Bedfordshire Fire and Rescue Authority

Internal Audit Progress Report

6 July 2023

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Progress against the internal audit plan 2022/23 & 2023/24

The Internal Audit Plan for 2023/24 was approved by the Audit & Standards Committee March 2023. Four audits have been finalised since the last meeting, highlighted in bold below. A copy 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)
		L	M	H	
2022/23					
Data Management	**Reasonable Assurance**	**2**	**3**	**0**	**Q1**
Implementation of Actions from HMICFRS – Engagement with Local Community	**N/A - Advisory**	**0**	**0**	**0**	**Q3**
Key Financial Controls – Accounts Receivable	**Substantial Assurance**	**3**	**0**	**0**	**Q4**
Follow Up	**N/A - Advisory**	**0**	**6**	**1**	**Q4**
2023/24					
Contaminants and staff health and safety	To commence 22 June 2023				Q1
Strategic approach to partnerships and collaborations	To commence 24 July 2023				Q2
Governance of the Project Management Office	To commence 24 July 2023				Q2
Key Financial controls	To commence 26 October 2023				Q3

Assignment and Executive Lead	Status / Opinion issued	Actions agreed			Planned Timing (as per ANA)
		L	M	H	
Stock control in Stores and technical bay	To commence 15 January 2024				Q4
Follow Up	To commence 4 March 2024				Q4

Other matters

Head of Internal Audit Opinion

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.

Changes to the audit plan

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

Information and briefings

Since the last Audit and Standards Committee, we have issued our:

- Quarterly Emergency Services client briefing – May 2023
- Emergency Services Risk Register Analysis

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 – DATA MANAGEMENT

Why we completed this audit

We have undertaken a Data Quality review as part of the approved 2022/23 Internal Audit Plan to allow the Authority to take assurance over the design and effectiveness of processes in place to manage data, including how data is verified and utilised for decision-making across the governance structure. The review also sought to establish the Authority's data maturity level against the Nesta Data Maturity Framework and the strength of the organisation's 'data culture', including how data is handled in accordance with GDPR regulations and verified to ensure its integrity.

The Authority has a Data Policy which sets out the Authority's approach to data quality including providing training to managers and data users, validating third party data, and accurately mapping all master data sources and data flows. The Authority aims to ensure good data quality by focusing on accuracy, validity, reliability, timeliness, and relevance of performance information utilised for decision making.

Since the review we have been advised that the organisation now have an additional Senor Data Analyst and are planning to recruit an analyst into the Local Resilience Forum team

As part of the review, we conducted a Data Culture survey to obtain staff members' views regarding data quality and to establish whether a culture of data quality has been embedded across the organisation. 128 respondents participated in the survey, and a summary of the results has been presented in Appendix A of this report. We also circulated a Data Maturity Self-Assessment survey to the members of the Digital Data and Technology (DDAT) Steering Group, results of the survey were utilised to complete the Data Maturity tool facilitated by the Local Government Association (LGA). The tool is designed to help provide an assessment of how advanced public sector organisations are at dealing with data.

Conclusion

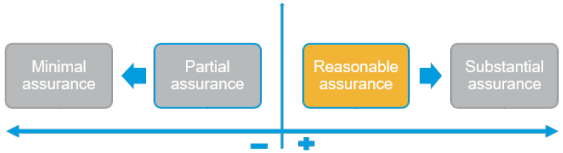
We identified data-led decision making throughout the governance structure; review of the meeting minutes and action logs for the Health and Safety Steering Committee, Community Risk Management Plan Steering Group, Service Delivery Leadership Team, and Corporate Management Team noted prevalence of data being used for evidence-based decisions. We also identified that the Authority's Digital Data and Technology Steering Group Terms of Reference document aligns with national best practice for data management (National Fire Chiefs Council Digital and Data Strategy and Nesta Data Maturity Framework). However, we could only agree six of 10 KPIs reported to the Fire Authority back to source data.

We identified control weaknesses including lack of training on Data Quality. In addition, we noted that the Data Quality Policy did not outline the roles and responsibilities of staff, and we were unable to confirm if the policy had been reviewed and approved in line with the review frequency. We also identified areas of improvement relating to the content and review of the Health and Safety Steering Committee (HSSC) and Service Delivery Leadership Team (SDLT) Terms of Reference. In addition, the questionnaire responses identified a number of positive themes including a consistent tone for data quality set from the top, understanding data-related organisational risks, quality of data and validation, data owners and effective utilisation of data, although some areas for improvement were identified including embedding data quality in the organisation, improving the tools and systems in place to collect, interpret and analyse data, further training on how to use data effectively and safely, and further support and training relating to appropriately handling data in accordance with laws and GDPR regulations.

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 risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).



Key findings

We identified the following weaknesses resulting in the agreement of three medium priority actions:

Data Quality Training

The Learning and Development Manager advised that the Authority does not deliver training specifically focused on data quality. We understand the Service is in the process of implementing a data literacy masterclass that is required to be completed by all Corporate Management Team members. Without the appropriate training in place on the effective collation and use of data and importance of data quality there is a risk that staff especially those responsible for handling, processing, compiling, and reviewing data may lack the competence and awareness to effectively handle and utilise data hence affecting overall business performance. **(Medium)**

KPI Dashboard

We selected a sample of 10 Key Performance Indicators (KPIs) from the Performance Report presented to the Fire Authority in September 2022 and sought to trace the sample of data items to their source records to ensure that the data presented was accurate, reliable, complete, and appropriately maintained to ensure that it is current and complies with relevant GDPR regulations. For six of the KPIs the data reported agreed to the source record with appropriate access restrictions, however in three instances the information did not agree, and one was a complicated measure that was complex to reperform and could not be verified. Of the three which did not agree, one was a human error where the wrong information had been reported, one no explanation for the difference could be provided and for the final one the source data used to populate the Performance report has been refreshed since the report was produced so we were unable to verify that the information reported at that point agreed to the source data at that time.

If the accuracy of performance data reported across the Authority's governance structure cannot be evidenced, there is a risk that inaccurate information can be utilised, negatively impacting upon effective decision-making. **(Medium)**

Data Culture Survey

As part of our audit approach, we circulated a questionnaire to all staff and officers at the Authority to obtain their views regarding data quality and to establish whether a culture of data quality has been embedded across the organisation, 128 responses were received. This identified a number of areas for improvement including embedding data quality in the organisation, improving the tools and systems in place to collect, interpret and analyse data, further training on how to use data effectively and safely, and further support and training relating to appropriately handling data in accordance with laws and GDPR regulations. **(Medium)**

We also agreed a further two low priority management actions, details of which can be found in section 2 of this report.

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

Digital Data and Technology (DDAT) Steering Group

Terms of Reference Content

We reviewed the Terms of References (ToR) within the governance structure to understand the roles and responsibilities in regard to data quality. Review of the DDAT Steering Group ToR confirmed it was currently in draft format, undergoing active review. The version obtained included tracked changes incorporating comments from the Head of Strategic Support and Assurance and Head of ICT and Programmes. Review of the draft ToR confirmed it defined the Group's duties, including establishing clear Data Governance to improve Data Quality so it is fit for purpose and agreeing Data Standards for Prevention, Protection and Response. Review of the ToR confirmed it detailed the Group's membership, meeting frequency and quorum, template agenda of standing items and reporting arrangements. We also noted that the Group's inputs, outputs, and governance structure were included in the document to identify its interaction with operational and strategic aspects of the Authority.

Terms of Reference Alignment with NFCC Digital and Data Strategy and Nesta Framework Principles

We obtained a copy of the NFCC Digital and Data Strategy and the Nesta Data Maturity Framework. Review of the documents noted they established criterion for the promotion of data use and integrity across the public sector and among Fire Authorities. We noted through a benchmarking exercise that the Authority's DDAT Steering Group ToR document aligns with national best practice for data management (National Fire Chiefs Council Digital and Data Strategy and Nesta Data Maturity Framework), the document covered provisions including but not limited to developing an overarching Data Quality Policy, richly using data intelligence and insight to drive decision making, and sustainable and continuous improvement.

Data-led Decision Making

Community Risk Management Plan Steering Committee (CRMP Steering Group)

The CRMP Steering Committee meetings are formally documented; with an action log being maintained. We confirmed through review of the action log that actions agreed indicated prevalence of data being used for evidence-based decisions including data register on public compliments, complaints, and transactions, and risk and the RAID review. Review of the action log also noted that action owners alongside target completion dates had been assigned.

Health and Safety Steering Committee (HSSC)

We identified through review of the HSSC January, March, and May 2022 meeting minutes that there was review of data and statistics to support decisions noting that the Committee consistently discussed Health and Safety KPIs involving the number of serious accidents. Review of the January 2022 meeting minutes also noted discussion on integrating Health and Safety data into the Business Management Information System (BMIS). Review of the Committee action log as of September 2022 confirmed all actions had been assigned an owner, a due date, and a progress update where applicable, with no actions overdue.

Service Delivery Leadership Team (SDLT)

Review of the March 2022 meeting minutes confirmed that the Team received project updates with customer insight data for review. The Team also reviewed data on turnover. Review of the April and May 2022 meeting minutes noted that formal meetings had not been held but workshops to formalise a new structure of the Team had taken place.

Corporate Management Team (CMT)

Review of the April, August and September 2022 meeting minutes noted that the Team received reports including the Budget Monitoring and Health and Safety Annual report with information to aid in decision-making. Review of the September 2022 meeting minutes noted that the Team reviewed the completion figures of the health and safety training to develop solutions to clear the backlog of outstanding training.

DETAILED FINDINGS AND ACTIONS

Data Quality Training				
Control	The Service currently does not deliver any training specifically focused on data quality.		**Design**	×
			Compliance	N/A
Findings / Implications	The Learning and Development Manager advised that the Service does not deliver training specifically focused on data quality, but they do provide training on GDPR, which includes elements of how to handle data appropriately and in accordance with laws and regulations. Without the appropriate training in place on effective collating and use of data and importance of data quality, there is a risk that staff, especially those responsible for handling, processing, compiling, and reviewing data, may lack the competence and awareness to effectively handle and utilise data, thereby affecting overall business performance. The Head of Strategic Support and Assurance advised that the Service is in the process of implementing a data literacy masterclass that is required to be completed by all Corporate Management Team members. The training will be delivered by the ONS Data Science Campus and will focus on providing senior managers with skills on how to make better use of data.			
Management Action 2	A data quality training needs analysis will be undertaken to identify the training requirements of each staffing group employed by the organisation. Following this the organisation will develop and implement e-learning modules on data quality to increase staff awareness and skills on how to effectively use and handle data to drive decisions and future service delivery requirements. In addition, the organisation will monitor the completion of the training and staff logged as having incomplete training will be chased and followed up by line managers.	**Responsible Owner** Paul Hughes	**Date:** December 2023	**Priority:** Medium

KPI Dashboard				
Control	The organisation has a Key Performance Indicator (KPI) Dashboard which is presented to the Corporate Management Team (CMT) and Fire Authority. The Authority's KPI Dashboard has 60 KPIs measuring and reporting the Authority's performance in delivery of the Authority's Community Risk Management Plan (CRMP) strategic aims of: • Prevention, Protection and Response (Service Delivery); • Utilising and Maximising (Corporate Services); • Empowering (Human Resources). Performance data reported in the KPI Dashboard is pulled together from various sources including Incident Recording System (IRS) and internal databases such as iTrent, Protection and Safe and Well databases.		**Assessment:**	**Design** ✓ **Compliance** ×
Findings / Implications	We selected a sample of 10 KPIs from the Performance Report presented to the Fire Authority in September 2022 and sought to trace the sample of data items to their source records to ensure that the data presented was accurate, reliable, complete, and appropriately maintained to ensure that it is current and complies with relevant GDPR regulations. For six of the KPIs the data reported agreed to the source record with appropriate access restrictions, however in three instances the information did not agree and one was a complicated measure that was complex to reperform and could not be verified. Of the three which did not agree, one was an error, one no explanation could be provided and for the final one the data has been refreshed since the report was produced so we were unable to reperform this. If the accuracy of performance data reported across the organisation's governance structure cannot be evidenced, there is a risk that inaccurate information can be utilised, negatively impacting upon effective decision-making. In addition, if data is not appropriately maintained this could potentially lead to issues with lawfulness of processing and retention of data.			
Management Action 4	The Authority will develop and implement a process or system of data checks to ensure data presented is accurate, reliable, complete, and appropriately maintained in line with GDPR regulations. This will include the maintenance of a central folder to provide a clear audit trail of the source data used to populate each report where applicable.	**Responsible Owner** Paul Hughes	**Date:** December 2023	**Priority:** Medium

Data Quality Culture Survey				Assessment:	
Control	As part of our audit approach, we circulated a questionnaire to all staff and officers at the Authority to obtain their views regarding data quality and to establish whether a culture of data quality has been embedded across the organisation. The questionnaire was distributed to all staff, and we received 128 responses.			**Design**	N/A
				Compliance	N/A
Findings / Implications	Responses obtained from the survey indicated that a culture of data quality has been generally embedded however, further notable comments obtained in some of the questions highlighted the following: • Data quality amongst operational staff is inconsistent and many still do not understand the benefits in using data. • There is room for improvement in validation of data as some information like safe and well online entries. • A lack of awareness of the data owners, and the roles and responsibilities of data owners. • Whilst there are tools and systems in place to collect, interpret, and analyse data however some staff are not aware of how to effectively use them. If staff are not fully aware of the benefits of data quality and data owners at the Authority accountable for the quality, integrity, and protection of data there is a risk overall business performance might be affected.				
Management Action 5	We will review the results of the questionnaire and identify action to be taken as a result.	**Responsible Owner** Paul Hughes, HICT		**Date:** September 2023	**Priority:** Medium

EXECUTIVE SUMMARY – IMPLEMENTATION OF ACTIONS FROM HMICFRS – ENGAGEMENT WITH LOCAL COMMUNITY

Why we completed this audit

An audit of the Implementation of Actions from HMICFRS – Engagement with Local Community was undertaken to review how the service has engaged with its local community to build a comprehensive profile of risk in its service areas following on from the issues identified in the 2021 HMICFRS report. This audit reviewed the development of the action plans to address the issues identified within the HMICFRS report and how the actions have progressed and are being monitored throughout the Authority.

Following an inspection of the Service during the summer of 2018, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) judged the Service to be good at 'effectively keeping people safe and secure' within the local communities. The Service welcomed the areas for improvement identified within their report and progress was made in addressing these areas in 2019. HMICFRS returned in February 2021 to conduct a full inspection covering the areas of Effectiveness, Efficiency and People. A report was published in December 2021 with graded judgements against the inspection criteria.

This audit focused on the following two areas for improvement as noted below from within the HMICFRS 2021 report.

The service identifies the risks within the communities it serves

The 2021 HMICFRS report said that whilst the service has made some progress with making contact with members of the community, the following area for improvement, identified in 2018, remains: more needs to be done to improve how the service engages with the local community to build a comprehensive risk profile. We found good examples of the service using new ways of getting messages to hard-to-reach groups. But there is a lack of central co-ordination to take this information about communities and use it to inform future activity.

The service has an effective community risk management plan

The service has robust plans in place at a local level to support the execution of the Community Risk Management Plan (CRMP). It has also introduced a live performance dashboard to support the plan. The service needs to develop the dashboard to enable senior leaders to assure themselves that risks in prevention and protection are being managed appropriately.

Our work identified that a Community Risk Management Plan (CRMP) is in place for 2019-2023, which was refreshed in 2022 and published on the website. The purpose of the CRMP is to provide assurance that the right resources were in the right places to respond effectively to the risks within Bedfordshire. The next CRMP is in the process of being developed for Bedfordshire for 2023-27, with the aim to publish in May 2023.

Each year, an Annual Action Plan is published that outlines what is intended during that particular year to support the delivery of the CRMP and the mission to provide outstanding fire and rescue services that help make Bedfordshire safer. To help make it easier to follow, the actions are aligned to the CRMP 'Aims'. The Annual Performance and Statement of Assurance Report explains how well they did in delivering the plans.

In addition, a HMICFRS Action Tracker is in place for management to track progress against the actions raised by HMICFRS.

Clear governance arrangements are in place to track the actions for both the HMICFRS and CRMP, whereby regular updates are provided to the Corporate Management Team (CMT), Executive Committee and the Fire and Rescue Authority.

This review was undertaken as an advisory review and therefore will not result in a formal opinion.

Conclusion

Overall, we confirmed progress has been made in addressing the areas for improvement identified in the 2020/21 HMICFRS inspection, with amendments made to the CRMP to include areas of improvement in engaging with its community, actions identified and tracked, which are monitored through the governance structure and the development of the Communication and Engagement Strategy 2023-27. This was further acknowledged by HMICFRS after a Fire and Rescue Service Inspection was carried out and reported in April 2023. The inspection focused on how well the FRS understood the risk of fire and other emergencies and found that the service has improved how it engages with its local community to build a comprehensive profile of risk in its service area. Where actions have already identified and are in progress, we have not raised anything further in our work.

Key findings

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

Community Risk Management Plan (CRMP)

The Community Risk Management Plan (CRMP) for 2019-23 was updated in 2022 and again for 2023-27 to address the areas for improvement identified by HMICFRS and Action Plans are in place which are published annually. The plans outline what the organisation intends to do during that particular year to support the delivery of the CRMP. The actions are aligned to the CRMP 'Aims'.

Through review of the Community Risk Management Plan 2019 – 2023 (CRMP), we confirmed that it sets out how the Service intend to deliver their mission of providing outstanding fire and rescue services by further improving: how they assess and analyse the risks faced by the communities they serve, the effectiveness of their prevention, protection and emergency response services, how efficiently they use their assets and resources to reduce and respond to the risks faced by their communities; and how they value, support and invest in their best asset, staff. Through discussion with the Head of Strategic Support and Assurance, we found the Service are in the process of developing their next CRMP for 2023-27, with the aim to publish in May 2023 which will take a much stronger focus on community engagement and communication issues previously highlighted by HMICFRS.

We reviewed the Annual action plan for 2022-23 and confirmed that the Service have defined their top six priorities along with a detailed summary of what they 'want to do' and 'why they want to do it'. The new CRMP for 2023-24 was published in early 2023.

HMICFRS Action Plan

A HMICFRS Action tracker has been developed for management to track their progress against the actions raised by HMICFRS. The Action Plan includes key actions related to the findings reported by HMICFRS. Actions are assigned an owner, start date, due date, and a section for rating the actions using the RAG methodology. Lastly, each action has an action update section where staff can document the progress made so far.

Through discussions with the BFRS Service Improvement Manager, we noted that the system originally required an action date for initial configuration and that due dates would change as owners set realistic dates for their specific actions. Review following this exercise confirmed that there were a total of 13 actions and due dates were amended to March 2023 to coincide with the new CRMP 2023-27. We found that all the actions appeared to have a completion date of either the 31 December 2022 or 31 March 2023, however the % completion column was not showing as '100% complete' for six of the actions. Through discussions with the Head of Strategic Support and Assurance, we found that the per cent column represented the status at the time of the HMISCRS inspection, and we received confirmation that all actions are now complete.

HMICFRS Action Plan Monitoring

An Effectiveness Action Plan, in response to the 2018/19 inspection was published in 2019. The action plan sets out how the Service will act upon the feedback received from HMICFRS to further improve their service delivery as they strive to deliver outstanding fire and rescue services to the communities of Bedfordshire.

Through review of the HMICFRS Effectiveness Action Plan update report, we confirmed that it included the areas identified for improvement by HMICFRS, background information, actions already undertaken by Bedfordshire Fire and Rescue Service (BFRS) following the inspection and actions BFRS will undertake to deliver improvement.

In relation to the two areas of improvement we are reviewing as part of this audit, we noted that the current CRMP in place addresses the improvement of engaging with local community and further actions have been identified for 2023/24 including further developing relationships with Community Groups building opportunities to engage and consult, to better understand and inform their understanding of risk in local communities. We confirmed, through discussions with the Head of Strategic Support and Assurance, that since the Effectiveness Action Plan was published, the Service have developed a Community Panel, who will meet for the first time on the 30 May 2023. This will include attendance of 33 partners and community groups, with a quarterly agenda discussing areas for improvement and provide scrutiny by the wider community. The community will include mental health trusts, domestic violence association and school representatives. The feedback will then be fed back to the Executive Committee, the CMT and the Fire and Rescue Authority meetings.

Communication and Engagement Strategy

The Service has developed a Communication and Engagement Strategy for 2022-27. Through review of the Strategy, we confirmed that it focusses on the Authority's new stratregic committments and highlights the actions that will be carried out during the next 12 months to achieve them. This includes establishing a functioning strategic corporate communication and engagement department which reflects the organisation's mission and priorities, secure commitment to effective communication and engagement from members and colleagues across BFRS, working with

Bedfordshire's partnerships and blue light collaborations and improving the presence of BFRS within the community both in the form of events and at Community Engagement meetings which will help to consult for the CRMP for 2023-2027. This strategy covers internal and external communications and how the Service will engage with the community when making decisions that affect them, primarily when developing the Community Risk Management Plan (CRMP) for 2023-27.

Governance Arrangements

Updates on the HMICFRS Areas for Improvement are provided at the Corporate Management Team (CMT) meetings. The CMT also had an away day in January 2023, which was introduced by the CFO to update the group on topics such as HMICFRS inspection. Furthermore, the Executive Committee is provided an update report on the progress of the CRMP and the progress of the actions plans. In addition, regular updates areprovided to the Fire and Rescue Authority on the progress made with the CRMP 2023-27.

CMT

Through review of the CMT papers and minutes for November 2022 and February 2023 and the CMT Away Day in January 2023, we confirmed that the CRMP was discussed in detail, with updates provided. This included providing an update on the revised 2023-27 CRMP, which contains a number of new features which respond directly to stakeholder feedback, CRMP approach to Action Planning and what the Authority has delivered post HMICFRS inspection, in respect of improving how it engages with its local community.

Executive Committee Meetings

We found through review of the Executive Committee Papers for October and November 2022 and January 2023, that regular updates were being presented on the CRMP and HMICFRS inspections. We noted that during the January meeting, the Head of Strategic Support and ssurance provided an update on the Community Risk Management Plan and the Chief Fire Officer advised that the final CRMP report for publication was scheduled to be considered by the Authority at its meeting in March 2023. They emphasised that two consultations on aspects of the CRMP had been ongoing throughout the year, including at major local events such as Bedford's River Festival, bringing the total level of responses received up to 1289 in 2022-23.

FRA Meetings

In addition, through review of the FRA minutes for July, September and October 2022, we confirmed that CRMP updates were a standing agenda item. We confirmed that members received an update on progress with the CRMP, the summer survey results and the FRA's Action Plans. We noted that actions were raised, including the approval of the CRMP action plans, subject to the requested amendments being made at the October 2022 meeting.

EXECUTIVE SUMMARY – KEY FINANCIAL CONTROLS – ACCOUNTS RECEIVABLE

Why we completed this audit

A key financial controls audit with a specific focus on the accounts receivable function was undertaken at Bedfordshire Fire and Rescue Authority as part of the approved internal audit periodic plan for 2022/23.

This review was undertaken to assess the robustness of the financial controls in place in respect of accounts payable. Testing was undertaken to assess whether the finance system is appropriately managed to ensure that financial transactions such as raising invoices and credit notes and the recording and chasing of bad debts are accurately recorded with the appropriate level of segregation of duties within these functions. The review included ensuring compliance with the Authority's Financial Regulations and internal procedures, that appropriate authorisation was granted for transactions where required, and that appropriate supporting documentation was retained on file.

As part of this review, we also assessed whether access to the Authority's finance system is adequately controlled. The organisation utilises the Great Plains finance system to support the key financial control framework.

Conclusion

Overall, we confirmed the Authority's accounts receivable function within the remit of key financial controls were generally well designed and complied with. We confirmed that financial reporting was evident through review of budget monitoring reports and performance reports and noted the fortnightly corporate management team meetings included discussions regarding financial performance.

We confirmed the appropriate segregation of duties with regards to raising invoices, whereby the invoices were prepared by a member of the finance team and independently approved by the Principal Finance Officer. We also confirmed credit notes had been subjected to the same level of robust review and approval and were processed in a timely manner. We confirmed that aged debtor reconciliation reports were run monthly, were checked and approved in line with the delegated authorities and were used to populate the historical aged trail balance spreadsheet that enabled debt chasing activities to be carried out. We noted four bad debts that were written off during the 2021/22 financial year were subject to debt chasing activities in line with the credit control procedure and the write offs were processed in line with delegated authority.

Internal audit opinion:

Taking account of the issues identified, the Authority can take substantial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective.

Key findings

We agreed three low priority management actions, details of which can be found in section 2 of this report.

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

Financial Reporting

We confirmed through review of the submission of Budget Monitoring Reports that were presented to the FRA in July 2022 and February 2023 that financial reporting is accurately carried out. We noted through review of the Q1 and Q2 Performance Monitoring Reports that were submitted to the FRA in September 2022 and February 2023 that KPI's relating to financial performance such as outstanding debts over 90 days were correctly reported. We also noted discussions around budgets and financial performance within the fortnightly Corporate Management Team meetings.

Leavers

When someone leaves the organisation an automatic 'workforce change' email is sent from HR to the IT and Finance department. At this point IT revoke the access rights of the leaver.

The Chief Accountant obtains a copy of the User Lists from the ICT department periodically to ascertain if those 'active' users on the list still require access to Great Plains. Where someone has been identified as no longer working for the organisation and needs to be removed from the list as an active user, the Chief Accountant will complete a FSIT 5 form and send this to the ICT department to remove from the Great Plains system. Testing on leavers since April 2022 confirmed that these had been removed from the system on a timely basis.

Review and approval of invoices

Through testing on a sample of 20 invoices, we confirmed that processes were followed with the appropriate FIN44 forms raised and completed in 16 instances, and the remaining four cases being part of the annual yearly fees schedule therefore not requiring a FIN44 to be completed. Invoices had been raised, reviewed and approved with a clear segregation of duties and invoices had been issued in a timely manner from receipt of the FIN44 form.

Approval and processing of credit notes

Testing undertaken on a sample of 10 credit notes confirmed that in nine instances credit notes had been raised by completing the appropriate FIN44A form, which was signed and subsequently reviewed by the Principal Finance Officer (PFO) and approved by the Chief Accountant (CA). The only exception was resolved through email correspondence between the PFO and CA. In all instances the value of the credit notes matched to that on the original invoice, reasons for the credit note being issued were documented and all credit notes were raised in a timely manner from receipt of the FIN44A form or email correspondence.

Control Account Reconciliations

The control account in respect of accounts receivable is reconciled on a monthly basis. The reconciliations are prepared by the Finance Officer and reviewed by the Principal Finance Officer. We confirmed through of the account receivables reconciliations for October, November and December 2022, they had been prepared each month by the Finance Officer and been reviewed by the Principal Finance Officer. There was evidence of signatures and dates of both parties on all three reports reviewed. We also noted the reconciliations were reviewed in a timely manner.

Aged debtors

Through review of the Debt Reconciliation Reports for October, November and December 2022, we confirmed all three had been prepared by a Finance Officer and reviewed by the PFO in a timely manner. We also noted through review of the Receivables Detailed Historical Aged Trial Balance reports from October, November, and December 2022 that the amount of debt reported on each reconciled to those shown on the reconciliation reports.

Bad and doubtful debts

Despite no bad or doubtful debts being identified for the current financial year, we noted four bad debts from previous financial years being subjected to enhanced debt chasing activities which included legal action being taken and the use of debt recovery agencies which was carried out in accordance with delegated authority. We confirmed these four bad debts had been chased in accordance with the ‘Credit Control’ internal procedure document with dates of letters issued and actions being recorded on the historical aged trial balance spreadsheet.

Write offs

We noted the four bad debts identified from previous years being written off in the financial year 2021/22 all received approval in line with delegated authority which was evident in email correspondence between the CA and Treasurer.

FOLLOW UP - EXECUTIVE SUMMARY

Background

We have undertaken a review to follow up on progress made to implement the previously agreed management actions from the following audits:

- Use of Risk Information (1.20/21)
- Risk Management (2.20/21)
- Procurement - Proactive Processes and Remedial Action (3.20/21)
- Cyber Essentials (4.20/21)
- Human Resources – Support Staff Recruitment (5.20/21)
- Key Financial Controls (6.20/21)
- Human Resources – Wellbeing (7.20/21)
- Service Governance (8.20/21)
- Follow Up (9.20/21)

The management actions considered in this review comprise of 27 medium priority actions. The focus of this review was to allow management to take assurance that all medium priority actions previously agreed during these reviews have been adequately implemented, no high priority were identified within the audits.

Conclusion

Of the 27 management actions followed up, we were able to confirm that six had been fully implemented. In the remaining 21 instances five actions had not been fully implemented and for 16 actions we did not receive evidence to support the completion of the actions.

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 attempted to verified this information and completed audit testing to confirm the level of implementation stated and compliance with controls.

For the actions, our findings did not verify the status of implementation of all management actions as reported to the Audit & Standards Committee via the internal action tracking process. We identified differences as follows:

Audit	Reported as complete	Agreed	Comment
Use of Risk Information (1.20/21)	1	0	No evidence provided
Risk Management (2.20/21)	4	3	One partly but not yet fully implemented
Procurement – Proactive Processes and Remedial Action (3.20.21)	5	2	Three no evidence provided
Cyber Essentials (4.20/21)	6	0	No evidence provided
Human Resources - Support staff Recruitment (5.20/21)	1	0	The action has been partly but not yet fully implemented as evidence not provided for one element
Key Financial Controls (6.20/21)	1	0	No evidence provided
Human Resources Wellbeing (7.20/21)	4	1	One action has been partly but not yet fully implemented, one not implemented and two no evidence provided
Service Governance (8.20/21)	3	0	One action has been partly but not yet fully implemented and two no evidence provided
Follow Up (9.20/21)	2	0	One action has been partly but not yet fully implemented and one no evidence provided

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)
Use of Risk Information (1.20/21)	1	0	0	1	0	0
Risk Management (2.20/21)	4	3	1	0	0	3
Procurement – Proactive Processes and Remedial Action (3.20/21)	5	2	0	3	0	2
Cyber Essentials (4.20/21)	6	0	0	6	0	0
Human Resources – Support Staff Recruitment (5.20/21)	1	0	1	0	0	0
Key Financial Controls (6.20/21)	1	0	0	1	0	0
Human Resources – Wellbeing (7.20/21)	4	1	1	2	0	1
Service Governance (8.20/21)	3	0	1	2	0	0
Follow Up (9.20/21)	2	0	1	1	0	0
Total	**27**	**6**	**5**	**16**	**0**	**6**

2 DETAILED FINDINGS AND MANAGEMENT ACTIONS

We have only included those actions below where they were found to be partly implemented, or a finding to raise for management attention. We have included in the appendices below those actions fully implemented, or where evidence was not provided.

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.
4	The action has been superseded and is no longer applicable.
5	The action is not yet due.

1. General

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 verify this information and complete 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 attempted to verify this information and complete audit testing to confirm the level of implementation stated and compliance with controls.
Audit finding	Previously evidence to confirmation implementation of management actions was obtained by management prior to sign off and reporting to the Audit & Standards Committee, but we understand this is no longer in place. As part of our audit we were unable to verify the implementation of 16 of the 27 management actions, in addition for a further five, whilst we were provided with evidence of the implementation of parts of the action, this did not evidence implementation of the full action. Therefore we were unable to confirm the status of the management actions as reported to the Audit & Standards Committee via the internal action tracking process.

		Responsible Owner:	Date:	Priority:
Management Action 1	Management should ensure that all elements of the management actions are implemented before reporting this as closed, in addition, evidence must be retained and available for review to support the implementation.	Steve Frank	31/03/23	High

2. Risk Management (2.20/21)				
Original management Action / priority	The Service Assurance Framework will be reviewed as part of the decision-making process in moving to a new risk management system, to ensure it reflects the policies and procedures established as part of that decision. Where local heads are required to maintain risk registers, this process will be complied with. **(Medium)**			
Audit finding / status	Through our risk management review we confirmed a Risk Management System has been implemented. However we were advised that, whilst monthly review of risks by risk owners was part of the revised approach to risk management in the organisation, these reviews had not yet commenced. There is a greater chance of risks materialising if they are not regularly reviewed and updated by risk owners. As per our separate review of risk management undertaken in 2021/22, we noted that the Corporate Risk Service Order was currently on hold and had not been reviewed since 2012. Review of the draft Corporate Risk Management Policy found that it detailed how corporate risks are derived, the aims of risk management, the corporate risks themselves and high-level responsibilities. We noted that this policy was not yet in use and had not been formally signed off by the Chief Fire Officer. **The action has been partly but not yet fully implemented.**			
Management Action 2	Risk owners will review their assigned risks on a monthly basis and ensure updates are recorded within BMIS. As per our separate review of risk management undertaken in 2021/22, the draft Corporate Risk Policy will be approved and made available to relevant staff. Further guidance on risk assessment, review, monitoring and reporting will be established. The organisation's risk appetite will be formally documented in the Corporate Risk Policy and be subject to regular review for appropriateness.	**Responsible Owner:** Steve Frank	**Date:** 31/03/23	**Priority:** Medium

3. Human Resources – Support Staff Recruitment (5.20/21)				
Original management action / priority	The organisation will ensure that there is a clear record of CMT discussion and approval of new posts. The supporting evidence will then be supplied to the Recruitment Team. The Authorisation to Increase Base Establishment Form will also be updated to remove the HR approval section. Supporting evidence for the actioning of posts by HR will continue to be retained by email. **(Medium)**			
Audit finding / status	Through review of the Authorisation to amend Base Establishment Form we confirmed HR approval had been removed. However, we were not provided with any evidence in relation to there being a clear record of CMT discussion and approval of new posts as the minutes provided did not include any detail regarding this. In the absence of CMT oversight and approval of new posts there is a risk that new posts may not be in line with post requirements and posts may be actioned without approval. **The action has been partly but not yet fully implemented.**			
Management Action 3	The organisation will ensure that there is a clear record of CMT discussion and approval of new posts.	**Responsible Owner:** Sarah Fecondi	**Date:** 31/03/23	**Priority:** Medium

4. Human Resources – Wellbeing (6.20/21)				
Original management action / priority	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. **(Medium)**			
Audit finding / status	We confirmed through review of the Wellbeing Matters Policy that it includes the policy statement and roles and responsibilities of staff at all levels although noted that this had not been signed by the Chief Fire Officer, and the policy provided was in respect of Essex County Fire and Rescue Service. We also noted reference was made to the Traumatic Risk Management (TRiM). We also noted that the policy had not been revised to include the following: - A completed version control summary - Current wellbeing governance structure, including the Mental Health and Wellbeing Steering Group There is a risk that if the wellbeing policy has not been revised to reflect the above then staff may not be following the most up to date policy and therefore may not be able to reflect on the most up to date practices within wellbeing. **The action has been partly but not yet fully implemented.**			
Management Action 4	The organisation will ensure that the Wellbeing Policy is 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: • Completed version control of the policy. • Current wellbeing governance structure, including the Mental Health and Wellbeing Steering Group • Refers to the correct organisation and structure throughout	**Responsible Owner:** Sarah Fecondi	**Date:** 31/03/23	**Priority:** Medium

5. Human Resources – Wellbeing (6.20/21)				
Original management action / priority	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. **(Medium)**			
Audit finding / status	Through review of the TRiM activity log we were unable to identify how the log can be reconciled to tip sheets. In addition we were not provided with evidence to confirm the Service capture and analyse TRiM statistics. There is a risk that the Service cannot be assured that all potentially affected individuals who should have been contacted have indeed been contacted. **The action has not been implemented.**			
Management Action 5	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:** Sarah Fecondi	**Date:** 31/03/23	**Priority:** Medium

6. Service Governance (8.20/21)				
Original management action / priority	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). **(Medium)**			
Audit finding / status	We were not provided with any agendas to confirm whether the nature of each agenda item was indicated as to whether it was a presentation, report, or verbal. Review of a sample of CMT meeting minutes and an Action Log confirmed that decisions and actions were being recorded. **The action has been partly but not yet fully implemented.**			
Management Action 6	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.	**Responsible Owner:** Steve Frank	**Date:** 31/12/22	**Priority:** Medium

7. Follow Up (9.20/21)				
Original management action / priority	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. **(Medium)**			
Audit finding / status	Through review of the Stock Adjustment Spreadsheet, we confirmed that each number now includes an item number and an inventory account number. However, we did not receive evidence that training has been provided for issuing stock and recording this on the system, nor did the evidence provided detail the current location coding. There is a risk that without providing training to staff for issuing stock, there is a greater change of errors and discrepancies occurring when recording stock on to the system. **The action has been partly but not yet fully implemented.**			
Management Action 7	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:** Jason Tai	**Date:** 31/03/23	**Priority:** Medium

For more information contact

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