DORSET & WILTSHIRE FIRE AND RESCUE

SWAP INTERNAL AUDIT SERVICES
Helping Organisations to Succeed

25/49 Appendix A

Dorset & Wiltshire Fire and Rescue Service

Report of Internal Audit Activity

Plan Progress 2025/26 Quarter 3

Internal Audit ▪ Risk ▪ Special Investigations ▪ Consultancy

Unrestricted

Internal Audit Plan Progress 2025/26 Quarter 3

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Internal Audit Plan Progress 2025/26 Quarter 3

Introduction

This report summarises the Internal Audit activity completed for Dorset & Wiltshire Fire and Rescue Service in Quarter 3 2025/26 in line with the Annual Audit Plan approved by the Finance & Audit (F&A) Committee and the Chief Fire Officer in February 2025.

The schedule provided in Appendix 1 contains a list of all Audits agreed in the Annual Audit Plan 2025/26.

We have provided a summary of activity which outlines our assurance opinion and the number and priority of any actions that we made in relation to the Audit work undertaken in Quarter 3. To assist the Committee in its monitoring and scrutiny role, a summary of each audit (objective, risk, controls tested, findings and actions) has also been provided, the content of which has been discussed and agreed with the responsible Director.

The scope for each Audit is agreed in advance with nominated managers. This process intends to focus on the key risks to which that area of the Services activity is exposed and the associated controls which we would expect to be in place to ensure that risk is managed.

The key controls have been assessed against those we would expect to find in place if best practice in relation to the effective management of risk, the delivery of good governance and the attainment of management objectives is to be achieved. Where applicable, selected and targeted testing has been used to support the findings and conclusions reached.

We have performed our work in accordance with the principles of the Institute of Internal Auditors (IIA) Global Internal Audit Standards (GIAS) and the UK Public Sector Application Note and the CIPFA Code of Practice for the Governance of Internal Audit in UK Local Government in so far as they are applicable to an assignment of this nature and you, our client.

Internal Audit Plan Progress 2025/26 Quarter 3

Audit Summary

In Quarter 3 2025/26, the following Audits were completed in accordance with the Audit Plan:

Audit Name	Healthy Organisation Theme	Linked To	Status	Opinion	No of Actions	Priority of Actions		
						1	2	3
Culture Plan	People & Asset Management	Strategic Risk 598 HMICFRS People Pillar Priority 5	Final	Substantial	4	-	-	4
Overtime (and secondary contract) Management	Corporate Governance Financial Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Reasonable	1	-	1	-

Assurance Definitions

Each completed Audit has been awarded an "Assurance opinion" rating. This opinion takes account of whether the risks material to the achievement of the Services objectives for this area are adequately managed and controlled. The Assurance opinion ratings have been determined in accordance with the Internal Audit "Audit Framework Definitions" as detailed in the below:

Audit Assurance Definitions	
No	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.
Limited	Significant gaps, weaknesses or non-compliance identified. Improvement is required to the system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.
Reasonable	There is generally a 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.
Substantial	A sound system of governance, risk management and control exist with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.

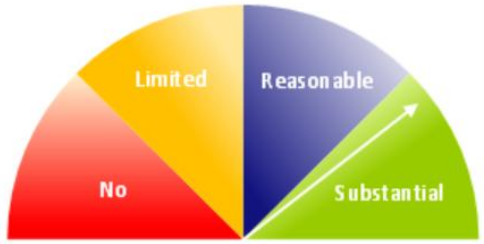
From our work we have raised actions which seek to strengthen the Services controls within each Audit area. We highlight those matters of that we believe merit acknowledgement in terms of good practice or undermine the system's control environment, and which require attention by management. All improvement actions are allocated a priority grading and have been agreed with the management teams in the appropriate area.

Categorisation of Actions	
In addition to the corporate risk assessment, it is important that management know how important the action is to their service. Each action has been given a priority rating at service level with the following definitions:	
Priority 1	Findings that are fundamental to the integrity of the service's business processes and require the immediate attention of management.
Priority 2	Important findings that need to be resolved by management.
Priority 3	Finding that requires attention.

Culture Plan Audit

Audit Objective	To assess the effectiveness, robustness, and transparency of the processes and mechanisms by DWFRS in delivering its Culture Action Plan

Executive Summary



Assurance Opinion	Management Actions		Organisational Risk Assessment	Low
The review confirmed a sound system of governance, risk management and control, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Priority 1	0	Our audit work includes areas that we consider have a low organisational risk and potential impact. We believe the key audit conclusions and any resulting outcomes still merit attention but could be addressed by service management in their area of responsibility.	
	Priority 2	0		
	Priority 3	4		
	Total	4		

Key Conclusions

The following area for improvement was identified during our review:

- Establish a structured, sustainable update process for cultural actions to ensure consistent progress tracking and accountability in the next iteration of the plan
- Progress with work underway to embed a structured process for all staff to periodically acknowledge the Code of Ethics
- Conduct a structured lessons learned exercise at the close of the action plan to capture successes, challenges, and insights that will inform and strengthen cultural initiatives
- Revise the CDC Terms of Reference to clarify reporting arrangements

The following key strengths were identified during our review:

- Roles and responsibilities for cultural action plan oversight are clearly defined, with quarterly reporting and committee meetings showing strong scrutiny and challenge

Audit Scope

We reviewed the following areas of control during this audit:

- The role of senior leadership in overseeing the cultural plan, including clarity of accountability for culture-related outcomes
- Existence and adequacy of KPIs to measure cultural progress against the plan
- How the culture plan is effectively disseminated across the organisation
- Desired cultural behaviours are defined, which are acknowledged and widely accessible to all staff

	• The Our Culture SharePoint provides staff with easy access to a wide range of cultural resources. Newsletters are used effectively to share updates and highlight new materials • The Core Code of Ethics is well-integrated into recruitment and onboarding processes, with leadership actively promoting ethical standards. Approved documentation outlines expected behaviours, reinforcing a values-driven approach from the outset of employment • A variety of feedback channels support open dialogue and cultural responsiveness.	• Reporting on progress against the culture plan to ensure outcomes are on track to be achieved, including mechanisms in place for when risks, issues, or underperformance occur; and • There are formal regular feedback mechanisms in place to ensure efforts are focused on embedding and sustaining the desired culture across the organisation

Appendix 1 Findings & Action Plan

Finding 1 – Culture Actions Progress	Action
While the Culture Assurance Framework (CAF) is used as a live tool to monitor progress against cultural actions there is no formal process in place to ensure that action owners provide regular and structured updates. This limits the ability to assess overall progress, identify slippage, or maintain momentum toward strategic goals. Although the service operates with limited capacity and seeks to balance action progress with workload pressures – an issue acknowledged within the culture plans – the lack of structured and consistent tracking of the actions weakens assurance over implementation. The current action plan was originally scheduled to close in April 2026. However, management has determined that the plan has been outgrown and intends to close the original action plan and move forward with a new iteration to account for the progress completed to date and reflect evolving priorities, it is essential that this transition is managed carefully. We acknowledge that some of the original actions were designed to support ongoing cultural improvement and strengthening and therefore may have not had definitive close dates. These actions are recorded within the Sycle system, and the ED Manager maintains oversight of this. However, updates to these actions are inconsistent. As a new iteration of the plan is developed, it is critical that actions are reviewed and adapted appropriately to maintain their relevance and impact. Without a consistent action tracking framework and transition to the new plan, there is a risk that cultural improvements may stall, become diluted, or fail to inform future planning effectively.	Embed a structured progress update process that requires action owners to submit regular updates and supporting evidence. This process must define reporting intervals, standardise the format and content of updates, assign oversight responsibility, and account for existing workload pressures to ensure it is practical and sustainable – specifically as part of the next iteration of the plan. **Management Response:** Since April 2025, all actions relating to the Culture Action Plan are now managed through our Performance Management System (Sycle). This enables clear corporate oversight at SDT quarterly performance meetings to take place through the SDT quarterly performance meetings. This approach is now embedded to ensure continuous monitoring and improvement and can be adapted and amended for future plans.

Priority	**3**	**SWAP Reference**	#7981
Responsible Officer		EDI Manager	
Timescale		30 November 2025	

Finding 2 – Cultural Behaviour Standards	Action
While new staff are introduced to the Core Code of Ethics during recruitment and onboarding, and assessed against these, existing employees are not consistently required to formally acknowledge these standards. However, there is no embedded process in place for existing staff to acknowledge the organisation's Code of Ethics and associated culture related behavioural expectations. We are aware that various avenues to introduce a refresh of the standards expected by staff is in a work in progress. However, the lack of this can create a gap in reinforcing ethical expectations across the full workforce. Without a consistent acknowledgement process, there is a risk that ethical standards may be unevenly understood or applied, weakening cultural alignment and accountability across the organisation.	Fully embed a formal process for all staff to periodically acknowledge the Code of Ethics and culture related behavioural standards. For example, through digital signatures, to ensure consistent understanding and endorsement of organisational values **Management Response:** This is acknowledged in our existing plans to update and re-issue DWFRS employee contracts. This will be further enhanced by the imminent introduction of a digital Code of Ethics resource which will include records of completion.

Priority	**3**	**SWAP Reference**	#7982 / #7983
Responsible Officer		EDI Manager	
Timescale		31/03/2026 – Digital CoE resource 30/06/2026 - Updated Contracts of Employment	

Finding 3 – Cultural Lessons Learned and Forward-Planning	Action			
Management has indicated that the current Culture Action Plan and Culture Delivery Plan have been outgrown, with closure of both imminent. This signals a transition point in the organisation's cultural journey and presents an opportunity to reflect on progress and shape future direction. However, there is no structured process in place to capture lessons learned from the lifecycle of the plans. Without a clear approach to review outcomes, assess effectiveness, and share insights, valuable learning may be lost, and future planning may lack the benefit of past experience. A structured transition process will be essential to ensure cultural momentum is sustained and future plans are informed by meaningful insight.	Perform a lesson learned exercise on the close of the action plan to identify areas that worked well, and improvements required for evolving cultural priorities **Management Response:** A lessons learnt exercise will be undertaken on delivery of the Culture Action Plan which will consider the content of this audit as well as the audit being undertaken by Practice to Progress and any additional HMI feedback following their re-visit. These areas of learning will help inform our approach going forward.			
	Priority	**3**	**SWAP Reference**	#7984
	Responsible Officer		EDI Manager	
	Timescale		31st March 2026	

Finding 4 – Cultural Development Committee Terms of Reference	Action
The Culture Development Committee (CDC) has been appropriately established as the oversight body for the Culture Action Delivery Plan, with its responsibilities clearly defined in the Terms of Reference (ToR). The committee's inclusive composition – comprising senior departmental representatives, staff network leads, representative bodies, and open seats for all staff – supports broad engagement and transparency. However, the reporting framework within the CDC ToR is insufficiently defined. The current reference to 'ad-hoc reporting to SLT' lacks clarity and does not specify the triggers, frequency, or scope of such reporting. This ambiguity may hinder consistent oversight and accountability. Furthermore, while a six-monthly highlight report is submitted to the Fire Authority's Finance and Audit Committee, this requirement is not reflected in the CDC ToR, creating disconnect between practice and documented governance.	Update the CDC ToR to clearly define the reporting arrangements, including: • Specific triggers for 'ad-hoc' reporting (e.g. escalation of risks, performance concerns) • Minimum reporting frequency to SLT • Inclusion of the escalation route for any identified slippage in delivery of culture goals • Inclusion of the six-monthly reporting requirement to the Fire Authority **Management Response:** We acknowledge these and will reflect this with immediate effect. The ToR is regularly reviewed in line with service priorities. We have a Strategic Risk (598) regarding Service Culture that is reviewed on a monthly basis, however, we will ensure that the SLT Strategic Focus Meeting Agendas include an item regarding our culture progress. This will enable corporate oversight on progress to include knowledge of any slippage and remediation action undertaken.

Priority	**3**	**SWAP Reference**	#7980
Responsible Officer		EDI Manager	
Timescale		31st December 2025	

Overtime and Secondary Contract Management Audit

Audit Objective

To provide assurance that DWFRS has adequate controls in place to monitor and oversee the processing of overtime claims. This review also followed up on the agreed management actions from the 2023-24 SWAP audit of Secondary Contracts.

Executive Summary

Assurance Opinion

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

Management Actions

Priority 1	0
Priority 2	1
Priority 3	0
Total	1

Organisational Risk Assessment Medium

Our audit work includes areas that we consider have a medium organisational risk and potential impact.

We believe the key audit conclusions and any resulting outcomes could be addressed by service management in their area of responsibility.

Key Conclusions

Our conclusions are made at a point in time and based on testing of key overtime management policies and procedural documentation, interviews with operational and corporate staff who were involved in approving and monitoring overtime claims, and on a sample of 22 overtime claims from across both Gartan and EClaim systems. This included incident response and pre-arranged overtime claims. It was not possible for the service to provide evidence in support of three originally selected samples. We were advised by the Employee Relations Manager that this was due to audit trail data not being recorded temporarily during a system transition at the time. Three alternative samples were selected to replace those which could not be evidenced. Sample testing of Gartan overtime claims identified five instances (out of 12 tested) where the same service number appeared for both the claimant and the approver, indicating a lack of forced segregation of duties within the Gartan system. The same issue was not present within the documentation reviewed for sampled e-Claims. This finding undermines control assurance and creates a risk of error or fraud whereby system controls do not prevent staff from approving their own overtime claims. Details to support the issues raised are provided in Appendix 1.

The Service has effectively implemented the recommendations from the 2023 Secondary Contracts audit. While not identical to the actions originally proposed, the new arrangements (daily automated monitoring and quarterly contract reviews) achieve the objectives originally intended.

Audit Scope

We reviewed the following areas of control during this audit:

- Policies and procedures in place to govern the claiming and approval of overtime,
- The process for submitting, approving, and recording overtime claims, including evidence of managerial authorisation and segregation of duties.

The scope was refined during the audit to focus on verification of approvals recorded within system data,

	The following key strengths were identified during our review: • All overtime-related policies are current (last reviewed between March–July 2024), formally approved, version-controlled, and accessible on the Service intranet. Procedures clearly define roles, responsibilities, thresholds and Working Time Regulation requirements, and align with operational practice. • Overtime expenditure is actively monitored. Variances are analysed monthly by Finance and discussed with management, with quarterly reports presented to the Finance & Audit Committee under Key Lines of Enquiry (KLOEs 6 and 7). • Interviews with Station Managers confirmed good understanding of overtime approval processes and monitoring responsibilities.	• Accuracy and completeness of overtime payments processed through the payroll system, • Oversight and monitoring arrangements in place to identify trends, control costs, and ensure compliance with budgetary and workforce objectives. The audit also included a follow-up of the previously agreed management actions from the 2023-24 SWAP audit of Secondary Contracts.

Finding 1 – Authorisation of Overtime	Action
Testing of 12 overtime claims submitted through the Gartan system found that in five cases (dated between December 2024 and May 2025) the approver's service number matched that of the claimant. Three of these claims were for Watch Managers. When we discussed the authorisation process with the Employee Relations Manager, they confirmed that Gartan has no built-in system controls to prevent employees from authorising their own overtime claims once submitted. When we explored whether any secondary or compensating controls exist to mitigate this weakness, we were informed that the Employee Relations Team "sense check" Gartan and e-Claims data and raise anything which looks obviously incorrect. However, they do not carry out any substantial checks prior to processing which would mitigate this weakness. The team work on the premise that all claims they are sent have already been properly reviewed prior to authorisation and they treat all claims as valid for payment. This issue is compounded by discussions with a Station Manager interviewed during the audit, who expressed that Watch Managers are able to submit and approve their own overtime within the Gartan system. Allowing staff to approve their own overtime claims removes a fundamental segregation-of-duties control, increasing the risk of: – unauthorised or inaccurate payments being processed; – potential misuse of the overtime process; – reputational and financial exposure if irregularities occur. System configuration in Gartan appears to permit approval rights to be retained by claimants in certain circumstances (e.g. small teams, watch management level) without enforced segregation.	Review Gartan user permissions and workflow rules to ensure that no individual can authorise their own overtime. **Management Response:** Changes will be made to Gartan to remove the ability for members of staff to sign off their own overtime claims. We have been assured that this will be possible, but we will need to submit a change request to Gartan as this will be development work. Work undertaken by Gartan has a minimum turnaround of 90 days unless the importance is increased and then we will pay for development time. An internal monitoring process will be run until the changes to Gartan have been implemented. The ultimate fix will be dictated by Gartan development time, but this may take up to 6 months to be implemented. As an interim measure, the compliance and investigation office will carry out a monthly dip test of whole time Watch Managers overtime claims to ensure that they are a true reflection of the work undertaken.
Priority 2	**SWAP Reference** I#7337
Responsible Officer	Assistant Chief Fire Officer - Response
Timescale	30 April 2026

Appendix 1 – 2025/26 Audit Plan and Performance

Audit Name	Healthy Organisation Theme	Linked To	Status	Opinion	No of Actions	Actions		
						1	2	3
Corporate Performance Management	Corporate Governance	HMICFRS Efficiency Pillar HMICFRS Effectiveness Pillar Priority 4	Final	Substantial	2	-	-	2
IT Asset Management	Information Management Procurement & Commissioning	Strategic Risk 301 HMICFRS Effectiveness Pillar Priority 4	Final	Reasonable	2	-	2	-
Treasury/Reserves Management	Financial Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Substantial	1	-	-	1
People Development	People & Asset Management	Strategic Risk 598 HMICFRS People Pillar Priority 5	Final	Reasonable	4	-	3	1
Culture Plan	People & Asset Management	Strategic Risk 598 HMICFRS People Pillar Priority 5	Final	Substantial	4	-	-	4
Overtime (and secondary contract) Management	Corporate Governance Financial Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Reasonable	1	-	1	-
Procurement Process Evaluation	Corporate Governance Financial Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Q4					
Pensions Administration	People and Asset Management	HMICFRS Efficiency Pillar Priority 4	Q4					

Internal Audit Plan Progress 2025/26 Quarter 3

Audit Name	Healthy Organisation Theme	Linked To	Status	Opinion	No of Actions	Actions		
						1	2	3
Placeholder for additional audit	TBC	TBC	Q4					
Follow Ups	All	All	-					

The performance results for progress against the internal audit plan for Quarter 4 of the 2025/26 Internal Audit Plan are as follows:

Performance Target	Average Performance	
	% of the Annual Plan	Number of Assignments
Audit Plan – Percentage Progress		
Final, Draft, Discussion, Removed	67%	6
In progress, Ongoing	0%	0
Not yet started	33%	3
	100%	9

The completion of the plan is currently on target.