REPORT REFERENCE NO.	**AGC/22/15**
MEETING	**AUDIT & GOVERNANCE COMMITTEE**
DATE OF MEETING	**29 NOVEMBER 2022**
SUBJECT OF REPORT	**INTERNAL AUDIT 2022-23 PROGRESS REPORT**
LEAD OFFICER	**Director of Governance & Digital Services**
RECOMMENDATIONS	***That the Committee:*** ***(a). approves the revised 2022-23 internal audit plan;*** ***(b). agrees that future updates on progress in addressing the findings of audits with a limited assurance rating is submitted to Committee on at least an annual basis until there is sufficient assurance that appropriate action has been taken; and*** ***(c). reviews and considers the outcomes of the work completed as set out in this report and indicates whether it requires any further assurance.***
EXECUTIVE SUMMARY	The Internal Audit Service provides independent assurance to the Service's senior officers and Members that governance, risk management and controls are sufficient in ensuring delivery of the Service's objectives. This report sets out the progress that has been made against the approved Internal Audit Plan for 2022-23 in addition to completion of the 2021-22 Internal Audit Plan.
RESOURCE IMPLICATIONS	Nil.
EQUALITY RISKS AND BENEFITS ANALYSIS	Not applicable
APPENDICES	A. 2022-23 Internal Audit Plan B. Definitions of Audit Assurance Opinion Levels.
BACKGROUND PAPERS	Report APRC/21/3 (2021-22 Draft Internal Audit Plan) to the [then] Audit & Performance Review Committee meeting on 5 March 2021 (and the Minutes of that meeting – APRC/43). Report AGC/22/1 to the Audit & Governance Committee on 7 March 2022 (and the Minutes of that meeting – AGC/21/17).

1. **INTRODUCTION**

1.1. The Internal Audit Plan forms the principal work of the Internal Audit Service and is a significant source of assurance of the effectiveness of the internal control environment.

1.2. The aim of this report is to update the Committee on progress in completing the 2021-22 plan and delivery against the 2022-23 plan.

1.3. The team can confirm that there are no significant facts or matters that impact on its independence as auditors that it is required to, or wishes to, draw to the attention of the Committee. The team confirms that it is independent and able to express an objective opinion on all statements provided.

1.4. The opinions contained within this report are based on audit examination of restricted samples of transactions/records and discussions with officers responsible for the processes reviewed.

2. **DELIVERY OF THE 2021-22 AUDIT PLAN**

2.1. The following three audits included within the 2021-22 audit plan are in the process of being finalised:

- Organisational Safeguarding Assurance. The management actions are currently being considered by Safeguarding Board. This will be formally signed off at the January 2023 Safeguarding Board meeting.
- Information Security – Availability of systems
- Use of Data

2.2. The outcome of the Key Financial Systems audit was inadvertently omitted from previous progress reporting on delivery of the 2021-22 audit plan. The outcome of the audit is therefore reported below in table 1 alongside the outcome of the programme assurance review which has also now been completed. Definitions of Audit Assurance Opinion Levels and Recommendation Priority can be found at Appendix B.

Table 1

Audit Area and Assurance Summary	Audit Opinion	Management Response
Key Financial Systems Except for the new creditor invoice matching software, there have been few changes within the Finance and Payroll services in 2021-22. Key Financial Systems continue to operate effectively overall with measures in place which mitigate risk to varying degrees in most areas examined.	**Reasonable Assurance**	Consideration will be given to introducing new arrangements for journal review and authorisation during the coming year. The Service is content that the level of debt in relation to Red One is falling in line with

Audit Area and Assurance Summary	Audit Opinion	Management Response
Positive actions have been taken regarding several agreed actions from last year's audit. In respect of journal authorisations, these continue to be undertaken by dip sampling post event, however the sample remains small. Under ideal circumstances a review and authorisation process for all significant journals at the time of input would be implemented; we understand that the external auditors have also made recommendations in this area. Although it is understood that the debt in relation to Red One is being monitored and there is a repayment schedule in place, concerns remain as the amount outstanding increases year on year.		expectations. Any invoices raised since July 2020 that are falling due are being paid within the credit terms and regular monthly payments are being made to clear the legacy debt.
Project Management Maturity Assurance 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. It was noted that the feeling of officers was that benefits were being managed at project rather than programme level as they were more	**Not Applicable**	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.

Audit Area and Assurance Summary	Audit Opinion	Management Response
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.		

3. 2022-23 AUDIT PLAN

3.1. The transfer of the internal audit service to Devon Audit Partnership (DAP) on 1 October 2022 has necessitated a review of delivery of the 2022-23 audit plan with a view to agreeing deliverables for quarters 3 and 4.

3.2. The delivery of the 2021-22 plan was impacted in quarter 4 by Covid-19 related sickness for Internal Audit, DAP and Service colleagues and deferral of annual leave to quarter 4. This resulted in delay to completion for a number of audits which in turn impacted the start of the 2022-23 internal audit plan which was approved by the Audit & Governance Committee on 7 March 2022.

3.3. The following 2021-22 audits were completed in the 2022-23 financial year:

- Community Safety: Fire Prevention
- Personal Protective Equipment Audit
- Fleet Management
- Organisational Safeguarding Assurance
- Flexi Duty Rota
- Key Financial Systems
- Use of Data (report to be agreed by Service)
- Information Security – Availability of systems (report to be agreed by Service).

3.4. The impact of the carry forward of the 2021-22 internal audit plan, implementation of the Transfer of Undertakings (Protection of Employment) (TUPE) process and establishment of a new partnership arrangement has inevitably impacted delivery of the 2022-23 internal audit plan. Appendix A sets out the 2022-23 internal audit plan (a review of Payment for Availability is an addition to the plan at the request of the Area Manager for Response), status of the work and a rationale as to whether or not this work should transfer to DAP for completion. A number of audits have been identified for deferral for consideration in the 2023-2024 internal audit plan if appropriate.

3.5. As part of this review of audit plan delivery and determination of how the remaining audit days should be used, a risk based review is currently being undertaken to determine how the remaining 20 days in the plan should be used.

4. DELIVERY OF THE 2022-23 AUDIT PLAN

4.1. Table 2 below shows the detailed status of the audits completed for the 2022-23 Plan.

Table 2

AUDIT PLAN 2022-23		
Audit Area and Assurance Summary	**Audit Opinion**	**Management Response**
Crewing Pool 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. There have been reported incidences of people taking advantage of the crewing pool perks, taking pumps off the run to go to other stations. The general opinion amongst Group Commanders is that Crewing Pool is not a good use of Service resources, and that the root cause of the issue is a lack of staffing. There are suggestions that increasing the employment radius around the stations, and diversifying available roles within the Service, would help to increase retention time. There is also a culture of reduced responsibility surrounding taking a station's pump off the run because staff know that the Crewing Pool is there as a back-up if the Service requires the station on the run.	**Limited Assurance**	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.

AUDIT PLAN 2022-23		
Audit Area and Assurance Summary	**Audit Opinion**	**Management Response**
Application of Learning 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. Resourcing levels have however been cited as a potential issue for some teams, who 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 against which the Policy, Procedure and Guidance Team have to co-ordinate an assessment. 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. The learning points themselves tended to be assigned to lead officers within service areas and progress updated periodically. Overall, whilst learning is identified, co-ordinated, 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	**Limited Assurance**	A new action tracking proess 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.

5. AUDIT AND REVIEW RECOMMENDATIONS

5.1. Where recommendations for improvements have been made within audit reports, action plans have been agreed with management and regular reviews conducted.

5.2. At its meeting on 22 July 2022, Audit & Governance Committee requested an update on the actions to address the audits that had been reported to that meeting with a limited assurance rating. Table 3 below sets out this update.

Table 3

Audit Area and Assurance Summary	Update
Community Safety – Fire Prevention 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.	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. 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.

Audit Area and Assurance Summary	Update
Personal Protective Equipment (PPE) 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.	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 log books on their station visits but this is still adhoc. 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.

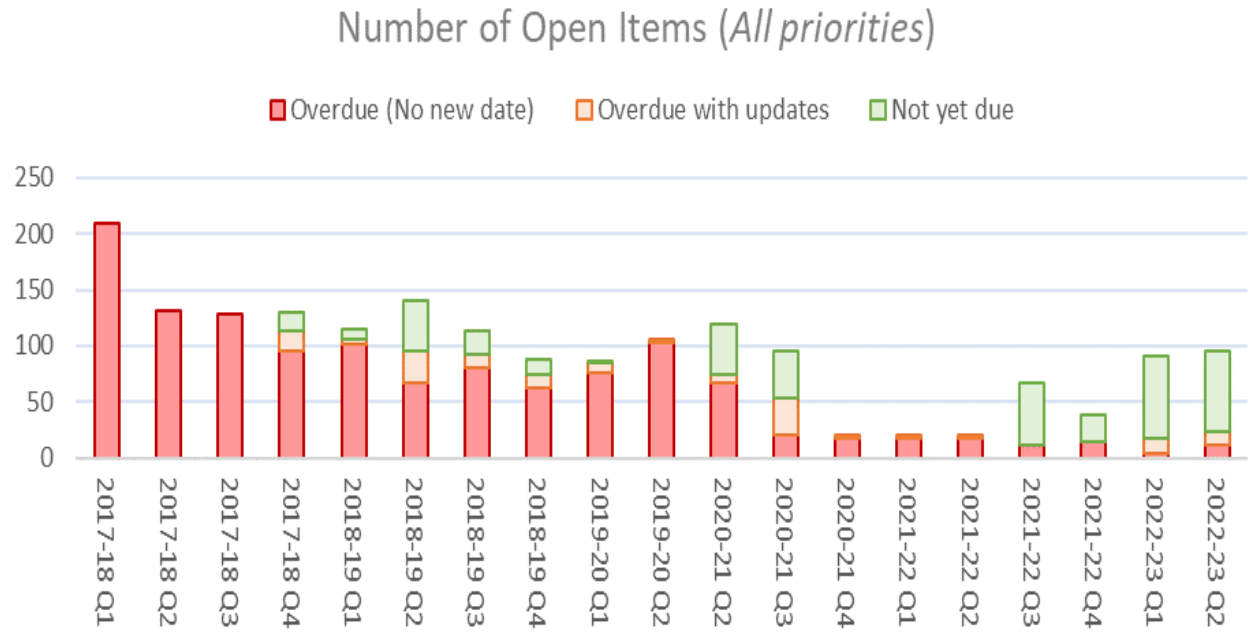
Audit Area and Assurance Summary	Update
Flexi Duty Rota In accordance with the Grey Book requirements, a Flexible Duty System (FDS) is in operation for officers at the Station Manager rank and above. Those utilising the Flexible Duty System undertake duties which can be split into two key types: Managerial 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. The audit concluded that the FDS, as operated within DSFRS, may not always be in the spirit in which the system was intended. Contingencies which the Policy states should be exceptional, have in many cases become the norm. There are potential risks to officer welfare and to the effective delivery of incident response. 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.	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.

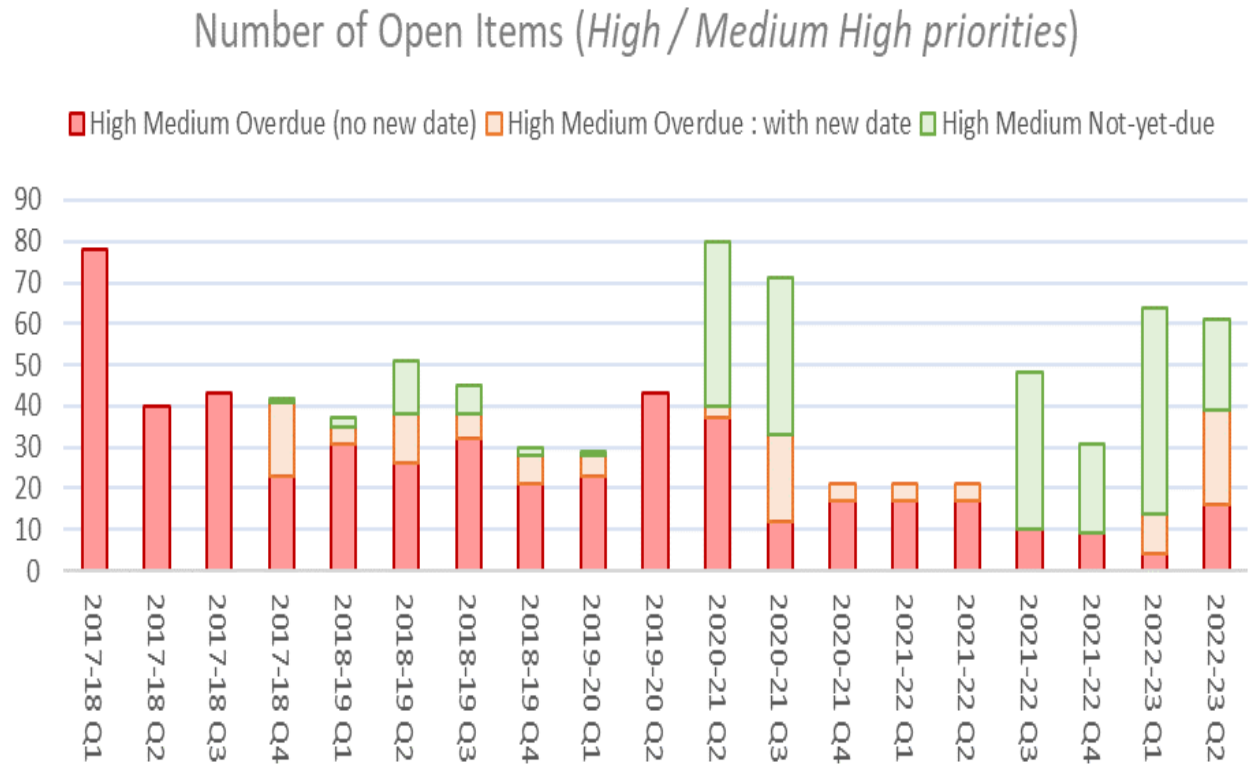
5.3. It is proposed that future updates on progress in addressing the findings of audits with a limited assurance rating is submitted to Committee on at least an annual basis until there is sufficient assurance that appropriate action has been taken.

5.4. The Audit Tracker records all recommendations and agreed actions arising from internal audit work. This has now been transferred to SharpCloud to provide greater visibility of action due dates and facilitate more effective management of the recommendations.

5.5. Some open actions have been superseded by changes to the Service structure, digital transformation, and other upgrade/changes. Work is ongoing to ensure that actions that have been superseded are documented and recorded as closed.

5.6. The tables overleaf show the number of open items on the Audit Tracker.





6. CONCLUSION AND RECOMMENDATIONS

6.1. The progress made against the agreed Audit Plan will be reported back to Audit & Governance Committee at regular intervals.

6.2. It is recommended that the Committee:

(a). approves the revised 2022-23 internal audit plan;

(b). agrees that future updates on progress in addressing the findings of audits with a limited assurance rating is submitted to Committee on at least an annual basis until there is sufficient assurance that appropriate action has been taken; and

(c). reviews and considers the outcomes of the work completed as set out in this report and indicates whether it requires any further assurance.

MIKE PEARSON
Director of Governance & Digital Services

APPENDIX A TO REPORT AGC/22/15

2022-23 Internal Audit Plan

Audit	Days	Status	Transfer?	Rationale
ORIGINALLY ASSIGNED TO INTERNAL RESOURCE				
Crewing pool	15	FINAL REPORT	**No**	N/A
Review the operation of the critical messaging process	15	DRAFT REPORT	**In part**	Predominantly completed internally. DAP to review.
Control of working hours	15	DRAFT REPORT	**In part**	To be completed internally. DAP to review.
Payment for Availability	20	WORK IN PROGRESS	**Yes**	Request for priority review.
Application of HR policy and procedure	~~25~~ 20	NOT STARTED	**TBC**	The rationale for this audit is that the People department is undertaking a significant amount of work to review and update HR policies and procedures. This audit will support continuous improvement in this area by reviewing the application of those new policies and procedures.
Community Safety - Schools & Engagement	20	PLANNING	**No**	The audit has been deferred until the Safeguarding Manager starts in December 2022
Station compliance - Environmental / waste management	25	NOT STARTED	**No**	Initial Environmental Review completed by external consultant with first annual review in process of being completed. Once priority areas of focus have been determined then audit work can be prioritised accordingly.
Support the Service's response to the HMICFRS 2021 report findings	30	NOT STARTED	**No**	Action plan has only just been developed so propose deferring until 2023/24.
Station-based Testing Regime	20	NOT STARTED	**No**	Already deferred to accommodate rollout of Phase 2 asset management and self-assessment audits rolled out in June.

Audit	Days	Status	Transfer?	Rationale
Personal Protective Equipment: Contaminants	20	NOT STARTED	**No**	Already deferred to allow contaminants work to progress.
Firefighter Fitness Training Review	10	NOT STARTED	**No**	Not required; HMICFRS discharged Cause of Concern.
Behavioural Risk	15	NOT STARTED	**No**	Links with work to support the Service's response to the HMICFRS 2021 report findings. Would also be beneficial to defer until after staff survey has been completed.
ORIGINALLY ASSIGNED TO DAP				
Key Financial Systems	32	NOT STARTED	**N/A**	Core element of the internal audit plan. Planned to start January 2023.
Application of learning	30	FINAL REPORT	**N/A**	N/A
Supervision for work completed internally	5	WORK IN PROGRESS	**N/A**	Critical messaging and control of working hours audits

Definitions of Audit Assurance Opinion Levels	
Assurance	**Definition**
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

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.