurate bills.

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 A sample of 20 Community Councils was selected to ensure that they had received the required precept and that arrangements were in place for Cyngor Gwynedd to collect the correct tax from the dwellings, considering the Community's tax base.

4.2 Records from the Accountancy Unit were verified and it was found that emails had been sent out to the Community Councils at the beginning of December 2024, requesting a budget figure to be returned by the end of January 2025, and it was explained that the budget would be paid in two instalments. It was discovered that some of the Community Councils had not responded within the specified timeframe, but it was noted that the Accountancy Unit had contacted them to remind them.

4.3 Upon receiving the information from the Community Councils, independent checks were being carried out within the Accountancy Unit to ensure accuracy as well as within the Revenue Service when transferring the information to the Council Tax system.

4.4 The Council Tax base is the number of dwellings that are assumed to be in Band D within a Community. The Council Tax base for 2025/25 is calculated by identifying the actual number of dwellings on the Council Tax system as of 31/10/2024 and adjusting it according to forecasts of changes over the following 17 months, further adjusted to consider relevant reductions, converting the different bands to be equivalent to Band D. The calculation of the Council Tax base was discussed with the Council Tax unit and a sample of the figures was reconciled back to the system, and it was found that they were appropriate.

4.5 For a selected sample, the requested precept was followed back to the Council Tax system by dividing the precept with the tax base. Formulas were used to ensure that the parameters of other bands within the system – which are proportional to Band D – were correct. A sample of Council tax bills were verified, and the figures were found to be accurate.

Appendix 7

LLOYD GEORGE MUSEUM ACCOUNTS

1. Background

1.1 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 2024-25 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 2024-25 accounts, giving assurance that the accounts presented to the Charities Commission is correct. This was done by reconciling the accounts with the Council's main accounting system, ensuring that the 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. Main Findings

4.1 Based on the tests carried out, an appropriate audit trail for the figures were seen and the independent examiner's report was completed to state this.

Appendix 8

TAN Y MARIAN

1. Background

1.1 Tan y Marian is based in the town of Pwllheli and is registered to provide residential care for up to 9 residents over the age of 18 who have learning disabilities and 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 ensuring that the home's arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and receipt of income, health and safety, and performance monitoring as well as ensuring that the service users and their belongings 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 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	7
MEDIUM	8
LOW	1

5. Main Findings

5.1 The Care Plans of 3 residents were checked during the visit. It was explained that these receive an annual review by a social worker, as well as monthly internal reviews. For the 3 care plans checked it was found that monthly reviews were not carried out regularly, with 1 plan having not received a monthly review since 2024.

The Manager noted that the content of the plans was up to date, and that they had met the requirements of the social worker carrying out the annual review. For the 3 plans checked, the most recent annual review reports were found to be dated 2024, 2018, and 2014. The Manager suggested that reviews had recently been carried out, but that she had not printed the reports for retention in the plans. Prior to the release of the Draft Report evidence was received that 2 of the 3 plans had been reviewed within the last year.

5.2 On one occasion, it was found that no record of a residents' personal items was present in their care plan, with the records of two other residents inadequate.

5.3 Some of the residents' individual risk assessments, such as 'Bathing', 'Make and Pour a Cup of Tea', had not been reviewed since 2018. This was the case for 2 out of the 3 care plans checked. It was also difficult to pinpoint the date of the last review, with the staff of the home signing and dating in various places on the document. The homes' generic risk assessments were found to be up-to-date, reviewed in the last year, but again, there was no order on the part of signing and dating.

5.4 Since October 2022 adult care home workers have been required to register with Social Care Wales. For the sample of 10 staff members who's training records were checked, 2 were not found to have registered. This was brought to the attention of the Manager. It was confirmed that 1 has now finished working due to medical reasons, with the remaining member of staff having recently registered.

5.5 Of the 4 staff members files selected for review, 3 were found to have been supervised in the last month, although they had not been supervised since 2024 prior to that. For the remaining member of staff, they had not received supervision since April 2024, where they are expected to take place every three months.

5.6 The home's Asset Register was not checked following confirmation from the Manager that it had not been reviewed for 3 years.

5.7 For the 4 residents whose pocket money records were checked, it was found that receipts for ice cream van spending were missing on several occasions, however, given the minimal spending, and the fact that vans do not give receipts, it is assumed that this is acceptable.

5.8 It was found that tests had been carried out on the alarm and fire extinguishers on the week of the visit, however, several tests had been failed prior to that, with tests not carried out at all for the period 08/05/25-20/06/25. It is noted that they are expected to be held weekly.

5.9 The home records staff training internally on a dedicated spreadsheet. Although the Manager noted that the spreadsheet was fairly up-to-date, it was found that no training had been identified for the Manager or the Deputy, with the records of the rest of the staff also incomplete compared to certificates seen at the home, and records on the Gwynedd Job System. Of the 10 members of staff selected for reviewing their First Aid training, none were found to have received training since 2018, where it is expected to be renewed every 3 years.

5.10 Similarly, it was confirmed on the Gwynedd Jobs System that none of the 10 staff members selected had read any of the Council's policies, including the Safeguarding Policy. The Manager explained that staff did not have access to the Policy Centre, with a paper copy of the Safeguarding Policy available at the home. Nor was it seen that a Safeguarding poster was displayed anywhere in the home.

5.11 Not all staff members who provide medication appear to have current training. Of the 10 staff members randomly selected for checking their training records, only 7 provide medication. While the 7 have completed relevant training in the last 3 years, it has been found that none have completed a competency test in the last year.

5.12 The temperature of the medicine room is not monitored daily as expected. The records were checked for July, and the temperature was not recorded for 25/07/25.

5.13 When returning medicine, it was found that the home does not use 'Return of Medication' forms, instead recording details such as the resident's name, the name of the medicine, the number of medicines and the reason for disposal on A4 paper. This will be signed by 2 members of staff, and arrangements will be made for the local pharmacy to collect. It was found that the pharmacy did not sign off on collection, and that there was no alternative documentation attesting to this. The Manager noted that this has been the procedure for years, and that the pharmacy never signed. The Learning Disabilities Delivery and Developmental Manager seconded that BCUHB was also satisfied with the arrangements.

5.14 It was found that the home did not keep all records of incidents resulting from an error with medication together in the medicine room, but rather in the individual files of the relevant residents. Following an enquiry on the numbers of incidents this year, and to view the corresponding records, the Manager confirmed that she was not aware of the numbers, but that there was a recent incident, and that they would collect the documents from the resident's file and submit them to the Auditor. However, these records could not be found.

6. Actions

The Manager is committed to taking the following steps to mitigate the risks identified:

- **Arrange a meeting with relevant staff to remind them of the frequency of reviewing care plans, maintain records and conducting regular checks to detect any underperformance.**
- **Ensure that the reports of the latest Annual Reviews are retained in the care plans.**
- **Ensure that a current record of residents' belongings, in the form of a list or photographs, is kept in their care plans.**
- **Remind relevant staff of the frequency of reviewing individual risk assessments, establishing an effective procedure for recording reviews.**
- **Keep proper records of staff registration dates, regularly monitoring and reminding staff when renewals are required.**

- **Compile a supervision and appraisal rota, ensuring that all staff receive supervision every 3 months, and an annual appraisal.**
- **Ensure that the home has a current record of all its belongings, arranging an annual review, or when buying/disposing of items.**
- **Arrange for resident care plans to be kept in a safe, locked place.**
- **Clearly label each resident's pocket money purse.**
- **Update the training spreadsheet to include up-to-date information, ensuring timely renewal of any training, in particular, First Aid.**
- **Arrange for all staff to read the Safeguarding Policy, and for appropriate records to maintained.**
- **Display a 'Safeguarding' poster in an appropriate place, where all members of staff will see it.**
- **Ensure that all staff who provide medication complete relevant training as soon as possible, including competency tests, and that a record is kept on the home's training spreadsheet.**
- **Ensure that all staff responsible for the provision of medication read the Medication Policy annually, and/or when there is any change, keeping appropriate records.**
- **Remind the relevant staff to record the temperature of the medicine room daily.**
- **Ensure use of correct documentation when disposing of medication.**
- **Create a dedicated folder for keeping records of events, educating staff of the new arrangements, to enable better monitoring and pattern identification.**

Appendix 9

Y FRONDEG

1. Background

1.1 Y Frondeg Home is based in the town of Caernarfon and is registered to provide residential care for up to 11 residents over the age of 18 who have learning disabilities and 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 encompassed reviewing that the home's arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and receipt of income, health and safety, and performance monitoring as well as ensuring that the service users and their belongings 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
SATISFACTORY	**Controls are in place to achieve objectives but there are aspects where the arrangements can be tightened 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	3
MEDIUM	7
LOW	1

5. Main Findings

5.1 The Care Plans of 3 residents were reviewed. It was explained that these receive a monthly review by key employees, who record any change to the resident's condition or practices on a 'post-it', with the Manager then entering the information onto electronic records, printing a current copy for the care plan. Of the 3 plans checked, only 1 had been reviewed monthly for 2025, 1 had not been reviewed since March 2025, and the other had no record of having been reviewed at all in 2025.

The Learning Disability Delivery and Developmental Manager noted that the statutory requirement is to review the plans every 3 months, but that the home maintains monthly reviews as good practice.

5.2 Some of each resident's individual risk assessments, such as 'Out in the Community', 'Driving in the Car', and 'Malnutrition and Dehydration',had not been reviewed since 2024, where they are expected to be reviewed every 6 months. This was the case for the 3 care plans checked. Similarly, it has been found that only 1 of the home's generic risk assessments are current, with the remainder unreviewed for over a year.

5.3 Of the 4 staff members selected for checking their staff files, only 1 has been found to have been supervised within the last 3 months. For the remaining 3, they have not been supervised since 2024. 1 of the 4 has been evaluated in the past year, with another 1 not evaluated since 2023. There was no evidence that any of the other 2 had ever been evaluated, despite working at the home for some years.

5.4 For a sample of 4 members of staff, it was also checked that the hours worked for the month of July were in line with those submitted to the Payroll Service. Discrepancies were observed for 2 members of staff for week ending 26/07/24, where the hours submitted to the Payroll Service were less than what was worked, from half an hour for 1 member of staff, and 1.5 hours for the other. This Assistant Manager investigated in detail during the visit and concluded that a mistake had occurred and would arrange a correction in the next payroll run.

5.5 It was found that the home's Inventory Register had not been reviewed since 2023.

5.6 4 residents were randomly selected for checking their pocket money records. On each occasion the amount of money within the purse agreed with the home's records. However, it was found that there were not many transactions. It was clarified that there are currently 10 residents in the home, of which the Council has financial responsibility over 7 of them. It was found that the home kept a record of spending on the cards, a separate record for each resident (E11 forms). The date of expenditure and the total amount is noted, attaching the receipt, with a member of staff signing. However, it is not possible to conduct a reconciliation, as the home does not receive any bank statements.

5.7 Staff did not sign the visitor book on all occasions when leaving the home. While confirming time of departure, the book wasn't signed on several occasions for the month of September.

5.8 The home records staff training internally on a dedicated spreadsheet. Although the Manager noted that the spreadsheet was up to date, it was found that no training had been identified for some members of staff, with others not included on the spreadsheet at all. Of the 10 staff selected for reviewing their training records, 4 were found to have no current fire training, and 3 no Moving and Handling training, or current First Aid training.

5.9 It was confirmed on the Gwynedd Jobs System that none of the 10 staff members selected had read any of the Council's policies, including the Safeguarding Policy. The Manager explained that staff did not have access to the Policy Centre, with a paper copy of the Safeguarding Policy available at home. It was noted that staff have access to self-service, and therefore the E-learning Portal. The 10 staff members selected were found to have completed several of the Council's mandatory modules.

5.10 The temperature of the refrigerator in the medicine room is not accurately recorded on all occasions. The NHS Medicines External Audit on 25/06/25 noted that neither the minimum nor maximum temperature was being recorded. It was found that the home has since purchased a new thermometer, which calculates the different temperatures. A new, simpler thermometer had since been installed.

5.11 While keeping proper records of incidents as a result of medication error, the records are kept electronically only on the personal files of the residents. Hence, it was difficult to confirm how many cases have been in 2025.

5.12 It was found that the home has a comprehensive Statement of Purpose, but it is not delivered to the standard expected by the Authority.

6. Actions

The Manager is committed to taking the following steps to mitigate the risks identified:

- **Arrange a meeting with relevant staff to remind them of the frequency of reviewing care plans, and to keep proper records, carrying out regular checks to detect any underperformance.**
- **Update care plans regularly to avoid information being lost.**
- **Remind relevant staff of the frequency of reviewing generic and individual risk assessments.**
- **Strive to adhere to the supervision and appraisal rota, ensuring that all staff receive supervision every 3 months, and an annual appraisal.**
- **Continue to train a Senior Carer to enable them to maintain supervision.**
- **Ensure accuracy in the submission of hours worked to the Payroll Service.**
- **Ensure that the home has an up-to-date record of all its belongings, arranging an annual review, or when buying/disposing of items.**
- **Check bank balances online regularly, maintaining reconciliations with the expenditure receipts.**
- **Arrange for a poster to be placed at the visitor book reminding everyone to sign and confirm a time when leaving.**
- **Ensure that the relevant members of staff receive First Aid and Moving and Handling training as soon as possible.**
- **Arrange for all staff to read the Safeguarding Policy, and for appropriate records to be kept of all who have done.**
- **Create a dedicated folder for keeping records of events, educating staff of the new arrangements, to enable better monitoring and pattern identification.**
- **Review the standard of the Statement of Purpose.**

Appendix 10

PLAS PENGWAITH FOLLOW-UP

1. Background

1.1 An internal audit of Plas Pengwaith Home was carried out as part of the 2024/25 audit plan, to ensure that suitable arrangements were in place for managing and maintaining the home appropriately and in accordance with relevant regulations and standards. A limited level of assurance was given to the audit, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of the Audit

2.1 The audit was intended to ensure that the agreed operations resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To achieve this, the audit covered reviewing supporting records and documentation, as well as conducting a site visit.

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 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	1
LOW	0

5. Main Findings

5.1 The home was visited on 04/09/25. Following ringing the bell at the entrance, the Auditor was allowed entry by a resident. Although legally acceptable, with no member of staff present, there is a risk of unauthorised persons gaining entry, and insufficient records of everyone who is in the building for fire purposes. It was explained by the Manager that the bell of the main entrance had been heard, but the door was not approached as she was aware that the resident would open it.

5.2 Of the 5 agreed actions from the original audit, only one was found to have been implemented, the conclusions are reported below.

5.3 It was confirmed that supervision with members of staff is expected to be carried out every 3 months, as well as an annual appraisal. It was found that the Manager had put together a dedicated rota for arranging for everyone to receive sessions in a timely manner, however, it was noted that it was difficult to free up staff to be able to conduct the sessions. Of the 4 members of staff selected for the verification of their records, 2 were found to have not been evaluated in over a year, with no record that the other 2 had ever received an appraisal. In terms of supervision, 2 have not been seen to have been supervised since 08/11/24 and 01/03/23. Although the remaining 2 had received supervision within the last 3 months, prior to that, they had not been supervised since 06/02/24 and 22/06/23. This had already been highlighted in the full audit, as well as by Quality Assurance in their reports following visits on 05/02/24 and 19/05/25.

5.4 The Clerk now maintains a record the date purchase order were created. For the sample of 10 invoices selected between the period 01/04/25-19/08/25, it was found that a purchase order had been created on all occasions prior to receipt of the invoice, with all invoices correctly recorded, and paid in a timely manner.

5.5 After checking the Fire Logbook, it was found that tests were not being carried out in a timely manner on all occasions. The fire extinguishers had not been tested since 26/06/25, where they are expected to be tested weekly. In addition, although the escape routes were checked within one week of the date of the visit, it was found that 7 weeks had been missed between the period 13/03/25-04/09/25. It was also found that records were not dated on all occasions, making it difficult to confirm when exactly the tests were carried out.

5.6 It was confirmed that night staff are responsible for carrying out stock checks on reserve medicines, i.e. complete, unopened medicines, on a weekly basis. It was noted that members of staff kept a 'running count' of medicines opened/in use, on each occasion following the provision of the medicine, noting the figure on the MAR ('Medication Administration Record') form. Checks on the reserve medicines were found to be accurate, and carried out in a timely manner. However, from the sample of 7 different medications on use checked (for 5 different residents), it was found that there was no running count at all for 2, and therefore the homes records were insufficient to enable confirmation that the correct number of tablets were present. This was also found to be the case for several randomly checked medications, which were not part of the selected sample. The Manager noted that she had recently discussed the issue at the staff meetings. It was confirmed that new MAR forms would be prepared immediately, and the number of medicines present would be recorded. It is noted that an external Medication Audit was also carried out on 20/06/25 where it was noted that medicines that had already been provided were not recorded on the MAR forms.

5.7 It was found that there is now a new thermometer in the medication room, and that the temperature was within the correct scales on almost all occasions. However, there are still cases where room and refrigerator temperatures are not recorded daily as expected. This was also noted in the External Medication Audit dated 20/06/25.

6. Actions

The Manager is committed to taking the following steps to mitigate the risks identified:

- **Ensure that fire tests are carried out in a timely manner, and recorded appropriately, considering allocating the task to a specific member of staff.**
- **Ensure that proper records are kept of medications in use, reminding staff of the need to record the correct number of medications on the MAR sheets on each occasion when providing medicine.**
- **Remind night staff to check and record the temperature of the fridge and medication room daily, carrying out regular checks.**
- **Strive to adhere to the supervision and appraisal rota, ensuring that all staff receive sessions in a timely manner, and that any missed sessions are rescheduled promptly.**
- **Ensure that any recommendations or findings arising from internal and external audits are addressed within the stated timeframe.**

Appendix 11

LLYS CADFAN FOLLOW-UP

1. Background

1.1 An Internal Audit of Llys Cadfan Home was carried out as part of the 2024/25 plan, to ensure that suitable arrangements were in place for managing and maintain the home appropriately and in accordance with relevant regulations and standards. A limited level of assurance was given to the audit, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To achieve this, the audit covered reviewing supporting records and documentation, as well as conducting a site visit.

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
SATISFACTORY	**Controls are in place to achieve objectives but there are aspects where the arrangements can be tightened 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 Of the 8 agreed actions from the original audit, 4 were found to have been implemented, the findings are reported below.

5.2 It was found that the home's Statements of Purpose, the Welsh and English versions, although containing all the information expected, was not presented to the standard expected by the Authority, with font size and style varying throughout the document, capital letters in mid-sentences, and unhighlighted headings.

5.3 Although the Manager confirmed that the home's Property Register received an annual review, the register could not be found during the visit for presentation to the Auditor.

5.4 It was found that the visitor's book was not completed on all occasions. For September 2025, there were a large number of occasions where staff and visitors did not sign or confirm arrival or departure times. The Manager explained that following the full audit last year, she had created a poster and displayed it at by the book reminding everyone to complete each section correctly. However, the poster had recently been taken down for re-decorating.

5.5 The home's generic risk assessments are kept electronically, with paper copies also available in a folder to allow better access for staff. It was found that several assessments, such as 'Medicine', Slips Trips and Falls', and 'Arts and Crafts', had not been reviewed for over a year.

6. Actions

The Manager is committed to taking the following steps to mitigate the risks identified:

- **Review the standard of the Statement of Purpose.**
- **Ensure that the home has an up-to-date record of all its belongings, arranging an annual review, or when buying/disposing of items.**
- **Arrange for a poster to be placed at the visitor book reminding everyone to sign and confirm arrival and departure times.**
- **Remind relevant staff of the frequency of reviewing generic risk assessments, carrying out regular checks to ensure that reviews are completed in a timely manner.**

Appendix 12

PLAS HAFAN FOLLOW UP

1. Background

1.1 An Internal Audit of Plas Hafan Home was carried out as part of the 2024/25 plan, to ensure that suitable arrangements were in place for managing and maintaining the home appropriately and in accordance with relevant regulations and standards. A limited level of assurance was given to the audit, although controls were in place, compliance with the controls needed to be improved and/or new controls introduced to reduce the risks to which the service is exposed.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that the agreed actions resulting from the latest full audit were implemented in a timely manner to mitigate the risks identified. To achieve this, the audit covered reviewing supporting records and documentation, as well as conducting a site visit.

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
SATISFACTORY	**Controls are in place to achieve objectives but there are aspects where tightening of the arrangements is expected 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 Of the 7 actions agreed from the original audit, 5 were found to have been implemented, the conclusions are reported below.

5.2 Care plans are kept in cupboards in the foyer. Where previously the keys were kept on an overhead hook, where all visitors to the home had access, a key safe is now located near each cupboard, with all staff aware of the code. However, while walking around the home, it was found that one cupboard was open, with the keys in the lock. The Manager explained that staff were currently updating the plans in the room next door, which is why the cupboard door was open.

5.3 A sample of 4 members of staff were selected, verifying that the hours for them on the work rota for a period of 3 weeks between 06/07/25-26/07/25 were in accordance with the spreadsheet submitted to the Payroll Service. One staff member's hours could not be reconciled at all, with the home's records confirming contract hours of 21 hours per week for her, but the spreadsheet indicating a 14-hour contract. It was explained that the staff member in question had reduced her hours from 21 down to 14, but that was not until the 27th of July. The Manager noted that they had not realised that the contract hours had been changed on the spreadsheet before, adding that similar adjustments were the responsibility of the Support Service. The Support Service confirmed that they had implemented the change in hours in accordance with the staff member's request, which was from the 27th of July. It was therefore asked why the spreadsheet dated 6th of July stated the contracted hours as 14 hours instead of 21 hours. No response had been received as of the release of the draft report. The pay slip of the staff member concerned was checked on the CYBORG (Payroll system) system, the August payslip, which is salary for the hours worked for the month of July, with that also confirming basic pay based on contract hours of 14 hours. There is a likelihood that the staff member did not realise the error as salary arrears was paid to all Council staff members that month as well. All evidence was submitted to the Home's Manager for investigation, suggesting that any due hours be paid to the staff member as soon as possible.

5.4 Of the 10 staff selected for the verification of their training records, it was found that all relevant staff members had completed Fire, First Aid, Movement and Treatment, and Medication training within the last 3 years.

6. Actions

The Manager is committed to taking the following steps to mitigate the risks identified:

- **Remind staff to lock the cupboards where care plans are kept on all occasions, keeping the key in the safe.**
- **Investigate discrepancies in the hours paid to one member of staff, in consultation with the Support Service, and ensure that any hours due are paid as soon as possible.**

Appendix 13

DIRECT PAYMENTS

1. Background

1.1 1,941 of Direct Payments were made from the period April to August 2025 amounting to the equivalent of £2.1million. There has been an encouragement to increase the numbers over the last few years to reduce reliance on traditional care through the Council. Direct Payments (DP) are paid to an eligible person that meets the criteria and an assessment from Social Services. The Direct Payments Team implement DP applications referred by the Social Services for Adults and Children Department and provides support to the social workers.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that suitable arrangements were in place to process Direct Payments (DP) and to check compliance with the relevant regulations such as the Care and Support (Direct Payments) (Wales) Regulations 2015 and the Social Services and Well-being (Wales) Act 2014. To achieve this, the audit encompassed checking the processing arrangements for direct payment applications to ensure that applications were processed in a timely and accurate manner against the care assessment, reviewing monitoring arrangements, financial records and care plans to support the direct payments.

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	3
LOW	0

5. Main Findings

5.1 The initial meeting was held in July 2025 and found that the Service has been undergoing transformation over the past few years and continues to operate on new plans since the appointment of the Resource and Financial Planning Manager in November 2022. Many improvements were underway and as a result the audit will be conducted and reported in two parts. Part one of the audit reports on the risks identified to date and part two will report on the operations planned to be implemented/completed by the end of January 2026 and any further risks that need to be mitigated, where relevant.

5.2 There is an increase in the numbers receiving DP and social workers seem to have been provided with regular support through contact, visits and conversations. These activities raise awareness of direct payments and enable the social workers to recommend where appropriate, the provision of care through DP to their clients, explain how DP works, encourage and support them effectively.

5.3 For the audit, a sample of managed and non-managed direct payments were selected. The sample was checked to ensure that the DP Service received a care plan or instructions from the Social Workers with an assessment of the hours of care. From the sample verified, it was found that proper instructions were given and the payments were processed correctly. Where there was a difference to the care plan, the DP Officer explained that clients were unable to employ a carer and were therefore claiming fewer hours than they were entitled to.

5.4 When checking the sample, no regular reviews (at least once a year) of the care plans was seen. The Direct Payments Officer expressed that care plans are not received following every review by the social workers, only for ones where changes affect the DP, although there is a possibility that some do not receive an annual review. Procedure have recently been put in place for identifying high amounts of DP accumulated in individuals' bank accounts, which suggests that the money is not being used and that the social workers need to carry out a review to confirm the reasons/ the client situation in order to be able to make the decision to whether they need to recover the payments. This is currently operational for managed DP only due to the convenience of checking the bank statements through the third party companies. For the 'non-managed', it is dependent on the willingness of the individual receiving DP to promptly provide the bank statements for carrying out checks.

5.5 It is the Social Workers responsibility to validate care applications and the Care Finance Team carry out a financial assessment on the client to identify if the individuals need to contribute towards their care. The social workers refer any DP requests to the DP Officer for implementation and payment will be received on the basis of the hours assessed. All payments are paid gross to DP accounts.

Adjustments are made i.e. if the individual is responsible for contributing towards their care costs, an invoice is raised by the Care Finance Team following the processing of the payments by the DP Officer, which is recorded on the WCCIS system.

5.6 The Resource Manager explained that the payments are processed on monthly runs and is loaded by IT and interfaced into the Council's payments system. Access to the monthly runs was granted and it was found that it was possible to reconcile the amounts to the main spreadsheet by the Payments Officer. The DP Officer is responsible for processing the payments with the Resource and Financial Planning Manager approving the payments.

5.7 No formal agreement was seen with terms and conditions in place for DP's clients prior to the receipt of any payments. The Resource Manager expressed that this is also a restriction to carrying out monitoring work on DP usage, and as such, an agreement has been drafted and is in the process of being reviewed by the Legal Service (August 2025).

5.8 To facilitate the monitoring process, the Resource and Financial Planning Manager reported that the service has decided to operate on 'prepaid cards' rather than allowing clients open their own accounts in the future. It is planned to transfer all clients to 'prepaid cards' which will allow the Council to receive direct access to the bank statements for inspection should it be required in the future.

5.9 No formal documentation has been distributed to DP's clients highlighting the client's responsibilities and spending constraints and as a result, there is a risk that DP clients are not aware or acting inappropriately.

6. Actions

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

- **Distribute a direct payments agreement with a clarification letter to DP clients to agree.**
- **Responsibilities are communicated through a letter and a formal agreement to ensure clients are aware of their expectations to managing DP.**
- **Establish arrangements and a plan for the regular monitoring of DP expenditure.**
- **Obtain the bank statements of clients with high DP balances and conducting enquiries with the social workers for reviewing the care plans.**
- **Establish arrangements for the provision and transfer of clients to use 'prepaid cards'.**
- **Conduct DP expenditure validation checks.**

CEGIN ARFON

1. Background

1.1 The Learning Disability Service has a number of community hubs across Gwynedd, among them, Cegin Arfon. In this setting, individuals with learning disabilities receive employment opportunities and learn new skills in a way that is open to the community. The café is located at Arfon Leisure Centre and sells drinks, cakes and light meals.

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 learning disability centres and in accordance with relevant regulations and standards. To achieve this, the audit covered visiting a sample of centres and ensuring that arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and receipt of income, health and safety, and performance monitoring as well as ensuring that the service users and their belongings 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 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	4
LOW	1

5. Main Findings

5.1 The café was visited on the afternoon of Friday, 7th November 2025. Service users were not present. The café was found to be clean and organised, with staff engaging with customers in a pleasant manner.

5.2 It was found that the café did not keep a register of staff or users on site. The Learning Disability Support Service Leader explained that there is a very small group of staff and users on site at any given time.

5.3 It was confirmed that staff are expected to complete Food Hygiene training every 3 years. The records of all staff members (4 in total) were checked, where it was found that none had completed training since 2020. It was also found that staff had not completed many of the Council's mandatory E-learning modules, with none having accepted the Safeguarding Policy. By the time the draft report was released, it was confirmed that the relevant member of staff had commenced a Food Hygiene course, and that a training matrix is being developed to allow better monitoring.

5.4 It was not seen that an Asset Register was maintained. However, a proper register had been created prior to the release of the Draft Report.

5.5 Prior to the visit, data was exported from the ledger in relation to the kitchen's expenditure, selecting a sample of 10 transactions and asking to see the corresponding invoices. It soon became apparent in the audit that, due to difficulties in locating the invoices, there were no adequate arrangements in place for recording, ordering, or paying for goods. The Leader agreed that the audit had been an eye-opener, and by the time of the visit, had established an effective system for orderly recording and keeping invoices together. Before the release of the Final Report it was confirmed that a Clerk was now available to support Cegin Arfon.

5.6 During the visit the kitchen's income records were checked for a period of one week at the end of October 2025. On each occasion the money and income from the PDQ machine matched end-of-day receipts from the till. However, an inconsistency was observed in the kitchen's banking arrangements

5.7 It was confirmed that staff did not receive an annual appraisal at all, and that the Leader was not able to carry out supervision every 3 months as expected.

6. <u>Actions</u>

The Learning Disability Support Service Leader is committed to implementing the following actions to mitigate the risks highlighted:

- **Order an attendance board to be located on the kitchen wall.**
- **Create an Asset Register, ensuring that any new items are added promptly, and any items that are disposed of are deleted.**
- **Arrange for all staff to complete Food Hygiene training every 3 years.**
- **Remind staff of the need to complete the Council's mandatory e-learning modules.**
- **Ensure that all staff read the Safeguarding Policy.**
- **Continue with the new arrangements of orderly recording and keeping invoices, investigating why there is no need for purchase orders.**
- **Ensure that money is banked regularly.**
- **Establish effective arrangements for ensuring staff receive an annual appraisal and supervision every 3 months.**

Appendix 15

SIOP GALWCH ACW

1. Background

1.1 The Learning Disability Service has several community hubs across Gwynedd, among them, Siop Galwch Acw. The shop is located in Caernarfon town centre and helps to develop employment and creative opportunities for users through crafts and art.

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 learning disability centres and in accordance with relevant regulations and standards. To achieve this, the audit covered visiting a sample of centres and ensuring that arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and receipt of income, health and safety, and performance monitoring as well as ensuring that the service users and their belongings 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 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	3
LOW	1

5. Main Findings

5.1 The shop was visited on Thursday, 18th December 2025 in the presence of the Learning Disability Support Service Leader, the Clerk, and several other members of staff. The staff were welcoming and willing to help, with all the required documents ready and waiting for the Auditor. Users seemed to enjoy themselves and communicate easily and cheerfully with staff, while participating in activities in clean and safe areas.

5.2 However, it was found that staff do not receive an annual appraisal or supervision every 3 months on all occasions. Of the 4 members of staff selected for the verification of their records, it was found that all were last supervised 4 months prior to the date of the visit. No appraisal records were seen. It is noted that lack of evaluation is a weakness across the service, and that they are looking at ways to carry them out effectively.

5.3 It was not seen that an Asset Register was kept. It was suggested that it would be beneficial to have an up-to-date register for insurance purposes. The Learning Disability Support Service Leader noted that she had already started compiling a register.

5.4 It was found that the shop does not have effective arrangements for recording and processing income. With the till being old and failing to create proper reports, the shop staff must record all sales manually, on paper. It was explained that the sales record at the till is used to reconcile the money, but does not reconcile on all occasions, with staff sometimes forgetting to record each transaction. The Auditor was surprised that the shop did not have a TR34 book for recording the income and confirming sales codes. It was noted that the only record following banking is a receipt, which is kept in the safe in the store. It is noted that out of the 5 income samples the Auditor asked to see the receipts for, receipts were missing for 4 of them.

5.5 It was found that fire tests were not being carried out in a timely manner on all occasions, with tests on fire exits and fire extinguishers not being carried out since 29/10/25, where they are expected to be carried out weekly

5.6 A Safeguarding poster was not seen displayed in the shop. The Auditor arranged for a copy to be provided. It is noted that while the lack of email addresses for staff makes it difficult to access the Safeguarding Policy, it has been found that commendable efforts have been made to familiarise staff with the contents.

6. Actions

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

- **Compile a supervision and appraisal rota, ensuring that all staff receive supervision every 3 months, and an annual appraisal.**
- **Ensure that the shop has an up-to-date record of all its belongings, arranging an annual review, or when buying/disposing of items.**
- **Establish effective arrangements and a specific timetable for reconciliation and processing of income, ensuring the use of TR34 forms as to enable an adequate audit trail.**
- **Ensure that fire tests are carried out in a timely manner, and appropriate records are maintained.**
- **Display a Safeguarding poster in a prominent location.**

CANOLFAN Y GWYSTL

1. Background

1.1 The Learning Disability Service has several community hubs across Gwynedd, among them, Canolfan Y Gwystl. The centre is the main hub for the Dwyfor area and offers new opportunities for users including a takeaway meal service, Popty Prysur kitchen, and a hairdressing salon.

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 learning disability centres and in accordance with relevant regulations and standards. The audit encompassed visiting a sample of centres and ensuring that arrangements were adequate in terms of administration and staffing, budgetary management, procurement of goods and receipt of income, health and safety, and performance monitoring as well as ensuring that the service users and their belongings 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 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	3
LOW	0

5. Main Findings

5.1 The centre was visited on Tuesday, 11th of November 2025 in the presence of the Learning Disability Support Service Leader and Deputy Leader. The staff were welcoming and willing to help, with all the required documents ready and waiting for the Auditor. Users seem to enjoy themselves and communicate easily and cheerfully with staff, while participating in activities in a clean and safe environment.

5.2 Although visitors to the centre were signing in and out appropriately, it was found that there were insufficient fire records for the staff members on site. There is a document next to the Visitor Book where staff can mark their attendance, however, very few staff use it, and there is no place to record arrival and departure times

5.3 Staff do not receive an annual appraisal or supervision every 3 months on all occasions. Of the 4 members of staff selected for the verification of their records, 1 was found to have no record of supervision at all, with the remaining 3 having been last supervised in 2020 and 2019. The Learning Disability Delivery and Developmental Manager confirmed that lack of appraisals is a weakness across the service, and that they are looking at ways to do this effectively.

5.4 It was confirmed that timesheets are only prepared for casual staff at the centre. It was explained that the hours worked were recorded on an 'attendance sheet', which was then used to create a timesheet to be submitted to the Payroll Service. While the Vice Leader prepares the leaflets, staff members check and sign them. It was decided to verify each staff member's timesheets for September 2025, comparing the claimed hours against the 'attendance sheet'. For the period, 4 members of staff had submitted timesheets. Of the 4, the hours for 2 could be agreed. Discrepancies were found for the remaining 2, where entire shifts were recorded on the 'attendance sheet' without being recorded at all on the timesheets.

5.5 It was seen that an Asset Register was not maintained. It was suggested that it would be beneficial to have an up-to-date register for insurance purposes.

5.6 A sample of 10 staff members were selected to review their training records. Of the 10, none had current fire training, with 7 without current Movement and Handling training either. First Aid training for 4 staff members had come to an end, with only 6 having completed the mandatory Safeguarding e-learning module. It is noted that staff training is only recorded on the Gwynedd Job System.

5.7 It was clarified that the Support Workers did not have a Council email address, and therefore did not have access to the Policy Centre. The records of the Gwynedd Job System confirmed this, as none of the 10 members of staff in the sample had read the Safeguarding Policy. It is noted, however, that the Leader is also among the sample, who has an email address. It was confirmed that every effort is being made to enable access for all staff.

5.8 A sample of 5 users was selected for checking their individual risk assessments. It was found that there were several assessments for each user. While some of the assessments have been reviewed in the past year, some have also been found to have not been reviewed since 2017. The Leader suggested that these had been reviewed but had not been signed. It was noted that the centre’s generic risk assessments are all up to date.

6. Actions

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

- **Ensure that members of staff sign in and out of the centre, noting arrival and departure times.**
- **Compile a supervision and appraisal rota, ensuring that all staff receive supervision every 3 months, and an annual appraisal.**
- **Investigate discrepancies in the hours paid to two members of staff, ensuring that any hours due are paid promptly.**
- **Ensure accuracy in the preparation of timesheets, encouraging staff to check that the hours are correct before signing.**
- **Ensure that the centre has an up-to-date record of all its property, arranging an annual review, or when buying/disposing of items.**
- **Consider creating a training spreadsheet to enable better monitoring, ensuring timely renewal of any training after it has ended First Aid, Fire, and Moving and Handling.**
- **Remind staff to complete the Council's mandatory e-learning modules, continuing to strive for access for all to the Policy Centre.**
- **Ensure that users individual risk assessments receive regular reviews, at least once a year.**

Appendix 17

YGC SUCCESSION PLANNING

1. Background

1.1 Ymgynghoriaeth Gwynedd Consultancy (YGC) is a commercial entity within the Highways, Engineering and YGC department of Cyngor Gwynedd, carrying out civil engineering and construction work.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that YGC has appropriate workforce planning arrangements, to meet client requirements for the future. To achieve this, the audit encompassed reviewing succession arrangements for key roles, and the steps the department is taking to develop staff so they can step up when opportunities arise.

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	1
LOW	0

5. Main Findings

5.1 It's good practice for every department to plan its workforce for the future, identifying key roles and putting arrangements in place to try to ensure succession. The 'Human Resources Intranet' raises awareness of the need for workforce planning, explains why it is important, and provides support on how to do it.

5.2 YGC operates in a specialist, multidisciplinary industry, and Senior Officers are expected to hold relevant professional qualifications such as RICS, IEng, CEnv and CEng. This is essential to attract work and generate income for the Council. The department has already recognised the risk of current workforce members approaching retirement age, and the need to maintain a skilled and qualified workforce to meet future business needs.

5.3 To this end, YGC has prepared a new Business Plan committing to invest in the professional development of its staff and to plan strategic succession. To support this, a Workforce Planning Strategy is being drafted. Workforce planning and succession issues have been discussed informally, but the aim is to formalise these arrangements within the new strategy. A meeting is planned for January 2026 to assess YGC's short, medium and long-term business needs — the first of such meetings intended to be held twice a year. These meetings will aim to ensure that workforce planning aligns with YGC's Business Plan and strategic goals.

5.4 As the work is in progresses, the audit will be revisited in 2026–27 to ensure that the strategy is operational and bearing fruit.

6. Actions

The Assistant Head has committed to implementing the following to mitigate the risks highlighted.

- **That YGC's Workforce Planning Strategy is formally approved and that plans aligned with the strategy are put into action.**

Appendix 18

BUSINESS CONTINUITY PLAN

1. Background

1.1 A Service Continuity Plan is a proactive planning process that seeks to ensure that critical services continue to be delivered during a crisis. They detail plans and actions that ensure users are not left without services they depend on in cases where there is a significant unexpected disruption or a complete failure to deliver the service.

2. Purpose and Scope of Audit

2.1 The purpose of the audit was to ensure that department had appropriate arrangements in place to continue providing services during a period of crisis. To achieve this, the audit included reviewing business continuity arrangements, including response arrangements, management, lessons learned, risk logs, training and monitoring.

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 It was observed that work had been carried out on the development and improvement of Service Continuity Plans for the Highways, Engineering and YGC department in accordance with the requirements of the new template of the Business Continuity Management Framework of the Regional Emergency Planning Service of North Wales Councils. The department is in a much better position than it was a few months ago, and was one of the first departments within the Council to collaborate with a leader from the Regional Emergency Planning Service of North Wales Councils (GCAR-CGC) to draft the document and mitigate the risks that an emergency would pose.

5.2 It was asked where the plan is kept, and the Head confirmed that a hard copy will be available in the Office of the Head's Secretary in Penrallt, Caernarfon. An electronic copy will also be available on the department's iGwynedd site, where all key staff of the department have access to it.

5.3 The department has a risk register that considers the main risks that could affect day-to-day operations, and it was found that these risks have been included in the Continuity Plan. Some of the main risks identified in the risk register are floods, severe weather, climate change, and security and IT risks. A clear link was observed between the continuity plan and the risk register, with service priorities listed, as well as solutions and business continuity action steps for various events, e.g., loss of staff, loss of IT systems, loss of utilities, loss of access to property and workplaces, and loss of key suppliers.

5.4 It was observed that the department had designated staff in senior or leadership positions to implement the plan and ensure timely compliance in the event of an emergency. Part 8 of the plan includes a list of these staff with their contact details and responsibilities. The Head explained that no exercises on the plan have taken place so far, but if an update or issue arises, 'toolbox talk' sessions are held with the workplace. There were no formal records of any lessons learned or post-incident reports available. Scenario exercises and training to test the Plan is something the department wants to consider. The Head is Chair of a weather Group for North Wales, and there is also an emergency Group among Council department heads that has been meeting quarterly since the pandemic.

5.5 The Council works with neighbouring councils to assist in an emergency. The Council can also ask other local authorities for help when needed, and a list of providers is included in the Continuity Plan. Although Cyngor Gwynedd has not requested assistance so far, it has been successful in providing support to other authorities, e.g., Flintshire recently in a case of fire.

6. <u>Actions</u>

The Highways, Engineering and YGC has committed to implementing the following steps to mitigate the risks highlighted.

- **Provide training on the Plan and scenario exercises to test its effectiveness, and the department's ability to continue operating during a crisis.**
- **Follow the correct procedure for recording any lessons learned and create reports following events.**

FALLING TREES

1. Background

1.1 Gwynedd Council owns and manages several areas where trees and shrubs grow. Many of these areas offer some degree of public access, and therefore the Council has a duty of care to ensure, as far as is reasonably practicable, that all trees on their land are maintained in an acceptable condition and do not pose an unreasonable danger to persons or property.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure that suitable arrangements are in place to ensure that the Council complied with statutory duties under the Highways Act 1980, and the Tree Preservation Orders regulations. To accomplish this, the audit encompassed reviewing the tree management policy, the frequency of inspections, risk grading methods, operations along with insurance arrangements. As the Department of Highways, Engineering and YGC are responsible for the majority of the Council's tree stock and serve as the main service for operational tree matters, the audit has focused mainly on their arrangements. Nevertheless, the findings are relevant across the entire Council.

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 Score Risk

4.1 The audit's risks are as follows:

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

5. Main Findings

5.1 The Council recognises that the management of falling trees poses corporate risks to the Council, and as a result has been included on the corporate risk register. Not only are there obvious environmental risks, but economic and health and safety risks from trees or branches falling on individuals, buildings, roads and vehicles.

5.2 At present, several small teams are responsible for different trees across areas of Gwynedd, with a dedicated Ash Dieback team set up in response to any ash dieback disease. Engineers from the Arfon, Dwyfor and Meirionnydd areas were questioned about their arrangements for conducting inspections of the trees, and it was discovered that only reactive work is currently being undertaken, where they will cut down trees as required. Annual proactive audits are not carried out by Highways teams, and they do not use a system to record their work.

5.3 A member of the Internal Audit Service brought a dangerous branch to the attention of the department via the Council's website. The branch had split above a public driveway and was about to fall. An officer came to inspect the branch within the hour, and the branch was safely cut within three weeks. The engineers will often use contractors and contact the ash dieback team to enquire if they have the capacity to carry out work from them.

5.4 A sample of trees assessed to be high risk (excluding ash trees were subject to specific internal audit) was selected across the three areas. As no records were available from the Highway teams, the Ash Team was questioned, and the sample was selected from their system, Ezytree, which also includes general trees. From the sample selected, and the records reviewed, it was found that 8 of the 15 trees had been inspected by the ash dieback team in the last two years. Some of the trees in the sample are located on or around Bontnewydd school, Glan y Môr school, Parc y Dre Caernarfon, Harlech park, some near parts of the A499, A497 and A493. The majority of the trees assessed as high risk were found to remain standing without further operation despite a recommendation to cut them down. The hope is that trees will be inspected at least every two years, and fragile trees annual until they have been pruned, but the lack of resources creates a risk of not being able to achieve this. Despite the relatively low probability of a tree or branch falling and causing injury or death, it is difficult to prove whether the current inspection is sufficient.

5.5 The Ash Dieback Senior Officer was questioned about the above sample and confirmed that the trees remain on the system and have not been cut. Their practice is to check the inspection data annually to gather ash tree information, and if they find trees that are not ash trees, they send a report to the responsible department for action. He confirmed that they are continuing to go through the data for the current year and the tree lists will go out as soon as possible to the appropriate teams. The Assistant Head of Department expressed that there is a need to have one Corporate tree team across the Council, but that this is quite a long way off at the moment.

5.6 Due to a lack of resources, the teams prioritise based on the likelihood and impact of an incident, and therefore inspect trees that are on, or close to, main roads, schools, cemeteries, and other public open spaces. As a result, several quieter roads and lands are still awaiting planned inspections, with the need to revisit high-risk sites to determine whether tree condition degradation is priority.

5.7 The shortage of resources is known to the Council, but several bids for additional funding to employ foresters have been unsuccessful. A successful application would have meant being able to sustain more of the work program and cutting trees.

5.8 A Tree Risk Management Policy is being developed at the time of the audit. However, the challenging resource situation means there is a risk that the trees will not be inspected and treated as frequently as indicated in the planned schedule.

5.9 A Corporate Tree Group has been established to develop a strategy that sets a long-term vision for the Council's trees and woodlands. The strategy will establish principles to protect, maintain, manage risk, and expand trees across several work streams. The strategy will include policies and plans that align with these principles.

6. Actions

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

- **Publish the Tree Risk Management Policy as final.**
- **Ensure that further discussions within the Corporate Tree Group are held in order to establish a single Corporate team across the Council to manage trees.**
- **Submit a bid for more resources.**
- **Cutting the trees that have been identified as high-risk in areas of high priority, within the resource limitations of the Service.**

Appendix 20

HOMELESSNESS PREVENTION GRANT 2024-25

1. Background

1.1 The Welsh Government allocated a £895k grant to Gwynedd during 2024/25 as part of a homelessness prevention campaign, divided into the 'No one left out' element (£663k) to fund support such as temporary accommodation and support that cannot be funded through the Housing Support Grant, £172k for discretionary homelessness prevention support to be used in a flexible way with the overall aim of preventing homelessness and supporting measures that reduce dependence on temporary accommodation, and £60k to fund a Strategic Coordinator position.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to ensure the appropriateness of the audit certificate for 2024/25 by verifying the claimed costs, as well as ensuring that the Service complied with the conditions of the grant offer letter.

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 introduces new controls to reduce the risks to which the service is exposed.**

4. Current Score Risk

4.1 The audit's risks are as follows:

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

5. Main Findings

5.1 In accordance with the requirements of the grant offer letter, an audit certificate for 2024/25 is required to be completed by 30 September 2025. The audit certificate confirms, among other things, the total grant allocated to the Authority, the expenditure, and the grant claimed during the year. However, no grant claims were submitted during the year and therefore the payments have not been paid to the Authority. It was decided not to sign the audit certificate until the grant has been received. This issue was also raised during the 2023/24 internal audit of the grant.

5.2 The grant offer letter states that the funding must be claimed on a quarterly basis in accordance with the Welsh Government's timetable, and they reserve the right to withdraw the grant offer if the Council does not claim promptly. A claim for the whole year was submitted after the end of the financial year, but no progress report was submitted, which is one of the required supporting documents the Welsh Government requires before releasing the money. The Service is in the process of preparing the report.

5.3 The Homelessness Prevention Grant has now ended, and from 2025/26 onwards, the Welsh Government has transferred the equivalent funding into the core financial settlement.

6. Actions

The Service has committed to implementing the following to mitigate the risks highlighted:

- **Submit a progress report to the Welsh Government and the Council's Head of Finance to be able to claim the Homelessness Prevention Grant.**

Appendix 21

HOUSING SUPPORT GRANT

1. Background

1.1 The Housing Support Grant is an early intervention grant programme, which helps prevent people from becoming homeless, stabilise their situation in terms of housing, or help individuals that could become homeless to find a home and retain it. It supports vulnerable people to address problems such as debts, employment, tenancy management, substance misuse, violence against women, domestic and sexual abuse, and mental health issues. Up to £7.4m was allocated to Gwynedd by the Welsh Government during 2024/25.

2. Purpose and Scope of the Audit

2.1 The purpose of the audit was to certify the Housing Support Grant's audit certificate for the 2024/25 financial year, by reviewing the costs claimed, as well as ensuring that the Service had complied with the conditions of the grant offer letter.

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.**

5. Current Score Risk

4.1 The audit's risks are as follows:

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

5. Main Findings

5.1 In accordance with the requirements of the grant offer letter, an audit certificate is required to be completed by 30 September 2025. The audit certificate confirms, among other things, the total grant allocated to the Authority, the expenditure, and the grant claimed during the year. The certificate also requires the Internal Auditor to confirm that the expenditure is appropriate and contributes towards achieving the objectives of the grant, in line with the requirements of the offer letter.

5.2 Although the audit certificate wasn't completed within the timetable, based on the tests carried out it was found that there is an audit trail to the figures and assurance can be given on the appropriateness of the Housing Support Grant audit certificate for the 2024/25 financial year. All the money has been claimed and received during the year.

6. Actions

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

- **Ensure that the 2025/26 audit certificate is submitted to the Welsh Government in accordance with the timetable.**