HUMBERSIDE FIRE AUTHORITY

Fire & Rescue Service Headquarters Summergroves Way Kingston upon Hull HU4 7BB

Telephone 01482 565333

To: Members of the Governance, Audit and Scrutiny Committee	**Enquiries to:** Rob Close **Email:** committeemanager@humbersidefire.gov.uk **Tel. Direct:** (01482) 393899 **Date:** 3 November 2023

Dear Member

I hereby give notice that a meeting of the **GOVERNANCE, AUDIT AND SCRUTINY COMMITTEE** of Humberside Fire Authority will be held on **MONDAY 13 NOVEMBER 2023 at 10.00AM** at HUMBERSIDE FIRE & RESCUE SERVICE HEADQUARTERS, SUMMERGROVES WAY, KINGSTON UPON HULL, HU4 7BB.

The business to be transacted is set out below.

Yours sincerely

R Close

for Lisa Nicholson
Monitoring Officer & Secretary to Fire Authority

AGENDA

Business	Page Number	Lead	Primary Action Requested
1. Apologies for absence	-	Monitoring Officer/ Secretary	To record
2. Declarations of Interest (Members and Officers)	-	Monitoring Officer/ Secretary	To declare and withdraw if pecuniary
3. Minutes of the meeting of 4 September 2023 and Action Schedule	(pages 3 - 8)	Chairperson	To approve
4. Internal Audit Reports	(pages 9 - 96)	Internal Audit (TIAA)	To consider and make any recommendations to the HFA
5. Management Accounts Period ending 30 September 2023	(pages 97 - 97)	Joint Deputy Chief Finance Officer & Deputy S.151 Officer	To consider and make any recommendations to the HFA
6. Treasury Management Half Year Report 2022/23	(pages 99 - 108)	Joint Deputy Chief Finance Officer & Deputy S.151 Officer	To consider and make any recommendations to the HFA
7. Scrutiny Item: On-call staff learning and development	(pages 109 - 114)	Head of Training/ Head of Organisational Development	To consider and make any recommendations to the HFA

Business	Page Number	Lead	Primary Action Requested
8. GAS Committee Scrutiny Programme 2023/24	(pages 115 - 118)	Monitoring Officer/ Secretary	To approve

HUMBERSIDE FIRE AUTHORITY

GOVERNANCE, AUDIT AND SCRUTINY COMMITTEE

4 SEPTEMBER 2023

PRESENT: Independent Co-opted Members Chris Brown, Melissa Dearey and Nigel Saxby

Officers Present: Matthew Sutcliffe – Assistant Chief Fire Officer & Executive Director of Corporate Services, Mark Blenkinsop – Head of Joint Estates, Andy Day – Head of Function, Jason Kirby – Area Manager of Emergency Response, Jamie Morris – Designate Head of Corporate Assurance, Martyn Ransom – Joint Deputy Chief Finance Officer & Deputy S.151 Officer, via Microsoft Teams Andy McCulloch – Internal Audit (TIAA), Lisa Nicholson – Monitoring Officer/Secretary, and Rob Close – Committee Manager.

External Audit

Ross Woodley – Mazars

Internal Audit

Andrew McCulloch - TIAA (in remote attendance)

Councillor Briggs was also in attendance.

The meeting was held at the Humberside Fire and Rescue Service Headquarters, Kingston upon Hull.

40/23 APOLOGIES FOR ABSENCE – Apologies for absence were received from Kathryn Lavery and Gerry Wareham.

41/23 DECLARATIONS OF INTEREST – No declarations of interest were made with respect to any items on the agenda.

42/23 MINUTES – Members of the Committee expressed an interest in seeing an update to the scrutiny item on grievance procedures in January 2024.

Resolved – *(a) That the minutes of the meeting held on 3 July 2023 be confirmed as a correct record.*

(b) That the Committee receive an update to the scrutiny item on grievance procedures in January 2024.

43/23 MANAGEMENT ACCOUNTS PERIOD ENDING 30 JUNE 2023 – The Committee received a report of the Deputy Joint Chief Finance Officer and Deputy Section 151 Officer detailing the final outturn report. The Committee was advised that the Service ran an underspend of £0.295m with all capital projects on budget. Investments were considered to be yielding an acceptable return. The reserve budget was still underspent however this took into account the forthcoming pay award.

It was clarified that the contracts awarded outside of tender process were done so with the knowledge that the providers had specialist knowledge and experience in those works. The decisions not to create a new tender was made at an area manager level and was subject to an audit.

The on-call fire fighters' pay underspend would be addressed as part of a reprofiling exercise. Impacts were seen as a result of bank holidays and new recruits.

Resolved - *That the report be received.*

44/23 INTERNAL AUDIT REPORTS – The Committee received a report of TIAA, the Authority's internal auditors, detailing the internal audit reports. The Committee was advised that there was one additional piece of work being included on the internal audit plan considering procurement exercises.

The Committee were interested to know how the field work for the audits was conducted. The internal auditors agreed to give some further detail of this outside of the meeting.

Resolved – *That the report be received.*

45/23 External Audit Completion Report – The Committee received a report of Mazars, the Authority's external auditors, detailing the external audit completion report. The Committee was advised that there were significant delays in local audits, and it was a great testament to the finance team for getting their audit completion report for 2022/23. There were no significant changes to bring to Members' attention and it was noted that the audit's sign off will follow the previous year's timetable.

The investment referred in the report to awaiting confirmation from the National Audit Office. This was an issue faced by all Fire and Rescue Services in the country and not specific to Humberside.

Resolved - *That the update be noted.*

46/23 ANNUAL STATEMENT OF ACCOUNTS 2022/23 (AUDITED) – The Committee received a report of the Deputy Joint Chief Finance Officer and Deputy Section 151 Officer detailing the audited annual statement of accounts for 2022/23. The Committee was advised that these accounts would be going, with some minor amendments, to the meeting of Humberside Fire Authority in September.

The Committee suggested that a further breakdown of the type of fires be added to the Service Performance Summary 2022/23.

Resolved - *That the update be noted.*

45/23 SCRUTINY ITEM: DIGNITY WORKS SCHEME – The Committee received a report of the Area Manager of Prevention, Protection, Fleet and Estates.

The Committee was advised that since 2011, the Service had been undertaking an improvement programme of dignity works to its Estate. Further to this, in 2018, the Service published its Professional Standards Dignity at Work Policy before making a marked improvement and significant increase in the provision of dignity works, to ensure full compliance with both the Dignity at Work Bill 2001 and the Equality Act 2010.

The Service always had a reactive approach to Estate management and since 2011/12 the Service invested just short of £4 million in dignity works across the Estate. Work began to ensure that the Service's Estate was fully compliant and appropriate for use, following the Service publishing its Professional Standards Dignity at Work Policy. Whilst this programme of work was being undertaken, the Service's inspection by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) in 2022 highlighted that problem areas still existed, resulting in a full review of the dignity improvement scheme.

Further works were already being planned or progressed to ensure that the Service became fully compliant with the support of a task and finish working group led by a Service Delivery Manager. To assist in the identification and progress of future work, the Service planned to adopt an NHS method of Estate inspection and improvement called 'The Six Facet Survey' which sought to consider:

- The building's condition
- Its overall functional suitability (this included Dignity and Welfare, Clean areas, Storage, Security and Gym/Rest areas).
- Space utilisation
- Quality of its amenities, comfort, and environment
- Statutory Compliance items, such as Health & Safety, Asbestos and Flood Risks.
- The buildings energy ratings

The Committee then considered the following aspects:

- **Requests for Transfers** – It was clarified that, while requests for station transfers were not uncommon, these usually came as a result of ambitions for busier work or proximity to home rather than the facilities offered at stations.
- **Staff Surveys** – Issues of facilities were not a common issue raised under staff surveys.
- **Expectations** – Officers were confident that staff were comfortable with the conditions currently available to them. There was some concern that facilities may act as a disincentive to recruitment, however the evidence available did not support this.
- **Inspections** – A new member of staff was recruited to, to join joint services for a full programme of inspections before the end of 2023. Following that, a five-year plan would provide a concise roadmap for ongoing maintenance and refurbishment.

Resolved – *That the update be noted.*

46/23 GAS COMMITTEE SCRUTINY PROGRAMME 2023/24 – The Committee Manager submitted a report summarising the Committee's Scrutiny Programme 2023/24.

Resolved - *That the Programme be received.*

ROLLING ACTION SCHEDULE OF FIRE AUTHORITY, GAS COMMITTEE & PENSION BOARD MEETINGS

Meeting	Date	Agenda Item	Minute Number	Resolution/Action	Officer to Action	Complete/Update
GAS Committee	4 September 2023	Minutes & Action Schedule	42/23	Resolved - (b) That the Committee receive an update to the scrutiny item on grievance procedures in January 2024.	Anne Stott - Head of HR	**Complete –** added to GAS Committee Work Programme for 22nd January 2024 meeting
GAS Committee	4 September 2023	Internal Audit Reports	44/23	Action - The Committee were interested to know how the field work for the audits was conducted. The internal auditors agreed to give some further detail of this outside of the meeting.	Jamie Morris – Designate Head of Corporate Assurance/ Andrew McCulloch - Internal Audit (TIAA)	**Complete –** Members sent as a reminder the agreed internal audit plan (attached) as approved and issued in March 2023 (specifically pages 2, 5 & 6) which covers the overarching arrangements and methodology. In addition each Internal Audit report the Committee receives sets out the specific methodology applied for each audit.
GAS Committee	3 July 2023	Scrutiny Item: Grievance Procedures	34/23	**Resolved** – (b) that Officers consider including an additional Member on the panel for the formal hearing formal stages; (c) that Officers consider the inclusion of a Fire Authority Member on the panel for a Stage 3 hearing, and (d) that Officers consider reviewing the Grievance Policy Equality Impact Analysis (EIA) to help inform the Policy.	Anne Stott - Head of HR	**Complete** (b) This was fully explored. Regretfully, there are inevitably challenges around availability owing to the shift patterns, etc which if the panel numbers increased, may delay the matter further. In addition, as it is the hearing officer who makes the decision, two hearing officers may be unable to reach an agreed outcome, thus requiring a third hearing officer to ensure a majority decision was able to be taken. Three hearing managers at Station Manager level or above, would be a challenge in terms of availability and in terms of efficient use of senior management time. HR's attendance is to provide guidance on process and policy, it does not offer a view as to the outcome hence is able to provide an objective and impartial view of the procedure which includes the decision-making process. (c) Having considered the matter, it was agreed that as the decision is made by the hearing officer, it may not be possible for two panellists to reach an agreed outcome. This would then necessitate a third panellist, again producing a challenge in terms of availability and efficient use of time. (d) Reviewed, revised and published.
GAS Committee	20 February 2023	GAS Committee Scrutiny Programme 2022/23	20/23	**Resolved -** (a) That an item considering Equality, Diversity and Inclusion Staff Forums be brought to the 3 April 2023 meeting of the Committee.	Committee Manager	**Complete**

ROLLING ACTION SCHEDULE OF FIRE AUTHORITY, GAS COMMITTEE & PENSION BOARD MEETINGS

Meeting	Date	Agenda Item	Minute Number	Resolution/Action	Officer to Action	Complete/Update
GAS Committee	20 February 2023	Scrutiny Item – General Data Protection Regulation (GDPR) Compliance	19/23	**Resolved -** (b) That a copy of the Data Protection Guide for Staff be circulated to the Committee for information upon publication.	Senior Corporate Assurance Officer	**Complete**
GAS Committee	20 February 2023	Treasury Management and Capital Expenditure Strategy 2023/24	18/23	**Resolved –** (b) That an update be given by the Joint Estates Manager on fleet replacement during the next municipal year; (c) That new members of Committee be offered training on Link.	Committee Manager	(b) **Complete** – Placed on Member Day Programme for 2023/24 (c) **Complete** – in process of being arranged
GAS Committee	5 September 2022	GAS Committee Scrutiny Programme 2022/23	69/22	**Resolved -** That the item titled 'Emergency Response Business Continuity' be deferred with a view to consider it at a later date.	Committee Manager	**Complete**

Agenda Item No. 4
Report by Internal Auditors

Internal Audit

FINAL

Humberside Fire and Rescue Service

Summary Internal Controls Assurance (SICA) Report

2023/24

November 2023

Summary Internal Controls Assurance

Introduction

1. This summary controls assurance report provides the Governance, Audit and Scrutiny (GAS) Committee with an update on the emerging Governance, Risk and Internal Control related issues and the progress of our work at Humberside Fire and Rescue Service as at 1st November 2023.

Whistleblowing - driving the conversation

2. **The importance of a healthy culture.**

We have seen, over the last few months, the publication of several high-profile reports such as the Metropolitan Police (Casey Review March 2023), University Hospitals Birmingham (Bewick Report March 2023) and Plaid Cymru's review (conducted by Nerys Evans May 2023) where a common theme for each organisation was reported around the treatment of whistleblowers as well as 'poor' organisational culture, failures in leadership and poor whistleblowing reporting mechanisms.

There are so many high-profile incidents that have arisen over the last few years across many sectors and industries, perhaps most notably the #METOO campaign which highlighted sexual abuse in the entertainment industry spanning decades, where, despite there being many reported incidents, the individuals were ignored, ostracised or simply closed down and the matter covered up.

There is a real drive within government to look at the Whistleblowing Laws in the UK to drive through change. It is anticipated that there will be greater onus on organisations to improve their culture and to provide greater support and protection for whistleblowers. The outcome of the government's research is due for completion by the Autumn 2023.

In anticipation of the key messages coming out from the government, we in TIAA are using our expertise and knowledge to support organisations by:

1. Working with organisations to 'health check' organisational culture in respect of whistleblowing;
2. Providing a platform for those responsible for governance, raising concerns, whistleblowing and freedom to speak up guardians to share knowledge expertise, good practice in a forum event.
3. Examining poor practice and looking at the lessons to be learnt from recent incidents in webinar events and through consultation exercises such as online surveys.
4. Sharing the information through benchmarking reports and roundtable events.

Please use this link to keep up to date with our campaign and/or to be part of the conversation and drive through real change and improvement in this important area.

https://www.tiaa.co.uk/publications/tiaa-organisational-culture-and-whistleblowing-webinar/

Audits completed since the last SICA report to the Audit Committee

3. The table below sets out details of audits finalised since the previous meeting of the GAS Committee.

Audits completed since previous SICA report

		Key Dates			Number of Recommendations			
Review	**Evaluation**	**Draft issued**	**Responses Received**	**Final issued**	**1**	**2**	**3**	**OEM**
Bullying, Harassment and Discrimination	Reasonable	25/08/2023	04/09/2023	06/09/2023	0	3	1	0
Mobile Data Terminals (Performance)	Reasonable	16/08/2023	18/09/2023	22/09/2023	0	6	2	0
Effectiveness of systems (used to learn from operational incidents)	Reasonable	07/09/2023	27/10/2023	01/11/2023	0	1	0	0
Staff Development	Substantial	26/09/2023	26/09/2023	04/10/2023	0	0	0	0
Service Absolutes / Heat Maps	Substantial	29/09/2023	16/10/2023	25/10/2023	0	0	1	1
Mid-Year Follow Up	N/A	09/08/2023	27/10/023	01/11/2023	-	-	-	-

4. There are no issues arising from these findings which would require the annual Head of Audit Opinion to be qualified.

Progress against the 2023/24 Annual Plan

5. Our progress against the Annual Plan for 2023/24 is set out in Appendix A.

Changes to the Annual Plan 2023/24

6. There are no proposed changes to the annual plan.

Progress in actioning priority 1 recommendations

7. We have made no Priority 1 recommendations (i.e. fundamental control issue on which action should be taken immediately) since the previous SICA.

Root Cause Indicators

8. The Root Cause Indicators (RCI) have been developed by TIAA to provide a strategic rolling direction of travel governance, risk and control assessment for Humberside Fire and Rescue Service. Each recommendation made is analysed to establish the underlying cause of the issue giving rise to the recommendation (RCI). The analysis needs to be considered over a sustained period, rather than on an individual quarter basis. Percentages rather than actual number of reviews/recommendations made permits more effective identification of the direction of travel. A downward arrow signifies a positive reduction in risk in relation to the specific RCI and will be included for the next tranche of reports.

Root Cause Indicator	Qtr 1 (2023/24)	Qtr 2 (2023/24)	Qtr 3 (2023/24)	Qtr 4 (2023/24)	Medium term Direction of Travel	Audit Observation
Directed						
Governance Framework	-	14%			N/A	
Risk Mitigation	-	7%			N/A	
Control Compliance	-	50%			N/A	35% from Mobile Data Terminal review
Delivery						
Performance Monitoring	-	29%			N/A	
Sustainability	-	0%			N/A	
Resilience	-	0%			N/A	

Frauds/Irregularities

9. We have not been advised of any frauds or irregularities in the period since the last SICA report was issued.

Other Matters

10. We have issued a number of briefing notes and fraud digests, shown in Appendix B, since the previous SICA report.

Responsibility/Disclaimer

11. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. The matters raised in this report not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Progress against Annual Plan

System	Planned Quarter	Current Status	Comments
Bullying, harassment & discrimination	1	Final report issued	
Mobile Data Terminals (Performance)	2	Final report issued	
Mid-year follow up	2	Final report issued	
Effectiveness of systems (used to learn from operational incidents)	2	Final report issued	
Staff Development	2	Final report issued	
Service Absolutes / Heat Maps	2	Final report issued	
National Occupational Guidance	3	Draft report issued 1st November 2023	
Enforcement Powers & Priorities	3	Fieldwork commenced 20th October 2023	
ICT Management Controls	3	Confirmed 20th - 22nd November 2023	
Procurement	3	Confirmed 3rd – 6th December 2023	In addition to the approved plan.
Key Financial Controls	4	Confirmed 4th - 8th March 2024	
End of year follow up	4	Confirmed 15th March 2024	

KEY:

(blue)	To be commenced
(yellow)	Site work commenced
(pink)	Draft report issued
(green)	Final report issued

Briefings on developments in Governance, Risk and Control

TIAA produces regular briefing notes to summarise new developments in Governance, Risk, Control and Anti-Crime which may have an impact on our clients. These are shared with clients and made available through our Online Client Portal. A summary list of those CBNs and Anti-Crime Alerts issued in the last four months which may be of relevance to Humberside Fire and Rescue Service is given below. Copies of any CBNs are available on request from your local TIAA team.

Summary of recent Client Briefing Notes (CBNs)

CBN Ref	Subject	Status	TIAA Comments
CBN - 20009	Guidance issued by HMRC on tax avoidance schemes		**Action Required** Raise the profile of tax avoidance across networks and communication channels Support HMRC by sharing the following link with stakeholders to help raise awareness among workers in the health and social care sectors, and to warn them of the risks of getting involved in tax avoidance. Link: https://taxavoidanceexplained.campaign.gov.uk/

Summary of recent Anti-Crime Alerts

Ref	Subject	Status	TIAA Comments
July 2023	Insider Invoice Fraud		**Action Required** The City of London Police were contacted by the organisation that the fraudster had targeted following their discovery that 29 fake invoices had been received and processed through their accounts department. All of the fake invoices had been received as attachments within e-mails that were purportedly sent from the PA of the CEO, and were found in the shared email inbox within the organisation's accounts department. The invoices were identified as fake as none of the companies requesting funds were legitimate. In addition, each of the invoices had what appeared to be the CEO's signature authorising payment. All of the fake invoices were processed by a member of staff and evidence was found that linked the insider to the scam. The member of staff, the insider, was instrumental in this fraud being carried out. Insider invoice fraud refers to cases of fraud in which an insider's access to the organisation's systems and processes are essential in committing the fraud. Examples of insider invoice frauds, which are likely to increase during this period of increased financial pressures and the rising cost of living include: • False payment requests typically during busy periods • Overbilling a debtor and pocketing the difference • Recording false credits or refunds • Creating fictitious suppliers or shell companies for fraudulent payments • Forging signatures on payment authorisations • Submitting false invoices from fictitious or actual suppliers for payments.
June 2023	Payment Systems Regulator confirms new requirements for Authorised Push Payment fraud reimbursement		**Action Required** This alert provides information and advice to staff about fraud and economic crime, and the risks associated with it. If you think that your organisation has been a victim of APP fraud, contact your Anti-Crime Specialist immediately for advice. The Payment Systems Regulator (PSR) confirms new requirements for banks and payment companies that will ensure more people will get their money back if they are a victim of Authorised Push Payment (APP) fraud; prompting more action to prevent these frauds from happening in the first place. The Financial Services and Markets Bill, which is currently making its way through Parliament, will remove current barriers and allow the PSR to direct firms to reimburse customers. The Bill is expected to receive Royal Assent in 2023, after which the PSR will be able to enforce its requirements on payment firms. Full details at: https://www.psr.org.uk/news-and-updates/latest-news/news/psrconfirms-new-requirements-for-app-fraud-reimbursement/

ALL SECTORS | AUGUST 2023

CLIENT BRIEFING NOTE

Guidance issued by HMRC on tax avoidance schemes

TIAA Anti-Crime Specialists have had sight of a letter to the Department for Health and Social Care's Permanent Secretary from the Chief Executive and First Permanent Secretary of HMRC.

The letter is to alert counter fraud networks on the subject of tax avoidance schemes. A summary of guidance provided within the letter follows.

What is tax avoidance?

Tax avoidance involves bending the rules of the tax system to try to gain a tax advantage that was never intended by parliament.

What are the types and consequences of tax avoidance?

The most common form of tax avoidance scheme is disguised remuneration (DR). DR avoidance schemes claim to avoid the need to pay Income Tax and National Insurance contributions on income from employment. These schemes often involve paying some or all of a worker's pay in the form of a loan, or other payment claimed to be non-taxable, that is unlikely to ever be repaid. The schemes do not work and the tax remains due. DR schemes particularly target contractors and agency workers, who are often paid through an intermediary such as an 'umbrella company'. Most umbrella companies are compliant and can ease the administrative burden for freelancers however in DR schemes non-compliant umbrella companies are often used to facilitate tax avoidance.

What action is HMRC taking to address the issue?

During the pandemic HMRC identified that healthcare professionals returning to the NHS were being targeted by promoters of schemes.

This was highlighted in HMRC's Spotlight series; short publications on GOV.UK that provide information on tax avoidance schemes.

Tax avoidance schemes currently in the spotlight - GOV.UK (www.gov.uk)

As an example, HMRC recently published details of a promoter of a scheme targeted predominantly at physiotherapists, radiographers, nurses and social workers. The following link takes you to this publication, plus a list of other named tax avoidance schemes, promoters, enablers and suppliers.

Current list of named tax avoidance schemes, promoters, enablers and suppliers - GOV.UK (www.gov.uk)

HMRC advise that in their last annual update on the use of marketed tax avoidance schemes, 'hospital activities' is the sector which identified the most people who have used avoidance schemes.

Promoters continue to target the health and social care sector and many workers are ending up with large tax bills from their involvement in a DR tax avoidance scheme.

Action Required:

Raise the profile of tax avoidance across networks and communication channels

Support HMRC by sharing the following link with stakeholders to help raise awareness among workers in the health and social care sectors, and to warn them of the risks of getting involved in tax avoidance.

Tax avoidance – don't get caught out – Don't get caught out by tax avoidance – learn what it is and how to spot it (taxavoidanceexplained.campaign.gov.uk)

This document is only for use by clients and under no circumstances is it to be given to third parties. It is not intended as a definitive and legally binding statement of the position: all clients should seek appropriate advice from their own specialist advisers.

23009
9th August 2023

tiaa ANTI-CRIME ALERT

Jail sentence for fraudster after £660K fake invoice scam

A fraudster who submitted bogus invoices amounting to £660,000 has just been jailed for six and a half years. They were found guilty of one count of conspiracy to defraud and four counts of fraud by false representation. The fraudster submitted fraudulent invoices by faking a signature from the CEO of a foreign exchange company.

The City of London Police were contacted by the organisation that the fraudster had targeted following their discovery that 29 fake invoices had been received and processed through their accounts department. All of the fake invoices had been received as attachments within e-mails that were purportedly sent from the PA of the CEO, and were found in the shared email inbox within the organisation's accounts department.

The invoices were identified as fake as none of the companies requesting funds were legitimate. In addition, each of the invoices had what appeared to be the CEO's signature authorising payment. All of the fake invoices were processed by a member of staff and evidence was found that linked the fraudster to the scam. The member of staff had previously pleaded guilty to conspiracy to commit fraud and had already been sentenced to two and a half years imprisonment in August 2021.

Insider Invoice Fraud

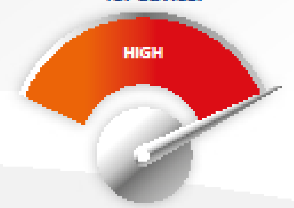
The member of staff, the insider, was instrumental in this fraud being carried out. Insider invoice fraud refers to cases of fraud in which an insider's access to the organisation's systems and processes are essential in committing the fraud. Examples of insider invoice frauds, which are likely to increase during this period of increased financial pressures and the rising cost of living include:

- False payment requests typically during busy periods
- Overbilling a debtor and pocketing the difference
- Recording false credits or refunds
- Creating fictitious suppliers or shell companies for fraudulent payments
- Forging signatures on payment authorisations
- Submitting false invoices from fictitious or actual suppliers for payments

STATUS

Action Required

This alert provides information and advice to organisations about fraud and economic crime, and the risks associated with it. If you think that your organisation has been a victim of invoice fraud, contact a TIAA Anti-Crime Specialist immediately for advice.



For advice on invoice fraud prevention and detection, including a review of processes and payment systems, contact:

- **Melanie Alflatt, Director - Risk and Advisory Email: fraud@tiaa.co.uk**

Disclaimer: This document is provided for guidance and awareness purposes only. This summarising article is not a full record of the key matters and is not intended as a definitive and legally binding statement of the position. While every effort is made to ensure the accuracy of information contained, it is provided in good faith on the basis that TIAA Limited accept no responsibility for the veracity or accuracy of the information provided. Should you or your organisation hold information, which corroborates, enhances, contradicts or casts doubt upon any content published in this document, please contact the Fraud Intelligence Team.

Handling & Distribution: This document must not be circulated outside of your organisation, on public facing websites or shared with third parties without written consent. Onward disclosure without prior authority may be unlawful under the Data Protection Act 2018.

www.tiaa.co.uk | 0845 300 3333

June
2023

tiaa ANTI-CRIME ALERT

Payment Systems Regulator confirms new requirements for Authorised Push Payment fraud reimbursement

The Payment Systems Regulator (PSR) confirms new requirements for banks and payment companies that will ensure more people will get their money back if they are a victim of Authorised Push Payment (APP) fraud; prompting more action to prevent these frauds from happening in the first place.

APP scams happen when someone is tricked into sending money to a fraudster posing as a genuine payee and has quickly become one of the most significant types of fraud, both in the UK and globally. APP scams generally fall into one of the following two categories:

- malicious payee', for example, tricking someone into purchasing goods which don't exist or are never received.
- 'malicious redirection', for example a fraudster impersonating bank staff to get someone to transfer funds out of their bank account and into that of a fraudster.

Every year thousands of individuals and businesses fall victim to APP scams, which can have a devastating impact on people's lives.

The PSR wants people to be protected when making payments. Following consultation, it has recently set out how mandatory reimbursement will work in practice, clarifying what this means for customers and firms. The aim of the new requirements is to improve fraud prevention and focus all firms on protecting people.

- There will be new rules in Faster Payments – the payment system across which the vast majority of APP fraud currently takes place.
- All payment firms will be incentivised to take action, with both sending and receiving firms splitting the costs of reimbursement 50:50.
- Customers will be more protected under consistent minimum standards, with most APP fraud victims being reimbursed within five business days and additional protections offered for vulnerable customers.
- Industry will have clearer guidance to follow, including around the ability to apply a claim excess and maximum level of reimbursement, which the PSR will consult on later this year.

The Financial Services and Markets Bill, which is currently making its way through Parliament, will remove current barriers and allow the PSR to direct firms to reimburse customers. The Bill is expected to receive Royal Assent in 2023, after which the PSR will be able to enforce its requirements on payment firms.

Full details at: https://www.psr.org.uk/news-and-updates/latest-news/news/psr-confirms-new-requirements-for-app-fraud-reimbursement/

Action Required

This alert provides information and advice to staff about fraud and economic crime, and the risks associated with it. If you think that your organisation has been a victim of APP fraud, contact your Anti-Crime Specialist immediately for advice.

For further discussion and support, including fraud awareness training services, contact:

→ **Melanie Alflatt, Director - Risk and Advisory Email: fraud@tiaa.co.uk**

Disclaimer: This document is provided for guidance and awareness purposes only. This summarising article is not a full record of the key matters and is not intended as a definitive and legally binding statement of the position. While every effort is made to ensure the accuracy of information contained, it is provided in good faith on the basis that TIAA Limited accept no responsibility for the veracity or accuracy of the information provided. Should you or your organisation hold information, which corroborates, enhances, contradicts or casts doubt upon any content published in this document, please contact the Fraud Intelligence Team.

Handling & Distribution: This document must not be circulated outside of your organisation, on public facing websites or shared with third parties without written consent. Onward disclosure without prior authority may be unlawful under the Data Protection Act 2018.

www.tiaa.co.uk | 0845 300 3333

Internal Audit

FINAL

Humberside Fire & Rescue

Assurance Review of Bullying, Harassment and Discrimination

2023/24

September 2023

Executive Summary

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

REASONABLE ASSURANCE

SUBSTANTIAL ASSURANCE
REASONABLE ASSURANCE
LIMITED ASSURANCE
NO ASSURANCE

KEY STRATEGIC FINDINGS

Staff inductions and regular briefings from the Chief Fire Officer cover the Service's position on bullying, harassment and discrimination. There is also a designated contact/ Freedom to Speak Up Guardian, however they are yet to be trained as a Freedom to Speak Up Guardian.

Complaints relating to bullying, harassment and discrimination are recorded centrally for monitoring purposes and are maintained by the Human Resources Team. Two open complaints/ cases were seen to not have been dealt with in a timely manner.

All employees are required to complete mandatory training on bullying, harassment, and discrimination. Testing showed 95.3% of employees have completed this to date.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Public confidence in Working Culture: As a result of the identification of unacceptable cultural behaviours within the emergency services sector, reported through independent inquiries, whistleblowing and media platforms, public perception is affected which may result in reputational damage to the organisation.

GOOD PRACTICE IDENTIFIED

Regular communication on the Zero Tolerance campaign are reinforced through the staff magazine/ bulletin, which is published every fortnight. In the most recent editions, the different support routes available to staff members who may be facing bullying, harassment and victimisation are listed.

SCOPE

The review considered the action taken to minimise instances of bullying, harassment and discrimination, the reporting and investigation processes. The review also considered promotion of the No Tolerance campaign.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**3**	**1**	**0**

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The case tracker / spreadsheet was thoroughly reviewed as part of the audit. This contained data only from September 2022 as, due to a cyber-attack in mid-2022, previous cases were lost. There are two current cases ongoing. For one of the cases, this is at a stage 2 hearing, but no details have been provided on the tracker as to whether a stage 2 hearing took place. Discussions with the Head of HR however confirmed this has taken place with the stage 2 outcome being awaited, however the tracker is yet to be updated. In the second case, this is due a stage 3 appeal hearing. It is however not clear whether this has taken place as it has not been updated on the tracker. The Head of HR also confirmed this is yet to take place. In both cases, the total number of days investigating and progressing between stages have totalled 230 days. Timescales were not strictly adhered to in both cases. It was confirmed, these are two sensitive and complex cases.	It be ensured that reported complaints are dealt with in a more timely manner to minimise potential stress to all those involved.	2	*A new approach has been recently implemented whereby upon receipt of a matter, the dates for the whole process will be provisionally scheduled into the appropriate calendars and the individual advised accordingly. In this way, the Service will be compliant with the timescales set out in its policy and the individual can make any necessary arrangements in advance. Furthermore, it will ensure that the appropriate hearing officers are also available, taking into account rota days, etc.* *Whilst every effort will continue to be made to identify a convenient date for the individual on which to hear their matter, in order to ensure the timescales are adhered to, it may not now be possible to schedule meetings on the days on which the individual is on duty/at work. There will therefore be a level of flexibility required by the*	*01/09/23*	*Head of HR*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
					individual themselves in terms of their availability. *Should the matter be resolved during the early stages, the dates can then be removed from the various calendars.* *It should be noted, however, that in the event that matters should be as complex and as sensitive as those reviewed by the auditor, involving the interviewing of a number of individuals, there may still be a need to extend the timescales, but this will continue to be done with the prior knowledge and agreement of the individual concerned.* *The Unions have been apprised of this approach and are supportive of the same.*		

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.		IMPORTANT	Control issue on which action should be taken at the earliest opportunity.		ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Delivery	There are no formal reports to the Senior Leadership Team on bullying, harassment, and discrimination. Discussions with the Head of Human Resources (HR) confirmed updates on cases, trends and overall information and data relating to this subject matter is verbally shared and discussed with the Executive Director of People and Development at the People and Development Directorate Board meeting and through regular catchups. As these are verbally discussed they are not formally documented or minuted. The Head of HR confirmed work is underway to ensure that formal reporting is made to the Senior Leadership Team.	The Senior Leadership Team be provided with regular updates on bullying, harassment and discrimination cases including actions taken and outcomes incorporating external complaints to the service, including any trends.	2	*Formal reporting to SLT will now take place on a quarterly basis, with trends, patterns, outcomes and actions taken forming part of the report. Monthly summaries of all ER matters will also be provided to SLT.* *The meetings have been scheduled into the diary, with the first being scheduled for Wednesday 6 September.*	*01/09/23*	*Head of HR*
4	Delivery	It was confirmed that the newly appointed Freedom to Speak Up Guardian has not attended relevant training since assuming the role. Discussions with the Freedom to Speak Up Guardian confirmed accessing training for this role has proved challenging. They have however joined the Fire Service Speak Up working group/ network led by Devon and Somerset Fire and Rescue Service in order to access training for Guardians.	Training for the Freedom to Speak Up Guardian be undertaken and completed as soon as it is practicable to ensure consistency is delivered and to ensure the Freedom to Speak Up Guardian understands speaking up and its importance in creating an environment in which people are supported to deliver their best.	2	*Freedom to speak up training was completed in August.*	*31/08/23*	*HOF Occupational Health*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	Exit surveys are completed for staff members when they leave the Service via an online link to complete following their resignation. They are also offered a face-to-face meeting with their Line Manager. Discussions with the Head of HR confirmed leavers are further offered the opportunity to speak with a different Line Manager, a member of HR or a member of the Senior Leadership Team. Data obtained from the meetings are then fed into a spreadsheet, which is used to show and monitor trends. This data is said to be reviewed by the HR Team and discussed informally with the Executive Director of People and Development. This is usually led by the Head of HR. A review of the exit form showed the different reasons for leaving included workplace issues and conflict with others and managers. Whilst there is no specific list for bullying, harassment, and victimisation, it was confirmed that where a leaver selects their reason as workplace issues or conflicts with others/ managers, this is picked up by the HR Team for further investigation.	The Exit Feedback Form be strengthened to include bullying, harassment, and discrimination as specific examples of workplace issues that are the reason for leaving.	3	*This has been actioned and the revised form is now live.* *Bullying, harassment and discrimination are now three separate categories, with discrimination have the following, additional subcategories:* - *Age* - *Disability* - *Gender reassignment* - *Marriage and civil partnership* - *Pregnancy and maternity* - *Race* - *Religion or belief* - *Sex* - *Sexual orientation*	*03/08/23*	*Head of HR*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.	2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.	3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially In place	1, & 2	-

Other Findings

The Professional Standards Dignity at Work Policy (anti Bullying and Harassment Procedure) in place was last reviewed in October 2022. The Policy is designed to provide support to members of staff who have been the subject of bullying and harassment to take action, access support and to ensure that all staff within the service understand their roles and responsibility in relation to this subject area. The policy further acts as a piece of guidance to managers involved in cases of bullying and harassment by defining their roles and responsibilities, setting out process to be followed and outlining support available to staff. Key areas covered within the policy include: Definitions of harassment, victimisation, discrimination and bullying; The procedure for managing bullying and harassment complaints (stage 1: informal procedure and stage 2: formal procedure); training, follow up and on-going resolution; and monitoring and evaluation.

Associated policies/ documents used jointly with the Professional Standards Dignity at Work Policy include the Professional Standards Grievance Procedure Policy, Professional Standards Whistleblowing Policy, Professional Standards Disciplinary Procedures Policy, Corporate Communication, Social Media and Events Policy, Professional Standards Mediation Policy, Corporate Equality and Inclusion Policy, Professional Standards Exits From the Service Policy, and the Equality Impact Analysis.

All policies were seen during the audit and it was confirmed that they were in date.

Other Findings

Overall responsibility for the management of bullying, harassment, and discrimination within HFRS sits with the Executive Director of People and Development. This role is supported by other members of staff such as the Head of Human Resources, Head of Occupational Health and Wellbeing, Workplace Wellbeing Manager and Corporate Communications Supervisor and different teams such as the Occupational Health Team, Training, Corporate Assurance Team and Organisational Development Team. The Professional Standards Dignity at Work Policy (anti Bullying and Harrassment Procedure) further sets out the roles and responsibilities of all employees including Line Managers and Trade Unions.

The following risk is a strategic risk on the Corporate Risk Register; "Public Confidence in Working Culture - As a result of the identification of unacceptable cultural behaviours within the emergency services sector, reported through independent inquiries, whistleblowing and media platforms, public perception is affected which may result in reputational damage to the organisation".

Mitigating controls include development of service policies such as Dignity at Work (anti bullying and harassment); Disciplinary Procedures Policy, Implementation of the Core Code of Ethics (including policy statements, eLearning & PDR integration); Commissioning of independent cultural review and the Zero Tolerance campaign. This risk is reviewed quarterly and was last reviewed in June 2023.

Complaints/ cases of bullying, harassment and discrimination are logged on a spreadsheet/ case tracker and on individual employee personnel files. The spreadsheet/ case tracker is used to record details of the specific cases, actions taken, to monitor trends and is also used to view case summary including outcomes. Testing identified this is only accessible to the HR Team including the Director of People and Development. Permissions are sought for any other member of staff wanting to view this spreadsheet outside of those who already have permissions

It was confirmed that Service Partners attend monthly district performance meetings with Station Managers, chaired by Group Manager (GMs), where topics relating to bullying, harassment and discrimination are discussed with workplace standards reiterated and reinforced and trends discussed. This forms part of the standard agenda discussed. The Freedom to Speak Up Guardian has also attended some of these district meetings to discuss their role. These monthly meetings are supported by the monthly district GM meetings that is attended by the Head of HR where similar items are discussed. It was also confirmed that there are regular HR engagement meetings where the Head of HR meets with On Call Watchers and Full time Watchers at their drill nights where discussions are held to ensure the working environment is free from bullying, harassment and victimisation and to ensuring that all employees are treated fairly and with respect.

As part of induction programme for newly appointed/ recruited members of staff, bullying, harassment and discrimination is discussed. This ensures that new staff are aware of the Core Code of Ethics for the Authority ensuring that this is applied appropriately. New employees are also directed to relevant key policies such as the Professional Standards Dignity at Work Policy (anti Bullying and Harrassment Procedure) and the Professional Standards Grievance Procedure Policy, so they understand their responsibilities under the policies. Details are also covered within the employee handbook which is provided at induction for new starters. It is understood that existing staff also have access to the employee handbook/ staff booklet as this is available on the Authority's intranet within the Organization Development section.

All staff, including Line Managers, have access to the E-learning portal which allows them to complete mandatory e-learning modules. This includes bulling, harassment, and discrimination, which is to be completed every three years and monitored by Service Partners/ OD Team for compliance. A review of the training data for all staff in the Service confirmed, 991 staff out of 1040 staff have completed their training on bullying and harassment. Compliance rate is therefore 95.3%. Discussions with the Head of Organisational Development confirmed 100% compliance rate may not be achievable due to reasons such as absences, sickness, maternity leave, however the Service expects a 100% compliance rate. It was further confirmed that when members of staff return to work, as part of their return to work, they are signposted to complete any outstanding training that is due.

Other Findings

Discussions with the Head of HR confirmed that where a complaint or allegation relating to bullying, harassment and discrimination is received, this is discussed with the relevant Line Manager in the first instance. The recently appointed Freedom Speak up Guardian is a designated contact that employees can also speak to and share concerns with. A dedicated page on Freedom to speak up is on the Authority's Sharepoint page detailing all options available, with a form available for members of staff to report concerns. When complaints or allegations of bullying and harassment are raised and, depending on the type, it is noted that this could be resolved informally through timely dialogue with a Line Manager, a representative from HR or a member of a trade union or formally where the matter is considered too serious. In these cases, a formal written complaint is to be made by the member of staff to their Line Manager who will then contact HR/ Director of People and Development in order that an investigation is launched. Where a formal stage is triggered, an Investigating Officer/ Investigating Manager is appointed. The Authority encourages the investigation and resolving of cases of bullying and harassment in a timely manner to minimise potential stress to all those involved, and timescales have been set. It was however confirmed the timescales are only a guide and may need extension for appropriate reasons such as gathering and reviewing evidence and arranging meeting dates. The Professional Standards Dignity at Work Policy provides several options for resolving issues and complaints of bullying and harassment and the appeals process should a member of staff be dissatisfied with the outcome from the investigation. This process is known as stage 3.

HFRS have nine internal mediators that are used to resolve issues relating to bullying, harassment and discrimination at any stage. This process is designed to help the staff members involved to discuss their experiences, identify the impact, consider change and discuss ways in resolving the situation. The Head of HR confirmed external mediators are sometimes used to obtain more successful outcomes in sensitive/ complex cases. Testing identified all nine mediators have been fully trained and have been issued with a certificate of attendance, however not all have been accredited at the time of the audit. In relation to accreditation, this is provided externally where participants/ the Service's internal mediators would need to provide a written case study of a live meditation that they have undertaken with a witness statement from either the mediation sponsor or disputants involved within 12 months of completing the training programme. It was noted three of the mediators are within their 12 months period for them to undertake a live mediation session and gain ILM certification. Whilst it was noted that some of the mediators completed their training programme in 2011, the Head of Organisational Development confirmed that mediators meet regularly through the regional mediator forums as part of continuous professional development.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially In place	3, & 4	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

The Governance, Audit and Scrutiny (GAS) Committee on the 3rd of July 2023 received a report written by the Head of Human Resources, that detailed grievances that were raised by members of staff during the period 1st April 2022 to 31st March 2023. The report provided an overview of how the Grievance Policy and Procedure was followed, identifying trends, learnings, or recommendations. It also detailed the training and resources available for key staff involved in the process. During the reporting period, it was noted there were 15 grievances raised. Three of these related to bullying and discrimination. For all 15 grievance cases, five were resolved at informal stage 1, three resolved at formal stage 2 with six proceeding to stage 3 which is the appeals stage. One further grievance is still to be heard at stage 2 and may proceed to stage 3 should the individual be unsatisfied with the outcome. The report also provided details of the outcome of the grievances with the majority being not upheld. In relation to training, it was confirmed in the report that 736 employees have completed their grievance training/module as at the time of the report.

In 2019 Humberside Fire Authority launched the Zero Tolerance for Bullying Campaign - Support, Challenge and Report. This campaign initiated and launched by the previous Chief Fire Officer was to encourage bullying to be reported with the emphasis that this would be dealt with seriously. Details of the campaign were included in the staff magazine SIREN in the August 2019 edition. This also provided a link for all staff to complete training relating to bullying and harassment. This was further reiterated in 2023 by the current Chief affirming the commitment to zero tolerance. This campaign is promoted to all members of staff through awareness posters in every service building. These posters detail confidential contact numbers and this is also on HFA's dedicated HR page on Sharepoint. It was confirmed that in March 2023, a team meeting/ training session was held, chaired by the Assistant Chief Fire Officer and the Executive Director for People and Development and Senior Corporate Assurance Officer, with all members of staff being asked to dial in. This was to further reaffirm and reinforce the Service's position on Zero Tolerance to Bullying and to discuss the Service’s stand on having a positive workplace culture.

It was identified, actions / recommendations were raised by the GAS Committee during the review of the Grievance scrutiny report, some of which included the review of the Equality Impact Assessment. Testing identified that actions from the meeting have not been logged on a separate spreadsheet, however the Head of HR confirmed that these actions are due to be logged with an update provided to GAS in September or November 2023.

Other Findings

As part of the options available to manage bullying, harassment and discrimination, members of staff have access to Occupational Health and Wellbeing who can refer them to partner organisations who offer counselling service 24 hours a day, every week.

An external provider has been commissioned to undertake an employee survey to help the Authority understand the attitude, behaviours, and beliefs of the workforce with the aim to continually drive the positive workplace culture. This is understood to launch in September 2023.

A Freedom to Speak Up Policy is being drafted by the Freedom to Speak Up Guardian with consultations and input from relevant teams including the HR Team. This policy is to promote the role of the Guardian in dealing with cases of bullying, harassment, and victimisation, ensuring that staff are able to report these issues / concerns without fear of reprisal and highlighting the support and options available.

Regular communications on the Zero Tolerance campaign are reinforced through the staff magazine/ bulletin which is published every fortnight. In the most recent editions, the different support routes available to staff members who may be facing bullying, harassment and victimisation are listed. They include through access to the dedicated SharePoint portal page that has all internal and external support routes available for staff to speak up, raise concerns and get support in confidence.

Ten members of staff, from different teams, were interviewed in order to establish their knowledge of the various bullying, harassment, and discrimination policies and other documentation and how HFRS manages cases. Questions asked included: had they experienced bullying, harassment, and discrimination since they joined the service; are they confident that they could speak up if they were to experience bullying, harassment, or discrimination; are they confident that the Service would treat the matter seriously; and do they know who the designated contact for reporting cases/ Freedom to Speak Up Guardian is?

Comments obtained confirmed that all employees knew the designated contact for reporting cases/ Freedom to Speak up Guardian and knew where to find the policies that relate to this subject area. All had completed relevant training and have knowledge on how to report cases that fall under this subject area.

Some comments, however, suggested that that the process may not have been fully embedded as hoped and should be considered as part of the external reviews to be undertaken to seek to build on some concerns highlighted during the audit. These concerns and comments were communicated to the Head of Corporate Assurance during the audit.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	12th July 2023	19th July 2023
Draft Report:	25th August 2023	4th September 2023
Final Report:	6th September 2023	

AUDIT PLANNING MEMORANDUM — Appendix B

Client:	Humberside Fire & Rescue		
Review:	Bullying, Harassment and Discrimination		
Type of Review:	Assurance	**Audit Lead:**	Ade Kosoko

Outline scope (per Annual Plan):	The review will consider the action taken to minimise instances of bullying, harassment and discrimination, the reporting and investigation processes. The review will also consider promotion of the No Tolerance campaign.
Detailed scope will consider:	The review will set out to provide assurance to the Governance, Audit and Scrutiny Committee that the organisation has robust controls in relation to the preventing and managing cases of bullying and harassment and discrimination. • The policy and procedures are up-to-date, clearly define responsibilities and are available to staff. • Practices are in place to prevent Bullying, Harassment and Discrimination. • Staff inductions and ongoing briefing cover these areas. • A designated trained contact is in place to receive and manage cases. • Reported complaints are dealt with in a timely manner. • Complaints are recorded centrally for monitoring purposes. • Exit meetings and staff surveys are utilised to gauge workplace culture and to track trends. • The No Tolerance campaign has been promoted to staff.

Planned Start Date:	21/07/2023	**Exit Meeting Date:**	28/07/2023	**Exit Meeting to be held with:**	Anne Stott (Head of Human Resources); Kevil Hill (Freedom Speak Up Guardian); Simon Rhodes, Jamie Morris (Designate Head of Corporate Assurance); Simon Rhodes (Head of Corporate Assurance) and Sam O'Connor (Head of Organisational Development)

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

Humberside Fire and Rescue Service

Assurance Review of Mobile Data Terminals (MDT) Performance

2023/24

September 2023

Executive Summary

OVERALL ASSESSMENT

KEY STRATEGIC FINDINGS

Humberside Fire and Rescue Service have Mobile Data Terminals (MDTs) mounted on all of its fire engines.

There is no formal training provided for relevant staff on the utilisation of Mobile Data Terminals.

Where end users experience faults and errors with the use of the Mobile Data Terminals, testing found these are not always reported. There is however a process for reporting these errors/faults/ defects.

Information provided through Mobile Data Terminals is sometimes inaccessible due to issues such as connectivity causing inaccuracy in the data being shared.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

MDT Failure - As a result of the upgrade to MDT2 there has become an increase in connectivity issues to our mobilising system which may result in a lack of risk information to responding crews. This is linked to the demountable nature of the device and its compatibility to operate with Airwave.

GOOD PRACTICE IDENTIFIED

National Operation Guidance (NOGs) and Standard Operating Procedures (SOPs) are available within the MDTs for operational crews to use when needed.

SCOPE

The review considered the effectiveness of the Mobile Data Terminals in use on fire engines including the accuracy, and accessibility of information provided through MDTs, training provided to staff and the utilisation of the reporting processes for defects.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**6**	**2**	**0**

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	There are 73 MDTs available to use within the service, including spare terminals. Discussions with the Senior IT Technician confirmed the new versions of MDTs currently in use were introduced in January 2022. It was noted, some fire engines/fire vehicles such as the ALPs, RSU and TRV have the old-style MDTs and these are to be replaced with the new version in September 2023. There are 49 MDTs currently live in stations with 48 of these having sim cards installed. One MDT "DH30PI-DH30A Howden Joinery" did not appear to have a sim card installed. Discussions with Management confirmed, the fire engine/ fire vehicle where this MDT is connected to, is not owned by the Service. The installation of Sim cards was undertaken in a bid to resolve connectivity issues. Whilst the installation of the Sim cards has significantly improved connectivity issues being faced by crew members, this still continues to be a concern facing some crew members in all of the stations visited.	It be ensured Management undertake a detailed review of the connectivity issues regularly faced by operational crews in a bid to provide appropriate lasting solutions.	2	*Digital Solutions will look to implement a form within our Service Desk tool to allow colleagues to report faults in regards to connectivity more effectively. This will then allow us to report on these and understand the implications across the service.* *Specials installs are due to start 2nd October.* *Howden Joinery Appliance isn't on a HFRS site and there are special arrangements*	*31/10/23*	*Head of Digital Services*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.	2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.	3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	In relation to training, it was found a formal training exercise providing practical guidance on how to use MDTs has not been provided for all responding fire crews. Discussions with fire crews from two of the three stations visited confirmed the use of MDTs has been self-taught with knowledge passed on to others. MDT training is however a module required for all fire crews to complete through the E-learning package. A review of the training data for all responding crews for whom a frequency-based training activity was assigned in relation to the MDT module showed that 99.14% had completed their training within the specified frequency.	A formal training programme providing practical guidance on how to use Mobile Data Terminals be developed for all operational staff / responding crews to ensure consistency on how the system is operated.	2	*Digital Solutions will work with Training to understand how we can implement a practical training session for all operational staff.* *Digital Solutions will also create a training video to show how to use an MDT and distribute accordingly.*	*31/12/23*	*Head of Digital Services*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.	2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.	3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	A review of the use of MDTs within three fire stations highlighted "MDT Failure" as a common issue experienced whilst using this device/ equipment. In some cases, MDT Failure could mean built in applications, such as the mapping app, not functioning properly causing delays in response time and causing crew members to use alternative methods such as using their mobile phones/ cat phones to navigate through routes in order that they can get to the location in time. Other reasons for MDT Failure include responding crew/ relevant staff not being able to access certain critical documents needed whilst attending to an incident, for example risk documents/ information, National Operational Guidance (NOGs) due to connectivity issues and not being unable to send status messages, or effectively communicate with the relevant buttons to provide accuracy. Crew members in two stations confirmed, not all faults are reported due to a lack of confidence that the issues/defects/errors will be resolved in a timely manner hence the use of alternative methods to by-pass the MDTs.	Fire crew members/ responding crew be encouraged and reminded to report and log all defects/ issues/faults/ errors experienced when using the Mobile Data Terminals.	2	*By carrying out Rec 2, this will enable this to be more effective. Digital Solutions will include areas to be able to log defects/issues and errors on this form.* *Communication to be delivered to all crews to encourage reporting.*	*31/10/23*	*Head of Digital Services* *District Managers*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	Testing found operational risk documents relating to two separate incidents in two stations were not being uploaded to MDTs. These were understood to be critical to the incident that the responding crews were attending to, and the risk information had not been uploaded.	Important risk information/ supporting document be uploaded onto the Mobile Data Terminals by the relevant staff in accordance with the Operational Risk Management SSRI Policy. This be regularly monitored by Management to ensure this is strictly adhered to	2	*Risk Information is updated every day at 2am, crews will be encouraged to report these incidents when they happen to insure Digital Services can investigate.*	*30/09023*	*District Managers*
6	Directed	MDTs are understood to be effective in locating hydrants and hazards. This was confirmed by crew members in all three stations visited. It was however confirmed by two of the three stations that the crash recovery and chem data functionality is not as effective and cat phones or relevant manuals are sometimes used to retrieve/locate chemical information.	All applications/ functionalities built into the Mobile Data Terminals be regularly tested to fix any issues that may slow down the performance and to also ensure they are working effectively	2	*Hydrants has since been updated to show the latest updates. This is being developed to become an automated process.* *Discussed with District Mnaagers on placing MDT's onto Standard Tests to ensure these are rebooted and tested weekly.*	*31/12/23* *31/10/23*	*Head of Digital Services* *District Managers*
7	Delivery	It was confirmed during the audit that the Senior Leadership Team do not receive any formal monitoring reports on the performance of MDTs.	The Senior Leadership Team be regularly updated by way of a formal report on the overall performance of MDTs. This should include providing information on defects logged, issues experienced by end users, upgrades completed, and any changes made to enhance the MDTs performance in line with an adopted frequency.	2	*Digital Solutions can export this information and provide overall performance once the data starts being populated as per the above when logging MDT faults on forms.*	*1/04/24*	*Head of Digital Services*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.	2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.	3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	"MDT Failure" is an identified risk on the Service's Strategic Risk Register. HFRS have identified this because the upgrade to MDT2 has increased the connectivity issues, which may result in risk information not being passed to responding crews. Mitigating controls include ICT Staff working at stations to lock down MDTs and operational debriefs. This risk was seen to be last reviewed in April 2023. Testing identified, whilst ICT Staff working at stations to lock down MDTs has been highlighted as a mitigating control, there is no indication that this regularly happens.	The Strategic Risk Register be updated to reflect appropriate mitigating controls in relation to the risk of MDT failing.	3	*Head of Digital Services with discuss with Corporate Assurance on updating the risk register to reflect the correct terminology.*	*31/10/23*	*Head of Digital Services*
8	Delivery	To improve the performance of the MDTs owned by the service, updates / fixes were seen to be done. The latest being completed in July 2022. This was to turn on Windows location services on all MDTs to help with determining where the device is at any moment in time. Whilst these updates are being completed, testing identified, they are not communicated with the fire crew members and as a result they are not aware of the changes that are being made.	Changes made to enhance the performance of the MDTs be regularly communicated with fire crew members/ responding crews so that they are aware.	3	*To confirm - Windows location services was turned on after the rollout of SIM Cards in April 2023.* *Digital Services will review how we can communicate accordingly to ensure all crews are notifie when organisational changes/updates are made on MDT's.*	*30/09/23*	*Head of Digital Services*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	1	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	2, 3, 4, 5, & 6	-

Other Findings

Humberside Fire and Rescue Service have Mobile Data Terminals (MDTs) mounted on all its fire engines. The MDT works as a tracking system/device/ equipment that receives messages, tracks incidents and specific locations whilst also providing/ holding information pertaining to the incidents, allowing data and information to be shared with authorised relevant parties such as the ICT Team analysis and reporting. This is used by all responding fire crews once an incident is logged/ received. The MDT is also used for mapping, status messaging, providing information on crash recovery, chemdata and is also used to access information such as site-specific risk information, and used to locate hazards and hydrants and to enter relevant data where applicable.

The Group Manager Emergency Response City of Hull has overall responsibility for the MDT arrangements within the service. This role is supported by individual Station Managers and members of the Information and Communication Technology Team (ICT) Team such as the ICT Data Manager and Senior IT Technician.

Discussions with responding crew members from three of HFRS fire stations confirmed, responding crews regularly meet to discuss issues / defects relating to MDTs and going through scenario testing to help with continuity.

Other Findings

Discussions with members of the ICT Team confirmed defects/ faults/issues with the MDT are identified following reporting by responding crew/ staff using the equipment. For cases that are reported, these are understood to be logged through the filling of a form which is sent through to the ICT service desk and assigned to the relevant ICT staff to attempt to resolve. Testing identified that 159 errors were raised between July 2022 until July 2023. The first quarter of the 2023/24 financial year shows a total of 18 defects/ errors/faults raised. These 18 defects/ errors have all been resolved

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	7, & 8	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

- Comments made by staff within the three station visited during the audit included “due to the multiple errors experienced by responding crews from the use of the MDTs, it is not very reliable or, accurate and information is not easily accessible in some cases”. All crew members however confirmed it is a very good system if all the functionality/ application works.
- Testing identified all operational risks are viewed on MDTs by operational crews and paper copies are not kept.
- National Operation Guidance (NOGs) and Standard Operating Procedures (SOPs) are available within the MDTs for fire crews to use when needed.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	12th July 2023	19th July 2023
Draft Report:	16th August 2023	18th September 2023
Final Report:	22nd September 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire & Rescue		
Review:	Mobile Data Terminals (MDT) performance		
Type of Review:	Assurance	Audit Lead:	Ade Kosoko

Outline scope (per Annual Plan):	The review will consider the effectiveness of the Mobile Data Terminals in use on fire engines including the accuracy, and accessibility of information provided through MDTs, training provided to staff and the utilisation of the reporting processes for defects.
Detailed scope will consider:	The review will set out to provide assurance to the Governance, Audit and Scrutiny Committee that the organisation has robust controls in relation to the use of Mobile Data Terminals. • The policy and procedures are up-to-date, clearly define responsibilities and are available to staff. • Appropriate training has been provided to end-users. • Information provided through MDTs is reliable, accurate and accessible. • Defect reporting processes are effective.

Planned Start Date:	31/07/2023	Exit Meeting Date:	03/08/2023	Exit Meeting to be held with:	Pete Allman (Group Manager Emergency Response City of Hull); Richard Jacques (ICT Data Manager); Martin Rodgers (Station Manager-Peakslane); Tom Sage (Senior IT Technician) and Jon Cawthra (Station Manager-Beverley)

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	Y (How operational risks are fed into the MDTs)

Internal Audit

FINAL

Humberside Fire and Rescue

Mid-Year Follow Up Review

2023/24

November 2023

Executive Summary

Introduction

1. This follow up review by TIAA established the management action that has been taken in respect of the recommendations arising from the internal audit reviews listed below at Humberside Fire and Rescue. The review was carried out in August 2023.

Review	Year
Year-End Follow Up	**2022/23**
Quality Assurance – Prevention and Protection	**2022/23**
Collaboration Activity	**2022/23**
Equality Impact Assessments	**2022/23**
Firewatch	**2022/23**
ICT GDPR	**2022/23**
Secondary Contracts	**2022/23**
Key Financial Controls	**2022/23**

Key Findings & Action Points

2. The follow up review considered whether the management action taken addresses the control issues that gave rise to the recommendations. The implementation of these recommendations can only provide reasonable and not absolute assurance against misstatement or loss. From the work carried out the following evaluations of the progress of the management actions taken to date have been identified.

Evaluation	Number of Recommendations
Implemented	21
Outstanding	15
Superseded	1
Not Implemented	-

3. The key issue identified is that there are 15 recommendations outstanding of which there are five that are due by the end of August/September 2023.

Scope and Limitations of the Review

4. The review considered the progress made in implementing the recommendations made in the previous internal audit reports and established the extent to which management has taken the necessary actions to address the control issues that gave rise to the internal audit recommendations.

5. The responsibility for a sound system of internal controls rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses that may exist. Neither should internal audit work be relied upon to identify all circumstances of fraud or irregularity, should there be any, although the audit procedures have been designed so that any material irregularity has a reasonable probability of discovery. Even sound systems of internal control may not be proof against collusive fraud.

6. For the purposes of this review reliance was placed on management to provide internal audit with full access to staff and to accounting records and transactions and to ensure the authenticity of these documents.

Disclaimer

7. The matters raised in this report are only those that came to the attention of the auditor during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Release of Report

8. The table below sets out the history of this report.

Date draft report issued:	9th August 2023
Date management responses rec'd:	27th October 2023
Date final report issued:	1st November 2023

Executive Summary

Follow Up

9. Management representations were obtained on the action taken to address the recommendations and limited testing has been carried out to confirm these management representations. The following matters were identified in considering the recommendations that have not been fully implemented:

10. **Year-End Follow Up**

Audit title	Fleet Management	Audit year	2019/20	Priority	3
Recommendation	Performance goals and RAG rating tolerances be agreed and incorporated into the KPI reporting arrangements.				
Initial management response	ESFM Board to agree performance thresholds for RAG rating.				
Responsible Officer/s	Head of Fleet and Estates	Original implementation date	31/12/2019	Revised implementation date(s)	30/06/2021 31/12/2022 31/03/2023 30/09/2023
Latest Update	The project is still not been implemented. This is due to major IT problems surrounding the security of the new system from the Humberside Police side. Their ICT Team and Civica are continuing to work up a solution but the go-live date has now moved to be the earliest July 2023. Once this work is completed and the system goes live, the KPI's mentioned in the internal audit will be negotiated, agreed and implemented. August 2023 Revised date not yet due				
New implementation date		Status	Outstanding	Implementation is in progress, but the revised target date has not been reached.	

Audit title	National Operational Guidance Project (Phases 3 and 4)	Audit year	2021/22	Priority	2
Recommendation	The planned changes to base Operational Assurance activity around the requirements of NOG be fully implemented. The results of this work be monitored to ascertain whether NOG has become fully embedded into operational activity.				
Initial management response	Procedures and processes at operational incidents have not changed significantly as a result of the introduction of NOG but the method of receiving information and guidance on scene has. Use of NOG scenarios at incidents has been scheduled as a dedicated theme for November and the monitoring activities leading up to this has progressed well. NOG scenario use following the thematic audit will be monitored as part of Business as usual within the operational assurance process.				
Responsible Officer/s	GM Plunkett	Original implementation date	01/11/2021	Revised implementation date(s)	30/09/2023
Latest Update	This remains outstanding. Following the Cyber-attack and the follow-on delays of Operational Assurance reviewing their processes, a second thematic review was not possible. MDTs have been renewed through IT and Emergency Preparedness are reviewing the receiving of NOG information in a practical sense. Reality testing has been tasked and due for completion by 30th May. A task and finish project has been started to establish the validity of a software systems that may fill the gap between guidance and a practical aide memoir on scene for operational staff. Full implementation date should be completed by 30/09/23. August 2023 Revised date not yet due				
New implementation date	30/09/2023	Status	Outstanding	Implementation is in progress, but the revised target date has not been reached.	

<table>
<tr><td>Audit title</td><td>Data Quality – Risk Information</td><td>Audit year</td><td>2021/22</td><td>Priority</td><td>3</td></tr>
<tr><td>Recommendation</td><td colspan="5">Work be continued to identify, obtain and validate the external Risk data from external sources, for all categories of information that are assessed as still of value to be retained for crew safety.</td></tr>
<tr><td>Initial management response</td><td colspan="5">Work to validate and sanitise operational risk data sets is ongoing utilising Service Delivery frontline staff. This work has the aim of validating the existing risks we hold and recovering the data backlog from a recently discovered ICT (mail server) system failure.
The introduction of a new ICT system (Chameleon) will both streamline risk administration processes and maintain validations correctly. This opportunity is being utilised to align datasets with those recommended by National Operational Guidance. Beta version Roll out commencing December 2021.</td></tr>
<tr><td>Responsible Officer/s</td><td>GM Control/WM Operational Risk</td><td>Original implementation date</td><td>01/12/2021</td><td>Revised implementation date(s)</td><td>31/03/2023</td></tr>
<tr><td>Latest Update</td><td colspan="5">This is related to the upgrade of the CFRMIS system, which was delayed due to the cyber incident and subsequent organisational changes designed to add resilience to the process, including through Emergency Preparedness taking responsibility for the operational side of the subject. As part of this work, Emergency Preparedness are currently reviewing the policy, process and all the data that is recorded on MDTs for crews.
August 2023
Revised date not yet due</td></tr>
<tr><td>New implementation date</td><td>31/08/2023</td><td>Status</td><td>Outstanding</td><td colspan="2">Implementation is in progress, but the revised target date has not been reached.</td></tr>
</table>

Audit title	Data Quality – Risk Information	Audit year	2021/22	Priority	3
Recommendation	All NOG requirements relating to SSRIs be incorporated into the new Chameleon system when this goes live, so that the Service is fully compliant with the latest guidance.				
Initial management response	The opportunity of the new ICT system (Chameleon) will fulfil National Operational Guidance Standards requirements including new SSRI forms to enhance risk information systems on Bodies of Water, Flooding, Sites of Special Scientific Interest, Transport, Tunnels and Underground Structures, Utilities and Fuel and Wildfires.				
Responsible Officer/s	GM Control/Head of Prevention/WM Operational Risk	Original implementation date	01/04/2022	Revised implementation date(s)	31/03/2023
Latest Update	The required functionality should be obtained through the new Ops Intel version of CFRMIS. This is currently on hold pending a review by Emergency Preparedness into Operational Risk Information. August 2023 Revised date not yet due				
New implementation date	31/08/2023	Status	Outstanding	Implementation is in progress, but the revised target date has not been reached.	

Audit title	Data Quality – Risk Information	Audit year	2021/22	Priority	3
Recommendation	The remaining outdated Public Safety Risk data items (Z4s) be reviewed as soon as possible and either confirmed as valid or removed as no longer relevant.				
Initial management response	Public Safety Teams (Service Delivery) are working through the out-of-date risk lists. Other areas of recovery work are ongoing through Control (working through Customer Contact Records) to release capacity for the Public Safety Team to concentrate on reviewing Z4 Public Safety risk data (domestic and other risk).				
Responsible Officer/s	SM Control/WM Operational Risk/Head of Prevention	Original implementation date	01/04/2022	Revised implementation date(s)	31/03/2023
Latest Update	The process is being reviewed in order to reduce the volume of data being captured and validated. There is a delay in that the data has some incorrect fields on the dashboard and is not currently downloadable. Part of the solution will be incorporated into the new CFRMIS and its workflows and so the Service is waiting for this to be progressed. The Service will be making some of this a system led workflow rather than a manual process, particularly for some of the older data. August 2023 Revised date not yet due				
New implementation date	31/08/2023	Status	Outstanding	Implementation is in progress, but the revised target date has not been reached.	

Audit title	Key Financial Controls	Audit year	2021/22	Priority	3
Recommendation	It be ensured that the Human Resources system and the payroll reports are reconciled periodically and the payroll form be accurately completed by the Payroll Bureau.				
Initial management response	To be reviewed with an internal control applied by HR to address the difference in records, prior to the next internal financial controls audit in Q4 of 2022/2023.				
Responsible Officer/s	Head of HR	Original implementation date	31/03/2023	Revised implementation date(s)	-
Latest Update	This finding has been identified as outstanding during the latest audit of Key Financial Controls in March 2023. The report for that audit has yet to be finalised, at which point the new recommendation would supersede this item. August 2023 This has now been superseded by a recommendation included within the 2022/23 Financial Controls audit and raised to a Priority 2 level and subsequently implemented.				
New implementation date	N/A	Status	Superseded	The recommendation has been superseded.	

11. Quality Assurance – Prevention and Protection

Audit title	Quality Assurance – Prevention and Protection	Audit year	2022/23	Priority	2
Recommendation	The outstanding areas of the Prevention and Protection Quality Assurance Frameworks be brought into operation as soon as possible once staffing allows and any necessary tools have been fully developed.				
Initial management response	The process and procedure for Protection QA is in place and should be able to be initiated as soon as further resources are recruited. Roll out of Prevention QA for Safe and Well visits with Operational Crews will commence from the beginning of October. Continue to complete QA of Prevention Advisors now CFRMIS is accessible. QA of Fire setters to commence with Prevention Advisors, led by Sarah Baker from the Education and Development Centre. Will develop the QA framework for Partner training and Education delivery for 1st November 2022.				
Responsible Officer/s	Head of Protection	Original implementation date	01/12/22	Revised implementation date(s)	
Latest Update	QA framework to be developed for Partner training and Education.				
New implementation date	30/09/2023	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

12. Collaboration Activity

Audit title	**Collaboration Activity**	Audit year	2022/23	Priority	2
Recommendation	A partnership agreement be put in place for each collaboration, detailing the expectations of HFRS and of any outside bodies. The level of detail of such agreements may vary and should be proportionate to the scale, cost and strategic importance of each collaboration.				
Initial management response	Review and revision of the current agreements, align to the new risk management processes and policy.				
Responsible Officer/s	Hof Corporate Assurance	Original implementation date	30/06/23	Revised implementation date(s)	
Latest Update	Up to date, signed agreements for all collaborations are to be obtained.				
New implementation date	31/10/2023	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

Audit title	**Collaboration Activity**	Audit year	2022/23	Priority	2
Recommendation	Evaluations be completed for all collaboration activities across the Service, in particular where none has been completed over the past year. It may be advisable to wait until a policy and updated evaluation form have been developed before taking this action.				
Initial management response	Introduction of new revised and consistent approach to evaluation included into the service improvement framework.				
Responsible Officer/s	Hof Corporate Assurance	Original implementation date	30/06/23	Revised implementation date(s)	
Latest Update	Up to date evaluations for all collaborations are to be undertaken				
New implementation date	31/12/2023	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

13. Equality Impact Assessments

Audit title	Equality Impact Assessments	Audit year	2022/23	Priority	2
Recommendation	Information, guidance and good practice be disseminated to demonstrate the full range of circumstances when an EIA should be undertaken, to ensure that these are completed according to the approved policy guidance.				
Initial management response	Agree with findings. Further IAG will be provided				
Responsible Officer/s	Lou Marritt, L&D Manager	Original implementation date	31/12/22	Revised implementation date(s)	
Latest Update	Training for target groups remains to be completed.				
New implementation date	31/08/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

14. Firewatch

Audit title	Firewatch	Audit year	2022/23	Priority	2
Recommendation	The opportunity arising from data input staff moving into the HR function be utilised to pinpoint the root cause(s) of inaccurate data entry. These should then be addressed through appropriate measures, such as additional support and supervision, targeted training, provision of procedural documentation on fundamental tasks, increased use of system prompts or reminders, and/or performance management of staff.				
Initial management response	The Firewatch establishment data was cleansed in 2020 and the process involved all of the HR team, Service Support and SMs. A tracker was introduced to monitor the progress of people forms, whereby all people forms were entered onto the tracker. People forms were revised to provide more detail and a bespoke Establishment form was created. There is an historic backlog of People forms due, in part, to the introduction of FSR. Now that two Service Support members have moved into HR, the appropriate focus and priority will be given to this area of work. Further training for the admin staff within the HR team is being provided to ensure consistency with data entry and to ensure there is no single point of failure.				
Responsible Officer/s	Head of HR	Original implementation date	Monitoring of the data is ongoing and all training completed by the end of 2022	Revised implementation date(s)	
Latest Update	The original action is not possible due to leavers and a full-time member of staff relocating. Recruitment is ongoing for a replacement. New member of staff will undertake intensive data cleanse. User List to be reviewed and restricted. Further training will be delivered when system upgrades to Version 7.8. and the new member of staff is in post. Data cleanse to completed by the end February 2024.				
New implementation date	28/02/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

Audit title	**Firewatch**	Audit year	2022/23	Priority	2
Recommendation	An assessment be made of the available modules, add-ons and updates for Firewatch and any associated costs, opportunities and operational impacts. A timeline be established for any items identified for adoption.				
Initial management response	A demonstration from Infographics regarding the scope of Firewatch is due to take place (to SLT) in October – after which time decisions will be taken as to how much of Firewatch functionality will be adopted. The outcome of this meeting will determine the Service's next steps with regard to Firewatch and any other IT systems. Consideration of a project team may be required.				
Responsible Officer/s	SLT/Heads of HR	Original implementation date	April 2023	Revised implementation date(s)	
Latest Update	Project now in place. The Project Lead is the Head of HR. Project Team to include new admin member. Anticipated completion April 2024				
New implementation date	30/04/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

Audit title	**Firewatch**	Audit year	2022/23	Priority	2
Recommendation	A plan be developed to move away from using substantial HR resources for duplicate data entry and parallel monitoring of the HFRS establishment, and towards robust procedures for ensuring the integrity of Firewatch as the primary data source.				
Initial management response	HR are in the process of creating a central online system together with Finance that will negate the need to have the tracker in future				
Responsible Officer/s	ICT/Finance/HR	Original implementation date	Ongoing - Review at April 2023	Revised implementation date(s)	
Latest Update	Tracker will remain live until data cleanse completed, user groups reviewed and relevant staff trained on version 7.8				
New implementation date	30/04/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

Audit title	**Firewatch**	Audit year	2022/23	Priority	2
Recommendation	A schedule of data cleansing routines be established to proactively identify and address known issues with Firewatch data, before these impact on other business processes and reports.				
Initial management response	The HR Service Partners cross reference all establishment data for each District and cross reference with the HR admin team who are carrying out the inputting of the data. Any anomalies raised are rectified at this stage.				
Responsible Officer/s	HR	Original implementation date	Ongoing	Revised implementation date(s)	
Latest Update	The tracker will remain live until the data cleanse has been completed, user groups reviewed and relevant staff trained on version 7.8				
New implementation date	28/02/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

15. ICT GDPR

Audit title	**ICT GDPR**	Audit year	2022/23	Priority	2
Recommendation	It be ensured that Corporate Assurance are involved with any projects and initiatives where personal data is involved.				
Initial management response	1. Challenge HoF to identify instances of personal data being shared 2. If not already existing, complete an ISA. 3. CA to continue to identify processing activities for which a DPIA is appropriate 4. Work with HoF and the DPO to ensure an assessment is completed. 5. Map data flows 6. Continue 'communications' promoting data protection				
Responsible Officer/s	IGO/HoF and IGO/HoF	Original implementation date	31/12/22 to 30/06/23	Revised implementation date(s)	
Latest Update	Plan and information for IAO is to be completed by 31/12/24				
New implementation date	31/12/2024	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

16. **Secondary Contracts**

Audit title	Secondary Contracts	Audit year	2022/23	Priority	3
Recommendation	Managers in areas of the Service known to employ firefighters in a secondary employment relationship be reminded to discuss the interaction between the two roles, and the staff member's responsibilities to the primary position. This should happen both at the beginning of the contract and periodically thereafter, in particular if the demands of the secondary contract change. A request should also be made to any arms-length organisation connected to HFRS (e.g. HFR Solutions) to follow an equivalent approach.				
Initial management response	Policy amended and re-issued to all of TLT and all SMs – along with guidance to monitor staff with 2nd jobs – with a reminder that it forms part of their managerial responsibility to manage staff with dual roles and external employment. Agenda item for TLT to remind all managers of their responsibilities. Letter to be drafted to Solutions to request consideration of employees also employed by HFRS				
Responsible Officer/s	HoHR	Original implementation date	March 2023	Revised implementation date(s)	
Latest Update	The letter relating to employees also employed by HFRS has not been drafted.				
New implementation date	31/08/2023	Status	Outstanding	Implementation is in progress, but the original target date has not been met.	

17. The following recommendations have been implemented.

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Collaboration Activity	A policy or delivery guidance be created to establish the expectations, roles and responsibilities and standard processes for the management of collaborations across the Service.	2	Hof Corporate Assurance	30/06/23
Collaboration Activity	The identification, reporting and management of risks be incorporated into the responsibilities of designated collaboration leads through the establishment of a policy and guidance around the management of collaborations across the Service.	2	Hof Corporate Assurance	30/06/23
Collaboration Activity	An information sharing agreement be put in place for all collaborations where personal data is being shared, as required under data protection regulations.	2	Hof Corporate Assurance	30/06/23

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Collaboration Activity	A scorecard be developed on the status, compliance, performance and risks of collaborations across the Service, for reporting on a periodic basis to senior management. The exact nature and frequency of reporting should be defined within a Service policy or guidance.	2	Hof Corporate Assurance	30/06/23
Collaboration Activity	The central tracker used by Corporate Assurance be updated to reflect the key data points identified within the Service-wide policy (once established). Gaps in required information should then be investigated and addressed. A tool that facilitates date stamps and version history (such as a SharePoint table) may be helpful in providing audit trails and facilitating more efficient reporting.	2	HoF Corporate Assurance	01/04/23
Collaboration Activity	The collaboration evaluation form be updated. This should require that the designated lead confirms that they have considered and evaluated identified key success factors, providing the opportunity to highlight any areas of concern.	2	Hof Corporate Assurance	30/06/23
Collaboration Activity	A definition be agreed of which types of arrangement with external parties should be treated as a collaboration. The list of current collaborations should be examined to ensure that only appropriate items are included, while those that could be managed through alternative processes (such as through supplier management arrangements) should be removed.	3	Hof Corporate Assurance	30/06/23
Collaboration Activity	Arrangements for the establishment of new collaborations be established through policy development. Consideration should be given as to whether the Project Management Delivery Guidance is the most appropriate method for managing the full lifecycle of collaborations or if an alternative approach is needed to cover activity that becomes "business as usual".	3	Hof Corporate Assurance	30/06/23
Equality Impact Assessments	The importance be reiterated of providing copies of EIAs to OD for review, analysis and monitoring, so that the Service can be assured that it is effectively undertaking its statutory duties in this area.	2	Sam O'Connor Head of OD	01/10/22
Firewatch	A routine be established for any establishment or people forms that cannot be immediately entered, to be regularly reviewed, so that they can be entered as soon as any pre-requisite actions have been completed.	2	HR	Ongoing

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Firewatch	While the master establishment spreadsheet is in use alongside Firewatch, regular reconciliations should be undertaken between the two sources of data, to highlight inconsistencies and facilitate investigation of errors. This could include relatively straightforward routines, such as comparison of names against job roles in each system.	2	HR	June 2023
Firewatch	Features of advanced Firewatch functionality that the Service wishes to make use of be identified, including specific reporting and analysis requirements. The best approach to obtain these should be considered, which may include external training, consultancy to design specific reports, or dedicating staff time to research best practice through user groups or other FRS.	3	HR	*April 2023*
ICT GDPR	It be ensured IARs and RoPAs are reviewed and updated as planned.	2	IGO and HoF	January – March 2023
ICT GDPR	It be ensured staff comply with their obligation to complete data protection awareness training.	3	Senior Corporate Assurance Officer and IGO	December 2022
Secondary Contracts	The secondary employment policy be updated to specify managers' responsibilities in monitoring the demands on staff known to have secondary employment, as part of their standard role in ensuring safe operations.	2	HoHR	31/01/23
Secondary Contracts	The proposed inclusion of the status of secondary employment within the PDR process be implemented as soon as possible, so that the outcomes can be assessed during the next cycle.	2	HoHR, HoOD and all managers	December 2022 to April 2023
Secondary Contracts	Functionality be identified that would allow the Service to monitor the working hours of staff across multiple contracts. This should be a risk-based approach, with any potential requirements considered for proportionality. If any functionality is identified as critical, but is unable to be obtained through the current system, this should feed into any decisions regarding the long-term product solution.	2	District GMs	31/04/23
Key Financial Controls	It be ensured that the Human Resources system and the payroll reports are reconciled periodically.	2	Head Of HR	31/08/23
Key Financial Controls	Expected due diligence controls be undertaken and recorded prior to all supplier details changes.	2	Head of Finance	31/05/23

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Key Financial Controls	The Scheme of Delegation be made clearer in the approval of invoices for the additional steps in the process adopted.	3	Head of Finance	31/05/23
Key Financial Controls	It be ensured that the payroll forms are accurately and fully completed.	3	District GM	30/04/23

Internal Audit

FINAL

Humberside Fire and Rescue Service

Assurance Review of Effectiveness of Systems (used to learn from Operational Incidents)

2023/24

November 2023

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

ER/2023/079: We do not have an acceptable level of assurance that our crews are applying guidance effectively or that we are communicating NOG to front end resources.

KEY STRATEGIC FINDINGS

An Operational Learning Policy, supported by the Operational Learning Policy Framework Guidance and the Operational Learning Policy Debrief Guidance, is in place.

Testing identified that practices are in place to ensure that operational incident reviews are undertaken and evaluated.

Lessons learned are captured, discussed, categorised, and shared with the appropriate teams including relevant external bodies.

A review of the actions log confirmed that several actions/ recommendations are yet to be allocated to a responsible owner and details of progress on implementing some actions were not completed.

GOOD PRACTICE IDENTIFIED

The Service is looking to develop a new system that will improve how actions/ recommendations are tracked for completion and implementation.

SCOPE

The review considered the arrangements in place to ensure that debriefs are undertaken in relation to a broad range of operational incidents and that appropriate lessons learned exercises are undertaken and communicated through appropriate channels.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**1**	**0**	**0**

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	Testing found that 241 actions have been logged since May 2022 following post incident reviews. These actions were confirmed to be monitored by the OL function/team. With the exception of two, all had recommendations raised against the learnings/actions. It was identified there were 196 of the 241 actions logged that did not have owners assigned to them. 21 of these 196 actions were rated high risk dating back to May 2022 as the date of submission. The remainder were split between low and medium risks ratings with low risks ratings being the vast majority. Testing also found the progress update fields were not being completed for 195 of the 241 actions logged. The status field was also not completed for 204 of the 241 actions logged. In terms of expected completion date this was only completed for 143 actions logged. Management confirmed this has been recognised as an ongoing challenge.	A review of the actions log be undertaken to ensure all recommendations are allocated a responsible owner, and to ensure all relevant fields are populated for effective monitoring. It also be ensured that there are progress updates recorded for actions/ recommendations that have been allocated.	2	*Review of the action log, against the recommended areas, managed through the Service Improvement Plan process to track and monitor completion.*	*30.11.2023*	*Head of Operational Learning*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1	-

Other Findings

An Operational Learning Policy, reviewed in May 2023, is in place. This sets out the approach that the Service will take to ensure operational response is provided in a consistent, open, and transparent way supported by a culture of learning and supportive leadership. This includes providing the infrastructure and resources to support the operational response provided to local communities. The Operational Learning Policy is supported by the Operational Learning Policy Framework Guidance that provides direction on how operational learning is delivered and how this contributes to the objectives of the Services' plan and the Operational Learning Policy Debrief Guidance that provides advice to firefighters and managers at all levels on how to support and participate in debriefs including their responsibilities.

The Service has an Operational Learning Team/ function that collects, gathers and process information to identify opportunities to improve safety and response. The OL function/team is made up of Operational Managers who supports the function by scrutinising activities to identify how to improve performance. As part of their activities, the OL function/ team co-ordinate all structured debriefs including ensuring that the Service is compliant with legislation and guidance related to operational learning. The Group Manager Head of Function for Health and Safety Environmental Sustainability and Operational Assurance has overall responsibility for the function supported by 18 Function Heads who make up the Tactical Leadership Team.

Other Findings

A review of the Services' Strategic Risk Register showed there are six risks relating to emergency response. Each of these risks are linked to the Service's Strategic Objectives of how communities are supported, how the Service is efficiently managed and what the Service must do well at. Whilst there are no specific risks that link to the effectiveness of systems used to learn from operational incidents, the closest risk to this subject area is described as "We do not have an acceptable level of assurance that our crews are applying guidance effectively or that we are communicating NOG to front end resources" Mitigating controls for this risk includes Hot Debriefs.

Discussions with Management confirmed that the Tactical Leadership Team meet monthly and where relevant will discuss debrief reports, lessons learnt, actions to be taken and recommendations ensuring that the actions are appropriately allocated and effectively managed. It was also noted that discussions are held with the relevant Function Heads by the GM prior to the formal monthly meetings held to discuss debrief reports. These meetings are also supported by quarterly meetings of all Function Heads chaired by the GM, where all actions/ lessons learnt from debriefs are evaluated to ensure they are progressing, implemented and embedded.

There are different types of debriefs undertaken within the Service. Each have different criteria and timescales to be followed for completion and are supported by the OL function as appropriate. They include On-scene debrief, Informal operational debrief, Structured/ Formal operational debrief, Tactical debrief, Strategic debrief and Multi agency debrief. Whilst each may take different forms depending on the event, the ultimate goal is to ensure that learning opportunities are identified in order that policies, procedures, response and overall safety can be improved. Management confirmed that the Service has a process where any operational personnel can perform a debrief regardless of the scale. It was however noted there may be occasions where a debrief is not considered necessary and this is determined by the Incident Commander. It was confirmed for each structured debrief, a report is written by the OL function, and this is placed on SharePoint and accessible for all staff. This report is shared with the Senior Leadership Team and Tactical Team as appropriate.

Learnings from incidents identified during debriefs are sent through to the OL function and are captured on Microsoft lists for monitoring by OL function. These learnings are also allocated to the relevant departmental action logs. The Heads of Function or their nominated representative have the responsibility for all actions and are to determine and prioritise actions and to update their records. Actions / learnings are categorised based on their priorities.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

- The Senior Leadership Team and the Fire Authority receive detailed reports on structured debriefs every six months. A copy of one of such reports was obtained for testing. This was a Multi-Agency Structured Debrief report dated 25th July 2023 that involved one or more agency, in this case the Police, and contained a summary of the debrief which highlighted challenges experienced and the agencies involved including areas of good/ notable practice, areas of concerns and recommendations with allocated owners following a review of the incident. The report was noted to meet the criteria for submitting to JOL online.
- Information about learning is captured from various internal and external sources with learning outcomes recorded and as these are raised, they are monitored by the OL function. The Service also gather data beyond operational incidents in line with NFCC Good Practice Guide by evaluating exercises and development sessions that influence operational response.
- Once learnings have been captured, they are shared internally and where appropriate externally. Internal learning is shared through operational updates, meetings, or briefings or through videos and podcasts. External learning is shared through the NOL and JOL providing the criteria for sharing information is met. These platforms provide a central storage of good practice and lessons learned across category one and two responders.
- The Service is seeking to develop a new system that will improve how actions and tracked for completion and implementation.

EXPLANATORY INFORMATION

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	31st July 2023	7th August 2023
Draft Report:	7th September 2023	27th October 2023
Final Report:	1st November 2023	

AUDIT PLANNING MEMORANDUM **Appendix B**

Client:	Humberside Fire & Rescue		
Review:	Effectiveness of Systems (used to learn from operational Incidents)		
Type of Review:	Assurance	**Audit Lead:**	Ade Kosoko

Outline scope (per Annual Plan):	The review considers the arrangements in place to ensure that debriefs are undertaken in relation to a broad range of operational incidents and that appropriate lessons learned exercises are undertaken and communicated through appropriate channels.
Detailed scope will consider:	The review will set out to provide assurance to the Governance, Audit and Scrutiny Committee that the organisation has robust controls in relation to reviewing the effectiveness of operational incidents. • The policy and procedures are up-to-date, clearly define responsibilities and are available to staff. • Practices are in place to ensure that operational incident reviews are undertaken and evaluated. • Lessons learned are documented and distributed to the appropriate staff/teams. The debriefing policy has been updated to make sure that it learns from a broader range of operational incidents (as recommended by HMICFRS)
Requested additions to scope:	(if required then please provide brief detail)
Exclusions from scope:	

Planned Start Date:	21/08/2023	**Exit Meeting Date:**	01/09/2023	**Exit Meeting to be held with:**	Hazel Bullen (Service Improvement Supervisor) and Ian Marritt (Station Manager)

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

Humberside Fire and Rescue Service

Assurance Review of Staff Development

2023/24

October 2023

Executive Summary

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

SUBSTANTIAL ASSURANCE

SUBSTANTIAL ASSURANCE
REASONABLE ASSURANCE
LIMITED ASSURANCE
NO ASSURANCE

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

SROAR/2019/046: Workforce Planning/ Workforce planning arrangements need further embedding and developing to ensure that up to date and accurate data is held to predict future workforce needs.

SCOPE

The review considered whether the Fire Service is applying appropriate practices related to staff development and talent management including workforce planning, recruitment and staffing strategies, succession management, learning and development and performance development reviews. The review also assessed the effectiveness and communication of the "Pipeline" process.

KEY STRATEGIC FINDINGS

The development of employees within the Service including talent management, succession planning and how the workforce is planned is underpinned by a People Strategy (2023/2024) and the Workforce Plan (2022-2025).

Testing identified that the Service have put in place an open, fair, and transparent process to identify, develop, and support high-potential staff and aspiring leaders.

There are practices in place that ensure employees are given the opportunity to develop within the Service.

GOOD PRACTICE IDENTIFIED

The Service is set to launch a Portfolio Pathway process in October 2023 that will replace the pipeline process. This process will enable continuous development and enhance the promotion selection process.

Other HR related policies such as the Recruitment and Selection Policy support the People Strategy and the Workforce Plan.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**0**	**0**	**0**

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No recommendations were made.							

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The People Strategy 2023-24 has been developed to support the aims and objectives/ Strategic Plan of the Service by ensuring that the right people are provided with the right skills and are in the right place at the right time. It also details how the Service will provide a working environment that values staff by supporting and encouraging staff to maximise their contribution to the effectiveness of the Service. The People Strategy is divided into six key areas, and these include Recruitment and Develop and Support. Other documents that support the People Strategy include the Workforce Plan (2022-2025); Leadership and Management Framework; Talent Management Pipeline/ Succession Planning Strategy/Framework.

It was noted, the objectives of the People Strategy are to support the Service in the delivery of the strategic plan by ensuring that the Service:

- Creates and maintains a workforce that is committed and able to achieve our mission;
- Supports employee improvement processes to enable staff to undertake diverse and changing roles; and
- Selects and retains a diverse workforce to reflect the community we serve.

Other Findings

The Service have adopted and are guided by the National Fire Standards Board's (FSB) Core Code of Ethics. which are Putting our communities first; Integrity; Dignity and Respect; Leadership; Equality, Diversity, and Inclusion.

The Services' Risk Register was reviewed. As part of the People and Development Risk, a Workforce Planning risk has been identified. The risk is described as "Workforce planning arrangements need further embedding and developing to ensure that up to date and accurate data is held in order to predict future workforce needs. There is also uncertainty and challenge regarding retention of staff, potentially exacerbated by the McCloud Judgement, which may lead to the loss of key skill sets across the organisation". This risk is reviewed every quarter and was last reviewed in June 2023 and is overseen by the Executive Director of People and Development. This risk is further linked to one of the Service's Strategic Objectives which is to value and support people that the Service employs.

Mitigating controls include: Workforce Plan; Retirement Profile; Establishment Tracker; Crewing and Re-engagement Meetings; Postings and Transfer Meetings.

The Service operates a Performance Development Review (PDR) process that runs annually starting in February each year and ending in April of each year. This process is understood to have evolved in the last three years and is designed to help employees on the job and through any personal and professional development. The PDR process helps to measure individual performance against set objectives and to identify development needs, thereby encouraging employees to deliver and perform at their best. Through the PDR process, learning and development opportunities for employees are identified and training delivered to help employees feel confident in their ability to carry out their role. This helps with talent management and succession planning within the Service. The Service encourages all employees to take part in Continuous Professional Development (CPD) and developing of talent internally to help with succession planning through talent management. Once all PDRs are completed, a report is generated, which is shared with the Directors and the Executive Team. A review of the draft report for PDR 2023 showed that the completion rate for PDRs during 2023 was 94.12% (846/901 employees). Reasons for non-completions include new starters, long term sickness and maternity leave. The OD team/ function is understood to have had discussions with relevant managers to stress the importance of completing PDRs as it is a missed opportunity for staff development.

The Service, through organisational development, offers several opportunities/ programmes for employees within the Service. These include mandatory courses to be undertaken and role specific training courses. Examples of the courses/ programmes available are : Coaching and Mentoring Programme which enables all employees to develop at all levels throughout the service, HFRS- Core Learning Pathway for Leadership and Management roles/ opportunities, Operational Firefighter Apprenticeship/ In -house Development Pathway, Core Skills Framework which sets out core competencies of all employees through ought the Service, Career Ladders which provide a pathway for progression and career development in each department, Role Specific Training Outlines which support the core competencies set out in the CSF and Career Ladders, and NFCC Supervisory Leadership Development Programme.

The Service introduced the Pipeline process in 2020 to help support the development of employees through promotion. Adverts and relevant supporting documents are placed, and appropriate support provided to employees who apply during the process. This is to ensure that all candidates know what is required and expected of them during the process. It was confirmed that pipeline briefings take place during the process to assist individuals with any questions they may have. This is also supported by District meetings where SPs discuss the process guidance with the Station Managers to ensure that they are informed and can answer any questions that may arise at their stations or teams. Upon completion of an application form by the relevant employee, these are reviewed by the selection panel for onward consideration. Selected candidates are interviewed and scored. Candidates are assessed and scored as either appointable, appointable on a temporary basis only or not appointable. Feedback on applications is provided and for those who are unsuccessful, discussions are held with the relevant manager around skills and individual development plans. The feedback aims to highlight where the candidates performed well, and areas needed to develop. It was noted that appointable candidates would remain in the pipeline for promotion for 12 months to ensure that they maintain their skills and individual development plans in readiness for substantive promotion. Any candidates that remain are removed from the lists and will need to apply again at the next process should they wish to gain substantive promotion.

Other Findings

Testing was undertaken for 10 employees to ascertain that an annual PDR was completed, and it verify whether learning and development opportunities were identified and recorded and to also confirm that, where learning and development opportunities have been identified, appropriate courses/ programmes have been completed. In the cases reviewed, nine employees had completed their annual PDR and one employee is on long term sickness absence. Of the nine that had completed their PDR, five had no learning and development opportunity identified hence no requests was made to the OD team. In relation to the remaining four where learning and development opportunities were identified, testing confirmed courses have been approved where eligible, and alternatives discussed with those employees that were seen not to be eligible for the courses requested. It was noted that in two cases, whilst the courses have been approved, the employees are yet to undertake them.

The promotion pipelines for 2023 were as follows:

- Group Manager Talent Pipeline – February to March 2023
- Station Manager Talent Pipeline – February to April 2023
- Watch Manager Talent Pipeline – March to May 2023
- Crew Manager Talent Pipeline – April to June 2023.

It is understood that a total of 107 candidates applied for promotion through the pipeline process and this included a small number of external applications. Of the 107 who applied, 53 were interviewed, however only 46 candidates gave consent for their information to be shared during the audit. Of these 46 candidates that were interviewed, 10 candidates were selected for testing to ascertain the outcome of their application and to assess the effectiveness of the process. Testing found all 10 had been successful, with two of the 10 candidates being appointed on a temporary basis. The other eight candidates were offered substantive promotion. All 10 candidates sampled had completed an application form detaining their experience, qualifications, and competencies. Testing also identified the vacancies had been advertised appropriately. Discussions with the Head of HR confirmed that all the individuals who were been deemed to be appointable on a substantive basis for the 2023 Pipelines have been substantively promoted, and all those who were deemed to be appointable on a temporary basis for the 2023 Pipelines have been or are currently temporarily promoted to ensure they have/are receiving the necessary support and development to maximise their opportunity for career growth and personal development.

Talent management and succession planning are addressed and included within the workforce plan. The talent management/ pipeline process is embedded within the Service and offers career development providing an open and fair process to the whole workforce to develop at every level and to support promotion. This is linked to the PDR process. The talent management process is managed by the OD function and supports development of talent up to Group Manager level. The service uses the NFCC Talent Management Toolkit. The talent management for Green Book staff is being considered as part of the succession planning framework that is currently underway with relevant Heads of Function and a portfolio is currently being developed for Group Managers. The succession planning process takes into consideration the requirements of the Strategic Plan and examining any challenges to ensure that the Service can proactively meet workforce capacity requirements whilst building skills and capability.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

In July 2023 the Executive Team received a detailed report on the implementation of talent management and succession planning frameworks. The report detailed the Services' approach to talent management and succession planning, the aims, and goals and how talent management and succession planning benefits the Service. It included various proposals for the implementation of a talent management framework for the succession planning of operational roles. The report confirmed that the implementation of the talent management framework will provide a pathway for acting up, temporary appointments and permanent appointments. In relation to succession planning, there were several proposals for the implementation of a succession planning framework which included the identification of potential successors and a process for selection of potential successors. It was further confirmed in the report that the OD function have undertaken an analysis and initial assessment of function/roles where succession planning may apply.

It was noted that the pipeline process is open to both internal and external applicants.

The Service is to launch the Portfolio Pathway in October 2023 which will replace the pipeline process. This will support temporary appointable candidates by reducing the need to re-apply at the next process should they wish to gain substantive promotion.

Discussions with the Head of Human Resources (HR) confirmed that a workforce planning meeting is held every quarter where matters relating to vacancies, retirement, posting and transfers, recruitment, and promotions are comprehensively discussed. In attendance are Group Managers (GMs), Head of Organisational Development, Head of HR, the Executive Director of People and Development and Area Managers. The meeting enables the Service to analyse their current workforce, determine future workforce needs and to identify gaps between the present and future whilst

Other Findings

also implementing solutions so that goals within the strategic plan can be achieved. The Services' Senior Leadership Team (SLT) have ultimate responsivity for the workforce plan and any local workforce plans that follow. They are also supported by Directors and Heads of Service/ Functions who have responsibility for delivering the plans within their area of responsibility. HR Service Partners, during their monthly district meetings, provide support to Managers in order to facilitate the delivery of local workforce plans. The revised workforce plan was agreed by the SLT on 31st March 2023. The workforce planning meeting is supported by Posting and Transfer meetings, which are usually held every month and chaired by a GM with support from the Head of HR, HR Service Partners (SP) and District Station Managers. It was noted that all District Station Managers are in attendance to ensure that each district is properly represented as this is where the main amounts of postings, transfers, re-engagements, posting of recruits and flexible working requests stem from. A Crewing Meeting is also held in addition, and this is held quarterly prior to the Workforce Planning meeting. In attendance are the Executive Director of People and Development, Area Manager for Emergency Response, Chair of the Postings and Transfer Board and Head of HR. It was confirmed, Finance attend where required.

EXPLANATORY INFORMATION

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	31st July 2023	7th August 2023
Draft Report:	26th September 2023	26th September 2023
Final Report:	4th October 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire and Rescue Service		
Review:	Staff Development		
Type of Review:	Assurance	Audit Lead:	Ade Kosoko

Outline scope (per Annual Plan):	The review considered whether the Fire Service is applying appropriate practices related to staff development and talent management including workforce planning, recruitment and staffing strategies, succession management, learning and development and performance development reviews. The review also assessed the effectiveness and communication of the "Pipeline" process.
Detailed scope will consider:	The review will set out to provide assurance to the Governance, Audit and Scrutiny Committee that the organisation has robust controls in relation to the development of staff. • The policy and procedures are up-to-date, clearly define responsibilities and are available to staff. • Practices are in place to ensure that staff are given the opportunity to develop within the Service. • The organisation has put in place an open and fair process to identify, develop, and support high-potential staff and aspiring leaders (as recommended by HMICFRS). • Details of the "Pipeline" process have been clearly communicated to staff.

Planned Start Date:	04/09/2023	Exit Meeting Date:	08/09/2023	Exit Meeting to be held with:	Sam O'Connor (Head of Organisational Development) Claire Tait (Head of Training) Anne Stott (Head of Human Resources) Hazel Bullen (Service Improvement Supervisor)

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

Humberside Fire and Rescue Service

Assurance Review of the Service Absolutes Process

2023/24

October 2023

Executive Summary

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

SUBSTANTIAL ASSURANCE

- SUBSTANTIAL ASSURANCE
- REASONABLE ASSURANCE
- LIMITED ASSURANCE
- NO ASSURANCE

KEY STRATEGIC FINDINGS

Station, Watch and Crew Managers demonstrated a good awareness of the Absolutes and how they link to the Corporate Objectives.

Up to date Station Heat Maps were prominently on display at only one station visited.

Appropriate commentary had been recorded on the Heat Maps in support of the performance rating assigned.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

A new process for the production of service absolutes and heat maps has been introduced within the last two years.

GOOD PRACTICE IDENTIFIED

The Heat Maps and Absolutes are available to all staff via the Service Delivery portal homepage within Sharepoint.

SCOPE

The review evaluated the consistency in application, value, accuracy, recording and alignment to related performance management measures for the absolutes process. The review also included the understanding of absolutes among staff.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**0**	**1**	**1**

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	During the station visits the following was identified: • The September Heat Map was displayed on a prominent notice board in one station. • The Heat Map was displayed on a notice board in one station; however, this was the April 2023 version. • One station does not place the Heat Map on the notice board as the Station Manager feels that it does not get looked at and the data is only at a point in time and is therefore out of date once printed. They commented that this would be better placed on a TV display screen in the reception/foyer area. • The last station did not have the Heat Map on display, however the Station Manager stated that it had been removed the previous day as they are in the process of producing the most up to date version.	It be ensured that up to date Heat Maps are displayed in prominent positions within stations.	3	*District Station Managers will undertake the responsibility for ensuring Heat Maps are displayed prominently on all stations, either digitally or in up-to-date paper form.*	*31/10/2023*	*District Station Managers*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Directed	Whilst one Station Manager stated that they send the Heat Map to their Watch and Crew Managers monthly, the Crew Managers met at other stations commented that they did not have access to the Heat Maps for their station. As Crew Managers act up as the Watch Manager on a regular basis, as demonstrated during the audit where two of the four stations had Crew Managers standing in for Watch Managers on the day of the visit, it would prove beneficial (including as a potential development tool) to actively involve Crew Managers in the operation of the station's Heat Map.	Consideration be given to routinely distributing Station Heat Maps to the Crew Managers.	*Station Managers to allow devolved responsibility to Crew Managers in the absence of Watch Managers with pro-active involvement from the CMs to gain a better understanding of the Heat Maps.*

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1	1

Other Findings

The Service Delivery Planning Policy - Station Routines was due to be reviewed by October 2022. Discussions with the Service Improvement Supervisor identified that this is currently being updated by one of the District Managers to reflect the significant changes being applied to Tactical Plans and the impact on service delivery.

The Policy sets out the Service's approach to ensuring that the Directorate Plan links into Station, Section and Watch Manager Heat Maps and Action Plans (and vice versa).

The Policy is supported by the Service Delivery Directorate, District, Fire Station and Team Planning Policy Delivery Guidance (last reviewed in October 2021 and due for review in October 2023). This makes reference to the maintenance of Heat Maps and Absolutes for each station and watch.

The Heat Maps provide a pictorial representation of performance, using a RAG rating, against each of the Service's Strategic Objectives under the headings of:

- What we must do well;
- How we support our communities;
- We value and support the people we employ; and
- We efficiently manage the Service.

Other Findings

Service Absolutes act as a record of the key areas of business for the Station or Watch. As with the Heat Maps, these are aligned to the Strategic Objective areas. Both the Heat Maps and Absolutes provide staff with a link to the strategic plan. In addition, the Absolutes detail the key workstreams for the day, i.e., things that have to be done, and form the basis for performance management and the agenda for monthly station meetings.

The Service Improvement Supervisor confirmed that there is no entry on the risk register in relation to Absolutes or Heat Maps as it is not currently deemed a risk to the organisation.

A series of discussions was undertaken with Station, Watch and Crew Managers in order to ascertain their understanding of what the Heat Maps and Absolutes mean in practice, what they are used for and how the performance displayed on the Heat Maps is determined and feeds into periodic performance meetings. The questions asked and comments made are detailed below.

What is your understanding of what the absolutes mean?

All staff interviewed were aware that the Absolutes linked into the Service's corporate objectives and could recall the key points within these areas. Comments made included that they:

- Focus staff attention in a number of areas in line with the strategic aims of the service.
- Are easy to understand and act as a job specification of that role and detail everything that must be completed on that day.
- Ensure that the crew is operationally ready.
- Act as a list of duties of the Watch Manager to perform each day.

A Station Manager also commented that they use the Absolutes as a prompt when carrying out Watch Manager's PDRs.

What are the Heat Maps? Responses given:

- If the Heat Map is green, then the Service achieves what HMICFRS want.
- The Watch Manager is responsible for cascading details of performance down to Crew Managers.
- They are a traffic light system, formulated by the Station Manager, showing possible areas for improvement.

How are Heat Maps used? Responses given:

- They are a tool to manage performance and know what areas to look at.
- Use this to direct what to talk about in the monthly meetings.
- It is a progress chart.
- Has been told to focus on the reds on the Heat Map.
- The Watch Manager has monthly meetings with the Station Manager where they go through the scoring on the heat maps.
- Look at power BI reports to see where they are against KPIs.
- The red and amber areas are discussed at monthly watch meetings. These were informal under the previous Station Manager; however the new Station Manager is making this process more formal.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of scope	-	-

Other Findings

A review of the Heat Maps at each station visited identified that the areas noted as red and amber were supported by sufficient and appropriate commentary, and these had been discussed at the monthly station meetings.

A small number of areas were also categorised as amber where, although performance was currently good (and therefore should be green), work plans and pressures within the coming month may impact on future performance in this area. This therefore acts to focus attention towards this area. One example noted was the completion of fitness tests, which were due to be completed in the next month. Although these were not overdue at the time of the visit, the Station Manager had noted these as amber as a reminder for all staff that they must be completed in September.

It was noted that whilst the Station and Watch daily Absolutes were on display in all stations visited, these were the versions taken from Sharepoint showing each activity aligned to its Strategic Aim. The version contained within the Policy Delivery Guidance, which has a space to allow for comments and details to be recorded against each heading, is not utilised. One of the Group Managers confirmed that the stations would not be expected to record activities on the chart within the Heat Map contained within the Policy Delivery Guidance. It is there as a visual to remind them of what the Absolutes are. This is also an older version of what is now on the Service Delivery SharePoint page and is likely to be changed within the review of the Policy Delivery Guidance.

EXPLANATORY INFORMATION Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	31st July 2023	7th August 2023
Draft Report:	29th September 2023	16th October 2023
Final Report:	25th October 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire and Rescue Service		
Review:	Service Absolutes Process		
Type of Review:	Assurance	Audit Lead:	David Robinson

Outline scope (per Annual Plan):	The review evaluated the consistency in application, value, accuracy, recording and alignment to related performance management measures for the absolutes process. The review also included the understanding of absolutes among staff.
Detailed scope will consider:	The review will set out to provide assurance to the Governance, Audit and Scrutiny Committee that the organisation has robust controls in relation to the service absolutes process. • The policy and procedures are up-to-date, clearly define responsibilities and are available to staff. • There is a mechanism in place to record and manage accomplishment of tasks aligned to prioritisation, service plans and performance metrics in operational fulltime station environments. • Information is accurately recorded. • Staff have been provided with relevant information in relation to the service absolutes process and the identified requirements.

Planned Start Date:	18/09/2023	Exit Meeting Date:	01/09/2023	Exit Meeting to be held with:	Vicky Shakesby – District Mgt East Riding, Jamie Morris - Designate Head of Corporate Assurance Hazel Bullen - Service Improvement Supervisor

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	Y – new Process introduced within the last 18-24 months
Are there any particular matters/periods of time you would like the review to consider?	N

Agenda Item No. **5**

Governance, Audit & Scrutiny Committee
13 November 2023

Report by the Joint Deputy Chief Finance Officer & Deputy S.151 Officer

MANAGEMENT ACCOUNTS 2023/24 – BASED ON PERIOD ENDING 30 SEPTEMBER 2023

1. SUMMARY

1.1 This report highlights the current financial position based on information to 30 September 2023.

1.2 The end of year projections are set out at section 4.1 for the revenue budget, the capital programme and the pensions account.

2. MATTERS FOR CONSIDERATION

2.1 Members may wish to take assurance from this report and the Authority's financial position for the period ending 30 September 2023. Members should also note the Fire Authority, at its meeting of 3 November 2023, was requested to approve a virement of £361k from interest receivable and interest payable to revenue contribution of capital outlay in order to reduce the Authority's need to borrow.

3. BACKGROUND

3.1 Management Accounts are reported to Members four times a year with the financial position at 30 June, 30 September and 31 December 2023, and 29 February 2024.

4. PERIOD ENDING 30 SEPTEMBER 2023

4.1 The summary estimated outturn position for the current financial year based on information to 30 September 2023 is as follows:

CATEGORY	2023/24 OUTTURN PROJECTION
HFA	
Revenue Budget	£0.394m underspend
Capital Programme	£5.069 spend against a £6.719m allocation
Pensions Account	£13.407m deficit

4.2 This is the second set of Management Accounts for the 2023/24 financial year and updates will be brought to the Authority based on the periods ending 31 December 2023 and 29 February 2024.

4.3 Further details on all of these areas are available electronically alongside the agenda papers on the Fire Authority's website at www.humbersidefire.gov.uk/fire-authority.

5. EQUALITY IMPLICATIONS

5.1 There is no requirement to carry out an equality impact analysis as this report does not relate to a policy or service delivery change.

6. CONCLUSION

6.1 Members should take assurance from this report and the Authority's financial position for the period ending 30 September 2023

6.2 The Fire Authority, at its meeting of 3 November 2023 was requested to approve a virement of £361k from interest receivable and interest payable to revenue contribution of capital outlay in order to reduce the Authority's need to borrow.

Shaun Edwards
Joint Deputy Chief Finance Officer &
Deputy S.151 Officer

Officer Contact

Shaun Edwards – Joint Deputy Chief Finance Officer & Deputy S.151 Officer
✉ sedwards@humbersidefire.gov.uk

Background Papers

Management Accounts September 2023

Agenda Item No. 6

Governance, Audit and Scrutiny Committee
13 November 2023

Report by Joint Deputy Chief Finance Officer/Deputy S151 Officer

TREASURY MANAGEMENT MID-YEAR UPDATE REPORT

1. SUMMARY

1.1 This report provides an update on the Authority's treasury management activities for the first half of the financial year 2023/24.

2. MATTER FOR CONSIDERATION

2.1 That Members consider the treasury management activities undertaken during the first half of 2023/24 and the Prudential Indicators as outlined in paragraphs 4.9 and 4.10 and detailed in Appendix 1.

3. BACKGROUND

3.1 Treasury Management, as defined by the Chartered Institute of Public Finance and Accountancy (CIFPA) Code of Practice 2009 is:

''The management of the organisation's investments and cash-flows, its banking, money market and capital market transactions, the effective control of the risks associated with those activities and the pursuit of the optimum performance consistent with those risks.''

3.2 The Authority on 10 March 2023 approved the annual 2023/24 Treasury Management Policy Statement and agreed a range of Prudential Indicators aimed at ensuring effective treasury management and affordability of capital plans.

3.3 This report ensures compliance with recommended practice as outlined in the Code, by providing Members with an update on treasury management undertaken since the beginning of the financial year and highlighting key Prudential Indicator information

4. PERIOD ENDING 30 SEPTEMBER 2023

Investment Activity

4.1 The Authority's temporary investments totalled £21.6m as at 30 September 2023.

Table 1 – Investment income earned April to September 2023

Interest Earned April to September 2023	Rate of return April to September 2023	Benchmark return at 30 September 2023*	Difference (Favourable) April to September 2023
£242k	4.76%	4.74%	(0.02%)

* Benchmark set as average SONIA (Sterling OverNight Index Average)

4.2 The Authority's rate of return has exceeded the benchmark return provided by Link Asset Services.

Borrowing

Short-Term Borrowing

4.3 The Authority has not taken any short-term borrowing in the first six months of the year. The Authority is unlikely to undertake short-term borrowing in the second half of the financial year.

Long-Term Borrowing

4.4 Long-term loans are taken out either to replace existing loans which have matured or to fund capital expenditure. Under the Prudential Regime there are no longer centrally imposed limits on borrowing, but individual Authorities are required to determine themselves what is a sustainable and affordable level of borrowing as an integral part of their Medium-Term Financial Planning processes.

4.5 The Authority's level of borrowing was £17.2m as at 30 September 2023, with an equated average rate of interest payable at 3.13%. An expected £545k of interest is projected to be payable on external debt for 2023/24.

4.6 The Authority has not undertaken any new long-term borrowing so far this financial year but this position will be reviewed in the second half of the financial year against the backdrop of interest rate changes and projections.

Prudential Indicators

4.7 Appendix 1 details the Prudential Indicators agreed by Members at the Fire Authority on 11 March 2023 and shows for comparison the actual figures as at 30 September 2023.

4.8 During the period April to September 2023, the Authority operated wholly within the limits approved.

Capital Expenditure

4.9 The S.151 Officer considers the current capital programme to be affordable and sustainable with the revenue effects of capital investment built into the Medium-Term Financial Plan. Through the Medium-Term Financial Planning Process the Authority has ensured alignment of its capital resources to key strategic priorities.

Treasury Management

4.10 External debt is currently £21.8m below the agreed authorised limit for 20230/24 and the maturity structure for both borrowing and investments remain within the approved upper and lower limits. Subsequent borrowing or re-scheduling will take in to account prevailing interest rates on offer from the Public Works Loans Board, the current maturity structure of loans, balanced with the need to reduce capital risk by maintaining prudently low levels of cash-balances.

Resourcing/Financial Implications

4.11 The Authority's approach to investment of surplus funds is designed to further mitigate against potential losses as a consequence of counterparty failure and reflects a prudent approach to treasury management activity.

Legal Implications

4.12 The Authority must comply with the requirements of the CIPFA Code of Practice on Treasury Management and the Local Authorities (Capital Finance and Accounting) (England) (Amendment) Regulations 2008. This report ensures such compliance.

Linkages to any Strategic/Corporate Plans/Policies

4.13 The application of and regular monitoring thereafter of a prudent Treasury Management Policy and related Prudential Indicators ensures that the Authority effectively manages financial risks such as exposure to interest rate changes, liquidity and market risk whilst minimising borrowing costs and maximising investment income. As an integral part of the financial planning process, it ensures that the financial plans upon which the Authority's Strategic Plan is based are effective and robust.

5. EQUALITY IMPLICATIONS

5.1 There is no requirement to carry out an equality impact analysis as this report does not relate to a policy or service delivery change.

6. CONCLUSION

6.1 Members are requested toconsider the treasury management activities undertaken during the first half of 2023/24 and the Prudential Indicators as outlined in paragraphs 4.9 and 4.10 and detailed in Appendix 1.

Shaun Edwards
Joint Deputy Chief Finance Officer &
Deputy S151 Officer

Officer Contact

Shaun Edwards – Joint Deputy Chief Finance Officer & Deputy S151 Officer
🖂 sedwards@humbersidefire.gov.uk

Background Papers

Treasury Management and Capital Expenditure Prudential Indicators, Management Policy Statement 2023/24 and Minimum Revenue Provision 2023/24 – Report to Fire Authority March 2023
CIPFA Code of Practice on Treasury Management
CIPFA Treasury Management Guidance

Abbreviations

CIFPA	Chartered Institute of Public Finance and Accountancy

Appendix 1

Prudential Indicators as at 30 September 2023

Indicator 1 - Capital Expenditure

The actual capital expenditure for the current year compared to the original estimate and revised budget, together with estimates of expenditure to be incurred in future years are shown below:

	2022/23 Actual £k	2023/24 Budget £k	2023/24 Revised* £k	2024/25 Estimate £k	2025/26 Estimate £k	2026/27 Estimate £k
Total Capital expenditure	3,238	6,719	5,069	5,664	3,482	3,440

*the revised 2023/24 figure reflects the latest estimate of spend, as reported to Members in the Management Accounts for the period ending 30th September 2023.

Indicator 2 - Capital Financing Requirement

The capital financing requirement for 2023/24 and estimates for future years are as follows:-

	Actual 31/03/23 £k	Estimate 31/03/24 £k	Estimate 31/03/25 £k	Estimate 31/03/26 £k	Estimate 31/03/27 £k
Capital Financing Requirement	18,399	20,169	22,837	23,200	23,308
Lease - Integrated Care Centre	1,013	996	977	956	933
Total CFR	19,412	21,165	23,814	24,156	24,241

The capital financing requirement measures the Authority's need to borrow for capital purposes. In accordance with best professional practice, the Humberside Fire Authority does not associate borrowing with particular items or types of expenditure. The Authority has, at any point in time, a number of cash flows both positive and negative, and manages its treasury position in terms of its borrowings and investments in accordance with its approved Strategy. In day to day cash management, no distinction can be made between revenue cash and capital cash. External borrowing arises as a consequence of all the financial transactions of the authority and not simply those arising from capital spending. In contrast, the capital financing requirement reflects the Authority's underlying need to borrow for a capital purpose.

A key indicator of prudence under the Prudential Code is: -

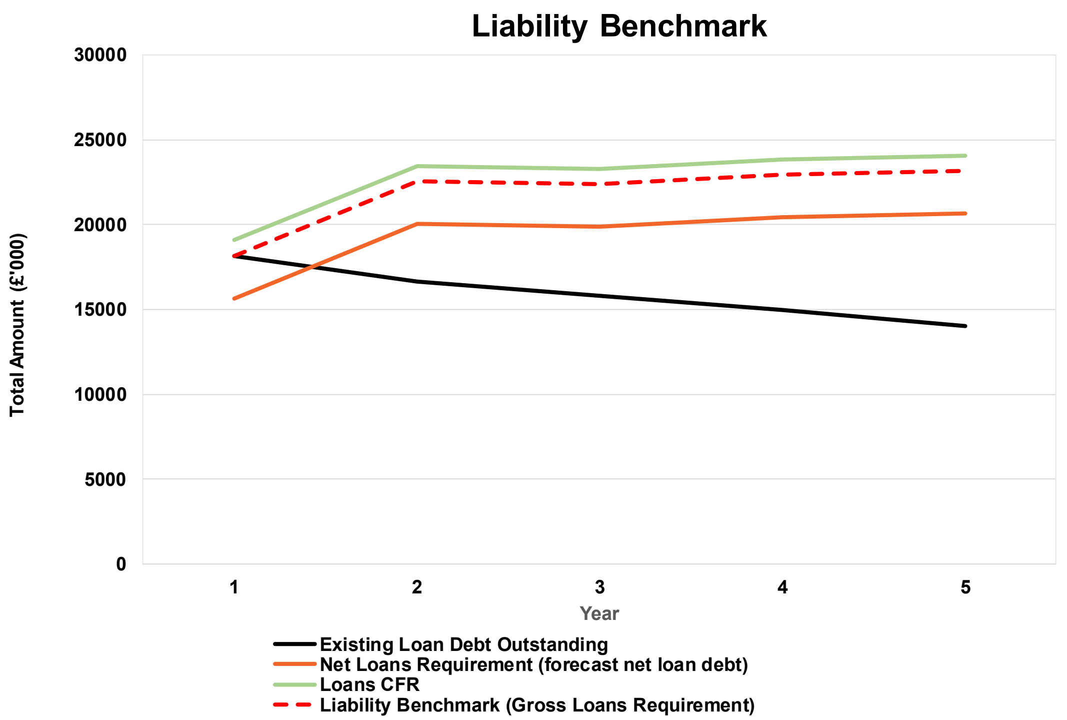
"In order to ensure that over the medium term net borrowing will only be for a capital purpose, the local authority should ensure that net external borrowing does not, except in the short term, exceed the total of the capital financing requirement in the preceding year plus the estimates of any additional capital financing requirement for the current and next two financial years".

The S151 Officer reports that the Authority has had no difficulty meeting this requirement during the course of this financial year and no difficulties are envisaged in future years. This takes into account current commitments, existing plans and the proposals contained in the Medium Term-Financial Plan.

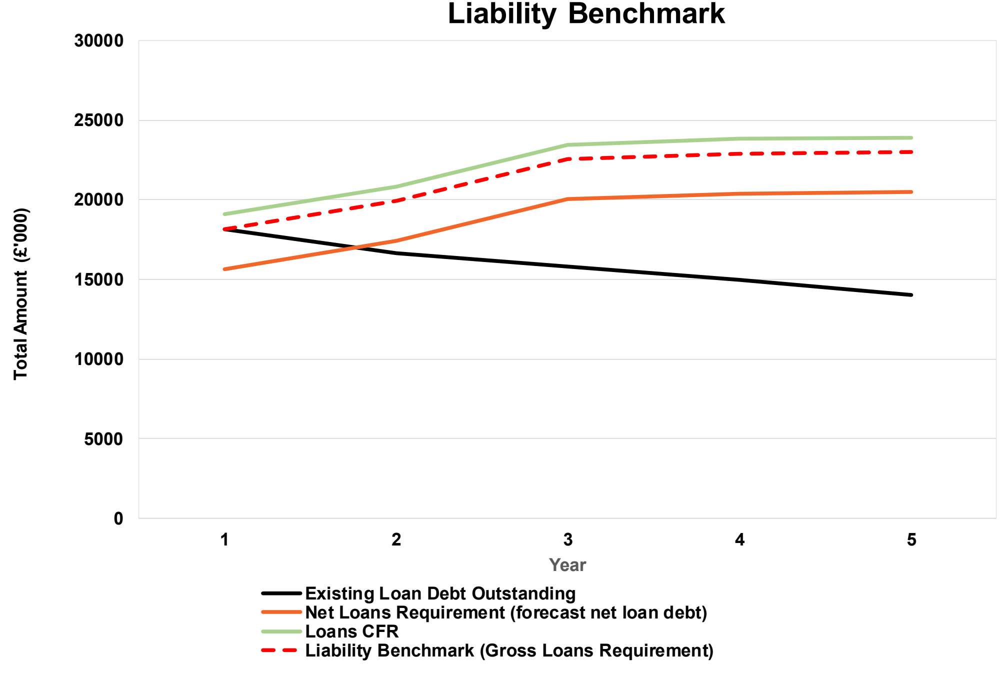
Indicator 3 – Liability Benchmark

The Authority is required estimate and measure the Liability Benchmark for the forthcoming year and the following two years as a minimum.

The following graph shows what the Liability Benchmark was estimated to be for 2023/24 onwards as set in the Treasury Management Strategy 2023/24:



The Liability Benchmark has been updated to show revised estimates for 2023/24 onwards and is show in the graph below:



The revised graph shows that the gap between existing loans outstanding and our future need to borrow (as shown by the liability benchmark line on the graph above) is reducing as we contribute more funding to reduce the need to borrow in the future. The gap between the

liability benchmark and the Existing Loan Debt Outstanding is the amount of borrowing that the Authority may have to take in the future, and there is therefore a risk that borrowing may have to be taken when the interest rate is in excess of the budgeted rate.

Indicator 4 – Core Funds and Expected Investment Balances

The table below shows the estimates of the year-end balances for each resource and anticipated day-to-day cash flow balances.

	2023/24 Original £k	2023/24 Revised £k	2024/25 Estimate £k	2025/26 Estimate £k	2026/27 Estimate £k
Total Core Funds	13,330	14,558	12,259	12,079	12,957
Expected Investments	5,030	8,558	3,750	3,379	4,149

The actual total investments held as at 30th September 2023 is £21.6m. This is higher than the expected investments due to the Pensions grant of which 80% was received in July 2023 which is drawn upon each month.

Indicator 5 - Operational Boundary for External Debt

The proposed operational boundary for external debt is based on the same estimates as the authorised limit but reflects directly the S151 Officer's estimate of the most likely, prudent but not worst case scenario, without the additional headroom included within the authorised limit to allow for example for unusual cash movements, and equates to the maximum of external debt projected by this estimate. The operational boundary represents a key management tool for in year monitoring by the S151 Officer.

	2023/24 Boundary £k	Actual As at 30/09/23 £k	2024/25 Boundary £k	2025/26 Boundary £k	2026/27 Boundary £k
Borrowing	31,500	17,169	31,500	31,500	31,500
Other Long-Term Liabilities	3,500	996	3,500	3,500	3,500
	35,000	18,165	35,000	35,000	35,000

The S151.Officer confirms that borrowing in the year has not exceeded the operational boundary at any point within the year to date and is not expected to do so over the course of the next period based on information currently available.

Indicator 6 - Authorised Limit for External Debt

The table below shows the Authorised limit for External Debt for 2023/24 and subsequent three-year period as approved by Members, compared to the actual level of borrowing as at 30 September 2023.

	2023/24 Limit £k	Actual as at 30/09/23 £k	2024/25 Limit £k	2025/26 Limit £k	2026/27 Limit £k
Borrowing	36,500	17,169	36,500	36,500	36,500
Other Long-Term Liabilities	3,500	996	3,500	3,500	3,500
	40,000	18,165	40,000	40,000	40,000

The Authorised Limit reflects the Authority's projected long and short-term borrowing requirements, together with any other long-term liabilities it may have. The figures are based on the estimate of most likely, prudent but not worst-case scenario, with sufficient headroom over and above this to allow for operational management of, for example unusual cash movements.

The S151 Officer confirms that the Authorised Limit has not been approached at any point during the first half of the year, nor is it likely to during the remaining six months of 2023/24.

Indicator 7 - Ratio of Capital Financing Costs to Net Revenue Stream

The ratio of financing costs to net revenue stream for the current year and estimates for future years are as follows: -

	2022/23 Actual %	2023/24 Original %	2023/24 Revised %	2024/25 Estimate %	2025/26 Estimate %	2026/27 Estimate %
Ratio of Financial Costs to Net Revenue Stream	3.03	2.81	2.03	3.75	3.84	4.07

These ratios indicate the proportion of the net budget of the Authority that is required to finance the costs of capital expenditure in any year. Estimates of financing costs include current commitments and the proposals contained in the capital programme of the Authority.

In calculating the ratio, Net Revenue Streams in any year have been taken to exclude any element of the net budget requirement that is intended to provide reserves for the Authority.

The projected increase in the ratio over the period reflects the increase in capital financing costs resulting from the capital allocations approved as part of the medium-term financial plan.

Indicator 8 – Upper and Lower Limits for the maturity structure of borrowings

This indicator seeks to ensure the Authority controls its exposure to the risk of interest rate changes by limiting the proportion of debt maturing in any single period. Ordinarily debt is replaced on maturity and therefore it is important that the Authority is not forced to replace a large proportion of loans at a time of relatively high interest rates.

"The Authority will set for the forthcoming financial year both upper and lower limits with respect to the maturity structure of its borrowings. The prudential indicators will be referred to as the upper and lower limits respectively for the maturity structure of borrowing and shall be calculated as follows:

Amount of projected borrowing that is fixed rate maturing in each period expressed as a percentage of total projected borrowing that is fixed rate;

Where the periods in question are:

- Under 12 months
- 12 months and within 24 months
- 24 months and within 5 years
- 5 years and within 10 years
- 10 years and above"

	Actual as at 30/09/23	Upper Limit	Lower Limit
	%	%	%
Under 12 Months	2.91	15	0
12 months and within 24 months	7.23	15	0
24 months and within 5 years	19.97	30	0
5 years and within 10 years	40.77	60	0
10 years and above	29.12	80	0

The S151. Officer confirms that the maturity structure of external debt as at 30/09/23 is within the upper and lower limits approved by the Authority.

Agenda Item No. **7**

Governance, Audit and Scrutiny Committee
13 November 2023

Report by the Head of Training and the Head of Organisational Development

ON-CALL STAFF LEARNING AND DEVELOPMENT

1. SUMMARY

1.1 The Service remains committed to providing excellent learning and development for all its staff, however this report will specifically focus on the learning and development opportunities and challenges in relation to On-Call firefighters and addresses the requirements of the scope for this report, which are:

- Identification of any differences between opportunities provided for fulltime staff opposed to On-Call;
- Effectiveness of how the PDR process is applied and managed for On-Call staff;
- Review of how the agreed outcomes and training, arising from the completed On-Call PDR's, are progressed and completed;
- Identification of any comments, references and overarching trend analysis arising from completed PDR's, including those relating to the Core Code of Ethics.

2. MATTERS FOR CONSIDERATION

2.1 The Committee may wish to endorse the Service's continuing commitment to learning and development and take assurance that in relation to On-Call firefighters these opportunities in relation to core competency requirements for effective service delivery and protection of the communities we serve are equal to those of all staff on different terms and conditions in the Service, although these opportunities for the reasons outlined in this paper, may be accessed and delivered in different ways.

3. BACKGROUND

3.1 This paper considers how the learning and development opportunities are provided for On-Call firefighters around their duty system and availability, bearing in mind the majority of them have other full-time employment commitments. We currently employ a total of 334 On-Call personnel, 122 (36%) of which are also Full-Time (dual contracted).

3.2 This report highlights the strategic initiatives undertaken to optimise the opportunities provided to On-Call firefighters within Humberside Fire and Rescue Service, aligning it with the specific requirements of local communities while also addressing the unique challenges presented by the On-Call duty system. Key priorities have been defined, emphasising the critical role of On-Call firefighters in prevention, protection, and response activities, with a particular focus on operational competence, as outlined within the Community Risk Management Plan, Service Improvement Plan and Station standards and plans. Subsequent training and development to achieve these priorities and operational competence are defined through National Operational Guidance (NOG) framework, and the Service Core Skills Framework, which are further defined through Role Specific Training Outlines for every role in the Service, including all operational roles.

3.3 To ensure the delivery of training and competence of On-Call firefighters, a maximum of 104 hours of paid development time per year has been allocated. This time is dedicated to weekly two-hour development sessions, supplemented by one additional hour of paid online theoretical learning, which can be completed at the convenience of each firefighter, with paid mandatory course attendance further supports their professional growth. This development time allocation differs from that for Full-Time

firefighters who have up to 6 hours per shift for training, development and CPD within their 24-hour shift pattern. This difference is due to the need to recognise and understand that many On-Call firefighters have other primary employment and the need to manage a work-life balance. It is also important to note that the 36% dual contracted firefighters will be eligible for up to 6 hours of development time within their Full-Time contract.

3.4 On-Call firefighters have two hours a week to maintain their competence; this is accomplished based around numerous factors including (but not exclusively) their PDRPro planning, Fire Fighter Development Pathway candidates, local risk exercise planning and availability of key staff. Furthermore, it is imperative to recognise that all On-Call Stations necessitate the presence of personnel possessing specialized proficiencies in areas such as emergency response driving, management, and incident command, all of which are also required from Full-Time firefighters.

3.5 Learning materials to support development needs are coordinated centrally by the Learning and Development Team, ensuring consistency across both Full-Time and On-Call duty systems. These materials are designed to accommodate the time constraints of On-Call personnel while maintaining uniformity in content delivery. The training calendar starts with the provision for On-Call firefighters in the first instance, ensuring that their needs are met through evening and week-end provision to fit around their primary employment.

3.6 In response to valuable feedback, the Learning and Development Team have also initiated trials of, and are actively planning to expand, a new suite of virtual training modules. These sessions are designed to be instructor-led and conducted in a virtual environment, fostering interactive engagement. Subject matter experts will lead these sessions, making them dynamic and informative. To ensure full inclusivity and seamless participation, these sessions have been thoughtfully scheduled during daytime, evening, and weekend hours encouraging enhanced collaboration and integration between our Full-Time and On-Call crews, promoting shared learning and a more cohesive learning environment between the two duty systems.

3.7 There are a number of challenges for both the Service and On-Call firefighters in achieving and maintaining the required level of competency and standards. These challenges consist of the following:

Availability Constraints

- On-Call firefighters often have primary employment or other personal commitments, making it challenging to align their schedules with training and study requirements. Their availability for accredited courses such as leadership and development, as well as focused exam preparation, can be limited due to these constraints. The Service therefore instigated and continues to support the 104 hours of paid development per year during which this is focussed for the competency requirements for their role and responsibility. However, for example, in meeting their core skills requirements such as leadership and management development attendance at day courses will be paid for by the Service, in addition to the 104 hours allocation.

Response Time

- The unpredictable nature of emergency response calls places significant demands on On-Call firefighters. They must respond promptly when duty calls, which can disrupt their study schedules and attendance at training sessions.

Work-Life Balance

- Striking a balance between their primary employment, family obligations, and fire service commitments is challenging for On-Call firefighters. This can potentially

limit the time and energy available for further professional/accredited development and education.

Remote Locations

- On-Call personnel often serve in rural or remote areas where access to training facilities and educational resources/facilities may be limited. The flexibility of training provision as described above widens the access to learning and development resources for our On-Call firefighters.

Limited Study Time

- Study time has been allocated (104 hours) for core competency and maintenance. However it was noted that there was a reluctance in On-Call firefighters putting themselves forward for promotion, a common barrier was the Service requirement for IFE examinations and formal accredited qualifications in leadership and management. On consultation with highly experienced and dedicated On-Call firefighters the Service made a decision to remove these requirements and enable a promotion process for those skilled and talented individuals, thus enabling a successful promotion process to be undertaken and securing this talent and individual commitment.

Challenges for promotion

- On-Call firefighters are limited in their pursuit of career advancement by the establishment of the station and the availability requirements of their on-call appliances, the impact of which is the need to strike an appropriate balance between their personal life and managerial responsibility.

4. PERFORMANCE DEVELOPMENT REVIEW (PDR) AND TRAINING NEEDS ANALYSIS (TNA) PROCESS

4.1 The annual PDR/TNA process is conducted between February and April of each year. The time frame of 3 months is to allow adequate preparation and completion time for all staff to partake in their PDR, in particular for on-call staff. PDRs are completed during Service time, if for any reason this cannot be accommodated during Service time then staff, including on-call staff should be paid for the hour allocated to PDRs. Preparation, training and support to conduct and participate in PDRs are provided in a variety of ways; online training, resources via SharePoint pages and team/watch based sessions, which are available for all staff including on-call.

4.2 The PDR process includes a section on the Core Code of Ethics as a supportive narrative section. This will be further enhanced through the introduction of a 360 degree feedback tool for all supervisory managers and above (from CM and equivalent fire staff to SLT) the questionnaire and accompanying report is uniquely designed to reflect the NFCC Leadership Framework and the Core Code of Ethics behaviours and standards. This will be available for the next round of PDR in 2024.

4.2 All operational training requests made through the annual PDR process are shared with Operational Training for consideration and for inclusion in the annual training plan. All other requests such as health and safety and prevention and protection are sent to the appropriate Head of Service. The Organisational Development manage all other core skills requests and the subsequent training commissioning/provision. Requests made by on-call members of staff are included in this process.

4.3 The organisational Development function conducts an annual report of the PDR/TNA process in which it dip samples 50 PDRs; 10 from each District (4 x Districts), including on-call personnel and 10 from Corporate functions. From this annual review process, we are able to identify areas for improvement or action, including for example, any areas of the Service that may not have a 100% return rate which the action undertaken

was for extra monitoring during the process and to escalate any concerns to the Head of Function/District and provide extra training/support as required.

4.4 As the PDR process is conducted and monitored through a power BI system we have real time monitoring of PDR completions. The completion rate for PDR's completed during 2023 was 94% overall with Emergency Response completion rate at 95% (which includes On-Call firefighters). Upon further inspection OD have confirmed several reasons for the non-completions, which include;

- The member of staff has retired (or is shortly planning to do so)
- The member of staff is on long term sickness leave
- The member of staff has left the organisation
- The member of staff is on secondment
- The member of staff was a Full-Time firefighter recruit*
- The member of staff was an On-Call firefighter recruit*

*Please note that all trainee firefighters (Full-Time and On-Call) will complete an interim PDR with their line manager as part of their development pathway. This tends to be completed during the transition to station phase following initial training

4.5 Relevant managers who had non completions showing in the monitoring phase were approached regarding their responsibilities to undertake PDRs and to understand from them any reasons why they were not completed.

4.6 To assist with those staff that did not receive a PDR in the annual cycle round during February to April and Interim PDR process was established from May to January so that those who were absent from the Service can have a PDR during the calendar year.

4.7 The common themes/findings that we have seen in the last 4 years of running an annual PDR/TNA process remain broadly similar; the reasons for non-completions (as stated above) and some variability in the quality/content of the PDRs that are produced. This could be for justifiable reasons, for example an individual is content and highly skilled in their current role and does not wish to consider promotion, their PDR return and training requests will be minimal. The PDR process is launched with refresher training, refreshed guidance and during the 'open' PDR period the returns are closely monitored to identify any areas of non-completions together with the annual sampling picks up any immediate or follow up actions required. The continuation of provision of training and a wealth of resources i.e. detailed guidance, e-learning, bite size modules and face to face support ensures both staff and managers are aware of the requirements to conduct an effective PDR/TNA on an annual basis.

4.8 We are currently awaiting the results of the RealWorldHR staff survey which may indicate and areas of note or action in relation to on-call personnel and their development/PDR opportunities that we can consider for any further improvements.

5. EQUALITY IMPLICATIONS

5.1 There is no requirement to carry out an equality impact analysis as this report does not relate to a policy or service delivery change

6. CONCLUSION

6.1 In summary the Committee may wish to endorse the Service's continuing commitment to learning and development and take assurance that in relation to on-call firefighters these opportunities in relation to core competency requirements for effective service delivery and protection of the communities we serve are equal to those of all staff on different terms and conditions in the Service, although these opportunities for the reasons outlined in this paper, may be accessed and delivered in different ways.

6.2 This assurance can be supported by the recent TIAA audit on staff development in September this year for which the Service received considerable assurance and no recommendations.

Claire Tait
Head of Training

Sam O'Connor
Head of Organisational Development

Contact Officers

Claire Tait – Head of Training
☎ 07851740201
✉ claire.tait@humbersidefire.gov.uk

Sam O'Connor – Head of Organisational Development
☎ 07980 684779
✉ soconnor@humbersidefire.gov.uk

Background Papers

None

Glossary/Abbreviations

CPD	Continuous Professional Development
PDR	Performance Development Review
TNA	Training Needs Analysis

Governance, Audit and Scrutiny Committee 13 November 2023

Agenda Item No. 8

Report by the Secretary & Monitoring Officer

GAS COMMITTEE SCRUTINY PROGRAMME AND WORKSTREAMS 2023/24

1. SUMMARY

1.1 This paper summarises the Governance, Audit and Scrutiny (GAS) Committee's Scrutiny Programme and work streams for 2023/24. Each year, the Committee will programme a number of specific, defined scrutiny items complete with scopes in order that relevant officers can focus their reports.

1.2 Appendix 1 to this report will serve as a point of reference for report-writers and as a 'living document' during the year for the Committee as it considers the scopes for its scrutiny items.

2. MATTER FOR CONSIDERATION

2.1 The Committee to receive approve its scrutiny programme as necessary.

2.2 The Committee to note it's work streams.

3. BACKGROUND

3.1 Public scrutiny is a corporate process undertaken by the Committee, appointed by the Fire Authority for its breadth of professional experience.

4. REPORT DETAIL & OPTIONS/PROPOSALS

4.1 Appendix 1 of this report sets out the topics and scopes for consideration and review as necessary.

4.1 Appendix 2 to this report sets out a forward plan of items to be considered by the GAS Committee for the year 2023/24.

5. EQUALITY IMPLICATIONS

5.1 There is no requirement to carry out an equality impact analysis as this report does not relate to a policy or service delivery change.

6. CONCLUSION

6.1 The Committee is requested to receive any updates and approve changes to its scrutiny programme as necessary.

Lisa Nicholson
Secretary & Monitoring Officer

Officer Contact

Rob Close – Committee Manager
☎ 01482 393899
✉ committeemanager@humbersidefire.gov.uk

Background Papers

None

Glossary/Abbreviations

GAS	Governance, Audit and Scrutiny Committee

Appendix 1

GAS Committee Scrutiny Programme 2023/24		
Meeting Date	**Responsible Officer**	**Item and Scope**
Monday 3rd July 2023	**Head of HR**	**Grievance Procedures** • Review of grievance policy and its consistency in application • Trend analysis of incoming grievances received • Effectiveness of the training of managers and supervisors in managing related situations • Quality of the communications and engagement with staff to increase understanding and confidence towards the procedures
Monday 4th September 2023	**Head of Fleets and Estates** Head of Organisational Development Head of Joint Estates	**Dignity Works Scheme** • Review of the scheme, records, monitoring and implementation • Consideration of how EDI is aligned to the scheme including the completion of related Equality Impact Analysis (EIA) for works completed • Review of any identified learning and adjustments resulting from the completed EIA(s) • Performance management and evaluations of work undertaken and the resulting learning outcomes • Communication of works schemes to relevant groups and / stakeholders
Monday 13th November 2023	**Head of Training** **Head of Organisational Development** District Manager East Riding District Manager North Lincs	**On-call staff learning and development** • Identification of any differences between opportunities provided for fulltime staff opposed to On-Call • Effectiveness of how the PDR process is applied and managed for On-Call staff • Review of how the agreed outcomes and training, arising from the completed On-Call PDR's, are progressed and completed • Identification of any comments, references and overarching trend analysis arising from completed PDR's, including those relating to the Core Code of Ethics

GAS Committee Scrutiny Programme 2023/24		
Meeting Date	**Responsible Officer**	**Item and Scope**
Monday 22nd January 2024	**Head of Emergency Preparedness & Control** Station Manager (Control)	**Fire Control - Exercises and Debrief** • Processes and procedures to ensure the inclusion of control room staff in exercise and debrief activities • How exercise and debrief activities are recorded to register Fire Controls involvement in the process. • Mechanisms in place to capture learning and actions for Fire Control to address, including evidence of their application and learning outcomes. • How the outcomes and leaning from exercises and debriefs are effectively communicated amongst Fire Control staff and other key stakeholders as applicable. • Review of any related policy and / or guidance to demonstrate compliance
Monday 19th February 2024	**Head of Organisational Development**	**National Fire Chiefs Council (NFCC) Maturity Model** • Processes used to manage the completion of the related maturity model subject(s) • Assurance and validation of the self-assessment evidence provided • Monitoring and review of self-assessment for changes and / or arising issues • Review of actions used to address identified GAPs through the self-assessment tool • Review of learning and outcomes generated from completed self-assessment(s) • As applicable how the outcomes from an independent review of the self-assessment(s) are addressed regarding sharing best practice and addressing areas of needed improvement
Monday 8th April 2024	**TBC**	Arising themes from HMICFRS reports or emerging sector requirements

Appendix 2

GAS Committee Scrutiny Programme 2023/24	
Meeting Date	**Item and Scope**
Monday 3rd July 2023	• Treasury Management Annual Report 2022/23 • Internal Audit Reports • Scrutiny item: Grievance Procedures
Monday 4th September 2023	• Management Accounts Period ending 30 June 2023 • Internal Audit Reports • External Audit Completion Report • Annual Statement of Accounts 2022/23 • Scrutiny item: Dignity Works Scheme
Monday 13th November 2023	• Internal Audit Reports • Management Accounts Period ending 30 Sep 2023 • Treasury Management Half Year Report 2022/23 • Scrutiny item: On-call staff learning and development
Monday 22nd January 2024	• Auditor's Annual Report 2022/23 • Internal Audit Reports • Review of Anti-Fraud Related Policies [verbal] • Scrutiny item: Fire Control - Exercises and Debrief
Monday 19th February 2024	• Internal Audit Reports • Internal Audit Plan 2024/25 • Treasury Management and Capital Expenditure Strategy 2024/25 • Scrutiny item: National Fire Chiefs Council (NFCC) Maturity Model