OFFICE OF THE NORTHAMPTONSHIRE POLICE, FIRE AND CRIME COMMISSIONER
&
NORTHAMPTONSHIRE POLICE
&
NORTHAMPTONSHIRE COMMISSIONER FIRE AND RESCUE AUTHORITY

JOINT INDEPENDENT AUDIT COMMITTEE

5th October 2022 2022 10.00am to 1.00pm

Microsoft Teams virtual meeting

If you should have any queries in respect of this agenda, or would like to join the meeting please contact Kate Osborne 03000 111 222
Kate.Osborne@northantspfcc.gov.uk

Members of the public, with the permission of the Chair of the Committee, may ask questions of members of the Committee, or may address the Committee, on an item on the public part of the agenda.

Further details regarding the process for asking questions or making an address to the Committee are set out at the end of this agenda notice

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Public Meeting of the Joint Independent Audit Committee				Time
	Meeting between members and auditors			10:00-10:15
	Public meeting of the Joint Audit Committee			
1	Welcome and Apologies for non- attendance			10:15
2	Declarations of Interests			10:20
3 (pg5)	Meetings and Action log 27th July 2022	HK/KO	Reports	10.25
4a (pg13) 4b (pg34)	Internal Auditor Progress Reports PFCC & CC NCFRA	 Mazars JF	Reports	10.35
5 (pg 88)	Audit recommendations - implementation update PFCC and CC	MR	Reports	10.45
6a 6b	External Audit update 2020/21 and 2021/22 PFCC & CC NCFRA	EY	Verbal Verbal	11:00
7 (pg 129)	NFRS Fraud and Corruption: controls and processes	JO/ RP	Report	11:15
8 (pg136)	2023/24 Budget Plan and MTFP Process and plan update and timetable PFCC and CC and NCFRA	VA	Report	11.25
9 (pg 144)	Agenda Plan	KO	Report	
10	AOB	Chair	Verbal	
11	Confidential items – any	Chair	Verbal	
	Resolution to exclude the public	Chair	Verbal	
	Items for which the public be excluded from the meeting: In respect of the following items the Chair may move the resolution set out below on the grounds that if the public were present it would be likely that exempt information (information regarded as private for the purposes of the Local Government Act 1972) would be disclosed to them: *"That under Section 100A (4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that if the public were present it would be likely that exempt information under Part 1 of Schedule 12A of the Act of the descriptions against each item would be disclosed to them".*			
12 (pg147)	OPFCC Risk Register	PF	Reports	12.20
13 (pg 152)	Enabling Services Update	PB	Report	12.30
14	Future Meetings held in public: - 14th December 2022			

	- 15th March 2023 - 19th July 2023 - Future Workshops not held in public: - 14th September workshop – Police Accounts - 1st November Workshop – Fire Accounts			

Further details regarding the process for asking questions or making an address to the Committee

i. General

Members of the public, with the permission of the Chair of the Committee, may ask questions of members of the Committee, or may address the Committee, on an item on the public part of the agenda.

ii. Notice of questions and addresses

A question may only be asked or an address given if notice has been given by delivering it in writing or by electronic mail to the Monitoring Officer no later than noon two working days before the meeting.

Notice of questions or an address to the Committee should be sent to:

Kate Osborne
Office of the Police, Fire and Crime Commissioner
Darby House, Darby Close, Park Farm Industrial Estate,
Wellingborough. NN8 6GS

or by email to:
kate.osborne@northantspfcc.gov.uk

Each notice of a question must give the name and address of the questioner and must name the person to whom it is to be put, and the nature of the question to be asked. Each notice of an address must give the name and address of the persons who will address the meeting and the purpose of the address.

iii. Scope of questions and addresses

The Chair of the Committee may reject a question or address if it:

- Is not about a matter for which the Committee has a responsibility or which affects Northamptonshire;
- is defamatory, frivolous, offensive or vexatious;
- is substantially the same as a question which has been put or an address made by some other person at the same meeting of the Committee or at another meeting of the Committee in the past six months; or
- requires the disclosure of confidential or exempt information.

iv. Asking the question or making the address at the meeting

The Chair of the Committee will invite the questioner to put the question to the person named in the notice. Alternatively, the Chair of the Committee will invite an address to the Committee for a period not exceeding three minutes. Every question must be put and answered without discussion but the person to whom the question has been put may decline to answer it or deal with it by a written answer. Every address must be made without discussion.

v. The Chair and Members of the Committee are:

Mrs A Battom (Chair of the Committee)

Mr J Holman

Mrs E Watson

Ms A Bruce

1 vacancy for a JIAC member

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Agenda Item : 3

Joint Independent Audit Committee (JIAC) ACTION LOG –27th July 2022

Attendees: Members: Ann Battom (AB), John Holman (JH), Edith Watson (EW), Alicia Bruce (ABR)

Helen King (HK), Kate Osborne (KO), Vaughan Ashcroft (VA), Julie Oliver NCFRA Officer (JO), Jacinta Fru (JF), Megan Roberts (MR), Neil Harris, EY (NH), Simon Nickless (SN), Nick Alexander (NA), Julie Kriek - EY (JK); Hussain Ghulam - EY (HG); Paul Bullen (PB)

Agenda	Issue	Actions	Comments/ actions
1	Welcome and apologies		Nicci Marzec (NM), Robin Porter (RP); Mick Stamper(MS); Nick Alexander (NA); Simon Blatchley (SB)
2	Declarations of Interests		None
3	Meeting Log and Actions – 9th March 2022	Action HK – circulate procurement updates	1. JIAC objectives agreed moving forwards. 2. Timescales – 3. Disaster recovery process – VA- yes plans in place – servers and cloud backup. MR – business continuity and risk recovery. 4. Limited assurance reports – JF – covered off in report by JO report 5. Audit plans – information and verbal update can be provided in meeting 6. JIAC workshop to be planned about JIAC workshop – pending todays discussion about benefits realisation. 7. See later in the agenda – MR – reassurance H&S 4.2 – health and safety is now complete. Follow up audit – 3 recommendations made – 1 outstanding. 8. HK – to email around about procurement updates.
4	JIAC annual report		1. AB presented report as a fair reflection of JIAC, members and activity and gives appropriate level of assurance from work undertaken. Provides objectives for next year 2. Any comments? 3. AB to present at Police and Crime plan in September 4. Formatting to be adjusted prior to panel meeting
5	Internal Auditor Progress Reports		1. A lot of papers included.

	PCC & CC NCFRA		2. Start of delivery 2022/23 – good start made. 1 final report (MINT closedown) and draft of report 4 released 3. Since report submitted – complaints management audit draft has been issued 4. Collaboration audit plan – first 3 fieldwork complete – quality review process taking place prior to draft audit released 5. Planning audit for other audits in progress 6. Performance management planning meeting august – scheduled October. 7. Questions – cyber security – limited assurance – GIRR certificate due by end of May – happen? – PB – now being replaced by government by new process – PB has inherited ownership, IT health check in progress. We are a pilot force for new system – new ISO is linked to national pilot. 8. Benefits realisation date – achieved – in agenda – force governance was signed off by that date. MR – purpose of future reporting – wont complete action until process is fully embedded. 9. Health and safety – pg 46 – priorities – JH are they the same outstanding priorities as previous (21/22) audit - - ML – health and safety policy audit and issue with change of staff and locating documents. But same priority as last time. 10. Cyber security 48 – JH – response timescale May 2023 – acceptable if priority 1 – ML – due to nature of accreditation and level of work required. 11. New finance system recommendations – AB should this priority 1 or 2? – ML – it is a priority 2. Core financials audit may impact on this. the controls of the new system are replicated so there could be teething issues in new system. HK – keen to have audit piece of work on opening balances – to reflect closing on old and opening on new system. VA – pleased with the controls set up but aware that new system testing may test those controls – doesn't guarantee a flawless financial audit. 12. Progress update for Q1 – not much to report. Show assurance there is progress on carried forward audits (completed to final stage). 2 audits begun 2022/23 plan. We are also bringing some audits forward to ensure completed within contract. 13. AB – pleased to see CFR are done and are all good. HK - No full audits are brought to committee.
6a	Year end reports PCC & CC		**1.** ML – pleased to bring annual report. Paper summarises year work and highlights any changes made to year plan. Summarised on pg 68 **2.** Impact on risk landscape as a result of covid. **3.** Bench marking JH – how do we compare with other organisations? – ML – we could benchmark against other forces in regions – however their plans are different, so this is not tended to be done.

6b	NCFRA		**4.** HK – audit plans are very unique to individual forces and although different forces may have the same theme, each force is likely to want a slightly different focus. ML - report where learning has been identified these are in full reports where there is a sector comparison section. **5.** MR share best practise at the East Midlands Risk and Business Continuity meetings. **6.** ML – the number of limited audit reports this year has reduced which is reflective of the overall audit opinion. **7.** AB – audit days – fleet management – is that deferred? – ML is in this years plan or q1 of following year – dependant upon new system in place. Procurement was covered in governance. **8.** JF - Opinion this year is satisfactory – number of limited assurance reports has gone down, but we are looking at general environment controls this has led to the satisfactory but highlighting the positive direction of travel. **9.** There are some significant changes the organisation is facing and so the risk associated with that have to bear impact upon this. **10.** JF – demonstrated work completed. Pg 93 detail audits completed and assurance opinions and majority are good or satisfactory. **11.** Risk management – the authority is on the ball with that so it is deemed satisfactory **12.** HK - agree satisfactory is a fair assessment. This is the 3rd annual report from the team. They know us well and they have seen the progress, but we are improving year on year and progress is being made. It is the imbedding which is taking the time. **13.** EW – satisfactory – what would alarm you this time next year if not completed? – JF – some of IT systems issues and peoples strategy (focus on embedding) – hoping for action plans moving forwards. **14.** JH – pg 99 – under what circumstances would a rating not be awarded? – JF – not applicable (risk management review)? – because compliance couldn't be checked due to embedding and improvement plans. So opinion was given on strategy but no assessment could be given on compliance. This will be reviewed after implementation to ensure compliance. **15.** HK – no impact if no recommendations **16.** AB – "capacity issues with access to client staff" – JF – sickness of staff caused issues and workload issues prevented contact with audit team. AB – request phrasing of this shows more negativity than necessary **17.** AB – 5.3 fire accounts – "on schedule to be produced with statutory timescales" – HK – yes they are published

7	Audit implementation update NFRS		1. JO presented report and asked for questions 2. AB- clarification – this is just for fire? – these previously were reported quarterly but they are now 9monthly. Hence the daunting report. 3. AB – positive now all 19/20 actions are complete. 4. AB – anything red – 1 – pg 103 – asset management and new date end of July – JO – policy went into TLT and approved and will be published imminently. 5. AB – "on schedule" – gives assurance – at what point would we know when the target is moved? – PB – as soon as we know it is not going to be met the target is moved. They are continuously reviewed and discussed. FEG, Risk assurance and other meetings. At least on Monthly basis. Can progress % be given?? 6. JH – if target is included – JIAC can assume target will be achieved. 7. JH – pg 103 – IT structured approached – what does this mean? – strategy and structured approach? – PB – policy and process which has been signed off where there wasn't one before. EW – how is this being monitored – PB – this is in progress. Governance structure is in place to have oversight on this. JO - related into new IVANTI system to enable monitoring to take place. 8. ABr – pg100 and 101 – moving dates due to realistic timescales – do you record them once they go over initial target dates, do they show as overdue? – JO – yes JO asks for new date and are assigned red until completed. Overall summary is on the overview report. 9. ABr – governance – FEG – what is FEG? – PB – most of actions are PB bag – they are reported from head of department through a scorecard. FEG – fire exec group – meets 6 weekly involving JO once per quarter – someone has to account for overdue actions. Service assurance board also picks up an element of this to provide assurance to Chief fire officer. HK – once per year the commissioner has report from CC and CFO on all audit activity of year and recommendations and status. And he picks out areas where he wants further investigations. PFCC – has identified ICT for forthcoming report. 10. AB – is there a diagram or list of meetings and governance and timeframe and terms? PB – not sure if what is available is current. JO they may be an overview but not into minute levels. 11. AB – end of month sign off. PFCC has suggested some changes so this document is pending. 12. JH – Redkite is this being used – yes but NOT for IT currently.
8 A	External Audit UPDATE	ACTION: Reserves strategy (paragraph 3.5) link to be sent from the panel reports	1. Financial statement for year end 2020/21 2. Progress 3. Number of areas concluded or final review processes 4. Constraints resulting in long-term sickness absences.

B	PFCC & CC CFRA		5. NH working closely with HK and VA to make progress. 6. Further issue external audit manager – Hussain – has resigned from EY and leaving end of July. So manager support is required before NH leaves EY on 9th September. 7. NH is to end audit before 9th September but this is currently carrying risk but this is being worked on to ensure right solutions are met. Working progress. Appropriate contingency plans will be in place should deadlines not be met. NH will keep in contact with HK and VA to keep updated on audits. 8. AB – appreciate honesty. HK – disappointing but don't want to shoot messenger. Requirement supporting vetted auditors. 9. EW – how are seniors reacting to this – what confidence we have for future? – NH – recent staff promotion and have full compliment of audit senior structure. However still a significant amount of work involved in bringing timeliness of reports. 10. Annual auditors report to replace letter 11. Information already contained in February – opinion is unqualified. Risk are consistent with prior year and audit plan 12. 140 – WGA not finished. Are aware there is an increase in the thresholds. This will not impact the authority. Cannot conclude until instructions are issues 13. Pension valuations – consistent with other audited bodies in that the actuaries estimates the 19 reports. Anything from period 9 to 10 data. Come year end the actuals will differ from actuals over reporting threshold. Because they were not material the authority decided not to adjust 14. 148 onwards – value for money – Good track record on savings and contributions to reserves. Most topical – 159 – audit fees - £65,000 – includes £25,000 additional fee scale fee. Response from Tony Redmond report. HK currently not agreed fee. PSAA have the power to overrule this. 15. Estimates, value for money commentary and COVID 16. JH – two highlighted areas – 1.) big saving 2.4 million – is it realistic saving. What is the impact of making the saving? 17. 2.) – reserve levels – don't seem particularly high. Is there a ratio between turnover and reserve? – 18. HK – MTFP – 2020 – savings at that particular time. Since taking on governance we have been vocal about funding for Northamptonshire Fire. As assessed by the police fire and crime panel – the authority has exceeded all the plans it set itself for the governance transfer. Feb 2022 – MTFP – shows much less of a gap in terms of efficiency savings – more realistically achievable and there are plans around this. 19. HMICFRS have also released a statement about the efficiencies of the organisation released today 27/07/22

			20. HK – reserves – reserves strategy is reviewed every February. Own criteria is set about level of reserves. We have never fallen foul of level of reserves taking into account HO stuff. ACTION: Reserves strategy (paragraph 3.5) link to be sent from the panel reports 21. AB – fees – there was a contracted level that was previously agreed. We have exercised the point of fees and will await PSAA 22. AB – good report and opinion and thanks to teams involved for all their hard work 23. AB – thanked NH for time and honesty in his service of JIAC and JIAC meetings and audits and audit content. And wish him best for the future.
9	Systems Implementation		1. Future systems – programme to exits MFSS and replace MFSS service and systems with new ones 2. Revision of what MFSS covered. 3. Good news – all of systems are live. MFSS due to be formally closed on 4th October 2022 4. Finance, HR, inventory – unit 4 – Live – gone pretty well – teams have adapted well. Feedback generally positive 5. Payroll – midland HR – positive move over – smooth transition – limited errors 6. Recruitment – live for 9months – Oleo – good example what we can do now in charge of own destiny. 7. Duty management – upgrade – gone smoothly. Officers seem not to have noticed a difference 8. Exiting LGSS for fire – timeline – end of this financial year for finance and HR – more work required regarding RedKite. 9. Payroll still planning for 1st April, recruitment 1st Jan live 10. Issues around leaving FireWatch. 11. VA - Recruitment has been an ongoing issue. 12. AB – exit from MFSS – impact of delays in audits and access to data – PB – MFSS management board have flagged this for consideration. Still a live risk. there isn't an option to extend contract so we are doing all we can do. HK - Nottinghamshire are in same position. Everything is being done to mitigate these risks. NH – nothing further to say – appropriate contingency plans are in place. 13. EW – have you got a lessons learned for the next set of work – PB – yes there is a list of lessons learned to be used from police implementation for fire implementation. Also lessons learned from MFSS experience, so we can share learning across partners.
10	Agenda Plan		1. AB – are we still going to hit the dates for workshops. HK – YES the workshops will provide an update. 2. February 2023 workshop to be decided.

			3. HK – update on internal audit recommendations used to be at every meeting – currently reporting annually. JIAC happy with this.
	AOB		KO announced she will be going on Maternity leave in October so there will be administration changes whilst she is off. The JIAC will be kept informed.
	Confidential items – any		
13	HMICFRS update – NFRS	ACTION :KO to circulate press release and link to report to JIAC members. – COMPLETED ACTION: members to let KO know if HMICFRS update is required at December JIAC	1. Fire service inspected December 2021 – Feb 2022. 2. See paper 3. Today report made public 4. 3 pillars – efficiency effectiveness and people 5. 4 grades currently given to fire – efficiency and effectiveness – graded Good. People – requires improvement. 6. improvement on previous years 7. concerns around diversity element of organisation. 8. ACTION :KO to circulate press release and link to report to JIAC members. 9. Will the news impact on the JIACs next years work 10. HMICFRS requirement at JIAC to be discussed outside meeting by members – to let KO know and agenda plan amendments once decision is made. Proposal December meeting
14	Benefits realisation		1. POLICE ONLY 2. Internal audit and HMIC flagged as area for improvement 3. PB – professionalising business change document – 21 changes – key bits – now make it so anything coming for decision has to go through the portfolio office. To ensure quality of papers, stakeholder management completed, benefits manager/ officer within the corporate development department to support this to ensure benefits tracked and benefits followed 4. Quarterly oversight on change group 5. Project closure reports 6. Force has supported all 21 recommendations 7. Already implemented process involving portfolio office. 8. If we follow process change benefits will improve.

			9. AB – 21 recommendations to following audit reports – we aren't duplicating are we? Include anything from internal audit. A lot of 21 recommendations around change management done right. 10. AB – what happens to any project that were in existence that didn't go through portfolio office? – PB – inevitably – have similar but different focus team that overlap that have been captured to get order. If they are big enough and significant enough they are being moved to oversight group 11. AB – skills of staff? Is there a training need? – PB yes – portfolio office are business change experts so there is a scalability and will be project managed but can also offer advice and guidance. 12. AB – looking at benefits is that the same as outcomes? – how are you classifying benefits? PB – not just financial we are trying to make it about efficiency, effectiveness, service delivery, timesaving – so there is a mix between finance etc. 13. ML – benefits – SMART assessment.

Police, Fire & Crime Commissioner for Northamptonshire & Northamptonshire Police

Internal Audit Progress Report

Presented to JIAC: 5th October 2022

mazars

Contents

mazars

01 Summary

The purpose of this report is to update the Joint Independent Audit Committee (JIAC) as to the progress in respect of the Operational Plan for 31st March 2023, which was considered and approved by the JIAC at its meeting on 9th March 2022.

The Police, Fire and Crime Commissioner and Chief Constable are responsible for ensuring that the organisations have proper internal control and management systems in place. In order to do this, they must obtain assurance on the effectiveness of those systems throughout the year and are required to make a statement on the effectiveness of internal control within their annual report and financial statements.

Internal audit provides the Police, Fire and Crime Commissioner and Chief Constable with an independent and objective opinion on governance, risk management and internal control and their effectiveness in achieving the organisation's agreed objectives. Internal audit also has an independent and objective advisory role to help line managers improve governance, risk management and internal control. The work of internal audit, culminating in our annual opinion, forms a part of the OPFCC and Force's overall assurance framework and assists in preparing an informed statement on internal control.

Responsibility for a sound system of internal control rests with the Police, Fire and Crime Commissioner and Chief Constable and work performed by internal audit should not be relied upon to identify all weaknesses which exist or all improvements which may be made. Effective implementation of our recommendations makes an important contribution to the maintenance of reliable systems of internal control and governance.

Internal audit should not be relied upon to identify fraud or irregularity, although our procedures are designed so that any material irregularity has a reasonable probability of discovery. Even sound systems of internal control will not necessarily be an effective safeguard against collusive fraud.

Our work is delivered is accordance with the Public Sector Internal Audit Standards (PSIAS).

02 Current progress

2022/2023

The delivery of the agreed 2022/23 Internal Audit Plan is progressing well and we are pleased to inform the committee that the final reports for Complaints Management and Released Under Investigation Follow Up have been issued. In addition, we have also issued the final reports in regard to three of the Collaboration Audits - EMCHRS L&D Governance, EMSOU – Business Continuity and EMSOU – Risk Management. See Appendix A3 for full details.

We have also been in touch with key contacts and have agreed dates confirmed in October to deliver the Core Financials and Positive Action & Recruitment Audits.

Per the last update to the committee the agreed 2022/23 Collaboration Audit Plan is progressing well with three final reports issued, the fieldwork for EMSOT Closedown and Digital Currency is taking place over September and the final audit of Performance Management is scheduled to take place in early October. See Appendix 4 for full details.

03 Performance

The following table details the Internal Audit Service performance for the year to date measured against the key performance indicators that were set out within Audit Charter.

2022/23

Number	Indicator	Criteria	Performance
1	Annual report provided to the JIAC	As agreed with the Client Officer	July 22
2	Annual Operational and Strategic Plans to the JIAC	As agreed with the Client Officer	Achieved (Mar 22)
3	Progress report to the JIAC	7 working days prior to meeting.	Achieved
4	Issue of draft report	Within 10 working days of completion of final exit meeting.	50% (3/6)
5	Issue of final report	Within 5 working days of agreement of responses.	83% (5/6)
6	Follow-up of priority one recommendations	90% within four months. 100% within six months.	Achieved
7	Follow-up of other recommendations	100% within 12 months of date of final report.	N/A
8	Audit Brief to auditee	At least 10 working days prior to commencement of fieldwork.	100% (8/8)
9	Customer satisfaction (measured by survey) Very Good, Good, Satisfactory, Poor, Very Poor	85% average satisfactory or above	100% (1/1) Very Good

A1 Plan overview

2022/2023

Audit area	Proposed Dates	Draft Report Date	Final Report Date	Target JIAC	Comments
MINT	Q1	May 22	May 22	July 22	Final Report Issued
RUI Follow Up	Q2	Jun 22	Sept 22	Oct 22	Final Report Issued
Complaints Management	Q2	Jul 22	Aug 22	Oct 22	Final Report Issued
Core Financials	Q3			Dec 22	Scheduled in Oct 22
Positive Action	Q3			Dec 22	Scheduled in Oct 22
Information Management (automated decision making)	Q4				
Risk Management	Q4				
Data Quality	Q3				
Estates Management	Q4				
MTFP	Q4				
Reasonable Adjustment	Q4				
Firearms Licensing	Q4				
IT Disaster Recovery	Q3				Scheduled in Dec 22

A2 Reporting Definitions

Definitions of Assurance Levels		
Assurance Level	**Adequacy of system design**	**Effectiveness of operating controls**
Significant Assurance:	There is a sound system of internal control designed to achieve the Organisation's objectives.	The control processes tested are being consistently applied.
Satisfactory Assurance:	While there is a basically sound system of internal control, there are weaknesses which put some of the Organisation's objectives at risk.	There is evidence that the level of non-compliance with some of the control processes may put some of the Organisation's objectives at risk.
Limited Assurance:	Weaknesses in the system of internal controls are such as to put the Organisation's objectives at risk.	The level of non-compliance puts the Organisation's objectives at risk.
No Assurance:	Control processes are generally weak leaving the processes/systems open to significant error or abuse.	Significant non-compliance with basic control processes leaves the processes/systems open to error or abuse.

Recommendation Priority	Description
1 (Fundamental)	Recommendations represent fundamental control weaknesses, which expose the Organisation to a high degree of unnecessary risk.
2 (Significant)	Recommendations represent significant control weaknesses which expose the Organisation to a moderate degree of unnecessary risk.
3 (Housekeeping)	Recommendations show areas where we have highlighted opportunities to implement a good or better practice, to improve efficiency or further reduce exposure to risk.

A3 Summary of Reports

Below we provide brief outlines of the work carried out, a summary of our key findings raised, and the assurance opinions given in respect of the final reports issued since the last progress report in respect of the **2022/2023 plan.**

Released Under Investigation – Follow Up

Overall Assurance Opinion Aug 21	Limited
Overall Assurance Opinion Sep 22	Limited

Recommendation Priorities		
	Aug 21	**Sep 22**
Priority 1 (Fundamental)	1	1
Priority 2 (Significant)	2	-
Priority 3 (Housekeeping)	-	2

Our audit followed up on the original Audit completed in 2021/22 that had a limited assurance opinion with 1 fundamental recommendation and 2 significant recommendations. Our audit considered the following risks relating to the area under review:

Governance Arrangements

- There are effective governance arrangements in place for the processing of RUI that includes defined roles and responsibilities, senior oversight and reporting arrangements.
- There are clear terms of reference in place that support the governance of RUI processes and these are in line best practice.

Policies, Procedures and Training

- Policies and procedures are in place to ensure that individuals RUI'd are dealt with in accordance with relevant legislation and the Force's policies and procedures.
- Suitable training is provided to officers and staff to ensure that they are aware of requirements of individuals.
- Areas of weakness/skills shortage are identified in a timely manner and actions taken to ensure staff are capable of performing the expected procedures.

Processing of Individuals

- There is a mechanism for accurately recording individuals RUI'd and the appropriate information is collected for these individuals.
- Individuals are correctly processed and dealt with in accordance with the relevant legislative and procedural requirements.
- The RUI procedure meets the objective of ensuring that all individuals involved have been treated fairly, even if the outcome is not what they were seeking.

Risk Mitigation

- There are key performance indicators and internal targets in place for the RUI process.
- There are processes in place to review RUI cases to confirm they have been completed accurately and correctly.
- Robust performance information is produced that enables the Force and OPCC to effectively manage the RUI process and provide assurance that individuals are being dealt with correctly and in a timely manner.
- Areas of underperformance are identified and plans put in place to address these.

Previous Recommendations

- Previous audit recommendations have been implemented and are embedded in the control framework.

The objectives of our audit were to evaluate the adequacy and effectiveness of the Released Under Investigation system with a view to providing an opinion on the extent to which risks in this area are managed. In giving this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control. We are only able to provide an overall assessment on those aspects of the RUI process that we have tested or reviewed.

We have raised one priority 1 recommendation which is fundamental, the full details of the recommendation and management response are detailed below:

<table>
<tr><td>Recommendation 1 (Priority 1)</td><td>The Force should restart the review process for individuals that have been on RUI for longer than a year to ensure that the current backlog is significantly reduced.

The Force should actively monitor and report on the aged RUI's to ensure that the transfer of responsibility and ownership of the process for reducing longstanding RUI cases to individual Chief Inspectors is effective in reducing longstanding RUI's.</td></tr>
<tr><td>Finding</td><td>As per the previous review, it was identified that it was necessary to prevent longstanding RUIs due to the negative effects they may present to afflicted individuals, particularly for those in the course of undergoing employment or other vetting processes.

Below is a summary of the status of longstanding RUI's at the time of our audits.

<table><tr><th></th><th>RUI 1-2 Years</th><th>RUI > 2 Years</th></tr><tr><td>Apr 21</td><td>328</td><td>139</td></tr><tr><td>May 22</td><td>242</td><td>113</td></tr></table>
While it is acknowledged that this is a reduction of 26 and 86 respectively, since April 2021, this remains a large number of individuals RUI'd for extended lengths of time.

Despite the introduction of a review process for longstanding RUI cases and subsequent chasing by the respective Chief Inspectors, these have not been operating effectively to make substantial progress against the backlog. We were informed that this was in part as a result of the reviews no longer taking place due the time they require, in combination with a prevailing culture of Northamptonshire officers to assign RUI to cases as the default.

It is noted that steps are being taken to automate sections of the review process for longstanding RUIs which should assist with addressing the current backlog. This responsibility for review of such cases has been transferred to the relevant Chief Inspectors and their teams.

Risk: Individuals on longstanding RUI are not treated fairly and may present a risk of reputational damage to the Force.</td></tr>
<tr><td>Response</td><td>The force accepts this recommendation. The Aged RUIs will be reviewed twice yearly as part of the Senior Officer Review process to drive down the numbers. The numbers have been reducing gradually and the risk is not critical, so the 28-day review process is sufficient to manage the risk.</td></tr>
<tr><td>Responsibility / Timescale</td><td>The first audit will be within 3 months (December 2022)

D/Supt Rich Tomkins</td></tr>
</table>

In addition to the above we also raised two priority 3 recommendations of a more housekeeping nature:

- The Force should record the type of error as part of the RUI Concerns Spreadsheet. These recording of error types should be standardised as to allow for effective identification of common errors. Common errors should be utilised when designing future communications and training.
- The Force should ensure Officers complete NCALT Bail and RUI training in a timely manner.

Management accepted both recommendations with implementation dates of January 2023.

Complaints Management

Overall Assurance Opinion	Significant

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	1
Priority 3 (Housekeeping)	-

Our audit considered the following risks relating to the area under review:

Governance Arrangements

- There are effective governance arrangements in place for the investigation and resolution of complaints that includes defined roles and responsibilities, senior oversight and reporting arrangements.
- There are clear procedures in place that support the complaints handling process and these are in line with the Police Reform Act 2002, Police (Complaints & Misconduct) Regulations 2020, Police (Conduct) Regulations 2020 and any other relevant legislation and good practice.

Processing of Complaints & Appeals

- There is a mechanism for accurately recording complaints information and adequate information is collected from the complainants and these tasks are completing in a timely manner.
- Complaints are correctly assessed and dealt with in accordance with the relevant legislative and procedural requirements.
- The complaints management process meets the objective of addressing the concerns of the complainants and/or satisfies them that they have been listened to and treated fairly, even if the outcome is not what they were seeking. Moreover the communication with complainants is maintained in line with legislation.

Risk Mitigation

- There are key performance indicators and internal targets in place for the complaint's management process.
- There are processes in place to review closed complaints cases to confirm they have been completed accurately and correctly.
- Robust performance information is produced that enables the Force and OPFCC to effectively manage the complaints process and provide assurance that complaints have been handled in line with statutory requirements.

The objectives of our audit were to evaluate the adequacy and effectiveness of the Complaints Management systems with a view to providing an opinion on the extent to which risks in this area are managed. In giving this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control. We are only able to provide an overall assessment on those aspects of the Complaints Management process that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We raised one priory 2 significant recommendation. Full details of the recommendation and management response these are detailed below:

Recommendation 1 (Priority 2)	The PSD and Customer Service Team should undertake a regular reconciliation (e.g. monthly) of complaints forwarded and complaints received to ensure no complaints are misplaced.
Finding	Upon receipt of a complaint, the OPFCC Customer Service Team assess whether a complaint should be handled under Schedule 3 of the Police Reform Act 2002, and if so, it is passed onto the PSD for investigation via email. We found that in one case (complaint reference CO/99/22), the complaint had been received by the Customer Service Team and recorded as Schedule 3, however, according to the PSD Business Manager, it was not forwarded to the PSD. Due to this, it was not possible to determine whether the complaints process had been followed e.g. an acknowledgement sent to the complainant. It is noted that this was identified during the audit and the PSD have contacted the Customer Service Team to investigate the problem. During discussions the Customer Service Manager stated that the complaint had been forwarded on however it was not received by the PSD. *Risk:* Failure to forward complaints to the PSD leads to complaints not being investigated.
Response	While this appears to be a one off incident we are accepting of the audit findings and recommendation as this provides an additional layer of assurance. A process for a monthly reconciliation between complaints sent between OPFCC and PSD and received will be put into place.
Responsibility / Timescale	To be in place by 30th September 2022. Ownership for implementation and monitoring with OPFCC Customer Services Manager and PSD Business Manager

Collaboration – EMSLDH Governance

Overall Assurance Opinion	Significant

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	-
Priority 3 (Housekeeping)	2

EMSLDH is a specialist learning and development hub, which supports the transformation of professional policing practice. It consists of thematic leads for initial police learning and pathways into policing, crime and criminal justice, ICT and digital innovation. Since the original inception in 2013, namely East Midland Collaboration Human Resources Services Learning and Development (EMCHRS L&D), EMSLDH remains the largest police Learning and Development collaboration. The collaboration provides strategic learning and development support to Derbyshire, Leicestershire, Northamptonshire and Nottinghamshire.

Our audit considered the following risks relating to the area under review:

- There is a Section 22 agreement in place to deliver the EMSLDH that sets out, amongst other elements, the following:
  - Decision-making and governance framework;
  - Accountability;
  - Financial / funding;
  - Workforce arrangements;
  - Legal duties; and
  - Performance and reporting.
- The corporate governance framework is supported by policies and procedures, such as a decision making framework and scheme of delegation and that these are appropriately communicated and monitored for compliance.
- The governance forums within the collaboration unit have clear terms of reference, agendas, meeting minutes or action logs.
- The roles and responsibilities of senior officers and staff within the Collaboration unit are clearly defined, particularly regarding their decision making responsibilities.
- Decisions are made in accordance with the governance framework in a clear and transparent manner, supported by the appropriate levels of relevant and timely information.
- There is appropriate oversight and scrutiny of the collaboration unit performance by the Forces that make up the collaboration unit, including annual reports against the objectives set out in the unit's strategy/business plan.

We are only able to provide an overall assessment on those aspects of the EMSLDH Governance that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We are only able to provide an overall assessment on those aspects of the EMSLDH Governance process that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We raised two priory 3 recommendations of a housekeeping nature:

- EMSLDH should consider adding sections to the Section 22 Collaboration Agreement in respect of decision-making, legal duties, workforce arrangements, and performance and reporting where applicable.

- Decision-making responsibilities should be added to the EMSLDH Organisation Governance Chart for senior management.

Management agreed with the recommendations and timetable for implementation was November 2022.

Collaboration – EMSOU Business Continuity

Overall Assurance Opinion	Satisfactory

Recommendation Priorities	
Priority 1 (Fundamental)	1
Priority 2 (Significant)	-
Priority 3 (Housekeeping)	-

We have carried out a follow up audit of the EMSOU Business Continuity review conducted as part of the 2019/20 internal audit plan to confirm that previous recommendations for improvements to the control framework have been embedded

Our review considered the following risk areas:

- Recommendation raised in the 2019-20 Internal Audit Report have been addressed and embedded

Roles and Responsibilities

- Roles and responsibilities in respect of Business Continuity across the unit are clearly defined, with officers and staff having a full understanding and accountability for associated processes.

Policies and Procedures

- Effective policies and procedures are maintained and regularly reviewed to ensure a consistent and effective approach to Business Continuity is applied across the unit.
- There is clear identification of critical functions within the unit.

Plans

- There are effective Business Continuity Plans to ensure that incidents are effectively escalated and emergency action is mobilised where required.

Business Continuity Test Plans

- The Business Continuity Plans are subject to regular testing to ensure they remain fit for purpose

Continuous Improvement and Lessons Learnt

- The delivery of testing plans, associated outcomes and unplanned events is monitored with systems embedded to drive continuous improvement and lessons learnt. Where issues are identified these are appropriately escalated.

Monitoring and Reporting

- There is regular monitoring and reporting of business continuity processes and there is opportunity for effective challenge and scrutiny.

The objectives of our audit were to evaluate the adequacy and effectiveness of the business continuity arrangements with a view to providing an opinion on the extent to which risks in this area are managed. In giving this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control.

We are only able to provide an overall assessment on those aspects of the business continuity process that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We raised one priority 2 recommendation of a significant nature. Full details of the recommendation and management response are detailed below:

Recommendation 1 (Priority 2)	EMSOU should introduce a testing schedule whereby its business continuity plans will undergo regular testing.
Finding	From our testing, we noted that there was a lack of regular testing to ensure that the Business Continuity Plans remain fit for purpose. We found that there were plans for EMSOU to be included on the Nottinghamshire testing schedule for business continuity however, there have been significant delays in this being implemented. As per the previous recommendation 3.3, the lack of a testing schedule for business continuity plans was a previously identified weakness. *Risk: The Business Continuity Plans are not fit for purpose.*
Response	It was originally intended that EMSOU BC tests would fall within the Nottinghamshire Police calendar. However, due to workload this has not been possible. Going forward EMSOU will now set up its own testing calendar with assistance from Nottinghamshire Police. This will ensure that all areas of EMSOU business are routinely tested. Each HOD & the Head of Unit will be consulted during the testing calendar.
Responsibility / Timescale	Oct 22 BSU Manager

Collaboration – EMSOU Risk Management

Overall Assurance Opinion	Satisfactory

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	1
Priority 3 (Housekeeping)	1

The audit objectives are to provide assurance that:

- Procedures are in place to ensure that risks relating to the unit are identified; assessed; recorded; and, appropriate risk owners are assigned.
- Responsibility for risk, both in terms of supporting the overall risk management process across the unit and individual risk owners, is delegated and understood.
- Risks are managed, where appropriate, at all levels of service delivery:
    - Strategic
    - Operational
    - Contracts
    - Projects
- Risk registers are in place and are adequate and reasonable in terms of risk scoring, documented mitigation and action plans
- The risk register is subject to regular review and is updated in a timely and consistent manner.
- Risk mitigation actions are in place and there is evidence they are monitored to ensure tasks are completed within agreed timescales.
- Appropriate oversight and reporting arrangements are in place and are working effectively.
- Collaboration unit risk registers are aligned with individual Force registers, including how risks are escalated and reviewed, ensuring that duplication is minimised.
- The extent to which risk registers are routinely shared with Force risk managers in order to ensure there is awareness across the region of the risks collectively being faced and how those risks are being mitigated.

The objectives of our audit were to evaluate the adequacy and effectiveness of the Risk Management systems with a view to providing an opinion on the extent to which risks in this area are managed. In giving this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control.

We are only able to provide an overall assessment on those aspects of the Risk Management process that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We raised one priority 2 recommendation of a significant nature. Full details of the recommendation and management response are detailed below:

Recommendation 1 (Priority 2)	EMSOU should review its Risk Management policy and include additional detail to the policy about the process of the allocation of risk owners. The policy should also be updated to clearly state the risk registers that should be in place and how risk registers should be aligned across the unit. In addition, there should be greater detail added to the policy in regard to the process for the escalation of departmental risks.

Finding	We reviewed the risk management policy which was last reviewed in March 2021 by the Head of Finance and noted that this policy has not been reviewed in the recent 12 months. In addition, we found that the process for assigning risk owners is not explicitly outlined in the policy. Moreover, as referred to above it is unclear what the expectations is in regard to 'departmental risk registers' across the EMSOU Unit. Furthermore, it was noted that the process for the escalation of departmental risks could have greater clarity in the policy. *Risk: The Risk Management policy contains outdated information, and the process of allocating risk owners is not consistent across the unit.*
Response	A) The Risk Management Policy has now been updated to include the allocation of risk owner's procedure. See section 5.5 B) Section 1.3 has been added to the policy to identify which Risk Registers are required The escalation process is outlined in Section 7.2
Responsibility / Timescale	Complete

We also raised one priory 3 recommendation of a housekeeping nature which was in relation to the unit considering its risk appetite approach and therefore its target risk scores. Management accepted this recommendation and have held discussions around this although due to the five force makeup of the unit it was felt this was not practical to take forward.

A4 Collaboration Audit Plan 2022/23

Audit area	Forces	Status
EMSOT Closedown	Leics, Lincs, Northants	Fieldwork Underway
EMSLDH Governance	Derby, Leics, Northants, Notts	Final Report Issued
EMSOU - Business Continuity	Five Force	Final Report Issued
EMSOU Risk Management	Five Forces	Final Report Issued
Collaboration Performance Management	Five Forces	Scheduled for early October
Digital Currency	Five Forces	Fieldwork Underway

A5 Statement of Responsibility

We take responsibility to Northamptonshire Police and the Office of the Police, Fire and Crime Commissioner for Northamptonshire for this report which is prepared on the basis of the limitations set out below.

The responsibility for designing and maintaining a sound system of internal control and the prevention and detection of fraud and other irregularities rests with management, with internal audit providing a service to management to enable them to achieve this objective. Specifically, we assess the adequacy and effectiveness of the system of internal control arrangements implemented by management and perform sample testing on those controls in the period under review with a view to providing an opinion on the extent to which risks in this area are managed.

We plan our work in order to ensure that we have a reasonable expectation of detecting significant control weaknesses. However, our procedures alone should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify any circumstances of fraud or irregularity. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud.

The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of our work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices.

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AGENDA ITEM 4b
APPENDIX 1

Internal Audit and Counter-Fraud Progress Update – Q2

JACINTA FRU, CHIEF INTERNAL AUDITOR

05 October 2022

1 INTRODUCTION

1.1 This progress report provides stakeholders, including the Joint Internal Audit Committee, with a summary of the Fire Authority Internal Audit activity for the period 1 July 2022 – 16 September 2022.

1.2 **Annex A** (page 5) provides the background and context for how Governance is tested and evaluated.

1.3 The report summarises work done on evaluating the robustness of systems of control and governance in place during the current year. This report covers progress made on audits within the new plan year that have been started as well as audits brought forward from the previous financial year, where completion was affected by the ongoing impact of the pandemic on capacity.

2 PROGRESS AGAINST 2022/23 AUDIT PLAN

2.1 The key target for the Internal Audit Service is to complete the agreed Plan by the 31st March 2023. **Annex B** (page 9) shows progress made against the audit Plan 2022/23 including audits brought forward from the previous year. As at 16 September, 38% of the Plan was in progress or planning had been completed.

2.2 Progress on Planned Audits understandably slowed down during quarter two as a direct result of staff annual leave, both NCFRA and Audit staff. That said, planning work has been completed for all of quarter two audits which will ensure that testing and reporting can be accelerated during the period. There have been no changes to the Audit Plan, to report.

2.3 Plan Performance as at 16 September 2022:

NCFRA AUDIT PLAN 2022-23	**Number of Audits**			
	Plan	**Draft/Final Report**	**In Progress**	**Not Started**
Strategic Reviews	3	0	2	1
Operational Reviews	3	0	0	3
Key financial Reviews	4	0	1	3
ICT	2	0	2	0
Risk Management review	1	0	1	0
2021-22 Brought Forward Audits	3	3	0	0
TOTAL Audits	**16**	**3**	**6**	**7**
	100%	18%	38%	44%

Assurance ratings are given for both the adequacy of the System and compliance with the System of Controls. The definitions are detailed in Annex A and Annex B highlights the assurance levels for the reports completed and issued to management.

2.4 Since the last Committee meeting, no limited assurance opinions have been issued for reports completed.

2.5 The table below provides a precis of the objectives of the audits to be undertaken and the associated key risks.

Audit Area	Objectives and Risk
STRATEGIC • Corporate Governance Framework -Nolan Principles • Key Policies and Procedures – Safeguarding end to end review of policies and compliance. • Target Operating Model - Performance Monitoring Framework	**Objective(s)** To test and provide assurance on the strategic governance arrangements, that they clearly and formally record NCFRA organisational management **Risks(s)** Reputational Risks
OPERATIONAL SERVICES • Project Management Governance (key projects to be confirmed) • People & Culture Strategy Implementation: • Contract Management – review of monitoring of adequacy of supplier H&S arrangements.	**Objective(s)** To test and provide assurance for those key priority areas of operational performance / improvement. **Risk(s)** organisational objectives not achieved
KEY FINANCIAL SYSTEMS • Accounting systems (AP/AR) • Payroll • Budget Management • Financial Control Environment (G/L; Bank rec; TM; VAT; Pensions) Including new arrangements with the Police force.	**Objective** To provide assurance on the effectiveness of financial management procedures and arrangements to ensure the integrity of the financial statements. **Risk** Financial and Fraud risks
RISK MANAGEMENT	Review and testing of implementation of actions noted.

Audit Area	Objectives and Risk
Attendance at Strategic Risk Register Quarterly meetings. Provision of Risk workshops as requested	
ICT Systems Security – Cybersecurity arrangements: • Network infrastructure security • Privileged access control	**Objective** To provide assurance that IT systems and infrastructures are secure and that the arrangements to support business continuity are robust. **Risk(s)** Data protection and reputational risks

3 Counter Fraud Update

3.1 Fraud cases are risk assessed, to determine whether detailed investigations are merited or alternative options to progress matters are more appropriate. The MKC Counter fraud team have received no reactive referrals during the year to date.

3.2 The Cabinet Office has requested for data extracts to be uploaded, for the 2022/23 National Fraud Initiative exercise. The counter fraud team is co-ordinating collection and upload of necessary data from relevant Services.

4 External Assessment

4.1 Public Sector Internal Audit Standards (PSIAS) requires that compliance with its provisions is externally assessed every 5 years. The last review was completed in 2016, and confirmed the service complied with requirements. Annual self-assessments, consistent with PSIAS have also confirmed ongoing compliance.

4.2 The required 5 year external assessment of the effectiveness of the MKC Internal Audit function was completed in July 2022. The final Report is attached at **Appendix A**

4.3 The assessment concluded that the Service demonstrated "positive indications of direction and effectiveness of Internal Audit, in terms of the application of the 10 core principles" of Internal Audit. An action plan developed to address the recommendations for improvement arising from the review is detailed from Page 30 of the Report.

4.4 In terms of conformance with the specific Standards, the review noted

- 49 areas where the Service was assessed as **Generally conforming** with the Standards.
- 6 areas where the Service was assessed as **Partially conforms** with the Standards -actions needed to address these.
- 1 area where the Service was assessed as **Does not Conform** with the Standards – action needed to address this.

Annex A

Internal Audit Context and Background

How Controls are Audited and Evaluated

There are three elements to each internal audit review. Firstly, the CONTROL ENVIRONMENT is documented and assessed to determine how the governance is designed to deliver the service's objectives.

IA then needs to test whether COMPLIANCE is evident in practice.

Finally, IA undertakes further substantive testing and/or evaluation to determine the ORGANISATIONAL IMPACT of weaknesses found.

The tables below outline the criteria for assessing the above definitions:

Control Environment Assurance	
Assessed Level	**Definitions**
Substantial	Substantial governance measures are in place and give confidence that the control environment operates effectively.
Good	Governance measures are in place with only minor control weaknesses that present low risk to the control environment.
Satisfactory	Systems operate to a moderate level with some control weaknesses that present a medium risk to the control environment.
Limited	There are significant control weaknesses that present a high risk to the control environment.
No Assurance	There are fundamental control weaknesses that present an unacceptable level of risk to the control environment.

Compliance Assurance	
Assessed Level	**Definitions**
Substantial	Testing has proven that the control environment has operated as intended without exception.
Good	Testing has identified good compliance. Although some errors have been detected these were exceptional and acceptable.

Satisfactory	The control environment has mainly operated as intended although errors have been detected that should have been prevented / mitigated.
Limited	The control environment has not operated as intended. Significant errors have been detected and/or compliance levels unacceptable.
No Assurance	The control environment has fundamentally broken down and is open to significant error or abuse. The system of control is essentially absent.

Organisational Impact	
Level	Definitions
Major	The weaknesses identified during the review have left NCFRA open to significant risk. If the risk materialises it would have a major impact upon the organisation as a whole.
Moderate	The weaknesses identified during the review have left NCFRA open to medium risk. If the risk materialises it would have a moderate impact upon the organisation as a whole.
Minor	The weaknesses identified during the review have left NCFRA open to low risk. This could have a minor impact on the organisation as a whole.

* Audit progress is measured within several stages
  - Unstarted
  - Planning ToR
  - Fieldwork in Progress
  - Fieldwork complete
  - Draft Report
  - Final Report

Progress is assessed as a percentage of the whole audit

ANNEX B

2022/23 - Audit Plan for NCFRA as at 16 September 2022

AUDIT TITLE	STATUS	PROGRESS	Quarter Work Allocated	Assurance Rating System	Assurance Rating Compliance
Plan - 2021/22					
Payroll	Final Report	100% complete	Q1	Good	Good
Accounts Payable /Accounts receivable	Final Report	100% complete	Q1	Good	Good
Target operating - performance framework	Final Report	100% complete	Q1	Good	Good
Plan - 2022/23					
Key Policies and Procedures- Safeguarding	Planning	25% complete	Q2		
Financial Control Environment (G/L; Bank rec; TM; VAT; Pensions)	In progress (Q1 review complete)	25%	Q2-Q4		
Corporate Governance Framework -Nolan Principles	Planning	15%	~~Q3~~; Q2		
Project Management Governance (key projects to be confirmed)	Not Started	0%	Q3		
Budget Management	Not Started	0%	Q3;		
Payroll	Not Started	0%	Q3		
ICT Privilege Access controls	Planning- ToR	15%	~~Q3~~; Q2		
People & Culture Strategy Implementation	Not Started	0%	Q4		
Target Operating Model - Performance Monitoring Framework	Not Started	0%	Q4		

AUDIT TITLE	STATUS	PROGRESS	Quarter Work Allocated	Assurance Rating System	Compliance
Contract Management – review of monitoring of adequacy of supplier H&S arrangements.	Not Started	0%	Q4;		
Network infrastructure security	Planning ToR	15%%	~~Q4;~~ Q3		
Accounting systems (AP/AR)	Not Started	0%	Q4		
Risk Management review	Q1 completed	25%	Q1- Q4		

Milton Keynes Council

Internal Audit Services

External Quality Assessment

29th July 2022

By

Dr R Milford

Contents

Internal Audit Services External Quality Assessment Executive Summary

Introduction

The External Quality Assessment (EQA) has been undertaken by Milford Research and Consultancy following the agreed methodology as set out in the proposal. The EQA applied the 10 core principles of the Public Sector Internal Audit Standards (PSIAS) as the basis for interviews and documentation review.

The PSIAS core principles are use to underpin the EQA as they are recognised in the standards as the means to assess the 'Effectiveness' of the service – see below:
"Core Principles for the Professional Practice of Internal Auditing

The Core Principles, taken as a whole, articulate internal audit effectiveness. For an internal audit function to be considered effective, all Principles should be present and operating effectively. How an internal auditor, as well as an internal audit activity, demonstrates achievement of the Core Principles may be quite different from organisation to organisation, but failure to achieve any of the Principles would imply that an internal audit activity was not as effective as it could be in achieving internal audit's mission (see Mission of Internal Audit).

1. *Demonstrates integrity.*
2. *Demonstrates competence and due professional care.*
3. *Is objective and free from undue influence (independent).*
4. *Aligns with the strategies, objectives, and risks of the organisation.*
5. *Is appropriately positioned and adequately resourced.*
6. *Demonstrates quality and continuous improvement.*
7. *Communicates effectively.*
8. *Provides risk-based assurance.*
9. *Is insightful, proactive, and future-focused.*
10. *Promotes organisational improvement."*

Mission of Internal Audit

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

It should be noted here that the EQA was commissioned within 12 months of the service delivery method changing from a shared service delivery model to a fully in-house model. This has been taken into account when considering the aspects of the PSIAS that may have been adversely impacted by this change, but the 'principle' remained consistent and evidenced.

Overview of the EQA Result

For Milton Keynes Council Internal Audit Service we are able to report:

Positive indications of direction and effectiveness of internal audit in terms of the application of the core principles

A summary of the core principles is set out below:

1. *Demonstrates integrity.*
   This is clearly indicated and supported by the interviews with key stakeholders.

2. *Demonstrates competence and due professional care.*
   This is an area for improvement as such issues as Continual Professional Development were not consistent or clearly evidenced. Although it was recognised that the team included experienced auditors, there was limited numbers of current professional body memberships maintained and CPD activities undertaken.

3. *Is objective and free from undue influence (independent).*
   The Audit Charter and interview discussion indicate that the service has an appropriate range of reporting routes and independence to operate effectively. Furthermore, the service was able to demonstrate the objectiveness of the internal auditor was safeguarded and not compromised in work allocations.

4. *Aligns with the strategies, objectives, and risks of the organisation.*
   This is an area for improvement in terms of the alignment to strategic objectives for the organisation. The service was able to demonstrate the audit planned work covered 3 of the 4 aspects of the STOI levels (Strategic, Tactical, Operational and Individual). The longer focused aspects of the Council's strategic vision and objectives was not clearly supported by the audit plan.

5. *Is appropriately positioned and adequately resourced.*
   Given the implications arising from the change in service delivery model, this was regarded as a principle in "transition". The audit team clearly had sufficient experience to cover most aspects of the audit plan/Council's needs, but the new structure has introduced potential bottlenecks and resource pinch points that could reduce the effectiveness of the service. In particular, the new Audit Manager position is resourced by the only internal auditor with

recognised IT audit skills and identified as the lead on investigatory works, thus coupled with the audit management role could lead to this position being overstretched.
Furthermore, the service was limited in its ability to demonstrate succession planning from the more junior levels and routes to qualify professional internal auditors.
The IT systems used by the service for both Audit Management and Computer Aided Audit Techniques (CAATS) would also benefit from review to align with the new service delivery approach and also that the Audit Manager was the only individual able to use the CAATS.

6. *Demonstrates quality and continuous improvement.*
   Again, given the transition of the service at this stage it is difficult to comment on the "continuous improvement" element, but the manner by which this EQA has been supported highlights that the new in-house service wishes to work towards becoming a more effective service.
   In terms of the quality there were inconsistencies found in work practices and evidence of silo working approaches that could impact on the effectiveness of the service.

7. *Communicates effectively.*
   Following observation of the Audit Committee, interview with senior management and review of reporting, it is clear that the Chief Internal Auditor has open and regular engagement with management and the Board (Audit Committee). The observation of the Audit Committee also identified that Milton Keynes Council make use of independent members on this non-political committee that brings an extra perspective and positive challenge.

8. *Provides risk-based assurance.*
   It was clear from interview that the service followed a suitable audit plan methodology and approach to allow for risk-based assurance work. For example, there was consultation with senior management and the Audit Committee to prepare the plan, along with the Chief Internal Auditor's audit universe assessment. Additionally, the service adapted the plan regularly to enable the audit activity to cover emerging risks as identified through the year.

9. *Is insightful, proactive, and future-focused.*
   This aspect links to the issues identified in principle 2 and 4. The service was not able to be as effective as possible in terms of insight and future-focused elements in part due to the limits identified in CPD and strategic focus. There was a reliance on researching the topical area prior to the audit engagement taking place and receiving risk emerging information from the auditee. There was little evidence of the service brining current or emerging risks to the organisation from internal audit pro-active activity of other information gleamed from horizon scanning and professional networking/CPD.

10. *Promotes organisational improvement.*
    It was clear from interview that the stakeholder for the service felt that the internal audit activity did help with promoting organisational improvement. It was also clear from Audit Committee papers that the Audit Committee supported the service in this objective.

Recognising the principles-based approach to the PSIAS - In terms of general conformance with the PSIAS standards there were (Also see Appendix 1):

- **49 areas of Generally Conforms**
- **6 areas of Partially Conforms - actions are in place to address these**
- **1 area of Does not Conform - actions are in place to address this**

Management Response

Findings are agreed -An action Plan has been agreed to address the weaknesses raised. See page 30.

Introduction, Legislation and the Public Sector Internal Audit Standards (PSIAS)

In June/July 2022 Milford Research and Consultancy was commissioned by Milton Keynes Council to review the in-house Internal Audit Service against the Public Sector Internal Audit Standards (PSIAS) 2017. This is a requirement under statute and must be conducted every 5 years (PSIAS Attribute Standard 1312).

External Quality Assessments are a requirement for all Local Government Internal Audit Services under the following statutory requirements:

England The Accounts and Audit Regulations 2015 Regulation 5	A relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control, and governance processes, taking into account **public sector internal auditing standards** or guidance.

The PSIAS include the following overarching material which sets the context in which the detailed internal auditing standards are to be used and each of which carry a definition shown below:

1. Mission of Internal Audit

2. Definition of Internal Auditing

3. Core Principles for the Professional Practice of Internal Auditing

4. Code of Ethics.

1. MISSION OF INTERNAL AUDIT

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

2. DEFINITION OF INTERNAL AUDITING

"Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

3. CORE PRINCIPLES FOR THE PROFESSIONAL PRACTICE OF INTERNAL AUDITING

"For an internal audit function to be considered effective, all principles should be present and operating effectively"

These principles are:

1. *Demonstrates integrity.*
2. *Demonstrates competence and due professional care.*
3. *Is objective and free from undue influence (independent).*
4. *Aligns with the strategies, objectives, and risks of the organisation.*
5. *Is appropriately positioned and adequately resourced.*
6. *Demonstrates quality and continuous improvement.*
7. *Communicates effectively.*
8. *Provides risk-based assurance.*
9. *Is insightful, proactive, and future-focused.*
10. *Promotes organisational improvement.*

4. CODE OF ETHICS

The code outlines principles relevant to the profession and practice of internal auditing under four headings:

***"Integrity:** The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement*

***Objectivity:** Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined.*

Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements.

***Confidentiality:** Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so.*

***Competency:** Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services*"

The CIPFA Principles of the Role of the Head of Internal Audit

"The head of internal audit in a public service organisation plays a critical role in delivering the organisation's strategic objectives by:

- objectively assessing the adequacy and effectiveness of governance and management of risks, giving an evidence-based opinion on all aspects of governance, risk management and internal control
- championing best practice in governance and commenting on responses to emerging risks and proposed developments.

To perform this role the head of internal audit must:

- be a senior manager with regular and open engagement across the organisation, particularly with the leadership team and with the audit committee
- lead and direct an internal audit service that is resourced appropriately, sufficiently and effectively
- be professionally qualified and suitably experienced

Methodology

Research and Conformance Evaluation

RACE Matrix – Research, interviews, documentation and confirmation – see Appendix 1.

In order to assess the internal audit service the assessors made use of a checklist based on the CIPFA 2019 checklist, and PSIAS for the Research and Confirmation Evaluation (RACE) which was used as an aid in ascertaining the conformance to the standards.

In addition, the core principles were used to inform and direct the line of questions in interviews with key stakeholders, including:

- Chief Finance Officer – who has the responsibility to ensure there is an effective internal audit activity in place at Milton Keynes Council
- Chief Executive Officer
- Monitoring Officer
- Audit Committee Chair
- The entire internal audit team
- Other auditees and service users

The Assessor(s):

- Applied the Public Sector Internal Audit Standards (2017), the CIPFA Local Government Application Note (2019) and made reference to the CIPFA Statement on the Role of the Head of Internal Audit (2019).
- Completed desktop/remote reviews – for example, website data, audit management software walkthrough, Audit Committee reports and meetings.
- Completed documentation review – for example, audit annual opinion and plan document reported to Audit Committee
- Completed semi-structured interviews and focus groups – delivered along the PSIAS Principles (see below)
- Plotted findings against PSIAS in the checklist and RAG rated

Core Principles applied:

1. Demonstrates integrity.
2. Demonstrates competence and due professional care.
3. Is objective and free from undue influence (independent).
4. Aligns with the strategies, objectives, and risks of the organisation.

5. Is appropriately positioned and adequately resourced.
6. Demonstrates quality and continuous improvement.
7. Communicates effectively.
8. Provides risk-based assurance.
9. Is insightful, proactive, and future-focused.
10. Promotes organisational improvement.

Application of the Core Principles of PSIAS

The principles are not as high-level as the mission or the definition of internal audit but provide more direction on the essential components of **effective** internal audit that will be required in practice. How an internal auditor or an internal audit activity demonstrates achievement of the Core Principles may be quite different from organisation to organisation, but failure to achieve any one of the principles would imply that an internal audit activity was not as effective as it could be in achieving the Mission of Internal Audit.

The inclusion of principles in the PSIAS is intended to demonstrate that the standards are principles-based rather than rules-based. The principles capture the essentials of effective internal audit in a way which is easy to communicate to stakeholders in the audit process, including those whose work is subject to audit, the audit committee and others who receive reports on the results of internal audit work. **The principles can also helpfully inform internal and external assessments of the effectiveness of internal audit activity**.

Set out below are the relevant results linked to the core principles:

Demonstrates integrity.

Result: This is clearly indicated and supported by the interviews with key stakeholders

All of the interviews with service users confirmed that there was a high level of trust in the internal audit service's work and there was a regular engagement between the Chief Internal Auditor and the Board/Senior Management. This included significant levels of 1-2-1 time with CFO, CEO and other key governance positions.

The Senior Management and Audit Committee interviews and assessment demonstrates that the Chief Internal Auditor and the service are supported by the Audit Committee and Senior management and have freedom of access and reporting. This is also detailed in the audit charter and the reports presented to the audit committee.

The internal audit service also provides the main counter fraud activity for the organisation. This requires significant levels of sensitivity and confidentiality. This is an indicator of the organisation's recognition of the integrity of the service as indicated by the Code of Ethics:

CODE OF ETHICS

Section 6 of the PSIAS sets out the Code of Ethics. It explains that a code of ethics is necessary and appropriate for the profession of internal auditing, founded as it is on the trust placed in its objective assurance about risk management, control and governance. The code is framed as guidance to members of the Institute of Internal Auditors, but is applicable to others who provide internal auditing services within the Definition of Internal Auditing:

this includes all internal auditors working in public sector organisations using the PSIAS, including internal audit in local government.

The code outlines principles relevant to the profession and practice of internal auditing under four headings:

Integrity: The integrity of internal auditors establishes trust and thus provides the basis for reliance on their judgement

Objectivity: Internal auditors exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined.

Internal auditors make a balanced assessment of all the relevant circumstances and are not unduly influenced by their own interests or by others in forming judgements.

Confidentiality: Internal auditors respect the value and ownership of information they receive and do not disclose information without appropriate authority unless there is a legal or professional obligation to do so.

Competency: Internal auditors apply the knowledge, skills and experience needed in the performance of internal auditing services. The code expands on each of these by setting out rules of conduct that describe behaviour norms expected of internal auditors.

Demonstrates competence and due professional care.

Result: This is an area for improvement as such issues as Continual Professional Development were not consistent or clearly evidenced. Although it was recognised that the team included experienced auditors, there was limited numbers of current professional body memberships maintained and CPD activities undertaken.

It was noted in the observation of the Audit Committee that the CFO stated that he relied on professional networking and CPD as part of the control system, in particular, for identifying emerging trends and national issues that may impact the council. This highlights the need for the need for internal audit to apply this control too.

The CIPFA guidance 2019 states:

PROFICIENCY AND DUE PROFESSIONAL CARE - PSIAS 1200, 1210, 1220 and 1230

PSIAS 1200 states that the CAE must be professionally qualified and suitably experienced. The subsequent standards set out specific requirements for all internal audit staff to be competent, to exercise due professional care, and to maintain their competence.

The CAE is responsible for recruiting appropriate staff, in accordance with the organisation's HR processes. This will normally require up-to-date job descriptions that reflect roles and responsibilities and person specifications which define the required qualifications, competencies, skills, experience and personal attributes. The CAE should periodically assess individual auditors against the skills and competencies set out in the relevant job descriptions and person specifications. Any training or development needs that are identified should be included in an appropriate ongoing development programme that is recorded and regularly reviewed and monitored.

In addition, all internal auditors have a personal responsibility to undertake a programme of continuing professional development (CPD) to maintain and develop their competence. This may be fulfilled through requirements set by professional bodies, for example by applying CIPFA's approach to CPD, or through the organisation's own appraisal and development programme. Auditors should maintain a record of such professional training and development activities.

In order for the authority to meet its statutory responsibilities, internal audit needs to be appropriately resourced to meet its objectives. The internal audit activity should have appropriate numbers of staff in terms of grades, qualifications, personal attributes and experience or have access to appropriate resources in order to meet its objectives and to comply

with these standards. PSIAS 1210.A1 explicitly requires that the CAE must obtain competent advice and assistance if the internal audit activity is unable to perform all or part of an engagement.

This requirement was supported by the Milton Keynes Council own Internal Audit Charter.

Is objective and free from undue influence (independent).

Result: ***The Audit Charter and interview discussion indicate that the service has an appropriate range of reporting routes and independence to operate effectively. Furthermore, the service was able to demonstrate the objectiveness of the internal auditor was safeguarded and not compromised in work allocations.***

The CIPFA guidance states:

INDEPENDENCE AND OBJECTIVITY - PSIAS 1100, 1110, 1111, 1112, 1120 and 1130

Various aspects of independence and objectivity are covered in PSIAS 1100 to 1200, including functional reporting lines of the CAE, the relationship between the CAE and the board and any impairment to individual internal auditors' objectivity or independence. Reporting and management arrangements must be put in place that preserve the CAE's independence and objectivity, in particular with regard to the principle that the CAE must be independent of the audited activities.

Organisational independence

There has been a long-standing debate over the positioning of the CAE within local authorities and in particular to the line management arrangements for that role. PSIAS 1000 expands on this, setting out the relationship between the CAE and the board. As highlighted in previous sections, individual local authority organisations must consider carefully which committee or individual fulfils the role of the board throughout the PSIAS. This is critical in considering independence.

CIPFA's Statement on The Role of the Head of Internal Audit in Public Service Organisations (2018) states that organisations need to ensure that the head of internal audit (CAE) is a senior manager with regular and open engagement across the organisation, particularly with the leadership team and with the audit committee.

PSIAS 1110 is similarly clear that the CAE must report to a level within the organisation that allows the internal audit activity to fulfil its responsibilities, and reporting to the board is the generally accepted method of helping to ensure that organisational independence is attained. The public sector requirement to PSIAS 1110 states that the CAE must report functionally to the board and this is underlined in PSIAS 1111 Direct Interaction with the Board, which requires the CAE to communicate and interact directly with the board.

CIPFA and the IIA expect that the CAE should not report administratively to or be managed at a lower organisational level than the corporate management team. These requirements fit with

the existing requirement in local authorities, where the head of paid service is responsible for ensuring the organisation has the right officers with the appropriate skills/ competencies and the appropriate grade to implement the policies of the local authority.

PSIAS 1110 explains that organisational independence is effectively achieved when the chief audit executive reports functionally to the board. There can be a difference between functional reporting and the line management of the CAE, which can also be influenced by the form of the internal audit provision.

The interpretation to PSIAS 1110 provides examples of functional reporting by the CAE/ internal audit activity to the board. These include the board approving the remuneration of the CAE. However, the public sector interpretation recognises that in the UK public sector, it would be unusual for the board to carry out such a role, although it may be the case where, for example, the internal audit service is supplied by contractors or through a partnership.

The PSIAS do not stipulate an administrative reporting line for local authorities. Remuneration decisions within individual organisations will depend on the arrangements within the local authority. Within local government, many CAEs are line managed by the CFO, and functional reporting arrangements need to be in place which avoid this compromising the independence and objectivity of the CAE, in particular the principle that the CAE must be independent of the audited activities.

Organisations must ensure that the CAE's independence is protected so that conflicts of interest, real or perceived, are avoided. The public sector interpretation explains that this can be achieved through the involvement of the chief executive (or equivalent) in the performance appraisal of the CAE and feedback from the chair of the audit committee.

PSIAS 1112 requires specific safeguards where the CAE has responsibilities for matters beyond internal auditing. The public sector interpretation requires the CAE to highlight to the board any matters which might need to be subject to such safeguards and requires the board to periodically review these.

Objectivity

PSIAS 1120 and 1130 expand upon the principles of integrity and objectivity set out in the Code of Ethics, which require internal auditors to be impartial and unbiased, and to avoid conflicts of personal or professional interest, whether real or perceived. PSIAS 1130 describes what constitutes an impairment to independence or objectivity, and requires that, in situations where it only appears that impairment to objectivity or independence has occurred, 'appropriate parties' have to be informed (determined according to each situation).

In order to avoid real or apparent impairments, internal auditors should:

- declare interests in accordance with the requirements set by the organisation on the type and nature of interests that should be declared
- not accept any gifts, hospitality, inducements or other benefits from employees, clients, suppliers or other third parties (other than as may be allowed by the organisation's own policies)
- not use information obtained during the course of duties for personal gain
- disclose all material facts known to them which, if not disclosed, could distort their reports or conceal unlawful practice, subject to any confidentiality agreements.

The interpretation to PSIAS 1130 notes that impairments to objectivity may arise through individual conflicts of interest or may be imposed externally by limiting the scope of internal audit activity through restrictions on access to records, personnel and properties or through resource limitations, such as funding.

PSIAS 1130.A1 and .A2 set out conditions which must be satisfied if an internal auditor has previously had operational responsibilities or when the CAE has responsibilities for other functions and audits are required in those areas.

The CAE should be alert to the fact that long-term responsibility for the audit of a particular activity in an organisation can lead to over-familiarity and complacency that could influence objectivity. The CAE should consider whether this risk needs to be managed, for example by rotating ongoing audit responsibilities from time to time within the internal audit team. The CAE will need to have regard to staff resources available, including specialist skills and knowledge where appropriate

While good working relationships with management can enhance internal audit's ability to achieve its objectives, these must not detract from internal audit's responsibility to report control issues to management and the board.

The public sector requirement requires the board's approval for any 'significant' additional consulting services that have not already been included in the audit plan. 'Significant' is not defined in the PSIAS but should be considered in the context of the specific organisation.

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

Result: ***This is an area for improvement in terms of the alignment to strategic objectives for the organisation. The service was able to demonstrate the audit planned work covered 3 of the 4 aspects of the STOI levels (Strategic, Tactical, Operational and Individual). The longer focused aspects of the Council's strategic vision and objectives was not clearly supported by the audit plan although there was some linkage to the corporate risks.***

Additionally, it was noted in the Audit Committee observation session that there were possible strategic partners or delivery vehicle models used by the council that internal audit needed to ensure featured clearly in the audit opinion/plan as the CFO highlighted that these aspects did impact on the council's financial systems.

Management Response:

Agreed Plan does not currently clearly align with Strategic Objectives. Discussions to be held with S151 and Senior management, to identify and agree Strategic Reviews. *MKC IA also provides the internal audit service for MKDP, so any issues arising are highlighted. Another Audit of arms length organisation to focus on monitoring arrangements for MKDP to be included i*n Audit Plan 23/24

The CIFPA guidance states:

MANAGING THE INTERNAL AUDIT ACTIVITY - PSIAS 2000, 2010, 2020, 2030, 2040, 2050, 2060 and 2070

The internal audit activity is effectively managed when it achieves the purposes set out in the internal audit charter, in accordance with relevant codes and standards, and having regard to trends and emerging issues that affect the objectives and risks of the organisation.

Planning

The PSIAS require the CAE to develop a risk-based plan. This must incorporate or be linked to a strategic high-level statement of how the internal audit service will be delivered and developed in accordance with the internal audit charter. It must also explain how the planned assurance delivery links to the organisational objectives and priorities. It should outline the assignments to be carried out, their respective priorities and the estimated resources needed. The plan should differentiate between assurance and other work.

The public sector requirement in PSIAS 2010 states that the risk-based plan must incorporate or be linked to a "strategic or high-level statement of how the internal audit service will be delivered

and developed". **The plan must therefore include some strategic elements, for example by showing how internal audit's work will identify and address local and national issues and risks over successive annual cycles.**

The risk-based plan should be fixed for a period of no longer than one year and should be sufficiently flexible to reflect the changing risks and priorities of the organisation. Internal auditors should keep risks under regular review and consider how their audit plans should respond to changing risks. This may result in more frequent reviews of the plan or for plans to cover periods of less than one year.

Is appropriately positioned and adequately resourced.

Result: Given the implications arising from the change in service delivery model, this was regarded as a principle in "transition". The audit team clearly had sufficient experience to cover most aspects of the audit plan/Council's needs but the new structure has introduced potential bottlenecks and resource pinch points that could reduce the effectiveness of the service. In particular, the new Audit Manager position is resourced by the only internal auditor with recognised IT audit skills and identified as the lead on investigatory works, thus coupled with the audit management role could lead to this position being overstretched.

Furthermore, the service was limited in its ability to demonstrate succession planning from the more junior levels and routes to qualify professional internal auditors.

The IT systems used by the service for both Audit Management and Computer Aided Audit Techniques (CAATS) would also benefit from review to align with the new service delivery approach and also that the Audit Manager was the only individual able to use the CAATS.

The PSIAS states:

2030 Resource Management

The chief audit executive must ensure that internal audit resources are appropriate, sufficient and effectively deployed to achieve the approved plan.

Interpretation:

Appropriate refers to the mix of knowledge, skills and other competencies needed to perform the plan. **Sufficient refers to the quantity of resources needed to accomplish the plan**. Resources are effectively deployed when they are used in a way that optimises the achievement of the approved plan.

The interviews identified that the current Audit Manager was also the lead specialist in IT audit and investigations and CAATs use. Given the role of the Audit Manager as seen in the Job Description, there is a clear risk that the capacity of this officer to meet the potential demands on this skill may be exceeded creating potential bottlenecks/delays in audit activity and timeliness. Although it was noted that this is a recent restructure/appointment the risks have not yet materialised.

Management Response:

Structure of the IA Service to be reviewed to

a) determine appropriateness and sufficiency of current levels of resource and action taken as necessary.
b) Incorporate an element of succession planning.

Demonstrates quality and continuous improvement.

Result: ***Given the transition of the service at this stage it is difficult to comment on the "continuous improvement" element, but the manner by which this EQA has been supported highlights that the new in-house service wishes to work towards becoming a more effective service.***

In terms of the quality there were inconsistencies found in work practices and evidence of silo working approaches that could impact on the effectiveness of the service

Management Response:

More work will be done by IA management to discourage silo working and enforce agreed methodology, including clarifying use of audit Software.

The CIPFA guidance states:

QUALITY ASSURANCE AND IMPROVEMENT PROGRAMME - PSIAS 1300, 1310, 1311, 1312, 1320, 1321 and 1322

The Quality Assurance and Improvement Programme (QAIP) has been designed by the IIA Global to assist in improving the performance of internal audit. Applying this across the public sector will help promote consistency and improvement. The QAIP was a new requirement for local authorities when the PSIAS were introduced in 2013 but echoed statutory requirements for many authorities to conduct reviews of the effectiveness of internal audit. (This requirement has since been removed from the regulations for England on the understanding that review will arise automatically from the application of the PSIAS).

PSIAS require the CAE to develop and maintain a QAIP to enable the internal audit activity to be assessed against the PSIAS (ie the Mission of Internal Audit, Definition of Internal Auditing, Core Principles, Code of Ethics and the standards themselves) for conformance. The interpretation to PSIAS 1300 states that the QAIP is designed both to assess conformance with the PSIAS and also to assess the efficiency and effectiveness of the internal audit activity and identify areas for improvement. Assessments of local authority conformance with the PSIAS should use this application note for guidance.

PSIAS 1310 clearly states that a QAIP must include both internal and external assessments. Internal assessments can be carried out on an ongoing basis and periodically. As a minimum requirement, an external assessment must be undertaken at least once every five years. By 31

March 2018, all authorities should have completed at least one external assessment of internal audit.

Internal assessments

Ongoing internal assessment can be carried out through performance monitoring which the CAE uses to manage the internal audit activity. When the CAE establishes policies and procedures to guide staff in performing their duties, these should both ensure that work conforms to the PSIAS and should provide evidence of conformance. This may be done in various ways, including maintaining an audit manual and the use of electronic audit management systems.

Assessments will also need to determine that audit work is carried out to the appropriate level of quality and that audit work has been allocated to staff with the appropriate skills, experience and competence. The assessment should also verify that internal audit staff at all levels are appropriately supervised, and work is reviewed throughout all audits to monitor progress, assess quality and coach staff. The extent of supervision will depend on the competence and experience of the individual auditor.

Ongoing performance monitoring may also incorporate the following:

- A comprehensive set of targets to measure performance, developed in consultation with appropriate parties. Performance measures should be included in any service level agreement. The CAE should measure, monitor and report appropriately on the progress against these targets.
- Stakeholder feedback.
- An action plan to implement improvements.

Periodic assessment will include a review of the internal audit charter, the role of the CAE within the organisation, and other structural features of the internal audit activity to confirm that these are sufficient to achieve the Mission of Internal Audit in line with the Core Principles. It may incorporate further review of engagement working papers on a test basis to confirm that individual pieces of internal audit work have been carried out in line with the PSIAS. It could also involve other people within the organisation who have knowledge of internal audit, for example senior management and members of the audit committee. It may also include a review of the activity against the risk-based plan and the achievement of its aims and objectives. The results of this should inform future risk-based planning.

Communicates effectively.

Result: ***Following observation of the Audit Committee, interview with senior management and review of reporting, it is clear that the Chief Internal Auditor has open and regular engagement with management and the Board (Audit Committee). The observation of the Audit Committee also identified that Milton Keynes Council make use of independent members on this non-political committee that brings an extra perspective and positive challenge.***

The CIPFA guidance states:

CIPFA's Statement on The Role of the Head of Internal Audit in Public Service Organisations (2018) states that organisations need to ensure that the head of internal audit (CAE) is a senior manager with **regular and open engagement across the organisation, particularly with the leadership team and with the audit committee**.

PSIAS 1110 is similarly clear that the CAE must report to a level within the organisation that allows the internal audit activity to fulfil its responsibilities, and reporting to the board is the generally accepted method of helping to ensure that organisational independence is attained. The public sector requirement to PSIAS 1110 states that the CAE must report functionally to the board and this is underlined in **PSIAS 1111 Direct Interaction with the Board, which requires the CAE to communicate and interact directly with the board**.

Provides risk-based assurance.

Result: It was clear from interview that the service followed a suitable audit plan methodology and approach to allow for risk-based assurance work. For example, there was consultation with senior management and the Audit Committee to prepare the plan, along with the Chief Internal Auditor's audit universe assessment. Additionally, the service adapted the plan regularly to enable the audit activity to cover emerging risks as identified through the year.

Interview and walkthrough review of the Sword Audit Management software use did highlight some inconsistencies in the use of the SAM and also the reported output. There were multiple comments about how the SAM was used and the information within the system to support the reports.

The PSIAS state:

2010 Planning

The chief audit executive must establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.

Interpretation:

To develop the risk-based plan, the chief audit executive consults with senior management and the board and obtains an understanding of the organisation's strategies, key business objectives, associated risks and risk management processes. The chief audit executive must review and adjust the plan, as necessary, in response to changes in the organisation's business, risks, operations, programmes, systems, and controls.

Public sector requirement

The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered and developed in accordance with the internal audit charter and how it links to the organisational objectives and priorities

2300 Performing the Engagement

Internal auditors must identify, analyse, evaluate and document sufficient information to achieve the engagement's objectives.

2310 Identifying Information

Internal auditors must identify sufficient, reliable, relevant and useful information to achieve the engagement's objectives.

Interpretation:

Sufficient information is factual, adequate and convincing so that a prudent, informed person would reach the same conclusions as the auditor. Reliable information is the best attainable information through the use of appropriate engagement techniques. Relevant information supports engagement observations and recommendations and is consistent with the objectives for the engagement. Useful information helps the organisation meet its goals.

2320 Analysis and Evaluation

Internal auditors must base conclusions and engagement results on appropriate analyses and evaluations.

2330 Documenting Information

Internal auditors must document sufficient, reliable, relevant and useful information to support the engagement results and conclusions

Is insightful, proactive, and future-focused.

Result: This aspect links to the issues identified in principle 2 and 4. The service was not able to be as effective as possible in terms of insight and future-focused elements in part due to the limits identified in CPD and strategic focus. There was a reliance on researching the topical area prior to the audit engagement taking place and receiving risk emerging information from the auditee. There was little evidence of the service brining current or emerging risks to the organisation from internal audit pro-active activity of other information gleamed from horizon scanning and professional networking/CPD.

The PSIAS state:

2100 Nature of Work

The internal audit activity must evaluate and contribute to the improvement of the organisation's governance, risk management, and control processes using a systematic, disciplined, and risk-based approach. Internal audit credibility and value are enhanced when **auditors are proactive, and their evaluations offer new insights and consider future impact**.

Management Response:

CPD to be made a mandatory exercise for the whole team and documentary evidence will be monitored on a biannual basis. Courses and other publications by relevant professional bodies to be made available to the team.

Promotes organisational improvement.

Result: ***It was clear from interview that the stakeholder for the service felt that the internal audit activity did help with promoting organisational improvement. It was also clear from Audit Committee papers that the Audit Committee supported the service in this objective.***

Interviews and documentation review highlighted that internal audit generate recommendations to specifically help promote organisational improvement in terms of governance, risk management and control.

All audit reports generated recommendations/action plans to aid management in addressing any risk that required mitigation in relation to the audited area and the governance, risk management and control.

milton keynes council

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APPENDIX 1 - PSIAS Conformance Scoring System

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
	Mission Statement & Definition of Internal Auditing	✓				
Reference	**Code of Ethics**					
1	Integrity	✓				
2	Objectivity	✓				
3	Confidentiality	✓				
4	Competence		✓		There was little evidence of CPD activity or similar to ensure the element 4.2 and 4.3 of this code was conformant	CPD to be made mandatory, with all staff required to undertake and record CPD annually. A template to be devised to ensure consistency. Progress to be monitored bi annually **Responsible officer – CIA/AM** **Target Date -30/10/22** Staff to be required to review relevant publications and attend

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
						relevant webinars as well as reviews of public reports published relating to LGA issues and professional bodies. **Responsible Officer – CIA/AM** **Target Date – 30/09/22**
Reference	**Attribute Standards**					
1000	Purpose, Authority and Responsibility	✓				
1010	Recognition of the Definition of Internal Auditing, the Code of Ethics, and the Standards in the Internal Audit Charter	✓			A minor note: the MK Council website data on internal audit is outdated and does not reflect the latest charter or guidance	Website to be reviewed and updated to ensure it contains latest version of the Charter and other guidance.- Manual and Charter were reviewed in January 2022. **Responsible officer – Audit Assistant** **Target Date – 30/08/22**
1100	Independence and Objectivity	✓				
1110	Organisational Independence	✓				
1111	Direct Interaction with the Board	✓				
1120	Individual Objectivity	✓				

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
1130	Impairments to Independence or Objectivity	✓				
1200	Proficiency and Due Professional Care (The sum of *Standards* 1210-1230)	✓				
1210	Proficiency		✓		Although there is an experienced team there was limited evidence of directives to ensure the following aspects of the standard's interpretation for public sector were applied: Internal auditors must possess the knowledge, skills and other competencies needed to perform their individual responsibilities. The internal audit activity collectively must possess or obtain the knowledge, skills and other competencies needed to perform its responsibilities. *Interpretation:* Proficiency is a collective term that refers to the	Job descriptions to be revised to include relevant qualification and requisite experience made as essential criteria for all Principal Auditor Roles. **Responsible Officer – CIA** **Target Date – 30/10/22** All staff at Principal Auditor level with no relevant qualifications to be required and supported to commence and complete work /study towards attaining a formal accounting, auditing qualification as detailed in the Standards. Completion of CPD records to be enforced and monitored. **Responsible Officer: CAI** **Target Implementation: 31/12/22**

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
					knowledge, skills, and other competencies required of internal auditors to effectively carry out their professional responsibilities. **It encompasses consideration of current activities, trends and emerging issues, to enable relevant advice and recommendations. Internal auditors are encouraged to demonstrate their proficiency by obtaining appropriate professional certifications and qualifications, such as the Certified Internal Auditor designation and other designations offered by The Institute of Internal Auditors and other appropriate professional organisations**.	Audit refresher training to be provided for staff at Senor Auditor level and below annually and all encouraged to update through Ia media. **Responsible Officer – CIA** **Target Implementation Date – 31/12/22**

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
1220	Due Professional Care	✓				
1230	Continuing Professional Development			✓	**This was the weakest area for the service. There was very limited CDP and/or evidence of direction to encourage this activity- even though the charter recognises this as a key aspect for the service** **The standards state:** "Internal auditors **must** enhance their knowledge, skills and other competencies through continuing professional development." **Noted in Audit Committee the CFO highlighted this as part of his control framework.**	All staff to be required to undertake and document CPD where necessary. Management to direct staff and or provide training as necessary. CPD records to be monitored biannually**.** **Responsible Officer – CIA** **Target Implementation Date – 31/8/22** Will seek evidence to confirm that all Principal Auditors who are currently members of a professional body have renewed their membership**.** **Responsible Officer – CIA** **Target Implementation Date – 31/01/23**

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
1300	Quality Assurance and Improvement Programme (The sum of *Standards* 1310-1320)	✓				
1310	Requirements of the Quality Assurance and Improvement Programme	✓				
1311	Internal Assessments	✓			Note: at the time of the EQA under 1312 the new in-house service had only recently completed an internal assessment and therefore the EQA was unable to clearly evidence the progress against the actions in this internal assessment but the "principle" was clearly in place	
1312	External Assessments	✓				
1320	Reporting on the Quality Assurance and Improvement Programme	✓				

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
1321	Use of Conforms with the International Standards for the Professional Practice of Internal Auditing	✓				
1322	Disclosure of Non-conformance	✓				
Reference	**Performance Standards**					
2000	Managing the Internal Audit Activity (Sum total of *Standards* 2010 – 2060)	✓				
2010	Planning	✓				
2020	Communication and Approval	✓				
2030	Resource Management		✓		The new in-house service structure and appointments to this structure have introduced a risk of bottlenecks in relation to IT audits, investigations and CAATs use due to the Audit Manager being the only in-house team member leading on these aspects.	Appointment of a counter fraud officer will reduce the anti fraud work burden on Audit Manager – **Appointment start – 30/10/2022** A detailed review of the current staffing structure to be undertaken to determine a workable structure that allows for effective delivery of IT audits and to expand/encourage use of IDEA CAAT. **Responsible Officer -CIA /AM** **Target Completion -28/02/2023**

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
2040	Policies and Procedures		✓		There was evidence of inconsistency in the application of procedures in the SAM system by the auditors. This was identified in interview and in a walkthrough test. (also see 2300 below) A minor note: the information about the service on the MKCouncil website is not current	Management will arrange for another training session on SAM and closely monitor adherence to ensure procedures are consistently followed. Checks to be undertaken at Monthly 1-2-1 and corrective actions enforced. **Responsible officer -CIA/AM** **Target -30/10/2022**
2050	Coordination	✓			NOTE: Audit Committee were concerned about assurances of partner and wholly owned company models that required assurance and also impacted on MK Council	Commentary to be included within MKC Annual Governance Statement. Adequacy of MKC arrangements for monitoring MKDP to be included within Plan 23/24.
2060	Reporting to Senior Management and the Board	✓				

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
2070	External Service Provider and Organisational Responsibility for Internal Audit	✓				
2100	Nature of Work (Sum of *Standards* 2110 – 2130)	✓				
2110	Governance	✓				
2120	Risk Management	✓				
2130	Control		✓		This standard highlights the need of internal audit to consider all levels within the organisation including the Strategic: The internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement. **2130.A1** The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within	Will undertake horizon scanning to Identify emerging strategic issues that may impact on MKC and discuss way forward for audit review with senior management, as part of audit Planning for 2023/24. **Responsible Officer – CIA** **Target completion – 31/12/22**

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
					the organisation's governance, operations and information systems regarding the: **achievement of the organisation's strategic objectives** reliability and integrity of financial and operational information effectiveness and efficiency of operations and programmes safeguarding of assets, and compliance with laws, regulations, policies, procedures and contracts.	
2200	Engagement Planning (Sum of *Standards* 2201-2240)	✓				
2201	Planning Considerations	✓				
2210	Engagement Objectives	✓				
2220	Engagement Scope	✓				

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
2230	Engagement Resource Allocation	✓				
2240	Engagement Work Programme	✓				
2300	Performing the Engagement (The sum of *Standards* 2300-2340)	✓				
2310	Identifying Information	✓				
2320	Analysis and Evaluation	✓				
2330	Documenting Information		✓		Interview and walkthrough testing identified inconsistencies and gaps in the SAM use. These included risks missing from reports and a variance in the range of supporting text in reports. This may be a software issue to some extent. 2330 Documenting Information Internal auditors must document sufficient, **reliable**, relevant and useful information to **support the engagement results and conclusions**	The current reporting template to be revised, to incorporate risk & control information from SAM system. Consideration will be given to engaging the software provider to update the reporting template. **Responsible officer CIA/AM** **Target Completion Date – 30/12/2022** An exercise will be undertaken to walk through SAM with the team, to highlight where information for the report is drawn from, to enable auditors to be better informed as to what data to enter where on the system.

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
						Responsible officer -AM **Target completion Date – 30/10/22**
2340	Engagement Supervision	✓				
2400	Communicating Results (Sum of *Standards* 2410-2440)	✓				
2410	Criteria for Communicating	✓			Note: There was a trend identified in interview that the opinions given in individual reports were not permitted to give the highest level of assurance available in principle – this is potentially misleading for the auditee as they can never achieve the highest level offered. **2410.A1** Final communication of engagement results must include applicable conclusions, as well as applicable recommendations	A misconception by staff who are too keen to please the auditees. The highest level of positive assurance has on several occasions been issued by auditors based on very limited independent audit evidence, with weaknesses subsequently identified when challenged at review stage. The instruction is that where we are proposing to issue **a substantial or no assurance opinion**, then the work will be subject to an extra layer of scrutiny. Managers are known to have been reluctant to accept a lower assurance opinion the following year, where in their

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
					and/or action plans. Where appropriate, the internal auditors' opinion should be provided. An opinion must take into account the expectations of senior management, the board and other stakeholders and must be supported by sufficient, reliable, relevant and useful information. *Interpretation:* Opinions at the engagement level may be ratings, conclusions or other descriptions of the results. Such an engagement may be in relation to controls around a specific process, risk or business unit. The formulation of such opinions requires consideration of the engagement results and their significance.	view the processes and procedures have not changed.
2420	Quality of Communications	✓				

		Generally Conforms	Partially Conforms	Does Not Conform	Comment	Action plan
2421	Errors and Omissions	✓				
2430	Use of 'conducted in conformance with the International Standards for the Professional Practice of Internal Auditing'	✓				
2431	Engagement Disclosure of Non-conformance	✓				
2440	Disseminating Results	✓				
2450	Overall Opinions	✓				
2500	Monitoring Progress	✓				
2600	Resolution of Senior Management s Acceptance of Risks	✓				


milton keynes council


MILFORD RESEARCH
& CONSULTANCY LIMITED

About the Assessor

Dr Robert Milford MA PhD MMS CFIIA CMgr FCMI CIA QIAL CTArc*f* AFHEA FInstLM

Rob is the Managing Director and Founder of Milford Research and Consultancy Ltd and an academic practitioner working in the field of collaborative assurance, governance, risk and control.

He is a former lecturer in leadership at Worcester and Coventry Universities and works with public sector clients to develop their internal audit, risk management and collaborative services. His PhD was based on internal audit in local government with a focus to corporate governance.

He has also spent over 20 years working with internal audit in local government.

He designed and built the unique "Institute Approved" Power-Up Mentor/Mentee Professional Programme for Schools and businesses. Also, the Collaborative Business Management and Leadership Professional Programme for managers and leaders of collaborative services/organisation.

END.

Agenda Item 5

Report to the Joint Independent Audit Committee
05 October 2022

Internal Audit Recommendations Summary Report

RECOMMENDATION

The Committee is asked to note this report.

1 PURPOSE OF THE REPORT

1.1 This report provides the Joint Independent Audit Committee (JIAC) with an update on the status of actions arising from recommendations made in internal audit reports.

1.2 The report contains actions arising from audits of Northamptonshire Police and the Office of Northamptonshire Police, Fire and Crime Commissioner and East Midlands Collaboration Units.

1.3 The attached Summary of Internal Audit Recommendations Report shows details and the current status of all open audit actions.

1.4 The Force Assurance Board has oversight of all outstanding audit actions and directs the activities required to complete any actions that have passed their targeted implementation date.

2 NORTHAMPTONSHIRE AUDITS

2.1 **Overall Status**

- The report shows in 2020/21, 2021/22 and 2022/23 a total of eighteen audits have been completed, making fifty-two audit recommendations. Of those fifty-two recommendations:
  - Forty-three recommendations have been completed and are closed.
  - Nine recommendations remain ongoing.
  - No recommendations are marked as overdue.
  - Further details regarding mitigation activity and progress updates can be found within the attached report, Quarterly Summary of Internal Audit Recommendations Report – September 2022.

3 OVERVIEW

3.1 **2020/21 Audits**

- Nine audits have been completed making thirty recommendations.

- Across all nine audits, a total of twenty-eight recommendations have been completed and are closed.
- Only two recommendations have not reached their implementation date and are ongoing.
- No recommendations are marked as overdue.

3.2 **2021/22 Audits**

- Seven audits have been completed making eighteen recommendations.
- The most recent audit carried out in July 2022 relates to Health and Safety Follow Up. Based on the findings, a rating of satisfactory assurance was given, and three recommendations made. Further details can be found in the attached Summary of Internal Audit Recommendations Report.
- Across all seven audits, a total of fourteen recommendations have been completed and are closed.
- Four recommendations have not reached their implementation date and are ongoing.
- No recommendations are marked as overdue.

3.3 **2022/23 Audits**

- Two audits have been completed making four recommendations.
- Of those nine recommendations, one action has been completed and are closed.
- Three recommendations have not reached their implementation date and are ongoing.
- No recommendations are marked as overdue.

4 COLLABORATION AUDITS

4.1 **2019/20 and 2020/21 Audits**

- All twenty-six recommendations have been completed and have therefore been removed from the Quarterly Summary of Internal Audit Recommendations report.

EQUALITY, DIVERSITY AND HUMAN RIGHTS IMPLICATIONS
None

HUMAN RESOURCES IMPLICATIONS
None

RISK MANAGEMENT IMPLICATIONS
None.

ENVIRONMENTAL IMPLICATIONS
None

Author:	Megan Roberts, Strategic Development, Risk and Business Continuity Adviser
Chief Officer Portfolio Holder:	Simon Blatchly, Deputy Chief Constable
Background Papers:	Quarterly Summary of Internal Audit Recommendations September 2022.

INTERNAL AUDIT RECOMMENDATIONS DASHBOARD

Summary of Audit Outcomes

Audits are graded as No Assurance, Limited Assurance, Satisfactory Assurance or Significant Assurance. Some thematic audits are advisory only and not graded. Recommendations are prioritised as Priority 1 (Fundamental), Priority 2 (Significant) or Priority 3 (Housekeeping) to reflect the assessment of risk associated with the control weaknesses.

Northants Audits

2020/21

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Fleet Management	27 August 2020	Limited Assurance	0	5	2
Procurement	02 December 2020	Limited Assurance	1	2	0
Health & Safety	23 February 2021	Limited Assurance	1	3	1
GDPR Follow Up	10 May 2021	Limited Assurance	1	0	0
IT Security	04 May 2021	Limited Assurance	2	1	1
Core Financials	01 March 2021	Significant Assurance	0	0	3
Workforce Planning	26 April 2021	Satisfactory Assurance	0	4	0
Performance Management	16 June 2021	Significant Assurance	0	0	1
Governance	05 November 2021	Satisfactory Assurance	0	1	1

2021/22

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Released Under Investigation	16 August 2021	Limited Assurance	1	3	2
Seized Property	07 September 2021	Satisfactory Assurance	0	1	2
Data Management	22 March 2022	Satisfactory Assurance	0	1	1
Business Change	01 March 2022	Limited Assurance	1	2	0
IT Security	22 April 2022	Limited Assurance	1	0	0

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
GDPR Follow Up	22 April 2022	Significant Assurance	0	0	0
Health & Safety Follow Up	12 July 2022	Satisfactory Assurance	0	2	1

2022/23

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Released Under Investigation Follow Up	TBC	Limited Assurance	1	0	2
Complaints Management	03 August 2022	Significant Assurance	0	1	0

Summary of Audit Recommendations Progress

This table shows a summary of the progress made on new audit recommendations raised at each JIAC during the current year and annual totals for previous years where audit recommendations are still active.

2020/21 AUDITS	RECOMMENDATIONS MADE	RED	AMBER	GREEN
Fleet Management	7	CLOSED		
Procurement	3	CLOSED		
Health & Safety	5	CLOSED		
GDPR Follow Up	1	0	1	0
IT Security	4	CLOSED		
Core Financials	3	CLOSED		
Workforce Planning	4	CLOSED		
Performance Management	1	CLOSED		
Governance	2	0	1	1
Totals	**30**	**0**	**2**	**28**

2021/22 AUDITS	RECOMMENDATIONS MADE	RED	AMBER	GREEN
Released Under Investigation	6	CLOSED		
Seized Property	3	CLOSED		
Data Management	2	CLOSED		
Business Change	3	0	2	1
IT Security	1	0	1	0
GDPR Follow Up	0	CLOSED		
Health & Safety Follow Up	3	0	1	2
Totals	**18**	**0**	**4**	**14**

2022/23 AUDITS	RECOMMENDATIONS MADE	RED	AMBER	GREEN
Released Under Investigation Follow Up	3	0	3	0
Complaints Management	1	CLOSED		
Totals	**4**	**0**	**3**	**1**

OUTSTANDING RECOMMENDATIONS

Key to Status	Action completed since last report	Action ongoing	Action outstanding and past its agreed implementation date	Action no longer applicable or superceded by later audit action

2020/21

Fleet Management – August 2020

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Tailpipe Emissions Target** *Observation:* As part of the Transport Strategy 2017-2021, the Force has set a target to reduce tailpipe emissions by 31% by 2020, in accordance with the Climate Change Act. The Transport Manager is responsible for monitoring this metric. Audit have noted that the Force have not updated the monitoring spreadsheet in place for this since May 2016. Therefore, there is insufficient evidence in place to confirm performance against the target. *Risk:* The Force are unable to demonstrate one of the objectives set out in the Transport Strategy has been met effectively. Failure to reduce emissions in accordance with Climate Change Act.	The Force should ensure that there is a robust monitoring mechanism in place, to monitor the tailpipe emissions for the Force's fleet. Carbon emission data should be taken into consideration by the Force when procuring new vehicles.	**2**	Following audit, figures have been put together from management information regarding all aspects of travel rail, flights, fuel etc and we are looking to extrapolate essential mileage from the MFSS system to give us correct figures. I have asked one of our data analysts to put this into a spreadsheet, graph to show our current usage and set a target for 2023. I am currently looking at suitable hybrid vehicles which are feasible for use and Estates are looking at the implementation of charging points across the Force which will enable me to purchase pure electric vehicles for non-response teams. Transport Strategy and Implementation Plan Update 03/12/20 - We currently do not have a mechanism to monitor emissions on our vehicles I have asked for a carbon report to be built within the new FMS and Fuel system, currently we have a manual report which identifies our carbon usage and have asked if this can be put in to graph form.	March 2021 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				Update 23/03/21 - The Transport Team now have a report that tracks CO2. The fuel ordered is monitored against usage and kept updated monthly as per the fuel reports submissions - The transport manager has also actively removed the majority of the fleet that was registered before 2015. This has increased the overall MPG and reduced the carbon footprint that the Force produces. Moving forwards this will be improved further by the implementation of a Telematics solution. Update 15/06/2021 – No further updates from the last period, most of the requirements will be rectified with the implementation of new Fleet Management system and Telematics which hopefully will be later this year and we will be in a considerably improved position for our next audit. Update 02/08/2021 – Manual carbon footprint report is ongoing and being updated via fuel usage. The telematics installation began on 19th July 2021 which will give mpg/usage of fuel directly from the vehicles. The older fleet pre-2015 that was due replacement has now been replaced with a ulez compliant vehicle. Update 19/10/2021 – The replacement programme is rationalised across both mileage and age of vehicle not carbon emissions. When the audit was carried out, we had vehicles that should have been replaced due to age but due to budget constraints they had been extended, the majority of these have now been replaced through the replacement programme.		
4.2	**Fleet Availability** *Observation:* Through discussions with the Head of		**3**	With the introduction of a fit for	March 2022	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Transport, it was found that the Force has set an informal target of ensuring fleet availability is at 95% at all times. However, there is no internal report that can be generated to provide this figure and audit noted that performance against this target is not reported anywhere. Audit undertook a recalculation of the Force's fleet availability (as at 24th July 2020) and noted the Force's fleet availability stood at 93.7%, which is below the 95% target. *Risk:* The Force are unable to demonstrate the servicing of vehicles is being scheduled effectively.	The Force should ensure that scheduling of repairs or services of vehicles take into consideration when calculating fleet availability. The Force should ensure that there is effective monitoring of their fleet availability.		purpose up to date Fleet Management system this will enable KPI data and productivity figures within the workshop environment. Also providing improved data integrity. Implementation of new Fleet Management System with agreed KPI's including vehicle availability Update 28/10/20 – Pending the introduction of the new system the force will continue to use the existing Fleet Management System which, while not ideal, does hold details of vehicles, mileage etc. Update 03/12/20 - The FMS is automated there will be no requirement for paper job cards to be produced as the technicians will be using tablets and all jobs will be raised and closed on the system reducing the human error aspect and delays from opening/closing job cards which currently is a manual process. With telematics/mileage app feeding via app into the FMS and scheduling module the servicing mileages will be up to date daily. Update 15/06/2021 – No further updates from the last period, most of the requirements will be rectified with the implementation of new Fleet Management system and Telematics which hopefully will be later this year and we will be in a considerably improved position for our next audit. Update 02/08/2021 – New Fleet Management system is under design and confirmation of implementation date is imminent. Once this is implemented with paperless job cards and Telematics is	Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				providing daily up-to-date mileages this will remove the human error and delays inputting manually on to the system and will generate scheduling of services in a timely and scheduled process. Update 18/10/2021 – The Fleet Management System is now in UAT (User Acceptance Testing). Current progress on the install of the new telematics system remains on track and currently has over 160 vehicles fully installed and uploaded to the system. The project remains on schedule and is already beginning to demonstrate real value and insight. We should be fully operational by January 2022, if not earlier. Update 11/01/2022 – Unfortunately, UAT testing has been delayed as NFRS has not been able to access the system. The go live date has been pushed back to March 2022, whilst the problem is rectified and UAT can be completed by both Police and NFRS. Telematics installation is now completed in over 80% of the Fleet and is already providing utilisation evidence and location data. Update 17/02/2022 – 99% fleet is now installed with Telematics and reaching the end of testing phase. Training from the reporting back end is being rolled out to appropriate areas of the business. Policy in draft to cover and audit trail for access being designed by D&T. Fleet Management is in UAT awaiting sign off from NFRS go live date is set for 15/16th March 2022 but additional work will be completed in-house following this. Update 20/04/2022 – Telematics is in the last phase of testing with the RFID upload		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				from the HR system being prepared following the move over to Unit 4 and preparation of comms in readiness of launch. Tranman new Fleet Management system went live on the 14th of April between Police and NFRS, issues arisen are being addressed and rectified and will be looking to progress the next phase of implementation in the following six months once bedded in. Within the FHQ workshop we now have a system which provides a current % availability of vehicles daily which is monitored by the Workshop Manager. Update 21/06/2022 – Telematics and Dashcam is now active, but we are awaiting RFID data from the HR/Estates system to upload into the telematics system which has been delayed due to the implementation of Unit 4. Tranman – Fleet Management system is now live and further improvements are planned to enable improvements on data and reduce paper. Update 02/09/2022 – This recommendation can now be closed. Telematics and Transman have been live for a while now. Further improvements are planned; however, these will progress over the next few years.		
4.3	**Servicing of Vehicles** *Observation:* There is a schedule in place at the Force that sets the parameters for the interval period at which services are undertaken for vehicles. Audit were advised that mileage of vehicles is tracked and then the mileage dictates when services are due. The interval period depends on the vehicle type, and is as follows: • ARV's (Armed Response Vehicles) –	The Force should ensure the servicing of vehicles is carried out in line with the schedule set out. This should be supported	**2**	With the introduction of a new fully automated Fleet Management System connected to a Telematics or Fuel system providing up to date mileages and vehicle check data these issues would be resolved. Our current paper process is outdated and time consuming by using tablets within the	March 2022 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	serviced every 6,000 miles; • Response Unit's – serviced every 8,000 miles and; • All other vehicles – serviced every 10,000 miles. There has been a change in the interval periods since the previous audit, as the Force has decided to service response units (which were previously serviced every 6,000 miles driven), to now be serviced every 8,000 miles. This is because response units do not undergo the same level of intensity as the ARV's. Whilst these service intervals are set, it is also noted that to ensure manufacturer warranties remain valid, certain work must be completed at set intervals, such as oil changes every 6,000 miles. Audit reviewed a sample of 15 vehicles to ensure the service of the vehicle is being carried out in line with the parameters set in the servicing schedule. From the testing undertaken, audit noted seven vehicles that have not been serviced in line with the servicing schedule, with the following results: • Four ARV's which were serviced after the 6,000 mile interval (ranging between 6,900 – 11,600 miles after the previous service); • One ARV which was serviced after approximately 4,000 miles; • One vehicle that was not serviced after the 12 month interval; • One response vehicle being serviced after 8,700 miles after the previous service (as opposed to 8,000) and; • One response vehicle was serviced after approximately 6,800 miles after the previous service (as opposed to 8,000 miles). *Risk:* Non-compliance with the Force's servicing schedule, does not demonstrate value for money for services that are being undertaken before their due date. The Force cannot demonstrate value for money is being achieved for services completed after their due date, as this increases the likelihood of further costs being incurred later in the life of that vehicle.	through accurately tracking the mileage of vehicles, and ensuring these are booked in for the required work in a timely manner, particularly for vehicles that the manufacturer stipulates should have their oil changed every 6,000 miles.		workshop environment the updates will be instant and the data integrity will be greatly improved. The service schedules set are a guide and a cushion is built in for additional mileage incurred this has to be done to enable an unforeseen lack of vehicles due to (RTC, Defect which cannot be planned for) Looking to invest in a new telematics solution which will enable direct accurate mileage data from vehicle canbus to Fleet management system. Update 28/10/20 – As per 4.2 Update 04/6/21 – As part 4.2 (Tranman upgrade has been approved and is currently with Mint). Update 02/08/2021 – As above. Update 18/10/2021 – As above. Update 11/01/2022 – As above. Update 17/02/2022 – As above. Update 20/04/2022 – As above. Update 02/09/2022 – This recommendation can now be closed. Telematics and Transman have been live for a while now. Further improvements are planned; however, these will progress over the next few years.		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Increased risk to the safety of officers, as a result of delayed services of ARV's.					
4.4	**TranMan Record** *Observation:* A job card is generated for each time a vehicle is repaired/serviced at the Force's workshop. This is a paper copy which lists details pertaining to the vehicle, including the mileage and registration, the reason why the vehicle has been called into the workshop and details of the work undertaken including parts used, their costs and any labour costs. This paper based data then requires manual input into the TranMan system. Audit reviewed a sample of 10 vehicles to ensure the records of vehicles recorded on the TranMan system are up to date and can be reconciled back to the respective job cards. Audit testing found five instances where the record of the vehicle held on TranMan did not reconcile with the information recorded on the physical job card. The discrepancies occurred on the following vehicle records: • KX12FKY • VK63RJJ • KX65DOH • FV63EBM • KX12DVF Furthermore, audit noted one vehicle (KS53RYB), which last had a service and MOT completed on 04/02/2020. However, the service and MOT prior to this was completed on 06/12/17 – demonstrating in a delay of over two years. Audit queried this with management and were advised during those two years, this vehicle was being used as a training vehicle and therefore had not left the site. However, audit were not provided with sufficient evidence to support this. *Risk:* Records held in TranMan are not accurate, which could render the servicing and maintenance programme ineffective, as services and MOT's will not be undertaken at the right time. Furthermore, the Force's servicing programme does not represent value for money.	The Force should ensure the records held on the TranMan system are accurate, as the Force utilises the TranMan system to coordinate the servicing programme. Furthermore, the Force should explore the possibility of moving away from an over reliance on physical copies of job cards, thus reducing the risk of human error. This can be done by exploring ways to integrate the process of inputting data of completed services into the fleet management system automatically.	**2**	Due to the current paper-based process the timings between closure of job cards and manual input onto the system creates the issue. As per management comments to 4.3 above the new system with tablets will replace this entire process and ensure the Fleet Management System remains accurate and correct. Update 28/10/20 – As per 4.2 Update 04/6/21 – As per 4.2 (Tranman upgrade has been approved and is currently with Mint). Update 02/08/2021 – As above. Update 18/10/2021 – As above. Update 11/01/2022 – As above. Update 17/02/2022 – As above. Update 20/04/2022 – As above. Update 02/09/2022 – This recommendation can now be closed. Telematics and Transman have been live for a while now. Further improvements are planned; however, these will progress over the next few years.	March 2022 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.5	**Jobs raised on TranMan** *Observation:* Jobs are raised on the TranMan system when work is required on the vehicle, these are categorised as – Services, MOTs or defect jobs (other types of job). As the use of Physical Job Cards requires manual input into TranMan (see 4.4 above) jobs are only closed when they have been input. Audit reviewed the TranMan dashboard, which provides an overview of any outstanding/upcoming jobs pertaining to the Force's fleet and noted the following results: • 167 Services due in the next four weeks • 0 services overdue for more than seven days • 121 defect jobs over seven days • 0 MOTs overdue • 19 MOTs due in the next seven days • 271 jobs over seven days old Audit queried the reason as to why 271 jobs were over seven days old, and were advised this is a result of the following issues: • Service jobs and MOT's which have been raised before their due date and therefore cannot be closed until these are completed; and • Service jobs and MOT's which have been completed, but the corresponding record on TranMan has not been updated. The latter issue has been caused because the member of staff responsible for updating the TranMan system has been shielding due to Covid-19 and has only acquired a work laptop in the last three weeks. Furthermore, the use of paper job cards has contributed to the time lag, as these have to be delivered to the member of staff who is shielding at home, after the service or repair job is completed. Audit also queried the existence of 121 defect jobs that are more than seven days old, and noted that these jobs related to minor defects and minor RTC's which will not be rectified until the vehicle is booked in for a service. *Risk:* The scheduling of services and repairs cannot be carried out effectively. Performance reports produced are not accurate.	The Force should ensure that jobs raised on the TranMan system are accurately categorised with priority level and timescales for completion. This will allow greater clarity of the performance of the technicians, and permit better management of the servicing programme including scheduling services effectively, particularly as the Force rely on manual insertion of data from physical job cards. The TranMan dashboard should be updated to show a clearer picture of outstanding work needed on the Fleet, this should include appropriate prioritisation of the jobs that have been raised. Furthermore, where a defect job	**3**	Unfortunately, there is a large cost implication to change the Dashboard configuration but with the introduction of the Fleet Management system the dashboard can be configured accordingly. Update 28/10/20 – As per 4.2 Update 04/6/21 – As per 4.2 (Tranman upgrade has been approved and is currently with Mint). Update 02/08/2021 – As above. Update 18/10/2021 – As above. Update 11/01/2022 – As above. Update 17/02/2022 – As above. Update 20/04/2022 – As above. Update 02/09/2022 – This recommendation can now be closed. Telematics and Transman have been live for a while now. Further improvements are planned; however, these will progress over the next few years.	March 2022 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
		relates to a minor RTC, the Force should ensure these are categorised accurately, so as to prevent the convolution of the different defect jobs, all of which warrant different priority levels.				
4.6	**Replacement of Vehicles** *Observation:* From a review of the Vehicle Replacement Policy Schedule 2020-21, audit noted there is a guidance document which indicates the replacement interval for each vehicle model, based on the vehicle life and the mileage with no vehicle having a vehicle life beyond 10 years. However the schedule mentions that certain vehicles, namely Response and Neighbourhood vehicles, will be reviewed at 100,000 miles so that it is not necessary that the age of these vehicles will be given priority, as mileage is considered the cost effective parameter. Audit reviewed the list of vehicles that the Force has in the fleet and noted 46 vehicles that were older than 10 years. All 46 vehicles were raised with management, and it has been noted that these are pending replacement. From a review of 23 of these vehicles, it was noted the Force has either replaced, is planning to replace, is salvaging or auctioning 16 of these vehicles. For the remainder of vehicles, the Force had a sound reasoning why vehicles were being retained, including vehicles that are being used as training vehicles but with mileage in excess of 100,000. However per the current guidance retaining vehicles beyond ten years is contrary to the guidance provided in the Vehicle Replacement Policy. Moreover, through discussions with the Head of Transport, it has been noted that the Force intends to	The Force should clarify their position regarding what their priorities are relating to older vehicles, whether this is to ensure that the maximum utilisation is sourced from the vehicle or whether priority is to be given to the tailpipe emissions objectives. Once a clear approach has been agreed, a longer term replacement schedule should be drafted to support the future	**2**	The replacement programme is currently based on mileage and age and role of vehicle but emissions will start to factor more prominently in the coming years and this will be part of the replacement programme. After this end of financial year we will be in a much better position with the replacement/removal of older vehicles. The training vehicles are not driven mainly used for searches, prisoner scenarios and would not be cost effective to purchase a vehicle solely for that use as it would use minimal mileage, hence the retention of high mileage/age vehicle which are at end of life. Transport Strategy and Replacement programme will be reviewed to reflect the needs of the Force whilst being mindful of the emissions objectives. Update 03/12/20 - No decision has been made around purchasing the vehicles according to emissions due to the nature of the emergency vehicles. We are currently looking at an EV scoping review to advise	March 2021 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	replace vehicles pre-2015 due to the changes in the regulations relating to emissions under the Road Vehicle Emission Performance Standards. However this is not currently factored into the existing Vehicle Replacement Policy. *Risk:* The Force are unable to demonstrate alignment to their carbon emission objectives, through the retention of older vehicles. Non-compliance of the guidance provided in the Vehicle Replacement Policy, as the vehicles used for training are over 100,000 miles.	capital requirements to meet the fleet replacement needs.		on charging infrastructure as without this we are unable to purchase fully electric vehicles. Update 23/03/21 - This has been reviewed and the bulk of the mentioned 2015 vehicles have been removed from the fleet. The new Transport Strategy will include the requirement of the Force to be able to utilise their fleet assets as required by the wider operational needs, such as the ability to retain vehicles past 10 years for training purposes or for use as Ghost vehicles. These usages are an essential operational tool and were missed for the previous Transport Strategy but will be built into the new Fleet Strategy to be in place by the end of 2021. Update 15/06/2021 – No further updates from the last period, most of the requirements will be rectified with the implementation of new Fleet Management system and Telematics which hopefully will be later this year and we will be in a considerably improved position for our next audit. Update 02/08/2021 – As above. Update 19/10/2021 – The replacement programme is rationalised across both mileage and age of vehicle not carbon emissions. When the audit was carried out, we had vehicles that should have been replaced due to age but due to budget constraints they had been extended, the majority of these have now been replaced through the replacement programme. Update 17/02/2022 – Due to delays with delivery of replacement vehicles we have		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				had to extend target replacement mileages on vehicles. Update 20/04/2022 – With the ongoing delays with delivery of replacement vehicles mileages will continue to be extended to provide resilience for the frontline. 21/06/2022 – We are still experiencing delays in replacement vehicles due to Covid/Ukraine as vehicle manufacturers try to source parts to build/repair vehicles.		
4.7	**Lack of Performance Monitoring and Reporting** *Observation:* There are no arrangements in place to monitor performance against the Transport Strategy, and as such the Force is unable to demonstrate adherence to the OPFCC's strategic objectives set out in the Police and Crime Plan 2019-2021, particularly ensuring the service is the most efficient and effective it can be. The performance in the workshop is not monitored due to the ineffectiveness of the TranMan system and the integrity of the data recorded within the system. There is no management information available which robustly monitors performance against the Transport Strategy. This prevents the Force from demonstrating value for money has been achieved in the management of the Transport vehicles. Furthermore, these vehicles are considered to be valuable public assets and the Force are unable to demonstrate robust scrutiny of performance has therefore taken place. *Risk:* There is an insufficient oversight over Transport, and improvement opportunities are missed through a lack of scrutiny.	The Force should effectively scrutinise the performance of the Transport department, and frequently set performance objectives to ensure the department's operations represent value for money to the Force. This should include the production of performance reports, which monitor a set of KPI's the Force aims to achieve from the fleet. Furthermore, the Force should undertake an exercise to	**2**	As noted in comments above - Implementation of new Fleet Management System will enable with agreed KPI's to be set that can be easily reported on. Update 28/10/20 – As per 4.2 Update 03/12/20 - The current KPI is 95% availability which we have maintained this year, this again is a manual report and an automated report is being built into the FMS. Update 04/6/21 – New KPI reports are now in place and monthly / quarterly review packs are being created for release. This combined with the upcoming Tranman upgrade will allow improved monitoring of fleet management and reporting. Update 02/08/2021 – As above. Update 18/10/2021 – As above. Update 17/02/2022 – As above. Update 20/04/2022 – As above.	March 2022 Theresa Cheney	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
		quantify the amount of productive time the Force is losing due to manually inputting data into the TranMan system. This will enable the Force to better understand the additional costs being incurred as a result of the current system. This exercise could also include assessing the cost of holding inaccurate data and the impact this is having on the servicing programme. The result of this will enable the Force to effectively compare the advantages against the disadvantages of the current TranMan system.				

GDPR Follow Up – February 2021

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**ICO Action Plan** The Force has engaged well with the ICO acknowledging its shortcomings, weaknesses in controls, insufficient resources and dealing with	The Force should maintain its focus on the completion of the	**1**	Recommendation accepted and already incorporated into the response being made to the ICO as part of their ongoing 2020	Interim audit was returned in January 2021	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	backlogs. To this end the Force has committed to a Data Protection Action Plan following an audit by the ICO in September 2020. The progress of this action plan is regularly assessed both internally and by the ICO with the most recent update being in January 2021. This most recent update demonstrated considerable progress has been made but further work is required to address the remaining outstanding actions. A further review by the ICO is planned for May 2021. *Risk:* The Force is unable to demonstrate progress to the ICO and compliance with regulations, leading to further action including potential fines.	outstanding actions within the ICO/Data Protection Action Plan.		audit covering Accountability & Governance, Records Management and Training & Awareness. Level of assurance will be reported upon by the ICO. Update 07/06/2021 - The ICO have confirmed that they won't be returning in September and have received sufficient assurances to allow them to close the audit with 63% of the actions agreed as completed. It is still however the case that we need to complete the remaining actions in good time, and we will be expected to meet the timeframes that we have set for specific pieces of work. It is the case that the outcome of this work will be publicly visible via our website and is therefore available to check by the ICO through open source. One action related to a suite of Infosec policies (action GA05). This has been agreed as completed by the ICO. There are risks that remain and work yet to be completed by the ICO, but the audit will not run to September as previously thought. Update 23/08/2021 – Although the ICO closed their audit for the purpose of returning in September, we have continued to work on the outstanding actions from the original plan. Since the ICO finalised their follow up audit we have locally closed another 17 actions, which have been closed as suitably actioned by DCC Nickless, most of which related to the completion of RoPA and associated works required. The intention was to have all remaining actions closed by September (local	which provided acceptance and closure of 30+ actions. The May interim audit has been submitted but is awaiting response. The audit is due to close September 2021 when assurance should be provided in full.	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				deadline of 31/08/21) as we would have intended for the ICO. We have continued to push for this and although some of the remaining actions will be closed, a number will remain open and are likely to remain open for some time due to the added complexities we have found since the original audit in relation to records management, however I would suggest that if the ICO were to return and audit these elements further they would be assured that our ongoing work against what we had found in addition to their actions would be evidenced as work in practice and continuous improvement on the original status. For this reason, despite the additional closures and ongoing works, I would suggest that it is appropriate for this RAG to remain at Amber for the time being. Update 17/09/2021 – As above. Update 18/10/2021 – We have continued to work towards the closure of all ICO actions. As work has moved on, we have identified greater needs and therefore prolonged timescales although the original essence of the action remains the work around rectification of the matter has changed. To ensure this work continues, it has been cross-referenced in the ICO action plan with a new action raised in the Information Assurance Action Plan as the greater piece of ongoing work. For the purpose of the internal audit register, I would suggest that the RAG remains as amber as the action remains open. Update 10/01/2022 – No change. Awaiting outcome of current audit and then will reassess.		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				Update 10/02/2022 – As above. Update 20/04/2022 – As above. Update 01/07/2022 – As above. Update 02/09/2022 – Risk: Controls, insufficient resourcing and backlogs. Also, ICO audit and additional reviews. Recommendation: Focus on necessary actions regarding ICO requirements and audit action plan. Response: ICO audit has now been closed with actions being addressed either directly or through other works completed. This doesn't mean there isn't further work to do. Information governance moves on and we are now measuring ourselves against the ICO Accountability tracker, this is highlighting new areas of focus, but we are separate to the risk raised here. The last remaining actions from the audit were in relation to records management. As these actions were addressed additional risks were identified. These are now all being addressed through the force Record Manager, focusing on the force RoPA and Asset Register and what feeds into that and also comes out of the process this in line is informing the audit plan which is also addressing risks to Information Management. The expansion of the MoPI team looking at the review, retention and deletion of force records is addressing the remaining concerns in relation to records		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				management and although that team expansion is still in the pipeline the budget has been agreed. Estates are expanding the available work area and by the end of September 2022, with a view to being RRD compliant, particularly in legacy data by September 2026. In relation to ICO associated work backlogs, there is no-longer a recordable risk for our force. There is of course always a risk of having backlogs and there is no pattern or trend in our work that allows for prediction and work planning. The current position, at todays date, we have only two overdue requests relating to this risk area. With regard to RAG until the MoPI tram are in place and the project is up and running to address the remaining RM issues I would suggest that we still flag as an amber however all other elements, in my opinion are now green. Timescale: For the remaining element I will put 01/11/22 as being able to report a position in relation to the MoPI team.		

Workforce Planning – April 2021

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Workforce Planning Strategy** The Force do not currently have an overarching Workforce Planning Strategy document. This is a key document, around which all Workforce Planning Processes should be structured and aligned to. This should also outline key roles and responsibilities, risk management processes, decision making and reporting arrangements.	The Force should produce a Workforce Planning strategy and set a timeline for its completion against which progress should be reported.	**2**	We have multiple documents e.g. Culture and People Strategy, FP25, but not a document that brings it together. We agree with this recommendation to produce a Workforce Planning Strategy.	Approved Workforce Planning Strategy to be produced by August 2021, with an annual	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	It should be noted that there are a few documents that have already been produced, e.g. the Talent Management Strategy, that aid the Workforce Planning process and would usually form the basis for an overarching strategy. The Force should also consider for future years, assessing prior year performance and lessons that can be learned. *Risk:* There is no overall direction for Workforce Planning, leading to operation inefficiencies.			Update 18/06/2021 – Workforce planning strategy presented at FEM, feedback received and construction of strategy in progress. Update 02/08/2021 – Workforce Strategy agreed and now in place. Also instigated a bi-monthly Workforce Planning Meeting for constant review and ensure deliverables are met. CLOSED.	review and update Head of Joint HR and Workforce Planning Manager	
4.2	**Succession Planning** The Force are in the process of improving their workforce succession plans. They have purchased a specific programme, 'Talent Successor', for this. However, this is not yet in operational use and the data inputting exercise is still to be undertaken. Initial interviews to gather the data have been held with senior stakeholders. Audit reviewed the questions that formed the basis of the interviews and confirmed that they are pointed towards achieving succession planning objectives. However, it is critical for purposes of future planning and gap analysis that this system be fully established soon. *Risk:* The Force is unable to fill key roles sufficiently quickly leading to operational deficiency.	Due to the criticality of this process to Force operations, a comprehensive review of this system should be undertaken at a set date to ensure the data is complete and appropriate for operational purposes. Consideration should be given to producing a formal timetable for completion of this project.	**2**	The Talent Successor requires scoping to ensure it meets the requirement of the Force. We agree a project plan is required to implement the Talent Framework. Update 18/06/2021 – Project in scope now (delay due to resources capacity). Update 02/08/2021 – Succession planning outline presented to CoT. Talent Successor project started, with trial on Inspector succession planning in November 2021. Update 15/09/2021 – The Talent Successor Project is running at a pace with the pilot due to go live imminently. A working group has been established and is meeting regularly to work through the implementation. We will be testing the system with those Sergeants that have registered for the NPPF Step 3 Professional Discussion to Inspector rank in November 2021. Update 18/10/2021 – Implementation plan established and on track to pilot with Sgt to Insp promotion in November. Further testing with operational staff and staff areas scheduled before full roll out.	Scoping by June 2021. Project plan aligning with Talent Framework to be activated by September 2021. HR Manager – Leadership and Management	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				Business critical roles to be included by April 2022. Update 17/01/2022 - Ran pilot in November and reviewed results and consulted with Headlight. Identified bug in analytics which has been rectified by Headlight and identified changes required to streamline the process. Further testing with PC – Sgt promotion progress agreed. The intended roll out across Force is scheduled for March 2022. Update 04/02/2022 – Sergeant pilot progressing with access given to candidates and line managers with supporting guidance video clips. Following Sergeant pilot concluding in May, agreed FCR as next area to roll out to. Update 21/04/2022 – As above. Update 27/06/2022 – As above. Update 02/09/2022 – The Talent Planning module was rolled out across the Force in June 2022, with guidance to officers and staff on using the system to let the force know their future aspirations. A successful pilot was completed with the Sergeants Promotion Process and further guidance on use of the system is planned for next week (w/c 12th Sept) with PDR/Talent drop-in sessions already running for individuals and managers. Once critical roles have been received from Workplace Planning these can be added to the system as talent pools have successfully been produced for Sergeants and Inspectors.		
4.3	**Vacancy Panel** The Force currently convene a bi-weekly Vacancy Panel that has oversight of all police officer vacancies.	The Force should consider creating a more direct feedback	**2**		June 2021	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	One of its primary tasks is to make decisions on vacancy requests that have been submitted by departments within the Force. These decisions are logged in the Vacancy Decision record. Audit reviewed the most recent Vacancy Decision record at the time of testing (05/01/2021). This record focuses on 'reason for vacancy' and 'comments from requestor'. There is seemingly only a 'Approved/ Not Approved' decision column from the board and no explanation or reason given. Furthermore, some of the requestor comments only state 'can this be discussed at the next vacancy panel? Many thanks', which is pulled straight from the request form. Through discussions with the Force, it was noted that some requests are made multiple times without amendment leading to repeated rejection. Hiring Managers will often also come to the Workforce Planning HR Manager for explanation. Both issues would be aided by a more direct feedback process. Concerns have also been raised that delays to the recruitment process arising from these inefficiencies could have an operational impact as roles aren't fulfilled sufficiently quickly. The Vacancy Panel process may also benefit therefore from the attendance of Heads of Department when vacancies in their area are being considered. This would allow them to elaborate further and answer any queries over the vacancy request that the panel may have, meaning the request can be agreed or amended sooner. *Risk*: Inefficiencies within the vacancy process cause unnecessary delays in recruitment process	process for requests to the Vacancy Panel that are rejected and mandating that feedback must be addressed before another request made. The Force should consider creating a process where Heads of Department are specifically invited to pitch Vacancy Requests to the panel.		We agree with this recommendation and will update the policy and process to enable this to happen. Update 18/06/2021 – Process in place, all vacancies recorded with decisions. Chief Superintendents attending on behalf of their commands, information received prior to meeting for prep. Staff vacancies process changed to weekly email approval to speed up process, all actions recorded. This action is now complete. CLOSED	Workforce Planning Manager	
4.4	**Establishment Officer Log** At present, the costs associated with the establishment structure are updated and reconciled with the Finance department through the Establishment Officer, who has responsibility for monitoring and amending establishment data, holding a series of informal meetings with various team leads on an ongoing basis. There are currently no records kept of each meeting.	The Force should consider how they can efficiently record the agreed actions and other notes from the meetings between the Establishment officer and various departments.	**2**	We agree with this recommendation and will update policy and process as suggested. Update 18/06/2021 – These meetings were due to take place in May but were postponed due to year end reviews and budget setting for 2021/22. These are now due to take place in June/July.	July 2021 Finance and Establishment Officer	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	The lack of recorded actions from these meetings creates a resilience risk should any of the key staff involved be unavailable. *Risk:* There is no clear record of decisions that have been taken, leading to insufficient oversight. *Risk*: The Force is unable to ensure consistent practice in the event of staff absence.			Update 03/08/2021 – The Establishment Change Tracker is now fully up to date with finance agreements. Regular meetings are now taking place between the Establishment Officer and Finance Team members to agree true establishment budgets. CLOSED.		

Governance – November 2021

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Review of Policies** The OPFCC website contains a section dedicated to the publishing of policies. Audit reviewed the following policies: • OPFCC Code of Conduct • Equality & Diversity Policy • Record Retention Policy • Anti-Fraud & Corruption Policy • Whistle Blowing Policy These policies indicate that they should be subject to review on an annual basis, however this could not be evidenced by a document control section. Due to this, it is not possible to determine when the document was last reviewed and updated. Through discussions with management, it was identified that the main policies and procedures located on the website are reviewed after each publication of the Police and Crime Plan. The last PCC election was undertaken in 2016 and following the elections in May 2021, in line with legislation, the next Police and Crime Plan will be published in March 2022. The review of the Code of Conduct (published 2016), Anti-Fraud and Corruption Policy and the Whistle	Policies published on the OPFCC website should be updated to contain a document control section indicating the date that the policy was last reviewed and updated.	**3**	Agreed – a document control section will be added. Update 12/01/2022 – Work is in progress on this recommendation. Update 07/02/2022 – Work is in progress on this recommendation. Mark Stuart has done an awful lot of work on them, so we expect more movement after the March deadline. Update 20/04/2022 – No recommendations have been actioned yet as different priorities took over. Our revised completion date will be the end of May, our aim is to complete them before the next update to the JIAC. Update 07/06/2022 – All policies were reviewed and updated in May 2022. A small number have identified on the website where a further review is underway. Additionally, a sign off and	March 2022 Head of Governance	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Blowing Policy (published 2015) since the date of publishing was not evidenced. It is noted that due to a move of the OPFCC headquarters, the Record Retention Policy has now been updated and published on the website, and in addition to this, the Equality & Diversity Policy was updated in June 2020 however this is not evident from the policy itself. *Risk:* Lack of transparency where it is not possible for the public and/or staff to determine whether the policies located on the OPFCC website are still relevant.			version box has been added to each Policy, Action now complete.		
4.2	**Decision Records** The Decision Making Framework is included as an Appendix to the Joint Code of Corporate Governance and states: *All decisions of Significant Public Interest will require the PFCC to sign a Decision Record, which will be published on the PFCC website within 5 working days of the decision. Alongside the publication of the Decision Record, all material information used to make the decisions will be published, including an officer report to the PFCC in the format specified in the "Supporting Report Template" to the Police and Crime Commissioner", as attached to this appendix.* Audit reviewed a sample of 8 decisions from a total of 40 made in 2021, and it was found that a decision record has been published online for all sampled. In addition to this, at the request of audit, a sufficient level of supporting information was available to justify the decision, however, a supporting officer report had not been published for any of the decisions sampled. Upon review of the remaining 32 decisions published on the OPFCC website, it was also found that none of these were published alongside an officer report. In discussions with management, it was states that the supporting information related to decisions is	The OPFCC should clarify their publication requirements for decisions set out within the Decision Making Framework. Once agreed, this should be clearly communicated to relevant staff to ensure compliance.	**2**	Agreed – the Decision Making Framework will be reviewed and communicated. Update 12/01/2022 – Work is in progress on this recommendation. Update 07/02/2022 – Work is in progress on this recommendation. Mark Stuart has done an awful lot of work on them, so we expect more movement after the March deadline. Update 20/04/2022 – No recommendations have been actioned yet as different priorities took over. Our revised completion date will be the end of May, our aim is to complete them before the next update to the JIAC. Update 07/06/2022 – The review of the Decision-Making Framework has now been rescheduled for the Summer 2022 which will align with the update of the PFCC website which is being undertaken. Revised timescale for completion end of September 2022.	March 2022 Revised estimated completion date of September 2022 Monitoring Officer/Head of Governance/Chief Finance Officer	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	supplied on request. Furthermore, summaries of every decision are provided to the public meeting of the Police, Fire and Crime Panel where questions are asked and responded to by the PFCC. Management also advised audit that the officer report within the decision-making framework is a template and that certain decisions will be made based on different information. For example, a business case for the purchase of a new building is different to procurement and budgetary information supporting the decision to award a contract extension. A detailed signing report is considered by the PFCC which supports decisions which are made; however, this control was introduced after the introduction of the decision-making framework and therefore is not referenced within it. Audit were provided with copies of these signing sheets as supporting evidence. *Risk:* Where supporting information related to a decision is not published on the OPFCC website, there is a risk of a perceived lack of transparency leading to reputational damage. The PFCC does not comply with the Decision-Making Framework.			Update 09/08/2022 – Not yet due, it is still envisioned this will be complete by end of September 2022.		

2021/22

Data Management – March 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Regular Review of Documentation** *Observation*: Audit reviewed 19 policies, procedures and guidance notes related to information security and noted that of those 19: • 6 had not been reviewed in a timely manner (i.e., in over 2 years where document control states annually),	The Force should review policy, procedure, and guidance documents regularly. This should include updating the document control sections even where no update has been required and	**3**	Policy templates have been updated and the library owner rejects all submissions not made on the new template. This template includes a control section and is the same template used for process/procedure. As documents are reviewed and updated, the template will be	March 2023 Data Protection Officer, Information Security Officer	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	• 3 were still under review • 3 were new documents not yet due for review and the remaining Additionally, it was noted that there were 3 different formats provided for guidance notes with differing levels of document control sections, including 2 guidance notes that had no document control at all. *Risk:* Policies, processes and guidance documents are not reviewed and provide out-of-date/incorrect guidance.	adding document control sections where required. The Force should consider consolidating guidance document formats.		seen more widely. See Action Plan IAB/007/22. The template is already in place in Information Management. Documents will be updated over a course of 12 months as review dates are highlighted. Update 20/04/2022 – Manager's response was made accepting the use of set templates for policy and to reduce the use of DPIA's, bringing a screening checklist instead, which is under development and tested last week. Update 07/09/2022 – This recommendation can be closed as this is now live.	and Records Manager.	
4.2	**Reference to DPIA Requirements** *Observation:* Data Protection Impact Assessments (DPIAs) are an integral part of UK GDPR, enabling organisations to clearly identify and minimise data protection risks within processing activities and projects on the protection of personal data. The Force is currently carrying out DPIAs over all new processing activities and projects, due to the perceived lack of knowledge and data maturity within the Force by the Information Unit. Due to the use of DPIAs for all new processing activities and projects, we would expect to see references to the DPIA process within the main Information Security Policy and any supporting documents where DPIAs may be relevant (i.e., enabling guidance relating to the Organisation of Information Security, Information Security Incident Management and/or Compliance). Audit reviewed all 19 existing policies, procedures and guidance notes related to information security and found that only the Force's Information Security Policy	The Force should consider including references to DPIA requirements, where applicable within process, procedure and/or guidance documentation.	**2**	Info Management will begin to work to a position where DPIA's are used less frequently and applied in a blanket fashion to all new processing and projects. A screening checklist will be produced which will identify the need for a DPIA rather than it being used to fill the knowledge and data maturity gaps. The checklist will be utilised for review work initially and as risk is identified and reduced and lower than initially thought, understanding is increased and better processes generally are introduced across force the checklist will be used more generally and the DPIA used less widely for new, innovative and/or high-risk processing. Checklist and process to be created and introduced to asset owners, change teams and projects leads. Responsibility for completion is with the Data Protection Officer.	Timescale for checklist and introduction September 2022. Timescale for position of reduced use of DPIA to fill gaps caused by data immaturity March 2023. Data Protection Officer	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	referred to the DPIA requirements, with no references in any of the supporting enabling guidance or procedure documents. *Risk:* DPIA process could be overlooked due to not being included within existing procedure documentation.			Update 20/04/2022 – Manager's response was made accepting the use of set templates for policy and to reduce the use of DPIA's, bringing a screening checklist instead, which is under development and tested last week. Update 07/09/2022 – This recommendation can be closed as this is now live.		

Business Change – March 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Benefits Realisation** *Observation:* The Project Initiation process requires either a project mandate, project brief or business case to be developed for all proposed projects. These documents include the identification of potential benefits that may result from the project, how to quantify them and targets to be monitored against. The Portfolio Office provides templates for Business Realisation Plans to be used as live documents for the identification, tracking and monitoring of benefits throughout the project lifecycle. This document also easily allows the Portfolio Office to ensure that benefits monitoring is being carried out by the project team. Audit has reviewed project documentation for three business change projects and noted that, for two of these, the benefits had been outlined in the Business Cases but had not been transferred to the Business Realisation Plan template to allow for tracking and monitoring in a live document.	The Force should ensure that benefits are clearly defined within project initiation documents and are transferred to Benefits Realisation Plans for monitoring, in line with implemented policies and guidance.	**2**	The updated business change and change management process will ensure that all project mandates, briefs, and business cases will come to the Portfolio Office for support and quality assurance before they are submitted. This is already happening to a large extent and the quality assurance includes making sure that benefits and return on investment are identified. It is recognised that we have to get better at lifting these in a plan for monitoring and this is something we have in hand. The highlight report summary that is submitted to Change Oversight Group does have a column that provides a benefits summary for each project or programme and a milestone plan is submitted that identifies when new capability will land. The Portfolio Office does have a business change manager that attends project boards that are run by our resources, but	31st May 2022 January 2023 Portfolio Office	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Risk: Benefits are not identified, quantified, and monitored for the entire project lifecycle. Projects fail to deliver their intended benefits.			less so for those that are not managed by us, this is something we will look at. Update 12/04/2022 – As above. We have provided a professionalising business change document to Mick Stamper, which, if approved, will resolve all the recommendations raised in the audit. It will take some time to embed. Update 08/06/2022 – The professionalising business change document, containing 21 recommendations was presented to FEM on the 7th of June 2022 and all recommendations were accepted. Benefits specific recommendations were: • All change will be business lead, including the tracking and realisation of benefits • The business lead is responsible for ensuring progress of benefits realisation for all change projects/programmes • All project briefs and business cases will identify benefits and return on investment • Benefits will be tracked and updated both during and post the change (to capture future business cycles) Work will now take place to embed this into the organisational change process. The Portfolio Office has been successful in a bid to recruit a Benefits Realisation Manager, and this is being progressed. The employment market will dictate when this role can be filled. Update 25/08/2022 – The Benefits Realisation Manager role is now out to advert, there were no applications in the		

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				first three weeks, so the deadline has been extended to the 5th of September. The lack of applicants could be due to it being prime leave period, but we will monitor and look at other options. The approved recommendations in the professionalising business change document are now starting to take shape with more project briefs being submitted to the portfolio office which then enables us to scrutinise the benefits of ROI.		
4.2	**Benefits Monitoring** *Observation:* As above, the Portfolio Office provides templates for Business Realisation Plans to be used as live documents for the identification, tracking and monitoring of benefits throughout the project lifecycle. This document also easily allows the Portfolio Office to ensure that benefits monitoring is being carried out by the project team. Audit has reviewed project documentation for three business change projects, and we were unable to confirm the monitoring of benefits throughout the entire project lifecycle to date. *Risk:* Benefits are not identified, quantified, and monitored for the entire project lifecycle. Projects fail to deliver their intended benefits.	The Force should ensure that benefits monitoring is carried out for projects through communication with project leads and encouraged use of the Benefits Realisation Plans. For larger projects, presentation of Benefits Realisation Plans to project boards and attendance of a Portfolio Office representative may also be effective.	**1**	It is recognised that as an organisation, we need to be stronger at benefits realisation. Where projects are being run by the Portfolio Office, we do track benefits and provide a report to the Change Oversight Group (COG). This is a standing agenda item for the meeting. Benefits realisation reporting is less so for projects that are not managed by the Portfolio Office, and we are looking at how we address this through learning, guidance and embedding processes. In reality though, throughout the project lifecycle, the focus is on delivery and the benefits often get left behind. The project team then disbands, and the benefits realisation can get left behind. To address this, we will aim to introduce checkpoint meetings post implementation to assess progress against benefits realisation. We will also feed this into the efficiency programmes that we have running in force. Update 12/04/2022 – As above. We have provided a professionalising business change document to Mick Stamper, which, if approved, will resolve all the	31st May 2022 January 2023 Portfolio Office	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
				recommendations raised in the audit. It will take some time to embed. Update 08/06/2022 – The professionalising business change document also outlines support and upskilling for business change leads so that benefits are monitored pre and post change. The Portfolio Office will also support with identification of benefits and frameworks for measuring/monitoring. The Business Change Manager already supports with many aspects of benefits identification and has developed a template framework which will continue to be refined. Update 25/08/2022 – The Benefits Realisation Manager role is now out to advert, there were no applications in the first three weeks, so the deadline has been extended to the 5th of September. The lack of applicants could be due to it being prime leave period, but we will monitor and look at other options. This post will support the benefits monitoring process, and also provides benefits reports to the Change Oversight Group as part of a standing agenda item. The portfolio office will look to develop a framework and tracking tool when the new benefits realisation manager arrives but there are processes in place. The business change manager also delivers training to the 2nd line managers in both business change and benefits, to increase knowledge and awareness across the organisation.		
4.3	**Use of Milestone Plans** *Observation:* The Project Initiation process requires either a project mandate, project brief or business case to be developed for all proposed projects. These documents include the identification of key project	The Force should ensure that, where produced as part of the Business Case/PID, Milestone Plans are updated to monitor and track progress of the project.	**2**	The project manager does monitor the milestone plans but this was difficult to represent as part of the audit process as there is often only one plan which is dynamic. Monitoring is normally done	31st May 2022 Portfolio Office	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	milestones that can be used to monitor the progress of the project. Audit has reviewed project documentation for three business change projects and noted that, for two of these, the milestones had been outlined in the Business Cases and milestone plans had been developed, however there was no evidence of these being monitored and updated as the project progressed. Additionally, the documentation related to the third project did not have defined milestones included and therefore the progress of the project could not be clearly monitored. *Risk*: Progress of the project completion cannot be clearly and effectively monitored.			through the submission of a highlight report which includes RAG status against milestones, rather than reviewing the actual plan. We will look to make this more formal by introducing a standing agenda item at project board meetings to review the milestone plan. Update 12/04/2022 – As above. We have provided a professionalising business change document to Mick Stamper, which, if approved, will resolve all the recommendations raised in the audit. It will take some time to embed. Update 08/06/2022 – The professionalising business change document includes support from the Portfolio Office through the project lifecycle and commissioning stage through to business-as-usual handover. The document recommends that a governance process is followed, and this is documented in a Terms of Reference from the SRO, critical path analysis is performed, and projects plans are in place. It should be noted that all programmes and projects that are managed by the Portfolio Office already have milestone plans in place. Update 25/08/2022 – Milestone plan templates are available on the Change intranet site and support is given for using these templates. All programmes and projects managed by the portfolio office have milestone plans.		

IT Security – April 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**IT Health Check Remediation** *Observation:* It should be noted that the GIRR is currently expired but has been submitted based on the July 2021 IT Health Check in common with similar forces. Following the July 2021 IT Health Check as of February 2022 the latest tracking figures had the following outstanding issues: • 6 Critical • 13 High • 81 Medium • 10 Low We were informed that work was ongoing to address outstanding vulnerabilities, some of which require long term resolution and they were being actively tracked and monitored, but it was acknowledged that some critical and high issues remained. *Risk:* Vulnerabilities go unresolved presenting risks to the IT security of the organisation.	Vulnerabilities should be addressed or further mitigated as soon as possible to support future GIRR accreditation.	**1**	I am satisfied that this audit report broadly reflects the current position, with some of the specifics having further improved since the Feb data was provided. Submission for GIRR was made in early February; any delay is now outside of our control due to the transition of NPIRMT into PDS. We are now expected to receive a response certificate by the end of May 22. Remaining Critical and High are regularly reviewed but all require significant work, such as major upgrades, but all are being progressed. Update 27/06/2022 – As above. Update 07/09/2022 – The HOB (Home Office Biometrics) CoCo was due to expire 18th August 2022. The Force Position confirmed to HOB we remained in the procurement stage for our ITHC with a date anticipated for end August beginning of September 2022 – leaving the force as non-compliant. NMC within force completes our internal vulnerability scanning. HOB have extended our CoCo certification for a further 6 months to allow the force a timeline to complete our ITHC. We have been advised this has now been procured and we are just awaiting a date.	April 2023 Information Security Officer	

Health & Safety Follow Up – July 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Health and Safety Policy Statement** *Observation:* The Force maintain a Health and Safety Policy Statement, which sets out the Force's intentions and objectives with regard to Health and Safety.	The Force should ensure that the review and resigning of the Health and Safety Policy	**2**	The Force can confirm that the Health and Safety Policy Statement for 2022 has been reviewed, updated, generated, and	Action completed by 30th June 2022.	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	The Health and Safety Manual states that "The Health and Safety Policy statement will be reviewed annually" and that will be "signed annually by The Police, Fire and Crime Commissioner, the Chief Constable and The Chief Fire Officer". During the previous March 2021 audit, we were provided with an unsigned December 2020 statement, and were informed by the Health and Safety Manager that this was at that time in circulation to be signed by the relevant individuals. At the time of this audit, it was noted that this iteration of the statement had been lost, and thus the most recent signed Health and Safety Policy Statement was that signed in November 2019. Through discussions with the Health and Safety Manager, audit was informed that a new statement has been drafted, for review and is due to be signed in June 2022. *Risk:* Where the Force's Health and Safety Policy statement is not regularly reviewed and updated, there is a risk that the statement contradicts the current practice or strategy regarding the H&S function at the Force. Staff are unaware of the most current version of the statement, increasing the risk that incorrect procedures are followed.	statement is effectively planned and scheduled to prevent delays. The Force should ensure that the statement planned for implementation in June 2022 is saved and made readily available to all relevant individuals.		circulated to the 3 parties for signing. The Force can confirm that the statement has been signed by The Police, Fire and Crime Commissioner, the Chief Constable and The Chief Fire Officer and returned to the H&S Manager. The statement has been scanned and is in the H&S files on the W drive and a hard copy is also kept centrally at Darby House in the charge of the H&S Manager. Copies have been circulated to all deputy facilities managers to display at all PFCC properties. Copies of the Health and Safety Policy and signed statement are available on the Health and Safety web pages.	Health and Safety Manager.	
4.2	**Health & Safety Manual** *Observation:* During the previous audit, it was noted that the Force have a Health & Safety Manual that is the overarching guidance document. However, several deficiencies were noted in the manual during the prior audit. As the manual has yet to be updated, the previous deficiencies remain.	The Force should ensure that the Health & Safety Manual is reviewed and updated. This should include referencing to the newly produced supporting procedures.	**2**	A full review of the health and safety manual has taken place in consultation with key stakeholders (including heads of department, Federation and Unison). Formal sign approval by Health and Safety Committee took place in May 2022. The committee approved the manual, and it has been uploaded onto the Force library	Action completed by 31st May 2022. Health and Safety Manager.	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Therefore, the following observations noted in Recommendation 4.2 of the previous audit remain: • *Audit reviewed the manual, and it is noted that it does not provide sufficient guidance to staff and officers in processing key tasks, such as the reporting of an accident or an incident.* • Furthermore, there is no requirement included for a regular review and update of the manual. Since the previous audit, the Force have produced standalone policies including Contractor Management and Occupational Driving to support the Health & Safety Manual, however these are not referenced within the manual. Although it was noted through discussions with the Health and Safety Manager that a new policy document is being drafted for implementation in June 2022, at the time of this audit the Force still use the same Health & Safety Manual. *Risk:* Insufficient guidance is provided to staff and officers in relation to health and safety. The Force do not meet their health and safety objectives. There is non-compliance to the joint health and safety policy statement.			and published on the Health and Safety web pages. Referenced materials for procedures and or/guidance is available and hyperlinked from the new Health and Safety manual to support users.		
4.3	**Accident Report System** *Observation:* The Force use an internal accident reporting system, that has been developed by the ISD team at the Force, for staff to report any incidents or near misses. Audit confirmed that the system has multiple stages for each accident raised. These include investigation, actions, review, and secondary investigation.	The Force should liaise with the ISD team to ensure that the identified issue with bypassed review stage is addressed.	**3**	The Force have introduced an interim process, so all secondary investigations go to the Health and Safety Manager, D&T have been advised of the long-term change that is required and a submission for D&T developer time has been requested. Health and Safety are awaiting the developer time to implement the long-term change to the process. This will involve	December 2022 Health and Safety Manager	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	The initial investigation is work flowed to the individual's line manager, whilst any actions raised are work flowed to the individuals responsible for implementing that action. A system issue was noted when the investigations are not completed by the originally assigned investigator (line manager) a secondary investigator can be assigned. However, when this occurs the system bypasses the review stage. Therefore, the accident could be closed off without the H&S Team carrying out the quality review. *Risk:* Where accidents are not subject to review by the Health and Safety Manager or by administration staff, accidents may be treated inconsistently, and inappropriate resolutions and/or actions may be raised.			adding another step for a final review step and closure. Once implemented, testing will be carried out before a final go live of the changes. Update 16/09/2022 – A service request has been submitted to D&T and we are now waiting for some programmer time to resolve this issue. However, there are more critical issues being addressed at present, which are taking priority.		

2022/23

Released Under Investigation Follow Up – June 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Longstanding RUIs** *Observation:* As per previous review, it was identified that it was necessary to prevent longstanding RUIs due to the negative effects they may present to afflicted individuals, particularly for those in the course of undergoing employment or other vetting processes. Below is a summary of the status of longstanding RUIs at the time of our audits. **RUI 1-2 Years** / **RUI > 2 Years** **Apr 21**: 328 / 139 **May 22**: 242 / 113	The Force should restart the review process for individuals that have been on RUI for longer than a year to ensure that the current backlog is significantly reduced. The Force should actively monitor and report on the aged RUI's to ensure that the transfer of responsibility and ownership of the process for reducing longstanding RUI cases to individual Chief Inspectors is	**1**	The force accepts this recommendation. Update 14/09/2022 – The Aged RUIs will be reviewed twice yearly as part of the Senior Officer Review process to drive down the numbers. The numbers have been reducing gradually and the risk is not critical, so the current 28-day review process is sufficient to manage this risk.	The first audit will be within 3 months. December 2022 D/Supt Rich Tompkins	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	While it is acknowledged that this is a reduction of 26 and 86 respectively, since April 2021, this remains a large number of individuals RUI'd for extended lengths of time. Despite the introduction of a review process for longstanding RUI cases and subsequent chasing by the respective Chief Inspectors, these have not been operating effectively to make substantial progress against the backlog. We were informed that this was in part a result of the reviews no longer taking place due to the time they require, in combination with a prevailing culture of Northamptonshire officers to assign RUI to cases as the default. It is noted that steps are being taken to automate sections of the review process for longstanding RUIs which should assist with addressing the backlog. This responsibility for review of such cases has been transferred to the relevant Chief Inspectors and their teams. *Risk:* Individuals on longstanding RUI are not treated fairly and may present a risk of reputational damage to the Force.	effective in reducing longstanding RUI's.				
4.2	**RUI Concerns** *Observation:* As per the recommendation from the August 2021 review, the Force have taken steps to ensure that RUI corrections identified, as part of the fortnightly review, are recorded on a spreadsheet which will be distributed to Chief Inspectors to cascade to their teams. IA reviewed the RUI Concerns spreadsheet from the first May fortnightly review and found that concerns had been logged, however there is no formalised procedure for identifying repeat errors and addressing these within further training materials. As a consequence, root causes for RUI errors are not sufficiently remedied which may result in slower	The Force should record the type of error as part of the RUI Concerns Spreadsheet. These recording of error types should be standardised as to allow for effective identification of common errors. Common errors should be utilised when designing future communications and training.	**3**	The force accepts this recommendation. Update 14/09/2022 – This will be part of the training and implementation plan introduced as part of the new Bail Reform Act 2022. There are no control measures necessary to manage any risk.	Within 4 months. January 2023 DCI Andy Rogers	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	reduction in the rate of incorrect allocation of RUI to individuals by custody officers. Risk: Repeated errors in processing RUI's are not identified and remedied.					
4.3	**Training** *Observation:* Subsequent to the 2021/22 review, the Force have proactively sought to increase the completion rates of NCALT Bail and RUI training by officers. We reviewed the most recently requested training log and noted that substantial progress had been made to reduce the number of officers yet to complete training from 293 to 152 since the previous review. Whilst it is acknowledged that this demonstrates good progress against the recommendation, it was highlighted to Audit that there was no intention to further proactively pursue the completion of training via regular email chasers. This decision has been made with the expectation of changes to the Bail Act in October 2022, rendering existing training outdated. Audit believe that it would be best practice to continue proactively increasing the completion rate for training to mitigate the risk of bail and RUI being administered inappropriately. *Risk:* Officers in the Force are inadequately trained and RUI's are incorrectly processed.	The Force should ensure Officers complete NCALT Bail and RUI training in a timely manner.	**3**	The force accepts this recommendation. Update 14/09/2022 – This will be part of the training and implementation plan introduced as part of the new Bail Reform Act 2022. There are no control measures necessary to manage any risk.	Within 4 months. January 2023 DCI Andy Rogers	

Complaints Management – August 2022

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
4.1	**Recording of Complaints Information** *Observation:* Upon receipt of a complaint, the OPFCC Customer Service Team assess whether a complaint should be handled under Schedule 3 of the Police	The PSD and Customer Service Team should undertake a regular reconciliation (e.g., monthly) of	**2**	While this appears to be a one-off incident, we are accepting of the audit findings and	30th September 2022	

	Observation/Risk	Recommendation	Priority	Management response	Timescale/ responsibility	Status
	Reform Act 2002, and if so, it is passed onto the PSD for investigation for email. We found that in one case (complaint reference CO/99/22), the complaint had been received by the Customer Service Team and recorded as Schedule 3, however, according to the PSD Business Manager, it was not forwarded to the PSD. Due to this, it was not possible to determine whether the complaints process had been followed e.g., an acknowledgement sent to the complainant. It is noted that this was identified during the audit and the PSD have contacted the Customer Service Team to investigate the problem. During discussions, the Customer Service Manager stated that the complaint had been forwarded on however it was not received by the PSD. *Risk:* Failure to forward complaints to the PSD leads to complaints not being investigated.	complaints forwarded and complaints received to ensure no complaints are misplaced.		recommendation as this provides an additional layer of assurance. A process for a monthly reconciliation between complaints sent between OPFCC and PSD and received will be put in place. Update 02/09/2022 – A process is now in place that will identify any missed complaints on a monthly basis. This is live now and have completed the first monthly process.	Ownership for implementation and monitoring with OPFCC Customer Services Manager and PSD Business Manager.	

Regional Collaboration Audits

2018/19

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Strategic Financial Planning	February 2019	Satisfactory Assurance	0	4	0
Risk Management	February 2019	Satisfactory Assurance	0	3	3
Business Planning	March 2019	Satisfactory Assurance	0	2	1

2019/20

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Performance Management	February 2020	Satisfactory Assurance	0	1	4
Health & Safety	September 2020	Satisfactory Assurance	0	3	3

2020/21

AUDIT	DATE	GRADE	RECOMMENDATIONS MADE		
			Priority 1	Priority 2	Priority 3
Workforce Planning	January 2022	Satisfactory Assurance	0	0	2

AGENDA ITEM: 7

NORTHAMPTONSHIRE POLICE, FIRE AND CRIME COMMISSIONER,

NORTHAMPTONSHIRE POLICE and

NORTHAMPTONSHIRE COMMISSIONER FIRE AND RESCUE AUTHORITY

JOINT INDEPENDENT AUDIT COMMITTEE

5th OCTOBER 2022

REPORT BY	Helen King Chief Finance Officer and Robin Porter ACFO
SUBJECT	Update on Fraud and Corruption Controls and Processes
RECOMMENDATION	To consider the report

1 PURPOSE OF THE REPORT

1.1 This report provides the Committee with updated details of the robust processes and procedures Northamptonshire Fire currently has in place to identify and mitigate the likelihood of fraud.

2 NATIONAL ARRANGEMENTS

2.1 In 2019, the National Fire Chiefs Council, following sector wide consultation published The NFCC Natonal Leadership Framework. This framework clearly defines the leadership behaviours required for each role within the Fire and Rescue Service. The behaviours complement our Service values which support the way we want to do things, and which we all hold ourselves accountable against.

2.2 NFRS has identified how the levels of leadership behaviours defined within the NFCC Leadership Framework aligns with all FRS staff roles, so that staff are aware of the expected behaviours associated with their role. The behaviours are discussed service wide in performance review meetings and annual appraisals to provide clarity on expected levels of performance.

2.3 All staff are expected to adhere to the behaviours relevant for their role for the purpose of performance expectations, including use within the appraisal process. overseeing that functional area.

2.4 NFCC have developed a 'Core Code' of ethics for all Fire and Rescue Services to guide all FRS employees in their day to day conduct, providing professional standards of practice and behaviour to carry out business honestly and with integrity and to underpin organisational culture.

2.5 The Core Code of ethics has 5 themes; Putting our communities first, Integrity, Dignity and Respect, Leadership, Equality, diversity and inclusion.

2.6 NFRS is in the process of embedding this core code into every aspect of its business, both day to day and operational firefighting activity.

3 LOCAL ARRANGEMENTS

3.1 Code of Conduct

3.1.1 NFRS's Code of Conduct policy sets out the general standards expected of all employees, these are in addition to any rules which apply in service areas. The code is not exhaustive and all staff are required to read and adhere to in conjunction with other service policies.

3.1.2 The Principles

3.1.2.1 The public have the right to expect the highest standards of integrity from our employees. Employees are required to:

- Always conduct themselves in a proper manner
- Not allow personal or private interests influence their conduct
- Not do anything as an employee which they could not justify to the Service
- Inform management of any breach of standards or procedure without fear of recrimination, if appropriate employees should use policy A52 – Whistleblowing
- Engage in any investigations about actual or potential breaches of this code

3.2 Our Values

3.2.1 NFRS developed its Core values in 2018 through consultation with all staff;

3.2.2 The Service Core values are threaded throughout our plans and performance framework processes and are was written follows:

4 NATIONAL FRAUD INITIATIVE

4.1 Since 1996 the National Fraud Initiative (NFI) has been undertaken which is , an exercise that matches electronic data within and between public and private sector bodies to prevent and detect fraud. This includes NFI participant bodies such as Fire and Rescue Authorities, Police Forces and OPCCs, Community Rehabilitation Companies, as well as local councils and several private sector bodies.

4.2 NFI data matching plays an important role in protecting the public purse against fraud.

4.3 For nearly two decades, this has been run every two years to help detect and prevent fraud as fraud can happen anywhere and fraudsters often target different organisations at the same time, using the same fraudulent details or identities. The NFI can help tackle this by comparing information held by organisations to identify potential fraud and overpayment.

4.4 A match does not automatically mean fraud. Often, there may be an explanation for a data match that prompts bodies to update their records and to improve their systems.

4.5 Prior to 2019, NCFRA would previously have been included in NFI as part of Northamptonshire County Council.

4.6 However, following the Governance transfer on the 1/1/19, as a separate corporation sole, NCFRA took part in the initiative in its own right in 2020 and are doing so again for the 2022 exercise.

4.7 The Internal Audit Service co-ordinate the arrangements on behalf of NCFRA; they undertook collection and review of the data for the 2020 initiative and are doing so for the 2022 exercise.

4.8 No concerns or anomalies were raised to the S151 officer from this review and the Internal Audit Team provide anti-fraud updates as appropriate in their update reports to the JIAC.

4.9 Data provided includes payroll, pensions and suppliers' data and in due course notifications will be sent and a notice published on the website.

4.10 Data matching showing little or no fraud and error can provide bodies with assurances about the effectiveness of their control arrangements. It also strengthens the evidence for the body's annual governance statement.

4.11 Colleagues from the LGSS Audit and Assurance Team are working with NCFRA. West Northants, the Pensions Administrator and NFI to coordinate the submissions on behalf of NCFRA, all of which will be due by the end of October 2022.

5 LOCAL POLICIES AND PROCEDURES

5.1 Several policies and procedures are in place which relate to managing integrity of Firefighters, Retained Firefighters and staff to which all individuals are required to adhere. These include:

- Bribery Act Compliance
- Code of Conduct
- Whistleblowing
- Drugs and Alcohol (Substance Misuse)
- Petty Cash/Imprest policy
- Government Procurement Cards
- Customer Interaction
- Complaints
- Disciplinary Procedure
- Raising Workplace concerns
- Grievance Resolution Procedure and Guidelines

5.2 All Policies, procedures and guidance documents are available to staff on 'Fireplace', the Service intranet.

5.3 The Service induction process for all new starters comprises a structured programme of learning to enable all to become familiar with role, responsibilities and the context in which they are working for the Service. Knowledge and understanding of Organisational Policies, Procedures and values form an important early requirement of the induction process.

5.4 The service recognises that a positive whistleblowing culture leads to good governance arrangements in any organisation.

5.5 To support the whistleblowing policy and provide a greater level of confidentiality for staff, the Service has recently contracted a third party, not for profit organisation to provide safe and confidential advice to all staff about what to do if they have witnessed wrong doing in the workplace.

6 CORPORATE GOVERNANCE FRAMEWORK INCLUDING CONTRACT PROCEDURE RULES AND STANDING ORDERS

6.1 The Corporate Governance Framework established on 1/1/19 sets out extensive arrangements with relation to several important areas which includes governance, risk, financial planning and contract procedures rules and standing orders, as well as prevention of Fraud and Corruption.

6.2 The Corporate Governance Framework also sets out the requirements for the S151 Chief Finance Officer and Head of Internal Audit in respect of any potential Fraud and Corruption.

6.3 It is a comprehensive document which in the main mirrors the Joint PFCC and CC Governance Framework and is due for review by the end of October 2022.

6.4 In respect of Contract standing orders and procurement specifically, in relation to managing fraud it covers:

- Confidentiality and Disclosure of Interest;
- Use of Contractors Services, Gifts and Hospitality;
- Corporate Supply Arrangements;
- Tendering Procedures for the Supply of Goods and Services; and
- Auditing.

6.5 A procurement card policy is in place, with authorisation controls over limits and spending and the transactions are closely reviewed by the Service Information Team, the Joint Finance Team and the Commercial Team to ensure that procurement cards are not being used to short circuit the correct Procurement processes and that NCFRA are not incurring costs are higher than they would be through normal audited processes. This is more of a responsibility to the taxpayer than an integrity issue, but the two are linked.

6.6 Oversight of the Procurement Card function is moving to the Joint Police and Fire Finance Team in 2022 to be overseen in a consistent manner for all three organisations of PFCC, CC and NCFRA. This oversight will include regular reviews of limits in addition to usage as set out above.

7 INTERNAL AND EXTERNAL AUDITS

7.1 Internal financial audits which would highlight any potentially fraudulent activity are conducted by the Internal Audit team throughout the year and the Audit Plan is informed by the risk Register.

7.2 At the year-end the Head of Internal Audit issues an audit opinion on the control framework and assurances in place. This report is used to inform the Annual Governance Statement as contained within the Statement of Accounts. The 2021/22 annual audit opinion assessed the control environment as satisfactory and was considered at the JIAC in July 2022. It is available on the OPFCC website within the July 2022 Internal Audit papers.

7.3 External audits which scrutinise NCFRA's accounting procedures and which would identify and mitigate the likelihood of fraud are conducted by the accountants Ernst & Young annually. The most up to date audited set of accounts are 2020/21 and are available on the OPFCC website.

8 HER MAJESTY'S INSPECTORATE OF CONTABULATY AND FIRE AND RESCUE SERVICES (HMICFRS) INSPECTIONS

8.1 During 2021/22 HMICFRS is undertaking its second full inspection of UK Fire and Rescue Services.

8.2 Northamptonshire Fire and Rescue Service was placed in Tranche 2 and inspected earlier this year.

8.2.1 Efficiency

8.2.1.1 The inspectorate indicate that an efficient fire and rescue service will manage its budget and spend money properly and appropriately. The FRS has financial controls and financial risk control mechanisms to reduce the risk of inappropriate use of public money.

8.2.1.2 For our last inspection the inspectorate did not identify any issues with financial control, financial risk control mechanisms or any inappropriate use of public money.

8.2.2 People

8.2.2.1 The inspectorate indicate that a fire and rescue service that looks after its people should be able to provide an effective service to its community. It should offer a range of services to make its communities safer. This will include developing and maintaining a workforce that is professional, resilient, skilled, flexible and diverse. The service's leaders should be positive role models, and this should be reflected in the behaviour of the workforce.

8.2.2.2 Following inspection, the inspectorate reported that Northamptonshire Fire and Rescue Service required improvement in this area.

8.2.2.3 Greater workforce awareness of the benefits of diversity, understanding positive action, challenging of inappropriate behaviour and timely application of its grievance processes provide the predominant focus for the improvements required for the Service within this area.

8.2.2.4 The Service has developed and published an extensive action plan and is seeking investment to embed improvements within this area.

8.2.2.5 The inspectorate did not raise any concerns in relation to Fraud or corruption within this section.

9 Summary

9.1 This report provides an update on Fraud and Corruption Prevention arrangements and processes in NCFRA.

9.2 It is intended that this will be regular report to the JIAC which is set out in the Annual Plan as appropriate.

AGENDA ITEM: 8

**NORTHAMPTONSHIRE POLICE, FIRE AND CRIME COMMISSIONER,
NORTHAMPTONSHIRE POLICE and
NORTHAMPTONSHIRE FIRE AND RESCUE SERVICE
JOINT INDEPENDENT AUDIT COMMITTEE
5 OCTOBER 2022**

REPORT BY	Vaughan Ashcroft
SUBJECT	Joint Budget and MTFP Process and Plan 2023/24 – Update and Timetable
RECOMMENDATION	To consider the report

1. Purpose of the Report

1.1. To update JIAC on the 2023/24 Budgeting and Medium Term Financial Plan (MTFP) and budgeting process for both Police and Fire organisations.

2. Background

2.1. The MTFPs are continually updated throughout the year to reflect new pressures and savings.

2.2. The full Joint Budget Strategy and Guidance paper has been produced to give context to the 2023/24 budget round, to provide information for the finance team and to give assurance to those charged with governance. The document is broadly similar to the papers in recent years, which proved a useful tool and was well received by all. It incorporates both Police and Fire in order to maximise consistency and standardisation whilst still highlighting specific areas for each organisation.

2.3. The key principles of the 2023/24 paper are summarised below.

3. Budgeting Principles

3.1. The strategic plans of each organisation will underpin the budget-setting process. All budgetary decisions need to be tested against them and should support delivery of the key objectives.

3.2. Budgets will be built incorporating efficiency savings identified over the previous 12 months and clearly recording any reinvestment and cashable benefits achieved.

3.3. The proposed budgets will be benchmarked against the indicative MTFP figures included in the 2022/23 Police, Fire and Crime Panel budget reports in each organisation.

3.4. Variations to the approved MTFP will be documented and shared with the Chief Constable/Chief Fire Officer and CC CFO in the first instance. The CC CFO will discuss any variances with the PFCC CFO for consideration.

3.5. Statutory and other unavoidable costs will be budgeted as required and variations to previous assumptions presented to the CFOs for consideration.

3.6. Devolved Budget Holders will be fully consulted and given opportunity to provide operational context throughout the budget build process. As part of this, [in Police] a process for 'Budgeting for the Future' will take place, where budget holders are required to provide savings options and ideas for innovation, to be scrutinised by a Panel and ultimately Chief Officers. Recognising that the new Chief Fire Officer will not be starting until October, it is suggested that a similar piece of work will be undertaken next year for Fire if the process in Police is successful.

3.7. Those included in the demand modelling exercise will have the deepest involvement in the process [Police]. As per usual practice, all others will contribute by way of one-to-one budgeting conversations with Finance Specialists.

3.8. Where practicable, budget proposals will be calculated using a zero-based approach.

3.9. Detailed workings will be recorded for all budgets over £10k or of a sensitive nature.

3.10. The budget proposals will be presented in such a way to clearly show department level and the subjective breakdown of all budgets, in particular to identify the cost of enabling services split between each organisation and in comparison to operational budgets.

3.11. Unavoidable budget variations will be separately identified to those discretionary pressures that are a result of internally agreed/implemented changes in each organisation. In doing so, it will be easier to assess which pressures are within or outside the control of the organisations.

4. MTFP Summary and Assumptions

4.1. The MTFP that was built and approved as part of the 2022/23 budgeting process was based on prudent grant and inflationary assumptions.

4.2. In both Police and Fire, it was projected that whilst the budget could be balanced in the first 3 years without drawing from reserves, a deficit was identified from year 4. New scenarios are now being modelled to take into account the unprecedented levels of inflation being felt. These are expected to significantly increase budget deficits in the short and medium term.

4.3. In light of the above, both organisations continue to identify savings opportunities and seek out cashable efficiency savings.

4.4. There remains uncertainty around rates of inflation, council tax receipts and government funding following the Covid-19 pandemic and a number of additional scenarios are being modelled to scope the potential impact. These will explore the varying effect of some material uncertainties including:

- 4.4.1. Inflation across both pay and non-pay budgets, exceeding all previous assumptions (in line with the national picture)
- 4.4.2. Collection Fund Deficits as a result of fluctuating collection rates
- 4.4.3. Business Rate Deficits as a result of fluctuating collection rates [Fire]
- 4.4.4. Impact on tax base growth
- 4.4.5. Recruitment and retention assumptions
- 4.4.6. Government spending cuts across policing and the wider public sector.

4.5. No changes have been made to assumed annual precept planning assumption increases of:

- 4.5.1. Police – £10 in 23/24 and 24/25, 1.99% per year thereafter

4.5.2. Fire – 1.99% per year

4.6. The MTFP is a live document regularly updated through the year and will be refreshed following completion of the draft budget proposal.

4.7. Police/Firefighter Pay modelling will be done as part of the budgeting process, which will take into account the projected glide-path relating to recruitment, promotions and rank profile.

4.8. Specific savings and pressures will be built into the modelling workbooks.

4.9. General inflation will be based on fixed rate assumptions.

4.10. Assumptions will be reviewed and updated by the S151 Officers.

4.11. Prior to the full detailed update as part of the budget process, the S151 Officers will outline a sensitivity analysis together with the high level MTFP positions for the two organisations with the PFCC, Chief Constable and Chief Fire Officer in early November 2022. This will enable a common understanding of the key pressures, messages and challenges and support targeted consultation and lobbying throughout the Budget and Precept process.

5. Pressures and Savings

5.1. The Commissioner issued budget conditions to both organisations, which included strategic outcome requirements for the year, the efficiency target and agreed investment monies.

5.2. There were a number of pressures and investment areas identified when the budget was originally approved, which will be reviewed and built into the base where appropriate/authorised to do so.

5.3. The agreed pay award increases will be built in where known, and future increases reviewed in light of these.

5.4. As a planning assumption, any savings on capital financing budgets resulting from slippage in the capital programme may be reinvested to fund capital costs, thereby reducing borrowing costs further in future years.

5.5. Previously agreed establishment numbers of Police Officers and Firefighters still stand, and the budgets will be based on achieving and maintaining full strength.

5.6. Given the increasingly uncertain levels of central and local funding, the budget will need to be prepared with options to enable decisions to be made quickly regarding possible savings. Scenarios will be modelled to provide options and

costed establishment levels, to provide a basis for discussion should funding settlement be unfavourable in light of other pressures.

6. Timelines

1.1. A detailed timetable has been produced to ensure key milestones are met (Appendix A). This allows sufficient time to ensure all key information is produced, and that statutory officers have the ability to challenge and scrutinise prior to the production of papers in good time for key meetings which include:

- **5th October 2022** – JIAC Meeting to receive an overview of the budget and MTFP process
- **1st December 2022** – Police, Fire and Crime Panel consider PFCC early thoughts on the proposed precept intentions
- **13th December 2022** – PFCC at Accountability Board – consider early indications
- December 2022 to January 2023 – PFCC consults on potential levels of precept following draft settlement
- **10th January 2023** – PFCC at Accountability Board to agree proposed budget
- XX January 2023 – Budget and Precept Considerations workshops held with the Police, Fire and Crime Panel, Parish Councillors and Northamptonshire MPs
- **2nd February 2023** – Police, Fire and Crime Panel to consider proposed precept
- **March 2023** (date TBC) – Treasury Management Strategy shared with JIAC.

7. Conclusion

7.1. Work continues on the budget and the budget and MTFP in line with agreed timescales.

7.2. The 2023/24 surpluses/deficits could vary greatly as a result of the national inflation situation, council tax receipts and central funding, so the budget needs to be built with these challenges in mind and sensitivity analysis used to until

figures are determined. As such, options will need to be available to reduce the budget requirement should the funding envelope be insufficient or investment is required.

7.3. The MTFP will continue to be revised as new information becomes available.

Appendix A – Timetable

Force Deadlines	Key Meetings	Capital

Activity	Timescale	Lead
Budget Process to be completed/shared	08/09/22	VA
Budget templates distributed for completion	09/09/22	VA
Team Briefing on Budget Build	08/09/22	VA
Capital Budgeting – Initial scrutiny meetings completed	16/09/22	MS
Capital Budgeting – Follow-up meetings to finalise proposed budgets	23/09/22	MS
Deadline for JIAC Papers	22/09/22	ALL
Police/Fire Staff reconciled and updated on Excel templates	23/09/22	SC/DS
JIAC briefed on 2023/24 Budget & MTFP Process	05/10/22	VA
Capital Budgeting – Final programme to be shared with CC CFO	05/10/22	MS
OPFCC Directors budget proposals due	06/10/22	OPFCC
Accountability Board	11/10/22	
Agreement of 3-way cross-charging	14/10/22	HK/VA
Budget bids completed by Finance Advisors	07/10/22	SC/DS/NA
First level of scrutiny by Finance supervisors	10/10/22-14/10/22	SC/NA
Consolidation of devolved budgets into Master Model	10/10/22-21/10/22	SC/DS
FEG [Fire]	13/10/22	
Estates Board	19/10/22	
Finalise Capital Financing for 23/24 revenue budget & MTFP	21/10/22	MS/NA
Briefing with Chiefs of current budget position	26/10/22	VA/NA
2022 Government Budget Announcement	Oct TBC	
Capital Programme shared with OPFCC (post-Chiefs' approval)	28/10/22	VA
Force Draft Budget discussed by S151s	28/10/22	VA/HK
Final Draft OPFCC Budgets	31/10/22	OPFCC/HK
MTFP Briefing to Chiefs	03/11/22	HK/VA/NA
Draft Treasury Management Strategy shared with OPFCC	04/11/22	VA/DC
Updated draft Budget & MTFP to be shared with OPFCC (both Police & Fire)	11/11/22	VA
Accountability Board	08/11/22	
Joint CC/PCC Board – submission of the collaborative budgets and PCC fund requests	16/11/22	
Deadline for Police, Fire and Crime Panel Papers	19/11/22	HK
Finalise draft budget proposals and reports	01/11/22-26/11/22	VA (Force) HK (OPFCC)
Strategic Planning Board (Police)	24/11/22	
Deadline for JIAC papers	01/12/22	ALL
FEG [Fire]	01/12/22	
Provisional Police Settlement Announced	Mid-Dec	HOME OFFICE
Police, Fire and Crime Panel – Budget Monitoring and budget update (as at Q2) and PFCC's early thoughts on precept intentions	01/12/22	HK

Regional PCC Board (PFCC only)	TBC	
Accountability Board – Consider: Force budget proposals (pending final settlement)	13/12/22 (papers 6/12/22)	VA
JIAC	14/12/22	
EM CFO/FD & Resources Board	05/01/23	
Accountability Board – Agree: Force budget 2022/23 Capital Programme Treasury Management Strategy Reserves Strategy	10/01/23	 VA/HK VA/HK VA/HK VA/HK
Draw the line on Council Tax Changes/Tax base to finalise total budget and requirement	14/01/23	HK/VA
Police, Fire and Crime Panel Papers finalised	20/01/23	HK/ALL
Joint CC/PCC Board – review of 2022/23 budgets if not previously agreed	12/01/23	
Statutory Date for CT Surplus and Tax base Confirmations	31/01/23	LAs
Police, Fire and Crime Panel consider proposed precept	02/02/23	HK/PCP
Police, Fire and Crime Panel Response to Budget	15/02/23	PCP
PFCC Issues Precept	22/02/23	HK
Advise of Grant and Council Tax Settlement Dates and Amounts	22/02/23	HK
Issue Budgets to Budget Holders	31/03/23	NA/VA

Joint Independent Audit Committee

5th October 2022

AGENDA ITEM: 9

REPORT BY	**Project Support Officer**
SUBJECT	**Joint Independent Audit Committee (JIAC) - Agenda Plan – Updated November 2021**
RECOMMENDATION	To discuss the agenda plan

1. Background

1.1 The agenda plan incorporates statutory, good practice and agreed scrutiny items and has been updated to reflect the items.

1.2 Areas highlighted from the JIAC Aims and Objectives and discussions between the S151 Officer and the Chair have been included on the plan in red type for member discussion and consideration.

1.3 Due to the two Final Accounts workshops being held in September and JIAC meetings in October and December, it is proposed not to hold a separate November workshop.

DRAFT AGENDA PLAN 2022/23

		frequency required	14th September Workshop – Police Accounts	5th October 2022	1st November workshop – Fire accounts	14th December 2022	February 2023 workshop	15th March 2023	19th July 2023
	Confirmed agenda to be circulated			19/08/2022		04/11/2022		01/02/2023	07/06/2023
	Deadline for reports to be submitted			22/09/2022		01/12/2022		02/03/2023	06/07/2023
	Papers to be circulated			27/09/2022		07/12/2022		08/03/2023	12/07/2023
Public	Apologies	every meeting		Apologies		Apologies		Apologies	Apologies
Public	Declarations	every meeting		Declarations		Declarations		Declarations	Declarations
Public	Meetings log and actions	every meeting		Meetings log and actions		Meetings log and actions		Meetings log and actions	Meetings log and actions
	JIAC annual report	Annually							JIAC annual report
Restricted	Meeting of members and Auditors without Officers Present	once per year		Meeting of members and Auditors without Officers Present					Meeting of members and Auditors without Officers Present
Public	External Auditor reports	every meeting Once a Year – Plan, Once a Year ISA260 and one a Year Annual Audit Letter (timescale Accounts dependent)		External Auditor reports		External Auditor reports		External Auditor reports	External Auditor reports – written End Annual report
Public	Internal Auditor reports (progress)	every meeting		Internal Auditor progress reports		Internal Auditor progress reports		Internal Auditor progress reports	Internal Auditor progress reports
Public	Internal Audit Plan and Year End REport	twice a year for NFRS and PCC & CC						Internal Audit Plans	Year End Reports
Public	Update on Implementation of internal audit recommendations	twice a year for NFRS and PCC & CC		Audit implementation update PFCC and CC		Audit implementation update NFRS		Audit implementation update PFCC and CC	Audit implementation update NFRS
Public	HMICFRS updates	1 per year per organisation						CC - HMIC update	NFRS – HMIC Update
Restricted	Risk register update (including current risk policy as an appendix)			PFCC Risk register (including current risk policy as appendix)		CC Risk register (including current risk policy as appendix)		NCFRA Risk Register (including current	
Public	Fraud and Corruption: Controls and processes	Once a year for NFRS and PCC & CC		NFRS - Fraud and Corruption: Controls and processes		PCC & CC - Fraud and Corruption: Controls and processes			

		frequency required	14th September Workshop – Police Accounts	5th October 2022	1st November workshop – Fire accounts	14th December 2022	February 2023 workshop	15th March 2023	19th July 2023
Public	Budget plan and MTFP process and plan update and timetable	annually for all		NFRS, CC and PCC - Budget plan and MTFP process and plan update and timetable					
Public		Once a Year – dates TBC							
Public	Statement of accounts	annually for all (subject to audittimescales)		Statement of accounts PCC and CC		Statement of account NCFRA			
Public	Treasury Management Strategy	annually for all						NCFRA, CC and PCC - Treasury Management Strategy and Mid Year Update	
Public	Attendance of PCC, CC and CFO	annually for all							
Restricted	Enabling Services (including new system arrangements)	twice a year		Enabling services update				Enabling services update	
Public	Specific Updates at each meeting throughout the year where appropriate								
	Benefits realisation								Benefits realisation (PB)
	Systems implementation								Verbal update – systems implementation
Restricted?	Review of new finance systems that replaced MFSS							Review of new finance systems	

RED: Areas Identified following discussion with Chair from 2021/22 JIAC Workplan Objectives