Suffolk Police and Crime Commissioner

Making Suffolk a safer place to live, work, travel and invest

ORIGINATOR: TIAA (INTERNAL AUDITORS)	**PAPER NO: AC22/16**

SUBMITTED TO: AUDIT COMMITTEE – 2 DECEMBER 2022

SUBJECT: SUMMARY INTERNAL CONTROLS ASSURANCE (SICA) REPORT 2022/23

SUMMARY:

1. The summary report provides an update on the progress of internal audit. The report is based on internal audit work carried out by TIAA and management representations that have been received during the period since the last progress report.

2. The follow up of internal audit recommendations undertaken by TIAA is undertaken throughout the year and reported to the Audit Committee during the year at each meeting.

RECOMMENDATION:

1. The Audit Committee is requested to consider the attached report.

Internal Audit

FINAL

Police and Crime Commissioner for Suffolk and Chief Constable of Suffolk Constabulary

Summary Internal Controls Assurance (SICA) Report

2022/23

November 2022

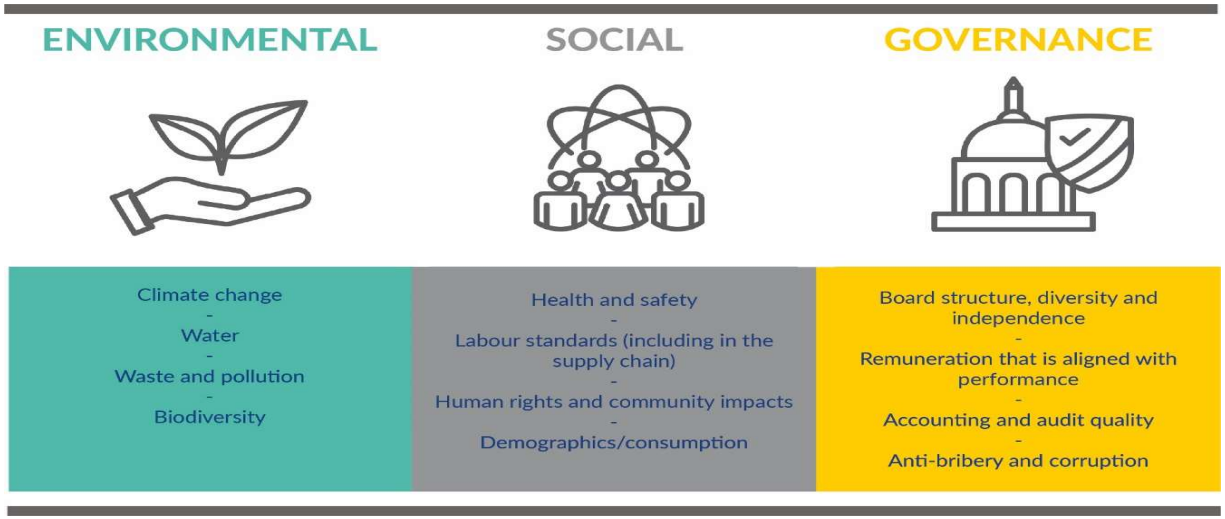
Summary Internal Controls Assurance

Introduction

1. This summary controls assurance report provides the Audit Committee with an update on the emerging Governance, Risk and Internal Control related issues and the progress of our work at Police and Crime Commissioner for Suffolk and Chief Constable of Suffolk Constabulary as at 22nd November 2022.

Emerging Governance, Risk and Internal Control Related Issues

2. Sustainability is becoming an ever more important consideration for organisations with the efforts of all sectors to reduce their emissions on a much bigger scale being integral to ensuring that global warming stays within the 1.5°C limit highlighted by the IPCC report and adopted by COP26. The increasing importance of Environmental, Social and Governance (ESG) objectives, as well as the introduction of reporting frameworks, both voluntary and mandatory, highlights the need for organisations to demonstrate greater transparency for their stakeholders. The need for strategic direction and the existence of risks and opportunities within ESG means that the Board and Audit Committee's role is integral in setting the ESG agenda.



Audits completed since the last SICA report to the Audit Committee

3. The table below sets out details of audits finalised since the previous meeting of the Audit Committee.

Audits completed since previous SICA report

		Number of Recommendations			
Review	**Evaluation**	**1**	**2**	**3**	**OEM**
Workplace Health	Reasonable	-	4	6	-
Complaints	Reasonable	-	3	4	2
PEQF	Reasonable	-	1	1	-

4. The Executive Summaries and the Management Action Plans for each of the finalised reviews are included at Appendix A. There are no issues arising from these findings which would require the annual Head of Audit Opinion to be qualified.

Progress against the 2021/22 and the 2022/23 Annual Plan

5. Our progress of work to date is set out in Appendix B.

Changes to the Annual Plan 2022/23

6. There have been no changes made to the 2022/23 internal audit plan.

Progress in actioning priority 1 & 2 recommendations

7. We have made no Priority 1 recommendations (i.e. fundamental control issue on which action should be taken immediately) since the previous SICA.. More information on overdue recommendations is provided in Appendix C.

Frauds/Irregularities

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

Other Matters

9. We have issued a number of briefing notes and fraud digests, shown in Appendix D, since the previous SICA report.

Responsibility/Disclaimer

10. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. The matters raised in this report not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Executive Summaries and Management Action Plans

The following Executive Summaries and Management Action Plans are included in this Appendix. Full copies of the reports are available to the Audit Committee on request. Where a review has a 'Limited' or 'No' Assurance assessment the full report has been presented to the Audit Committee and therefore is not included in this Appendix.

Review	Evaluation
Workplace Health	Reasonable
Complaints	Reasonable
PEQF	Reasonable

Executive Summary – Workplace Heath

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Failure to sustain an adequate and engaged workforce.

KEY STRATEGIC FINDINGS

The move towards automating processes for the management of staff referrals and surveillance programmes is progressing but current vacancies have led to some delays.

Key Performance Indicators should be introduced to help demonstrate the achievement of the department's objectives set out in the draft Workplace Health, Safety and Well-Being Strategy.

A review of the data available identified that there is some housekeeping to do to ensure that the information on the system is up to date and accurate, and to take advantage of the reports available within the system.

Updates in relation to the department's action plan and risk register are needed to demonstrate management's control over current priorities and resources.

GOOD PRACTICE IDENTIFIED

The OPAS-G2 system includes appropriate controls to ensure that consent is received before reports can be issued.

Testing of appointments found that there is appropriate sign off by the nurse or Force Medical Director.

SCOPE

The aim of the audit was to review the adequacy, effectiveness and efficiency of the workplace health system to establish if it is working effectively.

ACTION POINTS

Urgent	Important	Routine	Operational
0	4	6	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	Access to the OPAS-G2 system is limited to managers and Workplace Health department staff members. From discussion with the Workplace Health, Safety and Wellbeing (WHSW) Project Support Officer, controls to remove staff's access to the OPAS-G2 system automatically following leaver notification was thought to be in place, however a further check by the Project Support Officer found this not to be the case.	Weekly checks on leavers from the HR system, and OPAS-G2 user access be made to ensure that all leavers' access to OPAS-G2 is removed.	2	*This was a process that was originally thought to be part of the data import from OPAS. We are now working with HR Management Information team to obtain leaver information so this can be updated and form part of our leaver process. We will also work with Civica to explore if this is an automated process in the future.*	*01/09/22 for new process to be implemented* *01/11/22 for backlog of current leavers to be processed*	*WHSW Project Officer*
4	Directed	The department has an action plan which is split between the different Sections within Workplace Health, Safety and Wellbeing. This appears to be out of date and many of the actions are for review in February 2022.	The action plan for the department be updated, with renewed target dates for each action.	2	*Agreed.*	*19/09/22*	*Nurse Manager* *H&S Manager* *Wellbeing Manager*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
6	Directed	The department are in the process of transferring a number of records (held in spreadsheets) and surveillance programme procedures to the new system. One of the surveillance programmes is the Authorised Firearm Officers (AFOs), who are required to have a full medical every six years to ensure that they maintain their Firearm Certificate. Similar, work is being undertaken on insulin dependent drivers. At the time of the audit while there is an up to date (spreadsheet list), the member of staff inputting AFOs was unsure they had the current version for input.	A plan to populate the OPAS – G2 system with surveillance programme be put in place and completed. For the Authorised Firearm Officers, a check should be made against the Firearm Training Unit's system 'Chronicle' to ensure the department has the most up to date list of firearm officers.	2	*Agreed.*	*01/10/2022*	*WPH Nurse Manager in conjunction with WPH Technician*
10	Delivery	The People Board oversees the performance of HR departments including the Workplace Health, Safety and Wellbeing department. Performance reports for the last three meetings were provided which showed Workplace Health activity in respect of recruitment and management referrals. It was noted that there are no key performance indicators to set standards for delivery of the service and track workplace health improvements.	Key Performance Indicators be introduced to the department for monitoring and reporting adverse variances and trends to the People Board, along with reasons and actions to address shortfalls in performance.	2	*Agreed.*	*01/10/2022*	*Head of WHSW*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Wellbeing, Health and Safety Strategy is currently in draft. This is presented in three parts: the overarching departmental strategy, and two sections covering Wellbeing and Health & Safety. From discussion with Interim Head of Workplace Health, Safety and Wellbeing, the draft strategy needs to be reviewed and amended to ensure that it is a consistent format and style.	The draft Workplace Health Strategy be amended as necessary, and presented to the People Board for approval.	3	*Completed.*	*01/09/2022*	*Head of WHSW*
2	Directed	The department has a number of written procedures and protocol documents to help guide managers and staff when staff experience health issues which need addressing. It was noted that two of the procedures were either incomplete or needed a review and update (Cancer Guide for Managers, and Drug and Alcohol Protocol, respectively).	The written procedures for Cancer Guide for Managers and the Drug and Alcohol Protocol be reviewed, updated as necessary and approved. A system also be put in place to ensure the timely review and approval of procedures within the department.	3	*The Cancer Guide was replaced by the Macmillan Cancer and Work guides that are sent out to managers and colleagues as required.* *The department does have a review process for policies and procedures; due to staffing issues this hasn't been kept up to date, however this can now be rectified as staffing has improved.* *The Drug and Alcohol policy should be under the ownership of Professional Standards with an input on process from Workplace Health. Following discussions with PSD, they are still waiting for national guidance to be released before the local policy can be written.*	*N/A* *01/11/22*	*N/A* *WHSW Project Officer* *Head of PSD*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	Workplace Health risks are included within the HR department's risk register. These include: the use of manual files and potential lack of compliance with GDPR; Covid-19 related risks and Nurse capacity. Mitigations state that these are being managed. Actions being taken to mitigate these risks and their current risk levels are in need of review.	The risks associated with the Workplace Health, Safety and Well-being be updated to reflect improvements made in respect of manual files.	3	*Agreed.*	*01/10/22*	*Head of WHSW*
7	Directed	As well as 'live' status screens showing the number of management referrals, the OPAS-G2 system has a number of reports that the department can use to identify and follow up delays. It was noted from a download of management referral data, that there were 36 records that were stated as 'Pending'. There was also three records that were stated as 'Awaiting Review'. None of these had a name associated with these records. Department staff did not know what the status of these records meant.	The developers of the OPAS-G2 system be contacted to understand why records have a status of 'Pending' and 'Awaiting Review' status records and action taken to either update or close the records as appropriate.	3	*Developers have been contacted in relation to this and we are awaiting an update at our regular meetings.*	*06/09/22*	*WHSW Project Officer*
8	Directed	The department provides a Trauma Risk Management (TRiM) service. The Project Support Officer maintains a TRiM co-ordination spreadsheet where names of staff, and dates of Trauma incidents and the date the allocated practitioner are notified via Whatsapp. It was noted that there are several gaps in meeting dates within the spreadsheet.	The TRiM spreadsheet be updated to ascertain if risk assessment meetings took place, or to understand reasons why, if not.	3	*Two additional staff now in post who will be working through this as part of their weekly tasks.*	*05/09/22*	*Wellbeing Manager*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
9	Directed	It was noted from the management referrals data download, that there were 44 records with referrals dating back more than three months, and in some cases, to April 2021, with status denoted as 'OH - Initial Consultation' (which means that these are waiting for the initial consultation). Five of the oldest cases were investigated as to why they were still open. It was found that two records had no further information on them, and three where consent was requested but never provided by the employee. In accordance with a recent instruction from the Senior Nurse, these should have been closed.	All long standing 'Awaiting Consultation' records be reviewed and closed as necessary. In addition, where relevant, the department should consider surveying managers and staff to find out why either no further information or consent was provided, and why workplace health advice was no longer needed.	3	*Backlog of awaiting consultation records are being reviewed and will be completed.* *Moving forward, new processes should eliminate this issue as cases will be automatically closed.* *We will build in an automated email to the closing process so that we gather feedback as to why the case is no longer required.*	*01/11/22* *01/11/22* *01/09/22*	*WHSW Project Officer* *WH Nurse Manager* *WHSW Project Officer*

Executive Summary – Complaints

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Failure to deliver a good and safe service to the public and / or victims

KEY STRATEGIC FINDINGS

The Constabularies' Public Complaints Policy follows the latest Independent Office for Police Complaints (IOPC) guidance. A recommendation has been made to include how the Constabularies should react to an anonymous complaint.

Both Constabularies have shown a decrease in the number of complaints recorded for 2021/22 compared to the previous year (20% decrease for Norfolk and an 8% decrease for Suffolk)

The systems and processes for complaints have controls and assurance mechanisms in place to ensure that required processes and standards are met. Current vacancies have meant timeliness of processes are less than desired.

Some data quality issues were identified during the course of the audit which have been addressed.

GOOD PRACTICE IDENTIFIED

The Professional Standards Department routinely publicises lesson learnt from public complaints.

The Department have intervention officers to address and resolve public complaints at the earliest opportunity.

SCOPE

The audit reviewed controls in place to ensure that complaints are investigated accordingly as per legislation.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	4	2

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Directed	A review of complaints data found that in 34 cases, the time between a complaint being received and recorded was over seven days, with a maximum difference being 100 days. Following a review of the exceptions highlighted by Internal Audit by the Complaints Management Unit (CMU), it was established that a number of the delays were for valid reasons, for example where additional information was needed, however, it was noted on 11 occasions there were delays in the Professional Standards Department (PSD) being notified by the area. In addition it was found that there were errors with the dates input (see recommendation 4).	A reminder be sent to all relevant area staff to ensure that complaint forms are sent to PSD without delay.	2	Accepted, reminder will be included in Learning Times for timely submission of PSD1 to CMU/PSD. Data errors addressed at recommendation 4.	*31/12/22*	Sgt – Service Improvement Team (SIT)
6	Directed	If Complainants are not satisfied with the outcome of their complaints, they can appeal to their appropriate Office for Police and Crime Commissioner (OPCC) who will review the decision made. If the OPCC agree with the complainant, they will notify PSD who will allocate and look to address. The PSD has 29 days to take action and write to the complainant. A test was undertaken on a sample of 14 cases where the OPCC made recommendations, to ensure that action had been undertaken within the 29 day timescale. The results were that two responses were not responded within the timescale, and were delayed due to administrative error or oversight.	A reminder be input to the Centurion system so that all appeal recommendations are addressed and signed off within the 29 day timescale.	2	*Accepted. Delays in appeals authorisation were due to unavailability of Appropriate Authority (AA). Lack of AA will be raised with SMT so that this can be addressed.*	*31/12/22*	Senior Complaints, Appeals & Policy Manager

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
7	Directed	During testing of the complaints appeal process, a systemic issue had been identified by the Complaints Manager where changes made to the outcome (from Service Acceptable to Service Unacceptable) over writes the original decision, and therefore the audit trail is lost. The storage of the original data would enable a useful management report to be produced to show the number of outcomes that have been changed following the appeal process (or for any other reason).	The developers of the Centurion system be requested to include an audit trail for outcome decisions which have been changed.	2	Accepted, the CMU Supervisor believes that this information can be transferred to a progress entry. Enquiries to be undertaken with FIS to identify how this information can be retrieved.	31/12/22	CMU Supervisor
1	Directed	It was noted that there is nothing within the Complaints policy which states how the complaint is to be treated if it is anonymous. The Complaints Manager stated that as the policy is formulated on the guidance provided by the Independent Office for Police Complaints (IOPC), this will need to be taken back to them for consideration.	A recommendation be made to the IOPC to provide standard guidance on the process and policy to be adopted if the complainant is anonymous.	3	Accepted, this Issue will be raised with the Oversight Liaison for consideration, as there is nothing in the guidance which covers this.	*31/01/23*	Complaints Manager
2	Directed	The CMU maintain an assessment sheet to record all complaints received and the outcome of the initial assessment. Assessment sheets for the period 1st January 2022 and 26th May 2022 were provided for the audit, there were 1,106 allegations made. The different sources of the complaints are shown in Tab 'Assessment Nos' with the majority of them being through ForceWeb. There were some minor omissions within the spreadsheet in that one complaint received did not have the name of the person logging the complaint (assessment	The assessment sheet be independently reviewed periodically and staff be reminded to complete all details.	3	Accepted, regular audits will be undertaken of data held on spreadsheet. Also, a reminder will be issued to staff about importance of data quality.	31/12/22	CMU Supervisor

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		no.747) and there were 22 complaints where there was no 'Force' stated.					
3	Directed	A check of access to the Centurion system found that there was one member of staff listed that was not within the PSD organisational structure chart, and one member of PSD staff who was not on the Centurion access list. Following discussion with the Complaints Manager, it was established that both members of staff were current members of PSD and therefore require access to the Centurion system.	Access to the Centurion system be amended so that all members of PSD have access and the PSD structure chart be updated to ensure that it includes all PSD members.	3	Accepted, the PSD structure chart to be assigned to the Service Improvement Unit to maintain. Going forward the PSD staff Access list for centurion to be subject to regular review and will be maintained by CMU Supervisor.	*31/12/22*	Sgt – Service Improvement Team and CMU Supervisor
4	Directed	Data Quality checks are undertaken via various processes, such as the QA review on closure of complaints undertaken by area officers; through the OPCC dip sample checks, and when quarterly reports are run for performance reports. It was noted from one of the complaints data reports provided as part of the audit, the date the complaint was received was before the date the complaint was made in six cases. Further date input errors were identified in respect of some of the 34 exceptions (highlighted in recommendation 5 above). It is acknowledged that all of these cases are current 'live' cases and have therefore as yet no been subjected to a quality check. The Complaints Manager stated that the specific errors identified have been corrected.	A periodic check be made to highlight and amend any obvious date errors within the Centurion system. This could either be with 'Live' records or following closure.	3	Accepted, the cases that were reviewed and the anomaly with the dates, where the logging and recorded dates pre-dated the complaint made date were typos. These typos have now been amended and updated. Processes are complex and can involve an initial triage and/or engagement by area and multiple complaints received from the same individual on multiple dates by different methods, it can be difficult to determine what dates should be entered on the system. The team try to be ethical data recording and this can sometimes throw up anomalies, such as those flagged.	*31/01/23*	CMU Supervisor

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
3	**ROUTINE**	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
					The cases flagged were all still live. They are subject to review as part of the closure process and any anomalies addressed. The guidance for logging and recording dates on centurion have been circulated to all CMU staff as a reminder (19/07/2022) Additional training to be provided to CMU staff on logging cases and file closure, to include quality assurance of data recorded going forward.		

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Directed	There is a suite of written procedures and process flow charts for complaints. There is also a list of all the documents and version numbers. It would be useful if the date of the version numbers was included in the list so that it can be seen at a glance if there are any particularly old processes that might need review.	Management consider adding a date column to the list of procedure documents to highlight out of date procedures.	This will be actioned. Our procedures include version control and I will ensure that dates are also added to the documents.
2	Delivery	Comprehensive PSD Performance Data Reports are produced Quarterly. The Quarterly Reports include data and graphs to show trends; analysis of reasons for the complaint and levels of seriousness; timeliness of complaints; and outcomes. It was noted that whilst the report includes timeliness of recording complaints after a complaint has been made, there is no target Key Performance Indicator (KPI) for achieving this; i.e. in percentage terms.	To consider including a desired percentage for achieving the target of recording complaints within two days after it has been made.	*The* SLT will consider this, we don't currently have a target set by the IOPC.

Executive Summary – PEQF

OVERALL ASSESSMENT

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

PEQF is not delivered and the

KEY STRATEGIC FINDINGS

Both Norfolk and Suffolk met their target for going live with the policing education qualifications framework (PEQF) in April 2022.

Both Norfolk and Suffolk had full cohorts of Degree Holder Entry Programme (DHEP) students when PEQF went live.

KPIs need to be agreed with Anglia Ruskin University (ARU) to help enable effective monitoring of the ARU contract.

An end of project report for PEQF needs to be produced.

GOOD PRACTICE IDENTIFIED

Arrangements are in place to support PEQF being business as usual.

A Positive Action team has been established, this helps support Norfolk and Suffolk being able to adopt a more targeted approach to recruitment.

SCOPE

Reviewed the systems and controls in place for ensuring appropriateness and readiness of the constabularies for PEQF.

ACTION POINTS

Urgent	Important	Routine	Operational
0	1	1	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	Plans are in place to monitor the performance of the contract with ARU, but these could be strengthened. A monthly performance meeting is held with ARU, and KPIs are in the process of being developed. Appropriate KPIs need to be developed to ensure that there is a means to monitor the performance of ARU.	KPIs to be agreed with ARU and performance against these to be formally monitored.	2	*Agreed, draft KPIs have been drawn up and these are in the process of being developed and formally agreed with ARU. Once these have been agreed monitoring against the KPIs will commence.*	*31/01/23*	*PEQF Project Lead*
1	Directed	An end of project report has not been produced, although it has been identified that there is a need to produce this. The report is needed, as it is used by project managers to evaluate how successful a project was and to identify any potential lessons to be learnt going forward.	An end of project report to be produced.	3	*Agreed, this will be produced.*	*31/01/23*	*PEQF Project Lead*

Progress against Annual Plan

Appendix B

2021/22 Plan

System	Planned Quarter	Current Status	Comments
Overtime	1	Final Report	
Transport Management - Maintenance, Repair, Disposal, Transport Stock	1	Final Report	
Dog Handling	1	Final Report	
Business Continuity	1	Final Report	
Joint Justice Services	1	Final Report	
Capital Programme	3	Final Report	
Shared Service Transaction Centre	1	Final Report	
Pension Administration	3	Final Report	
Risk Maturity and Development	4	Final Report	
Corporate and HR Policies	4	Final Report	
Procurement Strategy and Policy	4	Final Report	
Key Financials	4	Final Report	
Seized Monies Follow-up	4	Final Report	The days originally for the Transformation and Strategic Planning / Change audit were used to undertake the seized monies work

PEQF	4	Final Report	
Establishment, Capacity, Recruitment and Retention	4	Draft report stage	It was requested by management that the audit was moved until 2022/23.
Absence Management, with limited duties	4	Draft report stage	It was requested by management that the audit was moved until 2022/23.

2022/23 Plan

System	Planned Quarter	Current Status	Comments
Complaints	1	Final Report	
Workplace Health	1	Final Report	
Safeguarding	1	Draft Report	
Whistleblowing	2	Fieldwork commenced	
Use of Social Media	2	Fieldwork commenced	
Cyber Security	2	Fieldwork commenced	
Overtime and Additional Allowances	2	Planned start date agreed	Moved to Q4 at the request of management
Local procurement compliance including waivers	2	Planned start date agreed	Moved to Q4 at the request of management
Vetting	3	Planned start date agreed	
Firearms Licensing	3	Planned start date agreed	
Resource Management Unit	3	Planned start date agreed	
Data Protection / Freedom of Information	3	Planned start date agreed	
Agile Working	3	Planned start date agreed	
Security of Seized Proceeds of Crime (Cash and Assets)	3	Planned start date agreed	

Performance Management	3	Planned start date agreed	
Change Management Programme	3	Planned start date agreed	
Succession Planning	4	Planned start date agreed	
Data Quality	4	Planned start date agreed	Audit carried forward from the 2021/22 audit plan at the request of management. Planned start date agreed for audit.
Commissioners Grants	4	Planned start date agreed	
Risk Management	4	Planned start date agreed	
Key Financials	4	Planned start date agreed	
ICT Strategy	3	Start date being arranged	
ICT Project Management – Support for New Projects	4	Start date being arranged	
Systems– ERP / Enact / DMS / Chronicle interfaces	4	Start date being arranged	Audit carried forward from the 2021/22 audit plan at the request of management. Planned start date agreed for audit.

KEY:

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

Internal Audit Recommendations - Progress update

Recommendations implemented since the last audit committee

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Comments
Vetting	MV clearances be reviewed on an annual basis, in accordance with the requirements of the APP.	2	*The draft APP July 2020 has now been circulated to all forces in anticipation of implementation December 2020/January 2021. The new APP states: "8.48.3 In addition to making disclosures after vetting clearance has been granted, individuals holding MV clearance should be subjected to review at least twice during the validity of the clearance. Any MV conducted in conjunction with SC or DV clearance must be subject of annual review alongside the review of the SC or DV i.e. it is not necessary to complete two reviews per year for MV/SC or MV/DV clearances. The remaining MV clearances will be reviewed and appropriate review dates set in future.*	*01/04/21*	*Head of Vetting*	*Additional resources have been recruited and the team are now at full establishment. Plans are in place to ensure that MV clearance is undertaken at the appropriate intervals.*
Workplace Health	Weekly checks on leavers from the HR system, and OPAS-G2 user access be made to ensure that all leavers' access to OPAS-G2 is removed.	2	*This was a process that was originally thought to be part of the data import from OPAS. We are now working with HR Management Information team to obtain leaver information so this can be updated and form part of our leaver process. We will also work with Civica to explore if this is an automated process in the future.*	*01/10/22*	*Head of WHSW*	*This has been completed. A new process has been adopted and in place to incorporate checking OPAS when individuals leave to ensure any access is removed.* *It has been confirmed that previous leavers checked and OPAS access has been removed.*
Workplace Health	A plan to populate the OPAS – G2 system with surveillance programme be put in place and completed. For the	2	*Agreed*	*01/10/22*	*Head of WHSW*	*This has been implemented a plan has been agreed, these checks are now part of the process.*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Comments
	Authorised Firearm Officers, a check should be made against the Firearm Training Unit's system 'Chronicle' to ensure the department has the most up to date list of firearm officers.					
Workplace Health	Key Performance Indicators be introduced to the department for monitoring and reporting adverse variances and trends to the People Board, along with reasons and actions to address shortfalls in performance.	2	*Agreed*	*01/10/22*	*Head of WHSW*	*This has been implemented. KPIs have been agreed, and reporting against the KPIs is now in place.*
Workplace Health	The action plan for the department be updated, with renewed target dates for each action.	2	*Agreed*	*19/09/22*	*Head of WHSW*	*This has been completed. It has been confirmed that the action plan has been updated.*
Workplace Health	All long standing 'Awaiting Consultation' records be reviewed and closed as necessary. In addition, where relevant, the department should consider surveying managers and staff to find out why either no further information or consent was provided, and why workplace	3	*Backlog of awaiting consultation records are being reviewed and will be completed. Moving forward, new processes should eliminate this issue as cases will be automatically closed. We will build in an automated email to the closing process so that we gather feedback as to why the case is no longer required.*	*01/10/22*	*Head of WHSW*	*This has been completed. It has been confirmed that all old cases have been cleared, and a new process has been adopted to prevent future re-occurrence.*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Comments
	health advice was no longer needed.					
Workplace Health	The risks associated with the Workplace Health, Safety and Well-being be updated to reflect improvements made in respect of manual files.	3	*Agreed.*	*01/10/22*	*Head of WHSW*	*This has been implemented, the risk has not been added.*
Workplace Health	The developers of the OPAS-G2 system be contacted to understand why records have a status of 'Pending' and 'Awaiting Review' status records and action taken to either update or close the records as appropriate.	3	*Developers have been contacted in relation to this and we are awaiting an update at our regular meetings.*	*06/09/22*	*Head of WHSW*	*This has been completed, the developers have been contacted and they are working on a solution to address the concern raised.*
Workplace Health	The TRiM spreadsheet be updated to ascertain if risk assessment meetings took place, or to understand reasons why, if not.	3	*Two additional staff now in post who will be working through this as part of their weekly tasks.*	*05/09/22*	*Head of WHSW*	*This has been completed, with the additional resources in post it has enabled the TRiM spreadsheet to be updated.*
Workplace Health	The draft Workplace Health Strategy be amended as necessary, and presented to the People Board for approval.	3	*Completed.*	*01/09/22*	*Head of WHSW*	*This has been completed, it has been confirmed that the workplace health strategy has been finalised.*

The following table lists the recommendations that are overdue;

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	Current status and latest update
Workplace Health	The written procedures for Cancer Guide for Managers and the Drug and Alcohol Protocol be reviewed, updated as necessary and approved. A system also be put in place to ensure the timely review and approval of procedures within the department.	3	*The Cancer Guide was replaced by the Macmillan Cancer and Work guides that are sent out to managers and colleagues as required. The department does have a review process for policies and procedures; due to staffing issues this hasn't been kept up to date, however this can now be rectified as staffing has improved. The Drug and Alcohol policy should be under the ownership of Professional Standards with an input on process from Workplace Health. Following discussions with PSD, they are still waiting for national guidance to be released before the local policy can be written.*	*01/11/22*	*30/04/23*	*Head of WHSW*	***Update 21st November 23*** *Still awaiting national guidance to be able to review and update the procedures.* *A revised due date has been requested for this recommendation.*
Procurement Strategy and Policy	A review be undertaken of the process for approving orders less than £50,000 where local signatories are unavailable.	3	*Agreed, a review will be undertaken, in the interim the Head of Commercial Support will continue to authorise so that orders are appropriately authorised. The Head of Shared Services Transaction Centre will consult with appropriate personnel to ensure that the expenditure is appropriate prior to authorising.*	*30/09/22*	*31/12/22*	*Head of Shared Services Transaction Centre*	***Update 21st October*** *A revised due date has been requested for this recommendation. This is a bigger job than first anticipated, and will be competed as part of the review of PO hierarchy that is planned.* *A revised due date of the 31st December has been requested*
Recruitment	A recruiting of police officer policy be produced and made accessible.	2	*The production of this policy remains a key priority, but the key dependencies (the introduction of PEQF and the OLEEO E-Recruitment System) remain*	*30/06/22*	*30/04/23*	*Head of Resourcing*	***Update 23rd November*** *The policy is being reviewed to take into account changes that are being brought in following the implementation of OLEEO. The Constabularies are implementing a*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	Current status and latest update
			outstanding. The Implementation Date therefore takes these into account.				*new recruitment system. The OLEEO project has only just commenced so currently in the process of defining what everything will look like when launched. The policy will need to go out for consultation and is scheduled to go to the March JNCC meeting for sign off.* *A revised due date was approved at the last audit committee.*
Recruitment	The recruiting of police staff policy be reviewed to ensure that it reflects current legislation.	2	*As stated within the finding, this has been delayed by the expected implementation of the new e-recruitment system. The review will take place as soon as implementation allows.*	*30/06/22*	*30/04/23*	*Head of Resourcing*	***Update 26th September*** *The policy is being reviewed to take into account changes that are being brought in following the implementation of OLEEO. The Constabularies are implementing a new recruitment system. The OLEEO project has only just commenced so currently in the process of defining what everything will look like when launched. The policy will need to go out for consultation and is scheduled to go to the March JNCC meeting for sign off.* *A revised due date was approved at the last audit committee.*
Seized Monies	Additional resilience be factored into the seized monies process after the monies have been banked.	2	*This post forms part of the Shared Service Transaction Centre (SSTC). The SSTC Governance Board has commenced Phase 3 of the SSTC business case to review the AP/AR/Supplies Teams (which includes seized monies) and this will be considered as part of this. This will be*	*30/09/22*	*30/04/23*	*Head of Shared Transactions Services*	*Work has commenced to address this recommendation. A recruitment process has commenced to recruit an additional staff member, but this was not successful, but in the interim an additional staff member in the finance team has been trained up.*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	Current status and latest update
			implemented as recommended by the 30th September 2022.				*A revised due date for the recommendation has been requested.*

The following table lists the recommendation that we are proposing to close as not able to implement

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Comments
Data Quality	Work needs to continue to get the automated match and merge function switched on in Athena to help address the potential number of duplicates in the system.	2	*Work is ongoing to develop the rules to enable automated match and merges to be undertaken, but with this being a national system it takes time for this to be addressed. Work is already ongoing to address this through the Athena Regional Group. It is hoped that the first stage of this will be delivered within the next 6 months. Delivery of this relies on the support of Northgate who are the external provider of Athena.*	*31/03/22*	*Records Manager*	*This is out of the control of Norfolk and Suffolk, as they are relying on an external provider to do this and required agreement from the other Athena Regional Group forces. There are no plans currently for the automated match and merge function to be switched on, as this is likely to increase data errors.* *Whilst the automated match and merge is not going to be switched on, the Norfolk and Suffolk inhouse data quality team for Athena will be undertaking manual data quality checks of potential duplicates.*

KEY:

Priority Gradings (1, 2 & 3)

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.

3	**ROUTINE**	Control issue on which action should be taken.

Briefings on developments in Governance, Risk and Control

TIAA produces regular briefing notes to summarise new developments in Governance, Risk, and Control which may have an impact on our clients. These are shared with clients and made available through our Online Client Portal. A summary list of those briefings issued in the last three months which may be of relevance to Police and Crime Commissioner for Suffolk and Chief Constable of Suffolk Constabulary is given below. Copies of briefing notes are available on request from your local TIAA team.

Summary of recent Client Briefing Notes (CBNs)

CBN Ref	Subject	Status	TIAA Comments
CBN-22019	Internal Audit: Untapped Potential		**Action Required: For Information Only** Audit Committees and Boards / Governing Bodies are advised to note the report.
CBN-22023	UK Government reveals new Data Protection rules		**Action Required: For Information Only** Audit Committees and Boards / Governing Bodies are advised to familiarise themselves with the response document in line with current Data Protection practices.
CBN-22024	ICO sets out revised approach to Public Sector enforcement		**Action Required: For Information Only** Audit Committees and Boards / Governing Bodies are advised to note this information.
CBN-22026	Rise in Environmental, Social and Governance and supply chain fraud		**For Information Only:** Audit Committees and Boards / Governing Bodies are advised to note the outcome of the survey **Link:** https://www.pwc.com/fraudsurvey
CBN-22030	Government Response – Consultation on extending National Fraud Initiative data matching to new purposes		**Action Required: No action required** For information only to Audit Committees and Boards/Governing Bodies.

CBN Ref	Subject	Status	TIAA Comments
CBN-22031	Five-year local authority audit procurement results announced.		**Action Required: For Information Only** Audit Committees and Boards / Governing Bodies are advised to familiarise themselves with the new guidance.