ORIGINATOR: TIAA (INTERNAL AUDITORS)

PAPER NO: AC23/03

SUBMITTED TO: AUDIT COMMITTEE – 31 MARCH 2023

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

tiaa

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

Summary Internal Controls Assurance (SICA) Report

2022/23

March 2023

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 the Police and Crime Commissioner for Suffolk and Chief Constable of Suffolk Constabulary as at 21st March 2023.

TIAA'S CONFORMANCE TO THE IIA STANDARDS AND CODES OF PRACTICE

2. TIAA Limited commissioned an External Quality Assessment (EQA) of its internal audit services in 2022. An EQA is required every five years, in line with the requirements of the International Professional Practices Framework (IPPF) and the Standards set by the Global Institute of Internal Auditors (IIA). The independent EQA considered our conformance with the IPPF and the Standards and also the Public Sector Internal Audit Standards (PSIAS), which govern internal audit in the public sector.

   Our independent EQA was undertaken by a senior partner at Chiene + Tait, a long-established and high-quality accountancy firm headquartered in Edinburgh with offices in Scotland and London. The review assessed TIAA's internal audit methodology and delivery against the Core Principles, the Code of Ethics and the Standards. It took into account our comprehensive framework, our guiding policies, organisational culture, planning and delivery, investment in our people, tools and techniques and our quality assurance framework, including feedback from clients.

   We are pleased to confirm that the independent EQA assessor was able to conclude that TIAA 'generally conforms to the requirements of the Public Sector Internal Audit Standards and the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF)'. 'Generally conforms' is the highest rating that can be achieved using the IIA's EQA assessment model. It was also noted that there were no areas of non-conformance or partial conformance with the Standards.

   TIAA was also complimented on the standard of documentation provided which enabled them to form a positive conclusion.

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**
Establishment Capacity, Recruitment and Retention	Reasonable	-	1	1	-
Absence Management, with limited duties	Reasonable	-	1	1	-
Performance Management	Substantial	-	7	-	-
Safeguarding	Reasonable	-	-	5	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 2022/23 Annual Plan

5. Our progress against the Annual Plan for 2022/23 is set out in Appendix B.

Changes to the Annual Plan 2022/23

6. There have been one change to the audit plan management have requested that the Security of Seized Proceeds of Crime (Cash and Assets) is undertaken in Q1 of 23/24.

Progress in actioning internal audit 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 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
Establishment Capacity, Recruitment and Retention	Reasonable
Absence Management, with limited duties	Reasonable
Performance Management	Substantial
Safeguarding	Reasonable

Executive Summary – Establishment, Capacity, Recruitment and Retention

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

REASONABLE ASSURANCE

SUBSTANTIAL ASSURANCE
REASONABLE ASSURANCE
LIMITED ASSURANCE
NO ASSURANCE

KEY STRATEGIC FINDINGS

Trajectory to be developed to support the resourcing team to be able to be multi-disciplinary and to be able to undertake police staff and police officers recruitment.

The recruitment of both the police officer and the police staff policies are currently under review. There are outstanding recommendations in relation to this.

Following the introduction of the new e-recruitment system targets to be put in place so that the time to recruit can be reduced.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

SR1 - Failure to sustain Norfolk Constabulary

SR1 - Failure to maintain operational performance levels (Suffolk)

GOOD PRACTICE IDENTIFIED

Necessary pre-employment checks had been undertaken prior to starters commencing employment.

A formalised process has been agreed for monitoring staff turnover this is included in the monthly Workforce Data Report.

SCOPE

The review considered decision making around the establishment, capacity, and changes to recruitment criteria, around the arrangements for advertising, shortlisting, interviewing and appointing staff/officers

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)
1	Directed	The resourcing team has been assigned to co-ordinate the recruitment process for both police officers and police staff. Centralisation of the recruitment process has been undertaken, which has seen the resourcing team responsible for both police officers and police staff recruitment. It is planned for the resourcing team to be multi-disciplinary and be able to undertake both police officers and police staff recruitment, but currently they are still in transition stage.	A trajectory to be developed to support the resourcing team to be multi-disciplinary and able to undertake both police officer and police staff recruitment	2	*Agreed, this will be developed. Regular updates will be provided to ensure appropriate progress is made.*	*30/06/23*	*Head of Resourcing*
2	Delivery	KPIs are not in place in relation to recruitment, but with the introduction of the new e-recruitment system targets to be put in place so that the time to recruit can be reduced.	KPIs to be developed for recruitment and progress against these formally monitored.	3	*Agreed, these will be agreed following development of e-recruitment system, Once agreed these will be formally communicated and a reporting process to monitor performance will be developed.*	*30/06/23*	*Head of Resourcing*

Executive Summary – Absence Management including Limited Duties

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

REASONABLE ASSURANCE

SUBSTANTIAL ASSURANCE
REASONABLE ASSURANCE
LIMITED ASSURANCE
NO ASSURANCE

KEY STRATEGIC FINDINGS

A formalised process to be developed which requires individuals to obtain approval to continue with any secondary employment whilst on sickness absence.

Attendance support meetings are not consistently being taking place at the appropriate intervals

Annual adjusted review meetings are not consistently being undertaken at the appropriate interval

Recuperative duties review meetings are not consistently being undertaken at the appropriate interval

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

The Suffolk Constabulary Strategic Risk Register under strategic risk number four, 'failure to deliver a good and safe service to the public and / or victims', refers to inadequate staffing levels'. And whilst the risk register refers to inadequate staffing levels, it does not make reference to staff sickness. The Norfolk Constabulary Strategic Risk Register incorporates staff sickness within strategic risk number one, 'Failure to sustain Norfolk Constabulary'.

GOOD PRACTICE IDENTIFIED

A standard sickness pack has been developed, this supports managers in monitoring and identifying of potential trends in sickness absence.

Reporting of officers on limited duties has been enhanced so that line managers are better informed of their staff on limited duties.

SCOPE

The objective of the review was to assess the adequacy, effectiveness and efficiency of the systems and controls in place for managing absence. The audit also reviewed the progress that is being made to strengthen the controls in place for managing of individuals on limited duties

ACTION POINTS

Urgent	Important	Routine	Operational
0	**7**	**0**	**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)
1	Directed	There is a Joint Sickness Management Policy in place, this covers both police officers and police staff. The Joint Sickness Management Policy is still an interim policy, as whilst it was approved by JNCC in March 2020 it is still awaiting sign off by legal, this is a concern as was approved over two years ago and is due to be reviewed March 2023. The Joint Sickness Management Policy is accessible to staff via the intranet.	Confirmation to be obtained from legal services as to when the Joint Sickness Management Policy will be reviewed by legal services.	2	*Agreed, this will be addressed and confirmation will be obtained from legal as to when this will be formally approved. The finalised policy will also be published.*	*31/03/23*	*HR Policy Manager*
2	Directed	There is a Joint Limited Duties Policy, this is currently being reviewed in accordance with the review cycle for policies. The policy has been designed to provide officers and their line managers guidance in dealing with situations where an officer has an injury, accident, illness, medical incident or condition which means that they cannot take on their full substantive role.	The limited duties policy to be finalised and made accessible to all.	2	*Agreed, this will be addressed. The policy is out for consultation. Once reviewed the policy will be made accessible.*	*30/06/23*	*HR Policy Manager*
3	Directed	There isn't any formalised guidance which requires individuals on sick leave to obtain approval to carry on secondary employment whilst on sick leave.	A formalised process to be developed which requires individuals to obtain approval to continue with any secondary employment, and the absence management policy to be updated accordingly to reflect this.	2	*Agreed, this will be addressed. Guidance will be developed and this will be communicated so that a consistent approach is adopted.*	*31/03/23*	*HR Policy Manager*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Directed	A sample of 20 sickness cases were reviewed to establish if the attendance support meetings were taking place at the appropriate interval. For the 20 cases selected to test it was found that there were five cases where the individuals had not had their attendance support meeting at the appropriate interval. For two of these five individuals, they were leaving and thus the attendance support meetings were not necessary.	Managers to be reminded of the need to undertake attendance support meetings at the appropriate interval.	2	*Agreed, this will be addressed. Reminders will be issued to managers on the appropriate process to be followed.*	*30/04/23*	*HR Improvement Manager*
5	Directed	Line managers are responsible for ensuring that attendance support meetings take place. Reports are not produced to identify attendance support meetings that are not taking place at the appropriate intervals.	HR to ensure that Line Managers undertake attendance support meetings at the appropriate interval.	2	*Agreed, this will be adopted*	*30/04/23*	*HR Improvement Manager*
6	Directed	A sample of 30 officers on limited duties were selected for testing, ten of these were on adjusted duties and 20 of these were on restrictive duties. It was found that of the ten officers that were on adjusted duties, six of these had not had their annual limited duties meeting.	The annual adjusted duties review meetings to take place at the required intervals.	2	*Agreed, a new process has been put in place and enhanced reporting has been developed which will flag officers that have not had their limited duties meeting. This process was not in place at the time of audit.*	*31/03/23*	*HR Improvement Manager*
7	Directed	Where an individual is on recuperative duties, standard recuperative meetings are expected to take place at designated intervals. The first recuperative duties meetings are expected to be undertaken 28 days after the individual goes on to recuperative duties, and then a second recuperative duties meeting after three months, a third recuperative duties meeting after six months, and a fourth	Recuperative duties meetings to take place at the appropriate interval.	2	*Agreed, a new process has been put in place and enhanced reporting has been developed which will flag when recuperative duties meetings have not taken place at the appropriate intervals.* *This process was not in place at the time of audit.*	*31/03/23*	*HR Improvement Manager*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		recuperative duties meeting after nine months and then an annual review meeting. For the 20 individuals on recuperative duties sampled, it was found that in all but four cases recuperative duties meetings had been held. Whilst for the other 16 cases, recuperative duties meetings had been held, but for 13 of these the recuperative duties meetings had not been held at the appropriate interval.					

Executive Summary – Performance Management

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

SUBSTANTIAL ASSURANCE

- SUBSTANTIAL ASSURANCE
- REASONABLE ASSURANCE
- LIMITED ASSURANCE
- NO ASSURANCE

KEY STRATEGIC FINDINGS

The Analytics and Insight department within the Strategic, Business and Operational Services (SBOS) department are responsible for production of performance.

The performance framework has been developed in-house. Norfolk and Suffolk are on version three of the performance framework.

A data quality dashboard is maintained, this is in part used to highlight data quality issues so that concerns can be identified. Work needs to continue to highlight the importance of raising data quality standards.

Terms of reference are agreed for all work requests that performance analysts are asked to undertake. There would be some benefit in the analysts being part of the scoping meeting to aid understanding in the work they are requested to undertake.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

For Norfolk this is covered under strategic risk number 8 and for Suffolk it is covered under strategic risk number 8.

GOOD PRACTICE IDENTIFIED

The Performance Framework has been developed in-house, this enables the performance framework to be tailored appropriately.

SCOPE

The review considered the way in which key performance data is collated to inform effective decision making, taking in to account the accuracy, integrity and consistency of data. The audit focus on the performance framework that is in place.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**0**	**2**	**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)
1	Directed	Data quality measures are in-built within the performance framework. In addition, a data quality dashboard is maintained, this is in part used to highlight data quality issues so that concerns can be identified. Data Quality continues to be an issue, a Data Quality Improvement Board has been established. The Data Quality Improvement Board is chaired by the Norfolk Assistant Chief Constable. The Data Quality Improvement Board has been tasked with ensuring that any legislation changes in relation to data quality are identified.	Work to continue to highlight the importance of data quality across both forces, and ensure there is a cultural change made which emphasises that everyone is responsible for data quality.	3	*Agreed, this will be addressed. Work will continue to raise the awareness of data quality.*	*30/06/23*	*T/Head of Analytics and Insight*
2	Directed	Terms of reference are agreed for all work requests that performance analysts are asked to undertake. Scoping of work is undertaken by the Performance Team Analysis Manager. There would be some benefit in the analysts being part of the scoping meeting to aid understanding in the work they are requested to undertake.	The performance analysts be included in the scoping meeting for work requests.	3	*Agreed, this will be adopted going forward.*	*30/04/23*	*T/Head of Analytics and Insight*

Executive Summary – Safeguarding

OVERALL ASSESSMENT

Adequate & effective governance, risk and control processes

REASONABLE ASSURANCE

SUBSTANTIAL ASSURANCE

REASONABLE ASSURANCE

LIMITED ASSURANCE

NO ASSURANCE

KEY STRATEGIC FINDINGS

There is an up-to-date Child Protection Policy in place. The Policy is in need of review to ensure that the training section reflects current practice.

Risks, resources and delivery of safeguarding the public are routinely monitored and reported to the Senior Management Team. A recommendation has been made to include progress on actions against the Constabulary's Section 11 self-assessment as part of its reporting process.

Developments are in place to enable better prioritisation of referrals to the MASH team. The feasibility of including screening (timescale) targets should also be considered.

Testing of Multi Agency Safeguarding Unit referrals found that the Child Protection Policy had been complied with. Two minor issues were identified in respect of the records maintained.

ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Failure to support victims and reduce vulnerability.

GOOD PRACTICE IDENTIFIED

Potential Child Protection risks are reported routinely through the Athena system and screened by the MASH team.

SCOPE

The objective of the audit was to determine if there are effective controls in place to meet statutory obligations in relation to Child Protection.

ACTION POINTS

Urgent	Important	Routine	Operational
0	**0**	**5**	**1**

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)
1	Directed	The Child Protection Policy includes the following wording at paragraph 3.6: *'All police officers and police staff who interact with the public, in whatever format, must undertake appropriate elements of the College of Policing (CoP) Public Protection Learning programme. Such training will give officers and staff an understanding of safeguarding issues and signs to be aware of, which may indicate a child is suffering, or is at risk of suffering, harm. This training is mandatory and compliance will be monitored by the Learning and Development Department'*. Discussion with the Head of Safeguarding confirmed that the wording needs to be reviewed to ensure that it reflects current working practices.	The Child Protection Policy be reviewed to ensure that the training and monitoring requirements reflect current practice.	3	*Appropriate wording to be agreed with L&D in order to reflect current practice and policy document then to be updated.*	*31/12/22*	*Safeguarding D/Supt*

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.

2	Directed	The Police are required under Section 11 of the Children Act 2004 to work in partnership with the Local Authority and other agencies. Within Norfolk, there is a local plan for Multi Agency Safeguarding Arrangements, this is signed by all partners within the Norfolk Safeguarding Children Partnership (NSCP). As part of the NSCP governance arrangements, the Constabulary is required to complete a Section 11 assessment of how it discharges its responsibilities in relation to the NCSP's priorities for safeguarding children. Evidence of this was provided, which shows that the Constabulary marked itself as achieving 54 out of 70 (77%) of the improvements needed, and has an action plan to address the improvements needed. The self-assessment is used as a development tool based on officers/staff's views of how they are progressing against the priorities set by the NSCP. The process is made more robust through a scrutiny panel before the assessment is finalised. Whilst updates are provided to the NCSP, progress against the action plan is not routinely monitored and reported within the Safeguarding and Investigations Command Unit itself.	Updates on the Section 11 self-assessment action plan be either reported periodically to the Senior Management Team (SMT), or updates be included as part of the standard SMT agenda.	3	*The Section 11 Action Plan is now a standing agenda item for the S&I SMT Meeting.*	*31/10/22 (complete)*	*Safeguarding D/Supt*

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)
3	Directed	The Child Protection Policy states: '*A child is anyone under 18 years, and can remain in police protection for a maximum of 72 hours. Children's Services must be contacted when a child is taken into police protection.* *The Children Act 1989 states that the Designated Officer must be at least of the rank of Inspector*'. It was found from sample testing within the Multi-Agency Safeguarding Hub (MASH) unit, that in all cases reviewed that an Inspector is informed, but in one instance there was no record of the time he was informed on the Computer Aided Dispatch (CAD) system or the Protection Record on Athena.	Officers be reminded of the need to record when the inspector was informed.	3	*Rather than a completely standalone message to remind officers about this very specific requirement it will be woven into a wider piece of work that is now underway around missing children.*	*28/02/23*	*Safeguarding DCI*
4	Directed	During sample testing of five protection orders within the MASH unit, it was found that in one instance no Child Protection Record or file could be found (case reference numbers: 53875/22 & 53971/22).	To investigate where the Protection Record is for the individual case identified within the audit.	3	*Tasked to the MASH DI for further research to be carried out.*	*31/12/22*	*MASH DI*

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)
5	Delivery	It was noted when comparing information provided in the May 2022 Performance Pack to the Tactical Assessment report that there is a slight difference in the data. For example, the total number of MACE referrals is 171 at the end of April, when the tactical report states 180. There is also some comparison's in the tactical report with 2021 figures which again does not agree. For instance, the Tactical Assessment Report states on slide 10 that Child Exploitation screen stats were 44 for April 2022 and 56 for April 2021. The Presentation Pack data report shows that the respective totals are 47 and 64.	The differences between the tactical information reported and SMT's performance data be investigated and a check be put in place to ensure there are no errors, or unexplained differences in future.	3	*Tasked to MACE DI to double check data recording processes.*	*31/12/22*	*MACE DI*

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	High risk referrals are dealt with on the same day, however there are no specific targets for screening medium or standard risk referrals. From discussion with the Detective Inspector, work is being done with IT to assist in prioritising those that are risk assessed as medium or standard. There is however no plan to include arbitrary target dates for these.	Management to consider the inclusion of turnaround targets for screening medium and standard risk rated CPI referrals to the MASH team.	*All CPIs will be reviewed as soon as possible but, due to the high volume of CPIs there will always be some in the workload. It is not felt that the addition of arbitrary turnaround times will add anything to the management of CPIs, which are already subject to daily scrutiny via the Daily Management Meeting.*

Progress against Annual Plan

System	Planned Quarter	Current Status	Comments
Complaints	1	Final Report	
Workplace Health	1	Final Report	
Safeguarding	1	Final Report	
Establishment, Capacity, Recruitment and Retention	2	Final Report	It was requested by management that the audit was moved until 2022/23.
Absence Management, with limited duties	2	Final Report	It was requested by management that the audit was moved until 2022/23.
Performance Management	3	Final Report	
Whistleblowing	2	Draft Report	Was undertaken in quarter 3
Use of Social Media	2	Draft Report	Was undertaken in quarter 3
Cyber Security	2	Draft Report	Was undertaken in quarter 3
Overtime and Additional Allowances	2	Draft Report	Was undertaken in quarter 4
Key Financials	4	Draft Report	Was undertaken in quarter 4
Local procurement compliance including waivers	2	Fieldwork in progress	Was moved to quarter 4 at the request of management
Risk Management	4	Fieldwork in progress	
Commissioners Grants	4	Fieldwork in progress	
Data Protection / Freedom of Information	4	Fieldwork in progress	

Agile Working	4	Fieldwork in progress	
Data Quality	4	Fieldwork in progress	
Resource Management Unit	4	Fieldwork in progress	
Firearms Licensing	4	Fieldwork in progress	
Vetting	2	Fieldwork in progress	Moved to Q4 at the request of management
Change Management Programme	4	Planned start date agreed	
Succession Planning	4	Planned start date agreed	
ICT Strategy	3	Start date being arranged	
ICT Project Management – Support for New Projects	4	Start date being arranged	
Security of Seized Proceeds of Crime (Cash and Assets)	4	Planned start date agreed	Delayed at request of management. It has been requested that this is undertaken in Q1 of 23/24 financial year.
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 update

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Progress
PEQF	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.*	*31/01/22*	*PEQF Project Lead*	*This has been addressed, KPIs are now in place, and these are being reported against.*
Safeguarding	Officer be reminded of the need to record when the inspector was informed.	3	*Rather than a completely standalone message to remind officers about this very specific requirement it will be woven into a wider piece of work that is now underway around missing children.*	*28/02/2023*	*Safeguarding DCI*	*The training provided to officers as part of the missing children piece of work covered the processes to be followed and emphasised the point of ensuring officers are aware that they need to record when the inspector is informed. Officers have been reminded of the importance of ensuring that all necessary fields are completed.*
Complaints	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.*	*31/01/22*	*Complaints Manager*	*This has been addressed, this has been flagged to the Oversight and Liaison for consideration.*
Complaints	A periodic check be made to highlight and amend any obvious date errors within the Centurion system. This	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.*	*31/01/22*	*CMU Supervisor*	*This has been addressed, random checks are now undertaken to ensure accuracy of information recorded. If issues are identified in the sample checks undertaken this will be*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Responsible Officer	Progress
	could either be with 'Live' records or following closure.		*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. 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.*			*raised with the individual and training will be provided to address.*

The following table lists the recommendations that are overdue;

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	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*	*01/11/22*	*30/04/23*	*Head of WHSW*	*Still awaiting national guidance to be able to review and update the procedures.* *A revised due date has been requested for this recommendation.*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	Latest update
			Workplace Health. Following discussions with PSD, they are still waiting for national guidance to be released before the local policy can be written.				
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*	*31/03/23*	*Head of Shared Services Transaction Centre*	*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.*
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 outstanding. The Implementation Date therefore takes these into account.*	*30/06/22*	*30/04/23*	*Head of Resourcing*	*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, and work is progressing to get addressed by revised due date.*
Recruitment	The recruiting of police staff policy be reviewed to ensure	2	*As stated within the finding, this has been delayed by the expected*	*30/06/22*	*30/04/23*	*Head of Resourcing*	*The policy is being reviewed to take into account changes that are being brought in*

Audit	Recommendation	Priority	Management Comments	Original Due Date	Revised Due Date (s)	Responsible Officer	Latest update
	that it reflects current legislation.		*implementation of the new e-recruitment system. The review will take place as soon as implementation allows.*				*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, and work is progressing to get addressed by revised due date*
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 implemented as recommended by the 30th September 2022.*	*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.* *A revised due date for the recommendation has been requested.*

KEY:

Priority Gradings (1 & 2)

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, Control and Anti-Crime 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 CBNs issued since the last audit committee which may be of relevance to the Police and Crime Commissioner for Suffolk and Chief Constable of Suffolk Constabulary is given below. Copies of any CBNs are available on request from your local TIAA team.

Summary of recent Client Briefing Notes (CBNs)

CBN Ref	Subject	Status	TIAA Comments
CBN-22032	Government Sets Out Plans to Protect Public Places from Terrorist Attacks		**Action Required: Urgent** Organisations should ensure they are aware of the new regulations regarding public safety and to review their existing emergency plans frequently.