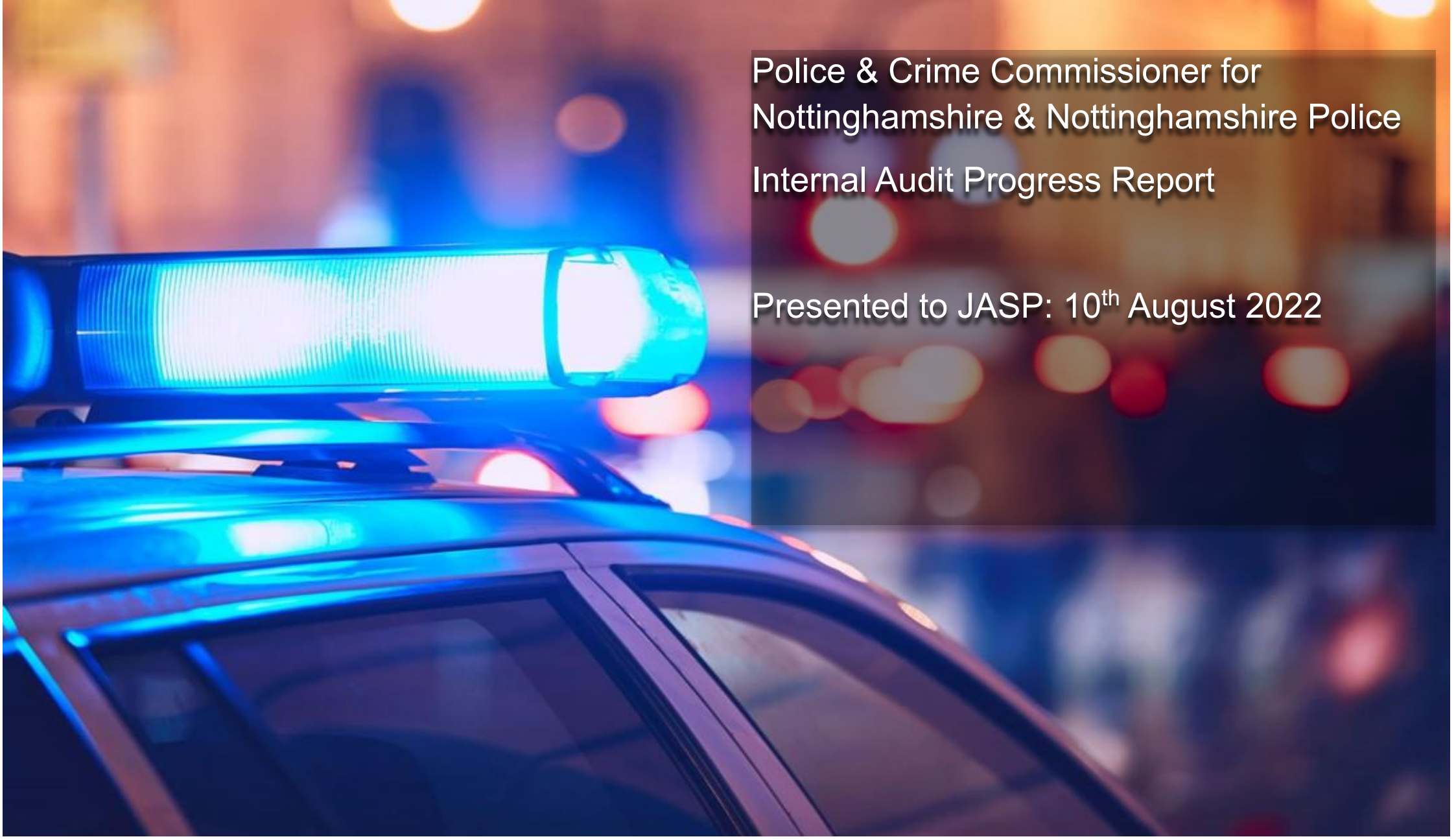

Police & Crime Commissioner for Nottinghamshire & Nottinghamshire Police

Internal Audit Progress Report

Presented to JASP: 10th August 2022

mazars

Contents

mazars

01 Summary

The purpose of this report is to update the Joint Audit & Scrutiny Panel (JASP) as to the progress in respect of the Operational Plan for the year ended 31st March 2022, which was considered and approved by the JASP at its meeting on 24th February 2021. Moreover, we are able to provide progress in respect of the Operational Plan for the year ended 31st March 2023, which was considered and approved by the JASP at its meeting on 28th February 2022.

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

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

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

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

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

02 Current progress

2021-2022

Since the last meeting of JASP we are pleased to inform the committee that the final report for Health & Safety and Partnerships have been issued, see Appendix A3 for full details. In addition, the remaining draft reports to complete the 2021-22 plan for Procurement & Seized Property have been issued and are awaiting management comment for finalisation.

The final report for the Collaboration EMSOU Wellbeing audit has also been issued which completes the agreed 2021-22 Collaboration Audit Plan, see Appendix A3 for full detail.

2022-2023

Since the approval of the 2022-2023 Internal Audit Plan at the February meeting of the JASP internal audit have been in touch with management to begin to agree dates for the delivery of the plan. We are pleased to inform the committee that the final report for the joint audit (with Northamptonshire) of the MINT service has been issued, see Appendix A3 for full details. In addition to this the draft report in regard to the audit of Custody has been issued.

Mazars have been communicating regularly with management and the audits of Medium Term Financial Planning and Business Continuity have been agreed to take place in August and September respectively.

A detailed discussion on the 2022/23 Collaboration Audit Plan was held at the regional CFO meeting with a number of proposals put forward by Internal Audit. It was agreed that the plan should include a total of six audits with the focus being to get this completed earlier in the 2022/23 year. We are pleased to update the committee that two have issued the draft report in respect of EMCHRS L&D Governance and the field work for EMSOU – Business Continuity and EMSOU – Risk Management have all been completed with draft reports soon to follow. Moreover, the audits of Digital Currency and EMSOT Closedown are scheduled to take place across the next two months. See Appendix 4 for full details.

03 Performance

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

2021/22

Number	Indicator	Criteria	Performance
1	Annual report provided to the JASP	As agreed with the Client Officer	Achieved
2	Annual Operational and Strategic Plans to the JASP	As agreed with the Client Officer	Achieved
3	Progress report to the JASP	7 working days prior to meeting.	Achieved
4	Issue of draft report	Within 10 working days of completion of final exit meeting.	92% (11/12)
5	Issue of final report	Within 5 working days of agreement of responses.	100% (10/10)
8	Audit Brief to auditee	At least 10 working days prior to commencement of fieldwork.	100% (12/12)
9	Customer satisfaction (measured by survey)	85% average satisfactory or above	100% (4/4) 3 x Very Good 1 x Good

A1 Plan overview 2021/2022

Audit area	Proposed Dates	Draft Report Date	Final Report Date	Target JASP	Comments
Performance Management	Q1	July 21	Sept 21	Sept 21	
Firearms Licensing	Q1	July 21	Sept 21	Sept 21	
MFSS Transfer - Q1 & Q2	Q1/Q2	Sept 21	Oct 21	Nov 21	
Core Financials	Q3	Jan 22	Feb 22	Feb 22	
OPCC Charities Account	Q3	Dec 22	Dec 22	Feb 22	
Business Change	Q4	Feb 22	Mar 22	Apr 22	
Health & Safety	Q4	Feb 22	Apr 22	Aug 22	
Workforce Planning	Q4	n/a	n/a	Mar 22	Removed from plan
Procurement	Q4	May 22		Jun 22	Draft Issued
Partnership	Q4	May 22	Jul 22	Aug 22	
Seized Property	Q4	May 22			Draft Issued
Information Assurance	Q3/Q4	Feb 22	Mar 22	Apr 22	
GDPR	Q3/Q4	Feb 22	Mar 22	Apr 22	

Plan overview 2022/2023

Audit area	Proposed Dates	Draft Report Date	Final Report Date	Target JASP	Comments
MINT	Q1	May 22	May 22	Aug 22	
Custody	Q1	July 22		Nov 22	
MTFP	Q2			Nov 22	Booked for Aug 22
Environmental Management	Q4			May 23	
Business Continuity	Q3			Nov 22	Booked for Sept 22
Core Financials	Q3			Feb 23	Scheduled for Oct 22
Fleet Management / Transport	Q4			May 23	
Asset Management	Q4			May 23	
Seized Property	Q4			May 23	
Risk Management	Q4			May 23	
Cyber Security	Q4			Feb 23	Planning call held, date to be confirmed

Collaboration Audit Plan 2021/22

Audit area	Forces	Status
EMSOT Risk Management	Leics, Lincs, Northants	As noted in section 02 EMSOT audits to be adapted and deferred into 22/23
ESMOT Business Plan	Leics, Lincs, Northants	As noted in section 02 EMSOT audits to be adapted and deferred into 22/23
EMSLDH Governance	Derby, Leics, Northants, Notts	Deferred into 22/23 Plan. Scheduled for May 22
EMCJS Performance Management	Leics, Lincs, Northants, Notts	Cancelled
EMSOU - Business Continuity	Five Force	Deferred into 22/23 Plan. Scheduled for May 22
EMSOU - Wellbeing	Five Forces	Final Report
EMSOU Risk Management	Five Forces	Deferred into 22/23 Plan. Scheduled for May 22
Asset Management (EMCJS)	Leics, Lincs, Northants, Notts	Cancelled

Collaboration Audit Plan 2022/23

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

A2 Reporting Definitions

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

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

A3 Summary of Reports

Health & Safety 21/22

Overall Assurance Opinion	Satisfactory

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

Audit completed a review of Health and Safety at Nottinghamshire in February 2019, where a limited level of assurance was provided. Five recommendations were raised in total, of which one was fundamental, three were significant and one was housekeeping. A follow up review was undertaken in February 2020 to review the progress made against these recommendations. Unfortunately, there was a lack of progress and a limited assurance opinion was again provided. The purpose of this review conducted in February 2022 was to review progress against previous recommendations, in addition to also validating that controls which were previously operating well are still in place.

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

Roles & Responsibilities

- Roles and responsibilities are clearly defined, and the individuals concerned are fully aware of these.
- Appointed officers have been assigned to support the organisation to meet its health and safety responsibilities.

Policies & Procedures

- The Force has in place policies and procedures which incorporate relevant legislative requirements and provide clear guidance to staff.
- The policies and procedures in place are comprehensive, up-to-date, and available to all relevant members of staff.
- The existing policies and procedures are regularly reviewed to ensure that they are up to date.

Governance

- There is an appropriate and effective governance structure in place through which health and safety issues are reviewed, scrutinised, and managed.
- Health and safety is promoted across the Force to ensure awareness from both police staff and police officers.

Monitoring & Reporting

- There is an effective system in place for recording, maintaining, and reporting health and safety data including any incidents or near misses.
- There is an effective accident and near miss reporting system in place than ensures that the Force complies with relevant legislation.
- Appropriate oversight and reporting arrangements are in place and are working effectively.
- Health and safety information is accurately produced and regularly reported to allow for effective monitoring, decision making, and reporting in line with senior management requirements.

Training

- Staff are fully supported with relevant training and guidance provided to allow compliance with health and safety requirements and responsibilities.
- The Force has a robust process in place to monitor the level of health and safety training undertaken by key staff including the Chief Officer Team and those who have statutory responsibilities.

Previous Recommendations

- Previous recommendations have been implemented, embedded, and are operating effectively.

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

We have raised two priority 2 (significant) recommendations and the detailed recommendation, finding and management response are provided below:

Recommendation 1 (Priority 2)	The Health and Safety team should undertake trend analysis of cases where there are report errors and non-engagement from managers in order to highlight repeat offenders. The results of trend analysis and incidents of non-engagement from line managers should be flagged and escalated to the H&S Strategic Board (Gold). Whether a minor injury is considered as a near miss during reporting should be clarified in guidance documents.
Finding	Incident Reporting Observation: Incidents (accidents, assaults, near misses, hate crimes) are reported via the APEX system through completion of a report after selecting the category of incident. Audit reviewed a sample of five accidents and found that: •2/5 cases the accident report was sent to the employee's line manager for further investigation however no response was received and due to the lapse in time the cases were closed. •1/5 cases the accident report section detailing further actions that could be taken in the future to prevent reoccurrence was not completed. •2/5 cases the incident supervisor section of the report was not completed, which details whether a referral to Occupational Health was considered and what further support was offered. Upon review of a sample of five near misses it was found that: •1/5 cases the line manager was contacted in order to further investigate the case however no response was received, and the case was closed. •1/5 cases the report notes that the employee hit their head and was disorientated afterwards. Although the employee appeared to have recovered with no issues, as this indicates an injury it is unclear why a near miss rather than accident report was filed. •3/5 cases the incident supervisor section of the report was not completed. On a weekly basis the Health and Safety team audits all submitted incident reports and investigations in order to scrutinise the level of completion, determine whether they are RIDDOR reportable, and whether the incidents have been closed off. The Health and Safety team focused on reviewing and closing historic incident investigations from April to September 2021, and as part of this the non-engagement from line managers in the incidents noted above were already identified and attempts had been made to contact them. Due to the timeframe

	between the incident and review by Health and Safety, these investigations were closed. It is also noted that there have been improvements in the reporting system over the last year, with 416 total reports in 2019/20 and 611 total reports in 2020/21. Risk: Investigations do not take place leading to potential health and safety risks not being identified. Incidents are not reported using the correct category leading to a proper investigation not being carried out.
Response	We are presenting trends at the Strategic H&S board and will continue to try and develop this further. We are transferring to a new H&S management system and hope that this will assist us in understanding non engagement better. We will review the definition of minor injury versus near miss to ensure clarity.
Responsibility / Timescale	December 2022 Senior Health and Safety Advisor

Recommendation 2 (Priority 2)	The Health and Safety team should continue monitor and prioritise the completion of mandatory training for staff. The importance of completing the training should be effectively communicated to ensure completion rates are increased.
Finding	All staff members are required to complete mandatory fire safety and DSE (display screen equipment) training, and there are also additional training courses in place for staff with more specific responsibilities, such as risk assessment training for inspectors. Mandatory training is monitored using a spreadsheet, and upon review by audit it was found that training completion rates were approximately as follows: • Fire Safety – 55% • DSE – 53% It is noted that this is a significant improvement over the last year, as the previous rate was around 20%. However, our review of the completion spreadsheet also indicated that a number of senior staff had also not completed the relevant training. In order to embed the H&S culture it should be ensured that senior staff are completing the training to lead by example. Risk: Staff members are not appropriately trained leading to health and safety risks at work. Staff do not have the opportunity to refresh their knowledge through fire safety and DSE refresher courses.
Response	We will continue to monitor and seek to increase completion further. We will develop expectations for training at different levels within the organisation. Revised process is being introducer to improve compliance monitoring and new starter process will include a check on mandatory training this was introduced in April 2022. Mandatory training
Responsibility / Timescale	Immediate. Senior Health and Safety Advisor

Partnerships 2021/22

Overall Assurance Opinion	Satisfactory

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

The specific areas that formed part of this review included: the arrangements for managing partnerships, current governance arrangements, evaluating how partnerships contribute to the strategic objectives of the OPCC and arrangements in place to ensure that partnerships remain relevant and effective.

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

- Determine what partnership arrangements the OPCC are involved in both statutory, non-statutory, commissioned etc.
- Assess current governance arrangements for individual Partnerships in terms OPCC engagement with the partnership; it will look at the following:
    - whether they are clearly defined.
    - roles and responsibilities are understood by all parties.
    - risks to the OPCC are being effectively managed.
    - resources required and objectives being delivered.
    - decision making is clear and transparent; and
    - reporting arrangements are in line with best practice.
- Evaluate how partnerships contribute to the strategic objectives of the OPCC, including the Police & Crime Plan.
- Determine whether partnership arrangements are regularly reviewed to ensure that they remain relevant, effective and that the stated objectives of the partnership are actually being achieved.
- Provide assurance that regular monitoring information is produced to inform reporting of Partnership activity, including the resources input to the partnership and whether value for money is being achieved.
- Assess arrangements for reviewing partnerships and how the OPCC ensures that they remain relevant, effective and that expected outcomes are delivered.

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

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

We raised three Priority 2 (significant) recommendations and the detailed recommendation, finding and management response are provided below:

Recommendation 1 (Priority 2)	The OPCC should map out partnership activity into a central record. The central record should include key information including but not limited to:

	- Legal Status - Staff Liaison - Lead/Chair - Membership - Start/End Date - Funding
Finding	The OPCC is engaged with a number of statutory and non-statutory partnerships. The PCC's Annual Report provides an indication of partnerships that the OPCC is involved with however, we noted that currently Nottinghamshire does not maintain a record of all partnerships that the OPCC are involved with. The amount of resources used in regard to staff time is also a key consideration by the OPCC. By mapping out the resources required for partnership activity into a single central record, this can be used as a reference guide to partnerships and aide evaluation of value for money considerations of each partnership. *Risk:* The OPCC fails to use partnerships and its resources effectively to achieve its key strategic objectives.
Response	The OPCC agrees to implement the recommendation once the new Chief Finance Officer is in place.
Responsibility / Timescale	December 2022

Recommendation 2 (Priority 2)	The OPCC should implement a formal review process of partnerships to ensure that they remain fit for purpose.
Finding	We noted that whilst within some of the partnerships themselves performance is evaluated, currently no strategic review of partnerships is undertaken by the OPCC. This as a key opportunity for ensuring that partnerships across the OPCC remain effective in achieving value for money and aligned to the strategic objectives of the PCC. We were advised by management that the OPCC were looking to undertake an evaluation of partnerships across the OPCC once the current restructure had been completed. *Risk:* The OPCC fails to identify inefficient partnerships.
Response	The OPCC agrees the recommendation and will take appropriate action
Responsibility / Timescale	Summer 2023

Recommendation 3 (Priority 2)	The OPCC should ensure that controls including the use of risk assessments and that controls outlined in the Financial Regulations are followed in regard to partnerships
Finding	The Financial Regulations for the OPCC includes a section that outlines the key controls in place to manage partnerships. We noted that these included: • A policy statement on partnerships signed by the PCC should be in place. • Risk assessment undertaken,

	• Exit strategy in place. We were advised that informal risk assessments were conducted however these were not formally recorded. In addition, whilst Partnerships are included within the Police and Crime Plan a formal policy statement signed by the PCC is not in place. *Risk:* The OPCC enter into high risk partnerships without appropriate controls in place resulting in ineffective use of resource.
Response	The OPCC agrees to implement the recommendation once the new Chief Finance Officer is in place.
Responsibility / Timescale	December 2022

Collaboration: EMSOU Wellbeing 21/22

Overall Assurance Opinion	Limited

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	4
Priority 3 (Housekeeping)	-

Since 2015/16 all Forces in the East Midlands have agreed to allocate internal audit time to provide assurance over the collaborative arrangements that are in place across the region. Over the first two years Internal Audit have undertaken high level reviews of the governance arrangements within most of the regional collaboration units. A change of approach was made in 2018/19 when thematic reviews were carried out by audit and were carried out across a sample of regional collaboration units. The approach for 2021/22 has been for more targeted audits within each collaboration unit. Through review of each unit's risk register a focused risk-based approach to the Collaboration audits has been planned.

As part of this review, we have carried out an audit of the process in place within the East Midlands Special Operations Unit (EMSOU) in respect of Wellbeing. The specific areas that formed part of this review included: Governance, Strategy & Policies, Implementation Plans, Feedback & Monitoring and Lessons Learned.

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

Governance

- Governance arrangements for Wellbeing are clearly defined, including roles and responsibilities, risk management processes, decision making and reporting arrangements.
- There is consistency and a clear line of reporting between the Forces' and the collaboration unit.

Strategy and Policies

- The Wellbeing Strategy is aligned to the Forces Strategic aims and is regularly reviewed and updated.
- The collaboration unit has appropriate Policies and Procedures with regards to Wellbeing that are aligned to the Forces', which provide clear direction as to the processes to be followed.

Implementation Plans

- The collaboration unit has robust implementation plans that are aligned to strategic objective and future needs.

Feedback and Monitoring

- There are robust monitoring processes in place to ensure that the collaboration unit has up to date and accurate Wellbeing data in place.
- Training needs analysis performed by the unit captures Wellbeing related data for Officers and Staff.
- The unit identify high risk business areas where Staff / Officer Wellbeing is most impacted and have developed plans to address this.
- Actions to address areas of weakness are set, monitored and reviewed to confirm the weaknesses have been addressed. These are incorporated within action plans, to support the achievement of short / medium / long term Wellbeing targets.
- Regular Management / Performance Information reports are produced in relation to Wellbeing and are shared at appropriate governance meetings, including alignment to the Forces'.

Lessons Learned

- Where issues are identified in projects / works for Wellbeing, evaluation of the issues takes place and improvements are made to existing processes so that the issues are not repeated in future Wellbeing projects / works.
-

The objectives of our audit were to evaluate the adequacy and effectiveness of the Wellbeing processes at EMSOU with a view to providing an opinion on the extent to which risks in this area are managed. In giving

this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control. We are only able to provide an overall assessment on those aspects of the Wellbeing process at EMSOU that we have tested or reviewed. Testing has been performed on a sample basis, and as a result our work does not provide absolute assurance that material error, loss or fraud does not exist.

We raised four priority 2 (significant) recommendations and the detailed recommendation, finding and management response are provided below:

Recommendation 1 (Priority 2)	The Unit should update the Wellbeing Board Terms of Reference and Wellbeing Strategy to include details of the roles, responsibilities, risk management processes, decision making processes and reporting arrangements relevant to Wellbeing.
Finding	Audit has reviewed the Unit's Wellbeing Board Terms of Reference and the Unit's Wellbeing Strategy; noting that neither documents include information regarding the roles, responsibilities, risk management processes, decision making processes and reporting arrangements relevant to Wellbeing. *Risk*: The Wellbeing governance bodies cannot properly execute their functions as roles, responsibilities and processes are not clearly defined.
Response	The roles and responsibilities of people involved haven't been clearly defined as there isn't a dedicated resource and these people are volunteers alongside their day job. Also EMSOU employees also have a lead force employment model and forces ask us to use that resource rather than creating our own internal roles. It was also felt formalising this may detract people from volunteering. However, It is recognised as a risk and a hybrid model though the current HR review is proposed to address this. The plan is to move HR resources around to provide a dedicated lead that covers HR and Wellbeing. There will also be a THEMATIC lead appointed from our SLT management team to lead in Wellbeing (Management Away day actions can be provided to show this has been progressed at the last two SLT away days). Both these roles will then feed into the Senior HR advisor in EMSOU HR as the strategic lead and link into command. Once finalised a structure chart can be produced that will clearly outlines roles and governance.
Responsibility / Timescale	May 22 Director of Corporate, Forensic and Technical Services

Recommendation 2 (Priority 2)	The Unit to consider using implementation plans for wellbeing projects to allow tracking of actions, issues and benefits; as well as ensuring appropriate governance structures are in place.
Finding	Discussion with the HR Business Partner indicated that implementation plans are not used for wellbeing projects within EMOU as there are so few wellbeing projects initiated from within EMSOU. Projects that affect EMSOU that are initiated from Home Forces (mainly Leicestershire) do include implementation plans. Audit subsequently reviewed documentation and communication regarding several Wellbeing projects to confirm that these have taken place. From this review and subsequent discussion with the HR Business Partner, we have confirmed that formalised implementation plans were/are not in place. *Risk*: Wellbeing projects are not completed effectively as actions, issues and benefits are not appropriately monitored/delivered.
Response	Although we don't have dedicated Wellbeing implementation plans, we do have Project initiation Documents that we are promoting for the use of projects throughout the fabric of EMSOU. It is felt to have a universal form will promote

	people to use it for a multitude of reasons and become familiar with it. With the new structure proposal we will do some further communication to launch these
Responsibility / Timescale	Immediate Director of Corporate, Forensic and Technical Services

Recommendation 3 (Priority 2)	The Unit should utilise workforce analysis, specifically regarding any required support, Training Needs and High-Risk Business Areas, to identify training and interventions that may be most helpful.
Finding	The Unit has a diverse range of roles with impacts on the wellbeing of staff coming in varying degrees from the role and from non-work related factors. Therefore, understanding the wellbeing needs of the unit is important to delivering an effective and efficient wellbeing provision. Following discussion with the HR Business Partner, it was noted that the unit does not carry out analysis of departments/divisions to identify those at high risk of poor wellbeing and/or any required/requested training needs. *Risk*: Wellbeing projects do not deliver value for money as they are not targeted towards the needs of the workforce.
Response	In EMSOU we have worked with the Institute for Public Safety, Crime and Justice at the University of Northampton on staff surveys as well as the College of Policing conducting a peer review. We did the original one a few years ago and have been waiting for the effects of COVID to reduce so we can benchmark against the original to see if there are any improvements or new areas of risks. These can be provided and are very in-depth with a lot of analysis completed by them and fed into the EMSOU delivery plan.
Responsibility / Timescale	May 22 Director of Corporate, Forensic and Technical Services

Recommendation 4 (Priority 2)	The Unit to utilise data from available systems and external service providers to identify trends related to wellbeing and assess the effectiveness of wellbeing projects and/or actions.
Finding	It is good practice to utilise necessary data when considering Wellbeing issues, trends and opportunities. This data is usually already collected as part of other Human Resources processes, e.g. reasons for being absent/taking sick leave. Additionally, this information can be collected by external service providers (i.e. employee assistance programmes) and be reported within management information. However, a review of the Unit's governance body's agendas and minutes indicated that this information was not presented to the Wellbeing Board and that Wellbeing management information had not been provided to the Unit. Audit noted from the reviews of the Home Force's Wellbeing processes that Wellbeing data can be and is produced for presentation at governance bodies, including information provided by external suppliers. *Risk*: Initiatives and actions recommended by Wellbeing Board are not guided by the latest data and are not effective.
Response	We have a performance project and team that is building a data lake to provide One Single Version of the truth for our data and then to be produced into Power Bi dashboards that can be analysed for trends and issues etc. HR and Wellbeing

	data is to form part of this so we can have accurate HR info into our data lake that we can then present and interpret.
Responsibility / Timescale	May 22 Director of Corporate, Forensic and Technical Services

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

MINT Closedown Project Up 22/23

Overall Assurance Opinion	Significant

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

We have undertaken an audit of the controls and processes in place in respect of the transfer of services from Mint Commercial Services Limited Liability Partnership ("Mint").

The objectives of our audit were to provide assurance with regards to the Forces' ongoing management of the transfer of services from Mint to in-house provisions at the Forces. In giving this assessment it should be noted that assurance cannot be absolute. The most an Internal Audit Service can provide is reasonable assurance that there are no major weaknesses in the framework of internal control.

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

- The project has an appropriate governance structure in place
- A project plan has been approved by both Forces
- The progress status of the project is reporting in line with the agreed timescales
- Any variance from timelines have been reported on and actions put in place to ensure the project remains on schedule.
- The staged sign off of the project has been authorised correctly.
- The progress of the project is being accurately reported on and has supporting documentation in regard to current status.

We have identified no areas where there is scope for improvement in the control environment.

A4 Statement of Responsibility

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

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

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

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

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