BEDFORDSHIRE FIRE AND RESCUE AUTHORITY

Internal Audit Progress Report

14 July 2021

RSM

Contents

Progress against the internal audit plan 2020/21

The Internal Audit Plan for 2020/21 was due to be presented to the Audit & Standards Committee in March 2020. This meeting was postponed and the proposed plan was provided to Committee members. The plan was then presented to the Committee in July 2020 where it was formally approved. The audits highlighted in bold have been finalised since the last meeting. Copies of the executive summaries and action plans are included as an appendix to this report.

Assignment and Executive Lead	Status / Opinion issued	Actions agreed			Planned Timing (as per ANA) / Committee reported
		L	M	H	
Use of Risk Information (1.20/21)	Final Report Reasonable Assurance	3	1	0	Q1 September 2020
Risk Management (2.20/21)	Final Report Reasonable Assurance	2	4	0	Q4 September 2020
Procurement - Proactive Processes (3.20/21)	Final Report Partial Assurance	1	5	0	Q3 September 2020
ICT - Cyber Security (4.20/21)	Final Report Advisory	5	6	0	Q1 December 2020
Human Resources – Recruitment (5.20/21)	Final Report Reasonable Assurance	3	1	0	Q3 March 2021
Key Financial Controls (6.20/21)	Final Report Substantial Assurance	1	1	0	Q3 March 2021
Human Resources – Wellbeing (7.20/21)	**Final Report Advisory**	**1**	**4**	**0**	**Q4**
Service Governance (8.20/21)	**Final Report Reasonable Assurance**	**6**	**3**	**0**	**Q2**

Assignment and Executive Lead	Status / Opinion issued	Actions agreed			Planned Timing (as per ANA) / Committee reported
		L	M	H	
Follow Up (9.20/21)	**Final report** **Reasonable Progress**	**2**	**2**	**0**	**Q4**

This completes our audit plan for 2020/21.

Other matters

Head of Internal Audit Opinion 2020/21

The Audit and Standards Committee should note that the assurances given in our audit assignments are included within our Annual Assurance report. The Committee should note that any negative assurance opinions will need to be noted in the annual report and may result in a qualified or negative annual opinion. The Internal Audit Annual Report 2020/21 including the Head of Internal Audit Opinion is included as a separate agenda item.

Changes to the audit plan

There have been no changes to the audit within the audit plan since the last meeting.

At the previous meetings, we reported that the timing of some reviews had been amended as a result of COVID-19 and reprioritisation of the audit reviews. In addition, we were requested to delay the Governance review to allow implementation of the revised governance structure, now planned for February 2021.

Information and briefings

We have issued the following client briefings since the last Audit & Standards Committee:

- Emergency Services News Briefing March 2021
- Emergency Services New Briefing June 2021

Quality assurance and continual improvement

To ensure that RSM remains compliant with the IIA standards and the financial services recommendations for Internal Audit we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews being used to inform the training needs of our audit teams.

The Quality Assurance Team is made up of; the Head of the Quality Assurance Department (FCA qualified) and an Associate Director (FCCA qualified), with support from other team members across the department.

This is in addition to any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments.

Appendix A – Executive summaries and action plans from finalised reports (High and Medium priority actions only)

EXECUTIVE SUMMARY – HUMAN RESOURCES - WELLBEING

With the use of secure portals for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit and provide you with the assurances you require. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely. Based on the information provided by you, we have been able to sample test.

Why we completed this audit

The purpose of this audit was to provide management with a view on the effectiveness of the controls in place for the promotion of health and wellbeing, ensuring policies and procedures to promote the welfare of support and operational staff are in place and effective to mitigate the risk of failing to deliver against the Our People Strategy 2018/22.

The MIND Blue Light Wellbeing Pledge was signed by the Chief Fire Officer in February 2019 evidencing the Service signing up to this framework. The Blue Light Wellbeing Framework (Framework) was developed as part of the Oscar Kilo Project launched in 2017. The Framework provides an independent set of standards tailored to meet specialist needs of emergency services staff. Organisations can use the Framework to audit and benchmark themselves against the standards. The Strategy became effective from December 2018 and includes a section on wellbeing and health and safety. A MIND Blue Light Wellbeing Pledge Action Plan (Action Plan) is in place to set out the approach to addressing the areas of focus outlined within the Strategy through actions and enablers which have been developed for the Service workstreams.

The Service intranet details the support tools and information for staff on how to manage their own physical and mental wellbeing, including weekly bulletins and COVID-19 guidance. The intranet also displays key contacts of wellbeing staff and Employee Assistance Programme services. The Service have also adopted the Traumatic Risk Management (TRiM) Model with a team of nine TRiM Practitioners from across green and grey book staff groups. As at February 2021, 55 contacts had been made by the TRiM Team to potentially affected staff and officers, with two referrals having been recommended.

As part of the review, we have also benchmarked the wellbeing practices of the Service with a comparable entity, Client A, to inform best practice. Please see Appendix B for details.

Due to this being a work in progress and some areas delayed due to COVID-19, we have completed our audit as an advisory review and therefore not provided a formal opinion.

Conclusion

Through completion of the audit, we identified that well-designed controls for supporting the wellbeing of staff and officers have been implemented. These included the adoption of the TRiM Model, the publication of the Our People Strategy and TRiM Policy, regular and ad-hoc wellbeing publications and sessions, the provision of mental health first aid training, and the conduct of two-yearly employee wellbeing survey which had helped inform the development of the Action Plan.

However, we noted whilst the Service have a Wellbeing Policy in place, it had not been reviewed in line with defined timescales. We also noted that whilst the Service have developed an Action Plan to address the employee survey results and Strategy objectives, it had not been appropriately monitored or updated.

We further noted that there are currently no means by which the Service can be assured that all potentially affected support and operational staff have been contacted by a TRiM Practitioner. In addition, we noted that a Terms of Reference (ToR) had not yet been developed for the newly established Mental Health and Wellbeing Steering Group.

Key findings

We noted weaknesses in control for which we have agreed four medium actions.

Wellbeing Policy

We confirmed through review of the Wellbeing Policy that it includes a policy statement which had been signed by the Chief Fire Officer and had been developed in line with the areas of focus outlined within the Our People Strategy 2018/22 (Strategy). The Policy covers all expected areas including defining the roles and responsibilities of all staff, how it is to be managed, and the training and the staff support network available. We also confirmed that the Policy had been made available to staff via the Service intranet. However, we noted that the Wellbeing Policy had not been reviewed in line with the three-yearly review timeline and was last reviewed in 2016. We were advised by the Service Fitness Advisor that the policy was being reviewed at the time of the audit and its revision would be informed by the results of the audit and an upcoming HMICFRS inspection.

If the Policy is not reviewed regularly, there is a risk that it is not up to date or reflective of current practice, leading to inappropriate actions being taken or inconsistent application of the Policy. **(Medium)**

MIND Blue Light Wellbeing Pledge Action Plan

The Service developed their MIND Action Plan 2018 in line with the Strategy objective of “developing and implementing a mental health and wellbeing plan across the Service linked to national good practice”. Through completion of the audit, we confirmed completion of the Action Plan in some areas, for example development of wellbeing-related policies, completion of employee surveys, and raising wellbeing awareness. We also confirmed through review of documented evidence that discussions on the Action Plan progress had taken place between the Service Fitness Advisor and the Employee Relations Manager (ERM) in January and February 2020.

However, we were advised by the Service Fitness Advisor that there was a backlog on action implementation due to COVID-19 and thus the Action Plan required updating to include additional actions and revised implementation timescales. We noted through review of the Action Plan as at February 2021, that it had not been updated since its creation in 2018. As a result, there is a risk that the Action Plan is unable to facilitate efficient action monitoring. In addition, we were advised by the Service Fitness Manager the Oscar Kilo Blue Light Framework Self-Assessment, which came into effect in September 2020 and complements the Action Plan, did not exist at the time of developing the Action Plan and had not yet been completed. Therefore, the Action Plan had been developed in the absence of completing the self-assessment. Nonetheless, there remains a risk the Action Plan is not in keeping with national best practice. **(Medium)**

Traumatic Risk Management (TRiM) Assessment – Sample Testing

The Service have adopted the TRiM Model, a peer support system. Through testing of five TRiM contact activities, we confirmed that:

- In one instance the correct process had been followed with evidence retained to show that the TRiM Practitioner contact the affected individuals upon receipt of a completed MED 22A return;
- In three instances the TRiM Practitioner contacted the affected individuals without receipt of a completed MED 22A return; and
- In one instance, the relevant email trails could not be located to enable testing.

We also confirmed in all instances that none of the affected individuals contacted had accepted to take part in a TRiM assessment. Therefore, no further records of subsequent TRiM assessment and referral and ensured follow up were available for review.

Through discussion with the Service Fitness Advisor, we were advised that TRiM Practitioners often make the judgement to contact potentially affected individuals within the Service based on the tip sheet records which log incoming 999 incident calls rather than only relying on MED 22A form return. We were further advised by the Service Fitness Advisor that tip sheets are not required to be retained for TRiM purposes. Whilst we acknowledged it is a good practice for TRiM Practitioners to proactively engage individuals they deem a risk even without a MED 22A return, which may not be submitted if a defusing from the Crew Manager was deemed unnecessary; in the absence of retained tip sheets and email correspondence, there is a risk that the Service cannot be assured that all potentially affected individuals who should have been contacted have indeed been contacted. **(Medium)**

Mental Health and Wellbeing Steering Group (MHWSG)

The Service established the MHWSG in October 2020 which we confirmed through review of the MHWSG meeting minutes for October and December 2020. Through review of the minutes we noted that wellbeing related matters had been discussed, such as completing the Oscar Kilo Blue Light Framework Self-Assessment to inform the Action Plan revision and procuring further wellbeing training from Fire Fighters Charity, a wellbeing training provider, and we confirmed that an appropriately detailed action log had been developed which was followed through and updated at the following meeting. We confirmed through review of the meeting minutes and resultant action logs that actions had been followed through in meetings. In addition, we were advised by the Service Fitness Advisor that the MHWSG do not have a formal reporting line upward to senior forums, but noting that the Vice Chair and Chair of the working group both sit on the Corporate Management Team (CMT), we deemed such governance structure to be sufficient to allow information flow from the MHWST to CMT as needed.

However, we found that the MHWSG ToR was in the process of being drafted at the time of the audit, and therefore we were unable to provide assurance over the adequacy of the content therein. As a result, there is a risk that the MHWSG are unaware of their remits, leading to inefficient discharge of roles and responsibilities. **(Medium)**

We noted the following controls to be adequately designed and operating effectively:

TRiM Policy

The Service have developed a TRiM Policy. We confirmed through review and testing of the Policy that it details the process for TRiM assessment, is supported by a flowchart in the appendix and that it was reflective of current practice.

Email correspondence evidenced that the Policy had been subject to internal review prior to issue by the Technical Manager, Service Assurance Assistant, ERM and Service Fitness Advisor. We confirmed through review of the Request for Issue of Service Promulgation form that the Policy had been marked to be issued without consultation, and noted through review of email correspondence that the Policy had been communicated to all staff as well as being made available to staff on the intranet. No issues were noted.

Our People Strategy 2018/22

We confirmed through review of the Strategy that it was up to date and had been signed by both the Chief Fire Officer and Assistant Chief Fire Officer. We also noted that it had been subject to both internal and external consultation and approved as stated within the Fire and Rescue Authority meeting minutes for September 2018. We confirmed through review of the Strategy that the Service had defined the areas of focus regarding wellbeing of staff, including:

- Providing effective occupational health services including pre-employment screening, ongoing health surveillance, absence referrals and professional advice and confidential counselling;
- Developing and implementing a mental health and wellbeing plan across the Service linked to national good practice; and
- Proactively support fitness and wellbeing across the Service.

We confirmed through completion of the audit that there was a “golden thread” of wellbeing practice being implemented and these are evident in subsequent controls and findings. No issues were noted.

Employee Wellbeing Surveys

We confirmed through review of the Health and Safety Executive (HSE) Wellbeing Survey Results Report that the Service had conducted employee surveys in line with the Action Plan. We were advised by the ERM that the next HSE Wellbeing Survey was due in 2021, however, due to the timing of the audit we were unable to provide assurance in this regard. We confirmed through review of the CMT meeting minutes for February 2020 that the survey results had been reported to the CMT. In addition, we also confirmed through review of the Action Plan that the actions therein had been devised to address the recommendations resultant from the survey. No issues were noted.

Raising Awareness

We confirmed through review of screenshots of the Occupational Health and COVID-19 intranet pages that the Service publish monthly bulletins and ad-hoc information on topical issues, covering such contents as the partnership with Fire Fighters Charity, TRiM Support, upcoming dates of wellbeing webinars and COVID-19 guidance. We noted through review of screenshots of intranet pages that key contacts of wellbeing staff and Employee Assistance Programme (EAP), had been made available to staff. We also noted through review of the MHWSG meeting minutes for December 2020 that discussions had taken place around displaying ESP contact details on new staff ID cards and Microsoft Teams meeting backdrops. In addition, we confirmed through review of email promotions that the Service hold ad-hoc sessions, including EAP awareness and mental health webinars, Time to Talk Days, Learn to Listen event, and virtual tea breaks. As such, we deemed the Service to have been adequately promoting mental health and wellbeing in line with the Strategy and Action Plan. No issues were noted.

In addition, we have agreed one low priority management action, and this is documented in the detailed findings below.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

1. Wellbeing Policy		Assessment:	
Control	The Service have a Wellbeing Policy to promote the wellbeing of all employees. It defines the roles and responsibilities of all staff within the Service regarding wellbeing and details the support available and guidance for assessing stress-related risks. The Policy is reviewed every three years and revised as appropriate based on internal and external consultations. The Policy is available to staff on the intranet.	**Design** **Compliance**	✓ ×
Findings / Implications	We confirmed through review of the Policy that it includes a policy statement which had been signed by the Chief Fire Officer in 2016 and had been developed in line with the areas of focus outlined within the Strategy. We confirmed through review of the Policy that it defines the roles and responsibilities of all staff regarding wellbeing and details how wellbeing of staff is to be managed, including combatting stress in the workplace, absences due to stress, training, the staff support network available, and appendices on risk assessment of stress for individual and appraisal use. We confirmed through review of a screenshot of the Service's intranet that the Policy had been made available to staff. However, we noted that the Wellbeing Policy had not been reviewed in line with the three-yearly review timeline. We were advised by the Service Fitness Advisor that the policy was being reviewed at the time of the audit and its revision would be informed by the results of the audit and an upcoming HMICFRS inspection. If the Policy is not reviewed in line with review timescale, there is a risk that it is not reflective of current practice, leading to inconsistent application of the Policy.		
Management Action 1	The Service will ensure that the Wellbeing Policy is reviewed, revised as appropriate and communicated to staff, following completion of the audit and HMICFRS's inspection. Areas for revision include, but are not limited to: • Policy statement signed by the Chief Fire Officer in 2021; • Additional wellbeing support, including Traumatic Risk Management (TRiM); • Current wellbeing governance structure, including the Mental Health and Wellbeing Steering Group; and • Version control of the Policy, including review frequency.	**Responsible Owner:** Ruth Howe, Occupational Health and Fitness Manager	**Date:** 31 August 2021

Priority: Medium

2. MIND Blue Light Wellbeing Pledge Action Plan		Assessment:	
Control	In 2017, the Blue Light Framework was launched as part of the Oscar Kilo Project. The Framework provides a set of standards against which organisations can benchmark their practices. In September 2020, a fully established Framework Self-Assessment was published by Oscar Kilo to enable the said benchmarking. As part of the Framework, a MIND Blue Light Wellbeing Pledge Action Plan is required to be developed and signed as a statement of intent. In 2018, the Service developed an Action Plan to deliver the areas of focus stated within the Strategy. The Action Plan contains information including aims and objectives, actions to be taken to address them, timescales for completion, responsible owners and performance indicators to measure completion.	**Design** **Compliance**	✓ ×
Findings / Implications	We confirmed through review of the MIND Blue Light Wellbeing Pledge Board that the pledge had been signed by the Chief Fire Officer in February 2019. We confirmed through review of the MIND Blue 2018 Action Plan that it had been developed in line with the objective of "developing and implementing a mental health and wellbeing plan across the Service linked to national good practice" outlined in the Strategy. We confirmed through review of the Action Plan that it had been developed to address the areas of wellbeing focus of the Strategy, specifically it includes actions and initiatives to address the objective of "proactively supporting fitness and wellbeing across the Service". Throughout completion of the audit, we confirmed implementation of parts of the Action Plan regarding wellbeing-related policies, employee surveys, delivery of mental health first aid training, raising wellbeing awareness, forming a TRiM Team and establishing a wellbeing working group. We also confirmed through review of documented evidence that discussions on the Action Plan progress had taken place between the Service Fitness Advisor and the ERM in January and February 2020. However, we were advised by the Service Fitness Advisor that the Action Plan had not been recently updated since its creation in 2018 due to COVID-19 and thus requires updates to include additional actions and revised implementation timescales. We were further advised by the Service Fitness Advisor that it was due to be updated by the MHWSG, and we confirmed through review of the MHWSG meeting minutes for December 2020 that the Vice Chair had requested MHWSG members to review the Action Plan and feedback in the February 2021 meeting. Nonetheless, there remains a risk that the Action Plan is unable to facilitate efficient action monitoring. In addition, we were advised by the Service Fitness Manager the Oscar Kilo Blue Light Framework Self-Assessment, which complements the Action Plan, did not exist at the time of the Action Plan development. Therefore, the Action Plan had been developed in the absence of completing the self-assessment. We noted through review of the MHWSG meeting minutes for December 2020 that the Vice Chair had expressed the desire to benchmark the Action Plan against the Self-Assessment however to date this has not happened. Therefore, there currently remains a risk that the Action Plan is not in keeping with national best practice.		

Management Action 2	The Service will complete the Oscar Kilo Blue Light Framework Self-Assessment to inform the revision of the existing MIND Blue Light Wellbeing Pledge Action Plan, including additional actions and updated timescales to address backlog of action implementation. Following this, the Service will monitor progress of the Action Plan through the Mental Health and Wellbeing Steering Group on a bi-monthly basis.	**Responsible Owner:** Ruth Howe, Occupational Health and Fitness Advisor	**Date:** 31 August 2021	**Priority:** Medium

4. TRiM – Sample Testing		**Assessment:**	
Control	The Service have adopted the TRiM Model to support staff and officers in normalising traumatic incidents. TRiM assessment is managed by TRiM Practitioners within the Service's TRiM Team. Following a traumatic incident, the Crew Manager is responsible for defusing the crew in the first instance. The defusing Crew Manager then completes a MED 22A form to indicate initial observations of crew reaction post-incident. The completed form is emailed to Occupational Health and Fitness Department and subsequently passed onto the TRiM Practitioners, who contact those affected to remind them of the support available. Informal meetings are then arranged with those who wish to participate in the TRiM process. A record of whether a TRiM meeting has taken place is documented in the TRiM Contact Activity Log. After a TRiM meeting, or upon request by peers, a follow up email is sent out to those affected one month after the incident to gauge if they are normalising the traumatic incident and whether a referral should be recommended. Participation of affected staff and officers in the TRiM process is entirely voluntary.	**Design** **Compliance**	✓ ×
Findings / Implications	The Service have adopted the TRiM Model, a peer support system. Through testing of five TRiM contact activities, we confirmed that: • In one instance the correct process had been followed with evidence retained to show that the TRiM Practitioner contact the affected individuals upon receipt of a completed MED 22A return; • In three instances the TRiM Practitioner contacted the affected individuals without receipt of a completed MED 22A return; and • In one instance, the relevant email trails could not be located to enable testing. We also confirmed in all instances that none of the affected individuals contacted had accepted to take part in a TRiM assessment. Therefore, no further records of subsequent TRiM assessment and referral and ensured follow up were available for review. Through discussion with the Service Fitness Advisor, we were advised that TRiM Practitioners often make the judgement to contact potentially affected individuals within the Service based on the tip sheet records which log incoming 999 incident calls rather than only		

	relying on MED 22A form return. We were further advised by the Service Fitness Advisor that tip sheets are not required to be retained for TRiM purposes. Whilst we acknowledged it is a good practice for TRiM Practitioners to proactively engage individuals they deem a risk even without a MED 22A return, which may not be submitted if a defuse was deemed unnecessary; in the absence of retained tip sheets and email correspondence, there is a risk that the Service cannot be assured that all potentially affected individuals who should have been contacted have indeed been contacted. We received TRiM-specific comments from the survey which expressed views for increasing the number of TRiM Practitioners and greater inclusion of support staff in the TRiM service. By increasing the number of TRiM Practitioners, it may help better facilitate the service and support a greater number of staff.			
Management Action 4	The Service will devise a means by which the TRiM Contact Activity Log can be reconciled with the sources of contact, such as tip sheets, so to take assurance that all potentially affected staff and officers are engaged by the TRiM Team. Further to this, the Service will also consider capturing and analysing TRiM statistics, such as response rate, to explore means to improve staff utilisation of TRiM support.	**Responsible Owner:** Ruth Howe, Occupational Health and Fitness Manager	**Date:** 31 August 2021	**Priority:** Medium

5. Mental Health and Wellbeing Steering Group		**Assessment:**	
Control	The Service established a Mental Health and Wellbeing Steering Group (MHWSG) in October 2020 The MHWSG is chaired by the Assistant Chief Fire Officer and has membership such as OH and Fitness Manager. The MHWSG is responsible for steering the culture of the organisation and explore all aspects of mental health and wellbeing, including provision, engagement, training and policy. The MHWSG meets every two months and meeting minutes and an action log are recorded after each meeting.	**Design** **Compliance**	× N/A
Findings / Implications	We confirmed through review of the MHWSG meeting minutes for October and December 2020 that such a working group had been established in line with the Action Plan. We confirmed through review of the minutes that wellbeing related matters had been discussed, such as completing the Oscar Kilo Blue Light Framework Self-Assessment to inform the Action Plan revision and procuring further wellbeing training from Fire Fighters Charity, a wellbeing training provider. We confirmed through review of the meeting minutes and resultant action logs that actions had been followed through in meetings. We also confirmed through review of the action logs that they had been updated after each meeting to reflect completion and addition items, with each individual action assigned an action owner and the next meeting date as the target completion date, unless otherwise stated. In addition, we were advised by the Service Fitness Advisor that the MHWSG do not have a formal reporting line upward to senior forums,		

	but noting that the Vice Chair and Chair of the working group both sit on the CMT, we deemed such governance structure to be sufficient to allow information flow from the MHWST to CMT as needed. However, we were further advised by the Service Fitness Advisor that the MHWSG ToR was in the process of being drafted at the time of the audit, and therefore we were unable to provide assurance over the adequacy of the content therein. We noted through review of the MHWSG action log for December 2020 that the Service Fitness Advisor had been tasked to complete the draft ToR by mid-February 2021. Nonetheless, there remains a risk that the MHWSG is unaware of their remits, leading to inefficient discharge of roles and responsibilities.			
Management Action 5	The Service will ensure that a Terms of Reference for the Mental Health and Wellbeing Steering Group is developed and approved by an appropriate forum, to include contents such as, but not limited to; • roles and responsibilities, • quorum, • meeting frequency, • membership, and; • reporting requirements to senior forums, if applicable.	**Responsible Owner:** Ruth Howe, OH and Fitness Manager Ian Hammett, Service Fitness Advisor	**Date:** 31 March 2021	**Priority:** Medium

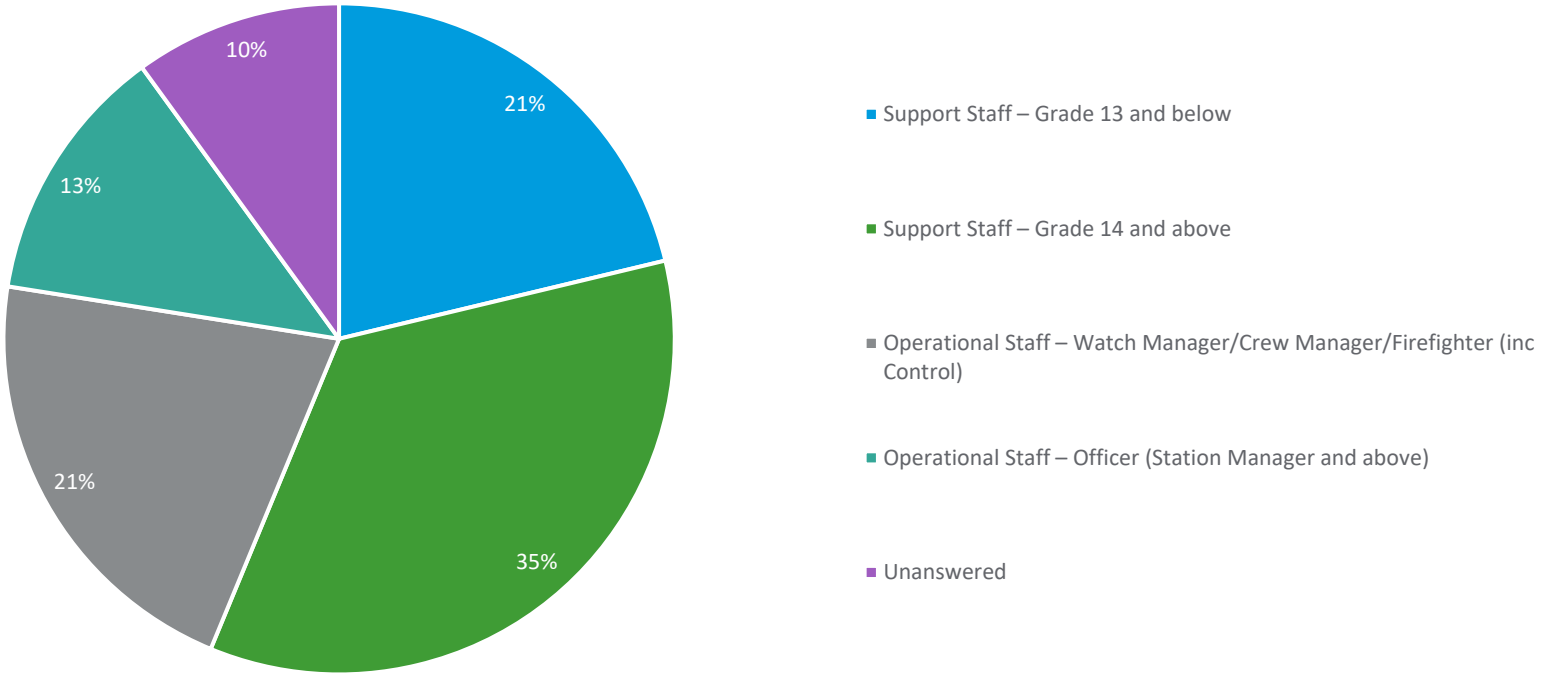
APPENDIX A: RESULTS OF SURVEY

We circulated a questionnaire to staff and officers at the Service to understand their perception on the current mechanisms in place with regards to wellbeing.

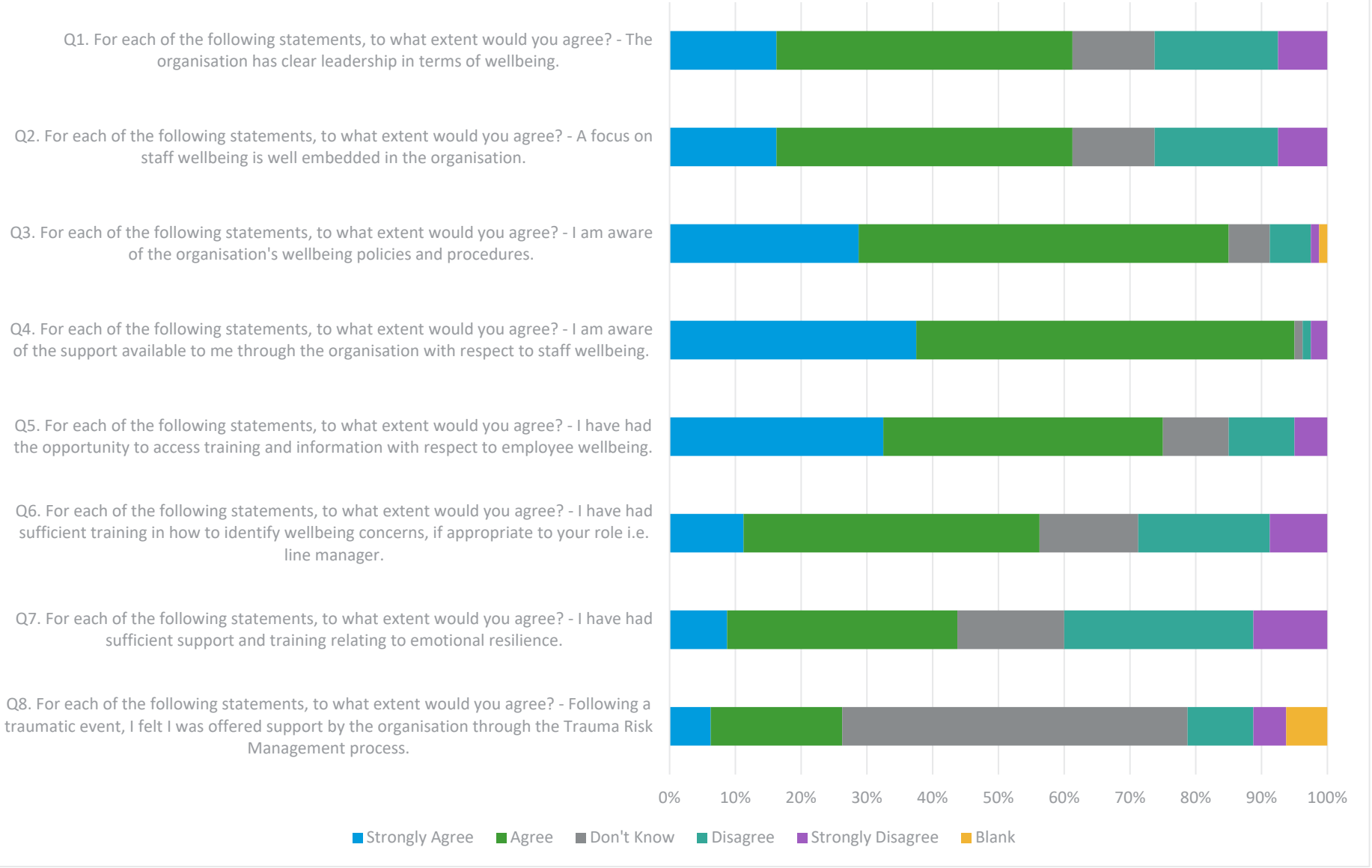
1. Staff Group Distribution of Respondents

Our survey was distributed to all staff and we had a total of 80 responses which are detailed below. We have also provided management with further analysis and specific commentary from respondents on elements for improvement, for the Service to consider and action.

Graph 1. Staff Group Distribution of Respondents, as at 9 February 2021



2. Response Summary



APPENDIX B: BENCHMARKING

We benchmarked the Service's practice with a comparable Fire and Rescue Service, Client A, within our client base and noted the following difference:

TRiM Process		
Control	**Bedfordshire Fire and Rescue Service** The Service have adopted the TRiM Model to support staff and officers in normalising traumatic incidents. TRiM assessment is managed by TRiM Practitioners within the Service's TRiM Team. Following a traumatic incident, the Crew Manager is responsible to defuse the crew in the first instance. The defusing Crew Manager then completes a MED 22A form to indicate initial observations of crew reaction post-incident. The completed form is emailed to Occupational Health and Fitness Department and subsequently passed onto the TRiM Practitioners, who contact those affected to remind them of the support available. Informal meetings are then arranged with those who wish to participate in the TRiM process. A record of whether a TRiM meeting has taken place is documented in the TRiM Contact Activity Log. After a TRiM meeting, or upon request by peers, a follow up email is sent out to those affected one month after the incident to gauge if they are normalising the traumatic incident and whether a referral should be recommended. Participation of affected staff and officers in the TRiM process is entirely voluntary.	**Client A** TRiM assessments are an assessment of risk to individuals following exposure to a traumatic event whilst at work such as death/collection of body parts. Where a major incident plan has been activated or **where there has been a near miss** to an individual or colleague, this is documented as part of the TRiM assessment. TRiM assessments are managed by the Health and Safety department and a procedural document is in place within the department to document how these are to be managed.
Best Practice	Whilst the Service have a more detailed documented process for TRiM assessment, we observed better practice from Client A who records major incidents, as well as near misses. We deemed it would be beneficial for the Service to contact as wide a pool of potentially affected staff and officers of incidents and near misses as possible to encourage usage of the TRiM service. This coincides with Management Action 4 in the detailed findings, whereby the Service will devise a means by which the TRiM Contact Activity Log can be reconciled with the sources of contact, such as tip sheets, so to take assurance that all potentially affected staff and officers are engaged by the TRiM Team.	

EXECUTIVE SUMMARY – SERVICE GOVERNANCE

With the use of emails for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit and provide you with the assurances you require. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely. Based on the information provided by you, we have been able to undertake our sample testing.

Why we completed this audit

We undertook an audit of Service Governance at Bedfordshire Fire and Rescue Service as part of the approved internal audit plan for 2020/21. The review focussed on the governance structure within the Service with a limited review of the Fire and Rescue Authority's Handbook, and the Executive, and Audit and Standards Committees' terms of reference following their restructure in 2020.

The Corporate Management Team (CMT) sits at the top of the governance structure within the Service with eight subgroups feeding into it. The Service also has other formal meeting groups which sit below the CMT subgroups.

As a result of the COVID-19 pandemic the Service Pandemic Planning Group (SPPG) has been established which meets to review and monitor the Service's response to the pandemic, for example monitoring and managing staff sickness. However, there have been no other major changes to the Service's structure as a result of the COVID-19 pandemic.

Through the review we selected a sample of five meeting groups along with the SPPG and reviewed their terms of reference and the following meetings' papers, minutes and action logs as relevant:

- CMT - 22 December 2020, 5 and 19 January, and 2 and 16 February 2021;
- Corporate Programme Board (CPB) - November 2020 and February 2021;
- Information Management and Assurance Board (IMAB) - June, August and November 2020;
- Blue Light Collaboration Board (BLCB) - October and November 2020, and February 2021; and
- Local Pensions Board (LPB) - June and September 2020, and February 2021.

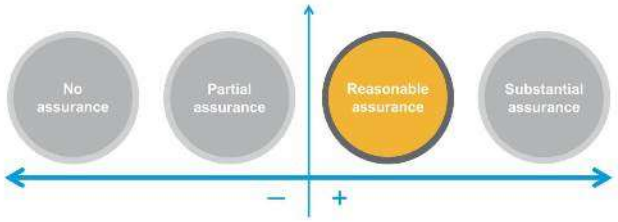
Conclusion

Our review confirmed that controls were generally well designed and complied with in relation to the Service's governance. We found that out of a sample of five meeting groups: four had a terms of reference; all were quorate or, where not quorate, no decisions were made; a sample of three responsibilities outlined in each of our sample of five groups' terms of reference were being met; and, actions were being routinely reviewed and added to a log. We also found that the Service Pandemic Planning Group had a terms of reference in place and they were meeting a sample of three of their responsibilities, and that the Fire and Rescue Authority and its committees had terms of reference in place with key information such as responsibilities, meeting frequencies and reporting arrangements.

However, we did find issues in relation to: the lack of a formal governance structure chart; three groups' terms of reference not including clear reporting and accountability lines and two not being regularly reviewed; meeting papers for the CMT not clearly indicating whether each item was for information only or required a decision; and conflicts of interest and quoracy were not being checked for all groups.

Internal audit opinion:

Taking account of the issues identified, the Authority can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied. However, we have identified issues that that need to be addressed in order to ensure that the control framework is effective in managing this area.



Key findings

We identified the following weakness resulting in the agreement of three medium priority management action:

Terms of Reference

We requested the Terms of reference (ToR) for five meetings and the SPPG, however were not provided the IMAB ToR. There is a risk that the IMAB will not fulfil their purpose and responsibilities without a ToR which could affect the performance of the Service.

Through review of the ToR provided, we found the following:

- the CPB, BLCB,LBP and SPPG's ToR did not highlight clear reporting and accountability lines;
- the BLCB and SPPG's ToR did not include quorum requirements;
- the LPB's ToR included outdated guidance, for example that it will report to the FRA when structural changes mean it reports to the CMT;
- the BLCB and LPB's ToR had not been reviewed annually with the LPB and SPPG's ToR not specifying the next review date; and
- the SPPG's ToR did not include membership or required meeting frequencies.

The Service Assurance Manager advised us that the content issues were potentially due to each meeting group not utilising a standard template for ToR. There is a risk that the meeting groups are following outdated guidance and will not fulfil their expected responsibilities appropriately which could negatively impact the performance of the Service.

We have agreed a medium priority action in relation to our ToR findings to ensure that all groups have a ToR in place which includes minimum information, such as membership, reporting and accountability lines, and are regularly reviewed with review dates recorded. **(Medium)**

Meeting Papers

Meeting papers are used by the CMT with cover sheets indicating whether a decision is required or if the item is for information only. Through review of the last five sets of meeting papers for the CMT we found that only one report included in each of the 19 January 2021 and 2 February 2021 meetings included a cover sheet which stated whether a decision was required or the item was for information. We were advised by the Service Assurance Manager that the Service was trying to make the CMT's meetings less formal and more agile and as such the use of cover sheets for all reports may not be appropriate. Whilst this may not be required through cover sheet, it is important to be clear on the purpose of the paper and if a decision is to be made.

There is a risk that meeting time is not used efficiently or effectively as required where the required action on an item is not included and as such we have agreed a medium priority action to state on CMT agendas the type of item (report, verbal updated or presentation) as well as whether the item required a decision or is for information. **(Medium)**

Conflicts of Interest and Quoracy

Meeting groups within the Service do not require conflicts of interest to be declared as part of each meeting. Through review of the sampled LPB minutes, we found that conflicts of interest had been checked prior to each meeting starting. However, we found that the CMT, CPB, IMAB and BLCB did not check conflicts of interest prior to their meetings starting. We were advised by the Service Assurance Manager that staff are expected to declare conflicts of interest as part of their role, however there is no process in place to check conflicts declared previously ahead or as part of meetings within the governance structure.

There is a risk that inappropriate decisions will be made where conflicts of interest are not checked prior to a meeting starting and as such we agreed a medium priority action to document in each formal meeting group's terms of reference that a check will be undertaken at the discretion of the chair depending on the planned agenda items. **(Medium)**

We noted the following controls to be adequately designed and operating effectively:

Terms of Reference - Responsibilities

Through review of the responsibilities for the four meeting groups in our sample that we received a ToR, we found that there were no clear areas of duplication or overlap.

Meeting Content

Through review of the papers for the CPB meetings we found that the reports included did not have a cover sheet. We also found through review of the papers for the IMAB, BLCB and LPB that the papers only included an agenda with no reports or other documents presented. We were advised by the Service Assurance Manager that groups below the CMT are not required to use meeting packs or cover sheets as the Service is trying to become more agile in response to HMICFRS findings that the Service spent too much time preparing for meetings and producing papers.

Quoracy

Quoracy requirements are included within terms of reference for formal meeting groups across the Service. We found through review of the minutes (or action logs) for the CPB, LPB, and four of CMT's five tested minutes, that all of the meetings were quorate. For the final set of CMT minutes (22 December 2020) we found that they were not quorate. We reviewed the minutes for this CMT meeting and found that no decisions were made and that the ToR did not specify that the meeting must end should it not be quorate, in addition, due to the holiday period, there were several staff on leave. As this was the case, we have not raised an action in relation to this finding.

We were unable to test whether the BLCB and IMAB were quorate during their meetings as their terms of reference did not include their quorum requirements and these were not shared during the course of the audit, we have identified an issue above in relation to this.

Discharging Duties

Responsibilities are outlined within each group's ToR. As the ToR for the IMAB were not provided, they were excluded from this testing and an issue identified above in relation to this. Through review of a sample of three responsibilities from the ToR for each group in our remaining sample of four, we found that in all cases those responsibilities were being met.

Decisions and Actions

Action logs are maintained by each formal meeting group. We confirmed through review of the CMT's minutes for all meetings except for 5 January 2021 and the minutes for each of the IMAB, BLCB and LPB's meetings that their action log had been reviewed. As for the CMT's 5 January 2021 minutes, we found that all actions had been closed at the previous meeting and as such review of the action log was not required.

We also confirmed through comparison of the minutes and action logs for each group, that the action log had either been updated in line with minutes or it had been closed as there were no actions remaining on the log. The CPB was excluded from this testing as they only maintain an action and decision log and do not log minutes, however we noted the action log was updated with completed actions being closed, new actions being added, and decisions being logged for each meeting.

COVID-19 Pandemic - Service Pandemic Planning Group

We selected a sample of three responsibilities from the SPPG ToR and found through review of the last five minutes, for 27 January and, 3, 10, 17 and 24 February 2021 that they were meeting these responsibilities and fulfilling their duties as required..

Fire and Rescue Authority and its Committees

We confirmed through review of the Fire and Rescue Authority Handbook, and the Executive and Audit and Standards Committee's ToR that they included key information as expected to enable them to guide the forums in their duties, and were in date being recently reviewed.

We have also agreed six 'Low' priority management actions which can be found in section two – detailed findings and actions below.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

Terms of Reference		
Control	Formal meeting groups within the Service have a ToR in place. The ToR outline the following: • roles and responsibilities; • membership; • accountability and reporting lines; • quorum requirements; • meeting frequencies; and • when the ToR will be reviewed.	**Assessment:** **Design** ✓ **Compliance** ×
Findings / Implications	**Terms of Reference Available** We selected a sample of six Service governance meeting groups, as follows; CMT; CPB; IMAB; BLCB; LPB; and SPPG. We requested a copy of the terms of reference for each group, however we were not provided with this for the IMAB. There is a risk that the IMAB will not fulfil their purpose and responsibilities without a ToR which could affect the performance of the Service.	
Findings / Implications	**Content** We confirmed through review of our sample of five terms of reference that in one case, the CMT, key information, such as meeting frequency, reporting and accountability lines and next review date had been included in the ToR. Through review of the remaining four, we found the following: • the CPB and LPB did not highlight clear reporting and accountability lines; • the BLCB did not include quorum requirements or clear reporting and accountability lines; and • the SPPG did not include membership, accountability and reporting lines, quorum requirements and meeting frequencies. If ToR do not document all required information, there is a risk that the meeting groups will not fulfil their responsibilities which could negatively impact the performance of the Service.	
Findings / Implications	**Regular Review** We confirmed through review of our sample of five meeting groups that two, the CMT and CPB, had been recently reviewed and specified a next review date. For the remaining three we noted the following: • the BLCB's ToR documented that they were last reviewed in February 2018 but did specify that they would be reviewed annually; • the LPB's ToR were last reviewed in August 2015 but did not specify a date of next review; and • the SPPG's ToR did not specify a last or next review date.	

Terms of Reference

We also found that the LPB's ToR referred to reporting into the Fire and Rescue Authority, however we were advised by the Service Assurance Manager that the Board now sits below the CMT.

If ToR are not subject to regular review, there is a risk that meeting groups are following outdated guidance and responsibilities which are no longer reflective of the Service's governance structure. This could lead duplication in the governance structure and inefficient decision making.

		Responsible Owner:	Date:	Priority:
Management Action 2	The Service will ensure that a terms of reference (ToR) is in place for all formal meeting groups, including the Information Management and Assurance Board, and that they have: • responsibilities; • membership; • meeting frequency; • quorum requirements; • reporting and accountability lines, frequency and nature; and • been recently reviewed, specify this date and a date of next review. As part of this, it will be considered whether a standard template could be used across each meeting group using, for example the Corporate Programme Board's ToR.	Head of Governance and Asset Management	31 July 2021	Medium

Meeting Papers

Control	Meeting papers are used by the Corporate Management Team but not by other formal meeting groups within the Service. Cover sheets are also used for each item to be presented and include an indication of whether a decision is required or items are for information only.	**Assessment:**	
		Design	✓
		Compliance	×
Findings / Implications	We found through review of the CMT's meeting papers for 19 January and 2 February 2021 that one paper included a cover sheet which had been completed, including whether the item was for information or required a decision. However, during review of the remaining papers for the CMT from 22 December 2020, and 5 January and 16 February 2021, we found that the reports included did not have a cover sheet. We were advised by the Service Assurance Manager that the Service was trying to make the CMT's meetings less formal and more agile and as such the use of cover sheets for all reports may not be appropriate. Whilst this may not be required through cover sheet, it is important to be clear on the purpose of the paper and if a decision is to be made.		

Meeting Papers				
	There is a risk that meeting time is not used efficiently which could mean that important information is not brought to the attention of the attendees and required decisions are not made. This weakness was highlighted as part of a later finding in relation to actions and decisions, where we noted that a decision was required according to the CMT's 2 February 2021 meeting papers, however whether a decision was made was not recorded within the minutes despite the item being presented. Further detail can be found as part of the Decision and Actions finding below.			
Management Action 3	The Service will add to the Corporate Management Team agendas, the nature of each agenda item (presentation, report or verbal) and whether the item is for information only or a decision is required. Where a decision is required this will be documented within the minutes (the outcome or whether it has been postponed).	**Responsible Owner:** Head of Governance and Asset Management	**Date:** 31 May 2021	**Priority:** Medium

Conflicts of Interest and Quoracy			
Control	Not all formal meeting groups within the Service require conflicts of interest to be declared as part of each meeting. Staff are expected to have already declared interests as part of their role, where required. Quoracy requirements are included in terms of reference but are not formally checked by all meeting groups for compliance prior to the start of each meeting.	**Assessment:** **Design** **Compliance**	 × N/A
Findings / Implications	**Conflicts of Interest** We noted during review of the last three minutes for the LPB that conflicts of interest had been checked prior to each meeting starting. However, we confirmed through review of the meeting minutes for the CMT, CPB, IMAB, BLCB and SPPG that conflicts of interest were not checked prior to each meeting starting. We were advised by the Service Assurance Manager that staff are expected to declare conflicts of interest as part of their role and abstain from related agenda items, however there is no process in place to check conflicts declared previously ahead or as part of meetings within the Service's governance structure. There is a risk that inappropriate decisions will be made where conflicts of interest are not checked prior to a meeting starting, giving staff the opportunity to abstain from relevant agenda items.		

Management Action 4	The Service will ensure that each formal meeting group within the Service document in their terms of reference that at the Chair's discretion conflicts of interest will be checked prior to the start of a meeting depending the nature of the agenda items.	**Responsible Owner:** Head of Governance and Asset Management	**Date:** 31 July 2021	**Priority:** Medium

Conflicts of Interest and Quoracy	
	Where it is required to be checked this, and any conflicts identified and action taken, will be recorded within the minutes.
Findings / Implications	**Meeting Quoracy** We understand that compliance with quoracy of checked at the start of each meeting. With any exceptions being documented. Through review of the standing agenda for the CPB's November 2020 and February 2021 meetings we found that there was an item to check whether the meeting was quorate. As the CPB do not maintain minutes, we were unable to confirm whether this check had been complied with. Through review of all the minutes for the remainder of our sample, we found that a check of whether the meeting was quorate was not evidenced as undertaken, despite all but the BLCB and SPPG outlining quorum requirements within their ToR. We were advised by the Service Assurance Manager that there was no particular reason for this, and it should be checked prior to each meeting starting. There is a risk that inappropriate or incorrect decisions are made where a sufficient mix or number of members are not in attendance. There is a reduced risk as we found that the CPB, IMAB and LPB were quorate for each of their meetings reviewed during testing, as well as the CMT at their 5 and 19 January, and, 2 and 16 February 2021 meetings.

EXECUTIVE SUMMARY – FOLLOW UP

Background

As part of the approved internal audit periodic plan for 2020/21. We have undertaken a review to follow up on progress made to implement the previously agreed management actions from the following audits:

- Asset Management – Asset Tracking (5.19.20)
- Follow Up – Operational Business Continuity and Property – Statutory Compliance (6.19.20)
- Mobilising System Project (8.19.20)
- Environmental Strategy and De-Polluted Scrap Vehicles (10.19.20)
- Use of Risk Information (1.20.21)
- Risk Management (2.20.21)
- Procurement – Proactive Processes and Remedial Action (3.20.21)
- Key Financial Controls (6.20.21)

Our audit review has focused on the implementation of the high and medium priority actions only, within the audits listed above this includes one high and 18 medium priority actions.

Conclusion

Taking account of the issues identified in the remainder of the report, in our opinion Bedfordshire Fire & Rescue Authority has demonstrated **reasonable progress** in implementing agreed management actions.

Of the 19 actions followed up, 14 had been implemented, one had been superseded, three were in the process of being implemented, and one had not yet been implemented. Those in progress related to: implementing a consistent stock check process, documenting approval of the Procurement Activity Plan and Contracts Commissioning Review, and periodic reporting of progress on the Procurement Activity Plan and Contract Commissioning Review. The remaining action not yet implemented related to tracking stock movements which was delayed due to the ongoing system transfer to BlueLight.

1.1 Action tracking

Action tracking enhances an organisation's risk management and governance processes. It provides management with a method to record the implementation status of actions made by assurance providers, whilst allowing the Audit & Standards Committee to monitor actions taken by management. As part of our Follow Up review, we have verified this information and completed audit testing to confirm the level of implementation stated and compliance with controls.

Action tracking is undertaken by Bedfordshire Fire & Rescue Authority's management on a regular basis, with an update provided to the Audit & Standards Committee at each meeting. As part of our Follow Up review, we have verified this information and completed audit testing to confirm the level of implementation stated and compliance with controls.

We were able to verify that the status of implementation of management actions, as reported to the Audit & Standards Committee via the internal action tracking process, is accurate for the following audits:

- Follow Up – Operational Business Continuity and Property – Statutory Compliance (6.19.20)
- Mobilising System Project (8.19.20)
- Environmental Strategy and De-Polluted Scrap Vehicles (10.19.20)
- Use of Risk Information (1.20.21)
- Risk Management (2.20.21)
- Key Financial Controls (6.20.21)

For the four actions outstanding (three in progress and one not started) relating to the Asset Management audit, Risk Management Audit and Procurement audit we noted these had been reported to the Audit & Standards Committee as complete, however, our findings did not support this. We identified differences as follows:

- Asset Management – Asset Tracking (5.19.20) - We were informed that the action around stock checks was complete, however our testing found they were not consistently documenting the discrepancy reconciliations to provide assurance over the completion hence why we have identified it as in progress, but the action has been downgraded to a Low.

- Asset Management – Asset Tracking (5.19.20) – We understand this had been closed off as management felt it was superseded due to implementation of the new system. However through our review and discussion with management it was agreed that the Authority must ensure the area of weakness and risk is addressed with the new system implementation, and so we have updated the action to reflect this and downgraded this to a Low.

- Procurement – Proactive Processes and Remedial Action (3.20.21) - The Procurement Activity Plan and Contracts Commissioning Review approval was recorded as complete, however, for the Contracts Commissioning Review whilst this was presented to CMT, formal approval was not documented. For the Procurement Activity Plan management agreed this still needs to be formally approved.

- Procurement – Proactive Processes and Remedial Action (3.20.21) - Only the Contract Commissioning Review Plan had been presented with management confirming they are still in the process of starting up the review process for the Procurement Activity Plan including an annual summary report once the approvals are in place.

Management must ensure that all elements of the action are fully completed, and / or risk mitigated prior to closgin actions.

Progress on actions

The following table includes details of the status of each management action:

Implementation status by review	Number of actions agreed	Status of management actions				
		Impl. (1)	Impl. ongoing (2)	Not impl. (3)	Superseded (4)	Completed or no longer necessary (1) + (4)
Asset Management – Asset Tracking	3	0	1	1	1	1
Follow Up – Operational Business Continuity and Property – Statutory Compliance	3	3	0	0	0	3
Mobilising System Project	1	1	0	0	0	1
Environmental Strategy and De-Polluted Scrap Vehicles	1	1	0	0	0	1
Use of Risk Information	1	1	0	0	0	1
Risk Management	4	4	9	0	0	4
Procurement – Proactive Processes and Remedial Action	5	3	2	0	0	3
Key Financial Controls	1	1	0	0	0	1
Total	**19**	**14**	**3**	**1**	**1**	**15**

2 FINDINGS AND MANAGEMENT ACTIONS

Status	Detail
1	The entire action has been fully implemented.
2	The action has been partly though not yet fully implemented.
3	The action has not been implemented.

Asset Management – Asset Tracking (5.19.20)				
Original management action / priority	The Authority will ensure that when stock items issued from stores to their final destination, the stock system and individual station equipment lists are correctly coded to show the movements. Evidence of the local stock list including correct location coding should be available where required. Training around issuing stock and recording this on the system will also be delivered for members of staff responsible for each store. **(Medium, 30 September 2020)**			
Audit finding / status	We were informed by the Transport and Engineering Manager that this action has not yet been implemented due to the ongoing system transfer to BlueLight. **The action has not been implemented.**			
Management Action 2	When BlueLight has been implemented the Authority will ensure that when stock items are issued from stores to their final destination, the stock system and individual station equipment lists are correctly coded to show the movements. Evidence of the local stock list including correct location coding should be available where required. Training around issuing stock and recording this on the system will also be delivered for members of staff responsible for each store.	**Responsible Owner:** Head of Governance and Asset Management	**Date:** 1 April 2022	**Priority:** Medium

Procurement – Proactive Processes and Remedial Actions (3.20,21)				
Original management action / priority	Progress against the Procurement Activity Plan and the Contracts Commissioning Review Plan, as well as reporting on compliance audit results and significant tender waivers will be reported quarterly to CMT. An annual summary report on procurement activity will be presented to the Audit and Standards Committee for oversight. **(Medium, 31 January 2021)**			
Audit finding / status	We received the CMT meeting minutes for September 2020, November 2020, December 2020 and February 2021 and through review we confirmed that the Contracts Commissioning Review Plan had been presented for discussion in February 2021, however we could not see evidence of the Procurement Activity Plan progress being presented or reviewed. We could also not see any evidence of reporting on compliance audit results or significant tender waivers within the last quarter on review of the minutes. We were informed by the Head of Governance, Assets, Procurement and Collaboration that the annual summary had not yet been implemented at the time of the audit, therefore this is still outstanding. **The implementation of the action is ongoing.**			
Management Action 4	Progress against the Procurement Activity Plan and the Contracts Commissioning Review Plan, as well as reporting on compliance audit results and significant tender waivers will be reported quarterly to CMT. An annual summary report on procurement activity will be presented to the Audit and Standards Committee for oversight.	**Responsible Owner:** Head of Governance and Asset Management	**Date:** 30 November 2021	**Priority:** Medium

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