Audit Committee

10 September 2019

Internal assurance report

Executive Summary

This paper provides information on internal assurance activities that have taken place since June 2019 and activities that are ongoing in this period. This report includes the following areas;

- Quality Assurance
- Complaints and Feedback
- Chief Information Security and Risk Officer report
- Near Miss Reporting –annual summary

Previous consideration	None.
Decision	The Committee is invited to discuss the report.
Next steps	The report is a standing item on the Committee's agenda.
Strategic priority	Strategic priority 1: Continuously improve our performance across all our regulatory functions
Risk	1 - Failure to deliver effective regulatory functions 3 - Failure to be a trusted regulator and meet stakeholder expectations
Financial and resource implications	None
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Quality Assurance departmental activities report

1 Executive Summary

The report covers the departmental activities since June 2019. It has been updated to demonstrate progress against the workplan, audit schedules and provide further audit detail. Feedback from the Audit Committee on the information presented in the report will continue to be collected and the report developed over this financial year.

Workplan progress

1.1 Progress against activities in the departmental workplan is on schedule. In this period the focus has been on the following areas:

- Delivering change in relation to BPI function transfer to Governance
- Review and development of organisation-wide auditing
- Development and delivering complaints training to key departments
- Input into the internal audit on the Quality Assurance function

The workplan has been updated where required to reflect the pieces of work in relation to the internal audit recommendations.

Audit schedules

1.2 The regulatory department audits are progressing according to the 2019-20 audit schedule determined at the start of the financial year. All quarter one audits have been completed, and all quarter two audits have commenced or completed their scoping activities as per the schedule. Quarterly meetings continue to be held with each regulatory head of Department, the latest were held in June / July and it was determined that no adjustments to the audit schedule were required at this stage.

Review of organisation-wide auditing

1.3 A review of organisation wide auditing has been taking place in quarter two. This is looking at current activities and organisational requirements, gathering input from key stakeholders and developing a revised auditing approach and an associated Quality Assurance Framework. Revised audits will commence in September.

Internal audit recommendations

1.4 The Department has fed into the internal audit on the Quality Assurance function in this quarter. Actions related to the recommendations will take place over this and next financial year, with some activities already underway. The priorities related to the recommendations for this quarter focus on updating the Audit Committee report, establishing a Quality Assurance Framework with the Governance Department and producing an overall recommendations tracker for the Department.

2 Regulatory department audit schedules 2019-20

2.1 The Department Quality Assurance Frameworks (QAFs) are produced for the Registration, Education and FTP Departments and detail the audits that will be undertaken during the year. An overview of the schedule is included below. This, along with the QAF, was presented to the SMT in May 2019.

2.2 The QAFs are prioritised to assess performance against the PSA Standards of Good Regulation, and are selected by reviewing areas of greatest risk, previous audit activity and recommendations. Quarterly meetings are held between the Head of QA, the relevant QA manager and the head of the relevant regulatory department. These meetings ensure that progress against the QAFs are reviewed regularly and the audits are discussed. Timescales and outcomes of the audits are also considered and adjustments are made to the schedule if required. The recommendations and actions from previous audits are reviewed to ensure that progress is tracked by both departments.

	2019									2020		
	April	May	June	July	August	September	October	November	December	January	February	March
FTP	Threshold audit - finalising from 2018-19 (key PSA)	Investigation Committee Panel Decision audit (key PSA)		Threshold audit (key PSA)		Risk Assessments audit (key PSA)		Investigations Cases Evaluation audit		Post Investigation Committee Panel / Interim Order Decision Making audit		
						Classification of concerns in CMS report					Classification of concerns in CMS report	
Reg	Registration Appeals Audit			CPD assessment decisions audit			Pass lists / FTP referrals (POT / DEC cases) audit			Comparable Qualifications List (CQL) audit		
Ed	Programme records audits - finalising from 2018-19	Major change process and decisions audit			Programme records audit (February 2019 - July 2019)		AM planning process audit		Concerns process audit		Programme records audit (August 2019 - Jan 2020)	

Key	Low priority	Medium priority	High priority

Audits completed in this period (June to August 2019)

Audit	Rationale	Outcomes	Status
Registration International and European Mutual Recognition (EMR) Assessment Decisions Audit to determine whether the process is being followed to the required standard, and in line with published guidance.	The audit was carried out to provide assurance to the Registration Department regarding the operation of the process and to identify any areas for improvement. Relates to PSA Standards of Good Regulation Registration Standards 1 & 2: • Only those who meet the regulator's requirements are registered. • The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving.	The audit found that the process is working well - accurate assessment decisions are being sent to applicants. Four recommendations were made which will improve clarity in the process guidance and tools utilised, identify ways to improve processing times and correct any application issues identified. • Ensure that written guidance is updated and covers all of the process. • Increase the number of initial decisions sent within service level. • Resolve issues found with the assessment log book spreadsheets. • Ensure any application issues raised in the audit are reviewed (and if required addressed).	Registration management have agreed the recommendations in full Report to be reviewed by SMT in September
Registration Appeals Audit to determine whether the process is being followed to the required standard, and in line with published guidance.	The audit was carried out to provide assurance to the Registration Department regarding the operation of the process and to identify any areas for improvement. Relates to PSA Standards of Good Regulation Registration Standard 2: • The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving.	The audit found that the process is working well – process timescales are being met and clear records are maintained throughout the process. Two recommendations were made which will improve clarity in the process guidance, ensure redaction errors / bundle checks are addressed and correct any case issues identified. • Ensure that written guidance is updated and provides greater clarity around redaction and case conferences. • Ensure any issues raised in the audit are reviewed (and if required addressed).	Registration management have agreed the recommendations in full Report reviewed by SMT in August The Department is tracking progress on the agreed activities
FTP Non-FTP Cases Audit of Protection of Title / Function (POT) and Health and Character Declaration (DEC) cases to determine whether decisions are	The audit was carried out to provide assurance to the FTP Department regarding the decisions being made and to identify any areas for improvement. Relates to PSA Standards of Good Regulation Registration Standards 1 & 5:	The audit found that the process is working well – DEC and POT cases are achieving the right outcomes and reasons for decisions are generally clearly recorded in both cases. Two recommendations were made which will improve clarity in the process guidance and tools utilised as part	Audit completed, high level findings sent to FTP and report with FTP management to review / agree recommendations

being made in line with respective policies and guidance, and concerns about registrants / applicants are being dealt with appropriately.	• Only those who meet the regulator's requirements are registered. • Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk based manner.	of the process and ensure that FTP staff continue to receive support to ensure consistency in applying policy and guidance in POT cases prior to closure, and ensuring greater clarity regarding approvals in DEC cases. • Ensure written guidance and tools are controlled and cover all of the process. • Review training and support to improve consistency in applying policy and guidance for POT cases.	
FTP Final Hearing Decision Audit to assess the quality of Final Hearing decisions made and recorded by the HCPC's Practice Committees.	The audit was carried out to provide assurance to the FTP Department that written decisions are clear and consistent and followed recently implemented updates to processes and guidance. Relates to PSA Standards of Good Regulation FTP Standards 5, 8 & 9: • The fitness to practise process is transparent, fair, proportionate and focused on public protection. • All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession. • All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.	The audit found that Practice Committees are consistently making clearly reasoned, well documented decisions and are consistently applying the relevant guidance. Given the audit findings, there were no recommendations made. The FTP Department has been encouraged to share the findings of the audit with the relevant HCPC partners.	Audit completed, high level findings sent to FTP and report with FTP management Report to be reviewed by SMT in September
FTP Threshold (2018-19) Audit to assess the quality of decisions made under the Threshold policy.	The audit was carried out immediately after the implementation of the new Threshold policy. This was to provide initial feedback to the FTP Department on whether decisions are being made in line with the policy, are clearly communicated to relevant parties and if the process is being followed. Relates to PSA Standards of Good Regulation FTP Standards 1, 3, 4, 5, 6 & 8:	The audit found that decisions were consistently being made in line with the new policy and clearly recorded at both decision points, the Triage stage and the Threshold stage. In most cases decisions were being clearly communicated. The findings were encouraging in that they offer assurances that the implementation of the Threshold policy is addressing PSA concerns with the previous policy (Standard of Acceptance). Two recommendations were made which will improve clarity in the process guidance and tools utilised as part	Audit completed, high level findings sent to FTP and report with FTP management to review / agree recommendations

	• Anybody can raise a concern, including the regulator, about the fitness to Practise of a registrant. • Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation. • All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel. • The fitness to practise process is transparent, fair, proportionate and focused on public protection. • Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders. • All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.	of the process and improve the recording and communicating of decisions. • Ensure written guidance and tools are updated to provide greater clarity around confirming identity of registrants when closing cases and cases that involve multiple registrants. • Ensure written guidance and tools are updated to provide greater clarity around communicating closure decisions to complainants who have failed to provide further information.	
Education programme records (October 2017 – January 2019) Biannual audits to check the accuracy and correct status of education programme records.	Two audits were carried out to provide assurance to the Education Department that information on programme records is correct and programmes were created, updated or closed based on information submitted by education providers. Relates to PSA Standards of Good Regulation Education Standard 4: • Information on approved programmes and the approval process is publically available.	The audits found that actions taken by the Education Department to ensure programme records are accurately maintained have been effective and changes in relation to this in operational processes have been embedded successfully. Two recommendations were made which will improve clarity in the process guidance and correct any programme record issues identified. • Ensure that written guidance is updated and provides greater clarity around identifying programmes for closure and completing closure activities.	Education management agreed the recommendations in full Report reviewed by SMT in July The Department is tracking progress on the agreed activities

		• Ensure any issues raised in the audit are reviewed (and if required addressed).	
Education Major Change Process and Decisions Audit to determine whether the process is being followed to the required standard, in line with published guidance and decisions are clearly recorded and communicated.	To provide assurance to the Education Department regarding the operation of the process, whether decisions are being made in line with the process and are clearly communicated to relevant parties, and to identify any areas for improvement. Relates to PSA Standards of Good Regulation Education Standards 2 & 4: • The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration. • Information on approved programmes and the approval process is publically available.	The audit found that the process is working well - decisions are clear, well-reasoned and are communicated clearly to education providers. Four recommendations were made which will improve clarity in the process guidance and correct any case issues identified. • Ensure that written guidance provides greater clarity in completing change notification forms. • Ensure that written guidance provides greater clarity around identifying programmes for assessment and changes to programme records. • Ensure that written guidance provides greater clarity around roles and responsibilities in receiving submission from education providers. • Ensure any issues raised in the audit are reviewed (and if required addressed).	Audit completed, high level findings sent to Education and report with Education management to review / agree recommendations

Ongoing audits		
Audit	**Rationale**	**Status**
Education Approval Process Audit to determine whether the process is being followed to the required standard, and in line with published guidance.	To provide assurance to the Education Department regarding the operation of the process, and to identify any areas for improvement. Relates to PSA Standards of Good Regulation Education Standards 2 & 4: • The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration. • Information on approved programmes and the approval process is publically available.	Audit completed and report in production

Education Programme Records (February – July 2019) Biannual audit to check the accuracy and correct status of education programme records.	To provide ongoing assurance to the Education Department that information on programme records is correct and programmes have been created, updated or closed based on information submitted by education providers. Relates to PSA Standards of Good Regulation Education Standard 4: • Information on approved programmes and the approval process is publically available.	Audit ongoing
FTP Investigation Committee Panel (ICP) Decisions Audit to assess the quality of written decisions, and the impact of recent changes to the process.	To provide ongoing assurance to the FTP Department regarding the operation of the process, the quality of decisions, and to assess the potential impact of changes to the process in the introduction of ICP-specific Chairs and the introduction of a Fast Track process. Relates to PSA Standards of Good Regulation FTP Standards 3, 5, 7 & 8: • Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation. • The fitness to practise process is transparent, fair, proportionate and focused on public protection. • All parties to a fitness to practice case are kept updated on the progress of their case and supported to participate effectively in the process. • All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.	Audit completed, high level findings sent to FTP and report being finalised
FTP Threshold (2019 - 20) Audit to assess the quality of decisions made under the Threshold policy.	To provide assurance to the FTP Department on whether decisions are being made in line with the policy, are clearly communicated to relevant parties and if the process is being followed. Relates to PSA Standards of Good Regulation FTP Standards 1, 3, 4, 5, 6 & 8: • Anybody can raise a concern, including the regulator, about the fitness to Practise of a registrant. • Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation. • All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel. • The fitness to practise process is transparent, fair, proportionate and focused on public protection.	Audit completed, high level findings to be sent to FTP and report in production

	• Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders. • All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.	
Registration CPD Assessment Decisions Audit to focus on the quality of written decisions by CPD assessors, that decisions are processed in line with published guidance and communicated to registrants.	To provide assurance to the Registration Department on whether decisions are being made in line with the policy, are clearly communicated to relevant parties and if the process is being followed. Relates to PSA Standards of Good Regulation Registration Standards 1 & 6: • Only those who meet the regulator's requirements are registered. • Through the regulator's continuing professional development / revalidation systems, registrants maintain the standards required to stay fit to practise.	Audit ongoing

3 Feedback and complaints

3.1 OMT received a six month review report in June on the feedback and complaints received by the organisation and their outcomes (October 2018 – March 2019). During this reporting period 256 complaints and 27 pieces of positive feedback were received. The majority of complaints received (66%) were not upheld. The report highlighted any patterns or themes in the complaints received in this period and identified potential further actions to address common complaints. Actions agreed by OMT included a review of Registration renewal letters, consideration of ways to improve service standards for complaints responses in FTP and to improve consistency in FTP case communication.

3.2 Quarterly meetings have continued with the Head of FTP and commenced with the Head of Registration (as heads of the departments that receive the greatest number of complaints) to ensure that the complaints process is operating effectively, to discuss key themes and activities to support the departments.

3.3 Complaints training was delivered to members of the Registration and FTP Departments in August. Further guidance documents for responders to complaints will be developed from the training material.

4 Organisation wide audits

4.1 Development of a revised approach to organisation wide auditing by the Department has been taking place in this quarter. Feedback has been sought from key stakeholders alongside a review of the organisation's requirements, including risk registers, assurance mapping, all audit activity and any certification requirements (such as ISO).

4.2 Development is taking place to produce a Quality Assurance Framework to cover these requirements, an audit schedule and an auditing framework. The revised audits will commence in September.

Chief Information Security and Risk Officer report

1. ISO certification and audits

Preparation for the next BSI Audit has commenced. The Quality Assurance Department will be carrying out internal process audits upon completion of the ISO QA Audit framework.

Awareness activities are planned for when the new Quality Management System technology is completely populated with the latest process maps in the next few weeks.

2. Information Security

This year's information security training will be rolled out to all Partners at the end of summer 2019 with the assistance of the Learning & Development team. The training will be announced to Partners via the Partner Newsletter in September.

To date there have been 57 incidents of minor information loss reported to the Governance team this calendar year. All incidents are risk assessed based on the risk of harm to the data subject.

3. Data reporting

The five year registrant forecast has been updated with end of July 2019 data. Results are broadly on track, but it is too early to make any definitive estimations for the rest of the year.

The Advisor to Council has been supported with various reports and presentational work on the modelling of past and recent HCPC costs and activity levels.

4. Risk Management

A Risk Assurance matrix is being developed based on BDO's previous output. This will be monitored annually, or when known organisational or process driven changes occur.

Risk Management training was provided to OMT in August.

5. Near Miss Reports (NMR) summary.

Two NMR's awaiting completion from the first quarter of the financial year. A NMR summary report is attached as an appendix.

Near Miss summary report

Introduction

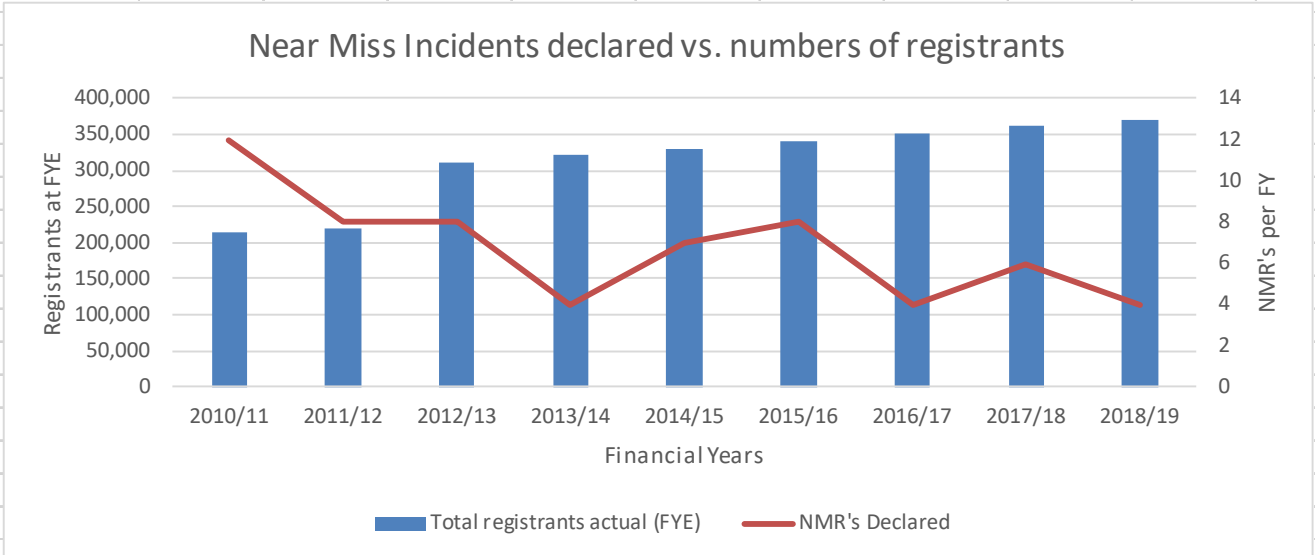
Near Misses, are those events that may bring HCPC's reputation into disrepute, either by an event almost happening, or actually happening. Investigation, proposed mitigations and tracking of those accepted mitigations aims to ensure the same event does not recur. The NMR process has been in place since 2009.

All Near Miss events must be agreed as worthy of investigation by the Chief Executive. Any SMT, OMT, or member of the information security team may raise a potential NMR. Although the final report may take several months to complete, immediate action will take place to minimise the impact of the event or prevent recurrence. Where suppliers are at fault, we will seek to gain recompense for any errors found.

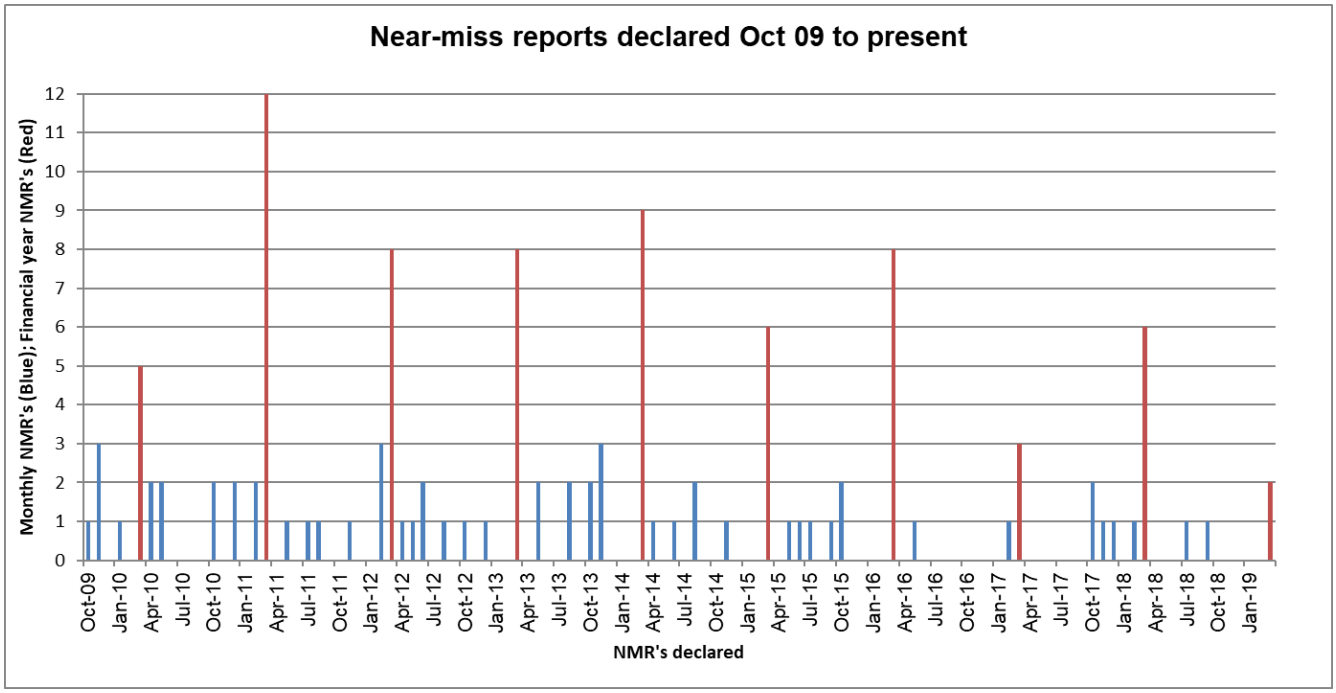
The Improvement Log is a document where any ongoing items requiring a fix / resolution are logged, with risk assessments, causes and resolution time scales. All NMR's are tracked long term through the Improvement Log process.

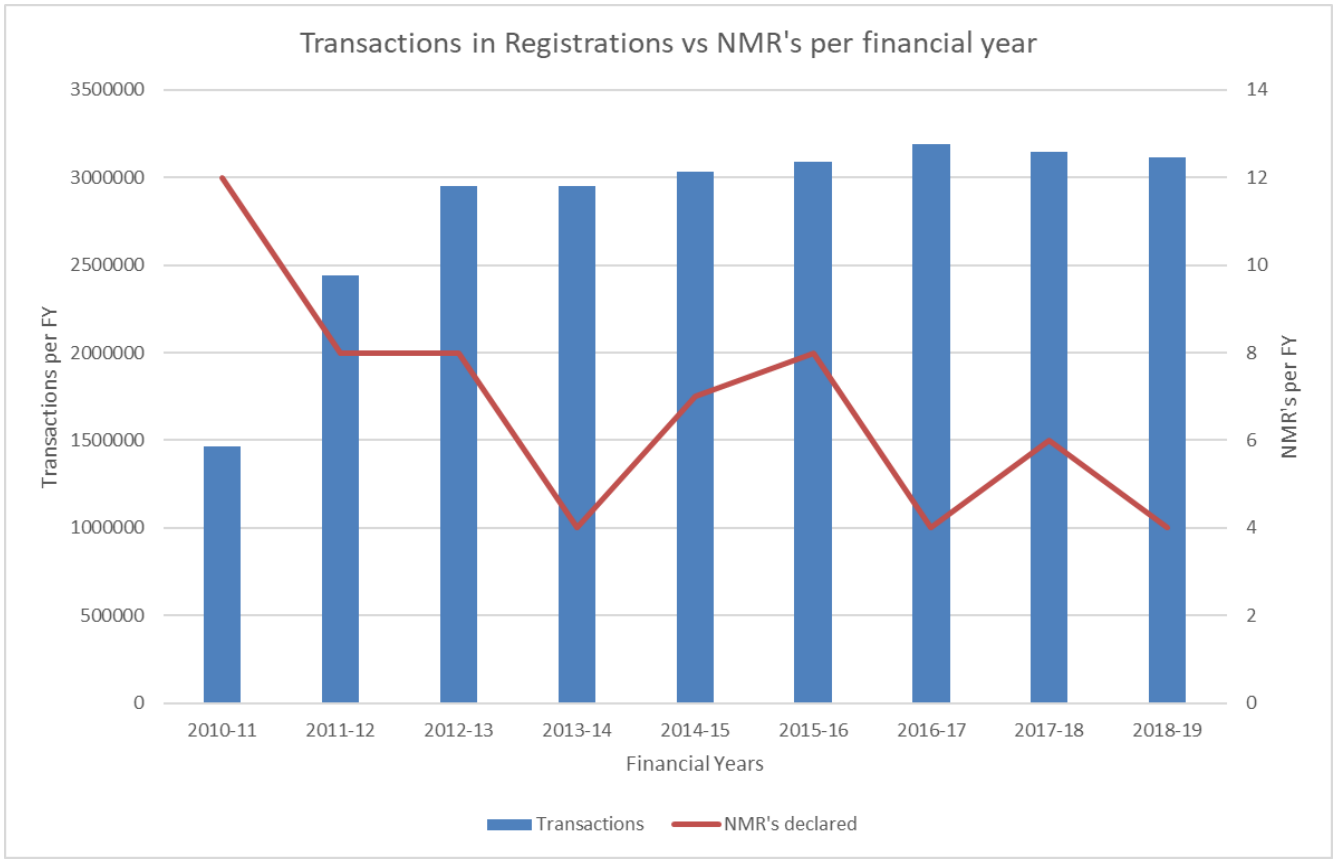
The table and graph below indicate the frequency of Near Miss Report events each Financial Year, since their inception in 2010. Events going back to 2009/10 were included in the first year so appears artificially high. Previous reports to Audit Committee or SMT have covered earlier periods in more detail.

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Employees	**142**	**158**	**177**	**210**	**238**	**242**	**278**	**310**	**344**
registrants actual (FYE)	215,095	219,212	311,952	322,037	330,887	341,745	350,330	361,061	369,139
NMR's Declared	12	8	8	4	7	8	4	6	4
Professions	15	15	16	16	16	16	16	16	16



HCPC's rolling registration cycle imposes workload on the Registration department, and other parts of the organisation. Registration transaction cycles mimic workload in Finance, mail out, incoming mail, do these cycles trigger greater numbers of NMR events as transaction numbers increase?





The initial frequency of NMR events has shown a slight relation to busy and quiet transactional periods. However this is more aligned to an increased opportunity for errors to be located, rather than the number of transactions themselves being the cause of the error events. Historically a similar trend has been seen in the number of Service Complaints and the main transactional cycles. Certainly we get more complaints from professions when they are in renewal but also more complaints during busy periods for applications as well or increased levels of enquiries.

This report covers the period 2016 – 2019 in more detail, which is included in Appendix 1.

NMR trends

Human Error is the main root cause of error. This can be from employees or suppliers. Often suppliers claim to have engineered out every possible potential cause of error. In one case in question a printer device had been decommissioned at a print location, and the “print jobs” in question were still sent to that printer device queue by a remote third party. The supplier monitoring systems reported that the items had been printed, when in fact the files were remaining in the queue unprinted.

Security there have been a few incursions into the HCPC estate at night, and even during the day, resulting in theft. Damage during the theft events have cost more than the items that were stolen. The disruption, whilst awaiting Scenes of Crime Officers has also delayed work in some departments.

Unauthorised members of the public in the building is an ongoing concern though relatively rare, We are actively encouraging employees and visitors to wear their passes at all times, and for employees to make themselves known by placing their image on their intranet profile.

Building we received a complaint about access to 405KR, from an existing Partner. Small steps in the public pavement and private carpark caused access issues. The Partners mobility scooter was theoretically unable to get onto the Disabled Lift at the rear of 405, due to a visual warning of “No mobility scooters” on the lift control panel. This was found to be aimed at heavier invalid scooters. The landlords initial suggestion was that HCPC cover up the incorrect signage. This was rejected by HCPC, and the landlord’s agent was asked to carry out the change.

Subsequently lift failures occurred on some occasions. The Partner has started to ask for a ramp to avoid potential issues with the lift. This would require agreement of the Landlord, and from initial discussions this seems unlikely. HCPTS and the Facilities Dept. will continue to test the lift before it is expected to be used.

Projects one NMR related to the discontinuance of a specific web software used at the suggestion of a blue chip supplier, in the creation of our new registration system. The leading software that was used in the development was purchased by another software supplier also involved in the project. The functionality of the product in use

by HCPC was to be gradually added to existing products of the new owner, and the product in use by HCPC discontinued, rendering our development inoperable without major cost and delay.

Overview summary

There is no direct link between the number if professions or number of employees and frequency of Near Miss events. In fact, a statistical analysis would suggest that the opposite is true on face value.

As registrants, professions and employee numbers have increased, the number of NMR's on average has fallen. In reality, this reflects the gradual refinement of processes and removal of scope for error within processes. Fewer single points of failure exist, and we are caught out by multiple concurrent events, or outright criminality.

Where suppliers are involved in our processes, we are dependent on them adhering to their own processes rigorously, as more and more we are outsourcing part of our processes. PSA reports on standards are not counted as NMR events.

A breakdown of where NMR's occur, regulatory (Education, FTP, Registration) or non-regulatory areas is as follows. Some NMR's cover both areas.

	2016/17	2017/18	2018/19
NMR's Declared	4	6	4
Regulatory	1	1	2
Non Regulatory	3	5	2

PSA standards notwithstanding, NMR events have become less frequent in Regulatory areas, and more frequent in non-regulatory areas. However, numbers are typically so low that these changes are statistically insignificant, when viewed against the numbers of transactions the organisation undertakes.

A table of recent NMR events, including two not yet concluded, (NMR72 & 73) is presented below.

Fin Year	Incident declared		Issue	Internal / External cause	Root cause dept or systems owner	Primary Dept impacted	Secondary Dept impacted	Tertiary Dept impacted	Supplier / non supplier
16/17	31/03/2017	NMR62	NMR62-CouncilMbr-NI-PUBLISHED	External	Council	Finance			N/A
17/18	20/04/2017	NMR63	NMR63-Employee payroll issues-PUBLISHED	Internal/External	HR/Finance	IT			Supplier
17/18	22/11/2017	NMR64	NMR64 - Access to 405KR for disabled persons-PUBLISHED	Interal	Office Services	FTP	Partners		
17/18	24/11/2017	NMR65	NMR65-Portalsoftware_support&vsn-PUBLISHED	External	IT	Registrations	Projects		Supplier
17/18	03/01/2018	NMR66	NMR66-Unauthorised access 22SS-24Dec2017-PUBLISHED	Internal/External	Office Services	Registrations	Communications		Supplier
17/18	05/01/2018	NMR67	NMR67- CoreHR-internal data exposure-PUBLISHED	Internal/External	HR,	Registrations	All Departments	ISO27001	Supplier
18/19	07/03/2018	NMR68	NMR68-CPD Mailing error_Supplier-PUBLISHED	External	Registrations	Registrations			Supplier
18/19	28/08/2018	NMR69	NMR69-OU_PA programme-PUBLISHED	Internal	FTP	FTP	EDU		N/A
18/19	17/09/2018	NMR70	NMR70 Protester scenario-CLOSED DOWN	N/A	N/A	N/A	N/A		N/A
18/19	22/10/2018	NMR71	NMR71 2018Oct22 break in-PUBLISHED	Internal/External	Office Services	Registrations	Communications		N/A
19/20	09/04/2019	NMR72	NMR72-Phone theft from Reception	External	Reception	OFS			N/A
19/20	26/06/2019	NMR73	NMR73-DD letter to collect Beneficiary names	Internal	Finance	Registrations	Finance		

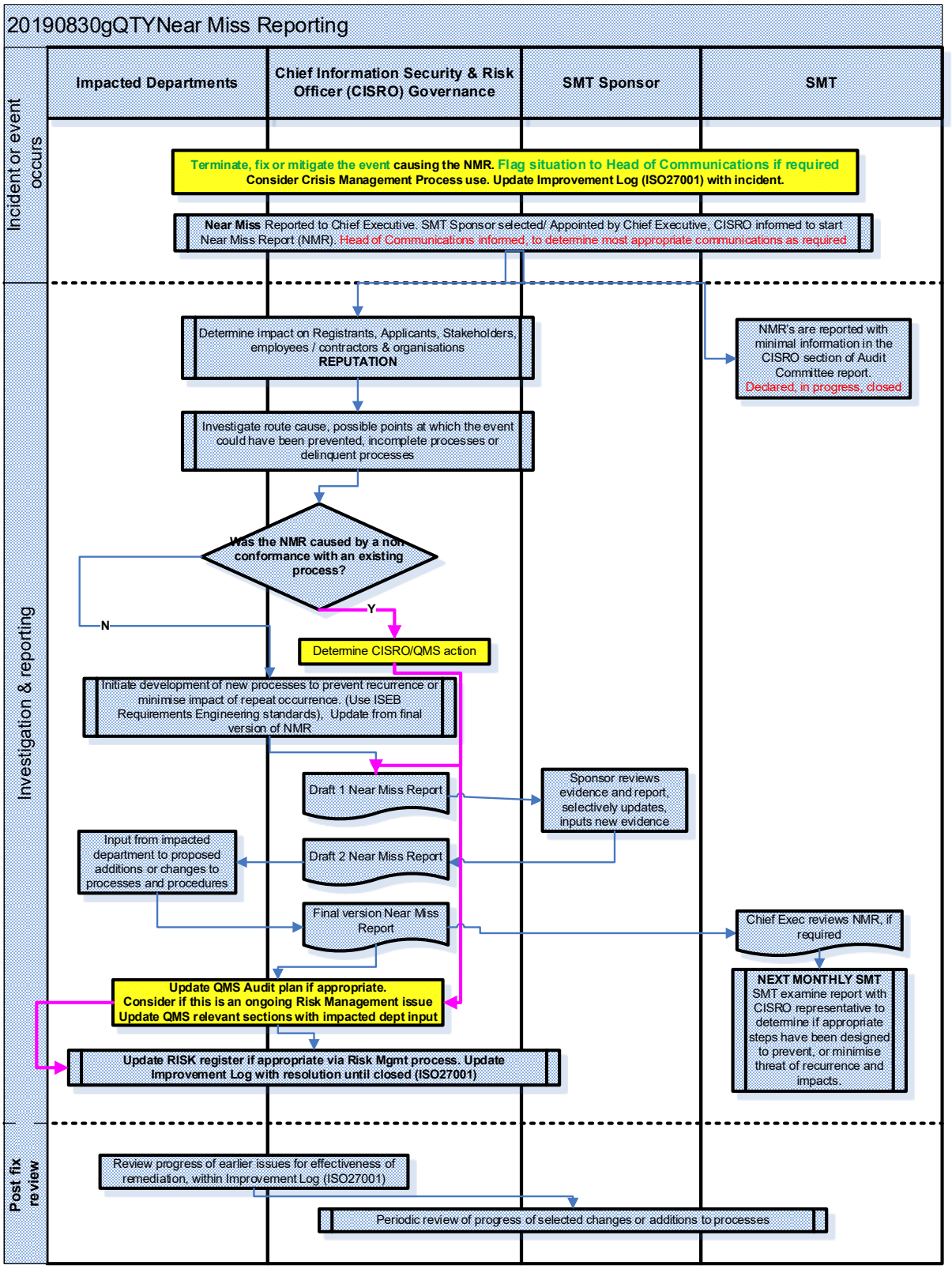
Appendix 1 Recent NMR issues in greater detail.

Ref No. BPI/IGM	Incident Date	Date Logged	Raised By	Type	Description of Finding/Issue BPI/IGM/Internal Auditor	Root cause. N/A if no Observations or NC's found in audit BPI/IGM/Internal Auditor	Corrective and/or Preventive action planned/taken MANAGEMENT RESPONSE
20170331QUARPTNMR62CouncilMbr-NI	2014?	31/03/2017	Dir FIN	NMR	Some Council members may have paid too much NI due to the way they are treated as Director or Office Holders. HMRC & Advisors are unclear of the correct solution	Incorrect advice from taxation specialists (?) - External supplier error	CURRENTLY UNKNOWN IF WE WERE CORRECT OR INCORRECT **Subsequently determined that HCPC had been using the correct approach, following confirmation from HMRC, and commercial taxation advisors.**
20170420QUARPTNMR63 Employee payroll	20/04/2017	21/04/2017	Hd of BPI	NMR	Some employees have been underpaid due to coding issues at the new payroll processing bureau - Transfer of data to new payroll provider resulted in some being considered second salary K codes. Incomplete process.	Transfer of data to new payroll provider resulted in some being considered second salary K codes. Incomplete process. - System error	New processes not yet supplied or audited against, schedule indicates Summer 2017 for stable set of processes.
20171122QUARPTNMR64 Access to 405 Kennington Park Road	22/11/2017	22/11/2017	Head of BPI	NMR	405 Kennington Road site. Rear door access threshold exceeds guidelines (height) making wheelchair access difficult. - Further work is required over time, some by the landlord, some by HCPC - Partner with disability issues could not access the dry area at the rear of the building without assistance. Difficult access for disabled at 405 KR - Access to the carpark from the pavement is uneven - Further work is required over time, some by the landlord, some by HCPC Rear lift signage indicates Disability Scooters not to be used in lift, where this only applies to heavier machines. **Occasional complaints that lift not working when required	Environmental Inadequate building access Incorrect signage	Build ramp access across rear threshold to 405 KR HCPTS site. Provide gate access code to the Partner in question, to allow access to the carpark area to the rear of 405 KR Provide gate access code to the Partner in question, to allow access to the carpark area to the rear of 405 KR - Access ramp similar to that on the rear threshold has been proposed from the carpark side door. Landlord to modify lift signage to allow low weight scooters to use facility Lift tested before Partner arives when known.
NMR65 Portal software impact	24/11/2017	24/11/2017	Dir of OPS	NMR	A key software product (ADXStudio) used to build the new CPD Portal through the Registration Transformation and Improvement project was purchased by Microsoft in September 2015 and will not be supported from 1 August 2018. Licences will expire and not be renewed. This potentially makes our recently developed portal redundant, with no obvious route to achieve a robust replacement.	Commercial risk	New processes not yet supplied or audited against, schedule indicates Summer 2017 for stable set of processes. Now functioning as required.

NMR66 - Unauthorised access 22SS	24/12/2017	08/01/2018	Dir of OPS	NMR	An unauthroised individual gained access to 22 Stannary St via an unsecured fire exit door, eventually activating motion sensors and alerting the alarm company and Police.	Human Error. Security Guard did not lock door; or cleaner unlocked door. Door should be checked before setting alarms.	Process for temporary storage of refuse in the lobby adjacent to the Fire Exit door immediately prior to it's placement in the bin store arranged. Only guard to open/unlock door and close / lock door. Link 184 & 186 KPR alarm systems together (SMT decision = Yes) Determine if a simple flag could be constructed to attach to thumb lock (knobs) indicating locked vs. unlocked. Provide motion sensitve lighting to rear doors to improve CCTV effectivness. (SMT decision = Yes)
NMR67. Core HR information release to recruiting managers	05/01/2018	05/01/2018		NMR	Recruiting managers accessing CoreHR for shortlisting purposes were able to see the full details of all existing applicants for positions at HCPC. Incident date may have been since original implementation	Human error / System failure?	Access to full range of data closed down after incident reported to CoreHR support. This may have been an original configuration issue.
NMR68 CPD invitation - Supplier failure	07/03/2018	17/05/2018	QCM - REG	NMR	CPD (1st) invitation letters are being reported as not received by registrants that have been selected. Supplier1 claims items were printed and despatched. Minimal number of CPD submissions received at HCPC suggests lettes not sent. Now determined to be a failure in control of data flows at Supplier2 Mgmt. Professional body complaints rcvd, so small number of indiviaduals impacted (104) but public issue.	Suplier error / failure	Supplier (3rd party and main supplier) to validate existing process, determine where it has gone wrong and document corrective action, then impliment it. HCPC Energysys to reset CPD clock for those effected - cost and system test implications
NMR69 OU-PA program, multiple allegations		09/08/2018	CER	NMR	Two PA registrants from the same cohort of an Open University course have FTP cases against them. (OU course is now closed). The two registrants had pre registration convictions that were not acted upon by the training organisation, and were not declared to HCPC upon application? Subsequently determined that no pre registration convictions, but FTP issues are around competence.	Human Error	Under FTP investigation process, then determine how to proceed. BPI have extracted a list of all PA's registered from the same training institution, same programme, same date etc. However the course is no longer accepting applicants. Determine if any apparent generic issues around this course? None found after FTP trawl of past and existing cases in September and December 2018 BPI not required to investigate small numbers of cases, as in this event.
NMR70 (?) Protester gained access to 186KPR	14/09/2018	14/09/2018	SMT?	NMR	External party protesting outside Park House gained access to the building.Employees were filed/videoed. The protester was addressing an issue that is not directly under HCPC's remit.	Stakeholder dissatisfactio n	Unknown if this will be trated as a Near Miss or just an incident at present. NOT A NMR. NOT A THREAT.

20181022QUARPTNMR71-12Nov	22/10/2018	22/10/2018	Hd of BPI	NMR	A break-in occurred when the rear glass airlock doors were forced from the outside, overnight. The alarm could not be set after weekend work, and the door floor bolts were not locked. 1) The floor bolts to the sliding airlock doors at 20-22 Stannary Street must be engaged to prevent the doors being forced. 2) Adding runners to the external doors, and alarm sensors for the floor bolts may improve security and access control to these doors. 3) An external steel roller shutter would provide additional security and may prevent intrusion even if the alarms are not set. 4) Intruder alarms must be set, and error messages around the failure to set, be simplified. The alarm systems should act as one, requiring only one location to activate or deactivate 184,	Human Error & Theft/Unlawful entry	1) Existing security measures must be used 2) Enhanced security could prevent derailing the sliding doors, and prevent the doors being forced backwards into the airlock. Extended runners may prevent the doors becoming derailed, and thus able to be forced inwards. 3) The glass doors should be protected from direct attack by adding shuttering for use and weekend, holidays and overnight. Externally fixing is preferable, as repair or replacement is relatively fast and inexpensive, compared to the glass airlock doors. 4) Existing security measures must be used, but simplified to prevent repeat of errors found in this case along with planned improvements. A map of sensor locations and marking / tagging of individual
NMR72-Reception phone theft	09/04/2019	upgraded to NMR 23/04/2019	Hd of BPI / CER	NMR	A personal mobile phone was stolen by an "intruder" from behind the reception area whilst "looking for/asking for a pen". Receptionist immediatley attempted to drive away "intruder" but from cctv evidence he was highly experienced at this type of theft.	Poor design (from security perspective)	Apply temporary barrier to prevent casual intrusion to lower desk space designed for wheelchair users. Investigate lockable swing gate to prevent incursion, with out specific access pass or opening of gate by Reception employees. Investigate options to close off visitor seating area also.
NMR73-Direct debit name request issue		16/05/2019	CER	NMR	A letter designed to collect the account holder names of direct debit payers was dispatched with insufficient time for the registrants to provide the detail required before the inferred "removal date".	timing of request	Some generic text that was included that relates to "non payment resulting in removal from the register" aggrevated / frightened recipients. They all had active direct debits in place. This was an administrative exercise to improve records for exiting dd's

Appendix 2 NMR process & policy



HCPC Near Miss Report policy

Introduction

With effect from 1st December 2009 the Executive of the Health Professions Council (HCPC) will introduce a "Near Miss" investigation policy. It will build on our existing corrective and preventive action processes which we run under ISO 9001

What is a near miss (NM)?

An event that has the potential to damage the reputation of HCPC

Purpose

The purpose of the Near Miss Policy is to ensure that a system is in place that will enable all events to be reported, investigated and collectively resolved. This will allow HCPC to:

i. Improve our culture
ii. Determine the cause(s) of the "Near Miss"
iii. Rectify any faults
iv. Improve practice and process
v. Prevent or reduce possibility of future occurrences
vi. Provide support to colleagues including training
vii. Reduce risk

Deciding if an incident is a near miss

- A Senior Management Team (SMT) member can declare an event a "Near Miss", or Operational Management Team member (OMT) or CISRO request a NMR to be declared.
- SMT member then notifies the Chief Executive in writing
- Formally reported at the next SMT meeting

Who Investigates

- A member of SMT from a department not directly affected by the "Near Miss"
- Assisted by Roy Dunn, Chief Information Security & Risk Officer (CISRO)

Reporting

- Written report to be addressed to the SMT
- Report to be prepared within a target of 28 days of the incident
- Report to include: Description of event, lessons learned, changes to practise, implementation timetable
- Report to be reviewed by SMT not more than two weeks after report completed
- Consider an annual review of all NMs

Review

- Review by the SMT every 6 months
- Review to cover all points above
- Review who reports go to, possibly after a set “cooling off” time period
- Reports (possibly redacted) available on HCPC’s Intranet,

The Near Miss process is not designed to assign blame for errors, but is designed to help the organisation prevent recurrence. The output of the NMR process is a report, delivered to SMT, possible changes to QMS processes, possible changes to departmental guidelines or work-orders (standing instructions for small parts of processes), or other structural changes to how we do things. This is an essential part of the Corrective Action elements of ISO 9001:2015; ISO27001:2013; and ISO10002:2014.

Standard NMR questions

i. What should happen?
ii. What did happen?
iii. How was the error discovered?
iv. What was the impact?
v. What could have been the maximum impact?
vi. Is the existing system or process on the QMS?
vii. (Is there enough detail in the system on this process / group of processes?)
viii. Will the revised process be placed on the QMS?
ix. What other suggestions do you have to prevent this incident / event happening again?
x. Was the level of documentation on the particular requirement adequate / fit for purpose?
xi. Was internal communication a factor in this incident?
xii. Was external communication a factor in this incident?
xiii. Was a lack of common understanding a factor in this incident?
xiv. If technology is required to fix the issue / prevent the issue or incident occurring again, do you have budget and time?
xv. Are safe “work arounds” available if a technology fix is not possible?