Meeting of the Audit Committee

to be held from 11:00 to 13:00 on Thursday 5 September 2013
at 23 Portland Place, London W1B 1PZ

Louise Scull Chair	Paul Johnston Secretary to the Committee

Agenda

1	**Welcome and Chair's opening remarks**	AC/13/55
2	**Apologies for absence**	AC/13/56
3	**Declarations of interest** To invite any member to declare an interest in the business of today's meeting.	AC/13/57
4	**Minutes of the previous meeting** Minutes of the open session of the Audit Committee held on 19 April 2013	AC/13/58
5	**Summary of actions** The Committee is asked to consider those actions arising from previous meetings of the Committee that are now considered completed and note further updates on issues arising from minute AC/13/41.	AC/13/59
6	**Committee terms of reference** Secretary to the Audit Committee	AC/13/60

Matters for discussion

7	**Risk management update** Director of Corporate Governance	AC/13/61
8	**Internal Audit Work Programme** Director of Corporate Governance	AC/13/62
9	**Historic Internal Audit / assurance recommendations** Director of Corporate Governance	AC/13/63

10	**NMC assurance map**	AC/13/64
	Director of Corporate Governance	

Matters for information

11	**Serious events and data breaches: report**	AC/13/65
	Director of Corporate Governance	
12	**Schedule of business**	AC/13/66
	Secretary to the Audit Committee	
13	**Any other business**	AC/13/67

The next meeting of the Audit Committee is scheduled to be held on
Tuesday 10 December 2013 at 11:00
at 23 Portland Place, London, W1B 1PZ

Meeting of the Audit Committee
Held at 10:30 on 8 July 2013
At AAGBI offices, 21 Portland Place, London

Minutes

Present

Members:

Louise Scull	Chair
Julia Drown	Committee member
Carol Shillabeer	Committee member (by teleconference)

NMC officers:

Jackie Smith	Chief Executive and Registrar
Lindsey Mallors	Director of Corporate Governance
Mark Smith	Director of Corporate Services
Mike Andrews	Assistant Director of Quality Assurance and Risk Audit
Verity Somerfield	Assistant Director, Finance
Paul Johnston	Council Services Manager (Secretary to the Committee)

Present:

Kate Mathers	National Audit Office
Martin Burgess	National Audit Office
Bill Mitchell	Moore Stephens
Sarah Hillary	Moore Stephens
Kathryn Burton	haysmacintyre

The meeting of the Audit Committee commenced at 10.30am.

The Chair of the Committee agreed to revise the agenda order. The minutes reflect the order in which items were considered.

Minutes

AC/13/37 Welcome and Chair's opening remarks

1. The Chair welcomed all attendees to the meeting. It was noted that this was the first meeting of the Committee with its reconstituted membership.

   The Committee noted that this would be Julia Drown's last meeting as a Committee member, and formally thanked her for her contribution to the Committee, both as a member and former Chair of the Committee.

AC/13/38 Apologies for absence

1. Apologies for absence were received from Stephen Thornton.

AC/13/39 Declarations of Interest

1. There were no declarations of interest.

AC/13/40 Minutes of previous meetings

1. The minutes of the previous Committee meeting were agreed as a correct record, subject to revision of paragraph 24.

AC/13/41 Summary of actions

1. The action list updating progress on matters arising from previous meetings was noted.

2. The Committee asked for further information on staff take-up of information security training to be presented to the next meeting. The Committee also asked for clarity on where responsibility laid within the NMC's governance structure for oversight of equality and diversity.

Action:	**Report to the Committee on 1) oversight for NMC equality and diversity activity; and 2) staff take-up of information security training**
For:	**1) Director of Corporate Governance** **2) Director of Corporate Services**
By:	**5 September 2013**

AC/13/42 Audit Committee – proposed terms of reference

1. The Committee considered proposed terms of reference, which had been drafted on the basis of recommendations within the recently undertaken governance review as well as recognised good practice.

2. It was noted that revised Standing Orders would be proposed to the Council in September 2013, and that these would include consistent provisions for all committees, including, for example, for quorum and membership.

3. The Committee endorsed the proposed terms of reference, subject to amendment of the remit to reflect NAO guidance (summarising the content of the most recent iteration of HM Treasury's Audit and Risk Assurance Committee Handbook) and to the addition of an addendum outlining the responsibilities of management for audit matters.

Action:	**Amend the terms of reference to reflect the Audit Committee's comments**

For:	**Secretary to the Committee**
By:	**5 September 2013**
Action:	**Provide a draft addendum to the terms of reference covering management responsibilities for agreement at the next meeting**
For:	**Director of Corporate Governance**
By:	**5 September 2013**

AC/13/45 National Audit Office audit completion report

1. Martin Burgess, National Audit Office, outlined the contents of the audit completion report undertaken on the 2012 – 13 financial statement audit.

2. The Committee noted the NAO's view that the organisation's internal controls had remained robust during the considerable changes within the organisation over the past year. It was recommended that, given the change in Council membership, the Council review in due course the quality and materiality of the information it received.

3. The Committee also noted that the NMC now had a more robust process in place for special payments, which would be subject to ongoing review.

4. The Committee noted the NAO report.

AC/13/44 External audit management letter

1. Kathryn Burton, haysmacintyre, outlined the contents of the external audit management letter. The Committee noted that haysmacintyre were content with the internal controls in place and that the NMC had fully addressed the points raised in the previous year's external audit management letter. It was specifically noted that disclosures on related party transactions were appropriate and that the treatment of the Department of Health grant was appropriate.

2. The Committee received updates on the following points:

   a) Progress on updating the Financial Procedure manual was ongoing and was subject to further revision upon the updating of finance systems.

   b) Discussions were ongoing with HMRC around reclaiming PAYE and NIC payments for Fitness to Practise panellists.

AC/13/43 Annual report and accounts

1. The Committee considered the annual report and accounts for 2012 -13 and noted the process in going forward for submission of the annual report and accounts to Parliament.

2. Members of the Committee had made a number of detailed comments on the annual report and accounts to officers prior to the Committee meeting and these had been carefully considered. The comments would be incorporated in the final accounts where appropriate.

3. The Committee suggested the following further amendments:

   a) Page 46, "Charitable activities costs" heading to be replaced by "Total resources expended";

   b) Page 75, remove "servicing of finance" from "Returns on investment and servicing of finance"

4. The Committee requested that the annual report be amended to reflect the fact that registrants' annual NMC fees may rise in future but that any such rise would be subject to consultation, in line with the wording of the original Council resolution. It was also agreed that the quality of disclosures within the report on overseas registration be reviewed.

5. Subject to incorporation of amendments proposed by Committee members both prior to, and during the meeting, the Committee endorsed the submission of the annual report and accounts to the Council for approval.

6. The Committee extended its thanks to Verity Somerfield and colleagues for their work in compiling the annual report and accounts.

Action:	**Amend the annual report and accounts to be presented to the Council**
For:	**Director of Corporate Governance**
By:	**Council – 18 July 2013**

AC/13/46 Fitness to Practise annual report

1. The Committee was asked to consider the Fitness to Practise annual report in order to provide internal assurance to the Council on its robustness and accuracy. The assurance mechanism for the annual report for future years would need to be reviewed.

2. The Committee considered the report and requested the following amendments:

   a) Table 3: greater clarity required on "unidentified referrals"

   b) All tables to include "percentage of register" in addition to "percentage of referrals"

3. Officers were asked to consider whether the information provided in

tables 6 – 9, 14 – 17, 21 – 24 and 28 – 31 should be excluded from the report and reported to stakeholders in another way, due to the high percentage of "unknown" in the analyses and the risks of drawing conclusions based on small numbers.

4. The Committee also stated that it would helpful to consider whether a glossary of terms would be beneficial for external stakeholders.

5. Subject to the above amendments, the Committee agreed to endorse the Fitness to Practise annual report to the Council.

Action: **Amend the Fitness to Practise annual report to reflect the Committee's discussions**
For: **Director of Corporate Governance**
By: **Council – 18 July 2013**

AC/13/48 NMC assurance map

1. Sarah Hillary, Moore Stephens, introduced the NMC assurance map, which was designed to provide the Committee and the Council with an understanding of where assurance on the NMC's activities could be provided. It was noted that the map was an assessment of assurance activities as reported by management and that the effectiveness of these activities would be tested through the internal audit and corporate QA programmes.

2. The Committee noted that further planned assurance activities should bolster the 'first line of defence' in a range of functions. Certain 'third line' defences, such as the Health Select Committee, would only be able to provide a limited source of assurance but would nonetheless be a source of information.

3. The Committee welcomed the introduction of the assurance map, which would support the Committee in being able to perform its assurance role to the Council on the robustness of processes in place across the organisation. It was noted that the Council would formally own the assurance map and that reporting of the map should be alongside the Risk Register.

AC/13/47 Draft internal audit strategy and year one work programme

1. The Committee noted the draft internal audit strategy and year one work programme. The strategy and direction of travel had been formulated following extensive discussions with management and this level of engagement was important in going forward.

2. The Committee noted progress to date, which included work undertaken already by Moore Stephens on outstanding recommendations from the NMC's previous internal audit providers, and the development of terms of reference and timetables for Q2 work.

3. It was noted that there were a small number of risks that appeared on the Corporate Risk Register that were not subject to internal audit work in year one. The year one work programme had been formulated to balance addressing risks on the register with risks in internal programmes being undertaken.

4. The Committee agreed that business continuity appeared to be a considerable risk to the organisation and asked that this be prioritised to be included within the year one work programme. The communication and engagement workstream would therefore be deferred to Q1 2014 – 15.

5. The Committee agreed that the Risk Register should be updated to reflect planned internal audit activities against relevant risks. The Committee would be updated at each meeting on internal audit activity.

Action: **Amend the internal audit year one work programme to include business continuity in Q4 of year one; and to include communication and engagement in Q1 of year two.**
For: **Moore Stephens / Director of Corporate Governance**
By: **5 September 2013**

Action: **Update the Risk Register to reflect proposed IA activity against relevant risks**
For: **Director of Corporate Governance**
By: **5 September 2013**

AC/13/49 Corporate quality assurance strategy

1. The Committee was asked to consider the corporate quality assurance (QA) strategy following the Council meeting on 20 June 2013. It was noted that the focus of the corporate QA programme would be on high risk areas and would sit alongside the assurance map and other internal audit functions.

2. The Committee agreed that it was appropriate for the QA team to raise concerns with the Director of Corporate Governance and the Chief Executive and Registrar in the first instance. It would then be appropriate for concerns to be raised directly with the Audit Committee if these routes had not addressed the concerns.

3. The Committee agreed the broad direction of travel for the strategy and agreed that resourcing to support delivery of the strategy was an operational issue. The next step would be for the Corporate Governance directorate to make a case to the Directors' Group for allocation of budget from the central pool.

AC/13/50 External audit provision

1. Kathryn Burton, haysmacintyre, left the meeting during discussion of this item.

2. The Committee agreed, in view of the high quality of support provided by haysmacintyre and the need for some consistency in audit provision given the recent appointment of Moore Stephens, to extend the contract for haysmacintyre for a further year.

3. The Committee agreed it would be appropriate to examine the case for retendering for the provision of external audit services next year in due course.

Action:	**Report to the Committee with proposals for external audit tender**
For:	**Director of Corporate Services**
By:	**November / December 2013**

AC/13/51 Format of future meetings

1. The Committee noted the recommendation from the previously constituted Committee that a seminar session be held prior to meetings to support members' induction and agreed that this was not necessary.

AC/13/52 Identified development needs

1. It was agreed that development needs be considered on an ongoing basis and that no discussion was needed at this stage on this item.

AC/13/53 Recent guidance on Audit Committees (National Audit Office)

1. The Committee noted the guidance.

AC/13/54 Any other business

1. It was noted that, further to the discussion by Committee, that quality assurance should be included within the addendum to the Committee's terms of reference (detailing management responsibility for audit provision).

The date of the next meeting is to be 5 September 2013.

The meeting ended at 12:55.

Item 5
AC/13/59
5 September 2013

Audit Committee

Summary of actions

Action:	For decision.
Issue:	A summary of the progress on completing actions agreed by the Audit Committee on 8 July 2013 and progress on actions outstanding from previous Audit Committee meetings.
Core regulatory function:	Supporting functions.
Corporate objectives:	Corporate objective 7: The action list supports effective governance processes by enabling the Committee to assure itself that action is being progressed.
Decision required:	The Committee is asked to note progress on actions agreed by the Audit Committee on 8 July 2013 and outstanding from previous meetings. Subject to members' views, it is proposed that, following this meeting, all actions arising that are due for reporting back and have been reported to this meeting be removed from the summary.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Summary of outstanding actions arising from the Audit Committee on 8 July 2013

Minute	Action	For	Report back to: Date:	Progress to date
13/41	**Summary of actions** Report to the Committee on 1) oversight for NMC equality and diversity activity; and 2) staff take-up of information security training	Director of Corporate Governance and Director of Corporate Services	Audit Committee 5 September 2013	13/41 (a) The Diversity Champions Forum, Chaired by the Chief Executive and Registrar, meets quarterly and reports to the Executive Board. It oversees the progress made by directorates in implementing the Equality Objectives and related deliverables in the corporate plan and directorate business plans. Responsibility for coordinating and monitoring progress rests with the Corporate Governance Directorate. An annual report is submitted to the Council before publication. The 2012-13 annual report was submitted to the Council in July. 13/41 (b): This relates to an action arising at the Audit Committee on 19 April. The Committee was informed at the July meeting that officers are monitoring completion of newly introduced online statutory and mandatory training modules (including information security) for all staff, including temporary staff and contractors. An update will be provided to the Audit Committee on 5 September 2013.

Minute	Action	For	Report back to: Date:	Progress to date
13/42	**Audit Committee – proposed terms of reference** Amend the terms of reference to reflect the Audit Committee's comments	Secretary to the Audit Committee	Audit Committee 5 September 2013	Completed.
	Provide a draft addendum to the terms of reference covering management responsibilities for agreement at the next meeting	Director of Corporate Governance	Audit Committee 5 September 2013	To be brought before the Audit Committee on 5 September 2013 under agenda item AC/13/60.
13/44	**Annual report and accounts** Amend the annual report and accounts to be presented to the Council	Director of Corporate Governance	Council 18 July 2013	Annual report and accounts amended accordingly, and agreed by the Council
13/46	**Fitness to Practise annual report** Amend the Fitness to Practise annual report to reflect the Committee's discussions	Director of Corporate Governance	Council 18 July 2013	Amended report to go to the Executive Board on 17 September
13/47	**Draft internal audit strategy and year one work programme** Amend the internal audit year one	Moore Stephens / Director of Corporate Governance	Audit Committee 5 September 2013	Completed.

Minute	Action	For	Report back to: Date:	Progress to date
	work programme to include business continuity in Q4 of year one; and to include communication and engagement in Q1 of year two			
	Update the Risk Register to reflect proposed IA activity against relevant risks	Director of Corporate Governance	Audit Committee 5 September 2013	An updated risk register was presented to the Executive Board on 29 August and will be presented to the Council on 12 September
13/50	**External audit provision** Report to the Committee with proposals for external audit tender	Director of Corporate Services	Audit Committee 10 December 2013	Not yet due

Summary of outstanding actions arising from the Audit Committee on 19 April 2013

Minute	Action	For	Report back to: Date:	Progress to date
13/30	**Risk register** Update the Committee on NMC compliance with statutory Welsh	Director of Corporate Governance	8 July 2013	The Welsh Language scheme annual report will be presented to the Council on 12 September, which will update members on compliance with statutory requirements

Minute	Action	For	Report back to: Date:	Progress to date
	language requirements.			
13/41	**Serious event and data breaches** Amend information to include what the intended outcome for each action taken and an assessment of whether that outcome had been realised	Director of Corporate Governance	8 July 2013	Future Audit Committee reports will include this information
13/46	**Francis report: governance issues** Amend Audit Committee report to Council to reflect the discussions held on this item	Secretary to Audit Committee	25 April 2013	Progress on the NMC's response to the Francis report recommendations is monitored at each meeting of the Council.
13/46	**Francis report: governance issues** Ensure periodic review by the Audit Committee of progress on addressing governance recommendations within the Francis Report	Secretary to Audit Committee	8 July 2013	The Committee schedule of business will be amended to reflect this. Members will have the opportunity to consider the forward schedule of business at its September meeting.

Summary of outstanding actions arising from the Audit Committee on 25 January 2013

Minute	Action	For	By	Progress to date
13/14/61	**Anti-fraud, bribery and corruption policy** Undertake full review of policy.	Director, Corporate Services	31 December 2013	Not yet due Committee schedule of business amended 29 April 2013
13/20/83	**Whistleblowing policy** Report back to Audit Committee on review of whistleblowing policy.	Director, Corporate Services.	31 December 2013	Not yet due Committee schedule of business amended 29 April 2013

Actions for Audit Committee from Council

None outstanding.

Item 6
AC/13/60
5 September 2013

Audit Committee

Committee terms of reference

Action: For decision.

Issue: The Committee is asked to consider the attached addendum to the Audit Committee terms of reference, which outlines management responsibility for audit activities as requested at the Committee meeting on 8 July.

Core regulatory function: All functions.

Corporate objectives: Corporate objective 7: "We will develop effective policies, efficient services and governance processes that support our staff to fulfil all our functions."

Decision required: The Committee is asked to review and endorse the addendum to the Terms of Reference.

Annexes: Annexe 1: Proposed addendum to the terms of reference for the Audit Committee

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:	1	Members will recall that the Committee considered its proposed terms of reference, which had been put drafted with reference to the recommendations arising from the governance review and to a wider benchmarking exercise against guidance from the Institute of Chartered Secretaries and Administrators (ICSA), the Financial Reporting Council, HM Treasury, other healthcare regulators and good practice in other sectors, at its meeting on 8 July.
Discussion and options appraisal:	2	The Committee endorsed the terms of reference, subject to amendments to the Committee's remit (which were incorporated within the terms of reference presented to the Council on 18 July) and the inclusion of an addendum outlining management responsibility for audit activities.
	3	**Recommendation: The Committee is asked to review and endorse the addendum to the Terms of Reference as set out in Annexe 1.**
Public protection implications:	4	None directly from this paper. The Audit Committee has nonetheless a crucial role in determining that NMC policies and processes are all sufficiently robust to ensure that the public are protected.
Resource implications:	5	None directly from this paper.
Equality and diversity implications:	6	None directly from this paper.
Stakeholder engagement:	7	The terms of reference have been reviewed in the light of the governance review undertaken by external consultants. Benchmarking has been undertaken as per paragraph 2.
Risk implications:	8	There are a number of risk implications arising. Specifically, if the terms of reference are insufficiently clear on remit, there is the risk of lack of clarity over decision-making and potential duplication of work. There is also a reputational risk associated with poor decision making. These risks have been mitigated through close regard to good practice in other areas through benchmarking organisations within and external to the sector.
	9	Risk management is an important role undertaken by the Audit Committee, and this role features prominently in the proposed terms of reference.

Legal implications:	10	None directly from this paper. The Audit Committee is not a statutory obligation, though its constitution is consistent with good governance.

Annexe 1 - Audit Committee Terms of Reference

1 The Audit Committee is established by the Council under Article 3 (12) of the Nursing and Midwifery Order 2001.

Remit

2 The remit of the Audit Committee is to support the Council and management by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

Responsibilities

Integrity of financial statements

3 Review the annual report and accounts before they are submitted to the Council for approval, focussing in particular on:

3.1 Consistency of, and compliance with, accounting policies.

3.2 Compliance with appropriate accounting standards.

3.3 Significant adjustments arising from audit and any unadjusted mis-statements.

3.4 Major accounting judgements.

3.5 Clarity of the annual governance statement and other disclosures in the annual report relating to internal control, risk management, audit, and other matters falling within the Committee's remit.

4 Ensure that the systems for financial reporting to the Council are reviewed to ensure clarity, completeness, and accuracy.

Internal controls and risk management

5 Review the adequacy of internal controls and monitor sources of assurance relating to them.

6 Review the risk management system, including the scope and effectiveness of the processes employed by management to identify, evaluate, manage, and monitor significant risks.

7 Review the financial regulations, including the scheme of financial delegations and the anti-fraud and anti-bribery policies.

8 Review the NMC's public interest disclosure (whistle-blowing) procedure and the serious event review policy.

Internal audit

9 Advise the Chief Executive on the appointment of the internal auditors.

10 Consider and approve the internal audit charter, ensuring that the internal auditors have sufficient standing in the NMC, have appropriate access to information, and are free from management or other restrictions, in order to allow them to perform their function effectively and in accordance with the relevant standards.

11 Consider and approve the high level annual internal audit programme.

12 Receive reports on the internal audit programme, reviewing and monitoring management's responsiveness to the findings and recommendations of the internal auditors.

13 Meet with the internal auditors at least once a year, without NMC management being present, to discuss their remit and any issues arising from the internal audits carried out.

External audit

14 Consider and make recommendations to the Council regarding the appointment, re-appointment and removal of the external auditors.

15 Oversee the relationship with the external auditors, including:

15.1 Approving their remuneration, terms of engagement, and the audit scope.

15.2 Assessing their independence and objectivity in accordance with relevant audit standards.

15.3 Agreeing proposals for them to undertake non-audit services.

16 Consider and approve the annual external audit plan.

17 Review the letter of representation requested by the external auditor before it is signed by the Trustees.

18 Review the findings of external audit work, including:

18.1 Reviewing the external audit management letter and the management responses.

18.2 Discussing any significant issues that arose during the audit.

18.3 Any accounting and audit judgements.

18.4 Levels of errors identified during the audit.

National Audit Office (NAO)

19 Oversee the relationship with the NAO.

20 Consider and approve the annual NAO audit plan.

21 Review the findings of the NAO's work, including:

21.1 Reviewing the NAO audit completion report and the management responses.

21.2 Discussing any significant issues that arose during the audit.

21.3 Any accounting and audit judgements.

21.4 Levels of errors identified during the audit.

Annexe: Summary of Management Responsibilities

1 The general responsibilities delegated by the Council to the Chief Executive and Registrar are set out in the Scheme of Delegation.

2 The Chief Executive and Registrar's responsibilities as Accounting Officer are set out in *Managing Public Money*.

3 In general terms, the responsibilities of management as regards the matters which fall within the remit of the Audit Committee are as follows:

Financial statements

3.1 Prepare an annual report and accounts which present a true and fair view of the NMC's affairs and comply with appropriate accounting standards.

3.2 Submit the annual report and accounts, once approved by the Council, to the Privy Council to be laid before Parliament.

3.3 Provide clear, complete, and accurate financial reports to the Council.

Internal control and risk management

3.4 Ensure that matters which call into question the effectiveness of internal controls are reported to the Audit Committee.

3.5 Implement the risk management system and report to the Audit Committee on its effectiveness.

3.6 Determine and implement the financial regulations, including the scheme of financial delegations and the anti-fraud and anti-bribery policies, and ensure they are presented to the Audit Committee for periodic review.

3.7 Determine and implement the public interest disclosure (whistle-blowing) procedure and the serious event review policy and ensure they are presented to the Audit Committee for periodic review.

Internal audit

3.8 Manage the relationship with the internal auditors in accordance with the internal audit charter, ensuring, in particular, that the auditors have appropriate access to information and are free from management or other restrictions.

3.9 Work with the internal auditors to develop an internal audit programme that provides appropriate coverage of internal controls and is aligned to the risk profile.

3.10 Provide management responses to internal audit recommendations.

3.11 Follow through and monitor the implementation of recommendations, reporting progress to the Audit Committee.

External audit and NAO

3.12 Manage the relationship with the external auditors and the NAO, ensuring, in particular, that the auditors have appropriate access to information and are free from management or other restrictions, and that all required disclosures and representations are complete and accurate.

3.13 Respond appropriately to the findings of audit activity and report to the Committee on the implementation of any recommendations.

General

3.14 Ensure that policies are updated to take account of relevant good practice, including, where applicable, guidance issued by the Treasury or the NAO.

Item 7
AC/13/61
5 September 2013

Audit Committee

Risk management update

Action: For discussion.

Issue: This paper presents an update on the implementation of the refreshed approach to risk management at the NMC.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7.

An effective system of risk management is an essential element of good governance.

Decision required: The Audit Committee is recommended to:

- Note (i) the steps that have been taken to implement the risk management policy and framework and (ii) the forthcoming reviews that will provide further assurance in this regard (paragraph 24).
- Discuss what information officers should present at each Audit Committee meeting, to provide assurance to the Committee about the risk management arrangements (paragraph 27).
- Discuss reporting arrangements which will enable the Audit Committee to provide a risk management update to the Council on a quarterly basis (paragraph 28).

Annexes: The following annexes are attached to this paper:

- Annexe 1: The Corporate risk register.
- Annexe 2: Risk management training session outline.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 The Professional Standards Authority (PSA), formerly CHRE, noted that the NMC's approach to risk management "is not consistently and effectively applied" (paragraph 7.13, Strategic Review, July 2012), and that improvements were required.

2 During 2012-2013, the NMC's risk management approach was refreshed and a revised policy and framework were approved at the April 2013 Audit Committee meeting.

3 These documents are available on the e-Net.

Discussion:

Rolling out the refreshed risk management approach

4 In April to June 2013, we raised awareness across the NMC about our refreshed risk management approach through corporate and directorate briefings, announcements on the staff intranet and through training sessions which the Corporate Governance directorate organised and lead on.

Risk management training

5 11 training sessions were held between 22 April and 5 June. 98 members of staff, including the Chief Executive, received the training. Training was offered to all directors, heads, team managers and executive assistants.

6 The content of the training sessions can be found at Annexe 2.

7 Training packs, which mirror the course content, were issued to staff. The sessions were interactive and attendees identified risk information which was noted and subsequently used to inform the development of the directorate risk registers.

8 Attendees were invited to complete an HR evaluation survey about the training they had received.

8.1 54 out of the 98 attendees completed the survey. The majority of responders (49) rated their training session as 'Good' or 'Excellent'.

8.2 The majority of comments were positive, complimenting the usefulness of the session, the trainers' delivery, and the material provided.

9 Staff who were invited but could not attend a training session will be invited to future sessions. We aim to hold a training session each quarter for new starter managers, other staff who have not had the training, and those who wish to refresh their knowledge.

Current arrangements for reviewing the risk registers

10 Key elements from the risk management framework are:

10.1 There are five main levels of accountability for risk management at the NMC. These include the Council, the Audit Committee, the Chief Executive and Executive Board, individual directors and their staff, and sponsors of programmes and projects.

10.2 There are wider responsibilities for all staff, our internal audit providers and contractors and partners.

10.3 The use of risk registers to document all aspects of the NMC's risk management cycle.

10.4 The Council defines and sets the NMC's risk appetite. Whilst 'green' risks are deemed to be tolerable by the Council, 'red' and 'amber' risks are deemed intolerable and therefore require specific management action and attention.

10.5 Ensuring risk management is a dynamic process. The risk registers are living documents in that the recorded risks and risk scores do not remain static.

11 The Council is responsible for ensuring that the risk management processes in place are robust and proportionate, for setting the strategic risk appetite and for reviewing the highest level risks on a regular basis. The Corporate risk register was presented in its new format to the Council for the first time at the June 2013 meeting.

12 Following the June Council meeting and the roll out of the training sessions, directorates started to build their risk registers in the refreshed format.

13 Directorates are still developing their risk registers but overall the organisation is now settling into a cycle of reviewing and updating the risk registers each month.

14 As part of the refreshed risk management approach, Corporate Governance carries out a monthly scrutiny of directorate and the Change Management and Portfolio Board (CMPB) risk registers.

15 At these meetings, risk registers are scrutinised for:

15.1 Compliance with the refreshed approach.

15.2 Substance.

15.3 Red risks that require escalation to the corporate risk register.

15.4 Cross directorate links.

16 Each directorate and the CMPB is provided with feedback on their risk register after the meeting.

17 Staff are continuing to seek advice and support about risk management from the Corporate Business Planning team.

18 Risks are also discussed at the monthly finance and business planning review meetings, which take place between each directorate and the Finance and Governance and Planning teams.

19 The Corporate risk register (Annexe 1) is reviewed monthly by the Executive Board (previously the directors' group). The directorate / CMPB risk registers are also presented alongside the Corporate risk register, for context.

20 The Corporate risk register is presented to the Council at each Council meeting as part of the 'Performance and risk report', which is a standing agenda item.

Planned work

21 The outcomes of risk management have been used to inform the NMC's internal audit strategy and plan (see Item 8) and the development of the assurance map (Item 11). As part of the audit plan, the NMC's risk management process will be subject to review in 2013-2014.

22 A post-implementation review of risk management is scheduled to be carried out during quarter 3 (October to December) by the Corporate Governance directorate. The outcomes will be reported to the Audit Committee in February 2014.

23 An annual review of risk management is planned for the end of the financial year and the outcomes will be reported to the Audit Committee.

24 **Recommendation: The Committee is invited to note (i) the steps that have been taken to implement the risk management policy and framework and (ii) the forthcoming reviews that will provide further assurance in this regard.**

Audit Committee responsibility

25 The Audit Committee is responsible for ensuring that the NMC's risk management "processes and procedures are robust and operate effectively."

26 The risk management framework envisages that this will be done through:

26.1 "Checking that there are fit for purpose policies and procedures in place to manage risk and that these are being applied across the organisation and in relation to all of its functions and activities.

26.2 "Undertaking detailed scrutiny of the application of processes and procedures in relation to each of the functions on a regular basis. This includes being satisfied that risks are being identified and managed appropriately and proportionately in accordance with the Council's risk appetite. The Committee should consider the management of risk in one directorate each quarter.

26.3 "Reporting the outcomes of the Committee's scrutiny to the Council on a quarterly basis."

27 **Recommendation: Discuss what information officers should present at each Audit Committee meeting, to provide assurance to the Committee about the risk management arrangements.**

28 **Recommendation: Discuss the reporting arrangements for providing a risk management update to the Council on a quarterly basis.**

Public protection implications:

29 Effective risk management across the organisation should result in serious risks to public protection being identified and effective strategies being implemented to mitigate these risks.

Resource implications:

30 Training costs were met from the Corporate Governance budget.

31 Resource implications are organisation-wide for continuing to embed risk management.

Equality and diversity implications:

32 An Equality Impact Assessment initial screening form for the risk management training was completed in April 2013.

33 Equality and diversity implications are considered when rating the impact of risks and determining actions required to mitigate risks.

Stakeholder engagement:

34 None.

Risk implications:

35 The risk that we fail to embed risk management across the organisation, resulting in our inability to fulfill our statutory functions, is detailed on the Corporate Governance risk register.

Legal implications:

36 Failure to identify and effectively manage risks potentially exposes the NMC to legal action.

Corporate risk register

					Date: 16 August 2013			Issue No: 5									
No.	**Date of origin**	**Risk Scenario**			**Inherent risk scoring**			**Mitigation in place / Planned action**	**Post-mitigation scoring**			**Risk Owner (and Sponsor)**	**Dates up-dated** (log of dates for when risk was updated)	**Status** (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	**Direction** (of risk score from the previous issue)
		Root cause(s)	**Potential situation**	**Consequences**	**Likelihood**	**Impact**	**Score**		**Likelihood**	**Impact**	**Score**				
CR1 A	May-13 (previously risk Reg 2011/02. Date of origin: Apr 2011)	**Integrity of the register - Current** (1) Wiser and Case Management System (CMS) not fully integrated. (2) Current policies, processes and procedures may be ineffective or inconsistently applied.	The online register may be inaccurate.	(1) Public protection compromised. (2) Negative impact on registrants. (3) Reputation damaged.	5	5	25	**Mitigation in place:** (1) Standard operating procedures and improved training. (2) Daily reconciliation reports and manual processes to address system anomalies. (3) Overseas registration procedures strengthened following pause and review. **Planned action:** (1) Implement Registration Improvement Programme (September 2013-September 2014). (2) Address prioritised system defects (September 2013). (3) Implement recommendations of independent audit as reported to Audit Committee in January 2013. (4) Further process refinements and alignment of FtP and Registration data (ongoing). (5) Planned internal audit activity: Internal audit activity planned for Q2 - 4 2013 - 14 on registration control framework; and for Q4 2013 - 14 on registrant data integrity (6) Establish longer term strengthened overseas process (April 2014). Incorporating competency test pending planned consultation.	4	4	16	Director, Registrations	07/08/2013 21/08/2013: Planned internal audit activity added	Open - on track. Risk reviewed monthly. Focused on current registration activity and therefore is more controllable through mitigation actions than the historic risk below. Risk reduction expected Oct 2013	No change
CR1 B	May-13 (previously risk Reg 2011/01. Date of origin: Apr 2011)	**Integrity of the register - Historic** (1) Policies and procedures may have been absent, ineffective or inconsistently applied in the past. (2) Historic decisions may have been made on a different basis, but cannot be reversed. (3) Circumstances may have changed after initial admission to the register, however these are not routinely checked.	We may identify individuals currently on the register who would not meet current requirements for admission, and we may not have appropriate plans in place to respond to this.	(1) Public protection compromised. (2) Reputation damaged.	5	5	25	**Mitigation in place:** (1) Standard operating procedures and improved training. (2) Initial Overseas Audit (April 2002 - 2013) results indicate a strengthening of process over time (since 2007). **Planned action:** (1) Analysis of specific cohorts where potential issues/risks are identified - to provide assurance or scope any issues (on-going). (2) Introduction of data integrity manager who will interrogate register to establish areas of risk (3) Risk based PREP audit(Jan 2014) (4) Investigate gathering employer data to allow analysis of appropriate registration(ESR)(July 2014) (5) Introduction of a Revalidation model to confirm currency of information held and to establish actions for dealing with registrants who do not meet the standards for registration (2015). (6) Further risk based audits as required.	5	4	20	Director, Registrations	Directors' group meeting 05.07.2013 - reviewed wording of risk.	Open - on track. Risk reviewed monthly. Involves a long lead time for any action to play forward and impact the risk scoring. Very marginal improvement predicted until after revalidation in place from 2015	No change

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Sponsor)	Dates up-dated (log of dates for when risk was updated)	Status (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	Direction (of risk score from the previous issue)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR2	May-13 (previously risk G28. Date of origin: May 2012)	**Fitness to practise** (1) Historic under investment in FtP. (2) Inflexible legislative framework. (3) Fluctuations in referrals above the forecast levels. (4) Possibility that processes may be unable to sustain required volume of case progression/hearings at the expected quality.	The quality of our decision making may be compromised and we may not achieve the investigation/adjudication targets	(1) Public protection compromised. (2) Negative impact on registrants. (3) Negative impact on referrers. (4) Reputation damaged.	5	5	25	**Mitigation in place:** (1) Detailed profiling and forecasting of caseload and activity and oversight by FtP Board. (2) Improved case management processes including voluntary removal and consensual panel disposal. (3) Standard operating procedures and improved training for staff. (4) Increased staffing base. (5) Targeted review of adjudication caseload. (6) Increase in number of panel members and introduction of rolling recruitment for panel members and chairs. (7) Training for panel members and introduction of rolling programme. (8) Increased number of hearing venues. **Planned action:** (1) External review of management information and forecasting assumptions (September 2013). (2) Further workforce planning (March 2014). (3) Quality assurance framework to be fully implemented (December 2013). (4) Review of thresholds for action (December 2013). (5) Closer working with employers (April 2014). (6) Legislative change (July 2014). (7) Contingency planning for increase in hearing activity at the end of Q3.	3	5	15	Director, Fitness to Practise	DG meeting 28.06.2013 - provided more explanation. 19.07.2013 - risk reviewed and no change	Open - on track Weekly performance/delivery against target reviewed at weekly management meeting and risk reviewed monthly. Risk reduction expected in early 2014 once adjudication caseload has decreased and new case management measures have embedded.	No change
CR3	May-13 (previously risk T30. Date of origin: May-13)	**Revalidation** (1) Possible lack of stakeholder buy-in. (2) Complexity of the revalidation model (3) Cost of revalidation process to the NMC and/or to the wider system	(1) Revalidation model which has been signed off is not delivered: (a) by December 2015 and/or (b) in an effective manner	(1) Public protection compromised (2) Negative impact on registrants (3) Reputation damaged	4	4	16	**Mitigation in place:** (1) Stakeholder engagement via Strategic Discussion Group and Task and Finish Group, Patient and Public Forum and engagement events in the four countries. (2) Options developed in collaboration with the stakeholders. (3) Oversight and scrutiny by Revalidation Board and by Change Management and Portfolio Board. **Planned action:** (1) Stakeholder engagement (ongoing). New Employer reference group and Revalidation advisory group to be set up. (2) Revalidation to be developed in phases - proposals to Council in Sept 2013. (3) Develop detailed costings to inform options - Sept 2013. (4) Planned internal audit activity foussing on continued practice, including the revalidation framework project for Q2 2013 - 14 (5) Consultations - Informal (Oct 2013); formal wider public (Jan 2014); Core Standards (April - June 2014) (6) Testing and piloting of new model - 2015.	3	4	12	Director, Continued Practice (sponsor) AD Revalidation (lead)	13/08/2013 - added more explanation. 21/08/2013: Planned internal audit activity added	Open - on track to reduce scoring. This will be achieved in Dec 2015	No change

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Sponsor)	Dates up-dated (log of dates for when risk was updated)	Status (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	Direction (of risk score from the previous issue)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR4	Jun-2012 (previously risk T26. Date of origin: Jan-13)	**Professional indemnity insurance (PII)** (1) Short timescale for implementation following outcome of DH consultation. (2) Changes to Wiser carry inherent risk. (3) Project manager not yet in place. Starts on 1 July 2013	We may be unable to implement a proportionate solution to the PII requirement by the required deadline of October 2013.	(1) Public protection compromised. (2) Negative impact on registrants. (3) Reputation damaged.	4	3	12	**Mitigation in place:** (1) Council decided NMC policy principles in April 2013. (2) NMC response to Department of Health consultation submitted May 2013. (3) Project plan currently overseen by Reg Programme Manager and existing staff. (4) Project Manager in place (01/07/2013). (5) NMC self declaration approach is approved (6) New Notification of Practice form (method of capture) re-designed. (7) FAQs detailing NMC position for staff circulated in July to assist in responding to registrant queries. **Planned action:** (1) Changes required to Wiser (October 2013). (2) Liaise with Department of Health outcome of review, latest dates and clarifications (Sept 2013) (3) Engage with stakeholders and develop communications plan and materials (June - September 2013). (4) Amend Intention To Practice to refer to PII (Dec 2013)	3	3	9	Director, Registrations	07/08/2013	Open - on track	No change
CR5	May-13 (previously risk G39. Date of origin: Mar-13)	**Financial resources** (1) Limited sources of income. (2) Possible increase in resource requirements as a result of external factors e.g. Francis report, external reviews, government policy etc. (3) Possible increase in fitness to practise referrals above forecast rate. (4) Resource requirements arising from several, simultaneous improvement projects. (5) Possibility that we do not achieve targeted efficiency savings.	We may have insufficient financial resources to meet all our planned operational requirements.	(1) Inability to deliver corporate objectives and/or improvement programme. (2) Negative impact on registrants. (3) Reputation damaged.	4	5	20	**Mitigation in place:** (1) Prudent budgeting aligned to corporate planning and change management programmes. (2) Financial strategy. (3) Risk based reserves policy. (4) Monthly finance and planning meetings with each directorate. (5) Monthly monitoring by Directors Group. (6) Standing financial report to the Council. **Planned action:** (1) Review of subsidiary fees - autumn 2013. (2) Annual review of registrant fees - spring 2014. (3) Mid year review of financial resources against emerging priorities and quantification of emerging operational risks (Sep 2013 completion).	4	5	20	Director, Corporate Services	Directors' group meeting 28.06.2013 - Likelihood increased by 1 following recent increase in FtP referrals.	Open - on track. Risk reviewed monthly ---------- Linked to Department of Health KPI of January 2016 ---------- Outcome of mid year review - risk reduction in October 2013	Increasing

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Sponsor)	Dates up-dated (log of dates for when risk was updated)	Status (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	Direction (of risk score from the previous issue)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR6	May-13 (previously risk T24. Date of origin: Oct-12)	**Information security** (1) Large volume, complex information processing. (2) Possibility that policies and procedures may be ineffective or inconsistently applied. (3) Security enhancements to some systems needed.	Sensitive information may be accessed by, or disclosed to, unauthorized individuals.	(1) Negative impact on data subject. (2) Regulatory intervention and/or fine by the Information Commissioner's Office. (3) Reputation damaged.	5	4	20	**Mitigation in place:** (1) Information security and data protection policies. (2) Mandatory training for staff and panellists. (3) Oversight by Information Governance Steering Group. (4) Laptop encryption programme. (5) Information security gap analysis completed and independently validated, identifying risk areas. **Planned action:** (1) Implement information security improvement plan, addressing highest risk areas as priority. High risks completed by Dec 2013. (2) New email encryption solution being implemented (July 2013). (3) Enhanced coverage and compliance with training (monthly review). (4) Planned internal audit activity on data security in Q2 2013 - 14	4	4	16	Director, Corporate Services	21/08/2013: Planned internal audit activity added	Open - on track. December 2013 review. Expect liklihood of impact and ratings to reduce.	No change
CR7	May-13 (previously risk G20 & G35. Date of origin: 26.3.2012)	**Quality of information** (1) Inconsistency in collection and use of data. (2) Ownership and governance arrangements for data and information management fragmented. (3) Enhanced system and analysis tools needed.	We may not consistently provide a coordinated response to management information and data requests.	(1) Inability to deliver corporate objectives and/or improvement programme. (2) Barrier to making sound business decisions and prioritisation of work. (3) Ineffective use of resources. (4) Reputation damaged.	5	3	15	**Mitigation in place:** (1) Short term improvements to strengthen understanding of management information across registration and fitness to practise systems. (Cross reference CR1) (2) Short term improvements to support stakeholder engagement intelligence needs underway, including liaison with other regulators. (3) Data produced for annual reports. (4) Improved FtP MI to support corporate KPIs. (5) Test report runs being done and results obtained to inform project scoping. **Planned action:** (1) Full data project to be scoped (Oct). (2) Further data test reports to be run (October-Dec). (3) Information strategy and governance to be developed through planned workstreams. (4) QA Strategy to include providing assurance on data quality and management. (5) Initial data sharing with CQC to be further developed (Started August, ongoing). (6) Coding architecture compatible with other regulators being developed (check with Andy Langler on timing). (7) Corporate data working group to be set up by the end of September. (8) Planned internal audit activity on quality assurance processes (Q2 and Q4 2013 - 14) and on risk management processes (Q2 2013 - 14)	5	3	15	Director, Corporate Governance	DG meeting 6 August - reviewed actions. Impact of mitigations not fully realised yet. 21/08/2013: Planned internal audit activity added	Open - on track. Project in early stages and will require time to diagnose and correct. Links to ICT strategy, post 2014 for full implementation. Review Dec 2013 for implementation progress.	No change

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Sponsor)	Dates up-dated (log of dates for when risk was updated)	Status (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	Direction (of risk score from the previous issue)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR8	May-13	**Leadership, governance and management** (1) Transitional issues arising from reconstitution of the Council and concurrent governance review. (2) Organisational structure still embedding. (3) New executive team and varying levels of management experience across the organisation.	We may experience difficulties in implementing/prioritising decisions effectively and/or sustaining change.	(1) Inability to deliver corporate objectives and/or improvement programme. (2) Negative impact on staff. (3) Reputation damaged. (4) Ineffective use of resources.	3	5	15	**Mitigation in place:** (1) Regular meetings of Directors' Group, Change Management and Portfolio Board and directorate senior management teams. (2) Annual corporate planning process. (3) Induction of new Council and continuing learning sessions in seminar. (4) Human Resources and Organisational Development strategy in place and being implemented. (5) Executive Board now established. **Planned action:** (1) Implementation of governance review - October 2013.	1	5	5	Chief Executive	7.08.2013 - considered mitigations are effective and likelihood of occurrence remains low	Open - on track. Review October 2013. One year on from restructure, 6 months into tenure of new Council and new governance arrangements in place.	No change
CR9	May-13 (previously risk T25. Date of origin: Oct-12)	**Staffing** (1) Perception that our rewards package is poor. (2) Organisational and people development historically a low priority. (3) Organisational structure still embedding. (4) Lack of clear career progression pathways.	We may experience continued high staff turnover.	(1) Inability to deliver corporate objectives and/or improvement programme. (2) Negative impact on staff morale, motivation, and performance. (3) Reputation damaged. (4) Ineffective use of resources. (5) Loss of corporate memory.	5	4	20	**Mitigation in place:** (1) Improved employee communication and engagement in place. (2) Human Resources and Organisational Development Strategy in place and being implemented. (3) Staff survey completed. (4) Learning and development programme launched. **Planned action:** (1) Pensions, pay and grading review to report (August and October 2013). (2) Review of HR policies ongoing (complete by March 2014). (3) Action plan in response to staff survey (August/September 2013). (4) Ongoing delivery of learning and development programme (all year). (5) Long term workforce planning (commencing June 2013).	4	3	12	Director, Corporate Services	15.8.13	Open - on track. Review December 2013. Linked to KPI on employer turnover.	No change

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Sponsor)	Dates up-dated (log of dates for when risk was updated)	Status (open / closed plus clear indication of whether and when on track / not on track to reduce scoring)	Direction (of risk score from the previous issue)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR10	May-13 (previously risk T29. Date of origin: Feb-13)	**Profile and proactivity** (1) Engagement with patients, public and stakeholders not yet fully embedded. (2) Complex healthcare landscape and regulatory environment. (3) Joint working with other regulators inconsistent.	The NMC's lack of public profile means we may not communicate our role effectively and therefore our role is not properly understood. Ineffective joint working inhibits sharing of information about potential identification of unsafe practice or health provision settings where nurses and midwives provide care.	(1) Inability to deliver public protection effectively. (2) Reputation damaged. (3) Inappropriate or lack of referrals to fitness to practise. (4) Inappropriate recommendations from external reviews.	4	4	16	**Mitigation in place:** (1) Strategic engagement commitment in place. (2) Programme of key stakeholder meetings ongoing between Chief Executive, Chair and senior staff with the DH, professional bodies and unions, patient groups, nurses, midwives and other regulators. (3) Patient and Public Engagement Forums held quarterly in England. (4) Strategic level initiatives being driven forward. (5) Short term improvements to support stakeholder engagement information needs underway. (6) FtP advice line for Directors of Nursing and LSAMOs. (7) In 2011/2012 and 2012/13 we held consultations and stakeholder listening events about VR (voluntary removal), sanctions on line, changes to case management processes including CPD (consensual panel determinations) and the IO process, and changes to guidance including the Indicative sanctions guidance and Conditions of Practice guidance. **Planned action:** (1) Patient and Public Engagement Forums to be held in Scotland, Wales and Northern Ireland (Sept 2013 - April 2014). (2) NMC employer roadshows to be held (Sept 2013). (3) The website will be relaunched to make it more public focused and interactive (March 2014). (4) The use of plain English to make publication more accessible will be adopted (October 2013 onwards). (5) Memoranda of understandings to be underpinned with information and data sharing protocols (March 2014). (6) Relaunch of escalating concerns guidance (Sept 2013). (7) FtP to develop a model to work proactively with employers across the UK (scoping to be completed by October 2013). (8) FtP to develop information sharing protocols with other regulators, and have a system in place to track all referrals to and from other regulators (by 30 Sept 2013). (9) Planned internal audit activity to look at communication and engagement in Q1 2014 - 15	2	3	6	Director, Corporate Governance	DG meeting 28.06.2013 - FtP activity needed to be added. Likelihood reduced by 1 as a result. Updated by Corporate Governance 11.07.2013. Updated by Corporate Governance 09.08.2013 21/08/2013: Planned internal audit activity added	Open - on track. Review March 2014 to measure impact of activity.	Reducing

AC/13/61
Item 7 – Annexe 2

Better risk management at the NMC

Training programme outline

1 Welcome and introduction

2 What is risk?

3 Why we need a system for risk management at the NMC

4 The risk management cycle

5 Identifying and framing risk
- root cause
- potential situation
- consequences

6 The risk register

7 Profiling and prioritising risk
- scoring
- risk appetite

8 Action planning
- action plans
- managing and monitoring

9 Process and support
- roles and responsibilities
- risk escalation
- link to business planning, quality assurance, complaints, SERs and other NMC procedures
- documentation and contacts

10 Summary and close
- next steps

For support, contact the Business Planning team:

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Or:

Matthew McClelland, Assistant Director, Governance and Planning, ext 5987
Mike Andrews, Assistant Director, Quality Assurance and Risk Audit, ext 5925

Item 8
AC/13/62
5 September 2013

Audit Committee

Internal Audit Work Programme

Action: For discussion.

Issue: Reports progress against the internal audit work programme 2013-2014.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: effective governance and internal control processes

Decision required: The Committee is invited to note the progress report.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Moore Stephens Internal Audit Update report

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 The Audit Committee approved the internal audit work programme 2013-2014 at its meeting on 8 July (minute AC/13/47).

2 Moore Stephens update on progress against the work programme is at annexe 1.

Discussion:

3 The work programme is currently on budget and on track.

3.1 Two substantive items are completed:

3.1.1 Development of the assurance map (see Item 11)

3.1.2 Follow up report on historic internal audit recommendations (see Item 9).

3.2 Two further assignments are in progress:

3.2.1 Audit of KPIs and management information

3.2.2 Audit of Data Security

Both will be presented to December Audit Committee.

3.3 Draft initial terms of reference for all other assignments have been received and comments provided to Moore Stephens. Revised drafts will be considered by the Executive Board on 17 September.

Public protection implications:

4 No direct public protection implications arising from this report. Effective internal audit arrangements should help the NMC deliver its core regulatory functions more efficiently and effectively.

Resource implications:

5 Resources for management of internal audit services are contained within the Corporate Governance directorate budget.

Equality and diversity implications:

6 No direct equality and diversity implications resulting from this paper.

Stakeholder engagement:

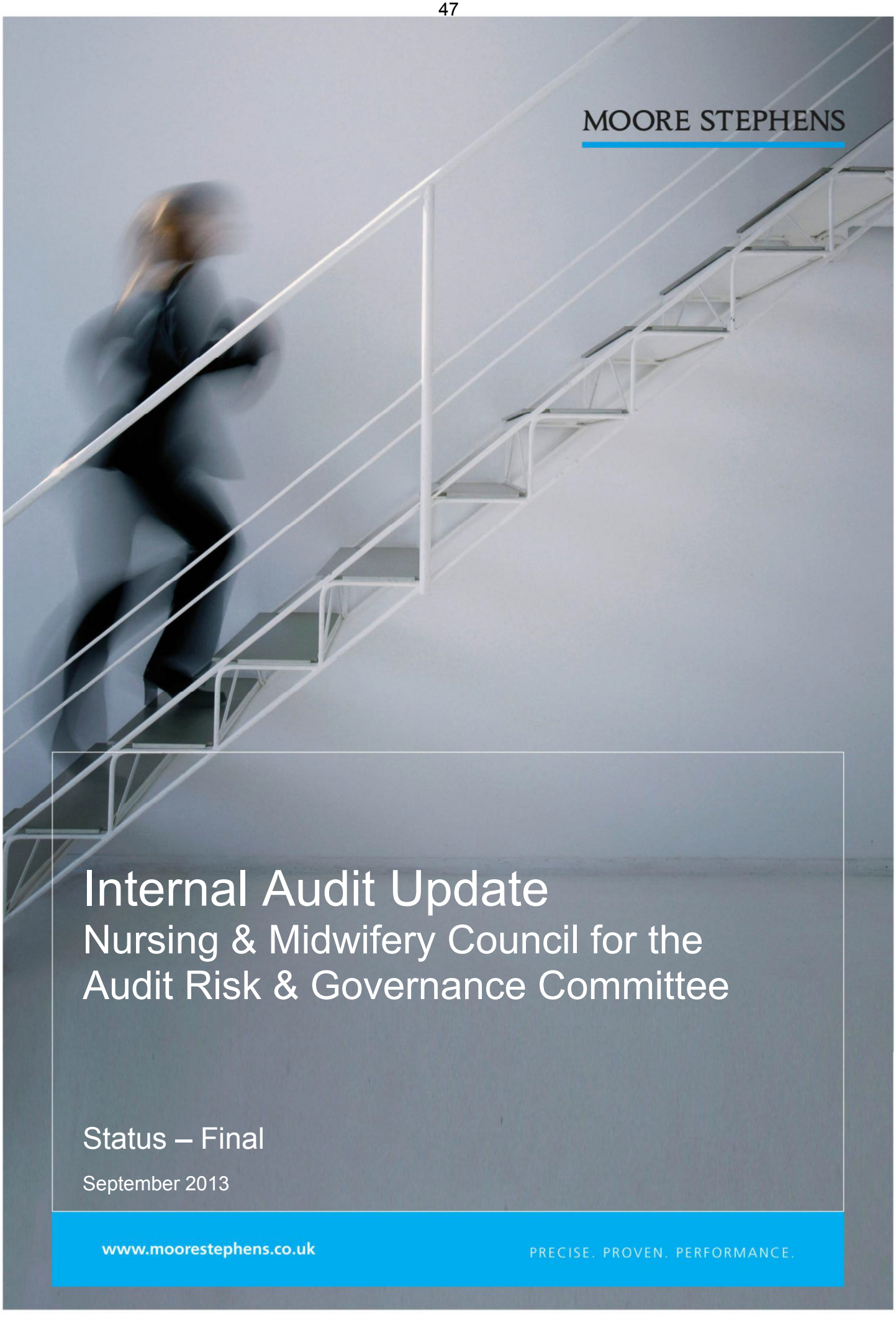
7 Not applicable.

Risk implications:

8 Effective internal audit arrangements should support the NMC in managing risks more effectively.

Legal implications:

9 Not applicable.



Internal Audit Update

Nursing & Midwifery Council for the Audit Risk & Governance Committee

Status – Final

September 2013

Document history			Distribution	
Draft	Version 1	19 August 2013	Fionnuala Gill	
Final		21 August 2013	Fionnuala Gill	
			Audit Committee	

Contents

1 Introduction

1.1 The purpose of this report is to update the Audit Committee of the Nursing & Midwifery Council (NMC) on the delivery of the Internal Audit Plan for 2013/14, which was agreed at the last Committee meeting in July 2013.

2 Progress on delivery of the audit plan

2.1 The internal audit plan for 2013/14 includes 13 assignments, including the assurance map, with a fourteenth being the second round of follow up work at the year end. Since the last Audit Committee meeting in July 2013, we have issued draft terms of reference for each audit in the plan so that management can assess the scope and timing of each review in more detail, as well as take an overview of the proposed work. The terms of reference will be considered by the Executive Board on 17 September 2013 . The timings and scope currently remain broadly the same as given in the audit plan.

2.2 Three internal audit assignments have been completed, one is at final report stage, the detailed follow up review, and two are at draft report stage, the KPI review and the data security review. The findings from the detailed follow up review are presented as a separate paper to this meeting.

2.3 The remaining work has been programmed and we have confirmed the fieldwork timetable with management. The programme of audits is on track and within budget. The current status of the plan is presented in more detail in Appendix A.

Appendices

A Delivery of the Audit plan for 2013/14

Assignment title	Functional area	High level scope	Work type	Output	Start Date	Days Planned	Days Actual	Current status
Core functions								
Registration control framework development	Registration	Project assurance and advisory activity, which will be defined as the project becomes defined.	Change Programme	Advice	Q2-4	6	-	Draft terms of reference issued
Registrant data integrity	Registration, FtP,	Accuracy of registrant details on the register.	Current processes	Audit	Q4	6	-	Draft terms of reference issued
Data security	ICT, Registration, FtP,	Includes the risk of serious data breach incidents and the incident reporting processes.	Current processes	Audit	Q2	6	-	Fieldwork completed. On target
Continued practice, including revalidation framework project	Continued Practice?	Project assurance and advisory activity.	Change Programme	Advice	Q2-4	6	-	Draft terms of reference issued
Core enablers								
KPI and management information	Registration, FtP, staff turnover	Reviewing the accuracy, timeliness of registration, FtP and staff turnover key performance information.	Current processes	Audit	Q2	10	10	Draft Report issued.
Quality assurance process	Governance and selected directorates	Pre-implementation review; post-implementation review. Both the function of the QA team and the quality processes undertaken within directorates. Focus on QA in Core Functions.	Current processes & Change Programme	Advice & Audit	Q2 Q4	3 7	1	Fieldwork commenced
Assurance map	Governance	Development of an assurance map. Free of charge. 5 days.	Current processes	Advice	Q1	-	-	Report Finalised. No charge for this work.

Assignment title	Functional area	High level scope	Work type	Output	Start Date	Days Planned	Days Actual	Current status
Risk management process	Governance	The scope of this review will include all aspects of NMC's risk management framework, including but not limited to, policy, guidance for staff, risk registers, and risk identification, formulation and assessment. A sample of risks and their mitigations will be reviewed as part of the work.	Current processes	Audit	Q2	6	-	Draft terms of reference issued
Core support systems								Draft terms of reference issued
Implementation of core IT systems upgrade project	ICT, Programme Management	To provide assurance that the core network systems upgrade, the bedrock of future developments has been implemented satisfactorily. MS Dynamics, business intelligence, TRIM & interim CRM are implemented adequately. To provide assurance on the project management methodology applied with a view to gaining assurance about the future IT projects	Current processes & Change Programme	Audit & Advice	Q3	8	-	Draft terms of reference issued
Programme and project management governance & review	All functions	The work will focus on the NMC's arrangements for programme management and project management governance and processes. Our work will involve attending relevant project meetings and examine benefits realisation.	Current processes & Change Programme	Audit & advice	Q3	6	-	Draft terms of reference issued
IT Strategy & Blue Print Review	ICT, Programme Management	Review of strategy and blue print, to give assurances about this important foundation stage to the change programme. The work will include benefits realisation.	Change Programme	Advice	Q3	6	-	Draft terms of reference issued
Business continuity planning	ICT, All functions	Emergency response, disaster recovery and business continuity, particularly ICT related, could have a significant impact on the business. Review of arrangements in place.	Current processes	Audit	Q4	6	-	Draft terms of reference issued
Follow up								
Follow up of recommendations prior to 2013/14	All	As requested by the Audit Committee April 2013. Includes review of the fraud risk review.			Q1-/2	10	8	Finalised

Assignment title	Functional area	High level scope	Work type	Output	Start Date	Days Planned	Days Actual	Current status
Follow up of recommendations post 31 March 2013	All	Our standard follow up of recommendations			Q4	2	-	
Audit Management								
Audit strategy & plan. Annual Report	-	Includes the development of this plan, the following year's plan and the 2013/14 Annual Internal Audit Report.				4	-	
Contract & senior management meetings						4	-	
Audit Committee preparation & attendance						4	-	
Total days						**100**	**19**	

Item 9
AC/13/63
5 September 2013

Audit Committee

Historic Internal Audit / Assurance Recommendations

Action: For decision.

Issue: Reports on historic internal audit and other assurance recommendations.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: effective governance and internal control processes

Decision required: The Committee is invited to:

- Note the follow up report produced by internal audit at Annexe 1.
- Agree that those recommendations verified as implemented together with the recommendation not implemented but viewed as no longer valid by the auditors, no longer be reported.
- Note the log of historic internal audit/assurance report recommendations at annexe 2.
- Note the prioritised list of historic internal quality assurance recommendations at annexe 3.
- Decide how historic and emerging internal audit or other assurance report recommendations should be reported in future.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Internal audit follow up report.
- Annexe 2: Log of historic internal audit/assurance recommendations.
- Annexe 3: Prioritised list of historic internal quality assurance recommendations.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 At April 2013, there were a number of historic recommendations arising from previous internal audit and other assurance reports still to be implemented or awaiting verification of implementation by internal auditors.

2 Moore Stephens was tasked to undertake a follow up review of those historic recommendations which would not be picked up in other planned audit activity during 2013-2014. The follow up report is at Annexe 1.

3 An updated log of those historic recommendations not included in the follow up review but which will be picked up as part of other audit activity during 2013-2014 is at annexe 2.

4 For completeness, the list of prioritised FTP internal quality assurance recommendations to be reviewed during 2013-2014 by Moore Stephens is at annexe 3.

Discussion and options appraisal:

Moore Stephens Follow up report (annexe 1)

5 Moore Stephens follow up review looked at 25 historic recommendations. The review found:

5.1 Nine (9) recommendations could now be verified as implemented (green).

5.2 Fourteen (14) recommendations were being addressed as part of ongoing longer term organisational activity (amber).

5.3 Two (2) recommendations had not been implemented (red): one of these was found to be no longer relevant.

6 It is proposed that the 9 recommendations verified as implemented now be removed from future reporting, along with the 1 red recommendation which the auditors consider no longer valid.

7 Treatment of the other recommendations not yet implemented (14 amber and one red) is discussed at paragraphs 11 and 12 below.

8 **Recommendation. The Committee is invited to:**

8.1 **Note the follow up report at annexe 1.**

8.2 **Agree that those recommendations verified as implemented together with the recommendation not implemented but viewed as no longer valid by the auditors, no longer be reported.**

Other historic internal audit/assurance report recommendations

(annexe 2)

9 In addition to the 25 recommendations considered in the follow up review, there are a further 32 historic recommendations as detailed in the log at annexe 2. This is in two parts:

9.1 Part A: internal audit and other assurance recommendations which have now passed target date (Total number = 25).

These recommendations will be reviewed as part of other planned audit work during the 2013-2014 financial year. Column G of the log indicates when these will be addressed and reported to Audit Committee.

9.2 Part B: internal audit and other assurance recommendations not yet passed target date. (Total number = 7)

Although not currently passed target date, some will pass target date during 2013-2014; others, particularly ICT related recommendations have longer implementation timescales. Progress against these will also be reviewed where relevant to planned audit assignments during 2013-2014.

10 A further group of recommendations to be reviewed by the internal auditors during 2013-2014 are the historic internal quality assurance recommendations relating to Fitness to Practise. For completeness these are included at annexe 3.

Future reporting of historic recommendations

11 The Committee is invited to consider how it would wish to monitor these historic recommendations in future.

11.1 The Committee could continue to receive a log at every meeting comprising both historic recommendations and any new recommendations arising from 2013-2014 audit assignments.

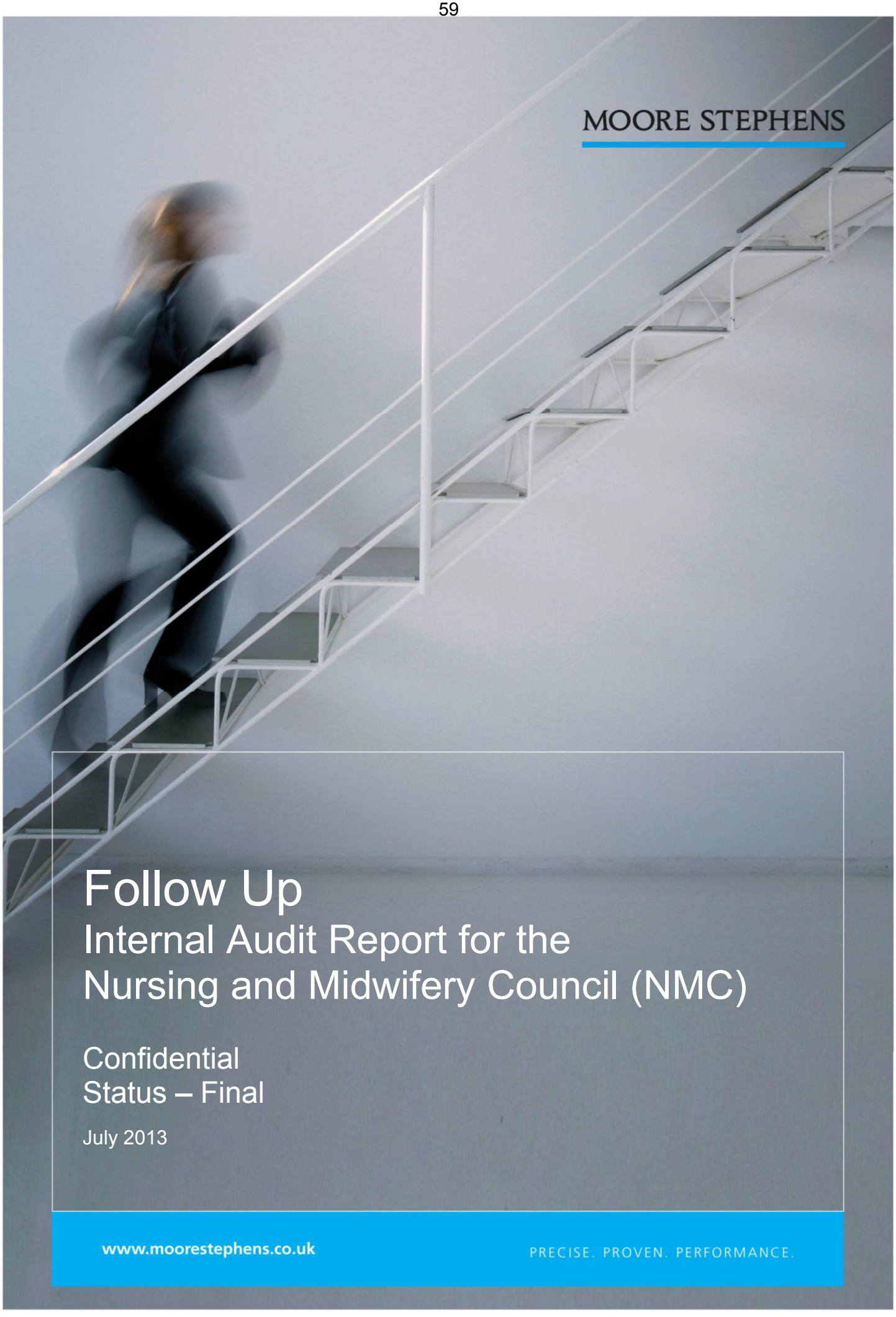
11.2 Alternatively, the Committee may be satisfied that assurance on addressing historic recommendations can be provided through future internal audit reports. Auditors would be expected to review any past outstanding recommendation and make a finding as to its continued relevance or produce fresh recommendations, as appropriate.

12 The second option above would enable the Committee to focus on monitoring any new or refreshed recommendations coming through internal audit work, avoid the risk of duplicate or repeated recommendations and ensure that recommendations for action remain valid and relevant.

13 **Recommendations - the Committee is invited to:**

- **Note the log of historic internal audit/assurance report recommendations at annexe 2**
- **Note the prioritised list of historic internal quality assurance recommendations at annexe 3.**
- **Decide how outstanding historic internal audit or other assurance report recommendations should be reported in future.**

Public protection implications:	14	No direct public protection implications arising from this report. Prompt implementation of issues identified by internal audit should help strengthen levels of assurance and internal controls should help the NMC deliver its core regulatory functions more efficiently and effectively.
Resource implications:	15	Resources for co-ordination of the reports are provided for in the Corporate Governance directorate budget. Work to implement specific recommendations would need to be addressed within the relevant directorate budget.
Equality and diversity implications:	16	No direct equality and diversity implications resulting from this paper.
Stakeholder engagement:	17	Not applicable.
Risk implications:	18	Improved levels of assurance should support the NMC in managing risks more effectively.
Legal implications:	19	Not applicable.



Follow Up

Internal Audit Report for the Nursing and Midwifery Council (NMC)

Confidential
Status – Final

July 2013

Document history			Distribution	
Draft	01	18/7/13	Lindsey Mallors, Matthew McClelland, Fionnuala Gill	Director of Corporate Governance Assistant Director – Governance and Planning Performance Improvement Manager
Draft	02	29/7/13	Fionnuala Gill	Performance Improvement Manager
Draft	03	30/7/13	Executive Board	
Final	04	02/8/13	NMC AC	

Contents

1 Introduction

1.1 This audit was completed at the request of the Nursing and Midwifery Council (NMC) Audit Committee and as part of the internal audit programme for 2013/14.

1.2 The NMC is an organisation undergoing a period of significant organisational transformation. This is a long term process, which will result in changes to systems, business process and staffing structures to ensure that the NMC is fit for purpose for the future and able to appropriately discharge its functions - particularly that of public protection.

1.3 As part of change to the NMC, the Council and Audit Committee have been reformed and reconstituted. The out-going Audit Committee recognised that there were a number of outstanding audit recommendations from the time of the previous internal audit providers.

1.4 The purpose of this review was to follow up outstanding internal audit recommendations, to ascertain the progress that has been made in the implementation of these recommendations. Given the volume of recommendations identified for review, we agreed the following protocol for the follow up with NMC management:

- where recommendations had been previously signed off as implemented by the previous internal auditors, this was accepted and no further work was undertaken;
- where recommendations had not reached their due implementation date, these were not included in the follow up review (unless they have been signed off by management as implemented); and
- recommendations marked as implemented were categorised into activity areas (for example, registration or finance.). If that area is to be covered as part of the 2013/14 plan, the recommendations were excluded from this follow up review and will be reviewed as part of the relevant assignment in the audit plan.

1.5 The Audit Committee also requested that Internal Audit follow up recommendations arising from the work of the former Fitness to Practice Quality Assurance Team. In total there were 72 of these recommendations to be followed up. After internal discussion, the NMC considered that to follow up these recommendations in light of their high number and historical focus on administrative processes which have since changed, did not represent an effective use of internal audit or staff time and an examination of the whole set of these recommendations would not be examined. However, we agreed with management that the implementation of the 14 key recommendations from the 72 FtP QA team work would be examined later in the year. The review will take place either as part of the planned audit work of the relevant subject areas outlined in the Internal Audit Strategy and Audit Plan or separately.

2 Conclusion

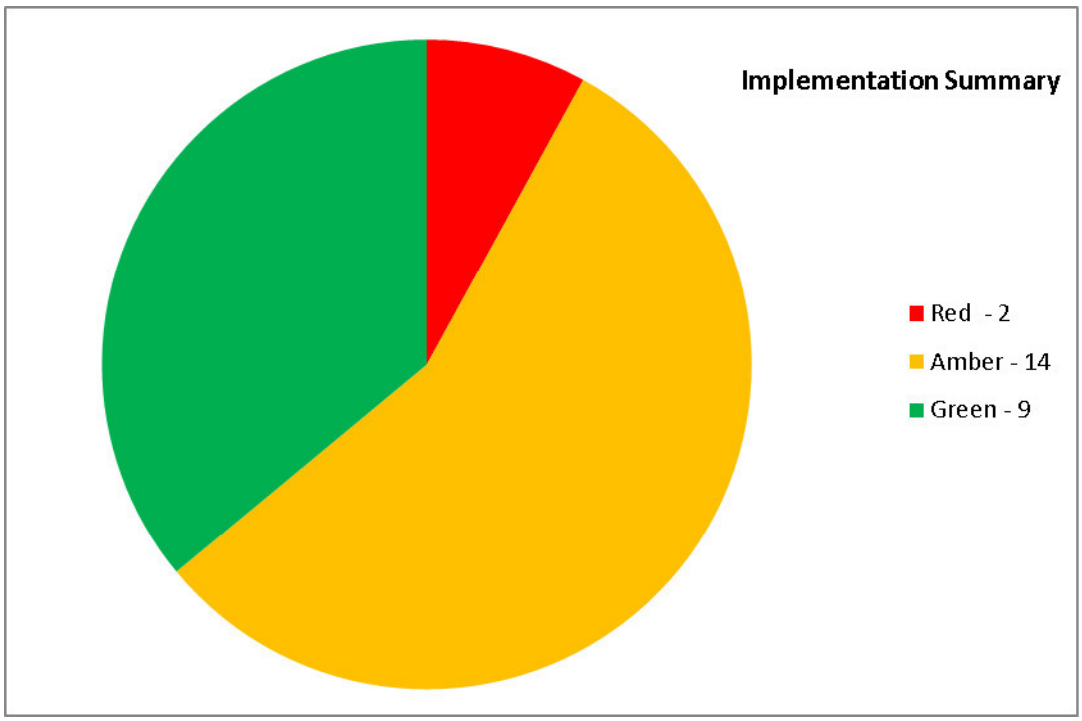
2.1 The table below depicts the 25 outstanding recommendations available for follow up and how these break down by operational areas:

Table 1: Breakdown of followed up recommendations across operational areas

Audit area	Number of recommendations
Counter Fraud Healthcheck	9
Financial Controls	1
IT Healthcheck	1
FTP Quality Assurance	10
HR Performance Management	1
Project Management/ Change Management Programme	3
Total:	**25**

2.2 The RAG rating in the report against each recommendation is internal audit's assessment as to whether the recommendations reviewed were implemented (green), where action is subject to on-going organisational developments or projects (amber) or not implemented (red). The chart below is a summary of our findings:

Chart 1: Internal Audit's assessment of recommendation implementation status



Implementation analysis

2.3 As already noted, the NMC is under-going a period of significant change. Nonetheless, Internal Audit assessed nine of the twenty-five recommendations followed up as implemented.

2.4 A further fourteen recommendations have been identified where the further progression of the recommendation is linked to an organisational change process such as a programme or project, for example, the Registration Improvement project or projects relating to replacement of WISER and the case management system. Where a recommendation has been assessed as falling into this category, it is likely that implementation will take place over a prolonged period but ultimately should result in business improvement.

2.5 Of the two marked as 'red', one related to 'proactive register management powers' (Recommendation 2 in our table in Section 4) and the other suggested joining the National Fraud Initiative (Recommendation 4). After discussions with management, we consider that the 'proactive register management powers' was not a relevant recommendation and thus should be withdrawn. With the other recommendation, we consider that there may be merit in consulting other databases as part of a registrant data verification process, but it may not be necessary to follow the recommendation to the letter. We will explore this more with our work with NMC on the registration process redevelopment.

2.6 The recommendations and fuller details of our findings are given in Section 4 of this report.

3 Audit approach

3.1 We met with the Assistant Directors for each of the follow up areas to determine their interpretation of the recommendation and ascertain the progress made in implementing the recommendation. Where available, information was gathered to substantiate implementation or audit testing undertaken.

3.2 A list of the NMC staff consulted during the completion of this review is included at Appendix C.

Key: Original priority ranking of recommendation by Parkhill
MA= Merits attention
S= Significant
F= Fundamental

4 Recommendations implementation status

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
1.	**Overseas Good Standing Certification** As part of the imminent review of Overseas Registration Policy, enhance / align with the EU applicants Good Standing Certification, e.g. to incorporate home and / or UK Police checks.	**S**	Alison Sansome Director Registrations	This is currently being considered as part of the overseas policy. No date was originally set for this.	Examined as part of the recent overseas registrations review and new processes implemented for overseas applications made with effect from 2 April 2013 (see annexe 2)	2 April 2013.	Implemented.	The recommendation originally arose from the internal audit work conducted by Parkhill, however, the importance of the recommendation was re-emphasised as a result of recent work undertaken by KPMG. A new process has been introduced from 2 April 2013 whereby overseas applicants are required to complete a 'character self declaration' which is risk assessed and may lead to the conduct of further checks by the NMC.
2.	**Proactive Register Management Powers** Pursue statutory powers amendment to allow for proactive maintenance of registrant' addresses rather than present passive mode.	**S**	Alison Sansome Director Registrations	This will be subject to the outcome of the Law Commission's review of regulation and is currently not in our gift.	Reviewed but not currently being pursued (see annexe 2).	Not applicable	Not applicable	The Registration Rules already require registrants to provide a change of address (Rule 16 (1A) and for the Registrar to update the register if information comes to attention in any other way (Rule 16 (3)). A rule change is not needed for NMC to proactively remind registrants of this obligation. The NMC may enable

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
								registrations to make amendments on line in the future to provide a more user friendly and efficient registrant experience and be consistent with many membership bodies.
3.	**Learning from Past Fraud** a. Implement the recommendations from the investigation into the 'Kent & Medway' identity fraud case. b. Future cases of and the response to fraud should be clearly communicated to the Audit Committee, required actions minuted and suitably tracked through to completion. Ref: Executive Summary 2.18	**F**	Alison Sansome Director Registrations	Agreed. An action plan has been drafted in response to the Kent and Medway Incident .While some of the recommendations are disproportionate, the majority of recommendations will be considered as part of a standard operating procedure review and checks to be made on changed records. Original target date end 2012.	The action plan referred to in the original management response was a high level multi-agency action plan produced following the Kent and Medway police investigation. This included one recommendation for the NMC that NMC should write to all employers stressing the importance of checking the register. This was completed. b. Any cases of fraud would be the subject of a serious event review report to the Audit Committee (*See row 2 above).*	Review of registrations policies and processes begun 3/4/13 (see annexe 2*).*		a. The recommendations from the 'Kent and Medway' identify fraud case can be found at sections 23-25 of this table. b. A procedure is in place to refer such cases to the Audit Committee as part of any Serious Event Reviews. Part of the review of registration processes will be considering the controls in place to confirm the authenticity of applicants.
4.	**Participation in National Fraud Initiative** Consider whether participation in the Audit Commission's National Fraud Initiative (NFI) 'data matching exercise' has worth over existing data matching via NHS ESR.	**MA**	Alison Sansome Director Registrations	No formal management response was made to this recommendation as it was not considered a sufficiently high priority. No original target date was therefore set.	This recommendation has been reviewed as part of the exercise to bring it up to date. Given the greater synergy between NHS ERS system and NMC data, this matching activity is considered more beneficial in terms of specific content	Not applicable.		The recommendation is not considered to be a priority at present and therefore is not being taken forward. However, there may be merit in introducing cross checks to 'other databases'

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	Ref: Executive Summary 2.19				and relevance and offers a more cost effective approach to providing assurance and meeting this intent. Reviewed see annexe 1 note being pursued.			held by other institutions as part of confirming the integrity of registrant details. We will explore this more with our work with NMC on the registration process.
5.	**Automated Workflow Monitoring Reports** Examine feasibility and consider the implementation of: a) capturing out of sequence processing of workflow queues on an automated daily audit / tracking / exception report. b) recording reasons for telephone calls to Registration's call centre and c) reconciling a sample between the two.	**MA**	Alison Sansome Director Registrations	No formal management response was made to this recommendation as it was not considered a sufficiently high priority. No original target date was therefore set.	Reviewed see annexe 2 and confirmed that this is not a priority to be pursued at present.	Not applicable.		We were informed that the feasibility of the recommendation has been considered by ICT and Registration but the recommendation is not considered to be a priority at present for WISER. WISER is reaching the end of its life and the requirements will be considered for implementation as part of the WISER Replacement Project. An integrated system which meets the needs of Registration and Fitness to Practice is being considered. The project is still at an embryonic stage.
6.	**Multiple Name Spelling Changes** Establish a trigger system to flag high-outliers for number of times name change requests received. Ref: Executive Summary	**MA**	Alison Sansome Director Registrations	No formal management response was made to this recommendation as it was not considered a sufficiently high priority. No original target date was set.	Reviewed further see annexe 2 not being pursed at this time.	Not applicable.		The requirement will be considered as part of the design of a new registration system and is not being taken forward with the existing system. There

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	2.25							alternatives to the approach recommended, such as running regular exception reports as opposed to the system generating a message once an address change frequency threshold has been achieved.
7.	Wiser Reconciliation Management should decide on reasonable action to be taken regarding the outstanding balance on the Wiser account.	**MA**	Verity Somerfield AD Finance	Decision will be taken after full year of operation of reconciliation with daily and enhanced reports, i.e. during 2012-13. Audit Committee keeps the reconciliation under review and there are no overall issues. Minor differences are to be expected but they are immaterial given the overall size of the balances being dealt with and variety of payment mechanisms at present available. Original Target date was September 2012 subsequently revised to December 2012	After extensive reconciliation work, the residual balance will be written off in the year end accounts for 2012-13.	31 March 2013	Implemented	The decision was reached to write off the outstanding balance on the WISER account. £17, 635 was written off at year end 2012/13 and confirmed in the external auditors management letter for year end 31 March 2013. As a result of the observations made by the previous internal auditors, the methodology for conducting WISER reconciliations has been strengthened. At month end May 2013, the un-reconciled difference was £76.
8.	**Records Retention Policy** The NMC Board should agree and ratify a Records Retention Policy as soon as possible. Ref: Executive Summary 2.11	**MA**	Christine Simmons Records and Archive Manager Lindsey Mallors	Accepted Policy is being created in consultation with all Directorates. To be shared with Senior Management Group May 31 2012 for discussion/ agreement and	Proposed policy developed and discussed at Senior Management Group on 17 July 2012. Proposals referred to Efficiency Board on 1 August 2012. Progress is not as fast as	Previous target dates not met (FTP records policy: scoping exercise. Agreed work plan by end June 2013. Non- FTP records Implementation end	Not yet implemented	The records retention policy has not been agreed and ratified by the NMC Board as yet. The policy has been drafted and was due to go to

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
			Director Corporate Governance	ratification by Directors June 2012. Original target date:30 June 2012 Subsequently revised: 30 October 2012	would wish due to both other pressing priorities such as restructure and the wider change programme. Directors discussed in November 2012 It has been decided to split non-FTP and FTP records policy. For FTP a properly managed programme needs to be set up to over see this work given the complexities around retention of FTP records. A project group is to be set up and the project scoped by March 2013. Work on review of retention of FtP records started on 1 February with a meeting of FtP retention review group. Corporate retention schedule (excluding FtP records) was presented to directors on 12 February. It was not agreed. Because the majority of this work was undertaken before and during the restructure in 2012 agreement for retention periods was reached with individuals who are no longer in post. It was recommended that the records manager meet individually with directors and department heads to	June 2013) Revised target is for revised proposals to be put to Directors Group 30 April 2013		a recent meeting of the Director's Group but this has been delayed due to staff illness. Director's Group minutes from 4 June 2013 indicate that the policy will be available by the end of July 2013, although staff sickness absence may mean that the work is not finalised until after July.

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
					review the retention periods and obtain agreement. It was also recommended that the complete Corporate Retention Schedule be re-presented to directors when the work to review the FtP records is completed with the section on FtP records added. The date for this to be completed and presented to directors is 30 April.			
9.	**Prioritisation & Grading** Recommendations [made by the FTP QA team] should be prioritised and overall opinions used within reports to direct management attention to those issues representing the greatest risk to the organisation.	**S**	Sarah Page Director of FTP AD Quality Assurance	Accepted: FTP QA audit findings will be prioritised and overall opinions will be used within those reports to direct management attention to the issues representing the greatest risk to the organisation. Original Target date: 1 May 2012	A further internal audit of FTP Quality Assurance was undertaken in October 2012 as part of the 2012-2013 work programme (*See Agenda Item 13*) Prioritised key recommendations will be included the AD Quality Assurance's paper to be considered by the Committee on 19 April		Not implemented	Since the substantive internal audit work was conducted, the NMC has changed its approach to quality assurance. The designated FTP Quality Assurance team has been moved in a restructure to the Corporate Governance Directorate and will form the basis of a corporate quality assurance function which is currently under development. Upon coming into post, the Assistant Director Quality Assurance prepared a paper for Audit Committee which identified priority recommendations for implementation from those outstanding from the work of

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
								the former FTP Quality Assurance Team. Going forward, the newly formed quality assurance function will adopt the recommendation and move to a risk based methodology for the execution of their audits and reporting outcomes, but this has not been rolled out as yet.
10.	**Scope of Delivery** Quality Assurance should deliver a degree of assurance across the breadth of FtP activity. Focusing upon one element limits the organisation's knowledge of other risk areas and may result in missed opportunities for improvement. Resources may still be skewed towards those areas of greatest risk. To support the delivery of wider assurance we suggest that the sample sizes may be reduced and work targeted to ensuring the application of controls or following up known compliance weakness.	**S**	Sarah Page Director of FTP	The initial programme of audits of cases closed in Screening has been completed. Audits of cases closed at IC stage will commence in May 2102, audit of cases closed at CCC & HC will commence in February 2013. Once the 2012-2013 closed case audit programme has been completed consideration will be given to an audit programme based on identified risks. Based on recommendations from the National Audit Office a reduction in sample size for 2012-2013 from 735 to 588 closed cases is being considered. QA action plan will be discussed at the FtP	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. Details of this are included in his paper.		Not implemented	■ The designated FTP Quality Assurance team has been moved in a restructure to the Corporate Governance Directorate and will form the basis of a corporate quality assurance function which is currently under development. The intention is that the team deliver assurance not only across FTP but corporate activity. The Assistant Director Quality Assurance has developed a strategy, policy and work programme to support this activity.

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
				Group meeting before the June Council meeting.				
11.	**Case Management System (CMS)** The CMS is not well aligned to the needs of the users or the FtP process. The CMS should be reviewed and developed to support the FtP process; this is likely to require considerable investment. A well structured CMS should reflect the work flow, effectively capture core data minimising the use of free-form text fields, perform validity / sense checks, prompt users and facilitate QA. The need for such a system is heightened by the function's high staff turnover.	**S**	Sarah Page Director FTP Mark Smith Director Corporate Resources	Agreed. Work has commenced to identify which processes can be amended within CMS to meet the business requirements. Initial findings have been submitted to the supplier for cost/time estimate. Target date: no specific target date set pending cost/time estimate from supplier.	A new version of CMS is due for implementation in Q2 2013. • Delivery of new software version into test – Feb '13 • Testing of the new software – March '13 • User acceptance testing – April '13 • Release into production – April / May 2013 This release will only partially address the concerns raised in the initial finding and a further release will be required in Summer 2013 to address issues raised in the Hays McIntyre report and changes to work flow subsequently identified by FtP and CMS Action team	Slipped to April/May 2013 (1 month)	Ready to be implemented.	Work is presently on going to review and refresh CMS. A new release is planned for September – November 2013. NMC informed us that the CMS update planned for March 2013 was withdrawn as further analysis revealed that it would impact the CMS workflow in a detrimental way. Releases for September 2013, November 2013 and March/April 2014 have been scheduled, The September release has been developed and should move into testing in August. The risks identified will not be significantly mitigated until the November release and will not be completely eliminated until Spring 2014
12.	**Regular Review of Audit Plan** As there have been a significant amount of changes within the structure	**S**	Sarah Page Director FTP, Lindsey Mallors Director Corporate	Agreed. The audit plan will be reviewed in the new year to ensure that the limited resources are deployed to key areas of risk.	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. See separate agenda item.			As a consequence of the restructure of quality assurance arrangements, the FTP quality assurance

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	of the FtP QA team this year, the current FtP QA audit plan should be reviewed to ensure that it still remains appropriate for the resources available.		Governance	28 February 2013.				plan is no longer relevant and has been succeeded by an organisation-wide quality assurance plan. The Quality Assurance team presently consists of the Assistant Director and a Quality Assurance Officer. We were informed that the Assistant Director is currently drawing up a business case to recruit the resources necessary to deploy the quality assurance work programme.
13.	**Documented Audit Procedures** Formal documented procedures should be in place for the preparation and performance of FtP QA audit assignments.	**S**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed. Documented procedure templates to be written by FtP QA to use to define scope of audit assignments. 28 February 2013	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. See separate agenda item.			A quality assurance strategy and policy is place and was presented to Council in 2013. As the corporate quality assurance programme has yet to be rolled out, there are no documented procedures in place at present for the preparation and performance of quality assurance assignments, though the intention is to draw up procedural documents in due course.
14.	**Completion of Audit Plan** In order to ensure that the	**S**	Sarah Page Director FTP, Lindsey	Agreed. This will be reviewed at the same time as a review of	This is being addressed in the corporate QA strategy being developed by the AD			Sample sizing has yet to be

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	FtP QA audit plan is delivered and completed on time sample sizes should be reviewed to ensure they are still appropriate in view of the resources available.		Mallors Director Corporate Governance	the audit plan takes place. 28 February 2013.	Quality Assurance. See separate agenda item.			decided and will be contingent on the individual requirements of the assignment.
15.	**Reporting of Plan Completion** A progress report should be produced and reported to the appropriate governance Committee which details progress against the current FtP QA audit plan.	**S**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed. Progress reports to be produced against the current and/or amended FtP QA audit plan following the review of 1, 2 and 3 above. Consideration will need to be given to the respective responsibilities of the FTP Committee which Council agreed to establish in October 2012 and the Audit Committee and what level of reporting should be made to each Committee. 28 February 2013.	The plan will be revised in light of the developing strategy. See Separate agenda item.			The corporate quality assurance strategy drawn up by the Assistant Director Quality Assurance makes provision for progress reporting to Director's Group and Audit Committee. This will be rolled out once the team commences the performance of quality assurance assignments.
16.	**New Reporting Lines** As part of the restructure and proposed move of FtP QA to within the Corporate Governance directorate, it should be ensured that new reporting lines and responsibilities of the FtP QA team within the Corporate Governance directorate are clearly communicated to all team members.	**MA**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed. An Assistant Director of Quality and Risk is currently being recruited to be based in Corporate Governance directorate. Once this appointment has been made, it will be possible to clarify future reporting lines for the FtP QA team and to communicate this to them.		Completed on 1 March 2013.		This recommendation has been implemented and the new structure and way of working communicated to both staff and through the governance structure.

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
17.	**Risk Based Approach** Although a move to risk based methodology has been previously agreed, the current FtP QA audit plan remains unchanged. It is recommended that the audit plan is revisited to ensure the audit requirements are appropriate.	**MA**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed in principle: This will be considered as part of the review of the audit plan in the new year to ensure that the limited resources are deployed to key areas of risk. 28 February 2013.	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. See separate agenda item.			A risk based approach will be rolled out as part of the deployment of the new strategy. This will be tested in future internal audit reviews.
18.	**Non-Programmed Assignments** As part of the review of the FtP QA audit plan (as recommended at 1 and 2 above), it should be ensured that the plan is sufficiently flexible, and resources available, to accommodate any additional requests for non-planned audits.	**MA**	Sarah Page Director FTP/ Lindsey Mallors Director Corporate Governance	Agreed in principle: this will be considered as part of the review of the audit plan in the new year to ensure that the limited resources are deployed to key areas of risk. 28 February 2013.	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. See separate agenda item.	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. Details of this are included in his paper.		The plan referred to in the recommendation no longer exists but a new plan has been developed and was taken to Directors Group in June 2013. Once the necessary staff resources are in place, the Assistant Director will ensure that the new corporate quality assurance plan is sufficiently flexible to respond to changing priorities.
19.	**Confirmation of Appraisal** It is acknowledged that a new appraisals system is being introduced for 2012/13 that will automatically confirm the authorisation, however, should this not be fully implemented by the April reviews, manual / email confirmation should be	**MA**	Mark Smith Director Corporate Resources	We note that this recommendation is only intended to apply if the electronic systems for confirming PDR outcomes and markings is not operational on 1 April 2013. The aim is that this will be in place. If it is not, then a system will be put in place for HR Managers to ensure that there is	The manual confirmation process will be followed for the April PDRs with HR enforcing full compliance with receipt of signed copies. This is the current process but will be subject to greater compliance checking. Guidance has been issued to staff and managers.	1 April 2013.	Partially implemented.	At the time of the follow up review, the new electronic appraisal system was not in place as yet, hence appraisal forms were being returned to HR in hard copy. Though in the first instance submission of an emailed version of the form is

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	obtained. Staff members and managers should both sign the appraisal form to confirm that they agree with the discussions held and the performance rate awarded to them. If this is completed via email, a copy of the email should be retained with the personnel file.			either manual or email confirmation of that both parties agree the PDR outcomes and markings.				acceptable, providing an appropriately signed hard copy is mandatory. The date for the return of completed forms was May 2013 and the rate of return of forms to date is 57%. Of a total of 280 forms returned to date, we reviewed a sample of 40 to determine whether returned forms had been signed by the staff member, line manager and authorising manager. Of the 40 appraisal forms reviewed, 3 lacked endorsement by of one of the three required signatories. These were highlighted to a responsible officer.
20.	**Project Management Resources** The new Project Management process is still in its infancy; Currently one person is project managing the Programme. There is a potential resource issue (recognised internally by management) that one	**S**	From Jan 2013 Jackie Smith Chief Executive and Registrar	Agreed. We fully accept that there is a resource issue and that one person is insufficient to control all the projects within the change management programme and that we also need to consider how other "business as usual" projects are supported and resourced. Proposals will be developed as part of the business planning and	Programme office comprising 3 staff from 1 April 2013. Recruitment of 2 staff to join programme manager to commence shortly.	1 April 2013	Partially Completed.	The Programme Office has been established and a Programme Coordinator engaged to support the Programme Manager. Recruitment is underway for a Programme Office Manager to complete the team. At the time of the follow up review, the NMC had not identified a candidate with the

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	person may be insufficient to suitably control the number of projects within the Change Management Programme. Additional resource may take the form of a Project Management Office as indicated by management during the review.			budgeting round 2013-2014 covering how project management will be taken forward in the NMC, including how this will be resourced and whether to establish a Project management office for this purpose or address in other ways. This will go to the Directors Group for consideration.				appropriate skills to fill the post and were entering another round of recruitment.
21.	**Project Training** The training proposal put to the Change Management Programme Board mentions a lack of resources to deliver the required training. It is recommended that the proposal expand on this to identify the 'expected' resources necessary in order that an informed decision may be taken / approved.	**MA**	From Jan 2013 Jackie Smith Chief Executive and Registrar	Agreed. This will be considered as part of the proposed future approach to project management as part of the business planning and budgeting process for 2013-2014.	1. Outline project training completed and agreed by Directors in October and delivered to Change Programme Board members. 2. Training proposals for basic project management in development and to be finalised by end January 2013. 3. Training content and materials to be developed by 31 March 2013. 4. Initial training rolled out from April 2013.	Training commenced March 2013.	Partially Completed.	Externally facilitated project management training has been delivered and is re-run according to business need. Once the necessary resource is in place, the Programme Manager hopes to run this training internally.
22.	**Project Benefit Analysis** The NMC Frameworks state that benefits should be defined at commencement. We would recommended that on-going project review documentation is expanded to include consideration as to	**MA**	Previously Lindsey Mallors, Director Corporate Governance From Jan 2013	Agreed in principle: A decision on who will be responsible and when this will be done by will need to follow on from any decisions made as part of the business planning and budgeting process for 2013-2014.about the	This is dependent on the resourcing decisions made in relation to recommendation 37	A decision to be made and timetable for taking this recommendation forward to be developed by no later than 30 June 2012.		The Programme Manager has developed a 'benefits management strategy' which will be rolled out through the project management framework.

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	whether the actual benefits remain in line those envisaged at the start of the project. It should also confirm that projects remain in line with organisational objectives as a whole as time progresses and projects span planning periods.		Jackie Smith Chief Executive and Registrar Mark Smith Corporate Services Director	proposed future approach to project management.				
23.	We need to strengthen measures to verify registrants' identity and manage the risk of identify fraud a. Identity verification on joining the register b. Online versus offline contact with the NMC c. Legal name versus 'names' d. Continued verification of identity throughout an individual's time on the register e. Proactive measures designed to detect identity fraud or irregularities in registrants' entries on the register	**N/A**	Alison Sansome Director Registrations Tom Kirkbride AD	None	Covered under items 8, 9, 10, 11.12 and 13 above and as attached in annexe 2. All comment relating to fraudulent registration and identity fraud have been considered as part of the process improvement work and are being taken forward and considered as part of new IT system design work, as well as revalidation process development. No further specific action on these.			The objective and spirit of this recommendation is to be taken forward as part of the Registration Improvement Programme. The timeline for completion of this workstream within the Registration Improvement programme is August 2014
24.	We need to better define procedures for the management of suspected	**N/A**	Alison Sansome Director	None	Covered under items 8, 9, 10, 11.12 and 13 above and as attached in annexe 2. All			The objective and spirit of

No	Recommendation	Priority (see key)	Officer Responsible	Original NMC management response and target date	Current NMC position and action planned or taken at June 2013	Latest target date	NMC implementation status as at June 2013	Moore Stephen's assessment of implementation
	malpractice by individuals not on the register but working in a health care setting.		Registrations Tom Kirkbride AD		comment relating to fraudulent registration and identity fraud have been considered as part of the process improvement work and are being taken forward and considered as part of new IT system design work, as well as revalidation process development. No further specific action on these.			this recommendation is to be taken forward as part of the Registration Improvement Programme. The timeline for completion of this workstream within the Registration Improvement programme is August 2014
25.	We need to ensure that there is a defined organisation-wide procedure for the management of concerns about irregularities within the register including suspected identity fraud.	**N/A**	Alison Sansome Director Registrations Tom Kirkbride AD	None	Covered under items 8, 9, 10, 11.12 and 13 above and as attached in annexe 2. All comment relating to fraudulent registration and identity fraud have been considered as part of the process improvement work and are being taken forward and considered as part of new IT system design work, as well as revalidation process development. No further specific action on these.			The objective and spirit of this recommendation is to be taken forward as part of the Registration Improvement Programme. The timeline for completion of this workstream within the Registration Improvement programme is August 2014

Appendices

A Audit definitions

Opinion/conclusion		
Green	*Recommendation implemented.*	
Amber	*Implementation of the recommendation is intended, but timing is contingent on wider organisational developments or programme/ projects.*	
Red	*No action taken on recommendation.*	

B Staff consulted during review

Name:	Job title
Fionnuala Gill	Performance Improvement Manager
Tom Kirkbride	Assistant Director - Registration
Phil Shoesmith	Assistant Director – ICT
Verity Somerfield	Assistant Director - Finance
Christine Hawkins	Head of Financial Services
Matthew McClelland	Assistant Director – Governance and Planning
Mike Andrews	Assistant Director – Quality Assurance and Risk
Dave Woodman	Assistant Director – Human Resources
Gaurav Shrivastava	Change Programme Manager
Darren Wheatley	Head of Business Improvement
Elspeth Crilly	Training and Development Assistant
Peter Pinto de Sa	Head of the Office of the Chair and Chief Executive

We would like to thank these staff for their assistance provided during the completion of this review.

Log of previous recommendations

Part A.1

Log of outstanding recommendations: Internal Audit (Parkhill) - target date passed

Not included in Moore Stephens Follow up Review (July 2013)
All to be reviewed during remaining internal audit assignments work plan 2013-2014

Total number = 9
P1 to P9

Part A.2

Log of outstanding recommendations: External Review of WISER/CMS (haysmacintyre) - target date passed

Not included in Moore Stephens Follow up Review (July 2013)
All to be reviewed during remaining internal audit assignments work plan 2013-2014

Total number = 16
H1 to H5
H7 to H13
H15
H17-H19

5 September 2013

Log of outstanding internal audit recommendations (Parkhill) - target date passed

Column A: Identification number (from September 2013)
Column C: Priority assigned by internal auditor. Green/MA= Merits Attention; Amber/S= Significant, Red/F=Fundamental *(NB Colour reflects priority assigned by the auditor not implementation status).*
Column D: Officer responsible: Updated to reflect the individuals/roles currently responsible
Column E: Original management response and implementation target date when audit report first received.
Column F: Updated management position and target dates at September 2013
Column G: Current implementation status
Column H: Current internal audit position

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
COUNTER FRAUD HEALTH CHECK - DECEMBER 2011							
P1	Embedding Risk Management of Fraud The Council's risk management function should: a) extend the risk assessment started by this health check; engaging and encouraging all senior managers within the organisation to recognise and	**S**	Lindsey Mallors Director of Corporate Governance	Agreed. No original target date was set. Target date for new risk management policy set 31 December 2012 Target date for inclusion of fraud 28 February 2013.	Risk management policy and framework with fraud included approved by AC April 2013 and rolled out from May 2013	Implemented	To be reviewed as part of Risk Management Audit Report to Audit Committee June 2014

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
	regularly consider the fraud risks within their areas of responsibility. b) consider/advise Directors and Managers if any risks should be prioritised for inclusion in the organisation's risk register.						
Data Security Health Check - December 2011							
P2	**Incident Reporting [of data security incidents]** a. Incident reports should clearly show the proposed recommendations with named owners and timescales. Additionally, the reports should use a standard template to ensure that all necessary details are included and clearly	**S**	Lindsey Mallors Director Corporate Governance Mark Smith Director Corporate Services	a. Serious Event Reviews are now completed for all security incidents using the NMC. Corporate Template b. Agreed. This is to be clarified in the new policy, which will cover incident reporting and Serious Event Reviews.	**See P6 below**	**See P6 below**	**Recommendation reviewed as part of Data Security Audit January 2013 and repeat recommendation made** **See P6 below**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
	presented. b. The role of the Information Governance Manager in the investigation and incident reporting process should be clarified to provide an understanding of the post holder's authority to propose recommendations and action owners.						
P3	**Information Security Training** The NMC should ensure that all staff and contractors receive Information Security training.	**MA**	Mark Smith Director Corporate Services	All new starters receive face to face and e-learning on information security training is already provided to all new starters. A refresher e-learning course is mandatory for them to complete a year after joining. It is managers' responsibility to ensure this is done. A review, planning to change some of the face-to-face training to e-learning is currently	**See P7 below**	**See P7 Below**	**Recommendation reviewed as part of Data Security Audit January 2013 and repeat recommendation made** **See P7 below**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
				taking place and should be completed soon. No target date set.			
DATA SECURITY HEALTH CHECK - JANUARY 2013							
P4	**Management reporting** The Learning and Development department should ensure that it has the tools to provide managers with reports on staff that need to attend Information Security training and report to them every 6 months.	**S**	Mark Smith Director Corporate Services	ICT and HR teams to implement changes over the coming months. 1. Learning & Development (L&D) Manager to provide 6 weekly reports to directors/managers on who has attended the training by 31 March 2013 2. AD, ICT & AD, HR - HRPro implementation will allow the NMC to capture all members of the workforce (FTE, Panellists, Temps and Contract) allowing reports showing who has completed the training and additional	1. Completed 2. Target date 30 September 2013 3. All staff, contractors and temps included in communication to complete e learning module. Policy to be approved by Directors on 2 April. Reporting subject to action 2. 4. Completed	1. Implemented 2. Implemented 3 Partially implemented 4.Implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report to Audit Committee December 2013

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
				improvements to the system over time will enable email reminders to be sent to the line manager where staff have not commenced the training by September 2013 3. Information & Data Governance (I&DG) Manager to agree a policy with Directors to ensure all members of the workforce receive appropriate training by 30 April 2013. Compliance to be monitored using the reports developed in 2 above from Sept 2013 4. ICT and L&D to sign off new eLearning module for Data Protection training.			
P5	**Non Blame Culture** The organisation should work	**S**	Mark Smith Director Corporate	An Organisational Development programme is being	Feedback gathered from staff induction and pay and grading	Partially implemented	Progress to be reviewed as part of Data Security audit 2013-2014

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
	proactively on fostering and supporting a non blame culture.		Services	developed supporting the NMC's change programme and move towards a new culture. This will include reference to openness, a learning organisation and one that is not based on blame. Assistant Directors are also looking at culture related issues	workshops, and assistant directors' work on development of culture and communications. Change programme to be refocused from 1 May with specific culture workstream. Staff survey to be launched at end of April 2013.		Report due for December Audit Committee
P6	**Incident Reporting [of data security incidents]** **Recommendation repeated from Data Security Audit December 2011** The organisation should define and agree: -The roles and responsibilities associated with the collation of SERs and	**S**	Mark Smith Director Corporate Services Lindsey Mallors Director Corporate Governance	Information & Data Governance Manager to work with Corporate Governance Manager to ensure that there is a clear policy and process for reporting events that fall outside the remit of the approved SER process for all Information Security / Data Protection related incidents by 30 April 2013. All security incidents are	A policy on the reporting of security incidents will be presented to the Executive Board in September to ensure that security incident reporting takes place consistently and promptly	Partially implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report due for December Audit Committee

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
	non-SER incidents; -The process for subsequent management of the outcome and learning relating to the SER incidents; -Reporting requirements and regular reporting mechanisms.			to be reported under the corporate serious event policy. Future reports to Information Governance Security Group (IGSG) to include breakdown of incidents by category and detailed reports on major incidents.			
P7	**Training** **Recommendation repeated from Data Security Audit December 2011** The NMC should ensure that all staff and contractors receive Information Security training.	**MA**	Mark Smith Director Corporate Services AD HR	Permanent staff continue to receive mandatory training on information security. We accept that the current statutory and mandatory training policy does not clearly specify if it covers contractors: it only refers to Permanent, fixed term and temporary staff. The policy will be amended and training options reviewed to	All staff, contractors and temporary staff included in communication to complete e learning module. Security training for panellists is now in place. Training for Temporary staff & Contractors will be in place once HR are capturing these members of the workforce from September 2013	Implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report due for December Audit Committee

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
				ensure that appropriate timely training can be provided. Policy to be approved by Directors by 30 April 2013.			
PROJECT MANAGEMENT – CHANGE MANAGEMENT PROGRAMME DECEMBER 2012							
P8	**Policy and Procedures** With the new Project Management regime being established, an operational framework of policy and procedures should be produced so that all users are aware of the project management methodology and processes for monitoring and reporting of projects.	**S**	Jackie Smith Chief Executive and Registrar	Accepted in principle. Project framework guidance already produced which sets out the general principles and minimum level of documentation required for a project to proceed through a stage gate. Project templates already revised or in development. Further work required to develop detailed guidance, procedures and policies for managing projects and Programmes dependent on decisions to be taken about how to resource	The PMO is now fully resourced. Programme Office Manager joined on 19 August. PMO now discussing with Programme & Project Managers what require from PMO. September – Prepare PMO charter/ agree roles and responsibilities September – begin roll out of the PMO Sept/Oct – review Project Management Framework and templates Oct/Nov – Project Management	Partially implemented	Progress to be reviewed as part of Programme and project audit. Report to Audit Committee February 2014

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
				this work and whether to set up a Project Management Office (PMO).	training Nov/Dec Benefits realisation framework implementation		
P9	**Project Cost Recognition** Cross charging between departments is not standard practice and therefore not all relevant costs may be captured and recognised against an individual project. A review should be undertaken on the most appropriate way to capture costs for each project to ensure a realistic state of efficiency is achieved and support resource and capacity planning across the organisation.	**MA**	Jackie Smith Chief Executive and Registrar	Agreed in principle: A decision to be made and timetable for taking recommendation forward to be developed by 30 June 2013.	Recommendation to be revisited early 2014 once HR work to develop workforce planning tool linking planning to activity and costs is complete. In the interim, CMPB is actively monitoring resource issues and have had number of discussions on prioritisation. Executive Board approved CMPB approach to prioritisation and tasked CMPB to carry out analysis to identify resource requirements for	Not yet implemented	Progress to be reviewed as part of Programme and project audit. Report to Audit Committee February 2014

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target date	G Implementation status	H Current audit status
					high priority projects.		

External review of Integrity of WISER and CMS - December 2012 Recommendations - Target Date Passed Nb haysmacintyre used a different classification for prioritising recommendations: Amber/Medium priority and Green/Low priority							
A No	**B Recommendation**	**C Priority**	**D Officer Responsible**	**E Original management response & target date**	**F Current position and action taken or planned**	**G Implementation status**	**H Audit Status**
H1	***Recommendation 1*** The Standard Operating Procedures are updated to explain the process for inputting data onto CMS and WISER and the review process carried out by management. We further recommend that all staff with editing access to CMS and WISER have read and been trained in the new procedures. These updated Standard Operating Procedures should be available on the intranet.	**Medium**	Sarah Page Director Fitness to Practise Lead officer Assistant Director Adjudication, FTP	Agreed 31 January 2013		Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H2	***Recommendation 2*** The legal team communicates with the Hearing Support Officers every two weeks and	**Low**	Sarah Page Director Fitness to Practise	Agreed 28 February 2013 revised to end of March 2013		Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

	produce a report of all changes made to WISER and the progress of legal cases. A central database/spreadsheet of these changes should be maintained by the Hearing Support Officers to limit confusion over legal cases in the future.		Lead officer Assistant Director of Legal Services, FTP				
H3	***Recommendation 3*** The process by which discrepancies are discussed and subsequently resolved by the Hearing Support Officers and Decision Letter Team should be formalised so the daily process can be retraced to ensure the discrepancies are resolved on a daily basis.	**Agreed**	Sarah Page Director Fitness to Practise Lead officer Assistant Director Adjudication, FTP	Agreed Implemented November 2012	Not applicable	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H4	***Recommendation 4*** Currently the report highlights discrepancies which are due to the decision letter not having been sent out within five days of the decision date. The Hearing Support Officers then remind the Decision Letter Team to send the letter. Though it is important to send the letter	**Low**	Sarah Page Director Fitness to Practise Lead officer Assistant Director Adjudication, FTP	Agreed to review current process to find best solution. 30 April 2013	Following organisational changes a separate Decision Letter team no longer exists. Decision letters are sent out by the Hearings team, Discrepancy report serves as	No longer applicable	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

	out promptly, this is arguably not an efficient use of the Hearing Support Officer's time. Instead a report could be generated which was just for the Decision Letter Team which would remind them a letter needs to be sent out.				an alert/trigger that a decision letter and/or update requires action within the KPI of 5 working days.		
H5	***Recommendation 5*** Discrepancies caused by delays in sending out the decision letter could be resolved by adapting CMS so the decision letter is auto-generated and sent out on the same day as CMS is updated.	**Low**	Sarah Page Director Fitness to Practise Lead officer Assistant Director Adjudication, FTP	It is not clear how practical this is and how much IT development work would need to be done. Scoping work to be carried out to assess the feasibility of this and a decision made by 31 January 2013	Scoping work carried out to assess feasibility of this recommendation. Provision for implementation has been Included in scope of requirements for update of the Case Management System (CMS) November 2013	Implementation planned for November 2013	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H7	***Recommendation 7*** Centralise the management of CMS and WISER which will enable a single team to help ensure the two systems correlate at all times. The other teams	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant	Agreed in principle Process to be streamlined by 31 March 2013	Streamlined process now introduced, daily discrepancy reports continue to be run and are actioned by the	Implemented.	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

	involved in the process of updating CMS and WISER should send weekly reports to the central team e.g. the Hearing Support Officers to enable them to monitor all changes and ensure these have been made correctly.		Director Adjudication, FTP		Hearings team.		
H8	***Recommendation 8*** Supervisors of both the Hearing Support Officers and Decision Letter Team should review a sample of the cases updated to ensure the event outcomes have been updated correctly. Special care should be considered when looking at the higher risk cases, i.e. striking off and suspension orders	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant Director Adjudication, FTP	Agreed 31 January 2013	10% daily checks by Hearings Managers from 14 February 2013. Centralised Master Spreadsheet captures outcomes of checks and follow-up actions required. Lessons learnt are fed through to Adjudication Super users	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H9	***Recommendation 9*** The Hearing Support Officers continue to investigate every discrepancy on a weekly rather than daily basis. Many of the discrepancies currently highlighted are due to a delay of a few days in sending out the decision	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant Director Adjudication, FTP	Agree to review processes 30 April 2013	Recommendation deferred and original process of running daily discrepancy reports maintained. Maintaining status quo provides a	Not implemented as the process serves another purpose	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

	letters, many of which would be resolved within a few days and so would not appear on weekly reports, saving the Hearing Support Officers time.				necessary and extra level of assurance to ensure that cases at risk of meeting FTP 5 day target for issues of decision letters are addressed.		
H10	***Recommendation 10*** All discrepancies investigated and then altered should be documented in a master spreadsheet so there is a clear audit trail for management to follow if there are any problems.	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant Director Adjudication, FTP	Agreed Implemented November 2012.	Not applicable	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H11	***Recommendation 11*** We recommend that for legacy cases, the memo pad continues to be updated with extensive information as has been the process in more recent times. In some older cases the memo pad did not give a full explanation of why the dates could not be amended, or what they should have been. This may create problems in the future for users who are	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant Director Adjudication FTP	Agreed and already implemented	Currently in operation. Further agreed that a review and update of older cases be undertaken for fuller memo entries. Completion date to be agreed by EMT to ensure alignment with business priorities.	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

	retrieving information about historical sanctions.						
H12	***Recommendation 12*** CAGE is an intensive process which uses up valuable time of many key management personnel. Therefore we recommend the structure and procedures of CAGE should be altered in the near future. CAGE should meet once a month and the number of members should be reduced. Once there is satisfaction that all historical discrepancies have been resolved and procedures have been put in place to prevent similar problems in the future you should consider whether CAGE should be disbanded.	**Low**	Sarah Page Director Fitness to Practise Lead Officer Assistant Director Adjudication, FTP	Agreed 31 January 2013	CAGE disbanded 22 March 2013	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H13	***Recommendation 13*** The EMT continues to approve all cases requiring manual removal.	**Low**	Sarah Page Director Fitness to Practise	Agreed and already implemented	Not applicable	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H15	***Recommendation 15*** CMS should be adjusted to allow for a field for high court appeals in which the substantive orders are over turned.	**Low**	Mark Smith Director Corporate Services	Agreed 30 June 2013	Included in scope of requirements for CMS release (update) November 2013	Planned for implementation November 2013	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

H16	***Recommendation 16*** The work which has been carried out so far to manually remove all legacy cases should be continued until none remain. Once CAGE and the EMT have approved the manual removal of all these cases, no more such cases should appear on the report.	**Low**	Sarah Page Director Fitness to Practise	Agreed and already implemented	Not applicable	Implemented	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H17	***Recommendation 17*** CMS should be altered so that any length of caution can be inputted into the CMS so this type of discrepancy is eliminated	**Low**	Mark Smith Director Corporate Services	Agreed 30 June 2013	Included in scope of requirements for CMS release (update) November 2013	Planned for implementation November 2013	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee
H18	***Recommendation 18*** Alter CMS so the direction box for the length of time of the substantive order has to be selected before CMS is updated. Therefore CMS will physically not let you update the event outcome without the direction box being ticked.	**Low**	Mark Smith Director Corporate Services	Agreed 30 June 2013	Included in scope of requirements for CMS release (update) November 2013	Planned for implementation November 2013	To be reviewed as part of Registrant Data Integrity Audit Report to June 14 Audit Committee

Log of previous recommendations

Part B.1

Log of internal audit recommendations (Parkhill) - target date not yet passed
Not included in Moore Stephens Follow up Review (July 2013)
All to be reviewed during remaining internal audit assignments work plan 2013-2014

Total number = 4
P10 to P13

Part B.2

Log of recommendations external review of WISER/CMS (haysmacintyre) - target date not yet passed
Not included in Moore Stephens Follow up Review (July 2013)
All to be reviewed during remaining internal audit assignments work plan 2013-2014

Total number outstanding = 4
H6
H14
H19

B.1- Log of internal audit recommendations (Parkhill) - target date not yet passed

Column A: Identification reference from September 2013
Column C: Priority assigned by internal audit: Green/MA= Merits Attention; Amber/S= Significant, Red/F=Fundamental *(NB Colour reflects the priority of the recommendation not the implementation status)*
Column D: Officer responsible: Updated to reflect the individuals/roles currently responsible
Column E: Original management response and implementation timetable at time audit report first received.
Column F: Updated management position and target dates at September 2013
Column G: Current implementation status
Column H: Current internal audit position

A No	B Recommendation	C Priority assigned by internal audit	D Officer Responsible	E Original management response & target date	F Updated management position & target dates at April 13	G Current implementation status	H Current audit status
DATA SECURITY HEALTH CHECK- DECEMBER 2011							
P10	**Information Asset Register & Data Flow Mapping** The NMC should produce an Information Asset Register and undertake a data-flow mapping exercise to fully establish its key information risks for integration within the existing corporate risk	**S**	Mark Smith Director Corporate Services	Agreed. This is on the Information Governance and Security Group (IGSG) workplan. Timescale subject to agreement by IGSG. Implementation date to be decided after completion of security gap analysis and provision of	Security gap analysis & resulting action plan completed and reported to IGSG November 2012. To be taken forward as part of the project for the NMC to become compliant with ISO 27001 Information Security standard. **By 30 June 2013** Agree scope of ISO 27001 programme & select suitable partner to assist in	Partially implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report to Audit Committee December 2013

A No	B Recommendation	C Priority assigned by internal audit	D Officer Responsible	E Original management response & target date	F Updated management position & target dates at April 13	G Current implementation status	H Current audit status
	management arrangements.			information from third party infrastructure managers (Advanced365)	implementation of compliant processes and standards **By 30 September 2014:** reach compliance with standard **By 30 June 2015:** Verification that in compliance with standard.		
IT HEALTH CHECK - MARCH 2012							
P11	**ICT Strategy** The NMC should as soon as possible finalise, agree and implement the ICT strategy being drafted by the Assistant Director of ICT.	**S**	Mark Smith Director Corporate Services	Presented at Public Session of Council March 29th 2012. To be re-presented in September with financial spend plan. Original target date: July 2012 Subsequently revised to September 2012	ICT Strategy and associated spending plan approved by Council September 2012. Progress report to Council Jan 2013 Stabilisation phase being implemented. Development programme to go to Council in November 2013	Partially implemented	Progress to be reviewed as part of ICT Strategy and Blueprint Advice work Report to Audit Committee February 2014
P12	**Information Security Management System** ICT management	**S**	Mark Smith Director Corporate Services	Accepted Currently working with NMC's third party infrastructure provider (Advanced	As detailed at P10 above	Partially implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report to Audit Committee

A No	B Recommendation	C Priority assigned by internal audit	D Officer Responsible	E Original management response & target date	F Updated management position & target dates at April 13	G Current implementation status	H Current audit status
	should ensure that it performs a systematic evaluation of information risk, such as through the implementation of an Information Security Management System in line with BS 27001. (*Note now ISO 27001*)			365) to finalise ISMS. Security Gap Analysis to take place No specific target date was set.			December 2013
P13	**Information Policy Compliance** The NMC should undertake proactive reviews of compliance with internal information policies and legislation including the Data Protection Act.	**MA**	Mark Smith Director Corporate Services	Agreed. This will be addressed during the Security Gap Analysis	Security gap analysis completed Work has been carried out to review the compliance of the NMC policies against current legislation. Next step is to monitor the NMC's compliance with the internal polices Process, roles & responsibilities to be agreed as to how this will be achieved	Partially implemented	Progress to be reviewed as part of Data Security audit 2013-2014 Report to Audit Committee December 2013

A No	B Recommendation	C Priority assigned by internal audit	D Officer Responsible	E Original management response & target date	F Updated management position & target dates at April 13	G Current implementation status	H Current audit status
					Security gap action plan target dates phased to 2014-15		

B.2 - External review of WISER and CMS (December 2012) - Recommendations Target Date Not Passed

NB haysmacintyre used a different classification for recommendations Green = Low priority

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Updated management position & target dates at April 13	G Implementation status	H Audit Status
H6	***Recommendation 6*** A long term strategy is developed regarding a new integrated computer system which will eliminate discrepancies and inaccuracies.	Low	Mark Smith Director Corporate Services	To be considered as part of the ICT strategy 31 December 2013	Reporting is now in place to identify any discrepancies and workflow to add further controls will be implemented as part of the ICT Transformational programme during 2014.	Target date not yet passed	To be reviewed: ICT Strategy & Blueprint- Report to Audit Committee February 2014 & Registrant Data Integrity Audit - Report to Audit Committee June 2014.
H14	***Recommendation 14*** WISER is changed so that a registrant can show as having	Low	Mark Smith Director Corporate Services	To be considered as part of the ICT strategy with implementation date to be	Recommendation will be implemented as part of the ICT Transformational programme during 2014.	Target date not yet passed	To be reviewed: ICT Strategy & Blueprint- Report to Audit Committee February 2014

	conditions and a caution order.			assessed according to priority 31 December 2013			& Registrant Data Integrity Audit - Report to Audit Committee June 2014.
H19	***Recommendation 19*** WISER should be altered so that it can reflect the most recent outcome for both cases where a registrant has more than one case against them so that the case will therefore not appear on the exception report.	**Low**	Mark Smith Director Corporate Services	Agreed: to be considered as part of the ICT strategy with implementation date to be assessed according to priority 31 December 2013	Recommendation will be implemented as part of the ICT Transformational programme during 2014.	Target date not yet passed	To be reviewed: ICT Strategy & Blueprint- Report to Audit Committee February 2014 & Registrant Data Integrity Audit - Report to Audit Committee June 2014.

Item 9
AC/13/63 Annexe 3
5 September 2013

Fitness to practise: Quality Assurance Recommendations

Outstanding key recommendations arising from QA reviews of FtP screening and investigations (Total = 14)

To be reviewed by Moore Stephens as part of work programme 2013-2014

No	Recommendation
QA 1	The investigation process needs to be more inclusive of the Referrer in terms of Case Officer introduction, case progress updates and advising when investigation is complete and ready for presentation to the IC panel. This change in emphasis needs to be advised to staff and included in the relevant SOPs. **(1st IC Review Report Ref D2.2.2)**
QA 2	Consideration is given to more directly linking the referral type and case speciality to the draft allegation types, so able to identify the different types of allegation involved as case speciality types more easily. **(1st IC Review Report ref E2.7) needs to be upgraded to types of public safety or public interest issue and fitness to practise breach within the draft allegation , but CMS referral types and case speciality need to be altered.**
QA 3	To establish the key process dates within the investigation process and ensure that these are consistently and accurately recorded as date fields within CMS to allow better management information direct from CMS, e.g. • allocation to case officer • issue of the IC NoR • approval of investigation plan • approval of extensions to investigation • approval of draft Report to IC • ILR review **(2nd IC review Report ref B2 & B2.2 replacing original 1st IC review recommendation as more detailed)**
QA 4	The monitoring of the investigation progress and the approval of the resulting IC report needs to be evidenced on CMS to allow compliance or performance to be adequately monitored by team managers. **(2nd IC review Report ref B2.4.1 & B2.2.2)**
QA 5	Ensure that investigation staff are made aware of the need to review and update the risk assessment form correctly where any additional information has been received during the investigation process. (Public Safety)

No	Recommendation
	Update the relevant SOP with the agreed review process. **(2nd IC review Report ref C1.2 & C2.3.2**
QA 6	Consider either upgrading the current Cautions, Convictions and Determinations Policy to include the handling of dishonesty cases or consider having a separate policy in relation to dishonesty by registrants. **(2nd IC review Report ref D1.3.2 & D1.2.7)**
QA 7	<u>Use of Risk Assessment Form</u> 1. The risk assessment should be used to set out the initial screening preliminary investigation plan (PIP) and when updated on transfer to investigation should be used to set out the final investigation plan. Each time that new information comes in the risk assessment and investigation elements should be reviewed and updated on the basis of public safety (possibly IO) and fitness to practise breach. 2. If used as above the risk assessment should then feed into the Screening Audit Form (SAF) used to record the decision to close at screening stage. If from the risk assessment decide there is not public safety, public interest or fitness to practise breach then case should be closed. Query whether need for separate SAF form. 3. Consider redesigning the form as a CMS input screen with a view to either getting a currently redundant CMS screen redesigned or having such an input screen set up for any new case management system.
QA 8	<u>Use of Screening Audit Form</u> 1. Name of form to be changed to Screening Closure Decision Form. 2. Consider redesigning existing CMS Maintain Respondent Profile screen to include key data fields being completed on the SAF with larger closure reason text box. Alternatively redesign form as if CMS input date field for any future case management system.
QA 9	Now that the Investigation teams and transition period is over, Screening and Investigation need to look at the definition of IFR and agree the division of enquiries before a case is deemed IFR including the chasing and obtaining of responses before the case is handed over to the relevant Investigation team. This needs to be reflected in any screening preliminary investigation plan (PIP) and the Investigation Plan to avoid either gaps or needless duplication. **(2nd IC review Report ref D1.2.4)**
QA 10	Consideration is given to: 1. Developing a standard checklist for drug and alcohol and caution and conviction setting out the tests to be applied and in what order.

No	Recommendation
	2. Using the completed checklist as part of the investigation plan and as an appendix to the IC report. **(2nd IC review Report ref D1.2.5) needs to be updated as policy needs to align with the Registrations' version of the same policies.**
QA 11	Consideration is given to introducing a quality check/review of the complete IC (NCTA) report to ensure that it has been adapted appropriately. This check/review needs to be done pre-IC either on all cases or a spot check basis. **(2nd IC review Report ref D3.5**
QA 12	Consideration given to requiring the Employer references to include, where appropriate: 1. Attendance record 2. Disciplinary record 3. Any current conduct and competence issues and whether any previous issues unresolved. Employer references need to be obtained directly from the employer representative, e.g. Director of Nursing/HR Manager even if the information has to be supplied by the registrant's line manager. **(2nd IC review Report ref D2.2.1 B & D2.2.5)**
QA 13	Consideration given to requiring GP references to include details of: 1. How long has the registrant been registered with the GP practice 2. Whether the GP have previous medical history on file in relation to drugs/alcohol. 3. Whether the registrant visited GP since the offence 4. Whether recent medical history indicates a drugs/alcohol issue. GP references need to be obtained independently and directly from the GP using a signed GP consent form. If received via the Registrant this should be noted clearly on the document for the IC panel. **(2nd IC review Report ref D2.2.1 D & D2.2.5)**
QA 14	Consideration given to adding child safety as a specific risk factor within the risk assessment form to allow proper consideration of any allegation involving a child (non-patient) or where the child's presence is incidental. **(2nd IC review Report ref D2.2.2)**

Item 10
AC/13/64
5 September 2013

Audit Committee

NMC Assurance Map

Action: For discussion.

Issue: Provides an update on the NMC assurance map.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: effective governance and internal control processes

Decision required: The Committee is invited to note this report.

Annexes: The following annexe is attached to this paper:

- Annexe 1: NMC Assurance Map

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 The Committee considered the NMC assurance map developed by Moore Stephens on 8 July (minute AC/13/48).

2 The assurance map should support the Committee in performing its role in providing assurance to Council on the effectiveness of the NMC's governance processes and systems for risk management and internal control.

3 The Committee submitted the assurance map to Council in July (NMC/13/132). Council agreed that it would review the assurance map, alongside the risk register, every six months.

Discussion:

4 As the Committee is aware, the current map (annexe 1) is based on management's assessment of assurances. Further work is needed to:

4.1 Address weaknesses/gaps identified in both the sources of assurance and the calibre of those assurances.

4.2 Develop timelines to show when more robust sources of assurance should be in place in the various functions.

5 In developing the map, Moore Stephens advised that the higher up the map, the greater the need for sound assurance. In terms of priority, efforts should therefore focus initially on regulatory functions, particularly continued practice, customer service, registrations and fitness to practise.

6 The following planned work will help to further identify gaps or duplication in the assurance processes:

7 Regulatory functions

7.1 Implementation of quality assurance reviews across regulatory functions (Registrations, FTP and Continued Practice) from July 2013.

7.2 Specific projects underway as part of the change programme, such as the Registration Improvement Programme, the FTP transformation plan, FTP witness experience programme, as well as other mechanisms for identifying issues such as outcomes of the PSA audit of Fitness to Practise initial stages decisions (due to report December 2013).

8 Organisation-wide

8.1 Implementation of quality management systems across the organisation by autumn 2014. This is subject to availability and recruitment of resources.

8.2 Ongoing monthly scrutiny of the corporate and directorate risk registers by the Executive Board and Corporate Governance

business planning team.

8.3 Emerging findings from internal audit assignments during 2013-2014.

9 Further development work on the assurance map will be undertaken over the coming months. An updated map will be brought to the Committee in December for consideration before submission to Council in January 2014.

Public protection implications:

10 No direct public protection implications. Ensuring that there are good levels of assurance around the governance framework and system of internal control should help the NMC deliver its core regulatory functions more efficiently and effectively.

Resource implications:

11 Co-ordination of this work is met from Corporate Governance directorate resources. Resources to address assurance issues within functional areas are the responsibility of the directorates concerned.

Equality and diversity implications:

12 No direct equality and diversity implications resulting from this paper.

Stakeholder engagement:

13 Not applicable.

Risk implications:

14 Improved levels of assurance should support the NMC in managing risks more effectively.

Legal implications:

15 Not applicable.

Item 10 - Annexe 1
AC/13/64
5 September 2013

NMC Assurance map summary

Objective or Function	First Line	Second Line	Third Line
Core functions			
Registration			
Continued Practice: Education			
Continued Practice :Standards			
Continued Practice: Revalidation			
Fitness to Practise			
Customer service			
Public protection			
Core enablers			
Communication & external relations			
Governance			
Projects, Programmes & change			
Strategy, business planning & performance			
Risk Management			
Core support functions/objectives			
People, knowledge & skills			
IT & data security , protection, records mgt.			
Legal & regulatory compliance			
Finance & payroll			
Procurement			
Business continuity			
Health & safety			
Efficiency and financial resources			

Key

Green	*Unlikely that further assurance activity is required in principle.*	
Yellow	*Assurance activity not sufficient but planned new assurance activity is moving this to a level of assurance that is reasonable.*	
Amber	*Limited assurance, requires improvement.*	
Red	*No assurance activity understood to be in place.*	
White	*New activity, no assurance activity as yet required*	

Notes:

1. The map is based on assurance activities reported by management; it does not guarantee translation into reality. The higher up the table, the greater the need for sound assurance.

3. In accordance with HM Treasury Guidance, the 'three lines of defence' are:
   - First: Procedures and checks directly undertaken by frontline staff and line management.
   - Second: Reviews/Checks by management and corporate quality assurance
   - Third: Internal or external audit (including external regulation).

Item 11
AC/13/65
5 September 2013

Audit Committee

Serious event reviews and data breaches

Action: For information.

Issue: To update the Committee on progress on implementing the Serious Event Review (SER) policy agreed in January 2013 and to provide details about recent SERs including learning points.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: Learning from serious events, complaints and data breaches is a key element of the governance framework.

Decision required: The Committee is asked to:

- Note progress on implementation of the corporate serious event policy (paragraph 8).

Annexes: The following annexes are attached to this paper:

- Annexe 1 - Register of current SERs (**CONFIDENTIAL**)
- Annexe 2 – information about data breaches in the first quarter of 2013-2014.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 The Audit Committee approved the current SER policy at its meeting in January 2013. The policy has been introduced across the organisation but it has not been consistently implemented.

2 We need to ensure that the SER policy is working well and that it provides a strong framework for managing SERs in the future and ensuring that learning identified from the SERs results in tangible improvements in how we carry out the key functions.

3 To date we have not systematically captured all of the learning from the SERS to date. Further work is being done on achieving greater awareness of the importance of the SER process across the organisation which will support embedding of a culture of continuous learning.

Discussion: **Update on the implementation of the SER policy**

4 We are undertaking an initial evaluation of the SER process and the organisational learning from those SERs identified to date. Further details about this will be provided at the next meeting of the Audit Committee.

5 Corporate responsibility for the operation of the SER policy has recently been transferred to the Assistant Director for Quality Assurance and Risk Audit. He will lead and deliver a comprehensive training programme to all managers in the organisation, starting with the Directors on 16 October 2013. The training programme will be completed by 27 November 2013.

6 The training will follow a similar format and roll out to that done earlier in the year on the risk management process. This was very helpful in embedding that process effectively. It will be stressed to all managers that they must cascade the training to their individual team members.

7 The key driver for the training is to raise awareness of the policy and to ensure that we apply a consistent approach across the NMC. This will ensure that we identify and report on SERs, we identify learning arising from SERs and we take the necessary actions to reduce the risk of the same or similar issues arising again.

8 **The Committee is asked to note progress on implementation of the policy.**

9 The table at annexe 1 contains details of all recent and outstanding SERs and the table at annexe 2 details of data breaches in the first quarter of 2013-2014.

10 The Assistant Director for Quality Assurance and Risk Audit will be setting up a database of learning from SERs and a process for checking whether the necessary remedial actions have been

implemented. This will be in place before the training has been delivered. As part of the QA programme we will also check that these remedial actions have been implemented. At future meetings we intend to report on learning points from reported SERs.

Public protection implications:	11	Reporting of serious events and data breaches, and identification of actions and learning to mitigate the risk of recurrence, is an important safeguard for public protection.
Resource implications:	12	The training programme is resource intensive but it will be delivered internally by the Assistant Director for Quality Assurance and Risk Audit and other staff in the Corporate Governance team.
Equality and diversity implications:	13	There are no equality and diversity implications arising from this paper.
Stakeholder engagement:	14	Effective engagement with staff on implementing change is essential. This is recognised by the considerable investment in time of the training programme.
Risk implications:	15	Failure to learn from previous SERs and data breaches represents risks to public protection and the reputation of the NMC.
Legal implications:	16	Individual serious events and or data breaches may have potential legal implications.

Item 11 - Annexe 2

Audit Committee

Report of information security incidents Q1 2013-14 (April – June 2013)

For information

Issue

1 This report presents statistics on the number of information security incidents reported in the NMC in the period 1 April – 30 June 2013.

2 The figures presented in this paper are based on notifications of information security incidents to the Information and Data Governance Manager. The data includes incidents irrespective of whether they are classified as an Adverse Incident or a Serious Event.

3 Where the date of an incident is not known, or the incident came to light a considerable time after it occurred, the incident is allocated to the month in which the incident was reported although this may be different from the month in which it occurred.

4 Where an incident has more than one classification, it has been assigned to the predominant classification.

5 For incidents which are subject to on-going investigation, the incident classification or severity level may change as the result of the investigation.

Recommendation

6 None

Annexes

7 None

Further information

8 If you require clarification about any point in the paper or would like further information please contact the author named below.

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Report of information security incidents April - June 2013

Information security incidents by month

Month	Total information security incidents	Data breaches (incidents which were an actual or potential data breach and/or breach of confidentiality)	Other information security incidents
April	8	5	3
May	8	6	2
June	0	0	0
Total	**16**	**11**	**5**

Information security incidents by classification

Classification	April	May	June	Total
Loss or theft of ICT equipment	0	0	0	**0**
Unauthorised disclosure of data (accidental or malicious). Includes breach of confidentiality / data breach / information sent to the wrong recipient / mislaid information. Includes potential (but not actual) unauthorised disclosure of data	6	5	0	**12**
Breach of physical security in an area housing ICT equipment	0	0	0	**0**
Information system access violations (includes attempted unauthorised access)	0	0	0	**0**
Malware attack	0	0	0	**0**
Detection of unauthorised wireless network	0	0	0	**0**
Non compliance with ICT policies	0	0	0	**0**
Fraudulent use of information systems and assets	0	0	0	**0**
Lack of data integrity: data corruption, accidental or deliberate unauthorised alteration of data / data incompleteness	2	2	0	**4**

Information security incidents by level

Level **(see attached guide to classification levels)**	**April**	**May**	**June**	**Total**
5	0	0	0	**0**
4	0	0	0	**0**
3	2	3	0	**5**
2	4	4	0	**8**
1	2	1	0	**3**

Information security incidents by cause

Cause	**April**	**May**	**June**	**Total**
Failure of policy or procedure: Policy or procedure followed but ineffective in preventing the incident. Indicates change required to policy or procedure.	1	1	0	**2**
Human error / procedure not followed / accident	4	3	0	**7**
Both failure of policy or procedure **and** human error	3	3	0	**6**
Deliberate or malicious action	0	0	0	**0**
Third party error [Add details for Audit Committee]	0	1	0	**1**
Other / cause not known	0	0	0	**0**

Incidents involving paper documents	
Percentage of incidents involving paper documents [11 of 16 = 68%]	**68%**

Information security incidents by directorate

Directorate	April	May	June	Total
Corporate Governance	0	0	0	**0**
Corporate Services	0	1	0	**1**
Fitness to Practise	8	7	0	**15**
OCCE	0	0	0	**0**
Registration and Standards	0	0	0	**0**

Information security incident trends: 12 months to end June 2013

9 Figure 1 shows the trend in the number information security incidents of levels 1-3 over the last 12 months.

10 As would be expected there is a fluctuating level of minor (level 2) and insignificant (level 1) incidents.

11 Human error continues to be a cause of the majority of incidents. Around a third of incidents were attributable to a failure of procedure and where a failure of process. is a contributing factor corrective action is recommended within the incident report.

12 One incident during this period was caused by a third party, and employer supplying the NMC with details of an incorrectly identified registrant.

13 No incidents of levels 4 and 5 occurred during the 12 month period

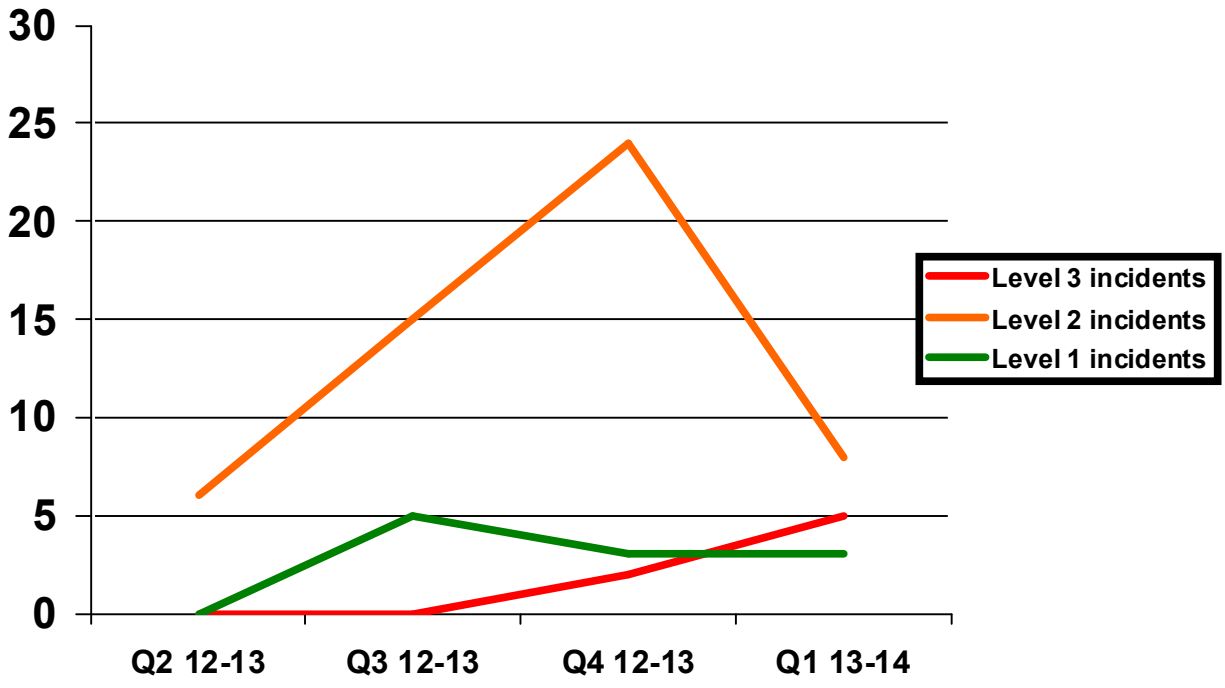

Figure 1

Classification levels for information security incidents

5	**A critical information security incident with a very high impact on public protection and/or reputation and/or operations** **Guidelines** • An **i**ncident which renders NMC unable to operate. **Examples** • An unauthorised attack on ICT systems rendering the entire network unable to function for one month. • Unauthorised disclosure of the entire contents of WISER
4	**A major information security incident with an high impact on public protection and/or reputation and/or operations** **Guidelines** • An information security incident involving the unauthorised disclosure of a very large quantity of confidential data and/or personal data; or • An incident with very significant operational consequences • If also an ICT incident, will be a P1 incident **Examples** • An unauthorised attack on ICT systems rendering a significant business system unable to function for 5 days • Unauthorised disclosure of data relating to 100 registrants
3	**Moderate: An information security incident with a moderate impact on the public protection, NMC's reputation and/or operations** **Guidelines** • An incident involving the unauthorised disclosure of personal data relating to at least 10 individuals, or • An incident involving the unauthorised disclosure of sensitive personal data relating to at least 3 individuals (or fewer than 3 individuals if the data is extremely sensitive, such as data about vulnerable witnesses) • An data integrity incident with a negative impact on public protection or NMC's reputation • An incident with short term operational consequences. • If also an ICT incident, will be a P1 incident

	Examples • An attack on ICT systems resulting in one critical business system being out of operation for 1 day. • Loss of unredacted health information relating to 4 named patients.
2	**Minor: an incident with a minor impact on NMC's reputation or operations** **Guidelines** • An information security incident involving the unauthorised disclosure of personal data relating to less than 10 individuals, or loss of sensitive personal data for up to 3 individuals. **Examples:** • A letter containing information about a registrant sent to the wrong address. **An incident which involves the unauthorised disclosure of personal data as defined by the Data Protection Act must always be a level 2 incident or above.**
1	**Insignificant: an incident with a very low impact on NMC reputation and reputation** **Examples** • Unauthorised disclosure of financial data for a short time, when the data is soon recovered and without damage to the reputation of the NMC. • Non-compliance with NMC policies, where there is no or minimal damage to the NMC. • Loss of an NMC laptop where the data on it is encrypted. **An incident which involves the unauthorised disclosure of personal data about identifiable individuals must always be a level 2 incident or above.**

AUDIT COMMITEE SCHEDULE OF BUSINESS (2013 / 14)

	OPEN SESSION	CONFIDENTIAL SESSION
Standing items for Audit Committee	• Chair's introduction • Apologies for absence • Declarations of interest • Minutes and matters arising • Schedule of business • Receipt of reports on internal audit programme (ToR 12) • Serious events and data breaches: report (ToR 8)	• Minutes and matters arising • Schedule of business

September 2013 (Q2)

Director Responsible	Paper	Responsibility (ToR)	Frequency
MS	Information security training take-up (to be addressed in matters arising)	ToR 5 (requested at April 2013 Committee)	Ad-hoc
LM	Business assurance map	ToR 5	Annual

December 2013 (Q3)

Director Responsible	Paper	Responsibility (ToR)	Frequency
MS	Financial regulations: review	ToR 7 (in July 2013 summary of actions for Q3 2013)	Annual
MS	Effectiveness of external auditors	ToR 18	Annual
MS	External auditors' engagement letter	ToR 15	Annual
MS	NAO audit plan	ToR 16	Annual
LM / MS	Review of anti-fraud, bribery and corruption policies	ToR 7	Annual
LM / MS	Whistleblowing policy	ToR 8 (in July 2013 summary of actions	Annual

		for Q3 2013)	
LM (internal audit)	NMC assurance map	ToR 5	Twice per year
LM	Quality assurance update	ToR 5	Twice per year

February 2014 (Q4)

Director Responsible	Paper	Responsibility (ToR)	Frequency
LM	Approval of internal audit work programme for 2014 - 15	ToR 11	Annual
MS	Annual review of accounting policies	ToR 4	Annual
LM	Post-implementation review of risk management policy	ToR 6	Ad-hoc
LM / MS	Process and timetable for tender for external audit provision	ToR 14	Every three years

April 2014 (Q1)

Director Responsible	Paper	Responsibility (ToR)	Frequency
LM	Draft annual governance statement	ToR 3	Annual
LM	Annual review of risk management	ToR 6	Annual
LM	Annual review of internal audit charter	ToR 13	Annual
LM (internal audit)	Internal audit annual opinion	ToR 13	Annual
N / A	Private session between internal audit providers and members of Committee (**CONFIDENTIAL SESSION**)	ToR 13	Annual
LM	Review of Committee effectiveness	Provided for within Standing Orders	Annual
LM	NMC assurance map	ToR 5	Twice per year

June 2014 (Q1)

Director Responsible	Paper	Responsibility (ToR)	Frequency
LM / MS	Draft annual report and accounts	ToR 3	Annual
LM / SP	Draft fitness to practise annual report	ToR 3	Annual
MS	External auditors' management letter	ToR 3	Annual
MS	NAO audit completion report	ToR 3	Annual
LM	Internal audit effectiveness	ToR 11	Annual
LM	Quality assurance update	ToR 5	Twice per year

Cyclical – every 3 years			
Director Responsible	**Paper**	**Responsibility (ToR)**	**Frequency**
LM	Proposals for tendering for internal audit services	ToR 9	Next due mid - 2015