HEREFORD & WORCESTER
Fire Authority

Audit and Standards Committee

AGENDA

Wednesday, 19 July 2023

10:30

Wyre Forest House Council Chamber
Wyre Forest District Council, Wyre Forest House,
Finepoint Way, Kidderminster, Worcestershire, DY11 7WF

Wyre Forest House Location Map

SAT NAV: DY11 7FB

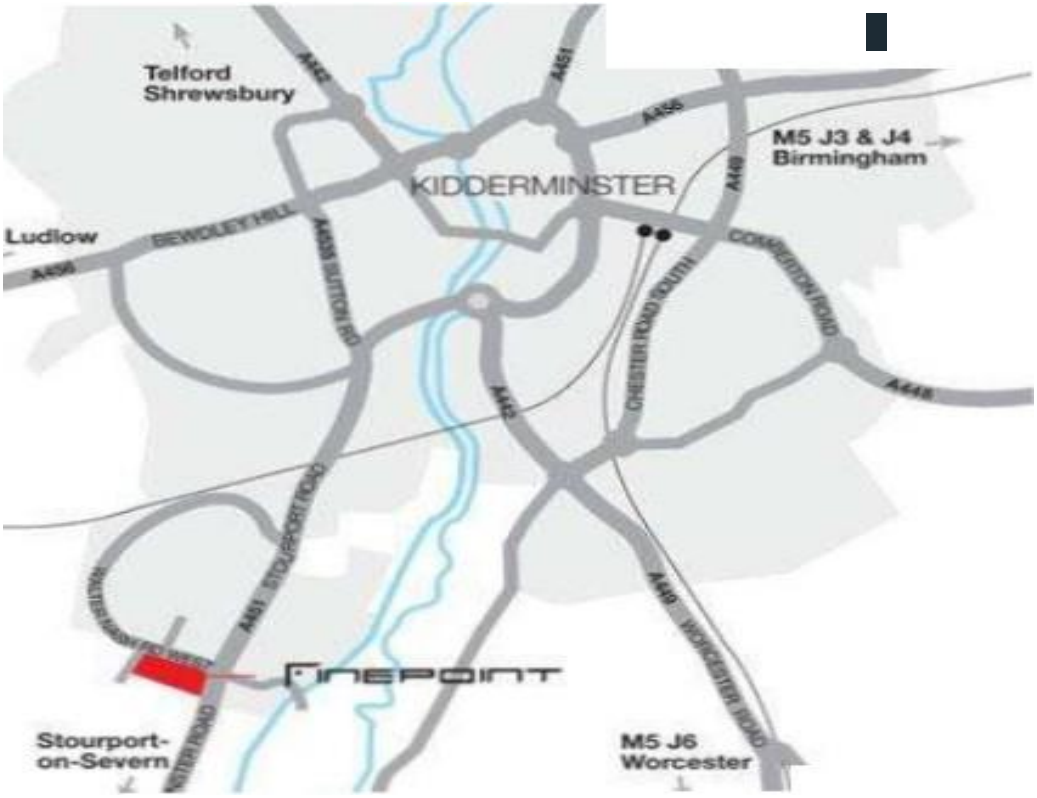
Wyre Forest House, Finepoint Way, Kidderminster, DY11 7WF
Reception at Wyre Forest House 01562 732101

From Stourport:

Head towards Kidderminster on the A451 Minster Road, passing Stourport High School and Stourport Sports Club on your left. When you reach the traffic lights at the crossroads, turn left into Walter Nash Road West (signposted Wyre Forest House). Then take your first left onto Finepoint Way. Follow the road around to your left and Wyre Forest House is at the end of the road on the left. Visitor parking is available and signposted from the mini roundabout.

From Kidderminster:

From Kidderminster, follow the signs for Stourport and head out of Kidderminster on the A451 Stourport Road, this road becomes a dual carriageway. You will pass 24/7 Fitness and Wyre Forest Community Housing on your left. At the crossroads with traffic lights turn right into Walter Nash Road West (there is a dedicated right hand-turn lane), signposted for Wyre Forest House. Then take your first left onto Finepoint Way. Follow the road around to your left and Wyre Forest House is at the end of the road on the left. Visitor parking is available and signposted from the mini roundabout.



ACCESS TO INFORMATION – YOUR RIGHTS. The press and public have the right to attend Local Authority meetings and to see certain documents. You have:

- the right to attend all Authority and Committee meetings unless the business to be transacted would disclose "confidential information" or "exempt information";

- the right to film, record or report electronically on any meeting to which the public are admitted provided you do not do so in a manner that is disruptive to the meeting. **If you are present at a meeting of the Authority you will be deemed to have consented to being filmed or recorded by anyone exercising their rights under this paragraph;**

- the right to inspect agenda and public reports at least five days before the date of the meeting (available on our website: http://www.hwfire.org.uk);

- the right to inspect minutes of the Authority and Committees for up to six years following the meeting (available on our website: http://www.hwfire.org.uk); and

- the right to inspect background papers on which reports are based for a period of up to four years from the date of the meeting.

Please note that when taking part in public participation, your name and a summary of what you say at the meeting may be included in the minutes.

A reasonable number of copies of agenda and reports relating to items to be considered in public will be available at meetings of the Authority and Committees. If you have any queries regarding this agenda or any of the decisions taken or wish to exercise any of these rights of access to information please contact Committee & Members' Services on 01905 368209 or by email at committeeservices@hwfire.org.uk.

WELCOME AND GUIDE TO TODAY'S MEETING. These notes are written to assist you to follow the meeting. Decisions at the meeting will be taken by the **Councillors** who are democratically elected representatives and they will be advised by **Officers** who are paid professionals. The Fire and Rescue Authority comprises 25 Councillors and appoints committees to undertake various functions on behalf of the Authority. There are 19 Worcestershire County Councillors on the Authority and 6 Herefordshire Council Councillors.

Agenda Papers - Attached is the Agenda which is a summary of the issues to be discussed and the related reports by Officers.

Chairman - The Chairman, who is responsible for the proper conduct of the meeting, sits at the head of the table.

Officers - Accompanying the Chairman is the Chief Fire Officer and other Officers of the Fire and Rescue Authority who will advise on legal and procedural matters and record the proceedings. These include the Clerk and the Treasurer to the Authority.

The Business - The Chairman will conduct the business of the meeting. The items listed on the agenda will be discussed.

Decisions - At the end of the discussion on each item the Chairman will put any amendments or motions to the meeting and then ask the Councillors to vote. The Officers do not have a vote.

Hereford & Worcester Fire Authority

Audit and Standards Committee

Wednesday, 19 July 2023,10:30

Agenda

Councillors

Mr M Hart (Chairman), Mr A Amos (Vice Chairman), Mr D Boatright-Greene, Mr B Brookes, Mr B Clayton, Mr I D Hardiman, Mr AI Hardman, Mr J Kenyon, Mrs E Marshall, Ms N McVey, Mr R J Morris, Mrs D Toynbee

No.	Item	Pages
1	**Apologies for Absence** To receive any apologies for absence.	
2	**Named Substitutes** To receive details of any Member of the Authority nominated to attend the meeting in place of a Member of the Committee.	
3	**Declarations of Interest (if any)** This item allows the Chairman to invite any Councillor to declare an interest in any of the items on this Agenda.	
4	**Confirmation of Minutes** To confirm the minutes of the meeting held on 19 April 2023.	**1 - 5**
5	**Internal Audit Annual Report 2022/23** To provide the Committee with: • the overall results in terms of meeting Internal Audit's (IA's) objectives as set out in the internal audit plan for 2022/2023, • an audit opinion and commentary on the overall adequacy and effectiveness of the internal control environment, • a copy of the current internal audit charter.	**6 - 29**

6	**Equality Objectives 2021-2025 Update for Quarter 3 and Quarter 4 2022-2023** To provide a summary of progress against the Service's Equality Objectives 2021-2025 for Quarter 3 and Quarter 4 2022-2023. To provide an update on the future delivery and governance of the Service's equality agenda from 2023-2024.	**30 - 39**
7	**Risk Management and Strategic Risk Register – Annual Update** To provide an annual update on the Risk Management Framework and Strategic Risk Register.	**40 - 47**
8	**Minimising Firefighter Exposure to Carcinogens – Service Update** To provide an update regarding measures being taken to minimise the risk of carcinogens to firefighters.	**48 - 61**
9	**Update from the Health and Safety Committee** To provide a Health & Safety update on activities and items of significance.	**62 - 81**

Hereford & Worcester Fire Authority

Audit and Standards Committee

Wednesday, 19 April 2023,10:30

Chairman: Mr M Hart
Vice-Chairman: Mr A Amos

Minutes

Members Present: Mr D Boatright, Mr S Bowen, Mr B Brookes, Mr B Clayton, Mr I D Hardiman, Mr Al Hardman, Mr M Hart, Mrs E Marshall, Ms N McVey, Mr R J Morris

0271 Apologies for Absence

Apologies were received from Cllr A Amos and Cllr D Toynbee.

[Cllr Boatright entered the meeting at 10.31am].

0272 Named Substitutes

There were no named substitutes.

0273 Declarations of Interest (if any)

There were no interests declared.

0274 Confirmation of Minutes

RESOLVED that the minutes of the meeting held on 18 January 2023 be confirmed as a correct record and signed by the Chairman.

In respect of minute 0260 External Audit Findings Report 2021/22 (to make representations regarding property valuations), the Treasurer advised that this was delayed pending the completion of the audit. Having received confirmation on 13 April that this was complete, the Treasurer advised that this will now be done.

0275 Internal Audit Progress Report

The Head of Internal Audit Shared Service presented Members with an

update in regards to the delivery of the Internal Audit Plan 2022/23.

Members were pleased to note that there were no high priority recommendations reported. With regard to the review of Payroll, Members were assured that there was a clear management plan now in place to address the points identified. All finalised reviews will be reported to Committee in due course.

RESOLVED that the report be noted.

0276 Internal Audit Plan 2023/24

The Head of Internal Audit Shared Service presented Members with the 2023/24 Audit Plan Revision.

Following the Audit and Standards Committee meeting on 18 January, the Strategic Leadership Board considered some revisions to the Plan which were accepted by Internal Audit that reflected the current risk and changing environment. Members were assured that there should be no issues reporting the annual opinion at the end of 2023/24.

RESOLVED that the 2023/24 Internal Audit Plan Revision be noted.

0277 Annual Governance Statement

The Head of Legal Services presented the draft Annual Governance Statement for approval.

Members were informed that the Authority has to review its governance arrangements once a year via self assessment. Members were pleased to note that the Authority had provided evidence of compliance with all the core and supporting principles of the CIPFA/Solace Code of Good Governance.

There were no areas where immediate action was required and there were no areas where the direction of travel had decreased during 2022/23 or where the status was less than satisfactory.

Members were pleased to note that for another year all areas were 'green' which gave the assurance necessary to approve the draft annual statement. Members gave compliments for all the work that was done to ensure compliance.

RESOLVED that the Draft Annual Governance Statement 2022/23 be approved.

0278 National Fraud Initiative 2022/23

The Treasurer updated Members on the National Fraud Initiative.

Members were informed that this was a biennial exercise for local government and other public bodies currently undertaken by the Cabinet Office to identify data matches to eliminate the possibility of fraud and/or error.

It was anticipated that the results of this year's exercise would mirror previous exercises, none of which had identified any frauds involving HWFRS.

A final report would be brought to the next Audit and Standards Committee to provide final details in relation to the outstanding matches.

RESOLVED it be noted that:

i) the process of examining all National Fraud Initiative matches is underway and that no fraud has been detected; and

ii) a further update relating to the completion of the fraud initiative will be brought to a future meeting.

0279 Annual Compliments, Complaints, Concerns and Requests for Information 2022/23

The Head of Legal Services presented a report on compliments, complaints, concerns and requests for information made by the public to the Service over the past 12 months.

Members were informed that there was an increase in the number of complaints received over the past 12 months compared to last year and were assured there were no recurring themes or trends in the concerns and complaints to give any cause for concern.

Members were assured that all complaints are investigated by duty officers, draft responses are sent to Legal Services to be reviewed and all complainants can ask for a further review by the Assistant Chief Fire Officer or make a complaint to the Local Government Ombudsman.

There was concern over the number of driving incidents, however reassurance was provided by the Chief Fire Officer that these were low level incidents and were in proportion to the number of miles that were driven. All incidents were analysed and investigated.

RESOLVED that the Committee notes that during the period 1 April 2022 to 31 March 2023:

i) a total of 297 requests for information containing 774 queries

about the Service were received. No requests were passed to the Information Commissioners Office for review.

ii) a total of 60 compliments were received from the public;

iii) 39 complaints or concerns about Service activities were made; and

iv) 26 complaints or concerns were received about activities carried out by other organisations or individuals;

v) 4 of the complainants appealed the response provided but none were passed to the Local Government Ombudsman for further investigation

vi) the Service has recently implemented an external, confidential reporting line for complaints and concerns which will be included in future reports.

0280 Health and Safety Committee Update: October to December 2022 (Quarter 3)

The Deputy Chief Fire Officer presented the Committee with a Health and Safety update on activities and items of significance.

Members were pleased to note that the number of safety events recorded in Quarter 3 had decreased by 3 compared to the previous quarter. The most significant decrease was in the personal injuries category which decreased by 6.

The Chief Fire Officer provided an explanation into the national review of contaminates. It is possible there could be legal cases in the next few years as some research had shown there are a certain type of cancers that firefighters may be more likely to contract. Over recent years a range of measures have been introduced for cleaning so as to minimise the risk to staff.

Members were pleased to note that fitness equipment had now been introduced across most stations and with the help of newly qualified in-house Personal Trainers, the Service was now in a position to work with employees to make sure their fitness is maintained.

Members were pleased that the violence against staff was at zero, which it hadn't been over the past few years. The Chief Fire Officer reaffirmed that violence was very tame within the two communities and was very rare.

RESOLVED that the following issues, in particular, be noted:

i) The involvement of the Service in Health and Safety initiatives;

ii) Health and Safety performance information recorded during October to December 2022 (Quarter 3); and

iii) Workforce Health & Wellbeing performance (Quarter 3).

0281 Late item: Statement of Accounts 2021/22

The Chairman agreed to the consideration of this Late Item pursuant to section 100B(4)(b) of the Local Government Act 1972 as a matter of urgency on the grounds that

- **a decision is required before the date of the next scheduled meeting of the Committee so as not to impact upon the preparation of the 2022/23 accounts.**

The Treasurer presented Members with the Statement of Accounts 2021/22 to be approved. Members were reminded that at the last meeting in January the Auditors had expected the remaining work to take 2 weeks, however this had actually taken 3 months and notification was only given on Thursday last week that the audit of the Statement of Accounts 2021/22 was complete.

Members were informed that the Accounts were fundamentally unchanged from the draft version issued in January and the audit findings report was similarly unchanged. Therefore the Accounts were ready for approval by Members.

RESOLVED that the Statement of Accounts 2021/22 be approved.

The Meeting ended at: 11:32

Signed:…… Date:…….

Chairman

Hereford & Worcester Fire Authority
Audit and Standards Committee
19 July 2023

Report of the Internal Auditor

Internal Audit Annual Report 2022/23

Purpose of Report

1. To provide the Committee with:

    - the overall results in terms of meeting Internal Audit's (IA's) objectives as set out in the internal audit plan for 2022/2023,
    - an audit opinion and commentary on the overall adequacy and effectiveness of the internal control environment,
    - a copy of the current internal audit charter.

Recommendation

The Treasurer recommends that the Committee note the Internal Audit Charter and that the audit plan delivered in 2022/23 has provided an assurance level of "full" for three core financial areas and that no limited or below assurance areas have been reported or any high priority recommendations made.

Introduction and Background

2. The Authority is responsible for maintaining or procuring an adequate and effective internal audit of the activities of the Authority under Authority under the Accounts and Audit (England) Regulations 2018. This includes considering, where appropriate, the need for controls to prevent and detect fraudulent activity. These should also be reviewed to ensure that they are effective. This duty has been delegated to the Treasurer, and, Internal Audit was provided by Worcestershire Internal Audit Shared Service (WIASS). Management is responsible for the system of internal control and should set in place policies and procedures to ensure that the system is functioning correctly. The Authority is required to publish an Annual Governance Statement to accompany the accounts later in the year.

Objectives of Internal Audit

3. The Chartered Institute of Public Finance and Accounts (CIPFA) Code of Practice for Internal Audit in Local Government in the United Kingdom defines internal audit as: "an assurance function that primarily provides an independent and objective opinion to the organisation on the control environment comprising risk management, control and governance by evaluating its effectiveness in achieving the organisation's objectives. It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper, economic and effective use of resource".

Internal Audit

Aims of Internal Audit

4. The objectives of WIASS are to:

- Examine, evaluate and report on the adequacy and effectiveness of internal control and risk management across the Fire Service and recommend arrangements to address weaknesses as appropriate;
- Examine, evaluate and report on arrangements to ensure compliance with legislation and the Fire Service's objectives, policies and procedures.
- Examine, evaluate and report on procedures that the Fire Service's assets and interests are adequately protected and effectively managed.
- Undertake independent investigations into allegations of fraud and irregularity in accordance with Fire Service's policies and procedures and relevant legislation.
- Advise upon the control and risk implications of new systems or other organisational changes.

5. WIASS is committed to providing an audit function which conforms to the Public Sector Internal Audit Standards as amended.

Assurance Sources

6. We recognise there are other review functions providing other sources of assurance (both internally and externally) over aspects of the Council's operations. Where possible we seek to place reliance on such work thus reducing the internal audit coverage as required.

Independence and Safeguards

7. WIASS internal audit activity is organisationally independent. Internal Audit reports to the Treasurer but has a direct and unrestricted access to the senior management team and the Audit Committee Chair. Where WIASS help with the preparation of areas of work such as Risk Management or the Annual Governance Statement there are clear safeguards in place to ensure independence is not compromised. Safeguards include review within the audit service by an independent person to those who have completed the work as well as independent scrutiny by the Treasurer of the authority. Audit Committee can also challenge the reported findings and the minutes would record this.

8. To try to reduce duplication of effort we understand the importance of working with the External Auditors. The audit plan was shared with the external auditors for information.

Risk Management

9. Risk Management is a high profile activity due to the nature of the Authority. Regular updates have been brought before Committee and a robust and embedded risk management process exists within the Fire Authority. Regular

review of the risk profile takes place with appropriate mitigation agreed and reported.

Summary of the Prime Features

2022/2023 Key Internal Audit planned Inputs for WIASS

10. A summary of the position is provided at Appendix 1

2022/2023 Key Internal Audit planned Outputs for WIASS

11. During 2022/23 Internal Audit was originally required to:

- complete ten systems audits (including critical friend reviews) of which four needed to suitably assist the External Auditor reach their "opinion".

- provide sufficient audit resources for other operational areas which assist the Fire Service maintaining/improving its control systems and risk management processes or implementing / reinforcing its oversight of such systems, i.e. provide an on-going consultancy to managers on internal control, for example where system changes are being made;

- meet Internal Audit's external work requirements;

- achieve a benchmark of delivery for 2022/23 of all audits as agreed in the operational programme as agreed at the 19 January 2022 Audit and Standards Committee.

12. Most audits, on completion, are assigned an assurance using a predefined definition and all reported recommendations are given a priority. The audit assurance and recommendation priority are agreed with Management before the final report is published. An example of the assurance and priority definitions is provided at Appendix 2 for information. The overall assurance that has been attributed to the various areas that have been audited regarding the 2022/23 programme reflects the fact there have been no 'high' priority recommendations to report.

Productive Work

13. During 2022/23, 80 productive audit days were delivered by WIASS against an overall budget of 111 days. During 2022/23 it was necessary to consider all Partner plans and adjust them where necessary. 2022/23 also saw a continuance of increase in the overall time frame to deliver audits due to remote working, teleconferencing or alternative means whereas prior to this a simple and brief conversation alongside an Officers desk or in passing would have sufficed. Priority was given to potentially higher risk areas and financial audits. The 2022/23 plan remained very flexible, with the core financial areas of the business were completed and reported on. Committee was continually and regularly informed of developments throughout the year and any variations to the plan were agreed by the Treasurer.

14. Consultancy, advice and guidance are demand led activities and can fluctuate from year to year but have been contained well within the agreed budget resulting in unused days.

15. Follow up in respect of audits provided to the Fire and Rescue Service have continued and were included as part of the 2022/23 audit programme and have been undertaken during the past twelve months for example Procurement as well as all the core financial reviews.

16. Internal audit has worked with external audit to try and avoid duplication of effort, provide adequate coverage for the 2022/23 financial year so that an internal audit opinion can be reached, and support External Audit by carrying out reviews in support of the accounts opinion work.

Work of interest to the External Auditor

17. The results of the work that we performed on four systems audits during 2022/23 was of direct interest to External Audit. Audit reports are passed to the external auditor on request for their information and for them to inform their opinion.

18. Dialogue continues with the External Auditor to ensure that the internal audit work will continue to provide the assurance they seek at an acceptable standard.

Quality Measures – internal

19. Managers are asked to provide feedback on systems audits as the audit progresses. Comments have been received from several Managers who have expressed their appreciation of the audit approach and the fact that it will assist them to add value to their service area. Feedback has predominantly been immediately forth coming from the appropriate Managers. A questionnaire is available/provided where a more formal response is required. WIASS analyse the returns during the year to ensure that the audit programme continues to add value. The Treasurer, Strategic Management Board and External Audit have also confirmed a high satisfaction with the audit product during discussions with the Head of the Internal Audit Shared Service.

20. Further quality control measures embedded in the service include independent individual audit reviews and regular Client Officer feedback. WIASS staff work to a given methodology and have access to reference material and the Charter which reflects the requirements of the standards. A copy of the Charter is included at Appendix 4 for information.

21. The Client Officer Group (i.e. management board) meet on a regular basis and consider the strategic overview and performance of the Shared Service including progress against the Service Plan as well as promoting continuous improvement of the Service.

22. To further assist the Committee with their assurance of the overall delivery WIASS conforms to the Public Sector Internal Audit Standards as amended.

23. Appendix 3 provides the audit opinion and commentary which provides further assurance to the Committee.

Corporate Considerations

Resource Implications (identify any financial, legal, property or human resources issues)	H&WFRS joined the Shared Service as a full partner in April 2016. The financial details are not fully detailed in this report, but any contribution is agreed by The Treasurer who is a voting Member of the Client Officer Group.
Strategic Policy Links & Core Code of Ethics (Identify how proposals link with current priorities & policy framework and align to the Core Code of Ethics)	There are legal issues e.g. joining as a partner in the shared service required consideration but are not fully detailed in this report. Internal audit provides an independent assessment of risk mitigation against corporate priorities.
Risk Management / Health & Safety (identify any risks, the proposed control measures and risk evaluation scores).	Yes, whole report.
Consultation (identify any public or other consultation that has been carried out on this matter)	N/A – no policy change is recommended
Equalities (has an Equalities Impact Assessment been completed? If not, why not?)	N/A
Data Protection Impact Assessment (where personal data is processed a DPIA must be completed to ensure compliant handling)	N/A

Supporting Information

Appendix 1 – Internal Audit Plan for 2022/23

Appendix 2 – Definition of Audit Opinion Levels of Assurance & Priority of Recommendations

Appendix 3 – Commentary and Audit Opinion 2022/23

Appendix 4 – WIASS Internal Audit Charter

APPENDIX 1

INTERNAL AUDIT PLAN FOR 2022/23

Audit Area	Source	Planned days 2022/23		Service	Comment/ Potential Outline Scoping	Strategy link	Finalised Report
Accountancy & Finance Systems							
Main Ledger (inc Budgetary Control & Bank Rec)	Fundamental to HWFRS CRMP delivery	**6**		Finance	Reduction in days for a light touch system audit. Standard scoping for core financial.	Resourcing for the Future	23rd December 2022
Creditors (a/c's payable)	Fundamental to HWFRS CRMP delivery	**7**		Finance	Reduction in days for a light touch system audit. Standard scoping for core financial.	Resourcing for the Future	23rd December 2022
Debtors (a/c's receivable)	Fundamental to HWFRS CRMP delivery	**5**		Finance	Reduction in days for a light touch system audit. Standard scoping for core financial.	Resourcing for the Future	23rd December 2022
Payroll & Pensions inc GARTAN	Fundamental to HWFRS CRMP delivery	**11**		Service Support	Reduction in days for a light touch system audit. Standard scoping for core financial.	Resourcing for the Future	28th February 2023
SUB TOTAL		**29**					
Corporate Governance							

Audit Area	Source	Planned days 2022/23		Service	Comment/ Potential Outline Scoping	Strategy link	Finalised Report
Training Centre Droitwich	Fundamental to HWFRS CRMP delivery	**10**		Finance	Management of content and system changes are working.	Fire & Rescue Authority	15th September 2022
Office Police Crime Commissioner Estates	Fundamental to HWFRS CRMP delivery	**12**		Service Support	Arrangements in place working, processes, reactive & planned maintenance acceptable.	Fire & Rescue Authority	16th May 2023
ICT	Fundamental to HWFRS CRMP delivery	**15**		Service Support	Cyber security, business continuity and back ups	Fire & Rescue Authority	Draft June 2023
SUB TOTAL		**37**					
System / Management Arrangements							
Stores & Equipment	Fundamental to HWFRS CRMP delivery	**12**		Service Support	Effective management, accountability of stock, systems are competent, equipment replenishment/ maintenance	Fire & Rescue Authority	Draft 5th June 2023
Fleet	Fundamental to HWFRS CRMP delivery	**10**		Service Delivery	Links to 2021-2025 CRMP promises and deliverables.	Fire & Rescue Authority	13th June 2023
SUB TOTAL		**22**					

Follow up Reviews	Good governance	**7**				
Advice, Guidance, Consultation, Investigations	Support	**5**				
Audit Cttee support, reports and meetings	Support	**11**				
SUB TOTAL		**23**				
Predicted Budget		**111**				
Actual Days Required		**80**				

Note: An additional piece of work was also completed regarding the Tech One system utilising a critical friend approach.

Summary of 2022/23 Audit Assurance Levels

2022/23	Number of Fire and Rescue Service Audits	Assurance	Overall % (rounded)
From 10 reviews	3	Full	30%
	4	Significant	40%
	2	Moderate	20%
	Nil	Limited	0
	Nil	No	0
	Nil	To be finalised	0
	1	Critical Friend	10%
	Nil	Deferred to 23/24	0

Note:
Follow Up, Advice, Audit Committee Support and management reporting areas are not included in the above figures.

Overall Conclusion:

- 70% of the finalised audits undertaken for 2022/23 which have been allocated an assurance returned a level of significant or above.

- Officers, Managers and the Treasurer continue to be satisfied with the audit process and service delivery from the feedback received from them.

APPENDIX 2

Audit Reports 2022/23

Definition of Audit Opinion Levels of Assurance

Opinion	Definition
Full Assurance	The system of internal control meets the organisation's objectives; all of the expected system controls tested are in place and are operating effectively. No specific follow up review will be undertaken; follow up will be undertaken as part of the next planned review of the system.
Significant Assurance	There is a generally sound system of internal control in place designed to meet the organisation's objectives. However isolated weaknesses in the design of controls or inconsistent application of controls in a small number of areas put the achievement of a limited number of system objectives at risk. Follow up of medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Moderate Assurance	The system of control is generally sound however some of the expected controls are not in place and / or are not operating effectively therefore increasing the risk that the system will not meet its objectives. Assurance can only be given over the effectiveness of controls within some areas of the system. Follow up of high and medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
Limited Assurance	Weaknesses in the design and / or inconsistent application of controls put the achievement of the organisation's objectives at risk in many of the areas reviewed. Assurance is limited to the few areas of the system where controls are in place and are operating effectively. Follow up of high and medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.
No Assurance	No assurance can be given on the system of internal control as significant weaknesses in the design and / or operation of key controls could result or have resulted in failure to achieve the organisation's objectives in the area reviewed. Follow up of high and medium priority recommendations only will be undertaken after 6 months; follow up of low priority recommendations will be undertaken as part of the next planned review of the system.

Definition of Priority of Recommendations

Priority	Definition
H	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. Immediate implementation of the agreed recommendation is essential in order to provide satisfactory control of the serious risk(s) the system is exposed to.
M	Control weakness that has or is likely to have a medium impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation within 3 to 6 months is important in order to provide satisfactory control of the risk(s) the system is exposed to.
L	Control weakness that has a low impact upon the achievement of key system, function or process objectives. Implementation of the agreed recommendation is desirable as it will improve overall control within the system.

APPENDIX 3

Hereford and Worcester Fire and Rescue Authority
Commentary and Audit Opinion 2022/23

1. Internal Audit: Hereford and Worcester Fire and Rescue Authority's responsibility for maintaining an adequate and effective internal audit function is set out in the Accounts and Audit (England) Regulations 2018.

2. 2022/23 financial year saw a continued recovery from the pandemic and the dawning of a new norm. Changes in the way services are now delivered and staff deployed has seen a consolidation of hybrid working and a move away from the traditional office-based working model. This continues to present many challenges and risks, especially cyber risks, as well as managing statutory and best practice requirements.

Overall Governance Conclusion

3. Based on the audits performed against the 2022/23 audit plan, the Head of Internal Audit Shared Service has concluded although not all audits have achieved full assurance the lack of serious shortcomings found in the range of audits carried out indicates that the Hereford and Worcester Fire and Rescue Service internal control arrangements are generally adequate and have effectively managed the principal risks identified by management as part of the audit plan and can be reasonably relied upon to ensure that the Authority's corporate objectives have been met.

Risk Management Conclusion

4. The Head of Internal Audit can confirm the development of formal risk management systems was sustained during the year and risk management continues to feature prominently throughout the activities of the Fire Authority.

5. The corporate risk register was regularly updated, and the Audit Committee have received the necessary updates on key risks. There is an expectation updates will continue to be made regularly to the Audit Committee. The link between risk identification and control is of fundamental interest to internal auditors, although the responsibility for controlling the risk itself rests firmly with line managers, who must ensure that appropriate controls are considered to mitigate the identified risks.

Findings

6. The Internal Audit function is provided by the Worcestershire Internal Audit Shared Service (WIASS) which was set up as a shared service in 2010/11 and hosted by Worcester City for 5 district councils and the Fire and Rescue Service. 2016/17 was the first year Hereford and Worcester Fire and Rescue Authority became a full voting member of the shared service. The shared service operates in accordance with, and conforms to, the Public Sector Internal Audit Standards as amended. It objectively reviews, on a continuous basis, the extent to which the internal control environment supports and promotes the achievement of the Fire and Rescue Authority objectives and contributes to the proper, economic and effective use of resources.

7. The Internal Audit Plan was agreed with External Audit, the Treasurer and s151 Officer and was approved by the Audit and Standards Committee on the 19th January 2022. It included:

    - several core systems which were designed to suitably assist the external auditor to reach their 'opinion', and,
    - other corporate systems for example Training Centre Droitwich and Fleet.

8. Regular updates regarding of review outcomes were reported before the Audit Committee during the year. Follow up reviews have also taken place during the year with outcomes reported before Committee. Based on the audits performed by WIASS in accordance with the approved and revised audit plan the Head of Internal Audit Shared Service can report that the Hereford and Worcester Fire and Rescue Authority governance framework arrangements during 2022/2023 three have provided assurance outturns of 'full' regarding core financial areas along with 'significant' and 'moderate' assurances in regard to other operational aspects. There were no 'limited' or below assurances reported.

9. 'Full' to 'moderate' assurance essentially provides there is generally a sound system of internal control in place, no significant control issues have been encountered and no material losses have been identified.

10. In relation to the planned reviews during 2022/23, all were finalised and reported on.

11. WIASS can conclude that no system of control can provide absolute assurance against material misstatement or loss, nor can Internal Audit give that assurance. This statement is intended to provide those charged with the responsibility of governance with a reasonable assurance based on the audits performed in accordance with the approved plan, any revisions thereto and the scoping therein and reflects the new norm of hybrid working and a move away from traditional office protocols.

Andy Bromage
Head of Worcestershire Internal Audit Shared Service
July 2023

APPENDIX 4

Worcestershire Internal Audit Shared Service (WIASS)

Internal Audit Charter

Hereford and Worcester Fire and Rescue Authority

Definitions

1. Management refers to the Chief Fire Officer, Deputy Chief Fire Officer, Assistant Chief Fire Officer/Directors and Area Commanders/Heads of Service.
2. Board refers to the Audit & Standards Committee

This Charter was last reported before the Audit and Standards Committee on the 20th July 2022.

1. Introduction

Purpose

1.1 The purpose of this charter is to define what Internal Audit is and explain its purpose, role and responsibilities.

Provision of Internal Audit Services

1.2 WIASS covers five district authorities Wychavon, Malvern Hills, Bromsgrove, Redditch and Worcester and one Fire Service, Hereford and Worcester Fire and Rescue Authority. WIASS will provide internal audit services to third parties under contractual arrangements.

Worcester City Council hosts the Shared Service provision under an on-going Administrative Collaborative Agreement. It is governed by a Client Officer Group (COG) which is made up of the district and Fire Service s151 officers each having an 'equal say'. The Client Officer Group meets approximately 4 times a year.

1.3 For line management matters internal audit will report to the Corporate Director of Resources (s151 Officer within Worcester City Council) and the Monitoring Officer in their prolonged absence.

2. Mission and Definition

2.1 Mission:

"To enhance and protect organisational value by providing risk-based and objective assurance, advice and insight".

Additional information can be found on the local intranet site: https://staffroom.worcester.gov.uk/internal-audit

2.2 Definition:

Internal Auditing is 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 bring a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

3. Scope and Authority of Internal Audit Work

3.1 Under the Accounts and Audit Regulations 2015 No. 234 Part 2 Regulation 5:

(1) A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.

(2) Any officer or member of a relevant authority must, if required to do so for the purposes of the internal audit—

(a) make available such documents and records; and

(b) supply such information and explanations;

as are considered necessary by those conducting the internal audit.

(3) In this regulation "documents and records" includes information recorded in an electronic form.

To aid compliance with Regulation 5 of the Accounts and Audit Regulations 2018 as amended, the CIPFA Code of Practice for Internal Audit in Local Government in the United Kingdom 2006 details that "Internal Audit should work in partnership with management to improve the control environment and assist the organisation in achieving its objectives".

Internal Audit work should be planned, controlled and recorded in order to determine priorities, establish and achieve objectives.

3.2 In the course of their reviews internal audit staff, under the direction of the Head of Service, shall have authority in all partner organisations to:-

- at all reasonable times after taking account of audit requirements, enter on any partners' premises or land;

- have access to, and where internal audit deem necessary take into their possession, any records, documents and correspondence relating to any matter that is the subject of an audit;

- require and receive such explanations as may be considered necessary from any officer of the Partner regardless of their position;

- require any officer of the Partner to produce forthwith cash, stores or any other property under their control.

for the Partner in which the internal audit service is being provided.

3.3 Internal Audit work will normally include, but is not restricted to:

- review and assess the soundness, adequacy, integrity and reliability of financial and non-financial management and performance systems, and quality of data;
- reviewing the means of safeguarding assets;
- examine, evaluate and report on compliance with legislation, plans, policies, procedures, laws and regulations;
- promote and assist the Partner in the effective use of resources
- examine, evaluate and report on the adequacy and effectiveness of internal control and risk management across the Partner and recommend arrangements to address weaknesses as appropriate;
- advise upon the control and risk implications of new systems or other organisational changes.
- provide a 'critical friend' to assist services to achieve value for money
- undertake independent investigations into allegations of fraud and irregularity in accordance with the Partner's policies and procedures and relevant legislation
- at the specific request of management[1], internal audit may provide consultancy services provided:

    - the internal auditors independence is not compromised
    - the internal audit service has the necessary skills to carry out the assignment, or can obtain skills without undue cost or delay
    - the scope of the consultancy assignment is clearly defined and management[1] have made proper provision for resources within the annual plan
    - management understands that the work being undertaken is not internal audit work.

3.4 IA's remit extends across the entire control environment of the organisation and is not limited to certain aspects or elements.

4. Responsibility of Management[1] and of Internal Audit.

4.1 At all times internal audit will operate in accordance with the partner's Constitution and legal requirements and all internal audit staff will adhere to recognised Professional Standards and Codes of Conduct and Ethics e.g. the Institute of Internal Auditors' and/or CIPFA as well as the Partner's Codes of Conduct and Anti-Fraud and Corruption Policies.

4.2 It is the responsibility of Management to put in place adequate controls to ensure systems meet their objectives and that they are notified without delay of any instances where systems are failing to operate properly. However, where there has been, or there are grounds to suspect that there is risk of a serious breakdown in a significant system, the Head of Service should be informed of the problem and any counter measures already in hand or proposed, as quickly as possible, in order that the Head of Internal Audit Shared Service can decide whether audit involvement is needed.

4.3 Similarly, it is the responsibility of Management to put in place adequate controls to prevent and detect fraud, irregularities, waste of resource, etc. Internal Audit will assist Management to effectively manage these risks. However, no level of controls can guarantee that fraud and the like will not occur even when the controls are performed diligently with due professional care. As a consequence all cases of actual or suspected fraud should be reported to the Head of Internal Audit Shared Service forthwith. The Head of Internal Audit Shared Service will then decide the course of action to be taken with due regard to the Partner's Constitution, e.g. Whistleblower's Charter, Stopping Fraud and Corruption Strategy, etc.

4.4 Any officer of a partner organisation who has genuine concerns at raising a suspected instance of fraud or malpractice through their normal reporting channels can raise the matter under the Partner's Whistleblower's Charter directly with any of the persons named in the policy document, including the Head of Internal Audit Shared Service. Head of Internal Audit Shared Service will then pursue the matter in accordance with the provisions of the policy document.

4.5 Internal audit is not responsible for any of the activities which it audits. WIASS will not assume responsibility for the design, installation, operation or control of procedures. However, should any partner/client contract for specialist services within an area then the WIASS staff member assigned will not be asked to review any aspect of the work undertaken until two years have passed from the completion of the assignment.

4.6 The Head of Internal Audit Shared Service will ensure that the relevant Head of Service and/or Section 151 Officer is briefed on any matter coming to the attention of internal audit, either through a review or otherwise, that could have a material impact on the finances, create an unacceptable risk or be fraudulent for the Partner as quickly as possible, and will ensure the appropriate Officer of the Authority e.g. Director, Monitoring Officer is regularly briefed on the progress of audits having a corporate aspect. Matters involving fraud or malpractice are to be reported in line with the anti-fraud and corruption policy. The most appropriate action/engagement of the relevant Head of Service will be determined by the HoWIASS depending on the circumstances.

4.7 In order to (1) maintain a broad skills base within Internal Audit and (2) maximise the ability of the team to offset the cost of providing the internal audit function to the Partner, the strategic plan will include a commitment that internal audit obtains income to the Partner from external work either from partnership working and/or selling its expertise. Such activities will be governed by targets set out in the Collaborative Administrative Agreement and will be approved and reported on to the Client Officer Group.

5. Planning and Reporting

5.1 To meet the objectives above, the Head of Internal Audit Shared Service shall:-

a) prior to the beginning of each financial year, following consultation with Management[1] and after taking into account comments from Members arising from the reporting process set out below, provide the Committee with:

- a risk based audit plan forecasting which of the Partner's activities are due to receive audit attention in the next 12 months. The risk based plan will take into consideration a number of risk factors including corporate risk register, service risk register, local knowledge, corporate promises or objectives, key strategic documents e.g. five year plan and any external audit guidance. Where there is a potential difference between strategy/plan and resource this is reported to the Board[2];
- a detailed operational plan using a risk based assessment methodology showing how/what resources will be required/allocated in the coming financial year in order to meet the requirements of the Partners strategic plans. The Plans will be flexible and include a small contingency contained as part of the consultancy budget to allow for changes in priorities, emerging risks, ad hoc projects, fraud and irregularity, etc. The Head of Internal Audit Shared Service will bring to the attention of the s151 Officer if this budget is depleted so an additional contingency can be agreed. 'Consultancy', for the purposes of WIASS activity, is defined as work that is of a specialist nature and commissioned/requested in regard to an area of work activity within a service area that is in addition to the agreed partners audit plan. The work can be financial or governance based and the output will provide management[1] with challenges to consider depending on its nature. The approach to the assignment can be flexible but follow a similar path in regard to the methodology.

b) during the course and at the close of each financial year provide the Board[2] with:
   - quarterly progress reports on actual progress compared to the plan and performance indicators. Such reports to highlight serious problems, either affecting the implementation of the plan, or, in the take up of audit recommendations;
   - an annual report summarising the overall results for the year compared to the plan and pointing out any matters that will impact on internal audit's ability to meet the requirements in the strategic plan;

c) during the course and close of each full systems/risk audit provide the client manager[1] with:
   - a copy of an audit brief and audit information request setting out the objectives and scope of the audit prior to commencement of the audit and a confirmation of resource requirements for the audit.
   - draft recommendations, which will be discussed with the responsible manager[1] prior to sending the draft audit report. The manager[1] is responsible for confirming the accuracy of the audit findings and is invited to discuss the report during the 'clearance' meeting prior to the issue of the draft report.
   - an audit report containing an overview of the quality of the control system, an opinion as to the level of system assurance and detailed findings and recommendations including priority. 'Assurance', for WIASS purposes, is defined as the determination of an overall outcome against a predetermined criteria leading to an applied level giving an overall summary for the work audited.

d) shortly after the close of each financial year provide for the purposes of the Annual Governance Statement:
   - an annual audit opinion of the Partner's system of controls based on the audit work performed during the year in accordance with the plans at 5.1(a) above and reported in accordance with 5.1(b) and (c) above and on the assurance methodology adopted, and, a statement of conformance

with the Public Sector Internal Audit Standards and the results of quality assurance and improvement programme.

5.2 Expectations of Clients:
Managers and staff should co-operate with the Auditors, and responses should be made to draft reports as outlined at 3 above. Responses should include an action plan, dates for action and responsibility where actions are delegated. The final 'High' and 'Medium' recommendations will be reported to the Board[2].

5.3 Audit reports will be drawn up following the internal audit report framework. A matrix type report displaying audit findings, risks and recommendations along with a column for management comments, as per 5.1(c), will be provided to management[1]. The report will also contain an introduction and priority categories for each of the recommendations. A covering report will be attached to the matrix providing details of the partner organisation, circulation, audit scope and objectives, an audit opinion, an executive summary and an audit assurance rating as well as a clear indication of what action is required by management.

5.4 Upon completion of audits, the audit exceptions will be discussed with the relevant line manager and will form the basis of the draft audit reports. The draft audit reports are issued to the relevant line managers for them to confirm the accuracy of the audit findings and content. Managers are invited to contact the Auditor if they wish to discuss the report and asked to show their response in the form of an action plan to each recommendation on the draft report. For accepted recommendations, dates for action or implementation are recorded. The managers' responses are recorded in the final reports that are issued to the appropriate Management[1] officers as deemed relevant for the audit.

5.5 In accordance with professional standards, after three/six months from the date of issue of the final report, follow-up audits are undertaken to ensure that the agreed recommendations and action plans have been implemented, or, are in the process of being implemented. A formal follow up procedure / methodology is used to follow up audit reports and reported on an exceptions basis.

5.6 Internal Audit works to the reporting quality standards of:

- draft audit reports to be issued within 5 working days of the clearance meeting;
- management responses received within 10 working days;
- final audit reports to be issued within 5 working days of the final discussions of the draft audit report and receipt of management responses;
- final reports to be followed-up initially within 3 to 6 months of the date issue of the final audit report depending on the recommendation priority and residual risk, to ensure that the accepted recommendations due for implementation have been established.

5.7 Escalation for late or non return of audit reports will be instigated when after two requests the reports have not been provided by management. The escalation will commence with the s151 Officer being informed of the late return. If the report remains outstanding then the Board[2] will be informed of the inaction with a view to them calling in the Officer to justify the late return.

6. 7 Principles of Public Life and how WIASS interprets and applies them.

1. Selflessness - protecting the public purse and ensuring all actions taken are solely in the public interest.

2. Integrity - completely independent and above undue bias or influence in the work that we do.

3. Objectivity – demonstrate impartiality and fairness in all aspects of our work and when reporting uses only the best evidence without discrimination or bias.

4. Accountability – provide transparency and assurance holding people to account in regard to decisions and actions and provide assurance to those in governance roles.

5. Openness – to promote and ensure through good governance that decisions are taken in an open and transparent manner and no information is withheld from the public unless there are clear and lawful reasons for so doing

6. Honesty – to provide independent assurance to those in governance of confirmation of truthfulness

7. Leadership – through the audit work actively promotes and robustly supports the principles and shows a willingness to challenge poor behaviour wherever it occurs.

For further information on the principles of public life:

https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

7. Core Principles for Professional Practice and how WIASS interprets and applies them.

1. Demonstrates integrity:

   WIASS works independently, without influence or undue bias. The audit plan is created so that there are no conflicts of interest between the officer and the audit. Potential conflicts of interest are formally checked annually with all members of the WIASS team. Areas of risk for WIASS are identified and mitigated. Potential areas of risk include, but are not limited to, auditors re-auditing Risk Management, NFI, and Regulatory Services in consecutive years and Services that they have transferred from. Officers that have conflicts of interest, or if they are / have been working in the area of audit, will not undertake any audits in the conflicting area for a minimum of three years, safeguarding the officers and WIASS' integrity. Further protection is in place by using randomly selected testing samples and a series of independent review stages. All audit working papers, reports and findings are reviewed and if necessary challenged before being issued to the client by either the Head of Service or Team Leader.

2. Demonstrates competence and due professional care:

   All reports are reviewed and signed off by either the WIASS Head of Service or Team Leader both of which are highly qualified and governed by professional institution standards. Regular 1-2-1 meetings are held with each officer to ensure progress and

personal development. An "open door" culture is adopted throughout WIASS allowing all team members to ask for assistance advice and support at any time. Training (both in-house and external) is available and is provided should it be deemed relevant and appropriate by Head of Worcestershire Internal Audit Shared Service (HoWIASS) / Team Leader.

3. Is objective and free from undue influence:

   Independence and safeguarding is a key element of internal audit provision. All WIASS staff are vetted via the Basic Disclosure Check, as well as making a Declaration of Interest on an annual basis declaring any potential conflicts of interest with upcoming audit programme and the partners that WIASS work with. No auditor, who has transferred from a Service, will audit that Service for a minimum of three years. The Service is organisationally independent for all Partners. Although the HoWIASS reports directly to the s151 Officers of the Partner organisations the role has direct and unrestricted access to the senior management team and Committee Chair. The Client Officer Group, who governs the Service, meets on a quarterly basis and is made up of the Partner s151 Officers. They each have an equal vote and consider the strategic direction of the Service as well as progress and performance. Further independence and safeguard checks are reported throughout this Charter in the form of checks, actions and process.

4. Aligns with the strategies, objectives, and risks of the organisation:

   The audit plan and its content is discussed with Management[1]and s151 Officers to ensure that risks are identified; appropriate processes, systems and strategies are tested and that areas of risk are monitored and mitigated. Corporate and service risk registers are used along with corporate knowledge and the promises and objectives. Five year plans are also considered as part of the risk profiling and plan definition.

5. Is appropriately positioned and adequately resourced:

   As a shared service, WIASS is hosted by Worcester City Council, but audit allocations ensure a presence in all authorities that it serves across the year. Resources are monitored and tracked throughout the annual audit plan, with forecasting used as often as possible to prevent resources becoming too stretched resulting in reduced coverage. WIASS is governed by a Client Officer Group made up from the Partner s151 Officers but also has direct access to Management[1] and the Board[2] Chairs. Delegated powers are used should there be any resourcing issues.

6. Demonstrates quality and continuous improvement:

   Continuous monitoring of the teams performance via trackers is conducted. Quarterly and annual reports are issued to committee and board members demonstrating trends in productivity and value. Individual reviews via 1-2-1 meetings are held monthly with the Team Leader and include personal development plans for all team members. Improvements and changes will also be made using external assessment as well as internally generated client feedback forms. A self assessment will be completed each municipal year to further provide assurance of quality and improvement. The Service is working with partners to ensure that it continues to provide a 'fit for purpose' Service by developing techniques that will complement requirements, continue to add value and work in a changing environment e.g. critical friend reviews. There is a continuous desire to ensure that the Service changes and adopts best practice methods as identified by the professional institutions e.g. IIA, CIPFA.

7. Communicates effectively:
   Various forms of communication are adopted (verbal, written, diagram / graph) throughout the review process by all members of the WIASS team. Continued monitoring and improvements to the methodology are conducted, making the report and testing documents clearer for all users. Findings are discussed verbally with management[1] prior to the issue of a formal report. Reports are issued to Officers and Committee[1] on a regular basis.

8. Provides risk-based assurance:
   The audit plans are risk based with reviews being classified from high to low risk. The review scope is risk based which drives the review without creating restrictions on the areas covered. All findings are rated high, medium or low risk. Risks associated with the findings are linked directly to the recommendation and the management action to mitigate it. The review risk is combined to create the overall assurance level of the audit, which will be presented to the client with explanation and reasoning in the form of a report.

9. Is insightful, proactive and future-focused:
   Insightful – where possible WIASS officers with relevant background experience will be assigned to conduct audits in similar fields. Continued monitoring of current "audit and fraud affairs" is distributed to all WIASS team members. A sharing of knowledge is encouraged in the Service and pre-engagement research. Identification of best practice is shared amongst the authorities. Reports identify areas that are working well as well as those that require improvement. Reviews look for efficiencies and better ways of working.
   Proactive – scoping meetings are held for all audits allowing for changes to the audit scope in line with changes in service delivery and legislation between annual planning and audits starting. There is also an ability to vary the plan should an emerging risk present itself using delegated powers so the audit service can be proactive is providing assurance to those in governance. Consultancy days are built into the plans to allow for pre implementation of new system/process advice.
   Future-focused – The Service will scan the horizon for risks and issues that are emerging. Networking using, for example, the Midlands Audit Group is used to help inform the audit plans and consultancy assignments to provide information to the partners before it becomes a potential issue for them. Monitoring of the next generation initiatives from Central Government and having a team of auditors aware of the potential risks and impact along with environmental control issues will assist in adding value for our partners.

10. Promotes organisational improvement:
    Ethics and culture are key aspects to organisation improvement. WIASS reviews consider ethical and cultural aspects and the potential impact and associated risk. Liaison with s151 Officers, Senior Management Teams and governance boards where applicable to promote continuous organisational development. Audit Reports are issued to management[1] to ensure oversight of the organisation and areas of concern including common themes are looked at and improved on. High and Medium priority findings are followed up after a 3 or 6 month period respectively using an established methodology to ensure that potential risks are being mitigated and there is continuous improvement. Findings will be followed up until such time that they are satisfied. Follow up on findings will be documented and reported to Management,

Heads of Service and or the appropriate s151 to give assurance of action and risk mitigation.

For further information please reference:
https://na.theiia.org/standards-guidance/mandatory-guidance/Pages/Core-Principles-for-the-Professional-Practice-of-Internal-Auditing.aspx

8. External Relationships

8.1 The main contacts are with:

- Institute of Internal Auditors
- External Auditors
- Local Authorities in the Worcestershire area
- Local Authorities in the Midlands area
- Organisations within the Exeter Benchmarking Group
- CIPFA (publishers of the systems based auditing control matrices written by Exeter IA section)
- National Fraud Initiative via DCLG and Cabinet Office

but may include other external parties as necessary.

8.2 Assurance will be accepted and reported from 3rd parties as long as WIASS can rely on their work, and they are suitably qualified to carry out the assessment. The relevance of the work will also be a consideration in using a 3rd party certification e.g. IT integrity testing.

8.3 Where work is undertaken on a contractual basis assurance will be provided to 3rd parties outside of the partnership as appropriately agreed. The methodology applied to audit 3rd party organisations will be the same as the methodology used for the members of the partnership. All of the safeguards used to protect the integrity of the audits carried out for the partnership will be extended to 3rd parties as well and appropriate reporting protocols established as part of any contractual agreement. These will be established as part of the engagement with a clearly identified engagement officer and requirements. No contract will be entered into if it is considered that the independence or integrity of the Service will be compromised. If, during the delivery of a contract, it becomes apparent that there is undue influence being brought to bare and/or that the actions of the client is undermining the ethos of internal audit the HoWIASS will inform the Client Officer Group without delay so a strategic decision can be made to avoid any potential reputational damage or compromised independence. Any assurances provided to 3rd Parties will be based on the established internal methodology and the defined definitions of the different levels and priorities.

Notes

a) In the absence of the Head of Internal Audit Shared Service all provisions relating to him/her above will apply to the relevant Team Leader in accordance with the duties allocated by the Head of Internal Audit Shared Service.

Version Control:	Date of Change	Action	Updated by
1.0	2nd March 2012	Charter for WIASS	AB
2.0	9th August 2012	Update to Charter	AB
3.0	23rd April 2013	Update to Charter re. International Standards	AB
4.0	21st Janaury2016	Update to Charter re. legislative requirements & title changes	AB
5.0	1st July 2016	Update re. titles and definition of 'consultancy' and 'assurance'.	AB
6.0	April 2017	Full review in line with Standards	HT
7.0	May 2017	COG suggestion: Update of H&WFRS name to reflect legal entity & 'Council's' to 'Partners'.	HT
8.0	June/July 2018	External Assessment recommendations: Update to Mission & Definition Inclusion of 3.4, IA remit Update to 4.6 regarding HIASS responsibility on briefing Inclusion of 5.7, escalation for late and non return audit reports Inclusion of 6 – Principle of Public Life Inclusion of 7 – Core Principles of Public Practice Inclusion of 8.2, assurance from 3rd Parties Inclusion of 8.3, assurance to 3rd Parties	HG, AB, HT
9.0	June 2021	Review of Charter	AB
10.0	June 2022	Review of Charter	AB
11.0	June 2023	Review of Charter	AB

Hereford & Worcester Fire Authority
Audit and Standards Committee
19 July 2023

Report of Assistant Chief Officer – Director of Prevention

Equality Objectives 2021-2025 Update for Quarter 3 and Quarter 4 2022-2023

Purpose of report

1. To provide a summary of progress against the Service's Equality Objectives 2021-2025 for Quarter 3 and Quarter 4 2022-2023.

2. To provide an update on the future delivery and governance of the Service's equality agenda from 2023-2024.

Recommendations

It is recommended that Members:

i. Note the progress made against the Equality Objectives 2021-2025 for Quarter 3 and Quarter 4 2022-23.

ii. Note the future delivery and governance of the Service's Equality Agenda from 2023-2024.

Introduction and Background

3. The Public Sector Equality Duty of the Equality Act 2010 requires all public sector organisations to prepare and publish specific and measurable equality objectives at least every four years.

4. The aim of setting these objectives is to assist the Service to perform the general Equality Duty and focus on its priority equality issues in order to drive and deliver improvements. The Service's current Equality Objectives were approved by the Fire Authority on 28 July 2021 and are published on the Service website:

Our Organisation: **Leadership and Corporate Commitment**	**Our Communities:** **Understand, engage and build good relationships**
Our leaders will provide visible leadership to ensure our people; our partners and our communities see the personal commitment to inclusion. We will maximise the transparency of our organisation so our activities can be scrutinised and we can be held accountable.	We will better understand our communities by ensuring we put in place systems that enable the collection, collation and analysis of community data and information. We will enhance our engagement with our communities to foster good relationships and understand the community priorities.

Our People: Develop, engage and understand	Our Partners: Working together
We will develop our people to better understand diversity and inclusion. We will create an inclusive culture where our people feel able to be themselves. We will better understand our workforce composition through our workforce data. We will put in place effective strategies to enable engagement with our staff and networks to continue to develop an inclusive culture.	We will work with external partners to develop strategies that enable effective service provision to our communities. We will collaborate across our own business functions and staff networks to better build equality and inclusion into our policies, processes and practices to ensure inclusion and our values are at the heart of everything we do.

Progress Headlines

5. The Equality Objectives are currently being met through an annual programme of work in support of the Service's People Strategy 2022-2025.

6. Appendix 1 provides a summary of activity against the deliverables expected in Quarter 3 and Quarter 4 2022-2023. Progress is RAG rated to demonstrate the areas where actions have been completed or are on-going. Good progress has been made and there are no significant areas of concern.

Approach for 2023-2024

7. The EDI Plan was developed in 2020 to support the Service in delivering against its strategic Equality Objectives. Significant progress has been made in this area, as previously reported to SLB and the Fire Authority over the last three years.

8. Members will be fully cognizant of national assessment of values and culture in FRSs conducted by HMICFRS, as well as the significant progress and improvements that the Service has already made in relation to culture and inclusion, such as:

- Adopting the NFCC Core Code of Ethics.
- Gaining excellent participation rates (65%), employee feedback and overall engagement score from the staff survey (84%).
- Commencing delivery of the bespoke EDI training to all staff, delivered by ioda.
- Improving Speak Up processes for staff through Say So.
- Commissioning an independent Service cultural audit.
- Commissioning an independent workplace environment review

9. As part of the Service's journey to further improve its organisational culture and workplace behaviours, the Service will evolve to a more holistic and aligned approach to EDI and culture going forward.

Therefore, although organisational oversight for the equality agenda will remain with SLB, delivery of actions will sit with the Culture & Ethics Steering Group, Chaired by ACO Anna Davidson, via a Culture & Ethics Improvement Plan, replacing the EDI Plan 2020-2025.

10. The plan will be reported on a biannual basis to SLB and annually to the Fire Authority.

Conclusion

11. The Service continues to make excellent progress in furthering our equality, diversity and inclusion agenda for the benefit of our employees and our local community. Meeting our Equality Objectives fulfils the requirements of the Public Sector Equality Duty of the Equality Act 2010 and more importantly confirms our commitment to equality, diversity and inclusion. The Service is now maturing its approach to embedding culture and inclusion via the Culture and Ethics Steering Group and the Culture and Ethics Improvement Plan.

Corporate Considerations

Resource Implications (identify any financial, legal, property or human resources issues)	• There are no resource implications arising from publishing the report. • Implications of championing and embedding equality into mainstream business may incur financial and management support for implementation, dissemination of resources and consideration of different ways of working. • The report helps the Service meet its statutory duty under the Equality Act 2010 and the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.
Strategic Policy Links & Core Code of Ethics (Identify how proposals link with current priorities & policy framework and align to the Core Code of Ethics)	• CRMP • Core organisational strategies • People Strategy • Core Code of Ethics and Code of Conduct • EDI Policy • Positive Action Statement of Intent
Risk Management / Health & Safety (identify any risks, the proposed control measures and risk evaluation scores).	• Failure to demonstrate an ongoing commitment to EDI, promoting an inclusion culture and addressing unacceptable behaviour may damage our reputation as an employer of choice and attract public, media and political scrutiny.

Consultation (identify any public or other consultation that has been carried out on this matter)	• There is a continued collaborative approach across all business functions. • Ongoing engagement with the Women@HWFire network, Neurodiverse staff network and Representative Bodies continues to take place.
Equalities (has an Equalities Impact Assessment been completed? If not, why not?)	• As this is an update report, no people impact assessment is required. However, any actions arising from the implementation of the equality outcomes may require individual assessment.
Data Protection Impact Assessment (where personal data is processed a DPIA must be completed to ensure compliant handling)	N/A

Supporting Information

Appendix 1 – Equality Objectives Progress Update Summary for Quarters 3 & 4 2022-2023

Appendix 1 - Equality Objectives Progress Update Summary for Quarters 3 & 4 2002 - 2023

Our Organisation – Leadership and Corporate Commitment				
Objective	**Action**	**Performance Measure**	**Progress Update**	**RAG**
Our leaders will provide visible leadership to ensure our people, our partners and our communities see the personal commitment to inclusion	**Strategic Leadership Board (SLB) Equality objectives:** SLB to set measurable Equality objectives for 2022/2023.	Objectives reviewed and outcomes published in Bulletin and website.	SLB have set their own equality objectives to demonstrate their personal commitment to mainstreaming diversity and inclusion practices across the organisation. These are reviewed on a regular basis and progress communicated to the wider workforce. Q1/Q2 - The Director of Prevention & Assets attended the Asian Fire Service Association (AFSA) Summer conference in June 2022 along with a cross-section of staff, and SLB members have contributed to staff bulletin articles about Ramadan and our attendance at local Pride events. **Q3/Q4 – Assistant Director of Response attended a Women in Leadership Conference facility by AFSA in March 2023, with operational and support staff representatives. SLB have updated staff on various EDI events such as World Mental Health Day, Neurodiversity Celebration Week and the Neurodiverse staff network.**	Green
We will maximise the transparency of our organisation so our activities can be scrutinised and we can be held accountable	**People Impact Assessments (PIAs):** Review current process and guidance. Establish Quality Assurance process. Deliver workshops. PIA available for scrutiny on our intranet.	All key decisions, policies and processes are supported by an EIA and published on the Service website, leads to positive outcomes for protected groups.	Q1/Q2 - Two in-house training videos, a toolkit and process have been established and are regularly used by staff and managers. Input on PIAs is included in the training for Station Prevention Champions to link into the need to understand our communities. Bespoke input and support for departments and teams in the Service is available on request. In liaison with the Performance & Information team, a quality assurance process has been established for PIAs accompanying Service policies.	Green
	EDI Policy: Develop overarching EDI policy	**Policy published and understood.**	**Q3/Q4 - EDI policy published.**	Green
	Equality & Gender Pay Gap Reporting: Complete report and publish results. Communicate results and future actions to staff and community.	Analysis informs specific actions to help reduce the gender pay gap.	Q1/Q2 – Report created. **Q3/Q4 - Report for 2021-22 presented at SLB in November 2022 and approved for publication at the Audit and Standards Committee meeting in January 2023. Gender Pay Gap reporting completed as per legislation.**	Green

Green – Completed **Amber** – In Progress/On Target **Red** – Delay

Our Communities – Understand, engage and build good relationships				
Objective	**Action**	**Performance Measure**	**Progress Update**	**RAG**
We will better understand our communities by ensuring we put in place systems that enable the collection, collation and analysis of community data and information.	**Communities at greater risk:** Enhance data collated regarding communities at greater risk.	Our communities are better protected from preventable risks.	Q1/Q2 - National statistics are available through the NFCC Equality of Access documents for protected groups. Local analysis of data undertaken by Prevention and P&I Team. The Senior Technicians in the Prevention team have been working on relevant action plans, with support from the EDI Officer. The Prevention team has adopted the NFCC Person-Centered Framework, which allows for the collection of standard national data, including ethnicity, age, specific vulnerabilities. *Data to be updated to reflect the 2021 census.*	Amber
We will enhance our engagement with our communities to foster good relationships and understand community priorities	**Community events:** Active participation in events e.g. local Pride events, etc. as a recruitment/ outreach opportunity. Incorporate into Station campaign calendars with rationale behind why Service is supporting; demonstrating how we champion inclusion locally and promote safety messages to specific groups.	Increased attendance and participation at events. Positive feedback gathered from protected characteristic groups in the community and workplace.	Q1/Q2 -Local Pride events at Bromsgrove, Malvern and Worcester have been supported with the opportunity fully utilised to promote working for the Service and our HFSV offer. Notable EDI events are incorporated into the NFCC campaign calendar which is shared with Stations. This will continue to be done annually.	Green
	Community groups: Develop and maintain a central list of community groups for engagement and consultation purposes.	Up to date list of contacts developed and utilised. Local priorities are shaped through partnership and community engagement. Groups are consulted on equality plans, recruitment messages, etc.	Q1/Q2 - A directory of community group contacts is in development and is due to be completed within Quarter 1 2023-2024. This will be shared and maintained with Senior Technicians in the Prevention team to aid engagement with protected groups.	Amber
	Promote accessible services to specific communities: e.g. the Emergency SMS Service for deaf and hard of hearing community to report fire emergencies and incidents.	Positive feedback gathered from protected characteristic groups in the community.	Q1/Q2 - Senior Technicians within the Prevention team have links with local partners and promote accessible services to specific communities as appropriate. The new Home Fire Safety Visit leaflet has been produced in large print for those who have a sight impairment. It has also been produced in other languages which are predominant within our communities. NFCC Equality of Access documents are being fully utilised by the Prevention Team who focus on specific topics each quarter, supported by the EDI Officer.	Green

Green – Completed **Amber** – In Progress/On Target **Red** – Delay

Our People – Develop, engage and understand				
Objective	**Action**	**Performance Measure**	**Progress Update**	**RAG**
We will develop our people to better understand diversity and inclusion	**EDI training:** Commission a service wide EDI Training Programme to be delivered by an external specialist.	Feedback from staff is positive and staff awareness in relation to EDI is increased.	**Q3/Q4 - Tendering process for a Service-wide EDI Training Programme completed and awarded to preferred provider. Mandatory programme to commence in April 2023 for all staff with delivery over an 18-month periods. One day in-person delivery for all Wholetime and Support Staff, and condensed 3-hour session for On-call.** **An associate from ioda, Dr Willoughby commissioned to undertake Service cultural review in Q4 to underpin and direct the content of the EDI Training.**	Amber
	Values / Code of Conduct: Develop guidance for inclusive behaviours to outline expectations of how staff can expect to be treated and how they should treat others.	Discipline, grievance and attendance levels demonstrate staff feel more included in the workplace.	Q1/Q2 - A Gap analysis has been conducted against the Core Code of Ethics Fire Standard and the Service's Ethical Framework & Code of Conduct. A People Strategy objective for 2022-2023 is to source an external provider to deliver a Service-wide inclusion training programme. A provider has been identified following a tender process, **Q3/Q4 – A Core Code of Ethics Steering Group has been established to embed the Code, meeting on a monthly basis from December 2022.** **The Steering Group are producing a short training session on the Code to be rolled out to staff in addition to the EDI Training, SharePoint page and promotional materials, as well as Staff communications via the Bulletin and triple play video. A new Code of Conduct is being developed to replace the Service's ethical framework and code of conduct, aligned to the NFCC Core Code of Ethics and associated Fire Standard.**	Amber
	Performance appraisals: Review performance management system and process, ensuring does not disadvantage any group and helps to promote inclusive skills and behaviours.	Ethical principle of EDI reviewed until Values and Leadership section of appraisal form.	**Q3/Q4 - Performance appraisal framework reviewed and people impact assessment completed. Revised form and guidance updated to comply with British Dyslexia Association recommendations. Guidance provided in a variety of formats – written document, separated into section online as well as a completion support video.** **Additional section included within the appraisal to consider employee's performance in relation to the Core Code of Ethics.**	Green

Green – Completed **Amber** – In Progress/On Target **Red** – Delay

We will create an inclusive culture where our people feel able to be themselves	**Local staff survey:** Conduct local survey focused on workforce opinion and understanding of EDI matters to inform EDI activity focus.	Enhanced understanding of staff experiences and perceptions of EDI.	**Q3/Q4 -Tendering process for a Staff Engagement Survey. Survey launched in January 2023 with an excellent, 65% participation rate. Results presented in March 2023 to SLB and Senior Managers at the Managers Away Day.** *Service-wide webinar and actions to be shared with staff in Q1.*	Amber
	EDI Allies: Develop this staff network and produce TORs, training, events/workshops, etc.	Learning shared amongst Allies and the wider workforce.	Q1/Q2 - Updates are shared with group members on a regular basis, including events such as NFCC "Lunch and Learns". An EDI Ally attended the AFSA Summer Conference to share learning and best practice. There may be opportunities to further develop EDI Allies as part of the Service-wide inclusion training programme and this will be explored within the rollout.	Green
We will put in place effective strategies to enable engagement with our staff and networks to continue to develop an inclusive culture	**Reasonable adjustments:** Review guidance available to staff and managers.	Updated information available to managers and staff.	Q1/Q2 - A Practical & Reasonable Adjustments Toolkit has been drafted to support line managers and staff in addition to the information already available on SharePoint. A newly formed Neurodiverse Staff Network, which is growing in membership, will be asked for their feedback on the toolkit before it is published. The process of seeking advice and support for reasonable workplace adjustments is now established and working well. *This is due to be completed in Quarter 1 2023-2024.*	Amber

Green – Completed **Amber** – In Progress/On Target **Red** – Delay

Our Partners – Working together				
Objective	**Action**	**Performance Measure**	**Progress Update**	**RAG**
We will work with external partners to develop strategies that enable effective service provision to our communities We will collaborate across our own business functions and staff networks to better build equality and inclusion into our planning, policies, processes and practices to ensure inclusion and our values are at the heart of everything we do	**Equality groups:** Establish/develop relationships with local, regional and national EDI groups and bodies e.g. Worcestershire Equalities Group	Greater engagement and consultation with equality groups. Resources, skills and expertise are pooled to deliver equality outcomes.	Q1/Q2 - Our EDI Officer is a member of regional and national EDI groups. Engagement continues with local groups e.g. North Worcestershire Hate Crime Partnership and Herefordshire Addressing Hate Crime Partnership and this has been useful in understanding issues and gaining contacts. Staff from our Women's network and our Neurodiverse Staff Network were invited to attend the AFSA Summer Conference to gather and promote learning to colleagues. Each one who attended found it a valuable, useful and inspirational experience. **Q3/Q4 - Our women's network partnered with West Mercia Police women's network in March 2023 to celebrate International Women's Day, with a photo session to commemorate a flower planting activity – one flower planted for every female employee of both services.** **Our women's network also played a key part in the success of our Wholetime Firefighter Recruitment Taster Sessions in January 2023. They further supported by reaching out to potential female applicants, answering any questions and encouraging applications. They also took part in a staff information video about to promote the Inclusive Recruitment approach. A member of the Neurodiverse Staff Network also took part in the video.**	Green

We will collaborate across our own business functions and staff networks to better build equality and inclusion into our planning, policies, processes and practices to ensure inclusion and our values are at the heart of everything we do	**Staff networks:** Continue to encourage and engage with staff networks as critical friends e.g. Organisational Development and Challenge Group, Women@HWFire.	Staff networks are contributing to organisational priorities and are agents for change.	**Q3/Q4 - Neurodiverse Staff network launched. Two well-attended meetings have taken place so far.** **Membership continues to grow as awareness increases within the Service. Members of the network attended The Dyslexia Show at the NEC in March 2023 to gather learning and information about supportive technology which can be fed back and considered. The group now provide input to new recruits on the existence and purpose of the group, and are key drivers in progressing training and awareness of neurodiversity.**	Green

Green – Completed **Amber** – In Progress/On Target **Red** – Delay

Hereford & Worcester Fire Authority
Audit and Standards Committee
19 July 2023

Report of the Deputy Chief Fire Officer - Director of Response

Risk Management and Strategic Risk Register – Annual Update

Purpose of report

1. To provide an annual update on the Risk Management Framework and Strategic Risk Register.

Recommendation

It is recommended that the Committee note the contents of this report.

Background

2. The Organisational Risk Management Service Policy Instruction (SPI) has been published. This supports the identification and treatment of corporate risks within the Authority. These are usually identified through an escalation process within the departmental risk registers.

3. The Organisational Risk Management Policy, Version 5, was published following a full review and consultation in October 2021. The review was completed in line with the ISO standards 31000/2018 and IEC 31010/2019 for corporate risk management.

4. The overall objective of the Risk Management Framework is to ensure that the Authority identifies strategic risks and applies the most appropriate and cost-effective control mechanisms to manage those risks wherever possible. It also provides a robust audit trail for how the Service has considered and mitigated those risks, should an issue be subject to scrutiny.

5. Department Heads are responsible for the completion of a quarterly risk register review, with support from the Emergency Planning and Resilience Officer (EPRO).

6. The Strategic Risk Register (SRR) is reviewed at a Strategic Leadership Board (SLB) meeting at the end of each quarter and is collectively owned by SLB and supported by the EPRO.

West Mercia Local Resilience Forum (WMLRF)

7. WMLRF is a multi-agency group comprising of bodies within West Mercia including Local Authorities, national and local health agencies, the three emergency services and the Environment Agency, among others. The purpose

of the LRF is to ensure effective delivery of the duties of the Civil Contingencies Act (CCA) 2004, which includes risk assessment. This requires partner agencies to assess local risks, undertake planning and co-ordinate resources so they can respond effectively when incidents do occur. The LRF acts not only as a reliable conduit for information on risks providing a multi-agency planning forum, but also assists in testing and responding to the type of events that are likely to affect our communities and pose business continuity issues for the Fire and Rescue Service.

8. The National Security and Risk Assessment (NSRA) 2022 is a national document intended to capture the range of emergencies that may have an impact on all, or significant parts, of the UK as well as local and internal risks. The NSRA informs the Community Risk Register held by the WMLRF Risk Assessment Working Group and this information is used to inform decision making on risk management. The newest iteration of the NSRA came out in October 2022 and the WMLRF Risk Assessment Working Group (RAWG) is currently undertaking reviews of each risk if applicable.

9. SLB consider emerging local risks from the Local and Community Risk Registers within the LRF which may become SRR issues in the future. The SRR also acknowledges departmental, project and partnership risks where relevant.

Strategic Risk Register (SRR)

10. The SRR is the overarching document that looks at the highest impact risks to the Service. The highest and/or most prevalent risks from departmental risk registers can be elevated to the SRR as appropriate, through the discussion held at SLB as a standard quarterly agenda item.

11. Identified risks should normally either be eliminated or reduced to an acceptable level, with systems in place to monitor and report against this. All risks at each level are evaluated by the responsible manager for that area, normally a Department Head. The residual risk after control measures have been implemented, where possible, is then recorded in the risk register.

12. In Q1 2021 all department risk registers implemented generic risks to standardise departmental risk management across the organisation. The risk descriptions were developed by identifying common themes in the previous risk registers and with input from all risk register owners.

    The finalised generic risks are:

    i) Short term loss of staff,
    ii) Long term loss of staff,
    iii) Loss of site,
    iv) Damage, loss, unauthorized access or inappropriate management of physical or electronic data
    v) Total or partial loss of ICT services, Including third party applications.

13. The quarterly reviews meet the requirements of the Audit and Standards Committee to monitor and review the Authority's organisational risk management arrangements.

14. Each strategic risk has either a Business Continuity Plan (BCP) or policy linked to the risk; these plans or policies provide control measures and steps to mitigate against those risks, e.g. dealing with the death of a member of staff, severe weather, pandemic, fuel shortages, etc. plan and policies are reviewed approximately every three-five years or earlier following live events or exercises identifying learning.

15. The Business Continuity SPI, outlines the requirements of BCPs. The policy requires Strategic level BCPs to be reviewed every three years, or after a related business continuity event. The SPI version 1.4 was published in June 2022 and aligns closely to ISO standard and the Fire Standards Board standard for Emergency Preparedness and Resilience.

16. The overall responsibility for ensuring risks are managed effectively lies with the Authority as professionally advised by Senior Officers. The live SRR outlines to Members the risk scoring for both impact and likelihood of each identified risk based on a matrix agreed by SLB and held in the Organisational Risk Management SPI.

Changes from 2021/2022

17. Five strategic risks were archived this year including:

- In Q3 2022-23 SRR2a 'Loss of Section 31 National Resilience Grant'
  Archived 21/02/2023:
  Rationale: Formal notification of withdrawal of grant yet to be received however informal notification indicates loss of grant (£600k) by April 2024. Therefore, this is will now be archived - risk management now covered by SRR2

- SRR2B 'Significant inflation pressures including pay awards no longer being sustainable within current resource projections'
  This risk was identified and added to the SRR on 09/08/2022
  Archived 02/05/2023:
  Rationale - Pay award now known and is being accounted for. Active planning to align future expenditure with current resource projections

- SRR13 'Uncertainty in the delivery of the Emergency Services Network (ESN). In terms of quality, timescales and cost and the resultant requirement to sustain Airwave beyond the current planned shutdown date at the end of 2026 with option to extend a further 2 years.'
  Archived 17/10/2022

Rationale: Delivery of ESN voice and data has been paused pending re-lotting with deployment teams stood down until at least 2025. The program has provided assurances that Airwave will not be shut down until ESN provides sufficient functionality and is operationally safe for the emergency services.

- SRR14 "HMI Cause for Concern - Escalated from Department Risk PRE001a Notes that the Service needs to provide: a) an effective system to define the levels of risk in the community b) the development and delivery of a prevention strategy that prioritises the people most at risk of fire and ensures that work to reduce risk is proportionate. c) the review of systems and processes for dealing with referrals from partner agencies. This is to make sure they are managed effectively and the backlog of safe and well visits is reduced and resourced in accordance with risk. Action plan is being created to address shortfalls - due by 31st August 2021."
  Archived 21/02/2023:
  Rationale: Final review and report stated the cause for concern has been discharged.

18. One newly identified risk (SRR15) was added this year relating to an illegal waste site.

Conclusion/Summary

19. The Strategic Risk Register and Departmental Risk Registers are a method for continual monitoring and reviewing the services risks by SLB and middle managers, informing the service's objectives and business goals.

20. The Authority's Strategic Risk Register is formally reported to Members annually, with significant changes being reported to the Audit and Standards Committee in a risk update.

Corporate Considerations

Resource Implications (identify any financial, legal, property or human resources issues)	N/A
Strategic Policy Links & Core Code of Ethics (identify how proposals link with current priorities & policy framework and align to the Core Code of Ethics)	Proposals support the Business Continuity SPI, Organisational Risk Management Policy, which broadly support the three core strategies.

Risk Management / Health & Safety (identify any risks, the proposed control measures and risk evaluation scores).	Risks documented and reviewed in the Strategic and Departmental Risk Registers
Consultation (identify any public or other consultation that has been carried out on this matter)	N/A
Equalities (has an Equalities Impact Assessment been completed? If not, why not?)	N/A
Data Protection Impact Assessment (where personal data is processed a DPIA must be completed to ensure compliant handling)	N/A

Supporting Information
Appendix 1 – Summary of the Strategic Risk Register 2022/2023

Appendix 1

Summary of the Strategic Risk Register – Active Risks

This section is not for publication

The full details of the register are available via EPRO.

Strategic risk code	Consequences	Description of actions already taken or controls in place to mitigate the risk.	Residual score (April 2023)
SRR1 **A widespread event or situation that leads to a significant loss of workforce in the workplace**	Inability to deliver core purpose and over a longer term the inability to maintain core systems and/or deliver Service infrastructure and obligations (e.g. financial, legislative, departmental such as Fleet and ICT)	All Actions here are generic that are elaborated upon in the sub risks specific to this category. 1. Business Continuity Plans as outlined in the specific sub risks below. 2. Section 13/16 agreements that will mitigate a certain loss of workforce 3. Temporary Staffing arrangements 4. National Guidelines 5. regular Meetings with relevant stakeholders or Rep Bodies 6. Business continuity plans	6 Low/ Medium
SRR1A **Major ill health epidemic affecting service levels**	Loss of a percentage of front line and/or support staff resulting in a reduction or loss in the ability to deliver the service that Hereford and Worcester Fire and Rescue Service provides, including but not exhaustive to Prevention and Service Delivery	1. Business Continuity Plans including pandemic influenza and severe weather plans. 2. NHS prioritisation of specific emergency service workers allows selective members of staff to be immunised. 3. Temporary staff arrangements either from temp agencies (support staff) or national brigades. 4. Section 13/16 agreements that are in place	6 Low/ Medium
SRR1B **Severe weather event(s) affecting service delivery**	1) Loss of a percentage of staff due to several factors including but not exhaustive to: a) Inability for staff to travel into work b) School closures leading to a reduction in service delivery	1. Business Continuity Plans to deal with severe weather and flooding 2. National mutual aid arrangements and Over the Border agreements between Fire and Rescue Services for Mutual Aid are in place (However, if severe weather is regionalised this may not be possible)	6 Low/ Medium
SRR1C **Industrial disputes**	1) Strike action for an unknown period of time of a percentage of frontline and or support staff 2) A period of action short of strike for an indefinite period of time which may result in a loss of extra activities such as but not including overtime. These may potentially result in an inability to provide services to the public as outlined in the FRSA 2004	1. Regular meetings with Representative Bodies to proactively maintain working relationships' 2. National Guidelines 3. Constant review of actions and guidelines 4. Business Continuity Plan for Industrial Action 5. National and Local Resilience Forum briefings 6. Work with National Joint Council 7. Industrial Action Management Group meetings and pre-planning 8. A review of the impact of the decision of the judges' legal case on pensions.	4 Low
SRR1D **Inability to recruit or retain key parts of the workforce.**	An inability to deliver and maintain core functions and systems, and/or significant impact on service delivery in core areas	1. Cover arrangements for stations if appliances are OTR. 2. BCP for loss of key departments or provisions for maintaining service provision. 3. Changes to Recruit training to create a more flexible approach to training to allow less impact on RDS Primary employment.	6 Low/ Medium

		4. Section 13/16 agreements to facilitate service provision. 5. There is currently an ICT audit underway to review workloads and staffing.	
SRR2 **Continuous pressure of reductions in real terms of grants and/or other income affecting service delivery**	1) Unable to deliver the same level of service/ Reduction in service 2) Having to source funding from elsewhere 3) Potential redundancies/ voluntary redundancies	1. Good financial planning and horizon scanning for future developments in Budget constraints 2. Strategic planning to ensure ground work is done to prepare for budget alterations rather than react. 3. Vigilant to future implications through monitoring 4. Senior Management Board team preplanning options 5. Meeting the challenge workshops with all staff 6. Integrated Risk Management Plan refers and Service streamlining. Note: Residual risk is the same as inherent risk because neither likelihood or impact are changed by the control measures 7. HWFRS efficiency plan has now been submitted and confirmed by the Government.	15 High
SRR2B **Significant inflation pressures including pay awards no longer being sustainable within current resource projections**	Same as SRR2	working with home office and NFCC to lobby for CSR revision to take account of revised cost base (other controls for SRR2)	15 High
SRR3 **Death or serious injury of a member of staff whilst at work as a result of their work activities**	1) Impact on other employees carrying out similar duties (e.g. Driving) 2) Reputational loss 3) Investigations and legal proceedings and prosecutions. 4) Financial implications of claims 5) Departmental resilience issues	1. Professional training standards & Role maps being developed and maintained 2. High quality of training in work related activities and quality PPE provision when required 3. Robust Health and Safety Arrangements (Policies and Training in place) with current and up to date Risk Assessments for all work-based activities. 4. Procedures in place for dealing with a range of generic work-based activities 5. Legislation and Governance 6. National, Regional and Local Frameworks 7. Risk Management 8. Asset Management 9. Internal Assurance	12 Medium/High
SRR4 **Significant changes to national policy which mean local reaction outside of planned work loads**	1) Not correctly adhering to national policy which could mean that Hereford and Worcester Fire and Rescue Service are not fulfilling statutory or legal or moral duties, under one or more national policies.	1. Horizon scanning through Chief Fire Officers Association, Local Government Association and other networks. 2. Cultural acceptance of the need to be flexible. 3. Limited reserves to use on unplanned or unforeseen work. 4. Maintenance of local and regional 'decision influence' networks.	12 Medium/High
SRR8 **Local or national loss of data and intelligence as a result of a cyber security attack**	Currently Unknown	1) cyber security patches always being updated 2) NSCC release warnings 3) ROCU training of SLB on cyber risks 4) Attacks are dynamic and frequently evolving, being proactive is difficult.	12 Medium/High
SRR9 **Death of a member of staff as a consequence of an operational incident**	1) Impact on other employees carrying out similar duties (e.g. BA wearing). 2) Reputational loss 3) Governmental and HSE scrutiny 4) Investigations and legal proceedings and	1. Professional training standards & Role maps being developed and maintained 2. High quality operational equipment and Personal Protective Equipment alongside robust Health and Safety Arrangements (Policies and Training in place) 3.Operational procedures and Standard Operating Procedures 4. Firefighter Safety remaining the top Organisational objective	8 Medium

	prosecutions. 5) Financial implications of claims made 6)Workforce loss of confidence in organisation 7) Media Scrutiny	5. Major Event Response Protocol in place and up to date 6. Legislation and Governance 7. National, Regional and Local Frameworks 8. Risk Management 9. Asset Management 10. Internal Operational Assurance	
SRR10 **Death or serious injury of Member of Public through Service activities**	1) Impact on other employees carrying out similar duties (e.g. Driving). 2) Reputational loss 3) Investigations, legal proceedings and prosecutions. 4) Financial implications of claims made 5) Departmental resilience issues	1. Professional training standards & Role maps being developed and maintained 2. Risk management- Gap analysis - using past incidents to tailor training and development 2. High quality operational equipment and Personal Protective Equipment 3.Operational Procedures and Standard Operating Procedures being reviewed and adhered to 4. Robust Health and Safety Arrangements including Policy and Training 5. Major Event Response Protocol in place. 6. Graded Response Policy	8 Medium
SRR12 **Legal challenge to Service's stance on suspending immediate detriment payments relating to Sargeant McCloud case.**	-high cost implications either outcome -time consuming internal dispute resolution	MOU received from LGA and FBU agreed by SMB to adopt MOU - MOU now suspended by SLB due to government directive. SLB members taking national lead at LGA and NFCC.	4 Low
SRR15 **Significant Fire occurring at illegal waste site**	a. Significant fire that could cause a prolonged response from FRS and multi-agency partners with long term impacts on surrounding communities and business. b. conflicting priorities or policies between LRF partner agencies leading to delay in response and loss of public confidence. c. Significant draw on FRS resource with high financial cost, impact on staff availability, alongside potential damage to public confidence among local communities.	a. Internal response plan and water plan. b. LRF response plan working group c. LRF dismantle and enforcement group. d. Engagement with site owner to provide advice on reducing fire risk e. LRF strategic leadership briefing	16 High

Hereford & Worcester Fire and Rescue Service
Audit and Standards Committee
19 July 2023

Report of the Deputy Chief Fire Officer

Minimising Firefighter Exposure to Carcinogens – Service Update

Purpose of Report

1. To provide an update regarding measures being taken to minimise the risk of carcinogens to firefighters.

Recommendation

It is recommended that current and planned measures being taken by the Service to minimise the risk of carcinogens to firefighters is noted.

Introduction and Background

2. In July 2022 the International Agency for Research on Cancer (IARC), the cancer agency of the World Health Organisation (WHO), classified occupational exposure as a firefighter as carcinogenic to humans. This followed several recent academic reports, including *'Minimising firefighters' exposure to toxic fire effluents. Interim Best Practice Report'*, commissioned by the Fire Brigades Union, conducted by the University of Central Lancashire and published in November 2020.

3. In response to this report the National Fire Chiefs Council (NFCC) released a position statement stating that the *'NFCC are committed to understanding, through evidenced based research, any risks to firefighters and supports a proportionate response to seek improvements and reduce risk where necessary'.*

4. The NFCC encouraged Fire and Rescue Services (FRS) to reduce the risk, so far as reasonably practicable, including decontamination procedures, training, Personal Protective Equipment (PPE) cleaning, measures to avoid cross contamination, and reduction of secondary exposure.

5. The Service have always taken a proactive response to firefighter safety from carcinogens, including the measures described above. This work began in 2016 led by the NFCC national Health and Safety Committee and the Service has been actively pursuing measures to reduce exposure since then. In addition, the Operational Policy Department completed a review, to establish the Service position in relation to this report, in order to identify current good practise and any potential areas for improvement.

6. The review identified that the Service have implemented a significant number of safety measures since 2016, including PPE and Respiratory Protective Equipment (RPE) provision, decontamination procedures, welfare and cleaning facilities, health screening, safety procedures and training.

7. This proactive approach is demonstrated in the review summary, which identified 156 areas for consideration; and concluded that the Service had comprehensive evidence in 103 areas, evidence in 36 and there were 17 areas for further consideration. The results are summarised in the table below:

Description	Comprehensive evidence	Evidence	Areas for consideration
Personal Protective Equipment	6	3	2
Fire Incident: Minimising Contamination	29	3	1
Return to the workplace from Fire Incidents	33	15	5
Breathing Apparatus (BA) Workshops: Contamination Control	7	1	2
Training Centres: Contamination Control	8	4	4
Vehicles: Additional Considerations	6	2	1
Health Screening	4	4	1
Pregnancy, Maternity and Fertility	8	1	0
Training and Awareness	2	3	1
Totals	**103**	**36**	**17**

8. The following table expands on the 17 areas for consideration, identified through the review, and current measure in place to mitigate the risk. A more detailed action plan to address the 17 areas is shown in Appendix 1:

Safety measures implemented by the Service

9. The following points provide an overview of actions taken by the Service to support safety measures highlighted by the review. A detailed overview of measures implemented by the Service can be seen in Appendix 2.

- **Personal Protective Equipment (PPE)** – Sufficient PPE has been provided, including spares, with a procedure in place to bag/seal contaminated PPE. Local and professional cleaning procedures in place.

- **Respiratory Protective Equipment (RPE)** – Breathing apparatus (BA), respirators and compressors provided with procedures in place. Face fit tests completed for all staff.

- **Decontamination** – Risk Assessments, guidance and procedures in place to decontaminate PPE, equipment and vehicles at incidents, training venues and stations.

- **Welfare** – washing facilities at incidents (welfare vehicle), wipes for both skin and equipment on appliances and showers at all Service locations and training venues.

- **Health Screening** - medicals including lung function screening for operational staff, annual medicals for BA Instructors, VO2 max tested at annual fitness test, and healthcare referrals.

- **Training** – BA Refresher and Compartment Fire Behaviour Training (CFBT)training programme in place. Risk assessments completed, respirators available for staff and instructors, and clean burn training in place.

- **Guidance** – posters, training risk assessments, safety briefs and guidance available.

- **BA Workshops** – ventilated, clean, PPE and RPE available.

- **Fire Investigation (FI)** – PPE and RPE issued, paper suits and cleaning equipment available, 2 sets of FI kit issued.

- **Pregnancy, Maternity and Fertility** - Pregnancy and Maternity policy in place protecting pregnant staff and nursing mothers, including breastfeeding areas and breast milk storage.

Additional areas under review

10. The following provides an overview of areas where evidence is available, however further measures are now being considered to support the Response strategy:

- **PPE** – consideration for moisture wicking undergarments and changes of clothes.

- **Decontamination** – 6mm decontamination bags, use of sealed storage for all contaminated PPE, and station signage.

- **Exposure logs** – expansion of use of existing exposure logs (water / hazmats etc.)

- **Stations** – air monitoring, laundry facilities on all stations, zoned areas.
- **PPE** – professional cleaning to include gloves and RPE for BA technicians
- **Healthcare provider** – informed of increased cancer risk for firefighters
- **Pregnancy, Maternity and Fertility -** Risk Assessment checklist made available on new SharePoint.

Area for consideration	**Current measures in place to mitigate the risk**
3 areas proposing air monitoring / filtration assessments at Service locations	Station and equipment cleaning procedures in place. PPE available for staff to utilise
3 areas proposing the use of 'contamination zoning' on Service locations	PPE and procedures in place to manage contaminated equipment and PPE
2 areas proposing additional refresher training for staff	Training, awareness previously provided to all operational staff
2 areas proposing outdoor hanging for lightly contaminated PPE	Facilities in place to air tight bag contaminated PPE and send for professional cleaning
1 area proposing Health screening for BA technicians	Health screening procedures established for other staff
1 area proposing BA sets not stored in appliance cabs	Facilities available to clean BA sets at incidents and air tight bag contaminated sets, as required
1 area proposing air filtration systems on appliances	Pollen filters and air circulation controls fitted to current appliances
1 area proposing air tight storage for contaminated hose	Facilities to clean hose at incidents and transport in lockers
1 area proposing drying room signage for PPE only	Signage and awareness required
1 area proposing cotton liner gloves	Cleaning and welfare facilities available at incidents and Service locations
1 area proposing disposable overshoes for Fire Investigation (FI) Officers	Cleaning facilities available at incidents on request.

Summary

11. The Service has completed a review against the findings of the *'Minimising firefighters' exposure to toxic fire effluents. Interim Best Practice Report'*. The analysis found that the Service have implemented a significant number of proactive steps to minimise the risk of carcinogens to firefighters.

12. Potential areas for improvement have also been identified, and an Action Plan has been agreed with Strategic Leads to discharge actions where reasonably practicable.

13. In addition, a working group has been established, consisting of operational staff, Health and Safety Union representatives and Health and Safety staff. This group have created a refresher training package, which will be delivered to all operational staff from July 2023. This group will also be supporting stations with risk assessments and control measures, such as signage and guidance posters.

Corporate Considerations

Resource Implications (identify any financial, legal, property or human resources issues)	Response staff are required to support the working group, to deliver training, assess locations and implement control measures
Strategic Policy Links & Core Code of Ethics (Identify how proposals link with current priorities & policy framework and align to the Core Code of Ethics)	This links to staff competence, and availability requirements of the Response Strategy; develop and Train in the People Strategy; and Integrity and Leadership of the CCoE.
Risk Management / Health & Safety (identify any risks, the proposed control measures and risk evaluation scores).	Carcinogenic risks identified and an action plan agreed to discharge risks where practicable.
Consultation (identify any public or other consultation that has been carried out on this matter)	Proposed consultation with the Fire Brigades Union on the review and action plan
Equalities (has an Equalities Impact Assessment been completed? If not, why not?)	n/a

Data Protection Impact Assessment (where personal data is processed a DPIA must be completed to ensure compliant handling)	Procedures in place for safeguarding health screening staff information

Supporting Information

Appendix 1 – Action Plan for areas of potential improvement

Appendix 2 – Overview of measures implemented by the Service

Appendix 1 - Areas of potential improvement - Action Plan for consideration

GC Operational Logistics			
Potential Area for Improvement	Air filtration, PPE, storage, laundry facilities		
HWFRS Action		**Assigned to**	**Target Date**
Future procurement of Fire gloves to consider meeting the requirements of BS EN 374-3		GC Ops Logs	On-going
Automated disinfectant dispenser in cab		GC Ops Logs	Q4 23/24
Future procurement of Fire Appliances to consider high efficiency particulate air filter in appliance cabs		GC Ops Logs	On-going
Future procurement of Fire Appliances to consider creation of non-BA seats i.e. external BA compartments		GC Ops Logs	2024/5
Future procurement to consider moisture wicking undergarments, designed to be worn beneath PPE		GC Ops Logs	Q4 23/24
Future procurement to consider cotton liner gloves to reduce exposure to debris		GC Ops Logs	Q2 24/25
Provide 6mm thick bags for contaminated PPE and equipment, including BA sets		GC Ops Logs	Q2 23/24
Provision of airtight storage containers for hose		GC Ops Logs	Q3 23/24
Sealed containers, replacing bags for PPE sent to Bristol for cleaning		GC Ops Logs	Q2 23/24
Change of clothes available at an incident		GC Ops Logs	Q4 23/24
Locations to be assessed to provide laundry facilities for base layers		GC Ops Logs	Q4 23/24
Strategic lead	**AC Assets**		

GC Operational Logistics			
Potential Area for Improvement	Air monitoring and filtration, cleaning, RPE, welfare facilities PPE		
HWFRS Action		**Assigned to**	**Target Date**
Provision of air quality monitoring (stations and training facilities)		GC Ops Logs	Q4 23/24
Locations to be assessed to provide external ventilated hanging areas for slightly contaminated (slight smell of smoke) PPE (stations & training)		GC Districts	Q3 23/24
Future cleaning contracts to consider professional cleaning service for gloves		GC Ops Logs	Q4 23/24
Air filtration in 'clean' areas (stations and training facilities), if at risk of contamination		GC Ops Logs	Q4 23/24
Investigate additional welfare facilities at Defford, including base layer washing facilities		GC Ops Logs	Q4 23/24
Provide respiratory protection for BA Technicians		GC Ops Logs	Q3 23/24
Investigate the requirement to provide additional hooded tunics for Breathing Apparatus Instructors		GC Ops Logs	Q4 23/24
Consider and Industrial BA set cleaning machine in future procurement		GC Ops Logs	Q4 23/24
Provide heavy duty nitrile gloves and disposable overshoes for Fire Investigation Officers		GC Ops Logs	Q3 23/24
Strategic lead	**AC Assets**		

GC Operational Policy	
Potential Area for Improvement	H&S procedures, training, signage, exposure monitoring

HWFRS Action	**Assigned to**	**Target Date**
Hazmats exposure logs to be utilised for carcinogenic hazards	H&S Advisor	Q2 23/24
Risk assessed waste disposal procedure for contaminated waste	H&S Advisor	Q2 23/24
Station / Technician room signage designating clean and dirty zones (possibly red, amber and green zones)	H&S Advisor	Q2 23/24
Signage designating drying rooms only suitable for PPE	H&S Advisor	Q2 23/24
Exposure monitoring of BA Technicians - *completed*	HR	Q1 23/24
Contamination zone signage at Strategic Training Facilities	H&S Advisor	Q2 23/24
CTR training package regarding long term exposure to fire debris - *completed*	Working Group	Q1 23/24
On-site posters / documentation highlighting risks and control measures	Working Group	Q2 23/24

Strategic lead	**AC Protection**

GC District Commanders			
Potential Area for Improvement	Training		
HWFRS Action		**Assigned to**	**Target Date**
Refresher awareness training for staff on hazards and standards, including showering, PPE storage and transporting contaminated PPE and equipment		DC West Dist.	Q3 23/24
Training on the acute and chronic toxicants produced by fires for all personnel		DC West Dist.	Q3 23/24
Training to include BA Technicians		DC West Dist.	Q3 23/24
Strategic lead	**AC Response**		

Head of Human Resources			
Potential Area for Improvement	Health screening and pregnancy and maternity		
HWFRS Action		**Assigned to**	**Target Date**
Update healthcare provider of increased cancer risks - *completed*		Head of HR	Q1 23/24
Annual health screening for operational staff, including BA Technicians		Head of HR	Q2 23/24
Pregnancy and Maternity Risk Assessment checklist made available on new SharePoint - *completed*		Head of HR	Q1 23/24
Strategic lead	**AC Prevention**		

Appendix 2 - Overview of measures implemented by the Service

Personal Protective Equipment

PPE

- **Helmets** - all have removable padding, cleaning function available through Bristol and a spare stock of helmets is available on stations
- **Flash hoods** – two Nomex flash hoods provided for operational staff
- **Fire Gloves** - two pairs of Southcombe Firemaster gloves, meeting EN659 standard provided for operational staff
- **Gauntlets** – 4 pairs provided on appliances, meeting hazardous material standard EN374-3

Respiratory Protection

- **Self-Contained Breathing Apparatus (BA) -** Draeger PSS 7000 BA provided for operational staff
- **Respirators** – Draeger FPS 7000 respirators available on fire appliances
- **Face fit** - Testing completed for all operational crews and those that entre the inner cordon
- **BA Compressors** – all BA compressors serviced in line with manufacturer's instructions

Appliance and appliance bay

- **Decontamination wipes** – available in appliance cabs, which can be wiped down
- **External BA compartments** – available in Compact appliances
- **Contaminated BA sets** – facility available to double bag BA sets on all appliances

Fire Incident: Minimising Contamination

- **Risk Assessments (RA)** – RA database in place
- **Decontamination guidance** – CTR training packages and Mobile Data Terminals guidance available to staff
- **Decontamination tools** – Stage 1 decontamination on appliances, Bristol double bagging procedures, re-robe packs available.
- **Workplace decontamination facilities** – BA Servicing rooms available on all stations
- **Sufficient personnel to decontaminate** – ability to request additional personnel in place
- **Hazard and decontamination briefing** – training and incident briefings take place, including eating and drinking guidance
- **Designated decontamination zones** – covered in firefighting, IC and Hazmats training
- **PPE checks** – inspection guidance available, PPE checks carried out at start of shift
- **Personal decontamination** – wipes available, welfare vehicles have washing and changing facilities, showers available on all stations/training facilities, posters reminding staff to shower
- **Hazard briefing** – Intel available, BA crew and OIC briefing, Safety Officers

- **Incident zones** – appliances park away from hot zone, hot zone PPE level set at scene, crews upwind where possible, hazmat training in place
- **Personal issue drinks bottles** – decontamination wipes also available to clean bottles
- **PPE should fit well** – personnel issue PPE fitted by Bristol, quarterly PPE audit completed

Return to the workplace from Fire Incidents

- **Clean boots** – ability to do this at the incident ground
- **BA Service Room** – marked and kept clean as part of station work routines
- **BA set cleaning** – in line with manufactures instructions and equipment safety file
- **BA checks** - include cleanliness
- **PPE storage** – designated area, moved away from appliance room and clean areas
- **Station cleaning –** in place through cleaners and station work routines
- **PPE cleaning** – Bristol total care cleaning package in place
- **Washing machines** – available on some stations
- **PPE log book -** maintained for all items of PPE for all staff
- **Kit and boot bags** – provided for all personnel
- **Velcro straps** – on tunics to allow gloves to hang free
- **Disposable gloves** – available at all locations
- **Vehicle cleaning** – facilities and standards in place
- **Appliance pollen filters** – inspected during the annual service
- **Cleaning facilities** – available to clean equipment stowed in appliance cabs

BA Workshops: Contamination Control

- **Ventilated and clean BA service room** (air conditioning and windows)
- **BA sets -** returned clean
- **RPE and PPE** available to handle impounded sets which may be dirty
- **Cleanliness posters** in place

Training Centres: Contamination Control

- **Clean burn** plywood and untreated timber, including minimal glue Oriented Strand Board
- **Respirators** – available to delegates (on their appliance) and instructors (personal issue)
- **Risk assessments**, including a safety brief in place
- **Shower facilities** available at all STF's
- **BA face masks** cleaned in line with manufacturers guidance

Vehicles: Additional Considerations

- **PPE and RPE** issued to Fire Investigation officers
- **Disposable paper suits** provided
- **Fire Investigations kit** - 2 sets of issued

Health Screening

- **3 yearly medicals** for operational staff
- **Annual medicals** for BA Instructors
- **Lung function screened** during 3 year medical and VO2 tested during annual fitness test
- **Additional healthcare referrals** available

Pregnancy, Maternity and Fertility

- **Pregnancy and Maternity policy** in place protecting pregnant staff and nursing mothers
- **Breastfeeding** - private areas available on stations for breastfeeding
- **Refrigerated storage** available for breast milk

Training and Awareness

- **BA Refresher and CFBT** training programme in place

Hereford & Worcester Fire Authority
Audit and Standards Committee
19 July 2023

Report of Assistant Chief Fire Officer

Health and Safety Committee Update: January to March 2023 (Quarter 4)

Purpose of report

1. To provide a Health & Safety update on activities and items of significance.

Recommendation

It is recommended that the following issues, in particular, be noted:

(i) The involvement of the Service in Health and Safety initiatives;

(ii) Health and Safety performance information recorded during January to March (Quarter 4) Health and Safety performance information recorded during January to March 2023 (Quarter 4)

(iii) Workforce Health & Wellbeing performance (Quarter 4)

Introduction and Background

2. Hereford & Worcester Fire and Rescue Service (HWFRS) aims to ensure the safety and well-being of its employees and reduce and prevent accidents and injuries at work, as outlined in the People Strategy 2020-2022.

3. The Health and Safety Committee is established to provide effective arrangements for the liaison and review of matters of common interest concerning Health and Safety (H&S). The Committee provides the opportunity for the Service to discuss general H&S issues and consult with the workforce via employee representatives. The Committee is chaired by the Assistant Chief Fire Officer and last met on 21st June 2023.

4. The Committee has the facility to task work to the H&S Working Group, which sits beneath it and is chaired by the Group Commander responsible for Health and Safety. The group meets as and when required.

5. The Working Group was formally tasked with the following:

- To promote and improve fitness standards across the Service.

6. The Group are meeting regularly, ensuring actions are monitored and implemented at the earliest opportunity.

Health & Safety Initiatives Update

National Activities

7. The NFCC National Health and Safety committee have issued minutes of a meeting held 29th March 2023 which promoted a number of subjects listed below.

- Training Packages Scottish FRS have saved their slow manoeuvring package onto Firelearn. There are still issues with trying to pass on this package from FireLearn. However, Scottish FRS have been asked to forward the package to the Chair who will make it available via Workplace.

- Contamination Position Statement – The creation of this document is still in progress following the second literature review. The Chair and Group are willing to work with the Unions on this matter of real importance, but it will need to be a complete report stating NFCCs stance on contaminants.

- The Contaminants Working Group has developed the following key work packages and will meet bi-monthly, 2 weeks prior to the Health and Safety Committee.:

    - Evidenced Based Literature Review
    - Personal Protective Equipment (PPE)
    - Risk Assessments and Safe Systems of Work
    - Appliances and Equipment
    - Health Surveillance
    - Training and competence
    - Premises
    - Operational Incidents – National Operational Learning/Joint Organisation Learning (NOL/JOL)
    - Legislation, Fire Standards, National Operational Guidance
    - Health Surveillance

- HSE reported that they are looking at conducting a fact-finding exercise (possibly after June) where they will visit ten Services to see what they are doing in relation to contamination etc.

Regional Activities

8. The regional group met on 18th April 2023.
- Regional Driving Instructors have been asked to attend the Regional Drivers group on 11 May and then feed their discussion into this committee in connection to slow speed manoeuvring.
- The audit of Staffordshire FRS took place in May 2023 with topics of Working at height/rope rescue and PPE and equipment. The H&S advisor will disseminate any findings that may be relevant to HWFRS once the report is available.

HWFRS Local Activities

9. The Service's new Health & Safety advisor started in April.

10. HWFRS have undertaken a GAP analysis and developed an action plan to ensure current best practices already in place remains up to date. The report is broken down into the sections listed below.

- Personal Protective Equipment
- Minimising Contamination at Fire Incidents
- Returning from a Fire Incident
- BA Workshops Contamination control
- Training Centre Contamination Control
- Vehicle Contamination
- Health Screening
- Training and Awareness

11. Of the current 26 Health & Safety Policies there are 5 scheduled for review in July. All other polices have been reviewed.

12. These policies will be reviewed in line with legislative and sector best practices and will undergo formal consultation across the organisation, where required, prior to publication.

13. The risk assessment database (Figure 1) is owned and maintained by local managers and reviewed by the H&S Advisor. Each risk assessment has a review period, and managers are prompted to carry out reviews. Where risk assessments are no longer applicable, they are archived from the database. During Quarter 4, 358 risk assessments were reviewed, and 39 new risk assessments were created.

Figure 1 – Risk Assessment Database

	Quarter 1 (22/23)		Quarter 2 (22/23)		Quarter 3 (22/23)		Quarter 4 (22/23)	
Location	Reviewed	Created	Reviewed	Created	Reviewed	Created	Reviewed	Created
North District	87	7	105	5	102	16	105	5
South District	75	6	80	7	53	13	97	14
West District	112	21	101	21	93	16	78	15
Training Centre	32	1	40	1	44	1	47	1
Others	15	2	22	1	9	4	31	4
Total	**321**	**37**	**348**	**35**	**301**	**50**	**358**	**39**

H&S Working Group activity updates

14. The new Fitness Policy has undergone formal consultation and amendments. The policy is currently undergoing a legal review prior to the new Policy being issued with a bedding in period of up to 12 months to allow for support to be provided to those personnel currently not meeting the standard.

15. The Service personal trainers are undergoing further nutrition training.

Quarter 4 Performance Report

16. Appendix 1 provides details relating to all safety events reported and investigated during Quarter 4 of the 2022-23 reporting year (January to March).

17. The total number of safety events reported in Quarter. 4 (26) decreased by sixteen compared to the previous quarter (42). The most significant decrease was in the personal injuries and vehicle collisions categories which decreased by fourteen between them.

18. Two events have been reported to the Health & Safety Executive (HSE) under the RIDDOR regulations, due to a loss of working days.

19. Six basic specialist investigations occurred.

Workforce Health & Wellbeing Update

Performance Overview – Quarter 4 2022-23

National Sickness data 2022-2023

20. The Cleveland Report (1 April 22 – 31 March 23) allows comparison between contributing Fire & Rescue Services across the UK on sickness absence.

21. Nationally, there were 3 main causes of sickness absence for all Fire Services; Musculo-Skeletal (MSK) (31%), Mental Health (22%) and Respiratory (12%).

22. HWFRS is ranked 4th out of the 27 Services who submitted data, at 12.95 days lost per employee. The lowest average was 6.33 days and the highest 21.06 days. The national average is 9.30 days.

23. During Quarter 4 2022/23, there has been a general increase in total days/shifts lost due to sickness across all workforce groups in HWFRS. Fire Control in particular have seen an overall increase of working days/shifts lost, coupled with a number of long-term sickness absences. There has also been an increase in the duration of these long-term sickness periods (11.79 long term days/shifts lost per person), which is higher than other workgroups, see Appendix 2, Table 1.

24. The average number of days/shifts lost due to long term sickness for Fire Control was 36.5 days in 2021/22, compared to 109.4 days in 2022/23. Main causes for absence were Mental Health and Respiratory conditions, however many of these cases have now been resolved, which will be reflected in Q1 2023/24 statistics. The Service will continue to monitor and review attendance levels in line with the Attendance Management SPI and support the Fire Control management lead in the resolution of these cases.

25. Across all workforce groups, there has been an increase in the number of Respiratory sickness absence occurrences (221) compared to the previous year (74) (see Appendix 2, Table 2). In 2021/22, COVID-19 absences were reported separately, and were not included within the Cleveland Report data. From 2022/23, COVID-19 was classed within a range of respiratory illnesses and is now recorded as such for sickness absence reporting purposes which may explain the increase.

26. There has also been a 36% increase in the number of Mental Health sickness absence occurrences in 2022/23, compared to the previous year (see Appendix 1, Table 2).

HWFRS Sickness data and activity Quarter 4 2022-23

27. Appendix 2 (Performance Overview) provides data relating to all sickness absence by workforce group and main causes of sickness absence in Quarter 4.

28. In comparison to Quarter 3, there has been an increase in the total days/shifts

lost to sickness absence for all staff (Q3 at 2.52 versus Q4 at 6.38). The main cause of sickness absence was Mental Health – Stress. There were 794 days/shifts lost overall in Quarter 4 for Mental Health sickness absences across all categories (Stress, Anxiety, Depression and Other), featuring a combination of work related and personal factors in some cases.

29. Some of the reasons reported for stress in individuals' personal lives included: exhaustion, sleep deprivation, bereavement and family issues or emergencies. Overall, there were 4 long term sickness cases within this category (2 within the Wholetime workgroup, 1 within Fire Control, and 1 within the Support workgroup) and 3 of the cases were cited as work related.

30. In addition to the comprehensive support already on offer, the Service is enhancing prevention strategies to ensure individuals receive person centred support which enables them to remain at work where possible, such as setting up a comprehensive line management support plan; working towards individual solutions and tools to improve their overall wellbeing. This includes signposting managers to Mental and Emotional Wellbeing resources, encouraging the line management team to remain in contact with the individual and continuing to monitor the wellbeing of their staff.

31. HR have arranged for Occupational Health to visit The Fire Fighter's Charity facility - Harcombe House to gain a better understanding about the mental health support which is available to inform management referrals and provide additional advice to employees.

32. The HR department has further developed the Wellbeing SharePoint site with a wealth of information. The CIST & Welfare Team and HR continue to work together and the Service has recently purchased "Back Up Buddy" – an app based mental health support tool for staff. A soft launch of the app is planned for July 2023 via the Station Buddy team in order to gain feedback to inform a wider roll-out Service-wide in September. The Service is continually working towards workplace resolutions which may be required to alleviate ill mental health, including reasonable adjustments and mediation.

33. There were 649 days/shifts lost in Quarter 4 for Respiratory related absences, the main cause being Respiratory – Other with 317 days/shifts lost. It is worthy of note that COVID related absences are no longer reported separately and will appear in this category.

34. There were 401 days/shifts lost in Quarter 4 due to Musculoskeletal (MSK) sickness absence. Individuals experiencing MSK issues are signposted to Occupational Health for physiotherapy support, and there has been an increase in the number of referrals for treatment in Quarter 4. The Service will continue to promote health and lifestyle advice to decrease the risk of injury for staff, and to promote optimal DSE arrangements.

Health Management data and activity

35. Appendix 2 (Health Management) provides data relating to Occupational Health referrals in Quarter 4. There were 28 new management referrals in Quarter 4, compared to 20 management referrals made in Quarter 3.

36. The top reasons for referrals to Occupational Health related to MSK disorders (13 referrals) and Mental Health (8 referrals).

37. Of the 8 referrals for Mental Health, 5 employees cited work related reasons. **N.B. mental health is not included in work related reporting figures.**

38. Where workplace factors have been identified within Mental Health referrals, the areas of concern are addressed on a case by case basis, using stress risk assessments as part of return to work plans, or through other resolutions such as offering mediation. Counselling support is offered through Occupational Health and the Service's Welfare Support team. External psychotherapy support is available via the NHS and the Fire Fighters Charity. The HR team has been working with the Fire Fighters Charity to promote their health and wellbeing workshops within the Service including mindfulness and improving sleep, to promote strategies for improving Mental Health.

Mental Health at Work Commitment

39. The Service signed The Mental Health at Work Commitment on behalf of the Service in February 2022 and submitted a high-level action plan in October 2022. The action plan outlines how the Service will embed the six standards of the Commitment and has been developed for delivery over a two-year period, formally commencing in 2023/24.

40. Work is underway on the Mental Health at Work Commitment action plan. Recent activity includes hosting a Mental Health Webinar with the Fire Fighters Charity which took place on the 18th May to mark Mental Health Awareness Week. The Service will be launching the previously mentioned "Back Up Buddy" through the Station Buddies to champion mental health and raise awareness.

Routine Medical Assessment Compliance and Outcomes

41. Appendix 2 (Routine Medical Assessment) provides medical and fitness data from the Operational Assurance Report for Quarter 4 2022-2023.

42. The medical compliance rate of operational staff has increased overall in Quarter 4 compared to Quarter 3, with an 89% compliance rate for 3 yearly medical assessments in Quarter 4, compared to 84% in Quarter 3. There was a slight decrease in the compliance rate for annual medical assessments, with 88% of employees who were in date in Quarter 4, compared to 94% in Quarter 3. The remaining out of date medical assessments are prioritised for Quarter 1.

Routine Fitness Assessment Compliance and Outcomes

43. The fitness compliance rate of operational employees has remained the same in Quarter 4 compared to Quarter 3. 93% of employees who are required to have an annual fitness test were in date in Quarter 4.

44. HR is closely monitoring these staff and providing support where needed. As part of the Fitness Standards policy work, the Service is exploring options for holistic support for those staff that may be in the amber and red VO2 max categories, via our Occupational Health provider and the University of Worcester.

Corporate Considerations

Resource Implications (identify any financial, legal, property or human resources issues)	Contained within H&S budgets and departmental capacity.
Strategic Policy Links & Core Code of Ethics (identify how proposals link with current priorities & policy framework and align to the Core Code of Ethics)	The work of the H&S Committee directly links to the three core Strategies and People Strategy, which in turn help the Service to deliver the CRMP.
Risk Management / Health & Safety (identify any risks, the proposed control measures and risk evaluation scores).	Reduces the overall impact for H&S management in the areas identified and safeguards the Services legal requirements.
Consultation (identify any public or other consultation that has been carried out on this matter)	Representative bodies attend H&S Committee and are fully consulted on H&S matters.
Equalities (has an Equalities Impact Assessment been completed? If not, why not?)	Equality Impact Assessments are undertaken on relevant policy and procedures related to H&S matters.
Data Protection Impact Assessment (where personal data is processed a DPIA must be completed to ensure compliant handling)	All personal data has been removed from the reports contained within Appendix 1.

Supporting Information

Appendix 1: Quarter 4 (January to March 2023) Event Reporting and Summary

Appendix 2: Quarter 4 (January to March 2023) Health & Wellbeing Data Reporting

APPENDIX 1

Health and Safety Quarterly Report
Quarter 4 (January 2023 – March 2023) Event Reporting and Summary

1. Overview

In the period of January 2023 to March 2023 a total of **26** Health and Safety (H&S) events were reported. They fall into the categories of:

- 7 Personal Injury
- 7 Vehicle Collisions
- 5 Property or Equipment
- 3 Near Hits or Causes for Concern
- 3 Exposure or Contamination
- 1 Violence or Aggression

Individual detailed summaries of reporting in the key areas above are outlined in Appendix A.

2. Breakdown of Events

By Activity

Table 1 shows that during Q4, vehicle collisions and personal injuries were the most frequently reported incidents. The majority of vehicle collisions occurred during operational work and training. Personal injuries mainly took place during training too.

	Total	**Training**	**Operational Activities**	**Routine Activities**	**Other**
Total H&S Events Q4	**26**	**14**	**5**	**4**	**3**
Personal Injury	7	6	1	0	0
Vehicle Collision	7	1	3	3	0
Property or Equipment Failure	5	4	0	0	1
Near Hit or Cause for Concern	3	0	0	1	2
Exposure or Contamination	3	3	0	0	0
Violence or Aggression	1	0	1	0	0

Table 1: Safety Event Breakdown Q4 2022-2023

By Injury Type

Table 2 identifies one area to be the main cause of personal injuries; Others (mix of injuries).

Total Personal Injuries	**7**
Manual Handling	0
Slips, Trips & Falls	1
Hit by Moving Object	0
Hit Stationary Object	0
Burns – Operational	0
Burns – Training	1
Other	5

Table 2: Personal Injury Breakdown Q4 2022-2023

By Vehicle Type

Table 3 highlights that vehicle collisions during this quarter have mostly involved appliances not on blue lights.

Vehicle Collisions	**Fire Engines**		**Cars and Vans**		**Non-Service related**
	On blue lights	Off blue lights	On blue lights	Off blue lights	
Total Collisions	3	4	0	0	1

Table 3: Vehicle Breakdown Q4 2022-2023

Vehicle Mileage Statistics

Vehicle mileage statistics for the year 2021-2022 were provided by the Operational Logistics Fleet Department and have been used to predict vehicle mileage for 2022-23. These are summarised in Table 3A below. It can be seen that there were zero white fleet safety events out of approximately 175,894 miles driven.
The seven safety events involving red fleet vehicles were out of approximately 67,202 miles driven, which equates to one event for every 9,600 miles driven.

Fleet	**Total Mileage 2021-2022**	**Predicted Mileage Q3 2022-2023**
White Fleet	703,576	175,894
Red Fleet	268,808	67,202
	Totalling 972,384 miles	**Totalling 243,096 miles**

Table 3A: Vehicle Mileage Statistics Q4 2022-2023

3. Events Requiring Investigation during Quarter 4 (January 2023 – March 2023)

Tier One Investigations

A Tier One standard investigation is required for all safety events and is usually conducted by the on-duty / line manager present at the time of the event. Events that are minor in nature usually remain at this tier.

Tier Two Basic Specialist Investigations

In addition to the standard investigation required for Tier One, a Basic Specialist Investigation (SI) is required for:

- Rare, unusual or unlikely events resulting in either serious injuries or losses, or with the potential to incur such injuries or losses.
- Events involving Breathing Apparatus (BA).
- Near Hits resulting from unusual conditions or with the potential to cause serious injury or loss that are rare or unlikely to reoccur.

Six events reported during Q4 required a Tier Two Basic Specialist Investigation:

1603 – Tightness of chest during exercise.
1605 – Needle injury.
1607 / 1616 / 1620 – BA set malfunction.
1618 – Skin reddening during training.

Tier Two Full Specialist Investigations

A full SI may be assigned immediately or following a Basic SI and is required for:

- Possible or likely events resulting in serious injuries or losses.
- All significant events involving Breathing Apparatus (BA).
- Near Hits resulting from unusual conditions or with the potential to cause serious injury or loss that are possible or likely to reoccur.

No safety events were reported during Q4 that required a full Specialist Investigation.

Tier Three MERP Specialist Investigations

A Tier Three Specialist Investigation is conducted as required by the Major Event Response Protocol (MERP) SPI. These are for the most serious events such as death or potentially life-threatening injury to a member of HWFRS whilst on duty, or a third party either occurring on Service property or as a result of an act or omission by HWFRS.

No safety events during Q4 required a Tier Three Specialist Investigation.

RIDDOR Events for Quarter 4 (January 2023 – March 2023)

During Q4, two RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reports were submitted to the Health and Safety Executive (HSE) as a dangerous occurrence/over a seven day injury.

1603 – Tightness of chest during exercise. RIDDOR over 7-day injury.
1618 – Skin reddening. RIDDOR over 7-day injury.

4. Comparison between Quarters and Trend Analysis

Comparison of Events Reported Showing Differences Q4 2021-22 & Q4 2022-23

Table 4 below compares the number of events reported in Q4 2021-22 and Q4 2022-23 for the different categories. For events over the last 12 months, only one of the categories experienced an increase, while three reported a decrease.

Overall, event reporting as a whole decreased by thirteen over the period, with 26 reports in Q4 2022-23 compared to 40 in Q4 2021-22. The decrease was driven by less vehicle collisions.

Event Type	Q4 2021-22	Q4 2022-23	Increase/Decrease
Personal Injuries	10	7	-3
Vehicle Collisions	17	7	-10
Property or equipment	3	5	+2
Violence & Aggression	1	1	-
Near Hits	6	3	-3
Exposure / contamination	3	3	-
Overall	**40**	**26**	**-14**

Table 4: Quarterly Events Reported Q4 2021-22 and Q3 2022-23

Trend Analysis

In summary compared with the previous year, there was a decrease in the number of events reported during Q4 (-14).

The main decrease was vehicle collisions (-10). The only increase was property or equipment (+2).

All events that occurred during the quarter were investigated at a minimum of Tier One local level investigation to identify preventative control measures and help to reduce the likelihood of similar occurrences.

12 Month Trend Analysis

Table 5 below breaks down the latest four quarters by reported accident type. Q4 figures show a significant decrease in the number of events reported.

Personal injuries and vehicle collisions driving this.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Total H&S Events	**37**	**45**	**42**	**26**
Personal Injury	11	24	18	7
Vehicle Collision	12	12	16	7
Property or Equipment Failure	1	1	3	5
Near Hit or Cause for Concern	11	7	5	3
Exposure or contamination	0	1	0	3
Violence or Aggression	2	0	0	1

Table 5: 12 Month Trend Analysis Q4 2021 – 2022 to Q4 2022 – 2023

Brief Description of all Safety Events

A1. Personal Injury

Of the **26** H&S events reported, **7** relate to the category of Personal Injury. These are described in Table A1 below:

Sub-Categories	Break-down of Injuries in Each Sub-Category
6 events were during operational training	1603 - Relates to injury to a Crew Commander while undertaking BA – BASIC SI. RIDDOR.
	1604 - Relates to an injury caused by a wasp sting to a Firefighter
	1612 - Relates to an elbow sprain occurring during Phase 1 recruits' course
	1615 - Relates to entrapment of hand whilst using RTC cutting gear whilst training
	1618 - Related to minor skin blistering during BA Health Check. BASIC SI. RIDDOR.
	1628 - Relates to injury occurring after equipment fell out of the appliance locker after not being stowed correctly.
1 event was during operational work	1606- Relates to an injury whilst carrying out a rescue from water
	Totalling **7** personal injuries
	22 Calendar Days / 30 Working days lost.

Table A1: Personal Injuries Reported during Q4 2022 – 2023

A2. Vehicle Collisions

Of the 26 H&S events, 7 relate to the category of Vehicle Collisions, which are further described in Table A2 below**.** Events highlighted in grey are attributed to the FRS driver. If these collisions occurred whilst responding to an operational incident the category of response has been provided in bold. Driver training have sent out a Bulletin item for crews to familiarise themselves with the 'Banks person' CTR technical knowledge package and requesting that when contact is made with tree branches, crews should contact the local highways team to get the hazard removed.

Sub-Categories	Breakdown of Vehicle Collisions in Each Sub-Category
3 events were during routine work	1621 - Relates to minor damage to wing mirror cover of appliance
	1623 - Relates to slow moving vehicle accident whilst moving appliance outside Station
	1627 - Relates to Vehicle collision whilst responding to station.
3 events were during operational activities	1613- relates to a collision between a fire appliance and a private vehicle. no injuries occurred **EMERGENCY RESPONSE**
	1617 - Relates to vehicle damage whilst on approach to incident on motorway. **EMERGENCY RESPONSE**
	1626 - Relates to vehicle damage which occurred during reversing Special Appliance. **EMERGENCY RESPONSE**
1 event was during training	1624 - Relates to slow moving manoeuvre in off road conditions in 4x4 vehicle, minor damage sustained.
1 event was classed as other	
	Totalling 7 vehicle collisions

Table A2: Vehicle Collisions Reported during Q4 2022 – 2023

A3. Property or Equipment Damage

Of the **26** H&S events, 5 relate to the category of Damage to Property or Equipment. These are further described in Table A3 below.

Sub-Categories	Breakdown of Property or Equipment Damage in Each Sub-Category
4 events were during Operational Training	1607 - Relates to a Set malfunction after an incident, set impounded for further inspection BASIC SI
	1616 - relates to BA set failure immediately prior to training in a contaminated atmosphere. BASIC SI
	1620 - Relates to a Set malfunction during training, set impounded for further inspection BASIC SI
	1625 - Relates to minor damage to ALP caused during training.
1 event was classed as Other	1608- Relates to an accident caused by a private vehicle to service property
	Totalling **5** property or equipment damage

Table A3: Property or equipment damage during Q4 2022 – 2023

A4. Near Hits or Causes for Concern

Of the **26** H&S events, **3** relate to the category of Near Hits or Causes for Concern - these are further described in Table A4 below.

Sub-Categories	Breakdown of Near Hits or Causes for Concern in Each Sub-Category
1 event was during Routine Work	1629 - Relates to a near hit following equipment falling out of a locker having not been stowed correctly.
2 events were classed as other	1605 - Relates to an issue where a needle was found in an RTC tunic caused by Bristol Uniforms BASIC SI
	1622 - Relates to drawer from locker on 252 sliding open whilst being driven due to bolt shearing
	Totalling **3** near hits or causes for concern

Table A4: Near Hits or Causes for Concern Reported during Q4 2022/23

A5. Violence or Aggression

Of the **26** H&S events, **1** relates to the category of Violence or Aggression.

Sub-Categories	Breakdown of Violence or Aggression in Each Sub-Category
1 event was during Operational Activities	1631 - Relates to aggression and violence from intoxicated male aimed at crews whilst they were assisting police following an RTC.

A6. Exposure or Contamination

Of the **26** H&S events, **3** relate to the category of Exposure or Contamination.

Sub-Categories	Breakdown of Violence or Aggression in Each Sub-Category
3 events were during Operational Activities	1607 - Relates to the crew becoming ill after being in the water, WFR training.
	1608 - Relates to the crew becoming ill after being in the water, WFR training.
	1609 - Relates to the crew becoming ill after being in the water, WFR training.

An exposure event will be investigated where a harmful substance has entered the body through a route e.g., by inhalation, ingestion, absorption, by injection or when the body is irradiated. Where there is uncertainty as to whether any exposure has taken place, or this is negligible, then this would be recorded as a potential exposure and an investigation would not normally be instigated, unless related symptoms develop.

A contamination event occurs where a substance has adhered to or is deposited on people, equipment or the environment, creating a risk of exposure and possible injury or harm.

There was one report of skin reddening during Q4. Skin reddening is recorded following training or incidents where immediately following exposure to high temperatures there is some skin discolouration which may be a result of this exposure. These occurrences are recorded and if they continue past 24 hours these are reported as a Personal Injury Safety Event.

3 potential exposure/contamination events/incidents were recorded during Q4, involving firefighters. Potential exposure/contaminations are where personnel have been exposed (during training or incidents) to hazardous environments but where appropriate control measures were implemented. For example, when entering open water during training.

APPENDIX 2

Health and Safety Quarterly Report
Quarter 4 (January 23– March 23) Data Reporting

1. Performance Overview

All sickness absences Q4 2022-23

Table 1: All sickness absence by workforce group Q4 2022-23

- Due to the on-call nature of the Retained Duty System, On-Call absence is not reflected in the below figures.

Days/Shifts lost due to sickness (per person)[1]			
	Short	Long	Total
All Staff	3.50	2.88	6.38
WT	4.07	3.01	7.08
FC	3.94	11.79	15.73
Support Staff	2.24	0.79	3.03

Table 2: Comparing the number of sickness absence occurrences in 2021/22 to 2022/23 across the main sickness absence categories

Category	Occurrences in 2021/22	Occurrences in 2022/23
MSK	79	73
Mental Health	22	30
Respiratory	74	221

Table 3: Main causes of sickness absence Q4 2022-23 (total days/shifts lost)

Category	Total days/shifts lost
Mental Health – Stress	495
Respiratory – Other (COVID19)	317
Respiratory - Cold/Cough/Influenza	268
Mental Health - Other	263
Musculo Skeletal - Back	151

2. Health Management

New management referrals Q4 2022-23

Category	Number of referrals
MSK	13
Mental Health	8
Hospital/Post Operative	2
Skin Condition	1

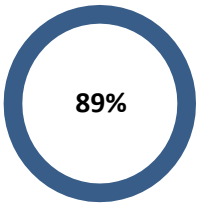
[1] Figures provided by P&I

Headache/Migraine/Neurological	1
Eye/Vision	1
Heart, Cardiac and Circulatory	1
Other (linked to fitness assessment)	1
Total	28

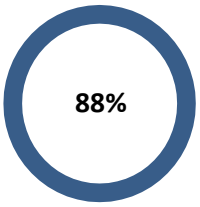
- Of these referrals, 6 were not related to sickness absence as the employee remained in work. There were no referrals relating to work-related sickness, however, 5 of the 8 Mental Health referrals cited work related stress. **Please note that mental health is not counted towards work related figures.**

3. Routine Medical Assessment Compliance and Outcomes

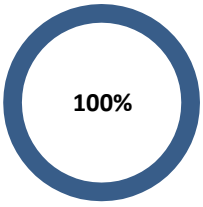
- The medical data below shows information from the Operational Assurance Report at the end of Quarter 4 2022-2023:



of operational employees requiring a 3 yearly medical are in date



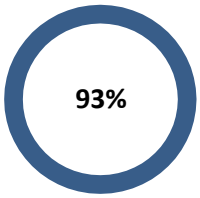
of operational employees requiring an annual medical are in date



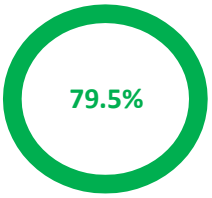
of operational employees have completed an asbestos medical

4. Routine Fitness Assessment Compliance and Outcomes

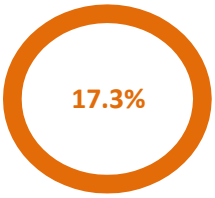
- The fitness data below shows information from the Operational Assurance Report at the end of Quarter 4 2022-2023 and is supplemented by management information provided by the Fitness Advisor at the University of Worcester:



of operational employees have an in-date fitness test.



have a VO^2 max of 42 and above



have a VO^2 max score of between 35-41.

have a VO^2 max score of below 35