Meeting of the Audit Committee

to be held at 21 Portland Place
at 10.15am, on 19 April 2013

Ruth Sawtell
Chair

Paul Johnston
Secretary to the Committee

Agenda

Item		Tab number
1	**Welcome and Chair's opening remarks**	-
2	**Apologies for absence**	-
3	**Declarations of interest** To invite any member to declare an interest in the business of today's meeting.	-
4	**Minutes of the meeting 25 January 2013** **AC/13/18 (page 5)**	4
5	**Summary of Actions from 25 January 2013** **AC/13/19 (page 23)**	5
	Risk	
6	**Risk management framework** **AC/13/20 (page 41)** Director, Corporate Governance	6
7	**Risk register** **AC/13/21 (page 81)** Director, Corporate Governance	7
	Update on key risks	Verbal update

8	**Scrutiny of Directorate Risks: Registrations** Director, Registrations	Verbal update	
	<u>Corporate assurance and internal control</u>		
9	**Internal Audit: Work Programme and Annual Audit Opinion 2012-2013** **AC/13/22 (page 97)** Director, Corporate Governance	9	
10	**Log of outstanding recommendations** **AC/13/23 (page 127)** Director, Corporate Governance	10	
11	**Internal Audit Strategy 2013-2016 and Work Programme 2013-2014** **AC/13/24 (page 185)** Director, Corporate Governance	11	
12	**FTP Quality Assurance** Report from FTP Committee **AC/13/25** Director, Corporate Governance	12	**To follow in 48 hour papers**
13	**Serious events and data breaches** **AC/13/26 (page 191)** Director, Corporate Governance	13	
14	**Whistleblowing Process: report on use** **AC/13/27 (page 217)** Director, Corporate Governance	14	
15	**Information Security Assurance** **AC/13/28 (page 221)** Director, Corporate Services	15	

16	**Finance update** **AC/13/29 (page 225)** Director, Corporate Services	16
17	**Report on Remuneration Committee Decisions** **There are no decisions to report.** Director, Corporate Services	
18	**Francis report: governance issues** **AC/13/30 (page 259)** Director, Corporate Governance	18
19	**NMC Governance Review - Progress Report** **AC/13/31 (page 269)** Director, Corporate Governance	19
20	**Review of Overseas Registrations**	Verbal Update
21	**Process for systematic review of policies** **AC/13/32 (page 273)** Director, Corporate Governance	21
22	**NMC Assurance Framework** Director, Corporate Governance Head of Internal Audit, Moore Stephens	Verbal Update
	Year end issues	
23	**Audit Committee Annual Report to Council** **AC/13/33 (page 283)** Director, Corporate Governance	23
24	**Draft Annual Governance Statement** **AC/13/34 (page 295)** Director, Corporate Governance	24

Transition to Reconstituted Council

25	**Audit Committee Transition/Forward Work Plan** **AC/13/35 (page 309)** Director, Corporate Governance	25
26	**Audit Committee Report to Council from this meeting** **AC/13/36 (page 329)** Director, Corporate Governance	26

Item 4
AC/13/18
19 April 2013

Meeting of the Audit Committee
10.30am on 25 January 2013, 1 Kemble Street, London

DRAFT Minutes

Present

Members

Ruth Sawtell (Chair)	Council member
Julia Drown	Partner member
Louise Scull	Partner member
Bea Teuten	Council member
Jane Tunstill	Council Member

Officers

Jackie Smith	Chief Executive and Registrar (to 13/16 only)
Lindsey Mallors	Director of Corporate Governance
Mark Smith	Director of Corporate Services
Sarah Page	Director, Fitness to Practise (to 13/16 only)
Verity Somerfield	Assistant Director, Finance (to 13/16 only)
Michael Andrews	Assistant Director Quality Assurance and Risk (designate) (to 13/16 only)
Tom Kirkbride	Assistant Director, Registrations (to 13/16 only)
Fionnuala Gill (minutes)	Performance Improvement Manager

In attendance

Martin Burgess	National Audit Office (NAO) (to 13/16 only)
Kathryn Burton	Charities Partner, haysmacintyre (to13/16 only)
Richard Weaver	Charities Partner, haysmacintyre (to 13/7 only)
Mark Leckie	Audit Manager, haysmacintyre (to 13/7 only)
Mark Finnigan	NMC Council Services Administrator

Apologies

Sue Hooton	Council member
Paul Johnston	Secretary to the Committee
Kate Mathers	National Audit Office (NAO)
Lee Glover	Divisional Director, Parkhill
Jenny Leeson	Audit Manager, Parkhill

Minutes

13/1 **Item 1- Welcome and Chair's opening remarks**

1 The Chair welcomed Jane Tunstill as a new member of the Committee and Richard Weaver and Mark Leckie, haysmacintyre attending in relation to Item 7.

2 The Chair noted that the Committee may have to adjourn and go into confidential session at 12.30 to ensure that key issues were considered whilst the Chief Executive was present.

13/2 **Item 2 - Apologies for absence**

3 Apologies for absence were received from Sue Hooton (Council Member).

13/3 **Item 3 - Declarations of Interest**

4 There were no declarations of interest.

13/4 **Item 4 - Minutes of the Audit Committee meeting 11 December 2012 AC/13/1**

5 The minutes were agreed as a correct record of the meeting.

13/5 **Item 5 - Action list from the Audit Committee meeting 11 December 2012**
AC/13/2

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

7 The Committee agreed that:

- There should be a report back from Remuneration Committee at the next meeting in relation to the arrangements for Audit Committee scrutiny of Remuneration Committee decisions (Minute 12/117, AC/13/2, row 15)
- References to previous outstanding actions being superceded should be corrected where appropriate, for example, development of a corporate serious event review policy (Minute 12/119, AC/13/2, row 19).
- The Committee should be updated on the outcome of Council's consideration of changes to the Scheme of delegation on 31 January 2013 (Minute 12/123).
- All items should be discharged as completed except:
    - Consideration of adjustment of the accounting policies (Minute 12/112, AC/13/2, row 8).
    - Annual Governance Statement: inclusion of information security assurance statement (Minute 12/118, AC/13/2**,** row

17).

- Report on information provided to the Committee on information security incidents and data breaches (Minute 12/118, AC/13/2**,** row 18).

Action: Update and correct action list
For: Secretary to the Committee
By: 31 January 2013

13/6 **Item 6 - Review of the Audit Committee's effectiveness**
AC/13/3

8 The Chair thanked all those who had contributed to the Committee's review of its effectiveness. The NAO checklist had provided a useful structure for consideration of key principles.

9 It was agreed to consider the exercise as completed rather than seek to continue to obtain further input. It was suggested that in future failure by members or Directors to contribute to such exercises might be the subject of comment in annual member and staff appraisals.

10 In discussion it was noted that:

- The Committee lacked IT expertise but there was IT expertise on the newly formed Finance & IT Committee.
- It was important to both identify any training/support required by existing members and ensure that in making future appointments members with the right skills and expertise were appointed to the right Committees.
- In the case of Audit Committee, there was a need for skills in areas such as IT, finance, governance, audit and risk management.

11 It was agreed to highlight to Council the following learning from the review to contribute to the planned governance review:

- There should be an induction checklist for members of all committees.
- All committee members (Council and Partner) should receive a letter of appointment setting out the role, expectations and length of appointment.
- All members should be subject to annual appraisal.
- Each committee should annually review its core purpose and its effectiveness.
- There should be assessment criteria for appointment to each committee to ensure that the skills base and expertise on each committee is appropriate.

12 It was further agreed that the newly appointed members of the Audit Committee should be sent proper appointment letters.

Action: Ensure learning from the review reported to Council for consideration as part of the governance review.

For: Director, Corporate Governance
By: 28 January 2013

Action: Send letters of appointment to new members of the Audit Committee
For: Director, Corporate Governance
By: 1 February 2013

13 The exercise had highlighted that the Committee had not previously reviewed the draft statutory accounts before external auditors began work on them.

14 Members discussed the respective roles of the Finance and IT and Audit Committees: Finance Committee reviewed the management accounts. Members considered that as a matter of good practice the Audit Committee should review the draft statutory accounts. This provided a useful opportunity for challenge and scrutiny before the accounts were finalised. There would be timing challenges, as the Committee needed to consider the audited accounts at the June meeting to ensure submission of the annual report and accounts to Parliament before summer recess.

15 The Committee agreed that the draft statutory accounts would be circulated to members for comment at the same time as they were submitted to the external auditors.

Action: Draft statutory accounts to be circulated to Audit Committee members for comment at the same time as submission to external auditors.
For: Director, Corporate Services
By: 29 April 2013

13/7 **Item 7- Report on the Integrity of WISER and CMS**
AC/13/4

16 Richard Weaver, haysmacintyre introduced the report. haysmacintyre had conducted a review of the work undertaken by the NMC to reconcile discrepancies arising between the registrations system (WISER) and the Fitness to Practise case management system (CMS). He confirmed that Kath Burton, the Partner at haysmacintyre responsible for external audit of the NMC's accounts had no involvement in the work.

17 haysmacintyre had conducted its sampling and audit work in November 2012. This had indentified only two discrepancies which had not been picked up by the NMC's processes. The review had concluded that the systems and controls put in place by the NMC provided adequate assurance. The report made one medium risk and 18 low level recommendations. It was important that the Committee monitored implementation of these.

18 The Director, Fitness to Practise (FtP) advised that work on many of the issues addressed in the recommendations had already been put in hand

prior to the review. She was confident that the timetables would be met for implementation. In relation to the one medium risk recommendation, although the Standard Operating Procedures (SOPs) should be completed by the end of January there had been slight slippage on training: this should now be completed by the first week in February. Further consideration was being given to how best to ensure that the SOPs were readily available to all staff with editing access and whether the staff intranet was the best vehicle for this.

19 Recommendation 5 was now proving more complex than initially envisaged: it was unlikely that a full feasibility assessment would be completed by the end of January but work was ongoing with IT staff. On recommendation 9, FTP agreed in principle that reviews should be undertaken on a weekly basis but staff strongly considered that the reviews should continue to be done daily for the present. The position would be reviewed in three months.

20 The Committee agreed that:

- The recommendations should be added to the internal audit recommendations log.
- The Audit Committee should review progress at the end of March and include this in its annual report to Council so that Council could include this in the Annual Governance Statement.
- There should be a full review in 12 months.

Action: Add recommendations to internal audit log
For: Performance Improvement Manager
By: 31 January 2013

Action: Report on progress of implementation of recommendations to the next Audit Committee meeting
For: Director, Fitness to Practise
By: 19 April 2013

Action: Ensure review included in Annual Report 2012-2013 and added to Committee's forward work plan for 2013-2014
For: Director, Corporate Governance
By: 31 March 2013

13/8 **Item 8 - Risk management framework**
AC/13/5

21 The Committee noted the report and that fraud risk would be added into the refreshed risk management framework, as recommended by internal audit. It was disappointing that this had not been picked up previously.

22 Members welcomed the short guide setting out key roles and responsibilities in relation to risk management, the flowchart and revised format for the risk register. The Committee agreed that these be incorporated into the revised framework and approved the proposed

implementation timetable.

Action: Amend risk management framework to address risk of fraud and produce final version for the next meeting
For: Director, Corporate Governance
By: 28 February 2013

Action: Incorporate short guide and flowchart into the revised framework; introduce revised risk register format; and implement training in accordance with timetable.
For: Director, Corporate Governance
By: 1 May 2013

13/9 **Item 9 - Risk Register**
AC/13/6

23 Members welcomed the significant improvements made to the risk register.

24 At the request of the Chair, the Chief Executive and Registrar outlined arrangements for consideration of the risk register. Directors Group discussed the risk register twice monthly and the Chief Executive also addressed risks in her meetings with individual directors. She had continued to discuss issues which were the subject of entries on the risk register with the Chair on an ongoing basis but had not yet gone through the risk register with the Chair item by item. However, with effect from 28 January, she would review the register with the Chair on a monthly basis in advance of each Council meeting.

25 The Chair asked whether Directors stepped back and reflected on whether they had got the "top risks" right. The Chief Executive confirmed that she was satisfied that this was the case, in addition to the issues around Registrations, IT remained a major risk, FTP would remain under close review and governance, particularly around reconstitution of Council, represented a major risk.

26 Members asked about the reasons for increasing the risk rating in relation to reconstitution of Council. The Chief Executive explained that ensuring that 11 members were appointed by 1 May represented a major challenge given the involvement of so many parties in the process: membership of the selection panel had only recently been resolved and the Professional Standards Authority and Privy Council also had roles to play. The Committee recognised the risk around this but members suggested that the bigger risk was in ensuring that the reconstituted Council was able to take effective decisions (General risk G37). In particular, the Audit Committee of reconstituted Council would need to be functioning effectively very quickly to fulfil its role in scrutinising the statutory annual report and accounts in early June to recommend these for Council approval.

27 The Committee agreed that this was an issue Council would wish to discuss and that it should be included in the Committee's update report.

Action: Raise in Committee's update report the risk of reconstituted Council not being able to take effective decisions including the risk of the Audit Committee being unable to fulfil its role in relation to the statutory annual report and accounts.
For: Director Corporate Governance
By: 28 January 2013

28 In response to members' questions, the Chief Executive explained that the risk rating in relation to Public Indemnity Insurance (T26) was based on the need to implement a major programme of cross-organisational work by October 2013. The position of some affected groups, such as independent midwives, had yet to be resolved with the Department of Health.

29 Julia Drown declared an interest as a pension fund trustee and asked for more information about the risk relating to increasing pension liabilities (G36). The Director, Corporate Services said that there were inherent risks due to the growth in pension costs as well as the need for auto-enrolment to be introduced in 2014. A review of the pension scheme was about to get underway which would report in summer. The external auditors (Kath Burton) drew attention to the changes in reporting requirements which may also apply in future.

30 A member queried whether the description of the risk was right: the risk should not be framed in terms of the impact of stock market performance on the pension fund if the real risk was employee costs. It was important to be clear about the risk to properly assess changes in the ratings.

31 It was noted that the Remuneration Committee would have a view, given its role in relation to staff reward and remuneration. The Finance and IT Committee would be examining the pension issues in detail and reporting to Council on the financial implications of any proposed changes to the pension scheme.

32 In relation to the risks around staff turnover (T25), a member asked whether Council was getting assurances that staff issues and concerns were being raised. She questioned whether the risk around equality and diversity issues was too high and asked who was monitoring equality and diversity issues. On the last point, it was noted that the Audit Committee's report to January Council had highlighted the need to clarify this (AC/13/21).

33 The Committee said that they would not normally expect to see the closed risks. A note in the papers queried why the risk relating to IT Technical Capability (T4) had been closed. The Director, Corporate Services said that this had been overtaken by the IT strategy.

34 The Committee noted the risk register. It should be presented single-sided in future to make it less cumbersome.

Action: Review description of risk on increasing pension liabilities
For: Director, Corporate Services
By: 31 January 2013

Action: Report back to Audit Committee on Council's decision about where responsibility rests for monitoring Equality and Diversity issues
For: Director, Corporate Governance
By: 19 April 2013

Action: Ensure Committee only receives open register in future and that register is produced single-sided
For: Director, Corporate Governance
By: 19 April 2013

13/10 **Scrutiny of Directorate Risks - Fitness to Practise**

35 The Director, FtP outlined the approach to risk management within the directorate. The directorate was working very hard to embed a culture of managing operational risk including encouraging staff to identify major new risks. This included:

- Raising risk issues in regular staff briefings
- Requiring each team to consider the risk register at least once each month. As an example, an operational risk identified in this way had related to inadequate printing and copying arrangements.
- Both the corporate and FTP risk register were reviewed every two weeks by the FTP Senior Management Team. The risk registers were reviewed both at the start of the meeting and at the end to ensure that any new risks which surfaced during the meeting were captured.
- Further development of the FTP risk register: initially this had been focused on projects but was now evolving to cover all directorate business.
- Risks were also captured through the longstanding adverse (previously 'serious') event review process. This had been recently updated and renamed given the new corporate serious event review process.

36 The key risks in FTP continued to be:

- Staff issues: including the high turnover and the impact of the influx of new staff. This was being mitigated through job specific induction and increased manager scrutiny.
- Decision quality: this was mitigated through the Decision Review Group examining cases where things had gone wrong to identify action and learning.
- Data security management: a particular issue raised through teams reviewing risk was around sending sensitive material by email in a way that was operationally workable. Currently there were only two options, encryption or using password protection.

37 In relation to data security, a member suggested that a simple but effective way was to adopt the practice of inserting attachments first, then the reply

and finally the addressee and the reply last which forced people to think about the email destination.

38 In response to questions about whether an amber rating on the risk register for FTP felt right for public protection, both the Chief Executive and Director, FtP considered that it did, given the level of checks now in place and that the same number of mistakes were not being made. The Chief Executive noted that considerable progress had been made in a number of areas and this appeared to have been accepted by the Professional Standards Authority.

39 A member noted that an area of concern remained around how Council obtained assurance around quality in FtP in terms of public protection and the quality of decision-making. The Chief Executive agreed: this was why it had been decided to appoint an Assistant Director, Quality Assurance based centrally in Corporate Governance directorate.

13/11 Item 11 - FTP Quality Assurance
AC/13/7

40 The Chair of the FTP Committee confirmed that the FTP Committee had considered the report in advance including the table of recommendations from the two programmes of work carried out to date by the FTP Quality Assurance (QA) team. The role of the Audit Committee was to provide assurance to Council that there was effective quality assurance in place for FTP. The FTP Committee's role would be to look at the outputs from the QA process, ensure actions were followed up and look at emerging trends from the QA, whilst responsibility for considering the detail remained with the executive team.

41 In response to questions, the Director, FtP explained that considerable work had been undertaken by the FTP QA team. Although the changes approved by Council in July 2012 around sampling size had been implemented, the proposals put to Council had not been truly risk based. The FTP QA team's work had been made more difficult because ongoing improvements in FTP meant that detailed recommendations had at times been overtaken. Other recommendations had not been implemented due to lack of resource. For all these reasons it had been decided not to make any further changes to the QA programme pending the appointment of an Assistant Director, Quality Assurance and Risk. The Chair of the FTP Committee noted that the FTP Committee saw it as a key priority to develop an FTP QA strategy and framework when the AD Quality Assurance and risk took up post.

42 Members considered that there was a need to be clear about the process for resolving differences of opinion about recommendations between the QA team and management in a similar way to internal audit recommendations. Management should explain why it did not accept or had not implemented QA recommendations. This should be more clear cut when the AD QA took up post and a date for this should be set as soon as possible. The Chief Executive confirmed that members would be notified when a date had been

set for the AD Quality Assurance to take up post.

43 The Committee agreed that its update report to Council should state that as yet the Committee had not received the assurance it required about Quality Assurance in FtP. It was particularly important that this be relayed to the reconstituted Council.

Action: Notify Committee when date set for Assistant Director, Quality Assurance and Risk to take up post
For: Director, Corporate Governance
By: 31 January 2013

Action: Advise Council that as yet the Committee had received no assurance in respect of FTP quality assurance.
For: Director, Corporate Governance
By: 28 January 2013

13/12 Item 12 - Outstanding Internal Audit Recommendations: progress report
AC/13/8

44 The Committee agreed to review the outstanding recommendations in turn by directorate as summarised in the report (AC/123/8, paragraph 7).

45 Corporate Governance - Risk management recommendations (rows 2, 3, 7, and 31)
It was noted that these had been addressed by the risk management framework discussed under Item 8. As agreed earlier the framework would be revised to include risks relating to fraud for finalisation at the next meeting. It was agreed that the recommendation around deleting risks from the register (AC/13/8, Annexe 1, row 3) should be regarded as closed and could be removed from the log.

46 Corporate Governance - Records Retention Policy (row 25)
Progress was now being made following a decision by Directors to address FTP record retention separately. A policy on non-FTP record retention would be put to Directors for agreement in February: work on scoping the FTP policy would be completed by the end March 2013. In response to Louise Scull's question about why this had been delayed since March 2012, the Director, Corporate Governance said that this had been due to the need to address the more pressing priorities arising from the CHRE strategic review.

47 Corporate Services - IT Security and Data Security (rows 4, 5, 23,24,26)
The Director, Corporate Services explained that these recommendations had been partially implemented but were difficult to close down fully as they were being addressed through the long term IT strategy. In response to a question from the Chair about the information security recommendations at rows 4 and 5, the Director Corporate Services said that the major information security risks had been identified through the security gap

analysis reported to the previous meeting. The immediate risks were being addressed but verification of compliance with ISO 27001 would not be achieved until 2015.

48 **Corporate Services - Finance (row 16)**
Considerable work had been done on the WISER reconciliation. Kath Burton confirmed that external auditors hoped that it would be possible to close this down through write off of the historical balance at year end and this should not be a recurring issue.

49 **Registrations - Fraud (Rows 8, 11,13,14,15)**
It was noted that most of these recommendations would be discussed under Item 13 and/or in the confidential session.

50 The position in relation to the recommendation on proactive maintenance of addresses of registrants (AC/13/8, Annexe 1, row 9) remained unclear. This should be established and reported to the next meeting. In relation to the recommendation on automated workflow monitoring (AC/13/8, Annexe 1, row 14), the AD Registrations with the help of the Performance Improvement Manager should identify the original reason for this recommendation and explain why it has not been accepted.

51 It was agreed that the recommendation on Academic partner risk (AC/13/8, Annexe 1, row 12), be removed from the log as proposed.

Action: Clarify the position on recommendation 9, identify the reasons for recommendation 14 and provide a full explanation to the next meeting
For: Assistant Director, Registrations
By: 19 April 2013

52 **FTP - Quality Assurance** (Rows 27 and 28)
The Committee considered that it was unsatisfactory for recommendations to be superceded because implementation had been delayed. The Director, FtP advised that as previously indicated, although Council had been asked in June to approve a risk based programme, it had subsequently transpired that the programme was not, in fact, risk based. The FTP QA team comprised only one QA manager and one compliance officer and they had sought to complete the original work programme before moving on to the revised programme approved by Council in July. However, the second audit had taken place in October.

53 The Committee considered that the fundamental principles in these recommendations remained applicable and should be addressed. It was agreed that FTP should consider and report at the next meeting on how the spirit of these recommendations was being addressed.

Action: Report on how spirit of FTP QA recommendations at AC/13/8, Annexe 1, rows 27 and 28 being addressed to next meeting.
For: Director, Fitness to Practise
By: 19 April 2013

54 Members reiterated previous concerns that there had been no original management response to a number of recommendations. It was agreed that this was not acceptable: management must always provide a formal response. If a recommendation was not agreed, the reasons for this must be explained and discussed with Audit Committee.

55 It was agreed that:

- Recommendations should remain on the log until implementation had been independently verified by auditors except where otherwise stated.
- In future, only outstanding recommendations which had passed the target date for implementation would be reported to the Committee.

Action: Ensure that:

- A formal management response is always made to internal audit recommendations.
- Management explains to Audit Committee its reasons for not accepting a recommendation.

For: All Directors
By: Immediate

Actions:

- Amend log to remove recommendations at AC/12/8, Annexe 1, rows 3 and 12
- Report only outstanding recommendations past target date in future

For: Performance Improvement Manager
By: 31 January 2013

13/13 **Item 13 - Learning from work on the outcomes of past fraud**
Verbal report

56 The Assistant Director, Registrations explained that he only became aware of this issue in early 2013 shortly after taking up post. The actions required of the NMC arising from the Multi-agency report (Operation Nairobi) had been completed. The NMC's internal investigation report from August 2011 arising from the Kent and Medway trust case had been kept confidential and due to limited circulation had only recently been rediscovered.

57 After a brief discussion, it was agreed that the recommendations from this report should be treated in similar fashion to internal audit recommendations with a formal management response being given to each one.

58 Members noted that the Committee had seen the report in September 2011 but for information only: Officers had advised that this was an "operational matter" and the Committee should have challenged this at the time. The Committee expressed serious concerns about how the report had disappeared from view and had not been addressed by management. This raised wider questions about how the Committee could be assured that all such internal reports were being actioned. It was noted that a report of this sort should in future be the subject of a serious event review, but the

Committee remained concerned that there could be further such issues which had not come to their notice.

Action: Treat the original NMC incident investigation recommendations from 2011 as internal audit recommendations and provide a full management response to each one.
For: Director, Registrations and Standards
By: 28 February 2013

Action: Develop proposals to ensure that all internal control and assurance reports are directed to Corporate Governance and reported to Audit Committee
For: Director, Corporate Governance
By: 28 March 2013

13/14 **Item 14 - Review of Anti-fraud, bribery and corruption policy AC/13/9**

59 The fundamental review of the policy proposed in September 2012 had not yet been undertaken due to the pressure of addressing the CHRE Strategic Review. This would be addressed alongside the review of HR policies and Financial Regulations planned by the Director, Corporate Services to be completed in 2013-2014. In the interim, the current policy was compliant with legislation and it was proposed that this be continued, subject to minor amends to reflect the recent changes to the organisational structure.

60 In discussion, it was agreed that it was inappropriate to have two reporting points within the policy: reporting should be to Corporate Governance. The Committee also noted that the wording of its own remit needed to be revised: this should be included in the review of Standing Orders as part of the Governance review.

61 The Committee approved continuation of the existing policy subject to the minor updates proposed and members' comments.

Action: Ensure issues around Audit Committee remit addressed in governance review work on standing orders.
For: Director, Corporate Governance
By: 28 March 2013

Action: Amend existing anti-fraud, bribery and corruption policy, as proposed with members' comments and publicise to staff.
For: Performance Improvement Manager
By: 31 January 2013

Action: Undertake full review of policy
For: Director, Corporate Services
By: 31 December 2013

13/15 **Item 15 - Financial Policies and processes: progress in responding to the CHRE strategic review**
AC/13/10

62 Members welcomed the progress made on improving financial policies and processes in response to the CHRE strategic review.

63 Two corrections to the paper were noted: that the independent member with financial capacity had not been appointed to Council but attended in an advisory capacity (paragraph 8.2); and that the issues in relation to financial expertise on Council needed to be addressed in the appointment process as well as in training the members of reconstituted Council.

64 The Committee noted the report.

13/16 **Item 16 - NMC assurance framework**
AC/13/11

65 Members discussed the proposals for an NMC assurance framework. This was consistent with recently published HM Treasury guidance on Assurance Frameworks (December 2012).

66 One member questioned the value added by developing a framework as it could prove a huge undertaking to cover the whole organisation. The challenge was to ensure compliance with policies and this exercise could distract from ensuring that a robust performance management framework was in place.

67 Other members considered that the assurance framework was needed and would enable the Committee to be proactive rather than reactive, as now. It should also identify areas where there was too much assurance as well as areas where there was none. The NAO considered that a framework would prove useful in enabling the NMC to provide evidence to support the Annual Governance Statement. The Chair noted that there was evidence from many directions of weaknesses in controls and gaps were being identified in an ad hoc manner: an assurance framework would enable the Committee to do its job more systematically and rigorously.

68 The Committee agreed that its update report to Council should draw attention to the importance of doing this work and that sufficient resources would be needed to undertake this.

Action: Raise the importance of developing a robust NMC assurance framework in the Committee's update to Council.
For: Director, Corporate Governance
By: 28 January 2013

The Committee adjourned at 12.35pm and went into confidential session, resuming in open session at 1.10pm.

13/17 **Item 17 - Corporate serious event policy**
AC/13/12

69 Members welcomed the development of the corporate serious event policy which had been requested for some time. It was confirmed that only incidents rated "moderate" or above (categories 3, 4 and 5) would be subject to the policy: minor or insignificant events (categories 1 and 2) would be subject to directorate reporting and learning. This could be made clearer and amended to ensure that events were reported within one working day of being assessed as serious (paragraph 12, annexe 1).

70 The Committee agreed the policy with the suggested amendments.

Action: Amend and implement the Corporate serious event policy.
For: Performance Improvement Manager
By: 14 February 2013

13/18 **Item 18 - Register of serious event reviews and data breaches**
AC/13/13

71 Members discussed the updated register at annexe 1 of the report. The Committee stressed that it was unacceptable to suggest that there was 'no organisational learning' to be gained and that in future an explanation of the reflection and learning should be provided. The following points were noted:

- A.1: all substantive actions were completed, the only outstanding action being to update the contracts database when resources were available. This could be removed from the log.
- A.3: the Committee was unclear that all recommendations had been actioned and requested a report back from Remuneration Committee.
- B.8: this should remain on the log pending confirmation that the Standard Operating procedure had been changed.
- B.16: this should remain on the log until the Committee was advised that the investigation had been completed.

72 The Committee agreed to remove all items on the register except A.3, B.8, B.16, B.17 and B.19.

Actions:
- Update register and report back to next meeting.
- Remind staff that organisational learning should be captured from each event.

For: Performance Improvement Manager
By: 8 February 2013

73 The Committee discussed the statistical report on data breaches at annexe 2. The Director, Corporate Services explained that new arrangements had been introduced for temporary staff and contractors from November 2012 which required line managers to ensure that they had read and understood data security requirements.

74 The Committee was unclear what information it could draw from the graph of incident trends at annexe 2 and asked for more information on incidents involving third party errors. It also noted that there were only 15 data breaches detailed on the register for Q3 but the statistics at annexe 2 suggested that there had been 17 incidents.

75 It was noted that the data security healthcheck was currently being undertaken by internal audit and would be reported to the next meeting.

Action: Review information on security incidents produced for Committee and provide information on incidents involving third party errors
For: Director, Corporate Services
By: 19 April 2013

13/19 **Item 19 - Procurement of internal audit service: specification, process and timetable AC/13/14**

76 The Committee noted that fundamental problems had come to light which should have been picked up over many years by effective internal audit. Good well resourced internal audit, well directed and with a strong audit plan was absolutely crucial and this needed to be reflected in the internal audit procurement.

77 It was agreed that the Committee's update to Council should highlight the need to significantly increase the resource expended on internal audit activity.

Action: Stress to Council importance of ensuring internal audit sufficiently resourced in Committee's update.
For: Director, Corporate Governance
By: 28 January 2013

78 Members considered that the content of the tender specification needed to be strengthened and needed to ensure that there was a more proactive approach. The comments which the external auditors (Kath Burton) had made earlier in the meeting on this item were noted: she had questioned whether there was a need to include financial systems given that both external auditors and the NAO had previously made clear that they placed no reliance on this. Members had made some suggestions outside the meeting to revise the award criteria and weightings and to achieve consistency across the documentation which would be taken on board.

79 It was agreed that the revised specification would be forwarded to the Chair for prior approval before issue and circulated to members once complete and that Louise Scull would represent the Committee on the tender evaluation panel.

80 It was agreed that the Committee must sign off the internal audit work programme at its next meeting.

Action: Amend the specification to reflect the points made by the Committee and arrange for Louise Scull to be a member of tender evaluation panel
For: Director Corporate Governance
By 31 January 2013

Action: Ensure draft internal audit programme submitted to the Committee for approval at next meeting.
For: Director Corporate Governance
By: 19 April 2013

13/20 **Item 20 - Whistleblowing: report on use of policy**
AC/1315

81 In response to questions, officers confirmed that there were no incidents to report since the last meeting.

82 The Director, Corporate Services advised that a review of the policy would be part of the review of HR policies to be completed by the end Q3 2013-2014.

83 The Committee noted the report.

Action: Report back on review of whistleblowing policy
For: Director, Corporate Services
By: 31 December 2013

13/21 **Item 21 - Audit Committee report to Council 31 January 2013**
AC/13/16

84 The Committee noted that the Chair had approved the report to Council on issues arising from the 11 December meeting under Chair's action. The Director, Corporate Governance reported that due to an oversight this had not been despatched with the main Council papers but would be included in the "48 hour" papers.

85 It was agreed that a written update report be provided from this meeting highlighting items discussed earlier including:

- That learning from the review of the Committee's effectiveness should be fed into the governance review (Minute 13/6).
- That Council should review the rating given to the risk of reconstituted Council not being sufficiently up to speed to make effective decisions (G37) particularly the potential implications of not having an effective Audit Committee in place to provide assurance and recommend approval of the statutory annual report and accounts(Minute 13/9).
- The need for an NMC assurance framework to help the Committee and Council to address their responsibilities effectively and that this should be properly resourced (Minute 13/16).

- That the Committee is not yet able to give Council any assurance in relation to the quality assurance (QA) work undertaken in FtP (Minute 13/11).
- That significantly higher investment needs to be made in internal audit provision to provide the level and quality of assurance Council needs (Minute 13/9).

Action: Ensure above issues included in update report to Council
For: Director, Corporate Governance
By: 28 January 2013

13/22 **Item 22 - Audit Committee: Forward Work plan**
AC/13/17

86 The Committee agreed that the following items be reinserted in the forward work plan at annexe 1 as follows:

- Review of risk management policy - three yearly
- Regular review of Standing Orders
- Private meetings between the Committee and internal and external auditors - annually
- External Audit Engagement letter - December 2013
- Resource risks to be addressed as part of Reserves policy

Action: Update the forward work plan
For: Performance Improvement manager
By: 31 January 2013

13/23 **Item 23 - Date of next meeting**

87 The Committee expressed serious concern that future meeting dates had been fixed without consultation with members. The dates should be revisited on this basis but bearing in mind the importance of achieving quoracy.

Action: Consult members on future meeting dates and ensure that in future members are consulted before meeting dates are fixed
For: Secretary
By: 31 January 2013

The meeting started at 10.30am and finished at 2pm. The Committee was in confidential session between 12.35 and 1.10pm.

SIGNATURE: **DATE:**

Ruth Sawtell
Chair, Audit Committee

Item 5
AC/13/19
19 April 2013

Audit Committee

Summary of actions

Action: For decision.

Issue: A summary of the progress on completing actions agreed by the Audit Committee on 25 January 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 25 January 2013 and outstanding from previous meetings.
- Note the evaluation of external audit effectiveness at annexe 1 completing an outstanding action from September 2012 (row 42).
- Agree that all items except those listed below can be discharged from the action list as having been progressed.
    - Items to remain on action list as set out in rows 3, 14, 23, 24, 26, 34 and 38.
- Consider the outstanding work which will need to be carried forward to reconstituted Council under item 24 on the agenda.

Annexes: Annexe 1 : Evaluation of External Auditors

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
Lindsey.mallors@nmc-uk.org

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

Row	Minute	Action	For	By	Progress to date
1	13/5	**Action list** Update and correct action list.	Secretary to the Committee.	31 January 2013	Completed
2	13/5/7	**Scrutiny of Remuneration Committee decisions** Remuneration Committee to report back on arrangements for Audit Committee scrutiny of its decisions	Director, Corporate Services	19 April 2013	The Remuneration Committee considered a report on 26 February 2013 and noted the proposed mechanism for Audit Committee scrutiny of Remuneration Committee decisions on special payments in future.
3	**13/5/7**	**NMC Scheme of Delegation** Update Audit Committee on Council's consideration of changes to Scheme of Delegation	Director, Corporate Governance	19 April 2013	Council has not considered the scheme of delegation since the last Audit Committee meeting. This will be taken forward as part of the wider governance review.
4	13/6/12	**Audit Committee effectiveness** Ensure learning from the Audit Committee's review of its effectiveness is reported to Council for consideration as part of the governance review.	Director, Corporate Governance	28 January 2013	Included in Audit Committee update report to Council on 31 January 2013 (NMC/13/16) and endorsed by Council (see minute NMC/13/20/3)
5	13/6/12	**Audit Committee effectiveness** Send letters of appointment to new	Director, Corporate Governance	1 February 2013	Completed.

Row	Minute	Action	For	By	Progress to date
		Audit Committee members			
6	13/6/15	**Audit Committee effectiveness** **Review of draft accounts** Draft statutory accounts to be circulated to Audit Committee members for comment at the same time as submission to external auditors.	Director, Corporate Services.	29 April 2013	The draft statutory accounts will be ready to go to the external auditors on 29 April and will be sent to Audit Committee members at the same time.
7	13/7/20	**External review of the Integrity of WISER and CMS** Add review recommendations to internal audit log.	Performance Improvement Manager	31 January 2013	Completed All the recommendations have been added to the outstanding recommendations log - see separate agenda item.
8	13/7/20	**External review of the Integrity of WISER and CMS** Report progress on implementation of recommendations to the next Audit Committee meeting.	Director, Fitness to Practise	19 April 2013	Completed All the recommendations have been added to the outstanding recommendations log - see separate agenda item.
9	13/7/20	**External review of the Integrity of WISER and CMS** Ensure outcome of review included in Audit Committee's Annual Report	Director, Corporate Governance	31 March 2013	Completed See separate agenda items on the draft Annual Governance Statement and the draft Annual Report of the Audit Committee to

Row	Minute	Action	For	By	Progress to date
		to Council 2012-2013 and Annual Governance Statement 2012-2013 Add review to Audit Committee's forward work plan for 2013-2014 and internal audit work programme			Council. See the separate agenda items on the Committee's forward work plan and draft internal audit work programme.
10	13/8/22	**Risk Management** Amend risk management framework to address risk of fraud and produce final version for the next meeting.	Director, Corporate Governance	28 February 2013	Completed - see separate agenda item
11	13/8/22	**Risk Management** Incorporate short guide and flowchart into the revised framework; introduce revised risk register format; implement training in accordance with timetable.	Director, Corporate Governance	1 May 2013	Completed - see separate agenda item.
12	13/9/27	**Risk register** Committee's update report to Council to raise the risk of reconstituted Council not being able to take effective decisions, including the risk of the Audit Committee being unable to fulfil its role in relation to the statutory annual	Director, Corporate Governance	28 January 2013	Included in Audit Committee's update report to Council (NMC/13/16) on 31 January 2013 and considered by Council (see Council minutes 13/07 3 & 4)

Row	Minute	Action	For	By	Progress to date
		report and accounts.			
13	13/9/34	**Risk register** Review description of risk on increasing pension liabilities.	Director, Corporate Services	31 January 2013	Completed
14	13/9/34	**Risk Register** Report back to Audit Committee on Council's decision about where responsibility rests for monitoring Equality and Diversity issues.	Director, Corporate Governance.	19 April 2013	Included in Audit Committee report to Council on 31 January 2013 (NMC/13/16). Council asked for a report on Equality and Diversity issues to be provided to April meeting (Council minute 13/20/1 & 2) At its meeting on 22 March 2013, Council decided to defer this item until reconstituted Council is in place (See Council minute NMC/13/65)
15	13/9/34	**Risk Register** Ensure Committee only receives open register in future and that register is produced single-sided.	Director, Corporate Governance.	19 April 2013	Completed - see risk register agenda item
16	13/11/43	**Quality Assurance** Notify Committee when date set for Assistant Director, Quality Assurance and Risk Audit to take up post.	Director, Corporate Governance.	31 January 2013	Completed: Committee members notified by email on 25 February 2013.

Row	Minute	Action	For	By	Progress to date
17	13/11/43	**FtP Quality Assurance** Advise Council that as yet the Committee had received no assurance in respect of FTP quality assurance.	Director, Corporate Governance.	28 January 2013	Included in Audit Committee's update report to Council (NMC/13/16) on 31 January 2013
18	13/12/51	**Outstanding Internal Audit Recommendations** Clarify the position on recommendation 9: proactive maintenance of registrants addresses. Identify the reasons for recommendation 14: automated workflow monitoring and provide a full explanation to the next meeting.	Director, Registrations.	19 April 2013	See discussion of these issues in agenda item 10.
19	13/12/53	**Outstanding Internal Audit Recommendations** Report to next meeting on how spirit of FTP QA recommendations at AC/13/8, Annexe 1, rows 27 and 28 being addressed.	Director, Fitness to practise.	19 April 2013	This is addressed in the separate agenda item on FTP Quality Assurance.
20	13/12/55	**Internal Audit Recommendations** Ensure that:	All Directors	Immediate	Directors reminded in writing on 22 March 2013 and discussed by Directors Group on 2 April 2013.

Row	Minute	Action	For	By	Progress to date
		• A formal management response is always made to internal audit recommendations. • Management explains to Audit Committee its reasons for not accepting a recommendation.			
21	13/12/55	**Outstanding Internal Audit Recommendations** • Amend log to remove recommendations at AC/12/8, Annexe 1, row 3 (deleting risks from the risk register) and row 12 (Academic partner risk). • Report only outstanding recommendations past target date in future	Performance improvement Manager	31 January 2013	Completed - see agenda item containing revised log of outstanding recommendations
22	13/13/58	**Registrations: Incident investigation report August 2011** Treat the original NMC incident investigation report recommendations as internal audit recommendations and provide a full	Director, Registrations	28 February 2013	Completed. See separate agenda item 10 section 2.

Row	Minute	Action	For	By	Progress to date
		management response to each one.			
23	13/13/58	**Corporate assurance** Develop proposals to ensure that all internal control and assurance reports are directed to Corporate Governance and reported to Audit Committee.	Director, Corporate Governance	26 March 2013	Directors reminded in writing on 22 March 2013 and discussed at Directors Group 2/4/13 Proposals to address this more formally to be developed as part of the comprehensive review of the governance framework documentation following reconstitution of Council.
24	13/14/61	**Corporate assurance** Ensure issues around Audit Committee remit addressed in governance review work on standing orders.	Director, Corporate Governance	26 March 2013	Proposals to address this more formally to be developed as part of the comprehensive review of the governance framework documentation following reconstitution of Council.
25	13/14/61	**Anti-fraud, bribery and corruption policy** Amend existing anti-fraud, bribery and corruption policy, as proposed with members' comments and publicise to staff.	Performance Improvement Manager	31 January 2013	Completed Directors reminded of the policy 22 March 2013 and revised policy published to staff on i-net.

Row	Minute	Action	For	By	Progress to date
26	13/14/61	**Anti-fraud, bribery and corruption policy** Undertake full review of policy.	Director, Corporate Services	31 December 2013	Not yet due
27	13/16/68	**Assurance Framework** Raise the importance of developing a robust NMC assurance framework in the Committee's update to Council.	Director, Corporate Governance	28 January 2013	Included in Audit Committee's update report to Council (NMC/13/16) on 31 January 2013 Council endorsed the Committee's view (Council minute NMC/13/20/3) There is also a separate item to update the Committee on this agenda
28	13/17/61	**Corporate serious event policy** Amend and implement the Corporate serious event policy.	Performance improvement Manager	14 February 2013	Partially completed. The policy has been amended as requested by the Committee and been applied to all events reported since January 2013. This has highlighted various issues to be resolved before training is rolled out to all staff. See separate report on the agenda.
29	13/18/72	**Corporate register of serious events and data breaches** • Update register and report back	Performance Improvement Manager	8 February 2013	Updated register on agenda for this meeting

Row	Minute	Action	For	By	Progress to date
		to next meeting. • Remind staff that organisational learning should be captured from each event.			
30	13/18/75	**Corporate register of serious events and data breaches** Review information on security incidents produced for Committee and provide information on incidents involving third party errors.	Director, Corporate Services.	19 April 2013	Partially completed. See separate agenda items on serious events and information security. Further work is being done to identify the data and KPIs to be reported to Directors Group, Audit Committee and Council.
31	13/19/77	**Procurement of internal audit service** Stress to Council importance of ensuring internal audit sufficiently resourced in Committee's update.	Director, Corporate Governance	28 January 2013	Included in Audit Committee's update report to Council (NMC/13/16) on 31 January 2013 Council endorsed the Committee's view (Council minute NMC/13/20/2)
32	13/19/80	**Procurement of internal audit service** Amend the specification to reflect the points made by the Committee and arrange for Louise Scull to be a	Director, Corporate Governance	31 January 2013	The specification for future internal audit services was amended as requested by the Committee. The final content of the specification was approved by the Chair of the Committee on 30 January 2013. The revised specification was included in the final

Row	Minute	Action	For	By	Progress to date
		member of tender evaluation panel.			tender documentation issued on 31 January 2013. Louise Scull was a member of the tender evaluation panel.
33	13/19/80	**Internal Audit Work Programme for 2013-2014** Ensure draft internal audit programme submitted to the Committee for approval at next meeting.	Director, Corporate Governance	19 April 2013	This is on the agenda for this meeting.
34	13/20/83	**Whistleblowing policy** Report back to Audit Committee on review of whistleblowing policy.	Director, Corporate Services.	31 December 2013	Not yet due
35	13/21/85	**Audit Committee Report to Council January 2013** Ensure above issues included in update report to Council.	Director, Corporate Governance	28 January 2013	Included in Audit Committee's update report to Council (NMC/13/16) on 31 January 2013
36	13/22/86	**Audit Committee Forward Work Plan**	Performance Improvement manager	31 January 2013	Completed - see separate agenda item

Row	Minute	Action	For	By	Progress to date
		Update the forward work plan.			
37	13/23/87	**Future Audit Committee meetings** Consult members on future meetings dates and ensure that in future members are consulted before meeting dates are fixed.	Secretary	31 January 2013	Completed - this meeting was moved from 17 to 19 April 2013 Future meeting dates will be proposed to Committee members to check their availability prior to fixing the dates.

Outstanding actions from 11 December 2012 meeting

Row	Minute	Action	For	By	Progress to date
38	12/112	**Accounting Policies** Adjust accounting policies as set out in annexe 3 to AC/12/79 to reflect changed depreciation periods of 3 to 5 years for Equipment and IT projects Consider adjustment of limit for capitalising tangible fixed assets	Director of Corporate Services Director of Corporate Services	31 March 2013 31 March 2013	This will be reflected in the year end accounts to 31 March 2013. A draft of the accounts will be sent to Committee members on 29 April. This has been considered. It has been decided to retain the current limit for 2012-2013 as this is consistent with practice across the majority of healthcare regulators. However, this will be kept under annual review.

Row	Minute	Action	For	By	Progress to date
39	12/118	**Information security assurance** Add information security assurance as a standing item on the Committee's agenda.	Secretary to the Committee	25 January 2013/19 April 2013	Added to Audit Committee work plan as standing item. Included on agenda for this meeting
40	12/118	**Committee administration** Ensure reports set out clearly the action being requested of the Committee.	Secretary to the Committee	25 January 2013	The Council Services team consider that the current report templates meet this aim, and have introduced a new QA process to check that ensures reports comply with the template.
41	12/118	**Information Security: Annual Governance Statement** Include agreed statement on information security in the Annual Governance Statement for the Annual Report 2012-2013	Director of Corporate Governance	19 April 2013	Draft Annual Governance Statement on agenda for consideration at April 2013 meeting.
42	12/118	**Information security** Incorporate information security into annual internal audit work programme from 2013-2014.	Director of Corporate Governance	19 April 2013	Added to provisional draft Internal Audit work programme for 2013 – 2014 - see separate item on this agenda.
43	12/118	**Information security**	Director of Corporate Services	19 April 2013	Completed - see separate agenda report on serious events.

Row	Minute	Action	For	By	Progress to date
		Produce report for April 2013 meeting addressing Committee's query as to whether the Committee was informed of all data security incidents or only those categorised above a certain level.			

Outstanding actions from 10 September 2012 meeting

Row	Minute	Action	For	By	Progress to date
44	12/82 15	**Internal audit work programme: finance issues** Internal audit to follow up on items in the external auditors' management letter in 6 months	Director of Corporate Governance	19 April 2013	Not Included in draft Internal Audit work programme as reviewed by external auditors - see Finance Update report on agenda.
45	12/93	**External Audit** Complete review of effectiveness of external audit.	Director of Corporate Governance, Audit Committee members	11 December 2012	Agreed with the Chair (12 November 2012) that due to pressure on December agenda, review of effectiveness of external auditors to be collated and circulated outside of meeting. Survey circulated December 2012 and all responses received by 31 January 2013. Evaluation report produced and sent to Committee members on 25 February 2013 and attached as Annexe 1 to this report.

Row	Minute	Action	For	By	Progress to date
46	12/68, 24.1	**Internal audit work programme** To ensure the audits are scheduled early on in the year.	Assistant Director, Governance Now for Director of Corporate Governance	10 September 2012	A discussion papers on the internal audit programme for 2013-2014 is included on agenda. Timing of the work programme has been affected by the procurement of new internal audit service.

Outstanding actions from Council for the Committee

Minute	Action	For	Report back to: Date:	Progress
12/169 47	Report on learning (from SERs, data breaches, complaints, FOIs and litigation) with single policy and template developed	Director of Corporate Governance	Audit Committee 19 April 2013	The policy was agreed by Audit Committee in January 2013 and reported to Council on 31 January 2013.
13/12c (Council – confidential session) 48	Add 'Process for systematic review of policies' to the April 2013 Audit Committee agenda	Secretary to the Audit Committee	Audit Committee 19 April 2013	Completed - see separate agenda item.

Item 5
AC/13/19 Annexe 1
19 April 2013

Evaluation of external auditors

1 An evaluation of the provision by external auditors was undertaken by members of the Audit Committee in January 2013. All distributed forms were completed and returned by members of the Audit Committee (four in total).

2 The evaluation tool used was the KPMG 'Checklist-Evaluating the external auditor' (KPMG, 2003).[1] This is specifically designed for audit committees, offering a framework against which the effectiveness and efficiency of external auditors can be assessed.

3 The checklist offers a series of questions under seven headings. Interestingly, there is no rating scale for respondents to complete against each question and it is unclear if quantitative or qualitative data is being sought.

4 The four respondents all ticked the one box aligned to each statement when they appeared to agree with the statement. All respondents annotated additional short comments where they were unable to answer or wanted to make a relevant point around a statement.

5 For the purpose of analysis, all responses were read, variations in views noted and then these were collated using each of the seven headings, as below:

Calibre of external audit firm

6 All respondents indicate satisfaction with the calibre and reputation of the external auditors.

Quality processes

7 Two of the respondents did not answer this subset of questions due to lack of knowledge. The other two respondents indicate satisfaction with these processes.

Audit team

8 Whilst all respondents agree with three of the four questions in this section, the fourth question relating to succession planning, audit partner rotation and facilitation of continued objectivity is indicated as an area for further consideration.

[1] KPMG (2003) Checklist – Evaluating the external auditor. Audit Committee Institute [online] Available from: http://www.kpmg.co.uk/aci/docs/205054.pdf (accessed 12/02/13)

Audit scope

9 Overall, all four respondents agree that the scope of audit is appropriate. Questions five and six in this section are agreed as not applicable. One respondent comments that specialist input into audit is less evident.

Audit fee

10 The reasonableness of the fee is generally agreed, with one respondent comparing it favourably with HCPC.

Audit communications

11 There is general agreement that communication is satisfactory with the external auditors in respect of advice, discussions and frequency of meetings, but two respondents identify that the auditors do not have formal arrangements in place for seeking feedback from the NMC on the provision of their services.

Audit governance and independence

12 There was agreement that the Audit Committee's oversight of external audit work is appropriately managed and within the governance framework.

Conclusions:

13 The evaluation indicates that the respondents have confidence in the external auditors and their ability to deliver effective and efficient services.

14 Where respondents feel less able to respond to a question, this is generally indicated as being due to lack of exposure to the area being assessed.

15 Two issues for development are indicated:

15.1 The processes for succession planning by external auditors

15.2 Arrangements for encouraging external auditors to put in place a process for seeking NMC feedback .

16 It is recommended that the KPMG tool used here is revised prior to any future use, to enable it to be offered as an online survey and to include a rating tool for ease of response and data analysis.

Further information

Stephanie Aiken
Research and Evidence Manager
Corporate Governance
020 7681 5654
Stephanie.aiken@nmc-uk.org

Item 6
AC/13/20
19 April 2013

Audit Committee

Risk management framework

Action: For information.

Issue: This paper presents the final versions of the refreshed NMC risk management framework and toolkit.

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 Council is recommended to:

- Approve the risk management framework (paragraph 5).
- Approve the risk management toolkit (paragraph 7).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Risk management framework.
- Annexe 2: Risk management toolkit.

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.

Author: Mary Anne Poxton
Phone: 020 7681 5440
maryanne.poxton@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 At its meeting on 11 December 2012 the Audit Committee agreed a revised risk management policy, framework and toolkit, subject to the inclusion of some additional definitions and further work to clarify roles and responsibilities.

2 At its January 2013 meeting the Audit Committee agreed the incorporation of a short guide on risk management roles and responsibilities, a flow chart showing the risk management process and revised risk register format.

3 Also at its January 2013 meeting, the Audit Committee agreed that the risk management framework be amended to address the risk of fraud and that the final versions of the documentation be brought back to its April 2013 meeting.

4 Whilst developing the training programme for the revised risk management approach, the need for some further changes to the documentation has been identified.

5 As it is the intention that Council will set the risk appetite for the organisation, all references to teams being able to set their own risk appetites have been removed.

6 In addition, reference to reviewing red risks every three months and amber risks every six months has been removed. This was misleading as directorate and programme/project risk registers will be reviewed every month and Directors Group will continue to review the corporate risk register every month.

Discussion:

Risk management framework

7 The following amendments have been made to the risk management framework:

7.1 The simplified guide to roles and responsibilities has been incorporated in the text (pages 1, 2 and 3).

7.2 Reference to each team being allowed to set its own risk appetite has been removed (page 5).

7.3 The requirement for Directors Group, directorate management teams and programme/project teams to ensure that risk management is ‘on their agenda regularly’ has been changed to a requirement that they ensure that risk management is ‘on their agenda at least once a month’ (page 6). This is in line with the risk management process flow diagram which shows that all risk registers will be reviewed at least monthly.

7.4 Reference to reviewing red risks every three months and amber risks every six months has been removed in the light of

7.3 above (page 6).

7.5 Definitions of ‘significant’ and ‘intolerable’ risks have been added to the glossary (page 9).

7.6 The definition of risk appetite in the glossary has been amended to reflect 7.2 above (page 9).

7.7 The flow chart and revised risk register format have been added (pages 11 and 12).

8 **Recommendation:** The Audit Committee is recommended to approve the amended risk management framework.

Risk management toolkit

9 The following amendments have been made to the risk management toolkit:

9.1 The pie chart showing categories of risk has been amended to include fraud (page 6).

9.2 Examples of risks falling into the category of fraud have been included in the relevant table (page 7).

9.3 A reference to the NMC’s Anti-Fraud, Bribery and Corruption Policy has been included in the toolkit (page 7).

9.4 Reference to team risk appetite has been removed (page 12).

9.5 The definition of risk appetite in the glossary has been amended to reflect 9.4 above (page 23).

9.6 A definition of fraud has been added to the glossary (page 23).

10 **Recommendation:** The Audit Committee is recommended to approve the revised risk management toolkit.

Public protection implications:

11 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:

12 There are resource implications in terms of staff time to implement and embed the new approach. Training sessions for directors, assistant directors and managers will be provided the Assistant Director, Governance and Planning and the Assistant Director, Quality Assurance and Risk Audit.

Equality and diversity implications:	13	An Equality Impact screening will be carried out by the time the Audit Committee meets on 19 April 2013.
Stakeholder engagement:	14	Members of the Council and the Audit Committee have been involved in the development of the new risk management framework through a workshop held on 27 September 2012 and a subsequent Council seminar session.
	15	Training sessions are in the process of being scheduled for staff.
Risk implications:	16	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 risk register (risk G6).
Legal implications:	17	None.

Item 6
AC/13/20 Annexe 1
19 April 2013

Risk management framework

Introduction

1 Our methodology for managing risk is set out in our Toolkit. This Framework sets out our roles and responsibilities for managing risk.

2 The NMC recognises that all members and staff need to have regard for risk in carrying out their duties. Staff have a particular duty to identify and to manage the risks that they encounter on a day-to-day basis, and for reporting these to their managers as appropriate.

3 Risk awareness and risk management are key parts of a consistent organisation and leadership culture that motivates people and teams to achieve the best possible outcomes.

4 Ultimately, risks are borne by the NMC on behalf of the public, registrants and staff. In this sense, risk management needs to operate within a framework of delegation just like other matters. No one individual or group is empowered to carry high risk without explicitly having the authority to do so.

Roles and responsibilities

5 Roles and responsibilities are illustrated in the flow chart at Annexe A.

6 As a corporate statutory body and registered charity, ultimately responsibility for risk management rests with the Council. Council members' involvement is essential, particularly in setting the parameters of the process and reviewing and considering the results.

7 This does not mean that Council members must undertake each aspect of the risk management process themselves. Much of the day to day work on identifying and managing risk can be delegated to staff. Council's level of involvement should be such that members can make the required declaration in the Annual Governance Statement with reasonable confidence and be satisfied that the important risks faced by the organisation are being managed properly with appropriate mitigating actions in place.

Key accountabilities

8 There are five main levels of accountability for risk management at the NMC:

8.1 Council, as the corporate body, is responsible for setting the strategic risk appetite and for ensuring that risks are identified and managed.

8.2 The Audit Committee is responsible for ensuring that the processes and procedures are robust and operate effectively.

8.3 The Chief Executive and Directors Group are accountable for the corporate risk register.

8.4 Individual directors and their staff are responsible for identifying and managing risks in their areas of responsibility.

8.5 Sponsors of programmes and projects are responsible for identifying and managing risks in their areas of responsibility.

Council

9 The members are jointly responsible for risk management. They need to maintain a high level strategic approach. Their responsibilities should be threefold:

9.1 To satisfy themselves that there are robust and proportionate processes in place to manage risk at all levels in the organisation. In achieving this, the Council should expect to rely on advice from the Audit Committee.

9.2 To set the organisation's risk appetite. They do this by defining the key strategic risks and deciding on the level of risk they are prepared to tolerate in relation to each of these strategic risks. Council should review the strategic risks and set the risk appetite every six months.

9.3 To review and monitor the highest level risks as reflected on the corporate risk register on a regular basis, including the impact of the mitigating actions. The Council should review the corporate risk register at every Council meeting.

Audit Committee

10 The Audit Committee plays a crucial role in satisfying the Council that risks are being managed appropriately and effectively. The Committee does this through:

10.1 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.

10.2 Undertaking detailed scrutiny of the application of the 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.

10.3 Reporting the outcome of the Committee's scrutiny under 10.1 and 10.2 to the Council on a quarterly basis.

Chief Executive and directors

11 The Chief Executive and Directors Group are accountable for the corporate risk register. These are the most serious risks to the organisation. The corporate risk register comprises those risks which have been assessed to be red risks in the individual directorate risk registers and corporate programme and project risk registers together with any additional risks identified by the Directors Group.

12 Directors Group is responsible for managing these risks and ensuring that effective and proportionate mitigation is in place. Directors will be expected to

challenge assumptions and it is important that they are satisfied that the stated mitigation is actually in place. The Chief Executive is responsible for reporting on the corporate risk register to Council.

Individual directors

13 Each director must maintain a risk register covering the risks relating to their directorate's work, using the format of the corporate risk register. The director must consider the risk register with their managers on a monthly basis at least. They must also ensure that all staff are alert to risk, aware of the mechanism for escalating risks and are encouraged to do so as a matter of course.

14 Any risks identified as red risks within a directorate risk register must be escalated to the corporate risk register immediately.

Programme and projects sponsors

15 Sponsors are responsible for ensuring that risks are managed for all programmes and projects for which they are accountable. As with directorate risks, these must be reflected on a risk register using the format of the corporate risk register and reviewed on a monthly basis. This will normally be done by the Programme or Project Manager. Again any red risks identified must be escalated to the corporate risk register immediately.

16 There are of course much wider roles and responsibilities within the organisation for managing risk. These include:

16.1 **All staff**

- Comply with the Policy, Methodology and Framework.
- Act as Risk Owner and/or Risk Sponsor where assigned.
- Be alert to significant risks facing the NMC that may not have been recognised and raise them with appropriate officers or, by exception, with the Audit Committee.

16.2 **Internal audit**

- Provides an objective opinion on risk management arrangements and their effectiveness in practice.
- Undertakes checks on risk management and control activity as part of its audits.
- Ensures unidentified risks and control and other weaknesses revealed through its audits are addressed.

16.3 **Contractors and partners**

- Declare risk management policies and methodologies (for example, at pre-qualification stage).
- Maintain strong risk management principles and measures.

- Provide required evidence of application of principles and procedures.
- Provide appropriate access to premises, records and personnel to NMC staff and auditors.
- Cover the NMC's losses from agreed risks.

Risk maps, risk registers and risk action plans (RAPs)

17 The format for the corporate risk register is attached at Annexe B.

18 Risk maps (the completed risk matrix at any one time) and underpinning risk registers are the framework for documenting all aspects of the NMC's risk management cycle.

19 As well as an up-to-date risk map, risk registers must contain, or link to, for each risk:

- Unique risk identification number.
- Date of origin of risk.
- Risk scenario (root cause, potential situation and consequences).
- Current mitigation / planned action on the risk.
- Risk likelihood score.
- Risk impact score.
- Combined risk score.
- Risk action plan (RAP) on intolerable risks (showing any review and escalation processes).
- Risk owner (and risk sponsor where appropriate).
- Dates updated, to give a management trail for movements on and changes to the risk and its re-assessments since origin.
- Risk status (whether open or closed and, if open and red or amber, status against key dates or milestones, critical success factors, targets and performance indicators included in RAPs).
- Direction of travel of the risk (no change, increasing or reducing).

20 Risk registers should also record, at the bottom, 'emerging risks'. These are possible risks that will arise in future (for example, from possible policy or other changes) where not enough is yet known about the risk, or about the cause, to frame and map it properly. Once sufficient is known about the risk, it can be framed properly and included on the risk register and risk map.

21 A template risk map and risk register is available for completion, as is a template risk action plan. Risk action plans and other documents can be embedded into the risk register if appropriate.

22 Risk maps and risk registers must be kept:

- At the corporate level, by the Directors Group.
- At directorate level, by directors.
- At corporate programme and project level, by programme and project teams.

Risk appetite

23 Risk appetite is defined and set by Council. HM Treasury Orange Book defines risk appetite as *'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.'*

24 Risk appetite is not a magic number. It is dependent upon the aims of the business and the risks that have to be taken to achieve those aims. Providing guidance on the acceptable level of risk considered appropriate for all areas of operational delivery and individual programmes and projects is therefore a role for Council.

25 In practice, risk appetite means that no-one is empowered to tolerate risks that the NMC deems intolerable and must take prompt action to make them tolerable.

26 The Council's risk appetite results from a periodic decision made on the amount of risk that the Council is willing to tolerate, or accept, at any one time. The appetite determines which of three bands each risk falls into: red (high), amber (medium), or green (low):

- **Red risks** – are not tolerable, and will need immediate management action.
- **Amber risks** – are also not tolerable although management action is less time critical than red risks.
- **Green risks** – are currently tolerable (often as a result of existing action on them) and do not require specific extra action (although attention may be given to them to ensure they are not being over-managed thereby tying up resources that could be better employed).

27 In essence, this means that 'red' and 'amber' risks fall outside the risk appetite and so are intolerable, requiring specific management action and attention.

Risk Owners and Risk Sponsors

28 Each risk should be assigned a Risk Owner. This should ideally happen prior to risk assessment but must be assigned for risk planning on intolerable (red and amber) risks. A Risk Owner is responsible for determining and taking action to manage each risk.

29 If the Risk Owner is not a member of the team maintaining the risk register and/or cannot commit resources to manage the risk, a Risk Sponsor should be assigned.

Risk Owner

30 The concept of 'Risk Owner' is designed to build accountability for risk management and relates to the person who is charged with determining appropriate action to manage the risk to tolerable levels (generally to green status), within an acceptable timeframe, and who will be held to account for both taking that action and its effectiveness in managing the risk.

Risk Sponsor

31 The concept of 'Risk Sponsor' is also designed to build accountability for risk management and is introduced where the 'Risk Owner' is not a member of the

team maintaining the risk register and/or cannot commit resources to manage the risk. The Risk Sponsor will not actually take the action to address the risk, as that will be assigned to another individual or team. He or she is, however, the one who is held to account formally for managing the risk and reporting on the status of action.

32 The Risk Sponsor provides the interface between risk ownership and delivery. The Risk Sponsor acts as a single focal point of contact with the Risk Owner for the day-to-day management of the risk in the interests of the organisation. The Risk Sponsor is responsible for ongoing management of the Risk Owner to ensure that the desired risk management objectives are delivered. The person in this role must have adequate knowledge and information about the organisation and the risk to be able to make informed decisions.

33 It is envisaged that the Risk Sponsor will present to the appropriate management team and/or Directors Group (and any other body as appropriate, for example Council or the Audit Committee), with the Risk Owner as appropriate, on:

- The proposed action plan (including timelines, critical success factors and performance indicators for managing the risk).

- Progress against the agreed action plan at predetermined milestone points.

Regular monitoring and review

34 Directors Group, directorate management teams and corporate programme / project teams will need to ensure that risk management is on their agenda at least once a month. There also needs to be a facility for reporting risks by exception at any time.

Ensuring risk management is dynamic

35 Risk management is a dynamic process, and risk registers and risk maps should be viewed as living documents.

36 There are six key ways to keep registers dynamic:

- **Management of intolerable risks** – whereby risks naturally get demoted down the risk map as part of regular monitoring as actions on red and amber risks take effect in reducing risk.
- **New risks** – whereby obvious new risks are identified as part of regular monitoring.
- **Risk escalation** – whereby high risks from lower levels in the organisation are escalated to higher levels for ranking and corporate attention, where warranted
- **Risk relegation** – whereby risks fall off the radar after a period of time (but not necessarily off the radar of lower level management teams).
- **Risk re-assessment** – whereby existing risks are re-assessed to ensure they are elevated or relegated as appropriate as the situation changes.
- **Zero based review** – whereby a new exercise is undertaken periodically to challenge assumptions.

Intolerable risks

37 As the point of planning to manage, and managing, intolerable (red and amber) risks is to reduce risk, and regular monitoring processes will be identifying success in so doing, risks will naturally move down the risk map.

38 It is essential that there is tangible evidence of success in managing the risk before it is demoted in status.

New risks

39 Obvious new risks will be identified as part of regular monitoring as team members will identify circumstances leading to risk (for example, if policy and strategy direction change markedly or if there are significant internal or external changes such as environmental or social changes, new technology, new business processes, significant staff changes, or changes to or within partners, contractors and suppliers).

Risk escalation

40 The risk appetite also means that intolerable risks at one level should be escalated to those higher up in the organisation (for example, from directorate level to be considered for inclusion on the corporate risk register by Directors Group).

41 In practice, ***only red risks need to be escalated***.

42 However, managers will be held to account for their judgments on risk and, if in doubt, should seek advice and peer review of their assessments.

Risk relegation

43 If risks remain on the risk register indefinitely, the risk map will become cluttered which will detract from its usefulness as a management tool.

44 It is therefore recommended that risks ‘fall off’ the register if they remain green for one year or at the annual re-assessment (see below), whichever is greater.

45 However, it is expected that each risk ‘falling off’ a higher level register will be relegated to a risk register lower down the hierarchy unless the risk is clearly no longer relevant.

Risk re-assessment

46 Risks on the risk register will need to be re-assessed to ensure they are elevated up the risk profile, or relegated as appropriate, as the situation changes. Whilst this should happen automatically for red and amber risks as the management team calls them in for progress reports on management action, it will not happen for green risks. The likelihood and impact of these risks may alter in response to internal and external stimuli.

47 Accordingly, it is proposed that an annual re-ranking exercise is undertaken for green risks unless escalation processes suggest a need for more immediate re-ranking.

48 Questions that may be helpful during the review process on green risks include:

- Does the risk still exist and, if so, is it still as written or have there been changes that affect the risk?
- Are the existing actions still being applied and are they effective?
- Has anything happened to alter either the likelihood or the impact of the risk?

Zero based review

49 Over time, there is a danger that the risk register becomes detached from reality as it responds to the risks already on it and those escalated or relegated to it from others. Therefore it is recommended that a new exercise is undertaken periodically to ensure that the risk register remains up-to-date. It is recommended that such an exercise is undertaken say once every three years unless circumstances dictate that it should be earlier (for example, if policy and strategy direction change markedly or if there are significant internal or external changes such as environmental or social changes, new technology, new business processes, significant staff changes, or changes to or within partners, contractors and suppliers).

Risk challenge

50 As this Framework makes clear, risks are taken on behalf of, and in the name of, the NMC. Processes and judgments therefore need to be evidenced and subject to appropriate challenge and scrutiny. Annex 5 of the Risk Management Toolkit sets out a series of questions that risk challengers may ask on particular risks.

51 The Council, Audit Committee, Directors Group, directors and auditors all have a role to play in ensuring the adequacy and effectiveness of risk management. Transparency and consistency are key to gaining assurance on risk management arrangements as a whole. Compliance with this Policy, Methodology and Framework should ensure effectiveness.

Glossary

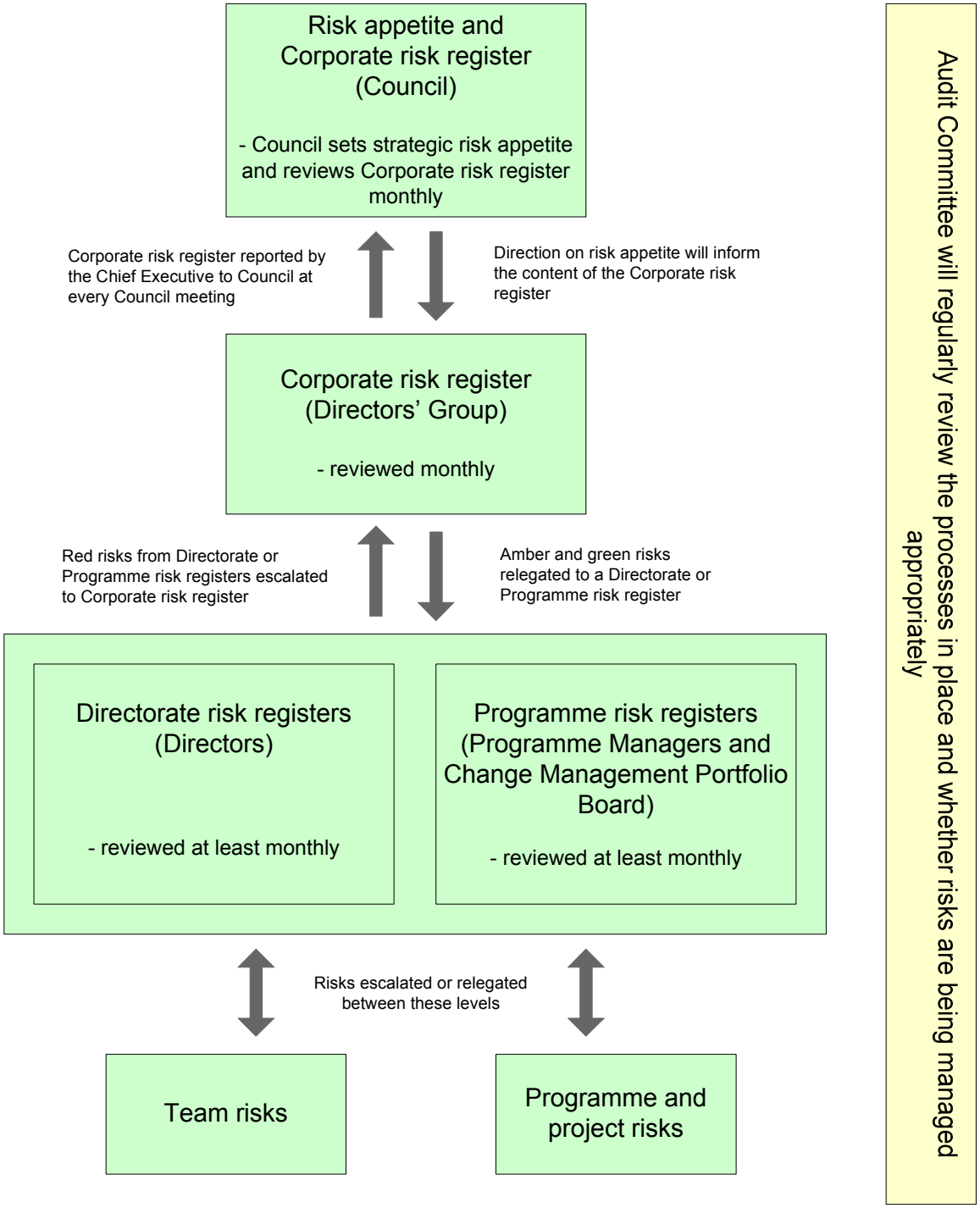
Business continuity management	A holistic and systematic process for the identification and assessment of, and preparation for, events or incidents (whether local, regional or national) that could threaten an organisation and its ability to fulfil its business objectives.
Consequence	The part of the risk that describes the possible effects if the potential situation were to arise.
Issue	A concern that either cannot be avoided, or is already happening. Issue refers to a known outcome, whereas risk refers to an outcome that might or might not actually materialise.
Impact	The assessment of the cumulative impact of the possible effects.
Intolerable risk	A red or amber risk which requires management attention or action to reduce the level of risk to green.
Likelihood	The assessment of the likelihood of the 'potential situation' arising.
Inherent risk	The threat arising from any one specific risk, prior to any management action having been taken.
Operational risk	Risks associated with the day-to-day working of the organisation.
Potential situation	The part of the risk that describes what may arise given the root cause.
Residual risk	The threat arising from any one specific risk, after management action has been taken.
Risk	The likelihood that a potential situation may arise leading to consequences which may impact adversely on our ability to achieve our objectives or carry out our functions. Needs to be split into its constituent parts of root cause, potential situation and consequences.
Risk appetite	The amount of risk which the Council is willing to tolerate, or accept, at any one time.
Risk management	A systematic process for the identification, assessment, planning, managing and monitoring of risks, in a cost effective manner.
Risk map	The completed risk matrix at any particular point in time, showing the red, green and amber risks.

Risk register	The framework for documenting each aspect of the risk management cycle.
Risk scenario	The risk divided into its constituent parts of Root Cause, Potential Situation and Consequences.
Risk score	The classification given to a risk based on its likelihood of occurring and its impact if it does.
Root cause	The part of the risk that describes where the risk exposure originates from, i.e. a situation that is true or widely held to be true, that gives rise to a risk exposure.
Significant risk	A risk that poses a key threat to achieving objectives or that threatens our assets, activities and/or people.
Strategic risk	Risks associated with threat or damage to the achievement of the NMC's objectives.
Target risk score	The risk score that the Risk Sponsor and/or Risk Owner would like to achieve, following successful implementation of risk management actions.

Item 6
AC/13/20 Annexe 1
19 April 2013

Annexe A

Risk management process and ownership of NMC risk register



Item 6
AC/13/20 Annexe 1
19 April 2013

Annexe B

Risk register template

Team Name:			Date:													
			Issue No: 1													
No.	**Date of Origin**	**Risk Scenario**			**Current risk scoring**			**Mitigation in place / Planned action**	**Post-mitigation scoring**			**Risk Owner and Sponsor**	**Dates up-dated**	**Status**	**Direction**
		Root Cause	**Potential Situation**	**Consequences**	**Like-lihood**	**Impact**	**Score**		**Like-lihood**	**Impact**	**Score**				
1	2012	**Managerial / Professional:** Staff from the department are being involved in corporate projects and there is no spare capacity to backfill.	Capacity falls below the level necessary to provide the service.	• Adverse effect on morale • Stress and absenteeism • Failure to achieve agreed objectives • Failure to deliver statutory services • Complaints /claims/ litigation • Adverse effect on performance • Censure by audit / inspection • Adverse publicity	3	4	12	Planned action to reduce risk by xx date Sample Risk Action Plan.doc				XX Owner XX Sponsor			
2	x	x	xx	• Xx • xx											

Item 6
AC/13/20 Annexe 2
19 April 2013

NMC Risk management toolkit

Introduction

1 This Risk Management Toolkit sets out how we manage risk, setting out the key steps to be taken at each stage of the risk management cycle. It provides practical guidance and examples.

2 It should be read in conjunction with Risk Management Policy and our Framework which sets out roles and responsibilities.

What is risk?

3 Risk is defined by H M Treasury in The Orange Book, Management of Risk – Principles and Concepts as: "*the uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance".*

4 Risks differ from issues or problems in that there has to be an element of ***uncertainty***. We are not sure if or when an event will happen and what the likely impact will be if it does.

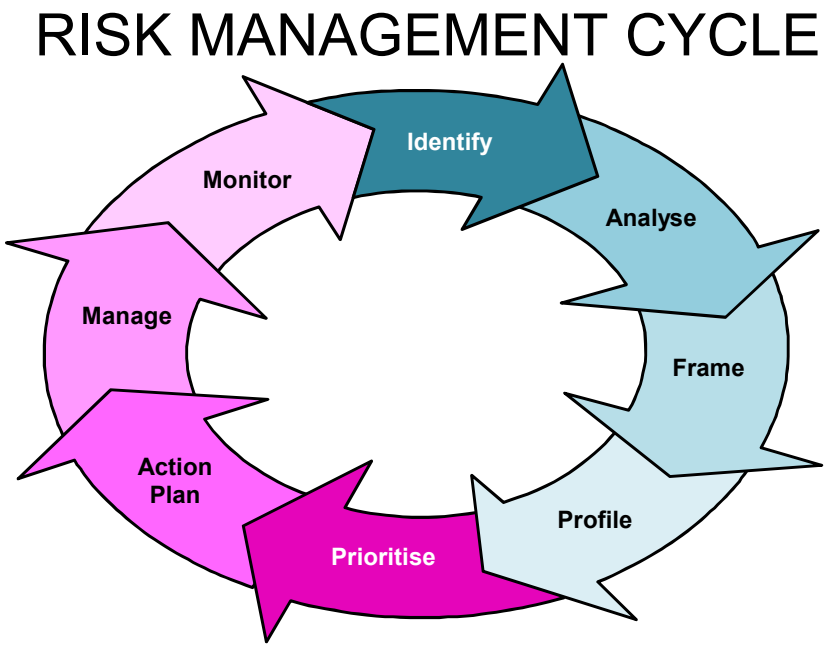
What is risk management?

5 Risk management is the systematic identification, assessment, management and monitoring of risks facing the organisation from whatever cause. It is designed to ensure that known risks are captured and maintained at a level that is tolerable or manageable for the organisation. It is an essential part of the corporate governance of an organisation and needs to operate in a manner which promotes openness, integrity and accountability.

6 Our approach to risk management provides our mechanism for managing uncertainty. It deals with risks not problems. It does this through ensuring that we separate out our risks into their causes, their potential situations and their consequences. It ensures that we do not focus on managing consequences as to do so represents crisis management not risk management.

The risk management cycle

7 Our methodology for managing risks is based on a cycle:



- **Identify** – the major risks arising from potential causes.
- **Analyse** – the major risks to understand them better.
- **Frame** – the risks into written scenarios.
- **Profile** – the identified risk scenarios to map the degree of risk presented by one scenario relative to others.
- **Prioritise** – the risk map according to the 'risk appetite'.
- **Action Plan** – to address the risks that require further management action/control.
- **Manage** – the risks in accordance with the action set out in the action plan.
- **Monitor** – the implementation and effectiveness of the action taken on the risks.

8 The following section is split into eight sections that mirror our risk management cycle.

Identify

9 Everyone has responsibility to identify risk and there are various ways to do it, for example:

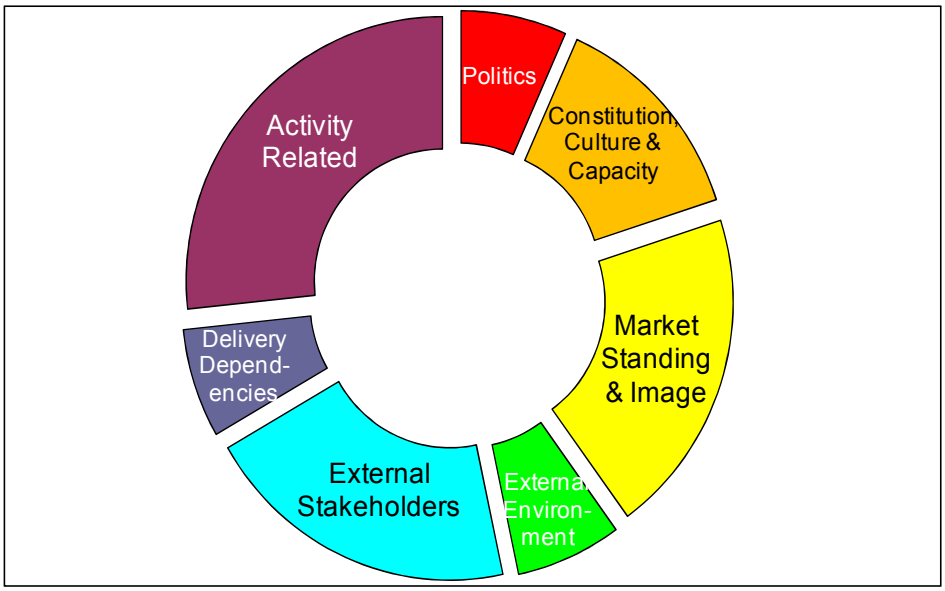
- Benchmarking with similar organisations or projects, for example, other healthcare regulators or similar projects.
- Using customer and other surveys and feedback.
- Reviewing emerging issues.
- Observation.
- Workshops and brainstorming sessions.
- Interviews.

10 We are not prescriptive on the approach to be used as all have merits in the right circumstances. What is important is that all the significant risks are captured and phrased in a way that aids transparency, challenge and accountability. If risks are not written appropriately and are assessed as 'high' or 'medium' risk, action to manage them down will not be appropriately targeted and successful.

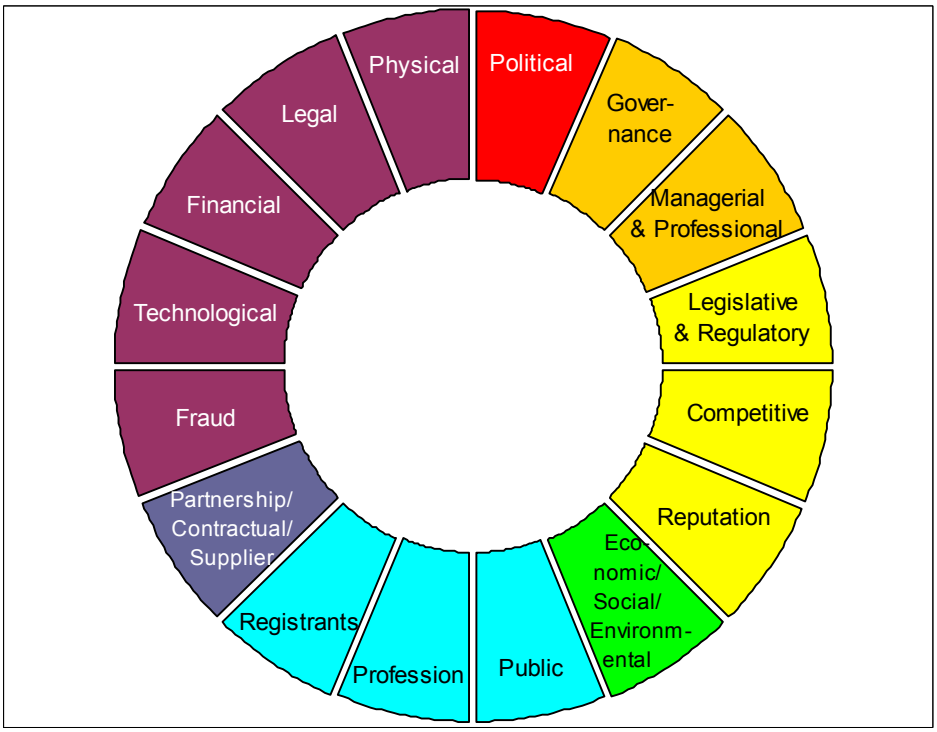
11 Before identifying risks, it is important to set the parameters of the exercise. What is its scope (for example, risks facing a service or project) and timescale (for example, one year or three)?

12 We are not looking for all possible risks but what we are looking for are key threats to achieving our objectives or that threaten our assets, activities and people. There may be no threats, although that is unlikely. Alternatively there may be quite a number.

13 The aim is to identify the latent threats, which we call the root causes. Root causes stem from a variety of sources including strategic and operational, and external (such as political and environmental) and internal (such as culture and activities). Broad categories are:



14 These broad categories can be further sub-divided into sub-categories that can be helpful in ensuring that risks from all causes are identified:



15 Examples of risks falling into each category are given below:

Category	Description
Political	Those relating to the political situation facing the NMC whether that is global, European, national, sub-regional or local. It covers things like election cycles, policy direction, political re-organisations, political relationships and styles, activism, war and terrorism.
Governance	Those relating to the corporate governance and decision-making arrangements of the NMC. It covers things like the constitution, codes of conduct, leadership, checks and balances, and member-officer relations.
Managerial/ Professional	Those relating to the need for the NMC to be managerially and professionally fit for purpose. It covers things like recruitment and retention, succession planning, management style, management systems (for example, project management and performance management), staffing, reliance on interims/agency staff/consultants, morale, capacity, skills, professional judgement, absence management, grievance and disciplinary policies, and employee relations.
Legislative and Regulatory	Those relating to new and pipeline legislation and the NMC's audit and regulatory environment. May also relate to the NMC's own legal and regulatory powers.
Competitive	Those relating to the market situation and the NMC's competitors. It covers things like exposure to the market, competiveness/value for money of services, spotlight seeking (for pathfinders, awards) and competition with nearby or benchmark organisations.
Reputation	Those relating to the NMC's reputation with government, partners, the media and the public.
Economic/ Social/ Environmental	Those relating to the global, national and local economy (like economic cycles, the economic base, employment and earnings patterns, migration and inflow patterns), global, national and local demographics and social trends (like age profile, ethnic profile, health trends, crime trends, skills base and educational provision and attainment), and the physical environment (like waste, drainage and flooding, disease, pollution, contamination, seismic activity, air quality, water quality, energy use and efficiency, noise).

Public	Those relating to the NMC's need to meet changing needs and expectations of the public. It covers things like complaints and litigation culture.
Profession	Those relating to the NMC's need to meet the needs of the professions. It covers things like consultation, communication and involvement.
Registrants	Those relating to the NMC's registrants and applicants. It covers things like consultation, communication and involvement as well as access, demand, complaints and litigation culture.
Partnership/ Contractual/ Supplier	Those relating to the NMC's partnerships, contracts and supplies. It concerns procurement, contract and relationship management, governance, funding, skills, quality and effectiveness.
Fraud	Those relating to all forms of fraud. It covers internal fraudulent acts undertaken by employers, contractors, agents or Council members (for example, falsification of expense claims, theft of cash or other company assets, falsification of invoices for payment, failure to account for monies collected or invoices paid, or dealing inappropriately with Registrations or Fitness to Practise cases of friends or relatives). It also covers fraudulent acts committed against the NMC by persons outside of the organisation (for example, false statements made in relation to Registrations and Fitness to Practise cases or the theft and alteration of NMC cheques for personal gain). Further detail can be found in the NMC's *Anti-Fraud, Bribery and Corruption* policy, 2013 (Trim no. 2160991).
Technological	Those relating to the NMC's technological situation and environment. It covers things like strategy, innovation, obsolescence, the nature of systems, support, maintenance, access, security, data protection and reporting.
Financial	Those relating to the NMC's financial situation and systems. It covers things like adequacy of funding, gearing, financial planning, financial delegations, budgetary control, monitoring and reporting, commitments, cash and treasury management, taxation, pension funds and insurance.
Legal	Those relating to the NMC's compliance with legislation and its legal advice and support (especially in Fitness to Practise).
Physical	Those relating to the NMC's physical and people assets. It covers things like its asset base (buildings, vehicles, plant and equipment) and its health and safety and security systems.

Analyse

16 Once you have identified the risk, but before you write it down formally, you need to think about what information you have to inform the way the risk is written. There are various methods of risk analysis including:

- Trend data.
- Probability theory and statistical techniques.
- Simulation techniques.
- Informed gut feel.

17 We are not prescriptive on the approach to be used as all have merits in the right circumstances. What is important is that the methods used are right for the area under review. If data is readily available, or easily obtainable, then clearly you should use it. Beware however in gathering new data, as there is a need to ensure the benefits outweigh the costs of the data. Any data needs to be reliable, accurate, complete and timely. You need to beware of over-analysis and recognise when you are in a 'data desert'. Do not underestimate the strength of 'gut feel'.

Frame

18 To aid transparency, risks are written in the following format:

Risk Scenario

Root cause	Potential situation	Consequences	Current/ Planned Action
The **root cause**, i.e. a situation that is true or widely held to be true, that gives rise to a risk exposure	The **potential situation** that may arise given the root cause	Some **possible consequences** if the potential situation were to arise	The **current or planned action** designed to reduce the risk through termination, transfer, treatment or toleration

19 In writing risks, we need to:

- Ensure there is uncertainty and that we are dealing with risks not problems.
- Separate out the causes, the potential situations and the consequences. Remember that managing consequences is crisis management not risk management.
- Ensure it is clear to all why the risk exists:
    - What is its root cause?
    - What is the potential situation(s) that may arise that might trigger the risk?
    - What are the possible consequences if the risk materialises?

20 Of course, the ‘potential situation’ and the ‘consequences’ fall into the cause categories too but it is important to capture the root cause rather than simply the consequences which will look similar for most root causes.

21 A couple of examples of risk scenarios are provided below:

Root Cause	Potential Situation	Consequences	Current / Planned Action
Managerial/ Professional Staff from the department are being involved in corporate projects and there is no spare capacity to backfill.	Capacity falls below the level necessary to provide the service.	• Adverse effect on morale. • Stress and absenteeism. • Failure to achieve agreed objectives. • Failure to delivery statutory services. • Complaints/claims/litigation. • Adverse effect on performance. • Censure by audit/inspection. • Adverse publicity.	None at present.
Partnership/ Contractual/ Supplier The service is outsourced.	The supplier goes into liquidation.	• Disruption to supply. • Adverse effect on performance. • Censure by audit/inspection. • Adverse publicity.	Due diligence at pre-contract stage.

22 If you have some data from the analyse stage to help inform the degree of risk then add this into the scenario. For example in the second scenario you may have metrics on the extent of the outsourcing (the risk exposure represents £XXX,000 or X% of our activity in this area); on the likelihood of the supplier going into liquidation (10% of that market collapses on average each year); and on the consequences (e.g. disruption to X% of our supplies, reduction in our performance by X%).

23 Once you have identified your risks, assign each risk with a unique number and collate them in a risk register. You are now ready to assess the risks.

Profile

24 Once you have identified the risks and created a risk register, you should use the Council's 5 x 5 matrix to profile the risks:

RISK MATRIX

Impact						
CRITICAL	5	5	10	15	20	25
MAJOR	4	4	8	12	16	20
MODERATE	3	3	6	9	12	15
MINOR	2	2	4	6	8	10
INSIGNIFICANT	1	1	2	3	4	5
		1	2	3	4	5
		VERY LOW	LOW	MED	HIGH	VERY HIGH

Likelihood

25 Take each risk in turn and determine how likely you think the risk is to happen from very low (1) to very high (5). For ease of ranking, you should determine how likely you think the 'potential situation' column is to happen.

26 Once you have determined the likelihood from 1 to 5, you then need to determine the impact, again from 1 to 5 ranging from insignificant to catastrophic. Again for ease of ranking, you should determine the impact of the possible consequences should the risk materialise.

27 In assessing each risk, you should take the 'worst likely' manifestation of the scenario not the 'most likely' (as that will end up being at the bottom right of the matrix) or the 'worst case' (as that will end up being top left).

28 The table below provides a guide to assessing the risks and more detail on the impact rating is provided in Annex 1:

Likelihood of the Risk Occurring			
Term	**Score**	**Guidance**	**Evidence**
Very High	5	There is ***strong evidence (or belief)*** to suggest that the risk ***will*** occur during the timescale concerned.	A history of it happening at the NMC. Expected to occur in most circumstances.
High	4	There is ***some evidence (or belief)*** to suggest that the risk ***will*** occur during the timescale concerned.	Has happened at the NMC in the recent past. Expected to occur at some time soon.
Medium	3	There is ***some evidence (or belief)*** to suggest that the risk ***may*** occur during the timescale concerned.	Has happened at the NMC in the past. Can see it happening at some point in the future.

Low	2	There is ***little evidence (or belief)*** to suggest that the risk ***may*** occur during the timescale concerned.	May have happened in the NMC in the distant past. Not expected to occur for years.
Very low	1	There is ***no evidence (or belief)*** to suggest that the risk ***may*** occur during the timescale concerned.	No history of it happening at the NMC. Not expected to occur.

Impact of the Risk Occurring		
Term	**Score**	**Guidance**
Critical	5	Critical impact on the achievement of objectives. Very high impact on public protection, costs and/or reputation. Very difficult to recover from; and long term consequences.
Major	4	Major impact on the achievement of objectives. High impact on public protection, costs and/or reputation. Difficult to recover from; and some long term consequences.
Moderate	3	Moderate impact on the achievement of objectives. Medium impact on public protection, costs and/or reputation. Not easy to recover from; and medium term consequences.
Minor	2	Minor impact on the achievement of objectives. Low impact on public protection, costs and/or reputation. Easy to recover from; and mostly short term consequences.
Insignificant	1	Insignificant impact on the achievement of objectives. Very low impact on public protection, costs and/or reputation. Very easy to recover from; and no lasting consequences.

29 You should only factor current mitigating actions into the ranking, not planned action.

30 In a perfect system, the inherent risk (the threat arising from any one specific risk prior to any management action having been taken) should be assessed as well as the residual risk (the threat arising from any one specific risk after management action has been taken). However, this can be difficult in practice so at the NMC, with the assumption that the management/control measures already being taken are successful, the assessment should take account only of the residual risk after that action. However, as current mitigating actions should be captured in the risk scenario, assumptions on the success of these measures should be backed by evidence and may be subject to independent testing.

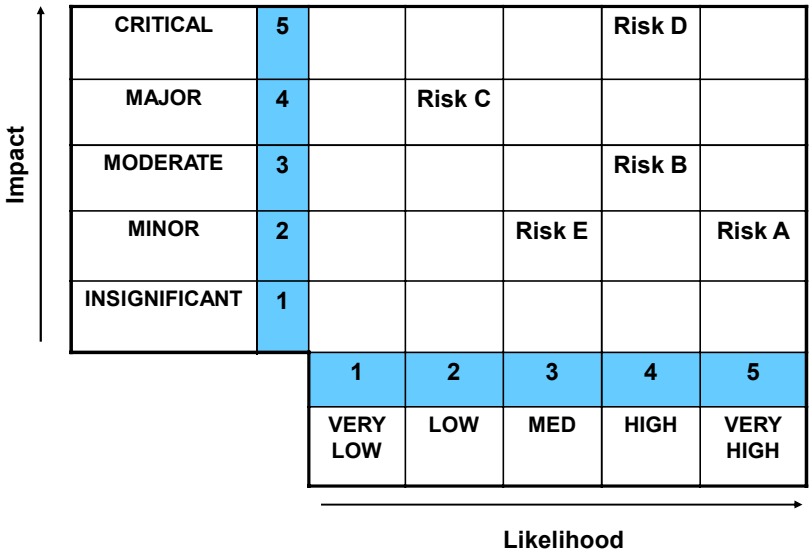
31 The assessment should be as factually based, and as quantitative as possible, though intuition and qualitative analyses are sometimes all that you have to go on (for example, the risk may not have occurred before).

32 If there is any doubt, or disagreement, over assigning a numerical value for either the likelihood, or the impact, the best policy is to assign it the higher number and then reassess at the planning stage if the risk requires active management.

33 Once you have assessed the risk, you can plot it on the matrix, using its unique risk identifier.

34 Assuming you have five risks, you would end up with a picture something like the following:

RISK MATRIX



35 Once you have a picture of your risks, you should carry out a sense check at the end to ensure each risk is ranked about right relative to the others. You should also check that you have not missed anything obvious.

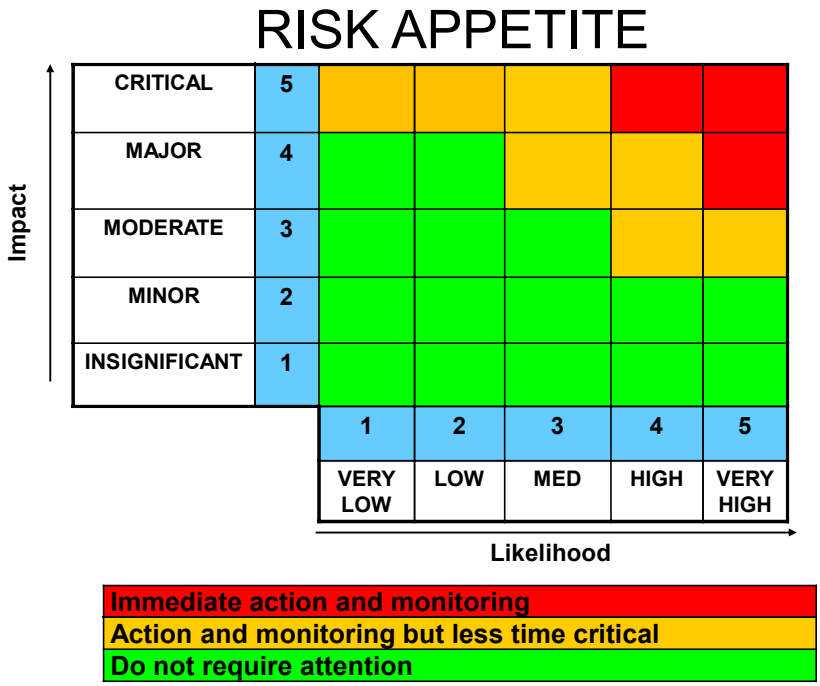
Prioritise

36 Assuming you are happy with the risk map you have created, you should set the risk appetite onto your risk map to create a RAG (red/amber/green) rating. The risk appetite is the amount of risk which the Council is willing to tolerate, or accept, at any one time.

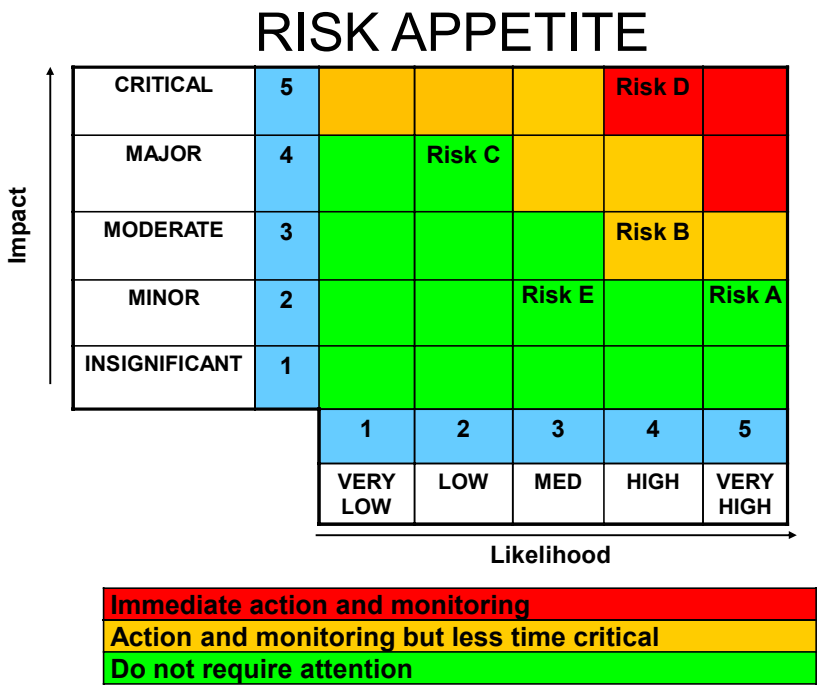
37 The risk appetite for the NMC is set by the Council for the corporate risk register.

38 It should be remembered that risks that have the highest impact rating (Critical) should be assigned as at least amber whatever the likelihood. Those that are less likely need only to be business continuity/ contingency/emergency planned for rather than necessarily managed down. These risks tend to be risks that cannot be avoided and would be very expensive to seek to avoid.

39 A possible risk appetite is:



40 So given the above risk map, your prioritised risk map would be:



41 You are now ready to go onto the action planning stage.

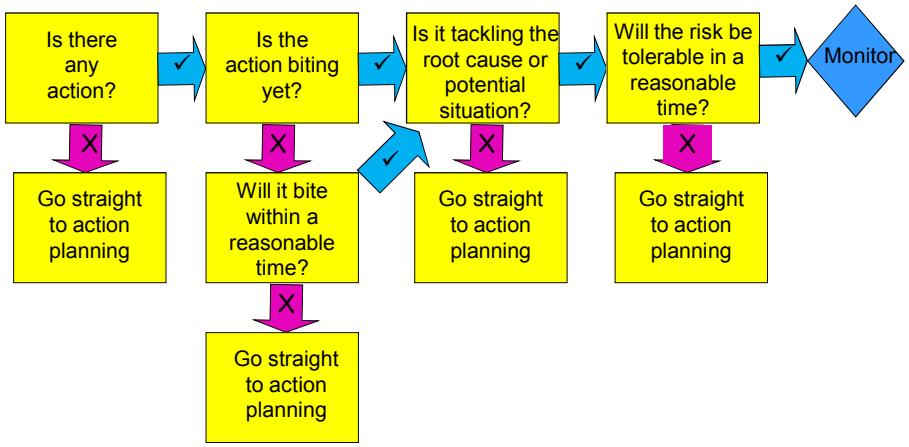
Action plan

42 Once the risk assessment has been undertaken it becomes clear which risks require the concentration of time, effort and resources, i.e. first red, then amber, depending on the ranking.

43 Once time and resources allow, it is also worth considering green risks. These risks may well appear to be well managed. However, there is the possibility that they might be being over managed, thus consuming resources that could be better deployed in other activities or in managing higher risks.

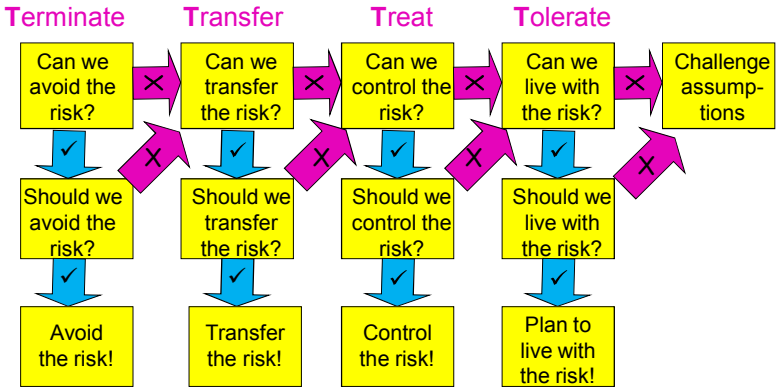
44 Your risk map shows that you have one red risk, one amber risk and three green risks. Red and amber risks are 'intolerable', i.e. they require management attention or action to reduce the level of risk to green. The difference between the two is that red risks require immediate action, whereas amber ones are less time critical.

45 You will need some form of action plan to address the intolerable risks. A template is attached as Annex 2. It is important to ensure that extra action is just that. You have already determined that existing action on the risk is not adequate and the risk is still intolerable. The action planning process is designed to ensure that you challenge the status quo. That said, it is a good discipline to first check that it is not simply a question of timing with existing action before determining what extra action to take:



46 Assuming you do need to action plan, then the key thing is to consider what form, or forms, of action is best and so you should go through the action planning decision tree to decide which one, or combination, of the four Ts (Termination, Transfer, Treatment or Toleration) is appropriate to the risk:

ACTION PLANNING DECISION TREE



47 Termination (i.e. avoiding the risk) is always best although it is seldom possible.

48 Transfer (i.e. getting someone else to bear the risk) is the next best option although there are usually residual risks to the authority if transfer is possible, for example reputation damage. Remember also that insurance is not risk transfer. It is simply getting someone else to reduce the financial effects of the risk if it materialises.

49 In most cases you will decide that treatment is the only option open to you. This is more commonly referred to as internal control. Some guidance on internal controls is included in Annex 4.

50 If you decide toleration is the option to be taken, or part of the solution, you need to develop a plan to live with the risk should it materialise. This will be some form of business continuity plan, or contingency or emergency plan. Reputation management issues should always be built into such a plan. Also note that contingency planning will also be needed for any risk that scores high on the impact axis, regardless of its likelihood. This is because the organisation needs to know that it can survive the risk occurring.

51 The risk action plan should always include key dates and milestones (for example, a target risk score should be given (likelihood x impact). Over time, this should make the risk tolerable (green) although it may take time to achieve that. In this event, you should record the in-year target as well as indicating the milestones, critical success factors and performance indicators that will indicate success in managing down the risk. For example, where the risk score is 20, placing it as a red risk, the desired outcome might be 10 (green) although an amber rating is the realistic target within the year.

52 The costs of management action, both in a financial sense but also in relation to human resources, should be proportional to the risk.

53 It is also worth remembering that there are likely to be some residual risks left after

management action (and possibly new risks created) and these should always be considered and ensured that they are tolerable.

54 As an example, a completed action plan for the risk scenario on contractor dependence given above, which lets say for arguments sake is risk number D (red risk with high likelihood and critical impact), is attached at Annex 3.

Manage

55 Once you have determined the appropriate action to take on the risk and have outlined it in an action plan, you will need to take that action.

Monitor

56 You then need to monitor the implementation and the effectiveness of the action taken.

57 You need to be prepared to open your risk management processes up to challenge and scrutiny. After all, you are taking risks on behalf of, and in the name of, the NMC. Your judgments therefore need to be evidenced. Following the guidance contained within this Methodology will enable you to demonstrate and justify your risk management procedures. For information, Annex 5 contains a set of likely questions to be asked by those challenging your risk management judgments.

58 You will need to follow the NMC's risk escalation procedure. This ensures that high risks from lower levels in the organisation are brought to the attention of higher levels in a timely manner to ensure that appropriate action is carried out on them. No one individual or group is empowered to carry high risk without explicitly having the authority to do so. In particular, red risks should be reported upwards immediately.

59 You will also need to ensure that the risk register and risk map are dynamic.

60 Where a potential situation becomes an actual situation (i.e. the risk has materialised) it is important that consideration is given to reporting the situation as a serious event in accordance with the NMC's serious event policy. Even if the situation is not deemed to be serious, it is important to capture what has happened so that the organisation can learn from its management of risk. For example, was the risk actually identified?; was it framed correctly?; was it profiled correctly?; and was management action on it appropriate?

Annex 1 – Impact guidance

Term	Financial Impacts	Degree of harm (to the public, staff, etc)	Impacts on claims, complaints, public outcomes	Impact on service delivery/ Business Interruption/ Projects	Adverse Publicity/ Audit, inspection and regulatory or enforcement action
Critical	• A major loss or deficit (over £100,000).	• Significant loss of life or limb, or other harm.	• Full inquiry. • Select Committee hearing. • Called before Public Accounts Committee. • Major claims.	• Critical breakdown in delivery of a key service for over a week.	• Very serious recommendations from audit/inspection/regulator. • Court enforcement or prosecution. • Government intervention. • Concerns raised in Parliament. • Major scandal in national/international media lasting several days. • Major loss of staff or jobs. • Complete change in the organisation's leadership, management or direction. • A vote of no confidence in the organisation's leadership. • Abolition of the organisation.
Major	• Significant financial loss or deficit (between £50, 000 and £100,000).	• Some loss of life or limb, or other harm. • RIDDO/Agency reportable.	• Serious complaint with longer term effects or a serious of complaints. • Ombudsman. • Major claim(s).	• Major breakdown in delivery of a key service for a few days.	• Major scandal in national media lasting a day or so. • Major effect on staff morale. • Confidence in NMC undermined. • Serious recommendations from audit/inspection/regulator. • Enforcement action.
Moderate	• Moderate loss (between £10,000 and £50,000).	• Semi-permanent injury. • RIDDOR/Agency major specified reportable.	• Justified complaint. • Inappropriate outcome. • Moderate claim.	• Moderate breakdown in delivery of a key service for up to a day.	• Moderate interest locally, with stakeholders, and some public interest. • Noticeable effect on staff morale. • Significant recommendations from audit/inspection/regulator. • Significant non-compliance with legal requirement.
Minor	• Minor loss (between £1,000 and £10,000).	• Temporary minor injury – requiring first aid up to A&E visit.	• Formal complaint readily resolvable. • Minor impact on outcome. • Minor claim.	• Minor breakdown in delivery of a key service for a few hours.	• Minor interest eg locally or with stakeholder. • Minor effect on staff morale. • Minor recommendations from audit/inspection/regulator. • Minor non-compliance with legal requirement.
Insignificant	• Insignificant loss (less than £1,000).	• Insignificant injury. • Near miss.	• Locally resolved complaint (unwritten). • Insignificant impact on outcome. • Small claims (up to £1,000).	• Insignificant breakdown in delivery of a key service for a few minutes.	• Local interest, rumours within NMC. • Insignificant effect on staff morale. • Small, insignificant recommendations from audit / inspection / regulator.

Note: This guidance relates to the corporate level only.
It needs to be scaled down accordingly to be meaningful for a particular service or project.

Annex 2 – Risk action plan

Risk no :		**Risk Sponsor:**	
Risk title :		**Risk Owner:**	
Risk score :		**Date of plan:**	
Risk status :			
Extra management action to be taken	**Key Dates**	**Critical Success Factors and Performance Indicators**	**Review mechanisms and frequency**
Consider which of the 4 Ts (Terminate, Transfer, Treat, Tolerate) the action is concerned with (Note: action can be a mix of the 4). Consider whether we are trying to reduce the likelihood of the risk occurring, the impact if it does, or both. If the action concerns transfer or treatment, ensure it addresses the 'root cause' of the risk, or the ‘potential situation’, not just the ‘consequences’. If the action concerns toleration, ensure the NMC can recover from the risk if it occurs and that robust (i.e. tested) recovery, contingency or continuity plans are in place. Consider the costs of management action and whether these costs are proportionate to the risk. Consider any residual risks left after management action (or new risks created) and ensure these are tolerable.	Consider completion date(s), i.e. when the risk will be tolerable. Consider milestone dates, i.e. when key actions will be complete – especially where completion date(s) is not within the financial year.	Consider what factors will make the risk tolerable, and what will indicate success in making the risk tolerable. These should be evidence backed and linked to completion date(s) and milestones.	Consider when, how and by whom the risk, and action on it as set out in this Action Plan, will be reviewed. Consider need to escalate risk upwards.

Annex 3 – Example risk action plan

Risk no: D (it is suggested you copy the actual scenario on the back of the Plan)	**Risk Sponsor: My Manager**
Risk title: Contractor dependence	**Risk Owner: Me**
Risk score: 20 (Very high likelihood; major impact)	**Date of plan: Day Month Year**
Risk status: Red	

Extra management action to be taken	**Key Dates**	**CSFs and PIs**	**Review mechanisms and frequency**
As a policy decision has been taken to outsource the service (to reduce risk as well as to improve performance and/or reduce costs), we cannot terminate or transfer the risk. Therefore the action is concerned with treatment through extra controls and with toleration through business continuity planning and insurance. We will improve detective controls through management review and monitoring of the supplier for early warning signs of it being in trouble. We will ensure that a robust business continuity plan is in place in the event of supplier failure; and we will explore the costs of insurance cover for this eventuality. The action should reduce the impact if the risk occurs (through reducing disruption to supply and the effect on performance). We cannot influence the likelihood of the risk materialising as it is outside our control (the NMC represents only a small proportion of the supplier's business). The action therefore only addresses the consequences of the risk although it also gives us early warning of the 'potential situation'. The costs of the monitoring action are minimal as they can be absorbed in existing working practices. The cost of the insurance cover will need to be considered, as will any costs arising from the business continuity plan. Residual risks left after management action should be minimal.	New monitoring controls to be in place by Day Month Year. Business Continuity Plan to be in place by Day Month Year. Insurance cover, if taken, to be in place by Day Month Year.	Monitoring gives early warning of any problems. BCP means that the service can continue to be provided within an appropriate timescale. Risk to be downgraded to green by Day Month Year.	Risk sponsor to review monthly until green. Risk sponsor to alert service management team that there is a red risk in the service but that management action is being taken to make it tolerable within a short timescale.

Annex 4 – Common controls to treat risk

Internal controls are designed, amongst other things, to reduce risk. Controls are mainly intended to be:

- **Administrative** controls – designed to ensure compliance with policies, plans, rules, regulations and procedures, e.g. Registers of Interest and Registers of Gifts and Hospitality.

- **Preventative** controls – designed to prevent invalid actions or transactions from being taken/processed, e.g. separation of duties and authorisation procedures.

- **Detective** controls – designed to identify errors or irregularities in actions/transactions already taken/processed, e.g. variation analysis, data matching, and exception reporting.

In designing and applying internal controls, judgments need to be made about the relative costs and benefits of the controls. Only those controls that are cost effective in reducing risk should be implemented.

A useful categorisation of controls is **SOAPMAPS**:

- **Segregation of duties** – roles and responsibilities should be defined so as to ensure areas of activity involving significant risk are separated, for example, the person responsible for authorising a payment should not be the same person inputting the data, making the payment, checking the transaction, taking custody of the associated assets, or destroying documents. No one individual should complete the whole process. Appropriate separation of duties reduces the risks of fraud, error or abuse and reduces the opportunity for collusion.

- **Organisation** – organisation structures (roles and responsibilities) should be clearly defined to maximise efficiency and eliminate gaps and duplications in the use of resources in achieving objectives and plans in a disciplined environment. Appropriate communication should occur and staff development should exist to foster commitment to the organisation, its objectives, plans and control environment.

- **Authorisation** – all transactions and decisions should be formally authorised or approved by people authorised to do so. Authorisation processes help ensure that policies and plans are adhered to and that only legitimate activities are performed and so reduce the risk of unauthorised access to systems, data and assets. They also provide a clear management (and audit) trail. Authorisation procedures should never be performed in advance, for example, pre-signing orders or timesheets.

- **Physical** – appropriate physical safeguards should be established to protect people and limit access to buildings, cash, other assets, systems, data and documents to those who need it. Physical safeguards reduce the risk of harm to people, theft, data loss and unauthorised alteration of data and documents.

- **Management review and monitoring** – financial and other performance information, e.g. exception reporting and data matching, should be produced and reviewed to identify that people understand the systems, processes and procedures and that unexpected activity and variations from expected performance or standards are

identified for attention.

- **Arithmetical and accounting** – appropriate arithmetical and accounting procedures should be operated to verify data and identify unusual or unexplained transactions that may indicate error, fraud, corruption and other financial irregularities. Examples of such procedures are casting (adding up) orders, invoices and payroll; reconciliations such as between bank accounts and accounting records; and control accounts.

- **Personnel** – appropriate personnel arrangements should exist to ensure, through recruitment, training and development, disciplinary, and appraisal procedures, that personnel have the integrity, honesty and competence to meet the needs and values of the organisation. Propriety checking of personnel, particularly those in positions that present significant risk, is essential before employment/engagement and periodically during it. In recruitment, it is essential to follow up references and check qualifications and for criminal records.

- **Supervision** – appropriate supervision procedures should exist, carried out by experienced personnel who understand the processes, to detect and correct deviations from proper procedures and employee relations. Management (and audit) trails should be built in to enable a transaction to be followed, with all supporting documentation, from beginning to end.

Annex 5 - Suggested questions for risk challengers

RISKS	BASELINE	EXISTING ACTIONS	NEW ACTIONS	SUCCESS	PROGRESS AND PROOF
1. Do we understand what the risk is? 2. Do we know what the root cause of the risk is (e.g. *external* source or threat; or *internal* source, problem or initiative)? 3. Do we know where the uncertainty lies in terms of the potential situation that could arise? 4. Do we know what the consequences could be if the potential situation does happen? 5. Do we know what the likelihood of the risk occurring is? 6. Do we know what the impact of the risk occurring is?	7. Are we clear why the risk is at the position it is on the risk register? 8. Where the risk has been on the risk register for more than one year, can we justify any movements up or down in its position?	9. What is already in place to manage the risk, and how adequate are these actions? 10. Where existing action is deemed adequate, are we happy that the action: a. is biting now or will within a reasonable timescale? b. is tackling the root cause or the potential situation not just the consequences? c. will make the risk tolerable within a reasonable time?	11. What new actions are we taking to manage the risk, where appropriate? 12. Are these actions concerned with: a. risk termination? b. risk transfer? c. risk treatment? d. risk toleration? e. a mix of the above? 13. Is this action appropriate bearing in mind costs and benefits, pathways and timescales, and new and residual risks? 14. If the action concerns transfer or treatment, what are we transferring or treating (i.e. the root cause or the potential situation not just the consequences)? And what are we trying to reduce (the impact, the likelihood, or both)? 15. If the action concerns toleration, are we confident that we could recover from the risk if it occurs and that we have appropriate and robust (ie tested) disaster recovery, business continuity or contingency plans in place?	16. Are we clear what the critical success factors, performance indicators, milestones and deadlines are that will confirm when management action has been successful in reducing risk?	17. What evidence have we got that progress is being made to manage the risk and that that action is being successful?

Glossary

Business continuity management	A holistic and systematic process for the identification and assessment of, and preparation for, events or incidents (whether local, regional or national) that could threaten an organisation and its ability to fulfil its business objectives.
Consequence	The part of the risk that describes the possible effects if the potential situation were to arise.
Fraud	The intentional distortion of records for the purpose of gain.
Issue	A concern that either cannot be avoided, or is already happening. Issue refers to a known outcome, whereas risk refers to an outcome that might or might not actually materialise.
Impact	The assessment of the cumulative impact of the possible effects.
Likelihood	The assessment of the likelihood of the 'potential situation' arising.
Inherent risk	The threat arising from any one specific risk, prior to any management action having been taken.
Operational risk	Risks associated with the day-to-day working of the organisation.
Potential situation	The part of the risk that describes what may arise given the root cause.
Residual risk	The threat arising from any one specific risk, after management action has been taken.
Risk	The likelihood that a potential situation may arise leading to consequences which may impact adversely on our ability to achieve our objectives or carry out our functions. Needs to be split into its constituent parts of root cause, potential situation and consequences.
Risk appetite	The amount of risk which the Council is willing to tolerate, or accept, at any one time.
Risk management	A systematic process for the identification, assessment, planning, managing and monitoring of risks, in a cost effective manner.
Risk matrix	The completed risk matrix at any particular point in time – showing the red, green and amber risks.
Risk register	The framework for documenting each aspect of the risk management cycle.
Risk scenario	The risk divided into its constituent parts of Root Cause, Potential Situation and Consequences.

Risk score	The classification given to a risk based on its likelihood of occurring and its impact if it does.
Root cause	The part of the risk that describes where the risk exposure originates from, i.e. a situation that is true or widely held to be true, that gives rise to a risk exposure.
Strategic risk	Risks associated with threat or damage to the achievement of the NMC's objectives.
Target risk score	The risk score that the Risk Sponsor and/or Risk Owner would like to achieve, following successful implementation of risk management actions.

Item 7
AC/13/21
19 April 2013

Audit Committee

Risk register

Action: For discussion.

Issue: Providing assurance that Directors are actively and appropriately managing risk.

Core regulatory function: The risk register covers all of our core regulatory functions.

Corporate objectives: The NMC corporate objectives provide the context for the identification and management of risk.

Decision required: No decision is required but the Committee is invited to consider the approach to managing risk and the changes and movements in the assessment of risks.

Annexes: The following annexes are attached to this paper:

Annexe 1: Risk matrix showing distribution of top and general risks.

Annexe 2: The risk register.

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.

Author: Mary Anne Poxton
Phone: 020 7681 5440
maryanne.poxton@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 A refreshed approach to how the NMC identifies and manages risk was approved by the Audit Committee at its meeting on 11 December 2012, subject to some agreed changes. The revised risk management framework, incorporating the changes requested by the Audit Committee, is presented elsewhere on the agenda.

2 At its meeting on 25 January 2013, the Audit Committee agreed a timetable for the new approach to be rolled out in April 2013. In the meantime, to avoid confusion, we are continuing to use the existing risk framework and risk register structure.

3 Risk is scored on a 5 x 5 matrix, whereby all risks assessed at eight and lower are green, risks that are assessed between nine and 15 are amber and all risks assessed at 16 and above are red. All red risks are classified as top risks. All risks that are rated at 16 and above are defined as top risks. The risk movement column shows the movement of risks on a monthly basis.

4 The top risks on the risk register will be reviewed by the Council at its April 2013 meeting. The risk register continues to be reviewed monthly by the Directors Group. The Chief Executive and the Chair of Council also review the risk register monthly. The Corporate Business Planning team oversees the administration of the risk register and quality assures any changes that are made.

Discussion

New top risks

5 Since the Audit Committee last considered the risk register in January 2013, a new top risk has been added relating to the implementation of recommendations in the Francis Inquiry report not being aligned with the NMC's current focus and priorities (T28). This risk is red and rated at 20.

6 A new top risk has also been added relating to the risk, highlighted in the Francis Inquiry report, that the NMC's lack of public profile impedes the organisation from carrying out its core public protection function (T29). This risk is red and rated at 20.

Amalgamated top risk

7 The risk that the Council is not appointed by 1 May 2013 has now been subsumed in the related greater risk of corporate memory loss at Council level due to the reconstituted Council not being familiar with the corporate agenda and therefore not able to make decisions effectively (T17). This risk is red and rated at 20.

Increased top risk

8 The risk around loss of sensitive data (T24) is up by four to a rating of 20.

Closed top risk

9 The risk that the Francis report is critical of regulation (T9) has been closed following the publication of the report on 6 February 2013. This closed risk no longer appears on the active part of the risk register.

New general risks

10 Since the Audit Committee last considered the risk register, two new general risks have been added.

11 There is a new risk relating to non-compliance with the Welsh Act 1993 and the Welsh Language (Wales) Measure 2011 (G38). This risk is amber and rated at 12.

12 The other new risk relates to lack of financial resource arising from a combination of factors, including the Francis Inquiry report and any resulting increase in referrals to Fitness to Practise (G39). This risk is amber and rated at ten.

Increased general risks

13 The risk around the integrity of the register (formerly G32) is up by five to a red rating of 20. This risk has therefore been moved to the top risks part of the register (T23).

14 The risk around the approved programmes database and Wiser not being fully synchronised (G1) is up by seven to an amber rating of 15.

Closed general risk

15 The risk around lack of financial resource specifically due to delay or refusal to approve a fee increase (formerly risk T21 and reduced to amber in January 2013) has been closed. This closed risk no longer appears on the active part of the risk register.

Public protection implications:

16 Public protection implications are considered when rating the impact of risks and determining action required to mitigate risks.

Resource implications:

17 Internal staff time has been accommodated as business as usual.

Equality and diversity implications:

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

Stakeholder engagement:	19	The risk register is in the public domain.
Risk implications:	20	The impact of risks is assessed and rated on the risk register. Future action to mitigate risks is also described.
Legal implications:	21	Legal implications are considered when rating the impact of risks and determining action required to mitigate risks.

Item 7
AC/13/21 Annexe 1
19 April 2013

Nursing & Midwifery Council

Risk matrix: mapping of NMC risks from March 2013

Likelihood							
	Almost certain	5				T28 T29	
	Likely	4			G20	T26 T25	T27 T23 T24 T17
	Possible	3			G9 G36	G5 G38 G6 G17 G34 G35	T5 G1 G27 G28
	Unlikely	2					G39
	Remote	1					
		Score	1	2	3	4	5
			Insignificant	Minor	Moderate	Major	Catastrophic
			Impact				

Risk scores:	1-8	L	9-15	M	16-25	H

NMC RISK REGISTER

Top risk

No	Entry date (approximate)	Ref	Type	Risk	Impact	Likelihood	Risk Rating	Movement	Mitigation	Future action	Owner	Review date	Target completion date
T28	**Feb-13**	**CE**	Strategic	**FRANCIS REPORT - MID-STAFFS INQUIRY - The risk that implementation of recommendations in the Francis report is not aligned with the NMC's current focus and priorities**	**4**	**5**	**20**	**0**	• Support externally for retaining focus on our current improvement plan, especially from DH • Council has considered Francis recommendations, in line with current priorities • Council approved budget for priorities planned for 2013 - 2014 • Organisational wide working group currently considering recommendations	• Regular and continued close contact with DH via the Mid Staffs Forum • Government response received 26 March. NMC response will be made available on the website • Francis will be a standing item on Council agenda for the foreseeable future	Jackie Smith	16/04/2013	31/03/2014
T29	**Feb-13**	**CG**	Reputation	**NMC PROFILE - The risk, highlighted in the Francis Report, that the NMC's lack of public profile impedes the organisation from carrying out its core function of public and patient protection**	**4**	**5**	**20**	**0**	• Public commitment to engagement agreed by Council and now published • Robust key stakeholder engagement delivery plan is being developed on a rolling basis • Patient and Public Engagement Forum being communicated with and meeting regularly	• Key stakeholder meetings being arranged now and throughout the year • Commitment to meet with members of the Health Select Committee by end of 2013	Lindsey Mallors	16/04/2013	31/03/2014
T27 (G19)		**R**	Safeguarding	**OVERSEAS APPLICANTS FRAUDULENTLY REGISTERED -The risk that the overseas registration policy and related processes are not sufficiently robust to ensure that all applicants satisfy the conditions of the NMC Order and Registration Rules when registered, thus undermining the integrity of the register**	**5**	**4**	**20**	**0**	• Early Warning Guide produced for Registrations staff • Current independent review of the overseas registration process • From 1 February 2013, no new overseas applications being processed until the review is completed. Planned start date for consideration of applications on 2 April 2013 • Press release issued on 11 March 2013 outlining key areas of the review	• Independent review will inform development of a new policy and process improvements linked to this	Katerina Kolyva	16/04/2013	30/06/2013
T23 (G32)		**R**	Safeguarding	**INTEGRITY OF THE REGISTER - The risk that the register is not accurate and therefore does not give information which safeguards the public**	**5**	**4**	**20**	**0**	• Discrepancies between register and CMS reconciled through agreed internal audit process (ongoing) • Daily update reports being run and checked • Training being delivered to FtP staff • Standard operating procedures in place • Independent review of overseas application process underway. Due to report in April 2013. Registration review due to commence in 2013 - will review strategic aims of the register and policies and processes in registration	• Internal quality control checks to continue • Daily update reports to be further refined • Report of recent independent audit to Audit Committee in January 2013. Recommendations accepted and work has begun on implementation • Registration review in 2013 will review policies and processes relating to registration	Katerina Kolyva	16/04/2013	30/06/2013

Key
CE - Chief Executive
CG - Corporate Governance
CP - Continued Practice
CS - Corporate Services
FtP - Fitness to Practise
R - Registration

NMC RISK REGISTER

Top risk

No	Entry date (approximate)	Ref	Type	Risk	Impact	Likelihood	Risk Rating	Movement	Mitigation	Future action	Owner	Review date	Target completion date
T24	**Oct-12**	**CS (IT)**	Safeguarding	**LOSS OF SENSITIVE DATA - There is a risk that we fail to safeguard sensitive data or there are further breaches of security due to inadequate controls or processes resulting in legal penalties and/or loss of public confidence.**	**5**	**4**	**20**	**0**	• Comprehensive, prioritised and risk assessed action plans developed to address gaps • Information Governance Security Group in place with cross-organisational representation • Information security improvement programme defined and being implemented • Improved communications to staff and policies updated	• Implementation of the Information Security Improvement Programme, tackling highest risk areas as priority • Laptops encryption and implementation of new enhanced encryption solution • Mandatory training for all staff to be enforced	Mark Smith	31/05/2013	31/12/2014
T17 (G33 and G37)	**Aug-12**	**CG**	Governance	**RECONSTITUTED COUNCIL - The risk of corporate memory loss at Council level due to the reconstituted Council not being familiar with the corporate agenda and therefore not able to make decisions effectively**	**5**	**4**	**20**	**0**	• Project manager for appointment of new Council in post and working closely with Council services on transition planning	• Induction programme being designed for delivery on 1 and 2 May 2013, to include coverage of trustee responsibilities, role of members, understanding of NMC business and business cycle • Phased induction to continue throughout first six months of reconstituted Council • Paper on transition planning process and timelines being prepared for April Council • Each committee is looking at work planning, with particular focus on transition	Lindsey Mallors	16/04/2013	01/05/2013
T26	**Jan-13**	**R**	Safeguarding	**PROFESSIONAL INDEMNITY INSURANCE - The risk that the NMC fails to implement the PII requirement by the DH deadline of October 2013**	**4**	**4**	**16**	**0**	• Policy work now commenced to bring options to Council - policy and presentation to be reviewed by Council in April 2013	• Establishment of a project plan and risk register • Planning for policy and process options to be brought to Council for a decision in April 2013 • Preparation of business case to make necessary changes to WISER • Recruitment of project manager in progress • Scoping of policy options underway • Task and finish group established to draft response to DH consultation - due May 2013	Katerina Kolyva	16/04/2013	25/10/2013
T25	**Oct-12**	**CS (HR)**	Staff	**STAFF TURNOVER - The risk that high turnover destabilises the organisation with high costs in terms of lost productivity and recruitment and loss of organisational knowledge.**	**4**	**4**	**16**	**0**	• HR and Organisational Development Plan in place and being implemented • Improved employee engagement in place, focused on face to face communication • Workshops undertaken in specific risk areas e.g. FtP	• Implement Pay and grading review and Pensions review and ensure enhanced level of engagement • Develop and implement a full learning and development programme for 2013-2016 • Raise focus of Organisational Development Programme as key element of change programme	Mark Smith	16/04/2013	30/09/2013

Key
CE - Chief Executive
CG - Corporate Governance
CP - Continued Practice
CS - Corporate Services
FtP - Fitness to Practise
R - Registration

NMC RISK REGISTER

General risk

No.	Entry date	Ref	Type	Risk	Impact	Likelihood	Risk Rating	Movement	Mitigation	Future action	Owner	Review date	Target completion date
T5	**Jan-12**	**CS (ICT) R**	ICT	**FAILURE OF WISER SYSTEM - There is a risk to the failure in our registration system, Wiser because of obsolete technologies, resulting in a backlog of applications, readmissions and renewals**	**5**	**3**	**15**	**0**	• Council has now approved the overall ICT strategy and the stabilisation plan which includes the following actions around the Wiser system: • The migration on to a more stable database platform to enhance the stability and performance of the system - completed • A schedule has been agreed with Advanced 365 for the application of all appropriate security fixes to the servers on which Wiser operates on a quarterly basis - in progress • Initial investigation has shown that WISER will function under Windows 7 (the proposed new desktop platform for NMC computers).	• Options for the replacement of the current Business Process management System (BPMS) within WISER, which is not supported by the supplier, are to be investigated • A business case for the options for a replacement strategy for WISER to mitigate risk of failure is to be developed • All appropriate security patches are to be applied to the WISER servers in line with the agreed schedule • Further work will now be carried out to test compatibility of all WISER components with Windows 7 in our testing environment	Mark Smith	16/04/2013	30/07/2013
G1		**CP**	Enabling	**APPROVED PROGRAMMES DATABASE/WISER LACK OF SYNCHRONISATION -** The risk that an unqualified person may be entered on the register due to the approved programmes database (APD) and Wiser not being fully synchronised	**5**	**3**	**15**	**0**	• Mitigation step 1:Improve quality of quality assurance records on the database. Outcome: Data cleansing completed and report provided. Mitigation step 2: Audit and synchronisation of the quality assurance records and Registration systems	• IT strategy to ensure full synchronisation between APD and Wiser. Mitigation step 2 is to address this issue as part of the Registration Programme in 2013	Katerina Kolyva	16/04/2013	30/06/2013
G27		**CS (HR)**	Staff	**TEMPORARY STAFF -** The risk that the level of temporary staff, filling budgeted posts, will undermine the ability of the NMC to deliver its core function of protecting the public, particularly in FtP	**5**	**3**	**15**	**0**	• Senior recruitment now complete, giving more stable leadership • Major recruitment campaigns undertaken converting temporary into permanent roles	• Strengthen organisational approach to workforce planning by centralising process and reporting	Mark Smith	31/05/2013	30/06/2013
G28 (T7)		**FtP**	Safeguarding	**PERFORMANCE OF FtP -** The risk that we will fail to deliver the level of activity required to meet the KPIs by the end of 2014 resulting in a lack of confidence in the NMC	**5**	**3**	**15**	**0**	• Development of a model to profile the FtP caseload and forecast activity • Introduction of changes to case management including VR and CPD • Efficiencies in processes • Recruitment, training and induction of new staff • Recruitment, training and induction of new panel members • Increase in hearing venues	• Improved use of management information • Workforce planning	Sarah Page	16/04/2013	31/03/2014
G5		**CG**	Enabling, Reputation	**NON-COMPLIANCE WITH EQUALITY ACT** - The risk that we fail to comply with our duties under the Equality Act 2010, fail to meet our equality and diversity objectives and are unable to respond to stakeholders legitimate requests for diversity data about our registration work	**4**	**3**	**12**	**0**	• Diversity data published • EQIAs carried out • Equality and diversity covered in every Council and committee paper • Legislation and Compliance Manager started 11 March 2013	• Gap analysis on progress against our Equality and Diversity objectives nearing completion • Action plan to be finalised • Equality and diversity annual report to be written and published	Lindsey Mallors	16/04/2013	31/12/2015

Key:
CE - Chief Executive
CG - Corporate Governance
CP - Continued Practice
CS - Corporate Services
FtP - Fitness to Practise
R - Registration

NMC RISK REGISTER

General risk

No.	Entry date	Ref	Type	Risk	Impact	Likelihood	Risk Rating	Movement	Mitigation	Future action	Owner	Review date	Target completion date
G38	**Mar-13**	**CG**	Enabling, Reputation	**NON-COMPLIANCE WITH THE WELSH ACT 1993 AND THE WELSH LANGUAGE (WALES) MEASURE 2011 -** The risk that we continue to be in breach of requirements under this legislation due to lack of ownership and designated responsible officer in place, resulting in sanctions and/or reputational damage	**4**	**3**	**12**	**NEW RISK**	• Negotiations with Welsh Language Commissioner have taken place on revised deadlines. Now working towards submission of action plan and position paper by end of April 2013 and detailed monitoring report by 20 September 2013	• Detailed action plan and position paper to be prepared for submission to the Welsh Language Scheme Commissioner by end of April 2013 • Detailed monitoring report to be prepared for submission to the Welsh Language Scheme Commissioner by 20 September 2013	Lindsey Mallors	16/04/2013	30/09/2013
G6 (T18)		**CG**	Governance	**CORPORATE RISK & PERFORMANCE MANAGEMENT NOT EMBEDDED -** The risk that we fail to embed risk management and corporate performance management, resulting in our inability to meet statutory functions	**4**	**3**	**12**	**0**	• Corporate register is reviewed by Council at every meeting • Audit Committee assures the process • Discussed monthly at directors meetings • Chair and Chief Executive discuss monthly • Balanced Scorecard in place to measure corporate performance and highlight areas needing additional focus • Refreshed risk management policy, framework and toolkit agreed by Audit Committee on 11 December 2012, subject to incorporation of agreed changes • Timetable for implementation and training agreed by Audit Committee on 25 January 2013 • Training sessions for CEO/directors scheduled for 26 April and for assistant directors on 30 April	• Risk management responsibilities to be included in management job profiles and personal development reviews • New directorates to discuss risks at team meetings • Develop and schedule risk management training for all managers • Amended risk management framework and toolkit to Audit Committee on 19 April	Lindsey Mallors	16/04/2013	30/04/2013
G17		**CP**	Safeguarding	**QUALITY OF STANDARDS, GUIDANCE AND REGULATION IN PRACTICE INFORMATION -** The risk that NMC standards, guidance and regulation in practice information are not fit for purpose resulting in failure to meet statutory obligations	**4**	**3**	**12**	**0**	• Council discussed standards prioritisation February 2012 • Regulation in practice information sheets cleansed May and June 2012 • Council agreed wholesale review of standards and guidance July 2012	• Keep regulation in practice information under review • Cleanse circulars • Start standards review, to include evaluation methodology • Agree standards development framework and implement • Prioritise programme of work on risk basis	Katerina Kolyva	16/04/2013	31/03/2014
G20		**CG**	Enabling	**DATA QUALITY AND USE** - The risk that we do not collect and use data consistently to understand, improve and report on our business and to contribute to work with other regulators	**3**	**4**	**12**	**0**		•CG to lead the development and implementation of a corporate data and information management strategy. The establishment of a project team and initial scoping of work will take place during the first half of 2013-2014 business year • Inter-regulatory research and evidence group to be set up (agreement with Professional Standards Authority November 2012). First event to be held in April 2013 • IT strategy and functions to enable valid and reliable data generation	Lindsey Mallors	16/04/2013	31/03/2014

Key:
CE - Chief Executive
CG - Corporate Governance
CP - Continued Practice
CS - Corporate Services
FtP - Fitness to Practise
R - Registration

NMC RISK REGISTER

General risk

No.	Entry date	Ref	Type	Risk	Impact	Likelihood	Risk Rating	Movement	Mitigation	Future action	Owner	Review date	Target completion date
G 34 (T1)	**Apr-12**	**CE**	Strategic	**CHRE STRATEGIC REVIEW -** The risk that public protection is not delivered resulting in a lack of confidence in the NMC	**4**	**3**	**12**	**0**	• Change management programme in place and continuing to develop to address performance improvement and delivery across the organisation • Introduction of monthly e-newsletter for patients and the public • Regular key external stakeholder formal engagement	• Continue to progress actions in the change management programme • Monitor critical milestones delivery • New Chair to continue strategic engagement with stakeholders • Use Patient Engagement Forum to take a patient view on progress • Re-positioning our core role and purpose throughout external communications • Staff conference focused on public protection being central to staff roles	Jackie Smith	30/12/2013	31/03/2014
G35 (T15)	**Mar-12**	**CS (HR)**	Staff	**MANAGEMENT CAPABILITY AND CAPACITY -** The risk that managers do not have the capability and capacity to support the delivery of the business and changes needed across the organisation	**4**	**3**	**12**	**0**	• Ongoing coaching and support provided for senior managers delivering change • Directors and Assistant Director roles now almost filled • High level behavioural framework established and utilised within selection process. Soft launch to start embedding behaviours through team development • FtP recruitment completed • L&D has rolled out sessions on HR policies run by HR • Management development program commenced in November for level 3, aimed at new first line managers • Development of new Assistant Directors' group and increased level of involvement	• Further development and roll out of HR strategy • L&D solutions being offered to new appointees in senior roles eg training on performance management • Behavioural competency framework to be fully rolled out and embedded • New learning and development policy and programme to be developed and implemented in line with change programme and corporate plan	Mark Smith	16/04/2013	31/07/2013
G39	**Mar-13**	**CS**	Financial	**LACK OF FINANCIAL RESOURCE** - The inherent risk of budgetary pressures from a combination of crystallising factors including; the recommendations in the Francis Report and any resulting increase in referrals over and above what is in our plan; the Health Select Committee report, and; failure to deliver budgeted efficiencies as set out in our Minimum Reserves Policy	**5**	**2**	**10**	**NEW RISK**	• Financial planning on 3-5 year basis to predict need • Close modelling work with Fitness to Practise on volumes and throughput • Close alignment of Corporate Plan and budget • FtP operational delivery is guided and overseen by the FtP Committee • Budgetary assumptions include prudent estimates and provisions • Risk factors set out in review of reserves	• Close monitoring of FtP performance and budgeted efficiency savings • Monthly budget meetings with all operational areas • Development of workforce planning tool	Mark Smith	31/05/2013	31/03/2015
G9		**CG**	Reputation	**RETENTION AND DISPOSAL OF RECORDS -** The risk that there is no planned schedule of destruction, leading to records being kept beyond retention periods, resulting in possible breaches of the Data Protection Act where records contain personal data; and the impact of responding to FoI and DPA requests where information which should have been destroyed will need to be considered for disclosure	**3**	**3**	**9**	**0**	• Records inventory lists, retention schedules, records management policy, guidance documents on management of records • Agreed retention periods for certain classes of records. Retention and disposition of records updated on inventory lists	• Corporate retention schedule (excluding FtP) presented to Directors Group on 12 Feb 2013 but not agreed • Records Manager will meet with directors and department heads to review the retention periods and obtain agreement • Work on review of FtP records started 1 February 2013 with a meeting of FtP retention review group • The complete Corporate Retention Schedule will be re-presented to directors on 30 April	Lindsey Mallors	16/04/2013	31/03/2013
G36	**Dec-12**	**CS (HR and Finance)**	Enabling	**INCREASING PENSION LIABILITIES -** risk to the financial health of NMC due to increasing pension liabilities caused by perceived weak stock market performance, low returns on gilts and the need to achieve obligations for auto-enrolment.	**3**	**3**	**9**	**0**	• Reformed pension scheme that shares risk more equally between employer and employee with greater certainty over future costs and benefits • Review of pension scheme underway	•Review of existing pension arrangements in the light of increasing liabilities, uncertainty and volatility and introduction of auto enrolment •Presentation of options to Council •Consultation with employees and pension trustees	Mark Smith	16/04/2013	01/10/2013

Key:
CE - Chief Executive
CG - Corporate Governance
CP - Continued Practice
CS - Corporate Services
FtP - Fitness to Practise
R - Registration

Item 9
AC/13/22
19 April 2013

Audit Committee

Internal Audit work programme and annual report 2012-2013

Action: For discussion.

Issue: Reports the outcome of internal audit work during the final quarter and provides the annual internal audit report for 2012-2013.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: internal audit is an essential element of the NMC's governance framework.

Decision required: The Committee is recommended to:

- Discuss the outcomes of internal audit work completed in quarter four and management's response.
- Note the annual internal audit opinion for 2012-13.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Parkhill - Internal Audit Report Block 3
- Annexe 2: Parkhill Annual Internal Audit Report to 31 March 2013

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 The Committee is responsible for approving and monitoring the internal audit work programme (Terms of Reference 2.1).

2 A report on internal audit work carried out during the last quarter by Parkhill, the NMC's internal audit providers is at annexe 1.

3 The annual internal audit opinion and report to 31 March 2013 is at annexe 2.

Discussion:

4 In December 2012, the Committee agreed that, internal audit work in the final quarter (January to March 2013) be limited to the planned data security health check and follow up of implementation of previous recommendations unless any additional work was necessary to the formulation of an overall annual internal audit opinion (AC confidential minute 12/113/15). The Executive was delegated to determine with Parkhill whether any other audit work was needed.

5 Following discussions, it was agreed to proceed only with the planned data security health check and follow up work to verify implementation of previous recommendations.

Data Security health check

6 The previous data security health check conducted in December 2011 resulted in an assurance rating of "adequate". The current review gives an assurance rating of "limited" (annexe 1 paragraph 2.10). The reports makes three “substantial” recommendations and one "merits attention" recommendation.

7 Two of the recommendations, relating to reporting of data security incidents and ensuring information security training for all staff and contractors, are repeated from the 2011 review:

8 Management accepts the findings and responses to the recommendations are provided in the report (annexe 1, appendix A).

9 Plans to improve information security and progress to date are discussed in more detail in the separate agenda item on Information Security.

Follow up of previous recommendations

10 The final block of work also included verification of implementation of recommendations from previous audits. The auditors confirmed that all but one recommendation submitted for verification had been implemented satisfactorily (see appendix B, annexe 1). The one not verified related to information security training as discussed above.

Annual Internal Audit Opinion to 31 March 2013

11 The annual internal audit report to 31 March 2013 is at annexe 2. The annual audit opinion at paragraph 6.2 is that the NMC has:

11.1 adequate and effective governance.

11.2 adequate and effective risk management.

11.3 adequate and effective control processes.

12 The account taken of this opinion in preparing the annual governance statement is discussed in the separate agenda item elsewhere on the agenda.

13 **Recommendation:** The Committee is asked to:

13.1 Discuss the internal audit review completed and management's response.

13.2 Note the annual internal audit opinion at annexe 2.

Public protection implications:

14 Internal audit should assist in identify ways of improving internal controls and risk management so as to help ensure delivery of the NMC's regulatory functions.

Resource implications:

15 The costs of internal audit are met from within the Corporate Governance directorate budget. Additional resource implications are:

15.1 Staff time in managing the client side requirements for internal audit services.

15.2 Staff time expended in contributing and responding to internal audit reviews.

Equality and diversity implications:

16 No direct equality and diversity implications result from this paper.

Stakeholder engagement:

17 Not applicable.

Risk implications:

18 Internal audit should help ensure the NMC manage its risks effectively.

Legal implications:

19 Not applicable.

Item 9
AC/13/22 Annexe 1
19 April 2013

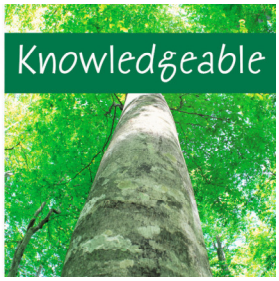
Internal Audit Services

Nursing & Midwifery Council

Internal Audit Report

Block 3 2012/13

March 2013



CONTENTS

CONTACT DETAILS – MANAGEMENT TEAM

Team Member	Role	Mobile	Email
Kevin Limn	Head of Internal Audit	07881 845472	kevin.limn@parkhill.org.uk
Jenny Leeson	Audit Manager	07825 780412	jenny.lesson@parkhill.org.uk

PERFORMANCE

Key Stage	Date	Target (Days)	Actual (Days)	Comments
Draft Report v1.0	18/02/13	10	5	
Final Report v1.0	01/03/13	5	1	

INTRODUCTION

OPERATIONAL AUDIT PLAN

1.1 This report summarises the outcome of work completed to date against the operational audit plan approved by the Council's Audit Committee and incorporates cumulative data in support of internal audit performance and how our work during the year feeds in to our annual opinion.

1.2 The sequence and timing of individual reviews has been discussed and agreed with management to ensure the completion of all audits within the agreed Internal Audit Strategy 2012/13; the current planned schedule is shown in Appendix D.

1.3 We would like to take this opportunity to thank all members of staff for their co-operation and assistance during the course of our visit.

1.4 The results of each audit are reported through the Executive Summary and agreed Action Plans; **Appendix A** for Fundamental and Significant recommendations and **Appendix B** for Merits Attention recommendations. A Summary of Opinions and Recommendations is shown as **Appendix C** and progress against the Operational Plan is detailed at **Appendix D**.

STANDARDS

1.5 We have performed our work in accordance with the principles of the Government Internal Audit Standards (GIAS) and the Chartered Institute of Internal Auditors (CIIA) International Standards for the Professional Practice of Internal Auditing. Our working papers are available for inspection by our clients at any time.

QUERIES

1.6 Should any recipient of this report have any queries over its interpretation or content they should contact the client engagement director either directly or through the client contact as appropriate and we shall be happy to discuss the assignments and provide any detail or explanations necessary.

SCOPE & BACKGROUND

1.7 We have reviewed each area in accordance with the scope and objectives agreed with management prior to our visit. Appendix A provides detail of the scope of our work, our conclusions regarding the level of assurance that can be provided and where appropriate the agreed Action Plan to be implemented by management to remedy potential control weaknesses.

1.8 Our approach was to document and evaluate the adequacy of controls operating within each system. For each system the key controls operated by management were assessed against the controls we would expect to find in place if best practice in relation to the effective management of risk, the delivery of good governance and the attainment of management objectives is to be achieved. Where applicable, selected and targeted testing has been used to support the findings and conclusions reached.

1.9 We report by exception and only highlight those matters that we believe merit acknowledgement in terms of good practice or undermine a system's control environment and which require attention by management.

AUDIT OBJECTIVE & OPINION

1.10 The objective of our audit was to evaluate the auditable area with a view to delivering reasonable assurance as to the adequacy of the design of the internal control system and its application in

practice. The control system is put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively.

1.11 Our opinion is based upon the control framework (as currently laid down and operated) and its ability to adequately manage and control those risks material to the achievement of the organisation's objectives for this area. We provide our opinion taking account of the issues identified in the Executive Summary and relevant Action Plans.

Overall Opinion

1.12 Each Executive Summary provides an overall assessment of our findings for each system reviewed and provides an opinion on the extent to which management may rely on the adequacy and application of the internal control system to manage and mitigate against risks material to the achievement of the organisation's objectives for each area.

1.13 We use the following four grades: Substantial, Adequate, Limited or No Assurance.

Conclusion on the Adequacy of Control Framework

1.14 Based on the evidence obtained, we conclude for each area upon the design of the system of control, and whether if complied with, it is sufficiently robust to provide assurance that the activities and procedures in place will achieve the objectives for the system.

1.15 We use the following three grades: Good, Adequate or Weak.

Conclusion on the Application of Controls

1.16 Based on the evidence obtained from our testing, we conclude for each area upon the application of established controls.

1.17 We use the following three grades: Good, Adequate or Weak.

Grading of Recommendations

1.18 For ease of understanding we utilise a traffic light system to prioritise the importance of individual recommendations. We use the following three grades (in order of importance):

F	=	Fundamental
S	=	Significant
MA	=	Merits Attention

1.19 Further explanation of our grading structure is provided within **Appendix D**.

VALUE FOR MONEY

1.20 Where value for money issues are identified as a result of our work the corresponding recommendation will be annotated with **VFM** in the bottom right hand corner. This is used to identify recommendations which have potential value for money implications for the organisation or which indicated instances of over control.

PREVIOUS AUDIT RECOMMENDATIONS (FOLLOW UP)

1.21 Where a previously accepted audit recommendation remains outstanding at the time of our review and the original implementation date has passed the corresponding recommendation within Appendix A or B will be annotated with **PAR** in the bottom right hand corner.

EXECUTIVE SUMMARY

FINDINGS & CONCLUSIONS

2.1 The results of our visit to the Nursing & Midwifery Council (NMC) are summarised in this section of the report and are considered in relation to each area reviewed.

2.2 The extent of comment in relation to each audit area is restricted deliberately so as to highlight the key issues that we believe need to be drawn to the attention of the Audit Committee and management and are supported by a more detailed analysis of each review that is contained as Appendix A to this report and Merits Attention recommendations stated at Appendix B.

Data Security Healthcheck

2.3 The objective of the audit was to ensure that the Council takes appropriate steps in line with good practice to protect the data collected in the fulfilment of its role and comply with relevant legislation. We specifically reviewed controls to ensure that all staff, members and contractors attend the necessary training programmes and their attendance is appropriately recorded; policy and procedures are in place to allow for reporting of security incidents and to ensure that security incidents are suitability captured, documented and reviewed.

2.4 Our review identified that relevant policies on Data Security were current and accessible through the intranet and the TRIM library.

2.5 We identified that the controls in place to ensure completeness in the coverage of Information Security mandatory training were weak. The only complete record of attendance was in the scanned attendance sheets, however, this format was not amenable to review or analysis. In addition, we identified that it was not clear to management within the organisation whether the responsibility for supporting line management in ensuring that their staff attended this training, though designated as mandatory, lay with the Learning and Development department or Information Security. Review of training records showed that approximately 50% of Fitness to Practice (FtP) staff had not received Information Security training within the last 2 years. There were also no procedures or controls to prompt attendance at refresher training. However, it was expected that the introduction of the new E-learning module would address this issue.

2.6 We found that reporting of Incidents through Serious Event Reviews (SER) was appropriate with lines of escalation to the Executive Team. It was noted, however, that there was little guidance on non-SER incidents though these could usefully inform management on trends and the potential for more serious incidents. The information incidents reviewed were managed by local management who consulted the Information and Data Governance Manager. The size of the organisation suggests this is a practical response to the need for independence.

2.7 The lack of a centralised incident reporting mechanism and supporting incident management framework makes full anonymity impractical. In addition, management had indicated that they had opted for a 'non-blame' culture to allow a focussing on learning from issues. It would, therefore, be difficult to engage in this fully with anonymity in place. However, there was some evidence from local managers that though there had been recognition of this culture in the past, it was no longer effective in the workplace.

2.8 In order to follow up on the agreed recommendations within our 2011/12 Data Security review we reviewed the latest management tracker recommendation log which showed actions in place. These included the definition and agreement of the following:

- The roles and responsibilities associated with the collation of SER and non-SER incidents;

- The process for the subsequent management of the outcome and learning relating to the SER incidents;
- The reporting requirements and format of regular reporting mechanisms.

We confirmed that work was ongoing for previous agreed recommendations in relation to:

- The Information Asset Register and Data Flow Mapping;
- Incident Reporting of Data Security Incidents;
- Information Security Training.

2.9 We followed the processes for two SER incidents in FtP and found appropriate controls in place. However, we found little evidence of compliance with controls on non-SER incidents. This should be addressed by the actions referred to in recommendation three below.

2.10 We have formed our opinion on the evidence and tests based on the restricted scope of the audit and recognise that it does not necessarily reflect the overall status of the wider Data Security control framework.

Taking account of the issues identified above and the recommendations contained within Appendix A, in our opinion the control framework for the area under review, as currently laid down and operated, provides **limited assurance** that risks material to the achievement of the organisation's objectives for this area are adequately managed and controlled.

APPENDIX A – PH 06/13 HR – DATA SECURITY HEALTHCHECK

Management Objective:	The Council takes appropriate steps in line with good practice to protect the data collected in the fulfilment of its role and comply with relevant legislation.		
Responsible Officer:	Marion Owen - Information & Data Governance Manager		
Areas for consideration: On this occasion we will consider the following aspects of control exercised over the Council's handling of personal data: ▪ Follow-up of recommendations raised in the 2011/2 review. ▪ Review the controls in place to ensure that all staff, members and contractors attend the necessary training programmes, their attendance is recorded and refresher training prompted. ▪ The clarity, accessibility and promotion of policy and procedures in place to allow for independent and anonymous reporting of security incidents. ▪ Review the controls in place to ensure that security incidents are suitability captured, documented, reviewed, reported through to Council, actions taken and lessons learnt.		**Limitations to scope:** ▪ The review is intended to deliver reasonable assurance as to the control arrangements in place to drive and protect the correct handling of personal data by the Council through its staff, members and contractors in the performance of their roles. ▪ The review will only cover those aspects of Data Security outlined above; subsequent reviews will consider and provide opinion over other aspects of the Council's Data Security procedures. ▪ The review is not designed to provide assurance or legal advice over the Council's compliance with the Data Protection Act or Freedom of Information Act. ▪ The review will not consider aspects of IT data security.	
Overall opinion:	Limited	Adequacy of control framework:	Adequate
		Application of control:	Weak

Findings Discussed With:	Phil Shoesmith, AD -ICT ; Andy Langler, Strategic ICT Programme Manager; Fionnuala Gill, Performance Improvement Manager; Marion Owen, Information and Data Governance Manager; Deepti Choudhary, Acting Learning and Development Manager

Recommendations	Priority	Management Response	Implementation Plan
1. 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. Ref: Executive Summary 2.4 & 2.5	S	The ICT and HR teams will implement a number of changes over the coming months. 1) Learning & Development can provide reports on who has attended the training every 6 weeks to managers and directors 2) The new 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 improvements to the system over time will enable email reminders to be sent to the line manager where staff have not commenced the training. 3) The Security Officer will agree a policy with Directors to ensure all members of the workforce receive appropriate training which will be monitored using the reports developed in 2) above 4) ICT and L&D to sign off new eLearning module for Data Protection training. .	1) Responsibility: Learning & Development Adviser, ICT Security Officer. **Target date**: 31 March 2013 onwards. The Information security module is to be piloted (after making changes on the 1st and 4th of March) with a group of 5-6 staff members, allowing for updates and changes, the module can then be rolled out to all relevant staff on 11 March 2) September 2013 – Assistant Director, ICT and Assistant Director, HR 3) April 2013 ICT Security Officer 4) March 2013 Learning & Development Adviser and ICT Security Officer
2. Non Blame Culture The organisation should work proactively on fostering and supporting a non blame culture. Ref: Executive Summary 2.7	S	An Organisational Development programme is being 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	**Responsibility:** Director of Corporate Services **Target date:** 31 March 2013

		culture related issues.	
3. Incident Reporting [of data security incidents] The organisation should define and agree: -The roles and responsibilities associated with the collation of SERs and non-SER incidents; -The process for subsequent management of the outcome and learning relating to the SER incidents; -Reporting requirements and regular reporting mechanisms. Ref: Executive Summary 2.6 **PAR**	S	The ICT Security officer to work with Performance Improvement 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.	**Responsibility:** Assistant Director, ICT **Target date:** 30 April 2013

APPENDIX B – MERITS ATTENTION RECOMMENDATIONS

Recommendations	Priority	Management Response	Implementation Plan
4. Training The NMC should ensure that all staff and contractors receive Information Security training. Ref: Executive Summary 2.4 **PAR**	**MA**	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 ensure that appropriate timely training can be provided.	**Responsibility:** Assistant Director, HR Learning and Development Policy to be updated to include contractors and subject to approval in accordance with normal procedures. **Target Date:** 30 April 2013.

APPENDIX B – FOLLOW UP

Our Internal Audit Strategy includes provision for the follow up of previously accepted recommendations to assess the level of implementation. We have reviewed management's own recommendation tracker and followed up those stated as completed. We have reviewed the evidence available, interviewed responsible staff (where necessary) and completed audit testing where appropriate to assess the level of compliance with the status and controls in place.

We report the detail of our follow up work by exception where previously agreed recommendations have not been fully implemented.

Data Security Healthcheck – Audit undertaken December 2011			
Recommendation	**Latest Update(s)**	**Status**	**Required Action(s) / Recommendation**
The NMC should ensure that all staff and contractors receive Information Security training.	Permanent staff continue to receive mandatory training on information security. The work on the e-learning module referred to in the original management response is underway with a view to going live in January 2013. In November 2012, fact sheets were introduced for temporary staff and contractors.	**Not implemented.**	See recommendations 1 and 2 above.

APPENDIX C – SUMMARY OF OPINIONS & RECOMMENDATIONS

Reports being considered at this Committee meeting are shown in italics. The definitions with regard to the levels of assurance given and the classification of recommendations can be found in the Notes section at the end of this report.

Audit	Progress	Opinion	Recommendations Made				
			F	S	MA	Total	Agreed
1. HR – Performance Management	Final report	Substantial	**0**	**0**	**1**	**1**	**1**
2. Register & Registrations	Final report	Adequate	**0**	**1**	**5**	**6**	**6**
3. Project Management	Final report	Adequate	**0**	**2**	**4**	**6**	**6**
4. Core Financial Systems	Cancelled	N/A					
5. Risk Management	Cancelled	N/A					
6. Data Security Health Check	*Final Report*	*Limited*	***0***	***3***	***1***	***4***	***4***
7. Fitness to Practise (QA)	Final report	Adequate	**0**	**4**	**3**	**7**	**7**
8. IT Development	Cancelled	N/A					
		Total	**0**	**10**	**14**	**24**	**24**

At the moment there is nothing that impacts negatively upon our annual opinion.

APPENDIX D – OPERATIONAL PLAN 2012/13

Following discussions with management the following schedule has been agreed:

Block 1 – September 2012	Audit Committee		Resource		Comments
Audit	Planned AC	Actual AC	Plan Days	Actual Days	
1. HR – Performance Management	Sept 2012	Dec 2012	8	8	Postponed to block 2 as per management request
2. Register & Registrations	Sept 2012	Sept 2012	12	12	
Follow Up	Sept 2012		3	0	Postponed to block 3
Management			3	3	
		Total	**26**	**23**	

Block 2 – December 2012	Audit Committee		Resource		Comments
Audit	Planned AC	Actual AC	Plan Days	Actual Days	
3. Project Management	Dec 2012	Dec 2012	10	10	
4. Core Financial Systems	Dec 2012		10	0	Cancelled
Management			2	2	
		Total	**22**	**12**	

Block 3 – March 2013	Audit Committee		Resource		Comments
Audit	Planned AC	Actual AC	Plan Days	Actual Days	
5. Risk Management	Mar 2013		8	0	Cancelled
6. Data Security Health Check	Mar 2013	Mar 2013	4	4	
7. Fitness to Practise (QA)	Mar 2013	Dec 2012	8	8	Completed in block 2
8. IT Development	Mar 2013		8	0	Cancelled
Follow Up	Mar 2013		3	3	
Management			3	3	
		Total	**34**	**18**	

TOTAL AUDIT DAYS 2012/13	**82**	**53**

NOTES

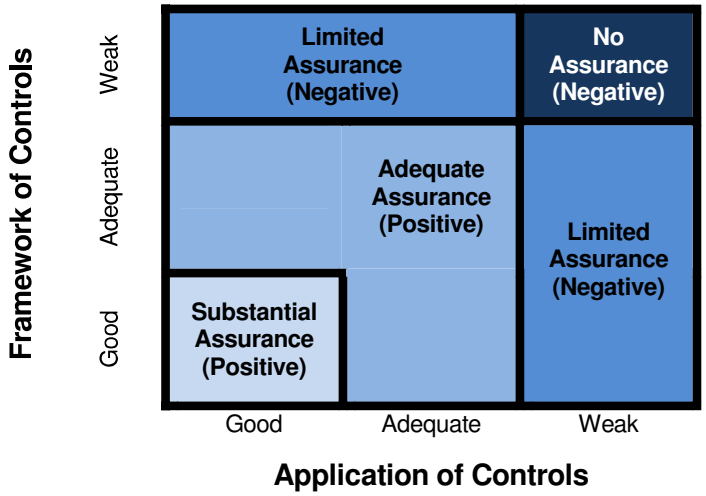
KEY FOR RECOMMENDATIONS (IN RELATION TO THE SYSTEM REVIEWED)

Fundamental (F)	-	The organisation is subject to levels of fundamental risk where immediate action should be taken to implement an agreed action plan.
Significant (S)	-	Attention to be given to resolving the position as the organisation may be subject to significant risks.
Merits Attention (MA)	-	Desirable improvements to be made to improve the control, risk management or governance framework or strengthen its effectiveness.

ADEQUACY & APPLICATION OF CONTROL

	Adequacy of Control Framework	Application of Control	Typical Indicators
Good	The control framework was found to be robust, well documented and suitable to manage the organisation's risks in the area under review.	Controls were found to be consistently applied in accordance with the control framework.	There are no fundamental or significant recommendations arising in the category.
Adequate	The control framework was generally considered sound with minor areas for improvement.	Testing highlighted only minor instances of non-compliance with the control framework.	There are no fundamental or no more than two significant recommendations arising in the category.
Weak	The control framework was generally considered poor exposing the organisation to significant levels of risk.	Testing highlighted that the control framework was not being applied consistently.	There is one or more fundamental recommendation or more than two significant recommendations arising in the category.
The above is for guidance only; professional judgement is exercised in all instances.			

OVERALL OPINION CRITERIA



Item 9
AC/13/22 Annexe 2
19 April 2013

Internal Audit Services

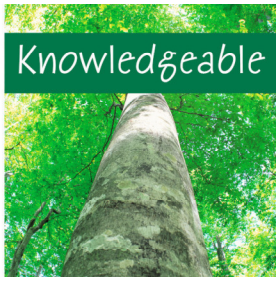
Nursing & Midwifery Council

Internal Audit Annual Report

Year Ended 31st March 2013

Approved by: Kevin Limn as Head of Internal Audit

Approved on: 26th March 2013



CONTENTS

Contact Details

Kevin Limn
Portfolio Director
Hammersmith Hospital
2nd Floor, South Admin Block
Du Cane Road
Hammersmith
London
W12 0HS

Tel: 07881 845 472
Email: kevin.limn@parkhill.org.uk

1. INTRODUCTION

1.1 The purpose of internal audit is to provide the Council, Audit Committee, the Chief Executive and management of the Nursing & Midwifery Council with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the organisation's agreed objectives. Internal audit also has an independent and objective consultancy role to help management improve risk management, governance and control.

1.2 The results of our internal audit work form part of the framework of assurances that the Council receives and should be used to assist the Council to prepare informed governance and internal control statements.

1.3 As your internal auditors we are required to provide you with an opinion on the overall adequacy and effectiveness of the organisation's governance, risk management and control processes.

1.4 Our risk based methodology and working practices are compliant with the Government Internal Audit Standards (GIAS) and the Chartered Institute of Internal Auditors (CIIA) International Standards for the Practice of Internal Auditing. These standards are adopted insofar as they are applicable to you as a client.

2. PLANNED COVERAGE & OUTPUT

2.1 Internal Audit work for the period 1st April 2012 to 31st March 2013 was carried out in accordance with the Internal Audit Strategy and Annual Audit Plan approved by the Audit Committee. The Audit Committee originally agreed to an input of 82 days of internal audit coverage in the year which was revised to 53 days. A further 9 days for the additional audit of expenses was also undertaken.

2.2 The planned review approved by the Audit Committee, the planned number of days and the actual time against each is shown in Appendix A.

2.3 Our audit assignments were undertaken over three visits, one in July, a second in October 2012 and a third in January 2013, as agreed with management and we are grateful for the co-operation which we received from those managers and staff that were involved with the audit process.

3. MANAGEMENT ACTION ON RECOMMENDATIONS

3.1 Based on the results of our follow up work, management responses and agreed implementation plans we believe that management have taken or planned appropriate and timely action to implement recommendations.

4. OPERATIONAL ASSURANCE

4.1 The internal audit service reviewed a number of areas during the year:

- HR – Performance Management
- Register & Registrations
- Project Management
- Data Security Health Check
- Fitness to Practice (QA)

In addition to the planned internal audit reviews we also undertook an audit at the request of management:

- Expenses Review

4.2 From these examinations, taking into account the relative risk of the business areas the internal audit service has formed the following conclusions (good, adequate or weak) regarding the policies, procedures and operations in place to:

- Establish and monitor the achievement of the Council's objectives: Good
- Identify, assess and manage the risks to achieving the Council's objectives: Good
- Advise on, formulate, and evaluate policy, within the responsibilities of the Chief Executive: Good
- Ensure economical and efficient use of resources: Good
- Ensure compliance with the Council's policies, procedures, law and regulations: Good
- Safeguard the Council's assets and interests from losses of all kind including those from fraud, irregularity and corruption: Good
- Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes: Good

5. OVERALL ASSURANCE

5.1 As the Internal Audit Service provider to Nursing & Midwifery Council, we are required to provide the Council and the Chief Executive with a statement on the adequacy and effectiveness of the organisation's risk management, control and governance processes.

5.2 In giving an opinion it should be noted that assurance can never be absolute. The most that the audit service can provide to the Council is a reasonable assurance there are no major weaknesses in the Council's risk management, control and governance processes.

5.3 In assessing the level of assurance to be given, the following have been taken into account::

- All audits undertaken during 2012/13;
- Any follow-up action taken in respect of audits from previous periods;
- Significant recommendations not accepted by management and the consequent risks;
- The effects of any significant changes in the organisation's objectives or systems;
- Matters arising from previous reports to the Council;
- Any limitations which may have been placed on the scope of internal audit;
- The extent to which resources constraints may impinge on the Head of Internal Audit's ability to meet the full audit needs of the organisation;
- What proportion of the organisation's audit need has been covered to date; and
- The results of work performed by other assurance providers including the work of the financial statement auditors and inspection (if applicable).

6. OPINION

6.1 We are satisfied that sufficient internal audit work has been undertaken to allow us to draw a reasonable conclusion as to the adequacy and effectiveness (or inadequacy and ineffectiveness) of the organisations risk management, control and governance processes.

6.2 Overall in our opinion, based upon the reviews performed during the year, Nursing & Midwifery Council:

- has adequate and effective risk management;

- has adequate and effective governance; and
- has adequate and effective control processes.

APPENDIX A: SUMMARY OF AUDIT OUTCOMES

2012/13

Audit Area	Progress	Overall Opinion	Plan Days	Actual Days	Recommendations Made				
					F	S	MA	Total	Agreed
Block 1									
HR – Performance Management	Final	Substantial	8	8	0	0	1	1	1
Register & Registrations	Final	Adequate	12	12	0	1	5	6	6
Follow Up	Cancelled	-	3	-	-	-	-	-	-
Block 2									
Project Management	Final	Adequate	10	10	0	2	4	6	6
Core Financial Systems	Cancelled	-	10	-	-	-	-	-	-
Block 3									
Risk Management	Cancelled	-	8	-	-	-	-	-	-
Data Security Health Check	Final	Limited	4	4	0	3	1	4	4
Fitness to Practice (QA)	Final	Adequate	8	8	0	4	3	7	7
IT Development	Cancelled	-	8	-	-	-	-	-	-
Follow Up	Final	-	3	3	-	-	-	-	-
Management									
Audit Management	-	-	8	8	-	-	-	-	-
		TOTAL	**82**	**53**	**0**	**10**	**14**	**24**	**24**

Additional Review									
Expenses	-	-	9	9	-	-	-	4	4

APPENDIX B: SUMARY OF MAIN FINDINGS

FUNDAMENTAL & SIGNIFICANT RECOMMENDATIONS

Ref	Recommendation	Priority
Register & Registrations		
1	Reconciling Ongoing Cases – Readmissions The Council should be proactive in reconciling ongoing cases. Applicants should be given a deadline to respond and these should be monitored. If a response is not forthcoming then the Council should take timely action to close the case.	Significant
Project Management		
1	Policy & 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.	Significant
2	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 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.	Significant
Fitness to Practice (QA)		
1	Review of Audi Plan As there have been a significant amount of changes within the structure 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.	Significant

Ref	Recommendation	Priority
2	Documented Procedures Formal documented procedures should be in place for the preparation and performance of FtP QA audit assignments.	Significant
3	Completion of Audit Plan In order to ensure that the 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.	Significant
4	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	Significant
Data Security Health Check		
1	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.	Significant
2	Non Blame Culture The organisation should work proactively on fostering and supporting a non blame culture.	Significant
3	Incident Reporting (of data security incidents) The organisation should define and agree: ▪ The roles and responsibilities associated with the collation of SERs and non-SER incidents; ▪ The process for subsequent management of the outcome and learning relating to the SER incidents; ▪ Reporting requirements and regular reporting mechanisms.	Significant

Ref	Recommendation
Expenses Review	
1	Finance should ensure that the CEO transactions are correctly posted to the relevant cost centre.
2	As stipulated by the Travel, Accommodation, Subsistence and Allowances Policy, all expense claims must only be processed where full VAT receipts have been provided in support of such claims. All expenses should also be appropriately authorised and for verified bona fide business events.
3	Travel to and from an employee's permanent place of work in the normal course of their role and duties and also costs associated with hotel accommodation not wholly and necessarily incurred in the normal course of business should be treated as a benefit in kind and taxed by the employer. If it remains the case that insufficient evidence and justification can be found for those irregularities stated in Appendix 1 the matter should be raised with the HMRC to ensure resolution.
4	Management should consider reviewing the NMC Travel, Accommodation, Subsistence and Allowances Policy to include detailed cut-offs / limits and guidance around senior management expenses, especially for the use of public transport, taxis and hotel accommodation. This will ensure that as part of the approval process, Finance staff are able to query expense claims where they feel that value for money has not been obtained.

APPENDIX C: PERFORMANCE OF INTERNAL AUDIT

Report Turnaround

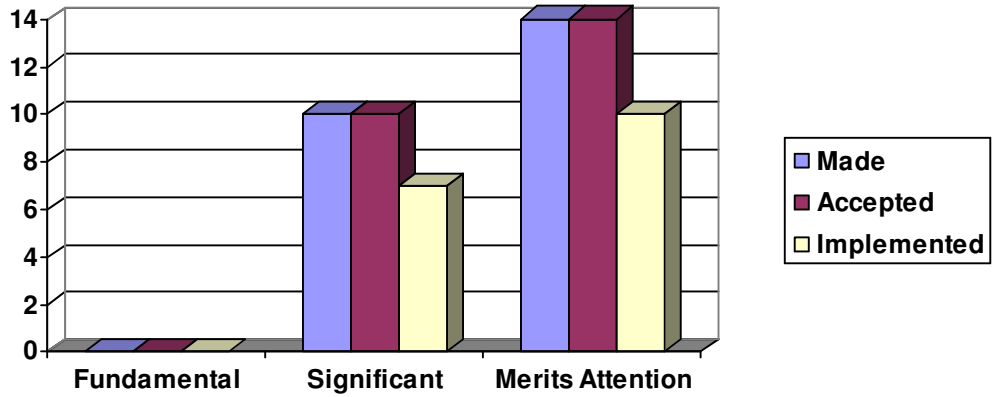
Performance Indicator	Target	Actual	Comments
Draft report turnaround (average working days)	10 days	8 days	
Final report turnaround (average working days)	5 days	1 days	

Resources

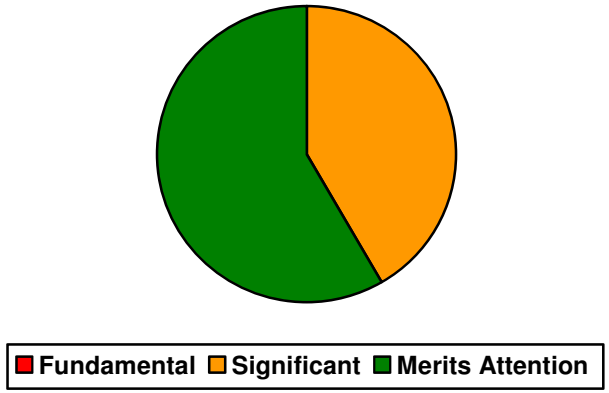
Performance Indicator	Target	Actual	Comments
Total Number of Audit Days	91	62	Plan days reduced as agreed with management
Audit Fee	Within Budget	Within Budget	
Director Input	15%	7%	
Manager Input	15%	22%	
IT Auditor Input	10%	12%	
Senior Auditor Input	30%	59%	
Auditor Input	30%	0%	

Recommendations

Made, Accepted & Implemented



Analysis of Priority



Implementation based upon management responses. Target dates may not have passed at date of report.

Item 10
AC/13/23
19 April 2013

Audit Committee

Outstanding recommendations: Progress report

Action: For discussion.

Issue: Reports on progress implementation of outstanding recommendations arising from internal audit and other internal reviews and investigations

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: internal audit and other internal review are an essential element of an effective governance framework.

Decision required: The Committee is invited to discuss and comment on this report.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Log of outstanding recommendations.
- Annexe 2: Counterfraud healthcheck recommendations.
- Annexe 3: Response of Registrations Directorate to the recommendations in the internal investigation report August 2011

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 At its meeting on 5 March 2012, the Committee requested that a report on outstanding internal audit recommendations be a standing agenda item for future meetings.

Discussion and options appraisal:

2 In January 2013, the Committee undertook detailed scrutiny of progress on all outstanding internal audit recommendations. The Committee asked that in future only recommendations past target date be included.

3 It was also agreed that recommendations from other internal or external review be included.

4 The log at annexe 1 now reports progress on:

- Outstanding internal audit recommendations which have passed, or are just about to pass, target date for implementation. (Section 1) and annexe 2.
- Recommendations arising from an investigation of an incident in August 2011 relating to Registrations fraud. (Section 2) and annexe 3.
- Outstanding recommendations from the independent review of Wiser and CMS. (Section 3)

5 Section 4 of annexe 1 provides a list of previously outstanding internal audit recommendations which internal audit has now verified as having been implemented (see previous agenda item).

6 The Committee is asked to agree that the items in section 4 of annexe 1 can now be removed from the log.

Public protection implications:

7 No direct public protection implications. Ensuring that internal audit and other recommendations are progressed in a timely fashion should help the NMC deliver its core regulatory functions more efficiently and effectively.

Resource implications:

8 Approximately 5 staff days have been expended on reviewing and revising the internal audit recommendations log to bring it up to date since the last meeting. In future it is anticipated that approximately 8 to 10 staff days a year will be required to ensure this is maintained.

Equality and diversity implications:

9 There are no direct equality and diversity implications resulting from this paper.

Stakeholder engagement:	10	Not applicable.
Risk implications:	11	Internal audit and other assurance reports and recommendations should support the NMC in managing risks more effectively.
Legal implications:	12	Not applicable.

Item 10
AC/13/23 Annexe 1
19 April 2013

Log of outstanding recommendations: updated version at 3 April 2013

Column A: Row number for ease of reference.
Column C: Priority assigned by internal audit. Green/MA= Merits Attention; Amber/S= Significant, Red/F=Fundamental
Column D: Officer responsible
Column E: Original management response and timetable for implementation at the time the relevant report was first received.
Column F: Progress report since last meeting of Audit Committee and planned work where appropriate.

Section 1 Internal Audit Outstanding Recommendations ie past target date/ revised target date for implementation

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
Data Security Health check - December 2011								
1	**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 presented.	**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	See row 5 below and response to repeated recommendation	See row 5 below and response to repeated recommendation	Partially implemented	**No** **Recommendation repeated in Data Security health Check 2013 (row 5 below)**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	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.			Reviews.				
2	**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 taking	Permanent staff continue to receive mandatory training on information security. The work on the e-learning module referred to in the original management response is underway with a view to going live in January 2013. In November 2012, fact sheets were introduced for temporary staff and contractors.	December 2012 (building the information security module) January 2013 The module will go live on the new e-learning platform	Implemented	**No** **Recommendation repeated in Data Security health Check 2013 (row 6 below)**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				place and should be completed soon. No target date set.				
DATA SECURITY HEALTH CHECK - JANUARY 2013								
3	**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. Ref: Executive Summary 2.4 & 2.5	**S**	Mark Smith Director Corporate Services 1. Learning & Development Adviser, ICT Security Officer. 2. Assistant Director, ICT and Assistant Director, HR	The ICT and HR teams will implement a number of changes over the coming months. 1.Learning & Development to provide reports on who has attended the training every 6 weeks to managers and directors 2. The new HRPro implementation will allow the NMC to capture all members of the workforce (FTE, Panellists, Temps and Contract) allowing reports	All staff not recorded as having undertaken IS training notified by email and given deadline for completion. Managers and Directors also advised. Not yet due.	1. 31 March 2013 The Information security module is to be piloted (after making changes on 1 & 4 March) with a group of 5-6 staff members, allowing for updates/changes, module to be rolled out to all relevant staff 11 March 2. September 2013	1. Implemented 2. Not yet due	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				showing who has completed the training and additional improvements to the system over time will enable email reminders to be sent to the line manager where staff have not commenced the training.				
			3. ICT Security Officer	3. The ICT Security Officer will agree a policy with Directors to ensure all members of the workforce receive appropriate training which will be monitored using the reports developed in 2 above	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 above.	3. 30 April 2013 policy; Sept 2013 reporting.	3 Partially implemented	
			4. Learning & Development Adviser and ICT Security Officer	4. ICT and L&D to sign off new eLearning module for Data Protection training.	4. New e-learning module launched 11 March and rolled out to workforce.	4. Completed	4.Implemented	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
4	**Non Blame Culture** The organisation should work proactively on fostering and supporting a non blame culture. Ref: Executive Summary 2.7	**S**	Mark Smith Director Corporate Services	An Organisational Development programme is being 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	Feedback gathered from staff induction and pay and grading 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.	May 2013	Partially implemented	
5	**Incident Reporting [of data security incidents]** **Recommendation repeated** The organisation should define and agree: -The roles and responsibilities associated	**S**	Mark Smith Director Corporate AD ICT	The ICT Security officer to work with Performance Improvement Manager to ensure that there is a clear policy and process for reporting events that fall outside the remit of	All security incidents are to be reported under the roll out of the Corporate Serious Event policy and related procedures which will include a standardised system for reporting all incidents.	30 April 2013		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	with the collation of SERs and non-SER incidents; -The process for subsequent management of the outcome and learning relating to the SER incidents; -Reporting requirements and regular reporting mechanisms. Ref: Executive Summary 2.6			the approved SER process for all Information Security / Data Protection related incidents	Future reports to Audit and ISIG will include a breakdown of incident by category and detailed reports on major incidents. Minor incidents or “near misses” will be influence our assessment of risk moving forward."			
6	**Training** **Recommendation Repeated** The NMC should ensure that all staff and contractors receive Information Security training. Ref: Executive Summary 2.4	**MA**	Mark Smith Director Corporate Services AD HR	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 ensure that appropriate timely training can	All staff, contractors and temps included in communication to complete e learning module. Policy to be approved by Directors by 30 April 2013.	30 April 2013	Implemented	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				be provided.				
COUNTER FRAUD HEALTH CHECK - DECEMBER 2011								
7	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 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.	**S**	Lindsey Mallors Director of Corporate Governance	Agreed. This will be considered as part of the review of risk management procedures. Fraud risks should be highlighted within general risk registers. No original target date was set. Subsequent target date 31 December 2012	The revised risk management policy and framework was agreed by Audit Committee in December 2012. However further work on the specific issue of fraud is needed and will be incorporated into the risk management framework.	Previous target date 31 December 2012 Following agreement of the revised risk management policy revised target date set of 28 February 2013.	Completed see separate agenda item.	
8	**Overseas Good Standing Certification** As part of the imminent review of Overseas Registration Policy, enhance / align with the EU	**S**	Alison Sansome Director Registrations	This is currently being considered as part of the overseas policy. No date was	Examined as part of the recent overseas registrations review and new processes implemented for overseas	2 April 2013.	Implemented.	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	applicants Good Standing Certification, e.g. to incorporate home and / or UK Police checks.			originally set for this.	applications made with effect from 2 April 2013 (see annexe 2)			
9	**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		
10	**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.	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 we should write to all employers stressing the importance of checking the register. This was	*Review of registrations policies and processes begun 3/4/13 (see annexe 2).*		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				Original target date end 2012.	completed. b. Any cases of fraud would be the subject of a serious event review report to the Audit Committee (*See row 2 above).*			
11	**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. Ref: Executive Summary 2.19	**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 and relevance and offers a more cost effective approach to providing assurance and meeting this intent. (*See row 5 above*). Reviewed see annexe 1 note being	Not applicable.		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
					pursued.			
12	**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.		
13	**Multiple Name Spelling Changes** Establish a trigger system to flag high-outliers for number of times name change requests received. Ref: Executive Summary 2.25	**MA**		No formal management response was made to this recommendation as it was not considered a sufficiently high priority.	Reviewed further see annexe 2 not being pursed at this time.	Not applicable.		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				No original target date was set.				
KEY FINANCIAL CONTROLS - AUDIT UNDERTAKEN DECEMBER 2011								
14	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, ie 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	After extensive reconciliation work, the residual balance will be written off in the year end accounts for 2012-13.	31 March 2013	Implemented	To be verified 2013 - 2014.

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				subsequently revised to December 2012				
IT HEALTH CHECK UNDERTAKEN MARCH 2012								
15	**ICT Strategy** The NMC should as soon as possible finalise, agree and implement the ICT strategy being drafted by the Assistant Director of ICT. Ref: Executive Summary 2.7	**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 in September 2012. Progress reports provided to Council in Jan 2013 and Finance & IT Committee in March 2013. Stabilisation phase being implemented. Development programme to go to Council in May/June 2013.	September 2012 deadline met Next phase of implementation to be reported Council May/June 2013	Partially implemented	
16	**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 Director	Accepted Policy is being created in consultation with all Directorates. To be shared with Senior Management	Proposed policy developed and discussed at Senior Management Group on 17 July 2012. Proposals referred to Efficiency Board on 1 August 2012.	Previous target dates not met (FTP records policy: scoping exercise. Agreed work plan by end June 2013. Non- FTP records Implementation end June 2013)	Not yet implemented	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
			Corporate Governance	Group May 31 2012 for discussion/ agreement and ratification by Directors June 2012. Original target date:30 June 2012 Subsequently revised: 30 October 2012	Progress is not as fast as 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	Revised target is for revised proposals to be put to Directors Group 30 April 2013		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
					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 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			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
					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.			
FTP QUALITY ASSURANCE - MARCH 2012								
17	**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	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
18	**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	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	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				735 to 588 closed cases is being considered. QA action plan will be discussed at the FtP Group meeting before the June Council meeting.				
19	**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	Slipped to April/May 2013 (1 month)	Ready to be implemented.	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
					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			
FITNESS TO PRACTISE (Quality Assurance) DECEMBER 2012								
20	**Regular Review of Audit Plan** As there have been a significant amount of changes within the structure 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. Ref: Executive Summary 2.15	**S**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed. The audit plan will be reviewed 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.			
21	**Documented Audit Procedures** Formal documented procedures should be in	**S**	Sarah Page Director FTP, Lindsey Mallors Director	Agreed. Documented procedure templates to be written by FtP QA	This is being addressed in the corporate QA strategy being developed by the AD			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	place for the preparation and performance of FtP QA audit assignments. Ref: Executive Summary 2.16		Corporate Governance	to use to define scope of audit assignments. 28 February 2013	Quality Assurance. See separate agenda item.			
22	**Completion of Audit Plan** In order to ensure that the 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. Ref: Executive Summary 2.18	**S**	Sarah Page Director FTP, Lindsey Mallors Director Corporate Governance	Agreed. This will be reviewed at the same time as a review of the audit plan takes place. 28 February 2013.	This is being addressed in the corporate QA strategy being developed by the AD Quality Assurance. See separate agenda item.			
23	**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. Ref: Executive Summary	**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	The plan will be revised in light of the developing strategy. See Separate agenda item.			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	2.19			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.				
24	**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. Ref: Executive Summary 2.14	**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.		

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
25	**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. Ref: Executive Summary 2.17	**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.			
26	**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. Ref: Executive Summary 2.18	**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.		
HR PERFORMANCE MANAGEMENT DECEMBER 2012								

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
27	**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 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.	**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 either manual or email confirmation of that both parties agree the PDR outcomes and markings.	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.	
PROJECT MANAGEMENT – CHANGE MANAGEMENT PROGRAMME DECEMBER 2012								
28	**Project Management Resources** The new Project Management process is	**S**	From Jan 2013 Jackie Smith Chief	Agreed. We fully accept that there is a resource issue and that one person is	Programme office comprising 3 staff from 1 April 2013. Recruitment of 2 staff to join	1 April 2013	Partially Completed.	Not yet applicable

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	still in its infancy; Currently one person is project managing the Programme. There is a potential resource issue (recognised internally by management) that one 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. Ref: Executive Summary 2.7		Executive and Registrar	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 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	programme manager to commence shortly.			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				ways. This will go to the Directors Group for consideration.				
29	**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. Ref: Executive Summary 2.9	**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.	

Section 2: Recommendations arising from an internal investigation into registrations August 2011

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
30	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.			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
31	We need to better define procedures for the management of suspected malpractice by individuals not on the register but working in a health care setting	**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.			
32	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			

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
					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.			

Section 3: Outstanding recommendation arising from external review of Integrity of WISER and CMS (December 2012)

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
33	***Recommendation 1*** The Standard Operating Procedures are updated to explain the process for inputting data onto CMS and WISER and the review	**Medium**	Assistant Director Adjudication Sarah Page Director	Agreed	**1. To review current SOP and suggest amendments** Existing SOP reviewed and replaced with	31 January 2013	Implemented	For 2013-14 work programme

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	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.		Fitness to Practise		detailed training manual / user guide. Rolling programme of training for Hearing Support Officers (HSO) commenced 11 February 2013 to be completed by 22 March 2013. Only trained staff updating Wiser and CMS. **2. To circulate and ensure all HSOs have signed as understood by 25 Jan 13** Completed.			
34	***Recommendation 2*** The legal team communicates with the Hearing Support Officers every two weeks and 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	**Low**	Assistant Director of Legal Services, FTP Sarah Page Director Fitness to Practise	Agreed	**2. Explore alternatives to WISER updating process.** WISER updates on High Court IO extensions and appeals remain with RLT.	28 February 2013 revised to end of March 2013 To go live 25th March 2013.	Implemented	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	Support Officers to limit confusion over legal cases in the future.				RLT super users will be invited to be training sessions (ongoing).			
35	***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**	Assistant Director Adjudication, Sarah Page Director Fitness to Practise	Agreed	Clear audit trail between HSOs and Decision Letter Team (DLT). Information capture in consolidated Master Discrepancy Spreadsheet. Daily discrepancies investigated resolved as appropriate.	31 January 2013	In place since November 2012.	
36	***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	**Low**	Assistant Director Adjudication Sarah Page Director Fitness to Practise	We agree that a review of the current process should take place to find best solution.	Discrepancy report as a alert which must be action within the 5 working days (KPI).	Review current process by April 2013	Recommendation deferred and existing/original process maintained	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	important to send the letter 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.							
37	***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**	Assistant Director Adjudication Sarah Page Director Fitness to Practise	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 taken at that stage.	Part of wider corporate CMS development programmed. Report submitted to Assistant Director of Operations. IT currently reviewing interface between CMS and WISER and report to EMT.	Scoping work completed and decision made by 31 January 2013	Feasibility of recommendation is being explored.	
38	***Recommendation 7*** Centralise the management of CMS and WISER which will enable a	**Low**	Assistant Director Adjudication	Agree in principle with recommendation and will ensure this	See recommendation 2 above regarding RLT.	31 March 2013	Partially implemented.	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	single team to help ensure the two systems correlate at all times. The other teams 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.		Sarah Page Director Fitness to Practise	process is streamlined.				
39	***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**	Assistant Director Adjudication Sarah Page Director Fitness to Practise	Recommendation agreed	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.	31 January 2013	Implemented	
40	***Recommendation 9*** The Hearing Support Officers continue to investigate every discrepancy on a weekly	**Low**	Assistant Director Adjudication Sarah Page		Maintaining the status quo.	30 April 2013	Recommendation deferred and existing / original process	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	rather than daily basis. Many of the discrepancies currently highlighted are due to a delay of a few days in sending out the decision 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.		Director Fitness to Practise				maintained.	
41	***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**	Assistant Director Adjudication, FTP Sarah Page Director Fitness to Practise	Recommendation agreed	In place since November 2012.	31 January 2013	Implemented	
42	***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	**Low**	Assistant Director Adjudication, FTP Sarah Page Director Fitness to Practise	Recommendation 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		Implemented	**To be verified as part of 2013-2014 work programme**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	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 retrieving information about historical sanctions.				EMT to ensure alignment with business priorities.			
43	***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**	Assistant Director Adjudication Sarah Page Director Fitness to Practise	Recommendation agreed	The CAGE group has been disbanded. Procedures are now being implemented at management level. Overall responsibility maintained by the FtP executive management team.	31 January 2013	22nd March 2013	

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
44	***Recommendation 13*** The EMT continues to approve all cases requiring manual removal.	**Low**	Sarah Page Director Fitness to Practise	Agreed and already implemented	Already implemented		Implemented	**To be verified as part of 2013-2014 work programme**
45	***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	Recommendation agreed and already implemented	All legacy cases reviewed for manual removal.			**To be verified as part of 2013-2014 work programme**

Section 4: Implemented recommendations verified by internal audit in Quarter 4 2012-2013

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
DATA SECURITY MANAGEMENT UNDERTAKEN MARCH 2011 (BY PFK)								

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
46	The contractual undertakings and assurances received regarding paper based data security arrangements from Paper escape should be double checked.	MA	Dhar Grewal Head of Procurement and Estates Mark Smith Director of Corporate Services	This was accepted but not progressed Original target date: September 2011	This was the subject of a serious event review report considered by the Audit Committee at its meeting on 10 September 2012 (Confidential minute 12/106). The necessary undertakings have now been received.	Not applicable	Completed	**Verified January 2013**
COUNTER FRAUD HEALTH CHECK AUDIT UNDERTAKEN DECEMBER 2011								
48	**Early Signs Guide** Publish an Early Signs guide for Registration staff to be alert to possible fraudulent activity.	S	Alison Sansome Director Registrations	Agreed. This will be undertaken in accordance with the review of Standard Operating Procedures in registrations July 2012	Guidance was developed as planned and has been available for staff use since end August 2012. The Guide has been reviewed and signed off as final by the current Acting Director on 23 November 2012.	Not applicable	Implemented.	**Verified January 2013**
KEY FINANCIAL CONTROLS - AUDIT UNDERTAKEN DECEMBER 2011								

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
50	**Budget Statements** Budget statements should be dispatched to all Budget Holders in a timely manner. Budget figures for Projects should be sent regularly to the relevant budget holders on a monthly basis and figures reported should be checked for accuracy.	MA	Verity Somerfield AD finance	Management Accounts meets with all business managers in the first 5-7 days of the month as part of the month end reporting process each month to go through draft results and accruals, so the business managers have a timely view of their progress against budget and can communicate this to their directorate. The BvA reports (budget vs actual monthly reports) are run regularly during the month end process. The distribution of the final reports is done once all the analysis and commentary is complete and this can sometimes be delayed if there are	The month end process has been shortened and the quality of reporting improved. Monthly performance is discussed with cost centre and project managers on a timely basis.	Completed with effect from October 2012	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				other priorities in the dept. However, information is available as required during the month end. Original target date June 2012				
51	**Finance Training** Finance should provide regular training sessions on financial issues for budget holders, including project leads (and other staff as deemed necessary).	MA	Verity Somerfield AD finance	Finance training should be taken forward with the Learning and Development team, and would depend on training needs identified in personal development reviews. Finance provide detailed inductions for new starters. Original timetable: 6 months after implementation of the restructure ie March 2013	Training programme developed and being rolled out across the organisation according to agreed plan. First session scheduled 29 November 2012 and further sessions being run in December 2012.	December 2012	Implemented.	**Verified January 2013**
52	**Credit Card Statements & Payments** As good practice, sufficient backing	MA	Verity Somerfield AD finance	Agreed. We reinforce this with managers and card	Completed	Not applicable	Implemented.	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	documentation should be submitted for all credit card transactions.			holders where receipts of the required standard are not supplied. Where there are repeat offences, we will not pay the expense on behalf of the employee. June 2012				
53	**New or Amended Creditor Accounts** The new supplier request form should be approved by an appropriate manager in all cases before a new supplier account is set up, or supplier details are amended, on Open Accounts.	MA	Verity Somerfield AD finance	Control in place: the exception report showing new and amended suppliers is reviewed quarterly by senior finance personnel. Original target date: May 2012 Subsequently revised to December 2012	Completed	Not applicable	Implemented	**Verified January 2013**
54	**Investment Strategy** As good practice, the Investment Strategy should be revised to include guidance on how and who is allowed to make / authorise investments.	MA	Verity Somerfield AD finance	Agreed, this will be updated. We are currently updating our signatory process	The investment strategy has been updated with instructions on the process for authorisation.	Completed November 2012	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				for investment accounts. Original target date June 12 revised to December 2012 due to priority being given to work on fees increase..	Signatories for investment accounts have also been updated following the restructure.			
GOVERNANCE- AUDIT UNDERTAKEN DECEMBER 2011								
55	**Covering Papers** Consideration should be given to expanding covering papers to include references to corporate goals, identified risks and legal implications as routine.	MA	Lindsey Mallors Director Corporate Governance	Agreed. This is currently being considered as part of our governance review and will be introduced over the coming month. Original target date 1 April 2012	Completed and new template for Council and Committee papers introduced from November 2012. Original target date not met due to priority being given to the restructure.	Completed	Implemented	**Verified January 2013**
REGISTRATIONS - AUDIT UNDERTAKEN SEPTEMBER 2012								
56	**Reconciling Ongoing Cases - Readmissions** The Council should be proactive in reconciling ongoing cases. Applicants should be given a deadline to respond and these	S	Alison Sansome Director Registrations	Appropriate resources have now been made available to ensure that all Registrations appeals are	This is now business as usual. Appeals are now being scheduled in good time and readmission officers have set a 14 day	31 August 2012	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	should be monitored. If a response is not forthcoming then the Council should take timely action to close the case. Ref: Executive Summary 2.27			scheduled within nine months of receipt. Readmission officers will set a 14 day deadline for registrants to respond to Prep audit form requests and will proactively send reminders	deadline for registrants and do proactively chase. BAU.			
58	**Imaging - Issue Logs** Staff should maintain an issue log of all images they are unable to retrieve from the Wiser system; collectively this may assist IT in identifying any further issues which require resolution. All scanning queries should be appropriately logged with the IT support desk. Ref: Executive Summary 2.15	MA	Alison Sansome Director Registrations	Accepted. An issue log has been created in Registrations to record problems with the retrieval of documents from Wiser. Staff have been made aware of this log and asked to notify the management team if any issues arise, which will subsequently be added to the log and then raised with ICT.	Completed Issues log created and details of this disseminated to staff – July 2012. •Staff continue to log any issues, which are subsequently raised with ICT. The number of tickets raised is reported in the monthly directorate performance report. This is now part of business as usual.	Not applicable	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
				Target date October 2012				
59	**Quality Assurance Standard Operating Procedure (SOP)** The SOP concerning Quality Assurance should be finalised, approved and available to staff on TRIM. Ref: Executive Summary 2.19	MA	Alison Sansome Director Registrations	Accepted QA SOP to be finalised in July 2012 and in place for the quality assurance of the work carried out in July 2012. The results of the QA will continue to be reported to the Director on a monthly basis as part of the Registration Team Manager meetings. The effectiveness will also be continually evaluated as part of this. Target Date: September 2012	QA SOP finalised and saved in TRIM – August 2012. Implemented by all team managers – August 2012. QA results for all Registration teams reported to Director on a monthly basis - incorporated into business as usual.	Not applicable	Implemented	**Verified January 2013**
60	**SOPs – Review & Maintenance** Sops should be routinely reviewed,	MA	Alison Sansome Director	Agreed: Existing SOPs and outstanding SOPs	Timeline of outstanding SOPs for UK Registration	December 2012	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	maintained and kept up to date to support the work of the Registrations team. Ref: Executive Summary 2.20		Registrations	to be finalised. Once finalised these will be stored in TRIM and disseminated to all relevant staff for implementation into daily processes. An annual review will also take place of all SOPs to ensure that these are correct and relevant. Target date October 2012	team drafted. Target date extended to November 2012 due to volume and Registrations busy period. 12 new SOPs for UK Registration team approved by Director, centrally stored in TRIM folder and made available to staff. Ongoing review and refinement of SOPs will be recommended part of the ongoing improvement process.			
61	**Registration & Readmission Workflows** The NMC should develop workflow / quick reference guides which staff can refer to quickly regarding the processing of all aspects of Registrations.	MA	Alison Sansome Director Registrations	Agreed. Quick reference guide template to be finalised by Registrations management team. Senior Registration officers within the teams will produce quick reference	Quick reference guide template finalised – August 2012. 17 quick reference guides implemented for the UK Registration team, saved centrally in TRIM and made	Not applicable	Implemented	**Verified January 2013**

A No	B Recommendation	C Priority	D Officer Responsible	E Original management response & target date	F Current position and action taken or planned	G Latest target date	H Implementation status	I Verified by auditor?
	Ref: Executive Summary 2.21			guides for all the. necessary work streams. Once finalised & stored in TRIM they will be disseminated to all relevant staff. Target date October 2012	available to staff - October 2012			

Item 10
AC/13/23 Annexe 2
19 April 2013

Audit Recommendations - Counterfraud Healthcheck

8. OVERSEAS GOOD STANDING CERTIFICATION

The feasibility of a "local" police records check as recommended in the Parkhill Audit report was explored in depth by KPMG and NMC staff during the recent Overseas Review.

Under the new processes implemented to take effect for all overseas applications received with effect from 2 April 2013, applicants are required to complete a "Character Self Declaration": This requires details to be provided of all criminal convictions, police cautions, disciplinary action taken by a professional/regulatory body or employer and any civil proceedings brought (other than a divorce / dissolution of marriage or civil partnership).

On the basis of this and all other information received on the applicant, where a concern arises criminal record checks are carried out in the UK/home country (where a central police records facility exists).

This brings overseas processes into line with UK and EU registrations and therefore this action is complete. The process will be part of business as usual and as such will be subject to normal monitoring review going forward.

9. PROACTIVE REGISTER MANAGEMENT POWERS

Proactive Register Management powers suggested to require Registrants to update their addresses could only be achieved through an amendment to the NMC Order and would be unlikely to yield significant benefits over the current position. Currently nurses and midwives provide address changes in communication with the NMC – usually around renewals. Even if this information were a requirement we would still be reliant on Registrant providing the information and have no mechanism for policing the provision. In terms of changes to the NMC Order or Rules there are more pressing matters that would continue to take priority over this issue.

Therefore this item is not being pursued further at this time.

10. LEARNING FROM PAST FRAUD (KENT & MEDWAY)

This is the response of the NMC to the report dated 17 August 2011 entitled "Investigation report for the incident of D Stewart".

This report has been further reviewed and potential actions considered. Most of the issues discussed were concerned with identity verification and prevention of identity related fraud. A number of points to note concerning this review are as follows:
Any changes to the NMC Order or rules required to support additional identity verification would by necessity take place as part of a co-ordinated programme.

However there are process and procedural changes that can support this intent and these will be defined as part of Registration process reviews following the recent introduction of an improved overseas process. The revised process has strengthened Identity verification on overseas applications and will be assessed against all areas of registration. This work is part of the Registration improvement work and is currently being scoped, with these recommendations feeding into that scoping activity.

During business year 2013-2014 Registration will undertake a full review of its policies and processes. At the centre of this work will be enhanced public protection based on strengthened processes at the point of registration.

11. PARTICIPATION IN NATIONAL FRAUD INITIATIVE

This recommendation suggests the consideration of the NMC participation in the National Fraud Initiative's data matching exercise in addition to the NMC's existing data matching exercise with the NHS Electronic Staff Record database.

Given the obvious synergy between the NMC's data and the NHS database it is considered that the current database matching exercise with the NHS has more immediate and content specific relevance for the NMC at this time.

Greater benefit could be derived from data matching links with private healthcare providers such as BUPA/BMI etc. This and other improvements to address identified risks/weaknesses will continue to be assessed on a proportionate basis.

12. AUTOMATED WORKFLOW MONITORING REPORTS

This recommendation arises from the Parkhill Counter Fraud Report Point 5 which highlights a potential area of fraud in that "Individuals using/hijacking a legitimate registrant's identity to obtain entry on the register". This has previously been covered in terms of Identity verification at item 10. However one of the component elements in fraudulent registration is the absence of workflow monitoring reports in terms of actions taken out of sequence. This recommendation appears to be highlighting a risk of collusion between would be registrants and NMC staff. Automated workflow would not prevent this – but may limit the opportunity.

The current IT systems do not offer this feature and work to produce automated workflow reports, integrated with the telephony system is a major piece of work requiring considerable resource, cost and time for development.

Currently a future ICT Strategy is being agreed and a replacement IT system is being scoped and analysed, therefore WISER will be replaced. As such any update work on WISER needs to be prioritised based upon urgent business need and the costs benefit profile of any potential work.

Given the above this is not a priority at this time, but will be a consideration in the design of the new system.

13. MULTIPLE NAME SPELLING CHANGES

Again this item is around identity verification, which has previously been covered at item 10. The IT systems do not currently alert users if an individual's name changes frequently. Although WISER stores an audit trail of all changes made to a registrant's record, it does not alert users to multiple changes.

As explained a future ICT Strategy is currently being agreed and a replacement IT system is being scoped and analysed, therefore WISER will be replaced. As such any systems work on WISER needs to be prioritised based upon urgent business need and the costs benefit profile of any potential work.

Given the current position this does not provide sufficient benefit to gain priority given other NMC activities, however this will be a consideration in the design of the new IT system.

Item 10
AC/13/23 Annexe 3
19 April 2013

Response of Registrations Directorate to the recommendations in the internal investigation report August 2011

1. We need to strengthen measures to verify registrants' identity and manage the risk of identify fraud	**The NMC Rules** 1.1 The NMC's Rules require that a registrant's qualifications and practice are verified, but they do not require verification of identity. In regard to identity, the Rules simply state a requirement for the registrant to inform the NMC of their name and address. 1.1.1 In order to make it a mandatory requirement for registrants to supply identity documentation which is additional to that already required by the NMC, changes to the NMC Rules may be required.	A student registering for the first time is required to complete an application form with a declaration regarding good health and good character etc and must also pay the fee. The HEI also provide a Declaration of Good Health and Good Character (DGHGC). The HEI are responsible for undertaking identity checks and CRBs as part of the course and will consider any issues that arise through their own procedures This point has been raised as a separate Audit Committee recommendation – any changes to the NMC Order or Rules will take place as part of a co-ordinated programme. At present this is not under consideration.
	Identity verification on joining the register 1.2 Although no procedure can entirely remove the risk of identity fraud, our procedures for identify verification should be strong enough to ensure that we are taking all reasonable steps to prevent and detect identity fraud. 1.3 The basis for the sound verification of registrants' identities must be the verification of the identity of each new registrant, which should be carried out independently by the NMC, in addition to the verification already completed by the Higher Education Institutes (HEIs). 1.4. It is not within the scope of this review to recommend in detail the standards of identity verification required. A number of existing standards and reviews of identity management previously conducted for the NMC provide guidance on the measures that the NMC should consider. Relevant documents include: 1.4.1 NHS Employers: *Verification of identity checks* standard (July 2010). The standard provides guidance on the required documentation to verify	Currently we do not undertake additional verification checks further to those completed by the HEI. Following the review of the Overseas registration process (Jan-March 2013) there will be a full review of the EU and UK registration processes. This review will focus particularly on ID verification – employing best practice from existing organisations and industry standard templates. It is anticipated that this work will be completed in business year 2013-2014.

	identity, and the treatment of such issues as name changes or the absence of documentation proving identity. 1.4.2 NMC: *Access to Registration Services: identity verification options* (Trim: 1007918) 1.4.3 NMC / Klarient (2009): *User Identity and Access Management Options Review revision 1* (Trim: 360455) 1.5 Photographic evidence of identity should be checked as part of the initial verification of identity and a copy retained on file for future identity checks. 1.6 The process of verification should include retaining legible copies of verification documents and maintaining a record of checks on the Wiser database. **Online versus offline contact with the NMC** 1.7 New procedures for identity checking can and should be designed to apply to both the 'offline' (paper and phone) and 'online' (website) settings. 1.7.1 It is not within the scope of this document to set out in detail the security requirements of the new NMC online portal, the security concerns being addressed by the project team and noted in the NMC portal project IdM requirements specification (Trim: 810567). 1.7.2 The key consideration is to ensure that the move to an increased use of online (website) contact between the NMC and registrants does not weaken the verification of registrants' identity, and that 'real world' documentation is still used to verify identity. 1.7.3 The document NMC: *Access to Registration Services: identity verification (*Trim: 1007918) provides some background information about the concerns about identity verification when applied to the online setting. 1.8 We must remove any inconsistencies between the verification involved in different methods of contact between a registrant and the NMC, since these inconsistencies provide 'loopholes' that might be exploited by any individual intent on committing identity fraud. For example, if previous address is required to	See comments above re: review of registration. See comments above re: review of registration The proposed move to online registration was postponed in 2011 and was not implemented. The NMC has announced its intention to move to an online platform for registration within the next business year. Before implementing this move a full review of the registration process will take place with particular emphasis and focus on identity verification – ensuring that the online environment maintains a strong physical identity verification process. The process for amending a registrant's address through our online capture form, written correspondence and telephone requires the following information NMC Pin, full name, previous address and current address. We do not request the date of birth on written requests as if this was intercepted by someone else, for example through the postal service, they would be in possession of all the

	change address, this should be asked for through any channel which the registrant uses to update their details, be that paper forms, online, or by phone.	registrant's security question information and could gain access to their registration information.
	Legal name versus 'names' 1.9 We should consider using separate fields on the Wiser database for the registrant's 'legal name' and 'known as' names. 1.9.1 The Rules currently require the registrant to supply their 'forenames' and 'surname' but do not specify that these must represent the registrant's legal name. 1.9.2 Distinguishing between a registrant's legal name and 'known as' names would assist in the verification and tracking of the true identity where a registrant uses a name different from the first forename given on the registrant's birth certificate, or where the registrant chooses to change the name by which he or she is known.	When first registering with the NMC the applicant's details are uploaded to us electronically by the HEI, this information is then recorded on Wiser. Upon receipt of the registrant's application form and the DGHGC from the HEI we cross check the full name and NMC Pin of the registrant against the Wiser record. WISER does not currently support the recording of "known" names. Registrants are advised on our website to practice in the name that they are registered so that employers, patients and members of the public can accurately locate them on our register. It is worth noting that the General Dental Council; Health & Care Professionals Council and the General Medical Council do not store registrant information by "known" and "legal" names.
	Continued verification of identity throughout an individual's time on the register 1.10 Verification of identity should continue throughout a registrant's period of registration, such that all reasonable precautions are taken to prevent and detect identity fraud and at any point in time we can demonstrate that we have verified a registrant's latest name and address. 1.10.1 Any changes of address should be verified with proof of address documentation. 1.10.2 Changes of name should be verified using the appropriate documentation. 1.10.3 The documentation acceptable to prove name changes is out in The NHS Employers' Verification of identity checks standard (July 2010). For example, as set out in the standard, changes of name should only be accepted where the individual is able to provide documentary evidence of	We do not currently ask for any proof in regards to changes of address, they can submit their request via the online capture form, written correspondence, or over the telephone. We briefly considered this but raised issues of those registrants who live with their parents, in shared accommodation, overseas etc would have difficulties.

	the recent name change because of marriage/civil partnership (i.e. marriage of civil partnership certificate), divorce/civil partnership dissolution (i.e. decree absolute /civil partnership dissolution certificate) or deed poll (deep poll certificate). Any other names changes which cannot be substantiated in this way should not be recorded, or recorded in a 'known' as' name field if the NMC chooses to introduce this new field to the Wiser database. 1.10.4 Changes to the NMC Rules may be required to allow the NMC to collect the required documentation as a mandatory requirement.	This point has been raised as a separate Audit Committee recommendation – any changes to the NMC Order or Rules will take place as part of a co-ordinated programme. At present this is not under consideration.
	Proactive measures designed to detect identity fraud or irregularities in registrants' entries on the register 1.11 We should introduce proactive monitoring to identify fraud and irregularities within registrants' entries on the register. 1.12 This monitoring might include both procedural and technical solutions. We should explore the possibility of technical solutions such as whether it is possible to develop Wiser to create an alert if any name field changes very frequently. 1.13 The NMC should make greater use of previous collected data about individuals in order to verify identity. 1.13.1 We might consider whether there are procedural or automated ways to check registrants' signatures against previously recorded signatures. 1.13.2 Forms should be re-designed to collect previously given names, surnames, or addresses as a mandatory requirement 1.13.3 Procedures should be redesigned to reject documentation from registrants where not all mandatory fields are completed.	Ultimately WISER will be replaced. As such any update work on WISER needs to be prioritised based upon urgent business need and assessment of the impact of the work not being completed. WISER can currently provide an audit trail highlighting all changes to a registrants record but this cannot currently be in the form of an alert to staff where for example, a registrant has changed their name of numerous occasions. The current Overseas review has resulted in forms/applications that will be rejected if all mandatory fields are not completed. When the EU and UK processes are reviewed later in 2013 the same principle will be applied. The points raised in this section will be considered as part of the registration review in business year 2013-2014.
2**. We need to better define procedures**	2.1 The NMC does not have any legal power to investigate individuals who are not NMC registrants. However, we need to clarify our responsibilities and procedures where we receive a referral about an individual who is not a registrant	We will develop a SOP for making referrals to the police, where we believe there is a fraudulent issue of practising whilst lapsed or could advise the referrer to notify the police, if the matter has been

for the management of suspected malpractice by individuals not on the register but working in a health care setting	but where the referral does have a potential implication for public health. 2.2 We need to decide for what types of referrals we have a responsibility, and the legal power, to refer a concern about a non-registrant to the police or to other authorities or regulators. We need to also review how our management of concerns about non-registrant fits in the context of our relationships with other organisations and our and agreements to share data. 2.3 Where we do not have legal power or responsibility to take further action about a referral about a non-registrant, we need clear procedures in place to ensure that correspondence with a referrer is clear in the way in which it closes the matter and recommends next steps, whether that be that a referrer should take the matter up with the police, alert an employer, or contact any other relevant regulator or authority.	brought our attention via a referral. If the registrant has lapsed and we are made aware in Registrations we will contact the registrant and their employer (if known) in writing. SOP to be developed; implemented and staff trained on its operation by September 2013 The registration review will also consider the creation of an "intelligence" function within registration that will capture intelligence received by the registration department and then assess the correct audience for the information.
3. 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	3.1. NMC's critical incident management processes and corporate-wide incident management policy and procedures already provide a suitable framework for the management of such issues. 3.2. The key requirement is for concerns about irregularities on the NMC register to be properly escalated and owned at an appropriately senior level until resolution of the issue is complete.	The Corporate Serious Event review policy processes now provide a framework for the codification; escalation and reporting of irregularities within the register.

Item 11
AC/13/24
19 April 2012

Audit Committee

Internal Audit Strategy 2013-2016 and work programme 2013-2014

Action: For discussion.

Issue: Informs the Committee of the appointment of new internal auditors for the NMC and plans for development of an internal audit strategy for 2013-2016 and work programme 2013-2014.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: internal audit is an essential element of the NMC's governance framework.

Decision required: The Committee is recommended to:

- Note the appointment of Moore Stephens as the NMC's internal auditors from April 2013.
- Note the planned approach to developments of the proposed internal audit strategy 2013-2016 and work programme 2013-2014.

Annexes:

- Annexe 1: possible areas for internal audit work programme 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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context: 1 The Committee is responsible for oversight of internal audit arrangements and approving and monitoring the internal audit work programme (Terms of Reference 2.1).

Discussion: **Appointment of Internal Auditors**

2 In December 2012, the Committee agreed that the NMC should secure new internal audit provision from April 2013. In January 2013, the Committee approved a procurement process using the Government Procurement Service. Louise Scull represented the Committee on the tender evaluation panel.

3 Three tenders were received and following evaluation, including presentations to the panel, the contract was awarded to Moore Stephens.

4 Audit Committee members will have an opportunity to meet the new internal audit team at the meeting. Arrangements are in hand to ensure a smooth transition, including:

4.1 Provision of key documentation and contact information relating to the NMC, such as the corporate plan and budget 2013-2016.

4.2 Provision of past internal audit reports and related documentation. The previous auditors, Parkhill have undertaken to provide any further assistance or information necessary.

4.3 Introductory and familiarisation meetings with the Chief Executive and Registrar, Directors, Assistant Directors and other key staff.

4.4 Introductory meetings with members of reconstituted Council as appropriate post 1 May.

4.5 Introductory meetings with external auditors and the NAO.

4.6 Ongoing engagement to develop day to day working arrangements.

Internal Audit Strategy 2013-2016 and work programme 2013-2014

5 Given the recent nature of the award of the new contract, the Chief Executive and Directors have not yet had an opportunity to meet with Moore Stephens to contribute views on the future shape of the strategy and work programme. This will happen over the next month.

6 Development of a robust assurance framework for the NMC, as previously stressed by the Committee will be the first priority area of work. This will also need to take account of the developing Quality

Assurance Strategy to be discussed under the next item.

7 Development of an assurance framework should also help identify gaps which would benefit from early internal audit work.

8 In developing the work programme, consideration will need to be given to the balance between regulatory functions and corporate service functions and the spread of in-depth reviews and healthchecks.

9 Other issues to be taken into account will include:

9.1 Risks identified in the corporate risk register.

9.2 Corporate plan and budget 2013-2016.

9.3 Work planned but not undertaken in 2012-2013.

9.4 Issues the Committee has previously highlighted for internal audit review.

10 An indicative list of possible areas for the internal audit work programme 2013-14 is at annexe 1. Because of the timing of the appointment of Moore Stephens, this has yet to be discussed between the internal auditors and the Chief Executive and Directors. Following those discussions, approval of the strategy and work programme will be an early item for consideration of the future Audit Committee.

Public protection implications:

11 Internal audit is intended to assist the Committee in determining the level of assurance it can give to Council, as well as helping the NMC identify ways of improving internal controls and risk management, to ensure delivery of core regulatory functions.

Resource implications:

12 The costs of internal audit services are met from within the Corporate Governance directorate budget. Additional resource implications are:

12.1 Staff time in managing the client side requirements for internal

12.2 Staff time expended in contributing and responding to internal audit reviews.

Equality and diversity implications:

13 No direct equality and diversity implications result from this paper.

Stakeholder engagement:

14 Not applicable.

Risk implications:	15	Internal audit should help ensure the NMC manages its risks effectively.
Legal implications:	16	Not applicable.

Item 11
AC/13/24 Annexe 1
19 April 2013

Internal Audit work programme 2013-2014: Items for consideration

Confirmed items	Reason	Timing considerations
Development of an Assurance Framework	Council and Audit Committee direction Moore Stephens proposals - 5 days allocated	Immediate
Items for consideration		
Regulatory Functions		
Registrations policies and processes	Risk Register T27 Indicative suggestion from Moore Stephens tender	
Registrations (WISER) and CMS Reconciliation	Risk Register T24 Audit Committee requested (January 2013) revisit of external review at an appropriate juncture	Quarter 3 2013: to allow time to make progress – this would be 12 months after the last review
Fitness to practise health check	Indicative suggestion from Moore Stephens tender Risk register G28	
Midwifery issues: Local Supervising Authorities	Audit Committee suggestion given risks arising from NHS structural changes Not reviewed since 2010	
Corporate Functions		
Core Financial systems Procurement Delegated Budgets Fee income management	Planned for 2012-2013 but not undertaken Indicative suggestion from Moore Stephens tender	Not Quarter 1 (clash with year end activity)

Risk management policy and framework	Planned for 2012-2013 but not undertaken Indicative suggestion from Moore Stephens tender	Not before Quarter 3: to allow time for new policy framework to embed
ICT infrastructure	Planned for 2012-2013 but not undertaken Indicative suggestion from Moore Stephens tender	
Information/data security	Work towards ISO includes an expectation of regular internal audit reviews "Limited Assurance" achieved 2012-2013 Indicative suggestion from Moore Stephens tender	Last Audit January 2013 need to allow some time to make further progress
Corporate serious event review policy	Audit Committee requested January 2013	Not before Quarter 3: to allow time for new policy to be rolled out
HR/Staffing issues/performance management/care/morale	Risk register T25 Indicative suggestion from Moore Stephens tender	
Change Programme issues Progress on implementation of PSA Strategic Review recommendations Data integrity Governance and Reporting Project Management Change control	Indicative suggestion from Moore Stephens tender	
Quality Assurance Strategy		Need to allow some time to implement

Item 13
AC/13/26
19 April 2013

Audit Committee

Serious event reviews and data breaches

Action: For decision.

Issue: Reports on :

- Implementation of the policy agreed in January 2013.
- Progress on outstanding actions relating to previously reported serious events and data breaches.

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 recommended to:

- Note progress on implementation of the corporate serious event policy approved in January 2013.
- Note that there is a separate confidential item on serious events reported since January 2013.
- Consider progress on implementation of actions from previously reported serious events at annexe 1.
- Agree that the following can be removed from the register:
    - Section A: Item A.3
    - Section B: All data breaches.
    - Section C: 13/01/FtP.
- Consider the statistical report on security incidents and data breaches at annexes 2 and 3.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Register of progress on actions relating to serious

events and data breaches previously reported.

- Annexe 2: Provisional statistics on security incidents and data breaches January to March 2013 and for the year to 31 March 2013.

- Annexe 3: Provisional statistics on security incidents and data breaches for the year to 31 March 2013.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 In January 2013, the Committee approved the Corporate serious event review policy (AC Minute 13/17/70).

2 This report updates the Committee on roll out of the policy including progress in developing a unified register of serious events, data breaches and complaints, so that progress can be monitored and learning captured across the piece.

3 Under the policy all serious events are reported to the Committee for scrutiny. Serious events which have come to attention since the last meeting of the Committee are at reported separately as a confidential item.

4 An update on progress in implementing recommendations from previous serious events is at Annexe 1.

5 Statistical information on security incidents and data breaches is at provided in annexes 2 and 3.

Discussion:

Implementation of Corporate Serious Event Policy

6 The policy agreed by Audit Committee has been applied over the last two months to events as they have been identified and reported. In testing the operation of the new procedures on incidents arising since January, a number of practical issues have become evident. Directors Group discussed the operation of the processes on 11 April and a verbal report will be provided on the discussions.

7 Recommendation: The Committee is asked to note progress on processes to implement the policy.

Updated register of serious events and data breaches (Annexe 2)

8 An update on progress on actions outstanding from previously reported events and data breaches is at Annexe 1. The register is in 3 parts:

8.1 Section A: serious events previously reported where action is outstanding.

8.2 Section B: data breaches October to December 2012 where the Committee requested further information at the last meeting.

8.3 Section C: Serious events previously reported: all outstanding actions now completed.

9 The Committee has previously indicated that completed items should not be removed from the register until it has confirmed that it

is satisfied with the action taken (AC minute 12/88/50).

10 Although the actions outstanding in respect of item A on the agenda are not completed, the Committee is asked to consider whether this should continue to remain on the register or be reported as part of progress on the comprehensive review of governance documentation and processes proposed.

11 **Recommendation**: The Committee is asked to:

11.1.1 Section A: Agree that Item A.3 can now be removed from the register

11.1.2 Section B: Agree that all data breaches be removed.

11.1.3 Section C: Agree that 01/13/FTP now be removed from the register.

Statistical report on security incidents/data breaches (Annexes 2 & 3)

12 Statistics on all security incidents and data breaches are provided as follows:

12.1 Annexe 2: Quarter 4: January to March 2013 (provisional).

12.2 Annexe 3: Full year 1 April to 31 March 2012 – 2013 (provisional).

13 The Committee requested clarification as to whether it was receiving information about all or only serious security incidents and data breaches. Prior to 30 September, security incidents/data breaches were not categorised: accordingly, all reports to the Committee have included information on all incidents reported, regardless of the seriousness. The reports at annexes 2 and 3 continue to provide information on all incidents but now additionally include information on the number in each category.

14 **Recommendation**: The Committee is asked to consider the statistical reports on security incidents and data breaches at annexes 2 and 3.

Public protection implications:

15 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:

16 None.

Equality and diversity implications:	17	There are no equality and diversity implications arising from this paper.
Stakeholder engagement:	18	Not applicable
Risk implications:	19	Failure to learn from previous serious events and data breaches represents a risk to the NMC.
Legal implications:	20	Individual serious events and or data breaches may have potential legal implications.

Item 13
AC/13/26 **Annexe 1**
19 April 2013

Single Register: actions outstanding from previously reported serious events, complaints and data breaches **(at 10 April 2013)**

Section A. Serious event reviews previously reported with outstanding actions

UIN	Date event occurred Date reported	Serious event	Responsible Owners	Recommendations and action taken	Organisational learning	Original timescales for action and any revisions	Progress Update
A.3	Event occurred: 24/6/11 NAO reported to Audit Committee 12/6/12	Special Severance payment Failure to obtain requisite advance HM Treasury approval. Failure to comply with NMC scheme of delegation and standing orders.	Director Corporate Services Director Corporate Governance	First serious event review report presented to Audit Committee September 2012. Committee requested this be re-investigated. Investigation completed and reported to Audit Committee December 2012. Six recommendations made to strengthen Governance and Corporate Services policies processes. **1. Governance compliance** As part of the review of the Governance framework ensure that all governance documents accurately reflect any legal or other restriction on the NMC's decision-making authority. **2. Directors responsibilities** The Chief Executive and Registrar and all Directors to personally sign an annual statement confirming their responsibilities for managing public	Need to strengthen understanding of, and arrangements for ensuring compliance with, legislation, guidance, and internal governance procedures at all levels within the organisation. To be addressed as part of the governance framework review taking place alongside reconstitution of Council	Between 1/01/13 and 31/03/2013	**Recommendation 3** Completed Written policy produced and in use by HR Managers. **Recommendation 6** Completed: the Council Services team now provide secretariat support to Audit Committee. **Recommendations 1, 2, 4 and 5** A review has been undertaken by external consultants to develop proposals to assist reconstituted Council determine a fit for purpose governance

				money, internal control and risk. • Produce a concise, user friendly summary of the responsibilities of the Accounting Officer and Directors in relation to HM Treasury "Managing Public Money". • Develop statement template • Produce personal statement • Incorporate into Annual Governance Statement **3. Special Severance Payments** Implement a written policy and process for handling special severance payments **4 Governance Assurance** Explore scope for a duty on the Corporate Governance Director to report any issues of concern such as impropriety etc **5 Contact with Privy Council** Provision to be included in scheme of delegation and all relevant governance documents and polices that all engagement with Privy Council Office to be directed through Direct or Corporate Governance **6 Remuneration Committee** Provide effective servicing and support to Remuneration Committee			structure going forward. Alongside decisions on future structures resulting from this work, a full review of all governance processes and documentation is to be undertaken. Rather than initiating piecemeal changes to governance policies and processes at this stage, the review will consider how the outcomes envisaged by recommendations 1, 2, 4 and 5 can best be achieved as part of a comprehensive review of arrangements.

Section B: Data breaches (Incident summaries for data breaches which occurred between October – December 2012): Further information requested by Audit Committee 25/01/13

Incident summary Data breaches which occurred between 1 October and 31 December 2012.			
	Incident description	**Cause**	**Organisational learning / actions**
B.8	34872 Paper documentation about one registrant sent to another.	Human error and procedural failure	The incident identified the need to change Standard Operating Procedure. This has been amended to include a note reminding staff to check names and reference numbers and raise any discrepancies with the case holder. Reminders have been issued through team meetings and communications about the importance of checking that the name and reference number relate to the correct registrant before submitting correspondence for filing.
B.16	No reference Possible lost bundle of FtP papers due to be delivered to Panel member.	Not Applicable	This incident was reported as soon as the bundle was believed not the have arrived. This was followed up immediately by the Facilities team and the bundle was located straight away as awaiting collection at the courier's deport. The bundle was returned to NMC fully wrapped. Accordingly there was no data breach.
B.17	030661 Information about a registrant's case sent to a witness in another case.	Human error	No specific WISER training courses available to mitigate for this error, however further training in using WISER correctly was given and Importance of information security compliance reiterated.
B.19	029262 / 028591 A bundle for a High Court Interim Order extension application contained an incorrect documentary exhibit which related to a different registrant	Human Error	Human error mitigated through team meeting reminders on the importance of checking bundles for correct documents with particular attention paid to those being sent with requests for administrative tasks to be completed. A copy of the incorrect document contained in the bundle and lodged with the court was sent to the Information and Data Governance Manager for a decision on any further action to be taken aside from that already completed.

C Serious event reviews previously reported where all actions have been completed

UIN	Date event occurred / Date reported	Serious event	Responsible Owner	Recommendations and action taken	Organisational learning	Original timescales for action and any revisions	Progress Update
13/01/FTP	Occurred March and June 2012 Discovered 11 January 2013 (reported by PSA)	As part of its performance review process, the PSA identified two cases where registrants were not showing on NMC online register, despite Conditions of Practice Orders being in force.	Director FTP	The two cases identified by PSA had lapsed because FTP flags had been removed from WISER inappropriately and registration fees were not paid. Both cases were updated on WISER and now appear correctly on the on-line Register. This issue had already been identified prior to being raised by PSA due to ongoing work to resolve the WISER/CMS discrepancies and to put sanction information on line from January 2013. A new daily report was put in place and 24 similar cases were identified. The correct status of these cases has now been updated. PSA was informed of the outcomes and may refer to this issue in its Performance Review report 2012-2013.	WISER update guide reviewed and launched to Adjudication staff FTP staff trained and signed off in WISER updates	**Completed 8/2/13**	**Not applicable**

Item 13
AC/13/26 Annexe 2
19 April 2013

Audit Committee

Report of information security incidents January – March 2013 [provisional as at 8 April 2013]

For information

Issue

1 This report presents statistics on the number of information security incidents reported in the NMC in the period 1 January – 31 March 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 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.

Further information

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

Marion Owen	020 7681 5408	Marion.Owen@nmc-uk.org

Report of information security incidents January - March 2013

Information security incidents and data breaches 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
January	10	10	0
February	15	13	2
March	3	3	0
Total	**28**	**26**	**2**

Information security incidents by classification

Classification	Total
Loss or theft of ICT equipment	2
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	24
Breach of physical security in an area housing ICT equipment	0
Information system access violations (includes attempted unauthorised access)	0
Malware attack	0
Detection of unauthorised wireless network	0
Non compliance with ICT policies	0
Fraudulent use of information systems and assets	0
Lack of data integrity: data corruption, accidental or deliberate unauthorised alteration of data / data incompleteness	2

Information security incidents by level

Level (see attached guide to classification levels)	**Total**
5	0
4	0
3	2
2	23
1	3

In addition, there was one **level 0** incident during this quarter.

Information security incidents by cause

Failure of policy or procedure: Policy or procedure followed but ineffective in preventing the incident. Indicates change required to policy or procedure.	1
Human error / procedure not followed / accident	19
Both failure of policy or procedure **and** human error	2
Deliberate or malicious action	1
Third party error [Details: The reasons for suspension of a registrant published on the NMC website related to an incorrectly identified registrant. Error due to the Association of Chief Police Officers (ACPO) incorrectly identifying an individual using correct information from the NMC]	1
Other / cause not known	4

Information security incidents by directorate

Corporate Governance	0
Corporate Services	2
Fitness to Practise	26
OCCE	0
Registration and Standards	0

Information security incident trends: 12 months to end March 2013

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

6 As would be expected there is a fluctuating level of minor (level 2) and insignificant (level 1) incidents. Improved compliance with the requirement for all teams to report incidents centrally is like to have contributed to the rising number of minor incidents reported.

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

8 The trend for the last 12 months shows moderately serious incidents (level 3) to be occurring occasionally.

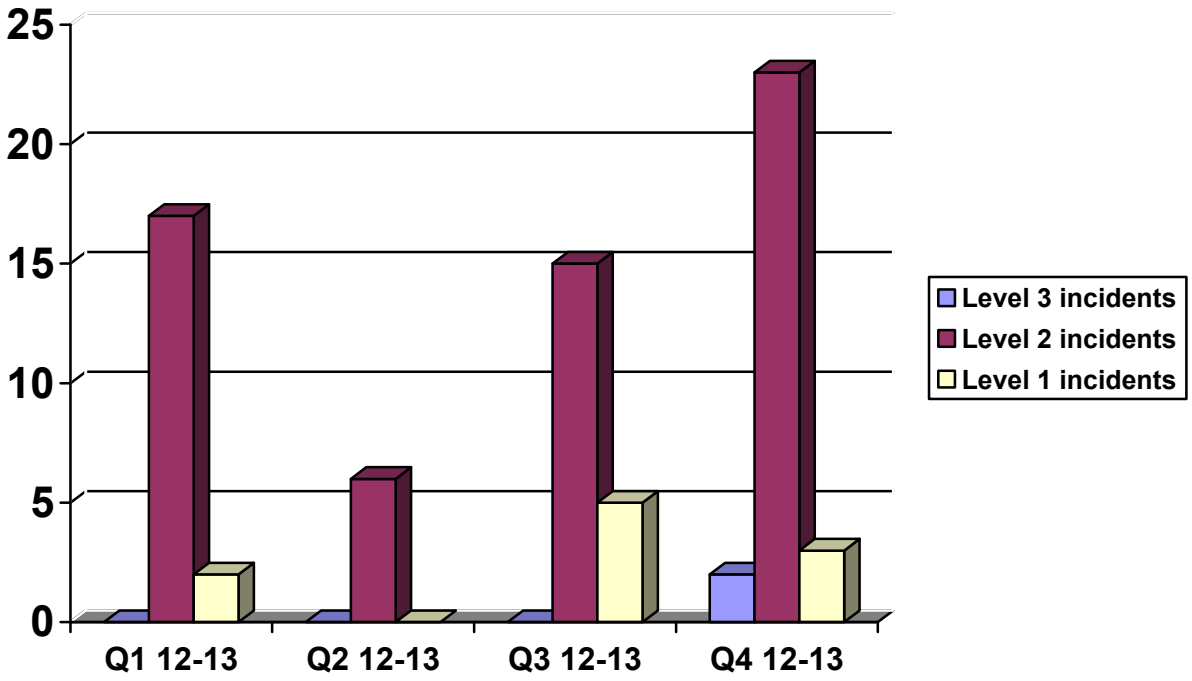


Figure 1

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 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.**
O '	**Learning points** • A 'near miss' or event which is prevented from becoming an incident, where the event indicates an area for security improvement • A very minor incident which is kept internal to the NMC. **An incident can only be a level 0 incident if it is kept internal to the NMC and has no impact on reputation or operations**

Item 13
AC/13/26 Annexe 3
19 April 2013

Nursing & Midwifery Council

Audit Committee

Report of information security incidents 2012- 2013 [provisional as at 8 April 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 2012 - 31 March 2013.

2 The figures presented in this paper are based on notifications of information security incidents to the Information and Data Governance Manager.

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

Further information

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

Marion Owen	020 7681 5408	Marion.Owen@nmc-uk.org

Report of information security incidents 2012 - 2013

Information security incidents by classification

Classification	Total
Loss or theft of ICT equipment	2
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	68
Breach of physical security in an area housing ICT equipment	0
Information system access violations (includes attempted unauthorised access)	0
Malware attack	0
Detection of unauthorised wireless network	0
Non compliance with ICT policies	1
Fraudulent use of information systems and assets	0
Lack of data integrity: data corruption, accidental or deliberate unauthorised alteration of data / data incompleteness	2
Total	**73**

Information security incidents by level

Level (see attached guide to classification levels)	Total
5	0
4	0
3	2
2	61
1	10
Total	**73**

Information security incidents by cause

Failure of policy or procedure: Policy or procedure followed but ineffective in preventing the incident. Indicates change required to policy or procedure.	4
Human error / procedure not followed / accident	57
Both failure of policy or procedure and human error	4
Deliberate or malicious action	2
Third party error	2
Cause not known	5
Total	**73**

Information security incidents by directorate

Corporate Governance	1
Corporate Services	4
Fitness to Practise	68
OCCE	0
Registration and Standards	0
Total	**73**

Information security incident trends: 12 months to end March 2013

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

6 As would be expected there is a fluctuating level of minor (level 2) and insignificant (level 1) incidents. Improved compliance with the requirement for all teams to report incidents centrally is like to have contributed to the rising number of minor incidents reported.

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

8 The trend for the last 12 months shows moderately serious incidents (level 3) to be occurring occasionally.

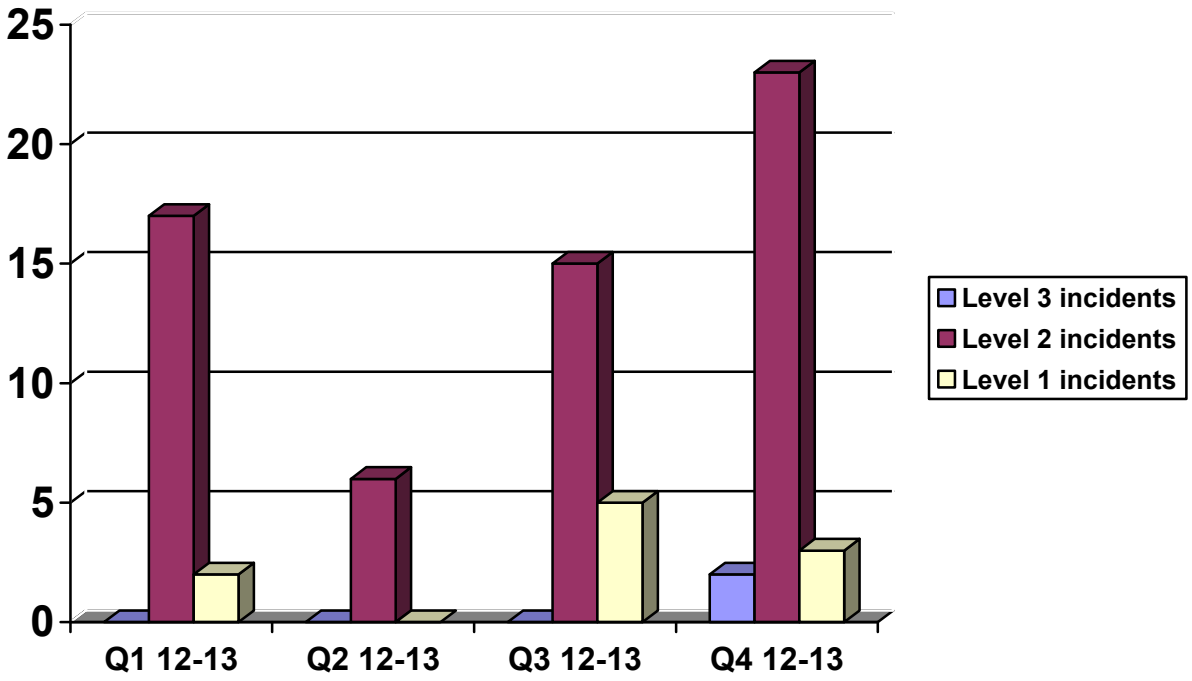


Figure 1

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 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.**
O '	**Learning points** • A 'near miss' or event which is prevented from becoming an incident, where the event indicates an area for security improvement • A very minor incident which is kept internal to the NMC. **An incident can only be a level 0 incident if it is kept internal to the NMC and has no impact on reputation or operations**

Item 14
AC/13/27
19 April 2013

Audit Committee

Whistleblowing Process: Report on use

Action:	For information.
Issue:	Use of the whistleblowing process since the last meeting of the Committee.
Core regulatory function:	Supporting functions.
Corporate objectives:	Corporate objective 7: the whistleblowing policy is part of ensuring that we have effective governance policies and processes in place.
Decision required:	None.
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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 On the recommendation of the Audit Committee, Council approved a refreshed whistleblowing policy for the NMC in July 2012 (Council July 2012, minute 12/128/3).

2 The Audit Committee requested in September 2012 that a report on use of the policy be a standing agenda item (Audit Committee, minute 12/81/10).

3 The Office of the Chair and Chief Executive (OCCE) maintains a log of instances where the whistleblowing process has been used.

Discussion

4 There are no instances of whistleblowing to report since the last meeting of the Committee.

5 The role of whistleblowers in highlighting concerns features in both the Francis Report and a recent report by the NAO. The charity Public Concern at Work has launched a whistleblowing commission to examine the effectiveness of existing arrangements. The government also recently announced plans to further strengthen the protections available to whistleblowers through provisions in the Enterprise and Regulatory Reform Bill. These developments will be taken into account in the review of the policy planned for 2013-2014 and the work on learning the wider lessons from the Francis report elsewhere on the agenda.

Public protection implications:

6 There are no direct public protection implications arising from this paper. The whistleblowing policy provides a means for staff to raise any concerns connected with their work at the NMC which they reasonably believe may be harmful or potentially harmful which could include concerns relating to public protection issues. The availability of a whistleblowing policy should help to enhance public protection.

Resource implications:

7 There are no resource implications arising from this paper or from the existence of the policy in itself.

Equality and diversity implications:

8 There are no direct equality or diversity implications arising from this paper.

Stakeholder engagement:

9 No applicable.

Risk implications:

10 The whistleblowing policy contributes to ensuring that potential risks to the NMC can be identified and addressed by providing a channel for these to be brought to attention, if necessary.

Legal implications:	11	None arising from this paper.

Item 15
AC/13/28
19 April 2013

Audit Committee

Information Security Assurance

Action: For information

Issue: Updates the Committee on the information security improvement plan.

Core regulatory function: Supporting functions

Corporate objectives: Corporate Objectives 1 and 7: ensuring information is kept securely is an essential part of governance.

Decision required: None

Annexes: None. However, a confidential annexe on the information security improvement plan management summary will be enclosed with the confidential papers.

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.

Author: Phil Shoesmith
Phone: 020 7681 5518
phil.shoesmith@nmc-uk.org

Director: Mark Smith
Phone: 020 7681 5484
mark.smith@nmc-uk.org

Context:

1 The Committee asked that information security be a standing agenda item in view of the importance of this issue and the substantive improvement work planned (AC minute 12/118/69)

2 The recent penalty imposed on the NMC by the Information Commissioner's Office further underlines the importance of this work.

Discussion and options appraisal:

Executive summary

3 In 2012 work was started on a programme of work to improve Information Security.

4 This work was based on the issues identified in the Information security gap analysis of October 2012.

5 During March 2013 an external consultant was appointed to:

5.1 Review the NMC's information security systems and processes.

5.2 Produce a detailed information asset register.

5.3 Produce a plan with detailed costs for achieving ISO27001 certification.

6 The final report will be available in April 2013.

Response to Internal Audit

7 As reported earlier in the agenda, the most recent internal audit of data security resulted in a 'limited' assurance rating and repeated two recommendations from the previous audit on 2011. The work planned during Q1 and early Q2 will address the key findings from the recent internal audit including:

7.1 Ensuring all security events are reported centrally.

7.2 Ensuring all staff, including contractors and temporary staffs receive appropriate data protection training.

7.3 Supporting the move to a learning rather than a blame culture.

Proposed Information Security reporting framework

8 Work conducted in February and March 2013 identified a requirement to improve the reporting of Information Security information to Directors, Information Governance and Security Group and Audit Committee. We are proposing to use the following framework from May 2013 onwards.

8.1 Security Events – Overview and detail of high priority events. This will not replace the existing Corporate Serious Event policy reporting

process but will to some extent provide additional information.

8.2 Security Risk Register based on the international security standard ISO27001 framework.

8.3 Security controls update – new and amended controls.

8.4 Information Security Audit findings and recommendations update.

8.5 Security KPIs (currently being developed).

9 An initial draft report in the new format will be presented to Directors Group for review in May 2013.

Next Steps – Q1 2013/2014

10 The following streams of work will be the focus in the next quarter.

10.1 Ensure compliance with policies on portable media and laptops.

10.2 Improve incident management process.

10.3 Improve information security training compliance: Ensure compliance in line with defined KPI for information security training.

10.4 Introduce information security training for panelists.

10.5 Continue work to achieve Payment Credit Card Industry Data Security Standards (PCIDSS) compliance.

11 We will evaluate the ISO27001 gap analysis to prioritise the next phases of work and will baseline the plan against their priority framework.

12 The corporate risks associated with Information Security should be reviewed after this work as many, if not all, of the highest risk items will have been addressed.

Third Party ISO27001 Gap analysis – Likely high priority issues

13 The external consultants's report regarding the organisation's move to ISO27001 will not be available until after the Audit Committee meeting. The consultant has provided informal verbal advice that the following items will be priorities:

13.1 Improving organisational clarity of roles and responsibility for Information Governance.

13.2 Completing formal record management programme identifying critical business documents and the rules for creating, updating and deleting them.

13.3 Focusing on data accuracy and completeness, improving systems

and reduce the use of spreadsheets in key operational functions.

13.4 Improving granularity of administrative access and improve segregation between production and test environments.

13.5 Improving internal audit capabilities.

14 A further update will be provided at the meeting.

Public protection implications:

15 The implementation of the Information security improvement plan is intended to.ensure that the organisation can meet legal obligations and maintain the confidence of the public and registrants while processing and storing confidential information.

Resource implications:

16 Budget and resource estimates for the implementation of the information security improvement plan have been included in the budget for 2013-2014.

Equality and diversity implications:

17 An EQIA is not required in relation to this paper but accessibility will be factored into all new ICT developments.

Stakeholder engagement:

18 We will be consulting extensively with internal stakeholders during all phases of the programme.

Risk implications:

19 There are a number of risks which should be considered on an ongoing basis.

19.1 Information Security responsibilities must be owned by all managers within the business and cannot be regarded as an IT function.

19.2 In the light of the ICO fine and the priorities defined in the latest organisational risk register delivery of the security work plan must be prioritised.

19.3 External pressure to reduce the FtP backlog or address issues in other areas of our business must not be allowed to compromise Information Security.

19.4 The historic performance on some ICT projects has been poor and we are diversifying our supplier base to mitigate risks arising from the current arrangements.

Legal implications:

20 The Data Protection Act requires us to keep confidential data secure. We also have contractual requirements to keep our information secure under PCIDSS and other legal contracts such as the Memorandum of Understanding with the Association of Chief Police Officers.

Item 16
AC/13/29
19 April 2013

Nursing & Midwifery Council

Audit Committee

Finance Update

Action: For decision.

Issue: Reports on various finance issues, including the annual review of the financial regulations.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: accounting policies and the financial regulations form an essential element of the NMC's governance and internal control framework.

Decision required: The Committee is recommended to:

- Note that external auditors are satisfied with progress made against the recommendations in the management letter for the year ended 31 March 2012.
- Approve the proposed treatment of the Department of Health grant of £20 million in the statutory accounts.
- Approve continuance of the Financial Regulations, subject to the minor amends to reflect current structures as proposed at annexe 2, pending a full review in 2013-2014.

Annexes: The following annexes are attached to this paper:

- Annexe 1: External Auditors' management letter to 31 March 2012
- Annexe 2: Financial Regulations showing proposed minor amends.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Mark Smith
Phone: 020 7681 5484
mark.smith@nmc-uk.org

Context: 1 The Committee's responsibilities include reviewing the adequacy of the response to external auditors' management letters; the accounting policies and the Financial Regulations. (Terms of Reference 2.2 to 2.6).

Discussion: **Issues arising from External Auditors' Management letter**

2 The Committee asked to be kept informed of progress against the issues raised in the External Auditors' Management letter to 31 March 2012 (annexe 1).

3 As part of interim audit fieldwork, the external auditors, assess progress made to date against the recommendations in the management letter. The most recent interim audit was carried out in November 2012: external audit staff reviewed and were satisfied with progress made against the recommendations from the audit for the year ended 31 March 2012.

4 **Recommendation:** The Committee is recommended to:

4.1 Note that external auditors are satisfied with progress made against the recommendations made in the management letter for the year ended 31 March 2012.

Accounting policies

5 The Committee asked to be kept informed of the proposals for treatment of the grant of £20 million received from the Department of Health.

6 The £20 million grant was received in full in February 2013. The terms of the grant set out that it has been given to support work to meet the FtP KPIs by December 2014 and to restore available free reserve levels to a minimum of £10 million by January 2016.

7 In keeping with SORP requirements, the grant has been recognised as restricted revenue £20 million in 2012-2013. It is being released to available reserves in equal instalments (£571k per month) over the period of reserve restoration, that is, over the period to January 2016. At period end the outstanding balance not yet released to available reserves is shown as the restricted reserve balance.

8 This will be disclosed in the reserve notes to the accounts, and will also be highlighted in the financial review in the Annual Report. The wording will be agreed with the Department of Health.

9 **Recommendation:** The Committee is recommended to:

9.1 Approve the proposed treatment of the Department of Health grant of £20million in the statutory accounts.

Review of Financial Regulations

10 The Committee's work programme provides for an annual review of the Financial Regulations. Substantive changes to the Regulations require approval by Council.

11 The Committee last reviewed the Financial Regulations in December 2011. Council subsequently approved an amendment to annexe 1 of the Regulations (levels of authority to make financial commitments).

12 A full review of the Financial Regulations is planned for 2013-2014, in parallel with the wider review of governance framework documentation following reconstitution of Council.

13 In the interim, the Financial Regulations have been reviewed and only minor amends are proposed at this stage to bring these up to date to reflect the current organisational structure. These are shown as tracked changes at annexe 2. As no substantive changes are being made, there is no need for Council approval at this stage.

14 **Recommendation:** The Committee is recommended to:

14.1 Approve continuance of the existing Financial Regulations, with the minor updates proposed at annexe 2, pending a full review of the Regulations in 2013-2014.

Public protection implications:

15 Appropriate resourcing and stewardship of financial assets is fundamental to allowing us to deliver the activities required to deliver public protection

Resource implications:

16 Resources (staff time) to undertake the review of Financial Regulations have been allocated in the Corporate Services directorate Business Plan for 2013-2014.

Equality and diversity implications:

17 No direct equality and diversity implications result from this paper.

Stakeholder engagement:

18 Not applicable.

Risk implications:

19 Poor stewardship of financial resources represents a risk to our ability to deliver public protection.

Legal implications:

20 Not applicable.

haysmacintyre

Fairfax House, 15 Fulwood Place, London WC1V 6AY
T 020 7969 5500 F 020 7969 5600

The Council
Nursing & Midwifery Council
23 Portland Place
London
W1B 1PZ

12 June 2012

KEB/VP/N70020/VP

Dear Sirs

Management letter – Nursing & Midwifery Council

Introduction

Following our audit visit in connection with the accounts of Nursing & Midwifery Council for the year ended 31 March 2012, we are writing to bring to your attention certain matters that arose during the course of our work, together with suggestions for improvements of controls and procedures operated by the organisation. We hope you will find our comments helpful and constructive.

Scope of work

Our work was planned and performed in order to issue an audit opinion on the financial statements of Nursing & Midwifery Council in accordance with International Standards on Auditing and the terms of our letter of engagement.

Our work during the audit included an examination of a sample of the organisation's transactions, procedures and controls. This work was not directed primarily towards discovering weaknesses other than those that would affect our audit opinion or towards the detection of fraud. We have included in this letter only matters that have come to our attention as a result of our normal audit procedures and consequently our comments should not be regarded as a comprehensive record of all weaknesses that may exist or of all improvements that might be made.

This report is set out under the following headings:

- Audit and accounting matters
- Detailed control points
- Sector issues

Audit and accounting matters

Audit opinion
Following the completion of our work, we confirm that we expect to issue an unmodified audit report on the accounts and that there were no limitations in the scope of our work.

Qualitative aspects of accounting practices and financial reporting

1) Areas identified within our planning letter as requiring further consideration:

Related Party Transactions (ISA550)

Due to the complex nature of payments made to Council members as well as the change in the pay structure in the year, we reviewed the adequacy of controls over the authorisation and recording of related party transactions to ensure that the disclosures made within the financial statements are both accurate and complete. We are satisfied with the disclosures made within the financial statements and identified no control weaknesses in the related processes.

Remuneration Report

We have liaised with the NAO to ensure that the Report meets the necessary disclosure requirements and are satisfied that the figures disclosed within the Report have been correctly extracted from the Council's accounting and payroll records.

Internal Audit

As in prior years we reviewed the work undertaken in the year by Parkhill on the key financial controls. During the course of our fieldwork, we have placed some reliance on the systems, controls and substantive work they undertook on budgetary controls.

Accounting policies
There have been no changes in accounting policies in the year and we are satisfied that the accounting policies adopted by the Trustees' are appropriate to Nursing & Midwifery Council and its circumstances.

Unadjusted misstatements
There are no unadjusted misstatements which were noted as part of our audit other than clearly trivial items.

haysmacintyre

Letter of representation
We attach the text of the letter containing those matters which International Standards on Auditing require us to obtain written representations from Trustees when you approve the accounts. The letter contains only standard matters with no additional items specific to Nursing & Midwifery Council.

Detailed Control Points

We have highlighted below certain matters which arose during the course of our audit fieldwork together with an update on control issues raised in the prior year.

Current year

BACS processes / Electronic payments

Based on our discussions with senior members of finance staff and a review of the BACS processes in place, we noted the following weaknesses in the system:

i) It is possible for finance staff with access to the Bank Payments module in Open Accounts to amend supplier standing data.

Members of finance staff with access to the bank payments module (six staff) can set up a new supplier and/or amend existing supplier data such as bank account details. Although there are internal procedures which require the appropriate paper forms to be completed (new supplier forms), and the standing data of new suppliers should only be added once this information is completed, it would be possible for a staff member with the access to set up a new supplier or amend supplier details.

An exception report which details all changes made to supplier standing data by each user is run and reviewed on a quarterly basis. While this report is a good control, it may only identify any issues after payments have been made. We would therefore recommend that the bank payments module access of those users is amended so that only a limited number of finance staff are able to access and amend the supplier standing data.

We would also recommend that the 'exception' reports are run more frequently (i.e. at least once a month) to ensure that any unauthorised changes are identified promptly and that this review process is evidenced and dated.

ii) All members of the payments team (five staff) within the finance department have access to set up and authorise payments without further authorisation being required, on the electronic payment system.

There are comprehensive internal 'detective' controls in place which require all BACS payment runs to be physically authorised by cheque signatories, both prior to the payments being made and subsequently on the post payment run listings which are also printed, checked and signed against the original authorised BACS payment run. However, the electronic payment system would allow payments through without these checks taking place. There is therefore a risk that these stages could be 'skipped' and payments made without the appropriate authority.

Our testing did not identify any unusual payments nor that the systems as they stand are not being adhered to, i.e. the controls in place are being followed, however further amendments to the underlying controls would enhance the overall control environment and ensure such incidences were unable to happen.

In order to protect those responsible for these functions as well as adding preventative controls and ensuring any errors are identified at the earliest opportunity, we would recommend that BACS rights should be altered so that the payments team only have payment set up rights and cannot electronically authorise the payments. The person who prepares the standing data onto the BACS payment system should not also have the ability to transmit the payment to the bank.

Management comment:

i. We will review the access rights to the bank payments module and consider the scope for limiting access or splitting responsibilities between staff, where it is practicable. The restructure of the financial transaction team should allow for rotation and better segregation of duties. In relation to the exception report, we have also formalised the review of the report as part of the monthend process.

ii. *This was also discussed with the previous internal auditors (PKF) and the controls were strengthened at that time, to be as described above. This was considered to be the most practicable solution for the NMC. Approved payments are also checked back via the bank reconciliations. The suggestion of a separate electronic authorisation by a signatory is one we have considered but are not keen to implement at this time given the small number of signatories, and the current changes to the organisation. However we will consider if we can 'decouple' the preparation of the BACs payment from the actual transmission to the bank within the transaction services team.*

Control Account Reconciliations

As part of our review of month end procedures, we noted that while monthly reconciliations are carried out for controls accounts (such as debtors, creditors, bank), these reconciliations are not signed and dated by the preparers or the reviewers. From our discussions with management we understand that going forward a control sheet will be implemented and both the preparer and the reviewer of reconciliations will be required to date and sign the sheet.

Management comment:

We are implementing the control sheet and this will be signed and dated by preparer and reviewer.

Prior year

WISER Reconciliation

It was noted last year that there was an unreconciled difference on the monthly reconciliation of fee creditors between the accounting system and the WISER system. There has historically always been a difference, however it had increased from a balance of £19,815 at March 2010 to £28,360 at 31 March 2011, being a potential overstatement of income and understatement in creditors.

We were aware that this difference was under investigation and appropriate action was going to be taken once the causes were ascertained.

In the year to 31 March 2012, £14,900 of historic balances have been written off leaving an unreconciled balance of £17,800. There has been a significant effort made in reconciling the WISER System, with Open Accounts and we are satisfied that the write off made in the year has been appropriately treated. Monthly reconciliations have been taking place throughout the year and the differences month on month have been reducing and on average are less than £1,000, with February 2012 reconciling to a zero difference.

Management are going to continue reconciling the two systems monthly and once the differences have stabilised, consideration will be given to writing off remaining historical items.

Management comment:

We are pleased with the progress made during the year and the increased understanding we have of reconciling items. However it should be noted that the reconciliation process is still a considerable

haysmacintyre

monthly undertaking and we expect substantial resource to continue to be used on this during 2012-13.

Sectors issues

The following are certain key issues which affect the wider charity sector and which have recently come into effect or are currently being debated and are likely to impact the sector within the next year.

Real time information for payroll
In April 2013 HM Revenue & Customs (HMRC) is introducing a new way of reporting PAYE called Real Time Information, or RTI. By using RTI, employers and pension providers will need to tell HMRC about PAYE payments at the time they are made as part of their payroll process. Payroll software will collect the necessary information and send it to HMRC Online. This means that employers will submit information about PAYE payments throughout the year as part of the regular payroll process, rather than at the end of the year as at present.

RTI only affects the submission of PAYE information – payment arrangements will remain unchanged. A pilot scheme is about to commence but most employers will be legally required to use RTI from April 2013 with all employers submitting RTI by October 2013. HMRC will inform you when your organisation needs to make this change. For some entities, RTI will require the introduction of new payroll software, at a time when pension auto enrolment also has to be considered. Giving adequate planning time to this is therefore essential.

Conclusion

If you require any further information or assistance, we shall be very pleased to help you.

This letter is for your private use only. It has been issued on the understanding that it will not be disclosed to any third party without our prior written consent and no responsibility is assumed by us to any other person.

Yours faithfully

haysmacintyre

Item 16
AC/13/29 Annexe 2
19 April 2013

Financial regulations

February 2012

Last reviewed by Audit Committee December 2011

Annexe 1 amended by Council February 2012

Corporate Governance

Version 7.0

Nursing & Midwifery Council

Contents

Deleted: 10

Deleted: 11

Deleted: 13

Deleted: 13

Deleted: 13

Deleted: Resources
Deleted: '
Deleted: 14
Deleted: 15
Deleted: 15
Deleted: 16
Deleted: 16
Deleted: 17
Deleted: 17
Deleted: 18
Deleted: 18
Deleted: 19
Deleted: 20
Deleted: 21
Deleted: 21
Deleted: 21
Deleted: 22
Deleted: 23
Deleted: ¶
Deleted: 22

Introduction

Purpose

1 This document contains the financial regulations as approved by Council. The purpose of these financial regulations is to ensure the proper use of resources, maintain assets and to regulate the conduct of the NMC's Council members and staff (including directors) in relation to all financial matters.

2 The financial regulations explain the financial responsibilities and policies adopted by the NMC to fulfil its financial control and legal obligations as laid down by the standing orders of the NMC, accounting standards, Government policy and law.

3 The financial regulations are the primary source of guidance on financial control within the NMC and override all other operational instructions and procedures.

4 The financial regulations are, however, subordinate to the standing orders of the NMC and the various laws that govern the activities of the NMC and its staff.

Legislative context

5 The NMC was established by the Nursing and Midwifery Order 2001 ('the Order') which sets out the powers and functions of the Council. The Order has been amended on a number of occasions, most notably by the European Qualifications (Health and Social Care Professions) Regulations 2007 and the Nursing and Midwifery (Amendment) Order 2008.

Standing orders of the NMC and prescribed powers of authority

6 The Nursing and Midwifery Council standing orders are made under powers contained in Paragraph 12 of Schedule 1 to the Order.

7 The Chief Executive and Registrar of the NMC ('the Chief Executive') is responsible to the Council for regulating and controlling the finances of the NMC, and the Audit Committee provides assurance to Council that adequate controls are in place.

8 The Chief Executive is responsible for the propriety and regularity of the finances of the NMC and for keeping proper accounting records. The Chief Executive has been appointed by the Privy Council as the Accounting Officer and as such is accountable to Parliament for the stewardship of the resources of the NMC.

9 The responsibilities of the Accounting Officer are described in *Managing public money produced by* HM Treasury[1]. This document should be referred to for advice on the standards expected of an accounting officer's organisation.

10 The Director of Corporate Services has, in turn via letters of appointment, been delegated the powers to control and regulate the NMC's finances and for the proper administration and reporting of the financial affairs of the NMC.

[1] www.hm-treasury.gov.uk/psr_mpm_index.htm

Deleted: ¶

Deleted: ¶

Deleted: ¶

Comment [N1]: Factual correction for accuracy

Deleted: is also recognised by statute

Deleted: ole

Deleted: is laid out

Deleted: , available from

Deleted: Resources

Deleted: ¶

Deleted: 22

11 The Director of Corporate Services is responsible, through the Chief Executive to Council for the proper administration and reporting of the financial affairs of the NMC.

Deleted: Resources

12 The Director of Corporate Services should be provided with sufficient resources to allow him to be able to fulfil his responsibility to ensure the proper administration of financial affairs.

Deleted: Resources

Deleted: ¶

Changes to the financial regulations

13 The financial regulations are the primary source of financial guidance. As such they should be regularly reviewed to ensure they remain accurate and incorporate any changes that have occurred in the NMC.

14 The Council is responsible for ensuring appropriate financial strategies, policies and procedures are in place. The Council should keep the financial regulations under review and make amendments as and when required.

15 The standing orders of the NMC also state that the Audit Committee will consider and comment on any proposed amendments to the financial regulations.

16 The Council is responsible for approving the financial regulations. Proposed changes to the financial regulations do not take effect until approved by Council.

Deleted: ¶

Scheme of financial delegation

17 Ultimate responsibility for the financial affairs of the NMC lies with the Council with delegation to the Chief Executive who, in turn, delegates to the Director of Corporate Services. Nevertheless, it is necessary to establish a system of further delegated powers to enable appropriate members of staff to manage the budgets, commit expenditure and carry out the day to day activities of the NMC. This system of delegated powers is known as the scheme of financial delegation.

Deleted: Resources

18 The scheme of financial delegation, will list all staff to whom financial responsibilities have been delegated, together with a specimen of their signatures. The Director of Corporate Services will ensure that procedures are in place to detect and prevent delegated powers being breached.

Deleted: Resources

19 Individual directors are identified as first line budget holders within the scheme of financial delegation. The Chief Executive delegates power to them to enable the efficient management of their directorate finances.

20 These budget holders must produce, update, formally approve and retain their own schemes of delegation for staff within their own organisational control and provide copies to the Director of Corporate Services.

Deleted: Resources

21 The fundamental principles of the scheme of financial delegation are set out below. It is important that all staff of the NMC understand these principles and apply them to all their actions.

21.1 No financial or approval powers can be delegated to a subordinate officer in excess of the powers invested in the delegating officer.

Deleted: ¶

Deleted: 22

21.2 Permission to authorise expenditure will only be delegated to staff who can evidence an appropriate level of experience and training, based on criteria set by the Director of Corporate Services.

Deleted: Resources

21.3 Powers may only be delegated to staff within the organisational control of the delegating officer.

21.4 All delegated powers must remain within the financial and approval limits set out in the scheme of financial delegation.

21.5 All powers of delegation must be provided in writing, duly authorised by the delegating officer.

21.6 All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent, must also be provided in writing by the delegating officer, prior to the period for which approval is sought.

21.7 Any member of staff wishing to approve a transaction outside their written delegated powers must in all cases obtain written approval from the relevant line manager with adequate powers, before any financial commitments are made in respect of the transaction.

22 Financial delegation does not include the authority to borrow or lend money on behalf of the NMC.

23 The authority to appoint permanent members of staff is retained by the Directors Group.

Deleted: Corporate Leadership Board (CLB) via the approval of the resources group

24 Failure to comply with these principles, or a material breach thereof, may result in the application of NMC's disciplinary procedures. Where such a breach results in clear financial loss, the officer may be personally liable to compensate the NMC.

Deleted: ¶

Procedure manuals

25 Despite being the primary source of financial guidance, it is neither possible nor desirable for the financial regulations document to outline all the detailed procedures. Instead, detailed guidance on systems, controls and procedures are to be found in the relevant procedure manuals.

26 Those responsible for producing detailed procedure manuals should ensure that they do not contradict the financial regulations, which at all times takes precedence.

27 Should any member of staff have concern over whether they are compliant with these financial regulations or the supporting procedure manuals, they should raise their concern immediately with their line manager or the Director of Corporate Services.

Deleted: Resources

28 Procedure manuals take formal effect once approved by the Director of Corporate Services.

Deleted: Resources

Deleted: ¶

Deleted: 22

Deleted: ¶

Requirement for compliance

29 These financial regulations form part of the terms and conditions of service for staff at the NMC. Compliance with the financial regulations is compulsory for all staff and failure to comply can result in the application of NMC's disciplinary procedures.

30 Staff are expected to know about and apply those sections of the financial regulations and other supporting guidance that are relevant to their day-to-day responsibilities.

31 It shall be the duty of the manager of each department to ensure that subordinate staff observe the requirements of these financial regulations.

32 Staff should consult with their line manager or the Director of Corporate Services, should be consulted on any questions about the applicability of the financial regulations, financial guidance and procedures.

Deleted: Resources

33 In the case of urgent need, the Chair of Council, upon recommendation of the Director of Corporate Services, may agree to the amendment of the financial regulations. Such amendment shall relate only to the circumstances in respect of which it is made and shall lapse if not confirmed by the next meeting of the Council.

Deleted: Resources

34 Any proposed departure from set procedures should be clearly documented and approved by the Director of Corporate Services before the action is taken. All departures should be reported to the next meeting of the Council.

Deleted: Resources

Codes of behaviour

Public service values

35 There are three crucial service values which must underpin the work of the NMC.

35.1 Accountability – everything done by those who work for the NMC must be able to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

35.2 Probity – there should be an absolute standard of honesty in dealing with the assets of the NMC: integrity should be the hallmark of all personal conduct in decisions affecting registrants, staff and suppliers, and in the use of information acquired in the course of NMC duties.

35.3 Openness – NMC activities should be transparent so as to promote confidence between the NMC and its staff, registrants and the public.

36 Further information can be obtained from the NMC code of conduct for members and the *Nolan Committee's first report on standards in public life*.

Deleted: ¶

Deleted: 22

Anti-fraud, bribery and corruption

37 It is important that the NMC has robust systems and procedures in place to ensure that the risk of impropriety is minimised as far as possible, and that where instances do occur, there is a prompt and effective response to them. Fraud, bribery and corruption and other irregularities are sensitive and damaging issues that can lead to financial loss, adverse publicity and loss of public confidence in the way an organisation's finances and resources are being used.

38 The NMC expects all Council members, directors and other staff to report any suspicions they might have of fraudulent or corrupt behaviour. The NMC's Whistleblowing policy (public interest disclosure policy) is available on the intranet.

39 The NMC imposes an obligation that all gifts given to staff in the course of their duties are centrally recorded on a gift register. The Assistant Director, Governance and planning, maintains a register of members' interests and members are also asked to declare gifts and hospitality.

40 For details on the above matters, please refer to the NMC anti-fraud, bribery and corruption policy available on the HR section of the NMC intranet.

Related party transactions and disclosure of interests

41 Council members and staff are required to declare any interests they may have in matters they are dealing with and, where appropriate, not be involved in such matters in which they have an interest. Members of staff are required to make a declaration of interest if they take part in tendering panels. Members of committees are bound to declare any interest in the business of the day, at each committee meeting, in addition to the disclosure requirement incumbent upon them under the NMC code of conduct for members 2009.

42 Council members and staff shall immediately disclose to the Chief Executive:

42.1 any family or close relationship they have with any other member of NMC's staff, any Council member, committee member, panellist or any provider of goods or services to the NMC

42.2 any financial or other interest of benefit to that person from a transaction or financial arrangement of the NMC, including any interest in a business trading with the NMC.

43 No member of staff may establish a company or commercial enterprise of any kind intended to exploit any activity carried on by the NMC or on the NMC's premises or to exploit any rights belonging to the NMC without the prior written approval of Council.

44 A register of interests is maintained by the Chief Executive for Council members, Directors and Assistant Directors, and this is to published on the NMC's website and, in respect of the register of members interests, made available at each Council meeting.

Deleted: ¶

Deleted: This is often known as "whistle blowing".

Deleted:

Deleted: ¶

Deleted: and members of the senior management team

Deleted: be

Deleted: in

Deleted: annual report

Comment [N2]: Anmended to bring into line with Standing Orders paragraphs 92-92)

Deleted: .

Deleted: ¶

Deleted: 22

45 The Director of Corporate Services shall monitor any related party transactions and the Chief Executive shall determine whether any such transaction should be considered material.

Travelling and subsistence allowances

46 The Director of Corporate Services shall be responsible for establishing procedures for the management of expense claims submitted by Council members, committee members, panellists, other office-holders and staff.

47 All rates and regulations regarding travelling and subsistence payments shall be reviewed on a regular basis, by the Director of Corporate Services.

48 For detailed guidance on the above matters, please refer to the NMC travel, accommodation and subsistence policy, available on the finance pages of the NMC intranet.

Recording, monitoring and reporting activities

Maintenance of, and access to records

49 The Director of Corporate Services shall be responsible for the maintenance of the accounting and payroll records and the provision of any relevant information to authorities that are entitled to receive it.

50 No unauthorised person is allowed access to the financial or payroll records, including records held in the computer system.

51 The NMC has a legal requirement to retain prime documentation for six years. This documentation includes:

51.1 purchase invoices

51.2 sales invoices and copies of receipt

51.3 tax and VAT records

51.4 bank statements

51.5 salaries and wage records.

52 To ensure fulfilment of this requirement, no person may dispose of a financial record of the NMC without the prior authorisation of the Director of Corporate Services.

53 The Director of Corporate Services shall have access to all records, documents, correspondence and explanations relating to any financial transactions of the Council; and any individual working for, or on behalf of the NMC, may be required to produce cash stores or any other NMC property.

Deleted: Resources
Deleted: ¶
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: ¶
Deleted: Resources
Deleted: ¶
Formatted: Bullets and Numbering
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: 22

ICT and data security

54 The Director of Corporate Services shall be responsible for the accuracy and security of the computerised financial data of the NMC and shall ensure that:

Deleted: Resources

54.1 procedures are in place to protect data, programs and computer hardware from deletion or modification, theft or damage, or accidental or deliberate disclosure to unauthorised persons

54.2 appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of data, as well as the efficient and effective operation of the system

54.3 adequate controls exist such that the computer operation is separated from development, maintenance and amendment

54.4 an adequate audit trail exists through the computerised system and that such computer audit reviews as necessary are carried out

54.5 the NMC remains compliant with the Data Protection Act 1998 and all other relevant legislation.

55 Changes to financial systems must be developed in a controlled manner and thoroughly tested prior to implementation. Where changes are carried out by other organisations, assurances of adequacy must be obtained from them prior to implementation.

56 Contracts for ICT services must clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also specify service level expectations, and ensure rights of access for audit purposes.

57 Further guidance on ICT and data security can be obtained from the ICT security policy available from the ICT services pages on the NMC intranet.

Preparation of the annual accounts

58 The Director of Corporate Services is responsible for the compilation of all necessary accounts and accounting records within the time required by law, and in accordance with accounting policies approved by Council.

Deleted: Resources

59 In reviewing and amending accounting policies, the Council shall:

59.1 have regard to recommended best accounting practice as defined by applicable accounting standards, external auditors and law

59.2 ensure that such practice is applied so that the accounts provide a true and fair view of the NMC's financial position.

Deleted: ¶

Deleted: 22

60 The annual accounts of the NMC shall be prepared in such form as the Privy Council may determine and should be signed by the Chair of Council and the Chief Executive in accordance with the accounts direction.

61 Annual accounts will be reviewed by the Audit Committee before submission to the Council for final approval.

62 In relation to the draft annual financial statements, the Audit Committee's terms of reference require it to pay particular attention to:

62.1 critical accounting policies and practices, and any changes to them

62.2 decisions requiring a major element of judgement

62.3 the extent to which the financial statements are affected by any unusual transactions during the course of the year, and how they are disclosed

62.4 the clarity of disclosures

62.5 significant adjustments arising from the audit

62.6 the "going concern" assumption

62.7 compliance with accounting standards

62.8 compliance with legal requirements

62.9 the content of the annual governance statement

Deleted: reviewing

Deleted: on internal control

Deleted: ¶

Annual reports

63 Article 50 of the Order, as amended, requires that the NMC has to produce:

63.1 an annual report that includes a description of the arrangements that it has in place to ensure that it adheres to good practice in relation to equality and diversity

63.2 a statistical report relating to its fitness to practise functions

63.3 a strategic plan.

64 The Council is also required to submit copies of these reports and the plan to the Privy Council and the Privy Council is required to lay copies of the reports and the plan before Parliament.

Deleted: ¶

External audit

65 Article 52 of the Order, as amended, requires the annual accounts of the Council to be audited by the Comptroller and Auditor General (National Audit Office) and by auditors appointed by the Council. The Order further requires that the audited accounts be submitted to the Privy Council for laying before Parliament.

Deleted: ¶

Deleted: 22

66 Access to the premises occupied by the NMC and to all necessary information, including books of accounts and other documents, must be provided and explanations given when required, to the Auditor appointed by the NMC and to the staff of the National Audit Office for the purpose of examining the NMC's accounts.

67 The reports from the Auditors are to be presented to the Audit Committee.

68 The Audit Committee may request such legal, internal audit, accountancy or other professional advice (including the attendance of advisers at meetings of the Committee) as it sees fit for the proper discharge of its functions.

Internal audit

69 The accounting and financial operations of the Council shall be subject to internal audit under the control and direction of the Audit Committee.

70 The Assistant Director, Governance and Planning and the Head of Internal Audit shall have direct access to the Chair of the Audit Committee, and in exceptional circumstances of which the Assistant Director, Governance and Planning and the Head of Internal Audit will be the judge, to the Chair of Council.

71 The Assistant Director, Governance and Planning and the Head of Internal Audit or an authorised representative shall:

71.1 have access to all records, documents and correspondence relating to any transactions of the Council

71.2 staff may be required to provide explanations as are necessary concerning any matter under examination

71.3 staff may be required to produce, cash, stores or any other Council property controlled by a member of staff.

72 Whenever any matter arises which involves, or is thought to involve, irregularities concerning the assets or functions of the NMC; it shall be the duty of the person who becomes aware of such irregularity to notify their line manager or the Assistant Director, Governance and Planning, the Director of Corporate Services and the Chief Executive as appropriate.

73 The Assistant Director, Governance and Planning shall take such steps as shall be considered necessary in order to investigate and report on matters of irregularity.

74 The person charged with the responsibility of examining and checking transactions, shall not have executive responsibility in any of these transactions.

75 Copies of all internal audit reports shall be forwarded to the Chief Executive and the Director of Corporate Governance and the Audit Committee.

76 The annual reports from the internal auditors are to be presented to Council.

Deleted: ¶
Deleted: open
Deleted:
Deleted:
Deleted:
Deleted: ,
Deleted: Resources
Deleted: Assistant Director, Governance,
Deleted: who is
Deleted: Resources
Deleted: ¶
Deleted: 22

77 The Assistant Director, Governance and Planning shall regularly present reports and audit plans to the Audit Committee. Further reports may be presented at the discretion of the Assistant Director, Governance and planning.

78 *The Public Sector Internal Audit Standards and associated guidance* should be applied as appropriate to the NMC[2].

Salaries and payroll

79 The preparation of payroll and the payment of all salaries and emoluments shall be the responsibility of the Director of Corporate Services.

80 All forms and documents required to be used for payroll and related purposes shall be in a form agreed by the Director of Corporate Services.

81 Deductions from salaries, except for statutory deductions for income tax and National Insurance, shall be approved and authorised in accordance with the scheme of financial delegation and forwarded by the payroll manager. They shall be paid to the relevant authority within 14 days of deduction.

82 Information needed to maintain records for income tax, National Insurance and superannuation shall be obtained from official documents, or from relevant organisations.

83 The method of payment of salaries, wages and other emoluments due to all staff, or former staff, of the Council, shall be determined by the Director of Corporate Services. Normally, payment will be by credit transfer, except for leavers, for whom the final payment may be made by cheque.

Budget monitoring and control

Introduction

84 Budgets and strategic plans are set and monitored so that Council can plan the work of the NMC and ensure that its targets are met. Unexpected budget underspends and overspends prevent other planned work from taking place in current and future periods.

The Council's role in budget monitoring

85 In relation to budget monitoring and control, it is the responsibility of Council to:

85.1 agree appropriate financial strategies, policies and procedures

85.2 agree an annual budget covering income, expenditure, capital and investment cash-flow

85.3 agree the Council's business planning processes

85.4 monitor financial performance against budget and forecast

[2] http://www.hm-treasury.gov.uk/psr_governance_gia_guidance.htm

Deleted: *Government internal audit manua*
Deleted: /
Deleted: adopted as the best practice approach and
Deleted: ¶
Deleted: Resources
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: ¶
Deleted: 22

85.5 establish, maintain and monitor performance measures for the organisation as a whole.

86 Any budget must be approved by Council before it takes formal effect.

Director of Corporate Services' role in budget monitoring

87 The Director of Corporate Services shall be responsible for the preparation, monitoring and control of budgets and shall ensure that:

87.1 all strategic plans and operational plans necessary for the proper planning of the NMC's finances are compiled and submitted to Council

87.2 budgets are set in accordance with the aims and objectives of the strategic business plan

87.3 procedures and guidance are in place to adequately collate, set and monitor budgets

87.4 council are provided with the necessary information to explain the causes of any significant in-year variances from the budget.

88 The Director of Corporate Services will prepare for Council, and the Chief Executive budgetary information as appropriate. The Director of Corporate Services will ensure that budget holders are provided with enough information to manage their budgets.

Responsibilities delegated to budget holders

89 Budget holders are responsible to the Chief Executive for the control of their budgets. Each budget holder shall prepare plans and estimates of the costs of the activities of his or her department and shall submit them to the Council for approval in conjunction with the business plan.

90 Budget holders shall consult the Director of Corporate Services with respect to any new proposals which have financial implications.

91 The Director of Corporate Services is entitled to full access to the financial, statistical and other relevant information to enable accurate setting and monitoring of budgets.

92 Transfers of approved funds between cost types within departments or directorates are permitted in order to give flexibility in the way that departmental objectives are achieved.

93 Transfer of budget funds from one cost centre to another must be agreed between the affected Directors and/or budget holders and approved by the Director of Corporate Services.

94 Budget holders are expected to ensure expenditure budgets are not overspent and income budgets are fully met. If a budget holder believes that an individual budget

Deleted: ¶
Deleted: Resources
Deleted: Resources
Deleted: Resources
Deleted: Resources
Deleted: ¶ ¶
Deleted: Resources
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: 22

may be overspent or underspent, the budget holder shall inform the Director of Corporate Services so that any appropriate action can be taken.

95 A budget holder may incur expenditure within the limits of the plans and budgets authorised by the Council. Budget holders should not make commitments that would lead to their budgets being exceeded, without the prior approval of the Directors Group.

96 Budgeted funds may not be reforecast for the purpose of taking on additional permanent or temporary staff until the requisite approval has been obtained from the Directors Group. Recruitment will be controlled through the HR department.

97 Budgets may not be reforecast for any other long term (i.e. more than one year) commitment which would bind the NMC to expenditure in future years (e.g. leasing equipment) without prior approval by the Directors Group.

98 Where significant funds are budgeted for a particular purpose and a saving is made or the activity is delayed to another year, resulting in an underspend of budgeted funds of more than £25,000, the budget holder must not reforecast these savings for other purposes. Instead, they should be brought to the attention of the Directors Group where a corporate view will be taken and the funds will be allocated to the area with highest funding priority.

99 Revised forecasts will be approved by the Directors Group.

100 Budget holders shall use the Council's accounting systems to enable effective monitoring of their budgets and shall ensure that expenditure and income are allocated to the appropriate activity in the accounts.

101 Further guidance on budgetary roles and reponsibilities can be found in the budget management handbook available from the Finance department or the finance section of the NMC intranet.

Ensuring value for money

Introduction

102 The NMC must be able to demonstrate that it achieves value for money in all its purchases.

103 The Chief Executive has overall responsibility for ensuring value for money, and together with the Director of Corporate Services will ensure that procedures and guidance are developed for competitive selection wherever possible in procurement exercises. These procedures should:

103.1 be open and clearly demonstrate fair and adequate competition wherever appropriate

103.2 offer flexibility whilst complying with best practice and mandatory requirements

Deleted: Resources
Deleted: CLB
Deleted: resources
Deleted: g
Deleted: CLB
Deleted: CLB
Deleted: CLB
Deleted: ¶
Deleted: ¶
Deleted: Resources
Deleted: ¶
Deleted: 22

103.3 give due regard to the costs and benefits of control.

Competitive selection requirements

104 'Best practice' as defined by the Director of Corporate Services, is required for purchasing all goods and services. The value of the goods or services being procured will determine the degree of formality of the tendering process.

105 Information on the financial thresholds that determine the formality of the tendering process to be applied can be found in the NMC procurement manual.

106 For high value goods and services, compliance with the requirements of the EU Directives is mandatory under the Public Supply Contracts Regulations 1995. Details of the current financial thresholds can be obtained from the NMC Procurement department.

107 The NMC should accept the tender which provides greatest value for money, defined as the optimum combination of whole life costs and benefits. However, if the budget holder proposes to accept a tender which is not the lowest price tender, he or she shall not do so without the prior approval of the Director of Corporate Services.

108 Further guidance relating to the regulations governing Government procurement, and the requirements of the EU Directives can be obtained from the Procurement department.

109 Further details on contracting, tendering and ordering are contained in the NMC procurement manual available from the Procurement department or the finance pages of the NMC intranet.

Contract terms

110 All contracts shall be in accordance with the terms and conditions of the NMC where possible and appropriate. Where this is not possible the contract should be signed by the Director of Corporate Services to evidence his approval of the non-standard contract terms.

111 All relevant contracts should allow the NMC to retain the right to audit all income received from third parties under income generation contracts, and to confirm the calculation of profit share.

112 The authority to commit the NMC to financial expenditure via contracts with external suppliers is vested in those individuals set out in the table in annexe 1.

Orders for goods and services

113 All purchases must be authorised by the relevant budget holder or by a member of staff to whom a budget holder has delegated budgetary control of appropriate specified levels of expenditure.

Deleted: Resources

Deleted: Resources.

Deleted: or on the Office of Government Commerce (OGC) website

Deleted: ¶

Deleted: Resources

Deleted: ¶

Deleted: 22

114 The Head of, Procurement and Estates has been delegated the authority to authorise expenditure to the extent outlined in the scheme of financial delegation.

Deleted: Assistant Director

115 Official orders shall be issued for all work, goods or services to be supplied to the Council, except for periodic payments such as rent and rates, petty cash items, credit card and purchasing card expenditure and such other exceptions as the Director of Corporate Services may approve.

Deleted: Resources

116 The Director of Corporate Services will ensure that appropriate controls and guidance are in place to ensure the proper use of credit cards and purchasing cards. The detailed guidance, included in the NMC procurement manual, should include:

Deleted: Resources

116.1 descriptions of the particular expenditure types the cards are restricted to (such as travel and subsistence)

116.2 limits to individual transaction values

116.3 monthly total expenditure limits

116.4 how cards are allocated and who is entitled to use one

Deleted: ¶

Responsibilities of credit and procurement card holders

117 Corporate and purchasing cards should be used solely for expenses incurred on NMC business and for no other purpose. All expenditure on monthly statements should be correctly coded and authorised, and the statements and receipts must be received by the Finance department within 10 working days from the date of the statement, together with any withdrawn cash unspent at the end of the statement month.

Deleted: ¶

Payment of accounts

118 The Director of Corporate Services shall be responsible for the proper and timely payment of all accounts and expense claims.

Deleted: Resources

119 Budget holders and staff have a responsibility to provide prompt notification of amounts payable by the NMC arising from transactions that they initiate.

120 Detailed procedures and guidance shall be maintained, covering the approval of accounts for payment. This includes rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered.

121 Where appropriate, requisitions for goods and services should be raised and approved by staff and budget holders via the electronic procurement system ‘eBis’, so that the associated purchase order can be raised. Once supplied, the goods or services should be entered as ‘received’ in eBis and amounts checked to facilitate the prompt and accurate matching and payment of the associated invoice.

Deleted: ¶

Deleted: 22

122 The guidance shall include instructions for the proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

123 The payment of invoices should be independent of the ordering and authorisation processes.

124 The normal method of payment of money due from the NMC for goods and services shall be by electronic transfer, supported by duly authorised invoice.

Safeguarding physical assets

125 All staff of the NMC have an individual and collective responsibility to safeguard the financial resources of the NMC. These resources may take the obvious tangible form of fixed assets or cash, as well as less tangible items such as lost opportunities to earn or recover income that is due.

126 Further to this requirement, each member of staff has an individual and collective responsibility for the security of property. All issues of concern or potential risk must be reported to Facilities Management. Any damage to NMC premises, assets, supplies or other Corporate Services must also be reported immediately to Facilities Management.

Banking arrangements

127 The NMC's policy towards its banking arrangements shall be determined by Council. The Director of Corporate Services shall ensure that banking procedures are carried out in accordance with this policy.

128 All sums received shall be paid into the income general account or the income direct debit account. No amounts shall be paid into any other account. No bank account can be opened or closed without being reported to the Directors Group. The Chief Executive and Director of Corporate Services are delegated the authority to open accounts that have been approved by Directors Group.

129 Transfers between the Council's bank accounts and the money market division of the Council's bankers shall be made on the authority of the Director of Corporate Services.

130 The Assistant Director, Finance shall ensure that all unused, pre-printed cheques shall be kept under secure custody.

131 Bank reconciliations shall be carried out on a regular basis, with a full reconciliation at least monthly. These reconciliations must be signed and stored for a period of 12 months to evidence the successful completion of the reconciliation.

Receipt of money

132 The collection of all monies due to the NMC shall be under the control of the Director of Corporate Services who shall be responsible for ensuring that all monies due to the Council are collected and properly accounted for.

Deleted: ¶

Deleted: resources

Deleted: ¶

Deleted: Resources

Deleted: CLB

Deleted: Resources

Deleted: CLB

Deleted: Resources

Deleted: ¶

Deleted: Resources

Deleted: ¶

Deleted: 22

133 An official receipt shall be issued for all counter payments, either by cash, cheque or credit card and also whenever requested by the payer. Stocks of all receipt books, vouchers or similar documents shall be controlled in accordance with approved procedure manuals.

134 All monies received by a staff member on behalf of the Council, shall be passed without delay to the Finance department for banking.

Deleted: ¶

Online receipts of money

135 The Director of Corporate Services will ensure compliance with the Payment Card Industry Data Security Standards (PCI DSS). The PCI DSS are a set of guidelines covering all aspects of transaction security and data protection to help protect against fraud. Compliance with PCI DSS is mandatory for processing credit card transactions online.

Deleted: Resources

136 All contractors and members of NMC staff must be compliant with the NMC ICT policy. Unacceptable use of data, or the supply to third parties may result in the application of the NMC disciplinary procedures.

137 Further information relating to procedures and controls over online receipts can be found in the finance income procedure handbook available from the Finance department.

Deleted: ¶

Security of cash

138 Security of money in all its forms is important and arrangements for handling it or transporting it shall be subject to the approval of the Director of Corporate Services.

Deleted: Resources

139 All cash, cheques and credit card payments must be held securely, and locked in the safe if held overnight. The holding of cash must comply in all respects with the requirements of the NMC's insurers.

140 The Director of Corporate Services shall provide such advances as he considers appropriate to certain members of staff for the purpose of defraying petty cash and other expenses.

Deleted: Resources

141 Petty cash payments shall be limited to duly authorised minor items of expenditure only and no single item shall exceed the amount of the individual petty cash float or the limit imposed from time to time by the Director of Corporate Services, whichever is the lower. Claims for items or amounts in excess of these limits will be paid via BACS transfer.

Deleted: Resources

142 Petty cash shall be kept securely locked at all times. Petty cash may be handled only by staff who have been authorised to do so by the Director of Corporate Services.

Deleted: Resources

143 Personal or other cheques must not be cashed out of petty cash or money held on behalf of the NMC.

Deleted: ¶

Deleted: 22

Credit finance arrangements including leases

144 No person other than the Director of Corporate Services can approve any contract or transaction which binds the NMC to credit finance commitments.

145 Prior to the signing of any credit or lease agreement, cost comparisons should be carried out for buy, hire or lease options to demonstrate that value for money is being achieved.

Investments

146 The Director of Corporate Services will produce an investment policy for approval by Council. The policy will include the Director of Corporate Services' responsibilities for advising Council on investments and reporting their performance.

147 Council may appoint an investment manager to conduct business, using the funds allocated by the Council.

148 The Directors Group shall agree, monitor and supervise the activities of any investment manager if appointed, on behalf of the Council.

149 The NMC's investments shall be made with due regard to ethical constraints, and to achieve any objectives set by the Council.

150 All investments made on behalf of the NMC shall be made in the name of the NMC.

151 All stock and share certificates and other proofs of ownership shall be lodged with the bank for safe custody. It is the responsibility of the Director of Corporate Services to arrange safe custody of such items.

Capital expenditure

152 The purchase of individual assets costing more than £1,000 (including VAT), whose usefulness is expected to extend over more than one year, and which are intended for use on a continuing basis, shall be classified as capital expenditure. Such assets, including equipment, furniture and property shall be recorded in the NMC fixed asset register.

153 Items of capital expenditure not already included in the approved capital expenditure budget shall require a bid for central pool funds in accordance with the procedures laid out in the budget management handbook.

154 Items of computer hardware with a cost of less than £1,000 (including VAT) should be treated as in-year revenue expenditure and not capitalised.

155 Individual personal computers and printers, even if not classified as fixed assets, should be recorded in the equipment register, marked and numbered, and included in any asset inventory.

Deleted: Resources

Deleted: ¶

Deleted: Resources

Deleted: Resources

Deleted: CLB

Deleted: Resources

Deleted: ¶

Deleted: ¶

Deleted: 22

156 Items of furniture, fittings and equipment with a cost of less than £1,000 (including VAT) shall be entered on the equipment register, with an adequate description of each item.

Equipment control

157 The Director of Corporate Services shall arrange an annual check of items on the equipment register, for taking action in relation to surpluses and deficiencies and updating the inventory accordingly.

158 NMC property shall not be removed from NMC premises except with the express permission of a line manager or the Director of Corporate Services or the Chief Executive.

159 All equipment belonging to the NMC shall be marked to show its ownership and referenced to the equipment register. No person shall remove or alter such a mark unless authorised to do so in the course of their duties.

Disposal of assets

160 The disposal of obsolete or surplus stock, equipment or furniture with a net book value of less than £2,000 (collective value of items) shall occur only with the prior approval of the Director of Corporate Services. Items with a net book value in excess of £2,000 shall be disposed of with the prior approval of the Chief Executive. The disposal of items with a net book value in excess of £10,000 shall require the prior approval of the Council.

Stores control

161 Stationery stocks shall be under the overall control of the Director of Corporate Services and stocks of NMC's publications shall be under the control of the Director of Corporate Governance.

162 An inventory of all publication stock shall be arranged at least once a year by the Director of Corporate Services.

163 Individual departments shall maintain stationery stocks at the minimum level required for efficient operation of the department, and should not carry excessive stocks.

Security of property

164 Directors have responsibility for the security of the property and stores of their department, for avoiding loss and for due economy in the use of resources.

165 The Director of Corporate Services will keep a record of all rights to titles to real property and rights to occupy premises and ensure safe custody of title deeds and associated documents.

166 The Director of Corporate Services is responsible for ensuring that all NMC property is adequately maintained and that, at all times, the NMC complies with

Deleted: ¶
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: Resources
Deleted: ¶
Deleted: Resources
Deleted: External Affairs
Deleted: Resources
Deleted: ¶
Deleted: Business managers
Deleted: Resources
Deleted: Resources
Deleted: ¶
Deleted: 22

the terms of its property leases, as well as the regulations relating to health and safety.

167 The Director of Corporate Services is responsible for the preparation of a maintenance plan and of annual estimates of the costs of repair and maintenance of NMC property, including leased office premises.

168 The manager of each budget area is responsible for the security, custody and control of all resources including office equipment, furniture, materials and stores appertaining to that area.

Insurance

169 The Director of Corporate Services shall arrange all insurance cover and negotiate all claims in consultation with other staff where necessary. The Director of Corporate Services shall ensure that the Certificate of Insurance and other necessary insurance records are maintained and securely stored.

170 Directors shall be responsible for minimising any insurable risks within their areas, and give prompt notification to the Director of Corporate Services of any new risks which require to be insured and of any alterations affecting existing insurance.

171 Directors shall notify the Director of Corporate Services in writing as soon as possible, of any loss, liability or damage, or of any event likely to lead to a claim.

172 The Director of Corporate Services shall annually, or after such shorter period as may be considered necessary, carry out a risk assessment and review all insurance, in consultation with Directors as appropriate. Independent advisers should also be consulted as necessary.

Deleted: Resources

Deleted: Resources

Deleted: Resources

Deleted: The business managers

Deleted: Resources

Deleted: The business managers

Deleted: Resources

Deleted: Resources

Deleted: business managers

Deleted: ¶

Deleted: 22

Annexe 1

Authority for financial commitment

Item	Council[1]	Chief Executive and Registrar with agreement of Chair plus one Council member	Chief Executive and Registrar or Assistant Registrar[2]	Director of Resources	Head of, Procurement and Estates
	Aggregate Value aggregate value means cost over the life of the item or contract including any VAT applicable				
Single tender exercise, contract award recommendation, form of agreement, contract variation or extension ≥	**≥1,000,000**	**≥500,000 <1,000,000**	**<500,000**	**<100,000**	**N/A**
Purchase order	**1,000,000**	**≥500,000 <1,000,000**	**<500,000**	**<100,000**	**<25,000**

All authorisations to commit sums of between £500,000 and up to £1,000,000 will be reported to Council at the earliest opportunity.

Decisions to commit sums of an aggregate value of £1,000,000 or over will usually be discussed by Council at a meeting. Where an urgent decision is required outside of the meeting schedule, a decision will be taken by email in accordance with Standing Orders.

[1]Where Council have made the decision, the Chair will sign on behalf of the Council.
[2]Only in the absence of the Chief Executive and Registrar.

Deleted: Asst. Director

Comment [N3]: It is proposed to delete names as only the "office" should be referred to not the person.

Deleted: (Assistant Registrars are Katerina Kolyva, Lindsey Mallors, Rita Newland, Stephen Williams)

Deleted: ¶

Deleted: 22

Item 18
AC/13/30
19 April 2013

Audit Committee

Francis Report

Action:	For information
Issue:	Reports on how the NMC is addressing governance and assurance issues raised by the Francis Report.
Core regulatory function:	Supporting functions
Corporate objectives:	Corporate Objective 7: Learning from the issues highlighted in the Francis report should help strengthen the governance framework.
Decision required:	The Committee is invited to consider the plans to learn from wider governance and assurance issues identified by the Francis Report.
Annexes:	The following annexes are attached to this paper: Annexe 1: Blueprint of arrangements for addressing the Francis Report Annexe 2: Overview of governance and assurance issues raised in the Francis 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.

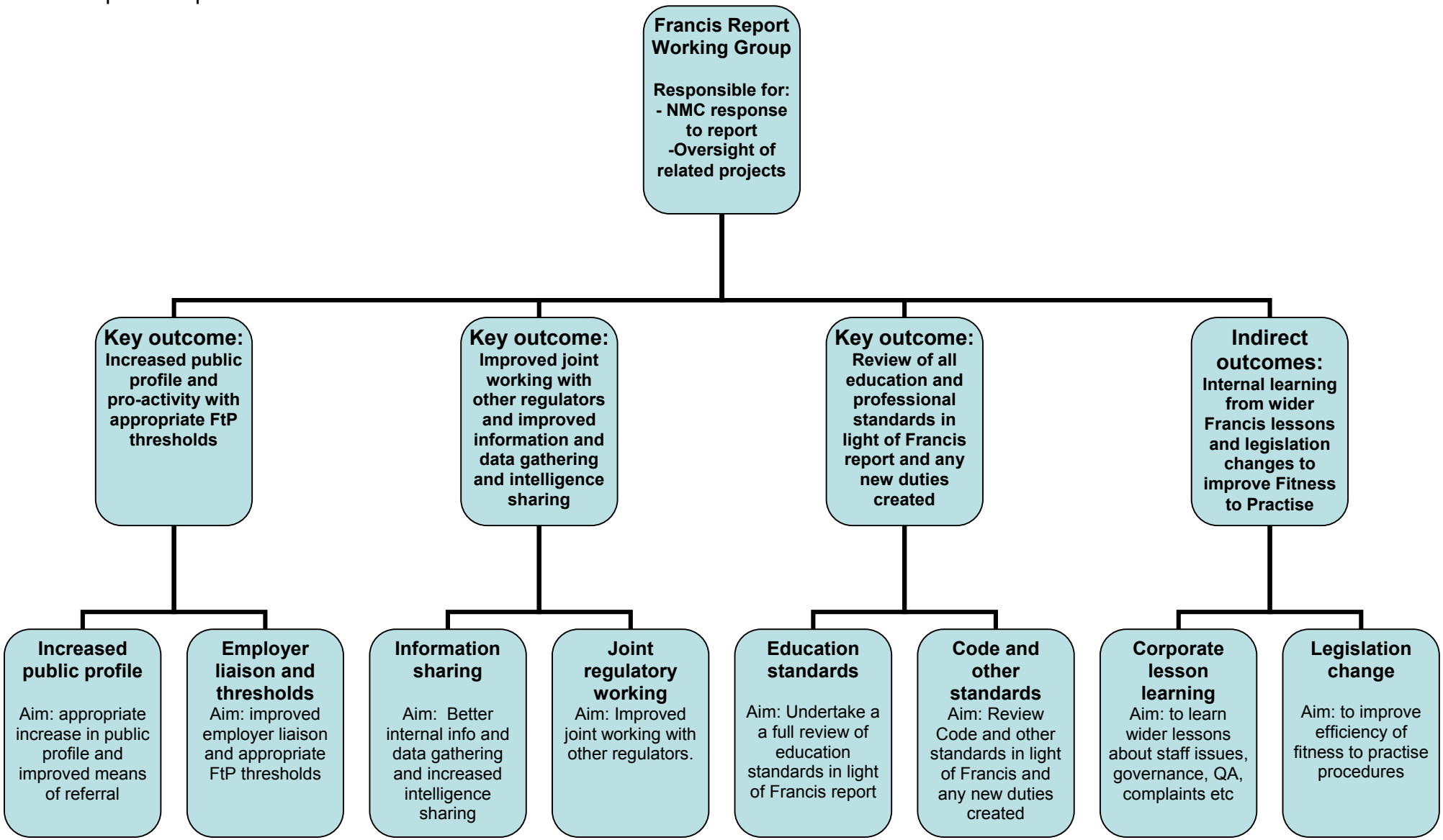
Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:	1	The Francis Report was published on 6 February. The Department of Health published an initial response on 26 March.
	2	The blueprint at annexe 1 shows how work arising from Francis is being taken forward by the NMC. The NMC's full response will be published following consideration by reconstituted Council
Discussion:	3	In addition to the specific recommendations for the NMC, the Francis Report raises wider issues the NMC should seek to learn from around governance, assurance and control.
	4	Annexe 2 provides a broad overview of those wider findings and issues raised in the Francis report about Boards and other organisations which are of particular relevance to the Audit Committee's remit and how these are being addressed.
	5	The Blueprint at annexe 1 includes a "corporate lesson learning" strand. This will include a project led by the Director of Corporate Services, as part of the wider change programme, to address organisational and cultural issues.
	6	The Committee is invited to consider how the NMC can best ensure it is doing all it can to learn from the wider issues identified by the Francis Report.
Public protection implications:	7	Strong governance is essential to ensuring delivery of public protection as the Francis report demonstrates.
Resource implications:	8	Work arising from the Francis report is being absorbed within existing staff resources.
Equality and diversity implications:	9	No direct implications from this paper.
Stakeholder engagement:	10	Not applicable
Risk implications:	11	Failure to learn from the issues addressed in the Francis report represents a risk to achieving our corporate objectives.
Legal implications:	12	None.

Item 18
AC/13/30 Annexe 1
19 April 2013

Francis report blueprint – March 2013



Learning from Francis Report

Page	Para	Findings/Learning	NMC approach
Board level/Council Effectiveness			
44	1.8 1.10 1.7	Lack of collective responsibility Poor grip on accountability and governance by Board. Importance of culture of openness and critical self analysis (not taking false assurance from good news or seek to explain away bad news).	Governance review Induction for members of reconstituted Council Programme of development/support/appraisal of Council and partner members
50	1.38	No system for ensuring transfer of information and knowledge from one iteration of (SHA) to another despite substantial staff cuts.	Transition planning for reconstituted Council
50	1.40	(SHA) too willing to place trust in (provider boards), readier to defend than consider implications of criticism/concerns being expressed. Too prepared to assume that others would share information raising concerns/requiring action without being asked.	Programme of development/appraisal of Council and partner members to include supporting members are equipped to scrutinise effectively. Review of governance framework/documentation to consider Audit Committee request to place obligation on Executive to ensure Council aware of all internal control/other assurance reports identifying weakness or concerns.
Putting patients first			
45	1.15	Wrong priorities - failed to put patients at centre of its work	Corporate Plan 2013-2016 puts public protection at the heart of the NMC's work. Reconstituted Council needs to be equipped to ensure this translated into day to day reality in delivering regulatory functions.

63 74	1.110 1.173	Boards should listen to patient experiences put patient perspective at the forefront of their minds. Involvement of patients and public in all that is done	Engagement strategy and developing mechanisms for obtaining increased public/patient involvement in NMC work, such as PPI forum.
Integrity and transparency			
57 75 81 1494	1.74 1.176 1.220 R177	Healthcare regulators should be a model of openness/welcome constructive criticism. There should be a shared culture throughout the healthcare system based on openness, honesty, transparency and candour. Every healthcare organisation must be honest, open and truthful in all dealings with patients and the public. No personal or organisational interest must ever be allowed to outweigh this duty. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	Continue to build culture of openness and public candour for example as demonstrated in past 12 months: • Acceptance of PSA Strategic Review criticisms and acknowledgement of organisational failures • Acceptance of part in system failures resulting in Mid-Staffs and public apology • Admission of issues around Overseas registrations Change programme project to address staffing and cultural issues will include further review of policy to be undertaken as part of wider review of HR policies during 2013-2014.
Attending to Quality			
42 45 53 51	1.2 Bullet 8 1.11-13 1.52 1.45	Lack of focus on quality Failure to recognise/scrutinise the impact of financial savings/staff cuts on quality Insufficient consideration given to consequences of failing to prioritise development of performance metrics/measures relating to quality.	Previously highlighted by Audit Committee and Council Recognition of need to address absence of quality metrics/assessment as part of review of performance measurement and balanced scorecard.
Identifying risks and weaknesses			
41	1.2	Internal audit reports not taken	Audit Committee has previously

62	Bullet 4 1.103	seriously Disconnect between policy and practical implementation	stressed the importance of taking internal audit seriously including: appropriate investment in internal audit provision; adherence to internal audit work plans; rigorous scoping of internal audit briefs; timely and relevant management responses. Appointment of new internal audit services from April 2013 provides an opportunity to strengthen the internal audit function including: • Continuing rigorous scrutiny of management engagement with, and response to, internal audit work. • Developing strong relationships and engagement between Members, Executive and internal auditors. • Increasing organisational understanding of the role of internal audit and how it can add value • Improving the benefit derived from internal audit services. Development of a robust assurance framework and new policy governance framework together with strengthened internal audit and implementation of quality assurance strategy should assist in identifying implementation of, and practical compliance with, policy.
45	1.13	Inadequate risk assessment	Strengthened risk management framework and toolkit being rolled out from April/May 2013. Planned development of a robust assurance framework will help to identify gaps and weaknesses in internal controls and risks.
Whistleblowing/Gagging Clauses			
42	1.2 Bullet 6	Whistleblowing: serious and substantive concerns raised but not addressed adequately. “Gagging clauses” or non disparagement clauses should be prohibited in the policies and	Revised Whistleblowing policy in place since September 2013. Ongoing oversight of policy by Audit Committee. Change programme project to address

		contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	staffing and cultural issues will include further examination of whistleblowing policy to be undertaken as part of wider review of HR policies during 2013-2014. Consider examining content of any "compromise agreements" used by NMC.
Learning from complaints/serious events			
44 56 58 72	1.9 1.70 1.80 1.152/ 1.157	Adequate process for dealing with complaints and serious events/surveys: board lacked awareness of reality. Direct observation/ contact with frontline staff / examination of real cases much more powerful than reliance on files of policies, minutes & overall figures. Patient feedback should be a priority. service users are the first to witness poor outcomes. More specific focus on complaints. Complaints, their source, their handling and their outcome provide an insight into the effectiveness [of an organisation]. They are a source of information that has hitherto been undervalued as a source of accountability and a basis for improvement. Learning from complaints must be effectively identified, disseminated and implemented.	Corporate serious event policy approved January 2013 seeks to bring together learning from serious events, complaints and data breaches. Ongoing scrutiny at Committee/Executive level of serious events/complaints/data breaches. Revised corporate complaints policy to be considered by Council in April, including Council's request for more direct information about complaints. Quality Assurance Strategy (in development) to ensure that intelligence and learning from complaints/ serious events informs QA work.
Structural and cultural issues			
62	1.104	Structural change is not only destabilising but can also be counterproductive in giving the appearance of addressing concerns rapidly while in fact doing nothing about the really difficult issues which require long term consistent	Review of NMC restructure in 2012 to consider whether outcomes achieved Change programme project to address staffing and cultural issues

		management.	
65	1.114	Negative aspects of culture contributing to failure include: • A lack of openness to criticism; • A lack of consideration for patients; • Defensiveness; • Looking inwards not outwards; • Secrecy; • Misplaced assumptions about the judgements and actions of others; • An acceptance of poor standards; • A failure to put the patient first in everything that is done.	Change programme project to address staffing and cultural issues
78	1.196	Common culture and values [..] must be applied at all levels but example set b leaders of particular importance	Nolan principles adopted in Council members/partners code of conduct Need to update and refresh code of conduct for Directors/Senior staff Change programme project to address staffing and cultural issues
Information			
80 1613	1.219 First bullet	The effective collection, analysis and dissemination of relevant information is essential for swift identification and prevention of substandard service, facilitating accountability, provision of accessible and relevant information to the public [..].	Development of a corporate data strategy to address both performance information and data required for accountability purposes and data needed to inform delivery of regulatory functions and drive improvement.

Item 19
AC/13/31
19 April 2013

Audit Committee

NMC Governance Review: Progress report

Action: For discussion.

Issue: This paper is a progress report on the governance review of Council and Committee structures.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 3, Goal 7: Fit for purpose Council and committee structures are a critical to ensuring the NMC has a sound governance framework to carry out its core regulatory function.

Decision required: The Committee is invited to discuss and comment on this report.

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.

Author: Biran Tharumaratnam
Phone: 020 7681 5424
biran.tharumaratnam@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 In response to the CHRE/PSA strategic review the NMC is fulfilling its commitment to undertake a governance review of Council and committee structures.

2 The NMC commissioned external consultants to undertake the review in order to provide a thorough independent perspective of current arrangements and those the organisation might need for the future.

3 The review started w/c 4 February 2013 and is expected to be completed by w/c 15th April 2013.

Discussion and options appraisal:

4 The review has progressed well to date and is on track to finish on time. This means the NMC is well placed to utilise to findings from the review to inform its plans for the reconstituted Council.

5 To ensure rigour and the desired quality the scope of the review has covered a wide range of activity including:

- Review of existing governance documentation.
- Interviews with the Chair, committee Chairs, Chief Executive, Directors, Assistant Directors, and other key NMC staff.
- Workshops with Council members and the Executive.
- Observation of Council, committee and Directors Group meetings.
- Interviews with a range of external stakeholders across the four countries e.g. Chief Nursing Officers, DH, PSA.
- Broad benchmarking with a range of organisations including more detailed benchmarking with the following regulators – GMC, HCPC, Monitor and SRA.
- Knowledge transfer to the NMC Council services team.

6 The review team has worked closely with the Chair, Chief Executive and Director of Corporate Governance to ensure that quality expectations are met.

7 While there is still further work to be done, key emerging headline provisional findings are as follows:

- There is the desire from internal and external stakeholders for the Council to be more strategic in its focus.
- Roles and responsibilities within the organisation could be clearer.
- Delegation of authority could be better aligned with risk and

strategy.

- There is scope to improve internal controls and levels of assurance.
- There is scope to review the frequency of meetings and volumes of agendas, papers and minutes to ensure better focus.
- Compared with other similar regulators the NMC Council meets almost twice as many times in the year as others (i.e. 11 times a year compared with an average frequency of 6 times a year of other similar regulators)

8 Next steps include:

- Further detailed benchmarking.
- Discussions with external stakeholders.
- Consideration and analysis of potential models for new Council and committee structures.
- Production of final report with recommendations, including potential options for new Council and committee structures.

9 **Recommendation:** The Committee is invited to discuss and comment on the progress of the governance review to date.

Public protection implications:

10 No direct public protection implications. Ensuring there are appropriate Council and committee structures in place should help the NMC deliver its core regulatory functions more efficiently and effectively.

Resource implications:

11 Review undertaken by external consultants. The Corporate Governance Directorate has project managed the review and will be responsible for leading on the implementation of the review report's recommendations.

Equality and diversity implications:

12 There are no direct equality and diversity implications resulting from this paper.

Stakeholder engagement:

13 The review has engaged a range of internal and external stakeholders.

Risk implications:

14 The NMC will be better placed to manage risks more effectively as refreshed Council and committee structures have the potential to

provide more proportionate and focused levels of assurance.

Legal implications:	15	Not applicable.

Item 21
AC/13/32
19 April 2013

Audit Committee

Process for systematic review of policies

Action: For discussion.

Issue: Reports on arrangements for ensuring that NMC policies are subject to systematic review.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: Ensuring systematic arrangements are in place for review of NMC policies and processes is a part of the internal control framework.

Decision required: The Committee is recommended to:

- Discuss progress in developing a more systematic and coherent approach to the approval, review and revision of NMC policies and procedures.
- Consider what assurance it should give to Council in this respect.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Proposed new NMC policy tiers
- Annexe 2: Proposed new Policy Library Requirements
- Annexe 3: Proposed terms of reference for new Policy Review Group

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Council tasked the Audit Committee to consider whether robust processes were in place to ensure that policies were regularly and comprehensively reviewed. (Council minute January 2013 13/12c).

2 Policies and procedures form an essential element of the internal control framework: it is important that effective arrangements are in place to ensure that these are compliant with legislation/case law, up to date, achieve the intended objectives and, crucially, are adhered to by staff. Accordingly, this work also links to the development of an NMC Assurance Framework.

3 Concurrently with Council's request to Audit Committee, Directors Group tasked a group of Assistant Directors to develop new policy governance arrangements. A report on the initial outcomes of this work was considered by Directors Group on 2 April.

Discussion:

4 The NMC has a range of strategies, policies and operating procedures in place relating to both corporate functions (eg governance, finance, procurement, ICT, HR) and delivery of regulatory functions (Registration, Education, Standards, FTP).

5 Arrangements for the approval, review and revision of these various forms of documentation vary:

5.1 Some, though not all, key governance documents and policies such as Accounting policies, Reserves policy, Whistleblowing policy, have generally been subject to regular (usually annual) review by the Audit Committee and/or Council.

5.2 Other strategies, policies and procedures including those relating to regulatory functions, have tended to be reviewed usually when changes have been required rather than on a regular systematic basis, for example, Registration policies.

6 An initial audit by the AD working group of existing policy, guidance, and other internal enabling documents identified various issues including: lack of a common naming convention; differing understanding of the distinction between strategies, policies, and procedures; differing approaches to revision of documentation and levels of oversight and scrutiny.

Proposed new policy governance arrangements

7 The AD Working Group has made a number of proposals to systemise the current approach across the organisation including:

7.1 A proposed new naming convention and set of tiers of policy documents (see annexe 1).

7.2 New governance arrangements to ensure that all strategy (Tier 1) and high level policy (Tier 2) documents are approved

by Council (unless otherwise delegated). A requirement for all internal operating procedure or guidance documents (Tier 3) to be linked to either a Tier 1 or Tier 2 document.

7.3 Clarity around the status of "panel member guidance" with approval of overarching policy to remain with Council but detailed operational guidance being developed and kept up to date by the Executive (except where changes of a strategic nature are proposed).

7.4 A new policy library (an organisation-wide system for storing and disseminating policy and related documents - see annexe 2), including arrangements to ensure systematic dissemination, review and quality assurance of documentation, with Directors to be responsible for ensuring this happens.

7.5 Proposals for strategies, policies and other documents to be subject to regular review, including agreement of a cycle of reviews for each type of policy document and ensuring that future review dates are built in as new policies are approved or existing policies reviewed. Written guidance to be developed on how reviews are to be carried out to ensure appropriate consultation (internal/external), checking for compliance with current legislation, undertaking equality and diversity assessments, and consistency with corporate/business plans.

7.6 The future role of the Corporate Governance policy team and legislation compliance team.

7.7 Setting up a new Policy Review Group, comprising Assistant Directors and other key policy staff, to oversee the development and review of all regulatory and corporate policies and ensure consistency, compliance with regulatory and other legislation and improve cross-directorate working (Terms of Reference at Annexe 3).

Further work required

8 The AD working group identified the following further work to be done:

8.1 Each directorate to complete a review of all current policies and guidance documents to ensure compliance with the new taxonomy and nomenclature arrangements and enable creation of the new policy library.

8.2 Each directorate to undertake a gap analysis to identify any areas where an agreed strategy or policy is needed to underpin an existing Tier 3 procedure of guidance document.

8.3 Development of corporate systems to support implementation and quality assurance of the new policy governance arrangements.

Links to the NMC Assurance framework

9 Development of a clear policy governance framework encompassing a more coherent, systematic approach to the development, review and revision of NMC policies and procedures should assist in the development of the NMC Assurance Framework requested by the Committee. This is the subject of a separate agenda item.

10 **Recommendation:** The Committee is recommended to:

10.1 Discuss progress in developing a more systematic and coherent approach to the approval, review and revision of NMC policies and procedures.

10.2 Consider what assurance it should give to Council in this respect.

Public protection implications: 11 Improved policy management and governance arrangements should enable more efficient and effective delivery of core regulatory functions.

Resource implications: 12 Resources (staff time) to undertake the work described in paragraphs 7 and 8 above is absorbed within existing directorate budgets. There are expected to be some costs associated with development of a Sharepoint system for the NMC policy library.

Equality and diversity implications: 13 No direct equality and diversity implications result from this paper. In developing strategies, policies and procedures, the NMC needs to be able to demonstrate compliance with the public sector equality duties.

Stakeholder engagement: 14 Not applicable.

Risk implications: 15 The failure to have systematic arrangements in place to review policies and processes represents a weakness in internal controls which represents a risk to the efficient and effective delivery of corporate objectives.

Legal implications: 16 Not applicable.

Item 21
AC/13/32 Annexe 1
19 April 2013

New policy tiers for the NMC

Statutory framework – Order, Rules etc								
Other legislation binding on the NMC as a regulator, employer, public body, data owner etc								
Tier	**Descriptor**	**Purpose**	**AKA**	**Audience/ users**	**Published**	**Governance**	**QA**	**Consultation**
1	**Strategy**	Sets out goals over a specific period. Not a framework for BAU, associated with defined change or improvement. Can be an explicit tool for accountability, eg post Francis actions	Vision; strategy; corporate plan; (strategic) improvement	External and internal	Yes	Council. May be the focus of specific internal governance, eg CMPB	Is the strategy consonant with our statutory remit, other legislation, and good practice?	Usually internal and sometimes external
2	**Policy**	Sets out at a high level our approach to an aspect of our work in steady state. Should be clearly derived from legislation.	Policy; framework	External and internal	Yes	Council, but may choose to delegate responsibility	Is this policy consonant with our statutory remit, other legislation, and good practice? Does it reflect any strategy for this aspect of our work or does it need amending in the light of desired change?	Sometimes – useful to secure understanding and buy in
3	**Procedure and Guidance**	Sets out in the required detail how staff (or contractors) should carry out a function. Should be cleared derived from policy. Includes guidance which sets out parameters in which	*Methodology; SOP; process; protocol* Guidance; handbook	Generally internal (including panel members, reviewers) but some 'high stakes' procedures	Sometimes. Should in any case always be shareable – eg in the event of an FoI request	Directors are responsible for the procedures in their field	Is this procedure consonant with our statutory remit and other legislation? Is it attuned to any policy in this area? Does the manner in which we carry out work in this function reflect	As above

		people empowered to make a decision for Council can act		are also external			what we have said about how we will do it?	

Responsibilities for policy documents

- Strategies and regulatory policies should be generated with the involvement of the corporate policy function. Strategies are high profile commitments on the part of the organisation and delivering them will have a direct or indirect impact on other areas of work so they must be subject to scrutiny. This is about improvement as well as governance. Whether development is led by the policy team or the delivery team in question will depend on the capacity in the delivery team and the nature of the topic.

- The corporate quality assurance function has a role (to be defined) in checking the link between legislation, strategy, policy and procedure for the NMC.

- The governance function has a role in ensuring that Council is involved in policy documents at the appropriate level.

- Directors own the policy documents (strategies, policies, procedures) for their functions and are ultimately responsible for ensuring that they are legal, up to date, fit for purpose and appropriate. They are also responsible for oversight of review.

- Responsibility for compliance with policies and procedures rests with Directors and their Assistant Directors and management teams. Assurance over compliance will be provided on a planned cycle by the quality assurance and internal audit functions.

Item 21
AC/13/32 Annexe 2
19 April 2013

Nursing & Midwifery Council

Proposed new Policy Library requirements

The policy library is being created in SharePoint and will hold all the current strategy, policy, guidance and procedure documents included in the three new policy tiers. The library will include information about the documents based on a common set of attributes (see below). This approach should allow users to locate the document they are interested in from the current set without the need to open potentially multiple documents to find the correct one.

The documents themselves would be stored within TRIM and would be accessible directly from the library. One advantage of hosting this within the SharePoint environment is that it can support appropriate levels of versioning and workflow for any documents that need to be updated without the need to circulate documents around the organisation via email.

Attributes to be attached to documents included in the proposed document library

- Reference
- Document title
- Document tier
- Linked enabling document
- Creation date
- Approval date
- Commencement date
- Last review date
- Next review date
- Retirement date
- Document types
    - *To be agreed*
- Status
    - Draft
    - Approved for use
    - In use
    - Under review
    - Retired
- Intended Audience
    - Council
    - Committee members
    - Directors
    - Internal staff
    - Public
    - Registrants
- Document Author
- Document Owner
- TRIM Ref.
- Approved by
    - Committee
    - Council

    - Directors
    - Finance
    - HR
- Responsible for review
    - Author
    - Owner
    - Administering entity
- Administering entity
    - Continued Practice
    - Corporate Governance
    - Corporate Services
    - Finance
    - HR
    - ICT
    - Procurement & Facilities
    - Fitness to Practise
    - OCCE
    - Registration
- Notes

Item 21
AC/13/32 Annexe 3
19 April

Policy Review Group

Aim

To provide corporate oversight of policy development and review and promote cross-directorate working.

Terms of reference

1. To coordinate the development and review of regulatory and corporate policies, ensuring that appropriate consultation and equality and diversity processes are observed.

2. To oversee the register and library of regulatory and corporate policies.

3. To provide support and advice to members of staff engaged in policy development.

4. To scrutinise proposed regulatory or corporate policies, or amendments to policies, and to make recommendations to Directors Group regarding their adoption by Council.

5. To advise, where appropriate, on the procedures required to implement the regulatory and corporate policies adopted by Council.

Composition

- Assistant Director responsible for Policy (Chair)
- One Assistant Director from each Directorate
- Policy Manager, Corporate Governance
- Legislation and Compliance Manager, Corporate Governance
- Other members with appropriate experience appointed by the Group
- Secretariat provided by Corporate Governance directorate

Item 23
AC/13/33
19 April 2013

Audit Committee

Annual Report

Action: For decision

Issue: To agree the Audit Committee's annual report to Council.

Core regulatory function: Supporting functions

Corporate objectives: Corporate Objective 7: this is part of the governance framework.

Decision required: The Committee is recommended to:

- Consider and, subject to any amendments, agree the draft annual report to Council at annexe 1.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Draft Annual Audit Committee Report to Council.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Standing Orders (paragraph 65) provide for reports to Council by Committees.

2 The Audit Committee's responsibilities require it to provide assurance to Council in relation to risk management, governance and internal control processes. Accordingly, the Audit Committee's annual report to Council needs to provide a comprehensive assessment of these issues.

3 The content of the report needs to be agreed so that it can be included in the "48 hour" papers to be considered by Council on 25 April 2013.

Discussion:

4 A draft annual report is at annexe 1. The Committee is invited to discuss and satisfy itself that the content of the report reflects it views appropriately.

5 **Recommendation**: The Committee is recommended to:

- Consider and, subject to any amendments, agree the content of the Committee's annual report to Council at annexe 1.

Public protection implications:

6 No direct public protection issues.

Resource implications:

7 None other than staff time to prepare the reports.

Equality and diversity implications:

8 Not directly as a result of this report.

Stakeholder engagement:

9 None.

Risk implications:

10 The role of the Audit Committee includes giving assurance to Council that risk is being managed effectively.

Legal implications:

11 None.

Item 23
AC/13/33 Annexe 1
19 April 2013

Council Draft

Audit Committee Annual Report to Council

Action: For discussion.

Issue: To consider the annual report of the Audit Committee.

Core regulatory function: Supporting functions

Corporate objectives: Corporate Objective 7: this is part of the governance framework.

Decision required: Council is invited to:

- Note this report.
- Address the issues raised by the Committee for Council as set out in paragraph 33 of the report.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Provides the annual report of the Audit Committee to Council.

2 The Audit Committee is responsible for ensuring that the business of the Council is conducted with the highest integrity, probity and efficiency, and that there are appropriate systems in place for managing risk. The Committee's remit is:

2.1 approving and monitoring the internal and external audit programme and monitoring the Council's risk management arrangements

2.2 monitoring the integrity of the financial statements of the NMC and recommending to Council the adoption of the annual report and accounts

2.3 approving the strategic processes for risk, control and governance

2.4 reviewing the accounting policies, the accounts, and the annual report, including the process for review of the accounts prior to submission for audit, reviewing errors identified and the letter of representation to external auditors

2.5 reviewing the adequacy of management responses to issues identified by audit activity, including the external auditor's management letter

2.6 approving anti-fraud policies, whistle-blowing processes, and arrangements for special investigations

2.7 approving proposals for tendering internal and external audit services or for the purchase of non-audit services from contractors who provide audit services

2.8 making recommendations to Council on the appointment, re-appointment and removal of the external auditor and the approval of the remuneration and terms of engagement of the external auditor

2.9 reviewing and monitoring the external auditor's independence and objectivity and effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements

2.10 periodically reviewing its own effectiveness and report the results of that review to Council

2.11 scrutinising the decisions of the Remuneration Committee to ensure that best practice is consistently applied to decision making.

Discussion: Membership

3 Between 1 April 2012 and 31 March 2013, the membership of the Audit Committee was as follows:

Ruth Sawtell	Chair
Julia Drown	Partner member
Sue Hooton	Council member (from 13 December 2012)
Kim Lavely	Partner member (resigned 13 December 2012)
Grahame Owen	Council member (to 13 December 2012)
Louise Scull	Partner member
Bea Teuten	Council member
Jane Tunstill	Council Member (from 13 December 2012)

4 The Committee would wish to record its appreciation of the contribution made by Kim Lavely who resigned in December 2012. The Audit Committee would highlight the importance of Council ensuring that the information provided to, and level of engagement with, partner members is sufficient to enable them to contribute effectively to the NMC's work.

5 The other changes to the membership of the Committee were the result of Council's decision to create a number of new Committees in late 2012.

Meetings in 2012-2013

6 The Committee met six times on: 30 April; 12 June; 10 September; and 11 December 2012; and on 25 January and 19 April 2013.

Oversight of Annual Report and Accounts 2011-2012

7 The Committee scrutinised the draft Annual Governance Statement and the draft Annual Report and Accounts 2011-2012. The Committee, whilst recommending approval of the substance of both the report and accounts, advised that Council delay submission to Parliament pending publication of the Professional Standard's Authority (Previously CHRE) Strategic Review, so as to ensure that the report and accounts could be certified without qualification by the Comptroller and Auditor General. Council accepted the Committee's advice and the annual report and accounts were submitted to Parliament on 18 September 2012.

NMC Assurance Framework

8 The Committee has pressed for the development of a robust assurance framework for the NMC. The Committee considers this important to help identify gaps and weaknesses in existing internal controls and processes and to support Council manage risk effectively. The Committee highlighted to Council the need for this work to be prioritised and for sufficient resources to be made available for this substantive piece of work.

9 The Committee welcomes the plan for this work to be addressed as a priority by the new internal audit service but is keen to ensure that momentum is maintained during the transition to reconstituted Council.

Risk management

10 The PSA (previously CHRE) Strategic Review report (July 2012) identified a need to strengthen the NMC's approach to risk management. A major focus of the Committee has been overseeing the development of a revised risk management framework and toolkit, together with improvements to the content of the risk register.

11 The revised risk management framework will be rolled out under reconstituted Council. Whilst the framework and toolkit should provide a robust basis for risk management, the Committee would stress the importance of ensuring this is embedded at all levels within the organisation and that both members and staff understand their respective roles and responsibilities in relation to risk and apply this on a day to day basis.

12 During the year, the Committee has engaged with both Council and the Executive to define respective roles in relation to risk more clearly. The Committee has refined its own approach to focus on providing assurance to Council that the processes for managing risk at all levels within the organisation are robust.

13 As part of this the Committee has:

13.1 Regularly sought assurance from the Chief Executive about how she identifies and manages risk including how the Chair of Council and the Directors Group are engaged in addressing risk management

13.2 Begun scrutinising each Director in turn about the management of risk at directorate level: the directorates examined so far have been Fitness to Practise and Registrations.

13.3 Reviewed the full corporate risk register at each meeting and interrogated decisions about how risks are defined, escalated,

mitigated and de-escalated.

Internal Audit

14 The NMC has an outsourced internal audit function which operates under the management of the Corporate Governance directorate and reports to the Audit Committee.

Internal audit programme and annual opinion 2012-2013

15 Outcomes of internal audit work undertaken during 2012-2013 were as follows:

Audit undertaken	Internal Audit opinion
Registrations	Adequate
HR Performance Management	Substantial
Project management	Adequate
Fitness to Practise Quality Assurance	Adequate
Data security health check	Limited

16 A key focus for the Committee during the year has been the number and extent of outstanding recommendations from previous internal audits. The Committee has put in place robust monitoring arrangements, including examining directors on progress and has seen some improvement. However, the Committee would suggest that this needs to be the subject of continuing attention for the future.

17 The Committee also identified issues with the robustness of the scoping of audit breifs and with changes to the timing and content of audits without the Committee's prior approval. The Committee has reinforces the importance of these issues to the Executive.

18 The internal auditors annual opinion for the year to 31 March 2012 concludes that the NMC has:

18.1 Adequate and effective governance.

18.2 Adequate and effective risk management.

18.3 Adequate and effective control processes.

19 The Committee has taken steps during the year to strengthen the management of internal audit. In December 2012, the Committee concluded that investment in internal audit should be significantly increased to provide an appropriate level of assurance to Council. The Committee, with Council's support, has overseen the procurement of new internal audit provision with effect from April 2013.

20 The Committee anticipates that the steps taken should ensure a greater level of future assurance and would suggest that

reconstituted Council and any successor Committee make it an early priority to approve an internal audit strategy for 2013-2016 and finalise the content of the internal audit work programme for 2013-2014.

Other assurance and internal control issues

Reconciliation of Registrations (WISER) and Fitness to Practise (CMS) Systems

21 In May 2012, Council asked the Committee to maintain oversight of work to reconcile discrepancies between the registrations system (WISER) and the case management system (CMS). In January 2013, the Committee received an external review of the work undertaken to address this which concluded that "the operation of the systems, controls and processes are adequate and are being followed by staff members". The Committee has monitored progress against the recommendations and is pleased to note that many have already been implemented, whilst others are dependent on the longer term ICT strategy.

Corporate serious event review policy

22 The Committee has oversight of incident management and reporting policies and of the process for undertaking serious event reviews (SERs) of any breach of policies, procedures or compliance with the Governance framework, including any lessons learnt and steps being taken to prevent recurrence. All serious event reviews are reported to, and scrutinised by the Audit Committee.

23 In its previous annual report (June 2012), the Committee expressed concerns about the inconsistent manner in which learning was captured from serious events, security incidents and complaints and asked for a single integrated approach to be developed.

24 The Committee approved an overarching policy for this in January 2013 and has since been updated on implementation of the policy.

Information Security

25 The Committee decided that this should be a standing item on its agenda, given the importance of this issue and has received regular reports on the number of information security incidents and data breaches.

Other governance and assurance issues

26 Additionally, the Committee has:

26.1 Reviewed and approved the NMC's whistleblowing policy. The Committee has monitored use of the policy and asked for issues raised to be addressed as part of the review to be

undertaken in 2013-2014, in the light of one instance of use of the policy.

26.2 Reviewed the Financial Regulations and approved minor updates to reflect the new organisational structures, pending full review of the Regulations in 2013-2014.

26.3 Reviewed the anti-fraud, bribery and corruption policy and agreed minor updates to reflect the new organisational structures ,pending full review of the policy in 2013-2014.

26.4 Reviewed plans for a new policy governance framework to ensure that NMC policies and procedures are subject to systematic review, as requested by Council.

External audit

27 The NMC is subject to audit by both external auditors, haysmacintyre, and the National Audit Office (NAO). The Committee approved the letters of representation for each and monitored progress on the issues raised in the external auditors' management letter and NAO completion report.

28 The Committee has:

28.1 Reviewed and approved the NMC's accounting policies, subject to minor adjustments requested by the Committee.

28.2 Approved the plans for the year end audit of statutory accounts by haysmacintyre and the NAO. Following the review of its effectiveness in December 2012, the Committee decided it should review the draft statutory accounts prior to external audit. The Committee will have a brief opportunity to review the draft accounts when these are ready on 29 April 2013.

29 The Committee agreed the process and timetable for appointment of external auditors from October 2013.

Committee effectiveness

30 The Committee reviewed its effectiveness in December 2012 and highlighted a number of issues to Council for wider learning to be taken forward as part of the governance review around member induction, appraisal and appointment to Committees.

Concerns and issues to be taken forward

31 The Committee would highlight the following issues which it suggests reconstituted Council and any successor Committee may wish to prioritise and/or pay close attention to:

31.1 **Risk and Assurance issues**

31.1.1 Production of a robust assurance framework for the NMC.

31.1.2 Embedding the revised risk management framework into day to day activity at all levels within the NMC.

31.1.3 Implementation of the proposals for improved policy governance and systematic reviews of policies and processes.

31.1.4 Development and implementation of an organisation wide Quality Assurance Strategy including in particular ensuring effective arrangements for Quality Assurance in FTP.

31.1.5 Ensuring that all internal or external reviews relating to internal control or assurance issues are reported to the Audit Committee in a timely fashion.

31.1.6 Embedding the policies and processes for learning from serious events, complaints and security incidents to ensure that action is taken to prevent recurrence and to promote a culture of learning and continuous improvement as envisaged in the corporate plan.

31.1.7 Ensuring that severance payments are subject to effective scrutiny and compliant with internal and external requirements.

31.2 **Internal audit:**

31.2.1 Approval of an internal audit strategy for 2013-2016 and content of the internal audit work programme for 2013-2014.

31.2.2 Maintaining rigorous oversight of management responses to, and implementation of, internal audit recommendations.

31.2.3 Ensuring that the most effective use is made of internal audit resources including through rigorous scoping of work and that internal audit reviews are conducted so as to be outcome focused, add value and provide robust assurance.

31.3 **External audit**:

31.3.1 Approve appointment of external auditors by October 2013.

Recommendation:

32 Council is recommended to:

32.1 Note this report

32.2 Consider how the issues highlighted at paragraph 33 be taken forward.

Public protection implications:	33	No direct public protection issues.
Resource implications:	34	Staff time to service the Committee and prepare reports.
Equality and diversity implications:	35	Not directly as a result of this report.
Stakeholder engagement:	36	None.
Risk implications:	37	The role of the Audit Committee is to give assurance to Council on the actuary of the governance, risk management and internal controls in place.
Legal implications:	38	None.

Item 24
AC/13/34
19 April 2013

Audit Committee

Draft Annual Governance Statement

Action: For decision.

Issue: As part of the NMC's annual report and financial statements, we are required to publish an annual governance statement. The draft annual governance statement is attached for the Audit Committee's consideration.

Core regulatory function: Supporting functions.

Corporate objectives: Corporate Objective 7: this is part of the governance framework.

Decision required: The Committee is recommended to:

- Consider and, subject to any amendments, recommend that Council approve the draft annual governance statement at annexe 1.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Draft Annual Governance Statement 2012 - 2013
- Annexe 2: National Audit Office Governance Statements Fact Sheet

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.

Author: Matthew McClelland
Phone: 020 7681 5987
matthew.mcclelland@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Like other organisations audited by the National Audit Office (NAO), the NMC is required to publish an annual governance statement as part of its annual report and accounts. The annual governance statement is an important public accountability document which is intended to provide the reader with a clear understanding of the dynamics and control structure of the organisation, and an assessment of the principal risks to corporate objectives.

2 There is no set template for the annual governance statement, although it must include key disclosures relating to governance, risk, and control. These are set out in HM Treasury (2012) Managing Public Money and reproduced in the NAO Fact Sheet at Annexe 2. The draft annual governance statement has been prepared in accordance with the guidance.

Discussion:

3 The draft annual governance statement is at Annexe 1. The Committee is invited to discuss the draft and suggest any amendments it considers appropriate.

4 **Recommendation**: The Committee is recommended to:

- Consider and, subject to any amendments, recommend that Council approve the draft annual governance statement at annexe 1.

Public protection implications:

5 No direct public protection issues.

Resource implications:

6 None other than staff time to prepare the reports.

Equality and diversity implications:

7 Not directly as a result of this report.

Stakeholder engagement:

8 None.

Risk implications:

9 The draft annual governance statement incorporates a description of the NMC's risk management process, including the Audit Committee's assurance remit, and an assessment of the principal risks.

Legal implications:

10 None.

Item 24
AC/13/34 Annexe 1
19 April 2013

DRAFT Annual Governance Statement

The Nursing and Midwifery Council is the independent regulator for nurses and midwives in the UK, established by, and governed in accordance with, the Nursing and Midwifery Order 2001 ("Order").

The NMC is a charity registered in England and Wales (number 1091434) and in Scotland (number SC038362). As required, we have had regard to the Charity Commission's guidance on public benefit.

The Council

The Council is the governing body of the NMC and the Council members are the charity trustees. The Council members are collectively responsible for directing the affairs of the NMC, ensuring that it is solvent, well-run, and delivers public benefit.

In accordance with the Order, the Council consisted of fourteen members during the year ended 31 March 2013: seven registrant members and seven lay members. Lay members are those who have never been a registered nurse or midwife. All members are appointed by the Privy Council.

The following served as Council members during the year ended 31 March 2013:

Mark Addison CB	(Chair from 10 September 2012)
Professor Judith Ellis MBE	(Council member since 1 January 2009, Deputy Chair from to 1 April 2012 to 9 September 2012)
Alison Aitken	
Dr Kuldip Bharj OBE	
Sue Hooton OBE	(appointed 12 June 2012)
Lorna Jacobs	
Grahame Owen	
Nicki Patterson	(appointed 12 June 2012)
David Pyle	
Carole Rees-Williams	
Ruth Sawtell	
Beatrice Teuten	
Professor Jane Tunstill	
Joyce Fletcher	(resigned 31 May 2012)

In accordance with the Nursing and Midwifery Council (Constitution) (Amendment) Order 2012, the Council was reconstituted on 01 May 2013 and all existing Council members, apart from the Chair, demitted office. Following the reconstitution, the Council consists of twelve members: six registrant members and six lay members.

The Privy Council appointed the following members to hold office from 01 May 2013:

[NAMES TO BE INSERTED FOLLOWING PRIVY COUNCIL DECISION]

Role of the Council

The Council is responsible for:

- Ensuring the NMC effectively fulfils its statutory objectives, general functions and duties and appropriately exercises the legal powers vested in it under the Nursing and Midwifery Order 2001, the Charities Act 2011, and other relevant legislation.
- Determining the overall strategic direction of the NMC.
- Annually approving the corporate plan and ensuring the necessary resources are available to achieve it.
- Monitoring the performance of the Chief Executive and Registrar through the Chair and holding them to account for the exercise of powers delegated by the Council in the scheme of delegation and delivery of the corporate plan and budgets.
- Promoting and protecting the NMC's statutory powers, values, integrity, image and reputation.
- Ensuring high standards of governance that command the confidence of all stakeholders.

Committees

The Order requires there to be a Midwifery Committee. The Council may establish other committees for specified purposes. The Appointments Board, the Audit Committee, and the Remuneration Committee operated throughout the year ended 31 March 2013. During the year, the Council established the Education Committee, the Finance & IT Committee, and the Fitness to Practise Committee. The key responsibilities and activities of each committee are summarised below.

Appointments Board

The Appointments Board is responsible for ensuring that the processes for the appointment, training, and performance management of partner members are independent, transparent, and follow good practice. Partner members include non-Council members of committees, fitness to practise panel members, and Local Supervising Authority reviewers. To maintain the Appointment Board's independence, its five members, including the Chair, are partner members. The Chair of the Appointments Board during the year was Professor Nigel Ratcliffe.

Audit Committee

The Audit Committee is responsible for ensuring that the NMC's business is conducted with the highest integrity, probity, and efficiency, and that there are appropriate systems

in place for managing risk. The Chair of the Audit Committee during the year was Ruth Sawtell, a Council member.

Education Committee

The role of the Education Committee is to advise the Council on discharging its responsibility for ensuring that the standards and requirements set for approved educational institutions in the United Kingdom, concerned with the education and training of nurses and midwives, are met. The Education Committee met for the first time on 24 January 2013. The Chair of the Education Committee during the year was Professor Judith Ellis MBE, a Council member.

Finance and IT Committee

The role of the Finance and IT Committee is to advise the Council on the development and implementation of appropriate financial and information technology plans, to enable the NMC to fulfil its statutory functions, maintain sound financial health and robust control over its information technology systems. The Finance and IT Committee met for the first time on 24 January 2013. The Chair of the Finance and IT Committee during the year was Grahame Owen, a Council member.

Fitness to Practise Committee

The role of the Fitness to Practise Committee is to advise the Council on the performance and management of the NMC's fitness to practise activities. The Fitness to Practise Committee met for the first time on 19 February 2013. The Chair of the Fitness to Practise Committee during the year was Beatrice Teuten, a Council member.

Midwifery Committee

The statutory remit of the Midwifery Committee is to advise the Council on all matters relating to midwifery. The Chair of the Midwifery Committee during the year was Dr Kuldip Bharj OBE, a Council member.

Remuneration Committee

The role of the Remuneration Committee is to advise on the appointment and remuneration of the Chief Executive and Registrar and of the directors and to agree remuneration arrangements for members of the Council. The Chair of the Remuneration Committee during the year was John Halladay, a partner member.

Attendance at Council and Committee meetings

Attendance by members and partner members at Council and committee meetings during the year is recorded below.

Council

Member	Council*	Attended
Mark Addison CB	6	6
Professor Judith Ellis MBE	10	10
Alison Aitken	10	7
Dr Kuldip Bharj OBE	10	6
Sue Hooton OBE **	8	6
Lorna Jacobs	10	10
Grahame Owen	10	10
Nicki Patterson **	8	7
David Pyle	10	9
Carole Rees-Williams	10	5
Ruth Sawtell	10	10
Beatrice Teuten	10	9
Professor Jane Tunstill	10	9
Joyce Fletcher	2	1

* not including a confidential only session of Council held on 24 January 2013
** The appointments of both Sue Hooton and Nicki Patterson took effect from 12 June 2012. Neither attended the 21 June Council meeting due to short notice.

Audit Committee

Member	Committee	Attended
Ruth Sawtell	4	4
Grahame Owen (until 12 December 2012)	3	2
Bea Teuten	4	4
Sue Hooton OBE (from 12 December 2012)	1	0

Member	Committee	Attended
Professor Jane Tunstill (from 12 December 2012)	1	1
Julia Drown (partner member)	4	4
Kim Lavely (partner member) (resigned 12 December 2012)	3	3
Louise Scull (partner member)	4	4

Midwifery Committee

Member	Committee	Attended
Dr Kuldip Bharj OBE	3	3
David Pyle	3	1
Gillian Boden (partner member)	3	3
Marie McDonald (partner member)	3	3
Dorothy Patterson (partner member)	3	3
Kirsty Darwent (partner member)	3	2
Ann Holmes (partner member)	3	1
Frances McCartney (partner member)	3	2
Rose McCarthy (partner member) (resigned 11 September 2012)	1	0

Remuneration Committee

Member	Committee	Attended
John Halladay	5	5
Dr Kuldip Bharj OBE	5	4
David Pyle	5	5
Professor Jane Tunstill	5	5

Finance and IT Committee

Member	Committee	Attended
Grahame Owen	2	2
Lorna Jacobs	2	1
Alison Aitken	2	1
Louise Scull (partner member)	2	2

Fitness to Practise Committee

Member	Committee	Attended
Bea Teuten	3	3
Lorna Jacobs	3	3
Carole Rees-Williams	3	1

Education Committee

Member	Committee	Attended
Judith Ellis	1	1
Sue Hooton OBE	1	0
David Pyle	1	1

Role of the Executive

The Chief Executive and Registrar is the NMC's chief officer and has executive responsibility for the operational management of the NMC. This includes procedures for financial matters, conduct and discipline. The Chief Executive and Registrar is supported by the Directors Group.

The Chief Executive and Registrar is responsible for ensuring the Chair and Council have timely, accurate and clear information to carry out their responsibilities.

The Chief Executive and Registrar is responsible for leading the Directors Group and staff in:

- Fulfilling the NMC's statutory objectives, general functions and duties and exercising its legal powers.
- Developing plans, programmes and policies for Council approval.
- Realising the Council's strategies and plans for the future.

- Delivering the NMC's services in line with targets and performance indicators agreed with the Council.

As the NMC's Accounting Officer, the Chief Executive and Registrar has personal responsibility for matters relating to financial propriety and regularity, keeping proper account of financial affairs and of the effective use of resources. They report to the Audit Committee on the NMC's use of registrant funds and have personal accountability and responsibility for the NMC's:

- Propriety and regularity.
- Prudent and economical administration.
- Avoidance of waste and extravagance.
- Efficient and effective use of available resources.
- General organisation, staffing and management.

Effectiveness of governance

The Council is committed to high standards of governance. Our practice broadly complies with HM Treasury's Corporate Governance Code of Good Practice to the extent that it is applicable to the organisation. We conduct our business in accordance with the seven principles of public life: selflessness, integrity, objectivity, accountability, openness, honesty, and leadership.

We have continued to make progress in addressing the recommendations of the PSA (formerly CHRE) Strategic Review regarding governance and leadership. Mark Addison CB was appointed as Chair of Council on 10 September 2012. Jackie Smith was appointed as the substantive Chief Executive and Registrar on 05 October 2012 for a one year period. In addition, two new Council members were appointed during the year. We have reviewed our approach to governance during the year, including:

- Revising the NMC governance framework to clarify the respective responsibilities of the Council and the executive, and the relationships between them.
- Improving the quality of information provided to the Council, in particular financial data and performance indicators, to support its decision-making and enhance the accountability of the executive.
- Constituting the Education Committee, the Finance & IT Committee, and the Fitness to Practise Committee in order to provide additional governance oversight of key functions.

Ensuring effective transition in the leadership and governance of the NMC remains a priority. We have commissioned an independent review to help establish a model of governance that is fit for purpose and well placed to support the reconstituted Council in the delivery of its objectives.

Council committees have undertaken an annual review of their effectiveness. [INSERT SUMMARY OF OUTCOMES FOLLOWING COMMITTEE MEETINGS].

Internal control and risk management

The Council is responsible for instituting and maintaining a sound system of internal control that enables the NMC to deliver its core regulatory purpose. The system of internal control is designed to manage, rather than to eliminate risk, and to provide reasonable, but not absolute, assurance of effectiveness. The Chief Executive and Registrar is responsible for implementing the system of internal control. The Audit Committee provides assurance to the Council regarding the operation of the system of internal control.

During the year, the NMC's internal audit service was provided by Parkhill, which operates to the Government Internal Audit Standards and the Chartered Institute of Internal Auditors International Standards for the Practice of Internal Auditing. The internal auditors submitted regular reports to the Audit Committee, which included an independent opinion on the adequacy and effectiveness of the system of internal control, together with recommendations for improvement. The Audit Committee's work was further informed by reports from management and by comments from the external auditors in their management letter.

Following a competitive process, we have appointed Moore Stephens to provide our internal audit service from 01 April 2013. Our priorities are to manage an effective transition in internal audit services and work with the incoming firm to continue to strengthen our internal control and assurance framework.

The Council has overall responsibility for risk management, including ensuring that the NMC has in place an appropriate risk management policy and that major risks are properly managed and reported. As part of the process for managing risk, the Council approves the corporate plan and budget, reviews progress against key performance indicators, and has due regard to opportunities and risks in decision-making.

The Chief Executive and Registrar is responsible for the implementation of the risk management policy and, through the Directors, for identifying and evaluating risks, putting in place appropriate measures to mitigate risks, and monitoring and reporting progress. The Audit Committee is responsible for providing assurance to the Council regarding the implementation of the risk management policy and the management of risk.

The Council has discussed the principal risks facing the NMC at each of its public meetings during the year. The Directors Group has considered the full risk register each month. The Audit Committee has discussed the process for risk control, and considered the effectiveness of the risk management process, at each of its meetings.

During the year, the NMC has taken steps to stabilise its financial position and to invest significantly in its fitness to practise operations to enhance public protection, and these remain matters to which the Council pays close attention. We have made progress in improving fitness to practise operations and continue to monitor performance closely. We have put in place an ICT Strategy to stabilise our current systems for the short-term and ensure that we have appropriate systems and infrastructure to meet our public protection obligations. The NMC continues to manage closely risks relating to its regulatory activities, including:

- Reviewing the overseas registration process in order that systems are sufficiently robust to ensure that all applicants satisfy the relevant conditions of registration.
- Implementing technical and organisational changes to improve the accuracy and integrity of the register.
- Ensuring that we respond appropriately and proportionately to the recommendations of the Independent Inquiry into Care Provided by Mid-Staffordshire NHS Foundation Trust (the Francis Report), and that our public profile is consistent with our core regulatory purpose.
- Taking steps to meet our obligations regarding the requirement for registrants to hold professional indemnity insurance.

The key matters of internal control and risk management discussed by the Audit Committee during the year included:

- An independent review of the work undertaken to reconcile discrepancies between the registrations system and the case management system.
- Overseeing the development of an integrated approach to serious events, security incidents, and complaints.
- Reviewing the whistle-blowing policy; the financial regulations; the anti-fraud, bribery, and corruption policy; the NMC's approach to the development of policies and procedures.
- Approving revisions to our risk management framework to strengthen our approach and ensure that it is embedded across the NMC.
- Outcomes of internal audit work undertaken during the year, progress in implementing internal audit recommendations, and the process for procurement of new internal audit provision with effect from April 2013.

Lapses in protective security

NMC policies require all information security incidents, including any loss of personal data, to be reported. Our definition of a data security breach includes events where there was a potential for a breach but no actual unauthorised disclosure of data. Incidents are monitored by the Information Governance and Security Group which is accountable to the Directors Group for ensuring learning is identified to prevent recurrence. During the year, there were [DATA TO BE INSERTED FROM AUDIT COMMITTEE REPORT]. The Audit Committee has received reports on data security breaches at each of its meetings and the risk continues to be closely managed.

During the year ended 31 March 2012, we voluntarily reported to the Information Commissioner a data security breach which had occurred on 07 October 2011. This resulted in a monetary penalty notice of £150,000 (which was reduced to £120,000 for early payment) being issued on 14 March 2013. In the intervening period we have strengthened our information security practices by revising our policy, introducing a new standard operating procedure, and amending our training for employees.

Fact sheet

National Audit Office

Governance Statements: good practice observations from our audits

Introduced in 2011-12, Governance Statements are important public accountability documents. Departments, their executive agencies and arm's-length bodies must provide a Governance Statement in their annual report and accounts.

Governance Statements replace and build on the old Statement on Internal Control (SIC). Aiming to support better governance and drive more consistent, coherent and transparent reporting, the Governance Statement, for the first time, brings together in one place in the annual report and accounts all disclosures relating to governance, risk and control.

To address "the fungus of boiler-plate", reporting has moved away from the template-based approach adopted for SICs. *Managing Public Money* encourages organisations to tailor their reporting to better reflect their own circumstances, whilst specifying "essential features" that should always be reported on (Box 1).

In 2012, we considered over 350 Governance Statements as part of our audits of government's accounts. Here we highlight the key messages and good practice we identified from our work. Organisations need to build on the foundations laid in year-one so that the intended benefits of Governance Statement reporting can be more fully and consistently realised. Organisations can use our good practice observations and "*challenge questions*" (Box 2) to help support better governance and drive more transparent reporting.

Key Messages From Our Work

Organisations materially complied with HM Treasury's requirements and the information presented was consistent with our wider knowledge of organisations.

There is a sense of evolution from the "old" SICs, but some organisations have made more progress than others. While some have reviewed and strengthened their approach to governance reporting, others have, essentially, re-badged the prior year SIC and "bolted-on" the new requirements.

Under *Clear line of sight*, group Governance Statements are helping to present a clearer picture of risk across government. Some organisations have identified a need to strengthen their group-risk escalation and assurance processes so that they can be confident that they are sighted on the right risks at the right time and can report transparently on them.

There was wide variation in the robustness of evidence underpinning Governance Statements and in how comprehensive and open the disclosures were about each "essential feature". Statements were often process-heavy, providing less insight into outcomes achieved or the risks faced.

Organisations have adopted a range of approaches to Governance Statement preparation and reporting. Organisations generally welcomed the more flexible reporting approach, but some expressed uncertainty as to whether they had "got it right".

Corporate Governance Code Compliance

Departments disclosed few departures from *Corporate governance in central government departments: Code of good practice* (the Code). Disclosed departures commonly related to Nominations and Governance Committee arrangements and board composition.

Some non-departmental bodies were unsure how the Code applied to them. A statement confirming compliance to the extent that it is relevant and meaningful should be made.

Better Governance Statements Are:

- concise and transparent. They help the reader "see the wood for the trees" by sign-posting key messages and avoiding long-winded process descriptions;
- comprehensive, tailored to organisational circumstances, focussed on outcomes – not on process, and include open and honest risk disclosures;
- drafted by a suitably senior member of staff with a strategic understanding of the organisation;
- underpinned by robust evidence and assurance and not treated as a one-off annual exercise;
- driven by the early engagement of the Accounting Officer and Board and subject to robust scrutiny and challenge by the Audit Committee and Non-Executive Members, with ample opportunity provided for debate.

Box 1

Essential features of the Governance Statement

- the governance framework of the organisation, including information about the Board's committee structure, its attendance records, and the coverage of its work;
- the Board's performance, including its assessment of its own effectiveness;
- highlights of Board committee reports, notably by the Audit and Nomination committees;
- an account of corporate governance, including the Board's assessment of its compliance with the *Corporate governance in central government departments: Code of good practice*, with explanations of any departures;
- information about the quality of the data used by the Board, and why the Board finds it acceptable;
- where relevant (for certain central government departments), an account of how resources made available to certain locally governed organisations are distributed and how the department gains assurance about their satisfactory use; and
- a risk assessment, including the organisation's risk profile, and how it is managed, including, subject to a public interest test:
  - any newly identified risk;
  - a record of any ministerial directions given; and,
  - a summary of any significant lapses of protective security (e.g. data losses).

Box 2

Challenge Questions

The Accounting Officer, Board and Audit Committee can use these questions to help inform their review of the Governance Statement (the Statement).

- How do we have assurance that the process for producing the Statement is adequate, covers all areas of our operations and has been followed?
- To what extent does the Statement comply with HM Treasury's requirements and include all the "essential features" (Box 1)?
- How clearly does the Statement give an understanding of the control structure and stewardship of our organisation, and a sense of its risks, vulnerabilities and resilience to challenges?
- What evidence have management presented to support the Statement and are we satisfied it is robust?
- How do we have assurance that all relevant matters are disclosed, including material issues from arm's-length bodies? How have any governance matters we have raised been dealt with?
- How has compliance with *the Code* been assessed and have all departures been explained and disclosed? What evidence underpins this assessment and are we satisfied it is robust?
- What involvement has internal audit or any other internal oversight body had in reviewing and/or challenging assurance statements and other evidence provided by management?
- How have we assured ourselves that management has responded appropriately to all observations on the draft Statement made by the internal and external auditors?

Other NAO Guidance

We have produced a number of publications to help support those involved in the preparation or scrutiny of Governance Statements.

Fact Sheet: Governance Statements
www.nao.org.uk/governance-statements

Corporate governance in central government departments: Code of good practice 2011: Compliance Checklist
www.nao.org.uk/support_to_boards

The messages in our previous guides to the Statement on Internal Control also remain appropriate to the arrangements and processes supporting the production of the Governance Statement.

A Good Practice Guide to the Statement on Internal Control
www.nao.org.uk/governance-statements

Statement on Internal Control: A guide for Audit Committees
www.nao.org.uk/governance-statements

Other Useful Guidance

Managing Public Money (HM Treasury), Annex 3.1, The Governance Statement: **www.hm-treasury.gov.uk/d/mpm_annex3.1.pdf**

Corporate governance in central government departments: Code of good practice 2011: **www.hm-treasury.gov.uk/d/corporate_governance_good_practice_july2011.pdf**

Assurance Frameworks: **www.hm-treasury.gov.uk/d/psr_governance_risk_assurance_frameworks_191212.pdf**

This fact sheet is available to download at
www.nao.org.uk/governance-statements

For further information contact your usual NAO team or the NAO's Financial Management and Reporting team:
Z5-FMGP@nao.gsi.gov.uk

DP Ref 10099-001
Date: February 2013

Item 25
AC/13/35
19 April 2013

Audit Committee

Transition/Forward work plan

Action: For decision.

Issue: Proposed transition and forward work plan

Core regulatory function: Supporting functions.

Corporate objectives: Corporate objective 7: the work of the Audit Committee is an essential element of the NMC's governance framework.

Decision required: Recommendations: The Committee is invited to:

- Approve the provisional forward work plan at annexe 1 and the provisional work plan for the June 2013 meeting at annexe 2, subject to any suggestions members may wish to make.
- Consider whether there are any particular items or concerns which it may wish to highlight to Council or any successor Committee.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Forward work programme overview.
- Annexe 2: Provisional work programme for June 2013.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Council will be reconstituted on 1 May 2013. Existing Committees have been asked to assist in ensuring an effective transition by identifying work which will need to continue under any new structures. The Committee's Annual Report to Council, to be considered under an earlier agenda item, includes a high level summary of issues which reconstituted Council and any successor Committee may wish to take forward.

2 Without pre-empting any decisions which reconstituted Council may make, as a matter of good governance it is anticipated that the work of the current Audit Committee will need to be taken forward by a Committee with a broadly similar remit.

Discussion:

3 Annexe 1 provides an overview of the forward work programme for any successor Committee based on the work programme pursued by the current Committee and which will continue to need to be addressed.

4 The overview includes a number of standing and cyclical items. Cyclical items have been allocated to specific meetings as appropriate and in accordance with past practice. Other non time-specific items, for example, annual reviews of key governance or assurance policies, have been spread across the forward plan to balance the workload across meetings.

5 In addition, 'non-routine' items arise from time to time which the current Audit Committee has addressed – some recent examples are given in annexe 1.

6 To assist any successor Committee, a provisional work programme for the June 2013 meeting is at annexe 2. This includes specific items of business which need to be carried forward from the current meeting.

7 **Recommendation:** The Committee is invited to:

- Approve the provisional forward work plan at annexe 1 and the provisional work plan for the June 2013 meeting at annexe 2, subject to any suggestions members may wish to make.
- Consider whether there are any particular issues or concerns which it may wish to highlight to any successor Committee.

Public protection implications:

8 The Committee's role is to give assurance to Council that the NMC is able to deliver its regulatory functions by ensuring that business is conducted with the highest integrity, probity and efficiency and that there are appropriate systems in place for managing risk.

Resource implications:	9	In addition to Committee members' time and expenses, the resource implications are: • Staff time to produce reports, particularly Corporate Governance and Corporate Services directorates. • Staff time to service and support the Committee.
Equality and diversity implications:	10	No direct equality and diversity implications result from this paper.
Stakeholder engagement:	11	Not applicable.
Risk implications:	12	The Committee's work is designed to help ensure the NMC manages its risks effectively.
Legal implications:	13	Not applicable.

Item 25
AC/13/36 Annexe 1
19 April 2013

Audit Committee Overview of Forward work plan

Standing Item to be taken at each meeting	**Reasons**	**Relevant Terms of Reference (ToR) and/or Minute references where appropriate**
Chair's Introduction	Protocol	
Apologies	To ensure an accurate record of those present and those sending apologies To ensure that the meeting is quorate	Standing Orders
Declaration of Interests	Members are required to declare an interest in items in which they may have a conflict and take appropriate action (either not participate in discussions or absent themselves for that item)	Standing Orders (paragraphs 46-48)
Minutes of last meeting	To correct any inaccuracies to ensure that the minutes represent a true and fair reflection of the discussions at the preceding meeting	Standing Orders (paragraph 51)
Actions from last meeting	As a matter of good governance to enable the Committee to sure that actions requested have been taken and to monitor progress.	Standing Orders
Risk Management		
Risk register	The Committee's role is to monitor the risk management arrangements and provide assurance to Council on the strategic processes for managing risk	ToR 2.1 & 2.3

Verbal update on key risks	As above. The Committee requested that this be a standing item on future agendas	ToR 2.1 & 2.3 Meeting: September 2012 Minute 12/83/28
Scrutiny of directorate risk	The Committee decide that it should assure itself of the processes which each directorate has for managing risk in turn	Meeting: September 2012 Minute: 12/98/76
Internal Audit		
Work programme Progress Report	The Committee is responsible for monitoring the internal audit work programme	ToR 2.1
Progress Report on Outstanding Recommendations	The Committee is responsible for reviewing the adequacy of management responses to issues identified by audit activity	ToR 2.5
Governance/Assurance/Control		
Report on instances of Whistleblowing since last meeting	Audit Committee requested that Whistleblowing be a standing item following relaunch of the whistleblowing policy in September 2012	ToR 2.6 Meeting: September 2012 Minute: 12/81/10
Serious events and data breaches: report on occurrences since last meeting and register of actions and learning	Audit Committee requested that a single register be maintained containing actions, learning points and timescales for completion arising from: -serious event reviews -data breaches	ToR 2.3 Meeting: June 2012 Minute: 12/59/15.3 12/65/21.2

	-complaints	Meeting: September 2012 Minute: 12/88/50
Remuneration Committee scrutiny ** Dependent on whether this remains part of future terms of reference of successor Audit Committee*	The Committee's role is to scrutinise the decisions of the Remuneration Committee to ensure that best practice is consistently applied to decision-making.	ToR 2.11
Quality Assurance: Quarterly report		
Information Security assurance	The Committee's role is to assure itself that robust processes are in place for managing and securing information held by the NMC.	Meeting: December 2012 Minute 12/118/69
Forward Work Plan	Good practice in the conduct of Committee business	

Confidential Items to be taken at each meeting	**Reasons**	**Relevant Terms of Reference (ToR) and/or Minute references where appropriate**
Apologies	To ensure an accurate record of those present and those sending apologies To ensure that the meeting is quorate	Standing Orders
Declaration of Interests	Members are required to declare an interest in items in which they may have a conflict and take appropriate action (either not participate in discussions or absent themselves for that item)	Standing Orders (paragraphs 46-48)
Minutes of last meeting	To correct any inaccuracies to ensure that the minutes represent a true and fair reflection of the discussions at the preceding meeting	Standing Orders (paragraph 51)
Actions from last meeting	As a matter of good governance to enable the Committee to sure that actions requested have been taken and to monitor progress.	
Whistleblowing	Standing report including nil return	ToR 2.6
Single tender action log	Standing report To ensure compliance with policies and processes. Usually confidential due to commercially sensitive content of reports	ToR 2.2 and 2.3
Any governance, control or risk issues which fall within the criteria for confidential discussion		Standing Orders Annexe 1

Cyclical Items: Annual	Reasons	References including meeting and minute where appropriate
June meeting		
Private meeting with internal and external auditors/NAO	Good practice	AC January 2013 minutes 13/22/86
External Auditors: - Letter of representation - Management letter and NMC response	The Committee is responsible for: • Monitoring the integrity of the NMC's financial statements • reviewing the letter of representation to external auditors • the adequacy of managements responses to the external auditors management letter	ToR 2.2 ToR 2.4 ToR 2.5
NAO Audit Completion Report	The Committee is responsible for: • Monitoring the integrity of the NMC's financial statements • reviewing the letter of representation to external auditors • the adequacy of managements responses to the external auditors management letter	ToR 2.2 ToR 2.4 ToR 2.5
Internal Audit Annual Report	The Committee is responsible for reviewing the adequacy of management responses to issues identified by audit activity including the overall assessment made by the internal audit of the assurance provided by the control and risk management arrangements	ToR 2.5
Annual Report and Accounts	The Committee is responsible for • reviewing the annual report and accounts • recommending to Council adoption of the annual report and accounts •	ToR 2.2 ToR 2.4

September meeting		
Standing Orders	Annual review	ToR 2.3 AC January 2013 minutes 13/22/86
Serious events, complaints and data breaches policy	Annual review	ToR 2.3
Reviewing the independence, objectivity and effectiveness of internal and external audit	As a matter of good practice this should be an annual review	ToR 2.9
Resource risks relating to Reserves policy	The Committee requested that this be an annual item	
Financial regulations: annual review	The Committee is required to monitor the integrity of the financial statements and therefore currently reviews the Financial Regulations annually	ToR 2.2
Anti-fraud, bribery and corruption policies	The Committee is responsible for reviewing anti-fraud policies	ToR 2.6

December meeting		
Private meetings with internal and external auditors/NAO		AC January 2013 minutes 13/22/86
Role, terms of reference and effectiveness of Audit Committee	As a matter of good practice governing bodies and committees should undertake an annual review of their own effectiveness.	HMT Guidance NAO Checklist
External Auditors Engagement letter Management Plan	The Committee is responsible for approving and monitoring the external audit programme	ToR 2.1
NAO Audit Plan	The Committee is responsible for approving and monitoring the external audit programme	ToR 2.1
Review of accounting policies	The Committee is responsible for reviewing accounting policies. As a matter of good practice it should do this annually and sufficiently in advance of the year end work on the annual accounts.	ToR 2.4
Information security: annual report	The Committee requested an annual report on information security. This is an essential element of the Annual Governance Statement. As a matter of good practice, the Committee should review the position on information security sufficiently in advance of the year end work on the annual governance statement	ToR 2.3, 2.4 Meeting March 2012-11-21 Minute 12/10.7

March meeting		
Considering the draft Annual Governance Statement	The Committee is responsible for reviewing the strategic processes for risk, control and governance. The Annual Governance Statement which must be included in the Annual Report should set out the NMC's arrangements for risk, control and governance, as required by HM Treasury. As a matter of good practice the Committee should review the annual governance statement in advance of its inclusion in the approval draft of the annual report in June.	ToR 2.2 , 2.3 and 2.4
Reviewing the Quality Assurance Strategy	An annual review of the Quality Assurance Strategy would seem appropriate, including to help determine the content of the internal audit programme	ToR 2.1 and 2.3
Reviewing the NMC Assurance framework	An annual review of the Quality Assurance Strategy would seem appropriate, including to help determine the content of the internal audit programme	ToR 2.1 and 2.3
Internal Audit: approval of annual work programme for the following year	The Committee is responsible for approving and monitoring the internal audit programme	ToR 2.1
WISER/CMS reconciliation: progress review	The Committee requested that this be added to the forward work plan January 2013 (AC minute 13/7/20)	ToR 2.1

Cyclical -every 3 years		
Process and timetable for tender for external audit provision for 2013-2016	The Committee is responsible for: • the proposals for tendering to external audit services • making recommendations to Council on the appointment, re-appointment and removal of the external auditor • the approval of the remuneration and terms of engagement of the external auditor	ToR 2.7, 2.8, 2.9
Proposals for tendering for internal audit services	The Committee is responsible for approving the proposals for tendering of Internal Audit Services	ToR 2.7
Review of risk management policy		ToR 2.3 AC January 2013 minutes 13/22/86

Examples of non routine items which the Committee has addressed from time to time		
PSA (previously CHRE) reports eg Strategic review Performance review FTP initial stages audit	The Committee should look at issues/reports which relate to or raise questions about the assurance provided by the organisation's governance, control or risk arrangements	
Change programme issues relevant to the work of the Committee	The Committee should look at issues which arise which have a bearing on or raise questions about the assurance provided by the organisation's governance, control or risk arrangements	

Item 25
AC/13/35 Annexe 2
19 April 2013

Audit Committee Detailed Work Plan June 2013

Remit	Item No		Standing, cyclical or exceptional item	Reason for item and any comments	Meeting and Minute references where applicable	Director Responsible
June 2013						
	1 2 3 4 5	Chair's Introduction Apologies Declaration of Interests Minutes of last meeting Summary action list	Standing Standing Standing Standing Standing			Corporate Governance
	6	Matters Arising Report	Standing if required	To address issues arising from previous meetings which do not warrant a separate report.	Agreed with Chair 18/10/2012	Corporate Governance
Risk Management	7a	Risk register	Standing	The Committee is responsible for monitoring the Council's risk management arrangements and approving the strategic processes for risk. It does this through regular review of risk management.	ToR 2.1 and 2.3	Corporate Governance
	7b	Verbal update on key risks	Standing	Committee requested that this be a standing item	ToR 2.1 and 2.3	All Directors
	7c	Scrutiny of directorate risk	Standing	Directorate to be decided.	Meeting: September 2012 Minute: 12/98/76	

Item 25
AC/13/35 Annexe 2
19 April 2013

Remit	Item No		Standing, cyclical or exceptional item	Reason for item and any comments	Meeting and Minute references where applicable	Director Responsible
Internal Audit	8	Internal Audit: Approval of Strategy 2013-216 and work programme for 2013-2014	Standing	Audit Committee requested that internal audits be scheduled as early as possible in the financial year	TOR 2.1 Meeting: June 2012 Minute: 12/68/21.	Corporate Governance & Head of Internal Audit
	9	Outstanding Recommendations: Progress Report	Standing		ToR 2.1	Corporate Governance
	10	NMC Assurance Framework	Cyclical once approved	Council and Audit Committee have requested development of an Assurance Framework	ToR 2.1 and 2.3	Corporate Governance & Head of Internal Audit
Other internal control and governance issues	11	Quality Assurance Strategy: progress update	Standing	Audit Committee should receive a quarterly progress report	TOR 2.3	Corporate Governance
	12	Report on instances of Whistleblowing since last meeting	Standing	Requested by Audit Committee that this be a standing item (including nil return)	ToR 2.6 Meeting: September 2012 Minute 12/81/10	Corporate Governance
	13	Serious events and data breaches: report on occurrences since last meeting and register of actions and learning	Standing	The Committee is responsible for approving strategic processes for risk, control and governance and for special investigations.	ToR 2.3 and 2.6	Corporate Governance

Item 25
AC/13/35 Annexe 2
19 April 2013

Remit	Item No		Standing, cyclical or exceptional item	Reason for item and any comments	Meeting and Minute references where applicable	Director Responsible
	14	Information security assurance	Standing	Agreed by the Committee December 2012 that this be a standing item.	Meeting December 2012 Minute 12/118/69.	Corporate Services
External Audit	15	External Auditors: - Letter of representation - Management letter and NMC response	Annual	The Committee is responsible for: • Monitoring the integrity of the NMC's financial statements • reviewing the letter of representation to external auditors • the adequacy of managements responses to the external auditors management letter	ToR 2.2 ToR 2.4 ToR 2.5	
	16	NAO Audit Completion Report	Annual	The Committee is responsible for: • Monitoring the integrity of the NMC's financial statements • reviewing the letter of representation to external auditors • the adequacy of managements responses to the external auditors management letter	ToR 2.2 ToR 2.4 ToR 2.5	
	17	Annual Report and Accounts 2012-2013	Annual	The Committee is responsible for • reviewing the annual report and accounts •recommending to Council adoption of the annual report and accounts		

Item 25
AC/13/35 Annexe 2
19 April 2013

Remit	Item No		Standing, cyclical or exceptional item	Reason for item and any comments	Meeting and Minute references where applicable	Director Responsible
Remuneration Committee	18	Scrutiny of decisions **Dependent on whether this continues to be part of future Audit Committee Terms of Reference*	Standing	Audit Committee ToR 2.11	Meeting: December 2012 Minute:12/122/77	Corporate Governance
Forward Work Plan	19		Standing	Good practice		Corporate Governance
Committee's Report to Council	20		Standing	Standing Orders (paragraph 65)		Corporate Governance
Confidential Agenda						
	1 2 3 4	Apologies Declaration of Interests Minutes of last meeting Summary action list	Standing			
Assurance	5	Whistleblowing Standing Report	Standing	Requested by Audit Committee that this be a standing item (including nil return)	ToR 2.6 Meeting: September 2012 Minute 12/81/10	
Internal Controls	6	Single Tender Action Log	Standing			

Item 25
AC/13/35 Annexe 2
19 April 2013

Remit	Item No		Standing, cyclical or exceptional item	Reason for item and any comments	Meeting and Minute references where applicable	Director Responsible
		Any other issues as they arise				

Item 26
AC/13/36
19 April 2013

Audit Committee

Report from this meeting to Council

Action: For decision

Issue: To agree the Audit Committee's report from this meeting to Council on 25 April 2013.

Core regulatory function: Supporting functions

Corporate objectives: Corporate Objective 7: this is part of the governance framework.

Decision required: The Committee is recommended to:

- Consider and, subject to any amendments, agree the draft report to Council at annexe 1.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Draft Audit Committee Report to Council on 25 April 2013

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:	1	Standing Orders (paragraph 65) provide for reports to Council by Committees.
	2	A report on the outcomes of this meeting needs to be submitted to Council for its meeting on 25 April 2013. This will be included in the "48 Hour" papers.
Discussion:	3	The draft report at annexe 1 has been put together based on the agenda items to be discussed at the meeting.
	4	The Committee is invited to discuss and suggest amendments to reflect discussions and decisions made at the meeting.
	5	**Recommendation**: The Committee is recommended to: • Consider and, subject to any amendments, agree the draft report to Council from this meeting at annexe 1.
Public protection implications:	6	No direct public protection issues.
Resource implications:	7	None other than staff time to prepare the reports.
Equality and diversity implications:	8	Not directly as a result of this report.
Stakeholder engagement:	9	None.
Risk implications:	10	The role of the Audit Committee includes giving assurance to Council that risk is being managed effectively.
Legal implications:	11	None.

Item 26
AC/13/36 Annexe 1
19 April 2013

Council Draft

Audit Committee Report from April meeting

Action: For discussion.

Issue: To consider the report of the Audit Committee following its meeting on 19 April 2013.

Core regulatory function: Supporting functions

Corporate objectives: Corporate Objective 7: this is part of the governance framework.

Decision required: Council is invited to note this report.

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.

Author: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Director: Lindsey Mallors
Phone: 020 7681 5688
lindsey.mallors@nmc-uk.org

Context:

1 Provides a report on the key issues considered by the Audit Committee at its meeting on 19 April 2013. The minutes of that meeting will be placed on the members' e-net.

Discussion:

2 The Committee addressed a wide range of issues at its April meeting.

Items which Council asked the Committee to address

3 The Committee and Council have both previously pressed for the development of effective arrangements to ensure that the NMC records and learns from mistakes, including issues arising from serious events, data breaches and complaints.

4 The Committee approved a high level policy in January and received a progress report on implementation at its April meeting. The Committee is encouraged that this is moving in the right direction and that the systems being put in place should encourage the development of a culture of learning and continuous improvement. The Committee has continued to monitor reports of individual serious events and data breaches to ensure action is taken and organisational learning addressed.

5 In January, Council asked the Committee to consider the way in which NMC policies and procedures are reviewed. The Committee received a report at its April meeting on plans for a new policy governance framework for the NMC which is being developed and was assured that this will include arrangements for systematic review of policies and processes.

Risk Management

6 The Committee agreed the final content of the revised risk management framework and toolkit for the NMC. This is being rolled out to staff and will be fully implemented following reconstitution of Council.

Internal Audit

7 The Committee received the report on internal audit work completed during the fourth quarter of the year and noted the "limited" assurance accorded following the health check of data security. The Committee therefore welcomed a progress report on improvements being made to strengthen data security.

8 The Committee continued to scrutinise progress against recommendations made by internal audit and other assurance reviews. The Committee was pleased to note the steps taken by management to reduce the number of outstanding internal audit recommendations as a result of its sustained focus on this issue.

9 The Committee reported to Council in January on the need for significant further investment to be made in internal audit services if Council is to receive the level of assurance it needs. The Committee has overseen a procurement process for new provision and was pleased at the appointment of Moore Stephens as the NMC's internal audit providers from April 2013.

10 The Committee held useful discussions with the new internal audit providers on the direction of the internal audit strategy over the next three years and the work programme for 2013-2014.

11 The Committee highlighted to Council in January the importance of developing a robust assurance framework for the NMC and welcomed Council's recognition of the significance of this work. The Committee is therefore pleased that this will be addressed as a priority item in the internal audit work programme going forward.

Other Assurance

12 The Committee approved minor amendments to the Financial Regulations to ensure that these are up-to-date and reflect current organisations structures. The Committee notes that the Regulations will be subject to a full review during 2013-2014 as part of the wider review of governance documentation following reconstitution of Council.

13 The Committee was reassured that a strategy has now been developed to address Quality Assurance in Fitness to Practise following the concerns previously raised with Council.

14 The Committee reviews use of the whistleblowing policy at each meeting and noted that there had been no reported incidents. The Committee was informed of recent developments, including Government plans to further strengthen the legal protection afforded to those raising concerns following the Francis report.

Governance

15 The Committee noted a progress report on the NMC's governance review and noted the plans for the governance framework and supporting documentation to be comprehensively reviewed following reconstitution of Council.

16 The Committee also considered wider governance issues and learning indentified in the Francis report and NMC plans to address these.

17 The Committee considered and, subject to comments, broadly approved the content of the draft Annual Governance Statement for inclusion in the statutory annual report and accounts 2012-2013.

18 The Committee approved the content of its annual report to Council.

External Audit

19 The Committee noted progress against issues raised in the external auditors' management letter. It also reviewed and approved the NMC's accounting policies for treatment of the £20 million grant from the Department of Health.

20 The Committee will be provided with the draft statutory accounts for comment on 29 April prior to audit by both the external auditors and the National Audit Office.

Transition and Forward work plan

21 The Committee approved a transition and forward work plan to assist any successor Committee responsible for audit and assurance matters which may be established following reconstitution of Council.

Recommendation:

22 Council is recommended to note this report.

Public protection implications:	23 No direct public protection issues.
Resource implications:	24 None other than staff time to prepare the reports.
Equality and diversity implications:	25 Not directly as a result of this report.
Stakeholder engagement:	26 None.
Risk implications:	27 The role of the Audit Committee is to give assurance to Council that the NMC has effective governance, risk management and internal controls in place.
Legal implications:	28 None.