Buckinghamshire & Milton Keynes Fire Authority

Internal Audit Service
Annual Report of the Chief Internal Auditor 2021/22

July 2022

Introduction

1.1 This report outlines the Internal Audit work undertaken by the Internal Audit Service for the year ending 31 March 2022 and seeks to provide an opinion on the adequacy and effectiveness of the control environment detailing the incidences of any significant control failings or weaknesses.

1.2 The Account and Audit Regulations require the Fire Authority to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The CIPFA Public Sector Internal Audit Standards (PSIAS), which sets out proper practice for Internal Audit, requires the Chief Internal Auditor (CIA) to provide a written report to those charged with governance, to support the Annual Governance Statement (AGS), which should include an opinion on the overall adequacy and effectiveness of the Fire Authority's control environment.

1.3 This is achieved through a risk-based plan of work, agreed with management, and approved by the Overview and Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described in this report. The updated CIPFA Statement on the role of the Chief Internal Auditor (CIA) in Local Government issued in April 2019 notes that the CIA in a local authority plays a critical role in delivering the authority's strategic objectives by:

- objectively assessing the adequacy and effectiveness of governance and management of risks, giving an evidence-based opinion on all aspects of governance, risk management and internal control; and
- championing best practice in governance and commenting on responses to emerging risks and proposed developments.

The updated CIPFA Statement notes that the CIA may look to the work of other assurance providers as evidence for their assurance.

2. Responsibilities

2.1 Section 151 of the 1972 Local Government Act and the Accounts and Audit Regulations 2015 sets out the requirement for all Authorities to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The PSIAS define internal auditing as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management,

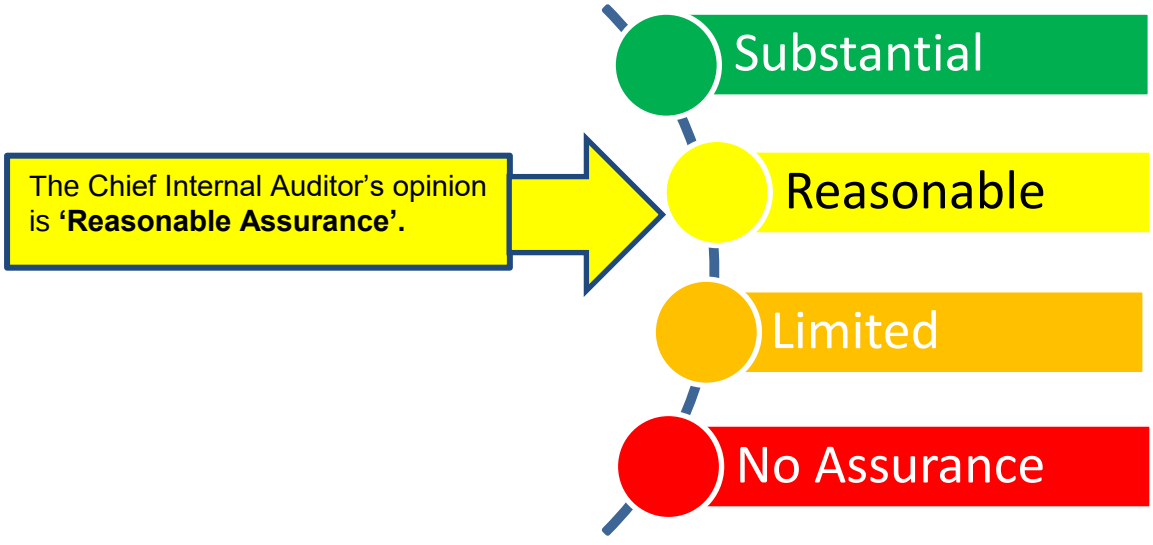
control and governance processes."

2.2 Internal Audit is not responsible for the control system. This responsibility sits with management who are accountable for maintaining a sound system of internal control and is responsible for ensuring that adequate arrangements are in place for gaining assurance about the effectiveness of the overall system of control. Management should ensure that the Authority operates in accordance with the law and proper standards, that public funds are safeguarded, properly accounted for, and used economically, efficiently, and effectively.

2.3 The role of the internal audit service is to provide management with an objective assessment of whether systems and controls are working properly. It is a key part of the Authority's internal control system because it measures and evaluates the adequacy and effectiveness of other controls so that:

- The Fire Authority can establish the extent to which they can rely on the whole system; and
- Individual managers can establish how reliable the systems and controls for which they are responsible are.

3. Chief Internal Auditor Opinion



**** See Appendix 3 for definitions of the assurance opinions.***

3.1 The results of the audit work undertaken, when combined with our experience and knowledge of previous years' performance and the current climate in which the Authority is operating, form the

basis for the overall opinion. As such, in my opinion the system of internal control provides **reasonable assurance** regarding the effective, efficient and economic exercise of the Authority's functions. However, the work undertaken during 2021/22 has identified further improvements that are required to ensure that the internal control framework remains adequate and effective. Findings raised from the 2021/22 internal audit reviews have not identified any material weaknesses. Overall, the Fire Authority has continued to demonstrate a robust and effective internal control and risk management environment.

3.2 The table below outlines the audit assurance opinions for the work delivered in 2021/22 for which the overall opinion is derived:

Audit	Assurance Opinion				Direction of Travel
	No Assurance	Limited	Reasonable	Substantial	
Core Financial controls				✓	⟺
HR/Payroll – Process Mapping	Assurance review deferred due to recruitment of new officers and implement process changes.				
HR People Management			✓		⟺
Asset Management System – Process Mapping	No opinion given for this review as an assurance mapping exercise was undertaken to assist the service in identifying the key control weaknesses in the current processes. This approach was taken due to the previous limited assurance reports in this area.				⟺
Procurement Governance and Compliance			✓		⟺
Portfolio Management Office Assurance			✓		⟺
Blue Light Hub – Post Project Evaluation		✓			N/A
Number of Findings	**-**	**10**	**21**	**2**	
Percentage	**-**	**30%**	**64%**	**6%**	

3.3 Internal Audit did not undertake a specific review of Corporate Governance in 2021/22. However, a number of audits considered the management oversight and decision-making processes as part of each audit assignment, and no concerns were raised. We would like to acknowledge that whilst the inspection undertaken in May and June 2021 by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) concluded with 'cause of concern', the Authority has shown strong commitment in its response to the recommendations raised; and has put in place an improvement plan that is supported by strong governance and a substantial resource structure that is working to ensure that all areas of improvement are achieved. For the coming year Internal Audit will be working with the Authority to provide assurance on the improvement plans.

4. Basis of Audit Opinion

4.1 The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAs). The Audit Strategy complies with the PSIAS and is summarised within the Service Level Agreement. This requires Internal Audit to objectively examine, evaluate and report on the adequacy of internal controls as a contribution to the proper, economic, efficient and effective use of resources.

4.2 The Internal Audit Plan was developed in consultation with the Director of Finance and Assets to focus specifically on financial management, corporate processes and key risk areas. There were no constraints placed on the scope of audit work in the year and there were sufficient resources to provide an adequate and effective audit coverage, however it should be recognised that due to the pandemic the majority of the audit plan was delivered through remote auditing with an increased reliance on officers providing the documentation to auditors electronically and demonstrating processes via screen-sharing.

4.3 The strategy for delivery of the Internal Audit Service is reviewed triennially and subject to the approval of the Overview and Audit Committee.

4.4 In reaching the overall opinion, the follow was taken into account:

- The results of all audits undertaken as part of the 2021/22 Internal Audit Plan. **Appendix 1** provides a detailed summary of the findings raised for each internal audit review undertaken.

- The results of follow-up action taken in respect of audits from previous years. **Appendix 2** provides a detailed summary of the implementation progress. It is management's responsibility for monitoring the implementation of the agreed actions following each audit review.
- Whether or not any 'high' priority recommendations have not been accepted by management and the consequent risks. It should be noted that all findings raised from the audit work undertaken were accepted by management and implementation of agreed actions is being progressed.
- The effects of any material changes in the Authority's objectives or activities.
- Whether or not any limitations have been placed on the scope of internal audit.
- Findings of work performed by other assurance providers (e.g. the External Auditors who we have liaised with throughout the year in order to share information and reduce any duplication of audit activity).
- The scope of the internal control environment - which comprises the whole framework of systems and controls established to manage BFRS to ensure that its objectives are met.
- Consideration of third-party assurances.

4.5 It should be noted that the Chief Internal Auditor opinion does not imply that Internal Audit has reviewed **all** risks relating to the Fire Authority. The most that the Internal Audit Service can provide to the Accountable Officers and Overview and Audit Committee is a **reasonable** assurance that there are no major weaknesses in control processes. The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

5. Anti-Fraud

5.1 There have been no suspected frauds or financial irregularity brought to the attention of the Chief Internal Auditor during 2021/22. Throughout the year we continued to work closely with the Director of Finance and Assets on fraud awareness and our work on the core financial systems included a review of the key anti-fraud controls.

6. The Internal Audit Team

6.1 The Internal Audit Service is provided by the Business Assurance Team at Buckinghamshire Council. All staff are qualified or part-qualified with either ACCA, CIIA, QICA or AAT qualifications, and all audit work is subject to a rigorous quality assurance process.

6.2 The quality of work is assured through the close supervision of staff and the subsequent review of reports, audit files and working papers by an Audit Manager. Exit meetings are held with the relevant officers to ensure factual accuracy of findings and subsequent reporting, and to agree appropriate action where additional risk mitigation is required.

7. Our Performance

7.1 With effect from 1 April 2013, the Public Sector Internal Audit Standards were introduced as mandatory guidance that constitutes the principles of the fundamental requirements for the professional practice of internal auditing within the public sector. All public sector internal audit services are required to measure how well they are conforming to the standards. This can be achieved through undertaking periodic self-assessments, external quality assessments, or a combination of both methods. However, the standards state that an external reviewer must undertake a full assessment or validate the internal audit service's own self-assessment at least once in a five-year period.

7.2 The Buckinghamshire Council Internal Audit Service was subject to its first external quality assessment of conformance to the PSIAS in quarter three/four of 2021/22. The assessment was conducted by CIPFA and the review concluded that:

'*It is our opinion that Buckinghamshire Internal Audit Service's self-assessment is accurate and as such we conclude that they* ***FULLY CONFORM*** *to the requirements of the Public Sector Internal Audit Standards and the CIPFA Local Government Application Note.'*

7.2 The table below shows Buckinghamshire Internal Audit Service's level of conformance to the individual standards assessed during this external quality assessment:

Standard/ Area Assessed	Level of Conformance
Mission Statement The Mission of Internal Audit articulates what internal audit aspires to accomplish within an organisation. Its place in the IPPF is deliberate, demonstrating how practitioners should leverage the entire framework to facilitate their ability to achieve the Mission.	**Fully Conforms**
Core principles The Core Principles, taken as a whole, articulate internal audit effectiveness. For an internal audit function to be considered effective, all Principles should be present and operating effectively. How an internal auditor, as well as an internal audit activity, demonstrates achievement of the Core Principles may be quite different from organisation to organisation, but failure to achieve any of the Principles would imply that an internal audit activity was not as effective as it could be in achieving internal audit's mission (see Mission of Internal Audit).	**Fully Conforms**
Code of ethics The purpose of The Institute's Code of Ethics is to promote an ethical culture in the profession of internal auditing. A code of ethics is necessary and appropriate for the profession of internal auditing, founded as it is on the trust placed in its objective assurance about risk management, control and governance.	**Fully Conforms**
Attribute standard 1000: Purpose, Authority and Responsibility The purpose, authority and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework (the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards and the Definition of Internal Auditing). The chief audit executive must periodically review the internal audit charter and present it to senior management and the board for approval.	**Fully Conforms**
Attribute standard 1100: Independence and Objectivity The internal audit activity must be independent and internal auditors must be objective in performing their work.	**Fully Conforms**
Attribute standard 1200: Proficiency and Due Professional Care Engagements must be performed with proficiency and due professional care.	**Fully Conforms**
Attribute standard 1300: Quality Assurance and Improvement Programme The chief audit executive must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity**.**	**Fully Conforms**

Performance standard 2000: Managing the Internal Audit Activity The chief audit executive must effectively manage the internal audit activity to ensure it adds value to the organisation.	**Fully Conforms**
Performance standard 2100: Nature of Work The internal audit activity must evaluate and contribute to the improvement of the organisation's governance, risk management, and control processes using a systematic, disciplined, and risk-based approach. Internal audit credibility and value are enhanced when auditors are proactive and their evaluations offer new insights and consider future impact.	**Fully Conforms**
Performance standard 2200: Engagement Planning Internal auditors must develop and document a plan for each engagement, including the engagement's objectives, scope, timing and resource allocations. The plan must consider the organisation's strategies, objectives and risks relevant to the engagement.	**Fully Conforms**
Performance standard 2300: Performing the Engagement Internal auditors must identify, analyse, evaluate and document sufficient information to achieve the engagement's objectives**.**	**Fully Conforms**
Performance standard 2400: Communicating Results Communications must include the engagement's objectives, scope and results.	**Fully Conforms**
Performance standard 2500: Monitoring Progress The chief audit executive must establish and maintain a system to monitor the disposition of results communicated to management.	**Fully Conforms**
Performance standard 2600: Communicating the Acceptance of Risks When the chief audit executive concludes that management has accepted a level of risk that may be unacceptable to the organisation, the chief audit executive must discuss the matter with senior management. If the chief audit executive determines that the matter has not been resolved, the chief audit executive must communicate the matter to the board.	**Fully Conforms**

7.3 We continue to monitor our performance standards as outlined in the service level agreement. This includes ensuring requests for assistance with suspected cases of fraud (% of responses made within 24 working hours) as appropriate and monitor relationship management issues in the areas of:

- Timeliness
- Willingness to cooperate/helpfulness
- Responsiveness
- Methodical approach to dealing with requests
- Quality of work/service provided

7.4 The 2021/22 Internal Audit Strategy set out six performance indicators that the Internal Audit Service was measured against. Below is a summary of our performance against the set indicators:

Performance Measure	Target	Method	2020/21 Results
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc.)	Internal Audit Performance Monitoring System	**90%**
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 Days	Internal Audit Performance Monitoring System	**90%**
Elapsed Time between issue of Draft report and issue of Final Report	15 Days	Internal Audit Performance Monitoring System	***100%**
% of Internal Audit Planned Activity delivered by 30 April 2019	100% of Plan by End of April 2019	Internal Audit Performance Monitoring System	**100%**
% of High and Medium priority recommendations followed up after implementation date	All High and Medium recommendations followed up within three months of the date of expected implementation	Internal Audit Performance Monitoring System	**100%**
Customer satisfaction questionnaire (Audit Assignments)	Overall customer satisfaction 95%	Questionnaire	****Nil – questionnaires not utilised for this year**

** Please note that measure looks at the timeliness of reporting by the team, and delays caused by the auditees are not factored in.*

*** Whilst questionnaires were not utilised this year, feedback was provided on completion of each audit and is also discussed as part of the regular meetings with the Director of Finance & Assets.*

Maggie Gibb

Chief Internal Auditor

July 2022

Appendix 1: Summary of 2021/22 Audits Performed Informing the Annual Opinion

Audit Assignment (No. Days)	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Core Financial Controls (10 Days)	Substantial	High = 0 Medium = 0 Low = 2	**1. Financial Control Framework – User training (Low)** **Finding:** Whilst the process for providing and recording training was identified as an example of best practice, in the case of one training record, the initial user training for the required Integra transactions was not recorded on the form. **Risk:** If user training records are not completed when training is completed, there is a risk that training records are not accurate or up to date and that users are not aware that they have received the relevant training. **2. Debtors – Payment plans (Low)** **Finding:** A walkthrough of the process for recovering aged debts was carried out for a £2,161.37 debt owed by Encompass Select Ltd, of which £1,330.25 was outstanding. The walkthrough found that the debt was chased in line with the Fire Authority's debt recovery process. A payment plan was subsequently agreed upon. Whilst emails were found chasing payment against a payment plan, there was no record that the payment plan was agreed by the debtor. The Finance Assistant and Principal Accountant (Technical Accounting) confirmed that emails are deleted after a year due to data storage capacity limitations, meaning the original email agreeing the payment plan could not be found. Review of the Aged Debt report and Aged Analysis report found no other debts that were being repaid by way of a payment plan. **Risk:** If an agreed payment plan is not held on file, there is a risk that the Fire Authority does not have recourse to continue the collection of the debt and that payment is further delayed or not collected, leading to financial loss to the Fire Authority.
HR People Management (10 Days)	Reasonable	High = 0 Medium = 3 Low = 2	**1. Starters, Leavers and Movers – New starters (Medium)** **Finding:** Examination of a sample of 20 new starters at the Fire Authority between January 2021 and July 2021 found: • One case where no contract, offer letter, checklist, references, or ID were provided. • Five cases where no references were provided. In all five cases references were requested but either not received or not available on the personnel file as of the audit. In seven further cases, only one reference was provided. Discussion noted that one was an apprentice, with apprentices only having one reference due to a lack of prior experience, and one was an agency employee for which a different process is in place. Therefore, five of the seven cases were exceptions. • Two cases where no medical questionnaire was held on file. • Two cases where the starter checklist was not fully completed. **Risk:** If a starter checklist is not completed and held on the employee's personnel file, and the required documentation is not received and reviewed, there is a risk that the new starter has not been correctly set up on iTrent and that the employee has not been adequately vetted. This will increase the risk of overpayments, underpayments and the risk that new starters are not suitable candidates for the role, leading to financial and reputational damage.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
HR People Management (10 Days)	Reasonable	High = 0 Medium = 3 Low = 2	**2. System Access, Data Security and Information Integrity – BCP testing log blank (Medium)** **Finding:** Whilst parts of the Business Continuity Plan (BCP) have been tested during the Covid-19 pandemic, which affected business as usual operations, and there are specific points in the BCP that address pandemic risk, the BCP testing log is blank meaning there is no record of a test having been carried out. There is also no detail of the tests in place for the HR BCP on the Authority's Resilience Direct system but discussion with the Head of Human Resources established that these are due to be updated next time the plans are reviewed. **Risk:** If there is no record of the BCP having been tested, there is a risk that the business continuity processes for people management have not been adequately tested and that key organisational activities cannot be carried out should a risk event occur, leading to the Authority being unable maintain its obligation as a CAT1 responder. **3. System Access, Data Security and Information Integrity – Open personal data actions (Medium)** **Finding:** The HR Personal data and permissions mapping document includes an issue and action log around personal data and GDPR compliance for HR files, data processing and communications which was last updated in 2018 and lists 16 open actions. Issues listed in the document, for which open actions were identified, include Privacy Notices not being GDPR compliant and issues around unauthorised access to information and inaccurate or duplicated data being held by HR. It was unclear if this document was superseded and if these actions were now closed or if they were still open as recorded. **Risk:** If progress on personal data actions is not updated and recorded appropriately and if the actions are not closed when completed, there is a risk that issues around personal data compliance have not been addressed, resulting in non-compliance with GDPR and putting the Fire Authority at risk of data breaches and penalties. **4. Starters, Leavers and Movers – Changes (Low)** **Finding:** Examination of a sample of 20 employees whose information changed between January and July 2021 found: • In one case, the instruction to make the change was received on the effective date. In this case it was entered on iTrent four days later. Whilst the other five changes applied retrospectively were deemed to be outside the control of HR, in this case HR was deemed to be partially responsible for the delay. • Two cases where there was no Change Control Form. Discussion established that these roles were both from a recruitment process. A Change Control Form is not a requirement for these as HR are involved in the interview processes and therefore know the details of the transfers. Some managers do provide Change Control Forms, but they are not required as approval is already received. However, there is another similar example where a Change Control Form was provided. Discussion with the Senior Administrator established that some operational roles have allowances that require the Appointments Board to provide additional approval on a change control form. However, where there are such variations in the process, they should be identified in the process notes. **Risk:** If changes are not processed accurately, in a timely manner and with the correct documentation, there is a risk that the pay implications of role changes are not actioned on iTrent before Payroll being run, leading to the creation of an overpayment and financial loss to the Fire Authority.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
HR People Management (10 Days)	Reasonable	High = 0 Medium = 3 Low = 2	**5. Performance and Monitoring – Monitoring of performance indicators (Low)** **Finding:** Concerns about staff performance are raised in employee appraisals, processing times are recorded in process notes for new starters and there is a Service Level Agreement in place for the HR Operations and Organisational Development service desks that includes delivery times for common requests and actions. However, there is no evidence to show that processing times are measured and monitored periodically. **Risk:** If performance indicators are not in place there is a risk that instances of poor performance are not identified and rectified in a timely manner, leading to increased instances of key HR tasks not being performed accurately and/or in a timely manner.
Blue Light Hub – Post Project Evaluation (10 Days)	Limited	High = 4 Medium = 3 Low = 3	**1. Governance Framework - Amount of Contingency (High)** **Finding:** The Executive Committee report from 15 September 2021 states, *"The West Ashland build is now complete. The final account, including retention fees, is yet to be finalised. The Authority will also be looking to recover some of the increased costs from the professional design team. The forecast variance for West Ashland total project costs is expected to be offset by additional capital receipts and contributions which will result in a net variance of circa £1m against the forecast expenditure and risks previously reported to Committee"*. As stated on 19 September 2018 Executive Committee meeting minutes, *"There was no contingency originally as the planned BIM process would not have required any. This is now allocated at £100k given that a number of the adverse variance issues have already presented themselves in the period since construction began and are therefore accounted for elsewhere in this document."* The contingency allocated of £100k is <1% of the initial £13.1145m budget. The January 2020 Learning Points created by the former Director of Finance and Assets indicates that *"Every major public sector construction project overspends. Include a general contingency of at least 15%".* **Risk**: If the contingency is not adequate, there is a risk that insufficient funds are available for the project delivery. This could result in reputational damage and/or financial loss. **2. Implementation Strategy and Project Delivery – Shared Risk (High)** **Finding:** The Director of Finance and Assets indicated that the percentage contributions from the TVP and SCAS were fixed, with no scope for BMFKA to negotiate further contributions from either service. As a result, BMFKA has borne most the of additional costs. **Risk**: If risks are not shared, there is a risk that all additional costs will be absorbed by one party within the contract, resulting in financial loss and inability to deliver the project. **3. Implementation Strategy and Project Delivery – Storage of Information – Shared Risk (High)** **Finding:** We could not obtain evidence of the HUB's procurement, establish how the procurement occurred, or provide assurance that the procurement of the HUB followed best practices. The Director of Finance and Assets at the time of the procurement of the HUB has since left. Discussion with the current Director of Finance and Assets, the Property Manager, the Procurement Manager, and the Programme Manager established there is no centralised folder where all project information and evidence is stored. **Risk**: If there is no centralised location where all project related documents are stored, there is a risk that documentation cannot be located, for instance, after a staff member leaves the organisation.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Blue Light Hub – Post Project Evaluation (10 Days)	**Limited**	**High = 4** **Medium = 3** **Low = 3**	**4. 2018/19 Follow Up Recommendations – Risk Registers (High)** **Finding:** Additionally, risk registers should include all present risks. We reviewed each risk in the Project Risk Registers and Transition Activities Risk Register obtained and did not identify any specific risks relating to poor performance of the HUB. **Risk:** If all relevant risks are not included within a risk register, there is a risk that further preventative actions are not identified to mitigate the risk in a timely manner, leading to an increased likelihood of the event occurring/escalating. **5. Governance Framework (Medium)** **Finding:** The agenda and papers from the Fire Authority meeting held on 7 June 2017 outline the delivery plan for the Blue Light Hub project. It also details who the project will be managed by. A Governance Arrangements document was developed, which provides a basis to manage and control the project implementation. However, we established that key tasks for the project team were not defined in a schedule of activities. Besides the 7 June 2017 paper delivery plan, there was no formalised project governance framework. **Risk:** If a formalised project governance framework is not in place, there is a risk that project objects, including time scales and budgets, are not met, leading to financial loss to the Fire Authority. **6. Implementation Strategy and Project Delivery - Project Implementation Process (Medium)** **Finding:** Examination of the BMKFA Delivery Plan found that it included: • an initial project plan; • use of resources; • project management; • a design release schedule and • an Indicative Procurement Timetable. However, from a review of the design release schedule, we found that there were 18 activities that did not have the actual release dates recorded, of which 12 activities did not have a supplementary note to give a clear indication as to why the target design release date was not met and what the related construction issue may be **Risk:** If a clear project implementation process is not documented, there is a risk that project objectives, including time scales and budgets, are not met, leading to financial loss to the Fire Authority. **7. Lessons Learnt (Medium)** **Finding:** Examination of documentation found that the former Director of Finance and Assets produced a 'Blue Light Hub – Learning Points' document. This details project learning points from its initiation to February 2020. Following the completion of the Blue Light Hub build and transition of BMKFA, SCAS and TVP staff members, no formal lessons learned activity has occurred at the time of testing. **Risk:** If a formal lessons learnt activity is not undertaken and reported on, there is a risk that insights and learning from the project are lost.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Blue Light Hub – Post Project Evaluation (10 Days)	Limited	High = 4 Medium = 3 Low = 3	**8. Implementation Strategy and Project Delivery- Resources (Low)** **Finding:** Through discussion with the Director of Finance and Assets and the Property Manager, it was highlighted that the Property Manager was not provided additional resource to manage the relationships between the HUB, Kingerlee and BMKFA. The initial budget did not allow for additional resources to support the Property Manager during the construction phase. Additionally, there was a change of the Director of Finance and Assets in 2020. Ideally, this individual would have been present throughout the project to provide continuity from the top level. We were informed that the resources available to the Property Manager did not impact the project's outcomes. However, it made an impact on the individual's workload. Prior to occupation of the building, additional resources were allocated to the project from across the organisation to ensure a successful transition to the new station. **Risk:** There is a risk that those who manage project deliverables in an operational setting do not have the necessary resources and training to manage them. **9. Monitoring of Project Benefits (Low)** **Finding:** The Director of Finance and Assets and the Property Manager established that there are no formal processes to monitor the continued benefits of the project since the transition of the three services. The Director of Finance and Assets informed us that the Portfolio Management Office will assess strategic level views. **Risk:** If project benefits are not monitored there is a risk that stakeholders are not aware of the improvements resulting from the project, and additionally whether, or not, the expected project benefits have been met. **10. 2018/19 Follow Up Recommendations – Budget Monitoring Meetings (Low)** **Finding:** We reviewed meeting minutes available on the Buckinghamshire Fire Authority website. We confirmed that there are quarterly monitoring report minutes available. However, no monthly monitoring budget meetings were held in April 2020, May 2020, August 2020, January 2021, April 2021, May 2021, or August 2021. **Risk:** If budgets are not monitored on a regular basis, there is a risk that overspend is occurring, which could lead to financial and reputational damage.
Portfolio Management Office Assurance	Reasonable	High = 0 Medium = 4 Low = 2	**1. PMO Key Performance Indicators (Medium)** **Finding:** The Head of Transformation, Technology and PMO confirmed that the Authority does not currently have KPIs in place to report against concerning the PMO but confirmed that this was something they would be interested in implementing. **Risk:** If there are no KPIs in place, the authority could miss identifying instances of poor performance and fail to address problems leading to repeated mistakes in future projects.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Portfolio Management Office Assurance	Reasonable	High = 0 Medium = 4 Low = 2	**2. The PMO's Standardisation of Project Processes (Medium)** **Finding:** The Head of Transformation, Technology, and PMO provided the Authority's guidelines around a project's process to ensure consistent and effective delivery. This included a detailed PMO presentation, a project life- cycle and various templated documents available for project managers. Furthermore, evidence was provided of an eLearning package and a page on the Fire Authority's intranet for PMs to review, explaining the process. In its design, the PMO's outlined a clear framework for consistency and successful delivery of projects. However, testing a sample of projects commencing after the PMO's creation outlined inconsistencies in the process they should follow and discrepancies regarding which documentation was completed for each project. The findings are as follows: • 1/3 projects is without a completed project mandate; • 2/3 projects are without a completed business case; • 1/3 project is without a completed PID; • 3/3 projects are without a completed risk register which is key to reviewing the risks and controls in place within a project; • 3/3 projects are without a completed project plan, resulting in a lack of progress monitoring during the life of a project; • 3/3 projects are without a highlight report that updates management on key areas such as managing risks and their impact; and • 3/3 projects are without evidence of stakeholder communication for any of the projects that have commenced after creating the Authorities PMO function, despite stakeholders being outlined within the early project documentation. Furthermore, we were informed that Property capital projects do not follow the process outlined within the PMO's lifecycle document. Consequently, they did not have evidence of the key documentation such as mandates, PID, business case and risk registers. These are key documents for successful project delivery and should be evident across all types of projects. **Risk:** If project managers fail to follow the standardised process set out by the PMO and neglect certain documentation which should be completed, best practice will not be consistently followed throughout the Authority. This could result in the failure to deliver projects to the standard expected. **3. Projects Over Budget/Time Request Approval (Medium)** **Finding:** The Head of Transformation, Technology and PMO confirmed that the Authority does not currently have an official process for extensions and instead held informal conversations with project managers. They encourage RAG ratings for updates within a project regarding budgets and timescales. However, going beyond estimated figures does not require approval. We were informed that this was due to the PMO being in its infancy. **Risk:** If there is no formal process to request additional budget requirements and timescale extensions, the budget may be exceeded without the Authority's notice and approval, putting unnecessary pressure on the Authority's overall budget. **4. Expenditure records (Medium)** **Finding:** From reviewing the document templates and project lifecycle we were provided with it was clear that there was no formal documentation where in which project managers should be recording expenditure. We were also informed this was a responsibility of the project managers and a consistent approach from the PMO was not evident. **Risk:** Where project expenditure is not formally recorded in documentation, the risk arises that projects will go over budget more frequently as spending may not be sufficiently tracked. This could have severe financial implications to the Authority.

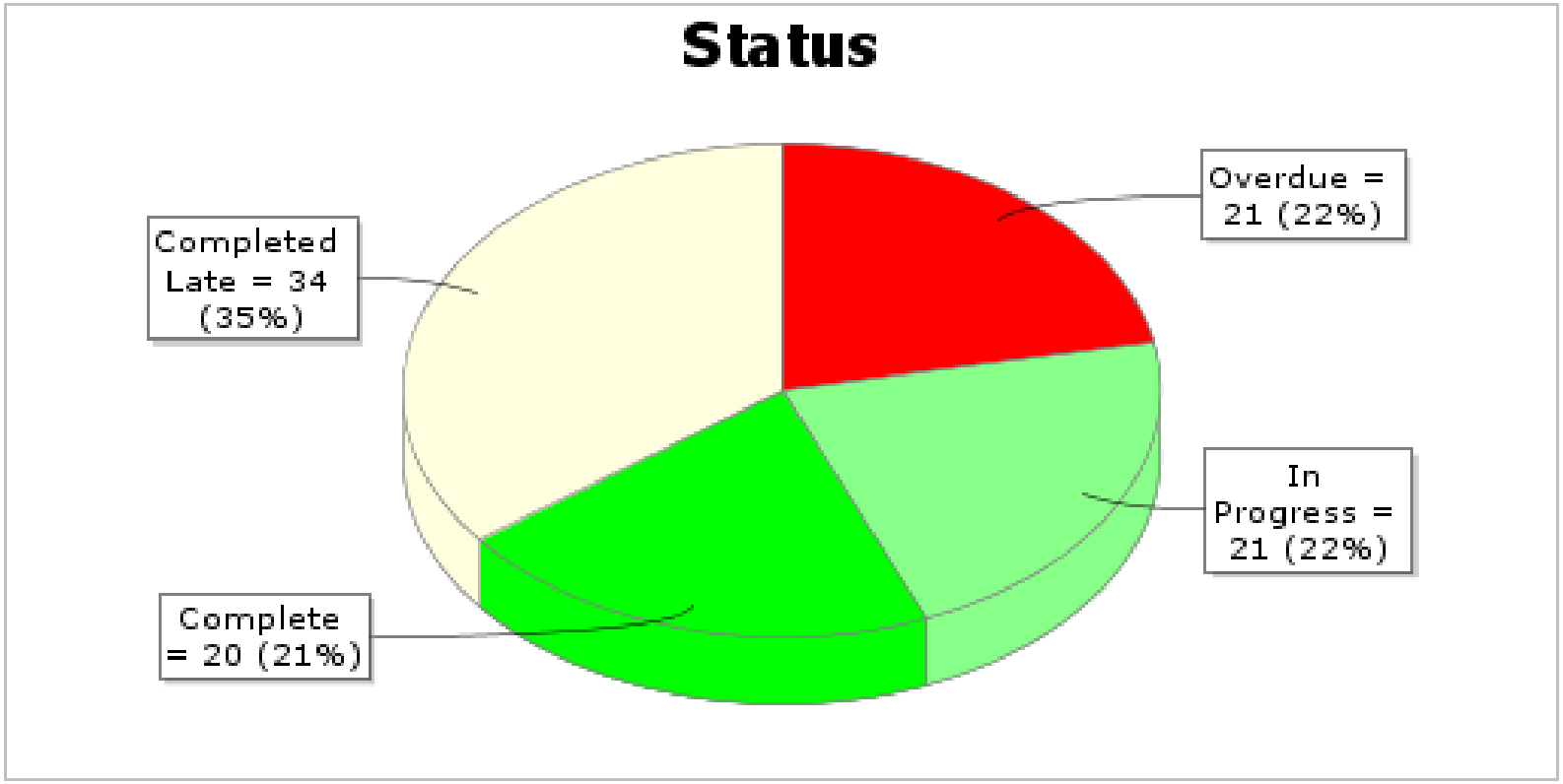
Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Portfolio Management Office Assurance	Reasonable	High = 0 Medium = 4 Low = 2	**5. Centralised System (Low)** **Finding:** The Head of Transformation, Technology and PMO confirmed there was no centralised system for the storage of project documentation. There was evidence of a project dashboard, presented on an excel spreadsheet, which summarised the progress of all projects underway and in the review stage. This stated some key dates, the names of PMs and progress updates. However, there is no evidence of a system where documents can be accessed for each project. This would be beneficial from an audit trail perspective and allow PMs to follow previous projects' processes and learn from their mistakes. **Risk:** Without a centralised system to store and access project documentation, there are missed opportunities to share important lessons learned across the organisation and avoid re-occurrences. **6. Quarterly Review Meetings (Low)** **Finding:** SMT meet to prioritise projects and make decisions about projects based on their alignment with Authority objectives. However, this is on an ad-hoc basis, and there was no formal timeline for the task. **Risk:** Where projects are not reviewed regularly, there is a risk that projects will be continued, where there is no business requirement, and they do not align with authority objectives. This could result in financial implications.
Procurement Governance and Compliance	Reasonable	High = 0 Medium = 5 Low = 5	**1. Strategy, Policy, and Procedures (Medium)** **Finding:** The new Strategy should also be version controlled, so it includes the following information: • Date of the last review; • Which officer/board conducted the review; and • The date of the following review. The current Procurement Strategy (2015 – 2020) has now expired. It does not contain a version control. There is a draft copy of the new procurement strategy set to be approved in 2022, but this has not been formalised. We noted that the Authority operated throughout 2021 without an effective Strategy. The 2015 – 2020 Strategy did not include any procedural guidance related to procurement, including information for contractor resilience which could be disseminated to other departments. It is the department's responsibility to conduct these checks. An up to date set of procedural guidance should be drafted covering the entire procurement process, including key points such as contractor resilience checks and approval; this could be added to the Authority's Finance Policy. **Risk:** If key strategies and procedural guidance relating to procurement are not kept up to date, there is a risk that an ineffective and/or consistent approach could be taken, resulting in significant financial loss for the Authority.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Procurement Governance and Compliance	Reasonable	High = 0 Medium = 5 Low = 5	**2. Financial Approval Limits (Medium)** **Finding:** The Authority should ensure it formalises financial approval limits within its Financial Instructions at the earliest opportunity, including the identification of individual roles and their respective financial limits. **Risk:** A lack of formalised, up to date financial approval limits can increase the risk that financial activity will not be appropriately managed and be subject to fraudulent activity/financial loss. **3. Contract Performance Monitoring (Medium)** **Finding:** We tested a sample of five procurements and noted that in two cases where procurements were conducted in partnership, the contracts required performance monitoring meetings no less than every six months. However, we found that in one case (TW Pumping Appliances), no such meetings had taken place since the procurement team of the lead authority, Oxfordshire County Council was no longer extant. In the remaining case (Water Hygiene Monitoring & Related Services), we were provided with certificates showing the performance of the contract by the supplier, but no formal meetings were taking place. **Risk:** If predetermined meetings are not adhered to, the Authority will have limited oversight regarding the performance of a contract. Subsequently, it may be exposed to non-compliant suppliers/service providers, meaning the Authority does not achieve value for money. **4. Procurement Key Performance Indicators (Medium)** **Finding:** The Procurement Manager confirmed that the Authority does not currently have KPIs to report against concerning procurements. A savings tracker is in place, but this is not actively used to monitor performance and was not reported to a governance meeting or the SLT. **Risk:** If there are no KPIs in place, the Authority may fail to identify instances of poor performance and fail to address extant problems, which may lead to repeated mistakes in future projects. **5. Compliance Monitoring (Medium)** **Finding:** Standing Order 2.2 (f) states that it is the responsibility of the Chief Fire Officer and Chief Executive to "ensure that his or her staff complies with these standing orders relating to Contracts". However, we note that the Authority does not conduct compliance-based monitoring activities. The Integra finance system includes predetermined steps requiring differing authority levels and illustrating clear segregation of duties through the procurement process from requisition to buyer approval. However, this does not ensure more broadly compliance with the CSOs or procurement and contract management requirements. **Risk:** If compliance against CSOs is not monitored, the Authority may become non-compliant with its responsibilities regarding procurement. This could lead to financial loss and/or reputational damage.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Procurement Governance and Compliance	Reasonable	High = 0 Medium = 5 Low = 5	**6. CSOs - Version Control (Low)** **Finding:** BMKFA should ensure that the CSOs are version controlled, including: • Date of the last review; • Which officer/board conducted the review; and • The date of the following review. The Authority has a set of Contract Standing Orders (CSOs). An updated version is being drafted with a provisional submission date and approval in February 2022. However, the current set of CSOs does not contain a version control, so we could not ascertain if they were up to date or when the last review occurred. **Risk:** If the CSOs are not version controlled, there is a risk that an outdated or wrong approach may be taken during the procurement process leading to substantial financial loss and non-compliance. **7. Strategic Outline Case - Version Control (Low)** **Finding:** Two of the samples we selected were over the threshold requiring strategic outline cases. We confirmed that both had provisions for version control. However, none of the cases had its version control information input. **Risk:** If strategic outline cases for projects involving significant expenditure are not version controlled, there is a risk that key projects are approved in error which could lead to financial loss and financial mismanagement. **8. Contract Register (Low)** **Finding:** We noted that the register did not include the name of the officer responsible for the contract in the register of contracts over £5,000, as required by Standing Order 2.2(g). As per regulation 31 of the Local Government Transparency Code 2015, it is only legally required for the Authority to state the local authority department instead of the officer responsible. We found that the department was included in the Authority's contract register. The Procurement Manager suggested that listing the officer was unfeasible given that officers in the authority often change departments. **Risk:** If CSOs relating to the ownership of contracts is unclear, the responsibilities associated with the performance of a contract may be unclear, resulting in improper management of the agreement, and queries regarding specific agreements may be ineffectively communicated. **9. Compliance with CSO 8.1 (c) (Low)** **Finding:** In two cases where the procurement was conducted under a partnership, a comparative assessment was made for the applicants regarding technical competence and financial health. However, no evaluation was made of the health and safety record of the potential service providers as per Standing Order 8.1(c) "Where the total value of the contract is more than £50,000, Officers must ensure that potential candidates are asked to provide sufficient detail to check their health and safety record". **Risk:** If CSOs related to the assessment of a contractor's health and safety standards are ignored, The Authority may procure services from suppliers with health and safety standards below that expected or required by the Authority, potentially leading to non-compliance with standards that the Authority is required to adhere to.

Audit Assignment	Audit Opinion	No. of Audit Actions by Priority	Summary of Audit Findings
Procurement Governance and Compliance	**Reasonable**	**High = 0** **Medium = 5** **Low = 5**	**10. Compliance with Contract Standing Orders (Low)** **Finding:** CSO 6.1(l) states that an officer must "retain evidence that the above steps (6.1(a)-(l)) have been carried out for examination by internal or external auditors;". In all three cases tested that were not conducted in partnership, evidence had not been retained regarding various steps required before letting a contract as per CSO 6.1, including estimation of the value of the contract, ensuring there is sufficient budgetary provision, and taking into account the outcome from any strategic service review. **Risk:** Where a clear audit trail is not maintained, the Authority may be in non-compliance with document/evidence retention regulations, and effective review and lessons learned exercises related to the suitability of the procurement, as well as the performance of the procurement team more generally is not possible.

Appendix 2: Current Status of Audit Actions as at 10 June 2022



** This is a summary status of all audit recommendations raised from 2017/18 to date.*

Detailed Description of Overdue Audit Actions as at 10 June 2022

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2021 2110 Asset Management System (5) Recording of Assets – Overdue tests	**Finding:** Fire crews must undertake regular stock checks and tests of equipment at fire stations and on appliances (vehicles). The frequency of these tests and inventory checks depends on the individual asset's testing schedule, usually dictated by the PIT number assigned to the asset. Results of tests and inventory checks should be recorded on Redkite by crews using either a handheld scanner or computer. Review of the report of tests due at Beaconsfield Fire Station run from Redkite found that 286 of the 288 tests listed had passed the due date as of 12 November, with one due date listed as being 13 February 2014 and 118 listed as having due dates of 2019 or earlier. A similarly high number of overdue tests were noted for Aylesbury Fire Station as of 3 November 2020. All 179 tests were overdue when viewed against the listed due date. Through discussion with the Station Commander, we were unable to establish whether these tests had been carried out or whether this was a system issue or data quality issue. A sample of 20 assets listed on Redkite was examined to confirm whether equipment tests and inventory checks were carried out promptly and accurately recorded on Redkite. The period covered was from November 2019 to November 2020. Of the 20 assets tested: • In 11 cases, assets were not tested in line with the frequency required by tests loaded onto Redkite. • In four cases, the most recent test was not carried out within a timely manner of the previous test. • In one case, no inventory checks or tests had been carried out since March 2018. In two other cases, an inventory was carried out promptly. However, no tests were carried out on the equipment since 2018 or earlier. In one of these cases, the most recent test was listed as being carried out in October 2014. • One asset was not found during an inventory check. **Risk:** If tests are not carried out periodically and promptly in line with the testing schedule loaded into Redkite for the asset, there is a risk that defective or missing equipment is not detected, increasing the risk that equipment is obsolete or unsafe or that stock levels are not sufficient. **Action:** Review of testing frequencies and recording of all equipment on Red Kite. Additional training for the operational crew in the recording of tests.	30-Jul-2021	**High Priority**	Testing frequencies are continually reviewed in line with new equipment procurement and joined up collaboration work with Thames Valley partner services. Review of equipment manuals is on-going and will continue with close liaison with Thames Valley partners, this is in conjunction with a planned review of the current stowage of all equipment on the Thames Valley appliance and review equipment carried. A self assessment was carried out by all "watch" groups on stations as part of station preparedness and improvement earlier this year. This has been followed up by in person visits by a team of Station Commanders and Group Commanders. Assessable areas include testing of equipment, cleaning of equipment, recording of equipment on Asset Managements system (including moving, defecting, inventories of equipment). Where required additional training has been provided and following completion, further actions, notes and training, where required will be issued These follow up visits are nearing completion.
BMKFA 2021 2110 Asset Management System (3) Asset Management Planning, Policies and Procedures –	**Finding:** Up to date asset management procedures should be in place. The procedures should be compliant with Financial Regulations and Financial Instructions and help deliver the asset management plan. Many processes were found not to be documented. This included tasks carried out by the Asset Management and Equipment Manager, Asset Management Technician and in the Stores/Mezzanine area that feed into RedKite. It was apparent that there was little awareness between team members and by the Station Commander Research & Development, of what other team members do. Especially of the tasks carried out in the Mezzanine, which are mostly manual and completed outside of Redkite.	30-Sep-2021	**High Priority**	All staff have access to the relevant user manuals. The flowcharts showing the process for tasks concerning assets from ordering, registering, issuing, defecting, testing etc. have now been produced. These detail the

Processes not documented	The team would benefit from mapping the process end to end to better understand their processes and where improvements can be made and help build resilience. **Risk:** If processes are not sufficiently documented there is a risk that staff are unaware of their roles and responsibilities. This could lead to inefficient and inconsistent use of the Asset Management System and reducing the reliability of the data it holds. **Action:** We have ensured that all staff have access to the relevant user manuals. We will review the roles and responsibilities of the Asset Team and ensure that Manager, deputy and SC R&D are aware of work practices and procedures of the whole team. Create a series of flowcharts showing workflow that could be picked up by "new" staff in the event of staff leaving/prolonged sickness or secondment out of current position. This will be supported by the end-to-end process mapping within the Internal Audit Plan for 2021-22.			responsible person / department at each stage. This action can be closed.
BMKFA 2021 2110 Asset Management System (6) Recording of Assets – Inaccurate records of stock	**Finding:** Stock records should enable identification of assets owned and determine those in use or not in use. The location of the asset should also be recorded accurately on the asset management system. A sample of 25 items was selected from the report of current assets generated from Redkite to check whether the assets could be found in the Stores and Workshops area. Of the 25 assets: • Sixteen assets could not be found. In one of these 16 cases, the asset had a system-assigned equipment number but no barcode number or serial number, which are the numbers used by the Authority to identify assets uniquely. If the asset was present in Stores, there would be no unique identifier in Redkite to identify the asset. Values were listed for six of the 16 items that were not located. The highest of these was £345. The total value of items not found for which the value was listed was £687.69. A further sample of 25 items was selected at random from the Stores area to check whether the assets could be identified on the Asset Management System. Of the 25 assets selected: • Seven did not have a label or tag with the barcode number. Of the seven that were not marked or labelled, three had a serial number. However, the serial number could not be found in Redkite. • In the 18 cases where the asset had a barcode label, nine assets could not be identified on Redkite. • In the nine cases where the asset was identified on Redkite, one asset was found in Stores. However, it was listed on the system as being in Stokenchurch. Further testing was carried at Beaconsfield Fire Station. A sample of ten assets was selected from the report of current assets listed on Redkite. Of the ten assets selected: • Two assets were not found at the fire station. One of these assets was a battery for a handheld radio. Discussion with the Station Commander established that these are always listed as auxiliary equipment linked to the station and are not scanned when moved to an appliance or someone takes it with them. However, during the audit visit, the fire crews searched the station appliances (vehicles) for the asset, and it could not be found. • Of the eight assets found, one was not marked with a barcode label, tag or number. Testing of a different sample of ten items selected at random from the Fire Station found no exceptions. All assets could be identified in the Asset Management System. **Risk:** If a complete and accurate record of assets and their location is not held on the Asset Management System, there is a risk that the value of the assets on the accounts will be misstated and that assets are not readily available to meet service requirements. **Action:** As part of the stock check of equipment within stores and on mezzanine equipment will be checked to ensure that it has an asset/barcode tag and that this is recorded against the serial number of the equipment item and recorded on Red Kite.	31-Aug-2021	**High Priority**	Stock checks and internal audits of equipment have been completed and good progress is being made in this area with adding legacy items to the asset management programme.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 1819 1947 Project Management BLH (2) The Hub Performance	**Finding** During the Audit it was confirmed that the HUB have had difficulties with technical support; which has had an impact of the timeliness of design work, changes or updates and which in turn has led to delays in providing information that is required by Kingerlee – the construction firm. The Quantity Surveyor maintains a schedule of delays caused by the HUB and the associated costs. It was confirmed that any financial implications that arise as a result of the HUB's poor performance could potentially be recoverable. However, Audit found that whilst these potentially recoverable costs are reflected in the Budget Monitoring Financial Statements, they are not separately identified as attributable to any party as this will be the subject of negotiation between all parties depending on final outcomes at the conclusion of construction. The risk of HUB poor performance has been recorded in the risk register. It was confirmed that the Director for the HUB Professional Services has been made aware of potentially recoverable costs and the issues that were causing poor performance have been addressed. **Risk** Where the impact of poor performance is not completely and accurately reflected in the budget and/or risk register, this may lead to project overspend as the budget will not be forecasting all expected costs. **Action** The necessary actions to deal with potential financial loss arising from delays on the part of HUB have already been addressed during 2018 and a significant improvement has been seen. The current delay in the construction programme (5-6 weeks) has not altered for some months. Both the HUB and Kingerlee have a responsibility to mitigate any delay as much as possible and with some 8 months of construction still to take place at the time of writing (Feb 2019) they must both maintain the opportunity to do so. Only at post construction and during the period when the final account will be negotiated and agreed, will any financial loss due to delays or failures be attributed. The Director of HUB's parent company (Integral UK Ltd) has been in discussions with both DFA and Property Manager and he is well aware of the potential claim the Authority may have in due course. The financial statements produced by the QS do show all costs (i.e. worst case) but do not at this stage set out which potentially claimable costs are attributable to which parties. The Authority's officers will continue to maintain dialogue with senior representatives at both the HUB and Kingerlee over any potential situation (either worsening or improving) that may lead to a claim.	31-Oct-2019	**Medium Priority**	Update from Director of Finance & Assets: The Service has commissioned Blake Morgan LLP to produce a scope of work in order to engage a claims specialist. The claims specialist will collate and assess the evidence required to support our claim against the professional team.
BMKFA 2021 2110 Asset Management System (2) System Transactions and Records – Resilience in the Asset Management Team	**Finding:** There should be a sufficient provisions and service resilience within the team to ensure business continuity should a risk event occur. The Asset Management Team established that the Asset and Equipment Manager had been absent for three months. As a result, the Asset Management Technician had picked up the majority of her responsibilities regarding the Asset Management System. Also, telephone calls still had to be made to the absent Manager in certain situations. The Technician stated that he was still learning what she used to do. Many of the processes, other than the Redkite user processes, were found not to be documented. The Manager appeared to be the only staff member trained in carrying out many of these tasks. This demonstrates a resilience issue in the team. **Risk:** If adequate measures are not in place to build resilience and mitigate single points of failure within the team, there is a risk that in the event of a prolonged team absence or a team member leaving the Fire Authority, the Asset Management Team cannot continue business as usual operations. **Action:** There are user guides available on the Red Kite software programme and a Red Kite Asset Management user guide on the intranet. These are accessible to all staff. The Asset Management Technician has been made aware of these documents. Access rights have been checked to ensure the suitable persons have access and can download Red Kite user guides from the login screen. Documentation to be reviewed for any gaps and process notes to be updated where required.	30-Jul-2021	**Medium Priority**	This action can be closed, as stated in description all staff have access to the user guide / manual. When notified of any changes within the supplier user guide these will be reflected with the service guides.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2021 2115 Core Financial Controls (2) Payroll – Flow of information from HR to Payroll during Leaver and Change of Role processes	**Finding:** Following a leaver's notification receipt, HR enter leaver data on iTrent, with a Leaver notification email then sent to the Payroll mailbox. This process should be completed swiftly and before the Payroll cut-off date to ensure that recurring payments to the leaver are promptly removed. Examination of a sample of 10 employees who left the Fire Authority's employment between April and November 2020 found that four leaver notifications were received by Payroll after the leave date. Three of these were received after the payroll cut off for that month. In one case this led to the creation of an overpayment. Discussion with the Payroll and Benefits Manager established that the Leaver process changed during 2019-20. Line managers no longer advised Payroll directly of Leavers. The amended process involves line managers advising HR and HR passing Leaver information on to Payroll. Following iTrent permission changes, Payroll can no longer process Leavers if HR does not have the capacity to or in the event of late leavers after the Payroll cut-off. The result of these process changes is that information reaches Payroll last, sometimes after the employee has already left the organisation, reducing Payroll's ability to address the risk of overpayments. To mitigate overpayments, Payroll manually adjusts pay within the record whilst it is still live. Payroll is more reliant on manual intervention and affects their timeliness in reporting to HMRC. Examination of a sample of ten On-Call and Overtime payments made to staff between April and November 2020 found one case where a request was submitted via email. This was due to a discrepancy with a change in role and a change in Terms and Conditions for the employee. Not all of the necessary managers were involved in this process, and contractual changes were not communicated effectively. This resulted in an overpayment. Corrective action was taken by the employee's line manager and Payroll. **Risk:** If Payroll is not provided with complete and timely information to process Leavers and role changes, there is a risk that Leavers and pay implications of role changes are not actioned on iTrent before Payroll being run, leading to the creation of an overpayment and financial loss to the Fire Authority. **Action:** End to end process mapping will be undertaken across HR, Payroll and the Resource Management Team in order to identify areas where processes can be streamlined, and all control weaknesses can be addressed.	31-May-2022	**Medium Priority**	Payroll/HR Process Review postponed until 2022/23 Q1 due to capacity constraints within the service.
BMKFA 2021 2119 GDPR (4) Retention and Destruction	**Finding:** The Records Retention and Disposal Information Asset Register procedure states that information stewards are responsible for ensuring the timely archiving and/or destruction of records and advising the Information Owners where it is believed a retention timescale should be amended following legislation or business needs. The Information Governance and Compliance Manager is responsible for maintaining and reviewing records management processes. The retention schedules for departments and stations are defined within the ROPA. The Authority relies on stewards to ensure that electronic data is disposed of per the retention schedule. However, there is no mechanism in place to ensure this takes place. **Risk:** If no adequate processes are in place to ensure lawful retention schedules and/or destruction of electronic records, there is a risk of accidental and/or unlawful alteration, destruction, or authorised personal data disclosure. **Action:** Agreed. A mechanism to review data disposals in line with the retention schedules will be formalised and monitored.	31-Dec-2021	**Medium Priority**	Update from Graham Britten, Director of Legal & Governance, 09/06/2022: Awaiting for confirmation from the preferred provider before other sources of expertise are considered.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2021 2120 Resource Management System (2) Joiners, Movers and Leavers Policy/Procedure	**Finding:** The Authority does not have a formalised user access management process outlining the processes/controls when a user joins, moves or leaves the organisation and the relevant user access requirements. We noted that: • When a joiner or mover requires new access or a change in access, a ticket is raised in the Vivantio service desk. Within this ticket, a 'child ticket' is sent to the Resource Management Team (RMT) to create/amend the user's access. • This ticket does not capture sufficient information for the RMT operator to provide access. • Often users will be provided access and then request further access as this has not been initially provided. Therefore, access being granted is an iterative process. • The lack of information on the ticket reduces the effectiveness of the audit trail. • Previously, when a user left the organisation, residual access could be left on the account, this is due to there being no formal procedure when revoking access. • The process has slightly changed whereby an operator will look at the user account to check what access they have before removing it. **Risk:** Unauthorised access to company resources may lead to loss and compromise of data. **Action:** A review of the processes will be undertaken, supported by the end-to-end process mapping within the Internal Audit Plan for 2021-22.	31-Dec-2021	**Medium Priority**	Update from Group Commander Resourcing & Projects: I have been the new Group Commander within resourcing since May 2021. All processes and procedures have been developed over the past year with existing staff and an array of new staff. To be marked as complete pending evidence of updates processes.
BMKFA 2021 2120 Resource Management System (3) Generic Accounts	**Finding:** We inspected the user account list on FSR and noted that seven generic accounts exist on the FSR application as follows: • Five of these accounts have the username 'bucks_demoffX' where X is a number between 1-5. The use and rationale of these accounts was not provided by management; • One account with the username 'rmtcrashtestdummy' which, similarly, was not rationalised; • One account has the username 'usardog'. It was noted that this account is created for the canine unit that the Urban Search and Rescue (USAR) team utilise. • It was further noted that the 5 'demoffX' accounts had never logged into FSR, the 'crashtestdummy' account was last accessed in May 2020. **Risk:** There could be a loss of accountability of user performed actions. Unauthorised access to company resources may lead to loss and compromise of data. **Action:** A review of user accounts to be undertaken and redundant generic accounts to be removed.	31-Dec-2021	**Medium Priority**	Update from Group Commander Resourcing & Projects: An internal Bucks Fire project gets underway in Jan 2022, this project will work closely with FSR reference permissions within FSR. Current and required permissions will be both reviewed and created. As part of this work redundant generic accounts will be reviewed along with a change management process. Once it's been established what user permissions we require these permissions will be reviewed as appropriate or highlighted through change control.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2021 2120 Resource Management System (4) Change Management - Testing	**Finding:** The vast majority of change controls are operated by the Vendor. Irrespective, an internal change control process exists at the Authority. Changes are to be raised through the Vivantio service desk by a change initiator and must include key information However, we noted that: • The Authority does not have access to a test environment for FSR; • Changes are developed and tested by the Vendor; • Functional requirements and subsequent tender review for the application highlighted a question over access to a test environment to perform user acceptance testing (UAT) when a change is being made to the application; • Changes pass through over 1000 automated tests that are ran on the application to ensure that the change does not impact anything on the application, the change then has specific testing to ensure it is performing the functionality as per the design. • The Authority does not obtain any assurance from the vendor surrounding the change management process and is thus wholly reliant on the vendor for this. **Risk:** There is a risk that implementation of changes which are not aligned with business requirements and/or impact on the continued operation of the production application. Implementation of developments containing bugs or not matching the business' requirements. **Action**: Change management process to be reviewed and fully documented (see also Finding 5).	31-Dec-2021	**Medium Priority**	Update from Group Commander Resourcing & Projects: **Action to be closed following receipt of Managing Business Change procedure.**
BMKFA 2021 2120 Resource Management System (5) Change Management – Internal Tracking and Assessment	**Finding:** All changes are required to pass through the change management process with a request for change (RfC) document completed for each change. The Authority was unable to provide any documentation around the selected changes for inspection. Therefore, we were unable to determine if the change management process had been followed for the selected changes. This included cost benefit analysis and CAB minutes of discussion. **Risk:** There is a risk of implementation of changes that contain bugs, misaligned with business requirements or impact on the continued operation of the production application. Development changes are misclassified, create unforeseen cost and/or are not assessed for business need and risk. **Action:** Change management process to be reviewed and fully documented (see also Finding 6).	31-Dec-2021	**Medium Priority**	Update from Group Commander Resourcing & Projects: **Action to be closed following receipt of Managing Business Change procedure.**
BMKFA 2021 2120 Resource Management System (6) Backups – Disaster Recovery Testing	**Finding:** Backups and the associated disaster recovery procedures are controlled and operated by the Vendor. Although it was determined that backups are being conducted on the FSR application and that the Vendor are trained to conduct disaster recovery tests, no evidence was available to inspect to demonstrate a disaster recovery test had been performed. We recognise that this is often an annual exercise and FSR has only been in effect at the Authority since April 2020. **Risk:** There is a risk of partial or complete loss of data. Unavailability of systems and lack of business continuity. **Action:** A disaster recovery will be undertaken to test business continuity in this area.	31-Dec-2021	**Medium Priority**	Update from Group Commander Resourcing & Projects: **Action to be closed following receipt of evidence of a recent disaster recovery test.**

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2122 2203 HR People Management (1) Starters, Leavers and Movers - New Starters	**Finding** Examination of a sample of 20 new starters at the Fire Authority between January 2021 and July 2021 found: • One case where no contract, offer letter, checklist, references or ID were provided. • Five cases where no references were provided. In all five cases references were requested but either not received or not available on the personnel file as of the audit. In seven further cases, only one reference was provided. Discussion noted that one was an apprentice, with apprentices only having one reference due to a lack of prior experience, and one was an agency employee for which a different process is in place. Therefore, five of the seven cases were exceptions. • Two cases where no medical questionnaire was held on file. • Two cases where the starter checklist was not fully completed. **Risk** If a starter checklist is not completed and held on the employee's personnel file, and the required documentation is not received and reviewed, there is a risk that the new starter has not been correctly set up on iTrent and that the employee has not been adequately vetted. This will increase the risk of overpayments, underpayments and the risk that new starters are not suitable candidates for the role, leading to financial and reputational damage. **Action** HR to communicate to the organisation what is expected from them in order to process new starters according to the agreed process. HR to review the process notes and ensure completion of new starter checklist.	31-Mar-2022	**Medium Priority**	Complete. HR coach managers through the processes as part of the support they provide on recruitment and selection. The process notes have been and are reviewed on an ongoing basis, in line with legislation and best practice. The checklist is used for every new starter and stored on the employees personal file once complete, as per the agreed process.
BMKFA 2122 2203 HR People Management (2) System Access, Data Security and Information Integrity – BCP testing log blank	**Finding** Whilst parts of the Business Continuity Plan (BCP) have been tested during the Covid-19 pandemic, which affected business as usual operations, and there are specific points in the BCP that address pandemic risk, the BCP testing log is blank meaning there is no record of a test having been carried out. There is also no detail of the tests in place for the HR BCP on the Authority's Resilience Direct system but discussion with the Head of Human Resources established that these are due to be updated next time the plans are reviewed. **Risk** If there is no record of the BCP having been tested, there is a risk that the business continuity processes for people management have not been adequately tested and that key organisational activities cannot be carried out should a risk event occur, leading to the Authority being unable to maintain its obligation as a CAT1 responder. **Action** Business continuity plan to be reviewed, updated and tested in line with organisational requirements.	31-Mar-2022	**Medium Priority**	Complete. Business continuity plan reviewed, updated and resubmitted. Discussion undertaken with SC Resilience and Business Continuity. Review on a regular basis.
BMKFA 2122 2203 HR People Management (3) System Access, Data Security and Information Integrity – Open personal data actions	**Finding** The HR Personal data and permissions mapping document includes an issue and action log around personal data and GDPR compliance for HR files, data processing and communications which was last updated in 2018 and lists 16 open actions. Issues listed in the document, for which open actions were identified, include Privacy Notices not being GDPR compliant and issues around unauthorised access to information and inaccurate or duplicated data being held by HR. It was unclear if this document was superseded and if these actions were now closed or if they were still open as recorded. **Risk** If progress on personal data actions is not updated and recorded appropriately and if the actions are not closed when completed, there is a risk that issues around personal data compliance have not been addressed, resulting in non-compliance with GDPR and putting the Fire Authority at risk of data breaches and penalties. **Action** HR personal data and permissions mapping to be reviewed and actions closed or implemented as appropriate.	31-Mar-2022	**Medium Priority**	Complete. Personal Data and permissions mapping reviewed and updated, actions implemented and closed as appropriate. Discussion undertaken with Director of Legal and Governance. Review on a regular basis.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2021 2120 Resource Management System (7) User Access Reviews	**Finding:** We noted that periodic user access reviews are not undertaken by the Resource Management Team at the authority when managing users access. Although a review of user access was completed in July 2020, there are no plans for this to continue. **Risk:** There is a risk of inappropriate access to the Authority's resources. **Action:** User access to be reviewed every six months.	31-Dec-2021	**Low Priority**	User access is to be reviewed once the permissions / role profile project has been completed – March 2022. I don't require all user access to be reviewed every 6 months, only when/if a staff member changes their role within the service which may include additional or less access. Due to be completed in April 2022.
BMKFA 2021 2120 Resource Management System (8) Password Configuration	**Finding:** Fire service rota does not use traditional password configuration to manage passwords at a group level. FSR uses an 'entropy plugin' to set password configurations for all users which are set at 40 bits. Although 40 bits of entropy is considered 'reasonable' in regard to network and company passwords, full control over password parameters cannot be implemented as FSR (the application) does not allow for editing of password configuration. **Risk:** There is a risk of unauthorised access to company resources due to weak password configuration, which increases the likelihood of a brute force attack. **Action:** Potential updating of the password configuration to be discussed with the supplier.	31-Mar-2022	**Low Priority**	Update from Group Commander Resourcing & Projects: This action is still outstanding.
BMKFA 2122 2203 HR People Management (4) Starters, Leavers and Movers – Changes	**Finding** Examination of a sample of 20 employees whose information changed between January and July 2021 found: • In one case, the instruction to make the change was received on the effective date. In this case it was entered on iTrent four days later. Whilst the other five changes applied retrospectively were deemed to be outside the control of HR, in this case HR was deemed to be partially responsible for the delay. • Two cases where there was no Change Control Form. Discussion established that these roles were both from a recruitment process. A Change Control Form is not a requirement for these as HR are involved in the interview processes and therefore know the details of the transfers. Some managers do provide Change Control Forms, but they are not required as approval is already received. However, there is another similar example where a Change Control Form was provided. Discussion with the Senior Administrator established that some operational roles have allowances that require the Appointments Board to provide additional approval on a change control form. However, where there are such variations in the process, they should be identified in the process notes. **Risk** If changes are not processed accurately, in a timely manner and with the correct documentation, there is a risk that the pay implications of role changes are not actioned on iTrent before Payroll being run, leading to the creation of an overpayment and financial loss to the Fire Authority. **Action** HR to communicate to the organisation what is expected from them in order to process changes according to the agreed process. HR to review the process notes and conclude the new change control form consultation and relaunch the form.	31-Mar-2022	**Low Priority**	Complete. HR coach managers through the processes as part of the support they provide on changes and leavers. The process notes have been and are reviewed on an ongoing basis, in line with legislation and best practice. Change control form consultation undertaken and new electronic form launched, utilised by 95% of people, the others have used a business case as an alternative or the old form and told about the process for the future. HR welcome ongoing feedback on the form, and continue to make amendments as necessary.

Audit Title & Management Action	Description	Due Date	Priority	Latest Note
BMKFA 2122 2228 PMO Assurance (6) Quarterly review meetings	**Finding** SMT meet to prioritise projects and make decisions about projects based on their alignment with Authority objectives. However, this is on an ad-hoc basis, and there was no formal timeline for the task. **Risk** Where projects are not reviewed regularly, there is a risk that projects will be continued, where there is no business requirement, and they do not align with authority objectives. This could result in financial implications. **Action** Hold quarterly and annual review meetings with SMT and the Leadership team. All meetings to be documented. A 22/23 planning workshop took place on 31st January 2022.	31-Mar-2022	**Low Priority**	These meetings have now been scheduled and the first quarterly review meeting took place on 14 June 2022. This action can now be closed.
BMKFA 2122 2203 HR People Management (3) Performance and Monitoring – Monitoring of performance indicators	**Finding** Concerns about staff performance are raised in employee appraisals, processing times are recorded in process notes for new starters and there is a Service Level Agreement in place for the HR Operations and Organisational Development service desks that includes delivery times for common requests and actions. However, there is no evidence to show that processing times are measured and monitored periodically. **Risk** If performance indicators are not in place there is a risk that instances of poor performance are not identified and rectified in a timely manner, leading to increased instances of key HR tasks not being performed accurately and/or in a timely manner. **Action** HR service level agreements (SLA) to be reviewed and reports run on a quarterly basis to monitor improvements and lead to efficiencies. Any areas where SLA's not met to be addressed in a timely manner.	31-May-2022	**Low Priority**	Part completed. HR Operations Manager reviews the HR service desk on a daily basis to ensure service levels are adhered to. The HR Operations team action and close the tickets in a timely manner. Any areas of concern are addressed between the HR Operations Manager and the HR Operations team member. Improvements in customer service and processes are implemented on an ongoing basis, in consultation with service users.
BMKFA 2122 2234 Procurement Governance and Compliance (3) Strategic Outline Case - Version Control	**Finding** Two of the samples we selected were over the threshold requiring strategic outline cases. We confirmed that both had provisions for version control. However, none of the cases had its version control information input. **Risk** If strategic outline cases for projects involving significant expenditure are not version controlled, there is a risk that key projects are approved in error which could lead to financial loss and financial mismanagement. **Action** Version control information to be checked and completed on business cases.	30-Apr-2022	**Low Priority**	Version control is now being checked on business cases. Action can be closed.

Appendix 3 Definition of Assurance Opinions

For each audit an opinion was determined firstly on the framework of controls that exist for that operational area and secondly on compliance with the controls. From this an overall audit opinion is given for each audit. An opinion on the quality of risk management in place is also provided. Work has been planned and performed so as to obtain all the information and explanations which were considered necessary to provide sufficient evidence in forming an audit opinion. The range of audit opinions is:-