To: Members of the Governance, Audit and Scrutiny Committee	**Enquiries to:** Rob Close **Email:** committeemanager@humbersidefire.go.uk **Tel. Direct:** (01482) 393899 **Date:** 23 November 2022

Dear Member

I hereby give notice that a meeting of the **GOVERNANCE, AUDIT AND SCRUTINY COMMITTEE** of Humberside Fire Authority will be held on **TUESDAY 1 DECEMBER 2022 at 10.00AM** at HUMBERSIDE FIRE & RESCUE SERVICE HEADQUARTERS, SUMMERGROVES WAY, KINGSTON UPON HULL, HU4 7BB.

Public and press attendance at meetings

Due to current social distancing requirements, a **maximum of 4 people** will be permitted entry to the public gallery - **places must be booked in advance** by contacting the Committee Manager on the contact details above.

To access this meeting remotely please visit <https://zoom.us/join> and then enter:

Meeting ID: 833 2092 5497
Passcode: 686974

The business to be transacted is set out below.

Yours sincerely

for Lisa Nicholson
Monitoring Officer & Secretary to Fire Authority

Enc.

A G E N D A

Business	Page Number	Lead	Primary Action Requested
Procedural			
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

Business	Page Number	Lead	Primary Action Requested
3. Minutes of the meeting of 23 September 2022	(pages 1 - 2)	Chairperson	To approve
4. Matters arising from the Minutes, other than on the Agenda	-	Chairperson	To raise
Governance 5. Update: Matters Arising/ Feedback from Fire Authority	Verbal	Chairperson and Monitoring Officer/ Secretary	To consider and make any recommendations to the HFA
Audit 6. Internal Audit Reports	(pages 3 - 54)	Internal Audit (TIAA)	To consider and make any recommendations to the HFA
Finance and Performance 7. Treasury Management Half Year Report 2022/23	(pages 55 - 58)	Deputy Joint Chief Finance Officer	To consider and make any recommendations to the HFA
8. Management Accounts – Period ending 30 Sept 2022	(pages 59 - 64)	Deputy Joint Chief Finance Officer/Deputy S.151 Officer	To consider and make any recommendations to the HFA
Scrutiny Programme 9. Scrutiny Item - Procurement	(pages 65 - 72)	Deputy Joint Chief Finance Officer	To consider and make any recommendations to the HFA
10. GAS Committee Scrutiny Programme 2022/23	(pages 73 - 81)	Monitoring Officer/Secretary	To approve
11. Any Other Business	-	All Members	To raise

Under the Openness of Local Government Bodies Regulations 2014 members of the public may film, record, take photographs or use social networking during Authority and committee meetings that are open to the public. *The Monitoring Officer/Secretary kindly requests advance warning from anyone wishing to film, record or take photographs during open meetings so that suitable provision can be made.*

HUMBERSIDE FIRE AUTHORITY

GOVERNANCE, AUDIT AND SCRUTINY COMMITTEE

5 SEPTEMBER 2022

PRESENT: Independent Co-opted Members James Doyle (Chair) Chris Brown (remote), Kathryn Lavery, and Gerry Wareham.

Phil Shillito – Deputy Chief Fire Officer/Executive Director of Corporate Services, Jon Henderson – Director of Prevention and Protection, Steve Topham – Director of Emergency Response, Jamie Morris – Senior Service Improvement Officer, Nick King – Deputy Monitoring Officer/Secretary, Samm Campbell - Committee Manager, and Rob Close – Committee Manager were also present. Ross Woodley - External Auditor (Mazars) attended remotely.

The meeting was held at the Humberside Fire and Rescue Service Headquarters, Kingston upon Hull. The meeting commenced at 10.00 a.m.

PROCEDURAL

61/22 APOLOGIES FOR ABSENCE – Apologies for absence were received from Pam Jackson and Councillors Briggs and Green.

62/22 DECLARATIONS OF INTEREST – There were no declarations of interest.

63/22 MINUTES – ***Resolved*** – That the minutes of the meeting of the Committee held on 4 July 2022 be confirmed as a correct record as amended.

64/22 MATTERS ARISING FROM THE MINUTES, OTHER THAN ON THE AGENDA – There were no matters arising.

GOVERNANCE

65/22 UPDATE: MATTERS ARISING/FEEDBACK FROM FIRE AUTHORITY – The Deputy Monitoring Officer/Secretary provided feedback on items considered by the Fire Authority at its meetings of 22 July 2022.

Resolved - That the update be received.

AUDIT

66/22 EXTERNAL AUDIT COMPLETION REPORT - Ross Woodley (Mazars) presented a report updating the Committee on progress in relation to the external audit process.

The external audit was substantially completed and there appeared to be no matters that might affect the final audit opinion. Assurances were still outstanding from the pension fund auditor to allow for the significant risk resulting from the defined benefit pension liability valuation to be addressed. Those assurances were however, expected to be received in advance of the deadline. Moreover, the billing authorities' 2021/22 accounts were now available so the external auditors could assess that the accuracy of the estimates used by the Authority remained appropriate. No significant weaknesses to internal control or value for money were identified during the 2021/22 audit. A misstatement value of £263,000 was identified and would be corrected at the next valuation.

Resolved - That the report be received.

67/22 Internal Audit Update - The Sub-Committee received a report of the internal auditors, TIAA.

Resolved - That the report be received

FINANCE AND PERFORMANCE

68/22 HMICFRS UPDATE - The Senior Service Improvement Officer delivered a verbal update advising the Committee on the December HMICFRS inspection prior to it being formally received at the Humberside Fire Authority. The Authority received a Good rating over the thee pillars and increased four Requires Improvement ratings to Good, resulting in a universal Good rating throughout the sub-categories.

In response to a question seeking clarity on the higher than England average Firefighter cost per person, the Committee were advised there were a number of factors that may impact the cost per person including being a largely rural and coastal authority.

Resolved - That the updated be noted.

SCRUTINY PROGRAMME

69/22 GAS COMMITTEE SCRUTINY PROGRAMME 2022/23 - The Committee Manager submitted a report summarising the Committee's Scrutiny Programme 2022/23.

Under officers' advice, the Committee moved to defer the item titled 'Emergency Response Business Continuity' to be programmed for a future meeting stressing that they were keen for it to be scrutinised.

Resolved - That the item titled 'Emergency Response Business Continuity' be deferred with a view to consider it at a later date.

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Internal Audit

FINAL

Humberside Fire and Rescue Service

Summary Internal Controls Assurance (SICA) Report

2022/23

November 2022

Summary Internal Controls Assurance

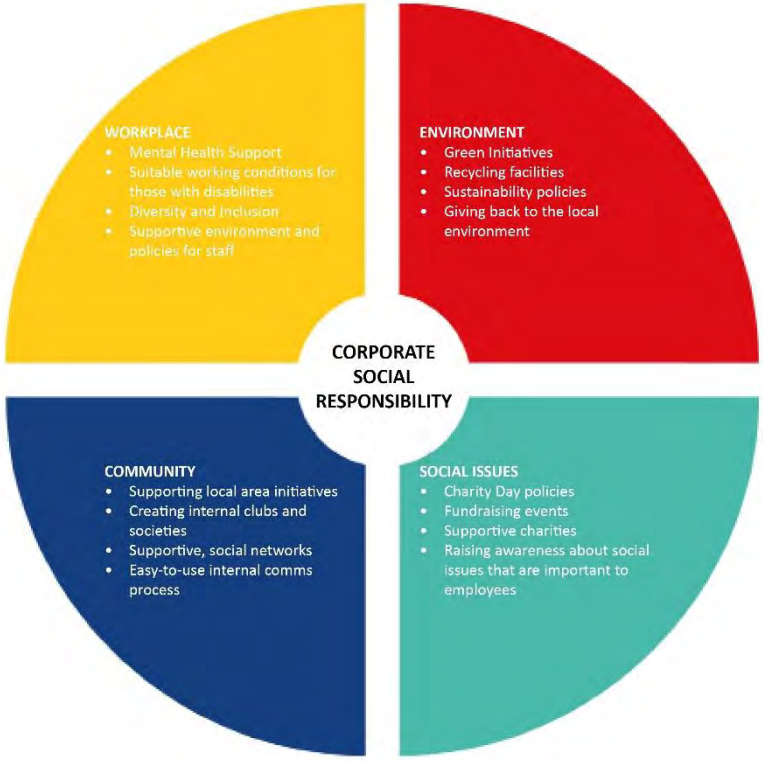
Introduction

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 (HFRS) as at 18th November 2022.

Emerging Governance, Risk and Internal Control Related Issues

2. Corporate social responsibility (CSR) refers to the self-imposed responsibility of businesses to society in areas such as the environment, the economy, employee well-being, and competition ethics. Many businesses use internal CSR regulation as a form of moral compass to positively influence the ethical development of their business.

   Traditionally, CSR was viewed as something only large businesses practiced. In the past, simply having a CSR intention in place was already enough for a business to be recognised as socially responsible, even if the idea of social responsibility did not influence the business model or the production processes. In today's market however, businesses of all sizes are increasingly held responsible for their social and environmental impact by their customers. And because every business is part of a value/supply chain consisting of other businesses, when they advocate for sustainability, ethical practices, and generosity, this creates a positive ripple effect on all stakeholders.



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**
Equality Impact Assessments	Reasonable	01/09/2022	22/09/2022	23/09/2022	0	2	0	0
Quality Assurance – Prevention and Protection	Reasonable	14/09/2022	22/09/2022	23/09/2022	0	1	0	0
Firewatch	Limited	08/09/2022	10/10/2022	11/10/2022	0	6	1	0
Follow Up (Mid-year)	N/A	03/11/2022	17/11/2022	17/11/2022	-	-	-	-

Progress against the 2022/23 Annual Plan

4. Our progress against the Annual Plan for 2022/23 is set out in Appendix A. Work was deferred at the request of HFRS following the ICT incident and our work was only able to commence mid-way through August 2022. Despite this delay the audit programme will be fully on track by the end of November 2022 and the work scheduled for Quarter 4 has had dates agreed with HFRS management, with the exception of the year-end Follow Up, which will be confirmed by the end of the current quarter.

Changes to the Annual Plan 2022/23

5. Two review subjects have now been confirmed following publication of the HMICFRS Inspection Report; these being audits of Secondary Contracts and Rota Availability System. Days were held and allocated in the original plan for two audits, so there is no additional cost to the Authority.

Frauds/Irregularities

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

Other Matters

7. We have issued a number of briefing notes, shown in Appendix B, since the previous SICA report.

Responsibility/Disclaimer

8. 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
Equality Impact Assessments	2	Completed	Presented to November GAS
GDPR	2	Scheduled for 21st November 2022	
FireWatch	2	Completed	Presented to November GAS
Quality Assurance – Prevention and Protection	2	Completed	Presented to November GAS
Follow up (mid-year)	3	Completed	Presented to November GAS
Collaboration Activity	3	Draft report issued 14th November 2022	
Secondary Contracts	3	Site work commenced 14th November 2022	
ICT-Management Controls	4	Scheduled for 6th February 2023	
Key Financial Controls	4	Scheduled for 6th March 2023	
Rota Availability System	4	Provisional date 20th March 2023	
Follow up (year-end)	4	Date to be agreed	

KEY:

	To be commenced		Site work commenced		Draft report issued		Final report issued

Briefings on developments in Governance, Risk and Control

TIAA produces regular briefing notes to summarise new developments in Governance, Risk and Control, 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 issued in the last three 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 -22023	UK Government reveals new Data Protection rules		**Action required:** Audit Committees and Boards / Governing Bodies are advised to familiarise themselves with the response document in line with the current Data Protection practices.
CBN - 22024	ICO sets out revised approach to Public Sector enforcement		**Action required:** Audit Committees and Boards / Governing Bodies are advised to note this information.
CBN - 22026	Rise in Environmental, Social and Governance and supply chain fraud		**Action required:** Audit Committees and Boards / Governing Bodies are advised to note the outcome of the survey.
CBN - 22030	Government Response – Consultation on extending National Fraud Initiative data matching to new purposes		**No action required:** For information only to Audit Committees and Boards/Governing Bodies.
CBN - 22031	Five Year Local Authority Audit procurement results Announced		**Action required:** Audit Committees and Boards / Governing Bodies are advised to familiarise themselves with the new guidance.

Internal Audit

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Humberside Fire & Rescue

Assurance Review of Quality Assurance – Prevention and Protection

2022/23

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Included on audit plan for 2022/23

KEY STRATEGIC FINDINGS

The process was found to be well directed through the overarching Quality Assurance (QA) frameworks. Most activity is being delivered in line with these.

Protection: inspectors in development are subject to 100% QA from competent inspectors. QA for competent inspectors is not currently taking place, however.

Prevention: QA is undergoing a phased implementation. While some elements are in place, others have been delayed following COVID and the cyber-incident.

Established data cleansing routines and retention periods are in place, in order to maintain the quality of information held in the CFRMIS system.

GOOD PRACTICE IDENTIFIED

The Prevention and Protection SharePoint page has recently been refreshed to provide a user-friendly, intuitive interface for accessing resources.

Management designed an alternative process for the collection and QA of data while system access was interrupted following the recent cyber-incident.

SCOPE

The review considered the process for the recording of data for prevention and protection activities undertaken by the Service, including: how and by whom the data is recorded, initial quality assurance checks, monitoring and how data is updated and/or removed.

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	An overarching Quality Assurance Framework is in place for both Prevention and Protection, published on the SharePoint site. These define the frequency of QA for each activity and group of staff. While the QA process was found to be well-established in several areas (see Other Findings), management confirmed that there are some elements that are not currently being undertaken. Protection: the QA of competent inspectors has not taken place since the onset of the COVID pandemic, due initially to the challenges in conducting in-person visits, but subsequently with resourcing issues and the prioritisation of conducting QA for inspectors in development. Prevention: QA for Fire Setter Education visits, and full time and on-call crew Safe and Well visits, is scheduled to begin in October 2022 following confirmation of staffing arrangements and the provision of training. The QA processes for School Education and Partner Training remain in development and will be launched at a later date.	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.	2	*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.*	*01/12/22* *01/10/22* *Ongoing* *01/10/22* *01/11/22*	*Head of Protection* *Head of Prevention* *Head of Prevention* *Head of Prevention* *Head of Prevention*

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
There were no operational effectiveness matters identified.				

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
There is a strong focus on ensuring that the data collected on visits and inspections is of a high standard at the time it is gathered. The recently updated Prevention and Protection SharePoint area contains valuable resources and advice for staff, along with links to critical documentation, including service delivery guidance for the various types of activity undertaken. Contact details are also available for crews to get in touch with specialist teams to provide real-time advice in case of doubt. This approach provides ample opportunity for data to be correct first time in most cases.
Standard forms are in place for crews, advisors and inspectors to use while recording the outcome of visits and inspections. These forms make use of tools such as mandatory fields and are designed to ensure that all necessary information is collected to a high standard during the engagement.
For Prevention visits, the pro-forma is completed via the mobile device while on-site, which syncs with CFRMIS when back at the station. Inspectors working on Protection matters write up their visits upon their return to the station, as this activity is more closely guided by external standards and requires a high level of judgement, which often benefits from additional reflection.
Management reported that the processes for collection and assurance of data were heavily impacted by the recent cyber-incident, due to the inability to access CFRMIS. It was explained that alternative forms were developed where necessary to ensure continuity of delivery. Work is now beginning to quality assure information before entering into CFRMIS.

Other Findings

Data held within CFRMIS is subject to agreed retention periods, to ensure that it remains up to date and valid. Retention periods vary with some items retained indefinitely, while others would prompt staff to re-validate or remove the entry after a specified period. The risk-based approach to assessing each type of data was found to be appropriate and this process for maintaining the quality of operational risk data was subject to a dedicated audit during 2021/22.

Observational QA activity is supported through a series of documents, to ensure that this process is itself of sufficient quality.

Prevention - each type of activity has an associated QA Framework document detailing the key actions required for the activity and rating performance as Outstanding, Good, Requires Improvement, or requiring Training/Support. A detailed review of two of these frameworks confirmed that they were well-aligned with the corresponding service delivery guidance directing that task. The outcomes of the QA are input into a SharePoint form, which generates a report to the Prevention Manager, facilitating trend analysis and monitoring of QA activity.

Protection - a standard framework is in place for all types of inspection, rating performance as Good, Satisfactory, or Requires Improvement. This approach was explained as more appropriate to the need for inspections to assess legal compliance and the need for highly qualified personnel to exercise professional judgement. The content of the framework was found to be appropriate, directing the QA process to consider the key elements of the inspection.

It was confirmed that all inspections carried out by inspectors in development are subject to QA by a competent inspector. Outcomes are fed back on an individual basis and any points for development fed into the individual's development plan. The Protection Manager explained that, given the small number of inspectors across the Service, there is insufficient data for meaningful trend analysis or to identify universal training needs; rather the 1:1 support from an experienced, qualified professional inspector is considered the best approach to quality assurance in the current circumstances.

Prevention data collected from visits is subject to quarterly QA by the Prevention Manager. This is a desktop exercise to identify compliance with expected values (such as invalid or blank entries), or to verify whether standard follow up has taken place (such as a referral following a safeguarding concern). This analysis provides an opportunity to address any quality issues for specific cases, but also to provide wider interventions such as extra training or guidance, or to amend pro forma.

It was confirmed that Prevention QA has been conducted into all recent serious incidents, in line with requirements. It was further noted that learnings regarding communication had been identified and action taken to address this with the relevant department.

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

A regular report is produced following the desktop reviews of Prevention data within CFRMIS. This is generally done on a quarterly basis, but the most recent was completed in April 2022 because data has not been available for analysis since the cyber-incident. This report is presented at various meetings including Safeguarding Compliance, Prevention Managers Meeting and External Safeguarding boards.

The Prevention Manager provided an explanation and supporting evidence of actions undertaken to address the findings arising from the April 2022 data analysis, which were all found to have been progressed appropriately.

The use of mobile data terminals for inspections and visits is well-embedded within the Service, with the strong expectation that paper copies of delivery guidance and forms are not used, to ensure that staff always have the most up-to-date version.

Although the QA process is very dependent on the systems and their links to CFRMIS, the Service demonstrated the ability to continue delivering and assuring Prevention and Protection activity following the cyber-incident when many systems or data were unavailable. Temporary forms were created, enabling visits to continue and facilitating the identification of key risks.

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:	25th May 2022	25th May 2022
Draft Report:	14th September 2022	22nd September 2022
Final Report:	23rd September 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire & Rescue		
Review:	Quality Assurance – Prevention and Protection		
Type of Review:	Assurance	**Audit Lead:**	Stuart Whittingham

Outline scope (per Annual Plan):	The review will consider the process for the recording of data for prevention and protection activities undertaken by the Service to include: how and by whom the data is recorded, what initial quality assurance checks, monitoring and how data is updated and/or removed.
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 prevention and protection arrangements. • The policy and procedures are up-to-date and clearly define authorisation limits and responsibilities. Any changes to process that have arisen due to Covid-19 working practices will also be considered to ensure that controls remain robust. • Data sources used to direct prevention and protection activities are appropriate. • Processes for uploading and importing data for use by the Service are robust, include appropriate checks and avoid the corruption of information. • Processes for reporting data within are adequate and produce reliable outputs. • The Service has considered the risks associated with data quality and appropriate mitigating controls are identified and operated. • Performance is monitored appropriately by senior management and the Authority

Planned Start Date:	05/09/2022	**Exit Meeting Date:**	07/09/2022	**Exit Meeting to be held with:**	Prevention and Protection Management Team

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.?	Y
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

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Humberside Fire & Rescue

Assurance Review of Equality Impact Assessments

2022/23

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Audit topic identified through analysis of HMICFRS findings.

KEY STRATEGIC FINDINGS

The Equality Impact Assessment (EIA) process was found to be designed around established best practice from the National Fire Chiefs Council.

From a sample of HFRS policies, it was ascertained that EIAs are consistently completed as these policies are reviewed.

Tracking and quality control processes are not yet fully embedded across HFRS, as not all EIAs are being submitted for publication and review.

Data suggests that EIAs are less common for key decisions, projects, community-facing activity and committee matters.

GOOD PRACTICE IDENTIFIED

An annual review of all EIAs submitted to Organisational Development (OD) is conducted, with key findings and recommendations identified.

Bespoke training from external specialists has been provided based on the annual report recommendations, with good rates of uptake across HFRS.

SCOPE

The review considered the arrangements in place for the completion of equality impact assessments (EIAs) and for acting upon measures identified within associated action plans.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	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	In order to facilitate monitoring, quality assurance and publication, the Delivery Guidance states that completed EIAs must be sent to Organisational Development (OD). A sample was selected of eight policies published since May 2021 on the HFRS website. All of these policies made reference to an associated EIA, but only five of the EIAs had been provided to OD, meaning that the remainder had not been available for review or monitoring through OD's established process. Two of the missing EIAs were provided during the audit by their authors, but the final one could not be located. It is suspected that this may have been affected by the loss of data within the local storage location during the recent cyber-incident.	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	*Agree with findings.* *A reminder will be sent to all EIA trained staff and TLT members.*	*01/10/22*	*Sam O'Connor* *Head of OD*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	The Delivery Guidance confirms that "An EIA must be carried out on every activity, policy, process, project or decision". Analysis of EIA tracking data held by OD found no actions relating to projects, nor to Authority papers, while only one item related to an SLT report. Very few items make reference to specific decisions and identify issues to be addressed before actions are taken. Furthermore, fewer than 10% of all actions were found to relate to external or community matters, with the vast majority focused on internal policies or equality among HFRS staff. While it is likely that further EIAs exist but have not been reported to OD, it is inferred from this analysis that, while there is widespread awareness of the need for EIAs in relation to HFRS policies, there has yet to be a full understanding of need for EIAs for other types of activity, project or decision. The Head of OD confirmed that policies have been the primary focus for EIAs thus far, while HFRS is currently planning a Service-wide EIA for all of its areas of activity, to cover key high-level matters and also raise general awareness among management.	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.	2	*Agree with findings.* *Further IAG will be provided.*	*31/12/22*	*Lou Marritt* *L&D Manager*

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
There were no operational effectiveness matters identified.				

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
A comprehensive EIA policy is in place, both linked to the wider Equality and Inclusion Policy and to delivery guidance specific to EIAs. These documents are all up-to-date, having been reviewed since summer 2021. Appropriate reference is made to Service's legal duties in respect of the Public Sector Equality Duty (PSED), and progress on EIAs is recorded within the PSED Action Plan.
The Policy and Guidance clearly state the situations in which an EIA should be conducted. Middle managers are specified as generally taking responsibility for producing an EIA, with Heads of Function accountable for any action plans arising from the assessment.
The wording of the Policy and Guidance was found to mirror that of the best practice materials published on the NFCC website, notably including the recommended five-stage approach. HFRS has also adopted the NFCC templates for the completion of EIAs.

Other Findings
The HFRS templates and guidance for policies, project plans and submission of committee papers all include the requirement to consider or complete an EIA, providing an ongoing prompt to staff to maintain compliance with requirements.
The Community Risk Management Plan (CRMP) has an EIA in place, with a number of actions identified around both delivery and presentation. The version of the CRMP currently available on the HFRS website was found to have taken account of many of the matters identified.
OD maintain a tracker with all actions arising from completed EIAs that have been submitted to OD. Management are regularly requested to provide progress updates. An analysis of findings from the sampled selection of policies confirmed that all actions had been added to the tracker. It was noted that progress updates were not available for many of the actions being tracked. The Head of OD confirmed that the system supporting this process had been taken offline for several months following the cyber-incident, therefore the ability to provide updates had not been in place until very recently. OD will continue to monitor compliance in this area over the coming months.
Training records show that 60 staff members have attended bespoke training provided by external specialists. This includes 15 of the 20 individuals listed on the Senior Management page of the HFRS website. Staff who have received training across middle and senior management levels include representatives from all departments, ensuring that knowledge is widely held and all areas have some staff with the necessary training.

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.	In place	-	-

Other Findings

The EIA Policy requires that OD produce an annual report for the EDI Steering Group on the EIAs that have been published, in order to identify areas for improvement in quality, quantity or coverage.

In June 2021 the first of these reports was produced and resulted in multiple recommendations around process improvements and training. These were confirmed as having been acted upon by the time of the current audit.

The 2022 report was delayed due to the inability to access information taken offline following the cyber-incident, but is planned for the autumn of 2022.

Resilience in the overall process is achieved through building a wide network of staff with experience in the completion of EIAs, so that there is a sufficient pool of knowledge to facilitate peer support across the Service. As competence and confidence develops further, resilience and consistency of approach should also increase.

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:	26th July 2022	1st August 2022
Draft Report:	1st September 2022	22nd September 2022
Final Report:	23rd September 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire & Rescue		
Review:	Equality Impact Assessments		
Type of Review:	Assurance	**Audit Lead:**	Stuart Whittingham

Outline scope (per Annual Plan):	The National Fire Chiefs Council considers effective completion of equality impact assessments to be a critical consideration in order to: meet legal and statutory obligations; meet any established equality commitments within the Service's policies; and to help identify risks of unintentional, indirect or hidden disadvantage or discrimination. The HMICFRS inspection 2021-22 identified this as an area for improvement for HFRS: 'The service should make sure it has robust processes in place to undertake equality impact assessments and review any actions agreed as a result'.
Detailed scope will consider:	To provide assurance to the Governance, Audit and Scrutiny Committee that there is an adequate and effective process for carrying out, and acting upon, equality impact assessments, and that this is applied in practice: • Policy and procedures are up to date and reflect best practice, defining roles and responsibilities for the process. • Compliance with the policy including sample testing to assess implementation and embeddedness. • Process for reviewing and signing off equality impact assessments and reporting arrangements. • Provision of appropriate training and awareness. • Relevant risks are identified and mitigating controls implemented

Planned Start Date:	22/08/2022	**Exit Meeting Date:**	24/08/2022	**Exit Meeting to be held with:**	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.?	Y
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

Internal Audit

FINAL

Humberside Fire & Rescue Service

Assurance Review of Firewatch

2022/23

Executive Summary

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Included on audit plan for 2022-23

KEY STRATEGIC FINDINGS

The use of Firewatch was not found to be effectively directed through policy and procedure. There have been long-standing and ongoing problems with unreliable data.

System training and documentation is not comprehensive, contributing to poor quality data input and knowledge gaps on more advanced functionality.

Substantial staff time is dedicated to mitigating the impact of Firewatch data issues, through maintaining parallel tracking and monitoring processes.

Sample testing identified role changes that had not been updated in a timely fashion, both in Firewatch and on the establishment master spreadsheet.

GOOD PRACTICE IDENTIFIED

Staff responsible for data input into Firewatch have recently moved into the HR function, providing an opportunity to streamline processes.

ICT management controls and data protection arrangements for Firewatch were found to be robust and aligned with good practice.

SCOPE

The review considered the utilisation of and data management controls within the Firewatch system. The scope of the review did not include consideration of the IT network or the application security arrangements.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**6**	**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	Through discussion with management and review of correspondence records, it was confirmed that there are long-standing concerns regarding poor quality data within Firewatch. Efforts to address this over several years have not resulted in the necessary improvements. Staff responsible for data input have recently moved from another department into the HR function, now providing HR with greater oversight and control over the full process. The Head of HR noted several initiatives undertaken to improve data quality. "On-the-job" training by specialist users has been provided to staff inputting data. Training for the wider HR team from the software supplier has taken place, but was reported not to have met management expectations. A system manual has been provided by the supplier but management found this to be out-of-date. Limited procedural documentation on core tasks has been created internally.	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.	2	*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.*	*Monitoring of the data is ongoing and all training completed by the end of 2022*	*Head of HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	It was established that additional modules, add-ons and updates are available for Firewatch which HFRS is not currently using. Some of these are already available within the Service's current contract and others would require additional investment. No plan is currently in place confirming which items would fit with the Service's objectives, or the timeline on which they could be adopted. Correspondence records indicate that some of these items have been under active discussion for a considerable time. One example is a self-service module for staff to update their personal data, which is now standard practice in many similar organisations and may reduce the administrative burden. Other available updates may increase resilience and process efficiency, such as enhanced integration with cloud storage of personnel documents.	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.	2	*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.*	*April 2023*	*SLT/Heads of HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	A detailed monitoring process is in place for Firewatch data entry and establishment data. Two members of HR staff monitor the progress of all people and establishment forms received, tracking on a spreadsheet the receipt of required signatures and ultimately verifying the accuracy of colleagues' data input. Any changes are then also recorded on an establishment master spreadsheet, which is designed to act as a source of truth that can be used to validate data within Firewatch. The Head of HR stated that this process of duplicate data entry onto a parallel establishment record has been necessary due to the unreliability of data historically held within Firewatch, so that HR can undertake critical tasks such as workforce planning. It is acknowledged that this process carries a significant resource requirement, and that substantial efficiencies could be made if Firewatch data were of a standard where the process were unnecessary	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.	2	*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.*	*Ongoing - Review at April 2023*	*ICT/Finance/HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	Although HR staff monitor data entry and record the information on a parallel database, this process was found to rely on the vigilance of those individual staff members. No periodic data cleansing routines were identified, so if an error were missed at the time of input, it is possible that this would remain undetected until it had a downstream business impact. Examples were provided of missing data fields originating from Firewatch in information extracted from Power BI for a business report. There is currently no process in place for HR to proactively identify and rectify such issues. The ICT Data and Applications Manager stated that a dashboard is available within Power BI that would highlight a number of common data issues within Firewatch.	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.	2	*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.*	*Ongoing*	*HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
6	Directed	Establishment data was reviewed in detail for five areas of the Service, including one watch at two different full time stations, one on-call station, one central grey book function and one central green book function. The HR Data and Administration Officer was unable to obtain an overview from Firewatch of the establishment data for the on-call station, so a full analysis was not possible. This supports the need for enhanced training on reporting and analysis functionality (see Recommendation 2). In the other four areas, the establishment numbers were consistent between Firewatch and the establishment master spreadsheet. In one case, however, there was a discrepancy between the two sources regarding which individual was in a specific post. It was established that the name in Firewatch was correct according to a People form change effective 1st July 2022, which had not been updated in the master spreadsheet. Although the spreadsheet has generally been considered a more reliable source of data than Firewatch, this finding suggests that it also requires quality control measures if it is used as an integral tool for establishment monitoring.	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	*In the short term this measure will need to remain, but in the longer term the introduction of the electronic system will negate the need for this secondary monitoring.* *Issues with the overview are reflective of the need for further training and some staff are more familiar with the system than others.*	*June 2023*	*HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
7	Directed	A sample of ten people and establishment forms was selected from the HR tracker, including three marked as "not yet updated in Firewatch". These were reviewed in detail for authorisation, accuracy and timeliness of input and updates on the HR tracker. All seven of the entries marked as "updated" were found to have been entered into Firewatch accurately according to the form submitted. It was noted that the accuracy of all data input from these forms is reviewed by other members of the HR function, so any errors should be identified at that stage. The three items not yet entered into Firewatch all dated from June or July 2022. No valid reason could be found for these three items to still be awaiting entry. As two of the forms related to a "chain" of several changing roles and backfilling positions, these must be entered in the correct order. It is therefore presumed that the forms could not be entered immediately upon receipt as prior entries had not been completed at that point. These forms should, however, have been entered as soon as the other changes had been entered, without a delay of up to three months.	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	*This relates to the backlog of people forms and different ways of working in HR compared to other functions.*	*Ongoing*	*HR*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	It was confirmed through management discussions that there is a desire for some Firewatch users to increase their capability in using more advanced functions, in particular HR reporting and analysis. It is hoped that this would aid the achievement of business objectives through providing additional intelligence, although should not duplicate the reporting already available through Power BI. Training was requested from the software supplier to address these needs, but management feedback confirms that these areas were not included within the content delivered.	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	*Additional training for HR staff will need to be tailored to their specific requirements e.g. production of reports. Some staff appear to have different levels of authorisation and access to the system.*	*April 2023*	*HR*

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matters were identified.				

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.	Partially in place	1, 2, 3, 4, & 5	-
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	6, & 7	-

Other Findings
Multiple data cleansing exercises have been undertaken over recent years to correct data errors within Firewatch. These have involved a wide range of staff and management confirmed that they are extremely resource-intensive activities. Although the ongoing data quality issues within Firewatch have not been rectified as a result of these interventions, they have enabled critical pieces of work to be completed on the basis of adequate establishment data, notably the workforce plan.
Standard forms are available, for use by managers across the Service to inform HR of any additional posts, modifications to contracts, or changes in the individual undertaking a specific position. A clear process is in operation where these are completed by the line manager and submitted to HR. Although it is difficult to assess the level of changes that are not reported, there was no evidence reported of widespread non-compliance with this process.
A Data Privacy Impact Assessment is in place for Firewatch. This covers the key areas that would be expected around the management of personal and sensitive information and details appropriate security arrangements.

Other Findings

IT management controls were confirmed as in place. The system is hosted in the cloud, limiting the exposure to network issues (including the recent cyber incident affecting HFRS). User access is restricted to those with a confirmed need to access the system, with each user allocated to an appropriate security group. System administration rights are restricted to two members of the ICT Team and to the software supplier to facilitate support functions.

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	
	Reporting functionality for HFRS is primarily provided through the Power BI platform. There is a data feed to Power BI from Firewatch, allowing the data to be used in performance and financial reporting from across the organisation without giving access to personal or sensitive information.
	The Head of HR stated that the use of paper forms for changes to personal or organisational details is now extremely limited, with most sent by email.
	System support and technical knowledge is primarily provided by the ICT Data and Applications Manager. Knowledge is held by another member of the ICT team and additional support would be available from the software provider if these internal resources were not available for any reason to support critical activity.

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

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Effectiveness of arrangements

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Assurance Assessment

4. The definitions of the assurance assessments are:

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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:	24th March 2022	23rd June 2022
Draft Report:	8th September 2022	10th October 2022
Final Report:	11th October 2022	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Humberside Fire & Rescue Service		
Review:	Fire Watch		
Type of Review:	Assurance	**Audit Lead:**	Stuart Whittingham

Outline scope (per Annual Plan):	The review considers the utilisation of and data management controls within the Firewatch system. The scope of the review does not include consideration of the IT network or the application security arrangements.
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 Firewatch HR system. • The policy and procedures are up-to-date and clearly define authorisation limits and responsibilities. Any changes to process that have arisen due to Covid-19 working practices will also be considered to ensure that controls remain robust. • A review of the accuracy of information and data recorded in the system • Information governance system, including accessibility, aligned to GDPR principles • Alternate and / or duplication of recording methods used outside of the Firewatch system • Process and quality assurance measures used to manage the system

Planned Start Date:	30/08/2022	**Exit Meeting Date:**	01/09/2022	**Exit Meeting to be held with:**	ICT Data and Applications 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.?	Y
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

Mid-Year Follow Up Review

2022/23

November 2022

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 October 2022.

Review	Year
Year End Follow Up March 2022	2021/22
Data Quality – Risk Information	2021/22
Enforcement	2021/22
Grievance Arrangements	2021/22
National Operational Guidance Project (Phases 3 and 4)	2021/22
Out of Hours Arrangements	2021/22
Shift System Productivity – Follow Up	2021/22

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	16
Outstanding	8
Considered but not Implemented	1

3. There are eight recommendations that remain outstanding following the audits reviewed. It is recognised, however, that several of these were dependent on technology solutions that have been delayed due to the recent cyber incident. For all of the outstanding items, at least some progress has been made towards implementation and it is intended that most should be implemented by the time of the next follow up audit.

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:	3rd November 2022
Date management responses rec'd:	17th November 2022
Date final report issued:	17th November 2022

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. **Carried Forward from 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	GM Emergency Preparedness	**Original implementation date**	31/12/2019	**Revised implementation date(s)**	31/12/2022
Latest Update	Still awaiting the implementation of the new version of Tranman and since the cyber-incident no version of Tranman has been available to gather data. ICT are hopeful that a final resolution to this work will be implemented in early 2023.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

Audit title	**Procurement**	**Audit year**	2019/20	**Priority**	**3**
Recommendation	A rolling 12 month list of Direct Awards be provided to the GAS Committee at each meeting.				
Initial management response	Annual report to be taken to GAS committee, content and report to be discussed with Executive Director of Corporate Services and Head of Finance				
Responsible Officer/s	Procurement Officer	**Original implementation date**	31/03/2020	**Revised implementation date(s)**	31/12/2021
Latest Update	Procurement Policy and Authority Constitution have recently been updated, which has allowed work to begin on this recommendation. A method is now being set up to identify which decision records represent waivers, so that these can be reported.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

11. Data Quality – Risk Information

Audit title	**Data Quality – Risk Information**	**Audit year**	2021/22	**Priority**	**2**
Recommendation	The specific responsibilities and procedures relating to the co-ordination of activity in this area be documented and scheduled. Opportunities to bring together staff from different areas who are involved in this work should be explored, to facilitate cross-training and prioritisation of activity and to reduce reliance on one individual.				
Initial management response	The Control Support WM holds the majority of corporate knowledge and management oversight for the administration of operational risk provision. Work has commenced through the channel of a 'Power Bi' dashboard to spread the knowledge of operational risk status throughout the organisation (from operational crews through to strategic leaders) and provide a visible daily reporting system on the status of operational intelligence. The Control SM and responsible NEL District Manager are exploring restructure options to connect the work under a Risk and Intelligence team providing a replication of skillsets across staff working on the risk information process. An interim solution is the provision of a process flow chart to provide line of sight in risk mapping processes. Resolve by early 2022 due to implementation date of Prevention and Protection Review.				
Responsible Officer/s	GM / SM Control / Head of Prevention	**Original implementation date**	01/02/2022	**Revised implementation date(s)**	-
Latest Update	Additional staff have become involved in the process in order to spread knowledge more widely. Some procedural guides are now also in place that other staff could follow. Additional work is still required in this area, however.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

Audit title	**Data Quality – Risk Information**	**Audit year**	2021/22	**Priority**	**3**
Recommendation	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.				
Initial management response	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.				
Responsible Officer/s	GM Control/WM Operational Risk	**Original implementation date**	01/12/2021	**Revised implementation date(s)**	-
Latest Update	This is related to the upgrade of the CFRMIS system, which has been delayed due to the cyber incident. To be re-visited at year end to establish whether further progress has been made.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

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)**	-
Latest Update	Again, the required functionality should be obtained through the upgraded CFRMIS system (rather than Chameleon as originally planned). To re-visit in March 2023.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

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)**	-
Latest Update	The process is being reviewed, in order to reduce the volume of data being captured and validated. This is an ongoing piece of work, to be re-visited in March 2023.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

12. **National Operational Guidance Project (Phases 3 and 4)**

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)**	-
Latest Update	An initial review has been undertaken, but data collection has been impacted by the cyber incident. Work is ongoing to mend these connectivity issues; once this is completed further analysis will be undertaken and areas for attention identified.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

13. **Out of Hours Arrangements**

Audit title	**Out of Hours Arrangements**	**Audit year**	2021/22	**Priority**	**3**
Recommendation	Opportunities be explored to expand the pool of staff available to be recalled to duty, to ensure full coverage via this method as far as is practicable. One option may be to include qualified day shift staff within the pool who can be called upon.				
Initial management response	Alternative opportunities to utilise competent staff and increase the level of support to FDS OOH inspectors currently being explored. Development of day duty WM FDS role to include protection trained WMs.				
Responsible Officer/s	Responsible SMs	**Original implementation date**	31/12/2021	**Revised implementation date(s)**	-
Latest Update	While there has been an exploration of the possibility of expanding the pool of staff available to be recalled to duty, it has not been considered feasible to do this at this time. The focus is on supporting additional staff to achieve the Level 4 qualification as soon as possible. It was also noted that widening the pool would address a theoretical risk, which is considered unlikely to materialise given the combination of circumstances in which it would arise.				
New implementation date	-	**Status**	**Considered but not implemented**	The recommendation is no longer being progressed.	

14. **Shift System Productivity – Follow Up**

Audit title	**Shift System Productivity – Follow Up**	**Audit year**	2021/22	**Priority**	**2**
Recommendation	The submission, quality and allocated hours requirements of the Watch Planner and Recorder processes be fully and consistently applied across all stations, so that more complete evidence is available to confirm productivity levels.				
Initial management response	The Station and Watch Manager absolutes set the foundation requirement for daily fire station monitoring; this process needs to be further embedded. These processes quality assure full time watch activity, outcomes for the community and outputs. ACTIONS: 1. Monthly directorate assurance/development sessions with SMs. (To be expanded to non-Service Delivery SMs) 2. Monthly 1:1 with Head of Service Delivery to dip sample standard. 3. Station Manager Service Delivery managerial induction process to achieve consistency. 4. Peer review. 5. Weekend and public holiday core monitoring process to be developed.				
Responsible Officer/s	Director of Service Delivery	**Original implementation date**	01/04/2022	**Revised implementation date(s)**	-
Latest Update	Confirmation that the required procedures are now in place. Due to the number of changes in staff in key roles, however, these have yet to be fully embedded and further work is required in this area.				
New implementation date	31/03/2023	**Status**	**Outstanding**	Implementation is in progress but the original target date has not been met.	

15. The following recommendations have been implemented.

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Procurement (outstanding from Year End Follow Up)	The Procurement Policy be amended to document the conditions in which procurement waivers can be requested and for Direct Award Decision Records to denote which of the circumstances apply.	3	Procurement Manager	31/03/2020
Procurement (outstanding from Year End Follow Up)	In relation to contract extensions and direct awards to current suppliers, officers be required to confirm that extant contractual obligations, including attainment of KPIs, have been achieved.	3	Procurement Officer; Contract Officers	31/03/2020
Data Quality – Risk Information	Outstanding Station Manager approvals for SSRIs be completed as soon as possible.	2	GM Control / WM Operational Risk	15/12/2021
Data Quality – Risk Information	All High Risk premises without an Operational Pre-Plan be reviewed to confirm that the Pre-Plan is not required. The justification for not requiring a Pre-Plan should be documented.	2	Service Delivery Managers / WM Operational Risk	15/12/2021
Enforcement	All administrative procedures relating to enforcement and engagement activity be agreed and documented, while ensuring that these are fully understood and operating as intended.	2	Multiple officers including across Prevention and Protection	30/09/2021
Enforcement	The prioritisation of RBIP audits relative to other tasks be reviewed with District Protection Managers. Any improvement in delivery performance resulting from these discussions and subsequent organisational changes, should be monitored and further interventions made if necessary to achieve the required delivery standard.	2	Multiple officers including across Prevention and Protection	31/12/2021
Enforcement	The electronic quality assurance system be rolled out, along with associated analysis and evaluation processes, so that the Service is able to evidence the effectiveness of its enforcement work.	2	Multiple officers including across Prevention and Protection	31/10/2021
Grievance Arrangements	Analysis procedures be developed and rolled out to facilitate the review of trends and patterns in grievances. This should allow the Service to maximise the learning arising from the process and take improvement action where necessary.	2	Head of HR	31/10/2021
Grievance Arrangements	Training for managers on best practice in undertaking their role in grievance cases be incorporated into planned management training.	2	Director of People and Development	30/09/2021

Audit Title	Recommendation	Priority	Responsible Officer	Due Date
Grievance Arrangements	Engagement and training be undertaken with managers to clarify that further advice and escalation can be accessed before Stage One is completed, in order to increase the opportunity to resolve issues at the informal stage.	2	Director of People and Development/HR Service Partners	30/09/2021
Grievance Arrangements	All reasonable efforts be made to adhere to the timescales specified within the Grievance Policy.	3	HR Service Partners	31/10/2021
Grievance Arrangements	Managers be discouraged from expressing unambiguous support for grievances that cannot be resolved at Stage One. A more balanced position, such as acknowledging that the case could merit further investigation, may be more appropriate and reflective of the manager's responsibilities towards both the employee and the Service.	3	HR Service Partners	31/10/2021
National Operational Guidance Project (Phases 3 and 4)	Arrangements be confirmed for maintaining, overseeing and assuring that the Service remains compliant with NOG requirements after the end of the implementation project.	3	GM Plunkett	20/09/2021
Shift System Productivity – Follow Up	All reports of IT issues affecting the submission of Watch Planner and Watch Recorder forms be investigated and rectified, so that barriers to recording of evidence are removed as far as possible.	3	Director of Service Delivery	15/11/2021
The following recommendations are marked as implemented because a programme of training is in place and staff are following this to achieve fully qualified status. Achievement of the full qualification does, however, take several years so it is on that timescale that all gaps can be expected to be fully addressed.				
Out of Hours Arrangements	The ongoing Level 4 Protection training be completed as soon as possible, to provide greater coverage by fully-qualified Protection Officers able to serve prohibition notices out of hours.	3	Responsible SMs	Ongoing schedule of qualification and training
Out of Hours Arrangements	The long-term staffing requirements and succession planning for OOH Protection coverage be monitored closely. The training plan to upskill additional officers should be enacted to widen the pool and ensure sufficient coverage on an ongoing basis, taking into account the potential for staff absences, promotions, resignations and retirements.	3	Responsible SMs	Ongoing schedule of qualification and training

Governance, Audit and Scrutiny Committee
1 December 2022

Agenda Item No.
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 2022/23.

2. MATTER FOR CONSIDERATION

2.1 That Members consider the treasury management activities undertaken during the first half of 2022/23 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 11 March 2022 approved the annual 2022/23 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 2022

Investment Activity

4.1 The Authority's temporary investments totalled £21.0m as at 30 September 2022.

Table 1 – Investment income earned April to September 2022

Interest Earned April to September 2022	Rate of return April to September 2022	Benchmark return at 30 September 2022*	Difference (Favourable) April to September 2022
£43k	0.54%	2.19%	1.65%

* Benchmark set as 7 day compounded SONIA

4.2 The Authority's rate of return pleasingly 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 £19.1m as at 30 September 2022, with an equated average rate of interest payable at 3.40%. An expected £608k of interest is projected to be payable on external debt for 2022/23.

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 2022 and shows for comparison the actual figures as at 30 September 2022.

4.8 During the period April to September 2022, 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 £14.4m below the agreed authorised limit for 2022/23 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.

5. RESOURCING/FINANCIAL/VALUE FOR MONEY

5.1 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.

6. RISK/ HEALTH AND SAFETY/LEGAL IMPLICATIONS

6.1 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.

7. LINKAGES TO ANY STRATEGIC/CORPORATE PLANS/POLICIES

7.1 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.

8. EQUALITY IMPLICATIONS

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

9. CONCLUSION

9.1 That Members consider the treasury management activities undertaken during the first half of 2022/23 and the Prudential Indicators as outlined in paragraphs 4.9 and 4.10 and detailed in Appendix 1.

Martyn Ransom
Joint Deputy Chief Finance Officer/Deputy S151 Officer

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Background Papers

Treasury Management and Capital Expenditure Prudential Indicators, Management Policy Statement 2022/23 and Minimum Revenue Provision 2022/23 – Report to Fire Authority March 2022
CIPFA Code of Practice on Treasury Management
CIPFA Treasury Management Guidance

Governance, Audit and Scrutiny Committee
1 December 2022

Agenda Item No.
Report by Joint Deputy Chief Finance Officer/Deputy S151 Officer

MANAGEMENT ACCOUNTS 2022/23 – BASED ON PERIOD ENDING 30 SEPTEMBER 2022

1. SUMMARY

1.1 This report highlights the current financial position based on information to 30 September 2022.

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

2. RECOMMENDATIONS

2.1 That Members take assurance from this report and the Authority's financial position for the period ending 30 September 2022.

3. BACKGROUND

3.1 Management Accounts are reported to Members four times a year with the financial position at 30 June, 30 September, 31 December and 28 February.

4. PERIOD ENDING 30 SEPTEMBER 2022

4.1 The summary estimated outturn position for the current financial year based on information to 30 September 2022 is as follows:

CATEGORY	2022/23 OUTTURN PROJECTION
HFA	
Revenue Budget	£0.196m overspend
Capital Programme	£3.279m spend against £7.292m allocation
Pensions Account	£12.750m deficit

4.2 This is the second set of Management Accounts for the 2022/23 financial year and further updates will be brought to the Authority based on the periods ending 31/12/22 and 28/2/23.

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. RESOURCING/FINANCIAL/VALUE FOR MONEY

5.1 Sound financial management contributes to the achievement of the Authority's objectives.

6. RISK/ HEALTH AND SAFETY/LEGAL IMPLICATIONS

6.1 The quarterly Management Accounts help to ensure that the Authority meets its legal and regulatory requirements.

7. LINKAGES TO ANY STRATEGIC/CORPORATE PLANS/POLICIES

7.1 The production of robust, timely and detailed information in relation to the Authority's financial position contributes to the Strategic Plan objective of a 'Stronger Organisation'. The information specifically underpins good governance and good financial management.

8. EQUALITY IMPLICATIONS

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

9. CONCLUSION

9.1 That Members take assurance from this report and the Authority's financial position for the period ending 30 September 2022.

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Background Papers

2022/23 Management Accounts

Appendix 1

Prudential Indicators as at 30 September 2022

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:

	2021/22 Actual £k	2022/23 Budget £k	2022/23 Revised £k	2023/24 Estimate £k	2024/25 Estimate £k	2025/26 Estimate £k
Total Capital expenditure	1,960	7,292	3,279	7,345	2,847	3,707

The revised 2022/23 figure reflects the latest estimate of spend, as reported to Members in the Management Accounts for the period ending 30th September 2022.

Indicator 2 - Capital Financing Requirement

The capital financing requirement for 2022/23 and estimates for future years are as follows:-

	Actual 31/03/22 £k	Estimate 31/03/23 £k	Estimate 31/03/24 £k	Estimate 31/03/25 £k	Estimate 31/03/26 £k
Capital Financing Requirement	17,691	19,166	24,489	25,078	23,371
Lease - Integrated Care Centre	1,029	1,012	994	974	953
Total CFR	18,720	20,178	25,483	26,052	27,324

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 – 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.

	2022/23 Original £k	2022/23 Revised £k	2023/24 Estimate £k	2024/25 Estimate £k	2025/26 Estimate £k
Total Core Funds	13,214	14,077	11,280	11,040	10,818
Expected Investments	6,567	11,480	2,960	2,290	947

The actual total investments held as at 30th September 2022 is £21.0m. This is higher than the expected investments due to the Pensions grant of which 80% was received in July 2022 which is drawn upon each month.

Indicator 4 - 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.

	2022/23 Boundary £k	Actual As at 30/09/22 £k	2023/24 Boundary £k	2024/25 Boundary £k	2025/26 Boundary £k
Borrowing	25,000	19,069	25,000	25,000	25,000
Other Long-Term Liabilities	3,500	1,012	3,500	3,500	3,500
	28,500	20,081	28,500	28,500	28,500

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 5 - Authorised Limit for External Debt

The table below shows the Authorised limit for External Debt for 2022/23 and subsequent three-year period as approved by Members, compared to the actual level of borrowing as at 30 September 2022.

	2022/23 Limit £k	Actual as at 30/09/22 £k	2023/24 Limit £k	2024/25 Limit £k	2025/26 Limit £k
Borrowing	31,000	19,069	31,000	31,000	31,000
Other Long-Term Liabilities	3,500	1,012	3,500	3,500	3,500
	34,500	20,081	34,500	34,500	34,500

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 2022/23.

Indicator 6 - 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: -

	2021/22 Actual %	2022/23 Original %	2022/23 Revised %	2023/24 Estimate %	2024/25 Estimate %	2025/26 Estimate %
Ratio of Financial Costs to Net Revenue Stream	3.49	3.35	3.03	3.70	4.06	4.25

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 7 – 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 30/09/22	Upper Limit	Lower Limit
	%	%	%
Under 12 Months	9.96	15	0
12 months and within 24 months	2.62	15	0
24 months and within 5 years	19.24	30	0
5 years and within 10 years	36.71	60	0
10 years and above	31.47	80	0

The S151. Officer confirms that the maturity structure of external debt as at 30/09/22 is within the upper and lower limits approved by the Authority.

Governance, Audit and Scrutiny Committee 14 November 2022	Report by the Joint Deputy Chief Finance Officer/Deputy Section 151 Officer.

Procurement Scrutiny Report

REPORT EXECUTIVE SUMMARY

This report responds to the following questions raised as part of the GAS Committee Scrutiny Programme and sets out how the Constitution of the Authority along with the Policies and practices of HFRS ensure compliance with the Public Procurement Regulations and deliver value for money.

1. Assurance around compliance, ethics and value for money.
2. Calculation of value for money.
3. Environmental and climate considerations.
4. Safeguarding considerations and ethical requirements in relation to contractors.
5. Prioritisation of local procurement and weighting in the procurement process (with particular reference to capital projects).
6. Joint procurement - how it has worked in the past and impacts on ethics and standards.
7. Research and development procurement.
8. Potential standardisation of procurement nationally and the impact of guidance like the Fire Standards.
9. Revenue expenditure compared to capital expenditure

RECOMMENDATIONS

1. The GAS committee use the content of this report to take assurance that the policies, processes, knowledge and qualifications used within the HFRS are suitable to ensure its compliance with the legal and ethical responsibilities in relation to public procurement regulations.

2. The Procurement team comprises of four members of staff (some staff perform finance roles as well). HFRS has one member of staff qualified as a member of CIPS (Chartered Institute of Procurement and Supply), one member of staff studying Level 6 CIPS, one Level 5 Associate Member of CIPS and a further member of staff qualified to level 4 CIPS.

REPORT DETAIL

Assurance around compliance, ethics and value for money.

3. As a Public Sector Organisation HFRS is bound by a number of pieces of legislation in relation to Public Procurement and the award of contracts. Particularly, but not exclusively, the Public Contracts Regulations 2015.

4. Embedded within the Authority's Constitution are the Financial Procedures, Scheme of Delegation and Contract Procedure rules that provide the compliance framework for managing the Authority's Financial and Procurement affairs. They apply to every Member and Officer of the Authority.

5. The Contract Procedure rules within the Authority's Constitution have recently been reviewed and updated, with external legal support, as a result of the UK's exit from the European Union and a number of other legislative changes. The amendments to the Constitution were presented and approved at the Authority meeting held on 29th April 2022.

6. The Constitution feeds into and drives the aims and objectives of the Services Procurement Policy. Which provides officers structure and guidance as well as identifying their responsibilities when undertaking procurement on behalf of the Service.

7. The Service participates in the Cabinet Office's National Fraud Initiative, a data matching exercise to assist in the prevention and detection of fraud. We are required to provide particular sets of data to the Minister for the Cabinet Office for matching for each exercise.

8. Data matching involves comparing computer records held by one body against other computer records held by the same or another body to see how far they match. This is usually personal information relating to employees or supplier data. Computerised data matching allows potentially fraudulent claims and payments to be identified.

9. To further safeguard public funds the Service requires bidders of published tenders of value in excess of £50,000 to submit a declaration of interest. The types of interests and relationships that may need to be disclosed include investments, shareholdings, trusts or nominee companies, company directorships or partnerships, other significant sources of income, significant liabilities, gifts, private business, employment, voluntary, social or personal relationships that could, or could be seen to create a potential, actual or perceived conflict.

Calculation of value for money.

10. One of the objectives of the Services Procurement Policy is to obtain best value through competitive processes. This is done in line within the guiding principle of the procurement regulations which states that Contracting authorities shall treat economic

operators equally and without discrimination and shall act in a transparent and proportionate manner.

11. The way the Service meets these criteria is by setting out financial thresholds for the award of contracts and laying out a compliant and proportionate process to be undertaken at each threshold.

12. Through tender evaluation, officers seek to balance the issues of quality and price to ensure that the chosen bidder offers the most economically advantageous tender for the Authority. Upon receipt of formal tenders, the Authority will carry out a completeness and compliance check. Any bid which is incomplete or not fully compliant may be rejected.

13. Financial due diligence checks including credit reports generated by specialist 3rd party providers are used, where appropriate, to ensure financial stability of potential suppliers. Bidders who are unable to satisfy HF&RS of their financial soundness will at the discretion of HF&RS be removed from the process.

14. The most economically advantageous tender (MEAT) criterion enables the Service to take account of criteria that reflect qualitative, technical and sustainable aspects of the tender submission as well as price when reaching an award decision. Any criteria used must be linked to the subject matter of the contract in question.

15. The Regulations state that award criteria shall be considered to be linked to the subject matter of the contract where they relate to the works, supplies or services to be provided under that contract in any respect and at any stage of their life cycle.

16. The relative weighting of each criterion used to assess the submissions must be stated within the tender documentation. Quite often the award criteria stated in the contract notice and tender documentation will be made up of a number of sub criteria. These sub-criteria and their weightings are also published with invitations to tender.

17. The legislation lists the following criteria (although this list is not exhaustive):

    - Quality
    - price or cost using a cost-effectiveness approach
    - technical merit
    - aesthetic and functional characteristics
    - accessibility
    - social characteristics
    - environmental characteristics
    - innovative characteristics
    - after-sales service and technical assistance
    - delivery conditions such as date, process and period

Environmental and climate considerations.

18. In 2021 the Service adopted the Emergency Services Environment and Sustainability Group (ESESG) Charter.

19. The Emergency Services Environment and Sustainability Group (ESESG) includes members from UK Police Forces, Fire & Rescue Services, Ambulance Services and other Emergency Services who meet to share best practice and discuss emerging technologies, government policy and legislative requirements.

20. The Service recognises that all emergency services have the potential to affect the local and global environment, society, and the wider economy. We also recognise that climate change and global trends will continue to have an impact on the demands placed upon our emergency services.

21. We will wherever practicable purchase more sustainable goods and materials in accordance with Government standards. We will encourage our suppliers to demonstrate their commitment to environmental best practice within tendering processes and contracts.

22. The procurement of vehicles and equipment is no longer made in isolation. Whenever there is a need to make purchases, regional and national partners are considered, not only within Fire Sector but also the wider blue light partners. This will be achieved through existing frameworks or new joint procurement arrangements where appropriate to make the best use of resources, and leverage economies of scale. While innovation and value for money are key drivers for procurement, environmental sustainability must always be considered as part of the process.

23. When including sustainability-based criteria it is important to remember these criteria must be linked to the subject matter of the contract and be proportionate for the contract.

24. Every tender published for goods or services with an anticipated value in excess of £50,000 includes environmental considerations as part of the formal award evaluation criteria. These considerations cover the bidders' environmental policies, objectives and management systems.

Prioritisation of local procurement and weighting in the procurement process (with particular reference to capital projects).

25. Procurement of the bulk of capital projects is managed on behalf of the Service by the Joint Estates Function under collaboration with Humberside Police who use their regional procurement team for higher value contracts. As such procurement in this instance follows the policies and procedures of the Joint Estates Service detailed below;

26. One of the key cornerstones of this policy is that Social Value must be weighted at a minimum of 10% within the evaluation criteria for the awarding of contracts.

27. To facilitate this into the process and to identify where dependant on the nature of the goods, works or services to be procured this "Social Value" weighting is most effective, the Customer Considerations Document (CCD) asks the team to consider the sustainability impact assessment to maximise the opportunities afforded.

28. This consideration is outlined below;

Review the Sustainability Impact Analysis alongside the Themes Outcomes Measures (TOMs) to identify additional opportunities

<u>Proposed Themes</u>

Jobs: Promote Local Skills and Employment

- More local people in employment
- More opportunities for disadvantaged people
- Improved skills for local people
- Improved employability of young people

Growth: Supporting Growth of Responsible Regional Business

- More opportunities for "" SMEs and "" VCSEs
- Improving staff wellbeing
- A workforce and culture that reflect the diversity of the local community
- Ethical procurement is promoted
- Social Value embedded in the supply chain

Social: Healthier, Safer and more Resilient Communities

- Crime is reduced
- Creating a healthier community
- Vulnerable people are helped to live independently
- More working with the Community

Environment: Protecting and Improving Our Environment

- Climate impacts are reduced
- Air pollution is reduced
- Better places to live
- Sustainable Procurement is promoted

29. Once the assessment is completed the outcomes are embedded into the evaluation criteria to allow organisations to articulate their ability to meet the outcomes of the criteria and for their submissions to be scored during the evaluation process.

30. The proposed outcomes are then embedded into the contract management plans and are monitored during the delivery phase of the contract to measure the effective delivery of the company's proposals.

Safeguarding considerations and ethical requirements in relation to contractors.

31. This matter is considered at a number of stages within the procurement process specifically by the Joint Estates Service for contractors:

Pre-Procurement

32. A Customer Consideration Document (CCD) is completed which assesses the nature of the goods, works or services to be procured and utilising the assessment tools embedded within the CCD provides an indication of the likely risk factors and or opportunities identified and indicates how this should be articulated within the procurement documentation. This includes an identification of the risk of Modern Slavery and tools to mitigate any risk plus identifies the opportunities that effective use of social value within the process can bring to the force. This includes an assessment of the effective use of social value to bring additional Social, Environmental and Economic benefits to the region over and above the core purpose of the procurement. Once the CCD is completed and approved the procurement documentation is structured to include any recommendations identified.

Procurement

33. The procurement stage requires bidders to complete and respond to documentation issued to demonstrate to the relevant Service their suitability in being able to meet the requirements of the Goods, Works and Services required. With respect to safeguarding and ethical practices the response requires response to the following sections.

34. Selection – Mandatory requirements of all projects and looks at the suitability of the company. Companies are asked to confirm :

Please indicate if, within the past five years you, your organisation or any other person who has powers of representation, decision or control in the organisation been convicted anywhere in the world of any of the offences within the summary below and listed on the webpage.

- Participation in a criminal organisation.
- Corruption.
- Fraud.
- Terrorist offences or offences linked to terrorist activities.
- Money laundering or terrorist financing.
- Child labour and other forms of trafficking in human beings.

Please indicate if, within the past three years, anywhere in the world any of the following situations have applied to you, your organisation or any other person who has powers of representation, decision or control in the organisation.

- Breach of environmental obligations?
- Breach of social obligations?
- Breach of labour law obligations?
- Bankrupt or is the subject of insolvency or winding-up proceedings, where the organisation's assets are being administered by a liquidator or by the court, where it is in an arrangement with creditors, where its business activities are suspended or it is in any analogous situation arising from a similar procedure under the laws and regulations of any State?
- Guilty of grave professional misconduct?
- Entered into agreements with other economic operators aimed at distorting competition?
- Aware of any conflict of interest within the meaning of regulation 24 due to the participation in the procurement procedure?
- Been involved in the preparation of the procurement procedure?
- Shown significant or persistent deficiencies in the performance of a substantive requirement under a prior public contract, a prior contract with a contracting entity, or a prior concession contract, which led to early termination of that prior contract, damages or other comparable sanctions?

Confirm you have a Modern Slavery Policy which is embedded and communicated throughout your supply chain.

- If you have answered N/A to this question, list the measures you undertake to mitigate the risk of the prevalence of Modern Slavery in your supply chain.
- Are you a relevant commercial organisation as defined by section 54 ("Transparency in supply chains etc.") of the Modern Slavery Act 2015 ("the Act")?
- If you have answered yes to question 7.2 are you compliant with the annual reporting requirements contained within Section 54 of the Act 2015?
- Have you ever been convicted of an offence under the Modern Slavery Act 2015.

Joint procurement - how it has worked in the past and impacts on ethics and standards.

35. The Service evaluates its procurement activity and undertakes collaborative opportunities where there are benefits identified through a collaboration.

36. These benefits may be financial, additional resources or experience, combined working or contract convergence.

37. Where a collaboration has been identified a project team is set up to explore the opportunity and develop and agree a specification of requirements, risk assessments, equality impact assessments and evaluation processes are agreed followed by the development of terms of reference.

38. Once an agreement has been reached then the procurement teams take the requirement to market, having assessed the most suitable route, and carry out the sourcing exercise in partnership to identify a preferred solution and report the outcome to all Services involved in the collaboration.

39. Recently the service has undertaken a joint procurement project to undertake the replacement of the Services' PPE provision which produced a number of benefits such as cost savings, resource sharing, identification and the introduction of a new rescue jacket and a regional Laundry service.

40. The main benefit was the standardisation or PPE and interoperability across Yorkshire and the Humber.

Research and development procurement.

41. Contracts for research and development services are excluded from the scope of the Public Procurement Regulations unless the benefits of those services are reserved exclusively for the benefit of the contracting authority and that contracting authority pays for the services in full.

42. The exemption for this type of pre-commercial procurement only applies to research and development phases of a project however, meaning that should a public body wish to then acquire the outcomes of the R&D on a commercial footing then a separate compliant procurement process would be required.

43. To date HFRS has not awarded any purely research and development contracts.

Potential standardisation of procurement nationally and the impact of guidance like the Fire Standards.

44. The service is proactive in both national and regional procurement activities through the NFCC committee structure, and currently Chair the NFCC PPE and Uniform Sub Committee.

45. This enables the service to interact and develop the solutions to the requirements of the Fire Service as a whole, meeting the specific needs of services

46. There is a duty to collaborate, but it is not mandated that procurement activity should be undertaken on a national level. The Service explores routes to markets available and assesses the most suitable sourcing process which meets the needs of the service based on the solution required.

Revenue expenditure compared to capital expenditure.

47. There is no differential in the way the service carries out sourcing exercises where expenditure is from capital or revenue budgets.

48. All procurement activities are managed using the same policies and procedures.

STRATEGIC PLAN COMPATIBILITY

49. This report is aligned to the ‘We efficiently manage the Service’ objective within the Strategic Plan 2021-2024.

FINANCIAL/RESOURCES/VALUE FOR MONEY IMPLICATIONS

50. None directly in relation to this report. However effective procurement practices help to deliver value for money and efficient use of public funds through competitive and transparent processes.

LEGAL IMPLICATIONS

51. Compliance with Public Procurement Regulations 2015 and associated legislation

EQUALITY IMPACT ASSESSMENT/HR IMPLICATIONS

52. The Services Procurement Policy is subject to Equality Impact Assessment upon each review and actions undertaken as required.

CORPORATE RISK MANAGEMENT IMPLICATIONS

53. Financial risk arising from a legal challenge should a challenge be upheld from unsuccessful bidders where a non-compliant procurement exercise has been undertaken.

HEALTH AND SAFETY IMPLICATIONS

54. None directly arising

COMMUNICATION ACTIONS ARISING

None directly arising

DETAILS OF CONSULTATION AND/OR COLLABORATION

55. Humberside police who provide a procurement function as part of the Joint Estates Partnership.

BACKGROUND PAPERS AVAILABLE FOR ACCESS

56. Public Procurement Contract Regulations 2015
https://www.legislation.gov.uk/uksi/2015/102/contents/made

57. Humberside Fire Authority Constitution
https://s3.eu-west-2.amazonaws.com/server-asset-backups/humberside-fire-craft-3-assets/uploads/files/Constitution_v14-June-2021.pdf

58. Procurement Policy
https://s3.eu-west-2.amazonaws.com/server-asset-backups/humberside-fire-craft-3-assets/uploads/files/Policies/Procurements-Policy.pdf

RECOMMENDATIONS RESTATED

59. The GAS committee use the content of this report to take assurance in the policies and processes used within the Service to ensure its legal and ethical responsibilities in relation to public procurement are met.

M Ransom

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Humberside Fire & Rescue Service
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MR
6 November 2022

Governance, Audit and Scrutiny Committee 1 December 2022	Report by the Monitoring Officer/Secretary

GAS COMMITTEE SCRUTINY PROGRAMME 2022/23

REPORT EXECUTIVE SUMMARY

This paper summarises the Governance, Audit and Scrutiny Committee's Scrutiny Programme 2022/23. Each year, the Committee will programme six specific, defined scrutiny items complete with scopes in order that relevant officers can focus their reports. 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.

RECOMMENDATIONS

1. That Members consider and approve the Scrutiny Programme 2022/23.

PUBLIC SCRUTINY PROCESS

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

3. Five areas for scrutiny were identified by the Committee for its 2022/23 programme:

- Procurement
- Equality, Diversity and Inclusion - Equality Impact Analysis
- Fire Standards
- Emergency Response Business Continuity
- General Data Protection Regulation

STRATEGIC PLAN COMPATIBILITY

6. This paper supports the achievement of Strategic Plan 2021-24 through the provision of independent scrutiny of activity.

FINANCIAL/RESOURCES/VALUE FOR MONEY IMPLICATIONS

7. Independent scrutiny contributes towards efficiency review activity.

LEGAL IMPLICATIONS

8. None directly arising.

EQUALITY IMPACT ASSESSMENT/HR IMPLICATIONS

9. None directly arising.

CORPORATE RISK MANAGEMENT IMPLICATIONS

10. Scrutiny of performance provides an assurance that arising risks are being mitigated.

HEALTH AND SAFETY IMPLICATIONS

11. None directly arising.

COMMUNICATION ACTIONS ARISING

12. GAS Committee papers are publicly available via the HFRS Website.

DETAILS OF CONSULTATION AND/OR COLLABORATION

13. SLT regarding scrutiny topics.

RECOMMENDATIONS RESTATED

14. That Members consider and approve the Scrutiny Programme 2022/23.

R CLOSE
L NICHOLSON

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Humberside Fire & Rescue Service
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June 2022

Appendix 1

GAS Committee Scrutiny Programme 2022/23

Meeting Date	Responsible Officer	Item and Scope
4 July 2022	**Director of Service Improvement**	**Fire Standards** • Origin of fire standards. • Current fire standards. • Likely future fire standards. • Impact of fire standards on service delivery and quality. • Timeliness of adoption of new fire standards. • Impact on policy and strategy (particularly the Service Improvement Plan, Strategic Risk Register and Community Risk Management Plan). • Embedding changes introduced by fire standards (including reference to training and examples of the process of embedding fire standards). • Reporting on performance in relation to fire standards. • Assurance for Members around adoption and performance in relation to fire standards. • Impact of major incidents on fire standards.
5 September 2022	**Director Emergency Response**	**Emergency Response Business Continuity** **Deferred for future programming** • Business continuity arrangements (including crews and control). • Role of the East Coast Control Room. • Planning for industrial action. • The right to strike in the light of State of Fire and Rescue recommendations. • Impact of the White Paper. • Arrangements with the Fire Brigade Union (including reference to planning, co-production and the Joint Consultative Committee). • Arrangements with partner organisations. • Training for staff and volunteers.

01 December 2022	**Executive Director of Finance/Section 151 Officer & Head of Finance**	**Procurement** • Assurance around compliance, ethics and value for money. • Calculation of value for money. • Environmental and climate considerations. • Safeguarding considerations and ethical requirements in relation to contractors. • Prioritisation of local procurement and weighting in the procurement process (with particular reference to capital projects). • Joint procurement - how it has worked in the past and impacts on ethics and standards. • Research and development procurement. • Potential standardisation of procurement nationally and the impact of guidance like the Fire Standards. Revenue expenditure compared to capital expenditure.
23 January 2023	**Executive Director of People and Development**	**Equality, Diversity and Inclusion - Equality Impact Analysis** • Criteria for the use/requirement of Equality Impact Analyses (EIA) (including the relevant policies as background papers). • Training for managers/writers (with particular reference to the decision not to undertake an EIA). • Publication of EIA. • Quality assurance of EIAs. • Impact of EIAs on decisions and how they are followed up. • Learning from individual EIA outcomes.
20 February 2023	**Director of Service Improvement**	**General Data Protection Regulation** • State of GDPR in the Service in relation to action plan developed with East Riding of Yorkshire Council. • Assurance for Members that the Service is compliant with GDPR. • Awareness of GDPR across the Service (including training). • Key risks and vulnerabilities. • Collecting, processing and storing of data. • Response standards in relation to freedom of information and subject access requests. • Controls on devices and use of data. • Reporting of GDPR breaches and learning from breaches (including a summary of the nature of breaches and any identified patterns).

10 April 2023	**TBC**	**Topic to be decided following the publication of the HMICFRS inspection report in summer 2022.**

Deferred for future programming

Director Emergency Response	**Emergency Response Business Continuity** • Business continuity arrangements (including crews and control). • Role of the East Coast Control Room. • Planning for industrial action. • The right to strike in the light of State of Fire and Rescue recommendations. • Impact of the White Paper. • Arrangements with the Fire Brigade Union (including reference to planning, co-production and the Joint Consultative Committee). • Arrangements with partner organisations. • Training for staff and volunteers.