Internal Audit

FINAL

Police and Crime Commissioner Cumbria and Cumbria Constabulary

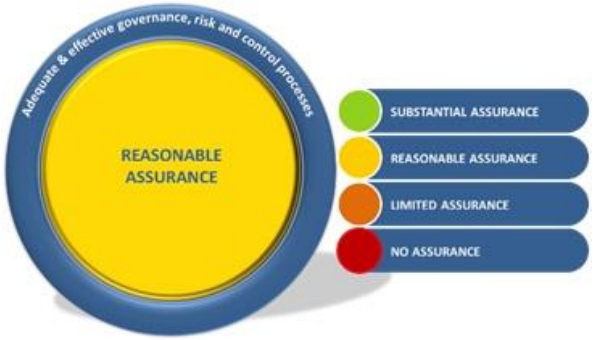
Assurance Review of Absence Management

2023/24

November 2023

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

As at 31st March 2023, there were 5,113 full-time equivalent (FTE) police officers on long-term absence in the 43 forces in England and Wales (equivalent to 3.5% of all officers).

KEY STRATEGIC FINDINGS

- **The process is directed by a number of appropriate and up-to-date policies.**
- **Training and support have been provided to line managers by the Human Resources team.**
- **Testing showed that review meetings with staff are not regularly conducted on a consistent basis.**
- **No risks have been identified in relation to absence management.**

GOOD PRACTICE IDENTIFIED

- **Regular performance reports are presented to Workforce Bronze and Workforce Gold.**
- **Support and wellbeing information is made available to staff via a dedicated section on the staff intranet.**

SCOPE

The review considered the arrangements for: recording, reporting and monitoring absence. The scope of the review also considered the arrangements to promote wellbeing and reduce absence.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	1	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Temporary Chief Superintendent confirmed that there are no strategic risks recorded in relation to absence management. Although it is acknowledged that absence levels at the Constabulary are below national averages, and therefore this may not be considered a major concern and strategic risk, operational risks should be recorded, particularly in relation to the completion of review meetings, and mitigating controls identified.	Risk(s) relating to staff absence be recorded and mitigating controls identified.	2	*S – Add operational risk to the risk register regarding completion of informal review meetings* *M – Check risk register* *A – Add to the register* *R – Managers should be adhering to the attendance support processes to ensure the Constabulary is supporting staff during absences, contributing to overall welfare, wellbeing, and retention of people in the workplace who are able to perform their role* *T – With immediate effect*	*With immediate effect*	*D Johnson* *HR Manager*
2	Directed	A series of meetings were undertaken with Senior HR Advisors and HR Advisors to review a sample of cases of staff members who had been, or were currently, on sickness absence. The intention was to establish what actions had been taken by line managers and members of the HR Team in relation to the completion of review meetings, Stage 1 meetings, where applicable, and what support and advice had been offered to staff. The sample of 17 cases identified seven where informal review meetings (IRMs) had	Line managers be reminded of the importance of completing informal review meetings in the early stages of staff absence and at regular intervals thereafter.	2	*S – Ensure attendance support processes are adhered to in relation to conducting timely informal review meetings* *This is as per the attendance support processes and clearly defined within the attendance policy* *M – Senior HR Advisors work with managers in their Command on individual cases and can track completion of IRMs.*	*With immediate effect*	*Di Johnson* *HR Manager*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		not been undertaken in a timely manner following commencement of the sick leave, or long periods were noted between the meetings. This also included one IRM that was undertaken after the employee had returned to work. These meetings are important as they set out what activities should be taken by the member of staff and by the Constabulary, and set timescales for a return to work or additional actions to be undertaken.			*IRMs are required for everyone who is long term absent, all managers receive an email from HR advising re the process and has a link to the IRM form* *If managers are not progressing IRMs timely, these are flagged to closed work force silver and will be discussed at weekly HR checkpoint meetings with Senior HRA.* *This part of the attendance process is covered in management training.* *Work is being undertaken in relation to using a Microsoft form as the IRM template which will provide better management information to track compliance.* *Absence data and compliance of processes will feature in future Performance Development Conferences for each Command, these are strategic inspection meetings chaired by the DCC.* *A – The IRM is part of the attendance process and guidance is provided to managers regarding completion and the reasons for conducting these meetings* *A message will be circulated to all work force bronze meetings as a reminder regarding this part of the process*		

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
					Forms part of attendance support training to mangers within the Leadership Development Courses and bespoke training to specific departments ie: CCR. Additional inputs and training can be arranged if required for specific departments. *R – An individual's wellbeing is important, and managers should offer the right support to enable people to attend work and be properly supported. An individual's manager is key in putting this support in place.* *The IRM is a process to ensure this support is considered and put in place, as well as providing the ability to progress through the formal support process.* *The current IRM form has lots of relevant information and signposting to different support.* *T – With immediate effect*		
3	Directed	It was noted that, in the sample tested, there were two members of staff where returned to work dates had been recorded within the Crown system, however it was established that they remained off sick. It is likely that the return-to-work date recorded was an anticipated return date and not an actual return date.	It be ensured that only actual return to work dates are recorded in this field within Crown Duties.	3	*S – Ensure managers understand their responsibility regarding updating absences on CROWN DMS.* *This forms part of attendance support training.* *M – Accurate recording on CROWN DMS for absent staff.*	*Completed*	*Di johnson* *HR Manager*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
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3	**ROUTINE**	Control issue on which action should be taken.

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
					The Attendance Support SharePoint page provides a link to the managers CROWN guidance. *HR send weekly emails to managers if a return-to-work interview has not been completed. This email also contains a link to the managers CROWN guidance regarding how to update a period of absence if the individual is still absent. This has been in place for several weeks.* *A – Guidance provided to managers* *Guidance is available and signposted to managers. Resource Co-ordination are commencing CROWN master classes mid-October covering different aspects of the system, including absence management.* *R – Managers are responsible for accurately recording absences to ensure the correct support can be put in place for individuals and the establishment figures for deployable and non-deployable are correct* *T – Ongoing* *This issue was raised as part of the RTWI process and guidance was put in place immediately.*		

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
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3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926
David Robinson	Audit Manager	David.Robinson@tiaa.co.uk	07766553339

Constabulary Staff	Title
Diane Johnson	HR Manager
Emma Chalmers	Senior HR Advisor
Shannon Parker	Senior HR Advisor
Jessica Pepper	HR Advisor
Kara Neeson	HR Advisor
Gillian McEwan	Senior HR Advisor

Exit Meeting Date	5th September 2023
Attendees	Diane Johnson, HR Manager

Director/Commander Comment	I am pleased to note that this review of Absence Management within the Constabulary has resulted in an overall assessment of reasonable assurance which I feel is fair reflection of the overall position. The audit recognises that processes and policies are up to date and that training for managers is provided alongside robust reporting the Workforce structures. The review did observe that review meetings with staff are not conducted on a consistent basis with the recommendations to address being agreed and progressed by HR Management. HR have now introduced fortnightly checkpoint meetings to review and manage progress of the informal review processes.

	In summary, the Constabulary will action the recommendations made within this review in order to build on the good work already in place which is evidenced by the continued low level of absences experienced. Stephen Kirkpatrick – Director of Corporate Support
Deputy Chief Constable's Comments	I have read this report and the comments from Stephen above and I am encouraged to see that actions raised are being addressed. Activity in relation to return to work interviews and processes will see an increase in focus as current levels of compliance within the Constabulary are unacceptable. A piece of work has been tasked to the Chief Superintendent (Westmorland & Furness Command) and this will be closely monitored through the monthly Workforce Board meetings. DCC Darren Martland
Considered for Risk Escalation	No

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Not in place	1	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	2, & 3	-

Other Findings

The overarching document in relation to absence management is the Constabulary's Police Staff Attendance Capability Policy and Procedure. This was approved by the Operations Board in September 2021 and was last reviewed in October 2022. This covers the processes involved in the formal stage one and two reviews, hearings, dismissals and appeals and capability on health grounds. A flowchart provides guidance in relation to the various steps to be taken, including where these differ for police officers and other staff.

There are a number of supporting documents to the Policy, which include the Attendance Support Policy and Procedure (February 2023), Flexible Working Policy and Procedure (February 2023), Leave Policy and Procedure (June 2023) and the Limited Duties for Police Officers Policy and Procedure (July 2021).

Furthermore, the Constabulary People Strategy 2022-2025 includes details of absence data for 2018 onwards, engagement activities in place aimed at reducing long-term and stress related absences and the 2022-2025 Future Plan to analyse sickness, to identify trend and engage with business leads to identify and implement proactive interventions aimed at reducing absence.

Other Findings

The Attendance Support Policy and staff member's Terms and Conditions inform staff that they should report all periods of absence to their line manager who subsequently enter this into the Crown Duties system. This in turn feeds into the iTrent payroll system to ensure that the correct sick pay is paid. Documented guidance has been provided in relation to how to place an individual on sick leave, the requirement to complete regular reviews and a return to work note with the member of staff, uploading fit notes and updating the expected return to work date.

The Human Resources team generate daily sickness report from Crown Duties in order to identify periods of long-term absence (where a trigger has been hit or a period of 28 days or more). They send out a template email to the relevant line manager to instruct them to review the absence with the member of staff. A standard Informal Review Meeting (IRM) form is completed. These record any updates from the member of staff on the absence, underlying reasons for absences, previous actions / supportive measures put in place, how improvements can be made or ongoing support provided and details of the agreed outcomes. The expiry date of the current fit note and return to work or next review date are also recorded.

Each Senior Human Resources (HR) Advisor has a portfolio area and they, supported by the Human Resources Assistants, are responsible for monitoring the review dates and requesting line managers to complete the next steps. Case files are set up for each employee on the shared G drive, which is accessible only by members of the HR team and all cases are logged on a tracker spreadsheet.

All relevant staff have received training from the Senior HR Advisors. This included the management of long-term sickness, sick/fit notes, the consideration of temporary recuperative duties and the completion and agreement of Fair Passports, which are a record of agreed long term reasonable adjustments. In early 2023, specific training sessions were also provided to managers and supervisors and to sergeants. These covered: the attendance support process; different leave types and support mechanisms; the requirements of the flexible working process; and managing performance.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

A significant volume of absence related data is reported to various groups, which include the Workforce Bronze, who meet fortnightly and include senior managers and the Human Resources Advisors, and Workforce Gold, chaired by the DCC with input from the Human Resources and Occupational Health teams, who review data and activities related to recruitment, learning and development, absence, and attendance.

Information collated includes: the percentage of employees absent at month end (split by all staff, officers only and staff excluding PCSOs). This data is also broken down by Business Command Unit and sickness reason. For information, excluding the categories of miscellaneous and unknown, the highest percentage of cases are in the groups of psychological and musculoskeletal problems.

Specifically in relation to long-term sickness, weekly reports show the reason for the absence and the number of days lost (at the time of the latest report being produced, 28th June, there were 56 cases on long-term sickness).

The Workforce Bronze meetings also review the progress made in individual cases of absence.

Commentary supporting the data tables presented to the Workforce Board detail the top three absence types within the reporting month and updates regarding any trends, initiatives and updates to guidance and support available to staff and line managers. The May 2023 report contained significant additional notes including updates on the Police Covenant, the use of Fair Passports, occupational therapy referrals and the emerging risk of the impact of the new Personal Safety Training on response officers, in particular the over 40's.

It was also noted that the report highlighted that return-to-work interviews were not being consistently undertaken with a completion rate of only 37%. Audit testing also confirmed that informal review meetings had not been completed in all cases and a recommendation has been made in relation to improving performance in this area.

Other Findings

	The Constabulary utilises its Yammer social network to communicate with staff. Examples of communications provided in relation to absence management included reminding managers to record absence in the Crown Duties system and information regarding the Fair Passport.
	The Constabulary utilises the Wellbeing and Inclusion Hub on its intranet page to promote welfare and support that is available to all members of staff. This includes links to information in relation to chronic illness, domestic abuse, mental health wellbeing, the menopause, carers, positive action and family support. A number of these areas have also been discussed at the monthly Wellbeing meetings.
	The Management of Limited Duties for Police Officers Policy and Procedure sets out the arrangements in relation to police officers who are to be considered for recuperative, adjusted, or restricted duties. A spreadsheet is maintained recording all staff who are on recuperative or adjusted duties, and this is reviewed weekly by the Senior Human Resources Advisors, identifying any cases where an intervention is required. Data provided showed that there were 83 officers and 11 police staff on limited duties at the time of the audit review. Appropriate notes had been recorded against each entry on the Limited Duties spreadsheet.
	Full quarterly reviews are undertaken to evaluate the status of all staff who are on sick leave. This includes a review of which staff are not in their substantive role and where they are currently placed. The Occupational Therapy team review any ongoing adjustments in place, for example in hours or days worked. For any staff who are not at work, consideration is given to redeployment on medical grounds into vacant posts within their command. A trail period (of a minimum of four and maximum of 12 weeks) may be used and additional training provided where required.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	16th June 2023	23rd June 2023
Draft Report:	20th September 2023	13th November 2023
Final Report:	13th November 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Police and Crime Commissioner Cumbria and Cumbria Constabulary		
Review:	Absence Management		
Type of Review:	Assurance	**Audit Lead:**	David Robinson

Outline scope (per Annual Plan):	The review considered the arrangements for: recording, reporting and monitoring absence. The scope of the review also considered the arrangements to promote wellbeing and reduce absence.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	(if required then please provide brief detail)	
Exclusions from scope:		

Planned Start Date:	13/07/2023	**Exit Meeting Date:**	30/08/2023	**Exit Meeting to be held with:**	Human Resources Manager

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

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Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

Assurance Review of ANPR Cameras

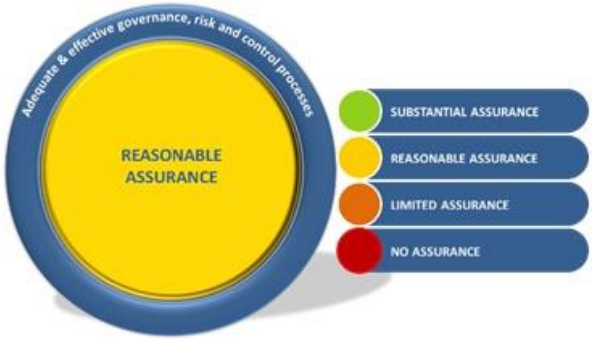
2023/24

June 2024

Agenda Item 08c

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Non-compliance with the National ANPR Standards for Policing and Law Enforcement (NASPLE).

KEY STRATEGIC FINDINGS

- **Testing supports that Cumbria Constabulary is materially compliant with NASPLE and the related Audit Standards.**
- **Records of local audit testing should be retained for a period of two years.**
- **A dedicated local NAS Auditor is now in place.**
- **An assessment should be made of the staffing requirements needed to provide sufficient cover for the local NAS Auditor.**

GOOD PRACTICE IDENTIFIED

- **There is an up-to-date, written ANPR Policy in compliance with NASPLE section 9.2.1.**
- **There are locally designed documented procedures in place, supported by a detailed schedule of audit testing to be performed locally throughout the year.**

SCOPE

The National ANPR Standards for Policing (NASP) guidance detail the standards that are required to be met for the development and use of ANPR systems. Our review confirmed whether the deployment of ANPR systems is consistent with NASP guidance and whether key accountability and responsibilities have been established.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	2	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	Paragraph 8.2.10 of the National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) document states that records of local audit are to be retained for a period of two years. For the period under review, written assurances were provided by the Cyber Security Risk and Intelligence Advisor as to the extent of local audit reviews performed and reported by exception to management and to the National Auditor. Detailed records of the actual testing performed were not made. It is understood that the exceptions encountered during local testing were minor in nature. The recently appointed Cyber Security Risk and Intelligence Assistant acts as the local NAS auditor and has begun documenting records of local audit, in compliance with paragraph 8.2.10.	In compliance with the National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) document, records of local audit testing be retained for a period of two years.	2	*Specific: Recording templates in place at time of audit to be populated with audit findings.* *Measurable: Population of the templates* *Achievable: Yes* *Relevant: National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) requirement.* *Time-bound:01/06/24*	*Complete 01/06/24* *Templates populated*	*Cyber Security Threat and Intelligence Assistant*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
2	IMPORTANT	Control issue on which action should be taken at the earliest opportunity.
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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Delivery	Records of local audit testing should be retained for a period of two years. Prior to the recent appointment of the Cyber Security Risk and Intelligence Assistant, written records were not retained of the local audit testing undertaken. To reduce the risk of future gaps in the records of local audit testing, an assessment should be made of the resource required to provide sufficient cover for the Cyber Security Risk and Intelligence Assistant, including any training, security clearance and infrastructure access requirements.	An assessment be made of the resource required to provide sufficient cover for the Cyber Security Risk and Intelligence Assistant, to include any training, security clearance and infrastructure access requirements.	2	*Specific: Skills retention and onboarding to be raised as a cross functional risk.* *Measurable: Presence on Risk Register* *Achievable: Yes* *Relevant: National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) requirement.* *Time-bound: 01/06/24*	*Complete 01/06/24* *Risk registered and resilience inbuilt by now having 2 trained auditors.*	*Cyber Security Threat and Intelligence Advisor*
2	Delivery	The government's website has a page headed National ANPR Service compliance dashboard. The dashboard has been designed to measure critical metrics for compliance with National ANPR Standards for Policing and Law Enforcement (NASPLE) and the National Standards for Compliance and Audit (Audit Standards) by Police Forces and Law Enforcement Agencies (LEAs). A National Compliance Dashboard survey is sent to forces on a biannual basis to collect certain metrics in reference to the Audit Standards. For the most recent reporting period, being Q3 and Q4 of 2023, no data is reported for Cumbria.	Data reported biannually on the National ANPR Service Compliance Dashboard survey be submitted on a timely basis.	3	*Specific: Contact with National auditor and update contact names.* *Measurable: Meeting and communication with National auditor* *Achievable: Yes* *Relevant: National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) requirement.* *Time-bound:01/06/2024*	*Complete 01/06/24* *Auditor fully embedded and in regular communication with the National auditor.*	*Cyber Security Threat and Intelligence Advisor*

PRIORITY GRADINGS

1	**URGENT**	Fundamental control issue on which action should be taken immediately.
2	**IMPORTANT**	Control issue on which action should be taken at the earliest opportunity.
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Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Delivery	The 'Camera locations' section of the Cumbria Constabulary website's ANPR page states "In assessing whether new cameras are to be set up, we'll do a Data Privacy Impact Assessment (DPIA)." NASPLE Paragraph 8.5.2 defines a DPIA to be a Data Protection Impact Assessment.	References on the ANPR page of the Cumbria Constabulary website to a Data Privacy Impact Assessment be amended to reference a Data Protection Impact Assessment.	3	*Specific Complete DPIA assessments of all ANPR sites on an annual rolling basis. The process will be led by D/Insp SOCU/RCU/ECU supported by the RCU team.* *Measurable: Submission of completed assessment forms to the Cyber Security Threat advisor and monthly Specialist Crime performance meeting* *Achievable: Yes* *Relevant: National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards) requirement.* *Time-bound: complete all sites by 31/12/2024 and maintain annual checks.*	*In progress as per SMART action plan completion date set as 31/12/2014*	*Head of Specialist Crime.*

PRIORITY GRADINGS

1	URGENT	Fundamental control issue on which action should be taken immediately.
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3	ROUTINE	Control issue on which action should be taken.

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Operations	Andrew.McCulloch@tiaa.co.uk	07980787926
Ian Goodwin	Principal Auditor	Ian.Goodwin@tiaa.co.uk	07867526292

Constabulary Staff	Title
Ian Hussey	Detective Superintendent
John Chambers	Cyber Security Risk and Intelligence Advisor
Sim Jain	Cyber Security Risk and Intelligence Assistant

Exit Meeting Date	19th April 2024
Attendees	John Chambers, Cyber Security Risk and Intelligence Advisor Sim Jain, Cyber Security Risk and Intelligence Assistant

Director/Commander Comment	I have noted the contents of this audit report. The recommendations have already been actioned out and will be monitored through the appropriate governance structures. Three of the four actions have been completed with Action 3 being progressed by T/DSU Myers with no identified blockers to this being signed off within agreed timelines. Temp. Chief Superintendent Ian Hussey

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Deputy Chief Constable's Comment	I have reviewed the audit report and comments from Temp. CS Hussey above. I note that the audit report provides 'reasonable' assurance and note that the report makes four recommendations for improvement (two important and two routine), three of which have already been complete with plans in place for the final recommendation. DCC Darren Martland
Considered for Risk Escalation	

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1	-

Other Findings

Automatic Number Plate Recognition (ANPR) technology is used to help detect, deter and disrupt criminality at a local, force, regional and national level. A National Law Enforcement ANPR Capability (NAC) enables Law Enforcement Agencies (LEAs) to benefit from operational use of ANPR. The NAC comprises the National ANPR Service (NAS) and the National ANPR Infrastructure (NAI). The NAS is a single national system comprising standardised functionality to enable use for operational response, investigation and intelligence purposes as well as a single national store of data. The NAI is a network of ANPR cameras, communications links, firewalls and other related supporting components.

In July 2022 the Home Office issued version 2.4 of the National ANPR Standards for Policing and Law Enforcement (NASPLE), with which LEAs must comply to access the NAC. There are over 100 Standards, split across three sections: Data Standards; Infrastructure Standards; and Data Access and Management Standards. Two further documents issued by the Home Office cover audit standards and technical requirements: the National Standards for Compliance and Audit of Law Enforcement ANPR (Audit Standards); and the National ANPR Service Technical Specifications (TSpec) respectively.

Other Findings

Section 9.2.1 of the NASPLE states that all LEAs that connect to, or have access to, the NAS must have an up-to-date written policy in place for the access, management and use of ANPR data, including provisions for audit, which must be consistent with the Audit Standards. Cumbria Constabulary has an ANPR Policy dated August 2021, with a review every three years by the Serious Organised Crime Unit Detective Inspector. The Policy owner is the Detective Superintendent Specialist Capabilities. The Policy states that the Chief Constable is the data controller for the ANPR system operated within Cumbria Constabulary, with the designated deputy being the Detective Superintendent Specialist Capabilities. The Policy comprises five sections: Why we use ANPR; Access to stored data, Auditing; User Access; and Camera Locations.

Paragraph 8.14.4 of the National ANPR Standards for Policing and Law Enforcement (NASPLE) states that provisions for performance evaluation must be defined in Law Enforcement Agency (LEA) policy and procedures. NASPLE paragraph 9.5.1 states that LEAs must establish procedures for the management and review of any data held under these provisions including arrangements for deletion as required. An Audit Methodology document was prepared by the Cyber Security Risk and Intelligence Advisor in satisfaction of these requirements.

Version 3 of the government's National ANPR Service – Using the Audit Functionality document was issued in September 2023. Paragraph 1.2 states that, in order to operationally use the NAS, Police Forces are required to appoint a local NAS auditor. The document provides guidance to local system auditors on how to effectively use the NAS audit tool and apply the relevant audit processes detailed within NASPLE and comprises two main sections: Using the NAS Audit Tool; and NASPLE Audit Processes. The recently appointed Cyber Security Risk and Intelligence Assistant satisfies the requirement to appoint a local NAS auditor. Day-to-day oversight is provided by the Cyber Security Risk and Intelligence Advisor.

NASPLE paragraph 9.3.6.1 requires each LEA to designate a senior manager who is accountable for the authorisation of staff who may access ANPR data. Audit Standards paragraph 8.2.1 requires the local auditor to confirm annually the identity of the senior manager. Testing confirmed the designated senior manager to be a Detective Superintendent and that the local auditor confirms this annually.

A detailed review of the NAS Audit Methodology document prepared by the Cyber Security Risk and Intelligence Advisor was performed, cross-checking it to the requirements of the Audit Standards. It was found to be an accurate summary of the Audit Standards and a useful tool in shaping local audit testing going forward.

Quarterly meetings are held with the National Auditor. Assurances were provided by the Cyber Security Risk and Intelligence Advisor and by the Cyber Security Risk and Intelligence Assistant that the National Auditor is satisfied that Cumbria Constabulary is in compliance with NASPLE and the related Audit Standards.

Evidence was provided to support the local audit testing performed by the recently appointed Cyber Security Risk and Intelligence Assistant. The tests are being recorded on a series of Excel spreadsheet templates designed and provided by the National Auditor. From a review of these templates, they were seen to provide the necessary detail required to support the proper recording of the testing required.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	2	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Partially in place	3, & 4	-

Other Findings

The Cumbria Constabulary website has a page relating to ANPR. It provides details on how the technology works, how data is stored, camera locations, and what to do if you think your vehicle has been cloned. Links are provided to further information, including guidance on the National ANPR standards; and the rights of data subjects under the Data Protection Act 2018.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	8th March 2024	8th March 2024
Draft Report:	13th May 2024	19th June 2024
Final Report:	19th June 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PFCC Cumbria & Cumbria Constabulary		
Review:	ANPR Cameras		
Type of Review:	Assurance	**Audit Lead:**	Ian Goodwin

Outline scope (per Annual Plan):	The National ANPR Standards for Policing (NASP) guidance detail the standards that are required to be met for the development and use of ANPR systems. Our review will confirm the deployment of ANPR systems is consistent with NASP guidance and key accountability and responsibilities have been established.	
Detailed scope will consider:	The review will set out to provide assurance to Joint Audit Committee that the organisation has robust arrangements for ANPR cameras. • The processes are directed by appropriate policy and procedures • The processes are in line with any contractual arrangements	• Risks have been identified and are appropriately monitored and reported • Deployment of the ANPR systems is consistent with the National ANPR Standards for Policing and Law Enforcement issued by the Home Office • Suitable performance monitoring arrangements are in place • key accountabilities and responsibilities have been established
Requested additions to scope:	None	
Exclusions from scope:	None	

Planned Start Date:	12/03/2024	**Exit Meeting Date:**	19/04/24	**Exit Meeting to be held with:**	John Chambers, Simran Jain

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

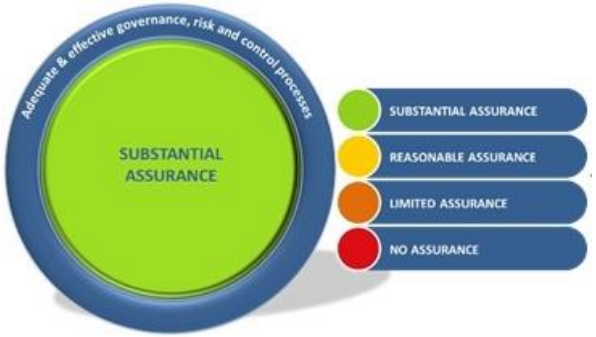
Assurance Review of Accounts Payable – Creditors

2023/24

February 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

CSD09 - Departmental resourcing and service delivery.

KEY STRATEGIC FINDINGS

There is a strong suite of controls covering the reviewing, authorising and paying of costs, including additional checks for larger valued payments.

Suppliers' standing data is only updated following rigorous and systematic checks and appropriate approvals, using detailed and standardised templates.

Evidence is retained to support the ongoing scrutiny and the required approval of expenditure incurred on the corporate cards.

Supplier payments are being made on a timely basis, with evidence provided to support that ongoing performance is above target.

GOOD PRACTICE IDENTIFIED

The Financial Regulations, Financial Rules and the supporting procedures and instructions together provide for a proper segregation of duties.

Staff are sufficiently trained and experienced in a range of relevant and appropriate disciplines to help ensure a continuous and acceptable service level.

SCOPE

The review considered the arrangements for reviewing and authorising and paying costs incurred by the organisation and the arrangement for control of the organisation's cheques and automated payments. The review considered the management of amendments to supplier standing data, including the verification of requests for change of bank details. The allocation and use of procurement cards was also considered including the month end reconciliation to statements.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No Recommendations were deemed necessary.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Ian Goodwin	Principal Auditor	Ian.Goodwin@tiaa.co.uk	07867526292
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926

Constabulary Staff	Title
Sarah Bradley	Central Services Team Leader
Ann Dobinson	Head of Central Services

Exit Meeting Date	18th January 2024
Attendees	Sarah Bradley, Central Services Team Leader

Director/Commander Comment	I am very pleased to observe that this Audit review of Accounts Payable – Creditors has achieved a substantial level of assurance with no recommendations being made. This recognises and highlights the excellent level of controls and governance in place which operates effectively across both the Accounts payable and Corporate Card management areas. The report also highlights the supplier payment performance exceeds the target of 80% of suppliers paid within their invoice terms, this shows the importance and recognition placed by the Constabulary to support businesses. The positive findings in this report are a credit to the Central Services & Financial Services departments who are committed to ensuring that the Accounts payable process continues to be managed effectively. Ann Dobinson Head of Central Services 13/02/2024
Deputy Chief Constable's Comment	I have read the report and the comments from Ann above. I can confirm that I am satisfied that the audit has provided the highest level of assurance "substantial" with no recommendations. The grading provides chief officers with confidence in the way that the creditor payments system is controlled and operated. DCC Darren Martland
Considered for Risk Escalation	No recommendations to escalate

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The Financial Regulations, dated March 2021, set out the internal framework and procedures for financial administration and control within the Cumbria Office of the Police and Crime Commissioner (OPCC). They include a section headed Ordering and Paying for Work, Goods and Services, which details the responsibilities of the Joint Chief Finance Officer (Joint CFO) and of the Chief Officers. The Financial Rules, also dated March 2021, are the detailed supporting guidance and instructions that accompany the Regulations. The section headed Ordering and Paying for Work, Goods and Services lists the key controls and details the responsibilities of the Joint CFO, of the Head of Central Services, of the Head of Commercial Solutions and of all Officers and Staff. Taken together, the Regulations and the Rules provide for a proper segregation of duties.

The Financial Regulations are subject to a biennial review and update, as a minimum, from the date of approval. The Commissioner is responsible for approving or amending the Regulations. The PFCC CFO is responsible for maintaining and reviewing the Regulations and submitting any additions or amendments to the Commissioner after consulting with the Chief Executive. The Constabulary Chief Finance Officer advised that an update is to be presented to the Joint Audit Committee in 2024, with the delay being due to staffing capacity issues.

Other Findings

A document entitled 'Fusion Payment Run Instructions' was evidenced. From an overall review, it was seen to be very detailed, comprising over 50 numbered steps supported by multiple screenshots and additional notes and comments. Three PFCC Corporate Card Procedures documents were evidenced, dated February 2023: Business Continuity Cards; Chief Officer Cards; and General Cards. Each was reviewed and seen to be laid out in a consistent manner and cover the expected areas.

The Central Services Risk Register was last updated on 6th February 2024 and comprises five risks; one of which is CSD09 - Departmental Resourcing and Service Delivery. This is the risk that staff turnover and lack of resilience will impact on the ability of CSD to deliver support services in a timely way. The latest score for the risk is 4 (amber). The mitigation strategy is to accept this level of risk. The risk owner is the Head of Central Services. The response action or management approach if the risk occurs is stated to be that priority would be given to delivering key services, including supplier payments.

There is a weekly BACS payment run. Five such runs were sampled at random from the current financial year-to-date. In each case, payment was properly authorised in line with the Financial Rules. Prior to payment, additional internal checks are carried out. These include specific checks on all payments over £10,000 and on a further sample of individual payments. Evidence was reviewed of these checks having been carried out on each of the five sampled payment runs.

From each of the five sampled payment runs, four invoice payments were sampled at random. Testing was successful in that, for each of the 20 invoices, it was confirmed that a segregation of duties was observed between key stages. In particular, the relevant provisions of the Financial Rules had been followed.

A spreadsheet was provided summarising 129 supplier additions or changes affected during the current financial year-to-date, from which ten were sampled at random for testing. In each case, it was confirmed that a standard template Supplier Details Form had been completed and signed by the supplier and that a standard template Supplier Approval Form had been properly completed and signed internally.

A spreadsheet entitled 'Current Corporate Card Issue List' was provided, from which three cards were selected. For each card, statements were reviewed for each of the three most recent months. For all sampled statements it was confirmed that individual transactions were within authorised limits and that the overall balance on the card was within its authorised limit. In line with the requirements of the relevant PCC Corporate Card Procedures document testing was performed to determine whether: (i) the month's accounting journal for the card was in agreement with the transactions in the statement; (ii) a Payment Record had been properly completed and authorised; (iii) invoices had been provided to support the expenditure; and, (iv) expenditure was allowable per the provisions of the relevant Procedure document. All testing was successful.

Corporate Card Procedures give examples of approved and excluded expenditure. For two of the sampled months, several potentially excluded expenses were noted. The expenditure had been approved in line with the Procedures. The Head of Central Services corroborated the approval by sufficiently clarifying the circumstances giving rise to their approval. Additional testing revealed that one further small item of expenditure had not been approved and was subsequently repaid by the card holder. Overall, this confirmed that sufficient internal scrutiny is being undertaken on corporate card expenditure.

Payments are also made by direct debit, cheque and CHAPS. A spreadsheet was provided of all such payments made during the current financial year-to-date. This was reviewed and a sample of large and/or unusual payments was selected. Reasons for the expenditure were determined to be appropriate and the payment methods in line with business requirements.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

	A spreadsheet was provided listing all supplier payments during the current financial year-to-date. An analysis of this data showed that overall almost 81% of payments were made within the invoiced term. The target is set at 80%.
	The most recent Payables Invoice Aging Report was provided. This was reviewed and a sample of five large and/or unusual overdue balances was selected. In each case, satisfactory explanations were provided as to why the amounts remained showing in the report. Additional evidence was provided showing that reasonable efforts are made to clear these and other such balances in a timely manner.
	Meeting Notes from a recent finance team meeting were reviewed. It is evident that matters within the scope of this review are regularly discussed at these meetings, including appropriate training arrangements.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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Effectiveness of arrangements

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Assurance Assessment

4. The definitions of the assurance assessments are:

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No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	8th January 2024	8th January 2024
Draft Report:	12th February 2024	
Revised Draft Report:	16th February 2024	21st February 2024
Final Report:	22nd February 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Accounts Payable - Creditors		
Type of Review:	Assurance	**Audit Lead:**	Ian Goodwin

Outline scope (per Annual Plan):	The review considers the arrangements for reviewing and authorising and paying costs incurred by the organisation and the arrangement for control of the organisation's cheques and automated payments. The review will consider the management of amendments to supplier standing data, including the verification of requests for change of bank details. The allocation and use of procurement cards will also be considered including the month end reconciliation to statements. The scope does not include providing an assurance that the expenditure was necessary or that value for money was achieved from the expenditure committed.	
Detailed scope will consider:	Governance Framework: • Assessing whether policies and procedures are appropriate. Risk Mitigation: • Assessing whether risks are properly identified, monitored and mitigated. Compliance: • Assessing the extent of compliance with relevant policies and procedures, including sample testing.	Performance Monitoring: • Assessing whether performance monitoring is sufficient to enable key decisions to be made in a timely manner. Sustainability: • Assessing the extent to which arrangements align with targets. Resilience: • Assessing whether there are sufficient resources in place.
Requested additions to scope:	None	
Exclusions from scope:	None	

Planned Start Date:	08/01/2024	**Exit Meeting Date:**	18/01/2024	**Exit Meeting to be held with:**	Sarah Bradley

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PCC Cumbria & Cumbria Constabulary

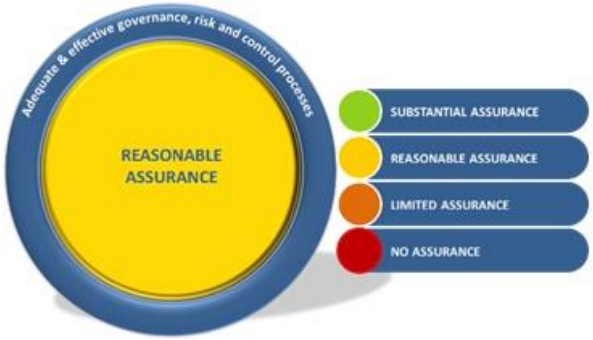
Assurance Review of Fleet - Strategy and Management of Fleet

2023/24

November 2023

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

The Constabulary needs to be providing and maintaining a vehicle fleet which is safe, modern, fit for purpose and readily available, to meet the diverse and variable demands across the organisation.

KEY STRATEGIC FINDINGS

A Fleet Strategy is in place and a detailed Fleet Demand review was undertaken in 2023 by the Director of Corporate Support.

Processes operating for vehicle servicing and repairs is appropriate but there are no formal procedures for staff to follow.

Vehicle checks by users are not always being undertaken in the prescribed manner or frequency.

Additional performance indicators relating to the workshop function would help identify any pinch points in the processes operating.

GOOD PRACTICE IDENTIFIED

The Constabulary has set service schedules at values lower than the manufacturers' guidelines to add additional assurance that they won't be exceeded.

The use of external independent MOT test stations provides an additional assurance on the work undertaken by the Constabulary's workshops.

SCOPE

The review considered the strategy for the management and replacement of the fleet of vehicles and effectiveness of the delivery of the fleet management repairs and maintenance arrangements, including the planning of services and MOT's, responsive repairs and general maintenance.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	1	1

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Fleet team provide the essential support for the availability of vehicles, maintenance and repairs to vehicles, fitting/defitting of vehicles and disposals. Through visits to the Fleet team offices at Penrith and discussions with the staff, it was identified that whilst many of the activities and practices are well organised and have appropriate controls, there is a heavy reliance on staff knowledge of process and policy. An example of this is the servicing schedules of vehicles, which although are set appropriately and also risk based, are not directed by a formal policy.	Policies be documented for the areas that fall under the Fleet team to provide clear direction and to support the delivery of the Fleet Strategy.	2	***Specific*** *- Fleet governance, policy and procedures are to be created. Setting guidelines and standard operating procedures for the fleet team for all core functions of fleet services.* ***Measurable*** *- Once established an internal audit plan is to be implemented to regularly test and revise.* ***Achievable*** *– Yes, these documents will contain all current working practices and procedures.* ***Relevant*** *– The fleet team requires guiding documents in policy and procedure. This will aid business continuity and allow best practice development with revisions and audits.* ***Time-bound*** *– Complete by Jun 24 with audit plan to commence Aug 24.*	*Development* *Sept 23 – Apr 24* *Implementation* *Apr 24 – Jun 24* *Internal audit* *Aug annually*	*Head of fleet*

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	Furthermore, many activities undertaken have become custom and practice but there are no documented procedures. This provides a potential point of failure should key staff be absent for a prolonged period or leave the employ of the Constabulary.	Procedures be documented for the activities undertaken across the Fleet team.	2	***Specific*** *– Fleet activities to be identified and procedure documents created to reflect along side rec 1.* ***Measurable*** *– Will regularly been seen in the application of activities carried out by the fleet team. Alongside the audit plan they will be refined into best practice.* ***Achievable*** *– Yes, these documents will consolidate all working practices.* ***Relevant*** *– This will give the fleet team procedures to follow increasing resilience and preventing single point of failure.* ***Time-bound*** *– along side rec 1, Complete by Jun 24 with audit plan to commence Aug 24.*	*Development* *Sept 23 – Apr 24* *Implementation* *Apr 24 – Jun 24* *Internal audit* *Aug annually*	

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	All vehicles are required to have a weekly check undertaken by a user to confirm key elements of the vehicle are in place and to identify any issues with tyres or damage. A review of the dashboard data for Cumberland BCU during the audit fieldwork identified 61% of vehicles compliant. Of the 30 vehicles overdue, there were 21 that were still recorded as available and therefore in use. Further investigation identified that some vehicle checks were being completed and submitted for vehicles that were unavailable and off the road. This activity suggests that users may either not understand the reason for the checks or that they are potentially submitting checks that may not have actually been done.	The completion of weekly vehicle checks be reviewed to ensure that all users understand the process and requirements for the checks being required.	2	***Specific*** *- Agenda item added to next TVG meeting 16 Oct 23 to review this process and implement stronger control measures. Guidance on vehicle check completion is to be reviewed with Driving school for relevance and currency, then published on force intranet "Need to know".* ***Measurable*** *– effective communication and completions will see vehicle check compliance rise.* ***Achievable*** *– Yes.* ***Relevant*** *- Vehicle safety checks are an important part of ensuring vehicles are fit for service and operational use.* ***Time-bound*** *– Complete by 31 Oct 23.*	*Next TVG* *16 Oct 23* *Reviewed and actions allocated to complete by 31 Oct 23.*	*Head of fleet*
4	Delivery	The Fleet Strategy identifies the key performance indicators, the majority of which are reported through the PowerBi dashboard. It was identified that there are no performance indicators available to monitor the elements of the processes undertaken by the maintenance and service provision. Testing noted that, when looking at the time a vehicle spent off the road, there was no indication if this was due to in-house delays or external factors. Additional performance indicators would help to identify any internal pinch points.	Performance indicators for the repairs and maintenance function be developed to help identify where and when issues may be arising.	3	***Specific*** *- Once governance, policy and procedures and fleet strategy revised and implemented, a KPI package is to be developed.* ***Measurable*** *– Yes, the nature of KPI is to give measurable data for action.* ***Achievable*** *– Yes, this will allow the fleet team to fine tune delivery of service.* ***Relevant*** *– Will allow transparency of service delivery to the force identifying issues and pinch points for action.* ***Time-bound*** *– Complete by April 24.*	*April 24*	*Head of fleet*

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
1	Delivery	As referenced elsewhere in this report, the Constabulary are currently operating two of three depots, which impacts on the volume of work that can be undertaken as well as the turnaround time for vehicles in for service or repair. During the testing undertaken, it was also noted that vehicles booked in don't always get started as expected and are therefore unavailable for longer or they remain in operation longer before work is carried out. It was noted, during discussions, that the Technicians are responsible for the ordering and receipting of all materials required. With the difficult recruitment of further technicians, it is suggested that a review of the technician duties is undertaken to determine how much time is spent on administration duties that could be made available for vehicle related work if there was administration support available.	Consideration be given to a review of technician duties to identify if administrative support would provide additional time for technicians to undertake vehicle work rather than administration of parts orders and booking of vehicles to external providers.	*Cumbria constabulary is currently partaking in an enabling services review. Head of fleet has requested that this be considered during the review.* *Head of fleet has engaged with head of business development to arrange analytical breakdown of the technician's admin functions and time to highlight any changes that can be implemented to drive efficiencies.*

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926
David Robinson	Audit Manager	David.Robinson@tiaa.co.uk	07766553339

Constabulary Staff	Title
Stephen Kirkpatrick	Director of Corporate Support
Ian Shaw	Interim Fleet Manager
Dianne Hill	Fleet Management Information Officer

Exit Meeting Date	18th August 2023
Attendees	Stephen Kirkpatrick, Director of Corporate Support

Director/Commander Comment	I am content that the reasonable assurance provided within this audit of Fleet Services represents an accurate and balanced view of the function. I am very pleased to observe that the audit has recognised the good practices in regarding service scheduling and MOT testing QA. The four actions, and one further observation are all accepted and will be action by the Fleet services team as per the management responses detailed. Whilst the audit identifies governance improvements being required (predominantly policies and procedures), I am very pleased to observe that no issues with the maintenance and servicing approach were identified which is a testament to the high standards of work that is achieved across all aspects of Fleet Services.

Deputy Chief Constable's Comment	I have read this report and the comments from Stephen above, and I am encouraged to see that the actions raised are being addressed. A review of our fleet arrangements had already been commissioned and completed, the recommendations of which are currently being refined and will be addressed and tracked through the Strategic Change Board. Equally the independent enabling services review has provided further opportunity to address some of the issues the audit highlights around governance, and its recommendations are currently being considered by Chief Officers. T/DCC Martland
Considered for Risk Escalation	Nothing to escalate.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, 2, & 3	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	-	-

Other Findings
A Fleet Strategy that covers the period 2022 to 2025 has been developed that provides a link between the Constabulary's strategic objectives and priorities for the vehicle fleet. The Strategy is also aligned to the delivery of Vison 25.
The Strategy is clearly set out with a simple overview of the Vision, Fleet Objectives and Fleet Strategy Actions. The four objectives are: Continually evolving to meet current and emerging operational needs; Excellent Maintenance arrangements to ensure safe a highly available provision; Affordability, provide an asset portfolio which is financially sustainable; and Reduce the carbon impact of operating a Police fleet - Plan Zero.
An Action Plan has been developed that sets out the key actions along with the timescale, key decisions and resource. An example of this is the introduction of telematics, which will improve vehicle utilisation and measure/capture benefits and align to the efficiency plan. This was originally expected to be rolled out in April 2023, however, a slight delay in the procurement and provision of the system has delayed this to late summer of 2023.

Other Findings

Appendices in the Strategy clearly set out the activities of the Fleet team as well as vehicle replacement criteria (Time/Mileage) and the use of a PowerBi dashboard to monitor performance.

In 2023, a Fleet Demand Review was undertaken by the Director of Corporate Support, which benchmarked the Constabulary's fleet against National benchmarking data, undertook an analysis of demand and growth requests, as well as setting out proposals for plain and marked vehicles, and the structure of the Fleet team.

The review also considered benchmarking of vehicle costs by type with a similar constabulary, availability of vehicles, sustainability and capital replacement costs over a 5 year rolling programme.

Four vehicles classified as unavailable were reviewed to ascertain the reason and confirm the status. In each instance, records were held to show the position of each vehicle with two relating to main dealer delays due to potential warranty claims, one booked for MOT but not yet done and one that had been off the road awaiting a new clutch for three weeks.

The Constabulary has three service and maintenance depots although one is currently closed due to reduced numbers of staff. There are nine Technician posts with two vacancies at the time of the audit fieldwork. It was advised that, although a recruiting exercise has been underway for some time, there is a lack of applicants across Cumbria for such roles.

Testing was undertaken on a variety of selected samples to review the processes undertaken by the Constabulary for vehicle servicing, vehicle MOTs, end of life disposal and vehicles scrapped.

A sample of 15 vehicles of varying types was selected to review the servicing records. All data was readily available and all but two vehicles were serviced in accordance with the schedules provided by the Fleet team. The two vehicles not serviced at the expected time were confirmed as being off the road due to damage at the time and were subsequently serviced once they were returned.

The service schedules have been set by the Fleet Manager and are less than the manufacturer's guidelines, although this is not formally documented in any policy, as referenced in the finding in Recommednation1 of this report.

Police vehicles are exempt from requiring an MOT providing that it is provided for police purposes and maintained in an approved workshop. The Constabulary, however, put all vehicles through an annual MOT, which are undertaken by an independent third-party provider and is seen as an additional assurance on the work undertaken by the in-house service and repair depots. A sample of ten vehicles was selected for review. Two vehicles were identified as having an MOT more than one month in advance of the existing expiry date; this was confirmed as being coordinated with the vehicle service to reduce the unavailability of the two vehicles.

A third vehicle was found to have no MOT test records, however, it was established that this vehicle had been transferred in from another Force, which didn't MOT their vehicles, and that a date had been booked for the MOT to take place.

A sample of five vehicles that were sold at reaching their end of life with the Constabulary and three vehicles that were scrapped was selected for review.

For the vehicles that were scrapped, an independent third-party report was evidenced to confirm the need to scrap, with each vehicle disposal being authorised by the Fleet Manager.

For the five vehicles that were sold, a Condition Report was provided for each vehicle, along with the CAP value and suggested reserve. All vehicles in this sample were authorised for sale by the Fleet Manager. A review of the income noted that each vehicle sold in excess of its suggested reserve and income was received that equated to 86% of the CAP value.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	4	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	1

Other Findings

The Fleet Demand review confirms that the national approach to sustainability is classed as in the start-up phase with limited coordination of plans across the sector. The review identifies that Cumbria Constabulary (at 3.6%) compares favourably with the national police fleet figure of 1.7% and UK wide figure of 4.5% for all electric vehicles (EV).

There are currently eight EVs on the Cumbria fleet, which will rise to 11, and a further 13 hybrid vehicles. The report acknowledges that infrastructure and vehicle range are significant factors in the roll out of EV vehicles going forward.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	19th June 2023	19th June 2023
Draft Report:	6th September 2023	13th November 2023
Final Report:	13th November 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Fleet - Strategy and Management of Fleet		
Type of Review:	Assurance	**Audit Lead:**	Andrew McCulloch

Outline scope (per Annual Plan):	The review will consider the strategy for the management and replacement of the fleet of vehicles and effectiveness of the delivery of the fleet management repairs and maintenance arrangements, including the planning of services and MOT's, responsive repairs and general maintenance.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	(if required then please provide brief detail)	
Exclusions from scope:		

Planned Start Date:	19/06/2023	**Exit Meeting Date:**	18/08/2023	**Exit Meeting to be held with:**	Stephen Kirkpatrick

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

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Internal Audit

FINAL

PFCC for Cumbria & Cumbria Constabulary

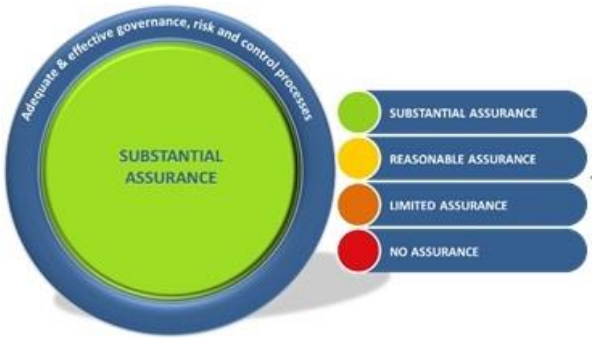
Assurance Review of General Ledger

2023/24

February 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

F&R/4 - Fail to meet timescales.

KEY STRATEGIC FINDINGS

Testing highlighted that there is an effective audit trail for data entered into the general ledger and that generated reports are appropriate to the processes.

Journals are approved in accordance with delegated authorities. Interfaces with feeder systems are accurate and run smoothly.

Control accounts are subject to regular review and sign off, with reconciliations completed and reviewed in a timely manner with a good audit trail.

The general ledger's chart of accounts is well-controlled, with amendments requiring an appropriate degree of approval.

GOOD PRACTICE IDENTIFIED

The Financial Regulations and Financial Rules are supported by relevant, clear and detailed procedures specific to daily tasks and close-down routines.

A comprehensive timetable of period-end routines, ownership and deadlines helps to mitigate the recognised risk of failure to meet timescales.

SCOPE

The review considered the arrangements for providing an effective audit trail for data entered onto the financial ledgers and the appropriateness of the reports generated. The scope of the review did not extend to the budgetary control arrangements and bank reconciliations.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No Recommendations were deemed necessary.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Ian Goodwin	Principal Auditor	Ian.Goodwin@tiaa.co.uk	07867526292
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926

Constabulary Staff	Title
Keeley Hayton	Financial Services Manager

Exit Meeting Date	2nd February 2024
Attendees	Keeley Hayton, Financial Services Manager

Director/Commander Comment	I welcome this report and its findings as part of the overall assurance placed on financial matters within the OPFCC and Constabulary. It is reassuring to note that the audit of the General Ledger system provides **substantial** assurance and contains no recommendations for improvement. Michelle Bellis, Constabulary Chief Finance Officer
Deputy Chief Constable's Comment	I have read this report and the comments from Michelle, as outlined above. I am satisfied that the audit has provided the highest level of assurance "substantial" with no recommendations. The grading provides chief officers with confidence in the way that the main accounting system is controlled and operated. DCC Darren Martland
Considered for Risk Escalation	No recommendations to be escalated.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The Financial Regulations, dated March 2021, note that the Joint Chief Finance Officer (Joint CFO) has a statutory responsibility to ensure that financial systems are sound and should therefore be notified of any proposed new developments or changes. It should be noted that the Financial Regulations and Rules are to be subject to an update in 2024 to reflect the change in responsibilities following the introduction of separate CFOs for the PFCC/Fire and the Constabulary from April 2023.

The Financial Rules, also dated March 2021, are the detailed supporting guidance and instructions that accompany the Regulations. They note that responsibilities of the Joint CFO, Deputy Chief Finance Officer, Head of Commercial Solutions and Head of Central Services include ensuring that all financial transactions are recorded electronically on the financial system and that all financial transactions entered onto the financial system are supported by appropriate input documentation, authorisation and validation checks. The input of feeder data to the financial system is controlled by the Deputy Chief Finance Officer and for the payroll system by the Head of Central Services.

Other Findings

An Oracle ERP Cloud Period Close Procedures document, prepared externally, provides generic step-by-step guidance on period-end closure routines. Two spreadsheets of more bespoke guidance have been prepared by the Financial Services Manager, relating to accounts receivable and to general ledger.

The Finance Risk Register was last updated on 2nd February 2024 and comprises five risks; one of which is F&R/4 - Fail to meet timescales. This is the risk that the Constabulary fails to meet statutory timescales for delivering major financial products e.g., the budget and final accounts. The latest score for the risk is 12 (Amber) and was reduced from the previous score of 16 (Red) to reflect that staffing levels in the team were improved and had stabilised. Having robust arrangements for providing an effective audit trail for data entered onto the financial ledgers and having appropriate reports generated are fundamental in successfully managing this risk.

A spreadsheet was provided of all journals posted to the general ledger throughout Q2 and Q3. An analysis showed there to be eight distinct sources of journals. The three largest sources of journals by volume accounted for 87% of all journals posted and 44% by value. A sample was selected of 20 journals, with each of the eight journal sources being selected. Testing included detailed discussions with the Financial Services Manager, screen-sharing of the finance system and viewing appropriate approvals and source documentation, such as invoices. No exceptions were noted and a good audit trial was evident and easily navigable.

A Chart of Accounts spreadsheet was provided, which included a tab of new codes added and of amendments to existing codes. An analysis showed there to have been 131 codes added and 23 code details amended throughout the current financial year-to-date. A further four codes were deactivated. Four new codes and one amendment were selected at random for testing, which included a review of New GL Code Change Request Forms and discussions with the Financial Services Manager. It was determined that controls over changes to the chart of accounts structure are operating effectively, including that changes are affected on a timely basis and that reports generated continue to be appropriate.

The nine monthly reconciliations of the accounts receivable ledger with the trial balance for the financial year-to-date were tested. There were no reconciling items throughout the period. A proper audit trail was provided with each reconciliation; which was prepared using a standard template format laid out in accordance with best practice. Each reconciliation was signed and dated by the preparer and by the reviewer. An analysis showed that, on average, reconciliations were prepared 10 days after the month-end and reviewed 17 days after being prepared.

The nine monthly reconciliations of the accounts payable ledger with the trial balance for the financial year-to-date were tested. One month showed three reconciling items, totalling less than 0.2% of the balance. There were no other reconciling amounts throughout the period. An audit trail was provided with each reconciliation; which was prepared using a standard template format laid out in accordance with best practice. Except for one month, each reconciliation was signed and dated by the preparer and by the reviewer. An analysis showed that, on average, reconciliations were prepared 14 days after the month-end and reviewed six days after being prepared.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

A detailed and well-presented Financial Period-End Timetable 2023-24 spreadsheet was provided. This lists all close-down routines and provides for each month the date and time by which the routine should be completed, naming the team having responsibility for the routine. A review of a sample of reports generated from month-end close-down routines showed no exceptions having been reported.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	15th January 2024	15th January 2024
Draft Report:	12th February 2024	
Revised Draft Report:	16th February 2024	21st February 2024
Final Report:	22nd February 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PFCC for Cumbria & Cumbria Constabulary		
Review:	General Ledger		
Type of Review:	Assurance	**Audit Lead:**	Ian Goodwin

Outline scope (per Annual Plan):	The review considers the arrangements for providing an effective audit trail for data entered onto the financial ledgers and the appropriateness of the reports generated. The scope of the review does not extend to the budgetary control arrangements and bank reconciliations.	
Detailed scope will consider:	The review will set out to provide assurance to Joint Audit Committee that the organisation has robust arrangements for maintaining the integrity of the financial ledgers. • The processes are directed by appropriate policy and procedures. • Segregation of duties exists between preparing and authorising ledger entries.	• Journals are approved in accordance with delegated authorities. • Month-end and daily reconciliations are performed in a timely manner with an audit trail to support completion and review. • Control accounts are subject to regular review and sign off.
Requested additions to scope:	None	
Exclusions from scope:	None	

Planned Start Date:	29/01/2024	**Exit Meeting Date:**	02/02/2024	**Exit Meeting to be held with:**	Keeley Hayton

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

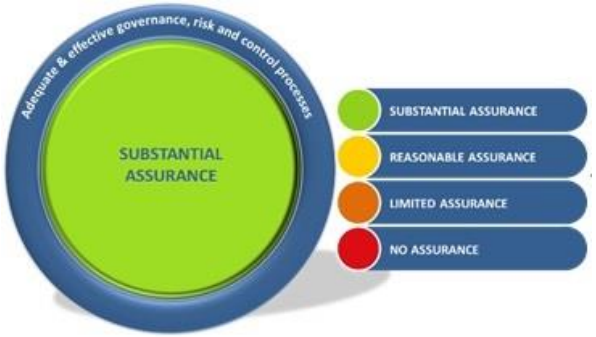
Assurance Review of Grievance Reporting and Management

2023/24

June 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

No specific risks have been identified in relation to grievance reporting and management.

KEY STRATEGIC FINDINGS

A comprehensive Grievance Policy and Procedure is in place providing a clear framework for dealing with grievances fairly, consistently and speedily.

From January 2023 to December 2023, there were 16 grievance cases, of which 13 (81%) related to issues with management.

On a bi-annual basis, a report is presented to the Ethics and Integrity Panel on Constabulary Grievances.

GOOD PRACTICE IDENTIFIED

A HR professional is allocated to each grievance to support the resolution managers and to provide guidance and specific information in relation to employment law, regulations, term and conditions and policy.

The Grievance Policy and Procedure is readily available to all staff on the on-line Policy Library and is signposted within other policies.

SCOPE

The review considered the arrangements for the operation of the grievance procedure at the organisation and focused on the effectiveness of the process and the appropriateness of the evidence held to support grievances. The review also considered whether the level of trends or patterns in relation to submitted grievances are being considered and actions are being taken to address concerns.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No Recommendations were deemed necessary.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Jane Butterfield	Operations Director	Jane.Butterfield@tiaa.co.uk	07580164521
Andrew McCulloch	Director of Operations – Internal Audit	Andrew.McCulloch@tiaa.co.uk	07980787926

Constabulary Staff	Title
Diane Johnson	HR Manager

Exit Meeting Date	29th April 2024
Attendees	Diane Johnson, HR Manager

Director/Commander Comment	I have reviewed the report and confirm that I am happy with the contents as discussed with the auditor. **Diane Johnson HR Manager**

Deputy Chief Constable's Comment	I have read this report and the comments from the HR Manager. I am happy that the audit has provided the highest level of assurance "substantial" with no recommendations. The grading provides chief officers with confidence in the way that the grievance reporting and management system is controlled and operated. DCC Darren Martland
Considered for Risk Escalation	No recommendations to escalate

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings
A Grievance Policy and Procedure is in place, last reviewed in September 2021 and due for review in September 2024. The Policy and Procedure includes the Code of Ethics and Policing Principles, which are linked to The Police Standards of Professional Behaviour.
The Policy and Procedure provide a clear framework to deal with grievances fairly, consistently and speedily and applies to all Police Officers, Special Constables, Volunteers and members of Police Staff. The Procedure takes into account current employment legislation together with the ACAS Code of Practice.
The Procedure includes an overview into the issues which may cause an individual to raise a grievance; the process if an individual leaves prior to the grievance being resolved / completed; Collective Grievances; Grievance and Disciplinary cases; Grievance in relation to bullying and harassment; and mediation.

Other Findings

	A flowchart is included within the Grievance Policy and Procedure detailing the processes to be followed for Informal; Formal Stage 1; Formal Stage 2 Appeal; and Mediation. This is supported by commentary explaining what action officers, staff, managers and supervisors need to undertake for each stage with hyperlinks to the relevant forms.
	The Grievance Policy and Procedure states “Appropriate training will be provided to managers”. Discussion with the HR Manager confirmed that a HR professional is allocated to each grievance and supports the resolution managers and provides guidance and specific information in relation to employment law, regulations, term and conditions and policy.
	From January 2023 to December 2023, there was 16 grievance cases. Of these, four (25%) had been withdrawn, seven (44%) had been resolved at Stage 1, three (19%) were ongoing, one (6%) had been resolved informally and one (6%) was on hold.
	Out of the 16 grievance cases between January and December 2023, 13 (81%) related to issues with managers, one to processes and discrimination, one to the leave process and one to the selection process.
	Whilst there are a number of issues with management, there is no particular trend and all are for differing reasons. Discussion with the HR Manager noted that there has recently been a lot of work regarding leadership and training for managers. In December 2023, the Constabulary launched its new Leadership Approach and leadership action plan within the PDR. The approach also links into leadership development training for all managers and those aspiring to be leaders.
	Sample testing was undertaken on two withdrawn cases (50% of the total number), three cases resolved at Stage 1 (43% of the total number) and one on-going case (33% of the total number).
	The sample cases were reviewed against the flowchart and it was noted that all adhered to the policy requirements with clearly documented decision making. In all cases reviewed, there was evidence to support the investigation and outcome of each grievance. On occasions where the prescribed timescales had not been adhered to, there was evidence of communication with the employee and their agreement to the time extension. In addition, it was evidenced that there was clear oversight and management from the HR team.
	There has only been one appeal, however, this was not classed as formal as the employee left. A review, however, was still undertaken of the case for due diligence purposes.
	The Grievance Policy and Procedure is available to all staff on the on-line Policy Library, is signposted within other policies (for example the Disciplinary Policy) and an update is provided at the Inspectors / Sergeants briefing days. Discussion with the HR Manager highlighted that grievances can also be submitted by the union representatives.
	During the review, the HR Manager requested that Digital Marketing create a "tile" called Engagement which will signpost officers and staff to the various policies.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings
On a bi-annual basis, in May and November, a report is presented to the Ethics and Integrity Panel providing a position overview in respect of ongoing, finalised and newly submitted grievances for the six months from 1st October to 31st March and 1st April to 30th September respectively.
The report also provides the number of grievances on a six-monthly basis from 1st October 2018 and a breakdown of the number of grievances by area; and gender and ethnicity.
An examination of the reports presented to the Ethics and Integrity Panel from May 2022 to November 2023 confirmed that appropriate information was provided in a clear manner.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	12th January 2024	12th January 2024
Draft Report:	16th May 2024	10th June 2024
Final Report:	13th June 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PFCC Cumbria & Cumbria Constabulary		
Review:	Grievance Reporting and Management		
Type of Review:	Assurance	**Audit Lead:**	Jane Butterfield

Outline scope (per Annual Plan):	The review considers the arrangements for the operation of the grievance procedure at the organisation and will focus on the effectiveness of the process and the appropriateness of the evidence held to support grievances. The review will also consider whether the level of trends or patterns in relation to submitted grievances are being considered and actions are being taken to address concerns.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	(if required then please provide brief detail)	
Exclusions from scope:		

Planned Start Date:	05/02/2024	**Exit Meeting Date:**	29/04/2024	**Exit Meeting to be held with:**	HR Manager

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

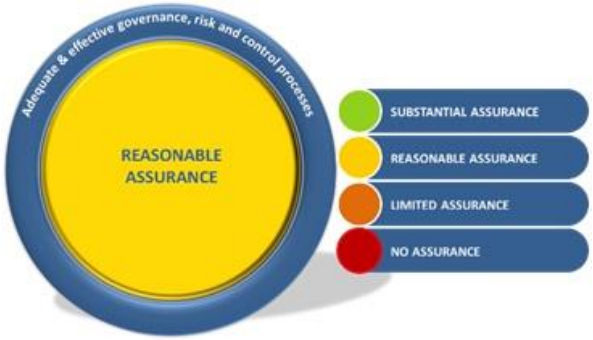
Assurance Review of Corporate Health and Safety

2023/24

July 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

H&S/02 - The organisation may not be fully compliant with H&S Legislation by not having a corporate risk assessment on the management of stress.

KEY STRATEGIC FINDINGS

The Constabulary has a dedicated individual to provide health and safety advice, strengthening the organisation's ability to comply with regulations.

The eLearning Suite hosts nineteen modules for health and safety training, however, the majority of these are elective rather than mandatory due to a wide variety of roles, it would be challenging to assign mandatory elements to specific role.

Accidents and near miss reports were evidenced for all incidents sampled during testing.

GOOD PRACTICE IDENTIFIED

Site inspections have been a focus of the new Health and Safety advisor and are currently all being brought up to date.

SCOPE

The review considered the adequacy of the arrangements for managing the health and safety requirements of the Police, Fire and Crime Commissioner and The Constabulary. The review considered the arrangements for compliance with key requirements of health and safety legislation but does not represent an exhaustive review of compliance with all health and safety legislation and cannot be relied upon as such.

ACTION POINTS

Urgent	Important	Routine	Operational
0	3	2	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	The Constabulary has an induction process that outlines the expected training required to be completed from the E-Learning Suite. There are three mandatory courses to complete from the learning suite, which has nineteen subjects that are health and safety related; the remainder are currently elective. Discussions with the Health and Safety Advisor confirmed that this was because of the wide variety of roles it would be challenging to assign mandatory elements to specific roles and that the staff member should be pointed to the training relevant to them. Elective rather than mandatory training may lead to staff not completing training and being unequipped to deal with certain scenarios; a review into changing elective modules to mandatory for specific roles would reduce the risk of accidents or near misses.	A review of all health and safety modules on the E-learning suite be undertaken to identify which modules can be assigned to roles as mandatory rather than elective, to provide additional guidance and knowledge across the workforce.	2	*S- Carry out a full review of available Health & Safety e learning courses on College Learn to identify if specific knowledge and training is required within departmental roles.* *M- Consult with departments.* *A – Add mandatory training to departmental induction.* *R – Managers should ensure their staff are suitably trained in areas of Health & Safety which is relevant to the role.* *T – At departmental induction and periodically.*	*30/11/24*	*H&S Advisor and digital learning manager*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	A sample of 18 members of staff covering office staff and police officers was selected for testing. Testing focused on confirming that induction forms, fire safety training, manual handling and DSE assessments have been completed. Of the 18 reviewed it was identified that 14 training areas were missing, including one member of staff who does not have any record of training. Discussions with the Health and Safety Advisor confirmed that training during induction is not validated at any point by the tutors which is reflected in the testing results.	All health and safety training be required to be reviewed and signed off by appropriate persons, such as line managers or tutors.	2	*S- CSD must monitor and follow up completion of mandatory H&S training with line managers. Tutors to police students must ensure completion of mandatory H&S training before completion of basic training.* *M- check new starter induction checklist for staff and PEQF checklist for Officers.* *A – Tightening up line management responsibilities.* *R – Managers should be proactively monitoring the training completed by officers and staff within their areas of responsibility.* *T – With immediate effect.*	*With immediate effect*	*Line Managers through CSD and L&D*
4	Directed	Recommendations made during site inspections by the Health and Safety Advisor are not given deadlines or RAG/Risk ratings. Discussions with the Health and Safety Advisor stated that resource pressures for the Regional Advisors and Estates Team would	Recommendations made on health and safety inspections be given a RAG rating to identify where higher level recommendations remain not implemented.	2	*S- Site H&S Inspections have been carried out over the previous 14 months with two still to be done. Teams with actions have previously used the inspection report as the action plan. Recently Durranhill station had an*	*With immediate effect*	*H&S Advisor and action owners*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
		make deadlines unfeasible. Considering this challenge, introducing a RAG risk rating system enhances clarity, prioritises actions, and improves communication in managing health and safety risks. This would also allow for enhanced reporting to the Health and Safety Committee by highlighting the number of high, medium and low risks throughout the Constabulary.			*action plan created by the estates team to track progress. Going forward, a detailed action plan will be produced by the H&S Advisor to highlight priorities using a RAG rating system before delivery to the action owners.* *M- Future action plans to be reviewed at the monthly estate's meetings.* *A – Easily achievable.* *R – This will assure work completion and H&S risk management in all areas.* *T – With immediate effect.*		

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Constabulary owns and maintains a Health and Safety Policy that was last approved by the Chief Constable and the Police, Fire and Crime Commissioner in October 2023. The Policy has a three year review cycle. The policy does cite that the Health and Safety Committee must review the policy annually and this was due for May 2024. The Health and Safety adviser confirmed that the committee has not met since October 2023 and that the next review is scheduled for July 2024. The policy also includes a record of changes made the policy over the last ten years.	The Health and Safety policy be reviewed in line with the document review cycle set out within the policy.	3	*S - The H&S Policy statement of intent is reviewed and signed by the Chief Constable and the Police, Fire and Crime Commissioner every three years or on appointment change. The details of the H&S Policy are reviewed annually at the H&S Committee meeting to highlight amendments.* *M – The policy can only be reviewed and approved by the H&S Committee if Committee meetings are held in line with the terms of reference.* *A – Only if meetings are held as scheduled.* *R- A review cycle is set to ensure compliance and accuracy so should be adhered to.* *T - This will be carried out on July 1st, 2024, at the H&S Committee meeting.*	*01/07/24*	*H&S Advisor, DCC and PA*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Delivery	The two most recent quarter's reports for Health and Safety Performance Report were reviewed. The data in the reports is collated by the Health and Safety Advisor. The reports were found to be comprehensive and include data on issues such as time lost to injury, near miss trends, accidents, assaults and issues of note. Health and safety data for estate issues were limited to one section of the report, which listed the sites due for inspection. There was no detailed information on inspections for other sites completed recently. Additionally, in the Q3 report, five sites were scheduled for inspection in Q4, yet the Q4 report stated that these same sites were now scheduled for Q1 without providing any context for the delay.	The Health and Safety Performance Report be enhanced to include information of inspections completed and reasons for those that are delayed.	3	*S - Previous quarterly reports have stated which stations have been inspected. The forecast for inspections included within the COG quarterly reports are only a guide to show the intention of work as proactive measures. Sometimes time restraints and workload on the H&S Advisor mean that inspections need to be pushed back and fitted in around other commitments. This should maybe be made clear within the report in the future.* *M – Should be recorded in future COG reports.* *A – This is an easy change to process.* *R – Senior Management and police and staff associations should be informed of the inspection programme and progress or delays.*	*With immediate effect*	*H&S Advisor*

PRIORITY GRADINGS

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

Operational – Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matters identified.				

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926
James Back	Senior Auditor	Jame.Back@tiaa.co.uk	07814581890

Constabulary Staff	Title
Philip Collins	Health and Safety Advisor

Exit Meeting Date	6th June 2024
Attendees	Philip Collins, Health and Safety Advisor

Director/Commander Comment	The report will be discussed at Organisational Board and any actions managed through that governance arrangement. ACC Blackwell
Deputy Chief Constable's Comment	I have reviewed the audit report, management comments and the comment from ACC Blackwell with regards to how the issues will be addressed via the Organisational Governance Board. I note that the audit report provides 'reasonable assurance' and contains five 'Action Points' for improvement (3 Important and 2 Routine), and can provide an assurance that plans are in place to address the 'Action Points' over the next 3 x months and updates will be monitored and reviewed at the (Strategic) Health and Safety Board (next meeting 1st July 2024). DCC Darren Martland
Considered for Risk Escalation	N/A

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1, & 2	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	3, & 4	-

Other Findings

The Health and Safety Policy outlines the responsibility of all parties within the Constabulary. The policy also directs employees to supporting policies via links; these include but are not limited to Accident / Incident Reporting, Defect / Damage Reporting, Fire Safety and arrangements for inspections.

Discussions with the Health and Safety Adviser confirmed that there are four Inspectors responsible for Health & Safety. Increasing the number of Inspectors from three to four over the past eighteen months when the county was split from three regions to four has improved the processes. There has been no reduction in compliance due to staff absences or similar issues.

The Constabulary own an Occupational Health, Safety and Wellbeing Risk Register that identifies risks relating to health and safety and is listed as “There is a risk that the Constabulary would not have access to any health and safety advice if the Health and Safety Adviser were to be off work for a prolonged period of time”. The register does contain mitigating actions, inherent and residual risks and responsibilities.

Other Findings

A sample of thirty incidents was selected for review. This included incidents, accidents as well as near misses. Every incident reviewed had a completed incident form presented and signed off. For accidents, the Health and Safety Regional Inspector (H&SRI) vets the forms to ensure the investigation has been handled correctly. Discussions with the Health and Safety advisor confirmed that the supervisor completes the initial investigation with the injured person and submits it via email. The H&SRI is responsible for reviewing, commenting, and closing the report.

The Constabulary owns seventeen buildings that they are responsible for. It was identified through discussions with the Health and Safety Advisor that inspections had previously been sporadic to their appointment with inspections having taken place between seven and nine years apart in some instances. The current advisor has been working diligently to bring all stations up to date with inspections and at the time of the audits there were just two sites that were past their review date, which were scheduled. The intention is to conduct these inspections every two years moving forward.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	5	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of scope	-	-

Other Findings

The Health and Safety Advisor collates relevant data for issues such as time lost to injury, near miss trends, accidents, assaults and issues of note for the quarterly reporting. Additional information on site inspections completed or missed should be included to ensure that readers are fully appraised on performance and issues.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	20th May 2024	20th May 2024
Draft Report:	12th June 2024	25th June 2024
Final Report:	5th July 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PFCC Cumbria & Cumbria Constabulary		
Review:	Corporate Health and Safety		
Type of Review:	Assurance	**Audit Lead:**	James Back

Outline scope (per Annual Plan):	The review considered the adequacy of the arrangements for managing the health and safety requirements of the Police and Crime Commissioner and The Constabulary. The review considered the arrangements for compliance with key requirements of health and safety legislation but does not represent an exhaustive review of compliance with all health and safety legislation and cannot be relied upon as such.
Detailed scope will consider:	The review will set out to provide assurance that the PFCC and Constabulary has robust processes in place for arrangements for corporate health and safety management. • The policy and procedures for the health and safety arrangements are up to date and provide adequate guidance to all users on the required actions to be taken and records to be maintained. • Risks associated with health and safety have been considered and appropriate mitigating controls are identified and operated. • There is an effective management structure in place, which are competent in health and safety and have sufficient resources to deliver health and safety. • There is a suitable and sufficient training strategy in place for staff to carry out their health and safety duties. • Senior management and appropriate groups are suitably and periodically provided with health and safety performance information.
Requested additions to scope:	(if required then please provide brief detail)
Exclusions from scope:	

Planned Start Date:	24th May 2024	**Exit Meeting Date:**	06/06/2024	**Exit Meeting to be held with:**	Health and Safety Advisor

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	
Have there been any significant changes to the process?	
Are there any particular matters/periods of time you would like the review to consider?	

Internal Audit

DRAFT

PFCC Cumbria & Cumbria Constabulary

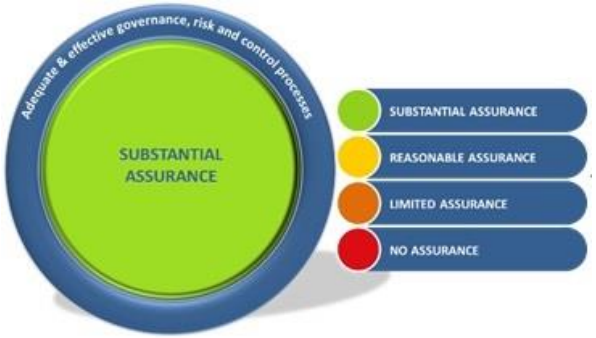
Assurance Review of Risk - Insurance

2023/24

March 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

F&R/12 - Revenue expenditure deviates

KEY STRATEGIC FINDINGS

Testing confirmed that there are robust processes in operation for managing insurance activities and that controls are operating effectively.

Policies were recently re-tendered and are under a long-term agreement with an option to extend up to two years. A new broker was also recently appointed.

In accordance with the Financial Regulations, an annual Insurance Renewal Report is presented to the Chief Officer Group and to the PFCC Executive Team.

GOOD PRACTICE IDENTIFIED

Both the Financial Regulations and the Financial Rues provide for robust arrangements for insurance, including appropriate Officer responsibilities.

The Constabulary CFO is a member of the NPCC Strategic Insurance Group looking at insurance nationally within the police sector.

SCOPE

The review considered the insurance arrangements including the identification of need; sourcing; payment of premiums; procedures to ensure the organisation operates within the requirements of the policies; and the claims procedures. The scope of the review did not include consideration of the appropriateness of the levels of cover obtained or the levels of premiums payable.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No Recommendations were deemed necessary.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Ian Goodwin	Principal Auditor	Ian.Goodwin@tiaa.co.uk	07867526292
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926

Constabulary Staff	Title
Sarah Walker	Financial Services Manager (Financial Accounting)

Exit Meeting Date	28th February 2024
Attendees	Sarah Walker
Director/Commander Comment	I welcome this report and its findings as part of the overall assurance placed on financial matters within the OPFCC and Constabulary. It is reassuring to note that the audit of the Insurance arrangements provides substantial assurance and contains no recommendations for improvement. Lorraine Holme, Group Accountant
Deputy Chief Constable's Comment	I have read this report and the comments from Lorraine, as outlined above. I am satisfied that the audit has provided the highest level of assurance "substantial" with no recommendations. The grading provides chief officers with confidence in the way that the Insurance arrangements are controlled and operated. DCC Darren Martland
Considered for Risk Escalation	No recommendations to be escalated.

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The Financial Regulations state that, in relation to the Cumbria Office of the Police and Crime Commissioner (OPCC), the Joint Chief Finance Officer (Joint CFO) is responsible for advising, in consultation with the Chief Executive, on the safeguarding of assets, including insurance. The Joint CFO is also responsible for advising on the safeguarding of the Constabulary's assets, including insurance. Responsibilities of the Police and Crime Commissioner include receiving an annual report on the overall arrangements for insurance. Responsibilities of the Chief Executive and the Chief Constable include ensuring that inventories are maintained for insurance purposes. It is noted that the CFO roles have changed since the Regulations were last revised and that this will be amended in the next revision of the document. The current version does not distract from the defined roles.

The Financial Rules state that responsibilities of the Deputy CFO include the co-ordination of information for the annual insurance renewal and to support the Joint CFO in making appropriate arrangements for insurance including identification of new risks and determining the level of self-insurance. One of the key controls of Risk Management and Business Continuity is listed to be that, where cost effective, insurance arrangements are put in place to offset losses that might result from risks which cannot be eliminated. Responsibilities of the Director of Legal Services include to administer all self-insured insurance claims and to maintain a central register of all insurance claims.

Other Findings

A review of the Governance Arrangements for Cumbria Constabulary highlighted that there is a detailed section headed Claims against the Chief Constable. This specifies the financial limits within which the listed responsible body or Officer is responsible for each of five stated activities, such as: approving settlement figures for third party insurance claims in respect of motor vehicle accidents: and, approving settlement of all uninsured claims against the Chief Constable and/or individual police officers and police staff for which the Chief Constable is vicariously liable.

The Finance Risk Register dated 30th October 2023 comprises five risks; one of which is F&R/12 - Revenue expenditure deviates. This is the risk that the Constabulary's revenue expenditure deviates significantly from budget both under and over. The latest score for the risk is 12 (amber). The mitigation strategy is to reduce this level of risk. The risk owner is the Joint CFO. Having robust processes in operation for managing insurance activities helps mitigate the risk of unbudgeted expenditure arising from claims against which insufficient insurance is in place.

The Director of Legal Services provided a spreadsheet showing claims by insurance year, ended 31st October. The Fleet Management Information Officer provided several spreadsheets summarising accidents and incidents as relating to fleet. From a review of these details and from discussions with the relevant Officers, it is evident that sufficient detailed records are being maintained and updated on a regular basis to help ensure that the relevant controls and procedures detailed in the Financial Regulations and the Financial Rules are operating effectively.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	In place	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

In accordance with requirements of the Financial Regulations, the annual Insurance Renewal Report was presented to the Chief Officer Group on 10th November 2023 and to the PFCC Executive Team on 14th November 2023. The Executive Summary section notes that: policies were re-tendered in 2022 and are under a long-term agreement until 31st October 2025, with an option to extend to 31st October 2027; a new broker was appointed from 31st May 2023; the tender of the combined liability bundle of policies provided annual savings of 4% per annum; and, the total of externally placed premium for the year ending 31st October 2024 is an increase of 10% over the previous year, which is broadly in line with inflation. The Report then summarises 10 policies, noting the excess and providing a brief narrative summary of the cover on each policy.

Notes from two recent quarterly meetings held at Police Headquarters of the Ethics and Integrity Panel were provided. At each meeting it was noted that the Head of Legal Services presented a report outlining active and closed Public Liability Claims, Employer Liability Claims and Employment Tribunal applications or proceedings. The Head of Legal Services advised at each meeting that no trends had been identified but that any learning or changes to work practices where identified had been implemented across the force.

The most recent annual Insurance Renewal Report notes that the Constabulary CFO is a member of the National Police Coordination Centre (NPCC) Strategic Insurance Group which is working with BlueLight Commercial to look at insurance nationally within the police sector.

A review of the chart of accounts showed there to be an extensive number of codes relating to insurance, thereby allowing for a comprehensive analysis of transactions within the scope of this review. Insurance premiums were seen to have been posted to the correct codes.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	29th January 2024	29th January 2024
Draft Report:	11th March 2024	
Final Report:		

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Risk - Insurance		
Type of Review:	Assurance	**Audit Lead:**	Ian Goodwin

Outline scope (per Annual Plan):	The review will also consider the insurance arrangements including the identification of need; sourcing; payment of premiums; procedures to ensure the organisation operates within the requirements of the policies; and the claims procedures. The scope of the review does not include consideration of the appropriateness of the levels of cover obtained or the levels of premiums payable.	
Detailed scope will consider:	The review will set out to provide assurance to the Joint Audit Committee that the organisation has robust processes in operation for managing insurance activities: • Robust policies and procedures are in place for the areas reviewed.	• Appropriate controls are in place for the accuracy and completeness of insurance claims. • All potential insurance claims are identified and processed in accordance with the requirements of the insurer. • Appropriate reporting is in place to senior management and Board.
Requested additions to scope:	None	
Exclusions from scope:	None	

Planned Start Date:	05/02/2024	**Exit Meeting Date:**	28/02/2024	**Exit Meeting to be held with:**	Sarah Walker

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

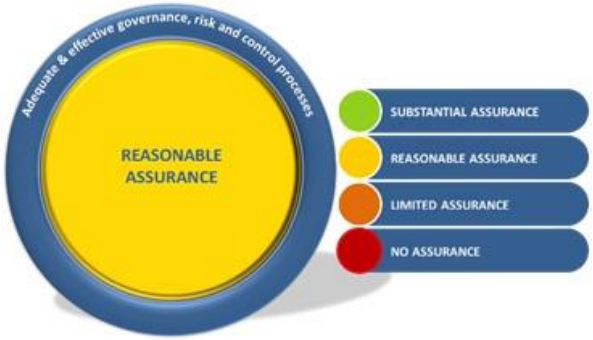
Assurance Review of Partnerships and Local Government Reorganisation

2023/24

April 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

The County of Cumbria has seen some significant landscape changes both in terms of health reorganisation and local government reorganisation on which has seen the County move from a County Council and six District Councils to two Unitary Authorities. The Safer Cumbria Partnership has remained a stable body in these changing times and is working across all partners to ensure that the reorganisation brings forth opportunities that recognises best practices and any associated areas of improvement.

SCOPE

The review considered the forming of relationships and arrangements with the newly formed unitary authorities of Westmorland and Furness, and Cumberland. The full scope agreed included partnerships established for County Drugs, Safer Cumbria, and Serious Violence.

KEY STRATEGIC FINDINGS

A Safer Cumbria Partnership Strategy is in place, however, when reviewed it was found to be out of date.

A Delivery Plan is documented and in place for all Groups. These were confirmed as having been approved by the Safer Cumbria Partnership Board.

Performance for each business area/group is regularly monitored by the relevant Boards/Operational Groups, including the Safer Cumbria Main Board.

GOOD PRACTICE IDENTIFIED

Management confirmed that for the year 2025 and beyond, the Partnership will be reviewed to ensure it is still fit for purpose and to ensure that it meets the needs of the partner agencies at a local and national level.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	The Safer Cumbria Partnership provides a forum for partner organisations to work together to deliver a coordinated approach to such areas as combating drugs and serious violence across Cumbria. The key/main functions of Safer Cumbria include Criminal Justice, Serious Violence and Drugs. A Strategy that directs the process relating to the period 2020-2025 is in place. The Strategy outlines the key priorities for the Safer Cumbria Partnership and how the priorities will be delivered to ensure positive outcomes and great service delivery. The Strategy also includes the "Crime and Community Safety Agreement "which delivers the statutory duty under Section 17 of the 1998 Crime and Disorder Act, stipulating that two tier authorities are required to prepare a Crime and Community Safety Agreement for the County. It was, however, noted that the Strategy is out of date and has not been updated following changes and reorganisations made through the local government reorganisation (LGR), Health Reforms, structural changes and key/main functions.	The Safer Cumbria Partnership Strategy be updated to reflect key changes as a result of the newly formed unitary authorities including structural and functional changes	2	*The changes to the Local Authority Landscape have been recognised through the work of the Safer Cumbria Partnership and named individuals from both Local Authorities are in attendance at both the main board and across the associated subgroups, with all terms of reference updated to reflect the changes.* *The changes to the strategy need to be made out with of the office due to the design packages required. This work is scheduled in with the Force Marketing and Media Department.*	*31/07/24*	*Safer Cumbria Business Manager*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Directed	No strategic risks in relation to Safer Cumbria Partnerships have been identified by the OPFCC. Given the collaborative and preventative work involved to ensure tangible improvements and outcomes are delivered to enhance the lives of the people of Cumbria, it is recommended that the risk management of this area remains a focus with mitigating controls listed and being regularly reviewed.	Risks in relation to Safer Cumbria Partnership arrangements be identified and appropriate controls recorded.	2	*The risk has been added to the PFCC Operational Risk Register and has been assessed with a mitigated total score of 2 due to the review work carried out and the continuing positive collaboration.*	*Complete*	*Safer Cumbria Business Manager*

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No Operational Effectiveness Matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Ade Kosoko	Principal Auditor	Ade.Kosoko@tiaa.co.uk	07779031139
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926

PFCC Staff	Title
Wendy Doreen-Binks	Business Manager
Jo Woof	Partnership Analyst

Exit Meeting Date	4th April 2024
Attendees	Wendy Doreen-Binks, Business Manager Jo Woof, Partnership Analyst
Director/Commander Comment	I welcome the report into an important partnership business area that has experienced significant change in the last 12 months. The report reflects the good work by the Safer Cumbria Manager to ensure the OPFCC delivers it statutory functions and makes a real difference to the people of Cumbria across a broad spectrum of crime areas. The recommendations will be easily addressed.
Considered for Risk Escalation	

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	1	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	2	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The Safer Cumbria Partnership Strategy sets out the different Boards, Groups, Forums and Safety Partnerships that works together with Safer Cumbria Partnership to deliver the outcomes of the Safer Cumbria Strategy. Terms of References are in place for the individual Boards and Subgroups.

A meeting structure is in place for all Boards and Groups of the Safer Cumbria Partnership and this is set out within the Accountability Framework. Each have different overarching aims and different meeting cycles. Testing of two subgroups and the main Board confirmed regular meetings being held and discussions of the set priorities taking place with the most recent meetings dated November 2023, December 2023, and March 2024. Other meetings held include multi -agency/ Community Safety Partnership meetings with the two newly formed unitary authorities and with other members of the Safer Cumbria Partnership.

The Safer Cumbria Partnership in consultation with relevant stakeholders and data obtained from local and national sources, such as the Cumbria Crime and Community Safety Strategic Assessment and the Cumbria Police Force Management Statement, have identified and determined key priorities needing dedicated input from the Partnership.

Other Findings

The following priorities have been agreed: Domestic & Sexual Abuse, Serious Violence and Crime, Reducing Reoffending and Covid-19 Recovery and Stabilisation. In addressing each priority areas, overarching outcomes have been identified. For example, for Serious Violence/ Violent Crime, one of its outcomes is to reduce serious violence linked to the nighttime economy. These priorities and their outcomes are monitored by the Main Board during each of their meetings.

Delivery plans have been developed by the different business area groups to address issues relating to these priority areas together with implementing national initiatives and managing day to day activities amongst the key functions.

It was noted other areas of work such as Modern Slavery, Hate Crime, Anti -Social Behaviour are also considered together with these priorities.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

The Delivery Plans for each business groups contain measurable actions that are monitored and evaluated to demonstrate successful completion and highlight areas requiring attention. The main Board provides oversight of this by holding the business groups to account against these delivery plans during the meetings of the Main Board and at the December meeting undertaken each year. Testing confirmed the Main Board determines the overarching strategic priority areas annually. It was further identified that Safer Cumbria measures performance based on a set of national performance related indicators as part of its key functions.

It was confirmed that each Business Area reviews their performance based on the set priorities and delivery plan and provides an update to the relevant Group. An example of a performance reviews was evidenced during the audit. This showed relevant data obtained nationally and locally including trends and progress made to one of the priorities (Reducing Offending), providing details on actions taken such as pathway programmes and housing and actions for the forth coming year.

Testing identified the Main Board approved the delivery plan for each area in December 2022. It was, however, confirmed that for the Community Safety Group, the delivery plan is being drafted following the formation of the two unitary authorities.

Information provided during the audit confirmed that there was less demand for Class A drugs in South Cumbria due to work undertaken by One CLIC and Cumbria Constabulary. In relation to Serious Violence, it was confirmed that during the 12-month period November 2022 to October 2023, violence against the person decreased by -8.3% (-1430 offences) although some categories

Other Findings

remained high when compared with the full pre-Covid year of 2018/2019. It was further confirmed that there was a 32.5% increase of possession of weapons. Action plans are in place for 2024/25 to support the delivery of the set priorities.

Testing identified that there is no data sharing agreement in place between Safer Cumbria and its related partners. Management confirmed that partners have their own data sharing agreements in place and that good working relationship over the years have resulted in excellent data sharing arrangements in place. It was further confirmed that the only data received is performance related and Safer Cumbria does not receive or tend to deal with personal details or specific spaces. In December 2023, during the Safer Cumbria Partnership Board discussions were held around adopting the national CJ Data sharing Memorandum of Understanding (MOU) but this was deemed not necessary as there have been no recognised issues with sharing data. It was noted that the Board however agreed to re- visit this if data sharing ever became less effective or an issue.

A CONTEST Board based on national requirement is in place. It was noted, the CONTEST Board oversees all the 4 Ps of CONTEST work; Prevent, Pursue, Protect and Prepare. It was further noted that the delivery plans around CONTEST sit with the relevant area of the 4Ps i.e. the Prevent Board which is a Local Authority responsibility has its delivery plan for the areas of the business that it covers. The CONTEST Board receives information on this.

Management stated that for 2025 and beyond, the Partnership will be reviewed to ensure it is still fit for purpose and to ensure that it meets the needs of the partner agencies at a local and national level.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	10th March 2024	10th March 2024
Draft Report:	19th April 2024	23rd May 2024
Final Report:	23rd May 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PFCC Cumbria & Cumbria Constabulary		
Review:	Partnerships and LGR		
Type of Review:	Assurance	**Audit Lead:**	Ade Kosoko

Outline scope (per Annual Plan):	The review will consider the forming of relationships and arrangements with the newly formed unitary authorities of Westmorland and Furness, and Cumberland. The full scope to be agreed.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	(if required then please provide brief detail)	
Exclusions from scope:		

Planned Start Date:	15/03/2024	**Exit Meeting Date:**	04/04/2024	**Exit Meeting to be held with:**	Wendy Doreen Binks (Business Manager) and Jo, Woof (Partnership Analyst)

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

Assurance Review of Recruitment - Inductions

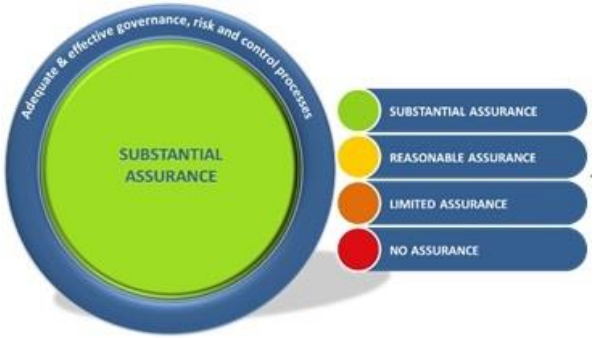
2023/24

June 2024

Agenda Item 08b

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Inductions provided new employees with key information on important policies, procedures and practice.

KEY STRATEGIC FINDINGS

A standard induction checklist is in place that is completed by police staff and signed off by the line manager.

For police officer new recruits, a timetable is in place that covers their activities to be undertaken within the 22-week training period.

Discussions undertaken with two new members of staff identified that they had mixed experiences of the induction process.

GOOD PRACTICE IDENTIFIED

The majority of induction learning is undertaken and recorded within the Police College e-learning system.

SCOPE

The objective of the audit was to ensure that there is a robust and consistent approach to the induction programme for police officers and staff. The review looked to ensure that appropriate planning and structure is in place to ensure that all aspects of the induction process can be provided at the appropriate moment in the process.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
Mo recommendations were made.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matters were identified.				

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Dabid Robinson	Audit Manager	David.Robinson@tiaa.co.uk	07766553339

Constabulary Staff	Title
Kate Ruddick	HR Manager

Exit Meeting Date	20th March 2024
Attendees	Kate Ruddick
Director/Commander Comment	I have reviewed the audit report and am content that the report provides a fair assessment of the recruitment/induction process within the Constabulary. I am pleased to note that the audit report provides the highest level of assurance 'substantial' and that the report makes no recommendations for improvement. The Constabulary will however strive to continuously improve recruitment and induction processes to help up to recruit and retain the best possible officers and staff for Cumbria Constabulary. The current on-boarding process is being reviewed by HR with a view to improving the employee experience further. HR Manager – Kate Ruddick

Deputy Chief Constable's Comment	I have read this report and the comments from Kate above. I am satisfied that the audit has provided the highest level of assurance "substantial" with no audit recommendations. The grading provides Chief Officers with confidence in the way that recruitment and induction processes are controlled and operated. DCC Darren Martland
Considered for Risk Escalation	None

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

A staff induction checklist is required to be completed by the new member of staff and their line manager within the first two weeks of commencing employment and is sent to the Central Services Department upon completion. This contains a record that the employee has completed the activities and, where required, read and understood a number of documents. These include the following discussions, and associated actions within the brackets:

- An introduction to colleagues and a tour of the building (confirmation that the COVID safe working guidance has been read and understood);
- A discussion regarding job descriptions, expectations and probation arrangements (and to view the Chief Constables Introduction video);
- A review of the IT set-up;
- An explanation of how Crown Duties operates including booking annual leave and accessing payslips (to read the Leave Policy);
- (Read the Staff Terms & Conditions Handbook, Flexible Working Practice and pension documentation);
- An explanation of the performance and development review process;
- Explain the sickness reporting system (read the Attendance Support Procedures);
- Explanation of the organisational structure (read the Our Plan on a Page, locate the Wellbeing support pages and consider the 'Fair Passport' process);
- (Read the Health and Safety Policy and complete the DSE package. Complete the E-Learning Packages relating to Health and Safety and Fire Safety);
- (Read documents in relation to professional standards, data protection, the Code of Ethics, the Information Security Supporting Procedures and Acceptable Use of ICT systems document. Completed E-Learning packages of sexual harassment in the workplace, information security and Managing Information – Non-Operational);
- Read the Official Secrets Act document; and
- Discuss any other policies, procedures or processes that are particularly relevant to the area of work.

There is also a condensed version of this document specifically for agency staff and volunteers.

For police officer new recruits, a timetable is in place that covers their activities to be undertaken within the 22-week training period. An example timetable was provided by the Learning & Development Team in relation to D23 intake. A review of this showed that it contains such areas as (excluding police officer specific areas): personnel and finance, health and safety, access to the Force systems, managing information, Crown Duties and occupational health. Discussions with management identified that, although completion of each individual session is not formally documented, students would not be able to pass the full course without attending each module. In addition to the timetable, officers also attend a welcome meeting where they collect their uniform.

It was identified that the following arrangements are also in place:

- New student officers undertake a 10-week independent patrol status (IPS) with a tutor. It was confirmed that the areas covered during this time include the attestation, ICT input, fingerprints and DNA, safeguarding, intelligence, a tour of the custody suite, Pathways, Policeworks and access to a transferee TEAMS channel and a Sharepoint page which contain a set of additional useful documents.

Other Findings

- Transferring officers are sent an email by the Area PDU Co-ordinator containing copies of the Attendance Support Policy and Procedure, Leave Policy and Procedure, "Duties – need to know for students and transferees" and the induction checklist. This also provides details of their timetable for the first four weeks and the areas that are to be covered within their first 2-3 days, which include dates that courses have been booked for first aid, personal safety training, Police Support Unit (PSU), and the Police National Computer (PNC). New starters are requested to complete their E-Learning, where possible, during shadowing shifts.
- In relation to initial entry Officers, performance reviews are covered in the Needs Concerns and Expectations session on the initial block timetable. Tutorials and reviews are carried out throughout the probation period, with Police Trainers, whilst on the Initial Block, and reviews with Area PDU Sergeants when on the Tutor phase and independent patrol phases of the programme. Sickness reporting is covered in the course introductions, and for new cohorts, Inspector Di Bradbury attends the Initial Block to let the Officers know how to use Crown and how to report sickness. In relation to Wellbeing support, the Occupational Health department speaks to the Officers on health and wellbeing at the start of the initial block, and they often carry out another session towards the end of the block. The Student Handbook also includes information as to where to find welfare support. There is also the wellbeing and inclusion hub on SharePoint. The Data and Information Assistant provides a lesson on information management and data protection as part of the initial block, which is within the first few weeks. The Student Handbook also has a section on information governance. All Officers are required to complete the e-learning package on sexual harassment. The topic is also covered in the Professional standards lesson, code of ethics lesson and VAWG lessons.

In relation to a sample of new officers selected for testing from the intakes in late 2022 and early 2023, the Learning Manager confirmed that all had completed their Initial Block and at least the majority of their independent patrol status (IPS).

A testing exercise was undertaken in order to establish whether a sample of new staff, including new officer recruits (selected from intakes between November 2022 and March 2023), and transferees and re-joiners (both officers and support staff) had undertaken all of the required elements of their inductions, including the e-learning packages that are recorded on the induction checklist. This utilised data in relation to the modules recorded in the College e-learning system provided by the Force and identified that:

- No staff had completed the Introduction to Health and Safety or information security modules. The introduction to health and safety was re-launched by the College of Policing on 3rd August 2023 and all new starters within the sample joined before this date. Prior to August 2023, staff were required to just read the policy on the SharePoint page. Information security is a link to the NCSC website and is therefore not recorded on College Learn.
- Display Screen Equipment (DSE) – 7 out of 21 had completed this module, 4 were enrolled and 10 had not completed the module. DSE is now an internal document that staff are required to read through and is not recorded on college learn.
- Fire safety – 13/21 completed, 1 had cancelled, 1 completed but failed, 1 in progress and 5 not completed. This module was launched in June 2023 and all staff within the sample started prior to this date.
- Sexual harassment in the workplace – 15/21 completed, 1 in progress, 5 not completed. This module was added in July 2023 and therefore did not form a part of the majority of the new starter's induction process.

The changes to the above modules were seen to be in place but no testing was undertaken as this was outside of the agreed intake cohort period.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Out of scope	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

Discussions were undertaken with a sample of new starters in order to ascertain their experience of the induction process. It was possible to talk to only two new starters who included a transferring officer and a member of support staff who was new to the service. The comments that they made included:

One officer had not been informed of what the induction process was. They stated that they may have been sent an email by the Senior HR Advisor regarding the induction, but this was when they were on maternity leave before they commenced work. They stated that they were given a poor induction and were given only a one-hour session on the IT systems and were not informed of how to access the e-learning system.

One member of support staff commented that their classroom training was well organised and supported by peers and supervisors. They went through the housekeeping elements of the induction at the beginning, speed read the documents initially, however they did look at them and digested them at a later date and confirmed that they were up to date with all e-learning packages.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

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

Effectiveness of arrangements

3. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	None sent	n/a
Draft Report:	12th June 2024	19TH June 2024
Final Report:	19th June 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Recruitment - Induction		
Type of Review:	Assurance	**Audit Lead:**	David Robinson

Outline scope (per Annual Plan):	The objective of the audit is to ensure that there is a robust and consistent approach to the induction programme for police officers and staff. The review looks to ensure that appropriate planning and structure is in place to ensure that all aspects of the induction process can be provided at the appropriate moment in the process.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.

Planned Start Date:	21/11/2023	**Exit Meeting Date:**		**Exit Meeting to be held with:**	

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

Police and Crime Commissioner Cumbria and Cumbria Constabulary

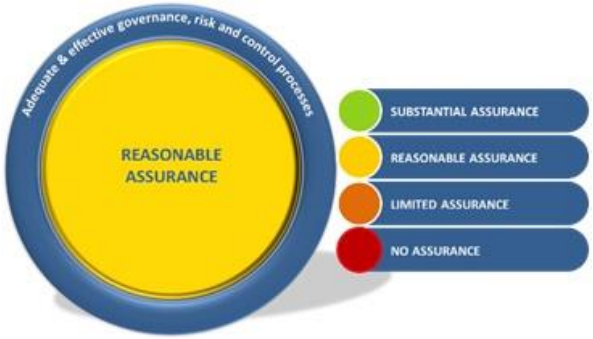
Assurance Review of Vetting

2023/24

November 2023

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Everyone in policing must maintain the highest ethical and professional standards, and must act with the utmost integrity. This is crucial in ensuring that public trust and confidence in the service is maintained.

KEY STRATEGIC FINDINGS

The Force Vetting Policy and associated procedures are aligned to the Authorised Professional Practice (APP).

All recommendations contained within the effectiveness of vetting and counter-corruption arrangements by HMICFRS in December 2021 have been implemented.

Arrangements are in place to ensure that all new starters undergo vetting before they commence employment.

One member of staff who returned from maternity leave in February 2023 has not been re-vetted within the required renewal period.

GOOD PRACTICE IDENTIFIED

Data in relation to vetting decisions has been investigated to identify any disproportionality in relation to the protected characteristics of applicants.

SCOPE

The review considered the extent to which vetting procedures have been strengthened in line with recent guidance and whether national recommendations in this area have been adopted and implemented. The review also considered what controls are in place to ensure that business interest, secondary employment and any declarations of interests are considered when undertaking vetting.

ACTION POINTS

Urgent	Important	Routine	Operational
0	2	1	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Directed	No strategic risks in relation to vetting have been identified by the Constabulary. Given the recent high-profile cases of officers convicted of serious offences, it is recommended that the risk management of this area remains a high focus with mitigating controls being regularly reviewed.	Risks in relation to the vetting arrangements be identified and appropriate controls recorded.	2	*Whilst this was not listed as a strategic risk on the risk register, vetting has been and is discussed regularly with the executive at Chief Officer Group and Strategic Management Board, to track progress. This has included several workstreams that have now been achieved, e.g., back record conversion of all vetting files onto CoreVet system, Historical Data Wash of officer and staff details through PND and HMICFRS inspection areas for improvement and recommendations.* *To raise this as a risk would now be retrospective when the workstreams are complete. However, we suggest vetting be added to the command risk register as an alternative and should we be unable to fulfil the demands of the upcoming APP and legislative changes, it can be escalated to the strategic risk register.*	*01/12/2023*	*Head of PSD*

PRIORITY GRADINGS

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

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Directed	Data provided showed that, at the time of the audit, there were three members of staff where the vetting renewal date had passed. Two of these were on career breaks (both returning in 2024) and are therefore not currently at work. In relation to the third, they were on maternity leave at the time that the re-vetting became due in January 2022. The Vetting Researcher confirmed that vetting renewal forms were sent out in November 2021, prior to the maternity leave commencing, however these were not returned. There has been no contact since they returned to work in February 2023 and they have therefore been working for the last six months with no up to date vetting in place. The Head of Professional Standards Department confirmed that the member of staff is a Detective Sergeant.	It be ensured that all staff returning to work following career breaks, including maternity leave, have up to date vetting in place at the time of their return.	2	*There is a process for identifying overdue reviews in CoreVet. This will be made to include a process of vetting being informed when staff return from career breaks.* *NB. The vetting for this officer was immediately actioned and clearance granted on 02/10/23.*	*01/12/2023*	*Head of PSD*
2	Directed	Testing was undertaken of a sample of 20 employees, encompassing police officers and support staff, with start dates from January 2023 to date. This showed that vetting had been carried out that was appropriate to their role and that the vetting had been passed prior to the member of staff commencing their employment. It was noted that in one case the decision record had not been uploaded into CoreVet, however, evidence was provided to demonstrate that the clearance certificate email had been sent.	It be ensured that decision records are held in CoreVet as evidence of the vetting checks completed and decisions made.	3	*This was raised with the vetting manager by the auditor, who explained it was due to human error.*	*07/09/2023*	*Head of PSD*

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
No operational effectiveness matters were identified.				

ADVISORY NOTE

Operational Effectiveness Matters need to be considered as part of management review of procedures.

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926
David Robinson	Audit Manager	David.Robinson@tiaa.co.uk	07766553339

Constabulary Staff	Title
Hayley Wilkinson	Head of PSD
Peter Morley	Force Vetting Manager
Kathrine Reeves	Vetting Researcher

Exit Meeting Date	8th September 2023
Attendees	Hayley Wilkinson, Head of PSD

Director/Commander Comment	I welcome this report and its findings. In the last 12 months there has been a significant focus on vetting arrangements owing to national scandals that significantly affected public confidence. This has led to multiple workstreams mandated nationally, and some managed locally resulting from our last HMICFRS inspection. 43 AFI's (areas for improvement) and recommendations arising from the national thematic inspection on vetting were mandated by NPCC and the HMICFRS for completion by all forces by June 2023. Cumbria Police achieved that deadline and have sent the returns to the HMICFRS. They will be subject to audit in our PEEL inspection which is already underway. In November 2023, the new vetting APP is being launched and will affect the demands of the PSD vetting team. To ensure that the department has the capability and capacity to meet those demands, Chief Officers have approved a formal business change review of PSD (including vetting) for which the TOR are already drafted for approval. This will ensure the Constabulary remains positioned to fully comply with all elements of the vetting APP. T/Ch Supt Bird 2989

Deputy Chief Constable's Comment	T/Ch Supt Bird has highlighted some of the vital developments in recent months aimed at bringing quality and consistency to vetting standards across police forces in England and Wales, and to restore public confidence. This remains a priority for Chief Officers and is the reason we have commissioned a full business change review of the department. This will ensure that the Force is well positioned to meet its obligations linked to vetting, whilst continuing to protect its colleagues and the public. My scrutiny of the PSD function will continue within the PSD, and HMIC governance boards. The HMICFRS actions in relation to vetting have been reviewed and have been fully completed. DCC Martland
Considered for Risk Escalation	Nothing to escalate

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Not in place	1	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	2, & 3	-

Other Findings
The Force Vetting Policy is currently at version 4 and was last updated in March 2023 to reflect that vetting reviews are completed in accordance with the Authorised Professional Practice (APP). This sets out the types of security vetting that are carried out, vetting reviews and renewals and the recording and review of diversity data in relation to vetting decisions.
Whilst the practices and rules regarding vetting are set out in the APP, the Constabulary has documented guidance in relation to the periodic vetting reviews. These were last reviewed and updated in April 2023.
A review into the effectiveness of vetting and counter-corruption arrangements at Cumbria Constabulary was undertaken by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) in December 2021. A number of areas for improvement were noted including that: The force does not have a system to ensure it periodically renews vetting clearances in line with the Authorised Professional Practice (APP) on vetting; The Force does not have a consistent process for informing the FVU when personnel move into designated posts; The force is not fully compliant with the APP on vetting; and The force does not monitor vetting decisions for any disproportionality.

The latest areas for improvement (AFI) action plan / Recommendation Outstanding List was provided by the Head of the Police Standards Department (PSD). This document notes all recommendations and AFIs as being implemented in full.

The APP on Police Vetting 2021 requires that a review of all posts in the force must be conducted to ensure that they have been designated the appropriate vetting level. This must be reviewed periodically to ensure that the information is kept up to date. There are three levels of force vetting applicable to the police service. These are non-police Personnel Vetting (NPPV), Recruitment Vetting (RV) and Management Vetting (MV). Police staff and police officers must be vetted to the appropriate level for their job. The Constabulary have determined and documented which posts come under the categories of Management Vetting, Security Check vetting and Developed Vetting.

Authentication is used to confirm an individual's identity prior to vetting being completed. There are two separate processes for this to accommodate police appointments (RV & MV) and non-police (NPPV). For police appointments, the Recruitment Team completes authentication prior to sending the notification to the Vetting Team for vetting to commence. Authentication documents are stored on the iTrent account for the candidate. For non-police personnel, internal vetting sponsors complete authentication before requesting vetting. They do this by signing a form to confirm that this has been completed prior to submitting it via SharePoint to the Vetting Team who then commence the vetting process.

Consent from the applicant is required for any biometric vetting undertaken for police officers. The Recruitment team arrange a date for biometrics to be taken at a police station and candidates are informed that, by attending the biometric appointment, they are consenting to the fingerprints and sample taken being the subject of a speculative search of the Police database.

A suitable process is in place to ensure that all new starters are identified, and the required vetting completed prior to the member of staff commencing their employment. The Recruitment Team receives a notification on iTrent detailing who the successful candidate is following the recruitment process and automated emails are sent to the relevant departments. This includes the Vetting Team who create a profile on CoreVet and send out a vetting application form to the candidate. Vetting is then completed and iTrent updated with the result, which generates an automated email notification to the Recruitment Team.

In order to identity staff who have changed roles to one that requires a higher level of vetting, Vetting Managers are required to generate a report periodically to check that the level of vetting held matches the role. This practice is in the early stages of being implemented. Discussions with a Vetting Manager identified that he is finalising the arrangements with the Recruitment Team so that their establishment spreadsheet of posts has the correct required level of vetting recorded. Once this is completed, the establishment spreadsheet will be updated to show all staff and what level of vetting that they have and what is require for their post. The process will then involve a weekly report being generated from the establishment spreadsheet so that checks can be made to see that those in post have the correct level of vetting.

Vetting renewal periods are set for each clearance level, ranging from three years for NPPV to 10 years for RV. The process of identify when the periodic re-vetting is required is automated on CoreVet with the re-vetting date generating a notification on the dashboard that the renewal is due in 42 days. The vetting team send out a renewal application at this point so that there is sufficient time to complete it before the expiry date of the vetting already in place.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	**Performance Monitoring**	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	**Sustainability**	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	**Resilience**	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Findings

The Vetting APP requires that Forces monitor statistics in relation to vetting decisions and investigate where there is a disproportionality in relation to the protected characteristics of applicants.

A report provided by the Head of PSD containing data for all applicants processed from 1st January to 2nd June 2023 (385 applicants) showed that there were 14 rejections (3.6%).

The rejections rates of male and female applicants were similar at 4% and 3% respectively.

Only six applicants identified as non-white and one of these was rejected. Although this is a large proportion of the rejections, the data set is too small to make appropriate comparisons.

In relation to sexuality, one applicant who identified as gay/lesbian and two of those who preferred not to state their sexuality were rejected. One applicant identifying as disabled was rejected.

Discussions with the PSD identified that vetting data is presented at the monthly PSD Governance Board for internal scrutiny. However, due to the small numbers of vetting data, there is only a sufficient data set to present and review this 6-monthly from a disproportionality perspective. Vetting data is also presented quarterly to the Constabulary's external Ethics and Integrity Panel to identify, understand and respond to any disproportionality.

The Head of the Police Standards Department (PSD) is designated as the Force Vetting Officer (FVO) and is supported by two Vetting Managers.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

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Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

4. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
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Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	7th July 2023	14th July 2023
Draft Report:	20th September 2023	13th November 2023
Final Report:	13th November 2023	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	Police and Crime Commissioner Cumbria and Cumbria Constabulary		
Review:	Vetting		
Type of Review:	Assurance	**Audit Lead:**	David Robinson

Outline scope (per Annual Plan):	The review considered the extent to which vetting procedures have been strengthened in line with recent guidance and whether national recommendations in this area have been adopted and implemented. The review also considered what controls are in place to ensure that business interest, secondary employment and any declarations of interests are considered when undertaking vetting.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.

Planned Start Date:	13/07/2023	**Exit Meeting Date:**	08/09/2023	**Exit Meeting to be held with:**	Head of the Police Standards Department and T/Chief Superintendent

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	**Y/N (if Y then please provide brief details separately)**
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N

Internal Audit

FINAL

PFCC Cumbria & Cumbria Constabulary

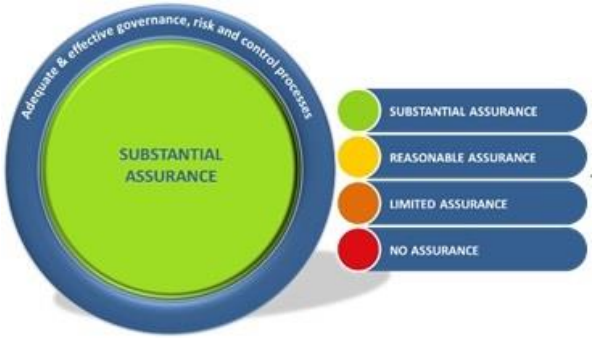
Assurance Review of Victim Support Services

2023/24

February 2024

Executive Summary

OVERALL ASSESSMENT



ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE

Operational Risk 8: Partnerships and Collaboration.

KEY STRATEGIC FINDINGS

The early commencement of the process allowed the OPFCC to consider different approaches and gather important feedback from users.

A robust procurement exercise with a detailed audit trail was confirmed as being in place.

Procurement approval timing allowed for sufficient time for mobilisation of the new contract.

Regular reporting highlighted progress as well as potential risks still to be mitigated.

GOOD PRACTICE IDENTIFIED

Engagement with the community as well as reviewing other Force area offerings provided alternative contract delivery for consideration.

Pre-market engagement with potential bidders allowed for a more tailored procurement approach.

SCOPE

The review considered the commissioning and introduction of the new victim support service and the steps taken to identify and deliver the new service, including market engagement, use of consultants and implementation of the service.

ACTION POINTS

Urgent	Important	Routine	Operational
0	0	0	0

Assurance - Key Findings and Management Action Plan (MAP)

Rec.	Risk Area	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
There were no recommendations raised.							

PRIORITY GRADINGS

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

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Risk Area	Finding	Suggested Action	Management Comments
There were no Operational Effectiveness Matters identified.				

Assignment Engagement Details

TIAA Auditors	Title	Contact Email	Telephone
Andrew McCulloch	Director of Audit	Andrew.McCulloch@tiaa.co.uk	07980787926
OPFCC Staff	**Title**		
Nicola Broomfield	Partnership and Strategy Manager		
Elaine Allan	Interim – Head of Commercial		
Exit Meeting Date	12th January 2024		
Attendees	Nicola Broomfield, Partnership and Strategy Manager		

Director/Commander Comment	I welcome the report and it reflects the hard work between the OPFCC and the Commercial Team to undertake a complex procurement exercise. I would like to thank the staff involved for their professionalism and determination to put in place a contract that will support victims for the next three years.
Deputy Chief Constable's Comment	Not appliable for this audit.
Considered for Risk Escalation	Not required.

Findings

Directed Risk:

Failure to properly direct the service to ensure compliance with the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	**Governance Framework**	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
RM	**Risk Mitigation**	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	**Compliance**	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-

Other Findings

The existing Victims Services contract, which includes the general crime Independent Victims Advocacy services, plus the Independent Domestic Violence Advisor and Independent Sexual Violence Advisor teams, was identified by the OPFCC as coming to an end in March 2024. The OPFCC team took this opportunity to review the service and consider researching what was offered in other PCC areas and to engage with the community on the potential provision from April 2024.

The team considered a number of models for the service, which included ones run entirely by the Police and ones where initial engagement was by the Force staff with an external provider providing on-going support.

Engagement within the Cumbrian community highlighted the importance of the perception of independence of the victim services to victims / survivors and, along with the additional transition time to move to an internal model, it was felt that this was not the appropriate approach for the continuation of the service.

Other Findings

	A report was taken to the Executive Team - Gold in early July 2023 setting out the proposed approach to procure the new service. Prior to this an engagement exercise had been undertaken and sufficient interest from a number of potential bidders confirmed that commissioning an external provider remained feasible.
	The report highlighted that the integrated service which was moved to in 2019 had brought benefits of flexibility and resilience since introduction. The report also covered the potential additional funding requirements required and sought guidance on the approach to the new unitary authorities.
	Evidence was seen to support the engagement to secure the required funding from both Councils to allow the process to continue to procurement stage.
	Further reports were taken to each meeting of the Executive Team - Gold to provide ongoing updates on progress.
	Having undertaken pre-procurement market engagement to ensure that all relevant elements had been captured, the procurement notice was issued in September 2023.
	The Operational Risk Register for the OPFCC records the risk of " failure to secure from partners funding for the Bridgeway and victim services (domestic abuse) contracts for 2024-25 and beyond" within Risk number 8, under the heading of Partnerships and Collaboration.
	The Operational Risk Register was regularly updated with progress against the new service procurement, which in September 2023 confirmed that funding had been secured from all partners.
	A review of the procurement activity was undertaken. Electronic records were provided/seen to support the procurement exercise, in which no anomalies were noted.
	A report was taken to the OFPCC in November 2023 to seek approval for the intention to award a contract and make budgetary provision for Victim Services for a period of three years effective from 1st April 2024, with options to extend the contract for three further periods of 12 months to 31st March 2030.
	The report clearly set out the financial implications of the service, including the Council contributions and was supported by a Tender Evaluation Report and the confirmation of funding from the Councils. The risks of not approving or approving a shorter contract period were highlighted in the report.
	The request was approved, which allowed the contract negotiations and pre-contract mobilisation to commence to ensure that the new service was in place for the start of April 2024.

Delivery Risk:

Failure to deliver the service in an effective manner which meets the requirements of the organisation.

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of scope	-	-

Other Findings
A robust audit trail of documentation was seen for all stages of the renewal process. Regular reporting to relevant teams was evidenced along with outcomes of engagement with third parties.

EXPLANATORY INFORMATION

Appendix A

Scope and Limitations of the Review

1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

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Acknowledgement

5. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

6. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	19th December 2023	19th December 2023
Draft Report:	20th February 2024	26th February 2024
Final Report:	27th February 2024	

AUDIT PLANNING MEMORANDUM

Appendix B

Client:	PCC Cumbria & Cumbria Constabulary		
Review:	Victim Support Services		
Type of Review:	Assurance	**Audit Lead:**	Andrew McCulloch

Outline scope (per Annual Plan):	The review will review the commissioning and introduction of the new victim support service and will consider the steps taken to identify and deliver the new service, including market engagement, use of consultants and implementation of the service.	
Detailed scope will consider:	Directed Governance Framework: There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation. Risk Mitigation: The documented process aligns with the mitigating arrangements set out in the corporate risk register. Compliance: Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Delivery Performance monitoring: There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner. Sustainability: The impact on the organisation's sustainability agenda has been considered. Resilience: Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.
Requested additions to scope:	(if required then please provide brief detail)	
Exclusions from scope:		

Planned Start Date:	02/01/2024	**Exit Meeting Date:**	12/01/2024	**Exit Meeting to be held with:**	Nicola Broomfield

SELF ASSESSMENT RESPONSE

Matters over the previous 12 months relating to activity to be reviewed	Y/N (if Y then please provide brief details separately)
Has there been any reduction in the effectiveness of the internal controls due to staff absences through sickness and/or vacancies etc?	N
Have there been any breakdowns in the internal controls resulting in disciplinary action or similar?	N
Have there been any significant changes to the process?	N
Are there any particular matters/periods of time you would like the review to consider?	N