

Audit Committee Agenda

Meeting date: Tuesday 13th October 2026 at 2pm.

Meeting location: Office of the Police and Crime Commissioner for Norfolk (OPCCN), Building 7, Wymondham.

Note for members of the public:

If a member of the public wishes to attend the meeting please contact the Office of the Police and Crime Commissioner for Norfolk, Building 7, Wymondham, Norfolk, NR18 0WW. Call 01953 424455 or email: opccn@norfolk.police.uk

For copies of any of the papers cited below please contact the OPCCN as detailed above.

1. Public Agenda

1.1 Welcome and apologies

1.2 Declaration of personal and prejudicial interests

1.3 To approve the minutes of the meeting held on 21st July 2026 – **Document available on request.**

1.4 Review and update of Action Log – **Document available on request.**

1.5 Update on the transition to a new PCC & Police and Crime Plan (Verbal update)

1.6 External Audit

a. Reserves Risk Assessment – **Document available on request.**

1.7 Internal Audit – **Documents Available on Request**

a. Final Reports from TIAA

- i. Limited Duties
- ii. PICs
- iii. Data Quality
- iv. Body Worn Cameras.

b. BDO Head of Internal Audit Reports - **Documents available on request.**

- I. Progress Report.
- II. Follow-Up Report
- III. External Quality Assessment (EQA) Report
- IV. Revised Internal Audit Plans
- V. Request for Change (RFC) Document

1.8 Devolution & LGR (verbal update)

1.9 Police Reform (Verbal update)

1.10 Impact of Oil Prices on financial resilience – Discussion (Verbal Update).

1.11 Forward Work Plan – **Document Available on Request.**

2. Private Agenda

2.1 Welcome and apologies

2.2 Declaration of personal and prejudicial interests

2.3 Minutes to approve for the meeting held on 21st July 2026

2.4 No actions on Action Log

2.5 Risk Update

- a. Constabulary
- b. OPCC

2.6 Fraud update (Verbal Update)

2.7 Internal Audit

- a. Update on outstanding confidential audits (Verbal)

Next meeting date: 8th December at 2pm

Meeting location: Office of the Police and Crime Commissioner for Norfolk, Building 7, Wymondham.

Audit Committee Meeting

21st July 2026

**Office of the Police and Crime Commissioner for Norfolk (OPCCN)
Building 7, Wymondham & via Microsoft Teams**

MINUTES

Members in attendance:

Anna Bennett (Chair)
Peter Hargrave
Simon Smith
Lucy Sales
Adrian Matthews

Also, in attendance:

Dave Marshall	Deputy Chief Constable
Simon George	Chief Finance Officer, (PCC CFO), OPCCN
Peter Jasper	Chief Finance Officer, Norfolk Constabulary
Vicky Curtis	Norfolk Constabulary
Alison Riglar	EY
Claire Lavery	TIA
Max Armstrong	BDO
Nathan Hall	BDO

Part 1 – Public Agenda

1. Welcome and Apologies:

Colin Sutton - Police and Crime Commissioner
Mark Stokes - Chief Executive
Paul Sanford - Chief Constable
Gurpreet Dulay - BDO

2. Declaration of Personal and Prejudicial interests:

No personal or prejudicial interests were declared.

3. Minutes of the last meeting:

The Committee agreed that the minutes were an accurate record.

The Chair noted that previous minutes had been relatively brief and requested that future minutes better reflect the challenge, discussion and assurance-seeking undertaken by the Committee.

4. Review and Update Action Log:

Data Breach (Item 104): Outstanding item relating to the data breach update was deferred to the private session due to legal sensitivity.

5. PCC Transition Update

Simon George provided an update on the transition following the resignation of PCC Sarah Taylor on 4 June 2026.

Members noted:

- Mark Stokes was appointed Acting PCC by the Police and Crime Panel on 16 June 2026.
- An election was held on 16 July 2026.
- Colin Sutton was elected and formally took office on 17 July 2026.
- A structured induction programme is underway, with all candidates having previously received briefings on the role and responsibilities of the PCC.
- The new PCC is currently undertaking a comprehensive induction process.
- The Committee received assurance that governance arrangements and continuity planning had been effectively managed throughout the transition period.

6. External Audit:

Alison Riglar presented EY's Audit Plan for 2025/26.

Key Audit Risks

Members noted the following significant risks:

- Management override of controls.
- Fraud risk through inappropriate capitalisation of revenue expenditure.
- Valuation of land and buildings.

- Pension assets and liabilities valuation.
- Ongoing ICO investigation relating to the historical data breach.

Key Points

Members noted that:

- The land and buildings valuation risk had reduced from a significant risk to an inherent risk status following stabilisation after the previous change of valuer.
- Changes to the accounting code of practice now require indexation of non-revalued assets.
- Materiality calculations for the group, PCC & CC now updated based on draft 25/26 accounts. No significant change.
- Value for money arrangement. No significant weaknesses had been identified from planning procedures.

Build Back of Audit Assurance

EY confirmed:

- A qualified opinion is expected again for 2025/26 as part of the national "build back" process.
- An unqualified opinion is currently anticipated for 2026/27.
- Risk assessment work to support rebuilding assurance has been completed and is under review.
- An audit plan addendum will be presented at the next Audit Committee meeting.

Committee Discussion

The Committee:

- Sought confirmation that the risk assessment work referred to in the plan had been completed.
- Reiterated its view that Norfolk remains a relatively straightforward organisation to audit with strong financial management and working papers.
- Encouraged EY to consider opportunities to bring forward the audit timetable where practical.

EY advised:

- Risk Assessment for build back work has been completed.
- Audit fieldwork is commencing this week with a 12-week timetable.
- The audit timetable remains constrained by the joint Norfolk/Suffolk audit approach and shared finance arrangements.
- A December Audit Committee meeting is being planned to allow earlier consideration of the audited accounts than in previous years.

Resolution:

The Committee noted the report and looking forward to the planned addendum at the next meeting.

7. Internal Audit (TIAA):

As a result of internal Audit going out to tender BDO have now been appointed. The tender process was undertaken by 7 Force Procurement with Officers and Audit Committee Chairs from Norfolk and Suffolk being involved in the process

Claire Lavery presented TIA's final report.

Key points:

- TIA has completed its final year as internal audit provider following procurement of a new contract.
- Three reports remained in draft, but management responses had been received, and finalisation is expected by the end of the week. Will hand over a clear list of all recommendations to BDO.
- Annual report summarises all work completed.
- The Head of Internal Audit Opinion from the TIAA annual report for 2025/26 is that they are satisfied that, for the areas reviewed during the year, the Police and Crime Commissioner for Norfolk (PCC) and Chief Constable of Norfolk Constabulary (CC) had reasonable and effective risk management, control, and governance processes in place.
- Generally, a positive audit assurance given in most areas however the review of limited duties was noted as providing limited assurance.

Discussion:

The Committee discussed:

- Arrangements for completion of draft audit reports.
- Handover arrangements to BDO.
- Ensuring outstanding recommendations are fully transferred and tracked.
- Access to final reports which had not yet been presented to Committee.

Agreed:

- All finalised reports will be circulated to Committee members following completion. These are Limited duties, PICS, Date Quality and Body Worn Cameras.
- Outstanding recommendations will transfer formally to BDO. A smooth transition is expected.
- The Committee thanked Claire Lavery and TIA for ten years of service and support to the organisation.

1.8 2026/27 Annual Audit Plan (BDO)

Nathan Hall presented BDO's proposed Internal Audit Plan.

Development of the Plan

BDO explained that planning had included:

- Review of corporate risks.
- Consideration of governance statements and accounts.
- Discussions with management, external audit and outgoing auditors.
- Review of historical audit coverage and assurance gaps.
- Consideration of wider assurance sources.

Audit Approach

Members noted:

- BDO intends to undertake broader thematic reviews in some areas, particularly technology, digital and AI.
- The plan includes core assurance reviews, future-focused reviews and management follow-up work.
- Flexibility remains to amend the plan during the year should risk priorities change.

Assurance Methodology

BDO explained that each report will include:

- Control Design Opinion.
- Operational Effectiveness Opinion.

Assurance ratings will be:

- Substantial
- Moderate
- Limited
- No Assurance

Recommendations will be categorised as High, Medium or Low significance.

Key Committee Discussion

The Committee requested:

- Future presentation of an "audit universe" showing historic and planned audit coverage.
- Continued visibility of limited assurance areas.
- Strong follow-up arrangements for implementation of recommendations.
- Clear challenge and validation of management implementation dates.
- Improved engagement with management on draft recommendations before reports are finalised.

The Committee also requested clarification regarding previous audit topics not appearing in the current plan, including:

- Firearms

- Health and Safety
- Reoffending

These should either be reflected within broader reviews or included on the "areas considered but not included" schedule.

Resolution

The Committee approved and accepted the Internal Audit Plan 2026/27, subject to the points raised during discussion.

9. Devolution, Local Government Reorganisation

Simon George provided a verbal update.

Members noted:

- Uncertainty remains regarding the timing of devolution and Local Government Reorganisation (LGR).
- Further clarity is expected when Parliament reconvenes in September.
- Judicial Review challenges may affect implementation timetables.
- Risks remain around delivery timescales if new authorities are expected to become operational by 2028.

1.10 Police Reform

Peter Jasper provided a verbal update.

Members noted:

- The Government's police reform programme continues.
- National initiatives on data exploitation, Police AI and digital transformation are progressing.
- Outcomes from national reviews affecting force structures remain awaited.

11. Accounting Policies

The Committee considered the proposed accounting policies for 2025/26.

Members noted:

- Only limited amendments had been made compared with 2024/25.
- The policies had been discussed during the members' pre-meeting briefing with Ivan Fearn. They have been updated on changes and key items. Committee now better informed.

Resolution

The Committee concluded that appropriate accounting policies had been adopted and supported their continued application.

1.12 Audit Committee Terms of Reference

The Committee reviewed the Terms of Reference.

Discussion

Members discussed:

- Updating outdated references.
- Clarifying the mechanism for extending member terms.
- Specifying expected attendees and organisational representation at meetings.
- Bringing the Terms of Reference to the attention of the PCC and CC.

Agreed

- Terms of Reference should be updated to clarify attendance expectations for key officers and their representatives.
- Simon George to draft a Decision Notice to extend current membership to May 2028

Resolution

Subject to minor amendments, the Terms of Reference were approved.

1.13 Audit Committee – Annual Report 2025/26

The Chair presented the Annual Report summarising:

- Committee activity during the year.
- Review of financial reporting.
- Oversight of governance and internal control.
- Internal audit programme.

Resolution

The Committee approved the Annual Report. Simon George will send the report to the CC and PCC.

14. Forward Plan and Briefings

Members considered future meeting topics.

Agreed Topics

- Governance arrangements following organisational changes.
- Devolution/LGR updates.

- Professional Standards Department briefing. To enable members to have a deeper understanding of fraud and integrity investigations, PSD caseloads and outcomes and counter-corruption work.
- Recruitment and retention trends within the constabulary to identify risks to the wider force.

Next meeting date: Tuesday 13th October 2026

Meeting location: Office of the Police and Crime Commissioner for Norfolk, Building 7, Wymondham.

Audit Committee
Public – Part 1

Action Log – 13th October 2026

Action Number	Meeting Date	Actions and update	Owner	Status
New actions: 24 January 2024				
104	24.1.24	Data Breach Report P Jasper to clarify with ACC Bridger when the data breach internal report will be finalised and issued to both PCCs 26.03.24 – P Jasper updated that internal report has been shared with both Chief Constables and sent to ICO. P Jasper will confirm with ACC E Bridger that the report can be shared with Audit Committee members. Leave open for further update. 23.07.24 – The report has been shared confidentially with Audit Committee members other than L Sales. To remain live.	P Jasper	Live

		13.09.24 – A Bennett advised L Sales proposed to come in and meet with P Jasper so she can read through report and sign off as action following L Sales return on 1.11.24. P Jasper agreed. 25.02.25 – L Sales has completed the review of the internal report. 25.03.25 – Action closed. 14.10.25 – Action reopened following information from ICO. Update will be received at next meeting. 21.07.26 – Action update to Committee on discussions with ICO. 13.10.26 – Further update to Committee following publication of ICO sanction.		
New actions:				

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

Rebuilding audit assurance: the path to an
unqualified opinion

Year ended 31 March 2026

6 August 2026



The better the question. The better the answer. The better the world works.



Shape the future
with confidence

6 August 2026

Police and Crime Commissioner for Norfolk and Chief Constable of Norfolk Constabulary
Jubilee House
Falconers Chase
Wymondham
Norfolk
NR18 0WW

Dear Colin and Paul

Rebuilding audit assurance – risk assessment update

We attach our risk assessment update for consideration at the forthcoming meeting of the Joint Independent Audit Committee.

The purpose of this paper is to provide the Police and Crime Commissioner (PCC), Chief Constable (CC) and the Joint Independent Audit Committee with further detail on the risk assessment procedures performed in respect of opening reserve balances. These procedures have been undertaken in response to the prior-year disclaimed audit opinions and in accordance with the National Audit Office's Local Authority Reset and Recovery Implementation guidance.

This update should be read in conjunction with our Audit Plan for the 2025/26 audit, issued on 27 April 2026.

We welcome the opportunity to discuss this report with you at the meeting on 13 October 2026, and to understand whether there are any additional matters which you consider may influence our risk assessment.

Yours faithfully

Debbie Hanson
Partner

For and on behalf of Ernst & Young LLP

Enc

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1 Background and regulatory context

2 Scope of our risk assessment

3 Summary of risk assessment findings

4 Implications for the 2025/26 audit

5 Appendix A

Public Sector Audit Appointments Ltd (PSAA) issued the 'Statement of responsibilities of auditors and audited bodies'. It is available from the PSAA website (<https://www.psaa.co.uk/managing-audit-quality/statement-of-responsibilities-of-auditors-and-audited-bodies/statement-of-responsibilities-of-auditors-and-audited-bodies-from-2023-24-audits/>). The Statement of responsibilities serves as the formal terms of engagement between appointed auditors and audited bodies. It summarises where the different responsibilities of auditors and audited bodies begin and end, and what is to be expected of the audited body in certain areas. The 'Terms of Appointment and further guidance (updated October 2025)' issued by the PSAA (<https://www.psaa.co.uk/managing-audit-quality/terms-of-appointment/terms-of-appointment-and-further-guidance-1-july-2021/>) sets out additional requirements that auditors must comply with, over and above those set out in the National Audit Office Code of Audit Practice 2024 (the NAO Code) and in legislation, and covers matters of practice and procedure which are of a recurring nature.

This report is made solely to the PCC, CC, Joint Independent Audit Committee and management of Norfolk Police. Our work has been undertaken so that we might state to the PCC, CC, Joint Independent Audit Committee and management of Norfolk Police those matters we are required to state to them in this report and for no other purpose. To the fullest extent permitted by law we do not accept or assume responsibility to anyone other than the PCC, CC, Joint Independent Audit Committee and management of Norfolk Police for this report or for the opinions we have formed. It should not be provided to any third-party without our prior written consent.

Management agree that they remain solely responsible for management decisions relating to the audited body and that we do not, and cannot, act in a managerial capacity nor can we make business decisions for management/the audited body in connection with the services or otherwise, nor advise or recommend that any accounting policy, treatment or reporting is suitable for any particular purpose or specific facts, and management agrees that they will not rely on us as having done so.

If you wish to discuss how our service to you could be improved, or if you are dissatisfied with the service you are receiving, you may raise the matter with the Key Audit Partner responsible for services provided under our appointment by PSAA Ltd. Alternatively, you may contact Stephen Reid, UK Head of Government and Public Sector Audit, at 1 More London Place, London SE1 2AF. We will consider any concerns carefully and promptly and will make every effort to explain our position clearly. If your concerns remain unresolved, you may escalate the matter to Anna Anthony, UK&I Regional Managing Partner, at 1 More London Place, London SE1 2AF. If you remain dissatisfied, you may refer the matter to PSAA Ltd or raise it with our professional institute; further details are available on request.

Rebuilding audit assurance – risk assessment update

1. Background and regulatory context

Appendix A explains the expected timeline to full assurance set out in the National Audit Office's (NAO) Local Authority Reset and Recovery Implementation Guidance (LARRIG 01), together with our assessment of the Police and Crime Commissioner for Norfolk and Chief Constable of Norfolk Constabulary's (the PCC and CC's) current position. During 2023/24 and 2024/25, the focus of the rebuild process has been on the PCC and CC's "natural" rebuild, through completing planned audit procedures for each respective audit year.

As set out in Appendix A, as all planned audit procedures for the 2023/24 and 2024/25 audits were completed, the PCC and CC's "natural" rebuild is now well progressed.

LARRIG 06, issued by the NAO, requires auditors to perform specific risk assessment procedures over reserves. The guidance recognises that reserves balances may contain the cumulative effect of unaudited transactions over more than one financial year and may therefore represent an area of accumulated audit risk. The purpose of this risk assessment is to identify the likelihood and potential magnitude of risks of material misstatement within reserves balances, together with management's readiness to support the historical rebuild process. This assessment informs audit planning, and any potential rebuild of assurance over future audit cycles as well as completion of the capacity and risk assessment return that we are required to make to the Ministry for Housing, Communities and Local Government ('MHCLG').

2. Scope of our risk assessment procedures

Our risk assessment covered all reserves disclosed in the PCC and CC's Movement in Reserves Statement, including both usable and unusable reserves. In performing the assessment, we considered:

- the nature and purpose of individual reserves;
- the scale and significance of movements during periods subject to disclaimer;
- susceptibility to material misstatement, including the risks of fraud and management bias;
- the wider governance and control environment of the PCC and CC's financial reporting processes; and
- risks associated with the classification of reserves between usable and unusable categories.

The assessment did not seek to re-establish assurance over historic balances. Its objective was to determine whether, where and when, such assurance could be rebuilt over time.

Rebuilding audit assurance – risk assessment update (continued)

3. Summary of risk assessment findings

The risk assessment process identified that the risk of material misstatement is not uniform across reserves. Certain reserves were assessed as presenting a higher risk of material misstatement, reflecting factors including:

- the size of balances and the extent of movements during periods subject to disclaimed opinions;
- the degree of judgement required in determining the appropriate accounting treatment; and
- reliance on complex statutory and capital accounting arrangements.

Other reserves were assessed as lower risk, with characteristics that may support a more targeted and proportionate rebuilding of assurance, without undermining audit quality, subject to the availability of sufficient appropriate audit evidence. This assessment underpins the differentiation in audit response which will be adopted across reserves and is intended to promote a consistent and proportionate approach.

The following dashboard summarises our assessment of the risk of material misstatement by reserve following the disclaimers of opinion.

Useable Reserves	Risk Assessment	Rationale for Risk Assessment
General Fund Balance	Higher Inherent Risk	This represents the cumulative impact of revenue and expenditure decisions. Whilst audit procedures in subsequent years have addressed movements in the General Fund, the closing balance at 31 March 2023 was not audited due to the disclaimer of opinion, and assurance has therefore not been obtained over the underlying brought-forward balance. As a result, there remains an increased risk that any misstatements arising in the disclaimed period were not fully identified or corrected through movement-only testing in 2023/24 and 2024/25 and may persist within the opening balance for the current audit year. In addition, the General Fund is sensitive to statutory adjustments and is a key indicator of financial resilience, increasing its susceptibility to misstatement and management bias. Whilst the movements in year are not material, we note that there is a risk of misstatement in classification between this and other reserves and therefore, we identify a completeness risk in relation to this reserve.
Earmarked Reserves	Higher Inherent Risk	Earmarked reserves are material and comprise amounts set aside for specific purposes with clearly defined approvals and documented movements. In the year following the disclaimed period of 2022/23, audit procedures planned to focus on testing movements into and out of earmarked reserves, with balances subject to clear purpose specific governance and limited judgement in their accounting treatment. Due to their materiality, and the gap in assurance over material movements in 2022/23, earmarked reserves are assessed as higher inherent risk.

Rebuilding audit assurance – risk assessment update (continued)

3. Summary of risk assessment findings (continued)

Unusable Reserves	Risk Assessment	Rationale for Risk Assessment
Revaluation Reserve	Higher Inherent Risk	The Revaluation Reserve is material and arises from periodic valuation, impairment and disposal of property, plant and equipment, which are inherently judgemental. Accordingly, there remains an increased risk that any valuation-related misstatements arising in the disclaimed period were not fully identified or corrected through movement-only testing and may persist within the opening balance of the reserve for the current audit year.
Capital Adjustment Account	Higher Inherent Risk	The Capital Adjustment Account is material and highly complex, comprising cumulative capital-related accounting and statutory adjustments arising from asset valuations, depreciation, impairments, disposals and financing transactions over multiple years. The closing balance as at 31 March 2023 was not audited due to the disclaimer of opinion, and audit procedures in subsequent periods were limited to testing movements rather than rebuilding assurance over the brought-forward balance. As a result, there remains an increased risk that any errors or misstatements arising in the disclaimed period have not been fully identified or corrected and may persist within the opening balance for the current audit year. Misstatement of this account could affect the accuracy of the General Fund balance, the Capital Receipts Reserve, the Revaluation Reserve and the Movement in Reserves Statement. Given the disclaimed years and the complexity of statutory capital adjustments, this heightens the risk associated with this reserve.

Any other reserves are considered to be very low risk. This is either on the basis of immaterial balances or transactions through those reserves, or that the nature of the reserves are such that they mirror the balances on the top half of the balance sheet and, therefore, no additional rebuild procedures are required.

Rebuilding audit assurance – risk assessment update (continued)

4. Implications for the 2025/26 audit

Our risk assessment process has found that the pre-2023/24 gaps in assurance - particularly those relating to reserves and other cumulative balances - can be sufficiently addressed as part of the 2025/26 audit, supporting future progression towards an unmodified audit opinion.

Before we commence our audit procedures, it will be essential for management to have completed a robust review and reconciliation of both usable and unusable reserves in the disclaimed periods, and to provide assurance to Those Charged with Governance that these balances are accurate, supportable, and appropriately documented. This reflects management's primary responsibility for preparing the financial statements and maintaining the underlying evidence base.

To rebuild assurance over the historic position, we will need to audit certain transactions and movements from 2022/23 (and earlier years, where applicable). We will share details of these transactions with management and will require confirmation that high-quality working papers and supporting evidence can be provided, together with sufficient management capacity to support this historic rebuild without compromising the delivery of planned audit procedures for 2025/26 over closing balances and in-year movements. We will then take the decision, with management, when is most appropriate time to commence the rebuild of reserves.

5. Fees

The activities undertaken in relation to this risk assessment, the preparation of the submission required by MHCLG, and the drafting of this addendum are outside the scope of the scale fee set out in our Audit Plan issued on 27 April 2026. In addition, procedures relating to the rebuilding of historical assurance will also be outside the scale fee.

Accordingly, we will seek a variation to the scale fee to reflect these changes to the scope of our work and will communicate further through our reporting once the costs are agreed.



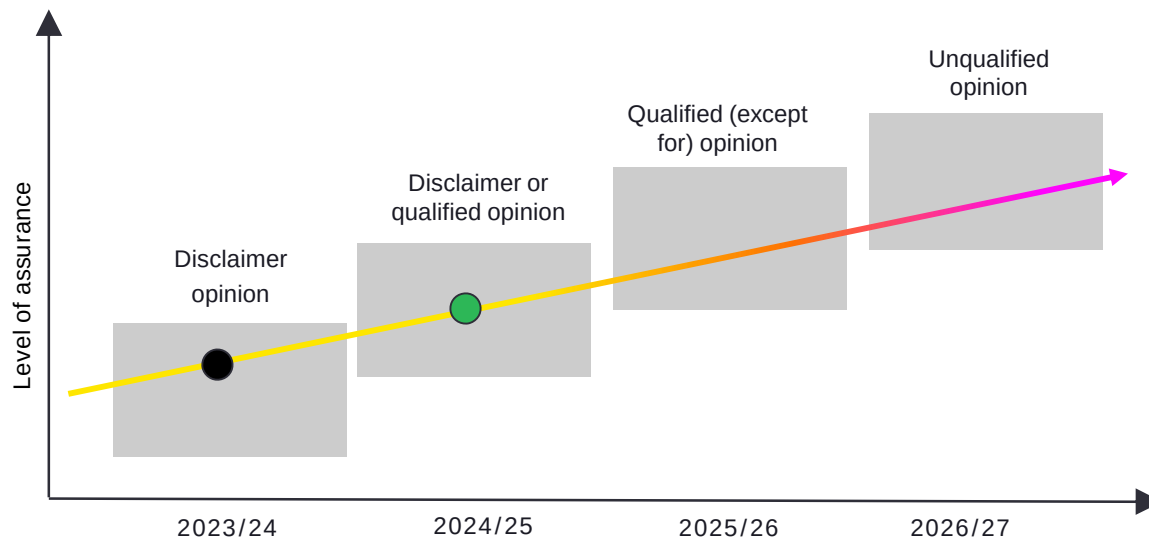
Appendix A

Appendix A – Rebuilding audit assurance

Progress to full assurance

The chart below illustrates the expected timescale for rebuilding audit assurance as set out in the NAO's LARRIG 01. It also shows our assessment of the PCC and CC's progress against that illustrative timescale, together with the reasons for that assessment and the key actions required to successfully rebuild assurance.

The guidance recognises that the journey to full assurance - and therefore an unqualified audit opinion - will typically take a number of years. Progress depends on sustained coordination and engagement between the Council and the audit team across successive audit cycles. Since 2022/23, we have applied a structured, risk-based prioritisation approach to local government audits. This approach is designed to support a return to unqualified audit opinions wherever feasible, while continuing to meet the statutory backstop requirements introduced as part of the local audit reset.



Norfolk PCC and CC progress

- A qualified audit opinion was issued for 2024/25 which drew attention to remaining gaps in assurance over Property, Plant and Equipment and Reserve Balances.
- In 2023/24 a disclaimer of opinion was issued due to the application of the backstop.

In our view, the PCC and CC's progress is in line with the expected timescales set out in LARRIG 01. The focus of the rebuild work for the PCC and CC is now on the valuation of property, plant and equipment and reserves.

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Norfolk Police Crime Commissioner

Assurance Review of Limited Duties

July 2026

Final

Executive Summary

OVERALL ASSESSMENT



LIMITED ASSURANCE

ACTION POINTS

HIGH RISK	MEDIUM RISK	LOW RISK	OPERATIONAL
2	6	6	0

KEY STRATEGIC FINDINGS

C	There has been a lack of grip due to lack of governance administration and lack of confidence and knowledge of the whole process by the line managers. A recommendation has been raised to address this. Documented procedures need to be produced and made available so that all staff involved in the process are aware and clear of their responsibilities.
C	There are some officers on Limited Duties which are not recorded on the Resources Management Unit (RMU) Duty Management System (DMS). The RMU teams do the day-to-day operational deployment and use DMS. There are separate RMUs in each force, but in the Suffolk RMU, they only log the CPC (County Policing Command) onto the DMS. They do not log the joint roles. Both constabularies need to know their current total deployable resource, particularly in an emergency.
RM	A risk needs to be developed with appropriate controls to mitigate non-compliance issues in relation to limited duties. The current Limited Duties Policy is silent on the matter of pay implications following the annual review meeting. This is not compliant with regulations. This has not been included on the People Directorate Risk Register.
C	Implementation of Quality Assurance processes to monitor policy compliance will support implementation and embedding of the revised Limited Duties policy.
GF	The Limited Duties processes are under review to ensure compliance with the Police Regulations 2003 (as amended in 2015) and to ensure improved grip across the Constabularies. The Limited Duties policy will be reviewed and revised as part of the review.
GF	Once the changes to the Limited Duties process and policies have been implemented and are starting to embed, it is proposed that Internal Audit undertake a walkthrough test with supporting sample testing to check the governance is robust.
PM	The Data Pack to the People Board requires enhances. Data presented to the People Board does not include the number of overdue reviews for recuperative or adjusted duties, nor does it include those still on recuperative duties for over one year. Without such information it limits the People Board ability to understand actual position and challenge where agreed processes are not being followed.
C	There are currently about 500 officers in total on Limited Duties (300 in Norfolk and 200 in Suffolk). The Performance Improvement Unit (PIU) has been created and funded by Norfolk mid 2025 because recuperative limited duty cases had doubled and improved management oversight was required. The PIU is tasked with providing greater oversight of limited duties, which in turn should lead to reduction in the number of officers on limited duties.
C	Proactive action is being taken to address and reduce the number of officers on limited duties. This includes a Power App being developed this will help guide individuals through the process. Currently, monitoring those on LD Policy is a central monitoring spreadsheet which is maintained by the HR Advisors. This is being changed to a Power App which will allow increased automation of processes.
C	With the new Power App, non-delivery of actions by the allocated line manager will automatically escalate to the next level of command, but it is not clear what action will be taken if non-delivery continues. The process for the consequences of not taking action/complying with the policy needs to be set and embedded.
	Once agreed escalation route is in place, breaches of non-compliance to be monitored and reported as part of the performance information presented to the People Board.

SCOPE	ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE
The review assessed the controls in place to ensure limited duties is appropriately managed. The audit reviewed the following key areas: • Adequacy of policies and procedures and compliance against agreed policies for limited duties. • Appropriateness of process to ensure accurate record keeping. • Appropriateness of process to ensure effective monitoring/follow-up action by HR and/or line managers. • Effectiveness of management by line managers for individuals on limited duties. • Monitoring continuation of limited duties.	Norfolk SRR6: People and Resources and the risk of failure to attract, retain, lead, train and support the workforce results in inability to resource the delivery model leading to a poor level of service to the public. Suffolk SRR1: People and the risk of failure to attract and develop well, to ensure our people are Healthy, Fit and Supported, and Innovate and Improve.

Assurance - Key Findings and Management Action Plan (MAP)

Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Compliance	There has been a lack of grip due to lack of governance administration and lack of confidence and knowledge of the whole process by the line managers. There is a need to ensure that the policy is comprehensive, the changes and key steps are understood, and all are clear on their responsibilities and what the escalation mechanisms are. Communication of the changes and key actions required is planned.	The key steps to be followed under the limited duties policy and manager responsibilities to be documented to ensure that they are clear and understood by all officers. An awareness campaign to be undertaken to ensure all are aware of their role in the process.	1	<i>The policy is currently going through a redrafting and ratification to enhance clear governance, processes and accountability for decision making.</i> <i>The Limited Duties app has been launched and an awareness campaign and briefings have happened.</i>	<i>January 2027</i> <i>July 2026</i>	<i>Tom Piggott</i> <i>HRM PIU</i>
2	Compliance	The Workforce Planning team do the overarching planning and use EBS, the Resources Management Unit (RMU) team do the day-to-day operational deployment and use DMS. Each force has their own RMU. The RMUs get all the Limited Duties information but Suffolk only log the CPC (County Policing Command) onto the DMS. They do not log the joint roles. Both constabularies need to know their current total deployable resource, particularly in an emergency. As a result of this discussion the HR Manager has raised this again and escalated through the Head of the Performance Improvement Unit. The team are also checking what this situation is in Norfolk.	The gap in recording of those on Limited Duties on the Resourcing Management Unit's DMS system to be established and resolved for both constabularies.	1	<i>Launched the Limited Duties Power App. Exploring how we can utilise this function to inform RMUs, in both forces, regarding the deployability of officers on Limited Duties.</i>	<i>January 2027</i>	<i>Tom Piggott</i> <i>HRM PIU</i>

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.
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3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
3	Risk Mitigation	The Limited Duties processes and policy are under review as there are identified gaps. The current policy states that they are not intending to make any pay deductions as a result of being on adjusted duties. This is not compliant with regulations. This is not included on the People Directorate Risk Register.	The lack of current compliance with the Regulations, and the recognised need for an improved Limited Duties process to be included as a risk on the People Directorate Risk Register. Appropriate mitigating controls to be developed and risk to be assigned to appropriate individual.	2	<i>The new Limited Duties policy is being redrafted with this stipulation (pay deductions / xfactor) in place with a clear guide to Senior and Chief Officers as to the determinants that shape such decisions, and that such decision should follow an NDM process and rational.</i>	January 2027	Tom Piggott HRM PIU
4	Governance Framework	The Regulations were changed in 2015 to allow the Chief Officer discretion to pay deductions for officers on adjusted duties. The current Policy is silent on the matter of pay implications following the annual review meeting. The previous policy states that it was not intending to make any pay deductions but that this would be reviewed in line with the national position. The Guidance to support changes to the management of police officers on limited duties states that If, after a period of time on adjusted duties, during which enabling adjustments must have been fully explored, an officer is unable to return to full duties and the range of duties they are able to undertake is such that it has an impact on the operational resilience of the force, they may be retained at a reduced rate of pay that reflects this. There is no reference to this in the current policy nor in the proposed changes. The Head of Performance Improvement Unit has proposed changes to the policy which include a section on 'X Factor Payments' stating that this will be considered at the 12-month Limited Duties review meeting. The inclusion of this is supported by Internal Audit to ensure compliance with the Regulations	The Limited Duties Policy to be revised to include the following for those on adjusted duties - the proposed wording on consideration of reduction of the deployable element of their pay; - the calculation for this (8% of the pay to which the officer is entitled in their rank; - and the need to give notice at nine months of the pay review.	2	As above.	January 2027	Tom Piggott HRM PIU

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
5	Performance Monitoring	The October 2025 data pack to the People Board was reviewed. It was identified that it does not include the number of overdue reviews for recuperative or adjusted duties, nor does it include those still on recuperative duties for over one year.	The sickness and limited duties dashboard to include the number of overdue reviews for recuperative and adjusted duties, and the number of officers still on recuperative duties for over a year.	2	<i>This is now shown on the Limited Duties tracker.</i> <i>These are reported, by HRAs, monthly to the command teams across Norfolk via the SLTs.</i> <i>The new Limited Duties app also prompts line managers as to when they should be actioning reviews for both recuperative and adjusted duties.</i>	July 2026	Tom Piggott HRM PIU
6	Compliance	A new Power App is being developed this will help guide individuals through the process. With the new Power App, non-delivery of actions by the allocated line manager will automatically escalate to the next level of command. It is not clear what action will be taken if non-delivery continues. The process for the consequences of not taking action/complying with the policy needs to be agreed and embedded.	The automatic escalation process to next level management in the new Power App is reinforced by a clear reporting and escalation process. Reporting of continuing breaches of the policy steps to be included in the dashboard to the People Board.	2	<i>This is now in place via the Limited Duties app; escalation goes from first line manager to second and then third.</i> <i>Breaches will be reported to the people board and are reported at local command level via the monthly SLT meetings with the HRAs.</i>	July 2026	Tom Piggott HRM PIU
7	Compliance	There are no current Quality Assurance processes undertaken. It is likely that a Quality Assurance process could be written into the new Power App and undertaken annually.	A Quality Assurance process is established to audit compliance with the Limited Duties (LD) Policy, ideally automated via the new Power App. A annual dip sample of completion of records is undertaken to evidence policy compliance. This requirement is included towards the end of the LD policy as a separate section.	2	<i>The quality assurance process does form part of the Limited Duties app. Notably, it is not possible to submit the form until all relevant information is complete.</i> <i>Dip sampling will also occur on an annual basis.</i>	July 2026	Tom Piggott HRM PIU

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
8	Compliance	The Limited Duties Policy does not include any reference to the option of retirement due to ill health or a permanent reduction in working hours.	The Limited Duties Policy on review of Adjusted Duties (sections 5.6 and 5.13) is amended to include consideration of a permanent reduction in working hours or retirement due to ill health.	2	<i>This is currently being worked into the new Limited Duties policy.</i>	<i>January 2027</i>	<i>Tom Piggott HRM PIU</i>
9	Risk Mitigation	Neither the Norfolk nor the Suffolk Forces' Strategic Risk Register, People Risk, include the Limited Duties Policy and management as a mitigation/control for managing an unsupportive culture or for managing poor mental health.	The Forces reference the Limited Duties Policy as one of their controls/mitigations in managing the People Risk.	3	<i>It has been requested that the Limited Duties Policy is included as a control in the strategic risk registers via the standard quarterly review process, which is currently under way for both forces. Inclusion is subject to final sign off by chief officers.</i>	<i>July 2026</i>	<i>Tom Piggott HRM PIU</i>
10	Governance Framework	The Policy does not state that it aims to prevent officers from entering a regime of Limited Duties nor provide a summary of what is in place to do this.	The Policy is amended to Include, at a minimum, a statement that the forces aim to prevent officers from entering a regime of Limited Duties and refers to those support arrangements already listed in 'other related documents.'	3	<i>This is currently in the new policy which is going through the review process. This includes a 6 week and 12 week review process to underpin a supportive return to work framework.</i>	<i>January 2027</i>	<i>Tom Piggott HRM PIU</i>
11	Performance Monitoring	The People Board oversees HR and workforce performance including limited duties. This is not referenced in the Limited Duties policy.	The Limited Duties policy references the role of the People Board in overseeing limited duties performance.	3	<i>This is currently in the new policy which is going through the review process.</i>	<i>January 2027</i>	<i>Tom Piggott HRM PIU</i>

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
12	Compliance	The Limited Duties Policy states that 'short term recuperative duties (usually less than one month) can be locally agreed'. Although an indication is provided, it is not specific about what short term means.	The Constabularies consider whether it would be helpful to provide a specific time period for short term recuperative duties, and the requirement for referrals to Workplace Health relating to periods of recuperation longer than short term.	3	<i>This has been worked into the new Limited Duties policy currently going through ratification process.</i>	January 2027	Tom Piggott HRM PIU
13	Compliance	The Deployment Policy states that the Constabularies have an authorised police establishment in terms of numbers, ranks and specialisms. No permanent change in the total establishment can be made without reference to the formal procedures in relation to this. There is no reference to the moving of other officers (bumping) to accommodate those on Adjusted Duties in exceptional circumstances to meet forces' deployment requirements.	The constabularies consider whether it would be helpful to reference the option of moving an officer into another role (bumping) in exceptional circumstances in order to accommodate an officer on Adjusted Duties within the Deployment Policy.	3	<i>This has been worked into the new Limited Duties policy currently going through ratification process.</i>	January 2027	Tom Piggott HRM PIU
14	Compliance	The Limited Duties Policy provides the key steps in allocation of adjusted duty officers to roles. All postings must comply with the Deployment Policy. In Section 2 of the Deployment Policy ('Deployments covered under this policy') there is no reference to deployments for those being managed under the Limited Duties policy.	Specific reference to those on Limited Duties to be included in Section 2 of the Deployments Policy (Deployments covered under this policy).	3	<i>This will be ratified as part of the Limited Duties policy review process.</i>	January 2027	Tom Piggott HRM PIU

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.
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3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Operational - Effectiveness Matter (OEM) Action Plan

Ref	Root Cause Indicator	Finding	Suggested Action	Management Comments
There were no Operational Effectiveness Matters raised.				

ADVISORY NOTE

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

Findings

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	3 & 9	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Not in place	1, 2, 6, 7, 8, 12, 13 & 14	-
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	4 & 10	-
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	5 & 11	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	Out of scope	-	-

Other Information



The individual can cease Limited Duties (LD) at the end of the recuperative Limited Duties (LD) stage or after time on Adjusted Duties (AD).

At the end of the recuperative LD stage there is a LD meeting whereby the HR Manager considers all the information and decides on next steps.

There is an annual review for each officer on AD. The outcome options are return to full duties, remains on AD with existing adjustments, remains on AD with reduced or increased adjustments. If the existing adjustments are no longer considered possible then the case will be referred to the Limited Duties Meeting, at which point consideration will be given to the appropriate alternative posting.

There are a number of outcomes from the review meeting which include staying on AD for another term, moving to permanently adjusted duties because they cannot recuperate from their injuries, retiring on ill health or consideration of use of the performance management processes.

Other Information



The officer is performance managed by the line manager. Where restrictions cannot be accommodated in the current post, the line manager will complete a form which must be signed by the Head of Department. It is passed to the HR Advisors who will seek alternative employment by looking at vacancy lists and having discussions with Head of Commands. Any move to Adjusted Duties will be agreed by the two Commands, approved at the current Limited Duties Workforce Planning Meeting and the move then happens. Effectiveness of the role undertaken by the officer is reviewed as part of the regular Limited Duty reviews.



The LD Policy includes a section on the recuperative duty procedure. This is managed by the line manager, supported by the HR Advisor where required. The LD Officer Record is used to record actions and decisions made throughout the LD process. The LD Notification Form is used to record any restrictions that the officer requires for planning of duties and resourcing. If the officer cannot stay in their substantive post after line manager support, the line manager (or HA Advisor) will refer the officer to Workplace Health to seek advice on how best to support the officer; this requires a health assessment.

There is a process flowchart which shows the key steps from identification of the need, regular reviews, through to the end of recuperative duties.

The LD Policy includes a section on the adjusted duties procedure which is led by the HR Advisor with input as appropriate from the line manager.



The main system for monitoring those on LD Policy is a central monitoring spreadsheet which is maintained by the HR Advisors. This is being changed to a Power App which will allow increased automation of processes. The policy and flowcharts will be reviewed and updated as necessary.

HR meet with all commands at monthly SMT meetings. Using the current monitoring spreadsheet, they work through all the live LD cases to ensure that they are on track. It is management's responsibility to ensure that the spreadsheet is accurate and up to date. HR do not mark anything complete until evidence of completion, i.e. the paperwork is received.

Once the Power App is up and running, it will send reminders to management and flags to senior management. It will store all the information in one place.

Key improvements include the app will;

- allow tracking of departmental performance and will identify trends, hotspots and any specific managers who require further support.
- send a chaser two weeks, and a week before review due dates. It will then send 2 follow ups post due date, and if not completed, will escalate up the management chain.
- Intend to align escalation and reporting right up to the People Board.
- Are building in financial implications – cost/benefit analysis of action or non-action.

Testing of the Power App is complete, they are migrating information and awaiting a confirmed go live date.



The LD policy is supported by the LD Recuperative and Adjusted Process flowchart and the LD HR Process flowchart.



There are currently about 500 officers in total on Limited Duties (300 in Norfolk; 200 in Suffolk).

The Performance Improvement Unit (PIU) was created and funded by Norfolk mid 2025 because recuperative limited duty cases had doubled and improved management oversight was required. The PIU was formed to look into performance and absence management of those on Limited Duties. Work is ongoing and officers are now involved in PIU as well as having organisational buy in which is positive. The new processes are implemented in Norfolk and work is underway to embed these. A review of the Limited Duties Policy has been undertaken and amendments identified which are not yet implemented. While Norfolk is funding the PIU, Suffolk will benefit from learning, and from the recommendations from this review.

Scope and Limitations of the Review

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

Disclaimer

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

Assignment Engagement Details

3.

TIAA Auditors	Title	Contact Email
Nicola Cocks	Principal Auditor	Nicola.cocks@tiaa.co.uk
Claire Lavery	Director of Audit	Claire.lavery@tiaa.co.uk

Effectiveness of arrangements

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

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

Assurance Assessment

5. The definitions of the assurance assessments are:

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

Acknowledgement

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

Release of Report

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

Stage	Issued	Response Received
Audit Planning Memorandum:	2 nd March 2026	9 th March 2026
Draft Report:	1 st May 2026	23 rd July 2026
Final Report:	24 th July 2026	



Chief Constables of Norfolk and Suffolk Constabularies

Assurance Review of Police Investigating Centres (PICs)

July 2026

Final

Executive Summary

OVERALL ASSESSMENT			SUBSTANTIAL ASSURANCE	ACTION POINTS	HIGH RISK	MEDIUM RISK	LOW RISK	OPERATIONAL
					0	0	0	0
KEY STRATEGIC FINDINGS								
C	Security arrangements are in place to prevent unauthorised access to the Police Investigation Centres (PICs).							
C	Unannounced visits were made to the PICs in all cases the correct processes were followed by individuals working at the PICs and access was not obtained.							
RM	The Norfolk and Suffolk County Police Command (CPC) issue logs identifies that there are a number of newly qualified sergeants which may be a concern as officers are likely to be less experienced. A number of controls have been put in place to help mitigate the issue identified.							
PM	An audit and inspection regime has been implemented to ensure appropriate processes are being followed within the police investigation centres (PICs). Investigation Custody Visitors (ICVs) are volunteers whose role is to attend Norfolk and Suffolk PICs on behalf of the Norfolk and Suffolk Police and Crime Commissioners (PCCs).							
SCOPE				ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE				
The review considered controls in place to ensure that Police Investigating Centres are operating effectively. The review also included site visits to the PICs to ensure that policies and procedures are being complied with.				Norfolk - Failure to adhere to regulatory frameworks and statutory requirements leads to non-compliance which results in fines, inefficiencies, poor service provision and low trust and confidence amongst our people, partners and communities. Suffolk - Failure to Keep People Safe, Protect People from Serious Harm, Prevent Crime in Partnership.				

Assurance - Key Findings and Management Action Plan (MAP)

Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
No recommendations have been raised.							

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.
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3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Operational - Effectiveness Matter (OEM) Action Plan

Ref	Root Cause Indicator	Finding	Suggested Action	Management Comments
No operational effectiveness matters have been identified.				

ADVISORY NOTE

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

Findings

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	-	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	-
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Information



In accordance with the College of Policing (CoP) licence, all police officers are required to complete Public Personal Safety Training (PPST) and First Aid (FA) Training on an annual basis.

Officers are required to successfully complete an annual refresher session of six hours per year, this is delivered via a one day course. Officers who fail to attend the full six hours will be deemed not competent. These officers will then be required to reattend a further training session. All officers will need to demonstrate competency to a safe, effective, and lawful standard. Those officers who do not attend refresher training for a period of three or more years will potentially need to attend an initial officer course in order to regain ability to deploy.

Compliance rates are recorded on Chronicle. Compliance is only confirmed where individuals have successfully reached the required standard of Safe, Effective and Lawful in all components of the PPST programme.

Other Information



Both constabularies have specific role profiles for the following roles:

- custody officer
- detention officer
- detention assistant
- escort officer

Each PIC has a designated custody sergeant on duty at all times



Norfolk and Suffolk Constabularies have a designated PPST team, this mirrors the national review process locally and where necessary implement changes. The syllabus for delivery is based upon a learner centred approach meaning that each officer or staff member receives the training that they require rather than revisiting skills that they are already competent in, which is in line with College of Policing APP.



All officers that work within custody are required to complete personal safety training. There is a current Public and Personal Safety Training Policy, this is current and has an appropriate responsible officer assigned to keep updated and compliant with necessary legislation. All custody officers are trained in public and personal safety training, in addition to initial training refresher training is also provided to custody officers and staff as appropriate to undertake their role.



A current custody policy is in place, this provides guidance to officers and appropriate staff on the correct process that should be followed. The policy is accessible to officers and police staff via the intranet. The responsible officer for the policy is the Chief Inspector, Specialist Operations Command. The policy covers required areas and has been drawn up in line with Authorised Professional Practice.



An audit and inspection regime has been implemented to ensure appropriate processes are being followed within the police investigation centres (PICs). Investigation Custody Visitors (ICVs) are volunteers whose role is to attend Norfolk and Suffolk PICs on behalf of the Norfolk and Suffolk Police and Crime Commissioners (PCCs). ICVs check on the welfare of detained persons and their conditions of detention. They will check that they have been provided with their rights and entitlements and are being treated with dignity and respect.



ICVs complete a report of their findings on the Custody Visit Report Form. One copy is scanned to the relevant Scheme Manager whilst a copy is retained at the PIC for local use.



Senior custody officers attend ICV Panel meetings which are held three times a year. Updates following ICV visit and any local custody issues are discussed in these meetings. Meeting details will be provided by Scheme Managers and in the event the Inspector cannot attend, a written update will be provided.

Scope and Limitations of the Review

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

Disclaimer

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

Assignment Engagement Details

- 3.

TIAA Auditors	Title	Contact Email
Claire Lavery	Director of Audit	Claire.lavery@tiaa.co.uk

Effectiveness of arrangements

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

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

Assurance Assessment

5. The definitions of the assurance assessments are:

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

Acknowledgement

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

Release of Report

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

Stage	Issued	Response Received
Audit Planning Memorandum:	9 th March 2026	9 th March 2026
Draft Report:	1 st July 2026	21 st July 2026
Final Report:	24 th July 2026	



Chief Constables of Norfolk and Suffolk Constabularies

Assurance Review of Data Quality

July 2026

Final

Executive Summary

OVERALL ASSESSMENT



REASONABLE ASSURANCE

ACTION POINTS

HIGH RISK	MEDIUM RISK	LOW RISK	OPERATIONAL
0	4	0	2

KEY STRATEGIC FINDINGS

C	The Records and Data Quality Department has overall oversight for data quality within Norfolk and Suffolk Constabularies. The team is overseen by the Senior Records and Data Quality Manager.
GF	There is a joint current data quality policy in place, this is accessible to both Norfolk and Suffolk Constabularies. The joint data quality policy is accessible to both police officers and police staff, this is accessible to staff via the intranet.
C	Data breaches have occurred, there is a need for further training to be provided to help reduce the risk of data breaches going forward.
C	The use of encrypted emails to be explored as they help reduce the risk of data being accessed by unauthorised or unintended recipient.
C	An AI policy is not currently in place; there is a need to develop an AI policy so that AI is used consistently across both Norfolk and Suffolk Constabularies.
GF	AI is not being used widely across Norfolk and Suffolk Constabularies', there may be areas where AI could be used. A review needs to be undertaken to establish if AI could be used more widely.
PM	A complete information asset register is not in place. A complete information asset register helps organisations understand what information they hold, where it is stored, and the risks associated with holding the information.
PM	Appropriate information assets owners to be assigned for each asset and these need to be trained appropriately to ensure they can undertake their role effectively.

SCOPE	ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE
The review considered controls in place to ensure the accuracy of data across both Norfolk and Suffolk Constabularies. It focused on the frameworks in place to ensure that there is an effective environment in place to ensure that data is held securely.	"Failure to effectively input, manage and protect our data results in a significant data event, e.g. breach or operational failure, leading to a loss in public confidence, inefficiencies and additional demand, regulatory failure, financial loss and negative publicity."

Assurance - Key Findings and Management Action Plan (MAP)

Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Compliance	Data breaches have occurred further training needs to be provided to reduce the risk and the use of encrypted emails to be explored to reduce the impact of a data breach.	Further training and the use of encrypted emails to be explored to reduce the risk of data breaches.	2	Agreed, further training will be provided reminders have been issued and encrypted emails will be considered.	31/12/26	Head of Information Management
2	Governance Framework	An AI Policy is in the process of being developed. There is a need to have an effective AI Policy in place, to ensure that AI is used appropriately and consistently.	AI policy to be developed and made available so that AI is used consistently.	2	Agreed	31/12/26	Head of Information Management
3	Performance Monitoring	A fully complete and updated information asset register is not currently in place. A complete information asset register assists with management of information assets is needed, as it supports compliance with legal and regulatory requirements, including data protection laws, and is essential for safeguarding both personal and non-personal information. By knowing what information is held, where it is stored, and who can access it, organisations can better mitigate risks such as data loss or breaches	A complete information asset register to be developed, this needs to cover the following; - Information Asset Owner (IAO) responsible for the asset - Retention periods for each asset - Access and permission - Sensitivity and risk	2	Agreed	30/11/26	Head of Information Management

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
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2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.
---	--------------------	--

3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
4	Performance Monitoring	There is a need to appoint appropriate information asset owners who are accountable for the security, quality, and distribution of information assets. They ensure compliance with legal, regulatory, and policy requirements.	Appropriate information asset owners to be identified and information asset owners to receive training to enable them to fulfil their role.	2	Agreed	30/11/26	Head of Information Management

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.
---	-----------	---

2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.
---	-------------	--

3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Operational - Effectiveness Matter (OEM) Action Plan

Ref	Root Cause Indicator	Finding	Suggested Action	Management Comments
1	Compliance	Systems used by both constabularies include national systems such as PNC which are used by all Constabularies' and Athena which is used by seven force members, as a result Norfolk and Suffolk Constabularies do not get much say in data quality verification fields, as prevention is better than corrective action. Athena has a number of data quality issues, but the size of the joint in-house data quality team means that they are not able to clear all potential incorrect information. There would be benefit in consulting information management team at the earliest opportunity when procuring new systems so that data quality verification checks can be inbuilt.	Consult information management team at earliest opportunity when procuring new systems so that data quality verification checks can be inbuilt where appropriate and where possible.	<i>Agreed</i>
2	Governance Framework	AI may pose a number of potential benefits to both constabularies'; there is a need to establish where AI can make real benefits.	The constabularies to establish where AI can be used and ensure that plans are made so that benefits from AI can be realised.	<i>Agreed</i>

ADVISORY NOTE

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

Findings

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	-	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1	1
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	2	2
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	3 & 4	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Information



Data Quality is identified as a key risk on both the Norfolk and Suffolk strategic risk registers. Controls have been identified to mitigate the risks, and appropriate owners have been assigned for each risk.



There is a current Joint Data Quality Policy, this was last reviewed in December 2024 and is scheduled for review in December 2026. The Joint Data Quality Policy has been assigned to the Information Management Department to maintain.

The Joint Data Quality Policy sets out the responsibilities to staff and officers with regards to data quality. These responsibilities cover complying with data quality standards, searching existing records to avoid inputting duplicate data, ensuring all data is as factual and complete as possible, to avoid personal opinions when inputting data and to only use professional language.

Other Information



Overall responsibility for data quality has been assigned, the Deputy Chief Constables for each constabularies' are assigned by the Chief Constables of each force to be both the Senior Information Risk Officer (SIRO). The SIRO is responsible for ensuring all risks relating to information are appropriately managed.

The Records and Data Quality Department has oversight of day-to-day data quality issues, as well as policy and procedure. This function is managed by the Senior Records and Data Quality Manager.



The Records and Data Quality Department has overall oversight for data quality within Norfolk and Suffolk Constabularies. The team is overseen by the Senior Records and Data Quality Manager.

To help ensure data quality is embedded across the constabularies' the following teams have been established;

- Dedicated Athena Data Quality team has been established. This team reports to the Records Management Department who are responsible for the Review, Retention and Disposal (RRD) function.

- A dedicated MoPI team has been established to identify and help resolve data quality issues in key business systems for legacy data. Initially the team is focusing on profiling the quality of nominal data in all Suffolk and Norfolk legacy systems including: CIS, CRCIS, NSPIS Custody, CATS and NFLMS with the specific aim of reducing duplicate person records and correcting nominal data where possible.



All Norfolk and Suffolk police officers and Norfolk and Suffolk police staff have a responsibility to comply with the Data Quality Policy. All Norfolk and Suffolk Constabularies have a duty to ensure they are aware of, and apply, the data quality standards relevant to their area of work.

The Joint Data Quality Policy outlines the roles and responsibility for all staff members and police officers.



Data quality training is mandatory for both police officers and police staff, compliance rates are monitored and instances of non-compliance is followed up.

Scope and Limitations of the Review

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

Disclaimer

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

Assignment Engagement Details

3.

TIAA Auditors	Title	Contact Email
Claire Lavery	Director of Audit	Claire.lavery@tiaa.co.uk

Effectiveness of arrangements

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

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

Assurance Assessment

5. The definitions of the assurance assessments are:

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

Acknowledgement

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

Release of Report

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

Stage	Issued	Response Received
Audit Planning Memorandum:	19 th January 2026	31 st March 2026
Draft Report:	1 st July 2026	22 nd July 2026
Final Report:	24 th July 2026	



Chief Constables of Norfolk and Suffolk Constabularies

Assurance Review of Body Worn Cameras

September 2026

Final

Executive Summary

OVERALL ASSESSMENT			SUBSTANTIAL ASSURANCE	ACTION POINTS	HIGH RISK	MEDIUM RISK	LOW RISK	OPERATIONAL
					0	0	1	1
KEY STRATEGIC FINDINGS								
C	Images are stored in accordance with GDPR requirements. Images not needed for evidential purposes are disposed of automatically after 31 days. A process is in place to ensure that images needed for evidential purposes are marked up and stored appropriately. A standard is in place in relation to naming of image and/or video evidence so that it is clear what is to be kept, and to enable retrieval of required evidence if the case ends up with criminal charges. The standard agreed processes were found to have been complied with.							
C	Police officers are aware of the process to be followed if a body worn video device is misplaced. The process to be followed is not documented in the body worn video policy, an operational effectiveness matter has been raised.							
C	Training has been provided on the safe and appropriate use of body worn cameras.							
C	A process is in place if a body worn video is to be misplaced or lost. Lost devices are locked down immediately images are encrypted to reduce the risk of images/videos falling into the wrong hands. A standard information security incident form is completed for any lost/misplaced body worn videos, these are reported to the information security team. It was confirmed that the standard form was being completed, but the process to be followed is not documented in the Body Worn Video policy, an operational effectiveness matter has been raised to address this.							
GF	The Joint Body Worn Video Policy has recently been reviewed this was reviewed in October 2025. The policy is still an interim policy, as awaiting sign off by legal services. A recommendation has been raised to ensure that the policy is formally signed off by legal so that it is no longer an interim policy.							
GF	There are designated ports for storage of body worn cameras. A visit to Aylsham Police Investigation Centre confirmed that body worn cameras are being stored appropriately, these were being stored in the docking stations when not in use.							
GF	Images from the body worn videos are uploaded to the Digital Evidence Management Solution (DEMS) when docked. Body worn video images are stored securely these are held on the DEMS system. DEMS is an end-to-end digital management system that is used by police forces and investigative bodies to store, analyse, prepare, and share all types of digital evidence.							
PM	Any misplaced body worn cameras are reported to the Information Management Security Group (IMSG). The IMSG is chaired by the Head of Information Management. It was confirmed that updates are being provided to the IMSG at the designated intervals.							

SCOPE	ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE
The audit focused on the following key areas: • Appropriate policies and procedures are in place; • Accountability and governance structure covering the process; • Awareness and training to ensure appropriate use; • Staff are aware of their responsibilities to ensure the policy is applied correctly and fairly and have received the requisite training; • Images are securely kept and backed-up appropriately in accordance with data protection rules; • Effectiveness of risk management arrangements covering the process; • Compliance and monitoring; • Monitoring and reporting arrangements	The Specialist Operations Command Risk and Issues Log records the following risk: “Unable to meet future volumes and complexity of digital media/evidence, and the subsequent management, storage and sharing within mandatory timelines”. In addition to being recorded on the Specialist Operations Command Risk and Issues Log, there are risks recorded on both the Norfolk and Suffolk strategic risk registers. Both the Norfolk and Suffolk strategic risk registers have the following risk; “Failure to effectively plan and prepare for a cyber-attack or major / critical incident or event results in a weak response leading to a catastrophic impact on operational effectiveness, performance and public confidence”.

Assurance - Key Findings and Management Action Plan (MAP)

Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Governance Framework	A designated Joint Policy on Body Worn Videos is in place, the policy is currently an interim policy, it is awaiting formal sign off by legal service. The policy is reviewed every two years the current interim policy was published in October 2025 and is scheduled for review in June 2027.	The Body Worn Videos Policy be formally signed off by legal.	3	Agreed.	30/11/26	Body Worn Video Lead with Legal

1

HIGH RISK

Fundamental control weaknesses or compliance issues that require immediate attention.

2

MEDIUM RISK

Control weaknesses that are not critical but require planned action at the earliest opportunity.

3

LOW RISK

Minor issues on which action should be taken or monitored as part of continuous improvement.

57

3

Operational - Effectiveness Matter (OEM) Action Plan

Ref	Root Cause Indicator	Finding	Suggested Action	Management Comments
1	Compliance	A process is in place if a body worn video is to be misplaced or lost. Lost devices are locked down immediately images are encrypted to reduce the risk of images/videos falling into the wrong hands. A standard information security incident form is completed for any lost or misplaced body worn videos. These are then reported to the information security team. It was confirmed that the standard form was being completed, but the process to be followed is not documented in the Body Worn Video policy.	The Body Worn Video policy be updated to include the process that is followed if a body worn video is to be misplaced.	<i>This will be considered.</i>

ADVISORY NOTE

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

Findings

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	In place	-	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	In place	-	1
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	In place	1	-
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	In place	-	-
S	Sustainability	The impact on the organisation's sustainability agenda has been considered.	Out of scope	-	-
R	Resilience	Good practice to respond to business interruption events and to enhance the economic, effective and efficient delivery is adopted.	In place	-	-

Other Information



There is clear guidance available to staff on the appropriate use of body worn cameras. Information is available to officers via the Constabularies' website. Body worn camera video images is an overt method and is not used in covert cases or by close protection officers. Officers have an option to switch their body worn video to a 'stealth mode' if they believe there is an operational necessity. This allows the body worn video to still be used overtly (not hidden), but does not illuminate the red light or screen, and thereby reduces the potential attention that these illuminations may attract. Once that deployment has ceased, the camera is returned to normal mode.

Other Information



The Body Worn Video policy supplements national guidance. The policy is accessible to staff via the intranet. The policy is owned by Information management. The policy aims to supplement the national guidance for body worn cameras for police staff and officers in Norfolk and Suffolk. The policy sets out the principles and reasoning behind the use of body worn video, as well as potential benefits.

The Constabularies Joint Body Worn Video Policy covers the required areas.

It includes the following areas;

- When to record
- When not to record
- Recording an incident
- Ending a recording
- Guidance on how to be use in domestic violence setting
- Guidance on how to use in attendance of rape and serious sexual offences
- Guidance on how to use to record children under 18
- It also covers process to be followed in relation to stop and search, scene searches, when being used in private dwelling settings

The policy does not cover the process to be followed if a device was to be lost, an operational effectiveness matter has been raised to address this, as there is a process that is being followed, but this is not formally documented.



Officers are aware of how body worn video cameras are to be stored. There are designated storage points for body worn cameras when they are not in use. A site visit to Alysham PIC confirmed that body worn cameras were being stored correctly, and access was restricted to authorised personnel.



Images in relation to body worn videos are stored on the Digital Evidence Management Solution (DEMS) system. DEMS is an end-to-end digital management system that is used by police forces and investigative bodies to store, analyse, prepare, and share all types of digital evidence and assets related to investigations and cases. DEMS works collaboratively with digital assets in one single space; integrated editing and analytics including object/motion detection and video redaction.



DEMS is a secure storage method for officer body worn video images. DEMS ensures full control of organisational digital assets in one single location. In addition, DEMS has inbuilt authentication and viewing restrictions for guaranteed access control. The inbuilt controls, helps ensure access is restricted to authorised and appropriate personnel.



Images on body worn cameras are uploaded onto DEMS when they are placed in docking stations. Body worn camera video images are automatically deleted after 31 days unless they are marked by officers to keep. Agreed processes are being complied with.



Misplaced body worn camera videos are reported to the Information Management Security Group (IMSG), it was confirmed that updates are being provided to the Information Management Security Group at the designated frequencies. The IMSG meets monthly, the group is chaired by the Head of Information Management. A standard agenda item is in place covering lost/misplaced and stolen body worn camera video devices.

Scope and Limitations of the Review

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

Disclaimer

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Assignment Engagement Details

- 3.

TIAA Auditors	Title	Contact Email
Claire Lavery	Director of Audit	Claire.Lavery@tiaa.co.uk
Fiona Roe	Director of Local Government and Emergency Services	Fiona.Roe@tiaa.co.uk

Effectiveness of arrangements

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

Acknowledgement

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

Release of Report

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

Stage	Issued	Response Received
Audit Planning Memorandum:	18 th April 2025	2 nd March 2026
Draft Report:	20 th April 2026	20 th August 2026
Final Report:	4 th September 2026	

Norfolk and Suffolk Police and the Offices of the Police and Crime Commissioner for Norfolk and Suffolk

Internal Audit Progress Report

October 2026



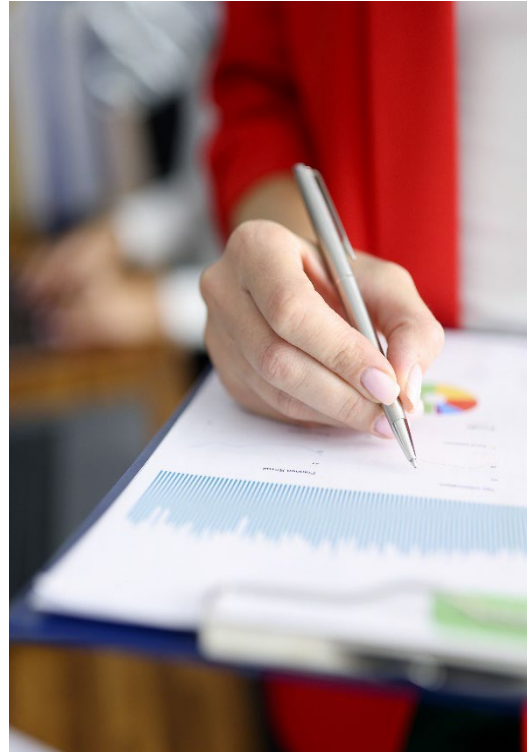
Summary of 2026/27 work

Internal Audit

This report is intended to inform the Audit Committee of progress made against the 2026/27 internal audit plan. It summarises the work we have done, together with our assessment of the systems reviewed and the recommendations we have raised. Our work complies with Global Internal Audit Standards in the UK Public Sector. As part of our audit approach, we have agreed terms of reference for each piece of work with the risk owner, identifying the headline and sub-risks, which have been covered as part of the assignment. This approach is designed to enable us to give assurance on the risk management and internal control processes in place to mitigate the risks identified.

Internal audit methodology

Our methodology is based on four assurance levels in respect of our overall conclusion as to the design and operational effectiveness of controls within the system reviewed. The assurance levels are set out in Appendix 1 of this report and are based on us giving either 'substantial', 'moderate', 'limited' or 'no' opinion. The four assurance levels are designed to ensure that the opinion given does not gravitate to a 'satisfactory' or middle band grading. Under any system we are required to make a judgement when making our overall assessment.



Internal audit plan 2026/27

We are making progress in the delivery of the 2026/27 audit plan.

Fieldwork or planning is underway in respect of the following audits:

- Victims' Code and Safeguarding
- Information Governance, Data Quality and AI
- Demand, Performance and Resource Planning

We anticipate presenting these reports at the January 2027 Committee meetings.

Review of 2026/27 work

AUDIT	EXEC LEAD	AC MEETING	PLANNING	FIELD WORK	REPORTING	DESIGN	EFFECTIVENESS
Victims' Code and Safeguarding	C Supt and Joint Justice Commander for Norfolk and Suffolk Police	January 2027	✓				
Information Governance, Data Quality and AI	Head of Information Management	January 2027	✓				
Demand, Performance and Resource Planning	Head of HR Strategy & Planning	January 2027	✓				
Disaster Recovery and ICT Resilience	Director of Joint ICT	January 2027					
Key Financial Controls - Budgetary Management	Joint Head of Finance	January 2027					
Professional Standards, Vetting and Complaints	Head of Joint Professional Standards	March 2027					
OPCC Governance Review	OPCC CEOs / CFOs	March 2027					
Out of Court Resolutions	Head of Criminal Justice Service	March 2027					

Sector update

Our quarterly Police briefing summarises recent publications and emerging issues relevant to the sector that may be of interest to your organisation. It is intended to provide a snapshot of current issues for senior managers, non-executive directors and executive directors.

POLICEAI PROGRAMME BEGINS NATIONAL ROLLOUT

The Home Office and policing partners have commenced the implementation of PoliceAI, a national programme designed to accelerate the adoption of artificial intelligence across policing. The initiative aims to reduce administrative burdens, support digital investigations, improve evidence review processes and enhance frontline productivity. Initial priorities include AI-assisted review of digital evidence, automated transcription of emergency and non-emergency calls, and improved identification of investigative leads from large volumes of data. The programme forms a key element of the wider Police Reform agenda and is intended to deliver significant efficiency improvements across forces.

PoliceAI to speed up investigations and fight crime - GOV.UK

FOR INFORMATION

For the Audit Committee Members and Executive Directors

EXPANSION OF LIVE FACIAL RECOGNITION CAPABILITY ACROSS POLICING

The Government continues to increase investment in Live Facial Recognition (LFR) technology as part of its wider modernisation programme for policing. Through the PoliceAI initiative, funding has been provided for an additional 40 live facial recognition units, significantly increasing national deployment capacity. Supporters of the technology highlight its effectiveness in locating wanted offenders, identifying individuals subject to warrants and strengthening public protection activity. However, continued expansion is also expected to attract scrutiny regarding governance, data privacy, proportionality and public confidence, making robust oversight arrangements an important consideration for forces and police authorities.

PoliceAI to speed up investigations and fight crime - GOV.UK

FOR INFORMATION

For the Audit Committee Members and Executive Directors

FINAL POLICE FUNDING SETTLEMENT 2026-27

Police forces continue to implement plans supported by the 2026-27 Police Funding Settlement, which increased overall funding for policing in England and Wales to up to £21bn, including additional investment in neighbourhood policing, counter-terrorism capability and modernisation initiatives. While the settlement provides increased funding compared with the previous year, forces remain focused on managing ongoing demand pressures, workforce costs, digital transformation requirements and productivity expectations. Financial sustainability and delivery of efficiency programmes remain key strategic considerations during 2026.

Written statements - Written questions, answers and statements - UK Parliament

FOR INFORMATION

For the Audit Committee Members and Executive Directors

Key performance indicators

QUALITY ASSURANCE	KPI	RAG RATING
The auditor attends the necessary, meetings as agreed between the parties at the start of the contract	All meetings attended including Audit Committee meetings, pre-meetings, individual audit meetings and contract reviews have been attended by either the Partner and/or the Assistant Manager.	
Positive result from any external review	Following an External Quality Assessment by the Institute of Internal Auditors in May 2021, BDO was found to 'generally conform' (the highest rating) to the International Professional Global Internal Audit Standards. The next EQA will be carried out in the next few months.	
REPORTING ARRANGEMENTS	KPI	RAG RATING
Draft Report	This will be assessed as the year progresses.	
Final Report	This will be assessed as the year progresses.	
Recommendations	This will be assessed as the year progresses.	
REPORTING ARRANGEMENTS	KPI	RAG RATING
Staffing and Training	At least 70% input from qualified staff. To date, 100% of staff working on the audit programme have been qualified.	

Appendix 1

OPINION SIGNIFICANCE DEFINITION

LEVEL OF ASSURANCE	DESIGN OPINION	FINDINGS FROM REVIEW	EFFECTIVENESS OPINION	FINDINGS FROM REVIEW
Substantial 	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
Moderate 	In the main, there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally, a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non-compliance with some controls, that may put some of the system objectives at risk.
Limited 	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
No 	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non-compliance and/or compliance with inadequate controls.

RECOMMENDATION SIGNIFICANCE DEFINITION

RECOMMENDATION SIGNIFICANCE	
High 	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium 	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low 	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.

Internal Audit Follow Up of Recommendations Report

**Norfolk and Suffolk Police and the Offices of
the Police and Crime Commissioner for
Norfolk and Suffolk**

October 2026



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SUMMARY TABLE

AUDITS	Total Recs	H	M	L	To follow up	Previously complete		Complete		In progress		Overdue		Not Due	
						H	M	H	M	H	M	H	M	H	M
2024/25															
Fleet Management Strategy	6	0	4	2	4	-	-	-	-	-	4	-	-	-	-
Recruitment and Induction Training	5	0	2	3	2	-	1	-	-	-	-	-	1	-	-
Workforce Planning	6	1	3	2	4	-	3	1	-	-	-	-	-	-	-
2025/26															
Data Quality	4	0	4	0	4	-	-	-	-	-	-	-	-	-	4
Learning and Development	1	0	1	0	1	-	-	-	-	-	-	-	-	-	1
Limited Duties	14	2	6	6	8	-	-	-	3	-	-	-	-	2	3
Risk Management (Forces)	5	0	3	2	3	-	-	-	-	-	-	-	-	-	3
Suffolk OPCC Risk Management	2	0	1	1	1	-	-	-	-	-	-	-	-	-	1
Totals	43	3	24	16	27	-	4	1	3	-	4	-	1	2	12

SUMMARY NARRATIVE

2024/25

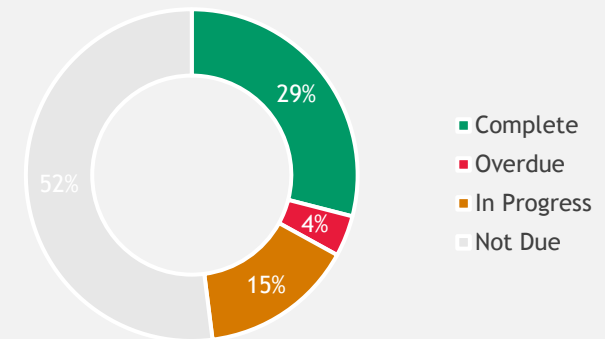
- ▶ Actions remain outstanding across three audits from the 2024/25 Internal Audit Plan. In total, six high and medium priority recommendations were subject to follow-up since the last Committee meeting. Of these, one high priority recommendation has been implemented and closed, four medium priority recommendations remain in progress, and one medium priority recommendation is overdue.
- ▶ Follow-up testing completed during Q2 2026/27 confirmed implementation of the remaining high-priority recommendation from the Workforce Planning review. Evidence demonstrated that a documented and embedded strategic workforce planning framework has been established, supported by appropriate governance arrangements, workforce planning activity, financial modelling, and integration with the annual planning process.
- ▶ Four Medium priority recommendations from the Fleet Management Strategy review remain in progress. Management has provided evidence of a substantial electric vehicle trial programme across both forces, designed to inform future fleet replacement decisions, charging infrastructure requirements, and wider fleet electrification plans. While implementation is not yet complete, it is clear that good progress is being made.
- ▶ One Medium priority recommendation from the Recruitment and Induction Training review is overdue. Despite repeated requests, no management update or supporting evidence was provided during the follow-up period.

2025/26

- ▶ Actions remain outstanding across five audits from the 2025/26 Internal Audit Plan. In total, 17 high and medium priority recommendations were subject to follow-up since the last Committee meeting. Of these, three medium priority recommendations remain have been completed and the rest are not yet due.
- ▶ Follow-up testing completed during Q2 2026/27 confirmed implementation of three medium priority recommendations from the Limited Duties review. These recommendations were addressed through the introduction of enhanced reporting, escalation, and quality assurance arrangements, supported by the Limited Duties Power App.

REQUIRED AUDIT COMMITTEE ACTION:

We ask the Joint Audit and Standards to note the progress against the audits with outstanding recommendations which have fallen due prior to 30 September 2026



RECOMMENDATIONS: COMPLETE

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
Limited Duties (25/26)	The sickness and limited duties dashboard to include the number of overdue reviews for recuperative and adjusted duties, and the number of officers still on recuperative duties for over a year.	Medium 	HR Manager PIU - Tom Piggott	July 2026 Closed	<u>Management Comments:</u> 17/09/2026 Tom Piggott The Limited Duties dashboard has been updated to include overdue reviews for recuperative and adjusted duties, together with officers remaining on recuperative duties for extended periods. Information is reported monthly through HR Advisor reporting, and the new Limited Duties Power App provides automated prompts to line managers regarding required reviews. <u>Internal Audit Comments:</u> Evidence provided included dashboard screenshots and Limited Duties reporting information. The dashboard clearly records overdue reviews, case durations and recuperative duty information, providing management oversight of outstanding cases. The evidence reviewed demonstrates that the recommendation has been implemented and embedded within management reporting arrangements. Conclusion: Implemented and closed.
Limited Duties (25/26)	The automatic escalation process to next level management in the new Power App is to be reinforced by a clear reporting and escalation process. Reporting of continuing breaches of the policy steps to be included in the dashboard to the People Board.	Medium 	HR Manager PIU - Tom Piggott	July 2026 Closed	<u>Management Comments:</u> 17/09/2026 Tom Piggott The Limited Duties Power App now incorporates an escalation process whereby overdue actions automatically progress through management levels. Breaches are reported through command team structures and local SLT meetings, supported by HR Advisors. <u>Internal Audit Comments:</u> Evidence reviewed demonstrated monitoring and escalation functionality within the Limited Duties arrangements. Automated notifications are issued where reviews become

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
					overdue and clear escalation routes exist to HR Advisors and senior management. The evidence provides assurance that compliance monitoring arrangements have been implemented. Conclusion: Implemented and closed.
Limited Duties (25/26)	A Quality Assurance process is to be established to audit compliance with the Limited Duties (LD) Policy, ideally automated via the new Power App. A annual dip sample of completion of records is to be undertaken to evidence policy compliance. This requirement is to be included towards the end of the LD policy as a separate section.	Medium 	HR Manager PIU - Tom Piggott	July 2026 Closed	<u>Management Comments:</u> 17/09/2026 Tom Piggott Quality assurance processes have been embedded into the Limited Duties Power App. Mandatory fields prevent forms from being submitted unless required information has been completed. In addition, annual dip-sampling arrangements have been established. <u>Internal Audit Comments:</u> Management evidenced a structured quality assurance approach through system controls within the Power App and annual compliance checking arrangements. Reporting and monitoring arrangements provide ongoing oversight of compliance with the Limited Duties process and support accountability amongst line managers. Conclusion: Implemented and closed.
Workforce Planning (24/25)	Develop a strategic workforce plan as a matter of urgency.	High 	Workforce Planning and People Analytics Manager - Seamus Garner	July 2025 Closed	<u>Management Comments:</u> 31/09/2026 Seamus Garner A strategic workforce planning framework has been developed and implemented across Norfolk and Suffolk. Workforce planning activity is undertaken through the Workforce Mix Transformation Programme and is supported by governance boards, workforce plans, financial modelling, target operating models and integration with the annual planning process. <u>Internal Audit Comments:</u> Evidence reviewed demonstrated a documented and mature workforce planning framework across Norfolk and Suffolk.

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
					Supporting documentation included workforce plans, governance reporting, implementation plans, senior leader briefings and workforce modelling. We are satisfied that a strategic workforce planning approach has been established and embedded. Conclusion: Implemented and closed.

RECOMMENDATIONS: IN PROGRESS

These recommendations have been marked as In Progress as they have not been implemented by their original date; a revised date has been provided.

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
Fleet Management Strategy (24/25)	A detailed plan to be developed stating when vehicles are to be replaced so that progress can be monitored appropriately.	Medium 	Head of Transport and Uniform Services - Mark Davy	December 2025 Revised Date: February 2026	<u>Management Comments:</u> 17/08/2026 - Mark Davey As part of the continued fleet electrification programme, Norfolk and Suffolk Constabularies are commencing a full Electric Vehicle (EV) operational trial to assess the suitability of battery electric vehicles within frontline service delivery.
Fleet Management Strategy (24/25)	A detailed plan to be developed covering rollout of charge-points across the estate. The plan to identify exactly how many are needed, where they need to be placed and when they are due to be put in so that progress can be monitored.	Medium 	Head of Transport and Uniform Services - Mark Davy	December 2025 Revised Date: February 2026	The trial will be based at Broadland Hub (Norfolk) and Landmark House and Stowmarket (Suffolk) and will utilise 17 Hyundai Kona Battery Electric Vehicles (BEVs). The trial is intended to evaluate vehicle performance, operational suitability, charging requirements, driver experience, environmental benefits, and whole-life cost implications.
Fleet Management Strategy (24/25)	Work to continue to electrify the fleet, there are potential savings that can be achieved from electrifying the fleet. In addition, there is a risk that parts will not be available for non-electric vehicles.	Medium 	Head of Transport and Uniform Services - Mark Davy	December 2025 Revised Date: February 2026	To ensure a robust assessment, a dedicated Business Analyst has been assigned to the project. The Business Analyst will monitor and evaluate key performance indicators throughout the trial, including vehicle utilisation, range performance, charging behaviour, operational impact (including response times), carbon reduction benefits, and financial outcomes. Findings from the assessment will be used to inform future vehicle replacement decisions, support the wider fleet electrification strategy, and shape the development and implementation of the EV charging infrastructure rollout plan.
Fleet Management Strategy (24/25)	Once detailed plan identifying charging points has been developed, implementation against this plan to commence.	Medium 	Head of Transport and Uniform Services - Mark Davy	December 2025 Revised Date: February 2026	This trial represents a significant milestone in the transition towards a lower-emission fleet and will provide the evidence base required to support future investment in electric vehicles and associated charging infrastructure.

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
					The trial will start to report findings from January 2027. <u>Internal Audit Comments:</u> Evidence provided demonstrates that Norfolk and Suffolk Constabularies are actively progressing their fleet electrification programme through the commencement of an operational EV trial across both forces. Whilst the detailed vehicle replacement programme, charging infrastructure rollout plan and associated implementation activity have not yet been fully developed and embedded, the evidence demonstrates that meaningful progress is being made towards delivery of the recommendations. Conclusion: The recommendations are considered Partially Implemented. We acknowledge the progress made to date and will undertake further follow-up work during Q4 2026/27 to assess the outcomes of the EV trial and confirm whether the recommendations have been fully implemented.

RECOMMENDATIONS: OVERDUE

These recommendations have been marked as overdue as they have previously revised their implementation date. Therefore, they have now missed at least two implementation dates.

AUDIT	ACTIONS AGREED	PRIORITY LEVEL	MANAGER RESPONSIBLE	DUE DATE	CURRENT PROGRESS
Recruitment and Induction Training (24/25)	Develop a Probation Policy or procedure to document the current process or add this information to the existing policy/framework.	Medium 	Senior People Services Manager, James Madsen	September 2025 Revised Date: Not Provided	<u>Management Comments:</u> None. <u>Internal Audit Comments:</u> Despite requests for an update and supporting evidence between August and September 2026, no management response or documentation was provided for review. As a result, we have been unable to assess progress made against the recommendation or validate its implementation.

Norfolk Police and the
Office of the Police
and Crime
Commissioner for
Norfolk

Internal Audit Standards - Essential Conditions

September 2026

Global Internal Audit Standards in the UK Public Sector

Global Internal Audit Standards in the UK Public Sector requirements

The Global Internal Audit Standards (GIAS) in the UK Public Sector encompass:

- The global Institute of Internal Auditors (IIA) Global Internal Audit Standards effective from January 2025
- The Internal Audit Standards Advisory Board (IASAB) Application Note Global Internal Audit Standards in the UK Public Sector effective from 1 April 2025.

As the activities of the Audit Committee, acting on behalf of the Police and Crime Commissioner (PCC) and Chief Constable (CC), together with senior management, are essential to the Internal Audit function's ability to fulfil the Purpose of Internal Auditing, we have set out on the following pages the respective responsibilities of each party together with our assessment of conformance with the specific requirements of Domain III.

Action: The Audit Committee is asked to note the conformance assessment and recommend its acceptance to the CC and the PCC, where appropriate.



Global Internal Audit Standards requirements

Whilst the Chief Audit Executive (CAE) is responsible for the requirements of Domain III, activities of the board and senior management are essential to the Internal Audit function's ability to fulfil the Purpose of Internal Auditing. These activities are identified as 'essential conditions' and establish the necessary foundation for an effective dialogue between the board, senior management and the CAE, ultimately enabling an effective Internal Audit function.

The GIAS refer to the 'board' as the highest-level body charged with governance. Within Norfolk Police and the Office of the Police and Crime Commissioner (OPCC), governance responsibilities rest with the PCC and CC. For the purposes of Internal Audit oversight, these responsibilities are discharged through the Audit Committee, which acts on their behalf.

The GIAS also refer to the '**chief audit executive**' as the 'leadership role responsible for effectively managing all aspects of the internal audit function and ensuring the quality performance of internal audit services. For Norfolk Constabulary and the Office of the Police and Crime Commissioner for Norfolk ('the Force and OPCC') this is the BDO-assigned director acting as the **Head of Internal Audit (HoIA)**.

The HoIA must meet regularly with the Audit Committee and senior management to discuss:

- ▶ The purpose of internal auditing
- ▶ The 'essential conditions' to enable an effective Internal Audit function
- ▶ The potential impact on the effectiveness of the Internal Audit function if the Audit Committee or senior management does not provide the expected levels of support.

Whilst responsibility for governance rests with the PCC and CC, the Audit Committee provides independent oversight and scrutiny of Internal Audit arrangements on their behalf. The Audit Committee reviews and scrutinises the Internal Audit Charter and Annual Plan, including the Internal Audit mandate, and makes recommendations as appropriate. Senior management's perspective supports the positioning and authority of the Internal Audit function. The nature and frequency of these discussions depend on the circumstances and any changes within the organisation.

Set out below and on the next page are the nine 'essential conditions.'



Internal Audit Mandate

Requirement: CAE to provide board and management with the information necessary to establish an Internal Audit mandate to determine Internal Audit's authority and role and responsibilities. CAE must assess whether changes in circumstance justify a discussion with the board and management about the mandate.

Board: Discuss with CAE and management the appropriate authority, role and responsibilities for the Internal Audit function.

Management: Participate in discussions with the board and CAE on the Internal Audit mandate. Support the mandate throughout the organisation and promote Internal Audit's authority.

Internal audit Charter

Requirement: CAE to develop and maintain an Internal Audit charter, outlining the purpose of internal auditing, commitment to the GIAS, Internal Audit mandate, types of service provided and the board's responsibilities and expectations regarding management's support for Internal Audit. CAE to review and update the charter periodically in consultation with the board and management.

Board: Engage in discussions regarding the charter and consider other topics to be included to enable an effective Internal Audit function. Approve the charter.

Management: Communicate with the board and CAE about management's expectations that should be considered for inclusion in the charter.

Board and senior management support

Requirement: CAE to provide board and management with the information needed to support and promote recognition of the Internal Audit function throughout the organisation.

Board: Champion the Internal Audit function, ensure unrestricted access to information, support the CAE through regular, direct communications, demonstrate support by requiring CAE be suitably positioned to fulfil the Internal Audit mandate, approve the plan, budget and resource plan, understand any restrictions placed on scope, meet with CAE without management present.

Management: support recognition of the Internal Audit function and allow unrestricted access to people and information.

Global Internal Audit Standards requirements (continued)

Independence

Requirement: CAE confirm to the board the independence of the Internal Audit function annually and any incidents where independence may have been breached. CAE must discuss with board and management any potential impairment to independence.

Board: Establish a direct reporting relationship with CAE, authorise their appointment / removal, provide opportunities for CAE to discuss sensitive matters without management, position CAE at a level they can operate without management interference.

Management: Position IA at a level in organisation that enables it to perform without interference and recognise CAE's direct reporting line to the board.

CAE qualifications

Requirement: CAE must help the board understand the qualifications and competencies necessary to manage Internal Audit. CAE must maintain and enhance qualifications and competencies necessary to fulfil responsibilities.

Board: Review the requirements necessary for CAE to manage Internal Audit. Approve the CAE role and identify necessary qualifications, experience and competencies required to fulfil responsibilities. Engage with management to appoint CAE with requirement qualifications and competencies.

Management: Engage with board to determine the CAE's qualifications, experience and competencies.

Board interaction

Requirement: CAE provides board with information needed to conduct oversight of the Internal Audit function. CAE escalates significant issues to the board when disagreements with management arise.

Board: Communicate with the CAE to understand how Internal Audit's activities fulfil its mandate, communicate the board's perspective on the organisation's strategies, objectives and risks, establish clear processes for escalating issues and support the CAE to resolve disputes with management.

Management: Share perspectives on strategies, objectives and risks to assist with determining priorities, establish escalations processes with the board.

Resources

Requirement: CAE to evaluate whether resources are sufficient to fulfil Internal Audit's mandate and achieve the Internal Audit plan.

Board: Collaborate with management to provide Internal Audit with sufficient resources, discuss resource with the CAE at least annually, consider the impact of insufficient resources and address any insufficiencies.

Management: Engage with board to provide sufficient resources to fulfil IA mandate and address any identified resource insufficiencies.

Quality

Requirement: CAE must develop, implement, and maintain a quality assurance and improvement programme (QAIP), conducting internal and external assessments and reporting results annually to the board and management.

Board: Discuss the QAIP with the CAE, approve the function's performance objectives, assess the function's effectiveness and efficiency of the Internal Audit function.

Management: Provide input on Internal Audit's performance objectives and participate in the annual assessment.

External Quality Assessment (EQA)

Requirement: CAE must develop a plan for an EQA at least every five years, ensuring that at least one person of the assessment team is suitably qualified.

Board: Review and approve CAE's EQA plan including scope / frequency of EQA, review results directly from the assessor, and approve action plans for addressing gaps.

Management: Collaborate with the board and CAE on the EQA and action plans.

Global Internal Audit Standards requirements conformance

Essential conditions evaluation

We have set out on the following pages our detailed assessment of conformance with the essential conditions for an effective Internal Audit function within the Constabulary and OPCC. This assessment is for consideration and discussion with senior management and the Audit Committee acting on behalf of the PCC and CC.

If either the Audit Committee or senior management disagrees with one or more of these essential conditions, and our assessment of the conformance, these should be discussed, with consideration for how the absence of the condition(s) may affect the Internal Audit function's ability to fulfil its purpose or conform with specific standards.

Where we are not fully conforming, we should either:

- ▶ Agree alternatives to the essential conditions to achieve the same results; or
- ▶ Reach agreement with the Audit Committee and senior management that one or more of the essential conditions are not necessary to conform with the Standards.

In such instances, the HoIA must document:

- ▶ The reasons for agreeing that a particular condition is unnecessary.
- ▶ Alternative conditions that compensate for the absent conditions, to support the judgments of the board and senior management.

If the HoIA does not agree with the Audit Committee's and/or senior management's reasons for not performing one or more of the conditions, the HoIA may conclude that the Internal Audit function cannot conform with the Standards. In such cases, the HoIA should document the reasons why the Audit Committee and/or senior management will not perform the essential conditions. This documentation should be shared with the Audit Committee and senior management to ensure clarity regarding their positions and made available to an external quality assessor.

Overview of assessment

In the assessment that follows we have recommended that the internal audit services is **fully conforming with eight out of the nine essential conditions and is generally conforming with one.**

The essential condition that is generally met relates to Standard 8.4 External Quality Assessment. This standard requires the CAE to develop a plan for an EQA and discuss the plan with the board. At BDO we have an EQA performed every five years, as required by the standards, however this is across all outsourced internal audit services that we provide to all our clients. For this reason, we do not meet all of the essential conditions that support conformance with this standard which require board approval of:

- The scope and frequency of assessments
- The competencies of the external assessor or assessment team
- The rationale for choosing to conduct a self-assessment with independent validation instead of an EQA (if applicable)
- The CAE's action plan to address identified deficiencies and opportunities for improvement (if applicable).

As a suggested alternative we will provide the Audit Committee, PCC, CC and senior management with a briefing on the scope, competencies of the team, and a summary report providing the outcome of the EQA assessment and any associated action plan.

Recommendation for approval

We recommend the Audit Committee note the conformance assessment and endorse the alternative condition in relation to Standard 8.4 on behalf of the PCC and CC.

Global Internal Audit Standards requirements conformance (continued)

Essential condition	Status	Commentary
Internal audit mandate	✓	▶ The internal audit mandate is defined by the IIA as the function's authority, role, and responsibilities, which may be granted by the board and/or laws and regulations. BDO has defined the mandate in the Internal Audit Charter that will be reviewed annually to confirm it is up to date and an accurate reflection of practice. This was included within the Annual Internal Audit Plan which was reviewed and scrutinised by the Audit Committee on behalf of the PCC and CC. ▶ Internal audit's mandate is: ○ Authority: the Internal Audit team has direct access to the Chair of the Audit Committee and attends all Audit Committee meetings. The Internal Audit team met with the Audit Committee Chair in the internal audit contract onboarding process and will meet annually as part of the planning process each year. The HoIA and Internal Audit team meet regularly with key senior officers from both the Force and OPCC, including finance leadership, to discuss strategy, risk, governance and the Internal Audit programme. ○ Role: the HoIA and Internal Audit team do not have responsibilities outside of the scope of internal audit. ○ Responsibilities: the Internal Audit function is responsible for the performance of internal audit services and conforming with the IIA International Professional Practices Framework which include the GIAS. ▶ During the development of the Internal Audit Strategy and Internal Audit Plan, the Internal Audit team met with the Chief Finance Officers (CFOs) of the Constabulary and OPCC to discuss the role, responsibility and authority of the Internal Audit function. ▶ In developing our Internal Audit Strategy and Audit Plan, we take into account the importance of securing value for money in the public sector. ▶ As part of individual assignment scoping meetings, we set out the purpose of Internal Audit, our role, authority and responsibilities to ensure there is no disparity on the service we can provide. ▶ All our Internal Audit reports include our conformance with the GIAS in the UK Public Sector.
Internal audit charter	✓	▶ The Internal Audit Charter was approved within the Internal Audit Plan. This set out the purpose of internal auditing, our commitment to conformance with the GIAS in the UK Public Sector and our authority, position and reporting lines within Norfolk Police and the OPCC.



Full conformance



Generally conforms



Partial conformance

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Non conformance

Global Internal Audit Standards requirements conformance (continued)

Essential condition	Status	Commentary
Board and senior manager support	✓	▶ The Internal Audit team will meet at least annually with the Audit Committee Chair outside of Audit Committee meetings. The Internal Audit team will also meet quarterly with the CFOs of the Constabulary and the OPCC. This allows direct interaction on the level of support for the Internal Audit function and whether any restrictions have been imposed in terms of the scope, access or authority of the function. ▶ The Audit Committee and senior management are involved in risk assurance mapping activity. ▶ Senior officers and senior management from both the Force and OPCC were actively engaged in developing the risk assessment and Internal Audit Plan.
Independence	✓	▶ The Internal Audit function maintains independence in multiple ways. As a function, we are ultimately responsible to the Audit Committee, on behalf of the PCC and CC, and have a direct reporting line to the Audit Committee Chair. In line with this, we will have annual meetings with the Audit Committee Chair, independent from management, which would allow any concerns to be shared freely. In a similar fashion, the Chair can also reach out to us at any point during the year. ▶ Should we identify any potential conflicts arising during the delivery of our Internal Audit services we would discuss the potential conflict with management and the Audit Committee Chair at the time to agree the appropriate actions required. This would also be communicated at the next Audit Committee meeting for transparency. Within our Annual report, we will confirm whether we have undertaken any work or activity during the year that would lead us to declare any conflict of interests. This will also be reported annually in our Internal Audit Annual Reports. ▶ Our internal risk management procedures include specific conflict checks in relation to the clients/projects which are flagged to the Internal Audit team so that these can be considered for potential conflicts and discussed with senior management and the Audit Committee, on behalf of the PCC and CC, if required. ▶ In addition, our public sector auditors are aware that they are also required to comply with the Seven Principles of Public Life (the 'Nolan Principles'), being Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership.
CAE qualifications	✓	▶ It is our policy that staff engaged in the provision of a specialist service be qualified in the relevant professional discipline. In Internal Audit, staff are qualified or are studying for the exams of the Chartered Institute of Internal Auditors or through an accountancy body. ▶ All professionally qualified staff are required by the firm to complete a minimum of 40 hours of continuous professional development (CPD) annually, as well as meeting the specific requirements of the professional body of which they are a member. ▶ Information regarding the qualifications, training and development of the Internal Audit function, was provided to the Audit Committee as part the Internal Audit Plan. ▶ The Audit Committee and senior management contribute to the determination of the qualifications, experience and competencies required of the HoIA through procurement and appointment arrangements and competencies through the specification and selection processes when tendering for the Internal Audit service. ▶ In the UK public sector, the HoIA must have a CMIIA or CCAB qualification or equivalent professional qualification which includes training on the practice of internal audit, and suitable internal audit experience. We confirm that Norfolk Police and the OPCC's HoIA conforms with this requirement.



Full conformance



Generally conforms



Partial conformance

87



Non conformance

Global Internal Audit Standards requirements conformance (continued)

Essential condition	Status	Commentary
Board interaction	✓	▶ The HoIA will provide the Audit Committee with the information it needs to conduct its oversight responsibilities. This includes the provision of: ○ The Internal Audit Plan, including the number of assigned audit days, and subsequent significant revisions to the plan (if applicable) ○ Changes potentially affecting the mandate or charter ○ Results of internal audits, including conclusions, themes, assurance, advice, insights, and monitoring results ○ Results from feedback surveys received in relation to the performance of the internal audits, as part of the Key Performance Indicators (KPIs) included in our Progress Reports and Annual Reports. ▶ The Audit Committee and senior management communicate their perspectives on strategic objectives, governance, risk and control through Audit Committee meetings, risk reporting, governance arrangements and routine engagement with Internal Audit. ▶ The Internal Audit team attends every Audit Committee meeting and presents the findings of each internal audit assignment. The Audit Committee members can ask questions of the Internal Audit team and senior management on the content of the reports. ▶ The Internal Audit team involves both the Audit Committee and senior management in determining the scope of the annual Internal Audit Plan to ensure to it is addressing key assurance needs and concerns.
Resources	✓	▶ We discussed the Internal Audit plan with senior management and the Audit Committee, on behalf of the PCC and CC. We ensure there is enough time allocated to deliver individual reviews. ▶ The Audit Committee and senior management engaged with the HoIA regarding the sufficiency of Internal Audit resources and any potential limitations that may affect the delivery of the Internal Audit mandate. ▶ As part of the planning process the relevant skills, competencies and expertise that are required to deliver the plan and Internal Audit mandate were considered. Use of subject matter experts is factored into the overall resource and budget for the plan. The Internal Audit plan clearly articulates where we foresee the use of specialist resources. ▶ BDO continually invests in platforms and technologies to drive innovation, efficiency, and value for you. We have several tools to support the Internal Audit function and provide valuable insights, such as various data analytics packages, Culture and Governance maturity assessments.



Full conformance



Generally conforms



Partial conformance



Non conformance

Global Internal Audit Standards requirements conformance (continued)

Essential condition	Status	Commentary
Quality	✓	▶ We follow a clear and defined method of working, which is aligned to the GIAS. This ensures that all assignments and deliverables have undergone a thorough review and approval process. ▶ BDO's Risk Management Unit oversees our quality assurance policies, procedures, and review approach. Quality assurance is our highest priority and is integral to our Conduct of Professional Services Manual (CPSM). This includes the review and approval of work, quality and documentation requirements, and annual 'cold' and 'hot' reviews of partner and manager files. ▶ Performance measures are agreed with the Audit Committee and reported through regular Progress Reports. We will also report on our KPIs in our Annual Report. ▶ We seek regular feedback through our Listening Programme, client satisfaction surveys, formal effectiveness/feedback processes, and regular communication. ▶ Our staff undergo continuous training through recognised providers, and we share our experiences internally to enhance the quality of our work.
External quality assessment (EQA)	✓	▶ The global standards of the IIA require every Internal Audit function that aims to comply with its standards to be reviewed, externally, every five years. ▶ At BDO we recognise the importance of independent quality assurance and so submit our Internal Audit team to an EQA review every five years. In 2021 we engaged the Chartered Institute of Internal Auditors (CIIA) to carry out the EQA and, in summary, their conclusion was that BDO generally conforms to the International Professional Practices Framework (IPPF). This was the highest of the three gradings awarded by the CIIA at the time. We are committed to continuous improvement and agreed a Quality Assurance Improvement Programme with the CIIA to respond to the recommendations and suggestions raised through the EQA exercise. A copy of the EQA report is available on request. ▶ We are currently making arrangements for the next EQA to take place later this calendar year. We will ensure that at least one person in the independent assessor team has the characteristics outlined for the CAE qualification, including relevant CPD and an understanding of how the GIAS are applied in the UK public sector, as required by the IASAB's <i>Application Note Global Internal Audit Standards in the UK Public Sector</i>. ▶ The EQA of the BDO internal audit services is not specific to Norfolk Police and the OPCC and the scope covers all of our out-sourced internal audit clients. For this reason, we generally conform with Standard 8.4 External Quality Assessment which requires the CAE to discuss the plan for the EQA with the Board. We do not meet all of the essential conditions under this standard which require collaboration and Board approval of: ○ The scope and frequency of assessments ○ The competencies of the external assessor or assessment team ○ The rationale for choosing to conduct a self-assessment with independent validation instead of an EQA (if applicable) ○ The CAE's action plan to address identified deficiencies and opportunities for improvement (if applicable). Instead, we determine these internally. We will however keep the Audit Committee, acting on behalf of the PCC and CC, informed of the EQA arrangements and outcomes as appropriate.



Full conformance



Generally conforms



Partial conformance

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Non conformance

FOR MORE INFORMATION:

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INTERNAL AUDIT PLAN NORFOLK CONSTABULARY AND THE OFFICE OF THE POLICE AND CRIME COMMISSIONER FOR NORFOLK

2026/27

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INTERNAL AUDIT APPROACH

BACKGROUND

Our risk-based approach to internal audit uses Norfolk Constabulary (the Force) and Office for the Police and Crime Commissioner (OPCC) own risk management processes and risk registers as a starting point for audit planning as this represents the Force's and OPCC's own assessment of the risks to it achieving their strategic objectives.

Our reliance on management's perception of risk is contingent on the maturity and effectiveness of the Force and OPCC's risk management arrangements. In determining the audit resources needed for significant risks, we have verified that senior management's risk assessment accurately reflects the Force's and OPCC's current risk profile.

PLANNED APPROACH TO INTERNAL AUDIT 2026/27

The indicative Internal Audit programme for 2026/27 is set out on pages 10 to 21. We met with senior management and members of the Audit Committee (AC) to bring together a full plan which will be presented to the AC meeting for formal review and approval. We will keep the programme under continuous review during the year and will introduce to the plan any significant areas of risk identified by management during that period.

The plan is set within the context of a multi-year approach to internal audit planning, such that all areas of key risks would be looked at over a three-year audit cycle. We have suggested future areas of focus as part of the three-year strategic internal audit plan, set out on pages 8 to 10.

HIGH RISK AREAS NOT INCLUDED

The following high-risk areas have not been included in our audit plan for 2026/27:

- Partnerships - Norfolk SRR 10: As this risk is currently one of the lowest scored risks within the Norfolk SRR (risk score of 6), we have elected not to cover this within the 26/27 plan but plan to provide assurance around this risk in the audit year 27/28 within the broader 3-year audit plan.
- Culture - Norfolk SRR 11: As there was an audit around culture covered in the 23/24 audit year, receiving a 'Moderate' audit opinion, we have elected to not cover this within the 26/27 plan, but we do plan to provide assurance around this risk in the audit year 27/28 within the broader 3-year audit plan.

Further details are included on page 21.

INDIVIDUAL AUDITS

When scoping each review, we'll reassess the estimated days needed to meet objectives and complete the work to a good standard, considering the Force's and OPCC's control environment. Any necessary revisions will be approved by the Accountable Officer before fieldwork begins.

In determining the timing of our individual audits, we will seek to agree a date which is convenient to the Force and OPCC, and which ensures availability of key management and staff and takes account of any operational pressures being experienced.

VARIATIONS TO THE PLAN

We review the three-year strategic plan each year to ensure we remain aware of your ongoing risks and opportunities. Over the coming pages we have mapped your key risks along with the audit work we propose to undertake, demonstrating we are focussing on your most important issues.

As such, our strategic audit programme follows the risks identified during our planning processes and confirmed through discussions with the management of both the Force and OPCC. If these were to change,

or emerging risks were to develop during this period, we would take stock and evaluate our coverage accordingly.

RESOURCING

The plan has been drafted giving consideration to the Force's and OPCC's budget and how coverage can be best obtained. Resource will be adequate to ensure the delivery of agreed reports to time, except where this is outside of our control. BDO has a core group of professionally qualified staff, including Chartered Accountants and Institute of Internal Auditors qualified staff, as well as other specialists and experienced auditors. Our team is fully attuned with modern internal audit practice and recognised risk and governance standards.

Subject to approval of the budget, we can confirm that we have sufficient human, financial and technological resources to deliver the internal audit plan.

CORE INTERNAL AUDIT TEAM

The core team that will be managing the internal audit programme is:

NAME	ROLE	QUALIFICATION	EMAIL
Gurpreet Dulay	Partner	CIPFA	Gurpreet.Dulay@bdo.co.uk
Nathaniel Hall	Assistant Manager	ACA	Nathaniel.Hall@bdo.co.uk
Max Armstrong	Manager	ACA	Max.Armstrong@bdo.co.uk

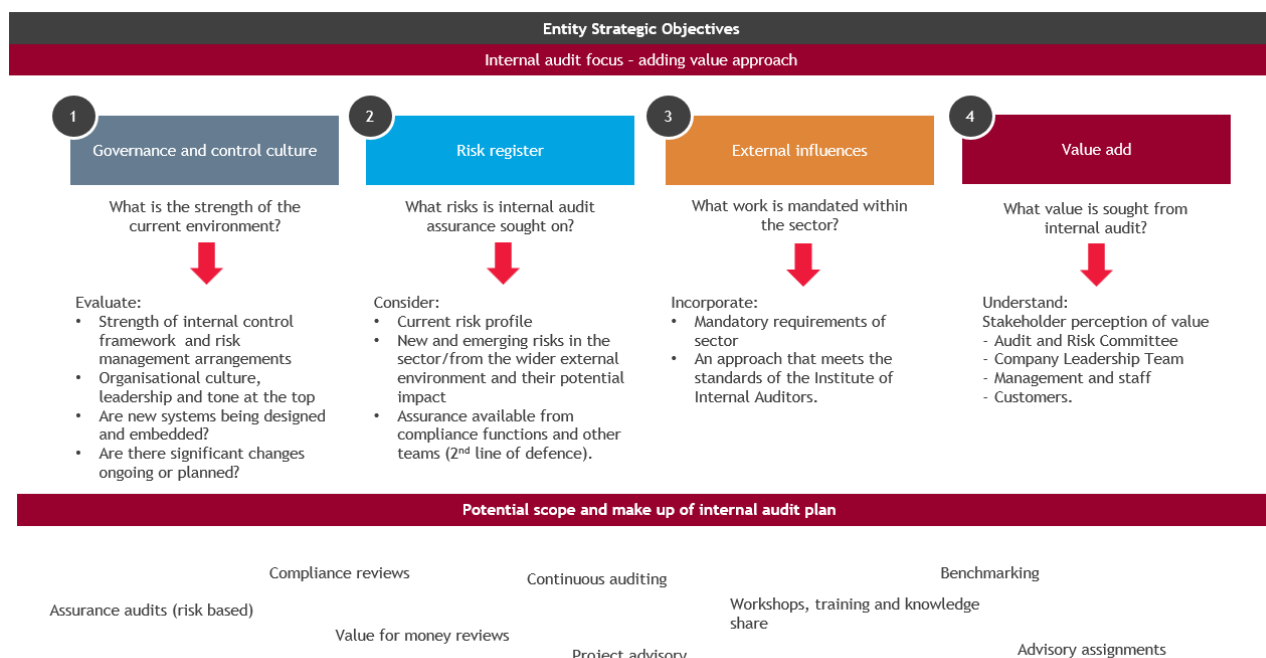
This team will be supported by our public sector internal auditors and members of our wider Risk Advisory Services (RAS) team, and wider firm, as and when required.

CONFLICTING DEMANDS, LIMITATIONS AND RESTRICTIONS

At the time of drafting this internal audit plan we are not aware of any conflicting demands for services between major stakeholders, such as high-priority requests based on emerging risks and requests to replace planned assurance engagements with advisory engagements.

We are also not aware of any limitations on the scope of work or restrictions on our access to information.

OUR APPROACH TO PLANNING



GOVERNANCE AND CULTURE

The governance and control culture is a fundamental consideration when developing the internal audit approach. We believe that governance is not only affected by procedures, rules and regulations (hard controls); another equally important component is the established culture and behaviour of employees within the Force and OPCC, as these determine the effectiveness of governance.

We have developed an understanding of these areas through a combination of our discussions with you about your business strategy and through review of documents such as your Annual Report and Accounts, your Annual Governance Statement, past AC papers and previous internal audit reports, as well as conversations held with the incumbent internal auditors and external auditors.

Assessment of culture and behaviour will be a key theme throughout the delivery of our work, and we will look to provide insight into whether these cultural factors support ethical behaviour on an ongoing basis.

In deriving the plan for 2026/27 and onwards we will focus on any planned and ongoing changes to core systems and processes to respond to the changes in the wider environment. We will be mindful of any significant change and the impact this can have on control culture during the delivery of the plan.

EXTERNAL INFLUENCES

Our programme of work is designed to comply with the Global Internal Audit Standards in the UK Public Sector, which encompass:

- ▶ The global Institute of Internal Auditors (IIA) *Global Internal Audit Standards* (GIAS)
- ▶ The Internal Audit Standards Advisory Board (IASAB) *Application Note Global Internal Audit Standards in the UK Public Sector*.

We will also consider in our work any externally imposed regulation relating to governance, risk and control. Such as those conducted by His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and the Independent Office for Police Conduct (IOPC).

CURRENT STRATEGIC RISK REGISTERS

On an ongoing basis, our audit plan will be based upon a detailed assessment of those risks that affect the achievement of the Force and OPCC's strategic objectives. Our audit programme will be designed to ensure that controls are in place such that key risks are appropriately managed and controlled. To understand the Force and OPCC's objectives and key risks, we considered the following:

- ▶ The Force and OPCC's strategy and objectives
- ▶ The Force and OPCC's Strategic Risk Registers
- ▶ The Force and OPCC's financial forecasts and performance
- ▶ Reports from other assurance providers
- ▶ The content of your most recent internal audit reports, the results of which are summarised in Appendix I.

The internal audit plan and Strategic Risk Registers will be periodically reviewed during 2026/27. Should the plan need to change we will seek approval from the AC.

ADDED VALUE

We understand that 'value' is perceived differently by each client and therefore we do not seek to have a standard approach to this element of the audit programme.

Our methodology considers the additional value the AC and management are seeking from internal audit, beyond the assurance our work provides.

We therefore consider this alongside our understanding of the risks. Added value may take a range of forms, from benchmarking and other peer comparisons to involvement with advising on new systems implementation, advisory assignments and providing training and seminars.

OUR NEXT GEN FRAMEWORK

Our innovative Next Gen approach to internal audit ensures you maximise the potential added value from BDO as your internal audit provider and the expertise we bring from our dedicated public sector internal auditors and wider BDO specialist teams.

The Next Gen approach allows us to deliver a healthy mix of assurance that is forward looking, flexible and responsive and undertaken in partnership with yourselves. The key components to this approach are outlined below and underpin our proposed plan coverage:

CORE ASSURANCE

Reviews of fundamental finance and operational systems to provide assurance that core controls and procedures are operating as intended.

SOFT CONTROLS

Reviews seek to understand the true purpose behind control deficiencies and provide a route map to enhance their effectiveness.

FUTURE FOCUSED ASSURANCE

Rather than wait for implementation and then comment on identified weaknesses, we will work with you in an upfront / real time way.

FLEXIBLE AUDIT RESOURCE

Undertake proactive work across the Force and OPCC, perhaps in preparation for regulatory reviews or change management programmes.



MAPPING YOUR STRATEGIC RISKS - NORFOLK CONSTABULARY

REF	STRATEGIC RISKS FROM YOUR RISK MAP	RISK ASSESSMENT (JUNE 2026)	RATING
SRR 1	Confidence Failure to engage with communities, ensure fair practice and maintain standards of conduct, leads to a disaffected public which results in the withdrawal of consent, therefore undermining our ability to police and meet targets.	8 - Within Tolerance	
SRR 2	Service Failure to plan and adapt to changes in demand and public requirements leads to unmanaged demand, resulting in poor performance and inspection outcomes and a negative impact on public trust and confidence.	9 - Outside of Tolerance	
SRR 3	Data Failure to effectively input, manage and protect our data results in a significant data event, e.g. breach or operational failure, leading to a loss in public confidence, inefficiencies and additional demand, regulatory failure, financial loss and negative publicity.	12 - Outside of Tolerance	
SRR 4	Protection Failure to respond to calls for service and investigate effectively with a focus on victims results in vulnerability and a lack of prevention leading to public harm.	8 - Within Tolerance	
SRR 5	Organisational Preparedness Failure to effectively plan and prepare for a cyber-attack or major / critical incident or event results in a weak response leading to a catastrophic impact on operational effectiveness, performance and public confidence.	9 - Outside of Tolerance	

SRR 6	People and Resources Failure to attract, retain, lead, train and support the workforce results in an inability to resource the delivery model leading to a poor level of service to the public.	8 - Within Tolerance	
SRR 7	Finance Lack of adequate funding due to external financial challenges results in increased pressure on financial controls and decision making leading to inability to meet strategic objectives, invest in key strategic areas or deliver required levels of service.	8 - Within Tolerance	
SRR 8	Future Enablers Failure to exploit emerging technology results in missed opportunities to increase efficiency and operational effectiveness leading to negative impact on performance, workforce condition and service to public.	6 - Within Tolerance	
SRR 9	Statutory Responsibilities Failure to adhere to regulatory frameworks and statutory requirements leads to non-compliance which results in fines, inefficiencies, poor service provision and low trust and confidence amongst our people, partners and communities.	8 - Within Tolerance	
SRR 10	Partnerships Devolution and local government reorganisation and financial pressure on partners results in unmanaged withdrawal from joint activity and service delivery leading to increased demand on police, poor service and low public confidence.	6 - Within Tolerance	
SRR 11	Culture Failure to cultivate a positive workplace culture results in a poor employee relations climate, a decrease in employee engagement and productivity, increased turnover, poor service to the public and a negative impact on trust and confidence.	8 - Within Tolerance	

INTERNAL AUDIT OPERATIONAL PLAN 2026/27

AREA	RISK REFERENCE	DAYS	TIMING (QUARTER)	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT TOPICAL REQUIREMENTS)
Core Assurance					
OPCCs - Governance Review	All SRR Risks	22	Q4	To assess the outcome of any internal corporate governance framework and to then utilise CIPFA guidance and internal policies and procedures to assess the effectiveness of governance structures and discussion. At a high-level, the review could cover: • Governance framework, committee structure and clarity of roles, responsibilities and delegated authority across the OPCCs and their interface with the Forces. • Quality, timeliness and completeness of governance reporting to support effective scrutiny and decision-making. • Effectiveness of key governance forums, including challenge, escalation and tracking of actions / decisions. • Alignment of governance arrangements with relevant good practice, including CIPFA principles and local governance requirements.	Good governance underpins overall effectiveness, and it is vital to achieving and maintaining good standards. This is an extensive review and in our first year will also give us a sound understanding of your arrangements/relationships.
Victims' Compliance Safeguarding	Code and SRR 4 - Norfolk	24	Q2	The review will assess compliance with the Victims' Code, focusing on the timeliness, quality and consistency of updates provided to victims. It will also evaluate safeguarding escalation processes and governance arrangements supporting vulnerable individuals. At a high-level, the review could cover:	Ensuring victims are supported effectively is a core policing priority and a key inspection area. Failures in this area directly affect victim outcomes, public confidence, and engagement with policing services.

AREA	RISK REFERENCE	DAYS	TIMING (QUARTER)	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT TOPICAL REQUIREMENTS)
				• Compliance with core Victims' Code requirements, including the timeliness, quality and consistency of victim updates. • Processes for identifying vulnerability and escalating safeguarding concerns appropriately and promptly. • Governance and oversight arrangements for victim care, safeguarding performance and management intervention. • Consistency of approach across functions / operational areas, including how learning and exceptions are identified and acted upon.	
Information Governance, Quality & AI	Data SRR 3 - Norfolk -	24	Q2	This review will examine the effectiveness of information governance arrangements, including the Information Asset Owner framework, data quality controls, and assurance processes. It will also assess governance, policy and oversight for AI usage, including emerging technologies such as Copilot. At a high-level, the review could cover: • Accountability and governance for information management, including roles such as Information Asset Owners and supporting oversight arrangements. • Controls to maintain data quality, accuracy, completeness and reliability for operational and management use. • Compliance and assurance processes covering data protection, incident management, breaches and wider information handling requirements. • Governance, policy, oversight and monitoring arrangements for the safe and appropriate use of AI and emerging technologies. The review will consider the risk of data misuse, manipulation and fraud, together with whether information and AI	This represents one of the highest inherent risk areas within both organisations. Data quality issues, legacy systems and AI misuse present risks of regulatory breach, operational inefficiency and reputational damage. As of June 2026, both data related strategic risks were considered 'over tolerance' for both Norfolk and Suffolk Constabularies.

AREA	RISK REFERENCE	DAYS	TIMING (QUARTER)	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT TOPICAL REQUIREMENTS)
				governance arrangements support the effective and efficient use of technology investments.	
Disaster Recovery and ICT Resilience	SRR 5 - Norfolk	24	Q3	This review will assess the completeness, maintenance and effectiveness of ICT disaster recovery arrangements, including recovery planning for critical systems, dependency mapping, testing and alignment with wider cyber and business continuity arrangements. At a high-level, the review could cover: • Recovery arrangements for critical ICT systems and services, including ownership, prioritisation and recovery objectives. • Dependency mapping across applications, infrastructure, suppliers and supporting operational processes. • Testing and exercising of disaster recovery arrangements, including lessons learned and follow-up action. • Integration between ICT disaster recovery, cyber incident response and wider business continuity arrangements.	This review has been included because organisational preparedness is outside tolerance in both Forces. A disaster recovery review is a targeted review of recovery capability and would provide more specific assurance over whether critical services could be restored in practice following a cyber incident or major systems failure.
Key Financial Controls (Budgetary Management)	SRR 7 - Norfolk	26	Q3	This review will evaluate budgetary management processes, including budget setting, forecasting, monitoring and variance analysis across departments. It will assess the effectiveness of financial reporting arrangements, the accuracy and timeliness of budget information, and the level of challenge and oversight applied by management. The review will also consider governance structures supporting budgetary control, including escalation processes, accountability for overspends, and the robustness of decision-making in response to financial pressures. At a high-level, the review could cover:	This review has been included in the audit plan due to financial risks identified within both Strategic Risk Registers (SRR7 for Norfolk and SRR5 for Suffolk). While previous finance audits have focused on transactional controls, budgetary management has not been a primary focus. Strengthening oversight of budgeting, forecasting and monitoring is critical to managing financial pressures and supporting effective decision-making. This

AREA	RISK REFERENCE	DAYS	TIMING (QUARTER)	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT TOPICAL REQUIREMENTS)
				- Budget setting, forecasting and in-year monitoring processes across departments and functions. - Accuracy, timeliness and usefulness of financial reporting provided to budget holders and senior management. - Challenge, governance and escalation around variances, overspends and emerging financial pressures. - Accountability of budget holders and robustness of decision-making in response to financial risk and affordability pressures. The review will also consider the adequacy of controls to prevent and detect fraud, error and financial irregularity, together with the extent to which financial management arrangements support economy, efficiency and effectiveness in the use of resources (Value for Money).	review will provide assurance over the robustness of these arrangements.
Out of Court Resolutions	SRR4 - Norfolk SRR9 - Norfolk	20	Q4	This review will assess the effectiveness of the Constabulary's arrangements for the use of Out of Court Resolutions (OoCRs), including community resolutions, cautions, conditional cautions and diversionary schemes. It will evaluate governance and oversight arrangements, compliance with legislative and policy requirements, the consistency and appropriateness of decision-making, and the extent to which OoCRs support victim outcomes, offender rehabilitation and organisational objectives. At a high level, the review could cover: - Governance and accountability arrangements for OoCRs, including roles and responsibilities, performance management, scrutiny processes and reporting to senior leadership. - Compliance with legislation, national guidance and force policy, including eligibility criteria, authorisation	This review has been included following a request from members of the Audit Committee who identified Out of Court Disposals (OoCDs) as an area where additional independent assurance would provide value. The review will provide assurance over the appropriateness, consistency and governance of OoCD decision making, compliance with national guidance and legislation, victim considerations, and organisational oversight arrangements. Effective management of OoCDs is important in maintaining public confidence, ensuring appropriate outcomes for victims and offenders, and

AREA	RISK REFERENCE	DAYS	TIMING (QUARTER)	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT TOPICAL REQUIREMENTS)
				requirements, victim considerations and evidential standards. • Effectiveness and consistency of decision-making, including supervisory oversight, the appropriateness of outcomes selected, and the quality of supporting rationale and record keeping. • Management and monitoring of conditions, interventions and diversionary activities, including arrangements to monitor completion and respond to non-compliance. • Victim engagement and outcomes, including consideration of victim views, communication arrangements and the effectiveness of restorative approaches. • Quality of management information and performance monitoring, including data accuracy, reporting arrangements, trend analysis and the use of information to support organisational learning and continuous improvement. The review will also consider whether governance, oversight and assurance arrangements support the consistent, proportionate and effective use of OoCRs across the Constabulary, while maintaining public confidence and supporting positive outcomes for victims and offenders.	demonstrating compliance with statutory responsibilities and criminal justice expectations
Total		140			

AREA	RISK REFERENCE	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT IIA TOPICAL REQUIREMENTS)
Soft Controls					
Professional Standards, Vetting and Complaints	SRR 9 - Norfolk	24	Q4	This review will assess the capacity and capability of Professional Standards functions in managing demand, including misconduct, vetting and complaints. It will evaluate vetting processes, backlog management, compliance with Authorised Professional Practice (APP), and the effectiveness of learning and prevention arrangements. At a high-level, the review could cover: • Capacity and capability to manage current and emerging demand across misconduct, vetting and complaints. • Design and operation of vetting processes, including compliance with APP and the management of refresh / review requirements. • Backlog management, prioritisation and governance over higher-risk cases or delays. • Arrangements for organisational learning, prevention and management oversight arising from complaints, conduct matters and vetting outcomes.	This area directly impacts legitimacy, trust and reputational risk. Both Constabularies' Strategic Risk Registers highlight that failures in standards of conduct, vetting and organisational culture can lead to a loss of public confidence, disengagement from communities and reduced consent to policing. Rising volumes of misconduct cases and the continued presence of vetting backlogs indicate sustained pressure on Professional Standards functions, creating a risk that issues are not identified, prioritised or addressed in a timely and proportionate way. A Vetting specific audit was last conducted in 23/24, achieving a 'Moderate' assurance rating.
Total		44			

AREA	RISK REFERENCE	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT IIA TOPICAL REQUIREMENTS)
Future Focused Assurance					
Demand, Performance and Resource Planning	SRR 6 - Norfolk	24	Q2	This review will assess the effectiveness of demand forecasting and its translation into workforce and operational deployment decisions. It will include an evaluation of forecasting models and assumptions across short, medium and long-term horizons, and how these inform planning through governance structures such as Contact/Control Room (CCR), Case Preparation Centre (CPC), Horizons and Command Team oversight. At a high-level, the review could cover: • Demand forecasting models, assumptions and the extent to which they cover short-, medium- and longer-term demand pressures. • How demand analysis is translated into workforce planning, deployment and other operational resourcing decisions. • Governance and oversight of demand, performance and resourcing through relevant management forums and reporting mechanisms. • Use of performance information to identify pressure points, adjust resourcing and support effective service delivery outcomes.	This is a root cause audit underpinning multiple strategic risks. Weak demand modelling leads to unmanaged demand, abstraction pressure and performance failure across the organisation. Strength in this area supports service delivery, workforce sustainability and financial planning. In the most recent SRR for Norfolk, SRR 2 - Service was considered to be 'over tolerance'. The risk is around failing to adapt to change in demand.
Total		24			

AREA	RISK REFERENCE	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION (INCLUDING ANY RELEVANT IIA TOPICAL REQUIREMENTS)
Flexible Audit Resource - To be allocated during the year as required but could include the examples shown below					
Flexible Resource	All	2	N/A	These days are held as contingency and can be allocated as required providing flexibility in the plan.	To allow flexibility in our work to adapt to requests from management or changes to the plan.
Total		2			

AREA	RISK REFERENCE	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Contract Management					
Planning / liaison / management	N/A	15	Q1 - Q4	Creation of audit plan, meeting with Executive Directors and Chief Officers	Effective contract management
Recommendations follow up	N/A	20	Q1 - Q4	Assessment and reporting of status of implementation of recommendations raised	Assurance for the Executive Team and AC
AC Attendance	N/A	10	Q1 - Q4	Attendance at AC meetings, pre-meets and AC Chair liaison	Effective contract management
Total		45			

SUMMARY	DAYS
Core Assurance	120
Soft Controls	44
Future Focused Reviews	24
Flexible Audit Resource	2
Contract Management	45
Total days	235

AREAS CONSIDERED BUT NOT INCLUDED IN 2026/27

The following areas have been considered for 2026/27 but have not been included. These will be considered in future years and should any areas of the Internal Audit Plan be removed during the year, we will consider whether any of these can be brought forward.

AREA	SRR REF	REASON FOR EXCLUSION
Risk Management	All SRR Risks	A risk management audit was completed in 25/26 receiving 'Moderate' assurance. To allow time for the recommendations coming out of that review to embed, we have decided not to include it within the plan.
Workforce	SRR 6 - Norfolk	A workforce planning audit and a staff retention audit were completed in 24/25 receiving 'Limited' assurances. To allow time for recommendations coming out of those reviews to embed, we have elected to not include this audit in the 26/27 plan but have included a review for later in the 3-year audit cycle (28/29).
Partnerships	SRR 10 - Norfolk	As this risk is currently one of the lowest scored risks within the Norfolk SRR (risk score of 6), we have elected not to cover this within the 26/27 plan but plan to provide assurance around this risk in the audit year 27/28 within the broader 3-year audit plan.
Culture	SRR 11 - Norfolk	As there was an audit around culture covered in the 23/24 audit year, receiving a 'Moderate' audit opinion, we have elected to not cover this within the 26/27 plan, but we do plan to provide assurance around this risk in the audit year 27/28 within the broader 3-year audit plan.
Communications	SRR1 - Norfolk SRR2 - Norfolk	This audit was initially included within the 2026/27 Internal Audit Plan but, following discussions with management, has been replaced with an alternative audit area considered to be of greater priority at this time. Planned organisational changes within the communications function, together with staff turnover, mean that management were supportive of deferring the review until 2027/28 when the operating environment is expected to be more stable. The audit has therefore been removed from the 2026/27 plan and will be reconsidered as part of the broader three-year audit planning cycle.



APPENDIX I

PREVIOUSLY AUDITED AREAS

The table below sets out the audits and advisory reviews that the Force and OPCC's previous internal audit providers have carried out over the last three years:

AUDITED AREA	DESIGN RATING	EFFECTIVENESS RATING
2025/26		
Estates Strategy	Moderate	Moderate
ICT Review of Cyber Security Management (SyAp)	Substantial	Substantial
Communication Strategy	Substantial	Substantial
Corporate Governance	Moderate	Moderate
Asset Management	Substantial	Substantial
Change Management	Advisory	
Contract Management	Moderate	Moderate
Risk Management	Moderate	Moderate
Key Financial Controls	Substantial	Substantial
Performance Management Framework	Substantial	Substantial
Procurement	Moderate	Moderate
2024/25		
Complaints	Moderate	Moderate
Contract Business Continuity	Moderate	Moderate
ICT Strategy & Project Management	Moderate	Moderate
Workforce Planning	Limited	Limited
Safeguarding - Cadet Programme	Moderate	Moderate
Key Financial Controls	Substantial	Substantial
Payroll	Moderate	Moderate
Recruitment and Induction Training	Moderate	Moderate

AUDITED AREA	DESIGN RATING	EFFECTIVENESS RATING
Staff Retention	Limited	Limited
Fleet Management	Moderate	Moderate
2023/24		
Culture and Expected Behaviour	Moderate	Moderate
Vetting	Moderate	Moderate
Expenses	Moderate	Moderate
Data Quality	Moderate	Moderate
Out of Court Disposals	Moderate	Moderate
Ill Health Retirement and Injury Awards	Moderate	Moderate
Absence Management including Limited Duties	Limited	Limited
Appraisals	Moderate	Moderate
Business Continuity	Moderate	Moderate
E-Recruitment System	Substantial	Substantial
Firearms	Moderate	Moderate
Fuel Usage and Security of Fuel Cards	Substantial	Substantial
Grievance Reporting and Management	Moderate	Moderate
Planned and Preventative Estate Maintenance	Moderate	Moderate
Data Protection and FOI	Substantial	Substantial

APPENDIX II

INTERNAL AUDIT CHARTER

This charter is a requirement of internal audit standards. The charter formally defines internal audit's purpose, authority and responsibility. It establishes internal audit's position within both Norfolk Police and the Office of the Police and Crime Commissioner for Norfolk (the Force and OPCC) and defines the scope of internal audit activities. Final approval of this charter resides with the Audit Committee (AC) on behalf of the Chief Constable and Police and Crime Commissioner (CC and PCC).

STANDARDS OF INTERNAL AUDIT PRACTICE

To fulfil its purpose, internal audit will perform its work in accordance with the Global Internal Audit Standards in the UK Public Sector, which encompass:

- ▶ The global Institute of Internal Auditors (IIA) Global Internal Audit Standards (GIAS) effective from January 2025
- ▶ The Internal Audit Standards Advisory Board (IASAB) Application Note Global Internal Audit Standards in the UK Public Sector effective from 1 April 2025.

The GIAS refer to the 'board' as 'the highest-level body charged with governance, such as a board of directors, an Audit Committee, a board of governors or trustees, or a group of elected officials or political appointees.' For the Force and OPCC 'board' is the AC acting on behalf of the Chief Constable and Police and Crime Commissioner.

The GIAS also refer to the 'chief audit executive' as the 'leadership role responsible for effectively managing all aspects of the internal audit function and ensuring the quality performance of internal audit services in accordance with Global Internal Audit Standards.' For the CC's and PCC's internal audit function, 'the chief audit executive' is the BDO-assigned partner acting as the Head of Internal Audit (HoIA).

INTERNAL AUDIT'S PURPOSE AND MANDATE

Purpose

The purpose of the internal audit function is to strengthen the Force and OPCC's ability to create, protect, and sustain value by providing the AC and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

The internal audit function enhances the Force and OPCC's:

- ▶ Successful achievement of its objectives
- ▶ Governance, risk management, and control processes
- ▶ Decision-making and oversight
- ▶ Reputation and credibility with its stakeholders
- ▶ Ability to serve the public interest.

The Force and OPCC's internal audit function is most effective when:

- ▶ Internal auditing is performed by competent professionals in conformance with the GIAS in the UK Public Sector
- ▶ The internal audit function is independently positioned with direct accountability to the AC.
- ▶ Internal auditors are free from undue influence and committed to making objective assessments.

The role of the Force and OPCC's internal audit therefore includes:

- ▶ Supporting the delivery of the Force and OPCC's strategic objectives by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal controls
- ▶ Championing good practice in governance through assurance, advice and contributing to the Force and OPCC's annual governance review
- ▶ Advising on governance, risk management and internal control arrangements for major projects, programmes and system changes
- ▶ Access to the Force and OPCC's collaborative and arm's-length arrangements.

Mandate - Authority

The Accounts and Audit regulations 2015 are the basis for internal audit's authority or mandate.

The AC grants the internal audit function the mandate to provide the AC and senior management with objective assurance, advice, insight, and foresight.

The internal audit function's authority is created by its direct reporting relationship to the AC. Such authority allows for unrestricted access to the AC.

The AC authorises the internal audit function to:

- ▶ Have full and unrestricted access to all functions, data, records, information, physical property, and personnel pertinent to carrying out internal audit responsibilities; internal auditors are accountable for confidentiality and safeguarding records and information
- ▶ Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques, and issue communications to accomplish the function's objectives
- ▶ Obtain assistance from the necessary organisation's personnel in relevant engagements, as well as other specialised services from within or outside the organisation to complete internal audit services.

Mandate - Independence, position, and reporting relationships

- ▶ The HoIA will be positioned at a level in the organisation that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function.
- ▶ The HoIA will report functionally to the AC and administratively to the OPCC's Chief Finance Officer and the Force's Director of Finance.
- ▶ This positioning provides the organisational authority and status to bring matters directly to senior management and escalate matters to the AC, when necessary, without interference and supports the internal auditors' ability to maintain objectivity.
- ▶ The HoIA will confirm to the AC, at least annually, the organisational independence of the internal audit function.
- ▶ The HoIA will disclose to the AC any interference internal auditors encounter related to the scope, performance, or communication of internal audit work and results. The disclosure will include communicating the implications of such interference on the internal audit function's effectiveness and ability to fulfil its mandate.

AC OVERSIGHT

To establish, maintain, and ensure that the CC and PCC's internal audit function has sufficient authority to fulfil its duties, the AC will:

- ▶ Discuss with the HoIA and senior management the appropriate authority, role, responsibilities, scope, and services (assurance and/or advisory) of the internal audit function
- ▶ Ensure the HoIA has unrestricted access to and communicates and interacts directly with the AC, including in private meetings without senior management present

- ▶ Discuss with the HoIA and senior management other topics that should be included in the internal audit charter
- ▶ Participate in discussions with the HoIA and senior management about the “essential conditions”, described in the GIAS, which establish the foundation that enables an effective internal audit function
- ▶ Advise management on the approval of the internal audit function’s charter annually, which includes the internal audit mandate and the scope and types of internal audit services
- ▶ Advise management on the approval of the risk-based internal audit plan
- ▶ Advise management, where appropriate, on the approval the internal audit function’s human resources administration and budgets
- ▶ Collaborate with senior management to determine the qualifications and competencies the Force and OPCC expects in a HoIA
- ▶ Provide advice and recommendations to management on the appointment and removal of the HoIA and outsourced internal audit provider
- ▶ Advise management on the approval of fees paid to the outsourced internal audit provider
- ▶ Review the HoIA’s and internal audit function’s performance
- ▶ Receive communications from the HoIA about the internal audit function including its performance relative to its plan
- ▶ Ensure a quality assurance and improvement program has been established and review the results annually
- ▶ Make appropriate inquiries of senior management and the HoIA to determine whether scope or resource limitations are inappropriate.

Changes to the Mandate and Charter

Circumstances may justify a follow-up discussion between the HoIA, AC, and senior management on the internal audit mandate or other aspects of the internal audit charter. Such circumstances may include but are not limited to:

- ▶ A significant change in the GIAS in the UK Public Sector
- ▶ A significant acquisition or reorganisation within the Force or OPCC
- ▶ Significant changes in the HoIA, AC, and/or senior management
- ▶ Significant changes to the Forces and OPCC’s strategies, objectives, risk profile, or the environment in which the Force and OPCC operates
- ▶ New laws or regulations that may affect the nature and/or scope of internal audit services.

Support for Internal Audit

Internal audit’s activities require access to and support from senior management, the AC and those charged with governance. Support allows internal audit to apply the mandate and charter in practice and meet expectations.

The CC’s and PCC’s will support the internal audit function by:

- ▶ Championing the role and work of internal audit to the staff within the Force and OPCC and to partner organisations with whom internal audit works
- ▶ Facilitating access to senior management, the AC and the Force and OPCC’s external auditor
- ▶ Assisting, where possible, with access to external providers assurance such as regulators, inspectors and consultants
- ▶ Engaging constructively with internal audit’s findings, opinions and advice

Building awareness and understanding of the importance of good governance, risk management and internal control for the success of the CC and PCC and of internal audit’s contributions. The CC’s and PCC’s will also put in place conditions to enable the internal audit work:

- ▶ Ensuring that the reporting line of the HoIA is not lower than a member of the senior management team and that the HoIA has access to all members of the team
- ▶ Ensuring that client responsibility lies with a member of senior management

The AC will support internal audit by:

- ▶ Enquiring of senior management and the HoIA about any restrictions on the internal audit's scope, access, authority or resources that limit its ability to carry out its responsibilities effectively
- ▶ Considering the audit plan or planning scope, and formally approving or recommending approval to those charged with governance
- ▶ Meeting at least annually with the HoIA in sessions without senior management present.

Senior management will establish and safeguard internal audit's independence by:

- ▶ Ensuring internal audit's access to staff and records, as set out in regulations and the charter, operates freely and without any interference
- ▶ Ensuring that the HoIA reports in their own right to the AC on the work of internal audit
- ▶ Providing opportunities for the HoIA to meet with the AC without senior management present
- ▶ Where there are actual or potential impairments to the independence of internal audit, working with the HoIA to remove or minimise them or ensure safeguards are operating effectively
- ▶ Recognising that if the HoIA has additional roles and responsibilities beyond internal auditing, or if new roles are proposed, it could impact on the independence and performance of internal audit; in such cases the impact must be discussed with the HoIA and the views of the AC sought
- ▶ Where needed, appropriate safeguards will be put in place by senior management to protect the independence of internal audit and support conformance with professional standards. Matters around the appointment, removal, remuneration and performance evaluation of the HoIA will be undertaken by senior management, but these arrangements must not be used to undermine the independence of internal audit. The AC will provide feedback on the performance evaluation of the HoIA, which should include feedback from the Chair of the AC.

Interaction between the Audit Committee and Internal Audit

The AC will support internal audit's independence by reviewing the effectiveness of safeguards at least annually, including any issues or concerns about independence from the HoIA. The HoIA will have the right of access to the Chair of the AC at any time. The AC can escalate its concerns about internal audit independence to those charged with governance.

To ensure there is good interaction between the AC and internal audit, the AC will agree its work plan with the HoIA to ensure there is appropriate coverage of internal audit matters within AC agendas. The AC workplan will provide for the internal audit mandate and charter, strategy, plans, engagement reporting and the annual conclusion, and quality reports.

The AC is familiar with the Force and OPCC's assurance framework, governance, risk management and internal control arrangements to facilitate its interactions with internal audit.

Senior management will engage with the AC on any significant changes to governance, risk and control arrangements and any concerns they may have on assurance. The AC will have oversight of the annual governance statement before final approval.

Where there is disagreement about the management of risks or agreed audit actions between internal audit and senior management, the AC will review and make their recommendation to either management or those charged with governance.

Internal Audit Resources

The AC and senior management will engage with the HoIA to review whether internal audit's financial, human and technological resources are sufficient to meet internal audit's mandate as set out in the regulations and achieve conformance with GIAS in the UK public sector. Where there are concerns about

internal audit's ability to fulfil its mandate or deliver an annual conclusion, the concerns will be formally recorded and reported to those charged with governance.

If resource issues result in a limitation of scope on the annual conclusion, this will be reported and disclosed in the annual governance statement. Decisions on internal audit resourcing by senior management and those charged with governance must take account of the longer-term risks to the governance and financial sustainability of the Force and the OPCC and internal audit's role in supporting those objectives. Where there are temporary resource constraints, senior management must work with the HOIA to establish longer-term plans for sustainable internal audit resources.

Quality

Annually, the AC will review the results of the HOIA's assessment of conformance against GIAS in the UK public sector including any action plan. The AC will review the HOIA's annual report, including the annual conclusion on governance, risk management and control, and internal audit's performance against its objectives. To meet the requirements of the regulations (the mandate) for internal audit, the AC will satisfy itself on the effectiveness of internal audit. They will consider conformance with the standards, interactions with the AC, performance and feedback from senior management. Their conclusions will be reported to those charged with governance, for example, as part of the AC's annual report.

External Quality Assessment

On behalf of those charged with governance and the AC, senior management will ensure that internal audit has an external quality assessment at least once every five years of its conformance against GIAS in the UK public sector.

Senior management and the HoIA will discuss the timing of the review and report the options and their recommendation to the AC. The proposals for the scope, method of assessment and assessor will be brought to the AC for agreement. The AC will receive the complete results of the assessment and consider the HoIA's action plan to address any recommendations. Progress will be monitored. Where the AC does not have delegated authority, the committee will report the overall results of the external quality assessment to those charged with governance.

HEAD OF INTERNAL AUDIT ROLES AND REONSIBILITIES

Ethics and Professionalism

The HoIA will ensure that internal auditors:

- ▶ Conform with the GIAS in the UK Public Sector, including the principles of Ethics and Professionalism (integrity, objectivity, competency, due professional care, and confidentiality) and the Seven Principles of Public Life (the 'Nolan Principles') (selflessness, integrity, objectivity, accountability, openness, honesty and leadership)
- ▶ Understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and be able to recognise conduct that is contrary to those expectations
- ▶ Encourage and promote an ethics-based culture in the organisation
- ▶ Report organisational behaviour that is inconsistent with the organisation's ethical expectations, as described in applicable policies and procedures.

Objectivity

The HoIA will ensure that the internal audit function remains free from all conditions that threaten the ability of internal auditors to carry out their responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the HoIA determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively such that they believe in their work product, do not compromise quality, and do not subordinate their judgment on audit matters to others.

Internal auditors will have no direct operational responsibility or authority over any activities they review. Accordingly, internal auditors will not implement internal controls, develop procedures, install systems, or engage in other activities that may impair their judgment.

Internal auditors will:

- ▶ Disclose impairments of independence or objectivity, in fact or appearance, to appropriate parties and at least annually, such as the HoIA, AC, management, or others
- ▶ Exhibit professional objectivity in gathering, evaluating, and communicating information
- ▶ Make balanced assessments of all available and relevant facts and circumstances
- ▶ Take necessary precautions to avoid conflicts of interest, bias, and undue influence.

Managing the Internal Audit Function

The HoIA has the responsibility to:

- ▶ Understand the Force and OPCC's governance, risk management and control processes, and the importance in the UK public sector of securing value for money, in developing an effective strategy and plan.
- ▶ At least annually, develop a risk-based internal audit plan that considers the input of the AC and senior management; discuss the plan with the AC and senior management and submit the plan to the AC for review and approval
- ▶ Communicate the impact of resource limitations on the internal audit plan to the AC and senior management
- ▶ Review and adjust the internal audit plan, as necessary, in response to changes in the Force and OPCC's business, risks, operations, programs, systems, and controls
- ▶ Communicate with the AC and senior management if there are significant interim changes to the internal audit plan
- ▶ Ensure internal audit engagements are performed, documented, and communicated in accordance with the GIAS in the UK Public Sector
- ▶ Follow up on engagement findings and confirm the implementation of recommendations or action plans and communicate the results of internal audit services to the AC and senior management periodically and for each engagement as appropriate
- ▶ Ensure the internal audit function collectively possesses or obtains the knowledge, skills, and other competencies and qualifications needed to meet the requirements of the GIAS in the UK Public Sector and fulfil the internal audit mandate (in public sector internal audit, the HoIA is required to have a CMIIA, or a CCAB qualification, or an equivalent professional qualification which includes training on the practice of internal audit, and suitable internal audit experience)
- ▶ Identify and consider trends and emerging issues that could impact the Force and OPCC and communicate to the AC and senior management as appropriate
- ▶ Consider emerging trends and successful practices in internal auditing
- ▶ Establish and ensure adherence to methodologies designed to guide the internal audit function
- ▶ Ensure adherence to relevant policies and procedures unless such policies and procedures conflict with the internal audit charter or the GIAS; any such conflicts will be resolved or documented and communicated to the AC and senior management
- ▶ Coordinate activities and consider relying upon the work of other internal and external providers of assurance and advisory services; if the HoIA cannot achieve an appropriate level of coordination, the issue will be communicated to senior management (including the barriers to effective co-ordination with other assurance providers) and if necessary escalated to the AC.

Communication with the Audit Committee and Senior Management

The HoIA will report quarterly to the AC and senior management regarding:

- ▶ The internal audit function's mandate

- ▶ The internal audit plan and performance relative to its plan
- ▶ Internal audit budget
- ▶ Significant revisions to the internal audit plan and budget
- ▶ Potential impairments to independence, including relevant disclosures as applicable
- ▶ Results from the quality assurance and improvement program, which include the internal audit function's conformance with the GIAS in the UK Public Sector and action plans to address the internal audit function's deficiencies and opportunities for improvement
- ▶ Significant risk exposures and control issues, including fraud risks, governance issues, and other areas of focus for the AC
- ▶ Results of assurance and advisory services
- ▶ Resource requirements
- ▶ Management's responses to risk that the internal audit function determines may be unacceptable or acceptance of a risk that is beyond the Force and OPCC's risk appetite.

Quality Assurance Improvement Programme

The HoIA will develop, implement, and maintain a quality assurance and improvement programme (QAIP) that covers all aspects of the internal audit function.

The programme will include external and internal assessments of the internal audit function's conformance with the GIAS in the UK Public Sector, as well as performance measurement to assess the internal audit function's progress toward the achievement of its objectives and promotion of continuous improvement.

The plan will assess the efficiency and effectiveness of internal audit and identify opportunities for improvement.

Annually, the HoIA will communicate with the AC and senior management about the internal audit function's QAIP, including the results of internal assessments (ongoing monitoring and periodic self-assessments) and external assessments.

External assessments will be conducted at least once every five years by a qualified, independent assessor or assessment team from outside BDO. Qualifications must include at least one assessor holding an active Certified Internal Auditor credential. For public sector internal audit, such a person should understand the GIAS commensurate with the Certified Internal Auditor designation, including internal audit relevant continuing professional development and an understanding of how the GIAS are applied in the UK public sector.

SCOPE AND TYPES OF INTERNAL AUDIT SERVICES

The scope of internal audit services covers the entire breadth of the Force and OPCC including all activities, assets and personnel.

The scope of internal audit activities also encompasses but is not limited to objective examinations of evidence to provide independent assurance and advisory services to the AC and management on the adequacy and effectiveness of governance, risk management, and control processes for the Force and OPCC.

The nature and scope of advisory services may be agreed with the party requesting the service, provided the internal audit function does not assume management responsibility. Opportunities for improving the efficiency of governance, risk management, and control processes may be identified during advisory engagements. These opportunities will be communicated to the appropriate level of management.

Internal audit engagements may include evaluating whether:

- ▶ Risks relating to the achievement of the Force's and OPCC's strategic objectives are appropriately identified and managed
- ▶ The actions of the Force and OPCC's officers, directors, management, employees, and contractors or other relevant parties comply with organisational policies, procedures, and applicable laws, regulations, and governance standards
- ▶ The results of operations and programs are consistent with established goals and objectives
- ▶ Operations and programs are being carried out effectively and efficiently
- ▶ Established processes and systems enable compliance with the policies, procedures, laws, and regulations that could significantly impact the CC and PCC.
- ▶ The integrity of information and the means used to identify, measure, analyse, classify, and report such information is reliable
- ▶ Resources and assets are acquired economically, used efficiently and sustainably, and protected adequately.

INTERNAL AUDIT PERFORMANCE MEASURES AND INDICATORS

The tables below contain some of the performance measures and indicators that are considered to have the most value in assessing the efficiency and effectiveness of internal audit.

The AC should approve the measures which will be reported to each meeting and / or annually as appropriate. In addition to those listed here we also report on additional measures as agreed with management and included in our Progress Report.

TABLE ONE: PERFORMANCE MEASURES FOR INTERNAL AUDIT

MEASURE / INDICATOR
Audit Coverage Annual Audit Plan delivered in line with timetable. Actual days are in accordance with Annual Audit Plan.
Relationships and customer satisfaction Customer satisfaction reports - overall score at average at least 4 / 5 for surveys issued at the end of each audit. Annual survey to AC to achieve score of at least 70% for satisfaction with the service. External audit can rely on the work undertaken by internal audit (where planned).
Staffing and Training At least 70% input from qualified staff.
Audit Reporting Issuance of draft report within 2 weeks of fieldwork 'closing' meeting. Finalise internal audit report 1 week after management responses to report are received. 95% recommendations to be accepted by management. Information is presented in the format requested by the customer.
Audit Quality High quality documents produced by the auditor that are clear and concise and contain all the information requested. Positive result from any external review.

MANAGEMENT AND STAFF PERFORMANCE MEASURES AND INDICATORS

The management and staff of the Force and OPCC commit to the following:

- Providing unrestricted access to all of the Force's and OPCC's records, property, and personnel relevant to the performance of engagements
- Responding to internal audit requests and reports within the agreed timeframe and in a professional manner
- Implementing agreed recommendations within the agreed timeframe
- Being open to internal audit about risks and issues within the Force and OPCC
- Not requesting any service from internal audit that would impair its independence or objectivity
- Providing honest and constructive feedback on the performance of internal audit.

The following three indicators are considered good practice performance measures, but we go beyond this and report on a suite of measures as included in each Progress Report to AC.

TABLE TWO: PERFORMANCE MEASURES FOR MANAGEMENT AND STAFF

MEASURE / INDICATOR
Response to Reports Audit sponsor to respond to terms of reference within one week of receipt and to draft reports within two weeks of receipt.
Implementation of recommendations Audit sponsor to implement all audit recommendations within the agreed timeframe.
Co-operation with internal audit Internal audit to confirm to each meeting of the AC whether appropriate co-operation has been provided by management and staff.

FOR MORE INFORMATION:

GURPREET DULAY

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Internal Audit – Request for Change



Date of request:	25/09/2026
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Title of Audit:	Out of Court Disposals audit (swapped for the previously included Communications audit in the BDO Internal Audit Plan)
Business Lead:	Kenneth Kilpatrick, ACO Finance and Support Services, Victoria Curtis, Head of Strategic Change & Portfolio Management (as plan sponsors)
Business SPOC:	Louis Provart (OOCOD operational lead) and/or Jules Dean
Change Requested: (Delete as appropriate)	Audit Change – amendment to a planned audit within the Internal Audit Plan
Please explain the rationale for change:	Following discussions with Norfolk and Suffolk senior management and Audit Committee representatives, it was agreed that the planned Communications audit should be removed from the 2026/27 Internal Audit Plan and replaced with a review of Out of Court Disposals (also referred to as Out of Court Resolutions). The Communications audit is proposed to be deferred to allow the relatively new lead in this area additional time to become established in the role. In contrast, an Audit Committee member identified Out of Court Disposals as an area where additional assurance would be valuable. Norfolk and Suffolk management have subsequently agreed in principle that the Communications audit should be replaced by an Out of Court Disposals audit, with the review commencing during Q4. The proposed review will provide assurance over the governance, oversight, consistency, appropriateness and effectiveness of the Constabularies' use of Out of Court Disposals, including compliance with legislation, national guidance and local policy. Audit Committee approval is requested for this amendment to the Internal Audit Plan.

Audit Committee - Forward Work Plan

Meeting date: 8th December 2026

Action	Outcome / Owner
Morning Briefing	Changes to constabularies governance (post DCC review)
Welcome and Apologies	Noted
Declarations of Interest	Noted
Minutes of meeting x July 2026	Noted
Actions from previous meeting	Action Log
External Audit	Report from Director, EY (Anticipating Audit Results Report)
Internal Audit	Reports from Head of Internal Audit
Devolution Update (Verbal)	ACC & PCC CFO
Police Reform (Verbal Update)	ACC & PCCCFO
Part 2 Private Agenda	Noted
Minutes of meeting 21st July 2026	Noted
Actions from previous meeting	Action Log
Fraud Update – Part 2 private agenda	Verbal Update

26th January 2027

Action	Outcome / Owner
Morning Briefing	TBC
Welcome and Apologies	Noted

Action	Outcome / Owner
Declarations of Interest	Noted
Minutes of meeting 13th October 2026	Noted
Actions from previous meeting	Action Log
External Audit	Report from Director, EY
Internal Audit	Reports from Head of Internal Audit
Devolution Update (Verbal)	ACC & PCC CFO
Police Reform (Verbal Update)	ACC & PCCCFO
Part 2 Private Agenda	Noted
Minutes of meeting 21st July 2026	Noted
Actions from previous meeting	Action Log
Fraud Update – Part 2 private agenda	Verbal Update

9th March 2027

Action	Outcome / Owner
Morning Briefing	TBC (Possible workshop on transfer to mayoralty)
Welcome and Apologies	Noted
Declarations of Interest	Noted
Minutes of meeting TBC March 2027	Noted
Actions from previous meeting	Action Log
External Audit	Report from Director, EY
Internal Audit	Reports from Head of Internal Audit
Devolution Update (Verbal)	ACC & PCC CFO
Police Reform (Verbal Update)	ACC & PCCCFO
Part 2 Private Agenda	Noted
Minutes of meeting 21st July 2026	Noted
Actions from previous meeting	Action Log
Fraud Update – Part 2 private agenda	Verbal Update

Report author: Simon George -Chief Finance Officer