Item 20/23 Appendix A

DORSET & WILTSHIRE FIRE AND RESCUE

SWAP INTERNAL AUDIT SERVICES
Assuring – Improving – Protecting

Dorset & Wiltshire Fire and Rescue Service

Report of Internal Audit Activity

Plan Progress 2020-21 Quarter 1 and 2

Internal Audit ▪ Risk ▪ Special Investigations ▪ Consultancy

Unrestricted

Contents

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Internal Audit Plan Progress 2020-21 Quarter 1 and Quarter 2

This report summarises the Internal Audit activity completed for Dorset & Wiltshire Fire and Rescue Service in Quarters 1 and 2 (2020-21) in line with the Annual Audit Plan approved by the Finance & Audit (F&A) Committee and the Chief Fire Officer in March 2020.

The schedule provided in Appendix 1 contains a list of all Audits agreed in the Annual Audit Plan 2020-21.

We have provided a summary of activity which outlines our assurance opinion and the number and priority of any recommendations that we made in relation to the Audit work undertaken in Quarters 1 and 2. To assist the Committee in its monitoring and scrutiny role, a summary of each audit (objective, risk, controls tested, findings and recommendations) 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 Service's 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) International Professional Practice Framework (IPPF) and the Public Sector Internal Audit Standards (PSIAS) in so far as they are applicable to an assignment of this nature and you our client.

Internal Audit Plan Progress 2020-21 Quarter 1 and Quarter 2

Summary

In Quarters 1 and 2 of 2020-21, the following Audits were completed in accordance with the Audit Plan:

Audit Name	Healthy Organisation Theme	Linked To	Status	Opinion	No of Recs	Priority of Recommendations		
						1	2	3
Asset Management Strategy	Performance Management Information Management People & Asset Management Corporate Governance	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Adequate	2	-	1	1
Critical Supplier Management	Commissioning & Procurement Financial Management	HMICFRS Efficiency Pillar Priority 4	Final	Substantial	1	-	-	1
Malpractice Management Controls	Information Management Risk Management	HMICFRS People Pillar Priority 5	Final	Adequate	3	-	-	3
Financial Resilience – Management of Reserves	Financial Management Performance Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Substantial	0	-	-	-
Information Security	Information Management Risk Management	Strategic Risk 301 Priority 4	Final	Adequate	1	-	-	1
Health and Wellbeing Programme	People & Asset Management	HMICFRS People Pillar Priority 5	Draft	Adequate	2	-	-	2

Assurance Definitions

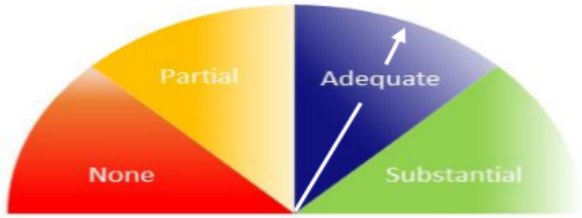
Each completed Audit has been awarded an "Assurance opinion" rating. This opinion takes account of whether the risks material to the achievement of the organisation's objectives for this area are adequately managed and controlled. The Assurance opinion ratings have been determined in accordance with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

Assurance Definitions	
None	The areas reviewed were found to be inadequately controlled. Risks are not well managed, and systems require the introduction or improvement of internal controls to ensure the achievement of objectives.
Partial	In relation to the areas reviewed and the controls found to be in place, some key risks are not well managed, and systems require the introduction or improvement of internal controls to ensure the achievement of objectives.
Adequate	Most of the areas reviewed were found to be adequately controlled. Generally, risks are well managed, but some systems require the introduction or improvement of internal controls to ensure the achievement of objectives.
Substantial	The areas reviewed were found to be substantially controlled. Internal controls are in place and operating effectively and risks against the achievement of objectives are well managed.

From our work In Quarter 1 we have made recommendations 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 Recommendations	
In addition to the corporate risk assessment it is important that management know how important the recommendation is to their service. Each recommendation 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.

Executive Summary

Audit Opinion		Recommendation Summary	
	Most of the areas reviewed were found to be adequately controlled. Generally, risks are well managed, but some systems require the introduction or improvement of internal controls to ensure the achievement of objectives.	Priority	Number
		Priority 1	0
		Priority 2	1
		Priority 3	1
		Total	2

Audit Opinion:
Adequate Assurance.

Objectives:
The objective of the audit is to provide assurances to management that DWFRS has an approved asset management strategy and that it is costed and linked to the corporate objectives of the Service.

Risk:
The Asset Management Strategy is not costed and/or does not align with corporate objectives, leading to financial loss, reputational damage and non-delivery of service.

Controls Tested:

- An approved asset management strategy or framework exists and seeks to deliver corporate priorities including value for money and efficiencies.
- Stakeholders are engaged, members and officers aware of roles including review, scrutiny, and challenge, particularly around costings included in the Strategy/supporting plans.

We were unable to complete in-depth testing around the plan costings within the restricted timeframe, though we have confirmed that the plans are intrinsically linked to the Medium Term Financial Plan (MTFP) and Capital Programme, and the Fleet plan includes a capital expenditure forecast up to and including 2024.

The Service has also purchased a new asset management IT system in March 2020, as part of their plans to align their asset management approach. We have not tested the new system giving the audit timing, nor have we reviewed the Service's alignment to the ISO55001 Asset Management Standard.

ICT, utility, communications, and staff assets have not been included within the audit scope as agreed during the audit planning process.

Areas of good practice:

The Asset Management Policy Statement sets out the objectives for the Service in relation to asset management. This policy delegates the responsibility for compliance to the Director of Service Support, who is required to provide the Authority with an annual assurance statement. The May 2019 statement included an overall judgement rating of "Good confidence, no major issues or failings, action plan in place". Department specific documents exist to support strategic planning for service delivery.

The Service has committed to increased capital expenditure to ensure that older unsustainable fleet is removed in a timely and cost-effective manner and this is reflected in the Integrated Fleet Asset Management Plan 2019-24 (IFAMP).

Summary of Recommendations:

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
The Service Delivery Plan included an action under KLOE 16 *"Are we making the most effective use of our assets to deliver our priorities?"* for the Head of Assets to create and resource separate property, fleet, and equipment asset management plans, with a completion date of September 2019 for the IEAMP 2020-25. We contacted the Head of Assets regarding the IEAMP 2020-25, who informed us that it is still to be finalised, as of April 2020. There is a risk that the Service loses momentum in development of the IEAMP 2020-25, does not maintain corporate oversight, increasing likelihood that corporate objectives are not achieved.	We recommend that the Head of Assets ensures the IEAMP 2020-25 is finalised, published, and included within the 2020 SDP update as planned. Actions should feed into the Sycle Performance Management System to ensure they are managed in line with corporate expectation.	Unfortunately, due to a departmental restructure in 2019 and the subsequent impact of Covid19 planning, the release of this plan was delayed. However, this document was finalised following the close out meeting and is due for publication on the staff website. All actions arising from the IEAMP 2020-25 will be added to the Sycle reporting system in a timely manner.	Head of Assets 30 June 2020 The Service has confirmed that this is Complete.	2

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
We reviewed two asset management plans during the audit. The IFAMP 2019-24 contained document control information pertaining to its version and issue date, plan owner and which stakeholders were consulted during the document's development and review. However, this information was omitted from the IPAMP 2018-22, which, although dated May 2018 on the front page, does not detail the version number, issue date, plan owner (Building Services Manager) or stakeholders. This information would benefit readers of the document, as without this information it is unclear whether it is the most recent version having taken review changes into account. The document also refers to an overarching Asset Management Plan, under the "Alignment to the corporate calendar" section. However, based on information received during the audit, we can confirm that there is no documented, overarching Asset Management Plan in place. The Service see the Asset Management Policy Statement as their overarching document. As such, this statement should be reworded to avoid confusion. There is a risk that the IPAMP 2018-22 is not being adequately maintained and reviewed, and that version issues are not appropriately tracked to log changes to the plan, leading to potential lack of cohesion with key planning documents.	We recommend that the Head of Assets includes document control information within the IPAMP 2018-22 which identifies the document's version and issue numbers, the dates of its creation and review, to identify the Policy Owner and which stakeholders were consulted during the plan's development and reviews. It should also be reworded to remove reference to an overarching Asset Management Plan.	Agreed. The revised IPAMP will be revised to include the latest agreed budgets, full document control and reference the Asset Management Policy Statement as the over-arching document.	Head of Assets 30 September 2020	3

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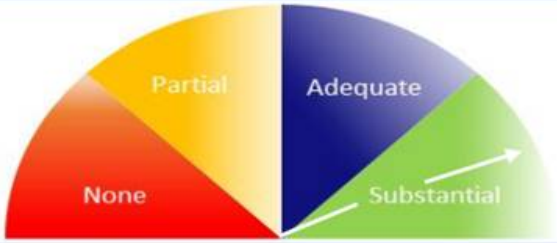
Audit Opinion



The areas reviewed were found to be substantially controlled. Internal controls are in place and operating effectively and risks against the achievement of objectives are well managed.

Recommendation Summary

Priority	Number
Priority 1	0
Priority 2	0
Priority 3	1
Total	1

Audit Opinion:
Substantial Assurance.

Objectives:
To provide assurance to management that Dorset & Wiltshire Fire and Rescue Service has a clear understanding of its critical suppliers and the impacts of failure.

Risk:
The Service does not have an understanding of its critical suppliers and/ or the impact of supplier failure, leading to the potential inability to deliver its core functions resulting in harm to employees/ service users/ members of the public and subsequent legal, financial and, political, reputational economic or social damage.

Controls Tested:

- Critical suppliers are identified, risk-assessed and records are reviewed on a regular basis.
- Supplier business continuity arrangements are captured as part of contract evaluation/ procurement and supplier plans provided where necessary.
- The point of contact and relationship is maintained and managed through an allocated responsible DWFRS officer.
- There are arrangements in place if key supplier chain fails and processes for escalation exist to notify management of failure.

The review has considered both, the 'normal' business arrangements and those that have been implemented following the Coronavirus pandemic and the subsequently declared major incident. Findings and considerations have, in the first instance, been discussed with the Head of Strategic Planning and Corporate Assurance verbally to ensure that these can be considered in line with the current pandemic response.

Areas of good practice:

The substantial opinion reflects the position with regards to the management of controls around critical suppliers, as at the end of April 2020. Continued, effective communication and monitoring of critical suppliers is paramount as the pandemic continues. The Service is currently identifying and actively monitoring emerging risks in relation to critical suppliers, but this will need to continue given the unpredictability of the Coronavirus pandemic.

Summary of Recommendations:

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
Audit testing found that there has been a mixed approach to supplier relationship management during the pandemic period. Some departments have asked their critical suppliers for statements of intent regarding supply chain, others have built a list of questions in relation to the impact of supply chain failure. The response across the Service was discussed with the Head of Strategic Planning and Corporate Assurance and it was agreed that a more formalised approach to supplier communications could be adopted as we move into the next stages of the pandemic, if needed. There is no significant risk exposure, but the implementation of a revised approach will help to provide improved, coordinated and consistent messaging to suppliers.	We recommend that the Head of Strategic Planning and Corporate Assurance implements coordinated and consistent messaging for critical suppliers during the remainder of the pandemic response.	The Service has robust arrangements in place, with clear identification of key suppliers. Individual departments have well established relationships with their suppliers and have been able to effectively ensure that the Service continues to receive appropriate services and supplies. The management of supply chains will be reviewed as part on ongoing learning for the event and this recommendation will be considered as part of the overall approach moving forward.	Head of Strategic Planning & Corporate Assurance 31 July 2020 The Service has confirmed that this is Complete.	3

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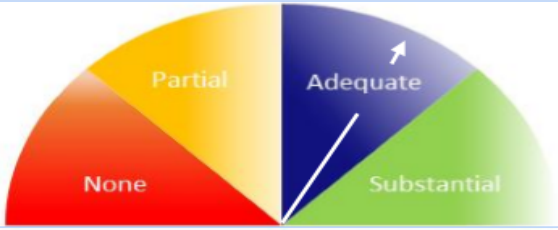
Audit Opinion		Recommendation Summary	
	Most of the areas reviewed were found to be adequately controlled. Generally, risks are well managed, but some systems require the introduction or improvement of internal controls to ensure the achievement of objectives.	Priority	Number
		Priority 1	0
		Priority 2	0
		Priority 3	3
		Total	3

Audit Opinion:
Adequate Assurance.

Objectives:
The objective of the audit is to provide assurances to DWFRS management that procedures are in place and suitably managed to reduce risk of malpractice.

Risk:
The absence of procedure/ policy and lack of effective management leads to malpractice, resulting in reputational, financial, and/ or legal damage.

Controls Tested:

- Procedures are in place and regularly reviewed and driven by best practice and legislation.
- Procedures are made available to stakeholders and training is available, where necessary, to enhance culture.
- Processes to capture, monitor, escalate and evaluate information are in place and operating in line with expectations.

We have not reviewed the following areas and these are therefore not included within our assurance opinion:

- We have not tested compliance with the staff induction checklist as part of this review.
- We were unable to obtain information relating to e-learning compliance due to the timescales.
- The Member Code of Conduct document was reviewed as part of the audit, but we did not test mechanisms for compliance with training or procedures in relation to Members.

Areas of good practice:

Procedures are in place to govern the following areas: Staff code, Whistleblowing, Anti-Fraud, Corruption and Bribery, Complaints, Bullying and Harassment. These documents are located on the staff Intranet site and on the Service's website, to which all staff, Members and other stakeholders have access. There is a standard layout for these documents which includes version control, an owner, and a review schedule.

As part of the new staff induction checklist, several key procedures are highlighted and staff must confirm their understanding of them by the end of their three-monthly review. There are also e-learning modules relating to some of the procedures above. The Service is currently creating a dashboard of e-learning information which will be shared with each Station and Department to better monitor completion of the modules.

Summary of Recommendations:

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
The Members Code of Conduct forms part of the Authority's Constitution, which is held within the Members handbook and is accessible publicly through the Service's website. The handbook was formally delivered and approved as part of the Combination in 2015 and is reviewed and updated on an annual basis, ensuring that any orders are revised as per Authority approval and that up to date Member information is available. Whilst the Code of Conduct has not been specifically reviewed by the Service since its approval in 2015, it is considered as part of this annual review to ensure appropriateness. In 2018 the Authority reduced its membership from 30 Members to 18 and the identified documents within the constitution were adjusted as necessary with the approval of the Authority, these being Standing Orders, Officer Delegations and Financial Regulation. As part of this it was agreed by the Authority that a full review on the Authority's governance would be independently completed in 2019. The independent governance review was undertaken in July 2019 by the Local	We recommend that the Head of Strategic Planning and Corporate Assurance ensures that a review is undertaken with regards to the Member Code of Conduct, upon the completion of the LGA model code consultation and from this point a review cycle is added to the code.	Upon completion and publication of the report from the LGA following consultation, the Service will review the Members code of conduct and provide recommendations to the Authority.	Head of Strategic Planning and Corporate Assurance. 28 February 2021 - Provided that the LGA has published the results of its consultation.	3

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
Government Association, where the full Constitution, including Code of Conduct, was reviewed resulting in full assurance being given to the Authority in relation to its governance arrangements with and no significant gaps or weaknesses identified. Whilst we understand that the handbook is reviewed on an annual basis, there is no formal document review schedule for the Code of Conduct document. As it is noted the LGA is soon to commence a consultation on a model code any review should be postponed until the results of this consultation are understood. There is a risk that version issues are not appropriately tracked to log changes to the Member Code, leading to potential lack of cohesion with key malpractice documents.				
Anti-Fraud, Corruption and Bribery and Whistleblowing are not directly referenced in the induction process under key procedure. These are both referenced within the staff code of conduct which and located on the Connect Intranet site. Both areas are also referenced in the Statement of Particulars for corporate staff, which must be completed as part of the probation process. Furthermore, Anti-Fraud, Corruption and Bribery and Whistleblowing are not listed in the mandatory modules in the e-learning platform.	We recommend that the Head of Strategic Planning & Corporate Assurance includes Whistleblowing and Anti-Fraud, Corruption and Bribery in the list of key procedures within the staff induction checklist for all employees.	To further strengthen awareness for new employees the Service will add the Whistleblowing and Anti-fraud, Corruption and Bribery procedures to the list of induction procedures required to be reviewed by all new employees.	Head of Strategic Planning and Corporate Assurance 30 September 2020 The Service has confirmed that this is Complete.	3

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
A decision was made by the Training and Response Co-Ordinating Group (TRCG) not to make the available Whistleblowing e-learning mandatory due to lack of capacity for additional non-operational training for on-call crews. Whilst there is recent evidence of signposting to procedures within the internal newsletter (FireWire and Weekly update) and visual reminders in office locations for Whistleblowing, mandatory inclusion as a key procedure within the staff induction list would enforce a stronger awareness across the Service.	We recommend that the Head of Financial Services and Treasurer periodically promotes the Anti-Fraud, Corruption and Bribery procedure as an effective deterrent to malpractice. This could include use of e-learning for targeted members of staff, examples of fraud related activity and controls that are in place to monitor and detect fraud at the Authority.	We will promote the Anti-Fraud, Corruption and Anti-Bribery procedure at least annually, and more often where relevant. In addition, the annual Budget Manager Agreement, which is signed by all Budget Managers at the start of each financial year, will be amended to include a specific reference to the Anti-Fraud, Corruption and Anti-Bribery Procedure.	Head of Financial Services and Treasurer 30 September 2020	

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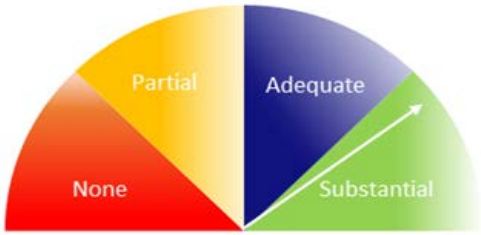
Audit Opinion		Recommendation Summary	
	The areas reviewed were found to be substantially controlled. Internal controls are in place and operating effectively and risks against the achievement of objectives are well managed.	Priority	Number
		Priority 1	0
		Priority 2	0
		Priority 3	0
		Total	0

Audit Opinion:
Substantial Assurance.

Objectives:
To provide an assessment as to whether the Service has adequate financial resilience, Reserves, and a plan for their utilisation and whether these are supported by a robustness statement.

Risk:
Ineffective management of the Service's reserves may result in financial instability, impacting on the services delivered to the public and therefore a risk of failing to meet corporate objectives.

Controls Tested:
- Management of Reserves and a plan for the utilisation of said Reserves.
- The robustness statement(s) supporting the above.

Our opinion reflects the areas that were included in the scope of this review and not the wider controls around financial resilience at the Authority.

Due to the COVID-19 lockdown in force across the UK between March – July 2020, the deadline for the Service to publish their accounts had been deferred. Due to the timeframe for our audit review and our audit reporting deadline of 29th July 2020, we have not been able to complete our standard assessment of the Service's Statement of Accounts for the FY 2019-20, and as such we cannot provide any assurances over its contents.

We did not seek to conduct testing of the Service's Reserve transactions as part of this audit to avoid duplication of efforts, having been informed that testing of Reserve transactions has formed part of the scope of the External Audit, which was still underway at the time of this report.

Areas of good practice:

The Service's management and utilisation of their Reserves is governed by their Reserves Strategy, within the Medium-Term Financial Plan (MTFP) 2020-2024. During our audit, we have reviewed the Reserves Strategy and associated processes against the requirements of the Fire and Rescue National Framework for England, which incorporates the Local Government Finance Act and CIPFA Local Authority Reserves and Balances guidance. We are satisfied, overall, that the management of the Service's Reserves, and the Reserve Strategy itself, follow the requirements of the applicable legislation and best practice.

Several of the Service's Reserves are managed centrally, with others managed through engaging Management from related departments.

We can confirm that the level of General Reserves held by the Service has been maintained in accordance with the Financial Principles set within their Reserve Strategy (*for the General Balances to be at £2.5m or 5% of the annual revenue budget, whichever is higher*). The scope and timeframe of our audit review has not allowed us to complete testing as to whether Reserve transaction controls are working effectively, however, we are satisfied that the processes and arrangements in place appear to be reasonable, if followed.

We are satisfied that the year-end position reported within the 2020-24 MTFP is reasonable, and that the projected Reserve Balances were accurately reported in the MTFP at the time of its collation.

We were provided with financial reports on the movement of the Service's Reserves over the last three financial years and discussed each of the Earmarked Reserves alongside the 2020-24 Medium Term Financial Plan with the Head of Financial Services and the Chief Accountant. It was highlighted that four of the Earmarked Reserves had not been utilised since 2018-19, and the Head of Finance confirmed their plans to revisit them during the annual review of the MTFP and the budget setting process for 2021-22. These Reserves were:

- Investment for Improvement – Leadership and Organisational Development Reserve
  This Reserve was set in support of the ongoing Leadership and Supervisory Development Programme. We are informed that the Leadership Programme has been delayed due to the Covid-19 pandemic and a new business case has been progressed to demonstrate how this reserve will now be used.
- Specific Projects – Emergency Medical Response Reserve
  This Reserve was set aside to fund projects that were originally planned to take place during the term of the MTFP.
- Other Earmarked Reserves – Hydrants and Safeguarding
  These "Other Earmarked Reserves" were initially put in place to support any shortfalls in future revenue budgets which are identified during the development of the MTFP.

No recommendations have been raised as part of this review.

Executive Summary

Audit Opinion		Recommendation Summary	
	Most of the areas reviewed were found to be adequately controlled. Generally, risks are well managed, but some systems require the introduction or improvement of internal controls to ensure the achievement of objectives.	Priority	Number
		Priority 1	0
		Priority 2	0
		Priority 3	1
		Total	1

Audit Opinion:
Adequate Assurance.

Objectives:
This audit assessed whether the Service has an appropriate approach to governance over their cyber security arrangements, and an effective cyber incident management plan.

Risk:
Without an appropriate approach to governance over information security and effective cyber incident management procedures, the Service is at risk of a lack of protection over their information assets and potential data loss. This could result in severe service disruption.

Controls Tested:
The following areas of control were covered under the scope of this audit programme:

- Governance arrangements are in place to ensure that the Service's information assets are protected from cyber threat.
- Incident management procedures are in place to ensure incidents are recorded, investigated and learnt from to reduce risk of recurrence.

There are many controls outside of the audit scope which have a direct impact on the management of cyber and information risk, including but not limited to the following:

- Information sharing protocol
- Hardware and software assets, inventory, and configuration
- Vulnerability management and software patching
- Account and administration privileges
- Records Management
- Firewall and boundary defence
- Encryption and migration of information
- Joiners, movers, and leaver processes

- Audit logs for IT applications
- Email and web browser protection
- Anti-malware deployment and management
- Network, port, and protocol
- Remote supplier access
- Security awareness, and training
- Application software security and development
- Penetration testing

Areas of good practice:

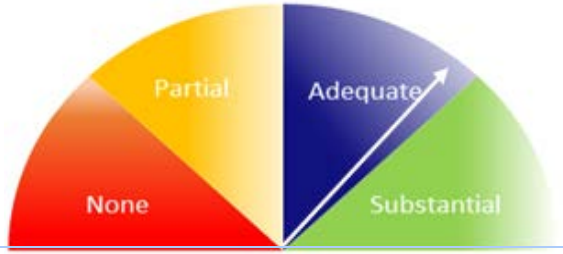
The Service has recognised several risks in relation to information security, one of which has been escalated to the Strategic Risk Register and relates to the protection of the Service against cyber threats and attack. There is also a clear link between information security and the key corporate documents which support the direction of the Service, namely the key Service Delivery Plan 2020-21 and the annual Corporate Governance Statement. There are established procedures and processes in place in relation to information security, including guidance to manage incidents and there is evidence to support these being available to key staff as required. The creation of a Cyber Security Manager post further indicates the corporate priority given to the security of information and data.

The Service is working towards compliance with the Emergency Services Network and are subject to an annual IT Health check. Internally, the Service has developed a cyber action plan, which provides direction and combines elements of ISO 27001 (framework), Cyber Essentials and the National Council Security Council (NCSC) Cyber Security Standards. These actions have not been subject to verification as part of this review.

Summary of Recommendations:

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
Security incidents are logged by the Information Governance Manager in a spreadsheet, which is available to the three members of the Information Governance Team. A review of the spreadsheet found that there are several gaps in information, including whether there was indeed a personal data breach or loss. There are also items where the chain appears to have stopped without further commentary. Most of the information gaps are from the 2019 records. It is acknowledged that the position has improved in 2020 and that incidents are now assigned an IG Lead; this was not always the case in 2019. It is also noted that the 15 incidents in 2020 are indicated as low risk. These mitigating factors have resulted in a priority 3 level of recommendation raised.	We recommend that the Information Governance Manager revisits each of the gaps in the security incident spreadsheet. An improved mechanism should be introduced to ensure that records of incidents are reviewed more regularly and closed promptly.	Information Governance Team will revisit the security incident spreadsheet and ensure that any gaps are completed and ensure a process is in place for regular review of these.	Information Governance Manager 4 September 2020	3

Executive Summary

Audit Opinion		Recommendation Summary	
	Most of the areas reviewed were found to be adequately controlled. Generally, risks are well managed, but some systems require the introduction or improvement of internal controls to ensure the achievement of objectives.	Priority	Number
		Priority 1	0
		Priority 2	0
		Priority 3	2
		Total	2

Audit Opinion:
Adequate Assurance.

Objectives:
To assure that the Fire Service has appropriate measures in place to support the Health and Wellbeing of its staff.

Risk:
Health and Wellbeing arrangements are unavailable to, or not utilised by staff, resulting in reduced output and a failure to meet organisational objectives.

Controls Tested:
This audit focussed on providing assurances over the following areas of control:

- The overarching Health and Wellbeing Programme objectives have been defined and agreed
- The Health and Wellbeing resources made available to staff have been scoped to ensure alignment with the objectives of the overarching programme
- The outcomes of the Health and Wellbeing Programme are measured through effective performance monitoring
- Health and Wellbeing resources are well publicised and promoted to all staff across the Service.

Areas of good practice:
The Service's Health and Wellbeing (H&W) Programme is governed by the People Policy Statement, the Community Safety Plan and the objectives within the Service Delivery Plan (SDP) for 2020, KLOE 8 which asks "How well do we promote our values and culture?", under which the H&W programme is monitored through workstream 8.3 "How well do we understand the wellbeing needs of our workforce and act to improve workforce wellbeing?". The objectives for the H&W team are defined within the SDP as Corporate Targets and a set of KPIs. These have been agreed by Senior Management during the development of the SDP for 2020-21.

On review of the above-noted documentation, we are satisfied that the objectives, which underpin KLOE 8.3., demonstrate the 'SMART' principle, in being specific, measurable, achievable, relevant, and time-bound.

We are satisfied that the service has a broad range of support resources and services available to support their staff, which in turn aim to deliver on the objectives of the H&W Programme.

A framework is in place for performance monitoring, through KPIs, corporate targets and management reporting on the Service's Programme.

We are satisfied that the H&W Programme is sufficiently promoted across the organisation, from the point of recruitment through to ongoing targeted newsletters and other internal communications. The Service's "CONNECT" intranet pages are the main resource base for H&W information. H&W procedural guidance and training are available to management regarding how to support their staff with their Health and Wellbeing, and how they can refer themselves or staff within their team to relevant support services.

Summary of Recommendations:

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
On discussion with management and having reviewed the tasks and performance data collected and reported within the Sycle system, we believe there is a gap in the H&W team's monitoring of whether the resources and information held within their intranet pages are 'fit for purpose'. The 'CONNECT' intranet pages are said to be the main repository for all H&W Programme resources and is predominantly where staff are directed towards within the H&W Procedure document. As the H&W Programme's overall aim is to deliver support to the workforce, the staff feedback gathered could be used to guide the future development of the H&W intranet pages, and to ensure that the resource continues to meet the needs of the Service's staff.	We recommend that the H&W Manager introduces a mechanism to seek and capture staff feedback in relation to the H&W intranet pages. The following information should determine whether: • Staff would access the intranet to locate H&W information in the first instance and their awareness of the content. • Staff have personally accessed the H&W intranet pages to seek H&W information for them or their family and if they feel that the pages are easy to navigate through.	The H&W Manager, with support from the HR Systems Advisor, will develop a staff feedback mechanism to assess access and usage of the H&W pages on 'Connect, and ease of use of the system, to inform any required improvements and improve the user experience.	H&W Manager 31 March 2021	3

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
During the audit, we viewed some of the 'CONNECT' intranet pages for H&W and it was noted that some of these resources were 'coming soon'. We are informed that when H&W Procedures are updated, it is not currently a part of the updating/review process to ensure that updated documents are reflected in those stored within the intranet pages. However, the H&W Manager informs us that the H&W team have begun work in this area to review the contents of the intranet, completing the pages and also to ensure that new information published via newsletters throughout the coronavirus pandemic in respect of H&W is archived so that it can be accessed at a later date. This was seen by management to be an ongoing process, to ensure the accessibility of the resources is maintained going forward.	We recommend that the H&W Manager promptly continues the intended review the H&W information and resources held within the intranet pages, to ensure these are all complete and up to date. A record of where H&W documents are stored and referenced should be maintained, to ensure that when the guidance is updated, the revised documents replace those which are rendered out of date as part of the standard review procedure. To resolve the issue in relation to keywords, the H&W Manager should liaise with the Head of Information, Knowledge and Communications, to ensure that the correct results are returned in relation to H&W roles on the staff 'CONNECT' site.	The H&W Manager to develop a process to continually review, update and maintain the H&W information and resources held on 'Connect'. The H&W Manager to liaise with the Head of Information, Knowledge and Communications who should review the search function on Connect to ensure that keyword searching is effective and responsive and that keyword search results appear for H&W roles and functions.	H&W Manager 31 March 2021	3
A matter was also bought to our attention, that not all of the H&W team appear as expected, within Contacts section of H&W pages within the intranet. We were informed that staff's profiles are automatically created with their job titles when they start, and staff are responsible for				3

Findings & Risk	Recommendation	Management Response	Officer Responsible/ Timescale	Rec Priority
inputting further information about their roles, including 'keywords' to describe their responsibilities. These keywords should mean that they will appear within intranet search results and on the relevant intranet pages 'Contact' sections, as the staff who can be contacted about the relative resource or service. The H&W Manager has assured us that the profiles of the H&W team are up to date, and having performed a keyword search, some the H&W staff did not appear within certain pages as expected. This could lead to the Service's staff being unclear of who to contact for certain H&W support and information, which may deter staff from contacting the H&W team. The responsibility for ensuring that the 'CONNECT' intranet search and contact elements function correctly sits with the Information, Knowledge and Communications team.				

Appendix 1 – 2020-21 Audit Plan and Performance

Audit Name	Healthy Organisation Theme	Linked To	Status	Opinion	No of Recs	Recommendations		
						1	2	3
2020-21								
Q1 - Malpractice Management Controls	Performance Management Information Management People & Asset Management Corporate Governance	HMICFRS People Pillar Priority 5	Final	Adequate	3	-	-	3
Q1 - Critical Supplier Management	Commissioning & Procurement Financial Management	HMICFRS Efficiency Pillar Priority 4	Final	Substantial	1	-	-	1
Q1 - Asset Management Strategy	People & Asset Management Financial Management Performance Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Adequate	2	-	1	1
Q2 - Financial Resilience	Financial Management Performance Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Final	Substantial	0	-	-	-
Q2 - Information security	Information Management Risk Management	Strategic Risk 301 Priority 4	Final	Adequate	1	-	-	1
Q2- Health and Wellbeing & fitness	People & Asset Management	HMICFRS People Pillar Priority 5	Final	Adequate	2	-	-	2
Q3 -Treasury Management	Financial Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Not Started	-	-	-	-	-
Q3 - IT Asset Management	People & Asset Management Information Management	Strategic Risk 0006 Priority 4	Not Started	-	-	-	-	-
Q4 - Project Management Framework (including business cases)	Performance Management Corporate Governance Programme & Project Management	Strategic Risk 0006 HMICFRS Efficiency Pillar Priority 4	Not Started	-	-	-	-	-
Q4 - People Development	People & Asset Management Performance Management	HMICFRS People Pillar Priority 5	Not Started		-	-	-	-

Appendix 1 – 2020-21 Audit Plan and Performance

The performance results for progress against the internal audit plan for Quarters 1 and 2 of the 2020-21 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	60%	6
In progress, Ongoing	-	-
Not yet started	40%	4
	100%	10

The completion of the plan is currently on target with follow up reviews being undertaken throughout the course of the year. As part of the Internal Audit Service and to review performance, SWAP will regularly ask the Service to complete a customer satisfaction questionnaire. These were paused during Quarter 1 due to COVID, however these have recently restarted at the time of writing and thus we anticipate being able to report on the results of these at subsequent meetings.