PUBLIC MEETING - AUDIT AND RISK ASSURANCE COMMITTEE

TUESDAY 8 APRIL 2025 @ 1000 HRS

BRAIDWOOD SUITE, SCOTTISH FIRE AND RESCUE SERVICE HEADQUARTERS, WESTBURN DRIVE, CAMBUSLANG, G72 7NA / VIRTUAL (MS TEAMS)

AGENDA

1 CHAIR'S WELCOME

2 APOLOGIES FOR ABSENCE

3 CONSIDERATION OF AND DECISION ON ANY ITEMS TO BE TAKEN IN PRIVATE

4 DECLARATION OF INTERESTS

Members should declare any financial and non-financial interest they have in the items of business for consideration, identifying the relevant agenda item, and the nature of their interest.

5 MINUTES OF PREVIOUS MEETINGS: THURSDAY 23 JANUARY 2025 *(attached)* — *B Baverstock*

The Committee is asked to approve the minutes of these meetings.

6 ACTION LOG *(attached)* — *Board Support*

The Committee is asked to note the updated Action Log and approve the closed actions.

7 INTERNAL AUDIT

7.1 **Internal Audit Progress Report 2024/25** (*attached*) — *Azets*
- Anti Fraud Arrangements Report *(attached)* — *S O'Donnell*

7.2 **SFRS Progress Update / Management Response** (*attached*) — *Azets*

7.3 **Draft Internal Audit Plan 2025/26** *(attached)* — *BDO*

7.4 **Internal Audit: Corporate Governance Scope** *(attached)* — *BDO*

The Committee is asked to scrutinise these reports.

Please note that this meeting will be recorded for minute taking purposes only.
The recording will be destroyed following final approval of the minutes.

8	**DRAFT ANNUAL AUDIT PLAN 2024/25** *(attached)*	*Audit Scotland*
	The Committee is asked to recommend this report.	
9	**HMFSI INSPECTION ACTION PLANS UPDATE** *(attached)*	*M McAteer*
	The Committee is asked to scrutinise this report.	
10	**AUDIT AND RISK ASSURANCE COMMITTEE QUARTERLY PERFORMANCE Q3 2024/25** *(attached)*	*M McAteer*
	The Committee is asked to scrutinise this report.	
11	**ARRANGEMENTS FOR PREPARING 2024/25 ANNUAL GOVERNANCE STATEMENT** *(attached)*	*M McAteer*
	The Committee is asked to scrutinise this report.	
12	**ACCOUNTING POLICIES** *(attached)*	*L McGeough*
	The Committee is asked to scrutinise this report.	
13	**QUARTERLY UPDATE OF GIFTS, HOSPITALITY, AND INTERESTS REGISTER** *(attached)*	*D Johnston*
	The Committee is asked to scrutinise this report.	
14	**INTERNAL CONTROLS UPDATE**	
14.1	**Risk Update Report** *(attached)*	*S O'Donnell*
14.2	**Anti-fraud and Whistleblowing** *(verbal)*	*S O'Donnell*
	The Committee is asked to scrutinise these reports.	
15	**REVIEW OF WHISTLEBLOWING POLICY** *(attached)*	*L Gaja/R Scott*
	The Committee is asked to scrutinise this report.	
16	**QUARTERLY REPORT ON HMFSI BUSINESS** *(attached)*	*HMFSI*
	This report is for information only.	
17	**REVIEW OF ACTIONS**	*Board Support*

Please note that this meeting will be recorded for minute taking purposes only.
The recording will be destroyed following final approval of the minutes.

18 FORWARD PLANNING *B Baverstock*

18.1 Committee Forward Plan Review *(attached)*

18.2 Items for Consideration at Future Integrated Governance Forum, Board and Strategy Day meetings

19 DATE OF NEXT MEETING

Thursday 19 June 2025

PRIVATE SESSION

20 MINUTES OF PREVIOUS PRIVATE MEETING: THURSDAY 23 JANUARY 2025 *(attached)* *B Baverstock*

The Committee is asked to approve the minutes of these meetings.

21 PRIVATE ACTION LOG *(attached)* *Board Support*

The Committee is asked to note the updated Action Log and approve the closed actions.

Please note that this meeting will be recorded for minute taking purposes only.
The recording will be destroyed following final approval of the minutes.

Agenda Item 5

SCOTTISH FIRE AND RESCUE SERVICE
Working together for a safer Scotland

PUBLIC MEETING - AUDIT AND RISK ASSURANCE COMMITTEE

THURSDAY 23 JANUARY 2025 @ 1000 HRS

VIRTUAL (MS TEAMS)

PRESENT:

Brian Baverstock, Chair (BB)	Malcolm Payton, Deputh Chair (MP)
Neil Mapes (NM)	Mhairi Wylie (MW)

IN ATTENDANCE:

Stuart Stevens (SS)	Chief Officer
Andy Watt (AW)	Deputy Chief Officer
Liz Barnes (LB)	Interim Deputy Chief Officer Corporate Services
Sarah O'Donnell (SOD)	Director of Finance and Contractual Services
David Johnston (DJ)	Risk and Audit Manager
Lynne McGeough (LMcG)	Head of Finance and Procurement
Jamie Fraser (JF)	Internal Audit (Azets)
Paul Kelly (PK)	Internal Audit (Azets) (Item 18 only)
Claire Robertson (CR)	Internal Audit (BDO)
Sean Morrison (SM)	Internal Audit (BDO)
Michael Oliphant (MO)	External Audit (Audit Scotland)
Tommy Yule (TY)	External Audit (Audit Scotland)
Graeme Fraser (GF)	HMFSI
Chris Fitzpatrick (CF)	Business Intelligence and Data Services Manager (Item 8 only)
Carol Wade (CW)	Information Governance Manager (Item 9 only)
Lyndsey Gaja (LG)	Interim Director of People (Item 11.2 only)
Greig Aitken (GA)	Head of ICT (Item 18 only)
Christopher Casey (CC)	Group Commander Board Support Manager
Heather Greig (HG)	Board Support Executive Officer
Debbie Haddow (DJH)	Board Support/Minutes

OBSERVERS:
None

1 CHAIR'S WELCOME

1.1 The Committee Chair opened the meeting and welcomed all those attending, in particular Claire Robertson and Sean Morrison, BDO.

1.2 Those participating via MS Teams were reminded to raise their hands, in accordance with the remote meeting protocol, should they wish to ask a question. This meeting would be recorded for minute taking purposes only.

2 APOLOGIES

2.1 Madeline Smith, Board Member
Mark McAteer, Director of Strategic Planning, Performance and Communications
Robert Scott, HMFSI

3 CONSIDERATION OF AND DECISION ON ANY ITEMS TO BE TAKEN IN PRIVATE

3.1 The Committee discussed and agreed that Item 18 *(Cyber Security Maturity Assessment*) would be heard in private session due to matters relating to confidential matters in line with Standing Orders Item 9G.

3.2 No further items were identified.

4 DECLARATION OF INTERESTS

4.1 For transparency, declaration of interests were recorded in relation to Agenda Item 11.2 (Risk Spotlight: POD015 Pension Remedy) for:

- Stuart Stevens, Chief Officer
- Andy Watt, Deputy Chief Officer
- Christopher Casey, Group Commander Board Support Manager

4.2 There were no further declarations of interest made.

5 MINUTES OF PREVIOUS PUBLIC MEETING

5.1 **Tuesday 29 October 2024**

5.1.1 The minutes were agreed as an accurate record of the meeting.

5.2 **Matters Arising**

5.2.1 There were no matters arising.

5.3 **The minutes of the meeting held on 29 October 2024 were approved as a true record of the meeting.**

6 ACTION LOG

6.1 The Committee considered the action log, noted the updates and agreed the closure of actions.

Action 13.5 Risk Spotlight: Retrieval of PPE (30/10/2023): SOD advised the Committee that due to the work undertaken, the levels of non-compliance were minimal. Although the issue relating to consequences of non-compliance had not been fully addressed, the overall position had significantly improved. It was agreed to close this action.

Action 9.1.11 SFRS Progress Update/Management Response Sickness Absence Management (27/06/2023) and Action 7.2.3: SFRS Progress Update/Management Response (29/10/2024): Action 9.1.11 to be reopened to ensure the audit trail was not lost and Action 7.2.3 would be subsumed into this action. Action 7.2.3 to be closed.

Action 15.2.2 Anti-fraud/Whistleblowing Update (26/03/2024): It was noted that the original desktop review had become a more substantive review. Action to remain open until the next meeting to allow the revised Whistleblowing policy and summary for changes to be presented.

Action 7.2.3 SFRS Progress update/Management Response (29/10/2024): Agreed to incorporate into Action 9.1.11 (see above) and close.

Action 10.1.5 Risk Report Update (29/10/2024): LB noted that there was a significant review ongoing within Operations Control and she was unaware of any issues with extracting the data. It was noted that a report would be submitted to the People Committee on 6 March 2025 and feedback on that would be provided to this Committee in due course.

6.2 **The Committee noted the updated Action Log and approved the removal of completed actions.**

7 INTERNAL AUDIT

7.1 **SFRS Internal Audit Progress Report 2024/25**

7.1.1 JF presented a report to the Committee which summarised the progress on the delivery of the 2024/25 Internal Audit Plan and the following key points were highlighted:

- Overall the 2024/25 Plan remains on track for completion by 31 March 2025. Small adjustment made to the timeline for the Anti-Fraud Arrangements audit but remains on course for presentation at the next meeting (8 April 2025).
- Briefing Note relating to the new Global Internal Audit Standards (December 2024) was provided for information and notification of a future Public Sector webinar.

7.1.2 In regard to the Anit-Fraud Arrangements audit, SOD commented on the discussions with Azets to ensure that the audit was both helpful and offered improvement pathways.

7.1.3 **The Committee scrutinised the progress report.**

7.2 SFRS Progress Update/Management Response

7.2.1 This report was presented to the Committee and outlined the status of the recommendations raised by Internal Audit and the following key points were highlighted:

- Seven actions were added, and 8 actions had been closed during this reporting period.
- Thirty-seven actions remain open however, since the submission of the report a further 4 actions had been closed or awaiting final evidence and would be confirmed at the next meeting.

7.2.2 The Committee noted that most of the open actions had the timescales of March 2025. The Committee queried whether the Service were being realistic in terms of fully understanding the initial recommendation and managing the prioritisation and resources appropriately to address the action required. JF reminded the Committee of some reasons why timescales may not have been achieved.

7.2.3 SOD highlighted the improvements and the work undertaken over the last year to close older actions. It was noted that the majority of the 37 open actions were reporting green which was a positive position. Noting the Committee's comments, SOD advised that the Service remained committed to addressing and closing all actions as timeously as possible.

7.2.4 **The Committee welcomed the update and the progress being made.**

7.3 Introduction and Approach to Internal Audit Plan 2025/26

7.3.1 BB introduced Claire Robertson and Sean Morrison from BDO, who have been appointed as the Service's new Internal Auditors from 1 April 2025. BB referenced previous discussions with CR on the approach to the 2025/26 audit plan. CR outlined the process and steps being undertaken to finalise the drafting of the 2025/26 audit plan. The draft plan would be discussed at the Committee's workshop on 19 February 2025 ahead of its formal presentation at the next meeting (8 April 2025).

7.3.2 SS informed the Committee of early discussions with BDO which focused on continuous improvement and supporting the Service in achieving this.

7.3.3 On behalf of the Committee, BB thanked JF and the wider Azets team for their support and contributions throughout their tenure.

7.3.4 **The Committee noted the verbal report.**

(C Fitzpatrick joined the meeting at 1035 hrs)

8 AUDIT AND RISK ASSURANCE COMMITTEE QUARTERLY PERFORMANCE Q2 2024/25

8.1 CF presented the Committee with the second quarter performance of KPIs 35–42 for fiscal year 2024/25 for scrutiny. KPIs 58-61, 64 and 65 were only reported annually as part of the fourth quarter report. The following key points were highlighted:

- Exception variation within KPI36 (Subject Access within timeframe) due to the target not being achieved for over 14 months and further decline outwith the lower limits of normal variance.
- Exception variation within KPI40 (Invoice in 30 days) due to decline in past performance.
- Exception variation within KPI42 (Service desk request within SLA) due to the second consecutive quarter's decline to below lower limit.
- No KPIs were deteriorating or improving (long term).
- No change to performance level within KPI38 (FOI within timeframe) which has been below target for several years.

8.2 In regard to KPI36 and KPI38, CF noted that concerns with resources were a factor for both.

8.3 In regard to KPI41, the Committee sought clarity on the "not known" status of this indicator. CF advised that some historic data (2023/24) had been inaccurate and as such there was not enough sufficient data available to determine any improvement/deterioration. CF noted that quarterly reporting would still be possible, however it would be another 3 or 4 quarters before there was sufficient data to determine performance levels. It was noted that the Committee could take assurance that quarterly targets were being met despite the inability to determine longer term performance levels. Consideration to be given to include explanatory narrative within future reports to aid understanding.

8.4 In regard to KPIs which were annually reported, the Committee queried whether there were arrangements to monitor performance throughout the year. CF noted that monitoring may be available locally and was only submitted at the relevant time. SOD advised that formal performance reporting was captured through other reporting methods such as Strategic Asset Management Plan Annual Review, Annual Accounts and Outturn Reports. The Committee noted that the new PMF would have to take account of annual reporting and the interim arrangements for monitoring and reporting.

8.5 In regard to the new PMF and KPIs, the Committee queried the level and process for engagement. SS noted that both the Strategy and PMF were being reviewed and a series of workshops for Board/Committees would be held to develop indicators to support the Strategy. Consideration would be given to identify indicators which would monitor compliance, performance and provide assurance. CF noted that this issue would be discussed at the Integrated Governance Forum later today.

8.6 **The Committee scrutinised the report.**

(C Fitzpatrick left the meeting at 1050 hrs)
(C Wade joined the meeting at 1050 hrs)

9 FREEDOM OF INFORMATION UPDATE

9.1 CW presented an update on the actions taken in respect of the Level 2 Intervention opened by the Office of Scottish Information Commissioner (OSIC) in relation to the Service's compliance for scrutiny. The following key points were highlighted:

- Inability to maintain targets due to increased volume and complexity of requests, increased subject access requests and long-term resourcing issues.
- Level 2 intervention was served by OSIC to support the Service to improve performance and resolve any issues.
- Action plan has since been developed and shared with OSIC.

- Regular meetings with OSIC are arranged to monitor progress as well as monthly updates to the Strategic Leadership Team.
- Temporary resources have been secured and some improvements on statutory response times have already been made.

9.2 The Committee commented on resources being a factor in the situation and queried how the Service identified, prioritised and addressed resourcing issues. SS advised that Directors had the responsibility for ensuring appropriate resources within their respective areas and the ability to realign resources appropriately. Business cases could also be developed however these would impact financial spend. SS noted that the Strategy was being developed and this would outline the Service's priorities. This would also reinforce the need to review corporate services to ensure delivery of organisational needs and priorities. AW informed the Committee of the resourcing tool being developed to capture both change and business as usual (BAU) activities which would aid understanding of resource and capacity issues and better inform decision making in this area.

9.3 In regard to the review of BAU requests for personal record files, CW advised that training had been delivered to the People Directorate on identifying and explaining the difference between subject access requests and BAU requests for personal records.

9.4 In regard to proactive publishing information, CW confirmed that the Service were actively doing this through the publication scheme. CW noted that the Information Governance team were committed to identifying and publishing additional information and were raising awareness within all Directorates on proactively publishing information.

9.5 The Committee asked for consideration to be given for an annual compliance report which would include FOI requests, trends, etc to be developed for information and to improve their understanding. To be discussed further outwith the meeting.

ACTION: BB/MMcA

9.6 In regard to the interim measures put in place for reviews, CW explained that the existing recording system was not functioning properly. To avoid any requests for reviews being overlooked, applicants were being asked to submit their requests to an alternative email address. CW noted that a new system was currently being explored.

9.7 The Committee requested that the OSIC Level 2 Intervention Letter and subsequent action plan be circulated for information.

ACTION: CW

9.8 The Committee commented on formal subject access requests being made by current and former staff members to access their personal information. To be discussed further under Agenda Item 11.2 Risk Spotlight Pension Remedy.

9.9 **The Committee scrutinised the report.**

(C Wade left and M Oliphant joined the meeting at 1120 hrs)
(Meeting broke at 1120 hrs and reconvened at 1130 hrs)

10 QUARTERLY UPDATE OF GIFTS, HOSPITALITY AND INTERESTS POLICY

10.1 DJ presented the Gifts, Hospitality and Interests Policy and Quarterly Update (Q3 2024/25) to the Committee for scrutiny. The following key points were highlighted:

- Total number of entries and declarations in this reporting period.
- Additional checks undertaken following the financial donation for Christmas decorations etc for use in community development/enhancement.
- High level of staff completing the LCMS Gifts, Hospitality and Interest module.
- Continued staff engagement to raise awareness and understanding.

- Change in reporting template to include risk appetite and the continued development in future reports.

10.2 The Committee noted and welcomed the inclusion of the risk appetite and supporting narrative within the Q3 report.

10.3 The Committee commented on the positive improvements, increasing level of awareness, understanding and declarations being made within the Service and commended the efforts made to achieve this.

10.4 In regard to declarations of interests, DJ advised the Committee that awareness of individual's responsibility would continue to be highlighted through staff engagement and the LCMS module. Brief discussion took place on the alternative option which would require all staff to submit an annual non-interest declaration and this would be discussed further outwith the meeting.

ACTION: DJ

10.5 **The Committee scrutinised the report.**

11 INTERNAL CONTROLS UPDATE

11.1 **Risk Report Update**

11.1.1 DJ presented the risk report and dashboard to the Committee for scrutiny. The following key points were highlighted:

- Inclusion of risk appetite and alignment to the risk rating and control measures.
- Going forward actions would remain open until sufficient evidence was provided.
- Corporate reporting template would be amended to help alignment of risk and risk appetite.
- Fifteen risks currently rated 15 or above and associated controls which were regularly reviewed and/or updated.
- Six new risks had been identified.
- Regular engagement with all directorates to ensure that risks and control measures remain relevant and accurate.
- Timescales of RAG status remains unchanged and continues to be aligned to internal audit process. To be discussed with BDO prior to any amendments being made.
- Within the covering report, SOD001 control measures were not accurate. Reference should be made to the Appendix for accurate information.

11.1.2 Within the Committee's advance questions, reference was made to technical jargon and acronyms within the report. DJ noted the comments and would request that these are simplified and explained in future reports.

11.1.3 DJ advised the Committee that future risk reports will be aligned to risk appetite with Section 5.1, identifying an alignment to the Service's Risk Appetite on Compliance.

11.1.4 In regard to the summary of risk appetite ranges table, the Committee discussed the merit of this table. DJ advised that this table would not be included in future reports and had been provided for continuity purposes within this report.

11.1.5 The Committee commented on the report focusing on lower risk levels. The report does not account for being risk positive on risks with lower that targeted risk ratings and the need for the Service to be ambitious/bold in some areas.

11.1.6 DJ agreed to provide a full list of risks, including lower-level risks, to the Committee for their awareness.

ACTION: DJ

11.1.7 The Committee noted that the inclusion of a summary analysis of lower-level risks in future reports would be helpful. Further discussion to be held outwith meeting.

ACTION: DJ

11.1.8 In relation to the assurance levels on control actions, DJ advised that these levels align to the risk register however, wider development work was ongoing for better alignment with the Good Governance Framework. The Committee noted that whilst assurance levels on the control actions may be positive, the level of the risk may not be and consideration could be given to the presentation of this information.

11.1.9 DJ agreed to circulate more information on the wider range of alignment between risks and risk appetites. DJ reminded the Committee of the information available via the risk dashboard.

ACTION: DJ

11.1.10 The Committee noted and welcomed the introduction of the risk appetite information with the risk report and additional feedback on formatting of the report would be provided outwith the meeting.

11.1.11 **The Committee scrutinised the report and noted the continuing progress being made.**

(L Gaja joined the meeting at 1210 hrs)

11.2 **Risk Spotlight: POD015 Pension Remedy**

11.2.1 For transparency, SS, AW and CC declared their interest in this agenda item and noted that there was no conflict of interest so could contribute to the discussion.

11.2.2 With reference to earlier discussions relating to personnel submitting subject access requests to gain access to their personal files, LG outlined the process and the information available. LG noted that the People Directorate and Information Governance team were working to raise awareness of the correct route to be used by staff.

11.2.3 LG presented the risk spotlight on POD015 Pension Remedy to the Committee for scrutiny. The following key points were highlighted:

- Three separate pension workstreams were being progressed concurrently as a result of successful legal challenges relating to pension arrangements.
- The Matthews O'Brien and Booth Bradshaw were specific to fire and rescue services and relate to options to purchase additional pensionable service for specific periods.
- The McCloud Sargeant impacts on the wider public sector and relates to age discriminatory or provision around the transition from final to average salary schemes.
- Scottish Public Pensions Authority were responsible for implementing the complex remedies, however SFRS were supporting the development of the approach to these matters and communications to staff.
- Capacity and resource challenges within both SPPA and SFRS.
- Risk spotlight was presented to the People Committee (December 2024).

11.2.4 In regard to the ongoing legal challenge to extend the terms of the Matthews O'Brien pension remedy, LG noted that should this be successful, it could result in a 3rd options exercise being undertaken.

11.2.5 The Committee recognised the impact on individuals and queried whether the true level of dissatisfaction was understood. LG noted that a specific subset of individuals were particularly impacted due to being at risk of exceeding annual allowance limits and being unable to provide self-assessments to HMRC. Discussions had taken place with SPPA regarding manual calculations being provided ahead of the 31 January deadline and a substantive response had not yet been received. LG further noted that individuals

approaching or considering retirement could also be affected by increased timescales in receiving their pension calculations. Some retired individuals were also affected as remedy statements from SPPA were required in order for informed decisions to be made on which scheme they would like their benefits to be paid from.

11.2.6 The Committee queried whether the Service was in a position to provide a safety net or assurances to affected individuals. LG advised that the Service were not in that position. The Service would provide limited updates on timescales and to signpost individuals to SPPA. LG stated that the Service could not provide advice on pension matters. LG noted that the Service would continue to work closely with SPPA to ensure that all lines of communications were aligned.

11.2.7 LG offered her opinion in relation to SPPA efforts to date, which included the systems development and recruitment.

11.2.8 LG advised that she was not aware of individuals making decisions due to inaccurate information, however, there were some instances of decisions being made on inaccurate timescales.

11.29 Noting the additional internal resources assigned in November/December 2024, the Committee queried whether the Service had been slow to act. LG advised that the timescale for securing the additional resources were appropriate and aligned with plans developed by SPPA.

11.2.10 Due to the significance of this subject matter, the Committee noted that periodic reporting would be appropriate. It was recognised that the People Committee would be the appropriate governance pathway and were already monitoring this issue. Consideration to be given to formal reporting to the Board.

11.2.11 **The Committee scrutinised the report.**

(L Gaja left the meeting at 1235 hrs)

11.3 **Anti-fraud/Whistleblowing Update**

11.3.1 SOD noted that there were no issues to report.

11.3.2 **The Committee noted the verbal report.**

12 REPORT FOR INFORMATION ONLY:

12.1 Quarterly Update Report on HMFSI Business

12.1.1 GF presented the quarterly report to the Committee to provide an update on HMFSI's inspection and reporting activity during 2024/25. The following key areas were noted:

- Ongoing work on the North Service Delivery Area inspection with fieldwork anticipated to complete within the next few months.
- Fieldwork ongoing for the Organisational Culture inspection.
- Fieldwork has restarted for the Operational Assurance inspection and would conclude in February 2025.
- Chief Inspector's Plan 2025-2028 was currently out for formal consultation and was anticipated to be published in April 2025.

12.1.2 **The Committee noted the report.**

13 REVIEW OF ACTIONS

13.1 CC confirmed that 3 formal actions were recorded during the meeting.

14 FORWARD PLANNING

14.1 **a) Committee Forward Plan Review**

14.1.1 The Committee considered and noted the Forward Plan.

14.2 **b) Items for Consideration at Future IGF, Board and Strategy Days Meetings**

14.2.1 The following items were identified for a future Integrated Governance Forum:

- Environmental Management report (to be raised on 23 January 2025)
- Development of new Performance Management Framework (to be raised on 23 January 2025)

14.2.2 No further items were identified.

15 DATE OF NEXT MEETING

15.1 The next public meeting is scheduled to take place on Thursday 8 April 2025 at 1000 hrs.

15.2 There being no further matters to discuss the public meeting closed at 1240 hrs.

(Public meeting broke at 1240 hrs and reconvened in Private session at 1245 hrs)

PRIVATE SESSION

16 MINUTES OF PREVIOUS PRIVATE MEETING

16.1 **Tuesday 29 October 2024**

16.1.1 The minutes of the private meeting held on 29 October 2024 were approved as a true record of the meeting.

17 ACTION LOG

17.1 The Committee considered the action log, noted the updates and agreed the closure of actions.

17.2 **The Committee noted the updated Action Log and approved the removal of completed actions.**

18 CYBER SECURITY MATURITY ASSESSMENT

18.1 PK presented the Committee with Cyber Security Maturity Assessment 2024 report, which included the summary of key recommendations and action plan for scrutiny.

18.2 **The Committee scrutinised the report.**

On behalf of the Committee, the Chair extended his thanks to Interim Deputy Chief Officer Corporate Services, Liz Barnes, for her commitment and contributions. The Committee wished her well for her imminent retiral.

There being no further matters to discuss the private meeting closed at 1325 hrs.

Agenda Item 6

AUDIT AND RISK ASSURANCE COMMITTEE
ROLLING ACTION LOG

SCOTTISH FIRE AND RESCUE SERVICE
Working together for a safer Scotland

Background and Purpose

A rolling action log is maintained of all actions arising or pending from each of the previous meetings of the Committee. No actions will be removed from the log or completion dates extended until approval has been sought from the Committee.

The status of actions are categorised as follows:

- Task completed – to be removed from listing
- No identified risk, on target for completion date
- Target completion date extended to allow flexibility
- Target completion date unattainable, further explanation provided.

Actions/recommendations

Currently the rolling action log contains 11 actions. A total of 9 of these actions have been completed.

The Committee is therefore asked to approve the removal of the 9 actions noted as completed (Blue status), note one action categorised as Green status and note one action categorised as Yellow status on the action log.

AUDIT AND RISK ASSURANCE COMMITTEE
ROLLING ACTION LOG

Minute Ref	Action	Lead	Due Date	RAG Status	Completion Date	Position Statement
Meeting Date: 27 June 2023						
9.1.11	**SFRS Internal Audit Progress Report 2023/24** - **Final Report – Sickness Absence Management:** Committee request to see what will be put in place for the significant control weaknesses identified and for ongoing compliance/ sample testing, for each recommendation or management action contained within. **Further action raised during 29 October 2024 meeting**: **Action 7.2.3 SFRS Progress Update/Management Response:** Recommendation 1.1 and 4.2 (Sickness Absence Management), clarity on the reason for the delay and whether there were any concerns regarding record keeping in the interim and what assurances could be provided. Further assurance to be provided on the anticipated improvements following the implementation of the new system. Update to be circulated via email.	**LBa**	**January 2025 (October 2023)**		**April 2025** ~~January 2025~~ ~~March 2024~~ ~~December 2023~~	**Updated (30/10/2023):** Managers guidance is currently being updated, along with reminder communications for managers of the procedures and their responsibilities under the Attendance Management Policy and Procedures, including for the completion of E-self-certs, ensuring fit notes cover whole of absence period, submission, and storage (single source) of fit notes and other absence documentation and undertaking/ recording of Attendance Support Meeting (ASM). Revisions being made to the middle manager development sessions, develop the inclusion of a managing absence toolkit in the management induction toolkit, as well as to the local and supervisory management development training to incorporate return to work interviews and attendance support meetings. Discussions underway with SDA DACO's and Risk & Audit colleagues to consider an independent process for managers vetting of case work within their areas or alternative options for future auditing which may assist in providing similar assurance. **Complete (18/01/2024):** Of the 5 outstanding actions, 4 are due to be complete by 31 December 2023 (following an extension to 3 of these) and are on track to do so. A request to extend the remaining action to Q1 2024/25 will be

						made to enable further discussions with Risk & Audit colleagues on a verification/QA process to provide future assurance that the completed actions have addressed the weaknesses identified. The detailed actions and progress updates are provided within the Audit Action report itself. **REOPENED (18/01/2023):** Further clarification to be provided that the action has been fully addressed. **Complete (26/03/2024):** Of the 6 actions identified, 3 have been accepted as closed by Azets and one is under consideration for closure. Recommendations 1.1 and 4.2 remain outstanding and a revised date of 30 April 2024 has been requested. Both are 90% complete, with a range of activity being progressed to update management guidance and development packages to ensure responsibilities and accountability are understood. To conclude the recommendations discussions have been taking place between the People Directorate and Audit & Risk colleagues regarding development of an independent periodic verification process for compliance, this is at an early stage and will be progressed during Quarter 4. **REOPENED (26/03/2024):** LB confirmed that this action should remain open. **Updated (25/06/2024):** Two actions remain open. Discussion around the development of an independent periodic verification process of compliance (all absence management file documentation being complete and recorded in e-PRF) between People and Audit & Risk commenced in Quarter 4. There have been some delays to developing a proposed process and approach due to

						competing priorities and some associated actions required related to GDPR and storage of documentation in centralised location however, it is anticipated that this will be completed in Q1. **Update (29/10/2024):** Two actions remain in progress. Work is progressing to complete activities related to GDPR and document storage before the remaining audit actions can be closed. Both actions have a due date of 31 December 2024 on the audit action plan. **Closed (23/01/2025):** Update provided against action at meeting date on 29 October 2024 (minute ref 7.2.3). As Action 7.2.3 (raised on 29 October 2024) below is related, proposal for this action to be closed. **REOPENED (23/01/2025):** Original action to remain open. Subsequent Action 7.23 (raised at 29 October 2024) to be merged to ensure audit trail is lost. **Update (23/01/2025) provided for Action 7.2.3:** Delays have been due to the inability at this stage to move to one single source for storage of absence data due to GDPR issues which are currently being worked through as part of a separate project. Meantime, specific actions have been progressed in Q3 2024/25 to address the outstanding requirements of Recommendations 1.1 and 4.2 of the Sickness Absence Management internal audit, with evidence being submitted to Azets in December in respect of these. Recording of absence data and records forms part of the Statement of

						Requirements for the PPFT and will be considered further within the Discovery Phase of reviewing the SG Oracle solution. **Complete (08/04/2025):** Azets have now considered all evidence regarding steps taken to address the 2 outstanding actions and are content that these have been closed with appropriate arrangements in place to mitigate the risk. This audit action plan is now complete and it is proposed that this action is also closed.

Minute Ref	Action	Lead	Due Date	RAG Status	Completion Date	Position Statement
Meeting Date: 26 March 2024						
15.2.2	**Anti-fraud/Whistleblowing Update:** SO'D agreed to review whether the Whistleblowing Policy was up to date and feedback	**SO'D**	**January 2025 (June 2024)**		**April 2025**	**Update (25/06/2024):** The SFRS Whistleblowing Policy is due for formal review in 2026. However, a desktop review will be carried out to ensure that the policy wording remains fit for purpose in the context of the recent issues raised related to fraud. **Update (29/10/2024):** The desktop review of the Whistleblowing Policy has not yet commenced due to competing priorities within the People Directorate. The completion date for this action has been extended until 31 March 2025. **Further Update (29/10/2024):** Committee requested that the review be undertaken before the January ARAC meeting. **Update (23/01/2025):** A desktop review of the Whistleblowing Policy commenced

						in Q3 to ensure this remains fit for purpose and take account of learnings from the recent fraud incidents. This will include refresher comms to ensure familiarisation of the revised Whistleblowing Policy and its purpose later in Q4. This will reflect the Whistleblowing Policy, the Safecall service and other complaints routes available to SFRS colleagues and clarify the distinctions between each. **Complete (08/04/2025):** A report has been prepared for the Committee on 8 April on the reviewed Whistleblowing Policy

Minute Ref	Action	Lead	Due Date	RAG Status	Completion Date	Position Statement
Meeting Date: 25 June 2024						
9.1.23	**IA report on Partnerships:** Provide assurance that relationships as defined within the Community Justice Act are understood throughout the service.	**MMcA**	**March 2025 (October 2024)**			**Update (29/10/2024):** Work has commenced to provide a principle-based guidance document that clearly defines our responsibilities/expectations with regard to partnership working and the reporting of such work. It is anticipated that this document will be developed by 31 March 2025. **Update (23/01/2025):** Work continues on the development of a principle-based guidance document that clearly defines our responsibilities/expectations with regard to partnership working. This document will include specific reference to the roles and responsibilities outlined within the Community Justice (Scotland) Act 2016. This work is running behind schedule as the Team's focus has been

						on the development of the SFRS Strategy 2025-28. It is anticipated, however, that a first draft of the partnership guidance document will be shared for feedback across the Service by March 2025. **Update (08/04/2025):** Due to the expediated development of the SFRS Strategy 2025-28 and the current focus on the associated Three-Year Delivery Plan and Performance Management Framework. We have had to prioritise the workload and it is anticipated that that this document will be published in September 2025.

Minute Ref	Action	Lead	Due Date	RAG Status	Completion Date	Position Statement
Meeting Date: 29 October 2024						
7.1.27	**Internal Audit Report on Environmental Management:** SO'D and NM would discuss and identify good reporting to Committee/Board around sources of environmental issues including funding.	**SO'D & NM**	**January 2025**		**April 2025**	**Update (23/01/2025):** We are working on agreeing the scope of items to include within the environmental update report. Meeting with Head of Asset Management, Environment Manager and Board Member (Neil Mapes) to be arranged to progress this matter further. **Complete (08/04/2025):** A meeting was held and it was agreed that the contents of the Service Delivery Board report are suitable for an ARAC paper. Any specific areas that are not included can be added as requested by the Committee.
10.1.5	**Risk Report Update:** Further analysis of attrition rate data for OC staff and other staffing groups to be provided to the People Committee	**LB**	**January 2025**		**April 2025**	**Update (23/01/2025):** Workforce Planning (WFP) have engaged with Operations Control (OC) to obtain the OC abstraction data, with a report to be

						compiled for People Committee on 6 March 2025 and will include the abstraction reasons and mitigating actions. **Complete (08/04/2025):** Report presented to People Committee and well received. Overview of abstraction and mitigating actions provided, supported by data from People and Central Staffing. Propose action is closed.

Minute Ref	Action	Lead	Due Date	RAG Status	Completion Date	Position Statement
Meeting Date: 25 January 2025						
9.5	**Freedom of Information Update:** The Committee asked for consideration to be given for an annual compliance report which would include FIO requests, trends, etc to be developed for information and to improve their understanding. To be discussed further outwith the meeting.	**BB/ MMcA**	**April 2025**			**Update (08/04/2025):** An annual FOI compliance report will be prepared and presented to the committee at its June 2025 meeting.
9.7	**Freedom of Information Update:** OSIC Level 2 Intervention Letter and subsequent action plan be circulated for information.	**CW**	**January 2025**		**January 2025**	**Complete (08/04/2025):** OSIC Intervention letter and response action plan was circulated to the Committee by email on 24 January 2025.
10.4	**Quarterly Update of Gifts, Hospitality and Interests Policy:** Brief discussion took place on the alternative option which would require all staff to submit an annual non-interest declaration and this would be discussed further outwith the meeting.	**DJ**	**April 2025**		**April 2025**	**Complete (08/04/2025):** Discussion took place between BB and DJ to consider best practise and ability to undertake and maintain an annual process. Agreed to continue work in relation to interests through LCMS, UIG's and engagement through DMT's, rather than a requirement for an annual declaration.

11.1.6	**Risk Report Update:** DJ to provide a full list of risks, including lower level risk, to the Committee for their awareness.	**DJ**	**January 2025**		**January 2025**	**Complete (08/04/2025):** Table of aligned Directorate risks with the new risk appetite statement was circulated to the Committee by email on 24 January 2025.
11.1.7	**Risk Report Update:** The Committee noted that the inclusion of a summary analysis of lower-level risks in future reports would be helpful. Further discussion to be held outwith meeting.	**DJ**	**April 2025**		**April 2025**	**Complete (08/04/2025):** A revised risk report has been provided for the meeting of 8 April for comment and/or review.
11.1.9	**Risk Report Update:** DJ agreed to circulate more information on the wider range of alignment between risks and risk appetites. .	**DJ**	**April 2025**		**April 2025**	**Complete (08/04/2025):** A revised risk report has been provided for the meeting of 8 April for comment and/or review.

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/09-25

Agenda Item: 7.1

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**08 APRIL 2025**							
Report Title:	**SFRS INTERNAL AUDIT PROGRESS REPORT 2024/25**							
Report Classification:	**For Scrutiny**	**Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	To provide a summary of progress in the delivery of the 2024/25 Internal Audit plan.
2	**Background**
2.1	This report is intended to enable the Audit and Risk Assurance Committee (ARAC) to consider the progress to date in the delivery of the audit plan for 2024/25.
3	**Main Report/Detail**
3.1	To provide confirmation of the progress made in relation to all audits contained within the 2024/25 agreed audit plan.
4	**Recommendation**
4.1	ARAC is asked to scrutinise the content of the report.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk** The internal audit programme forms part of the Service's Assurance Framework.
5.2 5.2.1	**Financial** There are no direct implications associated with the report.
5.3 5.3.1	**Environmental & Sustainability** There are no direct implications associated with the report.
5.4 5.4.1	**Workforce** There are no direct implications associated with the report.
5.5 5.5.1	**Health & Safety** There are no direct implications associated with the report.
5.6 5.6.1	**Health & Wellbeing** There are no direct implications associated with the report.
5.7 5.7.1	**Training** There are no direct implications associated with the report.

5.8 5.8.1	**Timing** The report notes progress in relation to audits to be undertaken in the 2024/25 financial year.
5.9 5.9.1	**Performance** Internal audit is intended to support the service and where relevant identify areas where performance can be enhanced.
5.10 5.10.1	**Communications & Engagement** Individual reports are issued and agreed with management for each of the audit assignments contained within the annual plan and are presented separately to the Audit and Risk Assurance Committee throughout the year.
5.11 5.11.1	**Legal** There are no direct implications associated with the report.
5.12 5.12.1	**Information Governance** Collection or use of personal data has not been required in the preparation of the Progress Report. For this reason, a Data Protection Impact Assessment has not been required.
5.13 5.13.1	**Equalities** For each audit assignment, relevant directors need to consider whether an Equality and Human Rights Impact Assessment is applicable**.**
5.14 5.14.1	**Service Delivery** There are no direct implications associated with the report.
6	**Core Brief**
6.1	Not applicable
7	**Assurance (Board/Committee Meetings ONLY)**

7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial~~**/Reasonable/**~~Limited/Insufficient~~
7.2	**Rationale:**	Azets are providing ARAC with an update on the progress of the audits within the IA plan for the year and identifying any specific recommendations for each audit completed.

8	**Appendices/Further Reading**
8.1	Appendix A: Internal Audit Progress Report Appendix B: Final Report- Anti Fraud Arrangements

Prepared by:	Jamie Fraser, Manager - Azets
Sponsored by:	Sarah O'Donnell, Director of Finance and Contractual Services
Presented by:	Gary Devlin, Partner - Azets

Links to Strategy and Corporate Values
Working Together for a Safer Scotland

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Audit and Risk Assurance Committee	*08 April 2025*	*For scrutiny*

APPENDIX A

Scottish Fire and Rescue Service

Internal Audit Progress Report

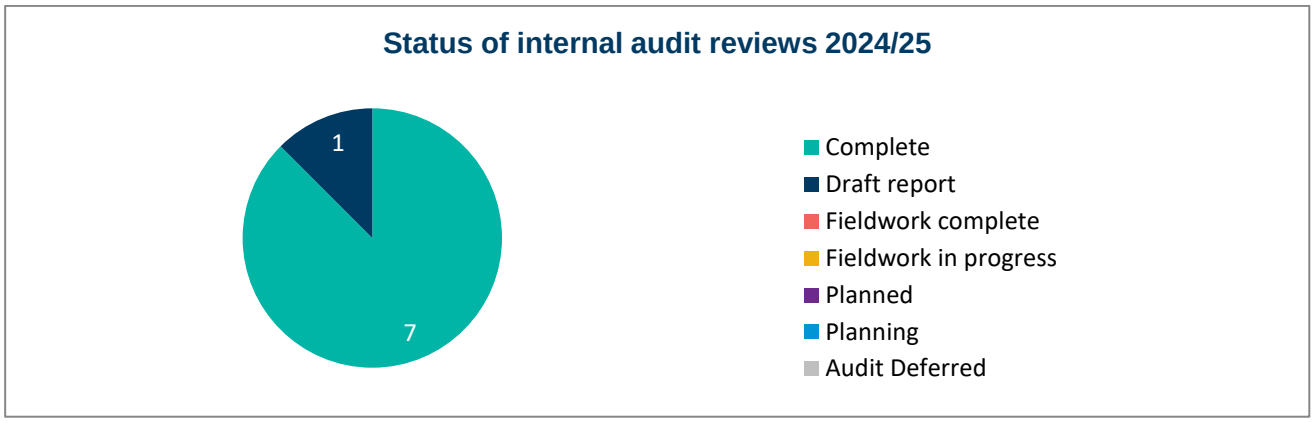
April 2025

Scottish Fire and Rescue Service

Internal Audit Progress Report

Summary

This paper provides the Audit and Risk Assurance Committee with a summary of activity in relation to the 2024/25 internal audit programme.



Action for Audit and Risk Assurance Committee

The Audit and Risk Assurance Committee is asked to note the contents of this report. We also invite any comments on the format or content of this report.

Gary Devlin, Audit Partner	gary.devlin@azets.co.uk	0131 473 3500
Jamie Fraser, Manager	jamie.fraser@azets.co.uk	0141 567 4500

2024/25 audit plan progress

Ref and Name of report	Days	Current status	Planned ARAC	Actual ARAC
C9. Anti-Fraud Arrangements	35	Complete	Jan 25 *See note 2 below*	Apr 25
C10. Environmental Management	20	Complete	Jan 25	Oct 24
C11. Change Management	30	Draft Report	Apr 25	
E3. Cyber Security	25	Complete	Oct 24 *See note 1 below*	Jan 25
F1.1 Follow Up Q1	2.5	Complete	Jun 24	Jun 24
F1.2 Follow Up Q2	2.5	Complete	Oct 24	Oct 24
F1.3 Follow Up Q3	2.5	Complete	Jan 25	Jan 25
F1.4 Follow Up Q4	2.5	Complete	Apr 25	Apr 25
G1. Annual report	n/a	n/a	Jun 25	

1) *The Cyber Security audit was originally intended to be presented at the October 2024 ARAC meeting but was delayed and the Environmental Management audit report brought forward.*
2) *The Anti-Fraud Arrangements audit was originally intended to be presented at the January 2025 ARAC but was delayed due to later commencement of fieldwork than planned. Additionally, an element of the fieldwork involved a staff survey which took longer than expected to complete. An initial draft report was issued to management on 29 November 2024, with a revised version issued on 5 December 2024 following receipt of further information. A meeting was held with management on 17 December 2024 which resulted in the receipt of additional evidence and further amendments.*
3) *The Change Management audit was originally intended to be presented at the April 2025 ARAC meeting. However, this report has been delayed. The draft report was issued on 18 February 2025.*

Key:	Description
Complete	Audit work complete and report has been agreed and finalised
Draft report	A draft report has been issued
Fieldwork complete	The audit work is complete but the draft report has not yet been issued.
Fieldwork in progress	The audit work is in progress.
Planned	The scope and timing of the audit has been agreed with management
Planning	The scope and/or timing of the audit has yet to be agreed with management
Audit deferred	Audit assignment deferred to following year

KPI status

KPI description	Performance standard	Status	Comments
1. Actual v planned hours per audit	Audits completed within days approved by ARAC	GREEN	
2. Cost of service by grade	Allocation of time per grade as agreed with management and provided for approval prior to invoicing	GREEN	
3. Cost per audit	Costs per audit based on allocated staff undertaking audits	GREEN	
4. Completion of customer feedback on each audit demonstrating satisfactory performance	Risk and Audit Manager to hold post audit discussion with key contacts	GREEN	

Key

RED	More than 15% away from target
AMBER	Within 15% of target
GREEN	Achieved

Global Internal Audit Standards

In January 2024, The Institute of Internal Auditors (IIA) published their updated Global Internal Audit Standards governing how internal audit activities are undertaken and assessed. This publication comes after a multi-year process to improve and refine the previous Standards, published in 2017. (globalinternalauditstandards_2024january9_printable.pdf (theiia.org))

The Standards provide guidance and best practice for internal audit professionals worldwide and the updated version introduces significant additions focused on continuing to improve the quality of internal audit services. Amongst other changes, they emphasise the importance of internal audit acting in the public interest and of delivering organisational value and seek to reinforce the importance of the Board/Audit Committee and Senior Management's role in working with, supporting, and championing the internal audit function.

The new standards will supersede the current Public Sector Internal Audit Standards (PSIAS). The UK Public Sector internal Auditing Standards Advisory Board (IASAB) also issued sector specific interpretations in December 2024 to make them suitable for UK Public Sector use. The IASAB have intimated an adoption date of 1 April 2025 for Public Sector bodies.

The key additional focus areas from the new Standards include:

- Board (or equivalent) involvement in and support for internal audit.
- Updates to the internal audit mandate, vision and strategic plan.
- An understanding of risks and coverage throughout the organisation.
- Enhanced requirement for Root Cause Analysis.
- Planning, tracking and measuring performance (e.g. efficiency and quality).
- Internal audit reporting, evaluating findings and effective communication.

There will also be new Topical Requirements and guidance to help internal audit functions on key risk areas. These include Cybersecurity, Information Technology, Governance, Privacy Risk Management, Sustainability and Environment, Social & Governance (ESG) and Third-Party Management.

We are anticipating full adoption of the new GIAS for our work at all public sector clients from 1 April 2025.

We provided a training workshop to the ARAC on 26 November 2024.

APPENDIX B

Scottish Fire and Rescue Service

Internal Audit Report 2024/25

Anti-Fraud Arrangements

March 2025

Scottish Fire and Rescue Service

Internal Audit Report 2024/25

Anti-Fraud Arrangements

Audit Sponsor	***Key Contacts***	***Audit team***
Sarah O'Donnell, Director of Finance & Contractual Services	*David Johnston, Risk & Audit Manager* *Karen Horrocks, Assistant Verification & Risk Officer* *Hazel Buttery, Fraud, Risk & Compliance Officer* *Lucy Waterman, Verification and Risk Officer*	*Gary Devlin, Audit Partner* *Gillian Callaghan, Senior Audit Manager* *Jamie Fraser, Audit Manager* *Mary Fitton, Data Analytics Manager* *Dominic O'Neill, Senior Internal Auditor* *Amy Young, Data Analytics Associate*

Disclaimer

Executive Summary

Conclusion

The Scottish Fire and Rescue Service has a zero-tolerance stance in relation to fraud. As a result, having recently reported two instances of confirmed fraud, commissioned this audit to evaluate the anti-fraud internal control environment, as well as the culture of the organisation in relation to fraud issues.

Our audit has identified several weaknesses in internal control arrangements that require attention to improve the anti-fraud culture of the organisation.

- **Policies and procedures have not been updated within their specific review period and to take account of learning opportunities from recent instances of fraud.**
- **While the Anti-Fraud and Corruption Policy includes some detail on reporting fraud, a separate Fraud Response Plan has not been documented with the required information as set out in the Scottish Public Finance Manual.**
- **A Fraud Risk Action log is in place, used to implement actions to mitigate against identified fraud risks. When sampling was carried out, only five of the 10 actions selected were supported by evidence to confirm the actions taken to mitigate these risks were in place.**
- **At the time of the audit, anti-fraud training provided via the LCMS training system was only mandatory for uniformed staff. The training was introduced in April 2024 with completion rates as at October 2024 being 72% and 42% for uniformed and non-uniform staff respectively. Management made us aware that the training would become mandatory for non-uniform staff in 2025.**
- **There are some fraud awareness raising activities carried out; however, there would be benefit to SFRS for a more formal approach which could include the development of a fraud awareness communication plan.**

Discussion of fraud related issues by the Senior Leadership Team and Audit, Risk and Assurance Committee do take place as and when required and as a standing agenda item respectively. However, the ARAC item is a verbal update, therefore, there is a missed opportunity to provide members with information on fraud related awareness activities and measures.

For the anti-fraud culture within the Scottish Fire and Rescue Service to improve, the above issues must be addressed in order to improve staff knowledge and awareness of fraud as well as to reduce the risk the issues identified present.

Background and scope

In recent months, SFRS has experienced an increase in cases of suspected fraud. As an organisation which operates from multiple sites dispersed throughout Scotland and which employs uniform as well as office staff, it is important that SFRS has comprehensive policies and procedures for all setting out its attitude towards fraud. In addition, it is essential that staff are provided with clear guidance on how to perform various aspects of their duties and that fundamental controls such as segregation of duties and authorisation controls are built into processes in order to minimise the risk of fraud. It is also imperative that all staff are aware of the Service's anti-fraud arrangements and know what to do should they suspect a fraud has taken place.

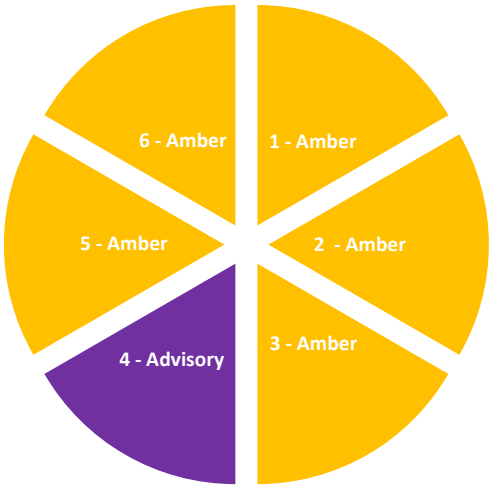
SFRS has adopted a zero tolerance stance in relation to fraud. Fraud risk assessments are completed as part of the annual governance process, with supporting awareness raising through LCMS training to staff and quarterly engagement with Heads of Function in relation to fraud assessment. Action plans completed as part of recent fraud investigations has increased awareness of fraud risks and the requirement to adhered to existing policy requirements in relation to fraud and other associated control policies, i.e. financial regulations.

In accordance with the 2024/25 Internal Audit Plan, we have performed an audit of the arrangements SFRS has in place to prevent and detect fraud and the process to be followed should an alleged fraud take place. This has included the following:

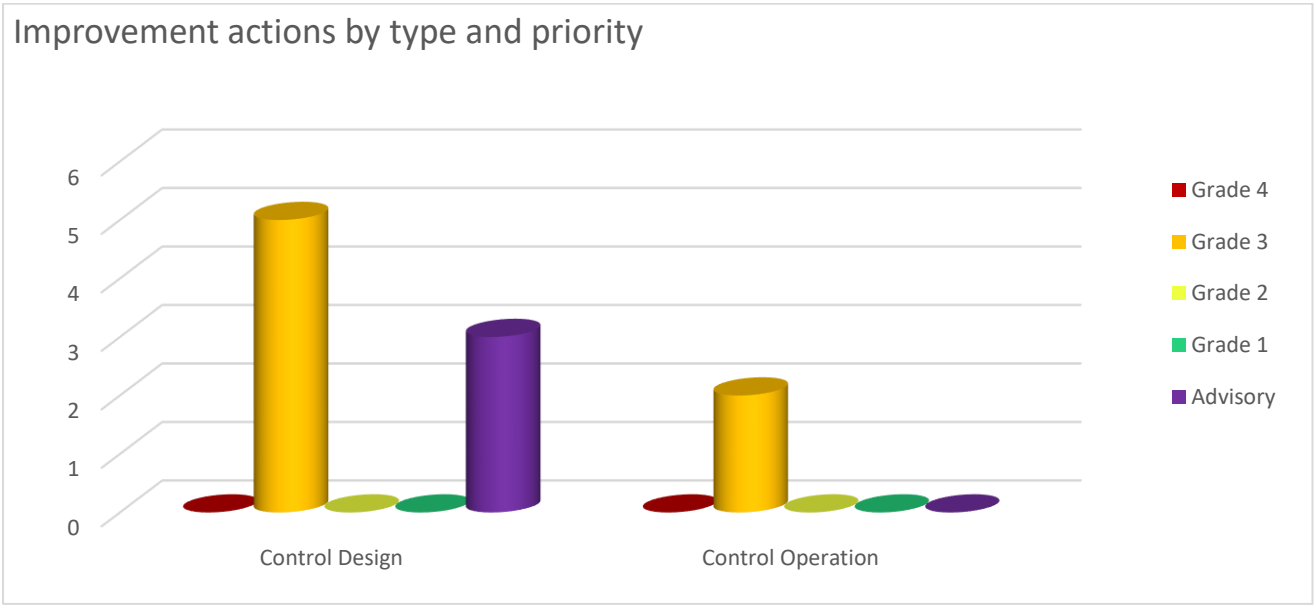
- Policies and procedures designed to promote an anti-fraud culture within SFRS e.g. Anti-Fraud & Corruption (including the arrangements in place to deal with a suspected fraud), Whistleblowing, Gifts & Hospitality, and Declaration of Interests etc.
- Arrangements for the identification and assessment of fraud risks to which the Service is exposed and the mitigating actions put in place to address them.
- Arrangements for ensuring that staff, including those working in Service Delivery Areas, have an awareness of the Service's policies and procedures in relation to fraud.
- An evaluation of the data analysis performed by the Verification team with a view to determining whether this can be developed further to support fraud detection.
- An examination of instances of alleged fraud which have recently taken place including how management responded to these and what lessons, if any were learned from this alleged fraudulent activity.
- Arrangements for reporting on fraud to SLT and the Board to ensure there is sufficient oversight and scrutiny of this area.

We have compared the anti-fraud arrangements SFRS has in place with recommended best practice and with arrangement we have observed at other public sector organisations, and where appropriate, have made recommendations for improvement to enhance the SFRS anti-fraud culture.

Control assessment



- 1. Policies and procedures exist that are designed to promote an anti-fraud culture throughout the Service. These enforce the organisation's zero tolerance stance on fraud and provide guidance on minimising the risk of fraud in their day to day operations.
- 2. Arrangements are in place for periodically conducting a fraud risk assessment which identifies potential areas for committing fraud. Fraud risks are assessed and prioritised with appropriate mitigating actions in place.
- 3. Staff awareness of SFRS's anti-fraud related policies and procedures is actively promoted to ensure staff are provided with sufficient guidance to minimise the risk of fraud and know what action to take if they suspect fraudulent activity has occurred.
- 4. Appropriate arrangements are in place to routinely analyse data produced by financial systems with a view to preventing and detecting fraudulent activity.
- 5. Appropriate action is taken in response to suspected frauds with matters investigated fully by competent individuals. Lessons learned from these investigations are taken forward with appropriate action taken to minimise the risk of reoccurence.
- 6. Appropriate reporting arrangements exist in respect of fraud in order to ensure that SLT and the Board have sufficient oversight and scrutiny of fraud-related matters.



10 improvement actions have been identified from this review, two of which relate to compliance with existing procedures, rather than the design of controls themselves. See Appendix A for definitions of colour coding.

Key findings

Good practice

- The Service has adopted a zero tolerance to fraud and undertakes fraud risk assessments as part of the annual governance process.
- The Service actively participates and reports on progress against the National Fraud Initiative, with additional engagement undertaken with Audit Scotland to continually mature the process.
- Procedures concerning Gifts, Hospitality and Interests are well known amongst staff, with the policy in place updated and reviewed on a regular basis.
- Any details of fraud investigations are kept within a Fraud Folder to which access is restricted to members of the investigating team only. Review of the records reviewed in relation to the two recent fraud cases revealed that indexes had been set up for each case in chronological order which referenced all the documentation available.
- When an alleged fraud is reported to the Risk & Audit Team, they undertake an R&A Fact Finding Exercise where they establish how the fraud took place and determine whether there were any failure in controls already in place and/or whether controls have been poorly designed which enabled to fraud to happen. Following this they draft an Internal Control Review report with the outcome of their review and recommended actions to address any weaknesses/failures in the control environment which is submitted to SLT for their consideration. Implementation of these actions is now scrutinised and tracked by the Corporate Board who should receive quarterly reports on the progress made in addressing the issues arising from the fraud.
- Review of related email correspondence and documentation in respect of the Kilmarnock fraud investigation revealed that the Service had responded promptly to the alleged fraud at the time it was discovered and had followed procedure. Moreover, disciplinary action had swiftly commenced and the matter had been reported to the police within a few days of the bank withdrawals being discovered.
- The introduction of the Verification Team and subsequent development of the interactive claim analysis dashboard has provided the basis through which additional fraud analysis can be undertaken. Development of the dashboard continues to be undertaken and interim solutions been introduced where longer terms system development is required.
- The Verification Team have a follow-up procedure for flagged potentially anomalous claims. This includes emailing line managers responsible for employees, and escalating beyond if no response is obtained from line managers. All claims flagged are investigated and the outcomes are documented with the reason for correction if needed, the value and who has proved the claim. The Verification Team uses this labelled data to further inform their approach to identifying potentially anomalous claims.
- Meetings with department management teams have been undertaken to discuss fraud and GHI across 24/25 and before this resulting in additional levels of engagement with Directorates – 1-2-1 engagement with Heads of Function in relation to Fraud Risk Assessments undertaken.
- Fraud Risk Action Plans developed and monitored following recent incidents of fraud.

Areas for improvement

We have identified a number of areas for improvement which, if addressed, would strengthen Scottish Fire and Rescue Service's control framework. These include:

- Key fraud related policies and procedures have not been updated or reviewed within their specified review cycle.
- There is no fraud response plan in place, despite this being a requirement of Scottish public sector organisations as per the Scottish Public Finance Manual.
- There are some fraud awareness raising activities carried out; however, there would be benefit to SFRS for a more formal approach which could include the development of a fraud awareness communication plan.
- At the time of the audit, anti-fraud training provided via the LCMS training system was only mandatory for uniformed staff. The training was introduced in April 2024 with completion rates as at October 2024 being 72% and 42% for uniformed and non-uniform staff respectively. Management made us aware that the training would become mandatory for non-uniform staff in 2025.
- From a sample of 10 actions from the Fraud Action Risk log, only 50% of those sampled had sufficient evidence to confirm that the actions noted to mitigate fraud risk, were being undertaken. Management confirmed that this is not currently a requirement of the process but will be going forward.
- For the Tighnabruaich fraud investigation the Director of Finance and Contractual Services was not notified in a timely manner of the suspected fraud which contravenes the SFRS's policy.
- Anti-fraud related matters are reported and discussed by both the Strategic Leadership Team (as and when required) and the Audit, Risk and Assurance Committee (as part of a standing agenda item) However, the agenda item at ARAC is a verbal update with no details provided to ARAC members on any recent awareness raising activities of anti-fraud measures.

These are further discussed in the Management Action Plan below.

Acknowledgements

The following staff were consulted during this review and we would like to thank them for their assistance and co-operation:

Meg Craigie – E-Systems Project Officer

Chris Fitzpatrick – Business Intelligence and Data Services Manager

Ellen Gayler – Senior Data Analyst

Management Action Plan

Amber

Control Objective 1: Policies and procedures exist that are designed to promote an anti-fraud culture throughout the Service. These enforce the organisation's zero tolerance stance on fraud and provide clear guidance to staff on minimising the risk of fraud in their day-to-day operations.

1.1 Lack of Policy Review

Whistleblowing, Gift, Hospitality, and Declaration of Interests policies are in place and up to date with evidence of regular amendments. However, policies and procedures relating to Anti-Fraud and Corruption are not reviewed in a timely manner.

The Anti-Fraud policy was last reviewed and approved in June 2022. The next review was due in October 2023. However, this has not taken place with the policy containing outdated references such as the individuals to report fraud to no longer being in post.

Risk

There is a risk that if policies are not updated in a timely manner, processes and guidance will become out-dated and not reflect current practice, resulting in a lack of clarity over correct processes, increased fraud risk and potential financial loss.

Recommendation

It is recommended to incorporate any lessons learned from the two confirmed instances of fraud into new versions of the policy and procedures. This should be carried out as a priority as the review and update of the Anti-Fraud and Corruption policy is a year overdue. Once the new version is published, this should be communicated to the staff within the organisation with suitable awareness raising taking place to compliment the publishing of these policies.

Management Action

Grade 3 (Design)

Review Anti-Fraud and Corruption Policy, update LCMS training module and issue suitable communication throughout the Service.

Action owner: Risk and Audit Manager **Due date:** 31 July 2025

1.2 Absence of a Fraud Response Plan

While there is some information available within the existing anti-fraud related policies to help make decisions in fraud and corruption incidents, there is no documented Fraud Response Plan in place. Within the Scottish Public Finance Manual it is stated that public bodies must draw up a fraud response plan. Without this there no formally defined way to respond consistently and effectively to suspected instances of fraud.

Risk

There is a risk that if a Fraud Response Plan is not documented, when fraud does take place, it may not be addressed in an appropriate manner resulting in poor investigation outcomes.

Recommendation

We recommend that as a priority a Fraud Response Plan is developed. This should cover several core roles, responsibilities, processes and procedures in the following key areas:

- Reporting of suspected fraud and corruption
- Investigation of suspected fraud and corruption
- Reporting of suspected fraud and corruption to External Legal Bodies (i.e. Police Scotland)
- Disciplinary and Legal Action procedures
- Recovery processes
- Internal and external communication.

Each section should clearly define the processes to be followed in the event of fraud to ensure that any investigations carried out are done so in a consistent manner to ensure suspected instances of fraud are effectively investigated. This should be widely disseminated to ensure that all employees understand the organisation's response to any suspected fraud, and the resulting disciplinary and legal action that will be taken in confirmed instances of fraud. Testing of the plan should also be undertaken to ensure that the plan functions as expected with a lessons learned process utilised after any test to allow for improvements to be made to the plan. Refer to Appendix B for an example fraud response plan as set out by the Scottish Government.

Management Action Grade 3 (Design)

Publish a standalone Fraud Response Plan in alignment with the revised Anti-Fraud and Corruption Policy.

Action owner: Risk and Audit Manager **Due date:** 31 July 2025

Control Objective 2: Arrangements are in place for periodically carrying out a fraud risk assessment which identifies potential areas for committing fraudulent activity. Fraud risks are assessed and prioritised with appropriate mitigating actions being put in place which are commensurate with the degree of risk to which the Service is exposed.

2.1 Fraud Risk Mitigation Actions

An overarching Fraud Risk Actions document is in place, this is an output of the fraud risk assessment undertaken across the organisation, which is submitted as part of the Annual Governance Statement process. The overarching Fraud Risk Actions document is created from the individual fraud risk assessments carried out by each directorate (aligned to the Internal Control Template and the SPFM). Within this it contains 72 open fraud risks, with each having a deadline for the completion of the mitigating action described. From our review of the mitigating actions required, the management responses are deemed adequate. A current position tab is also in place however it is not mandatory for this to be updated, with the amount of detail included varying from risk to risk, with some having no update.

We sampled 10 fraud risks from the Fraud Risk Action log. Only 50% of those sampled had sufficient evidence to confirm that the actions noted to mitigate fraud risk, were being undertaken. In some instances, no evidence could be provided. In one instance, the mitigating action was put into place because of the request for evidence as part of this review, with the fraud risk directly related to the confirmed instance of fraud, where false claims of attendance were made.

There is insufficient scrutiny applied to the actions that are stated to be in place, with a lack of oversight and review of required actions within Fraud Risk Action Log.

Risk

There is a risk that if the actions detailed within the Fraud Risk Action Log are not being undertaken, the risks detailed will not be adequately mitigated resulting in an increased likelihood of fraud.

Recommendation

We recommend that a full review of the Fraud Risk Action Log is undertaken with each action listed reviewed and only signed off when sufficient evidence is provided that the action listed is in place and being undertaken as stated. Responsibility for overseeing completion of the Fraud Action Risk Log should be assigned to a nominated officer.

Following this, the Fraud Risk Action Log should be reviewed on a regular basis to ensure progress has been made against actions put in place to address identified fraud risks. Where actions have already been implemented confirmation should be obtained that these are operating effectively.

Management Action

Grade 3 (Operation)

Review to be undertaken of the Fraud Risk Action Log, confirming responsible officer and requirement for evidence. The Fraud Risk Action Log will be reported regularly to the Corporate Board to ensure progress is being made. Associated Fraud Risk Assessment Guidance will be updated aligned with the new reporting requirement.

Action owner: Risk and Audit Manager **Due date:** 31 July 2025

Control Objective 3: Staff awareness of SFRS's anti-fraud related policies and procedures is actively promoted throughout the Service to ensure staff are provided with sufficient guidance in their day-to-day duties to minimise the risk of fraud and know what action to take if they suspect fraudulent activity has occurred.

3.1 Anti-Fraud Culture and Awareness Raising

We found that appropriate policies are currently in place in relation to anti-fraud arrangements. However, there is no mechanism in place for staff to confirm that they have read and understood policies/procedures related to fraud, therefore senior management have no oversight of how well anti-fraud measures are understood across the organisation. Ad-hoc anti-fraud awareness raising has been carried out, (e.g. meetings have been held with Department Management Teams (DMT) and Heads of Functions (HoF) regarding the fraud risk assessments and the LCMS training package development). However, this has not taken place in a formalised, planned manner to ensure full coverage across the organisation. A single fraud related article named as "The National Fraud Initiative in Scotland 2024" was published on the Fraud, Risk, and Compliance area of the Organisation's intranet. Additionally, emails containing fraud articles have been sent to specific individuals on an ad-hoc basis.

A survey of staff knowledge of anti-fraud and other related policies, processes and general awareness was undertaken in November 2024. However, the results of the sample cannot be relied upon as from the sample of 75 individuals selected for the survey, only 14 employees responded with their availability and a contact number. Therefore, the results of the survey provide contextual detail rather than statistical confirmation or assurance on knowledge on anti-fraud policies and procedures as it does not provide a representative sample across the organisation. The survey involved 15 questions regarding anti-fraud processes and situations.

- When the participants of the survey were asked what a definition of fraud constituted, the majority provided an adequate definition.
- When asked whether they were provided with anti-fraud training, the majority responded that they had not but had undergone some cyber training which may have had an element of anti-fraud information included.
- When asked if they were aware of any policies or procedures related to fraud, the majority knew policies existed in some form but were unsure of the contents or which policies were in place.
- When asked where to raise a suspicion of fraud, all individuals correctly named a line manager as the first person to raise concerns with. However, when asked where to report concerns if the initial concern was ignored by the line manager, no one knew to report the issue to the Director of Finance.
- When asked which external bodies reporting could go to all answer correctly stating Police Scotland would be the first port of call.
- When provided with two scenarios, all individuals correctly identified that they were instances of fraud and should be reported.

- When asked around Gifts, Hospitality and Interests while most knew a policy was in place, the majority were unable to state what the rules and thresholds were in place regarding this topic.
- Regarding the Whistleblowing Policy, the majority either did not know of its existence, or did know it existed but had not read it.
- With regards to specific behaviours that could indicate fraud is being committed, the majority provided at least one correct example of a 'danger sign' of fraud.

While the results of the survey cannot provide a representative analysis of the organisation, some conclusions can be made from the individuals that took part. Mostly, that while there is some awareness that policies are in place, there is a lack of knowledge around what procedures are contained within these policies, as shown by the period of several months taken for a confirmed instance of fraud to be reported through the correct channels. Whilst we appreciate that staff will retain the information they need from policies at the time of reading to carry out a procedure, it is important however to know where to find the relevant Policy when required to then allow appropriate application. Therefore, continued awareness raising of policies and procedures is paramount to ensure there is a culture of anti-fraud across the organisation.

From the issues detailed above, as well as other issues detailed within this report, more needs to be done to achieve an anti-fraud culture within the organisation particularly in improving fraud awareness raising activities and understanding of anti-fraud processes and procedures amongst staff. We do note that steps have been taken to raise anti-fraud awareness and improve the culture e.g. through the introduction of the LCMS training package.

Risk

There is a risk that without regular and formal awareness raising, an embedded anti-fraud culture will not be present within the organisation. This may lead to further instances of fraud due to lack of awareness and knowledge.

Recommendation

It is also recommended that a formal awareness raising, and communication plan is created. This should include a month-by-month schedule of activities and communications around fraud that will be undertaken, including but not limited to anti-fraud workshops, articles published on the organisation's intranet and webinars. The implementation of these recommendations will improve the degree of organisational knowledge of fraud, the anti-fraud procedures of the organisation as well as support a well-established anti-fraud culture.

To assist with the above, SFRS may wish to consider whether there would be benefit in establishing a Counter Fraud Team to provide expertise, support and a more structured approach to anti-fraud awareness across the organisation.

Management Action

Grade 3 (Design)

A schedule of briefing sessions will be arranged throughout the year with Heads of Function to raise awareness of related fraud issues and to monitor progress in relation to fraud risk assessments (FRA). Monitoring reports on the National Fraud Initiative (NFI) and FRA will be provided to scrutiny bodies and related iHub articles published.

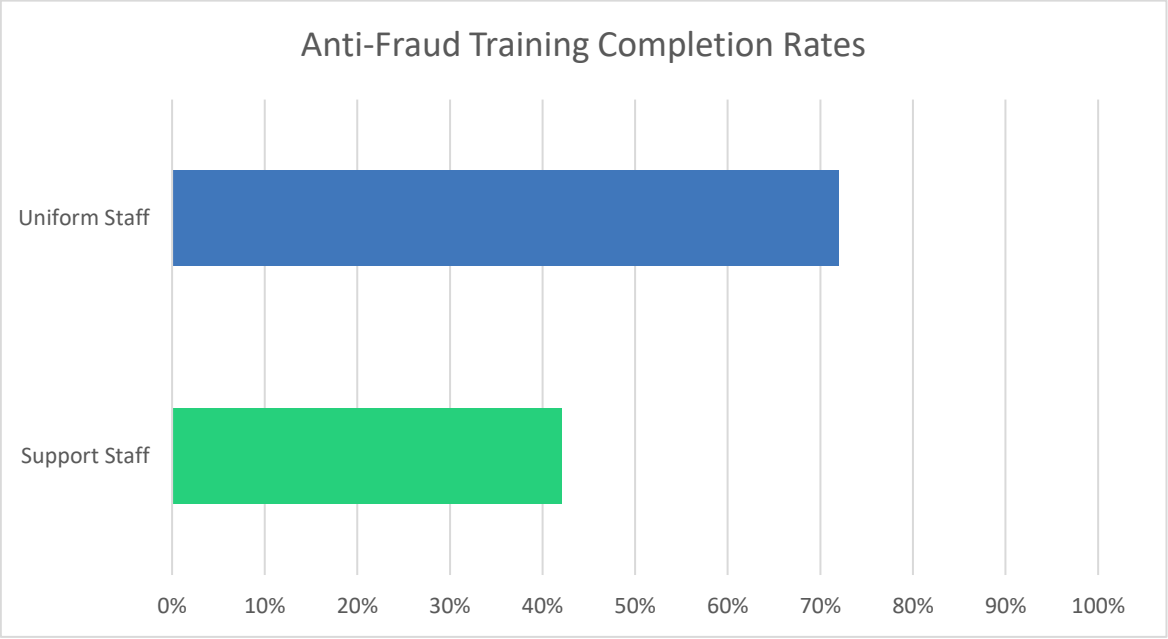
Action owner: Risk and Audit Manager **Due date:** 31 March 2026

Finance and Procurement to consider how counter fraud expertise and support could be supported within existing structures.

Action Owner: Head of Finance and Procurement **Due date:** 31 March 2026

3.2 Fraud Awareness Training

A new online fraud module named "Fraud Awareness Learning" was introduced to the LCMS training platform in April 2024. This module has appropriate content including definitions and examples of internal and external frauds, fraud risk assessment and systems of control that should be in place to avoid the risks associated with fraud. It also has links to visit various Anti-Fraud related policies available in the iHub library. At the time of the audit, the anti-fraud training was only mandatory for uniformed staff. Completion rates as at October 2024 being 72% and 42% for uniformed and non-uniform staff respectively. Management made us aware that the training would become mandatory for non-uniform staff in 2025. There is however assurance that Support Staff in key fraud risk areas, i.e. Payroll, Accounts Payable, Compliance and Verification have been provided with Fraud Awareness and Investigation training provided by Azets. This training was also widened out to other staff within the SFRS. Additionally, staff in support roles (such as procurement and finance) can access anti-fraud training via their professional bodies.



Where anti-fraud training is mandatory, personnel are instructed to undertake the learning in line with the prescribed quarterly training plan. This is then reported in the KPIs produced each quarter. The modules will be on those reports in the allocated quarters and anyone not recorded as completed will be prompted by local managers to complete it as soon as possible. However, as the fraud training has only been implemented within the last 6 months, timescales for completion have not yet been established. Additionally, it was stated that training is carried out on a three year cycle, meaning staff are only required to undergo the training once every three years.

Risk

There is a risk that without mandatory organisation-wide anti-fraud training, staff may not be fully aware of the correct organisational procedures, resulting in further instances of fraud or delays in the reporting of suspicions.

Recommendation

We recommend that the anti-fraud training is made mandatory for all staff in the organisation and carried out on an annual basis. Additionally, appropriate escalation processes should be in place to ensure that completion of training is at a minimum of 85% across the organisation, with directorates which are high-risk areas, such as procurement or finance, required to have a 100% completion. It should also be considered whether further

targeted training should be carried out for support staff in high-risk areas to address fraud risks specific to those directorates. Following this, timescales for completion to be established, with completion rates monitored and reported upon to the Audit, Risk and Assurance Committee.

Management Action

Grade 3 (Operation)

The Fraud LCMS package will be updated to incorporate a formal confirmation by the employee that they have read and understood the Anti-Fraud and Corruption Policy. The module will be a mandatory module for all staff.

Action owner: Risk and Audit Manager **Due date:** 31 July 2025

Finance and Procurement to consider how counter fraud expertise and support could be supported within existing structures.

Action Owner: Head of Finance and Procurement **Due date:** 31 March 2026

Control Objective 4: Appropriate arrangements are in place to routinely analyse data produced by financial systems with a view to preventing and detecting fraudulent activity.

Advisory

4.1 Limitations in Data Extracts Within Reports

The Verification Interactive Claim Analysis Tool (the dashboard) uses data from across SFRS to inform the Verification Team's efforts to ensure expense claims are submitted correctly. The Verification Tool is a compliance tool brought in due to the creation of the ESS system in order to provide some oversight of expense claims that are now automatically pre-approved. This tool has not been designed with fraud detection purposes in mind but does support the identification of unusual and potentially fraudulent claims.

During our review, we identified several data quality issues that impact the accuracy and completeness of information contained within the dashboard and limit the extent in which this tool can be used to detect fraudulent activity. These appear to be caused by limitations in the system producing incomplete and potentially inaccurate data.

Whilst a lot of information useful for fraud detection as well as verification purposes is entered into the system, this data cannot be included in reports and therefore cannot be analysed within the dashboard. These reports are either system generated reports or created through Business Objects by the Finance Systems Team. The Finance Systems Team has attempted to include additional fields within reports produced for the dashboard and found doing so led to duplication and distortion of data. The reason behind this distortion is not yet understood.

Additional fields contained within source systems but unable to be extracted in reporting includes:

- **Missing transaction IDs in mileage reports:** This prevents cross-referencing between mileage reports and other claim data sources.
- **Dates of expenses:** System reports do not provide the date of the expense and instead provides the date the claim was submitted. This produces false positives in duplication checks due to the claim date being used.
- **Descriptions for claims:** A description box is filled by employees for claims including disclosing key information however this is not currently able to be extracted into the report for input into the dashboard. Therefore, key context is missing in the analysis of claims, resulting in the Verification Team having to manually examine records within the system or analyse on high level information only.
- **Attachment flags:** Attachments for expenses are uploaded to the system and there is a flag in the system which indicates whether anything has been attached.

In addition to fields being excluded from reporting, SFRS staff reported concerns around the completeness of the reports that were produced. The Verification Team has identified instances where reports produced are missing data that is either included in other reports, appears in source systems and not in reports or appear in historical reports that should not have changed when rerunning. The Finance Systems Team has investigated these discrepancies in reporting and has not identified the reason behind these. We have listed several examples of conflicting reports produced:

- **Movement data:** The system is currently unable to appropriately deal with claims when employees have moved roles within the service. The claims in prior roles are often not included in reports. As there is a lot of movement of staff within SFRS, this is often a hundred lines of data. The Verification Team are aware of this data quality issue and have implemented a workaround to minimise the impact of this involving staff running a report to identify movers and manually extracting additional data to supplement reports produced. This is on average 2 days of manual work by a member of the Verification Team each month and may introduce errors due to the manual nature of this work. It is also inconsistent whether data for a staff member that has moved roles is included or excluded from reporting by the system with reports sometimes including extracts for movers.

- **Mileage claims:** Similar inconsistencies have been observed within mileage reports with some claims not appearing in Travel and Expenses reports. The reason why some mileage claims do not appear within this report could not be identified. The Verification Team cross reference additional reports in order to identify claims that have been missed when reporting and manually add these in.

- **Spoilt Meal Allowances:** This allowance type appears inconsistently under two different reports, Travel Expenses and Other Allowances. The Finance Systems Team could not determine why this is happening.

- **Historical reports:** An examination of historical mileage reports revealed that the number of records changed on different runs of the report. The mileage report downloads all claims including those in previous months. When the Verification team examined records by month against previous reports, they found that this number varied for no known reason.

In addition, the dashboard is reliant on other teams providing data extracts rather than the Business Intelligence team accessing the data directly from source systems. This approach introduces the potential for data loss or distortion . It also limits the data quality checks that can be performed to ensure data extracts are complete. While the Verification Team carry out their own data quality checks revolving around formatting of data and ensuring movers/ other discrepancies are accounted for, they cannot determine if extracts are complete. Due to the above issues as well as contradictory data contained within different systems the Verification Team reported challenges surrounding the completeness and quality of data feeding into the dashboard.

Risk

The presence of missing or incomplete data across multiple systems, along with the risk of data manipulation in Excel, poses significant risks to data quality and integrity. These issues directly impact the accuracy and reliability of insights generated by the Verification Interactive Claim Analysis Tool, leading to potential fraud being undetected.

Recommendation

As SFRS are in the process of onboarding new systems, we recommend that data quality and reporting are actively considered when setting these systems up. SFRS should consider their reporting needs to ensure that data required for reporting can be easily extracted from the system in question. How other systems interact should also be considered to ensure that information held across various systems can be cross referenced easily in order to provide further assurance over accuracy of claims.

Data quality checks should be implemented to ensure reporting and data within the systems is of sufficient quality. Data quality governance arrangements such as data standards, data governance boards and data owners will help embed data quality within systems and processes. Reporting should undergo sufficient data

quality checks to identify issues and their impact on reporting with caveats applied to products produced. Mandatory fields should be used where possible within systems to ensure essential information is collected.

If possible, the Business Intelligence Team should gain access to systems in order to obtain data directly rather than through other parts of the business. This will allow this team to implement additional data quality checks in order to provide some assurance over the data feeding into the dashboard and its completeness.

Management Action

Advisory (Design)

Engagement with all relevant Directorates has been undertaken within the PPFT project to review data quality and availability, i.e. Scottish Government discovery phase and other preparatory activity.

Action Owner: PPFT Project Manager **Due Date:** Complete

The Verification Team will continue to engage with the PPFT project in relation to reporting requirements and availability of management information within the new system, highlighting the importance of an integrated approach.

Action Owner: Risk and Audit Manager Due Date: Complete

The Verification Team will continue to liaise with relevant Directorates, as part of the verification process, where incorrect data is identified.

Action Owner: Risk and Audit Manager **Due Date:** Complete

4.2 Low Engagement from Line Managers

Line managers are sent regular reports detailing the expense claims submitted into ESS for their employees. They are asked to review these claims and confirm that these are all valid claims. Feedback and engagement from line managers for these reports is low. Initially, the first month the Verification Team calculated the reply rate in April 2024 was 74%, this declined on a monthly basis to an estimated 38% in September 2024.

Where the line manager fails to undertake a review of the expense claim the Verification Team will still undertake a sampling of claims to determine whether the claim is valid. Where additional information is required the Verification Team will undertake any additional investigation as required.

This line manager validation is the first check into identifying potentially fraudulent claims, with the Verification Team's checks being the secondary test on flagged claims.

Risk

The low feedback rate undermines the confidence that managers are investigating these incorrect or potential fraudulent claims, and therefore potential fraud may not be followed-up appropriately. The lack of line manager involvement may also delay or weaken fraud investigations, reducing SFRS's ability to confirm or mitigate potentially fraudulent claims promptly.

Recommendation

We recommend that SFRS review line manager roles and responsibilities to include the review of claims as part of wider fraud detection processes. The responsibilities and importance of line managers engaging in these processes should be communicated to staff. Consideration should be taken on how to ensure more active participation from line managers in this initial check of expenses including incorporating into job responsibilities and performance management and reporting on engagement rates to allow senior leadership to address persistent issues of low participation.

Management Action

Advisory (Design)

The Verification Team will continue to undertake sampling of all intimated claims and investigate any claim where additional information is required. This will include direct engagement with relevant Directorates highlighting areas where alignment to policy requirement is not demonstrated.

Action Owner: Risk and Audit Manager **Due Date:** Complete

The Overtime Policy will be reviewed during 25/26 and will consider current processes required for Line Manager authorisation.

Action Owner: People Directorate (aligned People Manager) **Due Date:** 30 April 2026

The Verification Team will continue to collate information regarding line managers responses in support of related policy application.

Action Owner: Risk and Audit Manager **Due Date:** 30 April 2026

4.3 Enhanced Fraud Detection and Reporting Capabilities in the Verification Interactive Claims Analysis Tool

Within the Verification Interactive Claim Analysis Tool, there are various filters for different conditions that will identify potential anomalies for further examination including based on amount, duplicate testing, first time claimers or leavers. This first iteration of the dashboard was designed for verification purposes and through significant work by various teams to make better use of data within SFRS. We have identified several areas the dashboard could be extended to strengthen the fraud detection capabilities of the dashboard. These include incorporating data from additional sources to provide further scrutiny such as on-call data and including overviews of activity across the period to highlight unusual activity. It should be noted that there are plans in place to extend the dashboard to cover these areas with discussions beginning for on-call data and a draft overview dashboard created examining activity across the year.

We reviewed the draft overview dashboard as well as the current dashboard and found that further analysis could be built into the system to develop common patterns across the year and therefore highlight claims that differ from these patterns, such as employees with an excessive number of claims submitted. Whilst the draft overview dashboard provides high level breakdowns of claims, much of it focuses on activity of the Verification team. Further, the dashboard provides the ability to view all expenses submitted by an employee but does not feature much benchmarking of claims across what has been observed for staff in similar roles. Threshold values can indicate unusual amounts. However, these are set values and may not identify employees that may be claiming amounts unusual against their role or the wider population or an unusual number of claims across the year. Verification staff have an awareness of trends they have observed through reviewing the data each month however the dashboard could be further set up to showcase these trends rather than relying on the knowledge of staff.

Risk

There is a risk that the Service fails to develop required analytical tools for the detection and prevention of fraud.

Recommendation

A caveat must be added that the Verification team reported recent reduction in resources including staff members, and inclusion of these recommendations require additional resources to enhance reporting.

It is intended that the new systems being brought in will mean data from other systems can be cross referenced for accuracy. We recommend that reporting is prioritised when setting this system up to support the Verification Team's work and for fraud detection purposes.

We are aware that on-call data is being incorporated into the dashboard. We recommend that where possible, other systems are cross referenced to ensure accuracy of data that previously was linked to potential fraud cases within SFRS for instance availability for on-call.

The Verification Interactive Claim Analysis Tool should be configured to highlight claims that differ from expected patterns such as flagging employees that have an unusually high number of claims compared to colleagues in similar roles / locations. This can be achieved through cross referencing yearly activity to baseline number or amounts by team / role / location / expense type. These baseline figures can act as a reference point to flag unusual activity. Previous threshold values on amount had to be increased due to the volume of anomalies identified. If additional engagement is obtained from line managers, unusual claims by amount expected for role / location could be further examined through this process.

We recommend that overview dashboards include additional analysis on yearly activity of claims to detect patterns and trends. This overview should highlight areas that may require additional scrutiny due to number of anomalies observed. For instance, this can include number of employees by number of claims, sub breakdowns of teams, roles and locations and average amounts by these. It may be beneficial to include reporting of response rates by line managers within this dashboard to promote better engagement.

Management Action

Advisory (Design)

Engagement with all relevant Directorates has been undertaken within the PPFT project to review data quality and availability, i.e. Scottish Government discovery phase and other preparatory activity.

Action Owner: PPFT Project Manager **Due Date:** Complete

Continued development of a Verification Dashboard allowing additional analysis of claim information, that may assist in the identification of potential fraudulent activity.

Action Owner: Risk and Audit Manager **Due Date:** 30 April 2026

Control Objective 5: Appropriate action is taken in response to suspected fraudulent activity with any such matters investigated fully by competent individuals. Any lessons learned from these investigations are given due consideration going forward with appropriate action taken to minimise the risk of fraudulent activity recurring

Amber

5.1 Notifying the Director of Finance & Contractual Services and Police Scotland of suspected fraud

The current Anti-Fraud and Corruption Policy states that "Managers are required to take seriously any allegations of fraud reported to them and be assured that there are reasonable grounds for concern. Where this is the case, they should notify the Acting Director of Finance and Procurement [now the Director of Finance and Contractual Services] without delay."

The alleged fraud at Tighnabruaich CFS came to light at the end of July 2023. However, it was not reported to the Director of Finance and Contractual Services until 1st November 2023. Moreover, Police Scotland do not appear to have been notified until January 2024.

In accordance with the policy, as it is the Director of Finance and Contractual Service's responsibility to ensure that "vigorous and prompt investigations are carried out if fraud occurs or is suspected", it is essential that she is notified immediately.

The delay in excess of three months in notifying her of this case means that it is less likely that appropriate action is taken to prevent the fraud from recurring and the possibility of recovering monies fraudulently obtained and/or securing a successful conviction is greatly diminished.

In relation to the investigation all three employees allegedly involved with the Tighnabruaich fraud resigned and left SFRS before disciplinary investigations could be concluded. Details of resignation and last day of service noted below:

Name	Notice Period	Date resignation submitted	Last day of service
Employee A	4 weeks	9.10.23	9.10.23
Employee B	4 weeks	9.8.23	6.9.23
Employee C	4 weeks	3.10.23	31.10.23

It is recognised that where an employee leaves the Service there is no obligation on the employee to participate in any disciplinary proceedings undertaken by the Service or for the Service to hold the employee to account under the employment contract. Separate Fraud investigations should continue regardless of the employment position, and it needs to be recognised that any delay in initiating this process could impact subsequent police investigations. Additionally, this could signal to other employees that alleged fraudulent activity may not be taken seriously, leading to erosion of morale and discipline.

Risk

Failure to report suspected fraud to the Director of Finance and Contractual Services in a prompt manner increases the risk of a lack of co-ordinated and effective response to fraud resulting in financial loss and reputational damage. Delays in reporting suspected fraud to the police hinders the investigative process and makes the possibility of successfully prosecuting the individual(s) responsible for the fraud less likely.

Recommendation

When updating the Anti-Fraud and Corruption Policy, incorporating an anti-fraud response plan, and the Disciplinary policy it must be emphasised that all suspected instances of fraud must be reported to the Director of Finance and Contractual Services at the earliest opportunity so that an effective and co-ordinated response to the fraud can be put in place including taking the decision as to when the police should be notified and by whom.

Management Action

Grade 3 (Design)

Information on the requirement to report all suspected instances of fraud to the Director of Finance and Contractual Services will be incorporated within the revised Anti-Fraud and Corruption Policy.

Action owner: Risk and Audit Manager **Due date:** 31 July 2025

People Directorate to consider alternative wording in the Disciplinary policy/procedure which captures that where an individual resigns during a disciplinary process consideration should be given to whether to continue with this or not, but each case should be considered on its own facts. Guidance will be added to support such considerations.

Action Owner: Deputy Head of Human Resources **Due date:** 30 September 2025

Control Objective 6: Appropriate reporting arrangements exist in respect of fraud in order to ensure that SLT and the Board have sufficient oversight and scrutiny of fraud-related matters.

6.1 Fraud Reporting and Discussion

The Terms of Reference (ToR) for the Audit & Risk Assurance Committee (ARAC) states that the board has a responsibility to scrutinise anti-fraud and corruption policies, whistleblowing processes and arrangements for investigations. Additionally, it states that fraud reports will only be provided as and when appropriate.

The Strategic Leadership Team (SLT) ToR includes no reference to fraud.

There are no SLT meeting minutes recorded, therefore it is not possible to comment on the whether fraud is discussed more widely by the SLT. However, a decision log is in place, and this includes minimal reference to fraud, with two points on the current audit and the national fraud initiative for the entirety of 2024. It was confirmed by the Director of Finance and Contractual Services that discussions on both frauds within the scope of the audit and others in the past have been discussed at SLT.

Fraud and whistleblowing is a standing agenda item at ARAC meetings. This allows for an opportunity to discuss fraud within the organisation. However, there is lack of formal reporting on fraud awareness and culture within the organisation. The current agenda item is a verbal update. It would be good practice to present a report to the ARAC to detail the awareness raising activities that have occurred in the quarter since the last meeting. This could include, but not limited to, internal activities or internal communications issued, training compliance, reference to recent articles/reports on fraud within the public sector, any intelligence received from other public sector organisations. Having a more formalised report, would allow for a much larger discussion around anti-fraud awareness and culture at meetings and ensure that the topic remains a key focus for the organisation.

Additionally, the Fraud Risk Action log previously discussed in MAP2.1 is not discussed or reviewed by the ARAC on a regular basis. The ARAC do receive this as part of the annual governance process and internal control checklist; however, this should be received on a more frequent basis.

Risk

There is a risk that a lack of effective scrutiny and oversight of fraud risks and issues will not support the achievement of an anti-fraud culture across SFRS..

Recommendation

We recommend that the Corporate Board should receive a formal report to discuss as part of the standing agenda item for fraud. This could include, but not limited to, internal activities or internal communications issued, training compliance, reference to recent articles/reports on fraud within the public sector, any intelligence received from other public sector organisations. The ARAC Terms of Reference should be updated to reflect this reporting requirement.

The SLT Terms of Reference should also be updated to detail senior management's responsibilities around fraud discussion, fraud reporting and the creation of an anti-fraud culture as the tone at the top of the organisation provides the foundation for the rest of the organisation's approach to anti-fraud. For any future

suspected frauds, the SLT should consider how to more formally record the discussions that take place in the absence of formal meeting minutes.

The ARAC should have the Fraud Risk Assessment contained as part of their standing agenda item to ensure the Fraud Risk Action log is discussed frequently as well as to ensure that there is adequate progress on improving the organisation's anti-fraud culture.

Management Action

Grade 3 (Design)

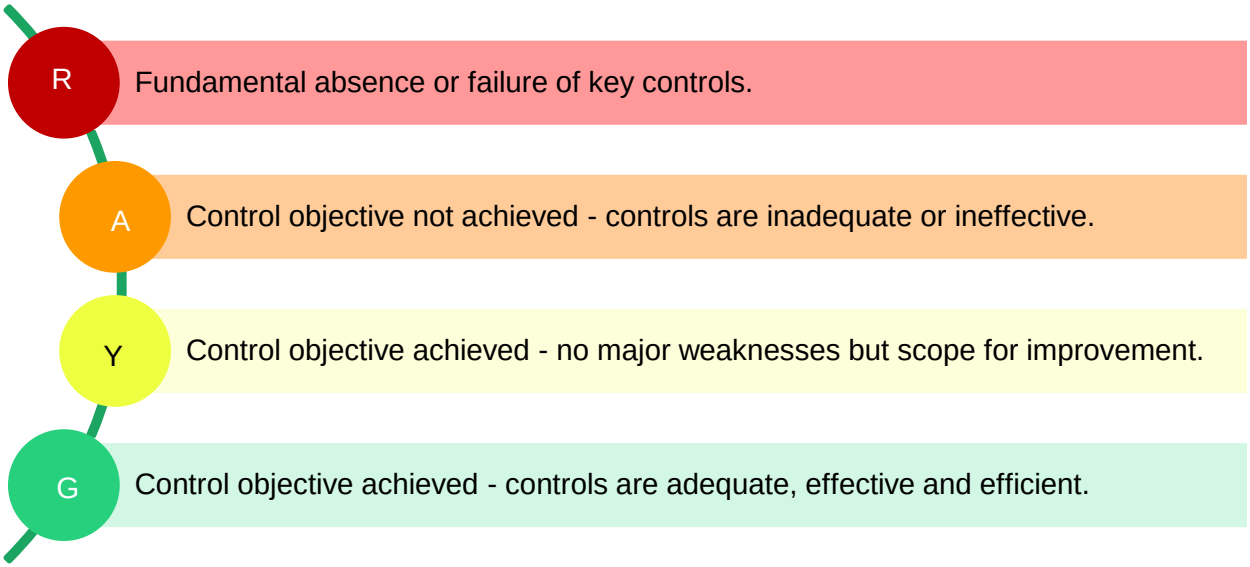
A regular highlight report to be provided to ARAC and SLT by exception on Fraud Risk Assessment monitoring activity and Terms of Reference for ARAC and SLT to be revised.

The Fraud Risk Action Log will be reported regularly to the Corporate Board to ensure progress is being made.

Action owner: Risk and Audit Manager **Due date:** 31 March 2026

Appendix A – Definitions

Control assessments



Management action grades

4	•Very high risk exposure - major concerns requiring immediate senior attention that create fundamental risks within the organisation.
3	•High risk exposure - absence / failure of key controls that create significant risks within the organisation.
2	•Moderate risk exposure - controls are not working effectively and efficiently and may create moderate risks within the organisation.
1	•Limited risk exposure - controls are working effectively, but could be strengthened to prevent the creation of minor risks or address general house-keeping issues.

Appendix B – Example Fraud Response Plan

Purpose

This Fraud Response Plan sets out arrangements to ensure that when suspected frauds against SFRS are reported, either to line managers, HR, Internal Audit, finance business partners or the Fraud Response Team, effective action is taken to:

- investigate the circumstances
- minimise the risk of subsequent loss
- ensure that appropriate recovery action is taken or, failing recovery, to initiate action to write off any losses
- remedy any weaknesses in internal control procedures
- initiate disciplinary and legal procedures, where appropriate
- demonstrate that the SG is not a soft target for attempted fraud

Fraud Response Team

The Fraud Response Team for the SFRS is based in the Finance Directorate. The functions of the Fraud Response Team include:

- To receive and record information (anonymously or otherwise) about suspected frauds, either by telephone or in writing, from individual members of staff or the public.
- To consult and coordinate on counter fraud matters as required; agree what action, assistance and communication is required from within SFRS, the Scottish Government and external sources (e.g. Police)
- To ensure that, where it is considered appropriate, senior management and/or the Audit Risk and Assurance Committee is informed about relevant cases as soon as possible after they come to light
- To report annually to the Audit, Risk and Assurance Committee

Roles

Counter Fraud Champion and Fraud Response Team will lead in promoting an anti-fraud culture including communications; coordinate reporting of fraud and lessons learned across the SG, including fraud alerts; assist in assessing the risk of fraud in policies and programmes; work with counter fraud networks in the public, private and voluntary sectors; coordinate fraud investigation activity across the SFRS and lead counter fraud policy development.

Finance, in conjunction with business areas: safeguard funds possibly at risk; plug any immediately obvious gaps in financial controls; consider the case for recovery action and initiate action to recover funds as required; determine the financial effects of frauds; arrange, where necessary, for notation of the relevant accounts.

HR: if appropriate, arrange to suspend SFRS members of staff pending the outcome of any investigations (and review the notice of suspension at regular intervals throughout the period of investigation); appoint an Investigating Officer; liaise with the Legal team on legal implications under employment legislation; consider, in consultation with line management, implement disciplinary procedures against perpetrators of frauds and other members of staff whose actions may have facilitated frauds; consider the action to be taken if lesser instances of misconduct have been identified during the investigation.

Internal Audit: if appropriate, carry out investigations and liaise with the appropriate Police/Procurator Fiscal Service contacts; make recommendations for improvement where appropriate and advise on potential lessons to be learned

While these responsibilities are listed separately, they are clearly inter-linked and close liaison on developments in specific areas is essential, as is the involvement of line management at an appropriate level. It will invariably be necessary to act with extreme urgency at this stage.

Investigations

Following the reporting of suspicions of fraud to either line managers, Human Resources, Internal Audit, finance business partners, the information must be passed on to the SFRS Fraud Response Team for coordination purposes. A recommendation from a specialist area (e.g. HR, Internal Audit or Legal Directorate) will then be sought, as appropriate.

If further action or investigation is agreed, the Fraud Response Team should initiate the following action, insofar as it is appropriate to the particular case:

- decide the level at which line management should be involved and bring the allegations to the notice of line management if it is not already aware of them, at the same time confirming the investigative arrangements and reporting lines
- secure records and assets, including restrictions on access to offices and computer terminals
- based on advice from HR, involving Legal Directorate as required, consider the prima facie case for suspension of SG members of staff who are the subject of allegations
- agree the scope and nature of any investigative work required to establish the facts of a particular case
- notify senior management as required, and relevant Accountable Officer(s)
- decide whether the appropriate Police/Procurator Fiscal Service contacts should be informed
- agree a timetable for completion of any agreed actions

Fraud investigations can be undertaken by Internal Audit, HR or an Independent Investigating Officer, depending on the circumstances.

Any investigation will take account of any relevant work or recommendations by a specialist area e.g. Internal Audit and HR reports. Preliminary investigation findings must be reported to the Fraud Response Team for consultation.

Selection of Investigating Officer

It is a matter for HR to appoint, where necessary, the independent Investigating Officer although the ARAC will be informed of the proposed appointment. The Investigating Officer should have th appropriate skills to undertake an investigation and, if necessary, knowledge of the area of work under investigation. The Investigating Officer should be a person who has not had close personal or work related ties with the person under investigation.

Action on investigation findings

1As soon as possible after investigations have been completed and the IG is satisfied that no further investigations are required, it must ensure:

- that disciplinary action, if any, is being taken (in line with Disciplinary Policy and Procedures)
- that disciplinary action, if any, is being taken if the initial allegation appears to be malicious
- that the form and content of any report to senior officers is appropriate
- that the Police/Procurator Fiscal is notified if required
- Case closure, follow up and review

Where evidence of fraud or serious misconduct has been identified, SFRS should consider whether any action needs to be taken to prevent a recurrence. In such cases, an action plan should be drawn up setting out recommendations. In practice, much of the required action is likely to relate directly to action plans drawn up by Internal Audit or HR and a cross reference to these plans is all that is required.

Action plans will include the required steps to take in response to an investigation's findings. An occurrence of fraud may hold lessons to be learned for an individual business area or the whole of SFRS. The Finance team has a lead role in ensuring that all appropriate action is taken forward effectively.

The ARAC should be informed by HR of the outcome of cases where a charge of gross misconduct has been made. In any case where such a charge has been brought but a disciplinary hearing does not uphold the charge or an appeal panel overturns the panel's decision, the ARAC should be informed of the reasons for the Panel's decisions. The ARAC must consider whether, in light of this information, there are lessons to be learned in terms of the handling of cases and whether the Fraud Response Plan and related guidance, for example on disciplinary procedures, is operating effectively.

The ARAC should make recommendations for any changes to procedures that it considers necessary in light of the outcome of individual cases and should consult relevant interests on any recommended changes. If appropriate, where individuals have been dismissed or subject to other disciplinary action for matters other than fraud (e.g. abuse of IT systems), HR will inform Internal Audit of the circumstances of the case and consideration given to whether a further review (by Internal Audit) should be undertaken to establish whether or not there has been possible misuse of other systems by the same individual(s).

Confidentiality

Members of the ARAC will receive the appropriate information relating to individual cases. They must treat all information relating to individual members of staff on a Restricted - Staff basis and should ensure that it is only passed on to colleagues on a strictly need to know basis. HR will place a record on the career folder of a SFRS member of staff only where there has been disciplinary action taken. Further information is provided under the SFRS Whistle-blowing procedures.

External fraud

External frauds are frauds perpetrated by third parties against the SFRS (e.g. contract fraud or fraudulent applications for grants or subsidies or expenses

The ARAC is available to advise on cases of external fraud. Procedures for responding to suspected external fraud, insofar as they are appropriate to the particular case, may include the following:

- a report by operational management on the circumstances
- a formal assessment of whether the evidence tends to substantiate fraud. Any invalid claims or invoices that could reasonably be argued were submitted in good faith should not normally be regarded as fraud
- notification of the Police / Procurator Fiscal, where appropriate
- recovery action
- consideration of control procedures and lessons learned

It will normally be sufficient to alert the IT Security about any cases of internet scams. If fraud by a supplier is suspected, the ARAC should be kept informed of developments. Cases of straightforward theft (which does not qualify as fraud) should be notified to the Police Scotland for action.

If there is any suspicion of collusion on the part of SFRS members of staff in a suspected or discovered external fraud, the procedures relating to internal fraud should apply as appropriate, given any requirements arising from ongoing Police/Procurator Fiscal investigations

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/10-25

Agenda Item: 7.2

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**SFRS PROGRESS UPDATE/MANAGEMENT RESPONSE**							
Report Classification:	**For Scrutiny**	**Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	To provide Audit and Risk Assurance Committee (ARAC) with the current status of recommendations raised by Internal Audit.
2	**Background**
2.1	This report maintains the previous format for updates with the addition of comments on the current status from Azets.
3	**Main Report/Detail**
3.1	39 actions remain outstanding with the oldest related to audits carried out in 2022/23. Internal Audit are working with management to assess progress and to consider the extent to which recommendations remain valid.
4	**Recommendation**
4.1	ARAC is asked to scrutinise the content of the report and consider the timelines noted for outstanding recommendations.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk** The internal audit programme forms part of the Service's Assurance Framework.
5.2 5.2.1	**Financial** There are no direct implications associated with the report.
5.3 5.3.1	**Environmental & Sustainability** There are no direct implications associated with the report.
5.4 5.4.1	**Workforce** There are no direct implications associated with the report.
5.5 5.5.1	**Health & Safety** There are no direct implications associated with the report.
5.6 5.6.1	**Health & Wellbeing** There are no direct implications associated with the report.

5.7 5.7.1	**Training** There are no direct implications associated with the report.
5.8 5.8.1	**Timing** The report notes progress made in implementing outstanding audit actions from 2022/23 - 2023/24.
5.9 5.9.1	**Performance** Internal audit is intended to support the service and where relevant identify areas where performance can be enhanced.
5.10 5.10.1	**Communications & Engagement** Meetings have taken place with management to discuss the implementation of agreed audit actions and to view evidence confirming work in progress and completed actions.
5.11 5.11.1	**Legal** There are no direct implications associated with the report.
5.12 5.12.1	**Information Governance** Collection or use of personal data has not been required in the preparation of the Follow Up Progress Report. For this reason, a Data Protection Impact Assessment has not been required.
5.13 5.13.1	**Equalities** For each recommendation contained within the Follow Up Progress Report, relevant directors need to consider whether an Equality and Human Rights Impact Assessment is applicable**.**
5.14 5.14.1	**Service Delivery** There are no direct implications associated with the report.
6	**Core Brief**
6.1	Not applicable
7	**Assurance (Board/Committee Meetings ONLY)**

7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial~~**/Reasonable/**~~Limited/Insufficient~~
7.2	**Rationale:**	Azets have reviewed the follow up work completed by audit action owners and are providing their view on the work done to date and evidence provided to support closure of any actions.

8	**Appendices/Further Reading**
8.1	Appendix A: Progress update on Internal Audit Recommendations Quarter 4 2024/25

Prepared by:	Jamie Fraser, Manager - Azets
Sponsored by:	Sarah O'Donnell, Director of Finance and Contractual Services
Presented by:	Gary Devlin, Partner - Azets

Links to Strategy and Corporate Values
Working Together for a Safer Scotland

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Audit and Risk Assurance Committee	*08 April 2025*	*For scrutiny*

Appendix A – Progress update on Internal Audit Recommendations (Quarter 4 2024/25)

1. Background

In accordance with the Internal Audit Plan 2024/25, we undertake Follow Up reviews on a quarterly basis. The purpose of the Follow Up reviews is to ascertain the progress made in implementing agreed actions arising from internal audit assignments. The following spreadsheet sets out the original recommendations which remain outstanding along with action due dates and an update on progress made in implementing the recommendations to date.

2. Summary of findings

We have made the following observations regarding the Quarter 4 Follow Up review:

- Seven actions have been added since the previous Quarter.
- For Quarter 4, sufficient evidence has been provided to close nine actions which are as follows:

Year	Audit Assignment	Rec Ref	Subject of Recommendation	Grade
2022-23	Post Pandemic Review	2.2	Hybrid Working Arrangements	3
2022-23	Personal Protection Equipment	5.1	Retrieval of PPE	3
2022-23	Training	4.1	Compliance Reporting	3
2023-24	Budgetary Controls	4.1	Business Case Process	3
2023-24	Budgetary Controls	4.2	Evidence of Business Case Process	3
2023-24	Equality, Diversity & Inclusion	1.2	Review of Equality and Diversity Charter	2
2023-24	Risk Advisory Assurance Review	2.4	Managing Risk and Assurance – Documenting Assurance	2
2024-25	Environmental Management	1.1	Terms of Reference (ToR)	2
2024-25	Environmental Management	4.1	Tracking other Emission Sources including Procurement Activities and Hybrid/Remote Working	Advisory

Dashboard – data as at 31st March 2025

***Partnership Working 2.1.1 & 2.1.2 are classed as 1 recommendation & would not be closed until both parts are classed as complete.**

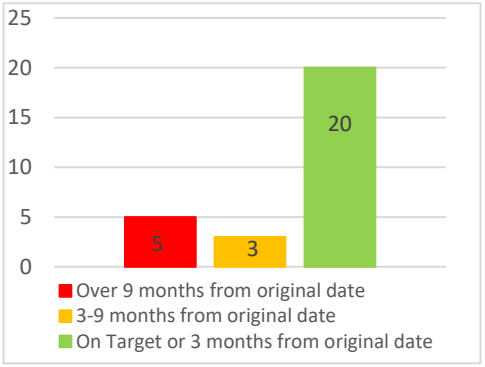
No. of actions complete past 12 months

34

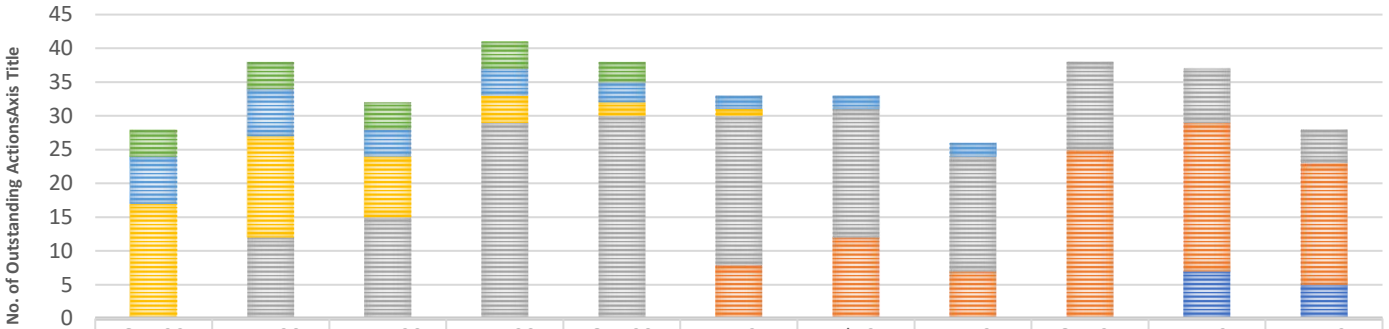
No. of Actions closed since last ARAC meeting

9

No. of actions outstanding – **28***

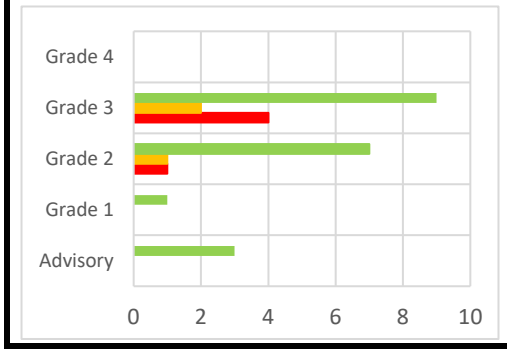


PROGRESS OF AUDIT YEARS ACTIONS



	Oct-22	Jan-23	Mar-23	Jun-23	Oct-23	Jan-24	Feb-24	Jun-24	Oct-24	Dec-24	Mar-25
2019/20	4	4	4	4	3	0	0	0	0	0	0
2020/21	7	7	4	4	3	2	2	2	0	0	0
2021/22	17	15	9	4	2	1	0	0	0	0	0
2022/23	0	12	15	29	30	22	19	17	13	8	5
2023/24	0	0	0	0	0	8	12	7	25	22	18
2024/25	0	0	0	0	0	0	0	0	0	7	5

Outstanding Actions by Risk Priority Level



RED STATUS ACTIONS – by months past original due date

No Months past original date (as at 31.03.2025)	AUDIT YEAR	AUDIT REVIEW	Action No.	Action Priority	Original Action Due	Revised Date	% Complete
24	2022/23	Revenue & Funding Maximisation	2.1	GRADE 3	31.12.2023	31.03.2025	65%
24	2022/23	Post Pandemic Review	1.1	GRADE 3	01.04.2023	31.12.2024	100%
21	2022/23	Revenue & Funding Maximisation	4.1	GRADE 2	30.06.2023	31.03.2025	15%
12	2022/23	Training	3.1	GRADE 3	30.04.2024	31.12.2024	95%
11	2022/23	Corporate Performance Management	3.1	GRADE 3	30.04.2024	31.07.2025	70%

STATUS KEY	
GREEN	On Target to complete within agreed due date or within 3 months of original due date.
AMBER	Delay from original due date of between 3 to 9 months
RED	Delay of over 9 months or no evidence of progress

2022/23	Post Pandemic Review	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		4	75%	0	3	0	0	0	1	0	0	0	0	0	0

Rec No. 1.1	RISK	There is a risk that BCPs are inadequate as a result of failure to update BCPs post pandemic, leading to inability to be able to respond effectively to a future pandemic or similar adverse incident resulting in failure to operate services, financial loss and/or reputational damage.				
	Update Directorate Business Continuity Plans A Business Continuity Framework should be developed to allow events that impact the organisation as a whole to be responded to and managed effectively. As part of this, directorate BCPs should be reviewed to access how they will interact and contribute to the overarching framework. In addition, all Business Continuity planning activity should be reviewed and updated to factor in learning from the pandemic, e.g. inability to divert working to another site, mass illness of staff impacting operations etc…		Report Agreed Date	4th Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Governance, Strategy & Performance**	*The Reset and Renew Review of BCP was accepted by SFRS Good Governance Board in June 2022. This contained specific recommendations included a more developed corporate approach to Business Continuity and the review and sharing of all plans across the service. All the recommendations contained within the review report were accepted. Responsibility for MCP has moved to SPPC as of September 2022 and this action will be coordinated by the Head of Governance, Strategy and Performance.*	01 April 2023	31 Dec 2024	Grade 3	100%	RED

Progress to date (Update provided 07/03/25)	Internal review of BCP during the Covid-19 pandemic completed as referenced by the audit. Initial planning undertaken and supporting business cases presented to SLT. Early engagement taken place with key internal stakeholders and external partners for benchmarking. Engagement with internal operations department to agree key milestones. Participation in exercise 'Hornet Morris 3' and internal debriefing completed with further recommendations identified. Review of BC plans for support functions undertaken in conjunction with civil contingencies officers. Review of Corporate Governance BCP completed, including standardisation of BCP template/recording. Arrangements are in place specifically in relation to potential industrial action. New BCP Policy moving to consultation in Q3/Q4. BCP Policy consultation is complete. All departments provided updated BC Plans during 2024 on the old template. Most departments have updated and provided BC Plans on the new updated template in line with the new policy.
Outstanding actions to close the recommendation	Responsible owner awaiting on final function to return plans before forwarding supporting evidence
Azets Comments	Awaiting evidence of updated BCP plans using new framework and template in order to close this action.

2022-23	Corporate Performance Management	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		4	75%	0	0	1	0	0	1	0	0	0	0	0	0

Rec No. 3.1	RISK	There is a risk that decisions are made based on incorrect or incomplete data, due to lack of processes in place to gather and review information related to KPIs, which could lead to financial loss and/or reputational damage.	Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Data Accuracy and Quality Management need to ensure that a strong focus is placed on ensuring the quality and accuracy of performance data which is being produced and reported upon. This includes the following: 1. Looking at ways to improve the quality of the data produced by focussing on the integration of management information systems and the automatic production of performance data, whilst at the same time endeavouring to minimise the use of spreadsheets and manual intervention in the process. 2. Ensuring data is quality assured and validated to supporting information prior to being reported. Management should ensure that sufficient resources are in place to perform this important task.						
	Responsible Owner Agreed Response **Head of Governance, Strategy & Performance**	1. *SFRS is establishing new data governance and quality management arrangements through the Data Governance Group. Integration or pipelining of SFRS systems to enable both greater automation and minimising of manual data processing has been identified as a priority. Requirements have been detailed, prioritised and submitted to ICT to be progressed throughout 2023.* 2. *SFRS will establish a central capability within the BI team to manage data quality and will put in place data quality action plans for key data sources.*	30 April 2024	31 July 2025	Grade 3	80%	RED

Progress to date (Update provided 07/03/25)	- Data and Information Governance Group. - Design of reporting product between BI and Data Services and all SFRS directorates is on-going. - SFRS Data literacy Conference held in May 2023. - Closure report for BI Strategy presented to Corporate Board
Outstanding actions to close the recommendation	- Work to progress the Office for Statistical Regulations (OSR) Standards as part of data quality work but is on hold due to lack of resources. - Work to create the Data Digital and Technology Strategy in progress.
Azets Comments	Awaiting evidence of the implementation of tasks stated above in order to class action as closed.

2022-23	Revenue & Funding Maximisation	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		8	75%	0	2	4	0	0	1	1	0	0	0	0	0

Rec No. 2.1	RISK	There is a risk that funds cannot be actively monitored in line with any specific requirements for monitoring and reporting, they cannot be assessed on an ongoing basis as to whether they meet the conditions and they cannot be reviewed post completion to see if the defined objectives have been met and that the funds have been maximised.					
	External Funding Documentation An exercise should be undertaken to identify which external funds have the applications and grant conditions on file. For those funds that do not have the documentation on files a re-engagement should be done to define the purpose, scope, objectives, conditions and monitoring arrangements for the existing funding projects. Further for all new external funding there should be a centralised shared file location where the funding documentation is saved. A specific staff member from each region should be assigned to centrally oversea record keeping and ensure that all funds have the required documentation on file.		Report Agreed Date	5th Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance & Procurement** (formerly Acting Head of Finance & Procurement)	*SFRS will review current external funding and seek appropriate documentation to support. In addition, a central repository for grants that include the applications and conditions will be created.*	31 March 2023	31 March 25	Grade 3	65%	RED
Progress to date (Update provided 23/01/25)	In conjunction with actions 1.3a and 1.3b this will complement the process of centralisation and will allow for a clearer oversight of funding documentation and in turn funding opportunities. Centralised process and repository have now been determined and evidence to be provided – Extension to date required to support timing of evidence to be provided to and reviewed by Azets						
Outstanding actions to close the recommendation	Further work is ongoing to review existing funding projects to ensure all documentation has been capture & re-engage if needed. This action has been delayed due to capacity issues and the key staff member resigning from the Service. Role replacement will start in the February and this will be a priority task for this individual on entering the Service.						
Azets Comments	Awaiting evidence of applications and grant conditions being retained on file centrally and/or re-engagement having taken place to agree details of the funding in order to close the action.						

Rec No. 4.1	RISK	If there is no formal evaluation framework in place to evaluate the effectiveness of funding and revenue generating activities out with the P&P directorate, there is a risk that funds may not have met the defined objectives and opportunities for maximising fund usage and revenue generation. If this is not identified in an evaluation process, then missed opportunities for fund usage and revenue generation could occur and amount to a potential loss of revenue.					
	Evaluation Framework The evaluation framework should be expanded to other external funding areas not currently covered to improve consistency of approach and to ensure that lessons learned are captured and fed into planning for the use of future external funding.		Report Agreed Date	3rd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance & Procurement** (formerly Acting Head of Finance & Procurement)	*The Service will expand the evaluation approach used by P&P to cover all external funding opportunities.*	30 June 2023	31 March 2025	Grade 2	15%	RED
Progress to date (Update provided 23/01/25)	Initial discussions have been ongoing around a process to accommodate this however further work will be completed post the review of policy and procedures and centralisation of external funding initiatives – this will allow the whole process to be joined, understood and compliment the organisational aims and objectives						
Outstanding actions to close the recommendation	Delays of progress due to other priority commitments, ie, Year end and subsequent resignations from Service – as per 2.1 this will be picked up as a priority action with new individual commencing employment.						
Azets Comments	Awaiting evidence of evaluation framework being extended to areas outwith P&P in order to close action.						

2022-23	Training	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		6	83%	1	1	3	0	0	1	0	0	0	0	0	0

Rec No.			Report Agreed Date	2nd[t] Agreed Revised Date	Priority	% Complete	Status
3.1	**RISK**	**There is a risk that SFRS is not achieving best value for money as there has been limited consideration of training delivery options with all training currently delivered in-house.**					
	Cost Efficiency As well as considering savings on in-house training delivered, management should undertake a cost/benefit evaluation to access if better value could be sought be using external training providers for at least some elements of mandatory training, e.g. casualty care. This evaluation should be reviewed on a periodic basis to ensure best value continues to be achieved.						
	Responsible Owner Agreed Response **AC Training Delivery**	Training will, as part of its continuous improvement and through its governance processes, consider the outsourcing of training delivery to ensure best value is achieved and that it is reviewed as necessary.	01 April 2024	31 Dec 2024	Grade 3	95%	RED

Progress to date (Update provided 07/03/25)	A further draft version has been presented to our Training FMT workshop in Oct'24 followed by continued staff engagement across our entire Training Instructor cadre. A programme of engagement with LSO Service Delivery Areas is currently underway by the Group Commander leads through Nov'24 with a final draft being presented to the Training, Safety & Assurance Directorate Management team in Dec'24 for approval. Once approved, this will be formally communicated into the new year and made available through our Service wide, Learning Content Management System (LCMS) for all to readily access. Our Training Framework(s) will also then be placed as an item on our Continuous Improvement Programme as this will continue to be a live document which will ensure the alignment to our National Training Standards, incorporating and building from our stakeholder feedback process to ensure it provides the information and support needed for end users. Continuing to work with procurement business partners (through a current change in internal management) to further develop our draft Commodity strategy for SFRS, linked to external training provision and to ensure that best value is active. Production of our Training Delivery Framework for SFRS. Production of our draft Commodity Strategy for the Training Function to support best value across the procurement supplier base and sourcing strategies in relation to external training. Met with Azets 09/01/2025 to review audit action and work completed to date. The only remaining item that Azets requires is the final sign off of the Commodity Strategy to allow the action to be classed as completed
Outstanding actions to close the recommendation	Since meeting with Azets on the 09/01/2025 there has been a delay in the final sign off as both the Training and Procurement functions consider alternative approaches in relation to the Commodity Strategy. Revised timescale will be advised once further consultation between functions have progressed
Azets Comments	Awaiting approval of Commodity Strategy to confirm closure.

2023-24	Partnership Working	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		3	0%	0	0	0	0	0	1	2	0	0	0	0	0

Rec No. 1.1	RISK	There is a risk that the SFRS does not have a consistent and effective approach to manage partnerships due to lack of clarity of approach based on the scale and complexity of individual partnerships and the role that SFRS is undertaking.					
	Operational deployment of partnership activities SFRS should develop a principles-based set of guidance that enables LSOs to manage partnership relationships effectively. This should focus on the effective deployment of resources and understanding the extent to which SFRS is meeting their obligations. This will include understanding: • Whether the partnership is large and/or complex • Roles and responsibilities of SFRS in meeting their obligations • Expected resource commitments both financial and non-financial • Agreed reporting arrangements Internal reporting arrangements should be focused on considering how SFRS have deployed their resources and how that effectively aligns with the objectives of SFRS.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Director of Strategic Planning, Performance and Communications**	We will develop guidance to compliment National Community Planning guidance setting out SFRS expectations for Local Senior Officers and their teams with respect to partnership working, including internal reporting arrangements on local partnership activity and resource commitments.	31 March 2025	n/a	Grade 2	40%	GREEN
Progress to date (update provided 07/03/25)	• Work is underway to review the National Community Planning Guidance and carry out research to identify similar guidance documents. • Work is underway to develop a reporting process and system that can be referenced within the Guidance document. • Work is underway to draft the guidance document. • This work is running behind schedule as the Team's focus has been on the development of the SFRS Strategy 2025-28 and Three-Year Delivery Plan. The timeline of these key pieces of work were brought forward following a request from the SFRS Board. • It is anticipated that the partnership guidance document will be available for publication by September 2025.						
Outstanding actions to close the recommendation	• Finalise the draft guidance document. • Carry out a consultation exercise with stakeholders. • Progress guidance through governance route and seek approval. • Publish guidance.						
Azets Comments	Awaiting evidence of the above in order to consider closing action.						

Rec No. 3.1	RISK	There is a risk that resources are not appropriately allocated resulting in either excessive time committed to partnerships to meet SFRS's obligations or insufficient time is committed resulting in objectives not being met.				
	3.1 Effective and proportionate planning of resources SFRS should review the resources committed to partnership working at a local level and ensure that appropriate resources are identified at both individual partnership and corporate levels. Periodically, the resources allocated should be reassessed to ensure that sufficient and not excessive resources are deployed to effectively develop and maintain partnerships.	Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status

	Action 1 Responsible Owner Agreed Response **Director of Strategic Planning, Performance and Communications**	Working in Partnership with PP&P, SPPC will develop and support improvements in local partnership reporting by developing a reporting framework that captures key information on SFRS local partnership working that allows SFRS to better assess resources allocated to partnership working.	31 March 2025	n/a	Grade 3	40%	GREEN
Action 1 Progress to date (update provided 07/03/25)	• Work has begun to identify the types of information we require to record and an accompanying process. This information and access to an interim reporting tool will form part of the guidance document referred to in Rec. 1.1. The same fields will later be used in Action 2 to develop an ICT module to record partnership activity. • The fields identified have been shared with ICT in advance of their work beginning for Action 2 to ensure requirements are understood and achievable. • This work is running behind schedule as the Team's focus has been on the development of the SFRS Strategy 2025-28 and Three-Year Delivery Plan. The timeline of these key pieces of work were brought forward following a request from the SFRS Board. • It is anticipated that the partnership guidance document will be available for publication by September 2025.					
Action 1 Outstanding actions to close the recommendation	• Finalisation of an improved reporting system and process in advance of CSET replacement review. • Carry out a consultation exercise with stakeholders (see 1.1.1). • Progress reporting proposal through governance route and seek approval. • Publish reporting system and process.						
Azets Comments	Awaiting evidence of the above in order to consider closing action.						
	Action 2 Responsible Owner Agreed Response **Director of Prevention, Protection and Preparedness**	SFRS will review the current Community Safety Engagement Toolkit to improve partnership reporting functionality.	31 March 2026	n/a	Grade 3	-	GREEN
Action 2 Progress to date (update provided 23/01/25)	• SFRS will replace the current Partnership Module hosted within the Community Safety Engagement Toolkit with a reporting tool that can capture partnership activity across the Service. • Initial discussions have taken place with ICT to progress the development of the outstanding modules on CSET.						
Action 2 Outstanding actions to close the recommendation	• Develop list of requirements for partnership recording tool • Initiative work with ICT business partner • Carry out testing • Launch new tool						
Azets Comments	Awaiting evidence of the above in order to consider closing action.						

	RISK	**There is a risk that either insufficient or excessive resources are deployed undermining the achievement of value for money..**					
Rec No. 4.1	**4.1 Reporting Arrangements** SFRS should periodically review the deployment of resources in relation to partnerships to ensure that they continue to meet their obligations in a value for money manner. This should build on processes identified within recommendation 1.1		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Director of Strategic Planning, Performance and Communications**	SFRS will incorporate the outputs from the partnership reporting framework into the annual SFRS Working in Partnership Report and provide highlight reports to Service Delivery Area DACOs in support of their management scrutiny of local area partnership.	31 December 2025	n/a	Grade 2	40%	GREEN

Progress to date (update provided 07/03/25)	• Initial planning has taken place to establish milestones and timeline to complete the action. • The process to ensure that timely Highlight Reporting has been noted and will be included in the guidance document referred to in Rec. 1.1. • This work is running behind schedule as the Team's focus has been on the development of the SFRS Strategy 2025-28 and Three-Year Delivery Plan. The timeline of these key pieces of work were brought forward following a request from the SFRS Board. • It is anticipated that the partnership guidance document will be available for publication by September 2025.
Outstanding actions to close the recommendation	• Ensure output from Partnership Reporting (see 3.1.1) is available to DACOs/HoFs to form timely Highlight Reporting. • Include a section in the draft SFRS Working in Partnership 2025/26 publication detailing output from the Partnership Reporting System (see 3.1.1).
Azets Comments	Awaiting evidence of the above in order to consider closing action.

2023-24	Risk Assurance Advisory Review	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				3	2	1	Ad	3	2	1	Ad	3	2	1	Ad
		5	40%	1	1	0	0	1	0	0	2	0	0	0	0

Rec No. 1.7	**RISK**	**Assurance should be a key component of any risk management framework as it is essential that there is a means for management and the Board to be able to determine whether the actions they are putting in place to address risk are effective and also, that appropriate action is taken where assurance is lacking. Failure to provide guidance on this to staff increases the risk of the actions put in place to mitigate risks not being effective which leads to the ineffective use of resources and increases the likelihood of the risk occurring.**				
	Risk Management Framework - Assurance The Risk Management and Policy Framework should be updated to provide detailed guidance on the Service's assurance framework including different types of assurance and how this should be collated/reported upon and monitored including the use of assurance mapping as a tool to assist this process. The policy should also be updated to include any changes which have been or will be made to processes following this review so that it reflects how risk management is/should be carried out in practice and provides sufficient guidance to relevant staff.	Report Agreed Date	1st Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Risk and Audit Manager**	The risk management policy will be reviewed to align with available guidance on the Assurance Framework. Any associated changes to the reporting framework will be incorporated within the risk management policy.	30 November 2024	31 March 2025	Grade 3	90%	GREEN
Progress to date (update provided 07/03/25)		The risk dashboard and associated risk register templates have been updated to incorporate lines of assurance, aligned with the Good Governance Framework. Input templates also now require evidence to be provided before control actions can be formally closed. Some amendments may be required to work undertaken once reports are provided to Committee. The risk management policy to be updated to reflect these changes once any additional changes have been completed.				
Outstanding actions to close the recommendation		Review work on the Risk Management Policy has been completed and going through peer review.				
Azets Comments		Awaiting evidence of updated Risk Management Policy in order to consider closing this action.				

Rec No. 2.14	**RISK**	There is a risk of different parts of the organisation operating in silos with regard to risk assurance which could lead to the risk assurance framework not being as effective or streamlined as possible with opportunities for a co-ordinated approach to managing and monitoring assurance not being explored and optimised.				
	Managing risk and assurance – Co-ordinated approach to risk assurance Management should consider adopting a more co-ordinated approach to risk assurance to ensure that processes are as effective and streamlined as possible with responsibilities clearly defined. At Appendix C, we have included a flowchart where we have suggested how risk management including the assurance framework could operate in practice to ensure this is achieved and that maximum use is made of the technology available for recording and reporting on risk.	Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Risk and Audit Manager / Head of Corporate Governance**	Further alignment between Assurance and Risk frameworks will be identified with additional guidance provided.	31 March 2025	n/a	Advisory	90%	GREEN
Progress to date (update provided 07/03/25)		Risk appetite statements have been agreed by the Board and now form part of the Services wider governance arrangement. The risk dashboard, input spreadsheets and reporting templates now include relevant information. The risk register input template also includes an alignment between control actions and lines of assurance, together with the added requirement for evidence of completion to be provided. The completion of the action is aligned to the updating of the risk management policy and additional guidance provided within guidance notes associated with risk registers.				

	Future improvement work, outwith the current control action will continue, in relation to the Power BI tool will continue throughout 2025/26 and discussions are being held between Data Services and ICT to support the streamlining of activities throughout the Service. For risk management, this would allow the removal of the input spreadsheet, with information able to be entered directly into the risk dashboard.						
Outstanding actions to close the recommendation	The risk dashboard has been developed to allow assurance information to be recorded and reported. Review work on the Risk Management Policy has been completed and going through peer review.						
Azets Comments	Awaiting evidence of updated Risk Dashboard and Risk Management Policy in order to consider closing this action.						
Rec No. 3.37	**RISK**	Failure to capture and make best use of the knowledge held by risk owners and associated managers in relation to assurance obtained for their Directorate risks increases the probability that gaps in assurance are not identified which could ultimately result in the risk materialising. Moreover, assurance activities could be duplicated leading to ineffective use of resources.					
	Assurance within the Directorates - Responsibility for documenting assurance Management should consider assigning responsibility for identifying and documenting assurances obtained in relation to individual Directorate risks to the risk owners and relevant managers in order to ensure that assurances are fully reviewed and that any gaps/duplication relating to assurance activities are more likely to be identified.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Risk and Audit Manager / Head of Corporate Governance**	The risk management policy will be reviewed and updated to include Directors' and relevant officers' responsibilities for the identification and documentation of assurances obtained in relation to individual risks.	31 March 2025	n/a	Advisory	90%	GREEN
Progress to date (update provided 07/03/25)	The risk dashboard and associated risk register templates have been updated to incorporate lines of assurance, aligned with the Good Governance Framework. Input templates also now require evidence to be provided before control actions can be formally closed. Some amendments may be required to work undertaken once reports are provided to Committee. The risk management policy to be updated to reflect these changes.						
Outstanding actions to close the recommendation	Review work on the Risk Management Policy has been completed and going through peer review.						
Azets Comments	Awaiting evidence of updated Risk Management Policy in order to consider closing this action.						

2023-24	Contract Management	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				4	3	2	1	4	3	2	1	4	3	2	1
		14	14%	0	0	2	0	0	8	4	0	0	0	0	0

Rec No. 1.1						
RISK	**There is a risk of staff being unaware of the current protocols for monitoring contracts in the absence of up-to-date and comprehensive documented procedures leading to an inconsistent and outdated approach to contract management resulting in poor supplier performance and financial and reputational loss.**					
Outdated Procurement Practice Note The Procurement Practice Note No.19 needs to be updated and approved as soon as practicable and be subject to periodic review going forward to ensure that it provides current and comprehensive coverage of the overall process and also reflects good practices in operation. This will assist in ensuring that a consistent approach is adopted for contract management throughout SFRS. Management also need to ensure that the Standing Orders for the Regulation of Contracts are also reviewed in a timely manner.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
Responsible Owner Agreed Response **Procurement Manager**	Management will progress a review and update of the Procurement Practice note and the Standing Orders for the Regulation of Contracts. These will be agreed through SFRS governance routes.	31 December 2024	30th September 2025	Grade 3	20%	GREEN
Progress to date (update provided 23/01/25)	Review of PPN and Standing Orders is currently underway					
Outstanding actions to close the recommendation	Slippage to actions due to illness and leave periods within the team.					
Azets Comments	Awaiting evidence of updated PPN and Standing Orders in order to consider closing this action.					

Rec No. 1.2						
RISK	**Assessment of the degree of risk associated with a contract is a key element of the contract management process as the type and frequency of monitoring including the level of resources allocated to the management of a contract is dependent on whether the contract is deemed to be high, medium or low risk. Failure to clearly define how risk is assessed in relation to contracts increases the likelihood of an incorrect risk assessment which could lead to inadequate and/or disproportionate contract management, resources not being used efficiently and effectively and subsequent poor supplier performance and financial loss**					
Risk Assessment When updating the Procurement Practice Note, management should also review the definitions of risk in order to provide clearer guidance for staff on the level of risk assigned to contracts.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
Responsible Owner Agreed Response **Procurement Manager**	Management will review the definition of risk as part of the review and update of the Procurement Practice note to ensure clearer guidance is provided on the level of risk assigned to contracts.	31 December 2024	30th September 2025	Grade 3	20%	GREEN
Progress to date (update provided 23/01/25)	Review of PPN and Standing Orders is currently underway					
Outstanding actions to close the recommendation	Slippage to actions due to illness and leave periods within the team.					
Azets Comments	Awaiting evidence of updated PPN and Standing Orders in order to consider closing this action.					

Rec No. 2.1	**RISK**	**Failure to keep a formal record of contract management meetings could lead to an increased risk of misunderstandings between SFRS and suppliers which could result in agreed actions not being carried out and potential conflicts between the two parties.**					
	Minutes of meetings not formally documented Minutes of formal contract management meetings should be recorded and shared with supplier to ensure transparency and accountability.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Procurement Manager**	Management will implement a process for recording of Contract Management Meetings and store within a centralised repository accessible by relevant individuals. Processes will be updated to ensure all minutes are shared formally with suppliers.	31 December 2024	30th September 2025	Grade 2	10%	GREEN
Progress to date (update provided 23/01/25)		Process of contract management recording being reviewed and updated – engagement with all relevant stakeholders will follow					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of process for recording Contract Management meetings and storing them centrally in order to consider closing this action.					
Rec No. 2.2	**RISK**	**There is a risk that contract managers may not adequately monitor the services being delivered under the contract in the absence of a method for formally determining and documenting the way in which the contract will be monitored. This could potentially compromise the quality and effectiveness of the contract management process.**					
	Monitoring mechanisms not formally documented Management should ensure that the way in which the services/goods provided under the contract will be monitored are determined and documented from the outset. This should encompass defined roles, responsibilities, monitoring type and intervals, quality criteria etc. for each contract to ensure comprehensive oversight and adherence to contractual obligations throughout the contract lifecycle		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Procurement Manager**	As part of the review of the PPN, management will ensure robust guidance and templates are implemented to ensure education provided to contract managers, enabling them to address the contract arrangements and the documentation required.	31 December 2024	30th September 2025	Grade 3	20%	GREEN
Progress to date (update provided 23/01/25)		Review of PPN on-going					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of updated PPN in order to consider closing this action.					
Rec No. 2.4	**RISK**	**There is a risk of duplicate efforts arising from self-monitoring activities being performed by both parties in the absence of a proper assessment mechanism to evaluate the frequency, nature and adequacy of the contractors' own monitoring practices. This could lead to inefficient allocation of resources resulting in financial and operational losses.**					
	Contractors' self-monitoring assessment As part of updating the Procurement Practice Note, management should incorporate guidance on assessing the frequency, nature and adequacy of self-monitoring conducted by contractors (including some illustrative examples) and determining whether reliance can be placed on this in order to ensure resources are used efficiently and any duplication is minimised.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Procurement Manager**	Management will incorporate guidance as requested as part of the review and update of the PPN.	31 December 2024	30th September 2025	Grade 3	20%	GREEN

Progress to date (update provided 23/01/25)	Review of PPN on-going
Outstanding actions to close the recommendation	Slippage to actions due to illness and leave periods within the team.
Azets Comments	Awaiting evidence of updated PPN in order to consider closing this action.

Rec No. 2.5			Report Agreed Date	1st Agreed Revised Date	Priority	% Complete	Status
	RISK	**There is a risk that contractor's performance may not be measured effectively throughout the period of the contract in absence of formally established quality standards/KPIs resulting in unaddressed performance issues or compromised quality.**					
		Contract specific quality standards/KPIs not defined Management should formally establish contract related quality standards/KPIs at the start of each contract either as part of tendering process or before commencing the contract and agree the frequency of assessing performance against those standards throughout the contract period.					
	Responsible Owner Agreed Response **Procurement Manager**	Management should formally establish contract related quality standards/KPIs at the start of each contract either as part of tendering process or before commencing the contract and agree the frequency of assessing performance against those standards throughout the contract period	31 March 2025	30th September 2025	Grade 3	10%	GREEN

Progress to date (update provided 23/01/25)	Review underway
Outstanding actions to close the recommendation	Slippage to actions due to illness and leave periods within the team.
Azets Comments	Awaiting evidence of contract related quality standards/KPIs being developed in order to consider closing this action.

Rec No. 3.1			Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	RISK	**There is a risk of insufficient capacity to conduct effective contract management activities due to inadequate resource allocation and the absence of periodic reviews. This situation may result in disruptions or failures to identify contract-related issues in a timely manner.**					
		Mechanism for resource allocation not developed Once the frequency and type of monitoring have been defined by management for a given contract (as per recommendation at 2.2), resource allocation to that contract should be conducted with due consideration of these factors, along with the contract's value and associated risks.					
	Responsible Owner Agreed Response **Head of Finance & Procurement**	Management are in the process of a recruitment campaign with the aim to obtain a fully established Procurement Team. Market demand is extremely competitive in this field, however all options are being considered to build the team. All resourcing of contracts is and will continue to be considered as capacity allows.	30 September 2024	n/a	Grade 3	100%	AMBER

Progress to date (update provided 23/01/25)	Recruitment is currently in progress to maximise the capacity within the team and fill all current vacancies where possible. Category Lead posts now finalised recruited, however capacity still stretched due to illness. This will be rectified in the new calendar year
Outstanding actions to close the recommendation	Supporting Evidence to be provided to Azets by responsible owner

Azets Comments		Awaiting evidence of mechanism for resource allocation being in place in order to consider closing this action.					
Rec No. 3.3	**RISK**	**There is a risk that staff may not have the necessary knowledge and skills required for managing contracts in absence of regular training on contract management leading to inefficiencies and errors in the contract management process.**					
	Training on contract management Management should devise a plan for providing training to staff involved in contract management with regular refresher training also provided on a periodic basis to keep staff up to date with evolving knowledge and practices in this area.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance & Procurement**	Management are currently exploring external training provision with the intention to implement across SFRS.	30 September 2024	30th September 2025	Grade 2	5%	AMBER
Progress to date (update provided 23/01/25)		Capacity limitations has delayed this					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of a training plan for contract management in order to consider closing this action.					
Rec No. 4.1	**RISK**	**There is a risk that contractors' performance is not reviewed and measured in the absence of periodic performance reports leading to compromised performance and inefficiency. There is a risk of inaccurate or incomplete monitoring of contractor's performance against established benchmarking in the absence of a structured comparison against the performance table and the failure to address all specified KPIs in the monthly progress report. This could lead to challenges in accurately assessing the contractor's adherence to contractual obligations and identifying areas for improvement or intervention.**					
	Performance measurement reports not prepared Management should enforce strict oversight to ensure contractors fully comply reporting requirements established within contracts. This includes mandating structured performance reporting at defined intervals, covering all related standards and KPIs. These reports should clearly articulate benchmarking criteria and deviations from these benchmarks.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Procurement Manager**	Robust Contract Management processes will be updated and implemented across SFRS. This will be encompassed within the PPN and centrally held repository for all contract information actions at 1.1 and 2.1.	31 December 2024	30th September 2025	Grade 3	20%	GREEN
Progress to date (update provided 23/01/25)		Ongoing as part of PPN review and update					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of updated PPN in order to consider closing this action.					
Rec No. 4.3	**RISK**	**There is a risk of continued underperformance by the contractor and compromised contract effectiveness in the absence of appropriate actions and penalties for unmet benchmarks leading to diminished value and financial loss to SFRS.**					
	Deductions for shortfalls against performance targets Management should ensure that appropriate arrangements are in place for determining if contractor performance falls below expected levels and whether this should result in penalties being incurred (as per the contract). Management should ensure that any financial or other penalties to be made are appropriately enforced.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status

	Responsible Owner Agreed Response **Procurement Manager**	As per previous actions, management will ensure robust processes are in place, are being followed and training is provided across SFRS to ensure action is taken if performance of a contractor falls below expected levels.	31 March 2025	30th September 2025	Grade 3	20%	GREEN
Progress to date (update provided 23/01/25)		On-going as part of all previous action / audit points					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of process for determining contractor performance in order to consider closing this action.					
Rec No. 6.1	**RISK**	**There is a risk of inadequate oversight and decision making in terms of contract cost and payments in the absence of appropriate cost reporting covering all the elements mentioned in the contract which could result in financial discrepancies, disputes and inefficiencies.**					
	Cost report not presented as agreed in the contract Management should enforce the contractual requirement for the supplier to present specified cost reports during monthly cost and procurement meetings. This requirement should be clearly communicated to the supplier with emphasis on the importance of timely and accurate reporting.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Procurement Manager**	As per previous actions, management will ensure a robust Contract Management review is undertaken and processes updated to clearly communicate supplier expectations and monitor adherence.	31 March 2025	30th September 2025	Grade 2	20%	GREEN
Progress to date (update provided 23/01/25)		On-going as part of all previous action / audit points					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of communication of supplier expectations and the monitor arrangements for this in order to consider closing this action.					
Rec No. 6.2	**RISK**	**There is a risk of inadequate oversight and transparency in contract management processes in the absence of structured periodic reporting to the board and/or sub-committees leading to key stakeholders being unaware of critical contract-related issues, including performance, compliance, and financial matters.**					
	Periodic reporting to the board Management should establish a formal mechanism for preparing and presenting periodic contract reports to the board or relevant sub-committees covering a summary of contract management activities for all the contracts and highlighting key issues, where appropriate.		Report Agreed Date	2nd Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance & Procurement**	Management currently report monthly through the FCS Procurement Group. New Governance structures have recently been introduced within SFRS – management will establish the most appropriate route for contract reporting and will produce reports for the appropriate boards.	31 December 2024	30th September 2025	Grade 2	20%	GREEN
Progress to date (update provided 23/01/25)		On-going as part of all previous action / audit points					
Outstanding actions to close the recommendation		Slippage to actions due to illness and leave periods within the team.					
Azets Comments		Awaiting evidence of periodic contract reporting to an appropriate forum in order to consider closing this action.					

2024-25	Environmental Management	Total No of Actions	% Complete Actions	Fully Implemented				Part/In Progress				Not Implemented			
				3	2	1	Ad	3	2	1	Ad	3	2	1	Ad
		7	29%	0	1	0	1	1	2	1	1	0	0	0	0

Rec No. 1.2	RISK	There is the risk of non-compliance with regulations, reduced effectiveness and operational inefficiencies.					
	Strategies, Plans and Policies Management should update the Waste Management Guidance Policy and set reminder to ensure timely reviews subsequently.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Environment and Carbon Manager**	Version control and documents to be saved in iHub to document library. This will ensure reviews of documents are timeously carried out	31 March 2025	n/a	Grade 1	100%	GREEN
Progress to date (update provided 05/03/25)	The Policy has been updated and sent to Document Control to update the register.						
Outstanding actions to close the recommendation	Awaiting Supporting Evidence from Responsible owner to be forwarded						
Azets Comments	Awaiting evidence of the above in order to consider closing action.						

Rec No. 3.1	RISK	There is a risk of non-compliance with terms and conditions, which could lead to penalties, loss of funding, or damage to the organisation's reputation.					
	Monitoring Funding Terms and Conditions Management should ensure that all conditions and terms of funding received are recorded and monitored. This should include establishing a centralised repository or log to ensure that all conditions are documented and tracked consistently.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance**	Management will ensure that all conditions and terms of funding received are recorded and monitored. This will include a log to ensure that all conditions are documented and tracked consistently	31 March 2025	n/a	Grade 3	0%	GREEN
Progress to date (update provided 23/01/25)	This is being addressed through work ongoing within Revenue Maximisation Audit actions. Full details and evidence will be provided in due course.						
Outstanding actions to close the recommendation							
Azets Comments	Awaiting evidence of the above in order to consider closing action.						

Rec No. 3.2	RISK	There is a risk of incomplete or inaccurate submissions, missed funding opportunities, and potential compliance and reputational issues					
	Approval of grant applications Management should ensure that all grant applications are reviewed and approved by the Director of Finance and Contractual Services before submission and maintain documentation of this review process to enhance accuracy, compliance, and funding success.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance**	Management will ensure that all grant applications are reviewed and approved by the Director of Finance and Contractual Services before submission and maintain documentation of this review process to enhance accuracy, compliance, and funding success.	31 March 2025	n/a	Grade 2	0%	GREEN

Progress to date (update provided 23/01/25)	This is being addressed through work ongoing within Revenue Maximisation Audit actions. Full details and evidence will be provided in due course.						
Outstanding actions to close the recommendation							
Azets Comments	Awaiting evidence of the above in order to consider closing action.						
Rec No. 3.3	**RISK**	**There is the risk that the absence of a repository and formal process for tracking funding applications and outcomes may lead to repeated mistakes and missed opportunities for improvement, reducing the effectiveness of future funding efforts.**					
	Funding Application Documentation Management should develop a central repository and formal process for tracking funding applications and outcomes. This will help minimise repeated mistakes, identify areas for improvement, and enhance the effectiveness of future funding efforts.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Head of Finance**	Management will develop a central repository and formal process for tracking funding applications and outcomes.	31 March 2025	n/a	Grade 2	0%	GREEN
Progress to date (update provided 23/01/25)	This is being addressed through work ongoing within Revenue Maximisation Audit actions. Full details and evidence will be provided in due course.						
Outstanding actions to close the recommendation							
Azets Comments	Awaiting evidence of the above in order to consider closing action.						
Rec No. 3.4	**RISK**	**There is a risk that environmental management projects aimed at reducing carbon emissions may not be completed, which could hinder the Service's ability to meet its environmental objectives and commitments.**					
	Aligning spending plans on Environmental management Initiatives to available resources/funding We recommended that the Service undertakes a further review of its strategic environmental goals to confirm they remain achievable over the planning period. Management should reassess its plans and set realistic targets that align with available resources. Plans for environmental management and carbon footprint reduction should be feasible and developed with clear consideration to the constraints of current funding and staffing levels. Regular reviews should be conducted to monitor progress and address any shortfalls promptly.		Report Agreed Date	Agreed Revised Date	Priority	% Complete	Status
	Responsible Owner Agreed Response **Environment and Carbon Manager**	A revised Carbon Management Plan is under development, this will have to be based on the outcomes of SSRP, as part of this work we will reassess the current plan and set targets that align with available resources.	31 December 2025	n/a	Advisory	10%	GREEN
Progress to date (update provided 05/03/25)	The action has been progressed, but the detailed areas of the plan cannot be finalised until the outcomes of the SSRP have been shared, available resources determined and carbon reduction budgets outlined by the Scottish Government.						
Outstanding actions to close the recommendation							
Azets Comments	Awaiting evidence of the above in order to consider closing action.						

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/11-25

Agenda Item: 7.3

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**DRAFT INTERNAL AUDIT PLAN 2025/26**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to provide the Audit and Risk Assurance Committee (ARAC) with the draft 2025/26 Internal Audit Plan for scrutiny and agreement.
2	**Background**
2.1	Internal Audit is an independent and objective assurance and consulting activity designed to add value and improve the operations of Scottish Fire and Rescue Service (SFRS). It helps senior management accomplish their objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.
2.2	The provision of an Internal Audit framework is a key dimension of assurance that is required by the Accountable Officer to enable them to sign the governance statement as part of the annual accounts, for which they are responsible.
2.3	For SFRS the Internal Audit function is provided by an external contractor with this work currently undertaken by AZETS. Following a tender BDO have been appointed as Internal Auditors from 1 April 2025, for a 5 year period, with the 2025/26 internal audit plan to be presented to the ARAC on 8 April 2025.
2.4	Within SFRS, internal audit engagement is led by the Director of Finance and Contractual Services, and audit planning is developed in conjunction with the Strategic Leadership Team (SLT) and ARAC. Draft audit scoping papers, completed assignment reports, and quarterly progress updates are reported to SLT in advance of submission to ARAC, to ensure internal audit work is meeting the organisation's needs.
3	**Main Report/Detail**
3.1	With the external appointment of BDO as the Services new internal auditors work was undertaken with the Strategic Leadership Team over February and March to identify review areas for inclusions within the 2025/26 internal audit plan.
3.2	The audits selected reflect the discussions held individually and collectively with SLT, the Audit and Risk Assurance Committee, together with consideration of the Service risk registers, and once completed will: • Enhance Risk Management • Improve Operational Efficiency

	• Ensure Compliance • Promote Continuous Improvement • Strengthen Stakeholder confidence
3.3	The revised audit plan is attached as Appendix A to the report and identifies 6 areas for review. Each review has an identified Executive Sponsor, outlined on page 11 of the plan, who will be responsible for identifying the relevant resource to support the review including planning, fieldwork, reporting and follow up.
3.4	For 2025/26 the following areas have been included for review, together with the anticipated timing of each audit and reporting date to ARAC:

REF	AUDIT TOPIC	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET ARAC
SFRS/FY25/01	Corporate Governance													OCT
SFRS/FY25/02	Risk Management													OCT
SFRS/FY25/03	Budgetary Management and Investment Prioritisation													JAN
SFRS/FY25/04	Estates & Facilities Management													JAN
SFRS/FY25/05	Freedom of Information													MAR
SFRS/FY25/06	PPE Process													MAR
SFRS/FY25/07	Follow Up													ALL

3.5	A high-level scope is identified for each review on page 11, with additional work to be undertaken with Executive Sponsors in advance of each audit to further define this remit. All agreed scopes will be provided to SLT for review in advance of reporting to ARAC.
3.6	The agreed audit plan will be presented to ARAC on 8 April 2025 with the Corporate Governance audit due to begin at the end of April. A separate report has been provided to SLT on the proposed scope of this audit.
4	**Recommendation**
4.1	The Audit and Risk Assurance Committee is asked to: • Scrutinise and approve the draft 2025/26 internal audit plan.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk/Risk Appetite** The report is aligned to the Services Compliance risk appetite in relation to our internal governance, including systems of control and data governance, where a Cautious risk appetite was identified.
5.1.2	The report reflects the general underlying principle that SFRS will operate in an open and transparent manner using our resources responsibly and demonstrating best value in the use of public funds.
5.2 5.2.1	**Financial** This review is part of the 2025/26 internal audit plan and has been incorporated within the budget for 2025/26.
5.3 5.3.1	**Environmental & Sustainability** Any implications arising from the report will be managed by the relevant Directorate.
5.4 5.4.1	**Workforce** Any implications arising from the report will be managed by the relevant Directorate.
5.5 5.5.1	**Health & Safety** Any implications arising from the report will be managed by the relevant Directorate.

5.6 5.6.1	**Health & Wellbeing** Any implications arising from the report will be managed by the relevant Directorate.	
5.7 5.7.1	**Training** Any implications arising from the report will be managed by the relevant Directorate.	
5.8 5.8.1	**Timing** The report is provided to the ARAC to allow sufficient time for the audit plan to be scrutinised and agreed and to allow work to begin in relation to the Corporate Governance review.	
5.9 5.9.1	**Performance** The internal audit contract will outline a number of agreed key performance indicators to demonstrate whether contract requirements are being met. Performance data will be provided by the Internal Auditor and reported quarterly to the ARAC.	
5.10 5.10.1	**Communications & Engagement** Any implications arising from the report will be managed by the relevant Directorate.	
5.11 5.11.1	**Legal** Any implications arising from the report will be managed by the relevant Directorate.	
5.12 5.12.1	**Information Governance** DPIA completed - No. the outcome of each audit review will provide a summary of information and actions to be taken by Directorates, and named individuals, to manage any significant risk identified. The responsible Directorate will ensure that any relevant DPIA is completed as required	
5.13 5.13.1	**Equalities** EHRIA completed - No. Where an equalities assessment is required, this will be determined by the responsible Directorate and progressed accordingly.	
5.14 5.14.1	**Service Delivery** Any implications arising from the report will be managed by the relevant Directorate.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance:** **(Mark as appropriate)**	NA
7.3	**Rationale:**	BDO, as appointed internal auditors, have developed the plan utilising their own knowledge and understanding of the Service's priorities and their ongoing assessment of Service risks. The draft plans have been discussed within an ARAC workshop and have been agreed by the Strategic Leadership Team.
8	**Appendices/Further Reading**	
8.1	Appendix A – Draft 2025/26 Internal Audit Plan	

Prepared by:	David Johnston, Risk and Audit Manager; Sean Morrison, Internal Audit Senior Manager
Sponsored by:	Sarah O'Donnell, Director of Finance & Contractual Services
Presented by:	Sean Morrison, Internal Audit Senior Manager

Links to Strategy and Corporate Values
The Internal audit process forms part of the Services Governance arrangements and links back to Outcome 5 of the 2022-25 Strategic Plan, specifically Objectives 5.1 and 5.6: **Outcome 5: We are a progressive organisation, use our resources responsibly and provide best value for money to the public.** • Objective 5.1: Remaining open and transparent in how we make decisions. • Objective 5.6: Managing major change projects and organisational risks effectively and efficiently.

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Strategic Leadership Team	*20 March 2025*	*For Decision*
Audit and Risk Assurance Committee	*8 April 2025*	*For Scrutiny*

APPENDIX A

SCOTTISH FIRE AND RESCUE SERVICE

ANNUAL INTERNAL AUDIT PLAN 2025-26 - DRAFT

MARCH 2025

IDEAS | PEOPLE | TRUST

CONTENTS

INTRODUCTION AND EXECUTIVE SUMMARY

Introduction

- Internal auditing strengthens the organisation's ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight.
- Our approach is to help the Scottish Fire and Rescue Service accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. Our approach complies with best professional practice, in particular, the principles set out in the Institute of Internal Auditor's (IIA's) International Professional Practices Framework (IPPF) which includes the new Global Internal Audit Standards that became effective from January 2025.
- The purpose of this paper is to set out, and seek agreement from, the Scottish Fire and Rescue Service Audit and Risk Assurance Committee on the Internal Audit Annual Plan for 2025-26.

Internal Audit at Scottish Fire and Rescue Service

We have been appointed as internal auditors to the Scottish Fire and Rescue Service to provide the Audit and Risk Assurance Committee and the Senior Leadership Team with assurance on the adequacy of risk management, governance and internal control arrangements.

Responsibility for these arrangements remains fully with management who should recognise that Internal Audit can only provide 'reasonable assurance' and cannot give any guarantee against material errors, loss or fraud. Our role is aimed at helping management to improve its risk management, governance and internal control mechanisms, so reducing the effects of any significant risks facing the service.

In establishing the internal audit plan for 2025-26 we have sought to further clarify our initial understanding of the Scottish Fire and Rescue Service's business and risk profile in the context of:

- Corporate risks
- Management's priorities and objectives for the coming year
- The key challenges facing the organisation, by reviewing the significant risk register
- The internal audit work carried out in prior years
- Cyclical coverage based on the audit universe

Priorities identified include prioritisation of resources, regulatory compliance, succession planning, equipment controls, estates management, health and safety, and significant change which the organisation faces in the coming years.

Summary

- The Internal Audit Plan for 2025-26 is set out within this document and comprises six audits, an annual follow up, and contract management totalling 156 days.
- The rolling four-year Internal Audit Plan is set out on page 15 onwards and will be subject to review each year.
- The total cost of the Annual Plan for 2025-26 will depend on the staff mix used but it is estimated to be in the region of £90,000 per the tender submission and agreed contract.

INTERNAL AUDIT STRATEGY

Internal Audit Vision

Our vision is to be a trusted, agile, and proactive internal audit service that enhances the integrity, efficiency, and effectiveness of the organisation.

Strategic Objectives

1. Enhance Risk Management
Contribute to identifying, assessing and providing assurance over the management of key risks to enhance risk management practices.

2. Improve Operational Efficiency
Streamline processes and procedures to enhance operational efficiency and effectiveness.

3. Ensure Compliance
Ensure adherence to laws, regulations, and internal policies to maintain high standards of governance.

4. Promote Continuous Improvement
Foster a culture of continuous improvement through regular audits and feedback. Enhance audit reporting in order to bring enhanced data insights and focus attention on key messages.

5. Strengthen Stakeholder Confidence
Build and maintain trust with stakeholders through transparent and accountable audit practices.

Supporting Initiatives

1. Risk and Assurance mapping
Continue to regularly review organisational risks and work with first and second line to continuously map assurance provision to risks.

2. Process Optimisation Reviews
Continue to perform detailed reviews of key processes to identify areas for improvement and implement best practices.

3. Compliance Audits
Schedule regular compliance audits to provide assurance that activities meet legal and regulatory requirements.

4. Stakeholder Engagement Sessions
Continue to hold regular sessions with stakeholders to discuss audit findings, gather feedback, and build trust, and to collaborate on assurance provision.

5. Technology Integration
Leverage advanced audit tools and technologies to enhance the accuracy and efficiency of audit processes.

6. Performance Metrics
Continue to monitor and report on key performance indicators (KPIs) to measure the effectiveness of the internal audit function.

By focusing on these strategic objectives and supporting initiatives, we aim to deliver exceptional internal audit services that support the mission and goals of the organisation.

INTERNAL AUDIT APPROACH

Background

- Our risk-based approach to internal audit uses the Scottish Fire and Rescue Services risk management processes and risk registers as a starting point for audit planning, as this represents the service's own assessment of the risks to it achieving its strategic objectives.
- The extent to which we can rely on management's own perception of risk largely depends on the maturity and effectiveness of the Scottish Fire and Rescue Service's own arrangements for managing risk. In estimating the amount of audit resource required to address the most significant risks, we have also sought to confirm that senior management's own assessment of risk accurately reflects the organisation's current risk profile.

In establishing the Internal Audit Strategy, we have sought to further clarify our initial understanding of the operations at the organisation, together with its risk profile in the context of:

- The overall strategy and objectives of the organisation
- Key challenges facing the organisation, by reviewing the standing corporate risk register and discussion with Senior Management
- Key areas where management wish to monitor performance and the manner in which performance is measured
- Financial and non-financial measurements and indicators of such performance
- The information required to 'run the organisation'

Our Risk Based Planning Approach for 2025-2026

The 2025-2026 Internal Audit (IA) plan has been created to exhibit the planned Internal Audits to be conducted within the audit year.

As part of the planning process to align the IA plan to the organisation's needs, the Internal Audit team spent time with Senior Management in the initial four-year programme development to discuss the key areas of focus and concern for the organisation in 2025-2026. During these discussions, we covered the potential areas of focus in as well as any emerging risks within the organisation. The outputs from these discussions were incorporated into the Internal Audit plan outlined within this document.

The 2025-2026 Internal Audit plan was formed using the information above, the risk register, the organisation's strategic documents, previous audit coverage, along with our own knowledge and understanding of the organisation's priorities, and our own ongoing assessment of risks.

Planned Approach to Internal Audit 2025-26

- The suggested Internal Audit Plan for 2025-26 is set out on pages 10 onwards. We will keep the plan under review throughout the year and we will highlight for consideration any significant areas of risk identified during that period that may need to be included as part of the internal audit plan.
- Where auditable areas correspond to corporate risks, we will take into account the mitigation strategies in place when performing our reviews. This is to ensure that the mitigating controls, as well as the actions that have been identified by management, are in operation and are effective.

High Risk Areas

There are no significant risks which are not being covered within the outlined four-year audit programme outlined within this plan.

Contingency Audits

The audit plan is flexible to allow priority topics and emerging risk areas to be included within the 25-26 coverage.

There are currently no set contingency audits outlined within the programme. However, audits can be moved forward from later years or to cover emerging risks as required.

INTERNAL AUDIT APPROACH

Variations to the Plan

We will continue to keep the Internal Audit Plan under review throughout the year. We will highlight for consideration any significant areas of risk identified during that period, which may need to be included as part of the annual plan.

We acknowledge that variations to this plan may arise if the organisation's strategic priorities, risk profile or governance arrangements change. Approval will be sought from the Audit & Risk Assurance Committee before any changes to the Internal Audit Plan are made.

Individual Audits

In determining the timing of our individual audits, we will seek to agree a date most convenient to the organisation which ensures the availability of key stakeholders. Once this plan is agreed we will discuss priorities and workloads with management and re-issue the plan including the proposed phasing of our internal audit work.

For each we have set out whether they are an assurance or advisory engagement. For each assurance review, we will identify the key objectives of the area subject to audit and the risks of those objectives not being met. We will assess the 'unmitigated' risk (i.e. before the operation of the controls in place) and, having identified and tested those controls, make an assessment of the 'mitigated' risk. This will enable us to confirm that the control infrastructure does reduce risk to a level the Scottish Fire and Rescue Service is comfortable with. Each of our audit reports will include two opinions:

- Firstly, on the design of controls that are in place
- Secondly, on the operational effectiveness of those controls in practice.

INTERNAL AUDIT RESOURCES AND OUTPUTS

Resourcing

The plan has been drafted giving consideration to the Scottish Fire and Rescue Service's budget and how coverage can be best obtained. Resource will be adequate to ensure the delivery of agreed reports to time, except where this is outside of our control. BDO has a core group of professionally qualified staff, including Chartered Accountants and The Institute of Internal Auditors qualified staff, as well as other specialists and experienced auditors. Our team is fully attuned with modern internal audit practice and recognised risk and governance standards.

Subject to approval of the budget, we can confirm that we have sufficient human, financial and technological resources to deliver the Internal Audit Plan.

Core internal audit team

The core team that will be managing the internal audit programme is:

Name	Grade	Qualification	Email
Claire Robertson	Director - Head of RAS Scotland	CA	Claire.Robertson@bdo.co.uk
Sean Morrison	Internal Audit Senior Manager	CA	Sean.Morrison@bdo.co.uk

This team will be supported by members of our Risk Advisory Services (RAS) team and wider firm, as and when required.

Reporting to the Audit and Risk Assurance Committee

Each year we will submit the Internal Audit Plan for discussion and approval by the Audit and Risk Assurance Committee. We will liaise with the Risk and Audit Manager and other senior officers, as appropriate, to ensure that internal audit reports, summarising the results of our visits, are presented to the appropriate Audit and Risk Committee meeting.

Internal Audit Charter

We have formally defined Internal Audit's purpose, authority and responsibility in an Internal Audit Charter, which can be found in Appendix I. The Charter establishes Internal Audit's position within the Scottish Fire and Rescue Service and defines the scope of its activities.

Definitions

We define in Appendix III our approach for grading individual audit findings and overall audit reports. These definitions have been designed to make the ratings clear to both the Internal Audit team and audit stakeholders.

Working Protocols

We have defined operating protocols for managing each assignment. These can be found in Appendix II. The procedures take account of how we will communicate with stakeholders before, during and after each audit.

OUR APPROACH TO PLANNING

Planning approach

Strategic objectives of Scottish Fire and Rescue Service

Internal audit focus - adding value approach

1 Governance and control culture

What is the strength of the current environment?

Evaluate:
- Strength of internal control framework and risk management arrangements
- Organisational culture, leadership and tone at the top
- Are new systems being designed and embedded?
- Are there significant changes ongoing or planned?

2 Risk register

What risks is internal audit assurance sought on?

Consider:
- Current risk profile
- New and emerging risks in the sector/from the wider external environment and their potential impact
- Assurance available from compliance functions and other teams (2nd line of defence).

3 External influences

What work is mandated within the sector?

Incorporate:
- Mandatory requirements of sector
- An approach that meets the standards of the Institute of Internal Auditors.

4 Value add

What value is sought from internal audit?

Understand:
Stakeholder perception of value
- Audit and Risk Assurance Committee
- Service Leadership Team
- Management and staff
- Public

Potential scope and make up of internal audit plan

- **Risk Aligned Audit Activities**: Assurance reviews that will provide an opinion over both the design and operational effectiveness of the internal controls in place for corporate risk areas. Benchmarking good practice and using our experience to improve processes and controls.
- **Key Policy Assurance**: Compliance testing and assurance of the organisations' key policies to help building a culture of compliance and accountability across the business.
- **Advisory Assignments:** Where processes and controls are knowingly not mature, we can provide advice and recommendations to improve the overall control environment.
- **Controls Assurance of Key Processes & Systems**: Controls testing and assurance of key processes and systems selected from the Audit Universe on a risk prioritised basis. This can include where appropriate continuous auditing.
- **Assurance Over Change:** Considering key change initiatives, capital expenditure and mission critical projects where assurance may be required as to progress made, realisation of notable benefits, and being delivered in line with good practice. This can include project advisory.
- **Follow Up Of Previous Audit Activities**: Management's agreed actions in response to each audit periodically followed up to ensure that they have been properly implemented as agreed and to escalate any concerns regarding their implementation to management and the Audit and Risk Assurance Committee.

OUR APPROACH TO PLANNING

Planning approach

1 Governance and control culture

The governance and control culture is a fundamental consideration when developing the internal audit approach. We believe that governance is not only affected by procedures, rules and regulations (hard controls); another equally important component is the established culture and behaviour of employees within the Scottish Fire and Rescue Service, as these determine the effectiveness of governance.

We have developed an understanding of these areas through a combination of our discussions with you about your business strategy and through review of documents such as the Strategic Plan, Annual Report, previous internal audit coverage, good governance framework, risk registers.

Assessment of culture and behaviour will be a key theme throughout the delivery of our work and we will look to provide insight into whether these cultural factors support ethical behaviour on an ongoing basis.

In deriving the plan for 2025-26 and onwards we will focus on any planned and ongoing changes to core systems, functions, resource, and processes to respond to the changes in the wider environment.

2 Current risk register

On an ongoing basis, our audit plan will be based upon a detailed assessment of those risks that affect the achievement of the Scottish Fire and Rescue Service strategic objectives. Our audit programme will be designed to ensure that controls are in place such that key risks are appropriately managed and controlled. To understand the organisation's objectives and key risks, we considered the following:

- Scottish Fire and Rescue Service's strategy and objectives
- Risk registers
- Financial forecasts and performance
- Input from other key assurance providers, including HMICFRS and External Audit
- The content of your most recent internal audit reports
- The internal audit plan and corporate risk register will be periodically reviewed during 2025-26. Should the plan need to change we will seek approval from the Audit and Risk Assurance Committee.

3 External influences

Our programme of work is designed to comply with the Global Internal Audit Standards which form part of the International Professional Practice Framework set out by The Institute of Internal Auditors.

We will also consider in our work any externally imposed regulation relating to governance, risk and control.

4 Value add

We understand that 'value' is perceived differently by each client and therefore we do not seek to have a standard approach to this element of the audit programme.

Our methodology considers the additional value the Audit and Risk Assurance Committee and management are seeking from internal audit, beyond the assurance our work provides.

We therefore consider this alongside our understanding of the risks. Added value may take a range of forms, from benchmarking and other peer comparisons, to involvement with advising on new systems implementation, advisory assignments and training.

We will clearly set out in the plan which elements of adding value activity we will deliver.

INTERNAL AUDIT PLAN – 2025-2026

Set out below is the Internal Audit plan for 2025-2026. Executive sponsors have been assigned to each review. The Executive sponsors will be responsible for identifying the relevant colleagues who should be involved in each stage of the Internal Audit review (e.g., planning, fieldwork, reporting, follow up.).

The budgeted number of days is subject to change, following the completion of the planning stage of each review and will be charged at the agreed blended day rate. In addition, the detailed significant risks each Internal Audit is associated with can be found on page 13.

REF	AUDIT TOPIC	SIGNIFICANT AND DIRECTORATE RISK REGISTER #	LINK TO STRATEGIC PRIORITIES	PRIMARY SOURCE & REASON FOR SELECTION	PROPOSED EXECUTIVE SPONSOR(S)	BUDGETED DAYS
SFRS/FY25/01	Corporate Governance	SPPC003	Improving Performance	Audit assessment, and management request	Director of Strategic Planning, Performance and Communications	18
SFRS/FY25/02	Risk Management	FCS020	Improving Performance	Audit Assessment and management request	Deputy Chief Officer	18
SFRS/FY25/03	Budgetary Management and Investment Prioritisation	FCS008; TSA019; POD020	Improving Performance; Investing in our People	Risk register, Audit assessment, and management request	Director of Finance and Contractual Services	20
SFRS/FY25/04	Estates & Facilities Management	FCS021; POD022; TSA014	Innovation and Investment; Safe and Effective Response	Risk register, Audit assessment, and management request	Director of Finance and Contractual Services	25
SFRS/FY25/05	Freedom of Information	SPPC004; POD018	Innovation and Investment	Risk Register, Audit assessment and management request	Director of Strategic Planning, Performance and Communications	20
SFRS/FY25/06	PPE Process	FCS021	Investing in our People; Innovation and Investment	Audit assessment and management request	Director of Finance and Contractual Services	25
SFRS/FY25/07	Follow Up	NA	NA	Audit assessment	Risk & Audit Manager	14
NA	Audit Plan Development	NA	NA	NA	NA	4
NA	Audit & Risk Assurance Committee Attendance and Preparation	NA	NA	NA	NA	5
NA	Client Liaison	NA	NA	NA	NA	5
NA	Annual Reporting	NA	NA	NA	NA	2
			Total			**156**

INTERNAL AUDIT PLAN – 2025-2026

For each review which forms part of the proposed Internal Audit plan for 2025-2026, we have outlined a high-level scope for illustration purposes to support the planning phase. Executive sponsors have been assigned to each review. The Executive sponsors will be responsible for identifying the relevant colleagues who should be involved in each stage of the Internal Audit review (e.g., planning, fieldwork, reporting, follow up.).

REF	AUDIT TOPIC	REVIEW TYPE	HIGH LEVEL SCOPE	EXEC SPONSOR(S)
SFRS/FY25/01	Corporate Governance	Assurance	The purpose of this review is to provide management and the Audit & Risk Assurance Committee with assurance over key corporate governance controls, including that the Board and Board sub-committees have a clear and appropriate terms of reference and programme of work; are provided with suitable training and efficient and effective support; that the governance structure is appropriate; that there are clear reporting lines and consistent reporting; and meetings are effective in delivering scrutiny and driving continuous improvement. The review will also assess the assurance reporting in place, including the process for developing, reviewing and updating the Directorate assurance reports.	Director of Strategic Planning, Performance and Communications
SFRS/FY25/02	Risk Management	Assurance	We will assess the risk management arrangements and provide management with advice and recommendations for improving the arrangements further. The deliverables will include an internal audit report and a populated risk management maturity model, to demonstrate to management in detail the maturity status and actions which can be taken to further develop the risk management processes. The review will also assess the assurance mapping processes in place within the organisation and how this is linked to risk management.	Deputy Chief Officer
SFRS/FY25/03	Budgetary Management and Investment Prioritisation	Assurance	The purpose of this review is to provide management and the Audit & Risk Assurance Committee, with assurance over the design and operational effectiveness of the key budget setting, business case and investment prioritisation controls in place, and to assess whether controls and processes regarding budget prioritisation and setting are well designed and operating effectively.	Director of Finance and Contractual Services
SFRS/FY25/04	Estates & Facilities Management	Assurance	The purpose of this review is to provide management and the Audit & Risk Assurance Committee with assurance that key controls in place to manage planned, preventative and reactive maintenance costs across the estate are well designed and operating effectively. We will also assess whether a clear Estates strategy is in place, with supporting operational plans, which are monitored effectively.	Director of Finance and Contractual Services
SFRS/FY25/05	Freedom of Information	Assurance	The purpose of this review is to assess the design and effectiveness of the controls in place to manage the requirements under the terms of the Freedom of Information (Scotland) Act, including consideration of the effective responses to requests, the lines of responsibility and governance arrangements in place, and training.	Director of Strategic Planning, Performance and Communications
SFRS/FY25/06	PPE Process	Assurance	The purpose of this audit is to provide independent assurance that appropriate policies and procedures are in place to ensure compliance with statutory requirements relating to PPE. This will include assessing the PPE lifecycle from purchasing, maintaining, quality inspection, allocation, disposal, return of equipment, and supplier management.	Director of Finance and Contractual Services
SFRS/FY25/07	Follow Up	Assurance	The effectiveness of internal control systems may be compromised if management fails to implement agreed audit recommendations. Our follow up work will provide the Finance & Audit Committee with assurance that recommendations are implemented within the expected timescales.	Risk & Audit Manager

INTERNAL AUDIT SCHEDULE - 2025-2026

The chart below sets out the proposed delivery schedule for the 2025-2026 Internal Audit plan.

REF	AUDIT TOPIC	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TARGET ARAC
SFRS/FY25/01	Corporate Governance													OCT
SFRS/FY25/02	Risk Management													OCT
SFRS/FY25/03	Budgetary Management and Investment Prioritisation													JAN
SFRS/FY25/04	Estates & Facilities Management													JAN
SFRS/FY25/05	Freedom of Information													MAR
SFRS/FY25/06	PPE Process													MAR
SFRS/FY25/07	Follow Up													ALL

LINK TO RISK REGISTER

We have linked the Scottish and Fire Rescue Service's significant risk register to the audits in our Internal Audit Plan (as of January 2025)

Ref	Risk Summary	Gross risk score	Net risk score	Previously audited	Audit in IA plan				Other assurance
					FY25	FY26	FY27	FY28	
FCS018	There is a risk of continued challenges with recruiting and retaining staff with the necessary skills and experience required to support the move to a Cloud based environment	20	20			✓		✓	
PPP005	There is a risk of insufficient levels of qualified and skilled Fire Engineering resources	20	20	✓		✓		✓	
SDD007	There is a risk of SFRS being unable to maintain adequate levels of Cyber Security to avoid any breach.	20	20	✓		✓		✓	
TSA019	There is a Directorate risk, of an inability to maintain or improve our training delivery due to the limited finance/budget available for capital investment, condition and location of our Training Estate.	20	20	✓	✓				
POD021	There is a risk to the health and safety of operational employees.	20	20			✓			
POD022	There is a risk of failure to undertake periodical examinations for asbestos.	20	20	✓	✓				
POD015	There is a risk that the People and Finance teams are unable to effectively support the significant number of concurrent Pensions related exercises.	16	16			✓			✓
FCS005	There is a risk that the Service may be unable to secure levels of funding required to achieve its strategic objectives.	16	16	✓					✓
FCS019	There is a risk that many of our critical services and systems, which support Operations Control team functions, could fail and be unrecoverable.	16	16	✓		✓	✓		

LINK TO RISK REGISTER

We have linked the Scottish and Fire Rescue Service's significant risk register to the audits in our Internal Audit Plan (as of January 2025)

Ref	Risk Summary	Gross risk score	Net risk score	Previously audited	Audit in IA plan				Other assurance
					FY25	FY26	FY27	FY28	
FCS022	There is a risk of continued challenges with recruiting and retaining staff with the necessary skills and experience required to support the Finance and Procurement Function.	16	16	✓		✓		✓	
SPPC004	There is a risk that the service fails to comply with information governance legislation	16	16		✓		✓		
POD020	There is a risk that the Directorate is unable to deliver against stated commitments and objectives or provide timeous support to wider SFRS projects and change initiatives, due to limited resources and capacity brought about by the current financial context and competing organisational priorities.	16	16	✓	✓	✓			
POD023	There is a risk that employee wellbeing records are not being maintained in accordance with the SFRS Policies and Procedures.	16	16	✓				✓	
OD001	There is a risk of a non-resilient fire control due to insufficient employees and an ineffective fire control structure.	15	15			✓			
SD001	There is a risk of failure to mobilise to an incident due to a technical failure of the existing mobilising systems.	15	15	✓			✓		

INTERNAL AUDIT FOUR-YEAR PROGRAMME 2025-2029

The table below outlines our proposed four-year internal audit four-year programme against the areas of the Scottish Fire and Rescue Service's Audit Universe for 2025-2029. Audits included in Year 2, Year 3 and Year 4 are indicative of what might be included based on our initial discussions with management, the current risk register and our audit needs assessment but will be subject to a formal review towards the end of each audit year.

AUDIT AREA	LAST AUDITED	PREVIOUS RATING		2025-26	2026-27	2027-28	2028-29	OTHER ASSURANCE
		DESIGN	EFF.					
Governance, Leadership and Management								
Corporate governance	FY20							
Risk management	FY20							
Risk assurance	FY23							
Strategic and business planning								
Management information and performance management	FY22							
Communications and stakeholder engagement								
Environmental and social	FY21							
Data Protection								
Health, safety and security								
Legal								
Business continuity planning and disaster recovery								
Compliance function								
Total								

INTERNAL AUDIT FOUR-YEAR PROGRAMME 2025-2029

AUDIT AREA	LAST AUDITED	PREVIOUS RATING		2025-26	2026-27	2027-28	2028-29	OTHER ASSURANCE
		DESIGN	EFF.					
Finance								
Revenue recognition	FY22							External Audit
Accounts receivable	FY20							External Audit
General ledger	FY20							External Audit
Accounts payable	Fy20							External Audit
Expenses/ credit cards	FY20							External Audit
Treasury management								
Budget management/investment prioritisation								
Capital investment strategy	FY22							
Budget setting and control	FY23							
General financial controls								
Fraud	FY24							External Audit
Procurement and tendering	FY20							
Supplier management	FY23							
Tax								External Audit
Total								

INTERNAL AUDIT FOUR-YEAR PROGRAMME 2025-2029

AUDIT AREA	LAST AUDITED	PREVIOUS RATING		2025-26	2026-27	2027-28	2028-29	OTHER ASSURANCE
		DESIGN	EFF.					
IT								
ITGC	FY24							
Cyber	FY24							
Artificial intelligence								
IT strategy implementation								
IT project management – Change management systems								
Service and support								
IT asset security	FY21							
HR								
Payroll								
HR general controls								
Staff recruitment								
Case Management								
Talent development	FY21							
Training	FY22							
Staff development, performance management and succession planning								
Workforce planning	FY23							
Absence management	FY22							
Culture								HMFSI
Equality, diversity and inclusion	FY23							
Total								

INTERNAL AUDIT FOUR-YEAR PROGRAMME 2025-2029

AUDIT AREA	LAST AUDITED	PREVIOUS RATING		2025-26	2026-27	2027-28	2028-29	OTHER ASSURANCE
		DESIGN	EFF.					
Core activities								
Change management	FY24							
Fire prevention services strategy delivery								
Freedom of information								
Environmental management	FY24							
Partnership working	FY23							
SVQ review	FY22							
PPE	FY22							
Post pandemic review	FY22							
Fact finding investigation	FY21							
Portfolio office	FY21							
Fire safety enforcement	FY21							
Remote working	FY21							
Operational equipment	FY20							
Estates Management	FY20							
Management action plans follow up								
Planning, liaison, management, committee attendance and reporting								
Contingency								
Total								

APPENDICES

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APPENDIX I: INTERNAL AUDIT CHARTER

Internal Audit's Purpose and Mandate

Purpose

The purpose of the internal audit function is to strengthen the Scottish Fire and Rescue Service's ability to create, protect, and sustain value by providing the board and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

The internal audit function enhances the Scottish Fire and Rescue Service's:

- Successful achievement of its objectives
- Governance, risk management, and control processes
- Decision-making and oversight
- Reputation and credibility with its stakeholders
- Ability to serve the public interest

The Scottish Fire and Rescue Service's internal audit function is most effective when:

- Internal auditing is performed by competent professionals in conformance with the Institute of Internal Audit's Global Internal Audit Standards ™, which are set in the public interest.
- The internal audit function is independently positioned with direct accountability to the board.
- Internal auditors are free from undue influence and committed to making objective assessments.

Mandate

Authority

The board grants the internal audit function the mandate to provide the board and senior management with objective assurance, advice, insight, and foresight.

The internal audit function's authority is created by its direct reporting relationship to the board. Such authority allows for unrestricted access to the board.

The board authorises the internal audit function to:

- Have full and unrestricted access to all functions, data, records, information, physical property, and personnel pertinent to carrying out internal audit responsibilities. Internal auditors are accountable for confidentiality and safeguarding records and information.
- Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques, and issue communications to accomplish the function's objectives.
- Obtain assistance from the necessary organisation's personnel in relevant engagements, as well as other specialised services from within or outside the organisation to complete internal audit services.

Independence, position, and reporting relationships

The Head of Internal Audit (HoIA) HoIA will be positioned at a level in the organisation that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function.

The HoIA will report functionally to the board and administratively to the Senior Leadership Team.

This positioning provides the organisational authority and status to bring matters directly to senior management and escalate matters to the board, when necessary, without interference and supports the internal auditors' ability to maintain objectivity.

The HoIA will confirm to the board, at least annually, the organisational independence of the internal audit function.

The HoIA will disclose to the board any interference internal auditors encounter related to the scope, performance, or communication of internal audit work and results. The disclosure will include communicating the implications of such interference on the internal audit function's effectiveness and ability to fulfil its mandate.

APPENDIX I: INTERNAL AUDIT CHARTER

Board Oversight

To establish, maintain, and ensure the Scottish Fire and Rescue Service's internal audit function has sufficient authority to fulfil its duties, the board will:

- Discuss with the HoIA and senior management the appropriate authority, role, responsibilities, scope, and services (assurance and/or advisory) of the internal audit function.
- Ensure the HoIA has unrestricted access to and communicates and interacts directly with the board, including in private meetings without senior management present.
- Discuss with the HoIA and senior management other topics that should be included in the internal audit charter.
- Participate in discussions with the HoIA and senior management about the "essential conditions," described in the Global Internal Audit Standards, which establish the foundation that enables an effective internal audit function.
- Review and approve the internal audit function's charter annually, which includes the internal audit mandate and the scope and types of internal audit services.
- Approve the risk-based internal audit plan.
- Approve the internal audit function's human resources administration and budgets.
- Collaborate with senior management to determine the qualifications and competencies the organisation expects in a chief audit executive.
- Authorise the appointment and removal of the chief audit executive and out-sourced internal audit provider.
- Approve the fees paid to the out-sourced internal audit provider.
- Review the chief audit executive's and internal audit function's performance.
- Receive communications from the HoIA about the internal audit function including its performance relative to its plan.
- Ensure a quality assurance and improvement program has been established and review the results annually.
- Make appropriate inquiries of senior management and the HoIA to determine whether scope or resource limitations are inappropriate.

Changes to the Mandate and Charter

Circumstances may justify a follow-up discussion between the chief audit executive, board, and senior management on the internal audit mandate or other aspects of the internal audit charter. Such circumstances may include but are not limited to:

- A significant change in the Global Internal Audit Standards.
- A significant acquisition or reorganisation within the organisation.
- Significant changes in the chief audit executive, board, and/or senior management.
- Significant changes to the organisation's strategies, objectives, risk profile, or the environment in which the organisation operates.
- New laws or regulations that may affect the nature and/or scope of internal audit services.

APPENDIX I: INTERNAL AUDIT CHARTER

HoIA Roles and Responsibilities

Ethics and Professionalism

The HoIA will ensure that internal auditors:

- Conform with the Global Internal Audit Standards, including the principles of Ethics and Professionalism: integrity, objectivity, competency, due professional care, and confidentiality.
- Understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and be able to recognise conduct that is contrary to those expectations.
- Encourage and promote an ethics-based culture in the organisation.
- Report organisational behaviour that is inconsistent with the organisation's ethical expectations, as described in applicable policies and procedures.

Objectivity

The HoIA will ensure that the internal audit function remains free from all conditions that threaten the ability of internal auditors to carry out their responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the HoIA determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively such that they believe in their work product, do not compromise quality, and do not subordinate their judgment on audit matters to others.

Internal auditors will have no direct operational responsibility or authority over any activities they review. Accordingly, internal auditors will not implement internal controls, develop procedures, install systems, or engage in other activities that may impair their judgment

Internal auditors will:

- Disclose impairments of independence or objectivity, in fact or appearance, to appropriate parties and at least annually, such as the chief audit executive, board, management, or others.
- Exhibit professional objectivity in gathering, evaluating, and communicating information.
- Make balanced assessments of all available and relevant facts and circumstances.
- Take necessary precautions to avoid conflicts of interest, bias, and undue influence.

APPENDIX I: INTERNAL AUDIT CHARTER

HoIA Roles and Responsibilities

Managing the Internal Audit Function

The HoIA has the responsibility to:

- At least annually, develop a risk-based internal audit plan that considers the input of the board and senior management. Discuss the plan with the board and senior management and submit the plan to the board for review and approval.
- Communicate the impact of resource limitations on the internal audit plan to the board and senior management.
- Review and adjust the internal audit plan, as necessary, in response to changes in the organisation's business, risks, operations, programs, systems, and controls.
- Communicate with the board and senior management if there are significant interim changes to the internal audit plan.
- Ensure internal audit engagements are performed, documented, and communicated in accordance with the Global Internal Audit Standards.
- Follow up on engagement findings and confirm the implementation of recommendations or action plans and communicate the results of internal audit services to the board and senior management periodically and for each engagement as appropriate.
- Ensure the internal audit function collectively possesses or obtains the knowledge, skills, and other competencies and qualifications needed to meet the requirements of the Global Internal Audit Standards and fulfil the internal audit mandate
- Identify and consider trends and emerging issues that could impact the Scottish Fire and Rescue Service and communicate to the board and senior management as appropriate
- Consider emerging trends and successful practices in internal auditing
- Establish and ensure adherence to methodologies designed to guide the internal audit function
- Ensure adherence to relevant policies and procedures unless such policies and procedures conflict with the internal audit charter or the Global Internal Audit Standards. Any such conflicts will be resolved or documented and communicated to the board and senior management
- Coordinate activities and consider relying upon the work of other internal and external providers of assurance and advisory services. If the HoIA cannot achieve an appropriate level of coordination, the issue must be communicated to senior management and if necessary escalated to the board.

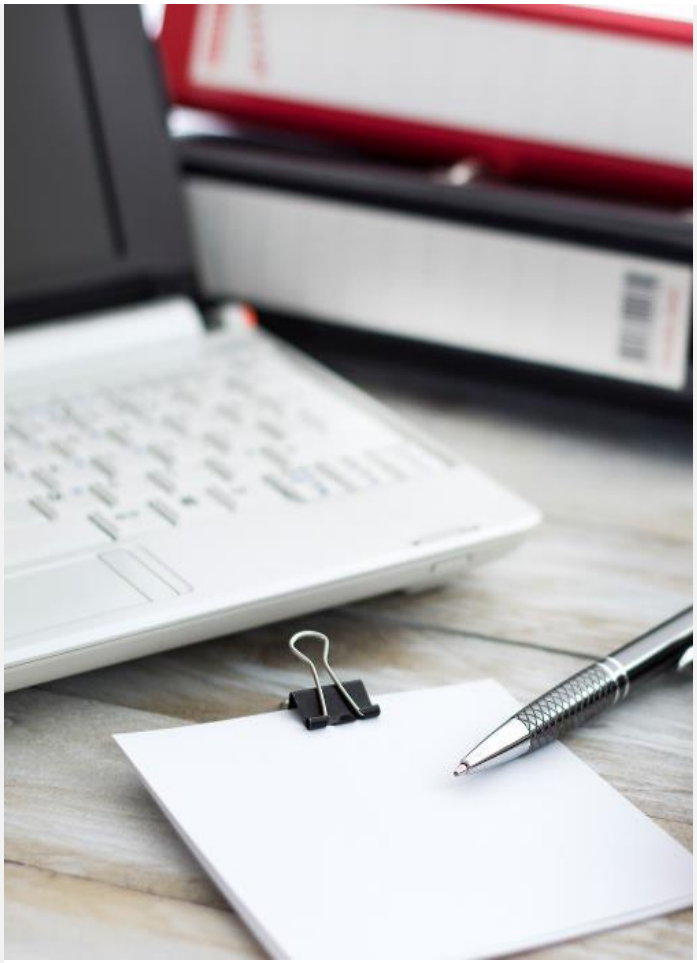
APPENDIX I: INTERNAL AUDIT CHARTER

HoIA Roles and Responsibilities

Communication with the Board and Senior Management

The HoIA will report as required or where appropriate to the board and senior management regarding (see appendix II for an example of proposed working protocols):

- The internal audit function's mandate
- The internal audit plan and performance relative to its plan
- Internal audit budget
- Significant revisions to the internal audit plan and budget
- Potential impairments to independence, including relevant disclosures as applicable
- Results from the quality assurance and improvement program, which include the internal audit function's conformance with the IIA's Global Internal Audit Standards and action plans to address the internal audit function's deficiencies and opportunities for improvement
- Significant risk exposures and control issues, including fraud risks, governance issues, and other areas of focus for the board
- Results of assurance and advisory services
- Resource requirements
- Management's responses to risk that the internal audit function determines may be unacceptable or acceptance of a risk that is beyond the organisation's risk appetite.



Quality Assurance Improvement Programme (QAIP)

The HoIA will develop, implement, and maintain a quality assurance and improvement program that covers all aspects of the internal audit function.

The program will include external and internal assessments of the internal audit function's conformance with the Global Internal Audit Standards, as well as performance measurement to assess the internal audit function's progress toward the achievement of its objectives and promotion of continuous improvement.

The plan will assess the efficiency and effectiveness of internal audit and identify opportunities for improvement.

Annually, the HoIA will communicate with the board and senior management about the internal audit function's quality assurance and improvement program, including the results of internal assessments (ongoing monitoring and periodic self-assessments) and external assessments.

External assessments will be conducted at least once every five years by a qualified, independent assessor or assessment team from outside BDO; qualifications must include at least one assessor holding an active Certified Internal Auditor credential.

APPENDIX I: INTERNAL AUDIT CHARTER

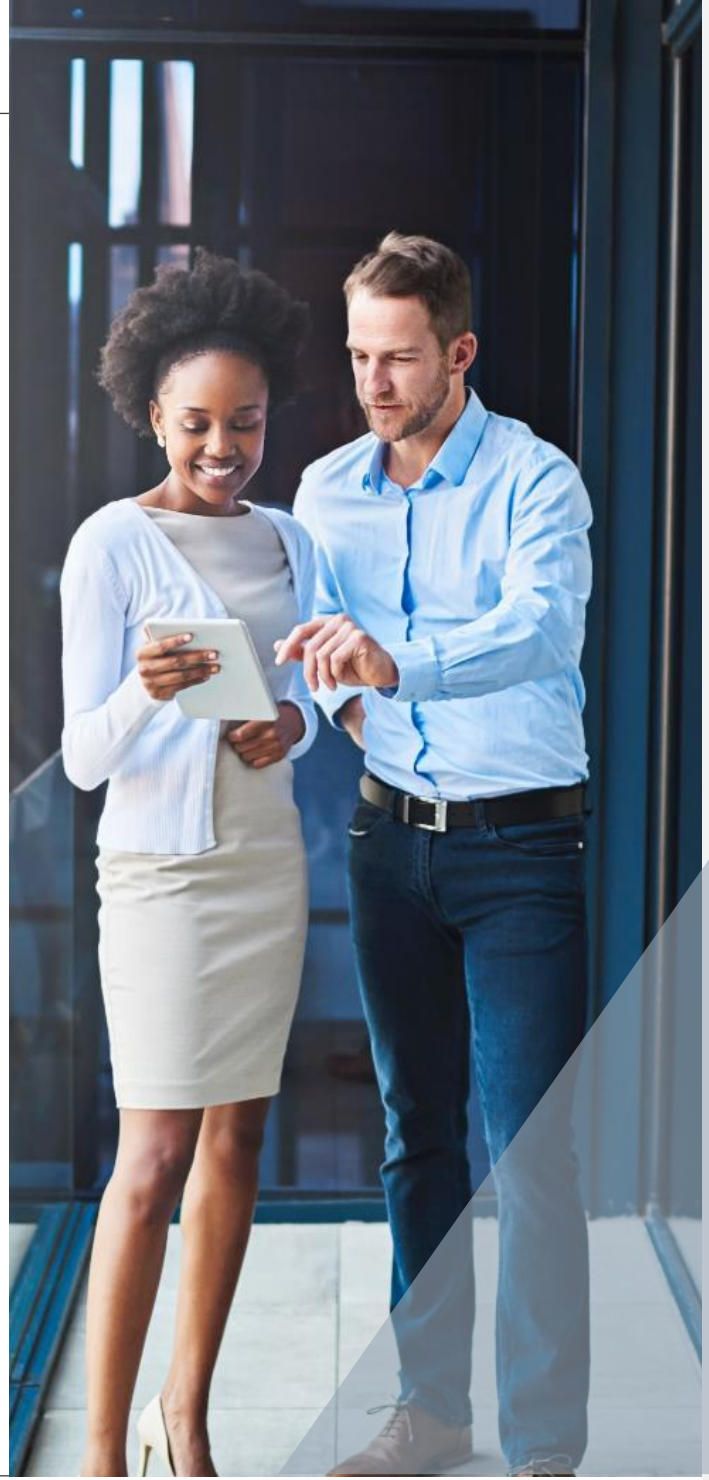
Scope and Types of Internal Audit Services

Scope and Types of Internal Audit Services

- The scope of internal audit services covers the entire breadth of the organisation, including all Scottish Fire and Rescue Service activities, assets, and personnel.
- The scope of internal audit activities also encompasses but is not limited to objective examinations of evidence to provide independent assurance and advisory services to the board and management on the adequacy and effectiveness of governance, risk management, and control processes for the organisation.
- The nature and scope of advisory services may be agreed with the party requesting the service, provided the internal audit function does not assume management responsibility. Opportunities for improving the efficiency of governance, risk management, and control processes may be identified during advisory engagements. These opportunities will be communicated to the appropriate level of management.

Internal audit engagements may include evaluating whether:

- Risks relating to the achievement of the organisation's strategic objectives are appropriately identified and managed.
- The actions of Scottish Fire and Rescue Service's officers, directors, management, employees, and contractors or other relevant parties comply with organisational policies, procedures, and applicable laws, regulations, and governance standards.
- The results of operations and programs are consistent with established goals and objectives.
- Operations and programs are being carried out effectively and efficiently.
- Established processes and systems enable compliance with the policies, procedures, laws, and regulations that could significantly impact the organisation.
- The integrity of information and the means used to identify, measure, analyse, classify, and report such information is reliable.
- Resources and assets are acquired economically, used efficiently and sustainably, and protected adequately.



APPENDIX II – WORKING PROTOCOLS AND PERFORMANCE

The tables opposite set out the principal communication and reporting points between and Internal Audit, which are subject to regular review. Any future changes to the communication and reporting points are reported to the Audit & Risk Assurance Committee for approval.

Table One: Liaison Meetings Between the organisation and Internal Audit and with External Audit

MEETING	FREQUENCY	ARAC	CHIEF OFFICER	SENIOR LEADERSHIP TEAM	RELEVANT STAFF	EXTERNAL AUDIT
Internal audit liaison meeting with management	As required		✓		✓	
Internal audit update meetings	As required		✓	✓		
Quality Assurance Meeting	As required		✓			
Liaison meeting with Chair of the Audit & Risk Assurance Committee	As required	✓				
ARAC to discuss audit progress	Quarterly	✓				
Meetings to raise immediate concerns	As necessary	✓	✓	✓	✓	
Meetings with external audit	As necessary					✓

Table Two: Key Reporting Points Between the organisation and Internal Audit

MEETING	ARAC	AUDIT SPONSOR	SENIOR LEADERSHIP TEAM	RELEVANT STAFF
Annual Internal Audit Plan	✓	✓	✓	✓
Individual internal audit planning documents		✓	✓	✓
Draft Internal Audit Reports*		✓	✓	✓
Final Internal Audit Reports*	✓	✓	✓	✓
Quality Progress Reports	✓		✓	
Annual Internal Audit Report	✓	✓	✓	

*Internal Audit reports are distributed to the relevant Management Team members only.

APPENDIX II – WORKING PROTOCOLS AND PERFORMANCE

Internal Audit Performance Measures and Indicators

Internal Audit's performance is assessed in two ways. Firstly, there is the ability for us to self-assess our performance on a regular basis and report back to the Audit & Risk Assurance Committee on certain measures around inputs and satisfaction from those members of management who have been subject to a review.

Secondly, the view of the Audit & Risk Assurance Committee as to the value being received from its internal audit provider has to be taken into account. Much of this can be drawn from our attendance at Audit & Risk Assurance Committee, in camera meetings and by the views of management. For our part, we look to report to the Audit & Risk Assurance Committee regularly on the internal audit inputs as detailed below.

The tables contain performance measures and indicators that we consider to have the most value in assessing the efficiency and effectiveness of Internal Audit.

Tables three and four contain performance measures and indicators that we consider to have the most value in assessing the efficiency and effectiveness of internal audit. We recommend that the Audit & Risk Assurance Committee approves the following measures which we will report to each meeting and/or annually as appropriate.

Table Three – Performance reporting to Audit & Risk Assurance Committee

MEASURE / INDICATOR
Audit coverage
▶ Audits completed against the Annual Audit Plan
▶ Actual days input compared with Annual Audit Plan
Audit planning and reporting
▶ Days to issue draft report after end of fieldwork

Table Four: Annual Performance Reporting

MEASURE / INDICATOR
Relationships and customer satisfaction
▶ Client satisfaction reports
Staffing
▶ Colleague mix compared with budget
▶ Percentage of Director and Manager time
▶ Continuity of staffing
▶ Use of specialist staff (e.g. IT Risk and Advisory)

Management performance measures and indicators

Management's ability to respond efficiently to internal audit findings and recommendations helps the Audit & Risk Assurance Committee to form its own view of the internal control framework.

Importantly, management's consideration of internal audit findings plays a contributory factor in our ability to deliver timely reports to the Audit & Risk Assurance Committee. Therefore, the following measures are also reported to the Audit & Risk Assurance Committee.

MEASURE/INDICATOR
Audit reporting
▶ Days for receipt of management responses

Other performance measures

In addition to the above mentioned measures, we will also provide the Audit & Risk Assurance Committee with the results of other reviews of our internal audit service as and when they become available, including:

- Independent quality assurance reviews as required by the Chartered Institute of Internal Auditors (IIA)
- BDO internal quality assurance reviews.

APPENDIX III: DEFINITIONS

Level of Assurance	DESIGN of internal control framework		OPERATIONAL EFFECTIVENESS of internal controls	
	Findings from review	Design opinion	Findings from review	Effectiveness opinion
SUBSTANTIAL	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
MODERATE	In the main there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally, a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non-compliance with some controls, that may put some of the system objectives at risk.
LIMITED	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
NO	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non-compliance and/or compliance with inadequate controls.

Recommendation Significance	
HIGH	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
MEDIUM	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
LOW	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.

FOR MORE INFORMATION:

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SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/12-25

Agenda Item: 7.4

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**INTERNAL AUDIT - CORPORATE GOVERNANCE SCOPE**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to provide the Audit and Risk Assurance Committee (ARAC) with the Corporate Governance review scope, as contained within the Internal Audit Plan for 2025/26.
2	**Background**
2.1	Internal Audit is an independent and objective assurance and consulting activity designed to add value and improve the operations of Scottish Fire and Rescue Service (SFRS). It helps senior management accomplish their objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.
2.2	The provision of an Internal Audit framework is a key dimension of assurance that is required by the Accountable Officer to enable them to sign the governance statement as part of the annual accounts, for which they are responsible.
2.3	For SFRS the Internal Audit function is provided by an external contractor with this work currently undertaken by AZETS. Following a tender BDO have been appointed as Internal Auditors from 1 April 2025, for a 5-year period, with the 2025/26 internal audit plan being presented to the ARAC on 8 April 2025.
2.4	Within SFRS, internal audit engagement is led by the Director of Finance and Contractual Services, and audit planning is developed in conjunction with the Strategic Leadership Team (SLT) and ARAC. Draft audit scoping papers, completed assignment reports, and quarterly progress updates are reported to SLT in advance of submission to ARAC, to ensure internal audit work is meeting the organisation's needs.
3	**Main Report/Detail**
3.1	Following agreement by the Strategic Leadership Team of the draft 2025/26 audit plan, BDO have provided a draft scoping document in relation to Corporate Governance for scrutiny and approval by the Audit and Risk Assurance Committee.
3.2	The purpose of the review is to provide the Service with assurance over key corporate governance controls and will cover: • Remits • Consistent application

	• Management Oversight • Governance • Planning • Board Capabilities • Training and Induction • Governance Office
3.3	The proposed review is attached as Appendix A, together with further detail on each of the areas to be covered. The document was prepared by BDO following discussion and agreement by Mark McAteer, as Audit Sponsor.
3.4	The audit is due to commence in April 2025, with 18 days allocated in relation to planning, field work, review and reporting. BDO have discussed required documentation in advance of the audit and have outlined required information within their document. In order to complete the audit in line with BDO's methodology and accommodate a post Easter start date the report will be submitted to the October ARAC meeting.
4	**Recommendation**
4.1	The Audit and Risk Assurance Committee is asked to: • Scrutinise and approve the draft scope for the Corporate Governance audit review.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk/Risk Appetite** The report is aligned to the Services Compliance risk appetite in relation to our internal governance, including systems of control and data governance, where a Cautious risk appetite was identified.
5.1.2	The report reflects the general underlying principle that SFRS will operate in an open and transparent manner using our resources responsibly and demonstrating best value in the use of public funds.
5.2 5.2.1	**Financial** This review is part of the 2025/26 internal audit plan and has been incorporated within the budget for 2025/26.
5.3 5.3.1	**Environmental & Sustainability** Any implications arising from the report will be managed by the relevant Directorate.
5.4 5.4.1	**Workforce** Any implications arising from the report will be managed by the relevant Directorate.
5.5 5.5.1	**Health & Safety** Any implications arising from the report will be managed by the relevant Directorate.
5.6 5.6.1	**Health & Wellbeing** Any implications arising from the report will be managed by the relevant Directorate.
5.7 5.7.1	**Training** Any implications arising from the report will be managed by the relevant Directorate.
5.8 5.8.1	**Timing** The report is provided to ARAC to allow initial work to be undertaken in relation to the Corporate Governance Review.

5.9 5.9.1	**Performance** The report provides information on the Corporate Governance audit as part of the 2025/26 internal audit plan for SFRS. The internal audit contract will outline a number of agreed key performance indicators to demonstrate whether contract requirements are being met. Performance data will be provided by the Internal Auditor and reported quarterly to the ARAC.	
5.10 5.10.1	**Communications & Engagement** Any implications arising from the report will be managed by the relevant Directorate.	
5.11 5.11.1	**Legal** Any implications arising from the report will be managed by the relevant Directorate.	
5.12 5.12.1	**Information Governance** DPIA completed - No. The report provides a summary of information and actions to be taken by Directorates, and named individuals, to manage any significant risk identified. The responsible Directorate will ensure that any relevant DPIA is completed as required	
5.13 5.13.1	**Equalities** EHRIA completed - No. Where an equalities assessment is required, this will be determined by the responsible Directorate and progressed accordingly.	
5.14 5.14.1	**Service Delivery** Any implications arising from the report will be managed by the relevant Directorate.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance: (Mark as appropriate)**	**Substantial/**~~Reasonable/Limited/Insufficient~~
7.3	**Rationale:**	The development of the draft scope for Corporate Governance has been undertaken in line with BDO's methodology and in discussion with Mark McAteer, as audit sponsor and Director of Strategic Planning.
8	**Appendices/Further Reading**	
8.1	Appendix A: Corporate Governance – Draft Terms of Reference	

Prepared by:	David Johnston, Risk and Audit Manager; Sean Morrison, Internal Audit Senior Manager
Sponsored by:	Sarah O'Donnell, Director of Finance & Contractual Services
Presented by:	Sean Morrison, Internal Audit Senior Manager

Links to Strategy and Corporate Values

The Internal audit process forms part of the Services Governance arrangements and links back to Outcome 5 of the 2022-25 Strategic Plan, specifically Objectives 5.1 and 5.6:

Outcome 5: We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

- Objective 5.1: Remaining open and transparent in how we make decisions.
- Objective 5.6: Managing major change projects and organisational risks effectively and efficiently.

Governance Route for Report	Meeting Date	Report Classification/ Comments
Strategic Leadership Team	*20 March 2025*	*For Decision*
Audit and Risk Assurance Committee	*8 April 2025*	*For Scrutiny*

APPENDIX A

SCOTTISH FIRE AND RESCUE SERVICE

CORPORATE GOVERNANCE TERMS OF REFERENCE - DRAFT

MARCH 2025

SIGN OFF			
ON BEHALF OF BDO LLP		ON BEHALF OF SCOTTISH FIRE AND RESCUE SERVICE	
SIGNATURE:	CLAIRE ROBERTSON	SIGNATURE:	MARK MCATEER
TITLE:	DIRECTOR	TITLE:	DIRECTOR OF STRATEGIC PLANNING, PERFORMANCE AND COMMUNICATIONS
DATE:		DATE:	

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BACKGROUND

BACKGROUND

As part of the 2025-26 Internal Audit Plan, it was agreed that internal audit would review the corporate governance arrangements in place within the Scottish Fire and Rescue Service (SFRS) and compare this with good practice to give advice to Management, the Board and its committees on areas that could be improved.

SFRS's governance arrangements are set out within the Framework Agreement in place with the Scottish Government. The framework agreement was approved by the Board on the 27th of February 2024, and Cabinet Secretary in April 2024.

The SFRS Board consists of a Chair and up to 14 members appointed by Scottish Ministers. Members ensures the effective governance and financial management of the Service. Their key focus is public service delivery and reform for the benefit of improving the safety and wellbeing of the people of Scotland. Formal board meetings take place six or seven times a year at approximate two-month intervals.

To support the Board the Service has the following Committees in place, Audit & Risk Assurance Committee, Change Committee, People Committee, Remuneration, Appointments and Nominations Committee, and the Service Delivery Committee. The roles and responsibilities are set out within the remits for each of the committees, which are required to be reviewed annually.

Programmes of work are set on an annual basis.

There is also an integrated governance forum which provides the Board and Committee chairs the opportunity to discuss Governance and organisational issues and ensure that the governance processes are conducted in an efficient manner.

Board and Committee effectiveness evaluations are conducted annually. Annual Committee assessments are completed by the respective Committee Chairs and presented to the Board.

Board training has been provided via a range of methods, including, Scottish Government led sessions, internal seminars, and SFRS subject matter sessions.

New Board members are provided with an induction once appointed.

PURPOSE OF THE REVIEW

The purpose of this review is to provide management and the Audit & Risk Assurance Committee with assurance over key corporate governance controls, including that the Board and its committees have clear and appropriate terms of references and programmes of work; are provided with suitable training and efficient and effective support; that the governance structure is appropriate; that there is clear reporting lines and consistent reporting; and meetings are effective in delivering scrutiny and driving continuous improvement.

SUMMARY SCOPE AND APPROACH

The following areas will be covered as part of the scope for this review:

- Remits
- Consistent Application
- Management Oversight
- Governance
- Planning
- Board Capabilities
- Training and Induction
- Governance Office

Interviews/documentation review will be undertaken to understand the process and design of control arrangements for controls for the areas under scope. Detailed testing through walkthroughs will be carried out, along with a review of evidence, periodic updates and follow up meetings as required.

A closing meeting will take place to discuss findings and agree actions. We will then produce a draft report that will be provided to management for confirmation of their management actions before issuing a final report.

MANAGEMENT COMMENTS

Edits have been made upon request

EXCLUSIONS/LIMITATIONS OF SCOPE

The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review.

Our work is inherently limited by sample testing and therefore will not provide assurance over all corporate governance matters within the organisation. We are reliant on the honest representation by staff and timely provision of information as part of this review.

DETAILED SCOPE, RISKS & APPROACH – PAGE 1

The table below and on the following page outlines the areas which will be covered as part of this review, the key inherent risks associated with the areas under review and our high-level approach to test the design and operational effectiveness (where applicable) of the controls in place to mitigate the risks outlined:

SCOPE AREA	KEY RISKS	HIGH LEVEL APPROACH
REMITS	1. Board and committee terms of reference may be unclear or overlapping resulting in insufficient coverage at the respective meetings or duplication of effort.	• Review and assess the Board and committee structure. • Review and assess the terms of reference for clarity of the role and responsibilities. • Review and assess whether there is appropriate and effective management of overlaps between the Board and Committee remits to ensure that there is no unnecessary duplication of effort.
CONSISTENT APPLICATION	2. Board and committees may not have a programme of work in accordance with their terms of reference that allows them to make an effective and timely contribution.	• Review and assess the programmes of work in place for the Board and each of the committees. • Review committee minutes for a full year and assess whether there is evidence of discharge of all duties mentioned in TOR. • Review and assess whether the timing of meetings and discussion is well planned to allow members to discharge their duties. • Review and assess the process for allowing business items to be added to meeting agendas, for example by the Chair of the AC, the external auditor, the internal auditor and members of the Executive team.
MANAGEMENT OVERSIGHT	3. Members may not be provided with sufficient, high quality management information in their areas of responsibility resulting in ineffective decisions being taken.	• Confirm with Board members whether they are satisfied with the content of the management information provided. • Review and assess the quality of management information being provided to the Board and each committee over the course of the year. • Confirm the process for papers going to the Board and committees and assess whether these processes are effective in supporting a sufficient level of quality assured Management Information. • Confirm whether papers are distributed in a timely manner. • Review and assess the process for preparing and quality assuring the Service's assurance reports. • Confirm whether there have been issues in the underlying information and data recorded within the assurance reports.
GOVERNANCE	4. Board and committees may be poorly attended, or members not sufficiently engaged resulting in ineffective governance and oversight of business activities.	• Review and assess whether members have assertively challenged or questioned issues at meetings. • Review and assess whether corrective or improving actions are taken and tracked relating to issues raised. • Review and assess Board and Committee minutes for the last 12 months and verify that required attendance has been met (quorum). • Review and assess the attendance and determine whether there are any members who are absent too often.
PLANNING	5. Board and committee meeting agendas are not agreed in advance and communicated to relevant parties to allow timely submission of papers.	• We will select a sample of meetings and confirm by review of documentation whether the agenda was agreed and circulated in line with good practice. • We will also consider whether the agenda and timelines are communicated to relevant parties to help support the timely submission of papers. • Review and assess whether the timing of meetings allows management with the time to prepare and present timely information.

DETAILED SCOPE, RISKS & APPROACH – PAGE 2

The table below outlines the areas which will be covered as part of this review, the key inherent risks associated with the areas under review and our high-level approach to test the design and operational effectiveness (where applicable) of the controls in place to mitigate the risks outlined:

SCOPE AREA	KEY RISKS	HIGH LEVEL APPROACH
BOARD CAPABILITIES	6. Board and committees may not have effectively assessed their performance and the balance of skills required resulting in member knowledge gaps not being identified and addressed.	• Review and assess the mechanisms in place to measure performance of the Board and committees. • Review and assess the skills mix in place and consider whether the skills mix has been assessed prior to the committee members being agreed. • Confirm whether any identified gaps have actions to address, for example training programme in place or recruitment of members with the required skills.
TRAINING AND INDUCTION	7. Board members may not have sufficient understanding of the organisation and policies and procedures in place and actions to be taken due to there being inadequate induction and training arrangements.	• Review and assess the arrangements in place for the induction of Board members. • Review and assess the process in place for identifying and communicating issues which should be brought to the attention of board members. • Confirm whether there is a Board training programme in place or whether there have been any Board training sessions in the last 12 months.
GOVERNANCE OFFICE	8. The governance process may not be supported by a sufficiently resourced governance office resulting in a lack of capacity to maintain standards and comply with the framework in place.	• We will consider whether the Governance Team is appropriately resourced to appropriately support meeting the requirements of the Corporate Governance Framework and confirm that responsibility has been assigned.

Sample sizes will be determined following the completion of our walkthroughs using our Internal Audit Methodology; for example, if a control is performed daily, we may select a sample of fifteen and if monthly a sample of two to three. Where possible full population testing will be conducted utilising data analytics. See the following page for further information. Internal Audit will bring to the attention of management any points relating to other areas that come to their attention during the audit. A closing meeting will be held to discuss findings emerging from the review prior to issue of the draft report. Once the report and recommendations have been agreed following discussions with management, a summary of the findings will be presented to the Audit, Risk and Assurance Committee at its next meeting.

Commencing the audit at the end of April (see the following slide) means that to complete the review in line with our methodology and submission to the SLT in advance of the ARAC it will not be achievable to present the reports in the June ARAC, as a result this review will be reported at the October 2025 ARAC meeting.

KEY CONTACTS, TIMELINE & LOCATION

KEY CONTACTS				
BDO LLP				
Claire Robertson	Director	Head of Internal Audit	T:07583 237 579	E:Claire.Robertson@bdo.co.uk
Sean Morrison	Internal Audit Senior Manager	Engagement lead	T:07812 463 131	E:sean.Morrison@bdo.co.uk
SFRS				
Mark McAteer	Director of Strategic Planning, Performance and Communications	Audit Sponsor	E: Mark.McAteer@firescotland.gov.uk	
Richard Whetton	Head of Corporate Governance	Key Audit Contact	E: Richard.Whetton@firescotland.gov.uk	
Chris Casey	Board Support Manager	Key Audit Contact	E Chris.Casey@firescotland.gov.uk	
Kirsty Darwent	Board Chair	Key Audit Contact	E: Kirsty.Darwent@firescotland.gov.uk	
David Johnston	Risk and Audit Manager	Support	E: David.Johnston@firescotland.gov.uk	
Sarah O'Donnell	Deputy Chief Officer (Corporate Service)	Key Audit Contact	E: Sarah.O'Donnell@firescotland.gov.uk	

The staff listed above will be contacted during the fieldwork to assist in completion of the assignment. All these staff will be contacted prior to fieldwork to agree the timing of our visit and should be issued with a copy of this terms of reference. It is important that staff involved with the assignment are notified. To assist us in planning the logistics of the assignment, including provision of documents and meeting organisation the above audit coordinator has been nominated.

PLANNED TIMELINE	
AUDIT ACTIVITY	DATE
SCOPING MEETING	12/03/2025
TERMS OF REFERENCE AGREED	TBC
DOCUMENTATION REQUEST DEADLINE	21/04/2025
FIELDWORK COMMENCEMENT	28/04/2025
END OF FIELDWORK	30/05/2025
CLOSING MEETING	30/05/2025
ISSUE OF THE DRAFT REPORT	13/06/2025
RECEIPT OF MANAGEMENT RESPONSES	27/06/2025
ISSUE OF UPDATED FINAL DRAFT	30/06/2025
ISSUE OF FINAL REPORT	01/07/2025
SENIOR LEADERSHIP TEAM DATE	08/10/2025
AUDIT & RISK ASSURANCE COMMITTEE DATE	23/10/2025

By accepting this Terms of Reference document you are agreeing to the timing of this audit

LOCATION

We plan to perform this review via a combination of remote and on-site working as required as agreed with you. We will use a combination of conference calls, video conferencing facilities and emails. We will endeavour to limit the amount of time required of key colleagues.

ALLOCATION & FEES

ALLOCATION

This is an 18-day allocation, split as follows:

AREA	DAYS
Planning	3
Fieldwork	12
Reviewing and Reporting	3

FEES

ACTIVITY	DAYS	RATE (£)	COST (£)
Estimated Cost of Review	18	£576	£10,368

BUDGET & ASSUMPIONS

We will charge fees for this assignment in line with our agreed Engagement Letter, including any subsequent changes agreed with you. Our fees for this engagement are set at £10,368 (excluding VAT), this includes planning, delivery, report writing and management review. This fee represents a total of 18 days on a blended day rate of £576. See the table to the left-hand side for a full breakdown of the fees.

The fees are based upon our estimate of the time required to complete the engagement. These costs have been calculated on the assumption that we will receive all information outlined on this page by the dates specified and that we will be granted access to all key personnel.

The allocation outlined to the left-hand side above is based upon our estimate of the time required to complete the engagement outlined within this document. If the scope of work changes, we will communicate with management any predicted over-or-underspend, before invoicing. In addition, we assume for the purposes of estimating the number of days of audit work that there is one control environment, and that we will be providing assurance over controls in this environment. If this is not the case, our estimate of audit day allocation may not be accurate.

TIMING CHANGES AND CANCELLATION

In accepting this Terms of Reference document, you are agreeing to the timing of this audit specified in this document. We will make every effort to accommodate timing changes or cancellation of the audit however any changes within 3 weeks of the start of the fieldwork may result in fees being charged in respect of the audit. Changes with more than 3 weeks' notice will be accommodated at no extra charge.

ACCESS TO INFORMATION & COLLEAGUES

Any unreasonable delay in gaining access to required information or key colleagues will place audit timings at risk and may result in additional fees to you. Any such charges would be notified to you and agreed at the time the issue is identified.

APPENDIX A: DOCUMENTATION REQUEST

Outlined below and on the following page is an initial information request relating to this audit. Timely receipt of this information is critical to ensure that the objectives of the audit are met and that the work is completed on time. We have provided an overview of what we require from you. If you can please ensure to present the requested documentation by 21 April 2025 that would be most appreciated. We have tried to be specific wherever possible; however, please do contact us as soon as possible if you are unsure about any of the information required. Please note that this is an initial request and is not exhaustive – further information requiring your attention (including meetings) will be required at the time of our fieldwork.

INITIAL DOCUMENTATION REQUEST LIST (IF IN PLACE)	SCOPE AREA
Board and committee terms of reference/remits	Governance
Board and committee minutes and papers for last 12 months	Management Oversight
Board and committee programmes of work	Consistent Application
Most recent board and committees effectiveness evaluations	Governance
Key governance documents – rules, constitution, scheme of delegated authority.	Policies and Procedures
Board skills matrix	Governance
Most recent version of framework agreement	Governance
Board code of conduct	Policies and Procedures
Board induction materials	Training
Board training evidence or training programme	Training
Board and SLT session report	Performance

FOR MORE INFORMATION:

CLAIRE ROBERTSON, HEAD OF RISK ADVISORY SERVICES – SCOTLAND

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SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/13-25

Agenda Item: 8

Report to:	**AUDIT AND RISK COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**SCOTTISH FIRE AND RESCUE SERVICE – ANNUAL AUDIT PLAN 2024/25**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this Annual Audit Plan is to provide an overview of the planned scope and timing of the 2024/25 audit of the Scottish Fire and Rescue Service (SFRS). The report outlines the audit work planned to meet the requirements set out in auditing standards and the Code of Audit Practice, including supplementary guidance.
2	**Background**
2.1	2024/25 is the third year of Audit Scotland's five year-appointment. The Annual Audit Plan is based on specific work undertaken in planning the 2024/25 audit as well as the audit team's cumulative knowledge and understanding from work undertaken in previous years.
3	**Main Report/Detail**
3.1	The Annual Audit Plan sets out the planned scope and timing of the 2024/25 audit of the Scottish Fire and Rescue Service as well as the responsibilities of both the auditor and the Scottish Fire and Rescue Service.
3.2	The plan sets out the proposed approach to the audit of the annual report and accounts; the approach to the wider scope audit set out by the Code of Audit Practise; and planned work in relation to Best Value.
4	**Recommendation**
4.1	The Committee is recommended to review, discuss and comment on this report.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk Appetite and Alignment to Risk Registers** Not applicable
5.2 5.2.1	**Financial** Not applicable
5.3 5.3.1	**Environmental & Sustainability** Not applicable
5.4 5.4.1	**Workforce** Not applicable

5.5 5.5.1	**Health & Safety** Not applicable	
5.6 5.6.1	**Health & Wellbeing** Not applicable	
5.7 5.7.1	**Training** Not applicable	
5.8 5.8.1	**Timing** Not applicable	
5.9 5.9.1	**Performance** Not applicable	
5.10 5.10.1	**Communications & Engagement** Not applicable	
5.11 5.11.1	**Legal** Not applicable	
5.12 5.12.1	**Information Governance** DPIA completed Yes/No. If not applicable state reasons.	
5.13 5.13.1	**Equalities** EHRIA completed Yes/No. If not applicable state reasons.	
5.14 5.14.1	**Service Delivery** Not applicable	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Deputy Chief Officer Corporate Services
7.2	**Level of Assurance: (Mark as appropriate)**	**Substantial/**~~Reasonable/Limited/Insufficient~~
7.3	**Rationale:**	The Annual Audit Plan has been developed in conjunction with Audit Scotland.
8	**Appendices/Further Reading**	
8.1	Appendix A: Scottish Fire and Rescue Service – Annual Audit Plan 2024/25	

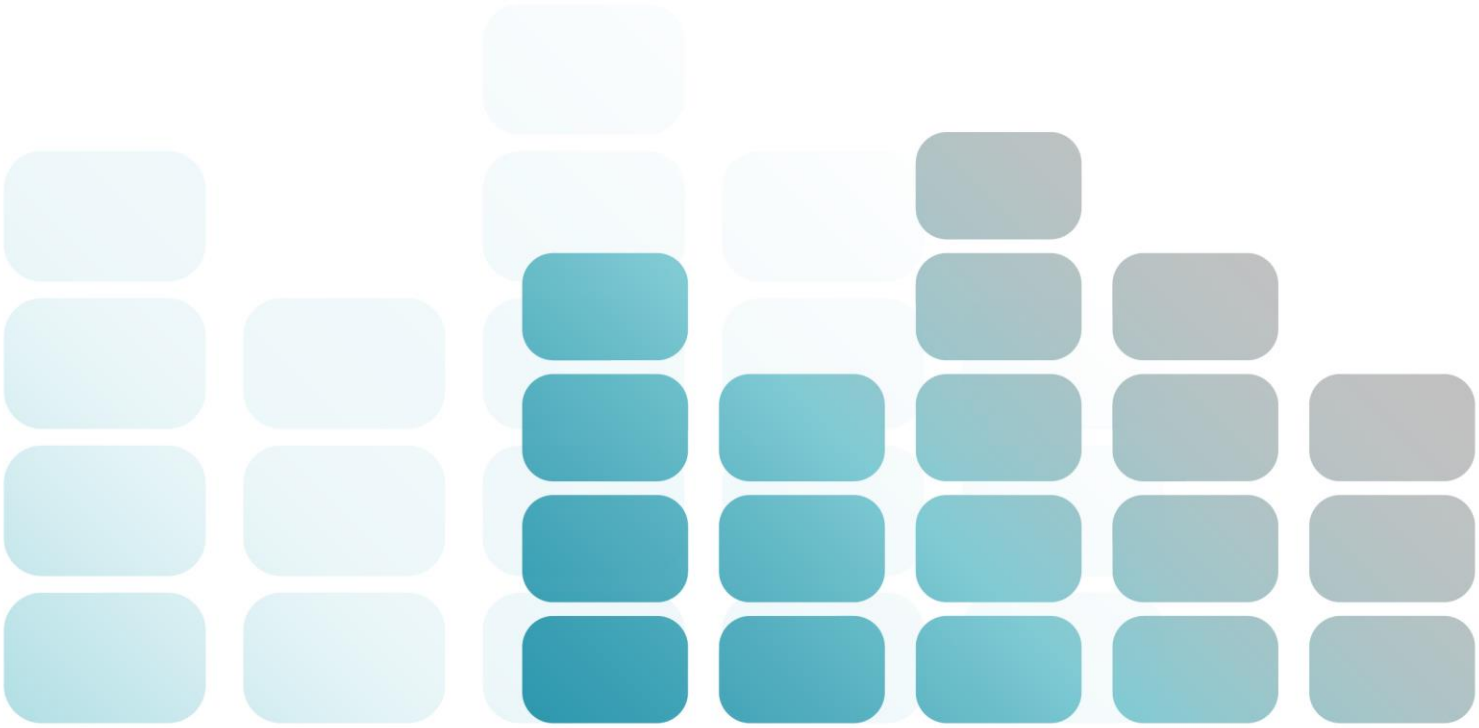
Prepared by:	Tommy Yule, Senior Audit Manager, Audit Scotland
Sponsored by:	Sarah O'Donnell, Deputy Chief Officer Corporate Services
Presented by:	Michael Oliphant, Audit Director, Audit Scotland and Tommy Yule, Senior Audit Manager, Audit Scotland
Links to Strategy and Corporate Values	

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Audit & Risk Assurance Committee	*8 April 2025*	*For Scrutiny*

APPENDIX A

Scottish Fire and Rescue Service

Annual Audit Plan 2024/25



AUDIT SCOTLAND

Prepared for Scottish Fire and Rescue Service
March 2025

Contents

Accessibility

You can find out more and read this report using assistive technology on our website www.audit.scot/accessibility.

Introduction

Purpose of the Annual Audit Plan

1. The purpose of this Annual Audit Plan is to provide an overview of the planned scope and timing of the 2024/25 audit of Scottish Fire and Rescue Service (SFRS) annual report and accounts. It outlines the audit work planned to meet the audit requirements set out in auditing standards and the Code of Audit Practice, including supplementary guidance.

Appointed auditor and independence

2. Michael Oliphant, of Audit Scotland, has been appointed by the Auditor General for Scotland as external auditor of SFRS for the period from 2022/23 until 2026/27. The 2024/25 financial year is therefore the third of the five-year audit appointment.

3. The appointed auditor and audit team are independent of SFRS in accordance with relevant ethical requirements, including the Financial Reporting Council's Ethical Standard. This standard imposes stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with ethical standards. The arrangements are overseen by the Executive Director of Innovation and Quality, who serves as Audit Scotland's Ethics Partner.

4. The Ethical Standard requires auditors to communicate any relationships that may affect the independence and objectivity of the audit team. There are no such relationships pertaining to the audit of SFRS to communicate.

Audit scope and responsibilities

Scope of the audit

5. The audit is performed in accordance with the Code of Audit Practice, including supplementary guidance, International Standards on Auditing (UK), and relevant legislation. These set out the requirements for the scope of the audit which includes:

- An audit of the financial statements and an opinion on whether they give a true and fair view and are free from material misstatement, including the regularity of income and expenditure.
- An opinion on statutory other information published with the financial statements in the annual report and accounts, the Performance Report, and the Governance Statement, and an opinion on the audited part of the Remuneration and Staff Report.
- Conclusions on the SFRS's arrangements in relation to the wider scope areas: Financial Management, Financial Sustainability, Vision, Leadership, and Governance, and Use of Resources to Improve Outcomes.
- Reporting on SFRS' arrangements for securing Best Value.
- Provision of an Annual Audit Report setting out significant matters identified from the audit of the annual report and accounts and the wider scope areas specified in the Code of Audit Practice.

Responsibilities

6. The Code of Audit Practice sets out the respective responsibilities of SFRS and the auditor. A summary of the key responsibilities is outlined below.

Auditor's responsibilities

7. The responsibilities of auditors in the public sector are established in the Public Finance and Accountability (Scotland) Act 2000. These include providing an independent opinion on the financial statements and other information reported within the annual report and accounts, and concluding on SFRS's arrangements in place for the wider scope areas.

Scottish Fire and Rescue Service responsibilities

8. SFRS has primary responsibility for ensuring proper financial stewardship of public funds, compliance with relevant legislation and

establishing effective arrangements for governance, propriety and regularity that enables it to successfully deliver its objectives. The features of proper financial stewardship include:

- Establishing arrangements to ensure the proper conduct of its affairs.
- Preparation of an annual report and accounts, comprising financial statements and other information that gives a true and fair view.
- Establishing arrangements for the prevention and detection of fraud, error and irregularities, and bribery and corruption.
- Implementing arrangements to ensure its financial position is soundly based.
- Making arrangements to secure Best Value.
- Establishing an internal audit function.

Audit of the annual report and accounts

Introduction

9. The audit of the annual report and accounts is driven by materiality and the risks of material misstatement in the financial statements, with greater attention being given to the significant risks of material misstatement. This chapter outlines materiality, the significant risks of material misstatement that have been identified, and the impact these have on the planned audit procedures.

Materiality

10. The concept of materiality is applied by auditors in planning and performing an audit, and in evaluating the effect of any uncorrected misstatements on the financial statements or other information reported in the annual report and accounts.

11. Broadly, the concept of materiality is to determine whether matters identified during the audit could reasonably be expected to influence the decisions of users of the financial statements. Auditors set a monetary threshold when determining materiality, although some issues may be considered material by their nature. Therefore, materiality is ultimately a matter of the auditor's professional judgement.

12. The materiality levels determined for the audit of SFRS are outlined in Exhibit 1.

Exhibit 1

2024/25 Materiality levels for SFRS

Materiality	SFRS
Materiality – based on an assessment of the needs of users of the financial statements and the nature of SFRS's operations, the benchmark used to determine materiality is gross expenditure based on the audited 2023/24 financial statements. Materiality has been set at [2%] of the benchmark.	£8.6 million

Materiality	SFRS
Performance materiality – this acts as a trigger point. If the aggregate of misstatements identified during the audit exceeds performance materiality, this could indicate that further audit procedures are required. Using professional judgement, performance materiality has been set at 75% of planning materiality.	£6.4 million
Reporting threshold – all misstatements greater than the reporting threshold will be reported.	£300,000

Source: Audit Scotland

Significant risks of material misstatement to the financial statements

13. The risk assessment process draws on the audit team's cumulative knowledge of SFRS, including the nature of its operations and its significant transaction streams, the system of internal control, governance arrangements and processes, and developments that could impact on its financial reporting.

14. Based on the risk assessment process, significant risks of material misstatement to the financial statements have been identified and these are summarised in Exhibit 2, page 8. These are the risks which have the greatest impact on the planned audit approach. The planned audit procedures in response to the risks are also outlined.

15. The risk assessment process is an iterative and dynamic process. The assessment of risks set out in this Annual Audit Plan and Exhibit 2 may change as more information and evidence is obtained over the course of the audit. Where such changes occur, these will be reported to SFRS and those charged with governance, where relevant.

Exhibit 2
Significant risks of material misstatement to the financial statements

Risk of material misstatement	Planned audit response
Fraud caused by management override of controls Management is in a unique position to perpetrate fraud because of management's ability to override controls that otherwise appear to be operating effectively.	The audit team will: • Evaluate the design and implementation of controls over journal entry processing. • Make inquiries of individuals involved in the financial reporting process about inappropriate or unusual activity relating to the processing of journal entries and other adjustments. • Test journals entries, focusing on those that are assessed as higher risk, such as those affecting revenue and expenditure recognition around the year-end. • Evaluate significant transactions outside the normal course of business. • Assess the adequacy of controls in place for identifying and disclosing related party relationships and transactions in the financial statements. • Assess changes to the methods and underlying assumptions used to prepare accounting estimates and assess these for evidence of management bias.

Risk of material misstatement	Planned audit response
Valuation of property, plant and equipment SFRS held £588 million of property, plant, and equipment (PPE) at 31 March 2024, of which £487 million was land and building assets. There is a degree of subjectivity in the measurement and valuation of PPE due to specialist and management assumptions adopted. Changes in the assumptions could result in material changes in the valuation. While the service has adopted a robust biennial approach for the valuation of its estate, there is a risk that the carrying value of assets not revalued in the year does not reflect their current value. Where any differences in value are likely to be significant, this increases the risk of material misstatement in the financial statements.	The audit team will: • Evaluate the design and implementation of controls over the valuation process. • Review the information provided to the valuer and assess this for completeness and accuracy. • Evaluate the competence, capabilities, and objectivity of the valuer. • Obtain an understanding of management's involvement in the valuation process to assess if appropriate oversight has occurred. • Review the appropriateness of the key data and assumptions used in the 2024/25 valuation process, and challenge these where required. • Review management's assessment that the value in the balance sheet of assets not subject to a valuation process in 2024/25 is not materially different to the current value at the year-end.
Estimation of the pension liability SFRS had a pension liability of £2.8 billion at 31 March 2024. SFRS is a member of LGPS which is a defined benefit pension scheme. It is also a member of SPPA which is an unfunded scheme. Due to the material value and significant assumptions used in the calculation of the liabilities, changes in the assumptions could result in material changes in the valuation.	The audit team will: • Draw assurances from the work of actuaries and review the assumptions they made in determining the valuations. • Audit Scotland uses PwC as an auditor's expert to inform the planned audit procedures outlined above. The audit team will review the information provided by PwC and reflect this in the planned audit procedures where required.

Source: Audit Scotland

Key audit matters

16. The Code of Audit Practice requires public sector auditors to communicate key audit matters. Key audit matters are those that, in the auditor's professional judgement, are of most significance to the audit of the financial statements and require most attention when performing the audit.

17. In determining key audit matters, auditors consider:

- Areas of higher or significant risk of material misstatement.
- Areas where significant judgement is required, including accounting estimates that are subject to a high degree of estimation uncertainty.
- Significant events or transactions that occurred during the year.

18. The matters determined to be key audit matters will be communicated in the Annual Audit Report. Exhibit 2 outlines the significant risks of material misstatement to the financial statements that have been identified, including those that have the greatest impact on the planned audit procedures and require most attention when performing the audit.

Wider scope and Best Value

Introduction

19. Reflecting the fact that public money is involved, the Code of Audit Practice requires that public audit is planned and undertaken from a wider perspective than in the private sector. The wider scope audit set out by the Code of Audit Practice broadens the audit of the annual report and accounts to include consideration of additional aspects or risks in four wider scope areas, which are summarised below:

- **Financial Management** – this means having sound budgetary processes. Factors that can impact on SFRS being able to secure sound financial management include the strength of the financial management culture, accountability, and arrangements to prevent and detect fraud, error and other irregularities, and bribery and corruption.

- **Financial Sustainability** – this means looking forward over the medium and longer term in planning the services to be delivered and how they will be delivered effectively. This is assessed by considering SFRS's medium to longer term planning for service delivery.

- **Vision, Leadership and Governance** – this means having a clear vision and strategy with set priorities. This is assessed by considering the clarity of plans in place to deliver the vision and strategy and the effectiveness of the governance arrangements to support delivery.

- **Use of Resources to Improve Outcomes** – this means using resources to meet stated outcomes and improvement objectives through effective planning and working with partners and communities. This is assessed by considering SFRS's arrangements for ensuing resources are deployed to improve strategic outcomes, meet the needs of service users, and deliver continuous improvement.

20. A conclusion on the effectiveness and appropriateness of arrangements SFRS has in place for each of the wider scope areas will be reported in the Annual Audit Report.

Duty of Best Value

21. The Scottish Public Finance Manual (SPFM) explains that Accountable Officers have a specific responsibility to ensure that arrangements have been made to secure Best Value. Best Value in public services: guidance for Accountable Officers is issued by Scottish Ministers and sets out their duty to ensure that arrangements are in place to secure Best Value in public services.

22. Consideration of the arrangements SFRS has in place to secure Best Value will be carried out alongside the wider scope audit, and a conclusion on the arrangements in place will be reported in the Annual Audit Report.

Auditors may also carry out specific audit work covering the seven Best Value characteristics set out in the SPFM. The risk assessment process did not identify a need to carry out specific audit work on any of the characteristics. However, auditors are required to carry out a review of the 'fairness and equality' characteristic at least once during the audit appointment. This will be carried out later in the audit appointment.

Significant wider scope and Best Value risks

23. No significant risks in the wider scope areas or Best Value were identified from the risk assessment process.

Reporting arrangements, timetable and audit fee

Audit outputs

24. The outputs from the 2024/25 audit include:

- This Annual Audit Plan.
- An Independent Auditor's Report to SFRS, the Auditor General for Scotland, and the Scottish Parliament setting out opinions on the annual report and accounts.
- An Annual Audit Report to SFRS and the Auditor General for Scotland setting out significant matters identified from the audit of the annual report and accounts, conclusions from the wider scope and Best Value audit, and recommendations, where required.

25. The matters to be reported in the outputs will be discussed with SFRS for factual accuracy before they are issued. All outputs from the audit will be published on Audit Scotland's website, apart from the Independent Auditor's Report, which is included in the audited annual report and accounts.

26. Target dates for the audit outputs are set by the Auditor General for Scotland. In setting the target dates for the audit outputs, consideration is given to the statutory date for laying the annual report and accounts, which is 31 October 2025 for central government non-departmental public bodies, and other similar bodies.

27. The Independent Auditor's Report and Annual Audit Report are planned to be issued by the target date of 31 October 2025.

Audit timetable

28. Achieving the timetable for production of the annual report and accounts, supported by complete and accurate working papers, is critical to delivery of the audit to agreed target dates. Exhibit includes a timetable for the audit, which has been agreed with management. Agreed target dates will be kept under review as the audit progresses, and any changes required, and their potential impact, will be discussed with SFRS and reported to those charged with governance, where required.

Exhibit 3
2024/25 audit timetable

Audit activity	SFRS target date	Audit team target date	Relevant committee date
Issue of Annual Audit Plan		31 March 2025	08 April 2025
• Submission of unaudited annual report and accounts and all working papers to audit team	31 August 2025		
• Latest date for audit clearance meeting	3 October 2025	10 October 2025	
• Issue of draft Letter of Representation, proposed Independent Auditor's Report, and proposed Annual Audit Report		8 October 2025	23 October 2025
• Agreement of audited and unsigned annual report and accounts	8 October 2025	8 October 2025	
• Approval by those charged with governance and signing of audited annual report and accounts	23 October 2025		23 October 2025
• Signing of Independent Auditor's Report and issue of Annual Audit Report		27 October 2025	27 October 2025

Source: Audit Scotland

Audit fee

29. SFRS's audit fee is determined in line with Audit Scotland's fee setting arrangements. The proposed audit fee for the 2024/25 audit is £152,580.

30. In setting the audit fee, it is assumed that SFRS has effective governance arrangements in place and the complete annual report and accounts will be provided for audit in line with the agreed timetable. The audit fee assumes there will be no significant changes to the planned scope of the audit. Where the audit cannot proceed as planned, for example, due to incomplete or inadequate working papers, the audit fee may need to be increased.

Other matters

Internal audit

31. SFRS is responsible for establishing an internal audit function as part of an effective system of internal control. As part of the audit, the audit team will obtain an understanding of internal audit, including its nature, responsibilities, and activities.

32. While internal audit and external audit have differing roles and responsibilities, external auditors may seek to rely on the work of internal audit where it is considered appropriate. A review of internal audit's 2024/25 audit plan was carried out to identify if there were any areas where the audit team could rely on its work. The audit team concluded it will not rely on internal audit's work. However, the audit team will review internal audit's reports and assess if there is any impact on the audit.

Audit quality

33. Audit Scotland is committed to the consistent delivery of high-quality audit. Audit quality requires ongoing attention and improvement to keep pace with external and internal changes. Details of the arrangements in place for the delivery of high-quality audits is available from the Audit Scotland website.

34. The International Standards on Quality Management (ISQM) applicable to Audit Scotland for 2024/25 audits are:

- ISQM (UK) 1, which deals with an audit organisation's responsibilities to design, implement, and operate a system of quality management (SoQM) for audits. Audit Scotland's SoQM consists of a variety of components, such as: governance arrangements and culture to support audit quality, compliance with ethical requirements, ensuring Audit Scotland is dedicated to high-quality audit through engagement performance and resourcing arrangements, and ensuring there are robust quality monitoring arrangements in place. Audit Scotland carries out an annual evaluation of its SoQM and has concluded it complies with this standard.

- ISQM (UK) 2 sets out arrangements for conducting engagement quality reviews, which are performed by senior management not involved in an audit, to review significant judgements and conclusions reached by the audit team, and the appropriateness of proposed audit opinions on high-risk audits.

35. To monitor quality at an individual audit level, Audit Scotland carries out internal quality reviews on a sample of audits. Additionally, the Institute of Chartered Accountants of England and Wales (ICAEW) carries out independent quality reviews on a sample of audits.

36. Actions to address deficiencies identified by internal and external quality reviews are included in a rolling Quality Improvement Action Plan, which is used to support continuous improvement. Progress with implementing planned actions is monitors on a regular basis by Audit Scotland's Quality and Ethics Committee.

37. Audit Scotland may periodically seek the views of SFRS on the quality of audit services provided. The audit team would also welcome feedback at any time.

Scottish Fire and Rescue ServiceScottish Fire and Rescue Service

Annual Audit Plan 2024/25

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 **Email: info@audit.scot**
www.audit.scot

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/20-25

Agenda Item: 9

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**HMFSI INSPECTION ACTION PLANS UPDATE**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to provide the Audit and Risk Assurance Committee (ARAC) with an overview update of the current HMFSI inspection action plans.
2	**Background**
2.1	HM Fire Service Inspectorate inspects and reports on the Scottish Fire and Rescue Service (SFRS) with the purpose of assuring the public and Scottish Ministers that we are working in an efficient and effective way, and to promote improvement in the Service.
2.2	In line with the thematic process agreed in May 2020, once approved, action plans to meet the report recommendations made will be presented to ARAC to scrutinise progress.
3	**Main Report/Detail**
3.1	ARAC members are presented with the current HMFSI Inspection Action Plan overview dashboard, attached as **Appendix A**, for information. This provides high level details of all action plans (HMFSI Actions Plans) and includes a section detailing ongoing and forthcoming inspections and reports.
3.2	The dashboard shows that 16 out of the 23 total Action Plans are complete. Of the seven remaining live Actions Plans: • 3 have entered the closure process with all actions completed - Firefighting in Highrise Buildings, Climate Change and Industrial Action Preparedness. • 2 have a single action remaining – Health & Safety and East Service Delivery Area • 2 are ongoing – Mental Health & Wellbeing and West Service Delivery Area
3.3	Current updates for the live Action Plans include: • **Health and Safety: An Operational Focus**: The overall BRAG rating for this Action Plan remains **red** and is estimated at over 95% complete. Despite being nearly complete, the Plan has been given a red BRAG status due to slip in delivery timescales. During the reporting period one action was completed, and the one remaining action has a red BRAG status due to the slip in timescales as a result of conflicting workloads and interdependency on other projects. It is anticipated that the remaining action will be completed by the next reporting period. • **East Service Delivery Area**: The overall BRAG rating for this Action Plan remains **green** and is estimated at over 95% complete. Work is on schedule and the remaining

	one action regarding Reinforced Autoclaved Aerated Concrete (RAAC) has a green status and is currently 45% complete, with remediation and reconfiguration work continuing for permanent resolutions to those stations in the East SDA that have Reinforced Autoclaved Aerated Concrete (RAAC) roofing. • **Mental Health and Wellbeing Support in the Scottish Fire and Rescue Service**: The overall BRAG rating for this action plan remains **red** due to the lack of progress made with no actions completed within the reporting period. Progress on 8 actions was significantly impacted by the Wellbeing Recovery Plan with these likely to be carried forward into departmental planning for 2025/26. A further 3 actions were delayed as these are to be led by the Chair of the Mental Wellbeing Learning Resource Group however several attempts to appoint a Chair have been unsuccessful and the Mental Health and Wellbeing group will be required to consider how and when these can be progressed. An additional 2 actions saw slippage from set timescales and revised due dates have been agreed. This action plan is currently 60% complete with 17 actions ongoing, all of which have a red or amber BRAG status. • **West Service Delivery Area (WSDA)**: The first formal progress update was presented to the Corporate Board on 17 February 2025. The overall BRAG rating for this action plan is **green** and it is estimated at 70% complete with 14 of 30 actions having been completed to-date. The remaining 16 actions are in progress with 3 of these being marked amber and 13 having a green BRAG status. Of these live actions, four actions saw slippage from set timescales and revised due dates have been agreed.
4	**Recommendation**
4.1	The ARAC members are invited to: • Scrutnise the progress of all action plans as presented in the HMFSI Inspection Action Plan Dashboard, attached as **Appendix A.**
5	**Key Strategic Implications**
5.1 5.1.1	**Risk** There are no risks associated with the recommendations of this report.
5.2 5.2.1	**Financial** There are no financial implications associated with the recommendations of this report.
5.3 5.3.1	**Environmental & Sustainability** There are no environmental implications associated with the recommendations of this report.
5.4 5.4.1	**Workforce** There are no workforce implications associated with the recommendations of this report.
5.5 5.5.1	**Health & Safety** There are no health and safety implications associated with the recommendations of this report.
5.6 5.6.1	**Health & Wellbeing** There are no health and wellbeing implications associated with the recommendations of this report.

5.7 5.7.1	**Training** There are no training implications associated with the recommendations of this report.	
5.8 5.8.1	**Timing** Each HMFSI Action Plan will be reported to the CB on a quarterly cycle until completion.	
5.9 5.9.1	**Performance** This process supports robust challenge and scrutiny of our performance against HMSFI recommended improvements.	
5.10 5.10.1	**Communications & Engagement** There is no implication associated with the recommendations of this report.	
5.11 5.11.1	**Legal** The arrangements for independent inquiries into the state and efficiency of the SFRS are a statutory requirement as laid out in Section 43 of the Fire Scotland Act 2005.	
5.12 5.12.1	**Information Governance** A Data Protection Impact Assessment (DPIA) is not required for this report as there is no sensitive information to consider.	
5.13 5.13.1	**Equalities** An Equality and Human Rights Impact Assessment (EHRIA) is not required for this this report. These will be captured by Directorate and LSO EHRIAs	
5.14 5.14.1	**Service Delivery** There are no service delivery implications associated with the recommendations of this report.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Mark McAteer, Director of Strategic Planning, Performance and Communications
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial/~~**Reasonable/**~~Limited/Insufficient~~
7.2	**Rationale:**	Following receipt of HMFSI Reports, Action Plans are developed in conjunction with Directorates and approved via the Strategic Leadership Team and the nominated Executive Committee of the Board. Quarterly reporting is made to the Senior Management Board and nominated Executive Board until full completion of the Action Plan.
8	**Appendices/Further Reading**	
8.1	**Appendix A**: Inspection Action Plan Overview Dashboard	

Prepared by:	Kirsty Jamieson, Planning and Performance Officer
Sponsored by:	Richard Whetton, Head of Governance, Strategy and Planning
Presented by:	Mark McAteer, Director of Strategic Planning, Performance and Communications

Links to Strategy and Corporate Values		
Our inspection process contributes to Strategic Outcome 5 of the Strategic Plan 2022-25: We are a progressive organisation, use our resources responsible and provide best value for money to the public.		
Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Corporate Board	*17 February 2025*	*For recommendation*
Change Committee	*1 May 2025*	*For scrutiny (CCMS)*
Service Delivery Committee	*25 February 2025*	*For scrutiny (Firefighting in Highrise Buildings; East SDA; Climate Change; Industrial Action)*
People Committee	*6 March 2025*	*For scrutiny (Health and Safety; Mental Health and Wellbeing)*
Audit and Risk Assurance Committee	*08 April 2025*	*For scrutiny*

HMFSI INSPECTION OVERVIEW DASHBOARD

APPENDIX A

HMFSI Thematic Reports Progress Dashboard

Published	Title	Relevant Committee	Due Date	Revised Due Date	Total Actions	Last Updated	Next Update	Committee Update	Not Started	In Progress	Deferred	Complete	On Hold	Transferred	Cancelled	Moved to BAU	Void	% Complete	RAG
Apr-22	Health and Safety: An Operational Focus	PC	Oct-24	**Mar-25**	18	Feb-25	Apr-25	Mar-25	0	1	0	16	0	0	1	0	0	95%	
Sep-22	Firefighting in Highrise Buildings	SDC	Jun-24	Jun-25	8	Feb-25	Apr-25	Feb-25	0	0	0	8	0	0	0	0	0	100%	
Apr-23	Command and Control Mobilising System (CCMS)	CC	Jul-24	-	6	Feb-25	-	May-25	0	0	0	6	0	0	0	0	0	100%	
Sep-23	Climate Change – Impact on Operational Activity	SDC	Apr-25	Mar-25	12	Feb-25	Apr-25	Feb-25	0	0	0	12	0	0	0	0	0	100%	
Oct-23	East Service Delivery Area (ESDA)	SDC	Mar-25	-	9	Feb-25	Apr-25	Feb-25	0	1	0	8	0	0	0	0	0	95%	
Dec-23	Mental Health and Wellbeing Support in SFRS	PC	Dec-25	-	30	Feb-25	Apr-25	Mar-25	0	17	0	8	0	0	5	0	0	60%	
Jun-24	West Service Delivery Area (ESDA)	SDC	Dec-25	-	30	Feb-25	Apr-25	Feb-25	0	16	0	14	0	0	0	0	0	70%	

HMFSI Focused Reports Progress Dashboard

Published	Title	Relevant Committee	Due Date	Revised Due Date	Total Actions	Last Updated	Next Update	Committee Update	Not Started	In Progress	Deferred	Complete	On Hold	Transferred	Cancelled	Moved to BAU	Void	% Complete	RAG
May-23	Review of contingency planning arrangements in relation to potential industrial action	SDC	Dec-24	**Jun-25**	7	Feb-25	Apr-25	Feb-25	0	0	0	7	0	0	0	0	0	100%	

Closed Inspection Action Plans

Published	Title	Relevant Committee	Due Date	Revised Due Date	Total Actions	Last Updated	Next Update	Committee Update	Not Started	In Progress	Deferred	Complete	On Hold	Transferred	Cancelled	Moved to BAU	Void	% Complete	RAG	Closed Date
Apr-15	HMFSI - Performance Management Systems	SDC	Jul-20	May-20	32	May-20	N/A		0	0	0	26	0	2	4	0	0	100%	Closed	
Jul-17	HMFSI - Operations Control Dundee and Highlands and Islands Support	SDC	Dec-20	May-20	24	May-20	N/A		0	0	0	24	0	0	0	0	0	100%	Closed	
Jan-18	HMFSI - Fire Safety Enforcement	SDC	Mar-20	Mar-23	20	Mar-23	N/A		0	0	0	19	0	0	0	0	1	100%	Closed	May-23
May-18	Audit Scotland - Scottish Fire and Rescue Service Update	ARAC	Dec-21	Feb-23	36	Feb-23	N/A		0	0	0	33	0	0	0	1	2	100%	Closed	Mar-23
Feb-19	HMFSI - Provision of Operational Risk Information	SDC	Mar-22	Dec-22	25	Feb-23	N/A		0	0	0	20	0	0	0	5	0	100%	Closed	Feb-23
May-19	HMFSI - Management of Fleet and Equipment	SDC	Mar-22	May-22	38	May-22	N/A		0	0	0	32	0	0	6	0	0	100%	Closed	May-22
Feb-20	LAI - Dumfries and Galloway	N/A	Jun-21	N/A	12	Dec-22	N/A		0	4	0	7	0	1	0	0	0	100%	Closed	
Jun-20	LAI - Edinburgh City	N/A	Apr-21	N/A	11	Dec-22	N/A		0	5	0	0	0	6	0	0	0	100%	Closed	
Aug-20	HMFSI - Command and Control: Aspects of Incident Command	SDC	Mar-22	Dec-23	25	Nov-22	N/A		0	0	0	25	0	0	0	0	0	100%	Closed	Nov-22
Mar-21	HMFSI - Assessing the Effectiveness of Inspection Activity	ARAC	-	-	0	-	-		-	-	-	-	-	-	-	-	-	-	Closed	
May-21	LAI - Midlothian	N/A	Mar-22	Mar-23	7	Dec-22	N/A		0	0	0	7	0	0	0	0	0	100%	Closed	
Dec-21	LAI - Argyll & Bute and East & West Dunbartonshire	N/A	Apr-23	N/A	6	Dec-22	N/A		0	5	0	1	0	0	0	0	0	100%	Closed	
May-22	SMARTEU Covid 19 Structured Debrief Summary	SDC	Mar-23	May-23	7	Mar-23	N/A		0	0	0	7	0	0	0	0	0	100%	Closed	May-23
Dec-20	Planning and Preparedness for COVID Review	SDC	May-26	Aug-23	15	Aug-23	N/A		0	0	0	12	0	0	0	3	0	100%	Closed	Aug-23
Mar-23	Training of RDS Personnel	PC	Mar-23	Aug-23	31	Aug-23	N/A		0	0	0	27	0	0	0	4	0	100%	Closed	Sep-23

HMFSI Inspection Forecast

Expected	Title	Type
2024-25	North Service Delivery Area (NSDA)	SDA
2024-25	Organisational Culture within SFRS - Volume 1	Thematic
2024-25	Operational Assurance	Thematic

HMFSI <u>Possible</u> Areas of Interest as outlined within the 2023-25 Inspection Plan

Expected	Title	Type
TBC	Climate Change : SFRS actions relating to reducing its carbon footprint	Focused
TBC	SFRS Planning and preparedness for a response to Marauding Terrorist Attack	Focused
TBC	The state of provision of specialist resources (appliances, equipment and staff inc. training)	Focused
TBC	Recognising and embedding organisational learning	Focused
TBC	National resilience assets - provision, location, skills and usage	Focused
TBC	Fire cover - distribution, modelling and standards	Focused
TBC	HR/Workforce planning - recruitment, attrition, diversity, skills (all duty systems); support to LSO areas	Focused
TBC	Administration and use of technology	Focused
TBC	Operations Control	Focused
TBC	RVDS Duty System	Focused

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/14-25

Agenda Item: 10

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**25 MARCH 2025**							
Report Title:	**PMF QUARTERLY PERFORMANCE – 2024-25 Q3**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	To provide members with third quarter performance of KPIs 35 – 42 for fiscal year 2024-25. KPIs 58 - 61, 64 and 65 are only reported annually as part of the fourth quarter report.
2	**Background**
2.1	The Performance Management Framework (PMF) defines how we, the Scottish Fire and Rescue Service (SFRS), manage our performance and how we use performance information to inspire change and improvement. This framework remains in place for the current fiscal year until the roll out of a new Strategic Plan in 2025.
2.2	56 quarterly indicators (8 for ARAC) and 9 annual indicators (6 for ARAC) were identified across directorates to provide senior leaders, committees and the SFRS Board with relevant information on our performance. This supports those responsible for scrutiny of how SFRS perform in delivering its Strategic Outcomes.
2.3	The quarterly performance dashboard (& report) provide an overview for those indicators and through the use of statistical process control charts (SPC) alerts stakeholders to situations deteriorating or improving or where performance is stable and in control.
3	**Main Report/Detail**
3.1	This paper covers all performance indicators stated in the PMF intended for scrutiny by the Corporate Board.
3.2	As an interim measure (pre 2025 SFRS Strategy & PMF), any current KPI indicators with compliance statutory or other legislative implications, are identified in red underlined text to assist their intended audience considering wider implications than just improving or deteriorating performance.
3.3	The indicators identified in this report as pertinent to the requirement of 3.2 are – • **36 – Subject Access requests within timeframe** – ICO Guidance on 'Right to Access' states "*Individuals have the right to access their personal data. SFRS should respond without delay and within one month of receipt of request*". • **38 – FOI requests within timeframe** – FOI and EIR information requests handling procedure states "*All public bodies have a duty to assist applicants in requestion information. Under the FOI Scotland Act SFRS has 20 working days to respond*".

3.4	Exceptional variation: • 36 - % Subject Access within Timeframe – BELOW TARGET • 40 - % Invoices in 30 Days
3.5	Deteriorating (long-term): • 42 - % Service Desk Requests within SLA
3.6	Improving (long-term): • None
3.7	Not changing: • 35 - Cyber Security Breaches • 37 - Data Breaches • 38 - % FOI within Timeframe – BELOW TARGET • 39 - Confirmed Frauds
3.8	Other • 41 - % Service Desk Incidents within SLA – Due to previously identified data quality issue, there is not enough historical data to determine the long-term direction of this KPI. It is currently achieving the desired target of 85% and has done so in 5 of the last 6 quarters.
4	**Recommendation**
4.1	Members are invited to scrutinise the contents of this, question KPI performance and provide feedback on practical use of reporting to ensure continuous development of user experience. The live version of the report can be accessed through the Governance area of the Power BI Landing Page.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk** SFRS has a specific risk SPPC001 There is a risk of the service not consistently providing accurate performance management information from some sources due to inaccurate data or inadequate systems resulting in loss of confidence in reporting service performance.
5.2 5.2.1	**Financial** Performance measures reported for Strategic Outcomes 5 and under ‘Annual Reporting’ provide insight to finance.
5.3 5.3.1	**Environmental & Sustainability** Performance measures reported under ‘Annual Reporting’ provide insight to environmental and sustainability.
5.4 5.4.1	**Workforce** There are no specific Workforce implications addressed in this paper.
5.5 5.5.1	**Health & Safety** There are no specific Health and Safety implications addressed in this paper .
5.6 5.6.1	**Health & Wellbeing** There are no specific Health and Wellbeing implications addressed in this paper.
5.7 5.7.1	**Training** There are no specific Training implications addressed in this paper.

5.8 5.8.1	**Timing** Some performance indicators rely on manual collation of data and are a 'snapshot' in time (2/3 weeks ahead of scrutiny) and may be subject to change dependant on relevant business areas business practices.	
5.9 5.9.1	**Performance** All performance measures reported are linked to Strategic Outcomes 5 amd 'Annual Reporting'.	
5.10 5.10.1	**Communications & Engagement** There are no specific Communications & Engagement implications addressed in this paper.	
5.11 5.11.1	**Legal** There are no specific Legal implications addressed in this paper.	
5.12 5.12.1	**Information Governance** DPIA completed - No	
5.13 5.13.1	**Equalities** EHRIA completed - No	
5.14 5.14.1	**Service Delivery** Performance measures reported for Strategic Outcomes 2 & 6 are linked to Service Delivery.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Mark McAteer, Director for Strategic Planning, Performance and Communications
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial~~/**Reasonable**/~~Limited/Insufficient~~
7.3	**Rationale:**	The service has continued to develop its approach to performance reporting. The Organisational Performance Dashboard, aligned to the SFRS Performance Management Framework, is now live and available across the service with a pdf version made available to the public. Scrutiny of service performance is evident across the service, at executive level and by the SFRS Board at committee and board level.
8	**Appendices/Further Reading**	
8.1 8.2	Appendix A: PDF copy of PBI0068 report Further Reading: - Link to Power BI Landing Page.	

Prepared by:	Chris Fitzpatrick, Business Intelligence and Data Services Manager
Sponsored by:	Richard Whetton, Head of Governance, Strategy and Performance
Presented by:	Mark McAteer, Director for Strategic Planning, Performance and Communications

Links to Strategy and Corporate Values
Strategy Outcome 5 – We are a progressive organisation, use our resources responsibly and provide best value for money to the public • Remaining open and transparent in how we make decisions. • Improving levels of Service performance whilst providing value for money to the public. • Improving the use of data and business intelligence to support decision making.

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Corporate Board	*17 February 2025*	*For scrutiny*
Audit and Risk Assurance Committee	*25 March 2025*	*For scrutiny*

SCOTTISH FIRE AND RESCUE SERVICE

Working together for a safer Scotland

Audit, Risk & Assurance Committee Performance Report

LIVE MANAGEMENT INFORMATION

Latest quarter shown: **2024-25 Q3**

Previous report

All previous reports

APPENDIX A

You can use these navigational buttons to go to other pages, or use the contents panel at the left-hand side of the screen

Welcome

The Audit, Risk & Assurance Committee Performance Report provides a view of how the Scottish Fire and Rescue Service is performing against its corporate performance measures, as mapped against our Strategic Plan Outcomes.

Our Performance Management Framework 2023-24 defines these corporate performance measures, whilst the Strategic Plan 2022-25 outlines the high-level outcomes through which the Service will continually work towards its overall purpose.

This report is a tool to support and scrutinise effective delivery of the Strategic Plan 2022-25. Each KPI has an owner, who's responsible for monitoring and commenting on its performance.

Key contact: BI@firescotland.gov.uk

BUSINESS INTELLIGENCE

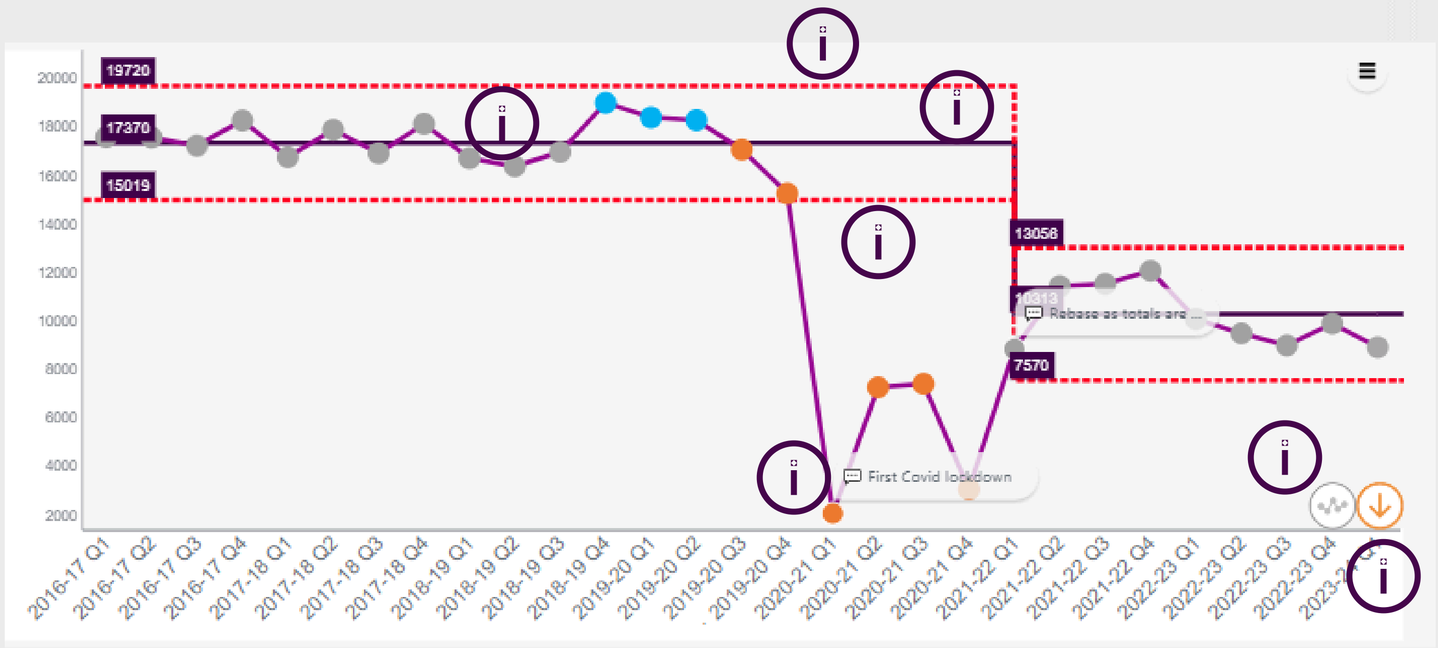
This report presents data over time for each of the quantitative performance measures as detailed in the Performance Management Framework 2023-24, broken down into the Strategic Plan Outcomes. The Contents page (next) provides direction as to where you can find certain information.

SPC Charts

In this PMF Board Report, we use **Statistical Process Control (SPC) charts** to analyse and visualise how the Service is performing against each of its corporate performance measures. We also use commentary as provided by the KPI owner to provide context and highlight key messages. This approach to analysis is how the Business Intelligence Team will analyse, interpret and present performance data going forwards.

SPC is an analytical technique that **plots data over time**. It helps us to **understand variation** and guides us to take the most appropriate action.

SPC alerts us to a situation that may be deteriorating, shows us if a situation is improving, shows us how capable a system is of delivering a standard or target, and shows us if a process that we depend on is reliable and in control.



Above: anatomy of a SPC chart

How to Interpret SPC Charts - see chart - anatomy of a SPC chart

Normally data points will fall **between the upper and lower control limits**. If any of the following scenarios apply, the change needs to be investigated and an explanation provided. Over time this lets us analyse performance in a meaningful way.

An **ORANGE** data point indicates special cause variation of particular concern and needing action. For example, whenever a data point falls outside of a control limit, or if 2 out of 3 data points are close to a control limit.

A **BLUE** data point indicates where improvement appears to lie.

A **GREY** data point indicates no significant change (common cause variation) as well as the baseline.

The following variation icons will also appear on each SPC chart:

Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Source: making-data-count-getting-started-2019.pdf (england.nhs.uk)

Data source for this report:

Details of each data source can be found on the Index page. Some of these are automated whilst others are manual.

Frequency of update:

This report will be updated quarterly.

OUTCOME 05 (Effective Governance & Performance)

We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

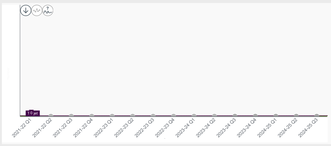
KPI	Indicator	Purpose	Geography	Frequency	Target	Business Area
35	Number of Cyber Security Breaches	To record the number of successful cyber breaches experienced by the Service	National	Quarterly	0	Information and Communication Technology
36	% of subject access requests responded to within the statutory timescales	Demonstrates if we are meeting the statutory timescales of GDPR/Data Protection legislation	National	Quarterly	95%	Corporate Communications
37	Number of Data Breaches	Demonstrates if staff are comlying with GDPR/Data Protection legisation to avoid data breaches	National	Quarterly	0	Corporate Communications
38	% of FOIs responded to within statutory timescales	Demonstrates if we are meeting the statutory timescales of Freedom of Information legislation	National	Quarterly	95%	Corporate Communications
39	Number of confirmed frauds	Unavailable	National	Quarterly	0	Finance and Procurement
40	% of invoices paid in 30 days	Unavailable	National	Quarterly	98%	Finance and Procurement
41	% Service Desk incidents resolved within Service Level Agreement	To demonstrate the level of compliance with Service Level Agreement for dealing with incidents (eg broken equipment or no access to an ICT system or service)	National	Quarterly	85%	Information and Communication Technology
42	% Service Desk requests resolved within Service Level Agreement	To demonstrate the level of compliance with Service Level Agreement for dealing with service requests (eg new or additional equipment or improvement to an ICT system or service)	National	Quarterly	85%	Information and Communication Technology
58	Average age of Heavy Fleet	The move towards reducing average age of heavy fleet.	National	Annually	12 years and below	Asset Management
59	Average age of Light Fleet	The move towards reducing the average of light fleet	National	Annually	6 years and below	Asset Management
60a	% of Community Fire Stations in good or satisfactory condition	The overall condition of the property estate	National	Annually	1% increase against previous year	Asset Management
60b	% of Station Gross Internal Area in Good or Satisfactory Condition	The overall condition of the property estate	National	Annually	1% increase against previous year	Asset Management
61	% of Community Fire Stations in good or satisfactory suitability	The overall suitability of the property estate	National	Annually	1% increase against previous year	Asset Management
64	Savings achieved as a % of Resource budget for year	Unavailable	National	Annually	3.5% for 2023/24	Finance and Procurement
65	Total Budget Outturn vs agreed funding (RDEL & CDEL)	Unavailable	National	Annually	Track	Finance and Procurement

Effective Governance and Performance

We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

KPI 35 — Cyber Security Breaches

PURPOSE: To record the number of successful cyber breaches experienced by the Service



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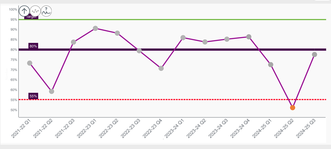
OWNER: Head of ICT

SUMMARY

No Performance Statement Available

KPI 36 — % Subject Access within Timeframe

PURPOSE: Demonstrates if we are meeting the statutory timescales of GDPR/Data Protection legislation



95%

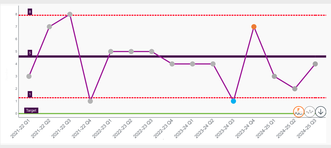
OWNER: Head of Corporate Communications

SUMMARY

Temporary staff assisting with cases and overtime agreed to deal with backlog.

KPI 37 — Data Breaches

PURPOSE: Demonstrates if staff are comlying with GDPR/Data Protection legislation to avoid data breaches



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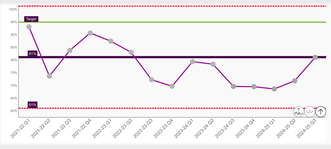
OWNER: Head of Corporate Communications

SUMMARY

Continual review of breaches to determine specific training required and also to make improvements to SFRS E-Learning tool for SFRS wide training.

KPI 38 — % FOI Responded within Timeframe

PURPOSE: Demonstrates if we are meeting the statutory timescales of Freedom of Information legislation



95%

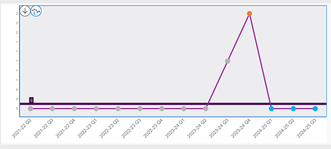
OWNER: Head of Corporate Communications

SUMMARY

Level 2 Intervention opened by the Office of the Scottish Information Commissioner (OSIC) in relation to our compliance with Freedom of Information legislation. SFRS asked to submit a formal response and action plan to make improvements.

KPI 39 — Confirmed Frauds

PURPOSE: Unavailable



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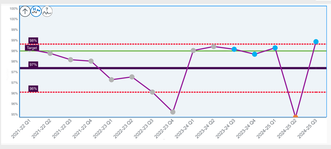
OWNER: Head of Finance & Procurement

SUMMARY

Whilst no frauds have been identified the completion of the LCMS Fraud Module will continue to raise awareness and ownership within the Service. The internal audit review of anti-fraud and corruption will identify additional control actions to mature the fraud framework.

KPI 40 — % Invoices Paid in 30 Days

PURPOSE: Unavailable



98%

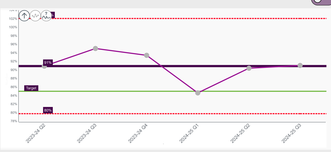
OWNER: Head of Finance & Procurement

SUMMARY

Weekly follow-up emails are issued to invoice authorisers to prompt them to check and approve any outstanding invoices. Invoices are generally input to the financial system within 1 day of receipt.

KPI 41 — % Service Desk Incidents within SLA

PURPOSE: To demonstrate the level of compliance with Service Level Agreement for dealing with incidents (eg broken equipment or no access to an ICT system or service)



85%

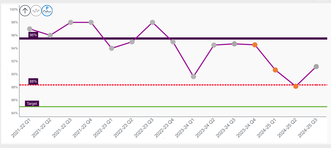
OWNER: Head of ICT

SUMMARY

ICT Operations continue to look for efficiencies in ways of working, and identify innovative opportunities to improve. ICT Service Desk are undergoing a modernisation programme which is now on the functions workplan for 2025/2026, which will seek to improve overall performance.

KPI 42 — % Service Desk Requests within SLA

PURPOSE: To demonstrate the level of compliance with Service Level Agreement for dealing with service requests (eg new or additional equipment or improvement to an ICT system or service)



85%

OWNER: Head of ICT

SUMMARY

ICT Operations continue to look for efficiencies in ways of working, and identify innovative opportunities to improve. ICT Service Desk are undergoing a modernisation programme which is now on the functions workplan for 2025/2026, which will seek to improve overall performance.

Full guidance can be found on the Power BI Users Yammer Community, along with details of available support.

How to navigate your way around this report:
You can use the navigational buttons on the left-hand/top of each page to return to the home page, go to the next page, return to the previous page, go to the Help page, or go to the About page.

How to interact with the report:
Power BI reports and dashboards are very interactive; this means you'll be able to interrogate the data yourself to look into certain periods or areas.
• Look out for the hint buttons on pages, which tell you how you can interact with the dashboard:

• You can view the details of data that make up a visualisation by **hovering over a chart/visual** (e.g. a point on a map or bar/line on a chart).
• You can change how a visual looks by sorting it, for example by numeric values or text data. To sort a visual, first select it and then click on the **More actions (…)** button on the visual, which will bring up the sorting options. Power BI reports retain the filters, slicers, sorting, and other data view changes that you make.
• You can use the filters on the report page to target specific areas or time periods etc. To select more than one option in a filter (for example more than 1 business area), **press and hold the Ctrl button on your keyboard** whilst you click on the filter selections.

Interpreting statistics and trends:
For help with interpreting the statistics within this report, identifying potential trends, or to gain a deeper understanding of what the data means, please contact the Business Intelligence Team.

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For further help, please contact the Business Intelligence Team -
bi@firescotland.gov.uk

BUSINESS
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bi@firescotland.gov.uk

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/19-25

Agenda Item: 11

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE (ARAC)**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**ARRANGEMENTS FOR PREPARING THE 2024-25 ANNUAL GOVERNANCE STATEMENT**							
Report Classification:	**For Scrutiny**	**Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	This report outlines the preparatory arrangements and reporting methods developed to provide sufficient levels of assurance in support of the 2024/25 Annual Governance Statement (AGS).
2	**Background**
2.1	The Scottish Public Finance Manual (SPFM) issued by the Scottish Ministers provides guidance on the proper handling and reporting of public funds. It sets out the relevant statutory, parliamentary and administrative requirements, emphasises the need for economy, efficiency and effectiveness, and promotes good practice and high standards of propriety. fCB
2.2	It requires the Accountable Officer to produce an AGS for inclusion within the accountability section of the Annual Report and Accounts.
2.3	In summary the AGS outlines the effectiveness of the arrangements that are in place for internal control, risk management and corporate governance, during the period under review.
3	**Main Report/Detail**
3.1	This report details Scottish Fire and Rescue Service's (SFRS) approach for preparing the AGS for the year ended March 2025. The approach and related documentation is outlined in the SFRS Policy for Preparing AGS for the Accountable Officer. This policy enables the Service to ensure SPFM compliance in a co-ordinated and structured way.
3.2	The content, layout and style of the AGS will be prepared to align with the: • Essential features outlined in the SPFM • Recent updates (March 2024) to the Internal Control Checklist with updated guidance supplied to support those completing • Strategic risks • Best practice of other public bodies • Changes to the structure of the Annual Report and Accounts • Greater focus on highlighting where assurances can be provided, demonstrated by achievements and outcomes during the period under review • Board and Committee effectiveness

3.3	Administering the SFRS Assurance Framework and preparing the 2024/25 AGS within the prescribed timescales requires engagement across the organisation. The Corporate Business Manager is responsible for the administration of the Framework, working in partnership with the Risk and Audit Manager to prepare the 2024/25 AGS on behalf of the Accountable Officer for inclusion in the end of year Annual Report and Accounts.
3.4	Collation of the Internal Control Checklist returns will continue to be co-ordinated and managed online using the 'Executive Support' SharePoint site with the appropriate access rights granted. This will support ongoing monitoring and improve oversight.
3.5	Formal guidance and a training module are hosted on the online Learning Content and Management System (LCMS) for those who are new to the process or require refresher training. A meeting has also been convened with all Heads of Function (HoF) early March led by the Head of Governance, Strategy and Performance to strengthen understanding of requirements to be met around assurance within the internal control checklist and the implications of ensuring any assurance concerns are appropriately recorded.
3.6	Improvement Action Plans (IAP's) produced following the review of Internal Controls are monitored and scrutinised through the Corporate Board (CB) and ARAC by exception reporting.
3.7	Fraud Risk Assessment (FRA) Checklists provide increased scrutiny around potential areas of Fraud. FRA Plans are monitored and scrutinised through the CB and ARAC by exception reporting.
3.8	The SFRS policy and related documents for preparing the AGS for the Accountable Officer have been reviewed. The Internal Control Checklist will be updated to reflect any changes to the content of the checklist made by Scottish Government February/March 2025.
3.9	External Audit's annual programme of work for auditing the SFRS requires the AGS to be completed for audit by the end of June each year. The Assurance Framework is owned by the Accountable Officer who will sign off the 2024/25 AGS as a statement of the adequacy and effectiveness of the SFRS's governance, risk and internal control arrangements. Directorates will assist in the preparation of the AGS by confirming the evidence against the areas highlighted in the SFRS Internal Control Checklist are in place.
3.10	It will continue to be the responsibility of the HoF to ensure the evidence in support of their Certificates of Assurance is readily available should this be required for any further Internal or External Audit purposes or further scrutiny by the CB and/or ARAC. Throughout this time there may also be a direct request for the responsible managers to attend the ARAC to answer any questions the Committee may wish to ask on progress being made.
3.11	The ARAC will have complete oversight of the SFRS Assurance Framework and will scrutinise the 2024/25 AGS at its public meeting planned for 19 June 2025.
4	**Recommendation**
4.1	The ARAC are requested to note the legislative background and scrutnise the SFRS approach towards the AGS preparations.
5	**Key Strategic Implications**
5.1	**Risk**
5.1.1	The Annual Governance Statement is linked to the Risk Management framework and is a core element of the Service's governance arrangements.
5.1.2	In relation to our internal governance, including systems of control and data governance, SFRS has a CAUTIOUS risk appetite.

5.2 5.2.1	**Financial** Not applicable
5.3 5.3.1	**Environmental & Sustainability** Not applicable
5.4 5.4.1	**Workforce** As this is a significant piece of work, which must be completed within relatively short timescales, resourcing will be reviewed by the Corporate Business Manager and Audit and Risk Manager on a regular basis. They will provide ongoing support and guidance to the identified HoF who are responsible for providing evidence to support the AGS.
5.5 5.5.1	**Health & Safety** Not applicable
5.6 5.6.1	**Health & Wellbeing** Not applicable
5.7 5.7.1	**Training** Guidance is available on the iHub and a training module hosted on the online Learning Content and Management System (LCMS), along with support from the Corporate Business Manager and Risk and Audit Manager to HoF's. Follow-up support sessions will be available to assist with AGS co-ordination and returns hosted on the 'Executive Support' SharePoint Site with access granted to HoF's and a designate responsible for co-ordinating the return.
5.8 5.8.1	**Timing** The support arrangements have been scheduled to ensure that the Timeline for Preparing Certificates of Assurance contained within the SFRS Policy for Preparing the AGS is adhered to.
5.9 5.9.1 5.9.2	**Performance** Further scrutiny in relation to the Internal Control Checklists, Improvement Actions Plans and Fraud Risk Assessments will be conducted by CB and ARAC. The Annual Operating Plan or business as usual arrangements remain in place to ensure that these are monitored and reviewed thereby ensuring continuous improvement. The Annual Governance Statement forms part of the Services wider governance arrangements and will collectively ensure improved performance.
5.10 5.10.1	**Communications & Engagement** The 2024/25 AGS will be reported to the CB and ARAC.
5.11 5.11.1	**Legal** The Public Finance and Accountability (Scotland) Act 2000 (PFA Act), which is framed in resource terms, sets out the rules for spending money, accounting requirements, accountability of officials and auditing arrangements. The basic principle is that spending can take place only if authorised by the Parliament in Budget Acts and must not exceed any amount so authorised in relation to that purpose. The AGS is a requirement of the SPFM and is a key feature of the Annual Report and Accounts, both of which are published to meet statutory and parliamentary compliance. The SFRS Assurance Framework will therefore enable the Service to manage the evidence required to prepare the AGS in a structured and co-ordinated manner.
5.12 5.12.1	**Information Governance** DPIA completed No. If not applicable state reasons.

	Issues associated with GDPR are covered within existing policy, procedure and practice. There are no anticipated specific additional requirements associated with the implementation of this report.	
5.13 5.13.1	**Equalities** EHRIA completed No. If not applicable state reasons. There are no key strategic equalities implications arising from the recommendations set out in this paper. An Equality Impact Assessment has been undertaken in relation to the Risk Management Policy. There are no additional equality implications associated with this report.	
5.14 5.14.1	**Service Delivery** The SFRS Assurance Framework will assist in compliance and will support the oversight of Improvement Action Plans to ultimately improve Service Delivery.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Mark McAteer, Director of Director of Strategic Planning, Performance and Communications (SPPC)
7.2	**Level of Assurance: (Mark as appropriate)**	**Substantial**/~~Reasonable/Limited/Insufficient~~
7.3	**Rationale:**	We have continued to develop processes for the AGS annually. Allied to our adherence to the Governance Assurance Framework, this enables me to provide substantial assurance.
8	**Appendices/Further Reading**	

Prepared by:	Marion Lang, Corporate Business Manager
Sponsored by:	Richard Whetton, Head of Governance, Strategy and Performance
Presented by:	Mark McAteer, Director of Strategic Planning, Performance and Communications

Links to Strategy and Corporate Values

This links to the **SFRS Strategic Plan 2022-25** and forms part of the Services Governance arrangements and links to **Outcome 5:** We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Corporate Board	*17 February 2025*	*For Information*
Strategic Leadership Team	*5 March 2025*	*For Information*
Audit and Risk Assurance Committee	*8 April 2025*	*For scrutiny*

SCOTTISH FIRE AND RESCUE SERVICE

Audit Risk and Assurance Committee

Report No: C/ARAC/21-25

Agenda Item: 12

Report to:	**AUDIT RISK AND ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**ACCOUNTING POLICIES 2024-25**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to present the Accounting Policies to be adopted in the Annual Report and Accounts 2024-25 to the Committee. These are attached as Appendix A.
2	**Background**
2.1	The Scottish Fire and Rescue Service (SFRS) is required to follow the Government Financial Reporting Manual (FReM) and Scottish Public Finance Manual (SPFM) when preparing the Annual Report and Accounts.
2.2	During the year, amendments to the FReM are formally published by Audit Scotland. A review of these documents is built into year-end processes to ensure that any relevant changes are incorporated, through reading of the Technical Bulletins prepared by Audit Scotland and discussions with our external auditors, also Audit Scotland.
3	**Main Report/Detail**
3.1	**Changes to the FReM 2024-25**
3.1.1	HM Treasury publish an overview of amendments to the FReM. There are no major changes affecting the SFRS in 2024/25.
3.2	**Accounting Policies**
3.2.1	The Accounting Policies have been reviewed to confirm they remain relevant and if any changes are required.
3.2.2	There is an underlying assumption that the financial statements will be prepared on a going concern basis, i.e. they should be prepared on the basis that the Service's functions will continue in operational existence for the foreseeable future. This is an area of interest for our auditors as our pension liabilities are significant due to participation in the unfunded firefighters pension schemes. The Service will continue to prepare the accounts on a going concern basis, recognising that the auditors will seek confirmation from Scottish Government regarding ongoing funding being provided.
3.2.3	The depreciation policy is reviewed annually in March and it was considered appropriate to retain the current policy for 2024/25 to depreciate a full year in the year after the asset is purchased. This will continue to be reviewed on an annual basis.
3.2.4	The review has concluded that no material changes are required. The proposed Accounting Policies for 2024-25 are attached at Appendix A.

4	Recommendation
4.1	The Committee is asked to note that a review of the Accounting Policies has been carried out and these will be adopted for 2024/25.
5	**Key Strategic Implications**
5.1 5.1.1	**Risk** There are no accounting policies that directly impact risk. The Annual Report and Accounts includes an Accountability Report that highlights our risk management and corporate governance processes that supports the achievement of the SFRS' policies, strategic aims and objectives.
5.2 5.2.1	**Financial** There are no financial implications relating to this report. The Annual Report and Accounts will include the financial performance of the Service.
5.3 5.3.1	**Environmental & Sustainability** There are no environmental and sustainability implications relating to this report. The Annual Report and Accounts includes a Sustainability Report which highlights our performance in response to climate change and environmental sustainability.
5.4 5.4.1	**Workforce** There have been no changes to the accounting policies that impact our workforce. SFRS includes accounting policies on benefits payable during employment as well as post-employment benefits (pensions). The Annual Report and Accounts includes a Sustainability Report which highlights our performance in response to workforce matters including gender pay gap and workforce profile. The Annual Report and Accounts includes a Remuneration Report covering Board and Directors remuneration during the year, as well as workforce numbers and salary information.
5.5 5.5.1	**Health & Safety** There are no health and safety implications relating to this report.
5.6 5.6.1	**Health & Wellbeing** There are no health and wellbeing implications relating to this report.
5.7 5.7.1	**Training** There are no training implications relating to this report.
5.8 5.8.1	**Timing** These accounting policies relate to financial year 2024-25.
5.9 5.9.1	**Performance** The Annual Report and Accounts communicates SFRS performance for the year and is formally audited before being laid by Ministers before Scottish Parliament.
5.10 5.10.1	**Communications & Engagement** There are no accounting policies that directly impact our engagement.
5.11 5.11.1	**Legal** The SFRS is required to follow the Government Financial Reporting Manual (FReM) and Scottish Public Finance Manual (SPFM) when preparing the Annual Report and Accounts.
5.12 5.12.1	**Information Governance** DPIA completed *No*. There are no implications for information governance relating to this report.

5.13 5.13.1	**Equalities** EHRIA completed *No*. There are no implications of equality relating to this report.	
5.14 5.14.1	**Service Delivery** There are no Service Delivery implications relating to this report.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance:** **(Mark as appropriate)**	~~Substantial~~/**Reasonable**/~~Limited~~/~~Insufficient~~
7.3	**Rationale:**	We have reviewed the accounting policies to ensure they align with the latest FReM published by Audit Scotland. The external audit of the accounts by Audit Scotland will confirm if we have correctly interpreted the FReM requirements but we will work with Audit Scotland where we need any further clarity.
8	**Appendices/Further Reading**	
8.1	Appendix A: Accounting Policies 2024/25	

Prepared by:	Alan Duncan, Accounting Manager
Sponsored by:	Sarah O'Donnell, Director of Finance and Contractual Services
Presented by:	Lynne McGeough, Head of Finance and Procurement

Links to Strategy and Corporate Values

SFRS Strategic Plan 2022-25 Outcome 1: Community safety and wellbeing improves as we deploy targeted initiatives to prevent emergencies and harm.
SFRS Strategic Plan 2022-25 Outcome 2: Communities are safer and more resilient as we respond effectively to changing risks.
SFRS Strategic Plan 2022-25 Outcome 3: We value and demonstrate innovation across all areas of our work.
SFRS Strategic Plan 2022-25 Outcome 4: We respond to the impacts of climate change in Scotland and reduce our carbon emissions.
SFRS Strategic Plan 2022-25 Outcome 5: We are a progressive organisation, use our resources responsibly and provide best value for money to the public.
SFRS Strategic Plan 2022-25 Outcome 6: The experience of those who work for SFRS improves as we are the best employer we can be.
SFRS Strategic Plan 2022-25 Outcome 7: Community safety and wellbeing improves as we work effectively with our partners.

Governance Route for Report	**Meeting Date**	**Report Classification/ Comments**
Audit and Risk Assurance Committee	*8 April 2025*	*For Scrutiny*

APPENDIX A

NOTES TO THE ACCOUNTS

1. Accounting Policies

These Annual Accounts have been prepared in accordance with the 2024/25 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public-sector context. The SFRS has selected the most appropriate accounting policy or estimation technique, as permitted by the FReM, to ensure the statements present a true and fair view.

The particular policies adopted by the SFRS in preparing these Annual Accounts are described below. They have been applied consistently in dealing with items that are considered material to the Accounts.

The Accounts have been prepared with reference to the following objectives:

- to provide information about the financial position, performance and cash flows in a way that meets the "common need of most users", and
- to show the results of the stewardship and accountability of Board members and management for the resources entrusted to them.

The following underlying assumptions have been adhered to:

- **Accruals** – with the exception of cash flow information, the statements have been prepared using the accrual basis of accounting, where the non-cash effects of transactions are included in the Annual Accounts in the year in which they occur, not the year in which cash is paid or received, and
- **Going concern** – the Accounts have been prepared on the basis that the SFRS will continue to function for the foreseeable future.
- **Currency** – the Accounts have been prepared in pounds sterling.

Application of new and revised Accounting Standards

a. Standards, amendments and interpretations early adopted this year

There are no new standards, amendments or interpretations early adopted this year.

b. Standards, amendments and interpretations issued but not adopted this year

At the date of authorisation of these Annual Accounts, the Board has not applied the following new and revised IFRS Standards that have been issued but are not yet effective:
Amendments to IAS 1: Classification of Liabilities as Current or Non-Current.

- **Amendments to IAS 1**: Non-current Liabilities with Covenants
- **Amendments to IAS 12**: International Tax Reform: Pillar Two Model Rules
- **Amendments to IAS7 and IFRS7:** Supplier Finance Arrangements

The Board does not expect that the adoption of the Standards listed above will have a material impact on the Annual Accounts in future periods.

c. Standards, amendments and interpretations effective in the current year

In the current year, the Board not has implemented any new standards, amendments or interpretations.

Accounting Convention

These Accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Accounting Period

The accounting period commenced on 1 April 2024 and ended on 31 March 2025.

Going Concern

The Resource Budget for the financial year ended 31 March 2025 has been approved by the Scottish Government and is considered adequate to allow the SFRS to meet its liabilities in the foreseeable future. In terms of future years, funding will be confirmed as part of the normal budget cycle in December 2024 and January 2025.

These Annual Accounts have therefore been produced on a going concern basis. The Scottish Fire and Rescue Service is fulfilling a statutory function and there are no plans to amend the primary legislation setting out those functions. The SFRS is therefore required to continue delivering fire and rescue activity in Scotland and the Scottish Government is in turn committed to providing the SFRS with grant in aid funding for that purpose. For the avoidance of doubt, Scottish Government funding also covers all ongoing employer and officer pension contributions and the pension liability which is not met directly from GiA.

Segmental Reporting

The SFRS is operated as a single service and is reported in this same format. Costs and support service overheads are not allocated to other parts of the organisation, and therefore there are no requirements for segmental reporting, however, a reconciliation between the management accounts position and the accounting statements is included in a Note to the Accounts.

Revenue Recognition

Revenue is recognised net of VAT to the extent that it is probable that the economic benefits will flow to the SFRS and the revenue can be reliably measured.

Grant in Aid and Revenue Grants

The SFRS is funded by the Scottish Government. Grant in Aid is received throughout the year and is intended to meet estimated expenditure for both capital and revenue purposes. It is accounted for as financing on a cash basis, not income, and is therefore credited to the SFRS reserves and not incorporated within the Statement of Comprehensive Net Expenditure (SoCNE). Grant in Aid cannot be drawn down in advance of need.

Grant in Aid, whether for revenue or capital purposes, is to be treated as a contribution from controlling parties giving rise to a financial interest in the residual interest of the reporting entity and is to be credited to general reserves and not to income or deferred income.

Where grants are subject to conditions such that non-compliance would result in the grant being repaid, the potential liability to repay, and the conditions to be met, should be disclosed in a Note to the Accounts.

The profit or loss on disposal of an asset financed by grant or Grant in Aid is taken to the Statement of Comprehensive Net Expenditure.

Capital Grants

Capital grants are accounted for in accordance with IAS20 *Accounting for Government Grants and Disclosure of Government Assistance* and recognised in the SoCNE once conditions are met. Grant is treated as a *capital grant received in advance* where carry forward is permitted and any conditions have not been met.

Provision of Services

Revenue from the provision of services is recognised when the SFRS can measure reliably the percentage completion of the transaction and it is probable that economic benefits or service potential associated with the transaction will flow to the SFRS.

Rental Income

Rental income from operating leases is recognised on a straight-line basis over the terms of the lease.

Expenditure Recognition

Supplies are recorded as expenditure when they are consumed – where there is a gap between the date supplies are received and their consumption, they are carried as inventories on the SoFP.

Expenses in relation to services received (including those rendered by the SFRS employees) are recorded as expenditure when the services are received, rather than when payments are made.

Interest payable on borrowings is accounted for on the cash flows that have been fixed or determined by the contract, or based on an annuity basis where borrowings have been provided by a local authority.

Where revenue and expenditure have been recognised but cash has not been received or paid, a receivable or payable for the relevant amount is recorded in the SoFP. Where there is evidence that debts are unlikely to be settled, the balance of receivables is written down and a charge made to revenue for the income that might not be collected.

Benefits Payable During Employment

Short-term employee benefits (those that fall due wholly within 12 months of the year end), such as wages and salaries, paid annual leave and paid sick leave, bonuses and non-monetary benefits for current employees, are recognised as an expense in the year in which employees render service to the SFRS. An accrual is made in the SoCNE for the year for the cost of holiday entitlements and other forms of leave earned by employees but not taken before the year end and which employees can carry forward to the next financial year. The accrual is made at the remuneration rates applicable in the following financial year.

Post-Employment Benefits

As at 31 March 2025, the SFRS participates in two pension schemes: The Local Government Pension Scheme (Scotland) for support staff and the Fire 2015 Scheme for Wholetime/Retained uniformed personnel. For the year ended 31 March 2025, the administration of the Firefighters' Scheme was undertaken by the Scottish Public Pensions Agency (SPPA) and the administration of the LGPS was carried out by the Strathclyde Pension Fund Office (SPFO) following a transfer during the year.

- Local Government Pension Scheme (Scotland)
  The LGPS provides members with defined benefits related to pay and service. It is supported by contributions from both employer and employee. Since the Service was formed on 1 April 2013, 8 schemes covered staff in Scotland, detailed in Note 13, however, during the year 2024/25, an exercise was undertaken to transfer all 8 schemes to a single provider, namely the SPFO.
  The LGPS is a Career Average Revalued Earnings (CARE) Scheme whereby pension benefits are based on earnings received within each year worked, which are index-linked and totalled on retirement to provide an annual pension.
- Fire 2015 Scheme
  The Fire 2015 Scheme was introduced on 1 April 2015 and is a CARE scheme rather than a final salary pension scheme. It is an unfunded defined benefit scheme where payments are made on a "pay as you go" basis. All new employees entering the Service will join this Scheme automatically. The normal pension age for firefighters is 60.

Contributions to the schemes are calculated to spread the cost of pensions over employees' working lives, in line with IAS19 *Employee Benefits*. The contributions are determined by an actuary on the basis of triennial valuations using the Age Attained Method and, in the intervening years, by rolling forward the scheme assets and liabilities in a desk top review.

Variations from regular cost are spread over the expected average remaining working lives of scheme members, taking into account future withdrawals. The expected cost of providing staff pensions to contributing employees is recognised in the SoCNE in accordance with IAS19, recognising retirement benefits as they are earned not when they are due to be paid.

Pension Scheme Assets

The Fire 2015 Scheme, being unfunded, has no assets built up to meet pension liabilities. The attributable assets of the Local Government Pension Schemes (LGPS) have been measured at fair value and are identified in a Note to the Accounts.

Pension Scheme Liabilities

The attributable liabilities of each scheme are measured on an actuarial basis using the projected unit method, i.e., an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates, etc.

The change in the Net Pension Liability shown in the SoFP consists of the following:

- **Current Service Cost** - This refers to the increase in liabilities as a result of years of service earned this year and is allocated to the cost of services in the SoCNE.
- **Expected Net Return on Assets** - The expected annual investment return on assets for the LGPS is based on long-term expectations as at 31 March 2025. This is shown net of the interest cost of each scheme, based on the discount rate and the present value of the scheme liabilities as at 31 March 2025.
- **Past Service Costs** - This refers to the increase in liabilities arising from current year decisions whose effect relates to years of service earned in previous years. This is debited to the surplus/deficit in the SoCNE.
- **Gains/Losses on Settlements and Curtailments** -The result of actions to relieve the SFRS of liabilities or events that reduce the expected future service or accrual of benefits of employees – debited/credited to the SoCNE.
- **Actuarial Gains and Losses** - Changes in the net pensions liability that arise because events have not coincided with assumptions made at the last actuarial valuation or because the actuaries have updated their assumptions – debited to the Pensions Reserve.

- **Contributions Paid to the LGPS Pension Funds** - Cash paid as employer's contributions to the pension fund in settlement of liabilities; not accounted for as an expense.
- **Discretionary Benefits** - The SFRS has restricted powers to make discretionary awards of retirement benefits in the event of early retirements. Any liabilities estimated to arise as a result of an award to any member of staff are accrued in the year of the decision to make the award and accounted for using the same policies as those applied to the relevant pension schemes.

Injury Awards

The SFRS has powers to make awards of injury benefits in the event of firefighters leaving through injury. Any liabilities estimated to arise as a result of an award to any member of staff are accrued in the year of the decision to make the award and accounted for using the same policies as those applied to the relevant compensation schemes.

Cash and Cash Equivalents

Cash and cash equivalents include cash in hand and deposits held with banks.

Property, Plant and Equipment

Assets that have physical substance and are held for use in the production or supply of goods or services, for rental to others or for administrative purposes and that are expected to be used during more than one financial year are classified as Property, Plant and Equipment.

Asset Recognition

All expenditure on the acquisition, creation or enhancement of property, plant and equipment (including Firefighter personal protective equipment) has been capitalised on an accruals basis, provided that it is probable that the future economic benefits or service potential associated with the item will flow to the SFRS and the cost of the item can be measured reliably. Expenditure that maintains but does not add to an asset's potential to deliver future economic benefits or service potential (i.e., repairs and maintenance) is charged as an expense when it is incurred.

Asset Measurement

Assets are initially measured at cost, comprising:

- the purchase price.
- any costs attributable to bringing the asset to the location and condition necessary for it to be capable of operating in the manner intended by management.
- the initial estimate of the costs of dismantling and removing the item and restoring the site on which it is located.

Land and Buildings are included at Depreciated Replacement Cost (DRC) where there is no market-based evidence of fair value because of the specialist nature of the assets. In all other cases, Existing Use Value (EUV) has been used. As a minimum, five yearly valuations of Land, Buildings and Dwellings are carried out as part of a rolling programme, on the basis of current market value for land and depreciated replacement cost for buildings. In addition, impairment reviews are carried out on major assets and assets on which there has been significant expenditure, to determine if there has been any change in value in the years between valuations.

Assets included in the SoFP at fair value are revalued regularly to ensure that their carrying amount is not materially different from their fair value at the year-end, but every five years as a minimum. Increases in valuations are matched by credits to the Revaluation Reserve to recognise unrealised gains.

At 31 March 2025, all land, buildings and dwellings assets due for valuation under the five-year rolling programme (59% of portfolio), were re-valued by the SFRS's in-house Estates and Valuations Surveyor, Russell Munn (BSC MRICS). Consideration will be given to the potential for material changes in value for properties not included in the rolling programme.

Where decreases in value are identified, the revaluation loss is accounted for:

- where there is a balance of revaluation gains for the asset in the Revaluation Reserve, the carrying amount of the asset is written down against that balance (up to the amount of the accumulated gains).
- where there is no balance in the Revaluation Reserve or insufficient balance, the carrying amount of the asset is written down against the relevant line in the SoCNE.

Donated Assets

Assets classified as donated are measured at fair value on receipt. The funding element is recognised as income and taken to the SoCNE. Any subsequent revaluations are taken to the Revaluation Reserve.

Impairment

Assets are assessed at each year-end as to whether there is any indication that an asset may be impaired. Where indications exist and any possible differences are estimated to be material, the recoverable amount of the asset is estimated and, where this is less than the carrying amount of the asset, an impairment loss is recognised for the shortfall.

Where impairment losses are identified, they are accounted for:
where there is a balance of revaluation gains for the asset in the Revaluation Reserve, the carrying amount of the asset is written down against that balance (up to the amount of the accumulated gains).

- where there is no balance in the Revaluation Reserve or insufficient balance, the carrying amount of the asset is written down against the relevant line in the SoCNE.
- Where an impairment loss is reversed subsequently, the reversal is credited to the relevant line in the SoCNE, up to the amount of the original loss, adjusted for depreciation that would have been charged if the loss had not been recognised.

Disposals

When it becomes probable that the carrying amount of an asset will be recovered principally through a sale transaction rather than through its continuing use, it is reclassified as an Asset Held for Sale. The asset is revalued immediately before reclassification and then carried at the lower of this amount and fair value less costs to sell. Where there is a subsequent decrease to fair value less costs to sell, the loss is posted to Other Operating Charges in the SoCNE. Gains in fair value are recognised only up to the amount of any previously recognised losses. Depreciation is not charged on Assets Held for Sale.

Assets that are to be abandoned or scrapped are not reclassified as Assets Held for Sale.

When an asset is disposed of or decommissioned, the carrying amount of the asset in the SoFP (whether Property, Plant and Equipment or Assets Held for Sale) is written off to the Net Gain/Loss on Disposal of Property, Plant and Equipment line in the SoCNE. Receipts from disposals (if any) are credited to the same line in the SoCNE (i.e., netted off against the carrying value of the asset at the time of disposal).

Assets Held for Sale

An asset is classified as held for sale when it meets all of the following criteria:

- It is available for immediate sale in its present condition subject only to terms that are usual and customary for sales of such assets and its sale must be highly probable.
- A plan agreed by management is in place and steps are actively being taken to conclude a sale, and
- It is actively being marketed with an expectation of a sale within the next 12 months.

Assets meeting these criteria are revalued and measured at the lower of their carrying amount immediately prior to reclassification and fair value less costs to sell. There is no depreciation on Assets Held for Sale.

Depreciation

Depreciation is provided for on all Property, Plant and Equipment assets by the systematic allocation of their depreciable amounts on a straight-line basis over their useful lives. An exception is made for assets without a determinable finite useful life (i.e., freehold land, Heritage Assets, surplus assets and assets held for sale) and assets that are not yet available for use (i.e., assets under construction).

Useful economic lives as estimated by experts are shown in the following table:

Category	Useful economic life
Buildings	10-64 years
Cars & Vans	5 years
Fire Appliances (including specialist appliances)	10-15 years
Equipment	3-20 years

Assets under construction are recognised at cost and are depreciated in the year they are transferred to operational assets.

Componentisation

In accordance with IAS16 *Property, Plant and Equipment,* a componentisation policy for material assets has been adopted with effect from 1 April 2013. The SFRS will componentise material assets with a carrying value over £0.5 million, unless, in the expert opinion of our professional valuer, it does not lend itself to componentisation by its complex nature. This will be carried out where material assets are acquired, revalued or enhanced.
The SFRS policy noted above has been applied to all relevant assets brought on from legacy services and will continue to be applied as they are revalued through the five-year rolling programme of valuations.

Intangible Assets

Intangible assets have no physical substance but are identifiable and controlled by the SFRS. It can be established that there is an economic benefit or service potential associated with the item which will flow to the SFRS. This expenditure is mainly in relation to software licenses. Expenditure on the acquisition, creation or enhancement of intangible assets is capitalised on an accruals basis when it will bring benefits of longer than one year.
Intangible assets are initially measured at cost and included in the SoFP at net historical cost. Intangible assets are depreciated on a straight-line basis over the life of the asset (3 years).

Inventories

Inventories are included in the SoFP on an average cost basis.

Leases

IFRS 16 *Leases* came into effect on 1 April 2022. All leases will be classified as a finance lease unless the underlying value is low or the lease term is less than 12 months.

Leases are classified as finance leases where the terms of the lease transfers substantially all the risks and rewards incidental to ownership of the property, plant or equipment from the lessor to the lessee.

Where a lease covers both land and buildings, the land and building elements are considered separately for classification.

Arrangements that do not have the legal status of a lease but convey a right to use an asset in return for payment are accounted for under this policy, where fulfilment of the arrangement is dependent on the use of specific assets.

Operating Leases

Leases that are not recognised as right-of-use assets under IFRS 16 (either because the underlying asset is of low value or the lease term is less than 12 months) will be classified as operating leases. Rentals payable under operating leases are charged to the SoCNE on a straight-line basis, over the term of the lease.

Provisions, Contingent Liabilities and Contingent Assets

Provisions

Provisions are made where an event has taken place that gives the Board a legal or constructive obligation that probably requires settlement by a transfer of economic benefits or service potential, and a reliable estimate can be made of the amount of the obligation.

Contingent Liabilities

A contingent liability arises where an event has taken place that gives the SFRS a possible obligation whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the SFRS. Contingent liabilities also arise in circumstances where a provision would otherwise be made but either it is not probable that an outflow of resources will be required, or the amount of the obligation cannot be measured reliably. Contingent liabilities are not recognised in the SoFP but disclosed in a Note to the Accounts.

Reserves

The General Reserve represents the excess of expenditure over income on Grant in Aid funded operations, or other grant income streams, e.g., transitional funding.

The Revaluation Reserve represents the increase in value of land and buildings over their historical costs.

The Pensions Reserve represents timing differences arising from the accounting and funding arrangements required by IAS19 for post-employment benefits.

Taxation

Value Added Tax (VAT) is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs (HMRC). VAT receivable is excluded from income.

Corporation Tax is payable on profit generated from business activities (including the disposal of assets no longer required) undertaken by the SFRS. Income from GiA is not subject to Corporation Tax.

Financial Instruments

Financial Assets

Financial assets held by the SFRS consist of Trade and Other Receivables and Cash and Cash Equivalents. Trade receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market.

As the Cash requirements of the SFRS are met through Grant in Aid provided by the Safer Communities Directorate, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. Cash balances are held with the Government Banking Service (GBS). Transactional services are provided by NatWest, with corporate banking arrangements held with the Royal Bank of Scotland. Therefore, the SFRS is not exposed to significant credit, liquidity or market risk in respect of financial assets. There is no difference between book value and fair value for cash and cash equivalents shown in the SoFP.

Financial Liabilities

Financial liabilities within the SFRS consist of Trade and Other Payables, Borrowings and Lease Liabilities. Trade payables are held at fair value and are typically non-derivative financial liabilities with fixed or determinable payments that are not quoted in an active market. They arise when the SFRS receives goods or services with no intention of trading the liability.

There are two types of Borrowings held by the SFRS:

i) Public Works Loan Board (PWLB) loans were taken out by legacy services that carried out the Treasury Management function (i.e., borrowings and investments) in their own right. These are recognised in the SoFP at the point when the SFRS becomes a party to the contractual provisions of a financial instrument and are initially measured at fair value and carried at their amortised cost, i.e., including accrued interest.
For borrowings held by the SFRS therefore, the amount presented in the SoFP is the outstanding principal repayable including accrued interest, and annual charges to the SoCNE for interest payable is the amount payable in the year on an accruals basis.

ii) The second type of financial liability arises where the Treasury Management function for legacy Fire Services was carried out by the lead authority. Schedules have been provided by the lead authorities showing total outstanding debt, amounts of principal repayable each year, and indicative amounts of related interest payable each year. The interest is calculated by each former lead authority using a pooled interest rate which is applied to all loans in their portfolio.
In these cases, financial liabilities are shown in the SoFP at the values provided by the former lead authorities. Annual charges to the SoCNE for interest payable are based on the carrying amount of the liability multiplied by the effective rate of interest for the instrument, as calculated by each former lead authority.

Further information on the Accounting Policy for Lease Liabilities is contained in the "*Application of new and revised Accounting Standards*" section.

Financial liabilities are derecognised when the contractual obligations are discharged, cancelled or expire.

Review of Accounting Policies and Estimation Techniques

These Annual Accounts have been prepared under IFRS incorporating any departures required by the FReM, and all accounting policies have been reviewed to ensure their continued relevance. Estimates and judgements are regularly evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Actual results may differ from those estimates and underlying assumptions are continuously reviewed.

The main areas of estimation relate to the following:

- The valuation of land and buildings, where the services of professionally qualified surveyors are used to ensure that best practice and consistency of approach is applied, and
- The valuation of Pension Scheme assets and liabilities, where professionally qualified actuaries are employed to provide the information required under IAS19 *Employee Benefits*.

Prior Period Adjustments and changes in Accounting Policies and Estimation Techniques

Prior period adjustments may arise as a result of a change in accounting policy or to correct a material error. Changes in accounting policy are only made when required by proper accounting practice or to provide more reliable or relevant information on the council's financial position. Where a change is made, it is applied retrospectively by adjusting opening balances and comparative amounts for the prior period, as if the new policy had always been applied. Changes in accounting estimation techniques are applied in the current and future years and do not give rise to a prior period adjustment. Material errors related to prior period balances may be identified during the course of a current year accounts preparation and are corrected to ensure comparability of balances in prior and current year for readers of the accounts.

These Annual Accounts have been prepared under IFRS incorporating any departures required by the FReM, and all accounting policies have been reviewed to ensure their continued relevance. Estimates and judgements are regularly evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Actual results may differ from those estimates and underlying assumptions are continuously reviewed.
The main areas of estimation relate to the following:

- The valuation of land and buildings, where the services of professionally qualified surveyors are used to ensure that best practice and consistency of approach is applied, and
- The valuation of Pension Scheme assets and liabilities, where professionally qualified actuaries are employed to provide the information required under IAS19 *Employee Benefits*.

Changes in accounting estimates are accounted for prospectively, i.e. in the current and future years affected by the change.

Events after the Reporting Period

Events after the reporting period end represent those events which occur between the end of the reporting period and the date when the Annual Report and Accounts are authorised for issue by the Board.

Material events for which conditions exist at 31 March are reflected on an accruals basis within the financial year. The Notes to the Accounts contain details of material events where their conditions did not exist as at 31 March.

There are no significant events affecting the SFRS which have occurred since the end of the financial year. Future developments have been included in the Performance Report.

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/15-25

Agenda Item: 13

Report to:	***AUDIT AND RISK ASSURANCE COMMITTEE***							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**QUARTERLY UPDATE OF GIFTS, HOSPITALITY & INTERESTS REGISTER**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to provide the Audit and Risk Assurance Committee (ARAC) with the 2024/25 Q4 update on the Gifts, Hospitality and Interests (GHI) Register.
2	**Background**
2.1	The Scottish Fire and Rescue Service (SFRS) Gifts, Hospitality and Interests policy establishes a formal and consistent approach in relation to the offer, refusal and acceptance of gifts and hospitality and ensures that conflicts of interest are identified and avoided where possible.
2.2	The policy reflects the general underlying principle that SFRS will operate in an open and transparent manner and aims to ensure that the conduct of all staff is impartial, honest and beyond reproach at all times, ensuring that SFRS suffers no reputational damage.
2.3	As part of the policy the Director of Finance and Contractual Services will publish a register of GHI with a value in excess of £50 submitting a report on a quarterly basis to the Audit and Risk Assurance Committee (ARAC) and the Corporate Board (CB) for noting. The Risk and Audit Section will be responsible for managing any relevant information.
3	**Main Report/Detail**
3.1	The Gifts, Hospitality and Interests (GHI) register for 2024/25, up to 6 March 2025, identifies 35 entries, with further information identified within Appendix A to this report. Separately, one further declaration, under the £50 threshold, was received but not published over the last quarter.
3.2	Engagement in relation to gifts, hospitalities and interests has continued with meetings held with all Directorate Management Teams, Local Senior Officer (LSO) meetings and Functional meetings to communicate the requirements of the policy and examples of declarations that need to be made. The GHI policy was also updated with additional criteria which will identify areas for further evaluation or escalation.
3.3	In relation to the mandatory Gifts, Hospitality and Interests LCMS module, within Training for Operational Competence (TFOC), approximately 4,810 members of staff have now completed this module, with monitoring of completion rates monitored through the Compliance Team.

4	Recommendation
4.1	The report is provided to the Audit and Risk Assurance Committee for scrutiny.
5	**Key Strategic Implications**
5.1 5.1.1 5.1.2	**Risk** The report reflects the general underlying principle that SFRS will operate in an open and transparent manner and aims to ensure that the conduct of all staff is impartial, honest and beyond reproach at all times, ensuring that SFRS suffers no reputational damage and minimises the risk of fraud to the Service. The report is aligned to the Services Financial risk appetite in relation to financial propriety, regularity and Fraud risks, with a strong focus on maintaining effective financial controls and accountability, where a Minimalist risk appetite was identified.
5.2 5.2.1	**Financial** The report identifies declarations made in relation to Gifts, Hospitality and Interests, minimising the risk of fraud and associated financial loss to the Service.
5.3 5.3.1	**Environmental & Sustainability** Any implications arising from the report will be managed by the relevant Directorate.
5.4 5.4.1	**Workforce** Any implications arising from the report will be managed by the relevant Directorate.
5.5 5.5.1	**Health & Safety** Any implications arising from the report will be managed by the relevant Directorate.
5.6 5.6.1	**Health & Wellbeing** Any implications arising from the report will be managed by the relevant Directorate.
5.7 5.7.1	**Training** Any implications arising from the report will be managed by the relevant Directorate.
5.8 5.8.1	**Timing** The report is provided to the Audit and Risk Assurance Committee on a quarterly basis as required.
5.9 5.9.1	**Performance** The report provides information on declarations received and actions taken to increase awareness and ownership within the Service, the result of which will be increased levels of reporting.
5.10 5.10.1	**Communications & Engagement** Any implications arising from the report will be managed initial through Finance and Procurement and by the relevant Directorate to ensure policy is adhered to.
5.11 5.11.1	**Legal** Any implications arising from the report will be managed by the relevant Directorate.
5.12 5.12.1	**Information Governance** DPIA completed – Yes, in relation to the Gifts, Hospitality and Interests Policy.
5.13 5.13.1	**Equalities** EHRIA completed – Yes, in relation to the Gifts, Hospitality and Interests Policy.

5.14 5.14.1	**Service Delivery** Any implications arising from the report will be managed by the relevant Directorate.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance:**	~~Substantial~~/**Reasonable**/~~Limited/Insufficient~~
7.3	**Rationale:**	Engagement undertaken throughout the Service is resulting in increased awareness within Directorates, with additional queries being received. The aligned LCMS module has been completed by over 4800 staff as at March 2025 and wider engagement activities will be continued to raise awareness across the Service.
8	**Appendices/Further Reading**	
8.1	Appendix A – Gifts Hospitality and Interests Register Q4 2024-25	

Prepared by:	Hazel Buttery, Fraud, Risk and Compliance Officer
Sponsored by:	Sarah O'Donnell, Director of Finance and Contractual Services
Presented by:	David Johnston, Risk and Audit Manager

Links to Strategy and Corporate Values

External Audit forms part of the Services Governance arrangements and links back to Outcome 5 of the 2022-25 Strategic Plan, specifically Objectives 5.1 and 5.6:

Outcome 5: We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

- Objective 5.1: Remaining open and transparent in how we make decisions.
- Objective 5.6: Managing major change projects and organisational risks effectively and efficiently.

Governance Route for Report	Meeting Date	Report Classification/ Comments
Audit and Risk Assurance Committee	*8 April 2025*	*For Scrutiny*

APPENDIX A

Date	Employee Name	Employee Position	Area/Directorate/Function		Details of Gift / Hospitality (G/H) & Interest	G/H or Interest	Estimated Value	From (Organisation offering)	Any other Organisation involved	Accepted / Declined / Interest Cat.	Comments
05/04/2024	Dougie Campbell	GC	Service Delivery North	Western Isles, Orkney Islands and Shetland Islands	Animal rescue gear for use at incidents & to enhance FF safety & animal welfare	Gift	£400	British Horse Society (Scotland)	British Horse Society (Scotland)	Accepted	This equipment has been identified to asset management for adding to register and TSA have authorised the training on the equipment and delivered
12/04/2024	Liz Barnes	SLT	SLT		Public Sector Leaders Luncheon	Hospitality	£50	Oracle	Oracle	Declined	Not attending due to conflict with SFRS
23/04/2024	David Dourley	AC	Service Delivery East	City of Edinburgh	Invitation received from the Head of the Munich Fire Department to attend the opening match of Euro 2024 to observe the FD's aligned operational activities	Hospitality	NA	Munich Fire Department	Munich Fire Department	Accepted	The declaration was received from David Dourley on behalf of 3 members of staff who attended the event. David did not attend the event but forwarded the declaration on behalf of the members of staff
25/04/2024	Ross Haggart	CO	SLT		Charity dinner at BT Tower in aid of FFC	Hospitality	£100	Motorola Solutions	Motorola	Declined	
09/06/2024	Julie McDonough	RCMC	Service Delivery North	City of Aberdeen, Aberdeenshire and Moray	£50 note within thank you card	Gift	£50	Mary Smart	Mary Smart	Accepted	Accepted card at community event not knowing monetary contents until afterwards. Money since donated to FF Charity
10/06/2024	William Stoops	WC	Service Delivery North	Perth & Kinross, Angus and Dundee	Part time personal trainer with David Lloyds Gym Group	Interest	Unknown	David Lloyds Gym Group	David Lloyds Gym Group	1	
11/06/2024	Jonathan Boal	Support Staff	Training, Safety and Assurance		Owns a Health & Safety Consultancy business	Interest	Unknown	Salus Risk Consultancy Ltd	Salus Risk Consultancy Ltd	7	
13/06/2024	Alan Taylor	WC	Service Delivery North	Aberdeenshire & Moray	Voucher for a free round of golf for up to 4 players	Gift	£140	Garmouth and Kingston Golf Club	Garmouth and Kingston Golf Club	Declined	Voucher has been destroyed
20/06/2024	Lewis Preston	RFFC	Service Delivery West	East and West Dunbartonshire and, Argyll and Bute	Works for Mitie Communities under Mitie Group	Interest	Unknown	Mitie	Mitie	1	
20/06/2024	Lorraine Taylor	RFFC	Service Delivery West	East and West Dunbartonshire and, Argyll and Bute	Works for Calmac Ferries Ltd who provide transport services the SFRS may use	Interest	Unknown	Calmac Ferries	Calmac Ferries	1	
01/07/2024	Barry Florence	RCMC	Service Delivery North	City of Aberdeen, Aberdeenshire and Moray	Company director of H.M Sheridan	Interest	Unknown	H.M Sheridan	H.M Sheridan	1	H.M Sheridan supply packed lunches to SFRS
06/07/2024	Graeme Junner	FF	Service Delivery West	East Renfrewshire, Renfrewshire and Inverclyde	FF Junners wife is a partner for Miller Samuel Hill Brown who SFRS trade with	Interest	Data retained by Compliance	Miller Samuel Hill Brown Solicitors	Miller Samuel Hill Brown Solicitors	7	
10/07/2024	Ross Haggart	CO	SLT		Charity dinner for Fire Aid	Hospitality	£50	Scrumptious Consultancy	Scrumptious Consultancy	Declined	
27/07/2024	Colin Stewart	Volunteer WC	Service Delivery North	Highland	Owns an industrial unit of which 1/3rd is rented to SFRS and utilised as Newtonmore Community Fire Station	Interest	Unknown			4	Rental agreements are arranged between legal property team and WC Stewart. There is no connection between Service Delivery management team and WC role
30/07/2024	Barrie McCutcheon	GC	Service Delivery West	City of Glasgow	Cash donation to SFRS in relation to a recent incident	Gift	£5,000	AS Scaffolding	AS Scaffolding	Declined	Advised we wouldn't accept this offer, but directed him to 2 of our supporting charities (Family Support Trust and The Firefighters Charity) advising him if he still wanted make a donation that he could contact them direct
31/07/2024	Gordon MacLeod	Support Staff	Finance & Contractual Services	Property	Hospitality at the 2024 SFRS Winter Ball	Hospitality	£100	Robertson Facilities Management	Robertson Facilities Management	Accepted	RFM have taken the gold sponsorship package at the SFRS Winter Ball 2024. Declan Gordon (RFM Account Manager) & Shona Dunsmore (Business Development Director) extended an invite. Attendance will develop the relationship with the RFM Team

31/07/2024	John Docherty	Support Staff	Finance & Contractual Services	Property	Hospitality at the 2024 SFRS Winter Ball	Hospitality	£100	Robertson Facilities Management	Robertson Facilities Management	Accepted	RFM have taken the gold sponsorship package at the SFRS Winter Ball 2024. Declan Gordon (RFM Account Manager) & Shona Dunsmore (Business Development Director) extended an invite. Attendance will develop the relationship with the RFM Team
01/08/2024	John MacKenzie	Retained	Service Delivery North	Highland	Operates as Director of garage providing services & MOTs to SFRS	Interest	Unknown	Highland Motors Ltd	Highland Motors Ltd	1	
08/08/2024	Martin McCabe	Support Staff	Finance & Contractual Services	Property	Hospitality at the 2024 SFRS Winter Ball	Hospitality	£100	Robertson Facilities Management	Robertson Facilities Management	Accepted	RFM have taken the gold sponsorship package at the SFRS Winter Ball 2024. Declan Gordon (RFM Account Manager) & Shona Dunsmore (Business Development Director) extended an invite. Attendance will develop the relationship with the RFM Team
25/08/2024	Andrew Watt	ACO	Training, Safety and Assurance		BBC Alba commentary covering 4 shinty cup finals	Interest	£1,600	BBC Alba	BBC Alba	1	
10/09/2024	Grant Kerrigan	WC	Service Delivery West	City of Glasgow	20 x tickets to upcoming Glasgow Warriors rugby game	Hospitality	£400	Glasgow Warriors	Glasgow Warriors	Declined	Declined offer following consultation with Compliance team for advice
11/09/2024	Elizabeth Jane Clements	Volunteer FFC	Service Delivery West	East Dunbartonshire, West Dunbartonshire and Argyll & Bute	Works as Seaman Purser for Cal Mac on the MV Loch Ranza	Interest	Unknown	Calmac Ferries	Calmac Ferries	1	
02/10/2024	Mark Witkowski	SC	Service Delivery North	Aberdeenshire & Moray	Food/Christmas meal for all 5 watch's at Elgin FS including a gift card for each watch	Gift	£300	Morag McPherson	Morag McPherson	Declined	
23/10/2024	Sarah O`Donnell	Support Staff	Finance & Contractual Services		Roundtable event including dinner	Hospitality	£50	Sodexo	Sodexo	Accepted	Sodexo Social Impact event at Scottish Parliament to provide SFRS perspective considering cross-sectoral social impact
25/10/2024	Iain Cameron	SC	Training, Safety and Assurance		2 places at Scottish Cycling Awards ceremony including a champagne reception & 3 course meal	Hospitality	£120	Clydesdale Colts	Clydesdale Colts	Declined	
05/11/2024	Liz Barnes	SLT	SLT		Event at Balmoral Hotel	Hospitality	£50	Franklin Covey	Franklin Covey	Declined	"Unlocking Potential & Driving Performance with the 7 habits of highly effective people"
12/11/2024	Garry Brown	WC	Service Delivery West	East Ayrshire, North Ayrshire and South Ayrshire	New Cumnock Development Trust donated Christmas decorations to New Cumnock Fire Station for the annual Christmas charity event	Gift	£3,000	New Cumnock Development Trust Team	New Cumnock Development Trust Team	Accepted	New Cumnock Development Trust donated Christmas decorations to New Cumnock Fire Station for the annual Christmas event with all money raised donated to Fire Fighters Charity
24/11/2024	Simon Cumming	RFF	Service Delivery West	Dumfries & Galloway	RFF Cumming is a sole owner of a private gym in Dalbeattie	Interest	NA	FitActive	FitActive	7	Declaration received following local engagement session on Gifts, Hospitality & Interests. FitActive is not a supplier on Tech One
03/12/2024	Iain Hepburn	RCC	Service Delivery North	Highland	RCC Hepburn is the Director of Bright Spark Burning Techniques Ltd who provide wildfire technical burns training to SFRS	Interest	NA	Bright Spark Burning Techniques Ltd	Bright Spark Burning Techniques Ltd	7	Foyers station is not a wildfire station so does not receive this training and RCC Hepburn does not undertake or deliver training a representative of SFRS. RCC Hepburn was not involved in the procurement/decision making process or the authoration of payments
05/12/2024	Jamie Mcallum	WC	Service Delivery West	East Ayrshire, North Ayrshire and South Ayrshire	Money gifted to Ayr Fire Station and donated to local charity	Gift	£200	Tina March	Tina March	Accepted	Gifted to Ayr FS, money collected at retired FF Jack Trayners funeral. Both Ayr appliances provided guard of honour at funeral. Donated to local charity "A Night Before Christmas"

23/01/2025	Lyndsey Gaja	Support Staff	People		Invitation to a networking event with dinner provided	Hospitality	£50	HR Network Magazine	HR Network Magazine	Accepted	Invitation from the publisher of a magazine for HR professionals to attend a networking event. This provides an opportunity to network, share best practice and benchmark with other senior People Professionals in the Scottish public and private sector, and to hear from a keynote speaker
07/02/2025	Chris Parker	SC	Service Delivery West	East Renfrewshire, Renfrewshire and Inverclyde	Tickets to attend a Boxing event	Hospitality	£750 (30 x £25)	Boxing Domination	Boxing Domination	Declined	
18/02/2025	Garry Brown	WC	Service Delivery West	East, North and South Ayrshire	6 used motorbike helmets to assist with station RTC training on helmet removal	Gift	£100	Local New Cumnock Biker Group	Local New Cumnock Biker Group	Accepted	4 helmets to remain at New Cumnock, 2 helmets going to Muirkirk
19/02/2025	Gavin Kotlewski	SC	Operations		SC Kotlewski's Uncle is the Director of Fraser Kotlewski (Joinery) Ltd who provide services to SFRS	Interest	NA	Fraser Kotlewski (Joinery) Ltd	Fraser Kotlewski (Joinery) Ltd	7	No authority to sign or raise Purchase Orders
01/03/2025	Fraser Kotlewski	RWC	Service Delivery East	Clackmannanshire, Fife and Stirling	Director of Fraser Kotlewski (Joinery) Ltd	Interest	NA	Fraser Kotlewski (Joinery) Ltd	Fraser Kotlewski (Joinery) Ltd	1 & 7	No authority to sign or raise Purchase Orders

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/16-25

Agenda Item: 14.1

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**RISK UPDATE REPORT (INFORMATION AS AT MARCH 2025)**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	The purpose of this report is to provide the Audit and Risk Assurance Committee (ARAC) with an overview of the current risks highlighted by Directorates.
2	**Background**
2.1	The purpose of the risk register is to inform decision making through Scrutiny and Assurance processes, providing additional awareness of the risks we face, and the actions required to minimise these risks.
2.2	The ARAC is responsible for advising the Board and the Accountable Officer on the adequacy and effectiveness of the Service's arrangements for risk management and has oversight of the Strategic Risk Register.
2.3	The Strategic Leadership Team (SLT) has responsibility for the identification and management of risk and will ensure that Risk Registers present a fair and reasonable reflection of the most significant risks impacting upon the organisation. The SLT will champion the importance of risk management in supporting the achievement of the Service's strategic outcomes and objectives.
2.4	Risk Registers are prepared in consultation with the Board and SLT and are managed collectively by the SLT, with each Directorate Risk allocated to a responsible Director. These Responsible Owners provide information on the current controls in place and identify additional actions still required.
3	**Main Report/Detail**
3.1	**Risk Reporting**
3.1.1	The risk register is a management tool that provides assurance to the Service and its scrutiny bodies that the significant risks of the organisation have been identified, managed and are subject to ongoing monitoring, review and discussion.
3.1.2	Previous discussions identified that reporting on risks above a defined threshold would allow more detailed scrutiny on the Services significant risks, with Directorates retaining responsibility for the management and oversight of all other risks. Appendix A provides details on risks above the threshold.
3.1.3	Discussions are currently being held on the future structure for risk reports and whether Committee's and Executive Boards should receive a single report detailing all risks held

within registers, rather than only those aligned to the related terms of reference and rated 15 or above.

3.1.4 Appendix B provides a draft template summarising risks falling below the 15 threshold, with details on the position of current control actions. The addition of Appendix B allows visibility of all risks held within register and new summary tables can be developed where changes are agreed to the current layout.

3.1.5 Both appendices currently require information to be manually extracted from the risk dashboard and recorded within templates. Whilst the provision of a single report would simplify reporting processes a considerable amount of resource is required to ensure the accuracy and currency of information. To ensure the best use of available resource, and minimise the potential for error, additional development of the risk dashboard would be required to support this process, automating the data extract directly into the required templates.

3.2 **Alignment to Strategic Outcomes**

3.2.1 The table below identifies the alignment between the 2022-25 Strategic Outcomes and the current Directorate Risks with each risk aligned to a single outcome:

Strategic Outcomes		Directorate Risks				Total
		VH	H	M	L	
Outcome 1	**Community safety and wellbeing improves as we deploy targeted initiatives to prevent emergencies and harm.**	1	1	1		3
Outcome 2	**Communities are safer and more resilient as we respond effectively to changing risks.**	6	2	2		10
Outcome 3	**We value and demonstrate innovation across all areas of our work.**			1		1
Outcome 4	**We respond to the impacts of climate change in Scotland and reduce our carbon emissions.**		1			1
Outcome 5	**We are a progressive organisation, use our resources responsibly and provide best value for money to the public**	4	5	4		13
Outcome 6	**The experience of those who work for SFRS improves as we are the best employer we can be.**	3	3	5		11
Outcome 7	**Community safety and wellbeing improves as we work effectively with our partners**			1		1
		14	12	14		40

3.2.2 All risks will be realigned to the new 2025-2028 Strategic Plan once this is agreed.

3.3 **Risk Appetite**

3.3.1 Following agreement of the Services risk appetite statements an alignment to current Directorate risks was undertaken. The table below provides information on each of the stated risk appetite levels:

Risk Appetite Levels	Category Description	Associated Risk Target Rating
Minimalist	Preference for low level of associated risk and uncertainty and will only look to accept risk where it is essential to do so. The creation of opportunity is not a key driver.	**Rating Appetite Rating of 1 - 3**
Cautious	Preference for safe options where the level of benefit and risk is limited but some opportunity may be experienced.	**Rating Appetite Rating of 4 - 9**
Open	Willing to consider all potential delivery options and to choose the one that is most likely to result in success and opportunity whilst also providing an acceptable level of risk.	**Rating Appetite Rating of 10 - 12**
Ambitious	Eager to be innovative and to take opportunities offering potentially higher reward, whilst accepting greater risk and uncertainty.	**Rating Appetite Rating of 15 - 25**

3.3.2 The table below identifies the alignment between risks rated 15 or over and risk appetite:

Risk ID	Governance Alignment	Risk Rating	Target Risk	Risk Appetite	RR Above or Within RA
FCS005	ARAC (CB)	16	8	Financial (Minimalist)	Above
FCS018	PC (CB)	20	12	People (Open)	Above
FCS019	SDC (SDB)	16	12	Technology (Open)	Above
FCS022	PC (CB)	16	12	People (Open)	Above
SDD007	ARAC (CB)	20	12	Organisational Security (Minimalist)	Above
OD001	SDC (SDB)	15	6	Service Delivery (Minimalist)	Above
SD001	SDC (SDB)	15	10	Service Delivery (Minimalist)	Above
SPPC001	SDC (CB)	16	8	Compliance (Cautious)	Above
SPPC004	ARAC (CB)	20	8	Compliance (Cautious)	Above
TSA019	PC (TSAB)	16	8	Financial (Open)	Above
TSA018	PC (TSAB)	16	6	Compliance (Minimalist)	Above
POD015	PC (CB)	16	4	People (Open)	Above
POD020	PC (CB)	16	4	People (Open)	Above
PPP005	SDC (SDB)	20	4	People (Open)	Above

3.3.3 The table below identifies the alignment between risks rated below 15 and risk appetite:

Risk ID	Governance Alignment	Risk Rating	Target Risk	Risk Appetite	RR Above or Within RA
FCS008	ARAC (SDB)	12	8	Environmental (Open)	Within
FCS011	ARAC (CB)	12	9	Financial (Minimalist)	Above
FCS015	ARAC (SDB)	12	8	People (Open)	Within
FCS020	ARAC (CB)	12	8	Financial (Open)	Within
FCS021	ARAC (SDB)	12	8	Financial (Open)	Within
POD018	PC (CB)	12	4	Compliance (Cautious)	Above
POD022	PC (CB)	12	4	People (Cautious)	Above
PPP004	SDC (SDB)	12	4	People (Open)	Within
SD006	PC (CB)	12	8	Service Delivery (Minimalist)	Above
SPPC007	ARAC (CB)	12	12	Political and Stakeholder Relationships (Cautious)	Above
SPPC012	ARAC (CB)	12	8	Organisational Security (Cautious)	Above
TSA014	PC (TSAB)	12	4	Compliance (Minimalist)	Above
POD016	PC (CB)	9	4	Service Delivery (Minimalist)	Above
POD019	PC (SDB)	9	4	People (Open)	Below
POD021	PC (CB)	9	4	Service Delivery (Ambitious)	Below
POD023	PC (CB)	9	4	People (Open)	Below
SD003	SDC (SDB)	9	9	Service Delivery (Minimalist)	Above
SD004	SDC (SDB)	8	6	Compliance (Cautious)	Within
SPPC003	ARAC (CB)	8	8	Compliance (Cautious)	Within
SPPC013	ARAC (CB)	8	8	Political and Stakeholder Relationships (Open)	Below
SPPC014	ARAC (CB)	8	8	Compliance (Cautious)	Within
POD005	PC (CB)	6	4	People (Minimalist)	Above
PPP006	SDC (SDB)	6	4	Compliance (Minimalist)	Above
SPPC015	ARAC (CB)	6	6	Political and Stakeholder Relationships (Ambitious)	Below

3.3.4 Whilst risks rated 15 or above fall above our stated appetites, the alignment between risks rated below 15 and risk appetite shows a closer relationship, with 13 risks currently sitting within or below the stated appetite. Work to revise target ratings is currently being undertaken with Directorates and where capacity and resource within Directorates are available to meet identified target levels this would allow 25 risks, out of all identified risks, to sit within or below our stated appetite.

3.5 **Risk Spotlights**

3.5.1 Work to revise the risk spotlight template to include information on risk appetite has been completed and the corporate report template has been amended to ensure information on risk appetite will be included within future reports.

3.5.2 Throughout 2024/25 Committee's have utilised risk spotlights to gain additional assurance on a number of risk areas, this is in addition to specific spotlight discussions on associated risk areas within submitted reports. These include:

- Pension Remedy and associated workstreams
- Operational Intelligence
- Management of Contaminants
- Protection Staffing and Development
- Statutory Duties
- Operations control Staffing Improvement Plans
- ICT Recruitment and retention
- OC Staffing Levels
- Cyber Security
- Fraud Action Plans
- Development of risk appetite

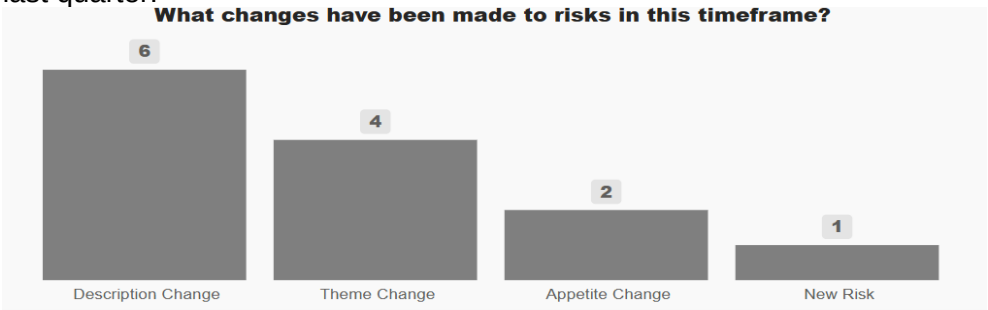
3.6 **Significant Directorate Risks**

3.6.1 In relation to the current period, Directorates reviewed their registers identifying 40 Directorate risks, 14 of which are assessed at 15 or above and coloured red within the table.

What is the current status of each risk?						
		Impact				
		Negligible (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Probability	Rare (1)					
	Unlikely (2)			3	4	
	Possilble (3)		1	6	8	1
	Likely (4)			4	8	1
	Almost Certain (5)			1	3	

3.6.2 Appendix A to the report provides information on the 14 risks rated 15 or above. The information is also available through the risk dashboard and a copy of the link is attached for information - Risk Dashboard.

3.6.3 Following review in March 2025 the following changes have been made to risks over the last quarter:

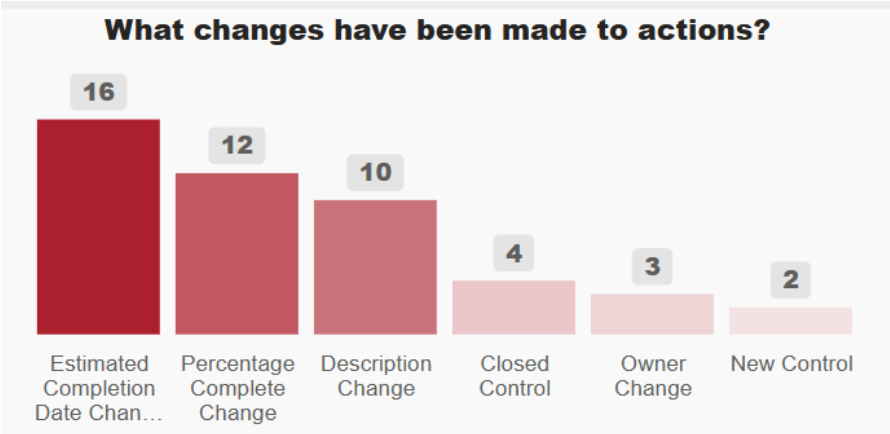


3.6.4 Information on the new risks is outlined below.

Risk ID	Risk Name	Description
FCS022	Recruitment & Retention	There is a risk of continued challenges with recruiting and retaining staff with the necessary skills and experience required to support the Finance and Procurement Function. This is particularly apparent within the Accountancy and Procurement Sections which is proving to have a very buoyant job market and provides pay grade challenges. This can result in the inability to support the service delivery of our Finance and Procurement function.

3.7 **Control Actions**

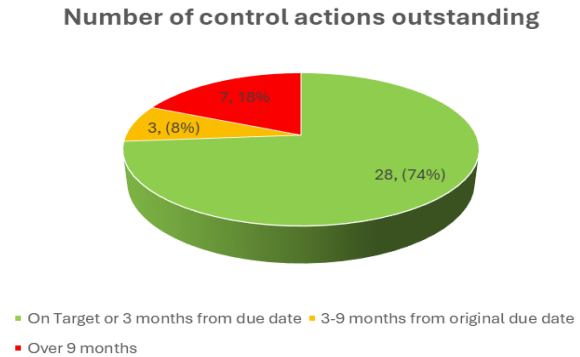
3.7.1 Following review, the following changes have been made in relation to control actions**:**



3.7.2 The table demonstrates ongoing work being progressed in relation to control actions, without which risks are likely to remain static. Discussions with Directorates will focus on identifying actions required within the current financial year with a RAG status incorporated within reports, aligned to the agreed process for Internal Audit, to identify progress made. This will focus scrutiny on priority areas, allowing responsible officers to provide assurance updates.

3.7.3 In relation to risks rated 15 or above, Appendix A identifies the 7 control actions now over 9 months from their original due date, 3 control actions 3-6 months from their original due date and 28 on target.

Green	On target or within 3 months of original due date
Amber	3-9 months delay from original due date
Red	Delay of over 9 months from original due date



3.7.4 The table below identifies the 7 control actions now over 9 months from their original due date. Discussions will be held with Directorates to ensure these control actions are progressed in line with revised dates:

Risk ID	Control Action	Control Action Comment
POD015	Ensure regular participation in process planning, and ongoing dialogue is in place with Scottish Public Pensions Agency and Finance colleagues through a number of informal and formal forums and provide regular progress updates to SFRS management teams and stakeholders to ensure appropriate oversight and escalation.	A phased approach to gathering "Expression of Interest" from inscope current and former employees for the 2nd Option exercise will be completed. A spotlight on this risk and mitigation was provided to the People Committee on 5th December 2024.
SD001	Procurement and implementation of DS300 ICCS (for Dundee and Johnstone Operations Control)	Dundee Control - Go live complete 25th February. Continue to monitor system performance and adjust configuration accordingly. Johnstone Control - continue to progress UAT with TETRA and Telephony testing scheduled to be complete 11th March - Cascade training due to complete 13th March, Equipment install 14th March. Go Live 19th March. Edinburgh Control - UAT will be complete at same time as Johnstone Control UAT due to being hosted on the same database, soft UAT scheduled for 12th March Go Live 8th April. Cascade training ongoing.
SD001	Procurement and implementation of Vision 5 Disaster Recovery System (for Edinburgh and Dundee Operations Control)	Vision modems reset and remain inoperable. Request from NEC to change sim cards however this has not resolved the issue. Modems remain inoperable and we are still unable to mobilise via Vision 5 - investigations continue. Meeting with NEC to be arranged to discuss a way forward.
SD001	Support the design, procurement, delivery and implementation of the New Mobilising System (NMS) - Phase 1	NMS Procurement now concluded with contract award to Motorola. NMS Project now moved onto Phase 1 - Planning and Implementation, with initial fact-finding workshops. Estimated completion date of ICCS implementation will be December 2025 with CAD implementation August to October 2026.
TSA018	Introduce supplementary Structural Firefighting PPE solutions in collaboration with Asset Management across the Training Function.	Meeting on 05/02/25 took place with Assets Management PPE Officer to discuss proposed admin procedure for additional PPE, solutions will be agreed and implemented end Feb 25. Meeting held with North Training Centre Led to discuss options for PPE storage in the NSDA, storage of PPE will be distributed between sites rather than being stored at a single venue. Agreed at FMT

			to extent completion date to end of financial year.
	TSA019	Engagement with Asset Management and Fleet, Equipment & Workshop FEW regarding facilities and equipment.	The new Training Service Asset Management Plan was approved in January by the SLT. With the implementation of this new document, **it was agreed that this Control Action is now complete**. A new Control Action will be opened to ensure that the implementation of the TSAMP/strategic document is delivered against. This new control action will be discussed at March FMT.
	TSA019	Scope out options to utilise temporary structures to increase venue capacity / improve welfare facilities.	The replacement of the welfare facility has been approved, feasibility report received, and the location of the new facility confirmed. A new Control Action will be opened to manage the next stage of the project which includes tender pricing, planning permission and the delivery of the works in 2025/26. This control action will be discussed in March FMT.

3.7.5	All risks and associated control actions are discussed quarterly in conjunction with Heads of Function, with other relevant changes recorded on a monthly basis.
4	**Recommendation**
4.1	The Audit and Risk Assurance Committee is asked to: • Scrutinise the information presented within the report. • Consider future report requirements for Committees and Executive Boards.
5	**Key Strategic Implications**
5.1 5.1.1 5.1.2	**Risk/Risk Appetite** The report identifies risks from each Directorate together with the significant changes made since the last update. Each Directorate will be responsible for the identification and mitigation of any associated risk and for the update of relevant risk registers. The report is aligned to the Services Compliance risk appetite in relation to our internal governance, including systems of control, where the Service has a **Cautious** appetite.
5.2 5.2.1	**Financial** The report identifies risks from each Directorate with financial implications arising from control decisions to be managed by the relevant Directorate.
5.3 5.3.1	**Environmental & Sustainability** Any implications arising from the report will be managed by the relevant Directorate.
5.4 5.4.1	**Workforce** Any implications arising from the report will be managed by the relevant Directorate.
5.5 5.5.1	**Health & Safety** Any implications arising from the report will be managed by the relevant Directorate.
5.6 5.6.1	**Health & Wellbeing** Any implications arising from the report will be managed by the relevant Directorate.
5.7 5.7.1	**Training** Any implications arising from the report will be managed by the relevant Directorate.

5.8 5.8.1	**Timing** The report is provided to the Audit and Risk Assurance Committee on a quarterly basis.	
5.9 5.9.1	**Performance** The risk report is used to ensure risks are identified and suitably managed by relevant Directorates.	
5.10 5.10.1	**Communications & Engagement** Any implications arising from the report will be managed by the relevant Directorate.	
5.11 5.11.1	**Legal** Any implications arising from the report will be managed by the relevant Directorate.	
5.12 5.12.1	**Information Governance** DPIA completed - No. The report provides a summary of risks identified by Directorates. Each Directorate will ensure that any relevant DPIA is completed as required.	
5.13 5.13.1	**Equalities** EHRIA completed - No. An assessment was undertaken in relation to the Risk Management Policy. Any individual elements of work, which may have an impact upon Equalities, will require to be assessed and managed by the relevant Directorate.	
5.14 5.14.1	**Service Delivery** Any implications arising from the report will be managed by the relevant Directorate.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Sarah O'Donnell, Director of Finance and Contractual Services
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial~~/**Reasonable/**~~Limited/Insufficient~~**:** There is room for improvement in the identification of the right risks, controls and the completion of mitigating actions within identified timescales.
7.2	**Rationale:**	The report is based upon risk information identified by each Directorate and I have confidence that the information is correctly reported based upon these returns.
8	**Appendices/Further Reading**	
8.1 8.2	Appendix A – Significant Risks – March 2025 Appendix B – Other Risk Summary – March 2025	

Prepared by:	David Johnston, Risk and Audit Manager
Sponsored by:	Lynne McGeough, Head of Finance and Procurement
Presented by:	David Johnston, Risk and Audit Manager

Links to Strategy and Corporate Values

Risk Management forms part of the Services Governance arrangements and links back to Outcome 5 of the 2022-25 Strategic Plan, specifically Objectives 5.1 and 5.6:

Outcome 5: We are a progressive organisation, use our resources responsibly and provide best value for money to the public.

- Objective 5.1: Remaining open and transparent in how we make decisions.
- Objective 5.6: Managing major change projects and organisational risks effectively and efficiently.

Governance Route for Report	Meeting Date	Report Classification/ Comments
Strategic Leadership Team	*20 March 2025*	*For Decision*
Audit and Risk Assurance Committee	*8 April 2025*	*For Scrutiny*
SFRS Board	*24 April 2025*	*For Scrutiny*

Appendix A

Significant Risks – March 2025

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS018	6	There is a risk of continued challenges with recruiting and retaining staff with the necessary skills and experience required to support the move to a Cloud based environment as well as the availability of budget to upskill existing staff with the skills required. This is because of a very buoyant ICT job market, pay grade challenges and the availability of budget to provide the necessary training. This can result in the inability to support our current systems and deliver innovation that new systems would bring.	PC (CB)	Director of Finance and Contractual Services	20	20	12	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Implement ICT Restructure	31/12/2024	30/04/2025	Head of ICT	Further engagement with TU's has taken place. Matching emails have been issued to staff. Consultation phase to remain open for a further few weeks.	On Target or 3 months from due date
Review current Market Allowance and propose new allowances for new roles	31/12/2024	31/03/2025	Head of ICT	Further evidence gathered and further work scheduled for Jan/Feb 25	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
PPP005	1	There is a risk of insufficient levels of qualified and skilled Fire Engineering resources due to challenges with recruitment, access to qualifications/training requirements, finances and retention of staff, resulting in the potential that the Directorate/SFRS may not be able to deliver against its statutory and organisational responsibilities and demands.	SDC (SDB)	Head of Directorate (DACO)	20	20	4	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Engage with the University of Edinburgh to establish new course in relation to Fire Engineering Degree and forward business case to LPG to secure interim funding for alternative degree course in England.	31/03/2025	31/03/2025	Head of Directorate (DACO)	Positive and productive discussions have taken place between SFRS and University of Edinburgh around feasibility of supporting delivery of required degree course. Funding application to support course nominations has been submitted,	On Target or 3 months from due date
Form contingency options to mitigate any Service failures to deliver Fire Engineering services through existing staff. Option to be progressed through governance for decision.	31/03/2025	31/03/2025	Head of Directorate (DACO)	Contingency options appraisal has been produced should this be required. This is awaiting to progress through governance.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SDD007	5	There is a risk of SFRS being unable to maintain adequate levels of Cyber Security to avoid any breach. This may result because of a lack of staff awareness, education and adherence to the policies and processes in place. This may result in the failure of access to or stability of systems, affecting SFRS activity	ARAC (CB)	Director of Finance and Contractual Services	20	20	12	Minimalist (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Staff Engagement and Education (KnowBe4 Training)	31/03/2025	31/03/2025	Head of ICT	Training is progressing well. 83% of staff have completed their Induction training and 44% have completed their Q3 training.	On Target or 3 months from due date
Complete Desktop Cyber Security Exercise (i.e. Phishing Exercise)	31/03/2025	31/03/2025	Head of ICT	Desktop exercise completed with Board members. 2nd session scheduled for SLT in February 2025.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC004	5	There is a risk that the service fails to comply with information governance legislation because of non-compliance resulting in sanctions and loss of stakeholder and public confidence	ARAC (CB)	SPPC	20	16	8	Cautious (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Review resource and structure of IG Team	31/03/2025	31/03/2025	Head of Governance, Strategy and Performance	Resource paper drafted for discussion with Director and business case to be developed.	On Target or 3 months from due date
Undertake review within SFRS to ascertain policy compliance	01/04/2025	01/04/2025	Head of Governance, Strategy and Performance	Discussions being held with FCS in relation to Compliance Monitoring	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FSC005	5	There is a risk that the Service may be unable to secure levels of funding required to achieve its strategic objectives. Additional pressure has been placed upon government finances causing uncertainty over future funding settlements	ARAC (CB)	FSC	16	16	8	Minimalist Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Medium Term Financial Plan	31/03/2025	31/03/2025	Head of Finance and Procurement	Draft budget allocation has been provided for 25/26 which is currently being aligned to SFRS Strategy and Priorities with the aim of achieving a balanced budget. Discussions continue with SG re financial demands and impact of settlements.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FSC019	2	There is a risk that many of our critical services and systems, which support Operations Control team functions, could fail and be unrecoverable. This is because of the age of both the hardware and software elements involved, much of which is substantially beyond end of life	SDC (SDB)	FSC	16	16	12	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Ensure key support contracts are managed in line with contract management arrangements	31/03/2025	31/03/2025	Head of ICT	All relevant support contracts now extended to 31/03/2025.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FSC022	6	There is a risk of continued challenges with recruiting and retaining staff with the necessary skills and experience required to support the Finance and Procurement Function. This is particularly apparent within the Accountancy and Procurement Sections which is proving to have a very buoyant job market and provides pay grade challenges	PC (CB)	FSC	16	16	12	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Review of Finance and Procurement Structure to ensure alignment with Strategic and Directorate priorities and associated projects.	31/12/2025	31/12/2025	Head of Finance & Procurement	Proposed structure developed and shared with FMT - potential revisions being considered at which point finalised structure will move through governance / unions etc. FMT discussions continue	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD015	2	There is a risk that the People and Finance teams are unable to effectively support the significant number of concurrent Pensions related exercises and associated implementations due to competing priorities and capacity constraints, and not receiving timely information and engagement from the Scottish Public Pensions Agency	PC (CB)	PEOPLE	16	16	4	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Continue to monitor the resource requirements related to each Pensions exercise and capacity within the People and Finance teams to support this as a result of reprioritising work activities or the need for business case for additional resource if appropriate.	31/03/2025	31/03/2025	Deputy Head of People	A request to expedite data reconciliation by SFRS's Systems team was met through the re-assignment of a System Analyst from the PPFT Team for a limited period. The project requirements in terms of SFRS resources will continue to be monitored closely to ensure that scheduled actions are met timeously, and quality of outputs is maintained.	On Target or 3 months from due date
Engage with Scottish Public Pensions Agency and stakeholders to develop appropriate employee communications on each Pension related exercise to ensure current and former employees are updated on the potential impacts and implementation arrangements timeously.	31/03/2025	31/03/2025	Deputy Head of People	A Communications Strategy to support the delivery of the Matthews 2nd option project has been implemented, highlighting the project and directing employees to further information on SFRS's iHub and the appropriate sections of the SPPA's website. Briefing notes have been sent to each RDS station giving details of the project, and posters placed in each station alerting current employees to the available information. A 13 week phased issue of individual "Expression of Interest" letters and forms to in scope current and former employees has been initiated and will be completed week commencing 9th December 2024.	On Target or 3 months from due date
Ensure regular participation in process planning, and ongoing dialogue is in place with Scottish Public Pensions Agency and Finance colleagues through a number of informal and formal forums and provide regular progress updates to SFRS management teams and stakeholders to ensure appropriate oversight and escalation of potential challenges should these arise.	31/12/2025	31/03/2025	Deputy Head of People	A phased approach to gathering "Expression of Interest" from inscope current and former employees for the 2nd Option exercise will be completed. A spotlight on this risk and mitigation was provided to the People Committee on 5th December 2024.	Over 9 months from original due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD020	6	There is a risk that the Directorate is unable to deliver against stated commitments and objectives or provide timeous support to wider SFRS projects and change initiatives, due to limited resources and capacity brought about by the current financial context and competing organisational priorities.	PC (CB)	PEOPLE	16	16	4	Open (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Develop business cases for additional resource to meet strategic priorities for consideration via governance and, if approved, undertake the required recruitment to appoint resources to support critical priorities	31/03/2025	31/03/2025	Head of People	Business Case being drafted explaining/justifying requirement for additional resource in certain areas and risk involved in not supplying additional resource.	On Target or 3 months from due date
Prepare report for SLT identifying proposals for the areas which the People Directorate can continue to support with existing resource and activity which may need to be slowed or deferred to focus on these priorities	31/12/2024	31/12/2024	Interim Director of People	Directorate Priority Paper being finalised which categorises Priorities and details what activities can progress, what activities are paused/stalled and what activities require additional resource.	On Target or 3 months from due date
Review Directorate meeting arrangements to ensure these enable regular review of People workplan in light of shifting organisational requirements, realigning resources and replanning work as required, as well as ongoing management of workloads and wellbeing check ins via regular team catch ups, 1:1s, etc	31/03/2025	31/03/2025	Head of People	Work ongoing to identify appropriate/suitable arrangements.	On Target or 3 months from due date
Undertake a priorisation exercise against all People activity (BAU and project based) and Directorate resource/capacity to consider whether resource meets existing and known commitments and organisational need from the People Directorate	31/03/2025	31/03/2025	Head of People	DMT and People Managers have had several workshops and captured all current and planned activity across the People Directorate. This has been categorised into continue, slow down or defer/stop based on the resource available to undertake this activity.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC001	5	There is a risk of the service not consistently providing accurate performance management information from some sources due to inaccurate data or inadequate systems resulting in loss of confidence in reporting service performance.	SDC (CB)	SPPC	16	12	8	Cautious (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Continue work to establish SFRS Data Governance arrangements	31/03/2026	31/03/2026	Head of Governance, Strategy and Performance	Evidence of data governance work progressing.	On Target or 3 months from due date
Development of Board Risk and Performance Reporting	31/03/2026	31/03/2026	Head of Governance, Strategy and Performance	Work being progressed in line with requirements.	On Target or 3 months from due date
Establish of Data and Information Governance Group	31/03/2026	31/03/2026	Head of Governance, Strategy and Performance	DIGG Group established	On Target or 3 months from due date
Ongoing Service Delivery dashboard development	31/03/2026	31/03/2026	Head of Governance, Strategy and Performance	Service wide reporting and dashboard development on-going	On Target or 3 months from due date
Produce SFRS Digital, Data and Technology Strategy	31/03/2026	31/03/2026	Head of Governance, Strategy and Performance	Procured support for DDaT Strategy and work underway	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
TSA018	2	There is a Directorate risk, of an inability to maintain or improve our training delivery due to insufficient capacity being available within the Training Function to meet current demand,	PC (TSAB)	TSA	16	12	6	Minimalist (Above Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Introduce supplementary Structural Firefighting PPE solutions in collaboration with Asset Management across the Training Function.	31/03/2024	31/03/2025	Group Commander Training	Meeting on 05/02/25 took place with Assets Management PPE Officer to discuss proposed admin procedure for additional PPE, solutions will be agreed and implemented end Feb 25. Meeting held with North Training Centre Lead to discuss options for PPE storage in the NSDA, storage of PPE will be distributed between sites rather than being stored at a single venue. Agreed at FMT to extent completion date to end of financial year	Over 9 months from original due date
Review of Driver Training instructor / examiner staff retention.	31/03/2025	31/03/2025	Group Commander Training	The review of the Driver Training Instructor role will be progressed via the Reward Team with an outcome expected this financial year.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
TSA019	2	There is a Directorate risk, of an inability to maintain or improve our training delivery due to the limited finance/budget available for capital investment, condition and location of our Training Estate and therefore lack of access to appropriate facilities, which could result in current and future negative impact on currency in operational skills & capacity and associated legal, regulatory, compliance, financial and reputational cost.	PC (TSAB)	Director of Training, Safety and Assurance	20	20	8	Open (Outwith Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Implementation of the recommendations from the draft contaminants POG with a timeline of Immediate, Medium and Long-term actions.	31/03/2025	31/03/2025	Head of Training	The first draft of SSoW and GRA have been produced and are in the process of being reviewed by the Contaminants team, no further update at this time.	On Target or 3 months from due date
Review the suitability of Dundee Airport site (course delivery and welfare facilities).	30/06/2024	31/12/2024	Head of Training	A further H&S audit of Dundee Airport has commenced to review progress. Perth Training Centre Station Commander liaising with Property and Instructors to ensure that required works and facilities are maintained, and where possible improved with H&S practices and further management are adhered to in the interest of continued staff welfare. Any interim improvements will allow for Dundee Airport to remain useable until the delivery of the CFBT build at Perth is in operation. Agreed at FMT to extent completion date to end of financial year	3-9 months from original due date
Engagement with Asset Management and Fleet, Equipment & Workshop FEW regarding facilities and equipment.	31/03/2024	31/03/2025	Head of Training	The new Training Service Asset Management Plan was approved in January by the SLT. With the implementation of this new document, it was agreed that Control Action 668 was now complete. A new Control Action will be opened to ensure that the implementation of the TSAMP/strategic document is delivered against. This new control action will be discussed at March FMT.	Over 9 months from original due date
Scope out options to utilise temporary structures to increase venue capacity / improve welfare facilities.	31/03/2024	31/03/2025	Head of Training	The replacement of the welfare facility has been approved, feasibility report received, and the location of the new facility confirmed. A new Control Action will be opened to manage the next stage of the project which includes tender pricing, planning permission and the delivery of the works in 2025/26. This control action will be discussed in March FMT.	Over 9 months from original due date
Analysis of USAR specialist skill delivery, including an options appraisal to identify short, medium and long term options to enhance capacity to optimise training delivery.	30/06/2024	30/12/2024	Head of Training	The extension will create the time required to manage the business case for the Collapsed Structure Simulator project at NTC to be progressed through governance to completion. (final point noted within the Control Action) Property continue to report that the build completion will be achieved within financial year 2024/25. The success of this achievement will be captured in a Comms piece.	3-9 months from original due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
OD001	2	There is a risk of a non-resilient fire control due to insufficient employees and an ineffective fire control structure. Failure to attract, recruit, personnel, high abstraction and sickness levels lead to ineffective workforce planning, as a result, we would be failing to provide a resilient fire control capability.	SDC (SDB)	Director of Operational Delivery	15	15	6	Minimalist (Outwith Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Develop succession planning strategy for OC	31/03/2025	31/03/2025	Head of Function	Ongoing engagement with Strategic People Partners in respect of recruitment, promotion and targeted development processes in line with Control Action 841, 844.	On Target or 3 months from due date
Develop and implement and active recruitment strategy	01/08/2024	31/01/2025	Head of Function	Recruitment now the responsibility of the resourcing team. No timeline confirmed for completion of strategy due to capacity issues.	3-9 months from original due date
Review OC structure.	31/03/2025	31/03/2025	Head of Function	Operations Control Structure now complete and approved by SLT.	On Target or 3 months from due date
Explore targeted development of OC Management (Supervisory to Strategic level).	31/05/2024	31/03/2025	Head of Function	Liaised with Lanarkshire LSO area, People to develop Supervisory Management Engagement session, focusing on Culture, Values, Behaviours, Managing Employee Performance, Standards and Management in Practice. This will be delivered to Supervisory Officers April/May	On Target or 3 months from due date
Implement OC structure.	31/03/2025	31/03/2025	Head of Function	Implementation of OC Structure has now commenced with full timeline still to be populated. This will extend past the current Estimated Completion date - this will be updated once full timeline is available.	On Target or 3 months from due date

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SD001	2	There is a risk of failure to mobilise to an incident due to a technical failure of the existing mobilising systems. As a result, we would be failing to meet our statutory duty and also potentially bring reputational damage to the Service.	SDC (SDB)	Director of Operational Delivery	15	15	10	Minimalist (Outwith Appetite)

Controls Actions	Original Due Date	Est' Completion Date	Owner	Comment	Action Status
Procurement and implementation of Vision 5 Disaster Recovery System (for EOC and DOC)	31/12/2023	31/03/2025	Head of Function	Vision modems reset and remain inoperable. Request from NEC to change sim cards however this has not resolved the issue. Modems remain inoperable and we are still unable to mobilise via Vision 5 - investigations continue. Meeting with NEC to be arranged to discuss a way forward.	Over 9 months from original due date
Procurement and implementation of DS300 ICCS (for DOC and JOC)	31/03/2024	01/03/2025	Head of Function	DOC - Go live complete 25th February. Continue to monitor system performance and adjust configuration accordingly. JOC - continue to progress UAT with TETRA and Telephony testing scheduled to be complete 11th March - Cascade training due to complete 13th March, Equipment install 14th March. Go Live 19th March. EOC - UAT will be complete at same time as JOC UAT due to being hosted on the same database, soft UAT scheduled for 12th March Go Live 8th April. Cascade training ongoing.	Over 9 months from original due date
Support the design, procurement, delivery and implementation of the New Mobilising System (NMS) - Phase 1	31/12/2023	31/10/2025	Head of Function	NMS Procurement now concluded with contract award type Motorola. NMS Project now moved onto Phase 1 - Planning and Implementation, with initial fact-finding workshops which will work to deliver the initial 'sandpit' environment in early December. Estimated completion date of ICCS implementation will be December 2025 with CAD implementation August to October 2026.	Over 9 months from original due date

APPENDIX B

OTHER RISK SUMMARY – MARCH 2025

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS008	4	There is a risk of that the Service will be unable to achieve environmental and carbon reduction commitments of 6% per annum; Because of limited investment or anticipated saving targets not being achieved through current projects	ARAC (SDB)	FSC	12	12	8	Open (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
3	1	1	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS011	5	There is a risk to the Service where incidents of fraud are undetected. This may be due to an unwillingness or a lack of awareness by individuals to follow policy and guidance on fraud prevention.	ARAC (CB)	FCS	12	12	9	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	0	1	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS015	6	There is a risk of a number of issues with regards to staffing, including the ability to recruit specialist staff, single points of failure across a number of key roles, lack of succession planning, age profile of staff in senior roles, staff retention rates and staff training; Because of a very buoyant job market in fleet and property, pay grades challenges and the need to review and update structure within sections not updated for 10 years	ARAC (SDB)	FCS	12	12	8	Open (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
2	1	0	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS020	5	There is a risk of SFRS not achieving best value from the resources it has because of inefficient systems and processes, a failure to respond to changing risks and/or ineffective governance.	ARAC (CB)	FCS	12	12	8	Open (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
4	3	1	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
FCS021	2	There is a risk of SFRS Property, Fleet and Equipment Assets failing to meet operational standards; Because of a lack of sufficient capital investment from Government	ARAC (SDB)	FCS	12	12	8	Open (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
4	4	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD018	5	There is a risk that SFRS is not fully compliant with Data Protection requirements due to a lack of effective processes related to how employee data is stored, accessed and maintained in paper based and electronic Personal Record Files	PC (CB)	PEOPLE	12	12	4	Cautious (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
4	2	2	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD022	6	There is a risk to maintaining positive and harmonious employee relations within SFRS and of potential legal challenge as a result of a lack of prioritisation due to capacity and inconsistent approach to employee relations investigations.	PC (CB)	PEOPLE	12	12	4	Cautious (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
3	3	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
PPP004	1	There is a risk of insufficient levels of qualified and skilled Fire Safety Enforcement resources due to challenges with recruitment, training/qualification requirements, finances, ICT and retention of staff	SDC (SDB)	PPP	12	12	4	Open (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
4	4	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SD006	2	There is a risk that Service Delivery is unable to maintain an effective level of capacity and resource within the Directorate because of challenges relating to the recruitment, promotion and retention of staff	PC (CB)	OD	12	12	8	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
4	3	0	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC007	5	There is a risk that the services reputation is adversely affected due to a lack effective communication and consultation plans and supporting management processes resulting in a loss of workforce, stakeholder and public confidence	ARAC (CB)	SPPC	12	12	12	Cautious (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
2	2	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC012	5	There is a risk that the service has inadequate organisation security because of a lack of up to date corporate security arrangements resulting in risk to staff and the public	ARAC (CB)	OD	12	12	8	Cautious (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
3	3	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
TSA014	6	There is a risk of not being able to demonstrate legislative compliance because of gaps identified in risk control measures, management arrangements and alignment with recognised standards resulting in potential criminal/civil litigation, and reputational damage.	PC (TSAB)	TSA	12	12	4	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	1	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD016	6	There is a risk that outdated 'Trainee Firefighter Development to Competent Policy and Procedures' and a lack of clarity amongst employees and managers around process leads to incorrect application of the MA/SVQ process, particularly for new apprentices	PC (CB)	PEOPLE	9	9	4	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	1	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD019	6	There is a risk of SFRS having an insufficient number of Assessors and Internal Verifiers due to potential constraints on the capacity to deliver and undertake the training, resulting in an inability for SFRS to meet SQA and SDS requirements under its Modern Apprenticeship contract.	PC (SDB)	PEOPLE	9	9	4	Open (Below Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
2	2	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD021	6	There is a risk to maintaining an effective Retained Duty System and meeting the Service's obligations under the Fire Scotland Act as a result of the impact of revisions to On Call T&Cs and associated policy / procedural arrangements, in particular effective management to meet the requirements of the Working Time Regulations	PC (CB)	PEOPLE	9	9	4	Ambitious (Below Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
3	3	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD023	6	There is a risk to maintaining positive and harmonious employee relations within SFRS as a result of current and planned organisational change activity for which the Service does not yet have an agreed suite of framework and accompanying policies/guidance related to the impact of change on colleagues.	PC (CB)	PEOPLE	9	9	4	Open (Below Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
2	2	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SD003	2	There is a risk of SFRS operational availability systems reaching end of life and failing and the existing supplier ceasing to support or maintain legacy systems. This would impact SFRS ability to effectively mobilise. It would also cause reliability issues and licence issues in some LSO areas of SFRS.	SDC (SDB)	OD	9	9	9	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
0	0	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SD004	2	There is a risk of failing to maintain a standard suite of Policies because of the volume of Policies and the consultation timeframe. This would result in having an inconsistent approach to service response and could lead to possible operational failures.	SDC (SDB)	OD	8	8	6	Cautious (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	0	0	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC003	5	There is a risk that the service does not have an appropriate and effective governance arrangements in place resulting in loss of public and stakeholder confidence.	ARAC (CB)	SSPC	8	8	8	Cautious (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	1	0	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC013	7	There is a risk that the service fails to secure adequate benefits from collaboration and partnership working due to a lack of effective management and the coordination and sharing of information	ARAC (CB)	SPPC	8	8	8	Open (Below Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
9	9	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC014	5	There is a risk that the service fails to demonstrate robust Business Continuity Planning arrangements, demonstrating lessons learned from Covid and other events	ARAC (CB)	SPPC	8	8	8	Cautious (Within Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	0	0	1

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
POD005	6	The risk of not developing and providing appropriate wellbeing support (both mental and physical health) to all SFRS employees	PC (CB)	PEOPLE	6	6	4	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	0	1	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
PPP006	1	There is a risk of SFRS being unable to undertake the powers detailed under Section 29 of the Fire (Scotland) Act 2005, to investigate the origin, cause and development of fires and fulfil it's obligations under the Joint Protocol Agreement with Police Scotland, British Transport Police and Forensic Services - Scottish Police Authority, due to a shortage of staff who have appropriate accreditation	SDC (SDB)	PPP	6	6	4	Minimalist (Above Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	1	0	0

Risk ID	Strategic Outcome	Risk Description	Governance Alignment	SLT Risk Owner	Risk Rating	Previous Risk Rating	Target	Risk Appetite
SPPC015	3	There is a risk that the services consultation and engagement processes do not adequately capture stakeholder feedback because of a lack of consistency across the organisation resulting in a loss of workforce, stakeholder and public confidence.	ARAC (CB)	SPPC	6	6	6	Ambitious (Below Appetite)

Number of control Actions	Number of Control Actions on Target or 3 months from due date	Number of Control Actions 3-9 months from original due date	Number of Control Actions Over 9 months from original due date
1	1	0	0

SCOTTISH FIRE AND RESCUE SERVICE

Audit and Risk Assurance Committee

Report No: C/ARAC/17-25

Agenda Item: 15

Report to:	**AUDIT AND RISK ASSURANCE COMMITTEE**							
Meeting Date:	**8 APRIL 2025**							
Report Title:	**REVIEW OF WHISTLEBLOWING POLICY**							
Report Classification:	**For Scrutiny**	**SFRS Board/Committee Meetings ONLY For Reports to be held in Private Specify rationale below referring to Board Standing Order 9**						
		A	B	C	D	E	F	G

1	**Purpose**
1.1	To provide an update on a desktop review undertaken of the Scottish Fire and rescue Service (SFRS) Whistleblowing Policy prior to approval and publication.
2	**Background**
2.1	The SFRS has in place a Whistleblowing Policy which is not due for formal review until 2026. This sets out arrangements for 'qualifying disclosures' made in the public interest regarding specific issues for which employees who make such a disclosure are protected under the Public Interest Disclosure Act 1998.
2.2	Audit and Risk Assurance Committee (ARAC) are aware of two instances of fraud occurred within SFRS in 2024. The need to revise the Whistleblowing Policy was identified following one such instance of fraud and was included in the action plan which was subsequently developed internally and agreed by ARAC. The agreed action set out that a desktop review of this Policy would be carried out to ensure that the policy wording remains fit for purpose in the context of the recent issues raised related to fraud and any specific amendments made out with the normal full review of the policy; with a due date of 31 March 2025.
2.3	An internal audit was also undertaken by Azets in 2024 on SFRS' Anti-fraud Arrangements, with the report and associated recommendations being finalised in March 2025. This was commissioned following reporting on the two instances of fraud referred to above. One area of this report also highlights a lack of awareness in terms of the Whistleblowing Policy and other policies which align to fraud.
3	**Main Report/Detail**
3.1	Employees with serious concerns about illegality, malpractice, wrongdoing or serious failures of standards of work are encouraged to come forward and voice their concerns. The SFRS Whistleblowing Policy is intended to encourage and enable employees to raise serious concerns within SFRS, rather than overlooking a problem or blowing the whistle externally, and to reassure employees that they can do so without fear of reprisal.
3.2	The Public Interest Disclosure Act 1998 (PIDA) makes provisions for the protection of individuals who raise legitimate concerns about specified matters, known as 'protected disclosures' or 'qualifying disclosures'. The Act gives legal protection to employees against being dismissed, penalised or treated badly by their employers as a result of publicly disclosing certain serious concerns.

3.3	A 'qualifying disclosure' under the Act is one made in the public interest by an employee who has a reasonable belief that one or more of the following is being, has been, or is likely to be, committed: • A criminal offence; • A miscarriage of justice; • An act creating any risk to health and safety of any individual; • An act causing risk or actual damage to the environment; • A breach of any other legal obligation; or • A deliberate attempt to conceal any of the above.
3.4	This may or may not include fraudulent activity.
3.5	It should be noted that a Whistleblowing or qualifying disclosure may be raised via the Service's external confidential reporting line, SafeCall. However, this will not always be the case and such disclosures of a serious nature can be raised directly internally to the Director of People.
3.6	There are interdependencies between the SFRS Whistleblowing policy and the SFRS Anti-Fraud and Corruption Policy which puts procedures in place, in line with Financial Regulations, for reporting suspected fraud and corruption. Both policies allow for the reporting of fraud and the Director of Finance and Contractual Services and the Director of People will determine which is the most appropriate policy to be followed where concerns related to fraud.
3.7	To address risks identified from recent fraud issues within the Service and the action outlined at 2.2, the desktop review of the Whistleblowing Policy has therefore focused on amendments to ensure the policy remains fit for purpose related to the following: • Sets out a clear position on what can/should be raised via the Whistleblowing Policy – this is a statutory arrangement with clear parameters on what constitutes a 'qualifying disclosure' for which specific protections are afforded to employees who raise such concerns • Ensures a clearer correlation between the Whistleblowing and Anti-Fraud Policy as outlined above • Ensures reference in the Whistleblowing Policy that disclosures raised under this policy require to be reported to ARAC • Ensures existing processes related to Whistleblowing disclosures are clear e.g. how to raise complaints, how these will be investigated, recorded/reported etc
3.8	The revised policy is attached as Appendix A, with amended text shown in red. Stakeholder engagement is currently being finalised in respect of these amendments.
3.9	An associated gap that has been identified from progressing this review is a lack of clarity and degree of misunderstanding regarding different ways to raise complaints within SFRS and the purpose of each policy/procedure. As such a flowchart has been developed as outlined in Appendix B which will form part of a communication plan to raise awareness with SFRS colleagues.
4	**Recommendation**
4.1	ARAC are asked to scrutinise the content of this report and accompanying amended Whistleblowing Policy and provide comment prior to this being submitted to Corporate Board for approval and onwards publication.

5	Key Strategic Implications
5.1 5.1.1	**Risk** There is a risk that a lack of awareness of the Whistleblowing and/or Anti-Fraud and Corruption Policies may result in matters not being reported, investigated or recorded appropriately. This may result in financial and/or reputational damage for SFRS.
5.2 5.2.1	**Financial** There is a cost to potential fraudulent activity within SFRS and there are financial penalties which may apply dependent on the nature of any Whistleblowing complaint and resulting investigation/outcome.
5.3 5.3.1	**Environmental & Sustainability** There are no environmental and sustainability implications related to this report.
5.4 5.4.1	**Workforce** The ability to raise concerns or complaints and to highlight potentially serious issues within an organisation is an important part of the employment relationship. Ensuring colleagues are aware how to do so and which policies and processes are available to support this is therefore vital.
5.5 5.5.1	**Health & Safety** A qualifying disclosure may be made in the public interest by an employee for a number of specific reasons, including a reasonable belief that an act creating any risk to health and safety of any individual (amongst other reasons) is being, has been, or is likely to be, committed.
5.6 5.6.1	**Health & Wellbeing** There are no specific health and wellbeing implications related to this report although raising a complaint particularly of a protected nature is likely to impact overall wellbeing.
5.7 5.7.1 5.7.2	**Training** A flowchart has been developed to assist in raising awareness of the differing routes through which complaints or concerns can be raised within SFRS, one of which is via the Whistleblowing Policy in relation to qualifying disclosures. The Whistleblowing Policy will be added as part of the 'Induction' section within LCMS to ensure all new employees are aware of this policy and its purpose. This will also allow monitoring of who has accessed/read this.
5.8 5.8.1	**Timing** The revised Whistleblowing Policy will be published in early Q1 following approval.
5.9 5.9.1	**Performance** A lack of awareness of how to raise complaints or protected disclosures or a lack of action in dealing with such serious matters may affect overall performance, engagement, recruitment and retention of colleagues.
5.10 5.10.1 5.10.2	**Communications & Engagement** Consultation is currently underway with the representative bodies on the revised Whistleblowing Policy. This will be communicated and published following approval via governance. A flowchart has been developed and attached as Appendix B which will be communicated via various channels to highlight to employees' routes for raising concerns or complaints, which includes via the Whistleblowing Policy where this is a protected disclosure.

5.11 5.11.1	**Legal** The Public Interest Disclosure Act 1998 (PIDA) makes provisions for the protection of individuals who disclose information about specific issues i.e. a 'qualifying disclosure'. The Act gives legal protection to employees against being dismissed, penalised or treated badly by their employers as a result of publicly disclosing certain serious concerns.	
5.12 5.12.1	**Information Governance** DPIA completed - No. No personal information is in scope of this paper.	
5.13 5.13.1	**Equalities** EHRIA completed - Yes. Existing EHRIA is in place to support the Whistleblowing Policy and remains relevant and up-to-date.	
5.14 5.14.1	**Service Delivery** Dependent on the nature of protected disclosures raised under the Whistleblowing Policy this may have an effect on delivery of service across SFRS.	
6	**Core Brief**	
6.1	Not applicable	
7	**Assurance (SFRS Board/Committee Meetings ONLY)**	
7.1	**Director:**	Fiona Ross, Director of People
7.2	**Level of Assurance: (Mark as appropriate)**	~~Substantial~~/**Reasonable**/~~Limited/Insufficient~~
7.3	**Rationale:**	SFRS has in place an existing Whistleblowing Policy which is aligned to statutory requirements related to protected disclosures. Some improvements have been identified to enhance the adequacy and effectiveness of procedures and these have been addressed via the desktop review of the Policy and measures to raise awareness of this.
8	**Appendices/Further Reading**	
8.1 8.2	Appendix A – Amended Whistleblowing Policy Appendix B – Flowchart	

Prepared by:	Rachael Scott, Deputy Head of People
Sponsored by:	Lyndsey Gaja, Head of People
Presented by:	Lyndsey Gaja, Head of People

Links to Strategy and Corporate Values

Links to the Corporate Value of Respect and to Strategic Outcome 6 *The experience of those who work for SFRS improves as we are the best employer we can be*.

Governance Route for Report	Meeting Date	Report Classification/ Comments
ARAC	*8 April 2025*	*For Scrutiny*
Corporate Board	*16 April 2025*	*For Decision*

APPENDIX A

SFRS WHISTLEBLOWING POLICY

1. POLICY STATEMENT

1.1 The Scottish Fire and Rescue Service (SFRS) is committed to the highest possible standards of openness and accountability. In line with that commitment, employees with serious concerns about illegality, malpractice, wrongdoing or serious failures of standards of work are encouraged to come forward and voice their concerns.

2. SCOPE

2.1 This policy applies to all individuals working at all levels of the organisation, Including SFRS employees, consultants, contractors and agency staff (collectively known as 'employees' for the purposes of this policy).

3. INTRODUCTION

3.1 It is a fundamental term of every contract of employment that an employee will faithfully serve their employer and not disclose confidential information about the employer's affairs. However, where an individual discovers information which they believe shows malpractice or wrongdoing within the organisation, then the information should be disclosed without fear of reprisal, and the disclosure may be made independently of line management.

3.2 This Whistleblowing Policy is intended to encourage and enable employees to raise serious concerns within SFRS, rather than overlooking a problem or blowing the whistle externally, and to reassure employees that they can do so without fear of reprisal.

3.3 This policy provides employees with:

- Avenues to raise concerns and receive feedback on those concerns
- Reassurance that they will be protected from victimisation for reporting their concerns
- Details of support available.
- Signposting to other policies

4. DEFINITIONS

4.1 What is Whistleblowing

The Public Interest Disclosure Act 1998 (PIDA) came into force on 2 July 1999. The Act makes provisions for the protection of individuals who disclose information about specific issues. The Act gives legal protection to employees against being dismissed, penalised or treated badly by their employers as a result of publicly disclosing certain serious concerns.

4.2 What is a Protected Disclosure

The law provides protection for those who raise legitimate concerns about specified matters. The Act defines 'protected disclosures' which are made by an employee as 'qualifying disclosures'.

A qualifying disclosure is one made in the public interest by an employee who has a reasonable belief that one or more of the following is being, has been, or is likely to be, committed:

- A criminal offence;

- A miscarriage of justice;
- An act creating any risk to health and safety of any individual;
- An act causing risk or actual damage to the environment;
- A breach of any other legal obligation; or
- A deliberate attempt to conceal any of the above.

An employee who makes a protected disclosure has the right not to be dismissed, harassed, victimised or subjected to any other detriment because they have made a qualifying disclosure. Victimisation of a worker for raising a qualified disclosure is a disciplinary offence.

5. PRINCIPLES

5.1 The Whistleblowing Policy must not be used for the purposes of personal gain and an employee, in all circumstances, must be raising a concern in the public interest for a reason believed to fall within the range of qualifying disclosures as listed in section 4.2.

5.2 The Whistleblowing Policy is not another mechanism for employees to raise personal grievances.

5.3 Any concern raised under the protected list stated in section 4.2 may relate to another employee, group of employees, the individual's own Directorate or another part of SFRS.

5.4 It is not necessary for the employee to have proof that an act is being, has been, or is likely to be, committed – a reasonable belief is sufficient.

5.5 The employee has no responsibility for investigating the matter – it is the responsibility of SFRS to ensure that an investigation takes place in line with this policy.

6. RELATIONSHIP WITH OTHER POLICIES

6.1 Fraud and Corruption

This Whistleblowing policy is aligned to the SFRS Anti-Fraud and Corruption Policy which puts procedures in place, in line with Financial Regulations, for reporting suspected fraud and corruption. Both policies allow for the reporting of fraud and the Director of Finance and Contractual Services and the Director of People will determine which is the most appropriate policy to be followed. **An employee reporting an issue will be protected regardless of which of these two policies is followed.**

6.2 Bullying, Harassment and Victimisation

From October 2024, the Worker Protection (Amendment of Equality Act 2010) Bill strengthened existing protection for workers against sexual harassment.

Workers Protection Act 2023 – Statement of Intent

SFRS has a zero-tolerance approach to bullying, harassment and victimisation, and condemns such behaviours. We believe our workplaces should be a safe place for all. By respecting all differences, we recognise the link between fairness, equality, and employment.

We are committed to proactively preventing bullying and all forms of harassment, including sexual harassment, victimisation and discrimination. To show our commitment, we have adopted a zero-tolerance approach to send a clear message that these actions in any form will not be tolerated.

We are fully committed to supporting and encouraging anyone who is experiencing / has experienced or witnessed any form of discrimination, harassment or bullying to come forward to receive support and advice. We recognise the significant impact these acts can have on physical and mental health, so we will prioritise prevention to ensure workplace safety.

Allegations of injustice, bullying, harassment or discrimination against individuals should, if at all possible, be dealt with under Bullying and Harassment and/or Dignity and Respect Policies and procedures which are intended to be flexible and to have high levels of confidentiality.

6.3 Grievance

The SFRS Grievance Policy is a separate procedure and should be used where employees wish to raise a personal, or collective, grievance about a perceived injustice about the application of their terms and conditions or other work-related issues which affect them directly.

A full list of associated policies is provided at section19 below.

7. RAISING A CONCERN WITH SFRS

7.1 Where an employee has a concern that they believe meets the definition of a qualifying disclosure, as detailed in section 4 and has considered the principles detailed in section 5, they should follow the guidance in this section to raise their concern(s).

7.2 **Where an employee is raising a concern about fraud and/or corruption then they should also consult the Anti-Fraud and Corruption Policy.**

7.3 If an employee is not sure whether to raise a concern, they can discuss this with their Strategic People Partner or People Adviser. There is also independent advice available from Protect at www.protect-advice.org.uk.

7.4 Employees who are members of recognised Trade Unions are encouraged to contact their Trade Union who can provide advice, support and assistance over any whistleblowing concerns.

7.5 Employees can raise any concerns with their line manager in the first instance or, alternatively, approach another manager to raise their concerns if they feel more comfortable.

7.6 Where the matter is more serious, or the employee would prefer to raise it with a more independent manager, they should contact the Director of People or t**he Director of Finance and Contractual Services (in matters of Fraud and Corruption) directly.**

7.7 Alternatively, employees can raise concerns using the external Confidential Reporting Line, **Safecall**, details of which can be found on iHub. This independent reporting facility provides access to a 24 hours / 365 days telephone line or, where preferred, a confidential online reporting tool.

7.8 An employee raising a concern must state that they are using the Whistleblowing Policy and specify whether they wish their identity and concerns to be treated confidentially, with such wishes being respected.

7.9 Where possible, the employee should identify which of the events in section 4.2 is being referred to and the particular facts and circumstances they believe to be applicable.

RAISING A CONCERN EXTERNALLY

7.10 The aim of this policy is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing in the workplace. In most cases, employees should not find it necessary to alert anyone externally and we would encourage staff to report such concerns

internally in the first instance. However, the law recognises that, in some circumstances, it may be appropriate for employees to report their concerns to an external body such as a regulator.

Government guidelines provide a list of prescribed persons or bodies to which qualifying disclosures can be made. Where a report is made to a prescribed person or body, it must be one that deals with the issue being raised.

The prescribed list includes:

- HM Revenue and Customs;
- The Financial Conduct Authority (formerly the Financial Services Authority);
- The Health and Safety Executive;
- Scottish Environment Protection Agency;
- The Procurator Fiscal Service;
- The Serious Fraud Office.

In addition further information on the Public Interest Disclosure (Prescribed Persons) Amendment Order 2013 can be found at the following web addresses:

Whistleblowing: list of prescribed people and bodies - GOV.UK

http://www.legislation.gov.uk/uksi/2013/2213/made

8. HOW SFRS WILL REPOND TO A REPORT OF A CONCERN

8.1 If urgent action is required to safeguard individuals or property then the Service will immediately take such action as is necessary.

8.2 In matters of fraud and/or corruption the Director of Finance and Contractual Services will be advised immediately. The Director of People and the Director of Finance and Contractual Services will decide whether this policy or the Anti-Fraud and Corruption Policy should be followed.

8.3 Complaints made under this policy require to be reported to the Audit and Risk Assurance Committee (ARAC) for scrutiny.

8.4 Director of Finance and Contractual Services will be responsible for authorising the reporting of criminal activities, in relation to fraud and corruption, to Police Scotland where they feel it appropriate to do so.

8.5 It will not be possible for an employee to prevent an investigation by withdrawing their concern.

8.6 Where a concern is raised with a manager under this policy, they should immediately take advice from their Strategic People Partner or People Advisor. In less serious matters it may be possible for the manager to investigate and respond to concerns in writing. The manager should always advise the Director of People of complaints raised under this policy.

8.7 Where the employee is dissatisfied with the response or the matter is more serious the Director of People will assign a member of the Strategic Leadership Team (SLT) to act as the Designated Whistleblowing Officer (DWO), usually within 7 days. Any member of the SLT can be appointed as the DWO. The DWO's responsibilities include carrying out an initial investigation into the employee's concerns and deciding on the most appropriate course of action to take.

8.8 The DWO will acknowledge receipt of the employee's disclosure and keep a record of further action taken.

8.9 The DWO may then invite the employee to a meeting to discuss their concern(s) within 7 days (timescale can be extended by mutual agreement). An employee is entitled to be accompanied by a Trade Union representative or workplace colleague at any meeting with the DWO (or the DWO's nominee) under this procedure and is encouraged to do so. The companion will be asked to respect the confidentiality of the disclosure and any subsequent investigation.

9 INVESTIGATION AND OUTCOME

9.1 SFRS is committed to investigating disclosures fairly, quickly and, where circumstances permit, confidentially.

9.2 Following their initial assessment, the DWO may consider a full investigation is necessary and decide what form this should take. This will depend on the nature of the matter(s) raised and there may need to be a referral to the relevant outside body, detailed in section 7.9.

9.4 Where the DWO considers it necessary, an investigator appointed may have relevant experience or specialist knowledge.

9.5 So far as appropriate and practicable, the individual who made the disclosure will be kept informed of the progress of the investigation. However, the need for confidentiality may prevent the disclosure of specific details of the investigation or actions taken.

9.6 On completion of the investigation, the DWO will inform the employee who made the disclosure what action is to be taken as far as this is possible. If no action is to be taken, the employee will be informed in writing of the reasons for this.

9.7 It may be decided that the matter would be more appropriately dealt with under an alternative procedure(s), such as the Grievance, Dignity and Respect, Discipline or the Anti-Fraud and Corruption Policy. In such instances, the whistleblower will remain protected under the principles of this policy.

9.8 If misconduct is discovered as a result of any investigation under this procedure, the SFRS Disciplinary Procedure will be used. Furthermore, depending on the circumstances of the case, SFRS may be required to consider whether appropriate external measures need to be considered, in line with professional advice.

9.9 If it is deemed necessary to refer the matter to an external authority for further investigation, SFRS will endeavour to inform the employee making the disclosure. However, in some cases, SFRS may need to make such a referral without the employee's knowledge, if considered appropriate, e.g. cases that may be considered a criminal matter and which, therefore, require confidentiality in order not to compromise any subsequent investigation.

9.10 SFRS will always endeavour to handle investigations promptly and fairly but, if an employee who has made a disclosure under the procedure is not satisfied with the investigation or the conclusions reached by the DWO, they can write directly to the Deputy Chief Officer detailing their concerns. The Deputy Chief Officer will be responsible for carrying out an independent review of the disclosure to determine whether there are any concerns with the integrity of the investigation and/or the outcome(s).

10 ENGAGING WITH THE MEDIA

10.1 The Media may contact employees directly for information or comment on behalf of SFRS. Employees should be familiar with the SFRS Engaging with the Media Policy which ensures a planned, co-ordinated and consistent approach.

10.2 In line with the aforementioned policy, employees must not comment or disclose any confidential SFRS information, including financial or confidential information about the Service, its employees, partners, suppliers or stakeholders to the media.

10.3 Employees should be aware that, under the terms of the Whistleblowing Policy, protected disclosures may only be made to organisations on the prescribed list as detailed in section 6.11 above. Protected disclosures cannot therefore be made to the media under the terms of this policy.

10.4 Staff should be aware that such unauthorised contact and disclosures to the media may result in action under the SFRS Disciplinary Policy and, in extreme cases, civil and criminal law.

11 RESPONSIBILITIES

11.1 Corporate Responsibilities

The Director of People will (in consultation with the Director of Finance and Contractual Services where allegations concern Fraud and Corruption) consider the sensitivity of the allegations in terms of public interest and whether the Communications Team, Chief Officer, Chair of the Board and Chair of the Audit and Risk Committee should be briefed.

Complaints raised under this policy will be reported to the Audit and Risk Assurance Committee (ARAC) for scrutiny.

The Director of People is responsible for this policy and will consult with the Director of Finance and Contractual Services regarding allegations of fraud and corruption.

The Director of People will assign a member of the SLT to act as the DWO for a Whistleblowing case. The DWO has day-to-day operational responsibility for any cases assigned to them.

11.2 Directorates

Directorate, through Heads of Function and Heads of Service Delivery, will ensure the Whistleblowing Policy is used when appropriate and any concerns raised are dealt with under the principles of this policy.

11.3 Departmental Managers

Departmental Managers are responsible for providing support to Heads of Function and Heads of Operational Delivery. To ensure the implementation of this policy, specifically, they are responsible for:

- Ensuring they comply with this policy within their areas/departments;
- Ensuring any concerns raised by an employee are handled under the principles of this policy;
- Ensuring no employee is victimised for raising a concern;
- Liaising with the Strategic People Partner as required

11.4 People Directorate

People Directorate is responsible for:

- Providing advice and guidance regarding this policy and other associated policies.

11.5 Duties of Employees

Employees are responsible for:

- Co-operating with managers to ensure the effective implementation of this policy;
- Using this policy to disclose any suspected danger or wrongdoing, in the public interest.

11.6 Role of Trade Unions

Recognised Trade Union representatives' functions include:

- Co-operating with SFRS to ensure the procedures outlined within this policy are effectively implemented;
- Consulting with managers and the People team on Whistleblowing related issues; and
- Encouraging staff to co-operate and comply with this policy.

12 CONFIDENTIALITY

Any employee who raises a qualifying disclosure has the right to confidentiality. An employee must make it known at the earliest opportunity should they wish this and SFRS will make every effort to protect their identity.

13 ANONYMOUS ALLEGATIONS

This policy encourages employees to put their names to allegations. Concerns expressed anonymously will be investigated at the discretion of the **DWO but in allegations of fraud and/or corruption, the Director of Finance and Contractual Services will always be advised**. In exercising this discretion, the factors to be taken into account would include the:

- Seriousness of the issue raised;
- Credibility of the initial information provided;
- Credibility of the concern; and
- Likelihood of confirming the allegation.

14 EXISTING DISCIPLINARY PROCEDURES

If an employee is already the subject of action under another procedure, such as Discipline, these procedures will not automatically be halted as a result of them raising concerns under this policy. However, the disciplinary process may be suspended, pending the outcome of an investigation where the whistleblowing concerns raised are closely related to the disciplinary case.

15 MONITORING AND REVIEW

Monitoring and Record Keeping

SFRS is committed to evaluating the effectiveness of its activities and operations and meeting its statutory obligations for monitoring. To do this, we will:

- create and capture necessary data to demonstrate evidence, accountability and information about our decisions and activities and the effectiveness of policies, procedures and processes;
- maintain securely and preserve access to records, as long as they are required to support SFRS operations, in accordance with the SFRS Records Retention Schedule;
- meet legal record keeping requirements, including the Data Protection Act 2018 and the Freedom of Information (Scotland) Act 2002, and confidentially destroy those records as soon as they are no longer required.

16 PRIVACY STATEMENT

SFRS processes personal data collected as part of this Whistleblowing Policy in accordance with the Data Protection Act 2018 and General Data Protection Regulation 2018 (GDPR). In particular, data collected as part of this policy is held securely and accessed by and disclosed to individuals, only for the purposes of supporting employees. In addition, Data Protection Impact Assessments are carried out, where necessary, for all new and revised policies, involving the processing of personal data.

This policy has been developed following full consultation with relevant stakeholders and representative bodies. It has been agreed by the relevant SFRS Boards / Committees who provide strategic advice and advice on matters affecting employees, whilst ensuring it supports the strategic aims of the SFRS.

17 POLICY REVIEW

This policy will be subject to update and review as necessary by the People Directorate, at no more than five yearly intervals or earlier should any relevant legislative, precedent, judgement, operational review or organisational changes occur prior to that date.

18 EQUALITY

The equality issues associated with this policy have been considered and are detailed within the Equality Impact Assessment, to which interested parties are directed for associated equality issues, both directly and indirectly relevant to this policy.

19 ASSOCIATED DOCUMENTS / REFERENCES

Anti-Fraud and Corruption Policy

Code of Conduct for SFRS Employees

Confidential Reporting Line

Dignity and Respect Policy

Disciplinary Policy and Procedure

Bullying, Harassment and Discrimination Policy

Engaging with the Media Policy

Grievance Policy and Procedure

Equality Impact Assessment – Whistleblowing

Policy Records Retention Schedule Data Protection Act 2018

Freedom of Information (Scotland) Act 2002

Public Interest Disclosure Act 1998 (PIDA)

The Public Interest Disclosure (Prescribed Persons) (Amendment) Order 2013

Department for Business, Energy & Industrial Strategy,

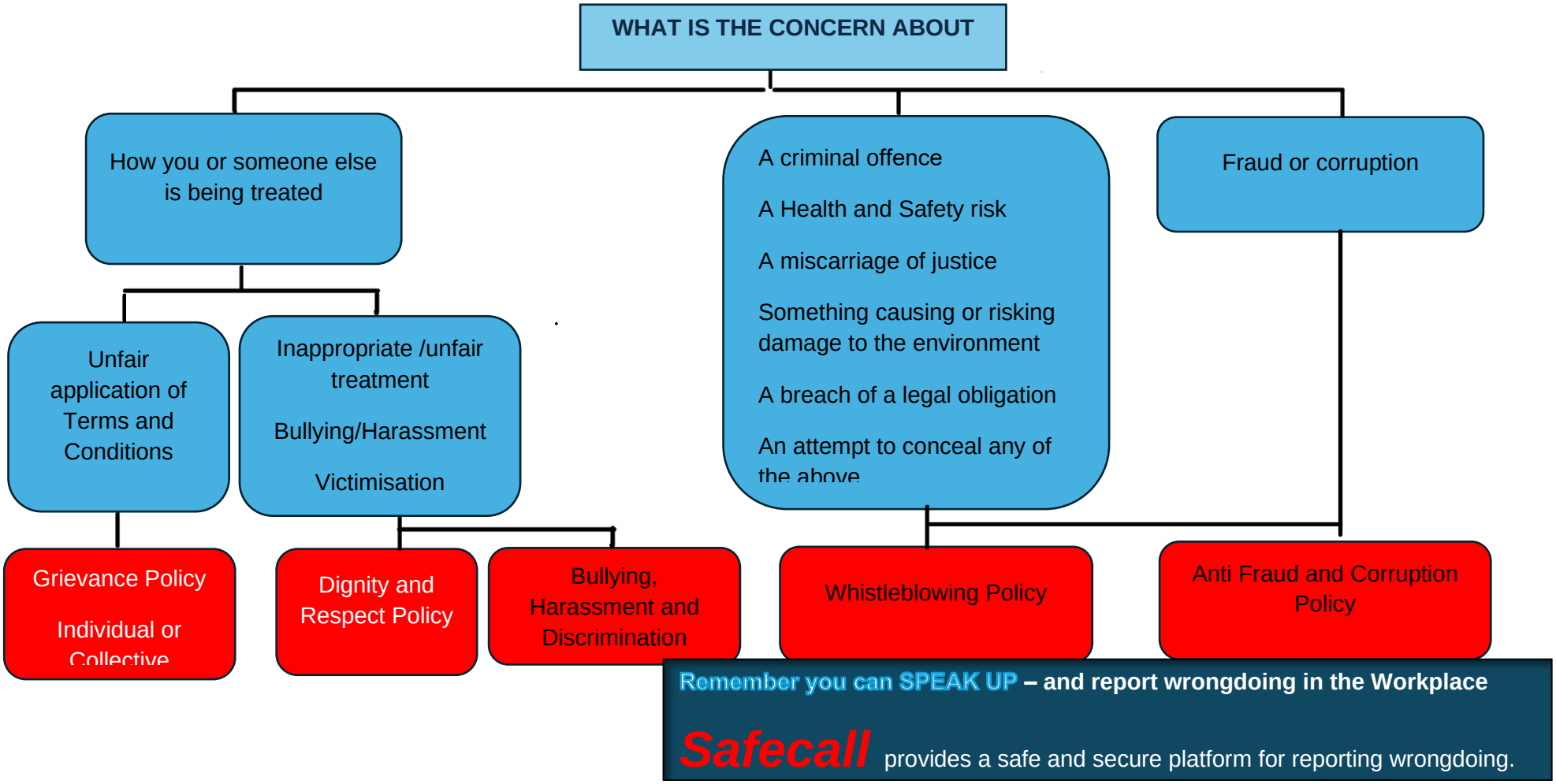
Guidance – Whistleblowing: list of prescribed people and bodies

APPENDIX B

I AM AN EMPLOYEE CONCERNED ABOUT SOMETHING HAPPENING IN SFRS

WHAT SHOULD I DO.

There are Policies and Procedures to support you



Remember you can SPEAK UP – and report wrongdoing in the Workplace

Safecall provides a safe and secure platform for reporting wrongdoing.

Report No: C/ARAC/18-25
Agenda Item: 16

HM Fire Service Inspectorate

Report to:	**SCOTTISH FIRE AND RESCUE SERVICE, AUDIT AND RISK ASSURANCE COMMITTEE**
Date:	**24 March 2025**
Report By:	**HM Fire Service Inspectorate**

Subject:	**Routine report on HMFSI business**

1. PURPOSE

1.1 To provide the Service Delivery Committee with an update on HMFSI inspection and reporting activity.

2. RECOMMENDATIONS

2.1 That the Committee notes the update from HMFSI.

3. ACTIVITY AND PROGRESS

3.1 Service Delivery Area Inspection

The inspection fieldwork for the North SDA has all but concluded and the first draft of the report has been shared with the Chief Inspector for comment. HMFSI will share the draft with key stakeholders within the Service for informal consultation commencing April 2025. This will be followed by formal consultation from the end of April until early May. It is envisaged that the North SDA Inspection will be published in the summer of 2025.

3.2 Thematic Inspection Work

Organisational Culture

HMFSI are undertaking a thematic Inspection of Culture of SFRS. To date, HMFSI has interviewed SFRS policy owners, representatives from across all support directorates, station-based personnel, Operations Control, staff network groups and Trade Union representatives. A further series of MS Teams interviews were held with a randomly selected sample of individuals from across functions of the Service. All of the interviews and visits sought views relating to organisational values, policies, procedures and training that support organisational culture. The inspection is now in the analysis phase. The publication of the report is anticipated for early summer.

Operational Assurance

HMFSI are currently carrying out a thematic inspection of Operational Assurance within the SFRS as per the previously agreed outline. All scheduled fieldwork has been completed with data analysis, report development and consultation ongoing. At the request of the Service and following positive engagement, the consultation is now due to take place by summer 2025 with the final report due to be published in the autumn of 2025.

3.3 Additional Inspection Activity

Chief Inspector's Plan 2025-2028

The Chief Inspector has a statutory obligation to publish an inspection plan outlining inspections scheduled, and information on how inspections will be carried out. Following a period of formal consultation, the Chief Inspector's plan for 2025-28 will be laid in Parliament in April 2025. The HMFSI Annual Operating Plan for 2025 -26 has also been shared with key stakeholders and outlines areas of inspection scheduled to commence this year.

The Chief Inspector and his team propose focussing on three key areas: -

- Operational Training and Development
- Service Delivery, from the perspective of those working in corporate functions.
- Organisational Culture – Phase 2 – behaviour, discipline, grievance etc.

We will also consider the Services planning and preparation for the 2026 Commonwealth Games and will produce a focussed report, in line with those published for previous events of this type.

4. Additional Update Information

Group Commander Lynne Gow, who was seconded to HMFSI, left the Inspectorate on 7 February 2025 to return to the SFRS. I would like to place on record my thanks to Lynne for all her efforts during her time with HMFSI, and to the Service for its continued support with regard to the secondment process.

HM Chief Inspector Robert Scott QFSM

Date: 24 March 2025

AUDIT AND RISK ASSURANCE COMMITTEE – ROLLING FORWARD PLAN

Agenda Item 18.1

	STANDING ITEMS	FOR INFORMATION ONLY	FOR SCRUTINY	FOR RECOMMENDATION	FOR DECISION
19 JUNE 2025	**ANNUAL PRIVATE MEETING WITH INTERNAL AUDIT**				
	• Chair's Welcome • Apologies • Consideration of and Decision of any items to be taken in Private • Declaration of Interests • Minutes of Previous Meeting • Action Log • Review of Actions • Forward Planning: Committee Forward Plan and Items to be considered at future IGF, Board and Strategy Days • Date of Next Meeting **HOT DEBRIEF**	**Standing/Regular Reports** • HMFSI Annual Report • HMFSI Action Plan Update **New Business** •	**Standing/Regular Reports** **Internal Audit** • Internal Audit Progress Report 2025/26 • Final reports: - TBC • Progress Update – Internal Audit Recommendations **External Audit** • • Internal Controls Updates - Strategic Risk Register - Anti Fraud/Whistleblowing • Gifts and Hospitality – Quarterly Update • SFRS Annual Governance Statement 2024/25 • Quarterly Performance report **New Business** • Annual FOI Compliance Rpt	**Standing/Regular Reports** • **New Business** •	**Standing/Regular Reports** • Committee Audit Annual Report 2024/25 to the Accountable Officer and Board (BB) **New Business** •
23 OCTOBER 2025	**ANNUAL PRIVATE MEETING WITH EXTERNAL AUDIT**				
	• Chair's Welcome • Apologies • Consideration of and Decision of any items to be taken in Private • Declaration of Interests • Minutes of Previous Meeting • Action Log	**Standing/Regular Reports** • HMFSI Quarterly Report • HMFSI Action Plan Update	**Standing/Regular Reports** **Internal Audit** • Internal Audit Progress Report 2025/26 • Progress Update – Internal Audit Recommendations **External Audit** • External Audit – 2024/25 Audit Plan Progress	**Standing/Regular Reports** • SFRS Draft Annual Report and Accounts 2024/25 (Private) **External Audit** • Private Session – Annual Report to Members and Auditor General for Scotland	**Standing/Regular Reports** •

AUDIT AND RISK ASSURANCE COMMITTEE – ROLLING FORWARD PLAN

	STANDING ITEMS	FOR INFORMATION ONLY	FOR SCRUTINY	FOR RECOMMENDATION	FOR DECISION
	• Review of Actions • Forward Planning: Committee Forward Plan and Items to be considered at future IGF, Board and Strategy Days • Date of Next Meeting **HOT DEBRIEF**	**New Business** •	Report • Internal Controls Updates - Strategic Risk Register - Anti Fraud/Whistleblowing • Gifts and Hospitality – Quarterly Update • Quarterly Performance report **New Business** •	• **New Business** •	**New Business** •
22 JANUARY 2026	• Chair's Welcome • Apologies • Consideration of and Decision of any items to be taken in Private • Declaration of Interests • Minutes of Previous Meeting • Action Log • Review of Actions • Forward Planning: Committee Forward Plan and Items to be considered at future IGF, Board and Strategy Days • Date of Next Meeting **HOT DEBRIEF**	**Standing/Regular Reports** • HMFSI Quarterly Report • HMFSI Action Plan Update	**Standing/Regular Reports** **Internal Audit** • Internal Audit Progress Report 2025/26 • Progress Update – Internal Audit Recommendations **External Audit** • • Internal Controls Updates - Strategic Risk Register - Anti Fraud/Whistleblowing • Gifts and Hospitality – Quarterly Update • Quarterly Performance report	**Standing/Regular Reports** **Internal Audit** • Draft Internal Audit Plan 2026/27 **External Audit** •	**Standing/Regular Reports**
		New Business	**New Business**	**New Business** •	**New Business** •