Audit Committee, 10 June 2020

Internal and External audit recommendations tracker

Executive summary

This report provides the Committee with progress updates on the implementation of recommendations arising from Internal and External audits. In addition, any significant Quality Assurance recommendations and recommendations arising from ISO standard audits will be added.

Recommendations which have been implemented have been removed from this report. The original numbering of recommendations has been retained.

Decision

The Committee is requested to note the paper.

Background information

Please refer to individual internal audit reports for the background to recommendations.

Date of paper

03 June 2020

Recommendations from internal audit reports

2019/20

Internal Audit report – FTP end to end process review (considered at Audit Committee 04 March 2020)

Recommendations summary

Priority	Number of recommendations
High	0
Medium	10
Low	1

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	Key Risk Area 1: End to end FtP Process				
1.1	**FtP end to end process (triage)** · The Case Management Manual (The Manual) states that the triage stage should be completed within two weeks of receipt of the concern. In 9 cases sampled, these were triaged outside the two week deadline. When deadlines are missed there is a risk of reputational damage, key performance indicators not being achieved and the risk that registrants are not appropriately removed from working with members of the public in a timely manner. · During the two-week triage period, all concerns must have an initial risk assessment completed within five working days of receipt of the concern. It was identified that in 14 cases this timescale had not been achieved. Where an initial risk assessment is not completed there is a risk that an interim order is not actioned in a timely manner and the registrants are continuing to	1 - We recommend that HCPC ensures that the triage process is sufficiently resourced so that all cases can be processed in line with the standard timescales. We recommend due to the complexity of the concerns raised, that HCPC should consider it's approach in resourcing to manage high influx of concerns. This could include use of external lawyers.	Medium	1 - Whilst SW cases were included, some team members had over 80 active cases. Now, after the transfer, that has reduced to 45-50. A range of management interventions to ensure cases progress to closure or threshold decision are being introduced, including expanding the profession specific approach, and matching the capacity required for cases that need to go to ICP panels. We will evaluate the impact of case flow assumptions in Q1+2 2020/21	1. **DL CRT** **Completion date**: Q2 2020-21 Progress June 2020: The Business Improvement work is establishing a capacity and demand model that will support us to improve flow through the FTP process. Early indicators from this are that the Triage team is sufficiently resourced to

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	work with members of the public. · For 16 cases sampled, these did not meet the 2 working days from triage to Case Team Manager allocation service standard. Allocations were found to range from 3 to 48 working days. Management advised, that The Case Reception and Triage time was recently established in May 2019. In addition there was no Manager until June 2019. During this period HCPC were heavily reliant on temporary and fixed term staff due to resourcing issues. Where service standards are not met there is a risk that cases are not being dealt with as efficiently as possible and bottlenecks exist. · In one instance, the Case Manager did not send an acknowledgement letter to the complainant. This oversight however was identified by the Case Team Manager, 22 working days after the acknowledgement should have been sent. The Case Team Manager telephoned the complainant to apologise and to set out the next steps. In addition, the Case Manager sent a written acknowledgement following the telephone conversation. Where complainants are not acknowledged in a timely manner there is a risk that duplicate complaints will be raised by complainants which can cause a strain on internal resources. · A case was transferred to the Serious Case Team and no acknowledgment letter was sent by the Case Manager. When we queried this further, the Serious Case Team had sent the letter two days later once it was transferred across. The Threshold guidance is not explicit as to which team should send the acknowledgement in cases which are referred to the Serious Case Team. The Department Lead - Case Reception & Triage advised that they have now advised the Case Team 1				manage post-SW referrals. However, the Triage process has been impacted by COVID-19 and the noticeable rise in FTP enquiries and additional COVID-19 related concerns we are receiving. Resource planning has taken place to respond to this.

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	that they should send an acknowledgement letter (unless there are specific reasons not to) before transferring over to the Serious Case Team. Where acknowledgement letters to the registrant and the employer are not sent there is a risk that registrants are practicing while posing risks to patients and the public depending on the severity of the concern.				
1.2	**Investigating Committee Panel (ICP) Stage** · We were advised by the Department Lead for Investigations that due to resourcing issues within the team, one case in the selected sample was outsourced to Capsticks (law firm). Management were unable to provide further information regarding this case. There is a risk that where cases are outsourced service standards will not be achieved.	2. We recommend where cases are externally outsourced, service standards should be identified and incorporated into the case management manual for transparency.	Medium	2 - Capsticks input was as a result of Council direction to add capacity to system, and never intended as permanent solution. A monthly SLA with Head of investigations and HFTP was carried out, with management information and progression provided. For the new legal services contract a robust SLA, along with management process, is being developed with the assistance of specialist consultancy.	2. **FTP DL team** **Completion date:** implementation of new contract (expected 1 April 2020) Progress June 2020: N/A. This comment relates to pre-ICP case investigation undertaken by an external legal provider. This was a one off project and does not form part of the legal contract for post-ICP work.
1.3	**Post ICP** · Cases that progress to the Conduct and Committee stage are externally outsourced to Kingsley	3. We recommend where cases are externally outsourced and service standards are not met these are to be escalated during contract	Medium	3 - There is an existing Service Level Agreement for cases managed under the contract. Performance against this SLA has improved in the last 18 months, leading to consistent (7 consecutive months) meeting	3. **FTP DLs team** **Completion date**: 1 April 2020

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	Napley (KN) (law firm). KN are required to provide a five week report on the status of any cases that are referred to them. For one case out of the two, it was identified that a five week report was received seven working days after the deadline. Where the five week reports are received after the deadline these should be tracked and monitored to understand if the delay is an ongoing issue for other cases and should be raised at contract management meetings between HCPC and KN. These types of delays impose further delays on HCPC meeting their service standards when progressing a case.	management meetings to prevent repeat occurrences.		or exceeding the post ICP KPI reported to Council. As outlined above for the new legal services contract a robust SLA, along with management process, is being developed with the assistance of specialist consultancy.	Progress June 2020: The new legal contract came into effect on 1 April 2020.
1.4	**Protection of title (POT)** · There were four instances of delays where the POT case had not met timescales. Where there are delays there is a risk to the safety of the public where persons are misrepresenting themselves.	4. We recommend that relevant staff are reminded of the importance of completing actions within given timescales to help protect the public interest and the reputation of HCPC and its professions.	Medium	4 - as set out in recommendation	4. **DL CRT** **Completion date**: Q4 2019-2020 Progress June 2020: completed by DL CRT.
1.5	**Miscellaneous cases** · Complaints should be acknowledged within five working days of HCPC receiving them. It was identified that for six out of 10 cases there were delays in acknowledgements. Delays could be up to two weeks. Where there are delays in assessing and acknowledging complaints there is a risk that some concerns are pertinent and therefore by not investigating sooner the general public are potentially at risk.	5. We recommend that staff are reminded of the time frames for miscellaneous cases to ensure that they are directed to the correct team in a timely manner and assed.	Medium	5 - as per recommendation	5. **DL CRT** **Completion date**: Q4 2019-2020 Progress June 2020: completed by DL CRT.
2	**Key Risk Area 2: Interim Orders** · We identified that there were timing delays in five out of 10 cases sampled. The timing delays were at the point of review by the operational manager or at the point at which the registrant was informed that an interim order was going to be reviewed by the panel. In addition registrants should be informed that an interim	6. We recommend that staff are reminded of target timescales to help ensure that IOs are dealt with in a timely manner and the risk to the public is therefore minimised.	Medium	6 - as per recommendation	6. **DL CPC** **Completion date**: Q4 2019-2020 Progress June 2020: see 8

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	order is being applied for within one day of the decision being approved by the operational managers. Where timings are not adhered to there is a risk that there is inconsistency within the process and registrants are working with the public when they are not safe to do so.				
	· There was one case identified, which had gone to panel for IO approval and the panel had adjourned the meeting due to lack of evidence. Additional evidence had been requested by the panel in order for the decision to be made. Where the panel are not provided sufficient information to make an informed decision the registrant may continue to work and thus put the public at risk and cause damage.	7. We recommend that all bundles that are sent to the Panel for consideration should be as complete as possible in order to not waste resources and ensure that the most effective decision is made.	Medium	7 - as per recommendation	7. **DL CPC Completion date**: Q4 2019-2020 Progress June 2020: see 8
	· The Manual states that within one working day of the officer identifying that an IO may need to be imposed, this should be raised with the case team managers prior to being sent to the operational managers. For nine out of the 10 cases sampled, there was no evidence to suggest these conversations took place. Where the conversations do not take place there is a risk that inappropriate cases are sent for IO consideration to operational managers.	8. We recommend that conversations between officers and case managers are documented with regards to potential IOs.	Low	8 - as per recommendation	8. **DL CPC Completion date**: Q4 2019-2020 Progress June 2020: For all of the above, the management of IOs and risk is a core element of the Business Improvement work and these issues are being addressed under that project strand. In addition, we have set up a monthly IO review group to look at issues arising in the management and presentation of IO cases, which

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
					includes representatives from the BI team and QCT.
5	**Key Risk Area 6: Quality assurance** · The QA team produce a performance report that is sent to the Audit Committee and Council. The performance report states the audits completed and due to be completed, in addition to the rationale for the upcoming audits. It would be beneficial if the report included the recommendations made and what percentage of these are still outstanding to be completed and the number that have already been completed. Where the Audit Committee and Council is not clear on the stages of recommendation implementation there is a risk that the full value of the QA team is not realised. · The FtP tracker in place has two issues. The first is that there are outstanding recommendations, of which some of these should have been implemented by December 2018. The reasoning for these not being completed is the FtP QA team are awaiting the FtP manual. Where there are delays in the completion or the finalising of the FtP manual there is a risk to the efficiency of the FtP process. The FtP tracker has audits that have been issued to the FtP team in the period covering May 2019-June 2019. However, the tracker has not been updated to include the responses from the FtP team nor does the tracker have responsible officers or due dates to completion for these recommendations. There is a risk that where issues are identified these are not resolved in a timely manner and corresponding risks are allowed to persist.	12. We recommend that the QA team include the number of recommendations that have been made, implemented and still pending implementation when reporting to Audit Committee and Council. This could be written as pure statistics to be quick to produce, read and understand. 13. We recommend that the FtP team respond to draft reports issued by the QA team in a timely manner and the tracker is subsequently updated once the required information is obtained from the FtP team. All Priority 2	Medium Medium	12 - This fits in with previous recommendations from internal audit that the Quality Assurance Department are already undertaking – to produce a central recommendations tracker and to develop the departmental report to Audit Committee. 13 - discuss at DL meeting and feedback to QA	12. **Head of Quality Assurance** **Completion date**: Q1 2020/21 Progress June 2020: New QA Lead/team to review current information provided to the audit committee and produce a methodology document that includes a rating system for future audits 13. **FTP DLs** **Completion date**: Each time Progress June 2020: Completed. All outstanding FTP audits have now been responded to and returned to QCT. The FTP manual has been finalised and went

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					live in October 2019.
6	**Key Risk Area 7: Management reporting** · We found figures were incorrectly reported to Council in April 2019's Chief Executive's organisational performance report for Median length of time from receipt to final hearing: 73 weeks and Number of open pre-ICP cases (not including Rule 12 cases*) 1600 open cases by 31/3/19. The reported figure reported for Median length of time from receipt to final hearing was 89.6 and the figure in the Management Information spreadsheet was 89.8. The reported figure for Number of open pre-ICP cases (not including Rule 12 cases*) 1600 open cases by 31/3/19 was 1958 and the figure in the Management Information spreadsheet was 1972. Where statistical information is incorrectly reported there is a risk that decisions made may be influenced by incorrect information and resources and time may be inappropriately dispersed.	14 - We recommend that information is double checked to ensure its accuracy prior to it being distributed.	Medium	14 - linked to systems development - This is a function of manual reporting systems. Replacement CMS system has identified improved reporting as part of benefits. In the interim a reminder will be given on the importance of the accuracy of manual reporting. **22.05.20 Update** CMS development is to commence shortly. Data quality and improved reporting function will be part of the new CMS. Considering Robotic Process Automation to strengthen in data production area. In the meantime, given 0.2% and 0.7% error rate identified in the audit sample, the manual process has been strengthened by the following activities - Revised Management Information process with additional checks has been implemented; - With support of Head of FTP, importance of ensuring data quality by cut-off date reiterated to the FTP team; - No data 'rework' after cut-off date implemented; - Ensuring that finalised monthly statistics is reported externally. When in doubt (especially within short timescales between data production and external reporting)	14. **A+D manager** **Completion date**: Q4 2019/20 Progress June 2020: Complete – see update in management comments

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				referring to A&D manager recommended.	

Recommendations from internal audit reports

2019/20

Internal Audit report – Business Continuity Planning (considered at Audit Committee 04 March 2020)

Recommendations summary

Priority	Number of recommendations
High	0
Medium	7
Low	2

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
2	**Key Risk Area 2: Risk assessments and business impact analysis** · We identified that the Business Continuity Management document refers to completing a Business Impact Analysis for the organisation. Our discussions with the Chief Information Security and Risk Officer indicated that the business impact assessment is not a formalised document, but a dynamic assessment which is completed at the time of the incident, by the individual invoking the plan through a combination of knowledge from recent tests, the risk information asset register and the risk register. Whilst we recognise the need for business continuity arrangements to be flexible to cater for a range of scenarios, for the avoidance of doubt during an incident guidance documents should be unambiguous. We therefore recommend that the dynamic nature of the risk assessment should be explicitly stated in the Business Management document.	2. For clarity and the avoidance of doubt in the event of an incident we recommend that the dynamic nature of the Business Impact Analysis is explicitly stated in the Business Continuity Management Document. This should clearly identify the risks of disruption to the organisation's activities and assess which would require action and identify activities that support the provision of products and services to assess the impact over time of not performing these activities.	Medium	2 - A list of aspects to consider in the dynamic impact analysis has been included in the new training material, and will be added to the ShadowPlanner app. 1. Protect life 2. Protect property and data 3. Maintain regulatory functions (Statutory responsibilities) 4. Maintain appropriate levels of governance and support functions. 5. Consider future organisational and regulatory change to support 1-4 above.	2. **Roy Dunn CISRO** **Completion date**: 31/01/2020 Progress June 2020: COMPLETE
3	**Key Risk Area 3: A BCP is in place to enable business critical elements of the plan to be backed up and running to prevent significant business disruption** · We identified that although the Recovery Time Objectives (RTOs) have been formally documented, HCPC has not documented the Maximum Tolerable Period of disruption (MTPD) within the BCP arrangements. Documenting the MTPD can be a useful tool to determine recovery options, depending on the amount of time systems are down for.	3. HCPC should consider formalising the maximum tolerable period of disruption in business continuity arrangements.	Low	3 - Business systems owners have provided MTPD, which have been recorded in the document REC 17A. Disaster recovery / business Continuity order of restoration of principle IRT system for HCPC, and maximum tolerable period of disruption v1.7	3. **Roy Dunn CISRO** **Completion date**: 06/12/2019 Progress June 2020: COMPLETE
4	**Key Risk Area 4: Third party management practices** · We reviewed the 'DOC A17 - Business Continuity Management' document, which broadly lists the	4. HCPC should determine whether ownership for maintaining supplier data should sit with the business or the finance department. Once agreed, the responsible department	Medium	4/5 - A stakeholder list has been provided and will be uploaded to ShadowPlanner, and maintained by the Communications Dept.	4/5. **Head of Communications; Tian Tian (Finance Director)**

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	groups of key suppliers. However, discussions with the Chief Information Security and Risk Officer highlighted that there is currently ambiguity within HCPC between whether the responsibility for maintaining key supplier information as part of business continuity arrangements should sit with the wider business or within the finance department. Currently therefore, there is no direct ownership for maintaining an up to date list of key suppliers as part of BCP arrangements. In the absence of regularly updating BCP arrangements with key supplier information, there is a significant risk that BCP arrangements will not accurately reflect key supplier information required in the event of an incident. · We understand from discussions with the Chief Information Security and Risk Officer, that a list of relevant stakeholders (to be notified when the BCP is invoked) is currently in draft, by the Communications team but this was not in place at the time of our audit. If a current list of key stakeholders is not developed and kept up to date, there is a risk that HCPC will not be able to communicate key information in the event of an incident.	should consider sending monthly updates to Chief Information Security Officer, much like the monthly HR data reports. Priority 2 5. The list of key stakeholders, (i.e. Regulators and Government departments) is currently in development by the Communications team should be finalised and incorporated into BCP arrangements. To ensure that this remains up to date, the list should be periodically reviewed and amended, as required. Priority 2	Medium	A list of Suppliers and their contact details will be provided by the Finance Dept for upload to ShadowPlanner	**Completion date**: 31/01/2020 Progress June 2020: JL - Completed: the key stakeholder list is updated by Communications and provided to BCP on a quarterly basis. TT- List of suppliers with contact details have been provided by Finance department and uploaded to ShadowPlanner.
5	**Key Risk Area 5: Business continuity testing** · Given that we have identified some gaps in current BCP arrangements at HCPC (see KRA 1-4), BCP arrangements will need to be tested to ensure that these areas are working effectively.	6. HCPC should address identified gaps in the current BCP and schedule another planned BCP test to ensure that updated areas are working effectively.	Medium	6 - A further test will be carried out in the next Financial year COVID-19 response (essentially a major interruption to normal business operations negates any immediate requirement for BCP testing) March – June 2020.	6. **Roy Dunn CISRO** **Completion date**: 31/03/2020 Progress June 2020: Live test in Covid-19 response
6	**Key Risk Area 6: Staff awareness** · We confirmed that BCP training for staff of the Shadow Planner app is not formally documented or recorded, we were advised that this is only because certain individuals within HCPC are required to have	7. The Chief Information Security and Risk Officer should document staff training (in the use of the Shadow Planner App).	Medium	7/8 - ShadowPlanner users are already trained on its use as the app is delivered to their device. Annual testing includes a training element. Standalone generic	7/8. **Roy Dunn CISRO**

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	access. If staff training is not formally recorded, HCPC will not be able to track employee training coverage. · We also confirmed that Shadow Planner app training is not periodically refreshed, and is only used by staff in the business as part of BCP testing or a real life incident. If staff are not regularly appraised of BCP arrangements and use of the Shadow Planner app, there is a risk that staff will not use the system correctly in the case of a real life incident. Furthermore in view of the difficulty and business disruption associated with fully testing the BCP on a regular basis, it can be difficult to identify staff knowledge gaps, especially regarding the functionality of Shadow Planner in real time. To maintain staff knowledge and awareness HCPC could refresh BCP training, for individuals who require it, or develop refresher material for app users, to ensure a maintained knowledge of the functionality.	8. HCPC should refresh Shadow Planner app training at least annually for users and could consider developing training and guidance to ensure a continued knowledge and awareness of the app.	Medium	BCM/DR training is being developed for SMT & Business system owners and Heads of department. 20200511 ShadowPlanner UserAccessGuide	**Completion date**: 31/01/2020 Progress June 2020: Shadow Planner has been updated to include specific instructions on five overarching principles. Complete
7	**Key Risk Area 7: Backup and restore provisions** · We understand that criticality for back-up and restore provisions has been defined by IT and has not been formally confirmed with the business. In the absence of confirmation with business owners, there is a risk that IT back up priorities will not be aligned to organisational strategic priorities and objectives. Whilst it may be appropriate that IT set the criticality there needs to confirmation with the business owners of the various operational processes to confirm this. · The review highlighted that whilst the data backup frequency is likely to be appropriate there needs to be confirmation that this aligns with the recovery point objectives of the various business processes. For example, if a Recovery Point Objective is 4 hours for a given business process then a daily incremental of 24 hours is likely to be insufficient.	9. Senior Management should review the Veeam back up schedule and confirm that priorities are aligned to HCPC business operational processes. 10. Senior Management should confirm that the data back-up frequency is appropriate to meet Recovery Point Objectives in the event of an incident.	Low Medium	Accept 9/10 - A paper will be presented to SMT detailing the current recovery time service standards set out by data owning departments.	9/10. **Executive Director of IT and Resources** **Completion date**: 27/02/2020 Progress June 2020: COMPLETE

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility

Internal Audit report – Fraud risk assessment (considered at Audit Committee 05 November 2019)

Recommendations summary

Priority	Number of recommendations
High	1
Medium	3
Low	3

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
1	**Heath & Care Professions Council's strategic approach to tackling fraud** • Although the risk of fraud (and bribery) is included within individual departmental risk registers, it was noted that there are some gaps and in some instances where there was not sufficient detail in relation to specific types of fraud HCPC is exposed to. For example, the risk of fraud is not explicitly included on the corporate risk register, whilst bribery is included. It is acknowledged that the financial impact of fraud would likely be low, however, the reputational damage in relation to a registration fraud would be high. As such, fraud is as a significant risk to HCPC and its absence from the corporate risk register may give the Council false assurance that the risk of fraud is being effectively managed across HCPC. Other registers where there are gaps include: − Finance risk register, where the risk is simply noted as the risk of fraud or theft. It does not distinguish between	2. It is recommended that specific fraud risks are included within relevant risk registers, and that they are subject to regular review – for example adding the risk of fraud to the corporate risk register.	Medium	2. As part of the next corporate risk register update, risk owners will be specifically asked if risk of fraud needs to be articulated within their risk	**2.Chief Information Security and Risk Officer** **Completion date:** January 2020 **Progress update** Progress June 2020: No further fraud opportunities highlighted March 2020 – **No further opportunities for**

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	internal or external fraud as the modus operandi would differ greatly and therefore the controls to prevent those frauds would also be different. − Harm Register does not explicitly reference fraud, though does state harm by an incorrectly registered person. Harm caused by a fraudulent registrant should have specific consideration – this risk could be linked risk 10.2 on the Registrations risk register.				**fraud have been identified by Risk Area owners.** This will be kept under periodic review.
2	**Raising fraud awareness (including training)** • The code of conduct, although makes good reference to conflicts of interest and the Nolan Principles; the code of conduct does not provide reference to fraud or whistleblowing. It is best practice for a code of conduct to refer to other related policies. • The Anti-Bribery Policy 2017 articulates HCPC's zero tolerance approach, provides a clear explanation as to what is bribery and the types of offences under the Bribery Act 2010, however, does not provide any guidance as to how staff can raise their concerns should they suspect someone is committing bribery. The policy simply states that staff must raise their concerns to the 'HCPC Secretariat' and the relevant paragraph is incomplete. Not providing a clear route to reporting concerns may result in issues going unreported, or matters being reported to inappropriate individuals. • We were provided with three versions of the Anti-Bribery Policy, the Anti-Bribery 2017, Anti-Bribery 2014, Anti-Bribery, Gifts and Hospitality Policy 2013 and Anti-Bribery, Gifts and Hospitality Policy 2012. Although all the policies do provide the same information, having too many versions available may cause confusion. **Prevention and Detection** Although staff are provided with specific training on how to use the accounting systems etc., there is no specific training in relation to fraud. Although, the residual risk of fraud to finance is considered low, due to the key financial controls, fraud could be successfully committed through	4. It is recommended that HCPC develop fraud awareness training to be completed by all staff. This could be in the form of e-learning. 7. HCPC should consider developing finance specific fraud awareness training to be included within the finance induction training. This will make staff more aware of the risk of fraud and more likely to report any concerns.	High Low	4. E learning will be developed by the Learning and Development team in conjunction with the Chief Information Security and Risk Officer, who will assume central oversight of fraud policy and awareness.	4. **Chief Information Security and Risk Officer** **Completion date:** Q4 FY19/20 **Progress update** Progress June 2020: Anti-bribery course 95.41% Completed March 2020 – Bribery course located for existing L&D platform and rolled out, Fraud element to locate or create. Aiming for roll out after information security training completes, first QTR FY 20-21

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
3	unknown methods or if a fraudster can convince staff within finance (through deception or coercion) to bypass certain controls. Although budget holders are provided with some training on how to manage contracts there is not specific fraud consideration within the training. A lack of awareness of the fraud risks associated with procurement may result in fraud going undetected or unreported. As part of the recruitment procedures, HR will undertake due diligence on the candidate – including reference checks and verify passports – which is best practice. However, these procedures are not outlined within the Recruitment Policy. As part of the risk assurance mapping review, it was identified that HR had not been subject to an internal audit review in recent time. Internal audit reviews are essential for establishing whether key controls are operating effectively. Registrants are not required to provide a DBS check (or relevant foreign police check) or prove they have the right to work in the UK as part of the registration process. It was explained that DBS checks and right to work checks would be undertaken by the registrants' employer. However, some registrants operate as sole traders, therefore these checks will not be undertaken. Not undertaking such checks, particularly criminal records checks, could potentially expose the public to harm. It is acknowledged that as part of the registration process, applicants have to make a declaration as to whether they have any convictions or ongoing court cases. Where an applicant has made a declaration, these are passed onto Fitness to Practise in order to make a determination, where they will most likely compete a DBS check. Additionally, for UK Approved Programme, students are required to pass an enhanced or equivalent criminal records check prior to commencement. Where there is a	9. It is recommended that the candidate vetting procedures are outlined within the Recruitment Policy.	Low	7. The Learning and Development team will assist the Finance Department in developing fraud specific induction material. 9. Vetting procedures will be outlined in the recruitment policy.	7. Interim Director of Finance / Director of Finance **Completion date:** Q4 FY19/20 **Progress update** Progress June 2020: Fraud training for finance team members have been included in the departmental training plan for the year. We are also working with CISRO to negotiate a corporate price for online courses on fraud awareness. March 2020 – Due to the Finance restructure, this has been delayed until Q1 FY20/21, after the team settles in their new roles. 9. **Director of HR and OD Completion date:** Q3 FY19/20 **Progress update** Progress June 2020: All policies

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	registrant commits and offence the UK Police inform HCPC. However, if the applicant, who has completed a non-UK Approved Programme, does not disclose that they have been convicted of a criminal offence (committing fraud by false representation), then the issue may not be detected via Registrations due diligence process.	10. It is recommended that an internal audit review is undertaken in the area of HR in order to assess the effectiveness of the key controls.	Low	10. BDO proposed a review of HR in its three year audit strategy. The Executive welcomes this review should it be prioritised by the Audit Committee as part of the 2020-21 Internal Audit Plan.	will be updated in Q2 20/21 March 2020 – All policies will be updated in Q2 10. **BDO / Audit C Completion date:** For Audit Committee to prioritise **Progress update** Progress June 2020: Part of the Audit plan – awaiting dates to be agreed.
		11. It is advised that HCPC explore whether, legislatively, they can perform criminal records (on registrants who have completed a non-UK Approved Programme) and right to work checks on registrants.	Medium	11. The costs of undertaking criminal record and right to work checks for c.370,000 registrants would be have a significant impact on the HCPC's budget. The human resource required to manage the check system (including renewal of checks) would also be considerable. These additional steps in the registration process would also lengthen registration processing times. The legal feasibility of this will be explored, as well as the current practise of other regulators. If this is legally possible (and desirable taking the above into account) consideration would be needed as to if the cost the check can be passed onto the applicant/registrant. **June 2020 – Management update RH**:	March 2020 – IDHROD - Audit proposals agreed – awaiting firm up of dates 11. **Head of Registrations Completion date:** Q4 FY19/20 **Progress update** Progress June 2020: **Complete** – see updated management response

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				Further to the outstanding audit item for Registration below. I have established that all the health regulators apart from the General Osteopathic Council require a self-declaration when applying for registration from overseas and do not ask for evidence of a criminal records check as part of the international application process. I have also explored the legal feasibility of performing criminal records (on registrants who have applied via the international application route) and right to work checks on registrants. The Health Professions Order 2001 (**the 2001 Order**) and associated regulations provides the HCPC with the authority to conduct non-UK criminal record checks. However, the HCPC may only take account of a non-UK criminal record to the extent that it would constitute an offence in the UK. However, the process for criminal records checks (or 'Certificates of Good Character') for someone from overseas varies from country to country. It either involves an application in the country or to the relevant embassy in the UK. Each country will have different requirements as to who can apply for a record check, and these may prevent certain entities from applying. Right to work checks are usually conducted by prospective employers of foreign individuals. This is because the penalties for employing individuals who do not have leave to remain in the UK fall upon the employer (see s15 of the Immigration, Asylum and Nationality Act 2006, government guidance and the code of practice). On a practical level, therefore, it is unnecessary for the	March 2020 – Currently investigating legal feasibility and current practises of other regulators.

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				HCPC to conduct such checks as it will not be exposed to the liabilities arising under the legislation. Whether the HCPC has the legal authority to conduct the right to work checks is less clear. Article 5(1)(b) of the 2003 Regulations (mentioned above) is not relevant here as the right to work check will not reveal any criminal offence, just whether the individual has leave to remain in the UK. Article 5(1)(d) is more applicable. It states that, for the purposes of satisfying itself of the *good character* of the applicant: • the HCPC shall have regard to "any other matters which, in the opinion of the Committee, appear to be relevant to the issue [of good character]". Is an applicant's right to work in the UK relevant to their good character? That is not clear and creates a distinct risk that the HCPC would be acting without authority. Nevertheless, the 2003 Regulations afford that question to the HCPC's 'opinion'. If the checks are deemed relevant with sufficient and robust justification – which will be difficult - then it is likely the HCPC can run the checks. Bearing in mind the HCPC will not be exposed to any liability, it will need to make a judgement on the necessity of this. The HCPC currently has robust verification processes in place verifying with the source an international applicant's qualification, professional experience and regulatory/ professional body information and given the legal advice above we do not feel it is appropriate or proportionate to introduce the	

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				requirement for criminal record or right to work checks at this time.	

Internal Audit report – Quality Assurance (considered at Audit Committee 10 September 2019)

Recommendations summary

Priority	Number of recommendations
High	None
Medium	4
Low	5

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
1	Our review of the QA reports and discussions with the Chair of Audit Committee highlighted that information sent to the Audit Committee is brief and does not include the full detail of the work being undertaken by the Department. For example the reports presented to the Audit Committee team did not: ▪ provide timelines and plans for the audits throughout the year for example broken down into Q1 through to Q4 of the year; ▪ report on the performance of the QA team; ▪ provide an overall significance or rating of the audit reports and the subsequent findings of the audits undertaken;	1. We recommend that Management reviews the current QA reports provided to Audit Committee and consider whether the following information should be included: • Timelines throughout the year of when reviews are expected to be undertaken and due to be completed. These are currently provided as part of the reporting to SMT. • Performance data of the QA team. • Significance and/or rating of reports. • Clear indicators of where the QA audits fit into the assurance map and overall assurance of the organisation.	Medium	1. As is documented, this is work that the Department is already undertaking. The QA Department report provided to Audit Committee will be developed over this financial year to provide a better overview of the work that the Department is doing in relation to the workplan, and to provide clarity about how the work of the Department fits in to overall assurance activities across the organisation. **Update June 2020**: • Due to significant changes to ways of working across the organisation due to the Covid-19 pandemic, normal QA activities have been temporarily suspended during Q1. As such, there has been a delay in the production of the Quality Assurance Framework for 2020-21. • The intention is for the QA team to trial a new approach to quality assuring FTP processes	1 Head of Governance **Completion date:** Q2-Q4 2019/20 (revised to Q1-Q2 2020/21) **Progress update** Progress June 2020: QA Lead/team to review current information provided to the audit committee and produce a methodology document that includes a rating system for future

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	▪ identify how the work of the QA Department fit into the HCPC assurance map; ▪ explain the positive impact that the QA Department is bring to the organisation. At the June's audit committee, these gaps were discussed and the Head of QA has committed to undertaking the changes within the report. We deem the above information to be important in ensuring that the Audit Committee can provide effect challenge. The Head of Business Process Improvement (HBPI) has recently transferred from the QA Department into the Governance Department. The audits undertaken for the organisation however still remains within the QA Department. Due to the change occurring during this audit, there is currently work ongoing to develop a framework of how the function will now work in light of this change. Historically, the HBPI has focused on British standards Institution (BSI)/ISO related audits. While Governance are now responsible for the management of ISO, the QA Department are still responsible for the auditing for the organisation. Audits currently undertaken for non-regulatory functions are mostly BSI/ISO related, and although this helps to maintain HCPCs ISO status, it does not give assurance in non-ISO related areas. We understand that the QA Department have recognised this risk and are currently reviewing the auditing requirements for the organisation, taking into account the risk registers, assurance	• The reasoning behind each audit undertaken and the benefits of undertaking such audits. These are currently 2. We recommend that as part of developing the framework for the ISO and non ISO audit activity that Management considers setting out the following: • Clearly define and outline the separation of assurance activities being undertaken by the QA Department and the Governance Department. • Considerations should be given to ownership, reporting, methodology and accountabilities for delivery.	Medium	during Q1-Q2. This is subject to ongoing business improvement work in the FTP department which may be delayed as a result of the Covid-19 pandemic. • The previous Head of Quality Assurance left in Q4 2019-20. A new QA Lead is now appointed. 2. As is documented, this is work that the Department is already undertaking. A review of how the QA Department conducts non regulatory department audits started in July 2019 with the aim of developing organisational audits that fully reflect the current needs of the organisation. Part of this work will be to develop a framework between the QA and Governance Departments. This will set out roles and responsibilities, an audit plan and the various factors that have been considered in the production of the plan such as risk registers, assurance mapping, audit activity across the organisation and any organisation requirements such as ISO. This is the same approach that is taken in the determination of the regulatory department quality assurance frameworks in each financial year.	audits. Audit frameworks for respective regulatory departments to be developed and to determine where QA fits within the assurance map. 04 March 2020 – Ongoing 2 Head of Governance **Completion date:** Q2-Q3 2019/20 (revised to Q2 2020/21) **Progress update** Progress June 2020: New QA Lead/QA team to review this framework and liaise with Chief Information

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	mapping, all audit activity and any organisation certification requirements (eg ISOs). A revised approach will therefore be designed and incorporated into a quality assurance framework. Additionally, a new Quality Assurance Development Manager has been recruited and one the roles of this post will be to develop a framework which details the working arrangements between the Governance Department and the Quality Assurance Department in regards to ISO compliance activities. At the time of clearing this report, work had commenced in developing the framework.	• In addition, the Head of QA, the Governance Department and the Internal Auditors should discuss other areas that could be audited that would add value to the organisation that are outside of BSI/ISO focused areas.			Security and Risk Officer and Head of Governance to clarify roles and responsibilities across teams. 04 March 2020 – The organisation framework (for non-regulatory audits) has been produced and pilot audits run. Given the current revised approach to ISO certification, movement of the QA Department into Governance and the change in approach for quality in the organisation this activity has been delayed.
2	Although the team are very knowledgeable in the areas in which they currently work there has been little cross training into other regulatory areas. To ensure a fully integrated QA team, it is important that all team members can undertake QA audits in all regulatory areas. This will also ensure that there will be continuity in the delivery of the annual QA plan should team members are on annual leave or other long term leave. Further discussions with Management confirmed that in the long term the organisation is working towards cross working within the Department.	4. We recommend that in the long term, as part of business continuity and succession planning arrangements, each team member be trained and undertake QA audits in each regulatory area. This will ensure there is full assurance coverage across all regulatory areas.	Medium	4. Wherever possible, in this financial year and last, we have identified opportunities to undertake cross team working within the Department. The managers work closely together on peer reviewing audit reports, providing input into audit activities, standardising audit materials and providing support for the service and complaints process. At officer level we have trialled a cross regulatory team member of staff and look to develop more cross working, particularly at this level. Research with QA teams at other heath regulators was carried out at the start of the year, to learn from their development as a central QA function and to determine if our structure and approach was suitable for the organisation. From this information it was apparent that, to develop to a stage where a QA team can undertake	**4 Head of Governance Completion date:** Review in Q4 for 2020-21 financial year workplan (revised to Q1-Q2-Q3 2020/21) **Progress update** Progress June 2020: QA team to trial new ways of working regarding

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				audits in any regulatory area, a long term approach is required across several years of development. The current aim is to develop a cross team working approach as much as possible within this financial year and revisit this objective when developing the workplan for next financial year.	FTP audits in 20-21. QA future state workshops with John Ettles, Lean 6 Sigma consultant with the Business Improvement team. QA team to ensure that methodology document encourages cross team working throughout QA activities eg scoping meetings, root cause analysis, conducting audits… QA team to continue peer reviewing 2019-20 audit reports 04 March 2020 – Ongoing the FTP QA manager is holding weekly briefing sessions for the Education and Registration managers on FTP process to improve knowledge with an aim to cross working.

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
3	There is no audit charter at which the QA Department operate by and are held accountable to though information that would form part of a charter exists in the quality assurance frameworks and workplans. There is no overarching strategy document for the QA function though information that would form part of such a document exists in the quality assurance frameworks and workplans. Without a strategy there is the risk that the organisation's approach and objectives in the context of its QA activities will not be detailed. A strategy should at the minimum set out an aim/key objectives to be met. Due to the timings of the change, a framework for the ISO specific audits and non-regulatory audits is not currently in place and should be produced and aligned with the new QA structure in place as the current framework is ISO focused and relates to the previous structure of the team. We understand that the new Quality Assurance Development manager has commenced the development of a framework to detail the working arrangements for ISO and non ISO activity between the QA and Governance Departments. Discussions with the business (the QA function's 'auditees') highlighted that in the case of one area, the auditee not aware of the findings of audits being undertaken until the draft report was issued. It is important that an exit meeting be a mandatory requirement as this is a key control in ensuring emerging findings	5. It is recommended that the QA function put an audit charter in place which will set out: ▪ the purpose of the function; ▪ reporting lines; ▪ roles and responsibilities; ▪ how audits will be selected to be undertaken (risk based approach); ▪ process for any deviations from the agreed audit plan; ▪ is a document that the QA function can be held accountable to; ▪ formally agreed at the Audit Committee. 6. It is recommended than an overall strategy for the QA function is developed. As a minimum this should include the following: ▪ the overall aim and objective of audits; ▪ the methodology that is being followed in order to conduct their reviews; ▪ how the QA function will achieve its aims and objectives; ▪ how the QA function determines the reviews it undertakes; ▪ the audit plan for the year; ▪ any deviations from the audit plan should be fully documented. 7. We recommend that an overall up to date framework is put in for the entire QA function and should include the three regulatory frameworks, the non-regulatory audits and it should be aligned with the new QA structure of the team.	Low Low Low	5 & 6: As is documented, much of the information that would form part of an audit charter and overall strategy is already documented in the Departments' workplans and quality assurance frameworks. We will look to produce these documents in the future so that this information can be provided to a range of stakeholders as standalone, high level overview documents. See above 7. As is documented, the Department currently has quality assurance frameworks with the regulatory departments and is currently developing a framework with the Governance Department. We will look to produce an overall framework for the QA Department in the future so that this level of overview can be provided to a range of stakeholders.	**Head of Governance** Recommendations 5-10 **Completion date:** Q2 – implementation in Q1 2020/21 (revised to Q1-Q2-Q3 2020/21) **Progress update** Progress June 2020: see Risk 1 for update – New QA Lead/QA team to present the framework at the Audit Committee for approval Q2-Q3 04 March 2020 – Ongoing 5-7 Given the delays to the organisational framework (for non-regulatory audits) and the change in approach for quality in the organisation this activity may be delayed.

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	and recommendations are discussed with auditees before the report is drafted. The review highlighted that the current performance reporting includes status and progress updates on individual reviews and against the annual plans. Performance reporting can be further enhanced through the introduction of performance metrics to measure the quality and timeliness of individual reviews and against the annual plan. This includes, for example, when audits are to be completed and reports are to be issued. Beneficiaries of the QA function, such as senior management and the Audit Committee do not get a clear sense of progress made against expected progress of work and thus the assurance they are getting. Further discussions with Management highlighted that conversations have commenced on developing a suite of service standards to measure performance of the QA activity. The scoping document reviewed, did not mention key staff to be consulted during the audit. This is important in ensuring that the right persons are consulted in carrying out the review. It also provides a clear evidence trail and clearly sets out expectations and parameters for the review.				
4	Reports do not contain an overall assurance rating, such as using a 'RAG' rating (RED AMBER GREEN). An overall assurance rating allows the reader at a quick glance to understand the overall assessment of the area audited. It would also inform future years' annual plan more easily.	11. We recommend that all reports should be given an overall assurance rating level. This can be based on an overarching assurance rating framework or differ based on the type of audit undertaken. A rating system similar to Internal Audit would be good to use, as it would also enable a read across to the work of internal audit.	Low	11. The Department will look into the introduction of either an overall assurance rating level that would work across the range of audits that the Department undertakes or a ratings system based on the type of audit that is being undertaken.	**Head of Governance** Recommendations 11-14 **Completion date:** Q2 – implementation in 2020/21 (revised to Q1-Q2 2020/21)

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	Recommendations produced are not currently given priorities of importance in any way. This therefore does not effectively support the business and other independent recipients of the report in understanding the full, overall implication of the findings and to prioritise the implementation of recommendations to improve processes. Also, by rating recommendations the regulatory departments can prioritise implementation of recommendations and interventions for addressing findings. Recommendations in reports do not always fully detail what is being recommended. For example in the Programme Report January 2019, 'Recommendation 1: The Education Management team should review the issues identified in this audit and undertake any required follow on actions'. The recommendation is broadly worded and does not clearly link the recommendations to the issues identified. Further, it does not detail in practical terms what the business should be implementing. There is not an overall recommendation tracker in place for the overall QA function. This is an area of work in the workplan for quarter 2 for the QA Department. An overall recommendation tracker would be easy to manage, monitor, review and present to the Audit Committee. The Audit Committee have agreed to receive the QA recommendations alongside the internal audit report recommendations and external audit management letter points.	12. We recommend that all recommendations are RAG rated or similarly priority rated. This will help to identify which recommendations and issues need to be addressed as a priority and will help to more easily assign an assurance level to the report. 14. We recommend that audits undertaken by the QA function include the areas with which it relates to with respect to the risk register.	Medium Low	12. Currently, the heads of departments receiving the audit reports review the recommendations, accept or reject these and determine the actions they will complete and timescales in which to complete these. These are then reviewed by the QA Department and SMT. The Department will look to introduce a priority rating for recommendations to assist departments across the organisation in identifying the QA Departments perspective on priorities. 14. Currently, the ISO audit reports produced by the Department include the part of the risk register that relates to the audit. In the current work being undertaken to develop organisational audits we plan to develop the links to the risk registers and other relevant sources of information in the reports. Currently, relevant areas in the risk register are also part of the information reviewed in order to determine the focus of the quality assurance frameworks and work plans for each financial year. The Department will consider incorporating reference to the relevant risk register areas in the regulatory department and service and complaints reports.	**Progress update** Progress June 2020: See Risk 1 for update 04 March 2020 - Not started 11-12 04 March 2020 – Ongoing 14 - Given the delays to the organisational framework (for non-regulatory audits) and the change in approach for quality in the organisation this activity may be delayed.

Assurance map (considered at Audit Committee 4 June 2019)

Recommendations summary

Priority	**Number of recommendations**
High	None
Medium	1
Low	1

	Finding and Implication	**Recommendation**	**Priority**	**Management response**	**Timescale/ Responsibility**
1	The finance systems SAGE and WAP are not well integrated and require a degree of manual input.	The finance systems and their integration should be considered to see if improved functionality can be identified.	Low	Revised Management response 10/09/19 SAGE and WAP are constraints until the systems can be replaced, therefore we need review the finance processes to create improvements plans for key risk areas e.g. cheque and postal order processing. This may also involve the production of improved control reports. The 2019-20 Budgets are being revised with the assumptions being clearly documented. The actual vs budget process is being revised with a turnaround lens resulting in a higher level of scrutiny of variances.	**Director of Finance** Target Date: Q4 FY 20/21 **Progress update** Progress June 2020: Sage and WAP will be upgraded to the latest version this year, we are hoping to maximise benefit and functionalities from the new version. We will continue to review the need for a replacement system in the future. March 2020 – New payment method through bank transfer has been introduced for new applicants (UK and Readmission routes). This was delivered through a

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
					joint project between Finance and Registration department. This will reduce payments through cheque and postal orders, together with a number of other benefits. The SAGE and WAP system replacement will be delivered as a major project in FY 20/21 05/11/19 – The contract with Worldpay has been extended to allow electronic payments to replace cheques and postal orders.
3	Assurances around the procurement function show weakness in the following areas. ***First line of defence*** A centralised procurement system is not in place, but is planned to be put in place in quarter 3. The current preferred supplier list is not up to date and includes suppliers that are no longer used. Staff involved with procuring goods and services have not had training ***Second line of defence*** Management reporting on procurement activity is not undertaken regularly	Updating of current preferred supplier listing. Appropriate training of staff involved in the procuring of goods and services. Capturing and monitoring of performance data related to procurement activity, for example procurement spend information, procurement routes, minimising supplier lists etc.	Medium	The HCPC has a centralised procurement support approach rather than a centralised function. A procurement policy is in place which includes thresholds and procedures. A procurement specific role is in place within the finance team to provide procurement support to other departments. An improvement plan will be created for our procurement function. The second line of defence – i.e. management reporting will be improved as a priority – e.g. ClickTravel.	**Director of Finance** Target Date: 31 October 2020 Progress June 2020: Procurement related management information has been included within Finance report that goes into SMT. There

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
				The third line of defence – i.e. expenditure commitment is being improved through the improved budget variance analysis.	has been delays with the implementation of new approval routes for Click due to Covid-19. March 2020 – the team is working with ClickTravel and budget holders with aim to give individual department authority to review and approve out of policy bookings. Reports have been written to allow regular reporting to SMT. Through the Finance restructure a procurement specific role has been created, together with a FP&A team to allow improved budget variance analysis. 05/11/19 – the improvement plan is being developed 10/09/19 – see updated management response

Key Financial Controls Review – Transactions Team (considered at Audit Committee March 2019)

Recommendations summary

Priority	Number of recommendations
High	None
Medium	2
Low	1
Improvement	None

	Finding and Implication	Priority	Agreed management action	Timescale/ Responsibility
2	**Finding** From a review of core policies and procedures which govern the Transactions Team, Registration Operations Team and Financial Accounting Team's operations, there were instances identified where documents do not clearly capture key processes and controls and where processes are not documented. Significant reliance is also placed on the knowledge of key personnel within HCPC. Specific observations include: • There is no detailed process document in place for credit controls. Although there is a process map, this is high-level and does not contain sufficient detail to re-perform the task without guidance from management. • Fitness to practice cases are complex and decisions on whether registrants should be contacted for fees are based on a complex set of outcomes from the case. There is currently no documented guidance in place for the Registration Operations Team in relation to contacting registrants on fitness to practice cases on unpaid fees. • From our discussions with the Treasury Accountant we understand that the bank reconciliations process document does not reflect the current practice. The document does not specify the owner and review dates. • The Director of Finance's payment authorisation limit is £25,000, which is documented in a July 2018 council meeting paper. From our discussions with the Director of Finance we understand that she is	Medium	Management will implement the following actions: 1.Develop a detailed process document for credit control related activities. 2. Management should ascertain whether the Council intends the £25k delegated amount to Directors to be sub-delegated	**1) Owner: Financial Control Manager** **Date Effective**: 30 September 2019 **Progress** **Target date: 31 October 2020** Progress June 2020: Due to other priorities such as year end and audit, policies are yet to be reviewed by the Financial Control Manager March 2020 – Following the Finance restructure, all policies will be reviewed by the Financial Control Manager 05/11/19 – Awaiting approval by FD but a process document for credit control related activities (non-FTP) has been done. All current process documents capture the owner and date of review and reason. 10/09/19 – Training notes on the credit control / balance report process (excluding those coming out of FTP processes which is covered by the Reg Ops team) has been done and requires approval by FD.

	Finding and Implication	Priority	Agreed management action	Timescale/ Responsibility
	able to delegate an amount to other managers in the team at her discretion and has delegated an authorisation limit of £10,000 for some expense items to the Head of Financial Accounting. These delegations are not documented and it is unclear whether the Council intends the £25k delegated amount to Directors to be sub-delegated without the Council's express authorization. • Detailed process documents are produced by the Transactions Manager on banking and refund processes, however these documents do not specify the owner and document review dates. **Risk** Lack of formally documented procedures heightens the succession risk in case of a loss of key personnel. This may lead to an incorrect/inconsistent application of key processes and decisions being taken. Outdated procedures can also cause confusion for a new person who joins any of the above teams regarding what processes to follow, and may lead to processing errors.		without the Council's express authorization. Based on the outcome of discussions with the Council, Management may have to document the delegations of authority capturing the Director of Finance's delegations. 3. Update all policies and procedure documents to capture the owner and dates of review. As part of the RCA of the process issues, we will process map the processes and document the control points. Improvement plans will be created based on risk.	**2) Owner: Director of Finance** **Date Effective**:31 July 2019 Progress June 2020: Progress June 2020: Updated scheme of delegation was approved by Council in March 20. - **Complete** March 2020 – The updated scheme of delegation will be presented to Audit Committee in March 2020. 05/11/19 – The scheme of delegation is currently being reviewed with a revised SoD to be presented to the Audit Committee in March 2020. 10/09/19 – see updated management response 04/06/19 – To be reviewed as part of the full review and update of the scheme of delegation. **3) Owner:** **Financial Control Manager** **Registration Operations Manager** **Treasury accountant / Head of Financial Accounting.** **Date Effective**:30 September 2019 **Progress** Progress June 2020: Due to other priorities such as year end and audit, policies are yet to be reviewed by the Financial Control Manager Target Date: **31 October 2020**

	Finding and Implication	Priority	Agreed management action	Timescale/ Responsibility
				March 2020 – Following the Finance restructure, all policies will be reviewed by the Financial Control Manager 05/11/19 – HOFA: About 80% of the finance procedures have been updated to include owner and review dates. The remaining 20% is currently being reviewed; this is due to the treasury manager being on long term sick. HOFA 10/09/19 – All Finance Procedure notes are currently being updated and will be completed by 30 September 2019 10/09/19 - All Transaction processes have been updated to include owner and review dates. 04/06/19 - Agreed management action is in the Treasury and Financial Accountant's objectives. Plans are in place to allocate a day a month to update procedures.
3	Management information and analysis surrounding aged debt balances are to be communicated to Senior Management. Frequency of reporting, and forums for which to report to are to be determined, though at a minimum Finance and Registration should have oversight. Management should define categories or reason codes for non-payment and these should be captured within the registrants balance report, in order to facilitate more detailed analysis and discussion. Areas to consider as part of reporting could include (but are not limited to): debtor trends over time (e.g.by profession), analysis on most common reasons for non-payment, and write-offs due to registrants being removed from the register.	Medium	Management information and analysis surrounding aged debt balances are to be communicated to Senior Management. Frequency of reporting, and forums for which to report to are to be determined, though at a minimum Finance and Registration should have oversight. Management should define categories or reason codes for non-payment and these should be captured within the registrants balance report, in order to facilitate more detailed analysis and discussion. Areas to consider as part of reporting could include (but are not limited to): debtor	**Owner: Financial Control Manager** **Date Effective**:31 July 2019 Target Date: **31 October 2020** Progress June 2020: Testing of the debtor report has commenced in UAT environment, we are awaiting result of this before deploy it into live environment. March 2020 – The debtor report is yet to be tested in UAT environment, we will work with the project team to find a gap between projects to complete the testing.

	Finding and Implication	Priority	Agreed management action	Timescale/ Responsibility
			trends over time (e.g.by profession), analysis on most common reasons for non-payment, and write-offs due to registrants being removed from the register.	05/11/19 – Energysys have designed the debt report but due to the volume of projects and server issues, it has been challenging getting access to the UAT environment to test. 10/09/19 - Energysys have been engaged to design and produce via NetRegulate a debt report highlighting overall debt, current debt, 30 days, 60 days and 90+ days including the statuses and registration numbers. We are awaiting deployment into the UAT environment of NetRegulate to test. In the interim, the TM includes reason codes via data validation tools into the current balance report for non-payment. 04/06/19 **-** Included in the transaction managers objectives. Some of reports recommended can be prepared internally and some will need assistance from the Supplier or It department.
4	**Finding** This audit identified some examples where information was not able to be shared between teams either at all or in a timely manner that has impacted on the ability for the Transactions Team to effectively process transactions and communicate with registrants. For example, hard copy registrant application forms are received by the Registration Team, stored short-term, scanned by a third party provider, and the scanned files are saved by IT onto NetRegulate for reference. Management advised that this process can take a number of months. There were 6/25 (24%) instances where registrant application forms could not be located, though three do relate to the prior three months. From our discussions with the Transactions Manager, we understand that in several cases the Transactions Team has spoken to registrants to request information that the registrant challenged was in their application form, leading to a negative registrant experience. The Transactions Team will request the registrant to fill in their payment information in a direct debit form, leading to duplication of work with the Registration Team.	Low	2. As an example this could include a requirement for increased detail on registrant's notes within NetRegulate, and/or copying the contents of email correspondence between Registration Officers and registrants on the NetRegulate communications log.	**2) Owner: Financial Control Manager and Registration Operations Manager Date Effective**: 30 September 2019 **Progress** Progress June 2020: The Financial Control Manager has been working closely with Registration on information sharing. - Complete March 2020 – Transaction team has been located within the Registration department to share information and look for process improvements, so far the teams were able to streamline a number of processes. Following the finance restructure, the Financial Control Manager will continue to work with

	Finding and Implication	Priority	Agreed management action	Timescale/ Responsibility
	The Transactions Team is not able to view the email communications between the registrants and the Registration Advisors. We understand that there have been instances of errors made by Registration Advisors in processing registrant's details on NetRegulate (such as errors in recording the registrant name or direct debit details). The Transactions Team has then contacted the registrants for the information in order to process their payments, which has led to registrants challenging that the information was already provided to the Registration Team accurately. **Risk** If the Transactions Team do not have access to registrant information and communications, there is a risk that they are unable to accurately process transactions and communicate with registrants. There is also a risk that both the Transactions and Registration Teams are communicating with the same registrant at the same time which could negatively impact on the registrant's experience.			Registration department to seek better ways to share information. 05/11/19 – Transactions are sharing information and adding notes. We are awaiting an update on SLA's for Direct Debits / Applications to be uploaded to NetRegulate records from Registrations. 10/09/19 -The Transactions team are adding notes when making changes to NetRegulate records. We are awaiting an update on SLA's for Direct Debits / Applications to be uploaded to NetRegulate records from Registrations. 04/06/19 - High level discussion have been held with Registration Finance and Projects to see if processes can be simplified

2018

Strategic and Operational Planning (considered at Audit Committee September 2018)

Recommendations summary

Priority	Number of recommendations
High	None
Medium	None
Low	2

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
1	The method in which HCPC communicates its Corporate Plan and strategic priorities to key stakeholders (e.g. Government and Professional	1)The Communications Team should ensure that HCPC's Corporate Plan is	Low	The organisation's Strategic Intent is a public document and available on our website.	**1)Owner: ED of Policy and External Relations**

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
	Standards Authority (PSA)) is not being performed consistently across the organisation. For example, the Corporate Plan has been discussed with the PSA by the Director of Regulations to highlight the organisation's commitment in ensuring that PSA standards are of strategic importance. In contrast, the Corporate Plan has not been communicated to government representatives (e.g. assemblies and members of parliament) and education providers (e.g., universities). We also noted opportunities for enhanced collaboration between the Communications Team and SMT in terms of tailoring communication to manage stakeholder expectations, for example through implementing Personal Communication Plans (PCPs). At present, through discussion with members of Management, it was identified that SMT members are typically communicating with stakeholders through individual silos. Implication - Without agreed communication protocols in relation to HCPC's Corporate Plan and strategic priorities, stakeholders such as the PSA, government and education providers may not be aware of the organisation's strategic priorities for the future. A lack of involvement from the Communications Team when communicating to external stakeholders may result in stakeholder needs not being satisfied, or known best practice not being consistently applied across the organisation.	consistently communicated to relevant stakeholders, for example through the organisation's intranet, newsletters, CEO communication and/or holding local events/seminars. 2)The Communications Team should create Personal Communication Plans for SMT members and relevant Heads of Department with objectives over the next six to twelve months being documented and progress reviewed.	Low	Following Council's decision in March to replace this document with a revised Corporate Strategy and corporate plan, we will be undertaking this work in Q3 and will build in communications to relevant stakeholders once this work is completed. In May 2018, the Council discussed a new approach to stakeholder communications and engagement. Part of this was the development of personal communications plans. With the restructuring of the EMT, we recognised this would be a good opportunity to do this and work is currently underway. Collaboration with communications continues, particularly in the development of agendas and briefing notes for stakeholder meetings as well daily alerts to external issues.	**Agreed date of implementation:** End of Q4 2018-19 **Progress** Progress June 2020: **Completed:** The interim corporate plan has been communicated to all employees as part of CEO briefings and progress against the strategic priorities has been published in Council reports on the website and in stakeholder updates. Plans for the development of a new corporate strategy are being put in place, and this will include stakeholder engagement. March 2020 – A dissemination plan will be put in place when the Corporate Strategy has been revised and approved by Council. The Executive will consider how best to update key stakeholders on the interim corporate plan that has been presented to Council. 05/11/19 – A dissemination plan will

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					be put in place when the Corporate Strategy has been revised and approved at Council. (HoC) 10/09/19 - A dissemination plan will be put in place when the Corporate Strategy has been revised and approved at Council. (HoC) 16/05/19 - A dissemination plan will be put in place when the Corporate Strategy has been revised and approved. **2) Owner**: **ED of Policy and External Relations** **Agreed date of implementation:** Completed Progress June 2020: Completed: The review of our communications function has been completed and a strategic communications consultant appointed. This will introduce new ways of working and our approach to internal and external

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					communications and engagement. March 2020 – Delayed, as below. However, Communications will be reviewed as part of business improvement in the change plan, workshops being held in February/March. Resourcing will be identified in the budgeting process. **Progress** 05/11/19 – Action has been delayed due to inability to recruit to two key roles in Communications due to recruitment freeze. 10/09/19 – A Personal Engagement plan for ED of Policy and External Relations is in development. Action on further plans has been delayed due to turnover of staff in Communications. Inability to recruit to two key roles in Communications due to the recruitment freeze is likely to mean slow progress going forward. (HoC)

	Finding and Implication	Recommendation	Priority	Management response	Timescale/ Responsibility
					16/05/19 - This is work in progress and part of the Communications Department workplan