Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of Body Worn Video

Draft Report Issued: **17th February 2020**

Final Report Issued: **10th March 2020**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	07810532759
Lead Auditor(s)	Sarah Fitzpatrick Steven Archibald	sarah.fitzpatrick@cumbria.gov.uk steven.archibald@cumbria.gov.uk	07464522833 07775111950

Audit Report Distribution

For Action:	Matt Kennerley (Superintendent)
For Information:	Andy Slattery (Assistant Chief Constable)
Audit Committee	The Joint Audit Committee, which is due to be held on 28th May 2020 will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of Body Worn Video. This was a planned audit assignment which was undertaken in accordance with the 2019/20 Audit Plan.

1.2. Body worn video is important to the organisation because it provides officers with an efficient and effective means of contributing to operational policing and the delivery of objectives in the Police and Crime Plan for Cumbria 2016-20 and Vision 2025. The use of body worn video by officers has a number of benefits for both the Force and the people of Cumbria. These include, improving the quality of evidence and intelligence gathered, enhancing trust and confidence in the police, securing earlier guilty pleas, increasing officer safety and encouraging better interactions with the public through greater self-awareness.

1.3. In 2018 body worn video cameras were issued to all operational officers, supported by a digital evidence management system and Body Worn Video Procedures. PCSOs and Special Constable were given access to pooled cameras. The equipment was provided to enable officers to overtly collect and secure evidence and intelligence at the scene of incidents and crimes.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Superintendent North. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following area:

- Compliance with the Force's Body Worn Video procedure.

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating around Body Worn Video provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There are **2** audit recommendations arising from this audit review which are summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives.	-	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts (see section 5.1).	-	1	-
3. Information - reliability and integrity of financial and operational information (see section 5.2).	-	-	1
4. Security - safeguarding of assets.	-	-	-

5. Value - effectiveness and efficiency of operations and programmes.	-	-	-
Total Number of Recommendations	-	**1**	**1**

4.3 **Strengths:** The following areas of good practice were identified during the course of the audit:

- The Body Worn Video Procedure is a key document used for training and ongoing reference. It provides clarity regarding when body worn video must be used and circumstances where it is not appropriate to use.
- Officers receive training on Body Worn Video usage before being issued with the kit so that they understand when and when not to record.
- There is a designated strategic lead for body worn video and key individuals (Inspector level) by area have been allocated body worn video portfolios. They are responsible for issues arising from body worn video usage and for monitoring hardware.
- There were a number of examples of senior management demonstrating their commitment to body worn video and communicating their expectations around usage to officers.
- Monthly data on body worn video usage is prepared for senior management on an area / department basis to highlight any issues or trends for consideration and appropriate action to be taken. The previous month's data is included for comparison.
- Body worn video checks undertaken by the Business Improvement Unit and Ethics and Integrity Panel and reporting to the Use of Force Board provides an additional level of oversight and scrutiny.
- Ongoing supervisory review of body worn video footage is firmly embedded into operational business as usual activity thus ensuring continuing checks of compliance with procedures.
- Learning points are identified for targeted action and good practice is commended by management as part of their commitment to ongoing performance improvement.
- The use of body worn video at incidents attended is increasing. A 27% increase from May to October 2019 was reported to Ethics and Integrity Panel in November 2019.

4.4 **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1 *High priority issues:* none identified.

4.4.2 *Medium priority issues:*

- An annual audit of evidence.com, as required in the body worn video procedure, has not taken place.

4.4.3 Advisory issues:

- There are inconsistencies across the force in the receipt of Quality Counts returns and the level of information included.

Comment from the Assistant Chief Constable:

I am are aware of the action in relation to audit that the Constabulary has signed up and have arrangements in place to monitor its implementation with a timescale of 6 months.
I am also satisfied that the action identified by Supt Kennerley address the issue of lack of consistency in the application of Quality Counts and associated risks identified within the audit to an acceptable level
The report can now be finalised and reported in summary to the next meeting of the Joint Audit Committee via the internal audit quarterly progress report.

A.Slattery
Assistant Chief Constable
10/03/20

Management Action Plan

5 Matters Arising / Agreed Action Plan

5.1 **Regulatory** - compliance with laws, regulations, policies, procedures and contracts ● **Medium priority**

Audit finding	Management response
(a) **Body Worn Video Procedure** The Cumbria Body Worn Video Procedure (2018) states that an audit of evidence.com will be carried out on a yearly basis and that it will be undertaken by the Business Improvement Unit (BIU). The procedure states that the audit will focus on the sharing aspect of evidence.com and will involve random dip sampling on an area basis. We were informed that that the audit of evidence.com has not taken place. Regular review of video footage in evidence.com is carried out as part of routine supervisory activity. However, an annual audit of evidence.com, as required in the body worn video procedure, would provide management with additional assurance around compliance with Body Worn Video Procedures and relevant legislation, ensuring that usage is proportionate, legitimate and necessary. The Data Protection Act 2018 has very specific requirements around access to personal data (including images) and the retention and disposal of this data.	Agreed management action: The Business Improvement Unit will undertake the first annual audit with assistance from the Superintendent (North). Arrangements will be made to ensure that annual audits are undertaken thereafter.
Recommendation 1: Annual audits of evidence.com should take place, in accordance with the Cumbria Body Worn Video procedures.	
Risk exposure if not addressed: • Sanctions arising from non-compliance with procedures and legislation. • Reputational damage arising from non-compliance with legislation. • Loss of trust in Cumbria Police and the use of body worn videos.	Responsible manager for implementing: **Superintendent (North) & T / Superintendent (BIU)** Date to be implemented: **08/2020**

5.2 Information - reliability and integrity of financial and operational information. **Advisory Issue**

Audit finding	Management response
(b) **Quality Counts** The Business Improvement Unit (BIU) prepares a Quality Counts publication on a monthly basis for senior managers across the force. It includes, as standard, a section on body worn video usage. The reports provide an overview of usage across the various shifts in each Area and Operational Support (OS) with embedded spreadsheets that breakdown the data by individual officer. Each report includes a reminder of circumstances where body worn video footage must be taken. The report recipients are expected to scrutinise the data and task supervisors to review the results, explore specific issues and take action where necessary with specific shifts or individual officers. A Quality Counts Audit Return is provided with each publication for feeding comments back to BIU, including details of any action taken. Internal Audit were informed of inconsistencies in the receipt of returns and the level of information included. Towards the end of the audit review the Head of BIU confirmed that he had met with Superintendents to discuss their views regarding the Quality Counts publication, explore any suggested changes to the content / format of the report and communicate expectations regarding what to do with it each month (in terms of dissemination, action and feedback to BIU). Because this had only happened recently, Internal Audit were unable to confirm through testing that the BIU now receives a full suite of fully completed returns each month. For this reason assurance could not be given that issues raised in the Quality Counts publication are considered and addressed in a timely manner across the force.	Agreed management action: The T/Superintendent (BIU) will ensure that properly completed Quality Counts returns are received on a monthly basis.
Recommendation 1: The receipt of Quality Counts returns should be kept under review to ensure they are all returned, properly completed and on a monthly basis.	

Risk exposure if not addressed:	Responsible manager for implementing:
• Performance issues and non-compliance with procedures and legislation are not identified and addressed. • Reputational damage arising from poor performance and non-compliance with legislation. • Failure to deliver ongoing performance improvement.	**T/ Superintendent (BIU)** Date to be implemented: **03/2020**

Appendix A

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of Trauma Risk Incident Management (TRiM)

Draft Report Issued: **28th November 2019**

Final Report Issued: **13th February 2020**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Sarah Fitzpatrick	Sarah.fitzpatrick@cumbria.gov.uk	01228 226255

Audit Report Distribution

For Action:	Lisa Hogan (Superintendent People Department) Jon Sherlock (Chief Inspector CJU & Partnerships)
For Information:	Stephen Kirkpatrick (Director of Corporate Support) Mark Pannone (Superintendent Ops HQ)
Audit Committee	The Joint Audit Committee, which is due to be held on 18th March 2020, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1 This report summarises the findings from the audit of Trauma Risk incident Management (TRiM). This was a planned audit assignment which was undertaken in accordance with the 2019/20 Audit Plan.

1.2 TRiM is important to the organisation because it contributes directly to overall Constabulary performance. It ensures that the organisation is proactively taking steps to reduce the impact on staff of dealing with traumatic incidents. It is designed to reduce long term mental health issues and absences from work, thereby contributing to the efficient and effective delivery of frontline policing to the people of Cumbria and the achievement of strategic objectives.

1.3 TRiM originated within the UK military in the late 1990s and is now used widely across a range of public organisations such as the emergency services. It is a peer based system of structured risk assessment and support designed to assist in the management of traumatic events by identifying people in difficulty and making referrals for medical support where necessary.

1.4 TRiM is not a mandatory service but is used widely by police forces to help fulfil their duty of care to employees exposed to traumatic events. Staff volunteer for TRiM positions to support colleagues in need.

2. Audit Approach

2.1 Audit Objectives and Methodology

2.1.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2 Audit Scope and Limitations

2.2.1 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Director of Corporate Support. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk

management and internal control in the following areas:

- Governance, co-ordination and oversight of TRiM arrangements.

2.2.2 There were no instances whereby the audit work undertaken was impaired by the availability of information.

3 Assurance Opinion

3.1 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2 From the areas examined and tested as part of this audit review, we consider the current controls operating around TRiM provide **partial** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4 Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2 There are **4** audit recommendations arising from this audit review and these can be summarised as follows:

Control Objective	No. of recommendations		
	High	Medium	Advisory
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	1	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts (see section 5.2.)	1	-	-
3. Information - reliability and integrity of financial and operational information (see section 5.3)	-	1	-
4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes (see section 5.4)	-	-	1
Total Number of Recommendations	**2**	**1**	**1**

4.3 **Strengths:** The following areas of good practice were identified during the course of the audit:

- The Constabulary have chosen to provide TRiM, which is not a mandatory requirement, to support the workforce.
- TRiM practitioners are volunteers who contribute their time, energy and skills to the support of their peers following traumatic events. Their commitment and proactivity is clearly demonstrated and is an important and integral part of the Constabulary's wider support offering.

4.4 **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1 *High priority issues:*

- Governance arrangements in respect of TRiM have not been defined, documented and communicated with clear lines of responsibility.
- Decisions taken around TRiM recruitment are based on geography and two day training rather than an interview and selection process and refresher training arrangements for TRiM practitioners do not meet national TRiM standards.

4.4.2 *Medium priority issues:*

- Up to date TRiM information is not readily accessible and arrangements are not in place to maintain data quality.

4.4.3 *Advisory issues:*

- Feedback is not currently sought from staff who have participated in TRiM processes to inform improvement activity.

Comment from the Director of Corporate Support:
I note that this review of the provision of the Trauma Risk Incident Management (TRiM) service provided within the Constabulary has achieved a Partial level of assurance with a number of recommendations being made as to how the service can be improved.

The provision of TRiM services is not a mandatory requirement, however it is noted positively within the report that the Constabulary has chosen to voluntarily provide TRiM services in order to support the wellbeing its workforce following traumatic events.

It is further recognised that the services provided by voluntary practitioners is of a high standard and is of clear benefit when utilised as an important and integral part of the Constabulary's wider support offering. That said, the report correctly recognises that the governance and coordination around service provision could be significantly improved which is reflected across the 4 recommendations made.

The first, and highest priority recommendation, focuses on improving the governance of the TRiM process. It is fair to observe that there has been a lack of clarity of ownership of the TRiM process since introduced. Additionally, due to the voluntary nature of the service, the resourcing to lead and administer has also been lacking at times. The Constabulary fully accept this recommendation and have taken steps to ensure clarity of ownership by the Superintendent People Department, with a nominated Chief Inspector taking operational responsibility for the service. The Constabulary are content that oversight will now be maintained through the Health & Wellbeing Board, chaired by the DCC, and are developing plans regarding how best to resource the administration of the service. The further recommendations are all accepted and are being addressed by the Constabulary.

In summary, I am content that the report has helped greatly in validating the Constabulary's understanding and has also helped provide increased focus in order to improve the coordination and governance around what is already a very valuable support service.

Management Action Plan

5 Matters Arising / Agreed Action Plan

5.1 Management - achievement of the organisation's strategic objectives.

● **High priority**

Audit finding	Management response
(a) Governance Governance arrangements in respect of TRiM have not been defined, documented and communicated with clear lines of responsibility. The following issues were highlighted by the audit review:- <u>Management Oversight</u> We were unable to identify whether a senior management group / body has been designated with responsibility for TRiM. As a result, clear direction and oversight of TRiM arrangements have not been provided. The Wellbeing Focus Group, chaired by the Deputy Chief Constable, recently tasked a HQ Superintendent to review the current TRiM arrangements, map current processes, identify any gaps and to look across the service and record other arrangements in place to see what initiatives could be co-ordinated and incorporated. Terms of reference are not in place for the Wellbeing Focus Group so it is unclear if this group is formally responsible for overseeing TRiM. <u>Reporting Lines</u> The absence of clear reporting lines around TRiM created difficulties and delays for the Advanced TRiM Practitioners when they were organising and seeking funding for the last TRiM Assessor training event. <u>Roles and Responsibilities</u> The role and responsibilities of a TRiM Co-ordinator have not been clearly defined and documented. The role of 'TRIM Co-ordinator' was allocated to the Community Safety Inspector who was absent	Agreed management action: Responsibility for TRiM has been assigned to the People Department, reporting into the Health and Wellbeing Board chaired by the Deputy Chief Constable. The Superintendent People Department is the deputy Chair. At an operational level the Chief Inspector CJU & Partnerships oversees three area Advanced TRiM Practitioners. A paper to Chief Officer Group is currently being drafted within the People Department to recommend the creation of a new post. The new post will include responsibility for TRiM co-ordination, administration and support, reporting to the Chief Inspector CJU & Partnerships.

from work for a period of time towards the end of 2018 and into 2019 and it took several months for the role to be re-allocated to the Chief Inspector CJU and Partnerships. The re-allocation was not communicated to the wider TRiM team and one of the Advanced TRiM Practitioners continued to pick up Co-ordinator duties during this time on an informal basis. There is no evidence of any risks around this extended period of absence being brought to the attention of management for action and monitoring. Arrangements are not in place to give management assurance that TRiM processes are being fully and effectively delivered and support the needs of the Constabulary.	
Recommendation 1: Governance and oversight of TRiM arrangements should be formally established and communicated. Consideration should be given to the arrangements for: • Management oversight • Reporting lines • Roles and responsibilities.	
Risk exposure if not addressed: • Failure to achieve strategic objectives because of poor leadership, direction and oversight. • Misunderstandings and inefficiency due to a lack of clarity around roles and responsibilities and reporting lines. • Actions not taken to address risks because risks are not being identified and managed.	Responsible manager for implementing: **Superintendent People Department** Date to be implemented: **29/02/2020**

5.2 Regulatory - compliance with laws, regulations, policies, procedures and contracts.

● **High priority**

Audit finding	Management response
(a) Recruitment, selection & training	Agreed management action:

At the time of the audit review SharePoint showed a TRiM team of 22 staff operating across the Force. However a formal assessment to inform the resources required has not been undertaken and the audit review highlights a number of issues around recruitment, selection and training arrangements:- <u>Recruitment</u> The TRiM Co-ordinator initiates recruitment drives periodically, the last was undertaken in 2018. The decision to recruit is not informed by management information because arrangements are not in place to capture and record TRiM referrals and assessments centrally. This makes it difficult for the TRiM Co-ordinator to monitor the level of demand and establish the workload of individual TRiM Assessors so that recruitment decisions can be made and adequate provision maintained. It is understood that responsibility for ensuring referrals are picked up rests with individual Assessors resulting in some picking up regularly and others picking up infrequently or not at all. TRiM Assessors are expected to flag when personal or work circumstances impact on their ability to participate in TRiM processes. In addition to this, National TRiM guidance states that TRiM Co-ordinators should look for instances where TRiM Assessors have reached their personal threshold for carrying out assessments to safeguard their health and wellbeing. In the absence of adequate management information for monitoring purposes there is a risk that Assessors may be overloaded and suffer as a result. <u>Selection</u> There are currently three Advanced TRiM Practitioners in the Force trained to be involved in the selection and training of TRiM Assessors. Selection is based primarily on location, to provide consistent coverage across Cumbria and thereafter attempts are made to secure a cross-section of departments and ranks. An interview / assessment process is not in place to determine skills, motivation to undertake the role or emotional resilience. Reliance is placed on the initial two day TRiM Assessor training event to assess suitability. There is a risk that practitioners are appointed who may not be suited to the role and end up delivering poor quality trauma support.	A new TRiM support post (if approved) will address capacity issues and meet the requirement for more effective co-ordination, record keeping, recruitment and resourcing arrangements. Refresher training for TRiM Practitioners is scheduled to take place on 25/03/20, a venue has been booked and funding has been secured. The event will provide an opportunity to explore issues such as who / how TRiM referrals are picked up and the balance of work across the TRiM team.

Training A representative of the force is required to attend an annual two day TRIM CPD event to maintain the annual operating licence. This requirement was not met in 2018 but it should be noted that two members of staff are booked to attend the November 2019 event. National TRiM standards require practitioners to carry out refresher training every two years, or every year if they carry out less than three TRiM risk assessments in a year to remain 'in date'. Management information is not currently available to determine refresher training requirements and arrangements are not in place to provide refresher training in accordance with national TRiM Standards. Again, there is a risk that trauma patterns may not be addressed or worsen because of poor quality support from inadequately trained practitioners.	
Recommendation 2: a) A formal and informed assessment of resources should be undertaken and approved. b) Selection arrangements should be put in place to ensure TRiM practitioners have clear and reasoned motives, demonstrate professionalism and sensitivity and are emotionally resilient. c) Refresher training arrangements to meet the requirements of the national TRiM standards and annual TRiM operating licence should be in place.	
Risk exposure if not addressed: • Inadequate TRiM provision because information is not available to support resourcing decisions. • Trauma patterns may not be addressed or worsen because poor quality support is delivered.	Responsible manager for implementing: **Superintendent People Department** Date to be implemented: **29/02/2020**

5.3 Information - reliability and integrity of financial and operational information**.**

● **Medium priority**

Audit finding	Management response
(a) Management Information Record Keeping Arrangements are not currently in place to centrally capture and record TRiM referrals, assessments undertaken (including those declined) and the outcomes of assessments. A TRiM Action Plan developed by the previous TRiM Co-ordinator includes an action around document storage and makes reference to a spreadsheet of cases. There is no evidence that this action has been progressed. Data Quality Arrangements for maintaining accurate and up to date TRiM information lapsed during the absence of the previous TRiM Co-ordinator. The audit identified the following data quality issues:- • Leaflets and posters used to raise awareness and understanding of TRiM processes are out of date. • Information published on SharePoint to explain TRiM processes and provide contact details are out of date. As a result of this hyperlinks to the SharePoint site are no longer embedded in emails offering staff TRiM assessments. • Arrangements are not in place to ensure that TRiM Assessor or Advanced Practitioner status is recorded in the Origin HR systems and maintained thereafter. • A 2014 version of a national TRiM document is in use when a 2018 version has been released. It is a requirement of the TRiM operating licence that previous versions of supplied materials are disposed of and not used under any circumstances.	Agreed management action: A new TRiM support post would include responsibility for ensuring that TRiM information is readily accessible and maintained accurately and up to date.

The collation and analysis of TRiM information could be used to inform decision making around resources, training plans and the overall welfare provision within the Force to ensure that support services are delivered effectively to meet the needs of the Constabulary. It is crucial that the data informing decisions around TRiM is maintained accurately and up to date and only the latest versions of national publications are available to staff.	
Recommendation 3: Arrangements should be in place to ensure that TRiM information is readily accessible and maintained accurately and up to date.	
Risk exposure if not addressed: • Flawed decision making because information is unavailable, inaccurate and out of date. • Reputational damage arising from a failure to meet TRiM operating licence requirements.	Responsible manager for implementing: **Superintendent People Department** Date to be implemented: **29/02/2020**

5.4 **Value** - effectiveness and efficiency of operations and programmes.

● **Advisory Issue**

Audit finding	Management response
(a) Improvement Activity Feedback is not currently sought from staff who have been exposed to traumatic events and subsequently participated in TRiM processes. Feedback could help to demonstrate that staff benefit from the process and that it contributes to the maintenance of a resilient workforce. It can also help inform changes and improvements.	Agreed management action: A new TRiM support post would include responsibility for collecting feedback from TRiM participants and identifying any improvements and learning going forwards.
Recommendation 4: Feedback should be sought to identify any learning that can be taken forward as part of a	

commitment to continuous improvement.	
Risk exposure if not addressed: • Failure to identify shortcomings in the TRiM process. • Opportunities not taken to make improvements.	Responsible manager for implementing: **Superintendent People Department** Date to be implemented: **29/02/2020**

Appendix A

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

This page has been intentionally left blank

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Office of the Police and Crime Commissioner

Audit of Blue Light Collaboration

Draft Report Issued: **30th October 2019**

Final Report Issued: **19th December 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Gemma Benson	gemma.benson@cumbria.gov.uk	01228 226252

Audit Report Distribution

For Action:	Vivian Stafford, Head of Partnerships & Commissioning.
For Information:	Sean Robinson, Blue Light Collaboration Manager.
Audit Committee	The Joint Audit Committee which is due to be held on 18th March 2020 will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of **Blue Light Collaboration**. This was a planned audit assignment which was undertaken in accordance with the 2019/20 Audit Plan.

1.2. Blue Light Collaboration is important to the organisation because the Policing and Crime Act 2017 introduced a high level duty for Blue Light services (Police, Fire and Rescue, and Emergency Ambulance Services) to keep collaboration opportunities under review and to collaborate where it is in the interests of their efficiency or effectiveness.

1.3. Following the introduction of this statutory duty the Police and Crime Commissioner developed and consulted on a Blue Light collaboration options appraisal in late 2017. Stakeholders consulted included the Chief Constable, Cumbria Police and Crime panel, the Leader of Cumbria County Council and Chief Fire Officer as the main collaboration considerations at this time impacted on Cumbria Constabulary, Cumbria Fire & Rescue Authority and Cumbria County Council (as the Fire Authority for Cumbria). All parties agreed to progress the voluntary collaboration option.

1.4. A collaboration agreement was drawn up and was signed by all parties, including the North West Ambulance Service in May 2018.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was Vivian Stafford, Chief Executive of the OPCC / Head of Partnerships & Commissioning. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- The governance of the Blue Light collaboration including arrangements to assess its effectiveness.

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating over Blue Light collaboration provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There are **4** audit recommendations arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	-	3	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	-	-	-
3. Information - reliability and integrity of financial and operational information	-	-	-

4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes (see section 5.2)	-	1	-
Total Number of Recommendations	0	4	0

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- A Blue Light collaboration agreement has been prepared, consulted on and signed up to by all parties.
- The collaboration agreement includes a shared vision, aims and strategic priorities as well as the delivery structure of the collaboration.
- Boards and working groups meet regularly and have good attendance by an appropriate level of officer.
- Project Leads have been established for all collaboration projects.
- Regular updates on collaboration projects are provided at board / group meetings.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- No high priority issues were identified.

4.4.2. *Medium priority issues:*

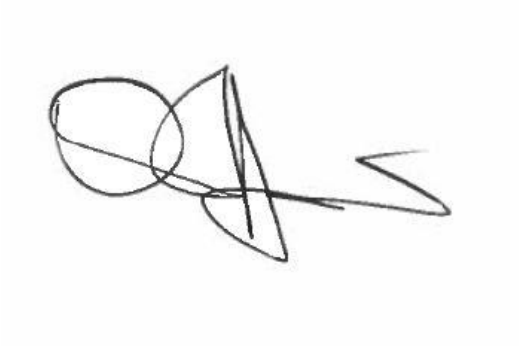
- Terms of reference have not been reviewed since the start of the collaboration agreement.
- There is a lack of evidence of items considered in determining the governance arrangements of the Blue Light Collaboration agreement.
- Minutes of Executive Leaders Board meetings do not always clearly show scrutiny undertaken, decisions made or requests for further information.
- There is no formal agreed performance framework in place for the Blue Light Collaboration agreement.

4.4.3. *Advisory issues:*

- No advisory issues were identified.

Comment from the OPCC Chief Executive / Head of Partnerships and Commissioning

I welcome the assurance that this audit gives to the OPCC and acknowledge the recommendations and actions within. The actions will be given priority over the coming months to ensure completion by the agreed dates.



Vivian Stafford – OPCC Chief Executive & Head of Partnerships and Commissioning

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Management - achievement of the organisation's strategic objectives.

● **Medium priority**

Audit finding	Management response
(a) **Governance Arrangements** The governance structure of the Blue Light Collaboration, in terms of the two Boards and Working Group in place, was agreed at the February 2018 Executive Board meeting and included in the approved Collaboration Agreement. Terms of reference for the Executive Leaders Board and the Programme Board were also presented at the February 2018 meeting of the Executive Board, along with key roles and responsibilities of certain posts (including Programme Director, Constabulary Senior Lead, Fire and Rescue Senior Lead and Work Stream Leads). A review of the governance structure for the Collaboration going forward was undertaken in October 2019 and, in light of this, we consider it to be an opportune time to review the terms of reference / key roles and responsibilities with updates prepared where necessary (e.g. group membership and reference to decision making agreement) to ensure they remain accurate. This review should be clearly documented. *See also 5.1b.* We were informed that the CIPFA Delivering Good Governance Guidance was reviewed and compared to the arrangements in place for the Blue Light Collaboration by the Blue Light Collaboration Manager. It was stated that the arrangement in place was considered to be reasonable and that a proportionate approach had been adopted for the Collaboration with bureaucracy kept to a minimum. The Blue Light Collaboration Manager also confirmed that a pure programme / project management approach was deemed unsuitable and too rigid for this Collaboration. Whilst elements of the CIPFA guidance are reflected in the governance arrangements of the collaboration there is nothing in place to specifically demonstrate the review of this guidance or the other factors considered in determining the governance arrangements for the	Agreed management action: *R1 and R2:* *We will review terms of reference for the Boards and roles and responsibilities for the revised structure. We acknowledge and will incorporate recommendation 2 in developing and making changes to the Blue Light Collaboration governance arrangements going forward.*

collaboration and how it was decided what was proportionate. It was noted that a key element of the good governance guidance, performance indicators agreed by all parties, is not in place for the Blue Light Collaboration. *See also 5.2a.*	
Recommendation 1: Key governance documents such as terms of reference / roles and responsibilities should be regularly reviewed to ensure they remain accurate. Recommendation 2: Appropriate arrangements should be in place to evidence the items considered in determining the governance arrangements for the Collaboration, including where key elements of good governance are not put in place.	
Risk exposure if not addressed: • Key governance documents are not accurate / do not reflect practice; • No evidence to support how key governance arrangements were determined.	Responsible manager for implementing: **Safer Cumbria Coordinator** Date to be implemented: **02/2020**

● **Medium priority**

Audit finding	Management response
(b) **Meeting Minutes** Through discussions with the Blue Light Collaboration Manager and review of meeting minutes it was identified that the minutes do not always clearly reflect the discussions held at Executive Board meetings. Our review of the Executive Board Minutes showed that they do not clearly show all decisions taken or requests made by the Board. For example, we were informed that the terms of reference for the Executive Leaders Board and Programme Board were agreed by the Executive at their meeting in February 2018, however the notes of this meeting did not clearly show this. Similarly, Executive minutes did not show where the Board had requested further information on certain projects though some of their requests could be seen in notes of the Working Group.	Agreed management action: *We will ensure 'actions' from meetings are clearly recorded moving forward.*

Recommendation 3: Meeting minutes should clearly record key items from meetings including Board scrutiny, decisions taken and requests for further information.	
Risk exposure if not addressed: • Scrutiny of Executive Board not clearly recorded; • No evidence of decisions taken; • Key decisions not recorded.	Responsible manager for implementing: **Safer Cumbria Coordinator** Date to be implemented: **02/2020**

5.2. **Value** - effectiveness and efficiency of operations and programmes.

● **Medium priority**

Audit finding	Management response
(a) **Collaboration Effectiveness / Performance Measurement** The briefing provided to the February 2018 Executive Board and various meeting minutes showed that initial plans were to have a performance framework in place for the Blue Light Collaboration. However, despite several discussions on this, no formal performance framework or agreed performance indicators have been put in place to assess the effectiveness of the agreement or collaboration projects. We were informed that whilst the areas to explore as part of the collaboration had been agreed, the potential of these were not known at the initial stage and that because projects can grow organically and change over time a formal framework was not practical in this instance. Project evaluation undertaken has varied between projects and evaluation criteria / performance indicators are not always identified in advance of each project commencing. Some projects have formal evaluation reports prepared (though the Executive requested further details on the two projects whose evaluation reports were reviewed by Internal Audit) while other projects are not proposed to be formally evaluated (including one where Working Group minutes show that the Executive Board had earlier requested an evaluation report). It was seen that progress with all collaboration projects is reported at Board meetings including practical examples where appropriate and it was stated that this progress provides assurance to the Board. There is nothing to demonstrate that the route that has been taken in relation to project evaluation was agreed by relevant parties or that it provides all parties with the level of assurance they require on whether the collaboration agreement and individual collaboration projects are effective. Whilst it is appreciated that projects may change during the course of implementation, objectives and outcomes of most projects and the area(s) of the collaboration agreement they link to (increased efficiency, effectiveness or community safety) should be identifiable up front / early on in each project. In turn, this should enable performance measures and areas to be included in project	Agreed management action: *We will ensure the Executive Board acknowledges how the Blue Light Collaboration and individual projects will be evaluated, and clearly set out how we will know that collaboration has been successful.*

evaluation to be identified and agreed on in advance / at an early stage in each project. This could help to ensure that the information reported provides all parties with the level of assurance they require and that the required information is readily available, and if not, it would allow parties to determine what needs to be put in place in order to provide / obtain evaluation information. This may also result in evaluations including a greater amount of information or for them to be undertaken more promptly than adding an evaluation measure after the project is already established. Changes to performance measures / evaluation criteria could still be made if a project took a different direction as it progressed.	
Recommendation 4: It should be evident how the success of the Blue Light Collaboration agreement will be measured and that this has been agreed by all relevant parties.	
Risk exposure if not addressed: • Effectiveness / performance of the collaboration is unclear; • Lack of clarity on whether agreement is achieving what it set out to; • Required data unavailable to assess success.	Responsible manager for implementing: **Safer Cumbria Coordinator** Date to be implemented: **02/2020**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

This page is intentionally left blank

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary & OPCC

Audit of Commercial Solutions - Procurement

Draft Report Issued: **30th October 2019**

Final Report Issued: **18th December 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226254
Lead Auditor(s)	Sarah Fitzpatrick	Sarah.fitzpatrick@cumbria.gov.uk	01228 226255

Audit Report Distribution

For Action:	Barry Leighton (Head of Commercial Solutions)
For Information:	Stephen Kirkpatrick (Director of Corporate Support) Roger Marshall (Joint Chief Finance Officer)
Audit Committee	The Joint Audit Committee which is due to be held on 18th March 2020, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of Commercial Solutions - Procurement. This was a planned audit assignment which was undertaken in accordance with the 2019/20 Audit Plan.

1.2 Procurement is important to the organisation because it contributes to the efficient use of resources to support operational policing needs and the delivery of the objectives in the Police and Crime Plan for Cumbria 2016-20. Effective procurement, in line with the organisation's constitution and legislation is necessary for the Constabulary to be able to demonstrate that funds are used and managed in a manner that is accountable and displays both probity and value for money.

1.3 The Commercial Strategy 2019-2022 states that the Constabulary has an annual budget in the region of £95 million with annual contract spend of around £23 million spread over approximately120 contracts. This accounts for 80% of procurement expenditure.

1.4 An audit of procurement was previously carried out in 2016/17. Based on the evidence provided at that time, the audit concluded that the controls in operation around procurement provided **partial** assurance. The recommendations and agreed improvements arising from this review were followed up in 2017/18 and although some improvements had been made the audit opinion remained unchanged and provided **partial** assurance.

1.5 Since the previous internal audit review in 2017/18 there has been renewed commitment to developing and improving procurement arrangements. Actions taken include new appointments within the Commercial Department, a review and update of the Joint Procurement Regulations, publication of a Commercial Strategy 2019-2022 and the inclusion of a Contracts Award Board in the governance structure.

2 Audit Approach

2.2 Audit Objectives and Methodology

2.2.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.3 **Audit Scope and Limitations**

2.3.1 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Director of Corporate Support. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control around the updated Commercial Strategy and Joint Procurement Regulations. The review also included detailed testing covering procurement activity on behalf of Cumbria Constabulary and the Cumbria Office of the Police and Crime Commissioner.

2.3.1 There were no instances whereby the audit work undertaken was impaired by the availability of information.

3 Assurance Opinion

3.3 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.4 From the areas examined and tested as part of this audit review, we consider the current controls operating within the Commercial Department - Procurement provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4 Summary of Recommendations, Audit Findings and Report Distribution

4.3 There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.4 There are **five** audit recommendations arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	-	-	2

2. Regulatory - compliance with laws, regulations, policies, procedures and contracts.	-	-	-
3. Information - reliability and integrity of financial and operational information (see section 5.2)	-	1	-
4. Security - safeguarding of assets.	-	-	-
5. Value - effectiveness and efficiency of operations and programmes (see section 5.3)	-	1	1
Total Number of Recommendations	**-**	**2**	**3**

4.5 **Strengths:** The following areas of good practice were identified during the course of the audit:

- An up to date and approved Commercial Strategy is in place which was fully consulted on and has clear links to strategic policing priorities as set out in the Police & Crime Plan 2016-2020 and Cumbria Vision 2025.
- Constabulary and OPCC strategic risk registers both capture and assess the risk around lack of capacity and skills in the procurement function for ongoing management and review by Chief Officers. A number of actions are being taken to mitigate the risk and progress is now being made to reduce dependence on the Head of Commercial Solutions as the department moves forwards with strategy implementation.
- Arrangements are in place to keep the Commercial Department fully informed of future procurement activity at the earliest opportunity for effective forward planning. Regular meetings are held with Heads of Service and the OPCC and there is ongoing involvement in project boards and strategic groups across the Constabulary to ensure good visibility is maintained.
- A number of staff within the Commercial Services Department have commenced a formal procurement apprenticeship programme to address identified gaps in skills.
- A Contract Award Board has been introduced into the governance structure to strengthen arrangements for the scrutiny and challenge of procurement decisions.
- Arrangements are in place to ensure appropriate approval is obtained for contracts (dependant on value).
- Appropriate approval is granted for any exemptions from normal procurement procedures prior to the order for goods, works and services being placed.
- Spend information is openly published on the OPPC's website for public scrutiny.
- The Joint Procurement Regulations now provide guidance on professional indemnity insurance requirements. New supplier forms reinforce requirements and capture details of insurance cover.

- Fraud risks are captured on the Corporate Support risk register for ongoing consideration and management and Commercial Department staff have received ethics training. The training raises awareness of potential fraudulent practices and supports understanding of expectations around individual professional and ethical behaviour. The formal procurement apprenticeship programme includes a module on ethical procurement.
- During the audit review it was noted that the procurement team display a professional manner and are demonstrably committed to their own personal development, improvement activity and progressing strategy implementation.

4.6 **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.6.1 *High priority issues: none identified.*

4.6.2 *Medium priority issues:*

- Arrangements for the supervisory review of work within the procurement team and the evidencing of this are not in place.
- Spend analysis is not undertaken on a regular basis to highlight opportunities for savings and efficiencies and to inform negotiations around approved supplier lists. Approved lists of suppliers have not been developed in accordance with the Joint Procurement Regulations.
- Post completion reviews are not undertaken to identify good practice and areas for improvement in procurement activity.

4.6.3 *Advisory issues:*

- The Joint Procurement Regulations and Procurement Guidance handbook do not reflect Contract Award Board arrangements as part of the procurement process.
- Plans to hold roadshows across the Force to further strengthen awareness and understanding of the commercial strategy have not taken place.

Comment from the Director of Corporate Support:

I am very pleased that the recent audit review of Commercial (Procurement) Solutions has demonstrated the significant progress made and has moved from partial to a **reasonable** level of assurance. This audit has recognised that there are generally good systems of internal control in place although it is recognised there are some areas where the controls still need more effective application and/or further development.

The Commercial Solutions department provide a wide range of procurement and contract management services for both the Office of the Police

& Crime Commissioner and the Constabulary. This audit recognises that the team is providing a good and improving service to both organisations.

I am pleased to note that the number of recommendations made within this report are significantly reduced from previous reviews which is, again, a testament to the hard work of all involved.

The report notes a number of strengths including an established strategy, strong governance and working practices and improved management of the procurement work streams. Without being complacent, I am also pleased to note that the report identifies no high priority areas for development. The small number of medium and advisory recommendations are welcomed and will be addressed by the team within the timescales agreed.

The Head of Commercial and his team are committed to continue on this positive trajectory in order to ensure that the positive progress recognised within this report is maintained and built on.

Management Action Plan

5 Matters Arising / Agreed Action Plan

5.1 **Regulatory** - compliance with laws, regulations, policies, procedures and contracts.

● **Advisory issue**

Audit finding	Management response
(a) **Joint Procurement Regulations & Procurement Guidance Handbook** A Contract Award Board has been operating since February 2019, the Joint Procurement Regulations and Procurement Guidance handbook do not refer to the Contract Award Board as part of the approval process for awards above £25k or include this stage in the procurement map. The Joint Procurement Regulations state that the document will be reviewed annually and the next scheduled review will take place in November 2019. This will provide an opportunity to ensure that the regulations accurately reflect current arrangements.	Agreed management action: The Joint Procurement Regulations and Procurement Guidance handbook have been updated to reflect Contract Award Board arrangements.
Recommendation 1: The Joint Procurement Regulations and Procurement Guidance handbook should be updated to reflect Contract Award Board arrangements as part of the next scheduled review.	
Risk exposure if not addressed: • Inadequate authorisation for procurement activity because of a lack of clarity around approval arrangements and responsibilities. • Inefficient procurement activity arising from reduced challenge and scrutiny of proposals.	Responsible manager for implementing: **Head of Commercial Solutions** Date to be implemented: **19/11/2019**

● **Advisory issue**

Audit finding	Management response
(b) **Communication** The Commercial Strategy, Joint Procurement Regulations and Procurement Guidance Handbook were updated and published in April 2019 on the commercial and stores pages of SharePoint. This was brought to the attention of all staff via a Force wide bulletin explaining key changes within procurement processes and the move to a more commercial approach. Links were provided within the publication to the new supporting documents. Reference was made in the bulletin to plans to hold roadshows across the Force to further strengthen awareness and understanding of the commercial strategy. A work tracker maintained by the Head of Procurement shows that a project to develop the roadshows has been allocated to a Commercial Officer. This action has not yet been progressed. Roadshows will provide an opportunity for all staff involved in procurement to better understand recent developments, their role within the updated approach and the overall direction of the service.	Agreed management action: The planned roadshows will take place before the end of Mach 2020.
Recommendation 2: Action should be taken to progress roadshow plans.	
Risk exposure if not addressed: • Priorities are not achieved because staff do not understand and contribute to strategy implementation. • Sanctions and reputational damage arising from non-compliance with procurement regulations. • Poor performance because staff are unclear of their roles and responsibilities.	Responsible manager for implementing: **Commercial Business Partner (Operations, Fleet & Estates)** Date to be implemented: **31/03/2020**

5.2 Information - reliability and integrity of financial and operational information**.**

● **Medium priority**

Audit finding	Management response
(a) **Management oversight** Arrangements are now in place for regular 1:1 supervision sessions, team huddles and team meetings within the Commercial Department to improve oversight of procurement activity. However arrangements for the day to day supervision of work within the procurement team are not fully established and evidenced. During the course of the audit review there were some instances where steps in the procurement process were not evidenced. For example instances were noted where framework contract call-offs had not been recorded on the Blue Light Procurement Database, contract variation forms had not been fully signed and quotations were not available for review. Whilst these issues were resolved at the time of the audit review the Head of Commercial Solutions cannot be assured that procurement activity is being undertaken consistently and effectively, in compliance with the Joint Procurement Regulations. The development and use of a Contract Check List by one of the Business Partners for procurements over £100k was noted during the audit. The check list ensures all required steps of the chosen procurement route are actioned per requirements and evidenced. There is an opportunity to further develop this example of good practice for use across the department and for other procurement routes. Recommendations were made in the previous two audit reports around arrangements for supervisory checking of work at key stages of the procurement lifecycle and for evidencing this. At the time it was considered that there was limited capacity and expertise within the procurement team to undertake supervisory checking. A Senior Business Partner has now been appointed and a number of staff in the department are undertaking a formal CIPS (Chartered Institute of Purchasing and Supply) apprenticeship programme. These actions will help to address skill and capacity	Agreed management action: An acceptable balance has now been achieved between supervisory and process checking. The number of errors / omissions is expected to fall and this will be monitored. Linked to this is the creation of a Commercial Assurance Lead from 1st April 2020.

issues.	
Recommendation 3: Management should define, document and communicate requirements around supervisory checking at key stages of the procurement lifecycle. Responsibility for supervisory checking should be clearly allocated.	
Risk exposure if not addressed: • Sanctions and reputational damage arising from non-compliance with procurement regulations. • Strategic policing priorities are not achieved. • Poor performance because opportunities for improvement are not identified and acted upon.	Responsible manager for implementing: **Head of Commercial Solutions** Date to be implemented: **01/04/2020**

5.3 **Value** - effectiveness and efficiency of operations and programmes.

● **Medium priority**

Audit finding	Management response
(a) **Supplier Spend & Approved Lists** Regular spend analysis is not currently undertaken within the Commercial Department to fully understand procurement activities and expenditure and identify improvement opportunities. A report of annual spend with suppliers has been received from the finance team but it hasn't been reviewed due to other priorities within the department. The value of undertaking spend analysis is recognised by the team and included in improvement plans as part of the Commercial Strategy. Formal, approved supplier lists that operate in accordance with procurement regulations are not currently in place. This issue was raised at the time of the previous audit review in 2016 when it was suggested that approved lists should be reviewed and re-advertised on a regular basis to demonstrate the Constabulary's commitment to genuine competition as an integral part of ethical procurement activity. Following the previous review the procurement team worked closely with the	Agreed management action: a) Joint working with the Corporate support Senior Leadership Team (SLT) to progress spend analysis as part of the improvement plan. b) Fully accepted and will be introduced by April 2020.

estates team to award framework contracts and reduce dependencies on approved lists. More recently work has been undertaken to negotiate prices with suppliers in areas of recurrent types of lower value spend and ensure insurance and vetting arrangements are in place. However, the procurement team acknowledge that further work is required to maximise opportunities and comply fully with regulations. The introduction of spend analysis, supplier performance management and relationship management is planned as part of the 'opportunity' phase of the Commercial Strategy for implementation over the next 18 months. The Head of Commercial Solutions intends to oversee this work which has been allocated to a nominated Business Partner. It is acknowledged that the receipt and analysis of accurate, comprehensive spend data presents a number of benefits such as the ability to highlight opportunities to reduce costs, increase efficiency and improve supplier relationships. It could also help to identify potential suppliers for approved lists and better inform negotiations with the suppliers in respect of prices and terms. Once negotiated, approved supplier lists may improve relationships, introduce lower and more consistent rates, establish agreed terms and conditions and ensure regular review. These actions should now be advanced as the organisation moves into Phase 2 of the Commercial Strategy implementation to ensure agreed timescales are met and the benefits realised.	
Recommendation 4: a) Plans to introduce spend analysis, supplier performance management and supplier relationship management should be progressed, in accordance with the Commercial Strategy 2019-22. b) Approved lists of suppliers should be fully developed, to fully comply with the Joint Procurement Regulations.	
Risk exposure if not addressed: • Reputational damage arising from a failure to comply with Joint Procurement Regulations. • Failure to deliver the Commercial Strategy and contribute to strategic objectives.	Responsible manager for implementing: **Head of Commercial Solutions** Date to be implemented:

• Poor value for money and inefficiency arising from a failure to identify opportunities for savings and improvements. • Challenge and reputational damage arising from a failure to demonstrate the exercise of genuine competition.	**a) 01/04/2020 b) 30/09/2020**

● **Advisory issue**

Audit finding	**Management response**
(b) **Lessons Learned** Post completion reviews are not undertaken on a formal basis to identify good practice and areas for improvement in procurement activity that can be taken forward to strengthen future procurement exercises and inform training plans for the procurement team.	Agreed management action: Accepted and will be implemented as an opportunity to improve and add value.
Recommendation 5: Formal, documented post completion reviews should be undertaken in respect of key procurement exercises in order to identify any learning that can be taken forward as part of a commitment to continuous improvement.	
Risk exposure if not addressed: • Opportunities not taken to learn lessons and improve. • Failure to train and develop staff to provide a more efficient and effective procurement function.	Responsible manager for implementing: **Head of Commercial Solutions** Date to be implemented: **01/04/2020**

Appendix A

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Peter McCall

Audit of Firearms

Draft Report Issued: **14 October 2019**

Final Report Issued: **19 November 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Diane Lowry	diane.lowry@cumbria.gov.uk	01228 226281

Audit Report Distribution

For Action:	Paul Telford – Inspector Firearms Ben Swinson – Chief Inspector Operational Support
For Information:	Dean Holden – DCI Crime Command Andy Slattery – Assistant Chief Constable
Audit Committee	The Joint Audit Committee which is due to be held on 18th March 2020 will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the recent audit of Firearms. This was a planned audit assignment which was undertaken in accordance with the 2019/20 Audit Plan.

1.2. Firearms or related items come into police possession for a variety of reasons and when they do there are a broad range of issues that must be addressed. This includes that consideration is given to recording the item's recovery on the National Ballistic Intelligence Service (NABIS) database, and submitting the item to a NABIS laboratory for the recovery of intelligence material that may link the item and those associated with it to firearms offences committed elsewhere.

1.3. NABIS is the national centre for forensic science, intelligence and knowledge which deals with the illegal use, supply and manufacture of firearms and ammunition. It provides a dedicated forensic service to link crime scenes through the microscopic examination of ballistic items. NABIS also manages the database on which the Constabulary (and other police forces / agencies) register the details of any firearm or ballistic item recovered. The data this generates can be used to provide strategic intelligence to forces and other stakeholders on the criminal use of firearms.

1.4. The effectiveness of NABIS as a national service is dependent on police forces and agencies sharing their information in relation to ballistic material and associated intelligence. In order to define the requirements needed to ensure maximum effectiveness within the NABIS system of work, a memorandum of understanding (MoU) exists between NABIS and the police forces of England, Scotland and Wales as well as with other UK law enforcement agencies.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Assistant Chief Constable. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control for the Constabulary's compliance with the requirements of the National Ballistic Intelligence Service (NABIS), in particular:

- Arrangements for recording ballistic items and intelligence that meet the NABIS Database Registry Criteria
- Arrangements for the submission of ballistic items that meet the NABIS Submission Criteria to NABIS.

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within firearms and their arrangements for ensuring compliance with NABIS provide **Reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There are **2** audit recommendations arising from this audit review and these can be summarised as follows:

Control Objective	No. of recommendations		
	High	Medium	Advisory
1. **Management** - achievement of the organisation's strategic objectives	-	-	-
2. **Regulatory** - compliance with laws, regulations, policies, procedures and contracts (see section 5.1.)	-	2	-
3. **Information** - reliability and integrity of financial and operational information	-	-	-
4. **Security** - safeguarding of assets	-	-	-
5. **Value** - effectiveness and efficiency of operations and programmes	-	-	-
Total Number of Recommendations	-	2	-

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- There is a memorandum of understanding in place between the Constabulary and NABIS, which sets out the agreed framework for the recording and physical submission of ballistics and the respective responsibilities.
- The Force has a named Operational Single Point of Contact (OSPOC) with responsibility for ensuring NABIS activity is carried out in accordance with the MoU.
- Quarterly firearms reports are provided to the Local Policing & Specialist Capabilities Board, which include an update on NABIS significant submissions.
- Firearms training is part of the National Police Training Curriculum (NPTC). A Module of the initial NPTC training is around the making safe of firearms which includes a section on NABIS and the information needed for input. The annual refresher training provided to Officers also includes a NABIS update section.
- Procedures for recording firearms and ballistics include updating the centralised electronic firearms register (EFR).
- The EFR includes fields to record whether NABIS registry or submission are required. This includes a mandatory field which is updated by Officers to record their initial NABIS assessment for each item they have entered.
- The NABIS OSPOC has oversight of all entries on the EFR and carries out a further assessment of all items recorded on it against the NABIS database criteria, prior to the database entry being made by the NABIS inputter.

- The Constabulary has named NABIS Inputters, who have received training from the NABIS Liaison. In accordance with the MOU access has only been granted to a limited number of staff.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- No High Priority issues identified.

4.4.2. *Medium priority issues:*

- The Constabulary is not fully compliant with one aspect of the NABIS database recording criteria and effective arrangements to assure Chief Officers that the force is NABIS compliant are not in place.
- The Firearms Policy and supporting Procedures reviews are overdue.

4.4.3. *Advisory issues:*

- No Advisory Issues identified.

Comment from the Assistant Chief Constable

- I am aware of the actions the Constabulary has signed up and have arrangements in place to monitor their implementation. In respect of non-compliance with the NABIS MOU in respect of firearms submissions, I expect the MOU to be fully complied with and will monitor this through my role as Chair of the Specialist Policing and Specialist Capabilities Board. I will consider any submissions made in respect of altering our MOU but expect compliance with any MOU in place at the time.

- I am satisfied that the actions identified by managers address the issues and risks identified within the audit to an acceptable level.

- This report can now be finalised and reported in summary to the next meeting of the Joint Audit Committee via the internal audit quarterly progress report.

Andrew Slattery

Assistant Chief Constable

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Regulatory - compliance with laws, regulations, policies, procedures and contracts.

● **Medium priority**

Audit finding	Management response
(a) Compliance with the Memorandum of Understanding In June 2019 NABIS requested that the force undertake a firearms property review as part of Phase One of their national schedule to work with forces to support them in carrying out annual firearms property reviews. This work by NABIS supports the formal tasking by the National Crime Agency which directed forces to fully comply with the NABIS MoU. The review undertaken by the Constabulary highlighted that they do not fully comply with one element of the required registration criteria, as set out in Appendix C of the MOU for recording items on the NABIS database, i.e. • All firearms (as defined in section 57(1) Firearms Act, 1968) coming into police possession; For the three month period that the report covered it was found that only 6 of the 18 items requiring a NABIS entry had been recorded. The MOU sets out at 2.18 "*Forces and agencies are not able to change or make individual policy decisions about what should or should not be added to the NABIS Database. If a force/agency believes that certain items should or should not be added to the NABIS Database outside of this MOU, it is the responsibility of that organisation to follow the formal change request process"*. The report submitted to NABIS and copied to the ACC stated that "*the absence of full compliance with NaBIS Database Registry criteria is as a result of the application of reasoned discretion rather*	Agreed management action: The rationale for decisions taken not to comply with the recording / submission requirements of the NABIS MoU to be reported on a monthly basis at Operational Services SLT. Approval of those decisions will be noted in the minutes of the meetings.

than oversight". The decision to apply reasoned discretion was not formally documented and we are unable to confirm that the formal change request process was followed. The MoU also requires that: • A Chief Officer within each force be responsible for ensuring compliance with the MOU. • The appointed OSPOC will be responsible for ensuring that all day-to-day activity in relation to NABIS is carried out in accordance with the MOU. Effective management oversight arrangements for ensuring MoU compliance would have identified the above non-compliance at an earlier stage.	
Recommendation 1: (a) Arrangements should be made to ensure that the decision not to register all items on the NABIS database if acceptable, is approved by senior management and the formal change request process as set out in the MoU should be followed. (b) Arrangements to assure Chief Officers that the NABIS MoU is fully complied with should be put in place.	
Risk exposure if not addressed: • The Constabulary fails to comply with the requirements of the NABIS MoU. • Areas of non-compliance are not identified.	Responsible manager for implementing: **Chief Inspector - Operations** Date to be implemented: **12/2019**

● **Medium priority**

Audit finding	Management response
(b) **Policy and Procedures** The Constabulary has a documented Firearms and Pyrotechnics Recovery Policy and guidance Procedures that set out end to end processes for the recovery, recording, storage, submission and	Agreed management action: We will review the Policy and Procedures and update as necessary.

disposal of firearms. This includes the need to consider the NABIS requirements for each item that comes in to the Force's possession. The documents are available to Officers on the force intranet. Audit testing noted that both documents have a review date of 2018 which is now overdue. It was also noted that the use of a NABIS checklist, referred to in Appendix 4 of the Firearms and Pyrotechnics Procedures, is not now part of the process. The checklist has been replaced by the dropdown menu on the electronic firearms property register, which is appropriately referred to elsewhere in the procedures.	The updated documents will be put to OS SLT for approval.
Recommendation 2: Arrangements should be in place to ensure that the Firearms Policy and supporting Procedures are reviewed and updated to reflect any changes to the actual procedure.	
Risk exposure if not addressed: • Responsibilities are not clearly defined or known by officers.	Responsible manager for implementing: **Chief Inspector - Operations** Date to be implemented: **12/2019**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of Constabulary Governance Structure

Draft Report Issued: **7th August 2019**

Final Report Issued: **4th November 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Diane Lowry	diane.lowry@cumbria.gov.uk	01228 226281

Audit Report Distribution

For Action:	Jane Sauntson - Director of Corporate Improvement
For Information:	
Audit Committee	The Joint Audit Committee which is due to be held on 20th November 2019 will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of the Constabulary governance structure. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. Effective governance arrangements are important to the Constabulary because they help in achieving the strategic objectives set out in the Police and Crime Plan and drive improvement across the organisation. A good governance framework also establishes a high degree of transparency, fairness, standards and accountability to the public.

1.3. The Chief Constable is responsible for putting appropriate governance arrangements in place within the Constabulary and is held to account on the adequacy and effectiveness of the arrangements by the Police and Crime Commissioner.

1.4. In 2017 the Constabulary took a decision to review its governance structure and a detailed proposal outlining new governance arrangements was prepared. The purpose of the proposed changes to the Constabulary's governance structure was to provide strategic co-ordination of delivery of Cumbria Vision 25 (CV25) and support realisation of its benefits. The new arrangements took effect from April 2018.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Director of Corporate Improvement. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- The operation of the new Governance Boards

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within The Constabulary Governance Structure provide **Substantial** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There is **one** audit recommendation arising from this audit review which can be summarised as follows:

Control Objective	No. of recommendations		
	High	Medium	Advisory
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	-	-	1
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	-	-	-
3. Information - reliability and integrity of financial and operational information	-	-	-
4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes	-	-	-
Total Number of Recommendations	-	-	1

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- Arrangements are in place, through Extended Chief Officer Group, to hold the leads of each of the four governance boards to account on benefits delivery and current workstreams. The governance structure flowchart clearly states that only decisions regarding strategic direction or growth require escalation to Extended Chief Officer Group thereby delegating authority to boards or individuals to resolve issues, take actions and manage resources.
- Each governance board is Chaired by a Chief Officer or Director to ensure that senior management have oversight and direct the delivery of the five areas of CV25. Boards meet on a monthly basis.
- A detailed report template has been introduced to report workstream progress. The report sets out:
    - the overall RAG rating for each workstream,
    - summary of the current position,
    - key milestones to be delivered over the next three months, including the benefits expected,
    - top three challenges, proposed resolution and impact

- top three upcoming activities for the next reporting period
- top three projects with which the workstream has interdependencies and;
- risks.

- Each workstream is assigned to a Senior Responsible Officer and is RAG rated on a two monthly basis (except for IT projects which are RAG rated monthly).
- Detailed workstream reports feed in to a balanced scorecard which has recently been developed under the five strands of CV25. At the time of our audit the first balanced scorecard had been prepared and was reported to the delivery boards and COG.
- A decision log is in place for each Board.
- Actions allocated by the governance boards are noted and tracked and actions are shown as closed on the system when complete.
- A corporate overview of CV25 risks is provided to Chief Officer Group on a four monthly basis.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- None Identified

4.4.2. *Medium priority issues:*

- None identified

4.4.3. *Advisory issues:*

- When changes to proposals, or planned reviews and evaluations, are made these should be formally recorded to provide an audit trail and reported to COG as appropriate.

Comment from the Deputy Chief Constable

Many strengths of the current governance structure are outlined in para 4.3 and it is welcome to see the audit opinion that the mechanism is working effectively. Notwithstanding that, the force Command Team continue to drive continual improvement in many internal processes, and this is particularly true of the governance arrangement as it is likely to be true that improvement can always be made, as well as recognising that these processes must always adapt rather than stay static. I have reviewed opportunities for improvement (this is the work referred to in the management response below) and board chairs and members have collectively recognised that further streamlining of meetings and governance boards would enable us to release organisational capacity whilst maintaining effective control. The work that then flows from this review will aim to drive further iterative improvement to the governance structure and document the advisory issue around process made within the report.

M Webster
4 November 2019

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Management - achievement of the organisation's strategic objectives.

● **Advisory issue**

Audit finding	Management response
(a) **Changes to the structure** A detailed report which proposed changes to the Constabulary's governance structure and approach in order to provide transparency, improve accountability and provide strategic co-ordination for the delivery of CV25 and support realisation of its benefits was prepared in 2017. The proposal was agreed by COG in November 2017 with the new arrangements to start on 1st April 2018. Prior to the structure going live a 'Governance Structure flowchart and principles' was agreed at COG in March 2018 which made some changes from the original proposal. Our testing identified that one of these changes ('the one master decision log' which COG agreed, in November 2017, would be maintained by every strand of CV25 and which would be visible to everyone in the Constabulary) has been replaced by individual decision logs for each Board and that these are not visible to everyone in the Force. This change to the governance structure was not captured in COG minutes relating to the governance structure flowchart. (b) **Review and evaluation of the new structure** COG minutes from the March 2018 meeting relating to the governance flowchart and principles show that it was agreed that the governance structure would be reviewed at 3 months and evaluated at 6 months. The review and evaluation did not take place as management decided to place reliance on the Internal Audit review of this area as this would provide independent assurance whether arrangements, as documented, are operating effectively. As this work did not commenced until 2019 it would have made sense to document this in COG minutes.	Agreed management action: Noted that these changes, although discussed, were not captured in the minutes. This will be addressed with immediate effect. The Deputy Chief Constable and his senior management team are undertaking a review of the current governance structure and its associated processes to establish whether it operates effectively to achieve our purposes. This is currently scheduled for completion by the end of November and these specific issues will be documented in the revised terms of reference.

Recommendation 1: When changes to proposals, or planned reviews and evaluations, are made these should be formally recorded to provide an audit trail and reported to COG as appropriate.	
Risk exposure if not addressed: • Lack of an audit trail for decisions made to change agreed proposals or planned work and the supporting rationale.	Responsible manager for implementing: **Jane Sauntson** Date to be implemented: **30 November 2019**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Review of Seized Dogs – Action Plan

Draft Report Issued: **October 2019**

Final Report Issued: **November 2019**

Action Plan

No.	Recommendation	Agreed	Management Response	Officer Responsible	Timescale
R1	Monitor the nightly kennel rates charged on an ongoing basis.	Yes	Proposed actions within this recommendation: R1a – All dog kennelling invoices to be progressed via the OS Chief Insp to ensure consistency in authorisation and costs. R1b – Kennel rates (overnight provision / assessment costs / production costs) should be monitored for consistency over time and across all available kennels.	Chief Insp OS (approves the invoices and has access to the management information)	Ongoing – checked on a monthly basis.
R2	Produce an analysis which considers the benefits and risks of using 'Dog' bail. If introduced, a clear process needs to be in place to document the reasons for the decision of whether to allow a dog 'bail' or not.	Yes	Initial concerns are held in relation to: • lack of a legal framework to permit the use of such a restriction; • risk around a secondary offence whilst the animal is "on bail"; • lack of a sanction in the event of said conditions being breached etc. It is however appropriate to consider the option from a low-level S2 minor or no injury type offence where the owner is compliant and voluntarily commits to such a process for example.	CJU Chief Inspector	2 Months
R3	Identify the key stages in an investigation and agree estimated timescales for each stage. Use this to monitor progress and prompt action.	Yes	R3a – Seized dog timings to be included within the investigation plan. R3b – Timings are to be incorporated into the spreadsheet as proposed at R4 which can in turn activate review requirements. R3c – Timings are to be shared frequently with finance lead to enable accurate forecasting of expenditures.	OS (PSG Insp / Dog Sgt)	1 month for implementation then ongoing

No.	Recommendation	Agreed	Management Response	Officer Responsible	Timescale
R4	Improve the arrangements with the areas for updating the Spreadsheet so that this is accurate and updated in a timely manner. Ensure that the Spreadsheet includes an assessment of progress to date.	Yes	R4a – governance of the locally held spreadsheet to be agreed (archiving tipping points; storage of closed cases; updating responsibilities) R4b – Governance to include an overarching owner of the spreadsheet to ensure timely, accurate and consistent compliance.	OS Chief Inspector	1 month for implementation then ongoing
R5	Introduce a high level monthly summary which is provided to management and shows: • Number of dog kennelled at start and end on month and movement in and out • Reason for holding dogs • State of play with each dog including details where timescale excessive • Any action required	Yes		Dog Sergeant / PSG Inspector	Post the implementation of R4 (6 weeks)
R6	Agree kennel invoices to the Spreadsheet to confirm completeness and accuracy prior to authorising for payment.	Yes		OS Chief Inspector	Post the implementation of R4 (6 weeks)

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of Local Focus Hubs

Draft Report Issued: **24th July 2019**

Final Report Issued: **9th September 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Sarah Fitzpatrick	sarah.fitzpatrick@cumbria.gov.uk	01228 226255

Audit Report Distribution

For Action:	Rob O'Connor (T/Chief Superintendent)
For Information:	Mark Webster (Deputy Chief Constable)
Audit Committee	The Joint Audit Committee, which is due to be held on 19th September 2019, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1 This report summarises the findings from the audit of Local Focus Hubs. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2 Local Focus Hubs and neighbourhood policing are important to the organisation because they contribute directly to the delivery of Police and Crime Plan objectives around working with partner agencies and communities to understand local issues and develop joint, sustainable solutions, tackle crime and anti-social behaviour and provide a visible uniformed presence in neighbourhoods.

1.3 Local Focus Hubs were launched in 2018 in each of the six Cumbrian districts. They bring different agencies together in a shared location for collaborative and effective problem solving at a local level. The launch of the Hubs, together with an increase in officers dedicated to neighbourhood policing demonstrates the Constabulary's commitment to working with partners and local communities to address issues within neighbourhoods and secure the best possible outcomes for the public.

2. Audit Approach

2.1 Audit Objectives and Methodology

2.1.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2 Audit Scope and Limitations

2.2.1 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Deputy Chief Constable. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- Agreed objectives (shared across partner organisations).

- Oversight arrangements.
- Joint decision making, planned outcomes and performance monitoring.
- Consistency of service across the force (delivery of core ethos with minimal local variances).

2.2.2 There were no instances whereby the audit work undertaken was impaired by the availability of information.

2.2.3 It should be noted that testing focused on two of the six districts (Carlisle and Copeland Hubs).

3 Assurance Opinion

3.1 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2 From the areas examined and tested as part of this audit review, we consider the current controls operating around Local Focus Hubs provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4 Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2 There are **3** audit recommendations arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**

1. Management - achievement of the organisation's strategic objectives (see section 5.1.)		2	
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts (see section 5.2.)			
3. Information - reliability and integrity of financial and operational information (see section 5.3)			1
4. Security - safeguarding of assets (see section 5.4)			
5. Value - effectiveness and efficiency of operations and programmes (see section 5.5)			
Total Number of Recommendations		**2**	**1**

4.3 Strengths: The following areas of good practice were identified during the course of the audit:

- There is a designated strategic lead and clear terms of reference for the 'Neighbourhood Policing and Local Focus Project' (Local Focus Hubs).
- Memorandums of Understanding, that clarify aims and objectives, have been prepared for the two Local Focus Hubs reviewed. Partner approval of both documents is evidenced within Community Safety Partnership (CSP) meeting minutes.
- An updated tasking structure is in place that incorporates six community tasking meetings across the six local authority areas to involve partners in the identification of community priorities. Senior officers are involved in the meetings to ensure strategic, national and local issues are considered.
- Two Hubs are now managed by staff from partner organisations rather than the Constabulary and this reinforces the importance of partner involvement and engagement in the initiative.
- Partners meet regularly to share / discuss information so that appropriate, co-ordinated and timely interventions are agreed.
- Management information (intelligence) is produced on a regular basis and shared with partners to highlight key community issues for partner discussion and decision making purposes.
- Community and tasking meetings provide for full discussion of community issues, the development of action plans, allocation of action managers and action tracking with regular updates. This process is embedded into the constabulary tasking process, relying on and contributing to management information that flows throughout the structure and the identification and communication of priority issues.

- Hub Managers attend Safer Neighbourhood meetings on a regular basis to discuss topical issues, share good and bad practice and standardise arrangements across the county.

4.4 Areas for development: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1 *High priority issues:* None identified.

4.4.2 *Medium priority issues:*

- The review of Local Focus Hubs, scheduled for February 2019, has not been finalised and reported to management. The review is expected to take account of inconsistent practices across the county and include proposals for moving forwards.
- A Local Focus Hub performance management framework has not been fully consulted on, approved and shared force wide.

4.4.3 *Advisory issues:*

- Information Sharing Agreements are not up to date with clear partner approval.

Comment from the Deputy Chief Constable:

The development of the Neighbourhood Policing Hubs was always going to be an iterative process, with the initial stages focussing on building a proof-of-concept in each district. Local factors and context have led to some differences in approach, and the time is now right with the findings of this review and the transfer of responsibility to Supt Jackson, for more consistency in the model to be applied where this is appropriate. Best practice should be spread across the partner hubs, whilst leaving some room for the further iterative development of new approaches. The review under recommendation 1 will facilitate this happening, and I'm content that the plan laid out will achieve the recommendation. It is of key importance that there is consistency of tasking across the force and through the hubs. Progress towards achieving this recommendation will be monitored by myself and through the Cumbria Constabulary Improvement Plan (CCIP).
The iterative approach taken has also had the effect of leaving some more work to do in finalising the Performance Management Framework. I agree with the thrust of the recommendation, and that the management action, particularly focussing on the use of Power BI dashboards, will greatly enhance visibility of effort and help to establish which approaches work. It is vital that we as a force are able to demonstrate the impact and of the hubs, and progress to achieving this recommendation will be closely monitored.

Thirdly, the action stipulated to direct the consistency of ISA to be used across all hubs by Ch Supt O'Connor is appropriate to the task.

Finally, I note and acknowledge the extensive list of strengths evidenced during the course of the audit and agree that these put us in a strong place to demonstrate the utility of the Hubs to the public.

M Webster
Deputy Chief Constable
30th August 2019

Management Action Plan

5 Matters Arising / Agreed Action Plan

5.1 Management - achievement of the organisation's strategic objectives.

● **Medium priority**

Audit finding	Management response
(a) **Force Wide Arrangements** Local Focus Hubs were launched in November 2018 in each of the six districts of Cumbria, following a successful pilot in Copeland. A strategic lead was appointed for the Neighbourhood Policing and Local Focus Project, with full time support from a nominated Police Sergeant for the duration of the project. A key requirement of the project, per the Terms of Reference, was to define the operating model for Local Focus Hubs and ensure a consistent approach to community based partnership activity across the county. There is an expectation that the core arrangements and overall ethos of the Local Focus Hubs will provide a level of consistent practice and service to the public whilst taking into account differences across the six Cumbrian districts in terms of crime patterns, partner organisations, levels of engagement etc After eight months of operation Hub Managers report that Local Focus Hubs are becoming increasingly embedded into the force tasking model and working more closely with partners and local communities. However audit testing has highlighted a number of inconsistencies in approach across the force:- • A template was not utilised for the drafting of Local Focus Hub Memorandums of Understanding and the resulting documents differ considerably in content and detail across the force, particularly in relation to partner responsibilities. • Local Focus Hub documentation in respect of the referral process was developed and shared by the Copeland Hub to encourage use of a common platform for capturing, prioritising, considering and tracking community issues. This has not been fully adopted across the force	Agreed management action: This audit clearly shows that good progress has been made to embed the Local Focus Units across the six District Council areas. There is also evidence of good practice being developed across the Force area, with the quarterly Safer Neighbourhoods meetings chaired by the Force lead allowing for the sharing of good practice between Police and partners. As covered in the audit, the Community tasking is becoming embedded, and that will be reviewed by a Senior Detective alongside Force tasking to ensure that the new processes have been successful and deliver what is required. That review will encompass part of this recommendation. On Tues 13 and Wed 14 August 2019 there was a peer review of Neighbourhood Policing (NHP) in

and alternative approaches have been developed. • One of the intentions of the Local Focus Hub project was to bring partners together in one location for closer working on joint solutions to community issues and maximising outcomes for the public. This has been achieved to some degree in Copeland but with less success in Carlisle. As an alternative, weekly meetings take place with partners in the Carlisle Hub to ensure ongoing and timely engagement. The two Hub Managers in the West of the county are District Council employees, the remaining four are Police Officers and it is considered that this has an impact on partner willingness to share Hub accommodation. • Force Analysts prepare Community and Tasking reports for each Hub to inform and support decision making at monthly multi-agency Community Tasking and Co-ordination meetings. The reports follow broadly the same format across the Hubs but changes have been made at a local level as the process has moved forwards to respond to specific requests. • The management information shared with partners remains very much police based with input from partners tending to occur verbally during tasking meetings. Internal Audit attendance at the Safer Governance meeting in July 2019 showed that progress is being made to address this issue, but with varying levels of success across the county. • Arrangements for sharing Community and Tasking reports with partners are not consistent across the county. Some Hubs restrict sharing of the report to a full on screen version during the tasking meeting, one Hub redacts the names on the report whilst another Hub provides a copy of the report to partners in advance of the monthly meetings. • The introduction of Local Focus Hubs was supported by the launch of six Local Focus Facebook groups as sub-groups of the main Cumbria Constabulary Facebook page. The pages offer the public the opportunity to liaise directly with a number of agencies, including the police, in one place. In practice, the willingness of partners to respond directly to public comments and queries on Facebook is variable, so too is the volume of posts to be managed. • There are limited and inconsistent arrangements across the Hubs for seeking feedback from individual complainants and communities regarding how effective intervention and initiatives are perceived to be. Ad hoc feedback is received via social media posts, partners and Borough / Town Councils but it is not collated, analysed or shared across the county.	Cumbria by Northumbria Police. All Forces were encouraged to partake in this peer review, and Cumbria will shortly inspect / review Durham Constabulary. A team of six officers from Northumbria, led by a Chief Superintendent and Chief Inspector conducted the peer review. They interviewed Police Officers and Staff who worked in the Allerdale Local Focus Unit, various persons from partner agencies, and reviewed the governance arrangements and terms of reference etc. They also interviewed Temp Ch Supt O'Connor as the Strategic lead. The Northumbria team undertook a hot debrief session and their findings were extremely positive in relation to how NHP is delivered in Cumbria and the benefits of the Local Focus Units, so much so that they want to maintain professional working relations and take some of the best practice they witnessed back to Northumbria. Formal written feedback is awaited. The Force lead who developed the Local Focus Units (Supt Slater) has recently retired, and will be replaced by Supt Jackson, who will undertake a review of the current position of both NHP and the Local Focus Units, and report back to the Chief

During a Safer Neighbourhood meeting in June 2019, the Project Lead proposed an Away Day for Hub Managers the following month to review a number of shared issues and make plans to address issues moving forwards. The event would provide a timely opportunity to discuss the inconsistencies and issues above, explore solutions, share best practice and success stories and determine actions moving forwards. It could also support an evaluation as to whether the original aim of the Local Focus Hub Project has been achieved, 'to effectively support the needs of local communities in accordance with the Chief Officer's vision for neighbourhood policing and the PCC's Police and Crime Plan'. An Away Day could feed into the planned evaluation of the tasking model across the force, as recorded in the Crime and TPA Risk Register. The evaluation was scheduled to take place in February 2019 and whilst work is progressing a formal report has not been finalised and reported. This issue has also been identified in an internal audit review of Force Tasking that has been reported separately	Officer Group once she is in post.
Recommendation 1: A review of Local Focus Hubs should be finalised and reported to senior management. The review should take account of the inconsistent practices across the county and include proposals for moving forwards.	
Risk exposure if not addressed: • Failure to achieve strategic priorities. • Missed opportunities to continuously learn and improve. • Difficulties engaging partners.	Responsible manager for implementing: **Supt Sarah Jackson** Date to be implemented: **December 2019**

● **Medium priority**

Audit finding	Management response
(b) **Performance Management Framework** The Corporate Improvement Team has developed a performance management framework (PMF) for Local Focus Hubs that comprises 48 performance indicators and ensures the information collected meets Force Management Statement requirements. There was some consultation with the Copeland Hub Manager during the development. In April 2019 each Hub was asked to provide performance figures for the period from Hub creation to 31st March 2019. Training and guidance was not provided to Hub Managers to assist them in completing the returns accurately and consistently. At the time of the audit review feedback had not been provided regarding any collation or analysis of results at a force wide level. This type of analysis could contribute to an evaluation of Local Focus Hub effectiveness (see section 5.1a above). It would give an indication of progress towards aims and objectives and whether Hubs are making a difference to communities. Regular performance information would also inform decision making at a strategic and local level, target activity and help to shape improvements going forwards. At a Safer Neighbourhood meeting in June 2019 the Allerdale Hub Manager reported current work being undertaken with a Force Analyst to challenge and further develop the existing performance framework. The planned Away Day for Hub Managers was cited as an opportunity to share and discuss developments.	Agreed management action: The Local Focus Unit Performance Framework (PF) was developed in consultation with the existing Units and Corporate Support and distributed in early 2018 to each of the developing Units. There has been a different pace of development across the County which made it challenging to implement it in its entirety in each location. The Constabulary now have the added bonus of Power Business Intelligence and support from Corporate Development, combined with the audit expertise of Emma Thompson as the manager of Allerdale LFU. Emma has reviewed the PF to make it more relevant to partners, and Corporate Development are looking to systemise it to make production of a performance document simpler and more user friendly. The national problem solving team are awaiting an update on this issue as Cumbria Constabulary are very much in the driving seat nationally in terms of the development of a representative performance framework.
Recommendation 2: A PMF should be agreed and shared following full countywide consultation that further supports and informs the identification of priorities and targeted interventions.	

Risk exposure if not addressed: • Poor decision making. • Wasted resources. • Failure to continuously learn and improve.	Responsible manager for implementing: **Supt Sarah Jackson** Date to be implemented: **December 2019**

5.2 **Information** - reliability and integrity of financial and operational information**.**

• **Advisory issue**

Audit finding	Management response
(a) **Information Sharing Agreements** Both Carlisle and Copeland Hubs refer to their Community Safety Partnership Information Sharing Agreements (ISA) as providing the basis for lawful exchange of information between Hub partners. Both agreements are out of date as they don't reflect the GDPR requirements of the Data Protection Act 2018. The approval and signatures of partners cannot be demonstrated for the Carlisle Hub. At the time of the audit review The Carlisle Hub Manager was in the process of re-drafting and updating the Carlisle & Eden ISA with the support of the HQ GDPR project team, expecting to receive partner approval and sign-off within a few weeks. The draft version includes provision for annual review. The Copeland Hub ISA was scheduled for review in November 2018, this review has not yet taken place.	Agreed management action: The Allerdale Local Focus Unit have recently developed an ISA that has been reviewed by the Constabulary's Legal Dept and GDPR team in Corporate Support. This ISA is seen as best practice and an excellent template to use, and a direction has been issued by Temp Chief Supt O'Connor to the six NPT Insps from the Local Focus Units to use the Allerdale ISA as a template and ensure all relevant partners are signed up to the ISA.

Recommendation 3: Information Sharing Agreements should be subject to regular review to ensure they are kept up to date and include the approval of all current partners.	
Risk exposure if not addressed: • Sanctions and litigation arising from non-compliance with data protection legislation and data breaches. • Reputational damage arising from non-compliance with data protection legislation and data breaches.	Responsible manager for implementing: **Supt Sarah Jackson** Date to be implemented: **December 2019**

Appendix A

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Peter McCall

Audit of Force Tasking and Co-ordination

Draft Report Issued: **24th July 2019**

Final Report Issued: **21st August 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Janice Butterworth	janice.butterworth@cumbria.gov.uk	01228 226289

Audit Report Distribution

For Action:	Detective Chief Superintendent - Dean Holden
For Information:	Assistant Chief Constable - Andy Slattery
Audit Committee	The Joint Audit Committee, which is due to be held on 19th September 2019, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of Force Tasking and Co-ordination. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. Force Tasking and Co-ordination provides managers with a mechanism for operational decision making. It enables managers to prioritise the deployment of resources based on the issues identified at strategic and tactical levels. As part of this review, Internal Audit attended a monthly Tasking and Performance meeting and observed the review of performance data, emerging issues and updates on previously allocated actions. Force Tasking follows the National Intelligence Model Code of Practice.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was T/Assistant Chief Constable Andy Slattery. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- Delegation and delivery of tasks arising from the monthly tasking meetings and escalation of local issues to the strategic force tasking team.

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within Force Tasking and Co-ordination provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There is **1** audit recommendation arising from this audit review and this can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives	-	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	-	1	-
3. Information - reliability and integrity of financial and operational information	-	-	-
4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes	-	-	-
Total Number of Recommendations	-	**1**	-

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- The 2018/19 Strategic Assessment has been produced and approved by the Chief Officer Group. The Assessment is used by the Strategic Tasking and Co-ordination Group to set the Force Control Strategy priorities.
- Meetings are structured and attendees are consistent across the various daily and monthly meetings.
- Actions are recorded, with action owners identified and they are followed up at the next meeting.
- Detailed analytical information is provided to the various meetings to assist with decision making.
- Area Management Co-ordination meetings are held monthly to review local issues arising from Local Focus Hub, Vulnerability and Serious Organised Crime monthly meetings; Area Tactical Menus are produced.
- Cumbria is represented at Regional Organised Crime Unit meetings (ROCU) and North West ROCU representatives attend Cumbria's monthly Force Tasking meetings, ensuring collaboration with other areas.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:* None identified

4.4.2. *Medium priority issues:*

- A review of the effectiveness and efficiency of the new tasking model has not been finalised and reported to senior management.

4.4.3. *Advisory issues:* None identified

Comment from the Detective Chief Superintendent – Head of Crime

I acknowledge the contents of this report and I am pleased that the audit provided reasonable assurance. The proposed response to the single recommendation in relation to the review undertaken by the BIU being formally written up and the outcome being reported to Force Tasking & Co-ordination Group chaired by the ACC, will be undertaken by Superintendent Patrick who was previously the Head of the BIU. This recommendation will be completed by 30th September 2019.

DCS Dean Holden

20/08/19.

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Regulatory - compliance with laws, regulations, policies, procedures and contracts.

● **Medium priority**

Audit finding	Management response
(a) **Review Arrangements** Chief Officers are required to have due regard to the National Intelligence Model (NIM) Code of Practice issued by the Secretary of State. The NIM is a framework for providing intelligence that senior managers can use during strategic and operational decision making to focus on key risks and priorities. It requires 'Chief officers to ensure that regular reviews of the National Intelligence Model take place within their force, together with an evaluation of its effectiveness and efficiency'. Changes to force tasking and co-ordination arrangements in November 2018 in relation to the development of six Local Focus Hubs to focus on community priorities led to the identification of a new risk for the Crime and TPA Risk Register. The risk is around the identification of risk, crime patterns or vulnerability being subject to reduced governance and accountability. The risk has been subject to regular review and management and ongoing updates to the mitigating actions. One action that remains open is a formal review of the tasking model across the force including an evaluation of its effectiveness and efficiency, as required by NIM. The review was scheduled to take place in February 2019. The Head of Business Improvement Unit confirms that the review work has been undertaken but has not been formally written up and reported due to a number of significant operations and events across the force in recent months. This issue has also been identified in an internal review of Local Focus Hubs that will be reported separately.	Agreed management action: The review work undertaken will be formally written up and the outcome will be reported to Force Tasking & Co-ordination Group which includes the ACC as Chair.

Recommendation 1: The review of the effectiveness and efficiency of the new tasking model should be formally written up with outcomes reported to senior management.	
Risk exposure if not addressed: • Reputational damage arising from non-compliance with NIM. • Missed opportunity to continuously learn and improve. • Failure to achieve strategic priorities.	Responsible manager for implementing: **Supt Carl Patrick – West Territorial Area Superintendent** Date to be implemented: **09/2019**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Peter McCall

Audit of Debtors

Draft Report Issued: **3rd May 2019**

Final Report Issued: **3rd July 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Steven Archibald	steven.archibald@cumbria.gov.uk	01228 226290

Audit Report Distribution

For Action:	Alison Hunter - Payroll and Transactional Services Manager
For Information:	Michelle Bellis – Deputy Chief Finance Officer Ann Dobinson – Head of Central Services Stephen Kirkpatrick – Director of Corporate Support Roger Marshall – Joint Chief Finance Officer
Audit Committee	The Joint Audit Committee, which is due to be held on 25th July will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of **debtors**. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. The debtors function is important to the organisation because it ensures a variety of sundry debts owed to the constabulary are received and accounted for within approved timescales. The efficiency, effectiveness and reliability of the debtors function is a key element in ensuring the constabulary's cash flow remains within approved levels.

1.3. This review forms part of a three year rolling programme of financial system audits which ensures that all main financial systems are independently reviewed on a cyclical basis.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsors for this review were the Deputy Chief Finance Officer and the Head of Central Services. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- Debt control/recovery process (to include Legal Services debt collection)
- Authorisation of write offs/cancellations

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within Debtors provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There is **1** audit recommendation arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	-	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts (see section 5.2.)	-	-	-
3. Information - reliability and integrity of financial and operational information (see section 5.3)	-	1	-
4. Security - safeguarding of assets (see section 5.4)	-	-	-
5. Value - effectiveness and efficiency of operations and programmes (see section 5.5)	-	-	-
Total Number of Recommendations	-	1	-

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- Controls and procedures in respect of debtors and write-offs are included within the OPCC and Constabulary Financial Rules. These are supplemented with Central Services Department procedures which set out the steps to be followed.
- Monthly reconciliations between the Debt Analysis Report and the ledger are undertaken and are independently reviewed by the Payroll and Transactional Services Manager.
- Write offs tested were subject to authorisation by both the Deputy Chief Finance Officer and the Joint Chief Finance Officer in accordance with the Financial Rules.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- There are no high priority issues to report

4.4.2. *Medium priority issues:*

- Documents relating to the recovery of debts had not been retained.

4.4.3. *Advisory issues:*

- There are no advisory issues to report

Comment from the Director of Corporate Support and Joint Chief Finance Officer

I am pleased that the audit of debtors provided reasonable assurance. The proposed response to the single recommendation in relation to document retention will provide an improved audit trail on actions taken to recover debts. Roger Marshall, Chief Finance Officer.

I echo the comments and observations of the Chief Finance Officer. I am assured that the management of debtors processes is both robust and effective. I am also satisfied that the proposed action regarding retention of documentation will adequately address the single recommendation made. Stephen Kirkpatrick, Director of Corporate Support.

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Information - reliability and integrity of financial and operational information**.**

● **Medium priority**

Audit finding	Management response
(a) **Retention of documents relating to debtor invoices / write-offs.** A sample of 10 debtor invoices from the July 2018 Debt Analysis Report (approximately 10%) was selected for audit testing to confirm that the documented debt recovery process had been followed. Testing found that of the 10 debtors invoices selected: **7** had since been paid in full. **2** remained outstanding at the time of audit testing (these invoices were included within a batch of outstanding invoices with the same supplier with negotiations ongoing). **1** invoice had been written off. Internal Audit testing found that the case files for each of the debtor invoices that had been paid had been deleted from the system and as a result evidence of any documents such as reminder letters relating to the debts could not be provided. We are therefore unable to confirm that the defined process has been followed. Audit testing also included write offs. A sample of 5 write offs from the last 3 financial years (approximately 20%) was selected for audit testing to confirm that the documented write off process had been followed. Due to a number of the case files being deleted, we were unable to confirm legal services decisions to write off the debts in our sample. Testing confirmed that all write offs in our sample had been authorised by the Deputy Chief	Agreed management action: The period looked at for the debt collection was prior to a changeover in staff administration. When the new member of staff took over they cleared the folder of any debts that were no longer outstanding resulting in the letters and chase up emails being deleted. Our spreadsheet record includes details of all actions taken in order to chase debts, which is retained for reference. In light of the recommendation a new process will be introduced where documents/correspondence are saved directly onto the Accounts Receivable System attached to the account holder. This will enable us to view and keep an audit trail via the system of all documents or notes relating to the company and debt collection. We also have a company looking to allow us to produce statements from the system to send out, which will streamline the debt collection process.

Finance Officer and the Joint Chief Finance Officer.	The new process and procedures will be in place by 31 August 2019.
Recommendation 1 Management should ensure that required information relating to debtors is retained in accordance with defined procedures.	
Risk exposure if not addressed: • Debtors and write off procedures are not fully adhered to.	Responsible manager for implementing: **Alison Hunter** - **Payroll and Transactional Services Manager** Date to be implemented: **08/2019**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

This page has been intentionally left blank

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Follow up Audit of Criminal Justice Unit - Digital Case File Preparation

Draft Report Issued: **6th June 2019**

Final Report Issued: **27th June 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor	Janice Butterworth	janice.butterworth@cumbria.gov.uk	01228 226289

Audit Report Distribution

For Action:	Chief Inspector Ben Swinson – CJU & Partnerships
For Information:	T/Chief Superintendent Rob O'Connor – Territorial Policing Command Assistant Chief Constable Andy Slattery
Audit Committee	The Joint Audit Committee, which is due to be held on 25th July 2019, will receive the report.

Executive Summary

1. Background

1.1. An audit of Digital Case File Preparation was carried out in 2016/17. Based on the evidence provided at that time, the audit concluded that the controls in operation provided **partial** assurance. Improvements were agreed in the following areas:

- **Case file quality** and **Value for money-** Arrangements to identify and address the root cause of file quality issues and propose options for improvement. (R1 & 5)
- **Risk register -** Arrangements to ensure that mitigating actions relating to the reported risk within digital case file quality are fully explored and challenged. (R2)
- **Training -** The arrangements for ensuring that relevant officers have received appropriate digital case file training. (R3)
- **Policies and procedures -** Defining internal procedures in relation to digital case file preparation. (R4)

1.2. Internal Audit has recently undertaken a formal follow up audit to provide updated assurance to senior management and the Joint Audit Committee that the previously agreed actions to address each recommendation have been fully implemented and all controls are working effectively to mitigate the risks previously identified.

2. Audit Approach

2.1. **Follow up Methodology**

2.1.1. The Internal Audit follow up process involved obtaining details of management updates to the Joint Audit Committee and then undertaking testing as necessary to confirm that the actions have been fully implemented and that controls are working as intended to mitigate risk.

2.1.2. It is the responsibility of management to continue to monitor the effectiveness of internal controls to ensure they continue to operate effectively.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. Where the outcomes of the follow up confirm that actions have been successfully implemented and controls are working effectively, the internal audit assurance opinion may be revised from that provided by the original audit.

3.3. From the areas examined and tested as part of this follow up review we now consider the current controls provide **reasonable** assurance. This has been revised from the original opinion of partial assurance. The revised audit opinion assumes that controls assessed as adequate and effective in the original report have not changed and these have not been revisited as part of the follow up**.**

4. Summary of Recommendations and Audit Findings

4.1. There are three levels of audit recommendation. The definition for each level is explained in **Appendix B**.

4.2. The previous audit raised **five** audit recommendations for action. All **five** recommendations have been successfully implemented (summarised at Section 4.3).

4.3. **Recommendations fully implemented**: Progress on these recommendations is summarised as follows:

Case file quality and **Value for Money:** As part of a wider resource allocation review COG approved a new establishment for the Area Compliance Teams (ACT) in March 2019. The ACT is now permanent with an establishment of 1 Sergeant and 8 Police Constables. The Compliance Team's role is to check compliance with evidential requirements thereby ensuring their quality. The posts form part of the Constabulary's options for restricted and adjusted duties officers.

- **Risk Register:** The risk and mitigating actions in respect digital case file quality was reviewed and updated following the audit. This risk was linked to the 2014 Change Programme which is now complete and as a result it is no longer on the Corporate Improvement Risk Register. Digital case file quality is now considered day business by the Constabulary.

- **Training** – A comprehensive 'File Guidance' training document has been prepared for new recruits. The guidance includes file content requirements for Guilty Anticipated Plea (GAP) and Not Guilty Anticipated Plea (NGAP) cases. A monthly, force wide PoliceWorks newsletter is circulated to all officers via the Intranet providing advice and guidance on case file requirements and common errors.

- **Policies and procedures** – The Constabulary follows the National Manual of Guidance (MOG) as the single reference document for preparing case files. A suite of electronic reference documents has been prepared, following MOG requirements, and is available to officers via the Intranet – File Quality Standards Site. The site provides advice and guidance on preparing and submitting digital case files

and includes a named individual to contact in the event of questions on the content.

Comment from the Assistant Chief Constable

I am pleased to note that all five recommendations from the original report have been fully implemented. I am satisfied that the Constabulary has addressed all remedial action identified and that compliance continues to be monitored by senior officers with responsibility for criminal justice.

Andrew Slattery
Assistant Chief Constable
26/6/19

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

This page has been intentionally left blank

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit Follow up of Offender Management

Draft Report Issued: **17 April 2019**

Final Report Issued: **9 May 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor	Pauline Connolly	pauline.connolly@cumbria.gov.uk	01228 226270

Audit Report Distribution

For Action:	Dean Holden – Chief Superintendent, Crime Command
For Information:	Andy Slattery – Assistant Chief Constable
Audit Committee	The Joint Audit Committee, which is due to be held on 23rd May 2019, will receive the report.

Executive Summary

1. Background

1.1. An audit of Offender Management was previously carried out in August 2017. Based on the evidence provided at that time, the audit concluded that the controls in operation provided Partial assurance. Improvements were agreed in the following areas:

- **Service objectives** - An Integrated Offender Management (IOM) Delivery Plan to be developed and agreed.
- **Record of decisions taken on identified risks and performance reports** – Arrangements to be put in place to record decisions and actions arising from review of identified risks and performance reports.
- **Performance managing and reporting** - Progress delivery of two overdue HMIC inspection recommendations.
- **Roles and responsibilities** - Police Staff Offender Management job descriptions to be reviewed and updated
- **Appraisals -** Performance relating to roles and responsibilities to be assessed and evaluated.
- **Memorandum of Understanding -** Review and update of Cumbria MAPPA Memorandum of Understanding "MOU".
- **Checks on ARMs risk assessments and risk management plans** - Arrangements for monitoring and reporting ARMs risk assessments and risk management plans.

1.2. Internal Audit has recently undertaken a formal follow up audit to provide updated assurance to senior management and the Joint Audit Committee that the previously agreed actions to address each recommendation have been fully implemented and all controls are working effectively to mitigate the risks previously identified.

2. Audit Approach

2.1. **Follow up Methodology**

2.1.1. The Internal Audit follow up process involved completing an update statement based on what has been reported to the Joint Audit Committee and then undertaking testing as necessary to confirm that the actions have been fully implemented and that controls are working as intended to mitigate risk.

2.1.2. It is the responsibility of management to continue to monitor the effectiveness of internal controls to ensure they continue to operate effectively.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. Where the outcomes of the follow up confirm that actions have been successfully implemented and controls are working effectively, the internal audit assurance opinion may be revised from that provided by the original audit.

3.3. From the areas examined and tested as part of this follow up review we now consider the current controls operating for Offender Management provide **reasonable** assurance. This has been revised from the original opinion of partial assurance. The revised audit opinion assumes that controls assessed as adequate and effective in the original report have not changed and these have not been revisited as part of the follow up**.**

4. Summary of Recommendations and Audit Findings

4.1. There are three levels of audit recommendation. The definition for each level is explained in **Appendix B**.

4.2. The previous audit raised **7** audit recommendations for action. All **7** recommendations have been successfully implemented (summarised at Section 4.3).

4.3. **Recommendations fully implemented**: Progress on these recommendations is summarised as follows:

- **Service objectives -** An Integrated Offender Management (IOM) Delivery Plan is now in place that includes the activities/actions required to deliver the 5 specific aims in the IOM Strategy 2016-2020. There is regular review of the progress updates against the IOM Delivery Plan at the Vulnerability Meetings.
- **Record of decisions taken on identified risks and performance reports -** A process is now in place via the Vulnerability Meetings to review by exception the MAPPA risks that relate to the Constabulary and to regularly review the monthly performance reports. There is now a record of the actions arising from these reviews. The risk register is now a standing agenda item on the Vulnerability & Crime Command SMT and a process has been put in place to escalate outcomes / issues from Vulnerability Meetings to the SMT.
- **Performance managing and reporting** - The two overdue HMIC inspection recommendations have been completed and closed.

- **Roles and responsibilities** – There has been a full review of the Police Staff Offender Manager's job profile / description with the updates defining staff roles and responsibilities for offender management and a schedule of designated powers is now included.
- **Appraisals** - A Strength Based Conversation process has replaced the 15 weekly reviews to evaluate staff's performance. Procedures and guidance on Strength Based Conversations is in place. Awareness and training on the new process has been provided and attended by staff involved in offender management via a 2 day training course for supervisors and team meetings for staff. There is a record of staff completing Strength Based Conversations and regular reports are provided to managers to monitor their completion.
- **Memorandum of Understanding** – The Cumbria MAPPA Memorandum of Understanding "MOU" has been fully refreshed and updated to include the Constabulary's responsibilities and accountability. Arrangements are now in place for the MOU to be reviewed every 2 years. There is a record of MAPPA SMB discussions and actions arising relating to the new MOU and of the Constabulary and all partners' approval.
- **Checks on ARMs risk assessments and risk management plans** – There is now a process in place each month to review all ARMS Risk Assessments and Risk Management Plans. There is a list of minimum checks that are required; as each review is bespoke to the individuals that are monitored. Monthly quality assurance audits are now in place with the outcomes of these fedback to staff and relevant corrective action taken where necessary.

Comment from the Assistant Chief Constable

I am satisfied that all the recommendations made in the initial audit report have now been fully implemented.

The report can now be finalised and reported in summary to the next meeting of the Audit & Assurance Committee via the internal audit quarterly progress report.

Andrew Slattery
Assistant Chief Constable
9/5/19

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

This page has been intentionally left blank

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of the Main Accounting System

Draft Report Issued: **23rd April 2019**

Final Report Issued: **10th May 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Janice Butterworth	janice.butterworth@cumbria.gov.uk	01228 226289

Audit Report Distribution

For Action:	Keeley Hayton, Financial Services Manager
For Information:	Stephen Kirkpatrick, Director of Corporate Support Roger Marshall, Joint Chief Finance Officer Michelle Bellis, Deputy Chief Finance Officer
Audit Committee	The Joint Audit Committee, which is due to be held on 23rd May 2019, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of the **Main Accounting System**. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. The main financial accounting system is the mechanism by which the PCC and Constabulary manage their financial affairs and record all financial transactions using Oracle. The Joint Chief Finance Officer is responsible for ensuring the financial affairs of the PCC and Chief Constable are properly administered and that financial regulations are observed.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Deputy Chief Finance Officer. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- Follow up of previous recommendation from the 2016/17 audit
- Operational policies and procedures
- Budgetary Control
- Coding Structure
- Feeder Systems
- Control Accounts
- Bank Reconciliations

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating within Main Accounting System provide **substantial** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2 The previous audit raised one recommendation regarding the arrangements for ensuring virements comply with financial regulations and financial rules. A copy of the Virement Listing spreadsheet 2018/19 was obtained and a sample of 10 virements was randomly selected for testing to confirm all were appropriately signed by an authorised budget holder and countersigned in accordance with financial rules, valid codes were used and the virements netted to zero. Testing confirmed that procedures are in place as per the agreed management actions and they address the original audit recommendation.

4.3 There are no audit recommendations arising from this audit review.

4.4 **Strengths:** The following areas of good practice were identified during the course of the audit:

- Comprehensive financial policies and procedures are in place, they are reviewed regularly and readily available to budget holders;
- An annual budget setting timetable and a Financial Period Ends timetable are established; adherence to deadlines is monitored;

- Budget holders accept their delegated budget responsibilities on an annual basis and evidence of this is retained. Our testing identified that where budget holders change, new budget holders are required to sign and accept delegated budget responsibility;
- Each business area has a designated Financial Services Officer who hold monthly meetings with budget holders;
- A Chart of Accounts is produced showing all valid cost, main, analysis and project codes for the year. Within the Chart of Accounts an audit trial is maintained showing amendments to the coding structure during the year. The accounting system does not accept invalid codes;
- Feeder systems information from Trent and Tranman are uploaded to the accounts on a monthly basis. The files are checked for coding accuracy and any miscoding is corrected prior to upload to the general ledger.
- There are a number of control accounts in use e.g. payroll, deductions, debtors, returned cheques, etc. The Financial Period Ends timetable identifies deadlines for monthly bank account and control account reconciliations. We tested April 2018 to February 2019 Bank Account, Payroll and Deductions reconciliations; testing confirmed that these were undertaken in a timely manner, in line with monthly deadlines and were independently reviewed. Compliance with monthly deadlines is monitored via a Control Account Reconciliation Monitoring spreadsheet;
- Access to the finance system is limited to named individuals with monthly reviews in place to ensure that access is current. The monthly audit of system access for February 2019 was reviewed; it contained 8 access removal and 3 new access requests relating to 5 employees. Testing confirmed that access change requests were authorised by the users' line manager and approved by Finance. Requests for changes to access, which may result in segregation of duties issues, are challenged.

Comment from the Joint Chief Finance Officer
The main accounting system and the associated procedures to ensure the integrity of financial records are the bedrock of financial management and the production of the financial statements. In this context, I am delighted the audit gives substantial assurance that financial controls are operating effectively, that the recommendation from the previous audit has been addressed and that there are no new recommendations. Thank you to all staff involved.

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority

		matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of processes for monitoring Police Overtime

Draft Report Issued: **24th April 2019**

Final Report Issued: **9th May 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Diane Lowry	diane.lowry@cumbria.gov.uk	01228 226281

Audit Report Distribution

For Action:	Sue Clasper – Financial Services Officer
For Information:	Rob O'Connor – Temporary Chief Superintendent, Territorial Policing Command. Andy Slattery – Assistant Chief Constable.
Audit Committee	The Joint Audit Committee which is due to be held on 23rd May 2019 will receive this report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of Overtime Monitoring Processes. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. One of the priorities set out in the Police and Crime Plan is to spend money wisely. It is therefore essential to the organisation that there are effective arrangements in place to control and monitor finances and this includes the monitoring of overtime.

1.3. The Constabulary has an overtime budget for the current financial year, in the region of £2.3M. This is for Police Officer, Police Staff and PCSO overtime.

1.4. Monitoring of overtime budgets changed at the start of 2018 in order to allow budget holders and senior management to better understand the reasons why overtime budgets were being overspent. Finance, together with the Senior Leadership Team, developed the level of detail contained in monitoring reports for budget holders to provide more insight to the reasons overtime was high and whether there were any trends etc. As a result a new framework for monitoring overtime was developed.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1. The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Temporary Chief Superintendent Territorial Policing Command. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control in the following areas:

- New arrangements for monitoring overtime

2.2.2. There were no instances whereby the audit work undertaken was impaired by the availability of information.

3. Assurance Opinion

3.1. Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.2. From the areas examined and tested as part of this audit review, we consider the current controls operating for the new overtime monitoring processes provide **substantial** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4. Summary of Recommendations, Audit Findings and Report Distribution

4.1. There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.2. There is **1** audit recommendation arising from this audit review and this can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives	-	-	-
2. Regulatory - compliance with laws, regulations, policies, procedures and contracts	-	-	-
3. Information - reliability and integrity of financial and operational information (see section 5.1.)	-	-	1

4. Security - safeguarding of assets	-	-	-
5. Value - effectiveness and efficiency of operations and programmes	-	-	-
Total Number of Recommendations	-	-	1

4.3. **Strengths:** The following areas of good practice were identified during the course of the audit:

- There is a framework for reporting and monitoring overtime. Responsibilities have been clearly defined for both budget holders and finance staff.
- Processes have been documented for staff to follow.
- When the new arrangements were introduced in 2018 finance provided support to budget holders and meetings took place to explain what the monitoring reports meant and how to use the information provided. Where budget holders change finance meet with the new post holder to explain the process.
- Regular discussion and liaison takes place between finance and budget holders as part of the budget monitoring process and this includes overtime. Established monthly meetings take place alongside more frequent meetings when required, an example being the weekly Operations overtime meeting which was set up to focus on areas where overtime was high.
- In order to ensure that overtime for specific operations are correctly coded, finance provide the operation specific cost centre code alongside the category code and officers are made aware of the arrangements. Finance undertake checks on coding to ensure that overtime costs are correctly reflected and recharges can be made as appropriate.
- Finance is a standing agenda item at Territorial Policing and Crime Command Senior Leadership Team meetings. Overtime monitoring reports for police officer overtime have been developed and the report for Territorial Policing includes a dashboard to summarise the key information and provide information such as a comparison with previous years, reasons for the overtime, spend by day and the top overtime earners. The meetings are attended by the Financial Services Officer.
- As a result of the new reporting arrangements, opportunities have been taken to further improve the way in which monitoring is carried out, this includes:
  - The Financial Services Officer has introduced a weekly report from the Duty Management System, the hours recorded are used to calculate an estimate of costs for planned overtime. The aim of this is to provide a more accurate estimate of Police Officer overtime commitments for Territorial Policing Operations.

- The Chief Superintendent Operations has introduced a weekly meeting to review and monitor overtime in Operational Support. This includes a look ahead at events for overtime planning and forecasting purposes; and to discuss any possible resourcing gaps that may need to be covered and could be accommodated through means other than overtime.

4.4. **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.4.1. *High priority issues:*

- None Identified

4.4.2. *Medium priority issues:*

- None Identified

4.4.3. *Advisory issues:*

- Finance hold regular meetings with the Superintendents from the Areas and Operational Support where overtime reports are discussed. However, there is no record retained of discussions held or of any decisions taken at the meetings.

Comment from the Assistant Chief Constable

I am aware of the content of this report, the action the constabulary has signed up to and have arrangements in place to monitor implementation of the control measure identified, namely the recording of budget monitoring discussions between operational Commands and Finance Dept.

I am satisfied that the action identified addresses the issue and risk identified within the audit to an acceptable level.

The report can now be finalised and reported in summary to the next meeting of the Joint Audit Committee via the internal audit quarterly progress report.

Andrew Slattery

Assistant Chief Constable

Management Action Plan

5. Matters Arising / Agreed Action Plan

5.1. Information - reliability and integrity of financial and operational information**.**

● **Advisory issue**

Audit finding	Management response
(a) **Evidence of Discussions / Decisions** Detailed overtime monitoring reports are prepared by the Financial Services Officer (FSO) in respect of Territorial Policing, Operations. The reports which include details of police officer overtime, are provided to the budget holders for review, each month in advance of the full management accounts. Internal Audit were advised that meetings are held meetings with the Superintendents from the Areas and Operational Support to go through the management accounts and overtime reports and discuss the figures in more detail. Looking at daily costs, areas of high spend and planned spend etc. to include in future forecasting. There is no record retained of discussions held or the decisions taken at the meetings in relation to overtime. Examination of the Overtime reports noted that they include Comments boxes for Finance and the relevant Department. However, discussions with the FSO indicated that the boxes are not generally used to record discussions, as any comments or feedback is verbal.	Agreed management action: Discussions and decisions made in meetings to be recorded commencing May 2019 when first accounts are produced.
Recommendation 1: In order to provide a permanent record of any decisions made or action required by Financial Services or the Department as a result of overtime monitoring consideration should be given to	

completing the comments box included on the TP overtime reports.	
Risk exposure if not addressed: • There is no evidence of decisions made or who has made them. • Possible issues or errors are not recorded or addressed.	Responsible manager for implementing: **Financial Services Officer** Date to be implemented: **05/2019**

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.

Cumbria Shared Internal Audit Service

Internal Audit Report for Cumbria Constabulary

Audit of the General Data Protection Regulation (GDPR)

Draft Report Issued: **28th January 2019**

Final Report Issued: **29th March 2019**

Audit Resources

Title	Name	Email	Telephone
Audit Manager	Emma Toyne	emma.toyne@cumbria.gov.uk	01228 226261
Lead Auditor(s)	Sarah Fitzpatrick	Sarah.fitzpatrick@cumbria.gov.uk	01228 226255

Audit Report Distribution

For Action:	David Cherry (Force Disclosure Manager) Lesley Johnson (Project Manager)
For Information:	Sarah Jackson (Superintendent People Department) Stephen Kirkpatrick (Director of Corporate Support)
Audit Committee	The Joint Audit & Standards Committee, which is due to be held on 23rd May 2019, will receive the report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Audit Manager.

Executive Summary

1. Background

1.1. This report summarises the findings from the audit of General Data Protection Regulation (GDPR) compliance. This was a planned audit assignment which was undertaken in accordance with the 2018/19 Audit Plan.

1.2. The General Data Protection Regulation (GDPR) is Europe's new framework for data protection laws that came into force on 25 May 2018. It is important to Cumbria Constabulary because it places additional obligations on organisations in respect of the security and privacy of personal data, offers greater protection and rights to individuals and imposes higher monetary penalties for non-compliance and data breaches. The regulation is intended to strengthen and unify data protection for all individuals within the EU and is integral to the UK's Data Protection Act 2018.

1.3. Cumbria Constabulary established a Data Protection Project Team in May 2018 to implement a plan for achieving GDPR compliance. Approval has recently been given to extend the project until the end of March 2019 to fully deliver the plan. It is generally accepted that the Information Commissioner's Office (ICO) acknowledge the scale of the undertaking, did not expect full compliance on 25th May 2018 and viewed the task as work in progress at this time. For this reason they are expected to take a more lenient view of data breaches in the immediate period following implementation of the Act, where it can be demonstrated that an action plan and resources are in place to achieve full compliance in a timely manner. The Act has now been operational for seven months and reports to the Constabulary's Business Support Board indicate that a further three months of Project Team activity are required to achieve full compliance. This delay leaves the Constabulary exposed to a greater risk of enforcement action by the Information Commissioner, the levying of a monetary penalty and reputational damage in the event of a data protection breach.

2. Audit Approach

2.1. **Audit Objectives and Methodology**

2.1.1. Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems. A risk based audit approach has been applied which aligns to the five key audit control objectives which are outlined in section 4; detailed findings and recommendations are reported within section 5 of this report.

2.2. **Audit Scope and Limitations**

2.2.1 The Audit Scope was agreed with management prior to the commencement of this audit review. The Client Sponsor for this review was the Director of Corporate Support. The agreed scope of the audit was to provide assurance over management's arrangements for governance, risk management and internal control around the Constabulary's plan for achieving GDPR compliance.

2.2.2 There were no instances whereby the audit work undertaken was impaired by the availability of information.

3 Assurance Opinion

3.2 Each audit review is given an assurance opinion and these are intended to assist Members and Officers in their assessment of the overall level of control and potential impact of any identified system weaknesses. There are 4 levels of assurance opinion which may be applied. The definition for each level is explained in **Appendix A.**

3.3 From the areas examined and tested as part of this audit review, we consider the current controls operating around the Constabulary's plan for achieving GDPR compliance provide **reasonable** assurance.

Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4 Summary of Recommendations, Audit Findings and Report Distribution

4.2 There are three levels of audit recommendation; the definition for each level is explained in **Appendix B**.

4.3 There are **2** audit recommendations arising from this audit review and these can be summarised as follows:

	No. of recommendations		
Control Objective	**High**	**Medium**	**Advisory**
1. Management - achievement of the organisation's strategic objectives (see section 5.1.)	-	1	1

2. Regulatory - compliance with laws, regulations, policies, procedures and contracts (see section 5.2.)	-	-	-
3. Information - reliability and integrity of financial and operational information (see section 5.3)	-	-	-
4. Security - safeguarding of assets (see section 5.4)	-	-	-
5. Value - effectiveness and efficiency of operations and programmes (see section 5.5)	-	-	--
Total Number of Recommendations	-	**1**	**1**

4.4 **Strengths:** The following areas of good practice were identified during the course of the audit:

- The Constabulary has a designated Data Protection Officer which is a statutory requirement of the new legislation.
- Senior management are committed to awareness raising activity across the force to ensure full understanding of GDPR and the changes it introduces.
- The risks of non-compliance with new data protection legislation are included on the strategic risk register for ongoing monitoring and management.
- Arrangements are in place for staying abreast of GDPR legislation and best practice.
- Senior management have approved dedicated resources through to March 2019 to undertake the necessary work to achieve GDPR compliance.
- Monthly meetings are held with the OPCC to review and discuss progress against the GDPR compliance plan.

4.5 **Areas for development**: Improvements in the following areas are necessary in order to strengthen existing control arrangements:

4.5.1 *High priority issues:* none identified.

4.5.2 *Medium priority issues:*

- Project management methodology and project governance arrangements are not fully developed.

4.5.3 *Advisory issues:*

- There have been issues with the quality of the data provided by the College of Policing in respect of completion of national GDPR training.

Comment from the Director of Corporate Support:
I am content with the findings of this Internal Audit review of the Constabulary's compliance with General Data Protection Regulations (GDPR) and feel that a level of reasonable assurance is a fair reflection of the position at the time the audit was undertaken.

As detailed within the report findings, the Constabulary have put a dedicated project team in place to address the requirements of the new GDPR regulations. Good progress has been made, however it is recognised that further work is required, including a review of the longer term resourcing requirements. The project team has been extended for a further six months period from April 2019. The Constabulary have also instigated a wider review of Information Management which will cover relevant aspects of Authorised Professional Practice relating to Information Management, specifically including GDPR, Management of Police Information (MOPI), Freedom of Information (FOI), Data Protection Act (DPA) etc.

The strengths articulated within the audit illustrate that the Constabulary are committed to meeting the requirements of the revised data protection legislation. With regards to the two recommendations made, the Constabulary has received assurances from the College of Policing regarding resolution of the technical NCALT issues and are making strong progress with relevant staff undertaking the required training. A revised project plan has also been developed which, together with introducing stronger project management disciplines, will address the concerns raised regarding the project governance.

As already detailed, the longer term processes and structures regarding GDPR will be addressed as part of the Information Management review.

Management Action Plan

5 Matters Arising / Agreed Action Plan

5.1 Management - achievement of the organisation's strategic objectives.

● **Advisory Issue**

Audit finding	Management response
(a) **GDPR Training** The National Centre for Applied Learning Technologies (NCALT) developed a Managing Information E-Learning package with the College of Policing to assist police forces across England and Wales. It explains how to handle, record and share information and covers the changes introduced by GDPR and the Law Enforcement Directive. Chief Officer Group decided in April 2018 that all police officers, police staff (including agency personnel) and PCSOs would be required to complete the national Managing Information E-Learning package before commencement of the new legislation on 25th May 2018. Business Support Board received a GDPR update report from the GDPR Project Manager on 4th December 2018 stating that just over 90% of personnel have now completed the course. There have been technical difficulties nationally with the E-Learning package and for a period of time an alternative PDF version of the training was put in place. The technical issues are monitored by the national co-ordinator for Data Protection Reform and she updates all Data Protection Officers and Heads of Information Management across the service on a monthly basis. It is understood from the national co-ordinator that the Information Commissioner's Office has also been made aware of the issues. The GDPR Project Team has found that the technical issues have impacted on the reliability of course completion data available to forces. The data provided from the NCALT system (via the College of Policing) has to be compared to establishment information in Origin HR to establish the course completion rate and provide details	Agreed management action: All technical issues have now been fixed and monthly reports on completion are received from the National Team. Regular reminders are issued to those whose GDPR e-learning completion is outstanding in order to further increase the over 90% completion rate. GDPR e-learning is now part of the induction process which will help to ensure that all new starters complete the training within their first week.

of employees who haven't completed the course for follow up. This task is necessary because there is no link from the NCALT system to the Origin HR system to update individual training records. Reliance is therefore placed on the training information provided by the College of Policing. The comparison activity is largely manual, which could further affect the quality of information produced and reported to management each month via Project Status dashboards. It is the responsibility of Data Controllers to ensure that all officers and staff complete an appropriate level of data protection training. Reliable data on course completion is necessary for ongoing monitoring and management, of the completion of initial training and any subsequent refresher training.	
Recommendation 1: Assurance should be sought from the College of Policing regarding the resolution of technical issues with the NCALT e-learning package and the quality of training data now available for monitoring and reporting purposes.	
Risk exposure if not addressed: • Data breaches arising from misunderstandings because of inadequate training. • Sanctions arising from non-compliance with data protection legislation. • Reputational damage arising from non-compliance with data protection legislation.	Responsible manager for implementing: **Project Manager - GDPR** Date to be implemented: **07/2019**

● **Medium priority**

Audit finding	Management response
(b) **Project Governance** A paper was presented to Chief Officer Group in April 2018 setting out some basic governance arrangements around the establishment of a Data Protection Project Team and nomination of a Data Protection Officer. However management are unable to demonstrate that established project	Agreed management action: Project governance has been further developed since the audit: Roles and responsibilities have been clarified, the

management methodology is being followed and that governance arrangements have been fully developed. For example: • There is limited clarity around the roles and responsibilities of the Project Manager and Project Assistant within the Project Team, their relationship with the Force Disclosure Manager and leadership roles. • Terms of reference for the project have not been fully developed to establish as a minimum: project objectives, work plan, monitoring and reporting arrangements (frequency & recipients), required level of stakeholder involvement, key phases of the project and resources. • A project risk register has not been developed to identify, monitor and manage risks that impact on the delivery of the plan on an ongoing basis, with escalation arrangements. • Management have not set out their expectations in respect of monitoring information to monitor and manage project progress on a timely basis. Good quality data is required for effective challenge of progress / performance and agreement of actions to address any slippage. • Project management software is not utilised across the project team (e.g. MS Project). A series of separate spreadsheets are used making it difficult to develop a comprehensive plan of activity, prioritise tasks, assign resources and responsibilities to tasks, establish timescales, review workloads and monitor progress. • The project team does not have designated office space making close and regular communication more difficult. This increases the likelihood of duplication and some tasks being missed altogether. Furthermore the Force Disclosure Manager remains within the Disclosure Unit and it is understood that business as usual in the unit can have an impact	project plan has been reviewed and reprioritised. This will be presented to Business Support Board on 10th April 2019. A wider review of Information Management will take place and will include processes and structures around GDPR.

upon his time, and therefore the project. • RAG status ratings on project work plans are not used effectively to indicate progress against time targets and highlight where intervention is needed. They are being used to indicate if a task has not been started, is underway or complete. Fully established project management methodology and governance arrangements would strengthen project management arrangements, improve project oversight and support assurances regarding full and effective project delivery.	
Recommendation 2: Management should ensure that project management methodology and project governance are fully developed.	
Risk exposure if not addressed: • Failure to achieve full compliance in a timely manner. • Reputational damage arising from non-compliance with data protection legislation. • Sanctions arising from non-compliance with data protection legislation.	Responsible manager for implementing: **Project Manager - GDPR** Date to be implemented: **04/2019**

Appendix A

Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The controls tested are being consistently applied and no weaknesses were identified. Recommendations, if any, are of an advisory nature in context of the systems and operating controls & management of risks.
Reasonable	There is a reasonable system of internal control in place which should ensure that system objectives are generally achieved, but some issues have been raised which may result in a degree of risk exposure beyond that which is considered acceptable.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently developed. Recommendations are no greater than medium priority.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses which have been identified and the level of non-compliance and / or weaknesses in the system of internal control puts the system objectives at risk.	There is an unsatisfactory level of internal control in place as controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. Recommendations may include high and medium priority matters for address.
Limited / None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist. Recommendations will include high priority matters for address. Some medium priority matters may also be present.

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are three levels of audit recommendations used; high, medium and advisory, the definitions of which are explained below.

		Definition:
High	●	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	●	Some risk exposure identified from a weakness in the system of internal control
Advisory	●	Minor risk exposure / suggested improvement to enhance the system of control

Recommendation Follow Up Arrangements:

- High priority recommendations will be formally followed up by Internal Audit and reported within the defined follow up timescales. This follow up work may include additional audit verification and testing to ensure the agreed actions have been effectively implemented.
- Medium priority recommendations will be followed with the responsible officer within the defined timescales.
- Advisory issues are for management consideration.