YORK AND NORTH YORKSHIRE COMBINED AUTHORITY – FIRE

Follow up

FINAL Internal Audit Report: 9.25/26

17 June 2026

OUTCOME OVERVIEW

Background:

We have undertaken a review to follow up on progress made to implement a sample the previously agreed management actions from the following audits:

- Credit Cards (1.25/26)
- Asset Management (7. 23/24)
- Gazetteer Patching Review (2. 22/23)
- Data Quality (4.24/25)
- Health and Safety (5.24/25)
- Follow Up (7.24/25)
- Estates Management (1.23/24)
- Security Framework (5.23/24)
- Misconduct (3.24/25)

The actions followed up in this review were 10 High and 15 Medium priority actions from the reviews noted above.

Headline findings:

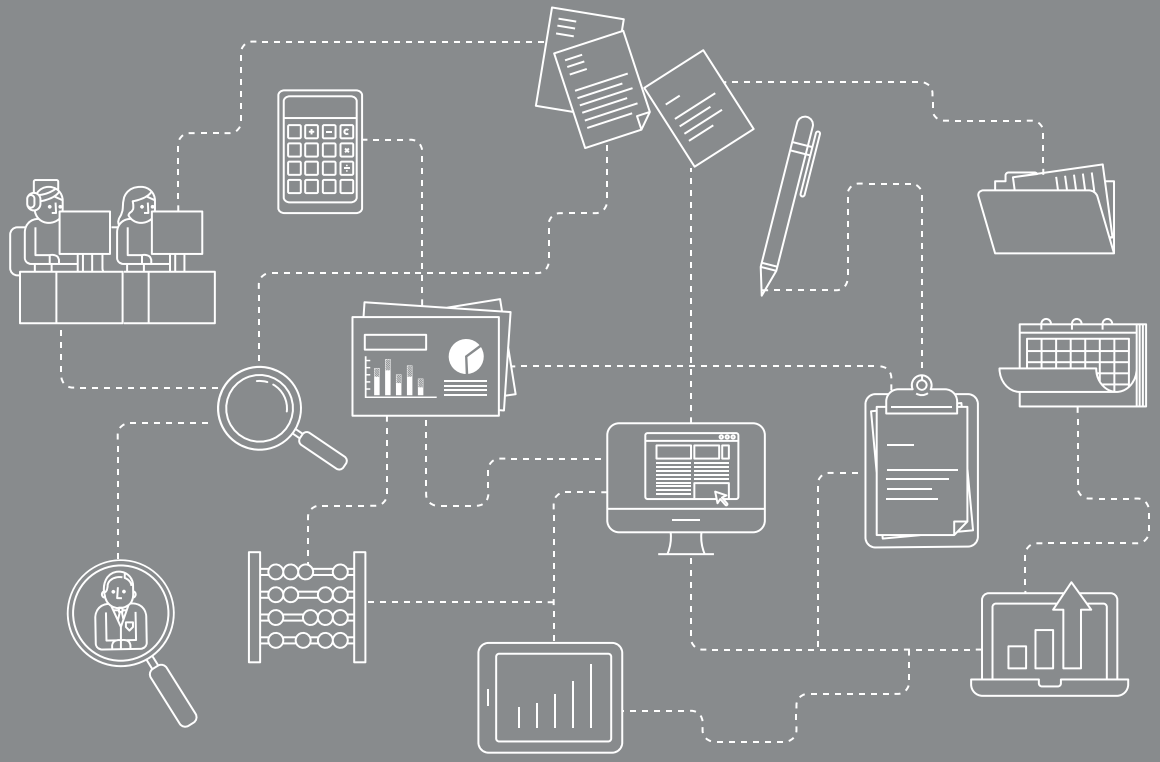
We were provided with satisfactory evidence in respect of 23 actions and therefore were able to confirm that these actions had been fully implemented and are listed in Appendix B.

The remaining two High priority actions we have categorised as partly, though not yet fully implemented, and based on the progress to date in mitigating the risks, we have reassessed both of the actions as medium priority. In the case of the Security Framework action, we split the agreed management action into two areas due to different ownership of each aspect of the response. We have also agreed an additional action regarding an analysis of our sample testing findings related to site inspections, where inconsistencies were identified. Details of the ongoing management actions can be found under section two of this report.

Taking account of these findings and in line with our definitions set out in Appendix A, in our opinion the Service has demonstrated **Reasonable Progress** in implementing the agreed management actions.

Progress on Actions

01

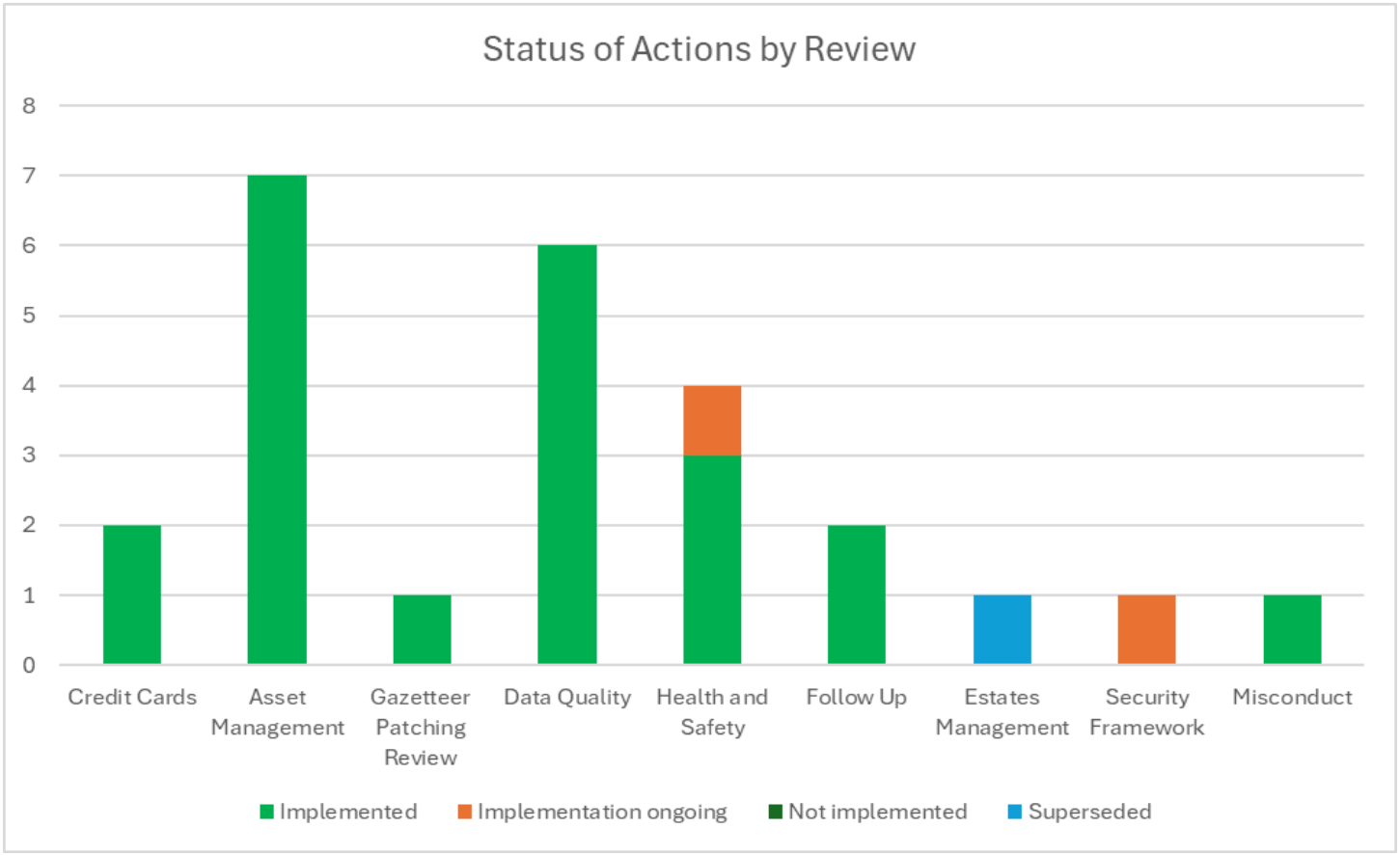


SUMMARY OF PROGRESS ON ACTIONS

The following table includes details of the status of each management action:

Implementation status by review	Number of actions followed up	Implemented	Implementation ongoing	Not implemented	Superseded	Not yet due
Credit Cards	2	2	0	0	0	0
Asset Management	7	7	0	0	0	0
Gazetteer Patching Review	1	1	0	0	0	0
Data Quality	6	6	0	0	0	0
Health and Safety	4	3	1	0	0	0
Follow Up	2	2	0	0	0	0
Estates Management	1	0	0	0	1	0
Security Framework	1	0	1	0	0	0
Misconduct	1	1	0	0	0	0
Total	**25***	**22**	**2**	**0**	**1**	**0**

*We have agreed an additional action which has not been included in this total.


Status of Actions by Review
8
7
6
5
4
3
2
1
0
Credit Cards
Asset Management
Gazetteer Patching Review
Data Quality
Health and Safety
Follow Up
Estates Management
Security Framework
Misconduct
Implemented
Implementation ongoing
Not implemented
Superseded

Findings and Actions

02

FINDINGS AND ACTIONS

Status	Detail
1	The entire action has been fully implemented.
2	The action has been partly though not yet fully implemented.
3	The action has not been implemented.
4	The action has been superseded.
5	The action is no longer applicable.

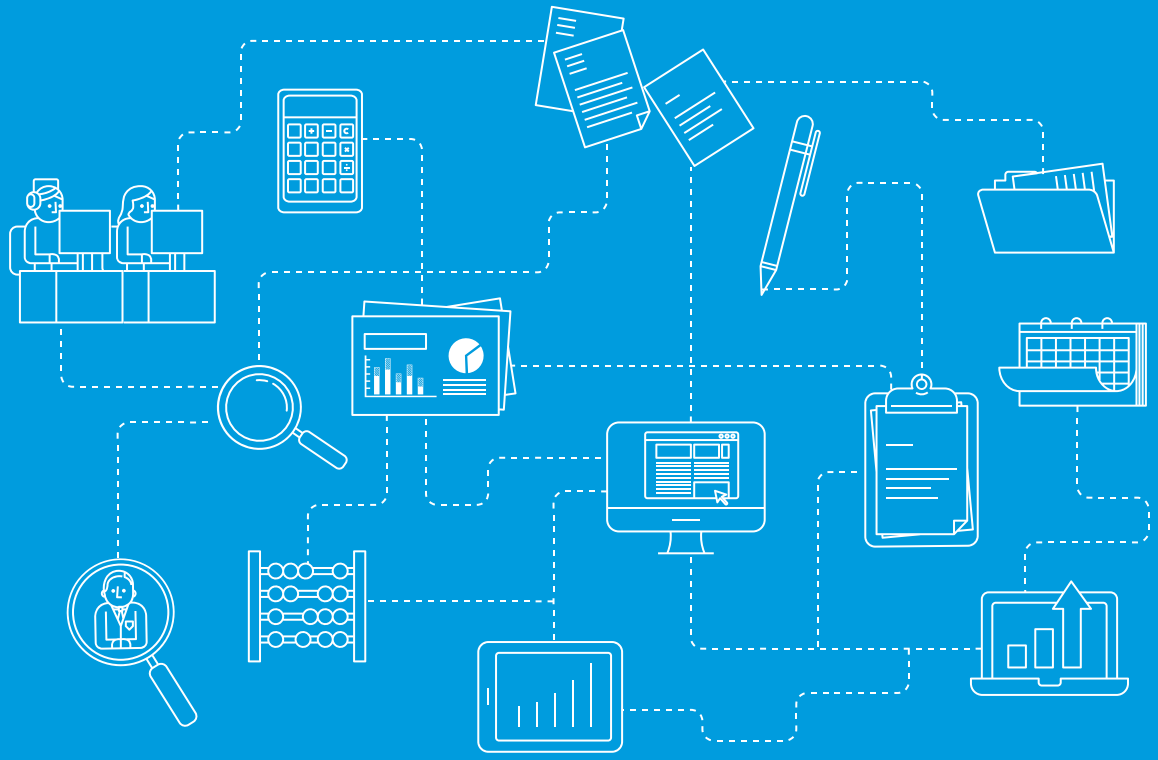
Assignment: Security Framework				
Original management action / priority	The Service will review the current accessibility options to all estates and ensure that the access options (for example, keys and contractor lock boxes) are changed or in adequate condition. Where budget allows, the Service may consider using an alternative access method across all estate sites, such as a digital lock or swipe card process, to minimise the risk of allowing staff members to make unauthorised copies of access equipment (such as keys). The Service will as a minimum introduce a regular review process of estates security to ensure keys or codes are updated on a regular basis. A frequent and periodic contractor safe box code change will be implemented across all sites, with a log of when each code has been changed. A leavers process will be implemented to ensure that when a member of staff exits the Service, any access options, such as keys and key cards, are returned. **(High)**			
Audit finding / status	We reviewed the Station Door Codes spreadsheet. The spreadsheet demonstrates that a review of codes and keypad access arrangements has been undertaken across a number of estate sites. We noted it contained a record of recent code changes, with dates mainly in January 2026. We reviewed the leavers process and noted it defines responsibilities for the return of any staff ID badges, keys, access passes etc. to a relevant receiving department. For a sample of five leavers, we received confirmation by the People Services Helpdesk Administrator that detailed that they no longer had FRS accounts. We also confirmed that as each staff member had been removed from the systems. Furthermore, we confirmed that only one barrier fob and been received back. However, we noted that physical access controls remained localised and so there was no central evidence held to provide assurance that any keys or access passes were returned. This provides a risk that stations across the Service could remain accessible by former employees. **The action has been partly though not yet fully implemented**			
Management Action	The Service will establish a central process for confirming that where applicable, keys and access passes are returned.	**Responsible Owner:** Deputy Director Support Services	**Date:** 30 November 2026	**Priority:** **Medium**
Management Action	As these issues link to physical access, the Service will evaluate whether a digital access method across all estates sites is viable to remove the need of manual tracking.	**Responsible Owner:** Director of Estates and Sustainability	**Date:** 30 November 2026	**Priority:** **Medium**

Assignment:	Health and Safety
Original management action / priority	Premises inspections will be completed at the required frequency and instances of non-compliance reported directly to the Health and Safety Committee for escalation. **(High)**
Audit finding / status	In reviewing the premises inspection log, we noted three locations where reviews had not been held in the last year. In each case, we were informed this related to a change of management which had resulted in more hands on support at those locations. Therefore, while we noted that a risk remains by these sites not having formal inspections, there was mitigation in the change of management leading to other means of ongoing oversight and support. Furthermore, we were provided minutes from the Health and Safety Committee that demonstrated that ongoing reporting is being shared at the meeting on these non-completion of visits to support oversight of the areas of increased risk. Our sample testing highlighted other discrepancies the Service will need to consider in strengthening this area, but given the progress made and greater oversight at locations that had not received inspections, we were satisfied that the risk level was reduced. **The action has been partly though not yet fully implemented** **Sample testing** We selected a sample of five stations inspection reports and noted the following: • all five of the reports contained sections that were wither blank or marked as non compliant without the corresponding risk score filled in. Failure to record risk scores on health and safety inspection reports creates a risk that hazards are not properly assessed, prioritised, or tracked, resulting in unrecorded risks remaining unmitigated. This increases the likelihood of control gaps going unidentified, potentially leading to harm to staff; • four of the five contained action plans. One of the five did not contain an action plan. This site included note under security and data protection that valuable and attractive items were visible, and sensitive documents were left out for others to see; • two of the five were not signed by the inspector. The remaining three were signed using typed text rather than a wet signature or e-signature tool. The absence of valid signatures undermines the authenticity of the records, increasing the risk that inspection reports have been formally reviewed and approved. This may lead to challenges from regulators or management over compliance; and • one of the five did not list the address of the station inspected. We reviewed a sample of three months (August, October and December 2025) HSSC meeting minutes and noted reporting of Causes for Concern, Near Misses and Adverse Incidents from the action log located on the HSSC Teams site. Two of the sample had reporting of issues raised to the committee. For the remaining three we noted the following: **Bentham Fire Station -** We reviewed the HSW1 health and safety inspection for Bentham Fire Station and noted a number of issues were identified, including an out of test fire extinguisher in the appliance bay rated as low risk, overdue portable appliance testing also rated as low risk, and unrestricted public access to the station due to scrap vehicles on site, which was assessed as a medium risk requiring fencing. Through review of the August, October and December 2025 Health and Safety Sub Committee minutes, we did not identify any reference to Bentham Fire Station or to the specific issues raised within

Assignment: Health and Safety				
	the inspection. As a result, HSW1 identified risks at Bentham Fire Station were not evidenced as having been formally escalated, reported, or monitored through HSSC governance arrangements. **Northallerton Fire Station -** We reviewed the HSW1 inspection for Northallerton Fire Station dated 26 June 2025 and noted that the sole issue raised was the absence of a recorded and evidenced annual fire evacuation drill, with an action raised to complete and formally record a drill, assessed as low risk. Through review of the Health and Safety Sub Committee minutes from August, October and December 2025, we noted that Northallerton Fire Station was referenced on a number of occasions in relation to other health and safety matters, including exhaust fumes extraction and air monitoring, ladder height and training risks, and appliance and equipment related concerns. However, the specific HSW1 inspection finding relating to the absence of a recorded evacuation drill was not explicitly referenced or tracked within the committee minutes, indicating that the inspection specific issue was not escalated through HSSC. **Masham Fire Station -** We reviewed the HSW1 inspection for Masham Fire Station dated 15 April 2025 and noted multiple issues were identified, including diesel exhaust emissions within the appliance bay with non compliant extraction arrangements assessed with a risk score of six, hygiene and cleanliness issues following station renovations, gaps in fire procedure and emergency lighting testing records, missing fire door and fire escape signage, absence of statutory health and safety and employer liability posters, and several estate related defects such as a cracked water pumping pit, loose overhead cabling, and damaged perimeter fencing. Through review of the August, October and December 2025 Health and Safety Sub Committee minutes, we did not identify any reference to Masham Fire Station or to the issues raised within the HSW1 inspection. Consequently, material health and safety risks identified at Masham Fire Station were not evidenced as being escalated, discussed, or subject to oversight within HSSC governance.			
Management Action	Premises inspections will be completed at the required frequency and instances of non-compliance reported directly to the Health and Safety Committee for escalation.	**Responsible Owner:** Health and Safety Manager	**Date:** 30 November 2026	**Priority:** Medium
Management Action	The outcomes of our sample testing will be reviewed and corrective measures taken. Lessons learned will be considered to strengthen future inspections.	**Responsible Owner:** Health and Safety Manager	**Date:** 30 November 2026	**Priority:** Medium

Appendices

03



APPENDIX A: DEFINITIONS FOR PROGRESS MADE

The following opinions are given on the progress made in implementing actions. This opinion relates solely to the implementation of those actions followed up and does not reflect an opinion on the entire control environment.

Progress in implementing actions	Overall number of actions fully implemented	Consideration of high priority actions	Consideration of medium priority actions	Consideration of low priority actions
Good	75% +	None outstanding.	None outstanding.	All low actions outstanding are in the process of being implemented.
Reasonable	51 – 75%	None outstanding.	75% of medium actions made are in the process of being implemented.	75% of low actions made are in the process of being implemented.
Little	30 – 50%	All high actions outstanding are in the process of being implemented.	50% of medium actions made are in the process of being implemented.	50% of low actions made are in the process of being implemented.
Poor	< 30%	Unsatisfactory progress has been made to implement high priority actions.	Unsatisfactory progress has been made to implement medium actions.	Unsatisfactory progress has been made to implement low actions.

APPENDIX B: ACTIONS COMPLETED OR SUPERSEDED

From the testing conducted during this review we have found the following actions to have been fully implemented and superseded. [Add testing detail if required by your client]

Assignment title	Management actions
Assignment: Credit Cards	**Implemented (High)** The policy will be reviewed and communicated to Credit Card users and Budget Holders asking that the policy is complied with in all respects including authorisation of claims. Budget Holders are responsible for authorising expenditure. Finance will undertake quarterly dip sampling to check for non-compliance with the policy. Any instances of non-compliance will be investigated.
	Implemented (Medium) The leavers process will be amended to include that People Services will notify Finance when an individual is leaving the Service. Once notified, Finance will immediately cancel the card and contact individuals to ask them to promptly return their card before their leave date, so it can be cancelled.
Assignment: Asset Management	**Implemented (Medium)** A copy of the Joint Strategic Asset Management Plan will be obtained and stored in a central location for staff to access. A supporting procedure document should be produced setting out how the Service should be maintaining assets, and those responsible.
	Implemented (Medium) The Service should ensure a clear stance regarding acceptance tests is agreed, and this should be communicated to all relevant individuals.
	Implemented (Medium) A central tracking process and log will be established to document all annual and six-monthly external maintenance tests, and ensure these are completed and in a timely manner.
	Implemented (Medium) Exception reports will be retained in a central location that is available to relevant staff members.
	Implemented (High) All Station Managers will be reminded of the importance of completing regular service and maintenance tests for all assets held within their station. As part of the reporting to the Service Delivery meeting, additional KPIs should also be included regarding the average length of overdue tests, and the number of tests that are currently outstanding and have exceeded their due date. The Service should continue to investigate the use of a dashboard to more easily identify non-compliance.
	Implemented (High)

	A process will be created on AMS to record and document the results of monthly reconciliations and approval from an appropriate individual. To support this, a monthly report should be run to identify areas of non-compliance.
	Implemented (High) For all equipment with an assigned end of life timeframe, a review will be undertaken to identify the date of their purchase and whether they are still in-date.
Assignment: Gazetteer Patching Review (Follow Up)	**Implemented (Medium)** EnableNY will ensure the outstanding minor updates are implemented to ensure that the system is up to date.
Assignment: Data Quality	**Implemented (Medium)** A Data Quality Policy or Strategy will be created, approved and made available to staff.
	Implemented (Medium) Roles and responsibilities will be agreed internally and formally documented. This document will be made available to staff to ensure they are aware and can identify those responsible for specific processes.
	Implemented (Medium) Core datasets will be identified, formally recorded, and responsible owners assigned to each. As part of the training that will be rolled out, additional consideration will be given to data owners to ensure that they are fully aware of their roles and responsibilities and how to effectively manage data quality.
	Implemented (Medium) Training will be rolled out to all relevant staff with refresher training provided on an ongoing basis following this.
	Implemented (Medium) An action plan will be produced setting out the Service's approach to managing data validation.
	Implemented (Medium) The Service will finalise the list of performance indicators and report on these on a regular basis.
Assignment: Health and Safety	**Implemented (Medium)** The Service will identify and record the largest risks associated with health and safety, document these on the operational risk register, and ensure they are appropriately managed and tracked.
	Implemented (Medium) Staff will be reminded that incidents must be reported within one day of occurring. Supervisors and managers will also be reminded that this is their responsibility if the staff member cannot submit the report (such as due to illness).
	Implemented (High) Mandatory training modules and IOSH courses must be completed by all staff. Further escalation routes will be considered to identify the best method for flagging continued non-compliance.
Assignment: Follow Up	**Implemented (Medium)** The Talent Acquisition Team will ensure a risk assessment is completed and approved as per the DBS Policy and Operating Procedure where an DBS check has not been completed prior to the employment start date.
	Implemented (High) The Service will finalise the process by which supplier dependencies will be monitored and reported.
Assignment: Estates Management	**Superseded (High)**

	The Service will ensure request for reactive maintenance work are approved in line delegated authority as documented in the scheme of authorisation. The Estates Team will ensure it retains approval of reactive maintenance work.
Assignment: Misconduct	**Implemented (High)** In accordance with management action 1 and any changes or streamlining of procedures, the Employee Relations Team should review how it ensures that all documentation is completed to ensure evidence is retained on file to fully support case progression. For example, the Employee Relations Team could implement an overarching tracker or checklist approach. A full reconciliation and audit of all cases dating back to April 2021 will be undertaken to confirm whether all associated supporting evidence is available and stored centrally. Learnings from audit findings will be communicated to the Employee Relations Team for future improvements. The Employee Relations Manager will consider how they ensure all documentation is retained on file for future cases, for example, regular dip sampling or checklists could be introduced.

APPENDIX C: SCOPE

The scope below is a copy of the original document issued.

Scope of the review

The internal audit assignment has been scoped to provide assurance on how York and North Yorkshire Combined Authority – Fire, manages the following area:

Objective of the risk under review
To meet internal auditing standards and to provide management with on-going assurance regarding implementation of management actions / recommendations.

When planning the audit, the following areas for consideration and limitations were agreed:

Areas for consideration:

- This review will examine the extent to which agreed management actions have been implemented.
- Testing will be performed as appropriate to confirm the implementation of agreed actions to manage risks identified as part of the initial fieldwork.
- Focus will be given to those management actions categorised as high and medium priority.
- Management assurances will be obtained for those management actions classified as low priority.

Limitations to the scope of the audit assignment:

- The review only covers the management actions stated and will not review the whole control framework. We are not providing assurance on the entire risk and control framework of the individual areas.
- We will provide assurance as to the implementation of recommendations arising from the assignments listed and any outstanding actions from prior years.
- Conclusions will be based on our assessments made through discussions with managers responsible for the implementation of management actions and where necessary evidence which demonstrates implementation.
- The level of implementation may be informed by sample testing.
- Further management actions may be raised based on sample testing. Where samples are required, records will be selected by the auditor from the time period.
- The results of our work are reliant on the quality and completeness of the information provided to us.

Our work will not provide an absolute assurance that material errors, loss or fraud do not exist.

Please note that the full scope of the audit can only be completed within the audit budget if all the requested information is made available at the start of the audit and the necessary key staff are available to assist the audit process. Delays in meeting our information requirements may lead to delays in any proposed timetable, which in turn

may cause us to incur additional costs; we reserve the right to raise a supplementary invoice for any such additional fees. We will notify you as soon as it is apparent that there are delays with meeting our information requirements and any consequent changes to the timetable.

To minimise the risk of data loss and to ensure data security of the information provided, we remind you that we only require the specific information requested. In instances where excess information is provided, this will be deleted, and the client sponsor will be informed.

Debrief held	N/A	**Internal audit Contacts**	Dan Harris, Partner and Head of Internal Audit
Draft report issued	2 June 2026		
Responses received	16 June 2026		Matthew Stacey, Managing Consultant
Final report issued	17 June 2026	**Client sponsor**	Director of Service Design and Delivery
		Distribution	Director of Service Design and Delivery

We are committed to delivering an excellent client experience every time we work with you. If you have any comments or suggestions on the quality of our service and would be happy to complete a short feedback questionnaire, please contact your RSM client manager or email admin.south.rm@rsmuk.com.

FOR FURTHER INFORMATION CONTACT

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