Internal Audit

Annual Audit Report 2022-23

Devon and Somerset Fire and Rescue Authority Audit and Governance Committee

July 2023

Official

Tony Rose
Head of Devon Audit Partnership

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Audit Manager

Auditing for achievement

Introduction

The Audit and Governance Committee, under its Terms of Reference is required to consider the Chief Internal Auditor's annual report, to review and approve the Internal Audit programme, and to monitor the progress and performance of Internal Audit.

The Accounts and Audit (Amendment) (England) Regulations 2015 (Updated 2021) introduced the requirement that all Authorities need to carry out an annual review of the effectiveness of their internal audit system and need to incorporate the results of that review into their Annual Governance Statement (AGS), published with the annual Statement of Accounts.

The Internal Audit plan for 2022/23 was presented and approved by the Audit and Governance Committee in March 2022. In October 2022, the Authority formally joined Devon Audit Partnership for the delivery of its Internal Audit Service and the plan was subsequently reviewed and revised.

The following report and appendices set out the background to audit service provision; any updates to the agreed plan; a review of work undertaken in 2022/23 and provides our opinion on the overall adequacy and effectiveness of the Authority's Internal Control Environment.

The Public Sector Internal Audit Standards require the Head of Internal Audit to provide an annual report providing an opinion that can be used by the organisation to inform its governance statement. This report provides that opinion.

Expectations of the Audit and Governance Committee from this annual report

Audit and Governance Committee members are requested to consider:

- the assurance statement within this report;
- the basis of our opinion and the completion of audit work against the plan;
- changes to the plan and the scope and ability of audit to complete the audit work;
- audit coverage and findings provided;
- customer satisfaction

In review of the above the Audit and Governance Committee are required to consider the assurance provided alongside that of the Senior Leadership Team, Corporate Risk Management and external assurance including that of the External Auditor as part of the Governance Framework (see appendix 4) and satisfy themselves from this assurance for signing the Annual Governance Statement.

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Overall Opinion Statement

In 2020-21 and 2021-22 the Internal Audit Opinion was 'Reasonable'. Whilst considering these, there are areas of concern arising from the work undertaken in 2022/23. Therefore the Head of Internal Audit's opinion on the adequacy and effectiveness of the Authority's internal control framework in 2022-23 is one of 'Limited Assurance'.

We note that work is already underway to address issues identified and therefore has the potential to positively impact the Opinion in 2023/24.

This opinion statement provides Members with an indication of the direction of travel for their consideration for the Annual Governance Statement (see appendix 4).

The Authority's internal audit plan for 2022-23 included specific assurance, risk, governance, and value-added reviews which, together with prior years audit work, provided a framework and background within which we assessed the Authority's control environment.

The reviews in 2022-23 have informed the Head of Internal Audit's Opinion. If significant weaknesses have been identified, these will need to be considered by the Authority in preparing its Annual Governance Statement as part of the 2022-23 Statement of Accounts. In carrying out reviews, Internal Audit assesses whether key, and other, controls are operating satisfactorily and an opinion on the adequacy of controls is provided to management as part of the audit report. All final audit reports include an action plan which identifies responsible officers, and target dates, to address control issues identified. Implementation of action plans rests with management, and these are monitored by Organisational Assurance.

This statement of opinion is underpinned by:

Internal Control Framework
The control environment comprises the policies, procedures and operational systems and processes in place to establish and monitor the achievement of the Authority's objectives; facilitate policy and decision making; ensure economical, effective, and efficient use of resources, compliance with established policy, procedure, law, and regulation; and safeguard the Authority's assets and interests from losses of all kinds. Core financial and administrative systems were reviewed by Internal Audit.

Where internal audit work has highlighted instances of non or part compliance, none are understood to have had a material impact on the Authority's affairs.

Risk Management
The Audit of Risk Management was undertaken in 2021-22, where we provided an audit opinion of 'Substantial Assurance'.

The risk register is regularly reported to the Executive Board, allowing Members to assess the risk and to have awareness of current risk to inform decision making. The risk register is also provided, at intervals, to the Audit and Governance Committee.

Governance Arrangements
The Authority has an established Protective Security Group which both monitor compliance and provide strategic oversight.

We undertook an examination of the maturity of Project Management. We found that the Change & Improvement Programme had made good progress since its inception in 2018. The new Programme Office has been established, and a Portfolio Board has now been formed.

Performance Management
Organisational Assurance monitor performance against Internal Audit recommendations made.

Risk Management performance is also reported to Executive Board and Audit and Governance Committee.

The Application of Learning Audit found that learning is identified, coordinated, assigned, implemented, tracked, and monitored. A new Operational Assurance system has now been implemented which will help to facilitate improved processes

Substantial Assurance	A sound system of governance, risk management and control exist across the organisation, with internal controls operating effectively and being consistently applied to support the achievement of strategic and operational objectives.	**Limited Assurance**	**Significant gaps, weaknesses or non-compliance were identified across the organisation. Improvement is required to the system of governance, risk management and control to effectively manage risks and ensure that strategic and operational objectives can be achieved**
Reasonable Assurance	There are generally sound systems of governance, risk management and control in place across the organisation. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of some of the strategic and operational objectives.	No Assurance	Immediate action is required to address fundamental control gaps, weaknesses or issues of non-compliance identified across the organisation. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of strategic and operational objectives.

Summary Assurance Opinions

Service Delivery	Service Delivery Support	Finance and Corporate Services
Operation of the critical messaging process Pay for Availability	Fleet Management	Key Financial Systems (Inc. Payroll)
Organisational Safeguarding Assurance Crewing pool	Application of learning (including internal investigations and external reports e.g., Grenfell)	Use of Data Information Security – Availability of systems Control of working hours (multiple contracts) Application of HR policy and procedure – Recruitment and Promotion
Informed the 2021/22 End of Year Opinion Community Safety: Fire Prevention Flexi Duty Rota Personal Protective Equipment Audit		Project Management Maturity Assurance

Key: **Green** = Substantial or Reasonable **Amber** = Limited **Red** = No Assurance **Blue** = Opportunity or Value Added

Appendix 1

Summary of audit reports and findings for 2022 - 23

Direction of Travel Indicators	
Indicator	Definitions
	No Progress has been made. The action plan is not being progressed at this time; actions remain outstanding.
	Progress has been made but further work is required. The action plan is being progressed though some actions are outside of agreed timescales or have stalled.
	Good Progress has/is being made. Good Progress has continued.

DEVON AND SOMERSET FIRE AND RESCUE SERVICE			
Risk Area / Audit Entity	**Audit Report**		
	Assurance opinion	**Executive Summary / Residual Risk / Audit Comment / Management Response**	**Direction of Travel Assurance**
The following prior year audits were completed and reported to Audit and Governance Committee in 2022-23			
Community Safety: Fire Prevention	**Status: Final** **Limited Assurance**	The team gained resource in 2019 with the introduction of ten additional home safety technicians. Whilst this has supported the quantity of checks completed, there are continued management gaps highlighted in data quality review, risk-based escalation culture, action logs and process that limit the effectiveness of fire prevention. The lack of accessibility of data and lack of skilled resource within the Prevention Team to analyse the Home Fire Safety data collected has limited the ability of the team to be able to challenge and manage performance or to ensure that vulnerable people are re-visited. The Community Safety Team is self-aware of many of the gaps identified in this audit, with many actions awaiting the introduction of Management of Risk Information (MORI) and reliant on the capacity of ICT to update the data management system that will support extraction of key data to align resource to risk. Implementation of the audit recommendations and the Prevention Team's strategy are highly dependent on the capacity of the Strategic Analysis / data team to support with the introduction and continued use of MORI. **Management Update Response (November 2022):** Since the report was issued, the Area Manager Service Delivery Risk has placed the home safety element of Prevention into Business Continuity due to problems with how the current home safety app is being used and is performing and the continued delay in the delivery of MORI. The Executive Board commissioned a review of ICT and Prevention ICT solutions. The outcome of this review will help to determine future ICT/Data strategy within Prevention. A business analyst has been seconded into Prevention to resolve data quality, risk escalation and processes. This is being communicated with the team through a series of workshops. The team is currently working with their business analyst to cleanse the current app of records and to ensure accurate process maps are in place ahead of any ICT solution and to ensure that the data is able to migrate to a new system. The Quality Assurance and Evaluation officer is establishing evaluation processes, in line with HMICFRS recommendations. These will have dependencies on ICT and the Strategic Analysis Team which may also be influenced by the review commissioned by Executive Board. Some technical changes have taken place within the doorstep home safety app to prevent duplication of records.	

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Risk Area / Audit Entity	**Audit Report**		
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		Although operational issues with the Home Safety app and data continue, the Prevention team is on track to deliver the target of 18,000 home safety visits this year and there has been an improvement in the targeting of risk, with the number of visits having 2 or more risk factors approaching the 60% KPI which is a significant improvement on previous years.	
Personal Protective Equipment Audit	**Status: Final** **Limited Assurance**	Firefighters within the Service are provided with fit for purpose, personal use, operational PPE. However, the Service cannot fully assure itself that adequate training is provided in how to use, store, and maintain this PPE in accordance with the PPE at Work Regulations 1992. Examples were identified of staff wearing incorrect PPE to an incident or using it in a way that increases the risk of injury. This suggests that if training is taking place, refresher sessions and management intervention are required to maintain a higher level of assurance of compliance. Policies and procedures meet legislative requirements. However, there is a lack of assurance that they are read and understood by relevant members of staff. The storage of PPE varies across stations with PPE either stored in the appliance bay or a designated area. A lack of segregation of clean / dirty PPE and storing PPE in the appliance bay does not comply with regulations. **Management Update Response (November 2022):** Subject matter experts from Health & Safety and Research & Development will ensure access to PPE manufacturers' guidance to ensure that the training package meets the requirements and provides assurance against Health & Safety Executive requirements. The intended training delivery model will be aligned to the same method as the recent helmet training: • Mandatory training for all operational staff to complete individually and recorded against their personal training record. • Training will have a requalification period applied - time to be determined. • Will be reportable on the 'Skills Dashboard' under the current PPE tile. • The training will be a requirement of all new operational posts. This will ensure that all current operational staff complete the training, all new starters have this as a requirement when joining, there is a requalification period set and that training completion is reportable. These actions are due for completion in April 2023. The Health & Safety team is completing premises audits, which are due to finish by April 2023. These audits include a review of PPE storage. Some locations do not have the space to fully comply with the regulations. As part of their rolling programme of improvements to stations, Estates will enhance the PPE storage where they are able to. ORMs do check PPE logbooks on their station visits but this is still ad hoc. A station operational readiness framework that sets out responsibilities for a number of matters including PPE is in the process of being implemented after a successful trial in Yeovil. Once implemented this will then be performance managed.	

DEVON AND SOMERSET FIRE AND RESCUE SERVICE

Risk Area / Audit Entity	Audit Report		
	Assurance opinion	Executive Summary / Residual Risk / Audit Comment / Management Response	Direction of Travel Assurance
Fleet Management	**Status: Final** **Reasonable Assurance**	Further to previous audit work (2019) in this area and the implementation of the fleet strategy, assurance was needed that improvements are being embedded. The audit found that good progress has been made, raising the level of assurance from 'Limited Assurance' to 'Reasonable Assurance'. With the implementation of a Fleet Service Plan, a Fleet and Equipment Strategy and a 10-year capital plan, the risk has decreased. The plans and strategies that are now in place look at short, medium, and long-term goals for the team and are set to become rolling projects with annual updates. The number of front-line vehicles has been reduced from 121 to 112, improving Fleet Management efficiency and saving the Service money. **Management Response (April 2022):** One review to be completed is that relating to Specialist vehicles. These vehicles are included in the fleet capital replacement plan and the Fleet and Research & Development teams are well placed to progress this in accordance with the prioritisation plan for replacement of vehicles. The Community Risk Management Plan has indicated the need to undertake a separate review on specialist activities which may impact progress of these plans.	
Organisational Safeguarding Assurance	**Status: Final** **Limited Assurance**	Safeguarding responsibility currently sits within the Community Safety department and work carried out within the Prevention team's remit; this current process and operational structure offers little support to safeguarding the rest of the organisation. A full policy review has been recommended and the Service is awaiting appointment of a Safeguarding Manager. **Management Response (April 2022, updated June 2023):** A Strategic Safeguarding Board has been established and a new Safeguarding Manager has been appointed. The report's recommendations have been aligned with the new Safeguarding Manager's action plan for the department.	
Flexi Duty Rota	**Status: Final** **Limited Assurance**	In accordance with the Grey Book requirements, a Flexible Duty System (FDS) is in operation for officers at the Station Manager rank and above. Those utilising the Flexible Duty System undertake duties which can be split into two key types: Managerial duties - referred to as 'positive' hours and Standby duties - where the officer is on call to carry out managerial duties as necessary. Standby duties require a set number of 'positive' hours to be worked, primarily used to provide support to stations within Commands, for instance attending a drill night at a station during an on-call shift. Contingencies which the Policy which state they should be exceptional have in many cases become normal activity leading to potential risks to officer welfare and to the effective delivery of incident response.	

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		The output from the audit will help inform the planned internal project to review the FDS and provide some helpful pointers regarding inconsistencies and areas where improvements may be possible. **Management Response (November 2022):** The Deputy Chief Fire Officer has commissioned a full and complete review of the FDO rota with a view to introducing a new policy, guidance documents and framework as well as rota pattern for the rota. This will be considered as part of the Target Operating Model with implementation expected in the new financial year.	
Project Management Maturity Assurance	**Status: Complete** **Added Value**	The Change & Improvement Programme has made good progress since its inception back in 2018. The review concurs with the vast majority of the self-assessed consensus scores and associated maturity statements. A Portfolio Board has been formed and started to meet. This and the new Programme Office appear to be embracing good Programme Management methodology. At the time of the assessment, there was still the issue of what initiatives, projects or changes to operations came under the Transformation umbrella and its governance and which remained outside. Attention has been paid to the management of benefits with the adoption of a Benefits Management Framework. A Benefits register has been created and is maintained, recording both financial and non-financial benefits, assigning owners responsible for their delivery/realisation. This has generally avoided managers using their own approaches to capturing and monitoring benefits. Officers stated that the benefits were being managed at project rather than programme level as they were more difficult to demonstrate at programme level. In addition, it was felt that validating the achievement of benefits through the provision of evidence was lacking. Whilst programme benefits are delivered, from an organisational point of view, re-distributing any resources/savings to something else that would benefit the organisation is recognised as being more of a challenge. In addition, where projects are interlinked or are dependent on other projects then the realisation of benefits can be hampered and is often caused by the draw on scarce resources or other delays. **Management Response (November 2022):** The team will undertake a review, and amendment where appropriate, of current guidance that sets out the criteria required for a new initiative to be directed under the portfolio governance as part of the risk critical and urgent pathway (RCUP) process. An overarching communications plan for transformation and Service wide communications on the Portfolio Office will be developed. Programme benefits to be visible at boards and to be part of the agenda. All benefits to ensure that they have baseline measurement data in place at full business case stage.	N/A

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Risk Area / Audit Entity	**Audit Report**		
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Use of Data	**Status: Draft** **Limited Assurance**	Wherever possible the Service's work should be data driven to determine how activity is prioritised to ensure that services are provided effectively and efficiently. This data should be readily available, accurate and up to date. **Management Response (April 2022):** Management responses are in the process of being collated.	
Information Security – Availability of systems	**Status: Draft** **Limited Assurance**	Information security is the foundation for high-scoring items on the Corporate Risk Register (CR037 & CR044). This is an area of increasing risk to all organisations, and with rapid increases in remote working and reliance on ICT, good security practices are essential. **Management Response (April 2022):** Management responses are in the process of being collated.	
2022-23 Audit Plan			
Operation of the critical messaging process	**Status: Final** **Reasonable Assurance**	Significant improvements to the critical messaging process have been made with greater assurance now available to the Service that staff read and understand risk critical messages and apply the required changes. Seven recommendations were made with a view to improving the process, particularly with regard to the station return process and automation of reporting. Some areas of non-compliance with current documented process were identified alongside scope for improvement in some areas which will help to improve the assurance process that has been established for critical messaging. **Management Response (June 2023):** Processes will be improved as recommended and individual accountability and performance management around safety critical issues will be built into operational performance management meetings.	
Crewing pool	**Status: Final** **Limited Assurance**	The Service's Crewing Pool has become an integrated part of improving operational capabilities. A group of staff intended for back up use are now heavily relied upon and use a large amount of financial resources. There is a lack of assurance that the Crewing Pool process is adequately managed Group Commanders advised that that the Crewing Pool is not a good use of Service resources and that the root cause of the issue is a lack of staffing.	

DEVON AND SOMERSET FIRE AND RESCUE SERVICE			
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		Management Response: Several risks identified in this audit are to be mitigated by the new Bank Staff Scheme. This was rolled out in October and the use of crewing pool ceased. A review of uptake, performance and costs will be undertaken in December 2022.	
Control of working hours (multiple contracts)	**Status: Final** **Limited Assurance**	There are processes and software in place to facilitate a controlled way of working, where hours worked can be monitored, however, these processes are not always utilised or are not used in the intended way. **Management Response:** The implementation of a new HR system and implementation of the HMICFRS actions related to monitoring of secondary contracts to make sure that working hours are not exceeded will provide improved processes and assurance.	
Pay for Availability	**Status: Final** **Reasonable Assurance**	P4A has had a mixed impact for crews in terms of their pay, work-life balance and morale and more work would be beneficial in determining whether the initiative is having a positive impact on diversity and inclusivity within the workplace. At the time of reporting we could not identify a marked improvement in recruitment with some priority stations remaining under resourced. It will be for the service to assess whether the benefits from the initiative sufficiently outweigh the costs of the model. The initiative also does not appear to have had anything other than a modest impact on availability, although further analysis using more recent data is advised. **Management Response:** The Service is now reviewing the terms of operation of the P4A model to ensure that it is sustainable for the future.	
Application of HR policy and procedure – Recruitment and Promotion	**Status: Draft** **Limited Assurance**	The People Services Policy and Guidance framework is under review and has been for some time. Whilst a number of documents have been newly created or updated, there is still work remaining to ensure the overall framework is fully updated and fit for purpose including documents which are directly related to recruitment and promotion. Overall, we have found that the service appears committed to principles such as diversity and inclusion within the workplace, however more work is needed to develop and embed these principles throughout the service and to improve the ability to monitor and report on progress. We understand that significant work is currently underway that in the medium term should help to improve recruitment and promotion, including the introduction of a new Human Resources system, and the	

DEVON AND SOMERSET FIRE AND RESCUE SERVICE			
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		development of new and updated policies and procedures. To ensure the appropriate values and principles within the framework are embedded, improvements to manager training will also need to be introduced. **Management Response:** Management responses are in the process of being collated.	
Key Financial Systems (Inc. Payroll)	**Status: Final** **Reasonable Assurance**	There have been no significant changes to processes or systems within the Finance and Payroll services this year. Key Financial Systems continue to operate effectively overall with measures in place to mitigate risk in most areas examined. Many actions from last year's audit have now been addressed. Some areas of control weakness remain, where management consider the associated risk to be within acceptable limits. This includes for instance system administrators who also undertake day to day processes, which reduces separation of duties but is seen as necessary for operational reasons due to team size. Other areas of potential weakness do however present opportunities for improvement or strengthening of controls, for instance in relation to record keeping and timeliness. **Management Response:** Actions have been agreed where appropriate to address the recommendations made and are in the process of being implemented.	
Application of learning (including internal investigations and external reports e.g., Grenfell)	**Status: Final** **Limited Assurance**	For the various sources of learning considered as part of this audit designated resources and processes are in place that help co-ordinate and monitor implementation of associated actions. Some teams indicated that they are unable to provide as much input or time to these activities as they would otherwise like. In part this may be due to the sheer scale of the exercises involved, such as the National Operational Guidance Strategic Gap Analysis which has over 2000 tactical actions across 20 areas. In this instance the assessment period is spread over a two year period. For most types of learning a formal sign off process exists involving reports to management at the most senior levels. The exception is the Operational Assurance Team, who indicate they can close out any tactical learning activities without further escalation. Each team demonstrated a process for tracking and reviewing learning points. Overall, whilst learning is identified, coordinated, assigned, implemented, tracked, and monitored, there are several areas where further improvements can be made to processes to ensure that the application of learning is consistent and more effective.	

DEVON AND SOMERSET FIRE AND RESCUE SERVICE

Risk Area / Audit Entity	Audit Report		
	Assurance opinion	Executive Summary / Residual Risk / Audit Comment / Management Response	Direction of Travel Assurance
		Management Response: A new action tracking process has been established in SharpCloud for the action plan designed to address His Majesty's Inspectorate of Constabulary and Fire & Rescue Services' (HMICFRS) report. Additional sign off evidence for the remaining actions in the Grenfell action plan is to be obtained and retained. The National Operational Guidance Strategic Gap Analysis two-year plan will ensure that all strategic actions are assessed, and records kept as to compliance. A quarterly follow up to the responsible department is now in progress as part of the two-year plan. A new Operational Assurance system has now been implemented which will help to facilitate improved processes and address a number of the points raised within the report through automation of workflows and removal of manual processes.	

The following audits were cancelled as part of a revised Audit Plan as reported at the November 2022 Audit and Governance Committee:

- Community Safety - Schools & Engagement
- Station compliance - Environmental / waste management
- Support the Service's response to the HMICFRS 2021 report findings
- Station-based Testing Regime
- Personal Protective Equipment: Contaminants
- Firefighter Fitness Training Review
- Behavioural Risk

Appendix 2 - Professional Standards and Customer Service

Conformance with Public Sector Internal Audit Standards (PSIAS)

PSIAS Conformance - Devon Audit Partnership conforms to the requirements of the PSIAS for its internal audit activity. The purpose, authority and responsibility of the internal audit activity is defined in our internal audit charter, consistent with the *Definition of Internal Auditing,* the *Code of Ethics* and the *Standards.* Our internal audit charter was approved by senior management and the Governance Committee in March 2023. This is supported through DAP self-assessment of conformance with Public Sector Internal Audit Standards & Local Government Application note.

The Institute of Internal Audit (IIA) are the key body involved in setting out the global standards for the profession which form the basis for the Public Sector Internal Audit Standards (PSIAS) and are undergoing review and revision. The proposed new standards which are likely to take effect in 2024 and this document helps clarity and raise awareness of the audit committee's governance roles and responsibilities in respect of this. IIA Document – Draft Standards.

Quality Assessment - the Head of Devon Audit Partnership maintains a quality assessment process which includes review by audit managers of all audit work. The quality assessment process and improvement is supported by a development programme.

External Assessment - The PSIAS states that a quality assurance and improvement programme must be developed; the programme should be informed by both internal and external assessments.

An external assessment must be conducted at least once every five years by a suitably qualified, independent assessor. For DAP this was recently conducted at the end of 2021 by the Head of Southwest London Audit Partnership, and the Chief Internal Auditor of Orbis (a partnership organisation covering Brighton and Hove, East Sussex, and Surrey County Council).

The assessment result was that *"Based on the work carried out, it is our overall opinion that DAP **generally conforms*** with the Standards and the Code of Ethics".* The report noted that *"As a result of our work, a small number of areas where partial conformance was identified. These were minor observations, none of which were significant enough to affect the overall opinion".* DAP is actively addressing these improvement areas.

*** Generally Conforms** – This is the top rating and means that the internal audit service has a charter, policies and processes that are judged to be in conformance to the Standards

Improvement Programme – DAP maintains a rolling development plan of improvements to the service and customers. All recommendations of the external assessment of PSIAS and quality assurance were included in this development plan and have been completed. This will be further embedded with revision of our internal quality process through peer review. Our development plan is regularly updated, and a status report reported to the DAP Management Board.

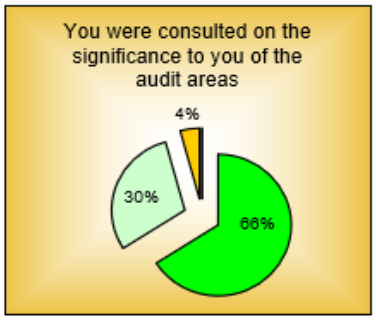
Customer Service Excellence

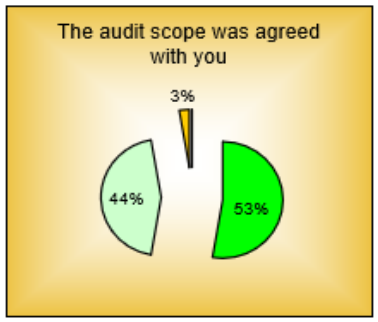
DAP was successful in re-accreditation by G4S Assessment Services of the CSE standard during January 2023. This accreditation is a UK-wide quality mark which recognises organisations the prioritise customer service and are committed to continuous improvement.

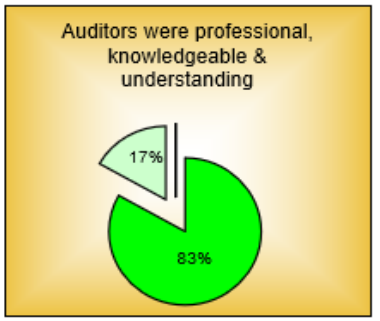
During the year we have issued client survey forms for some of our reports, and the results of the surveys returned were very good / positive. The overall result is very pleasing, with near 97% being "satisfied" or better across our services (see Appendix 7). It is very pleasing to report that our clients continue to rate the overall usefulness of the audit and the helpfulness of our auditors highly.

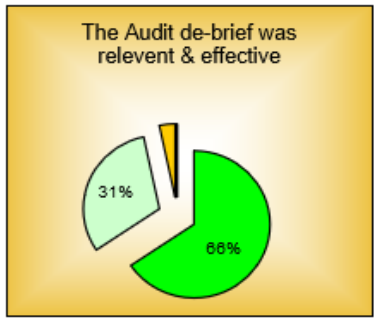
Customer Survey Results April 2022 - March 2023

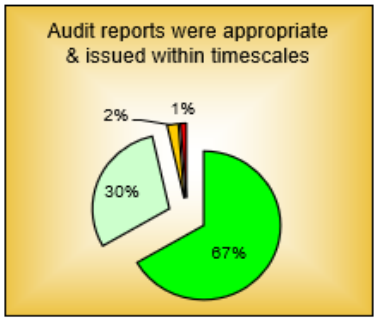
devon audit partnership

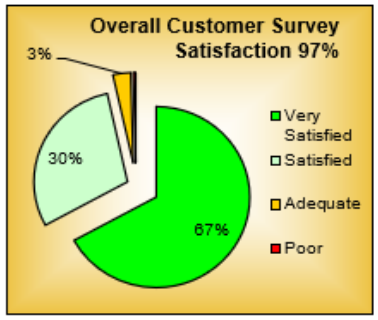












Appendix 3 – Audit Authority

Appendix 4 - Annual Governance Framework Assurance

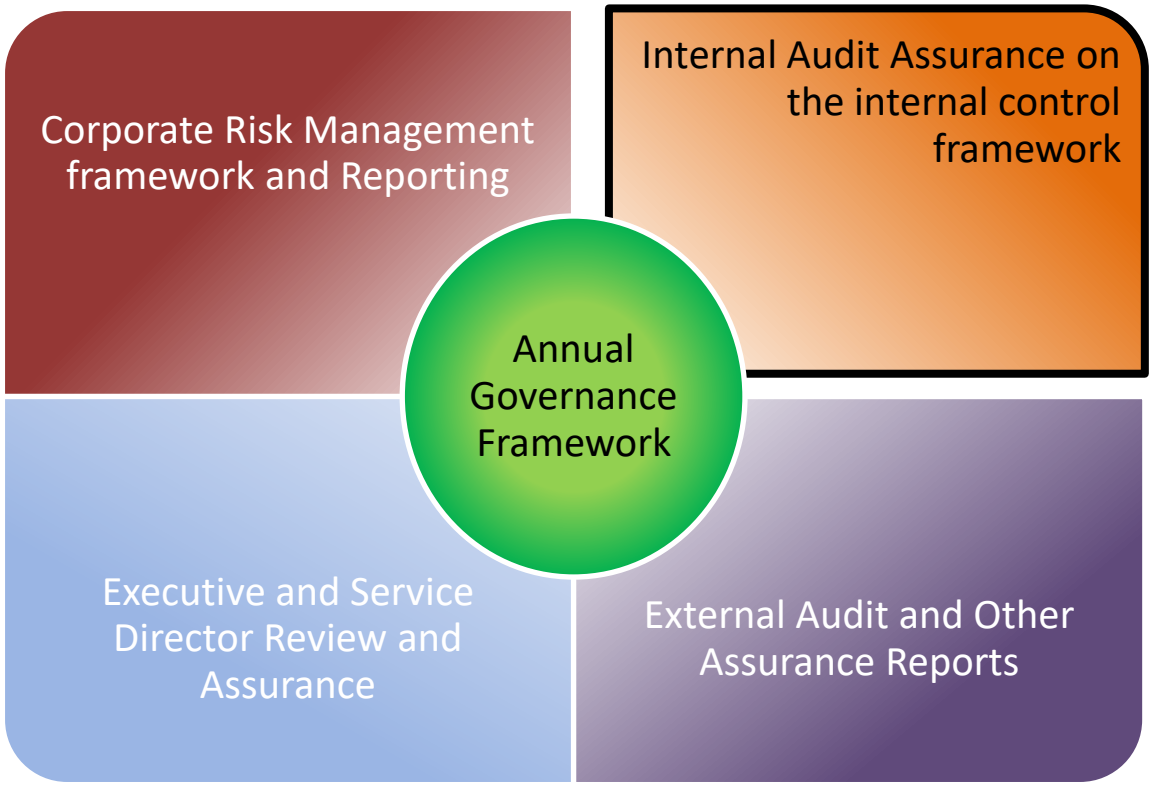
The conclusions of this report provide the internal audit assurance on the internal control framework necessary for the Committee to consider when reviewing the Annual Governance Statement.

The Annual Governance Statement (AGS) provides assurance that

- the Authority's policies have been complied with in practice;
- high quality services are delivered efficiently and effectively;
- ethical standards are met;
- laws and regulations are complied with;
- processes are adhered to;
- performance statements are accurate.

The statement relates to the governance system as it is applied during the year for the accounts that it accompanies. It should:-

- be prepared by senior management and signed by the Chief Fire Officer and Chair of the Audit and Governance Committee;
- highlight significant events or developments in the year;
- acknowledge the responsibility on management to ensure good governance;
- indicate the level of assurance that systems and processes can provide;
- provide a narrative on the process that has been followed to ensure that the governance arrangements remain effective. This will include comment upon;
  - The Authority;
  - Audit and Governance Committee;
  - Risk Management;
  - Internal Audit;
  - Other reviews / assurance.



The AGS needs to be presented to, and approved by, the Audit and Governance Committee, and then signed by the Chair.

The Committee should satisfy themselves, from the assurances provided by Organisational Assurance, Executive Board and Internal Audit that the statement meets statutory requirements and that the management team endorse the content.

Appendix 5 - Basis for Opinion

The Chief Internal Auditor is required to provide the Authority with an opinion on the adequacy and effectiveness of its accounting records and its system of internal control in the Authority.

In giving our opinion, it should be noted that this assurance can never be absolute. The most that the internal audit service can do is to provide reasonable assurance, formed from risk-based reviews and sample testing, of the framework of governance, risk management and control.

This report compares the work carried out with the work that was planned through risk assessment; presents a summary of the audit work undertaken; includes an opinion on the adequacy and effectiveness of the Authority's internal control environment; and summarises the performance of the Internal Audit function against its performance measures and other criteria. The report outlines the level of assurance that we are able to provide, based on the internal audit work completed during the year. It gives:

- a statement on the effectiveness of the system of internal control in meeting the Authority's objectives:
- a comparison of internal audit activity during the year with that planned;
- a summary of the results of audit activity.

The extent to which the work has been affected by changes to the audit plan are shown in Appendix 1.

The overall audit assurance will have to be considered in light of this position.

In assessing the level of assurance to be given the following have been taken into account:

- all audits completed during 2022-23, including those audits carried forward from 2021-22;
- any follow up action taken in respect of audits from previous periods;
- any significant recommendations not accepted by management and the consequent risks;
- the quality of internal audit's performance;
- the proportion of the Authority's audit need that has been covered to date;
- the extent to which resource constraints may limit this ability to meet the full audit needs of the Authority;
- any limitations that may have been placed on the scope of internal audit.

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Devon Audit Partnership	Confidentiality and Disclosure Clause
The Devon Audit Partnership has been formed under a joint committee arrangement. We aim to be recognised as a high-quality internal audit service in the public sector. We work with our partners by providing a professional internal audit service that will assist them in meeting their challenges, managing their risks and achieving their goals. In carrying out our work we are required to comply with the Public Sector Internal Audit Standards along with other best practice and professional standards. The Partnership is committed to providing high quality, professional customer services to all; if you have any comments or suggestions on our service, processes or standards, the Head of Partnership would be pleased to receive them at Tony.d.Rose@devon.gov.uk	This report is protectively marked in accordance with the National Protective Marking Scheme. It is accepted that issues raised may well need to be discussed with other officers within the Authority, the report itself should only be copied/circulated/disclosed to anyone outside of the organisation in line with the organisation's disclosure policies. This report is prepared for the organisation's use. We can take no responsibility to any third party for any reliance they might place upon it.