

COMMITTEE	GOVERNANCE AND AUDIT COMMITTEE
DATE	29 SEPTEMBER 2026
TITLE	OUTPUT OF THE INTERNAL AUDIT SECTION
PURPOSE OF REPORT	TO OUTLINE THE WORK OF INTERNAL AUDIT FOR THE PERIOD TO 20 SEPTEMBER 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 1 April 2026 to 20 September 2026.

2. WORK COMPLETED DURING THE PERIOD

- 2.1 The following work was completed in the period from 1 April 2026 to 20 September 2026.:

Description	Number
Reports on Audits from the Operational Plan 2026-27	11

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

2.2 Audit Reports

2.2.1 The following table shows the audits completed in the period from 1 April 2026 to 20 September 2026, indicating the relevant assurance level and a reference to the relevant appendix.

TTITLE	DEPARTMENT	ASSURANCE LEVEL	APPENDIX
Harbours Statement of Accounts 2025/26	Finance	High	Appendix 1
Welsh Church Fund	Economy and Community	High	Appendix 2
Lloyd George Museum Accounts	Economy and Community	High	Appendix 3
Cefn Rodyn	Adults. Health and Wellbeing	Limited	Appendix 4
Hafod Mawddach	Adults. Health and Wellbeing	Limited	Appendix 5
Tan y Marian – Follow-up	Adults. Health and Wellbeing	Satisfactory	Appendix 6
Plas Hedd – Follow-up	Adults. Health and Wellbeing	High	Appendix 7
Plas y Don – Follow-up	Adults. Health and Wellbeing	Satisfactory	Appendix 8
Direct Payments	Adults. Health and Wellbeing	Limited	Appendix 9
Siop Galwch Acw – Follow-up	Adults. Health and Wellbeing	Satisfactory	Appendix 10
Cegin Arfon – Follow-up	Adults. Health and Wellbeing	Satisfactory	Appendix 11

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

LEVEL OF ASSURANCE	HIGH	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.
	SATISFACTORY	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.
	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. ROOT CAUSE CATEGORY

- 3.1 In accordance with the requirements of the Global Internal Audit Standards, Standard 14.3 Evaluation of Findings, ***“internal auditors must evaluate each potential engagement finding to determine its significance. When evaluating potential engagement findings, internal auditors must collaborate with management to identify the root causes when possible, determine the potential effects, and evaluate the significance of the issue”.***
- 3.2 The Internal Audit Service has identified 10 main categories for root cause analysis:

1. Governance

Definition: How clearly the service is governed, including roles, responsibilities, decision-making authority, statutory duties, and risk/control arrangements.

Examples of Audit Findings: unclear governance structures; outdated policies; responsibilities not assigned; gaps in statutory compliance; weak oversight or scrutiny.

2. Process & Procedures

Definition: How well processes are designed, documented, understood, and followed consistently.

Examples of Audit Findings: procedures not followed; steps missing; reliance on 'custom and practice'; poor segregation of duties; controls bypassed.

3. Accountability

Definition: Clarity and acceptance of ownership for decisions, tasks, risks, and compliance across the service.

Examples of Audit Findings: unclear task ownership; failure to escalate; avoiding responsibility; weak management oversight; decisions deferred.

4. Assurance & Monitoring

Definition: How effective performance, quality, risk and compliance are checked, monitored and reported.

Examples of Audit Findings: repeated issues not identified; weak KPI reporting; supervisory checks are infrequent, undocumented or inconsistent; ineffective supervision.

5. Resources

Definition: Whether the service has enough people, capacity, skills, time, and funding to deliver statutory and operational duties.

Examples of Audit Findings: vacancies; staff overstretch; insufficient cover; only urgent tasks completed; lack of funding for service demand.

6. People, Skills & Training

Definition: Whether staff have the skills, training, supervision and competency required to deliver services safely and effectively.

Examples of Audit Findings: expired training; inadequate induction; missing competency checks; insufficient expertise; skills gaps.

7. Systems, IT & Digital Tools

Definition: How well systems support reliable, efficient and compliant service delivery (accuracy, access, automation, integration).

Examples of Audit Findings: outdated systems; manual workarounds; lack of reminders; poor system access; no integration with partners.

8. Information Management & Record Keeping

Definition: How well information is recorded, stored, shared and controlled.

Examples of Audit Findings: missing records; inconsistent documentation; no audit trail; version control issues; poor information sharing.

9. Communication & Coordination

Definition: Effectiveness of communication within teams, across services, and with external partners.

Examples of Audit Findings: breakdowns at handover; unclear instructions; poor coordination; partners not informed; delayed escalation.

10. Risk Management & Culture

Definition: How the service identifies and manages risks, and how culture supports openness, learning and improvement.

Examples of Audit Findings: known risks ignored; resistance to change; staff fear reporting issues; repeated problems normalised.

4. WORK IN PROGRESS

4.1 The following work was in progress as at 20 September 2026:

- Supply Teachers (*Education*)
- Pollution Control (*Environment*)
- Building Control Invoicing and Recovery Arrangements (*Environment*)
- Procurement – Category Management - People (*Corporate Services*)
- Health and Safety – Departmental Arrangements (*Corporate*)
- Lone Working (*Corporate*)
- Council Tax – Recovery and Write-off of Debts (*Finance*)
- Beach Management Plan (*Economy and Community*)
- Cist Gwynedd (*Economy and Community*)
- Balchder Bro (*Economy and Community*)
- Glyn Rhonwy (*Economy and Community*)
- Bryn Blodau (*Adults, Health and Wellbeing*)
- Canolfan y Gwystl – Follow-up (*Adults, Health and Wellbeing*)
- Bereavement Service (*Highways, Engineering and YGC*)
- Legionella (*Housing and Property*)
- Housing Support Grant (*Housing and Property*)
- Commissioning Arrangements – Housing Support Grant (*Housing and Property*)

5. RECOMMENDATION

5.1 The Committee is requested to accept this report on the work of the Internal Audit Section in the period from 1 April 2026 to 20 September 2026, comment on the contents in accordance with members' wishes, and support the actions agreed with the relevant service managers.

HARBOURS STATEMENT OF ACCOUNTS 2025-26

<i>Assurance Level</i>	<i>Definition</i>
High	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.

1. Background

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

2. Purpose and Scope

- 2.1 The purpose of the audit was to confirm the accounts on the Harbours' annual accounting statement for the 2025-26 financial year, as well as to confirm that appropriate internal controls were in place.

3. Main Findings

- 3.1 Assurance can be given that the Harbours' accounting statement for the 2025-26 financial year was appropriate. Based on the tests carried out, it was seen that there was an appropriate audit trail for the figures and that the internal controls could be relied upon to achieve their objectives. Appropriate accounts have been kept and bank reconciliations are made as part of Council wide bank reconciling.
- 3.2 Based on the tests carried out it was found that a sample of payments were supported with appropriate invoices or receipts, and that VAT had been properly treated. There was also an appropriate trail for a sample of other transactions, such as internal transfers.
- 3.3 Staff costs are administered through Cyngor Gwynedd's Payroll Unit where PAYE and National Insurance requirements have been appropriately applied. These staffing costs are appropriately recorded in the statement.
- 3.4 The fixed asset figure on the accounting statements is supported by an asset register.

WELSH CHURCH FUND

<i>Assurance Level</i>	<i>Definition</i>
High	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.

1. Background

- 1.1 The Welsh Church Fund derives from the Welsh Church Act 1914. Cyngor Gwynedd administers the fund and allocates the interest as annual grants to registered charities in Gwynedd in order to promote and support activities which will benefit the people of Gwynedd and enrich the local communities. Organisations such as local Eisteddfodau, activities within the arts, education, leisure and sports, conservation, and charities that support sick or disabled individuals can apply for the grant. It's possible to apply for any amount, but individual grants will tend to be up to £5,000.

2. Purpose and Scope

- 2.1 The purpose of the audit was to conduct the independent examination of the Welsh Church Fund accounts for the 2025-26 financial year, in accordance with the requirements of the Charity Commission.

3. Main Findings

- 3.1 In accordance with the requirements of the Charity Commission, an independent audit of the accounts must be carried out if the fund's annual income is over £25,000. Fund money was invested in order to attract interest, so the income threshold was exceeded in the 2025-26 financial year.
- 3.2 Assurance can be given that the Welsh Church fund accounts for the 2025-26 year are appropriate. Based on the tests carried out, an appropriate audit trail for the figures were seen.

LLOYD GEORGE MUSEUM ACCOUNTS

<i>Assurance Level</i>	<i>Definition</i>
High	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.

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' accounts and annual report for 2025-25 must be submitted to the Charities Commission, including an independent examiner's report of the accounts.

2. Purpose and Scope

- 2.1 The purpose of the audit was to complete the independent examiner's report on the museum's 2025-26 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 and reviewing a sample of transactions.

3. Main Findings

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

CEFN RODYN

<i>Assurance Level</i>	<i>Definition</i>
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.

1. Background

- 1.1 Cefn Rodyn is located in the town of Dolgellau and is registered to provide residential care for up to 21 residents aged 55 and over, who have different needs, including dementia.

2. Purpose and Scope

- 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 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. Strengths

- 3.1 The home was visited on Friday, April 24th, 2026. There was a lovely atmosphere in the home with staff and residents chatting lively. Everyone was eagerly looking forward to the Dolgellau Carnival to be held the following week, where staff and residents would take part in the parade. Everyone's excitement and enthusiasm was infectious, and it was enjoyable to see the residents practising their dance throughout the visit. The Manager's love and pride for her work and for the home was evident from hearing the enthusiasm in her voice as she guided the Auditor around. It was very evident that the residents were enjoying themselves and receiving the full attention of the staff.

4. Risks and Procedures

<i>Number</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Inadequate monitoring arrangements result in a failure to identify staff failing in their duties when reviewing risk assessments, and to keep complete records resulting in a failure to protect residents.	Dedicate time to regularly review a sample of care plans, to ensure that the content is up to date, and staff are completing their duties as expected.	12	Assurance and Monitoring
R02	Lack of training and opportunities to maintain/practice timesheet related tasks resulting in staff receiving under/over payments, which can result in financial losses for the Council.	Arrange relevant training for senior officers to enable them to complete tasks relating to salaries correctly in the absence of the Manager.	15	People, Skills and Training
R03	Failure to conduct fire tests in a timely manner resulting in a failure to protect staff, residents, and visitors.	Remind staff to conduct fire testing in a timely manner.	6	Processes and Procedures
R04	Failure to accept policies and complete mandatory modules resulting in a failure to protect staff, residents and visitors, and a failure to meet Cyngor Gwynedd's requirements.	Ensure that staff complete the Council's mandatory E-learning modules and read and accept the Safeguarding Policy.	6	People, Skills and Training
R05	Staff incompetent to carry out their duties which may result in a risk to the life of residents.	Ensure that all staff responsible for dispensing medication complete a competency test annually and read and accept the Medication Policy.	9	People, Skills and Training
R06	Failure to carry out stock checks and to keep records of the numbers of all medicines can result in a under/over stocking, and failure to identify theft.	Establish effective arrangements for carrying out stock checks of all medicines, delegating the task to qualified members of staff, with regular reviews by management.	12	Information Management and Recording

HAFOD MAWDDACH

<i>Assurance Level</i>	<i>Definition</i>
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.

1. Background

- 1.1 Hafod Mawddach home is located in the town of Barmouth and is registered to provide residential care for up to 31 residents aged 18 and over, who have different needs, including dementia.

2. Purpose and Scope

- 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 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. Strengths

- 3.1 The home was visited on Friday, May 22nd, 2026. The staff were very welcoming and enthusiastically interacted with the residents. The residents were clearly familiar with the staff and comfortable in their company. It was a pleasure to see and hear their playful conversations. This brought vitality to the home and the feeling that it was an enjoyable place to live.

4. Risks and Actions

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Failure to report the correct number of hours worked by staff resulting in staff receiving incorrect salaries, and financial losses to the Council.	Investigate the March 2026 pay errors, working with the Payroll Service to recover any overpayments. Ensure accuracy when entering working hours, checking the records again before publishing.	20	Processes and Procedures

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R02	Lack of monitoring leads to a failure to identify and act on unauthorised expenditure against the budget.	Investigate any salary payments made from the home's budget in error, ensuring to carry out detailed monthly checks on expenditure against the budget from now on.	9	Assurance and Monitoring
R03	Lack of training can lead to a failure to respond promptly and effectively to issues relating to first aid.	Ensure that a high percentage of staff in the home receive up to date first aid training.	6	People, Skills and Training
R04	Failure to accept policies and complete mandatory modules result in a failure to protect staff, residents and visitors, and a failure to meet Cyngor Gwynedd 's requirements.	Ensure that staff complete the Council's mandatory E-learning modules and read and accept the Safeguarding Policy. Enquire with the E-learning Officer about the possibility of receiving monthly reports on staff progress in relation to the completion of e-learning modules, to allow for better monitoring, and to present them to staff in a campaign to encourage them to complete training promptly.	6	People. Skills and Training
R05	Lack of control over household property can lead to failure to identify theft, and inadequate records for insurance purposes.	Ensure that the home has an up-to-date Asset Register, arranging annual reviews and when equipment is purchased/disposed of.	12	Accountability
R06	Failure to keep proper records of each resident's personal items can result in items going missing or stolen, leading to emotional distress, and possibly insurance claims against the Council.	Arrange for appropriate records to be kept of each resident's personal items, including photographs.	9	Processes and Procedures
R07	Failure to identify the risks that may arise and to respond to them promptly and effectively results in a failure to protect staff and residents.	Ensure that the home has current generic risk assessments, which are reviewed at least every year. Remind relevant staff to sign off when reviewing resident risk assessments, conducting random checks.	20	Accountability

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R08	Failure to keep complete records of visitors can result in unauthorised persons gaining access to the home, and inadequate records for fire purposes.	Staff reminded that departure times need to be signed and confirmed on all occasions, stressing to pass the message on to any visitors. Relocate the poster reminding visitors and staff to complete the Visitor Book, choosing a prominent location.	6	Processes and Procedures
R09	Failure to conduct fire tests in a timely manner, results in a failure to protect staff, residents, and visitors.	Ensure that fire tests are carried out in a timely manner, with a view to delegating the task to specific members of staff.	6	Accountability

TAN Y MARIAN FOLLOW-UP

<i>Assurance Level</i>	<i>Definition</i>
Satisfactory	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate risks.

1. Background

- 1.1 An Internal Audit of Tan y Marian Home has been carried out as part of the 2025/26 plan, to ensure that suitable arrangements are in place for the proper management and maintenance of the home and in accordance with relevant regulations and standards.

2. Purpose and Scope

- 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. Strengths

- 3.1 Overall, it was found that the home had made an effort to mitigate the risks highlighted in the full audit, and that the new Manager was proactive in ensuring that such failures did not happen again. It was found that significant work had been carried out to ensure effective arrangements for the recording of any incidents resulting from an error with medication, and for the disposal of medications. Similarly, a current copy of the Medication Policy is available to staff, with 33% of staff providing medication having already read it, which is considered acceptable given the size of the policy, and the difficulty in freeing up staff to read it.

4. Risks And Actions

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Failure to review and update care plans in a timely manner leads to failure in identifying the needs of residents, which can lead to a failure to provide quality care.	Ensure that care plans are reviewed at least every 3 months.	12	Assurance and Monitoring

No.	Risk	Agreed Action	Risk Score	Root Cause Category
R02	Failure to keep proper records of residents' personal items can lead to a failure to identify theft, leading to "emotional distress".	Ensure that a current record of residents' belongings, in the form of a list or photographs, is kept in their care plans.	6	Assurance and Monitoring
R03	Staff not registering in a timely manner leading to failure to comply with SCW requirements and leading to jeopardise the quality of care and create safeguarding risks for vulnerable individuals along with enforcement action and damage to the reputation of the Council.	Keep proper records of staff registration dates, regularly monitoring and reminding staff when renewals are required.	9	Assurance and Monitoring
R04	Failure to keep proper records of staff training leads to failure to effective monitoring, with staff ineligible to perform their duties.	Continue to update the training spreadsheet, ensuring timely renewal of any completed training, in particular, First Aid, Medication, Fire, Moving and Handling, and Safeguarding. Ensure that the Digital Champion supports staff in completing e-learning modules and accepting policies, monitoring progress.	9	Assurance and Monitoring
R05	Lack of regular supervision and evaluation leading to a failure to review/assess competence, and to give staff the opportunity to express concerns.	Ensure that all staff receive supervision every 3 months and an annual evaluation.	6	Processes and Procedures
R06	Failure to carry out fire tests in a timely manner in lead to a failure to protect residents, staff and visitors.	Continue to train staff to conduct fire tests in a timely manner.	6	People, Skills and Training

PLAS HEDD FOLLOW-UP

<i>Assurance Level</i>	<i>Definition</i>
High	Certainty of propriety can be stated as internal controls can be relied upon to achieve objectives.

1. Background

- 1.1 An Internal Audit of Plas Hedd Home was carried out as part of the 2025/26 plan, 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.

2. Purpose and Scope

- 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. Main Findings

- 3.1 Of the 6 agreed actions from the original audit, all were found to have been implemented.
- 3.2 The home was visited on Wednesday, 15th July. For a sample of 4 residents, it was found that their pocket money received regular reconciliations, with the amount within the wallet agreeing with the records on each occasion, with receipts present for all expenditure.
- 3.3 A sample of 10 staff members were selected for checking their medication training records. For everyone in the sample responsible for providing medication, they were found to have completed relevant training in the last 3 years, as well as a competency test in the last year.
- 3.4 Similarly, the staff members in the sample had completed a large number of the Council's mandated e-learning modules, with the Manager keeping appropriate records of everyone who has read a paper copy of the Council's Safeguarding Policy. Of the 10 in the sample, 7 had read the policy since the full audit. It is noted that 2 of the sample are on long-term sick leave, and the latter has been new to the home for two months.

PLAS Y DON FOLLOW-UP

<i>Assurance Level</i>	<i>Definition</i>
Satisfactory	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate risks.

1. Background

- 1.1 An Internal Audit of Plas Y Don Home was carried out as part of the 2025/26 plan, 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.

2. Purpose and Scope

- 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. Strengths

- 3.1 The home was visited on Tuesday, 14th of July. It is noted that the Manager has only worked here since April 2026, but that significant work has been undertaken to respond to the risks identified in the full audit.
- 3.2 For the 3 Care Plans checked during the visit, all had been reviewed within the last 3 months as expected, including current risk assessments, as well as detailed records of the residents' property.
- 3.3 A sample of 4 members of staff were selected to review their evaluation and supervision records, all had recently been supervised, and 2 had been evaluated. It was found that a dedicated matrix was in place to ensure that all staff members received timely sessions.
- 3.4 For the same sample of staff, it was verified that the hours worked for May 2026 according to the work rota agreed with the hours paid. They agreed on every occasion.

4. Risks and Actions

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Visitors failing to confirm the time and signing when leaving home can lead to a failure to protect residents, staff and other visitors, with wrong information possibly being shared with the fire service in the event of a fire.	Remind staff to sign and confirm time when leaving home.	6	Processes and Procedures

DIRECT PAYMENTS

<i>Assurance Level</i>	<i>Definition</i>
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.

1. Background

- 1.1 1774 of Direct Payments were made from the period April 2025 to March 2026. amounting to the equivalent of £2.7million. 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. There are two ways to pay DP which are 'managed' and 'non-managed'. Managed means that a third party controls the money for the client, i.e. is responsible for paying the carers' salaries and taxes as an employer. These who are 'non-managed' are responsible for managing DP themselves i.e. the money is paid directly to the suitable person.

2. Purpose and Scope

- 2.1 Following part one of the Direct Payments audit in November 2025, 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, and reporting on operations for monitoring DP use, as well as the actions agreed in part one of the DP audit. To achieve this, the audit encompassed reviewing the arrangements for establishing DP agreement, ensuring that applications were processed in a timely and accurate manner against the care assessment and reviewing the DP usage monitoring arrangements. The audit did not include reviewing the financial assessments carried out by the Care Finance Team as this was beyond Direct Payments processes.

3. Strengths

- 3.1 A new Team Leader is reviewing the current processes and has implemented new arrangements for managing new DP cases and risks such as distributing new DP contracts. An experienced member of staff was seen responsible for processing DP applications following the hours agreed and allocated by the Social Workers and these are placed on a monthly schedule. In addition, a new officer has been employed and is accountable for monitoring the use of DP and balances and is to report significant balances to the relevant officers/team for review.

4. Risks and Actions

No.	Risk	Agreed Action	Risk Score	Root Cause Category
R01	A DP applicant is unaware of their responsibilities and expectations in order to agree to receive DP, which can lead to failure to effectively and efficiently administer and monitor the use of DP, non-compliance by the applicant and possible financial losses to the Council.	Distribute a formal agreement and establish new arrangements for new DP. Agreements are signed prior to establishing the payments. Review prepaid card distribution arrangements with the current provider and possibly new providers.	6	Process & Procedures
R02	Direct Payments being misused, the Council failing to take enforcement action/holding individuals accountable, resulting in misuse of public funds with no implications, financial losses to the Council and the possibility of fraud not being detected.	Ensure that individuals who are already in receipt of payments receive the new agreement, that there is a procedure for communication, distribution and agreeing responsibilities in place.	9	Accountability
R03	Vulnerable adults/children not receiving the appropriate care or DP overpayments accruing resulting in financial losses to the Council.	If there is evidence that there is over 12 weeks' worth of package in accrual on the direct payments account, the DP team will contact the relevant social worker/team to implore them to review the situation to investigate the reasons for the accrual. This may lead to a review of the individual's situation.	8	Resources
R04	A lack of accountability for monitoring, verifying and reporting the use of DP resulting in a failure to properly identify and report developments and/or anomalies, which may lead to the possibility of false payments and/or misuse of public funds and financial losses to the Council.	Monitoring policy/arrangements in place. Formally documenting DP monitoring actions so that accountable officer(s) can be identified for monitoring and following up on monitoring DP balances and DP usage. Staff to save documents to a central drive and use a general mailbox for receiving DP evidence. Establishing a process for reporting DP statistics and status so that any discrepancies can be identified and dealt with promptly and by the relevant social service officers/team accountable for managing the DP funds.	12	Risk Management & Culture

SIOP GALWCH ACW FOLLOW-UP

<i>Assurance Level</i>	<i>Definition</i>
Satisfactory	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate risks.

1. Background

- 1.1 An Internal Audit of Siop Galwch Acw had been carried out as part of the 2025/26 plan, to ensure that suitable arrangements are in place for the proper management and maintenance of the shop and in accordance with relevant regulations and standards.

2. Purpose and Scope

- 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. Strengths

- 3.1 Since the full audit, it has been found that an up-to-date register has been compiled of all the store's assets, and that effective arrangements are in place for the prompt reconciliation and banking of income.

4. Risks and Actions

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Lack of regular supervision and evaluation of staff leading to a failure to review/assess competence, and to give staff the opportunity to express concerns.	Ensure that all staff receive supervision every 3 months, and an annual evaluation.	6	Processes and Procedures
R02	Failure to carry out fire tests in a timely manner resulting in a failure to protect consumers, staff and visitors.	Ensure that fire tests are carried out in a timely manner, and appropriate records are kept.	9	Processes and Procedures

CEGIN ARFON FOLLOW-UP

<i>Assurance Level</i>	<i>Definition</i>
Satisfactory	Controls are in place to achieve their objectives but there are aspects of the arrangements that need tightening to further mitigate risks.

1. Background

- 1.1 An Internal Audit of Cegin Arfon was carried out as part of the 2025/26 plan, to ensure that suitable arrangements were in place for the proper management and maintenance of the kitchen and in accordance with relevant regulations and standards.

2. Purpose and Scope

- 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. Strengths

- 3.1 Since the full audit, it has been found that an up-to-date register has been compiled of all kitchen inventory, that an attendance notice board is being used for fire purposes, and that effective arrangements are in place for the processing and retention of invoices.

4. Risks and Actions

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R01	Lack of regular supervision and evaluation leading to failure to review/assess competence, and to give staff the opportunity to express concerns.	Ensure that all staff receive supervision every 3 months.	6	Processes and Procedures
R02	Failure to properly train staff may result in a failure to protect service users and customers.	Arrange for all staff to complete Food Hygiene training every 3 years.	6	People, Skills and Training

<i>No.</i>	<i>Risk</i>	<i>Agreed Action</i>	<i>Risk Score</i>	<i>Root Cause Category</i>
R03	Failure to accept Council policies and not completing mandatory training, leading to a failure to comply with Council requirements.	Remind staff of the need to complete the Council's mandatory e-learning modules. Ensure that all staff read the Safeguarding Policy.	9	People, Skills and Training
R04	Failure to protect monies and giving consideration to insurance conditions can lead to financial losses.	Consider better arrangements for cash storage and banking, such as investing in a suitable safe to enable storage of more than £500.	12	Resources