INTERNAL AUDIT ANNUAL REPORT

2019-20

HEALTH & CARE PROFESSIONS COUNCIL

CONFIDENTIAL
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Contents

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1. Executive Summary & Opinion

Introduction

1.1 Although HCPC receives its funding mainly through the fees from registrants, HCPC is deemed a public sector organisation. Internal Audit thus aligns with the UK Public Sector Internal Audit Standards (PSIAS), as revised in January 2017.

1.2 The Public Sector Internal Audit Standards (PSIAS) require the Head of Internal Audit to provide a formal annual report to the Accounting Officer, providing assurance on the effectiveness of the organisation's risk management, control and governance processes.

1.3 PSIAS also requires the Head of Internal Audit to provide a summary of the internal audit work undertaken across the year to formulate an overall opinion, timed to support the Governance Statement.

1.4 This report:

- provides assurance to the Chief Executive on areas reviewed, to support the Governance Statement, which is included in the Health & Care Professions Council annual report and accounts;
- summarises internal audit activity in 2019-20;
- highlights the assurance ratings and key issues arising from the individual reviews undertaken in the year; and
- confirms compliance with the Public Sector Internal Audit Standards.

1.5 While this report is a key element of the framework designed to inform the Annual Governance Statement, there are also a number of other important sources to which the Accounting Officer should look to gain assurance.

Scope

1.6 In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control - the organisation's system of internal control. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit & Risk Committee, which should provide a reasonable level of assurance, subject to the inherent limitation of internal audit (covering both the control environment and the assurance over controls) described below and set out in Appendix C. The opinion does not imply that Internal Audit have reviewed all risks relating to the organisation.

Internal Audit Annual Opinion

1.7 The audit opinion takes together the assurance ratings and recommendations of individual assignments conducted in 2019-20, management's responsiveness to internal audit recommendations and the direction of travel with regard to internal control, governance and risk management.

1.8 There is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and internal control.

1.9 The basis for the opinion is given in the next section (Section 2), with a summary of the findings from our assurance work is in Section 3.

2. Basis for the annual opinion

Introduction

2.1 The annual opinion is drawn mainly from the results and assurance ratings stated in our individual audit reports. Our opinions for each assignment are based on our assessment of whether the controls in place support the achievement of management's objectives as set out in our individual assignment terms of reference.

2.2 We also consider other factors in forming our annual opinion, including the:

- responsiveness of management to the implementation of our audit recommendations during the year;
- results of any other relevant work such as advisory assignments, investigations and special exercises conducted by ourselves, management or third parties, where applicable; and
- the direction of travel of the effectiveness of the organisation's internal control, governance and risk management processes.

Individual Assignment Assurance Ratings

2.3 Overall, there were nine assignments conducted during the year, comprising of five audit assurance reports, three advisory reviews and the delivery of a Risk Appetite workshop.

2.4 The charts (Figures 1a and 1b) across summarise the assurance ratings provided in our audit assurance reports and the recommendation priorities for recommendations raised. We include recommendations or 'suggestions for improvement' for advisory reviews because they give an overall indication of the gaps in internal controls.

Fig 1a. Summary of Audit Report Assurance Opinions 2019-20

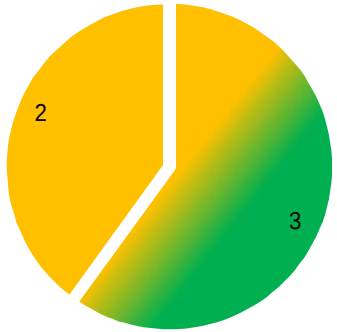
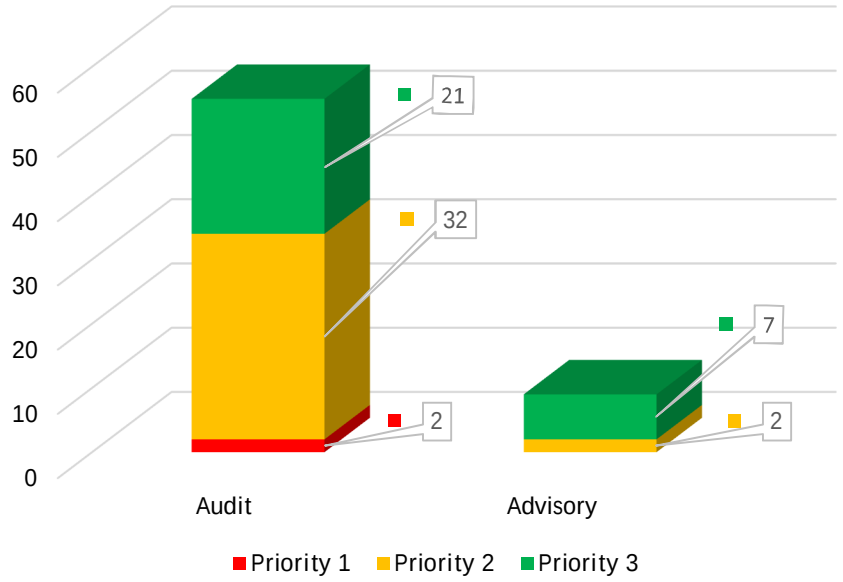


Fig 1b. Summary of Recommendations Prioirty Ratings Raised 2019-20



2.5 The specific breakdowns of audit assignments and recommendations raised are set out in Table 1 below.

Assignment Table 1: Assurance ratings for all audit plan assignments conducted 2019-20

Assignment	Assurance Rating	Recommendations Priority rating		
		1	2	3
1. Assurance Map*	N/A	-	2	7
2. Quality Assurance		-	7	8
3. Procurement Project Assurance – Part 1 Review*	N/A	-	-	-
4. Transfer of Social Workers to social Work England		-	-	3
5. Fitness to Practise		-	13	1
6. Fraud Risk Assessment		2	5	6
7. Business Continuity Planning		-	7	3
8. Procurement Pt. 2*	N/A	-	-	-
9. Risk Management Workshop*	N/A	-	-	-
TOTAL for 2019-20		2	34	28

Source: Internal Audit analysis. *Advisory review

Significant Findings Affecting the Opinion

2.6 It is a requirement of the PSIAS to highlight any significant issues identified during the year and for management to include them in the Governance Statement. There were two 'amber' rated audit assignments during the year, 'Fitness to Practise' and 'Fraud Risk Assessment'. Summaries of our assignments are set out in Section 3 below.

2.7 Moreover, in August 2019, the Professional Standards Authority (PSA) conducted a performance review of HCPC, which found that 6 out of 10 standards of good regulation were not met with respect to Fitness to Practise (FtP) arrangements. This was consistent with our audit of FtP arrangements where we raised 13 'Priority 2' recommendations. FtP is a core function for any professional regulator and so HCPC should continue to focus on making improvements in this area.

2.8 We also conducted a Fraud Risk Assessment audit where two 'Priority 1' recommendations were raised. The key issues related to a lack of an overall strategic approach to fraud risk management resulting in the lack of fraud awareness within HCPC.

Effects of any Significant Changes in Organisational Objectives or Systems

2.9 HCPC has gone through some significant changes to its operations and management structures during the year, mainly due to the transfer of the regulation of social workers to Social Work England and the equivalent organisations in the devolved countries, in November 2019. We reviewed the project plans in advance of the change and gave management assurance and guidance. However, while this change was far-reaching, it had not affected adversely the core internal control arrangements.

Significant Matters Arising from Previous Internal Audit Reports

2.10 There are no specific matters arising from previous internal audit reports that may impact on our annual opinion for this year.

Responsiveness to internal audit recommendations

2.11 A critical part of an organisation's internal control, governance and risk management framework is management's responsiveness to the implementation of agreed internal audit recommendations. Timely and full implementation of internal audit recommendations indicates that management are making positive steps towards improvement.

2.12 The Health & Care Professions Council monitors the implementation of recommendations and reports the outcome of the implementation process to the Audit & Risk Committee. Internal Audit reviews the implementation of recommendations as part of the work conducted for individual assignments where the assignment covers areas of work subject to previous internal audit recommendations. Moreover, Internal Audit selects a sample of higher priority recommendations for specific evidenced confirmation or retesting.

2.13 We reviewed 22 recommendations and found:

- 12 had been fully implemented;
- 7 were in progress but overdue; and
- 3 were in progress but had not reached their due dates.

For the 7 recommendations which were overdue, the delays were mostly caused by staff changes in the Quality Assessment and Finance teams.

Direction of travel

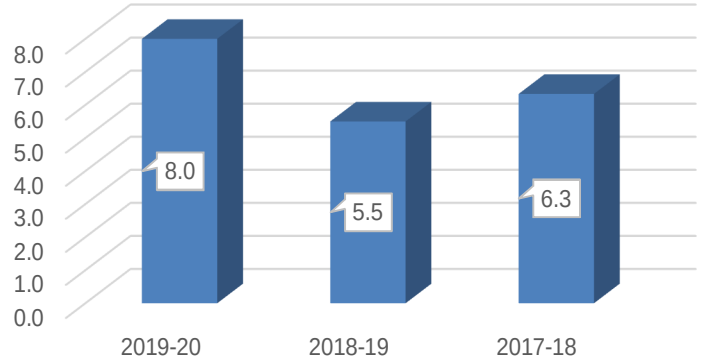
2.14 Our assurance ratings are an assessment at the time the assignment was conducted. However, organisations rarely remain static – the internal control, governance and risk management in an organisation may improve or deteriorate in individual areas or across the whole organisation over time.

2.15 One indicator of the direction of travel is the assurance rating and number of recommendations per assignment between the current year and previous year. While assignment subjects differ each year and thus coverage to what the assurance ratings refer, such a comparison can give an indication of the direction of travel for an organisation. As this is our first year as internal auditors we have not been able to begin to make comparison with our own previous years' audit assessments, however have the previous two years of audit work from Grant Thornton.

2.16 Furthermore, it is important to note that the areas selected for audit tend to be those in which the Health & Care Professions Council believes it has control weaknesses, as opposed to those areas in which processes are well embedded and are stable. This approach has been endorsed by Audit Committee

2.17 Figure 2 below sets out the average recommendations per audit for the past 3 years. :

Fig 2. Average Recommendations per Assignment (excluding follow up)

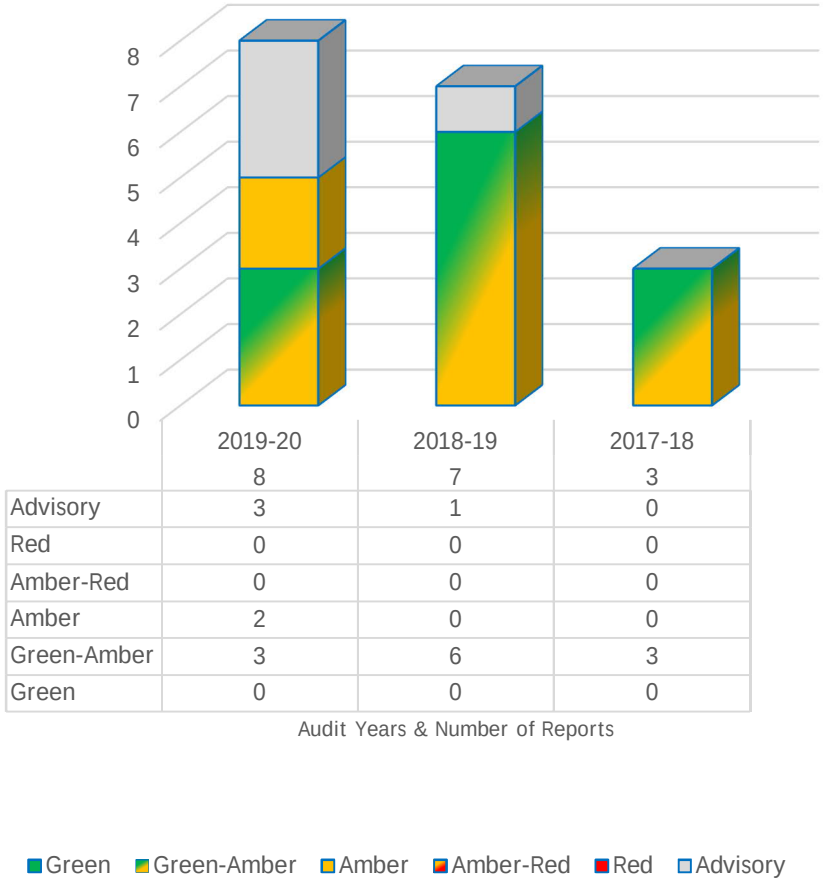


Source: Internal Audit analysis. Follow-up reports are excluded to avoid double counting of recommendations

2.18 Figure 2 shows that the number of recommendations per assignment has slightly increased in our first year as Internal Auditors, though it should be noted that 2019/20 represented the first year in a change of internal audit provision. In our first year as internal auditors we have focussed more heavily on regulatory risks than in previous years, which partly explains the increase in the number of recommendations.

2.19 We have also compared the audit report 'traffic light' opinions over the last three years and the associated priority rating of recommendations. This is shown in Figures 3a and 3b overleaf in absolute numbers, and Figures 4a and 4b as a percentage of the total number of audits and recommendations respectively.

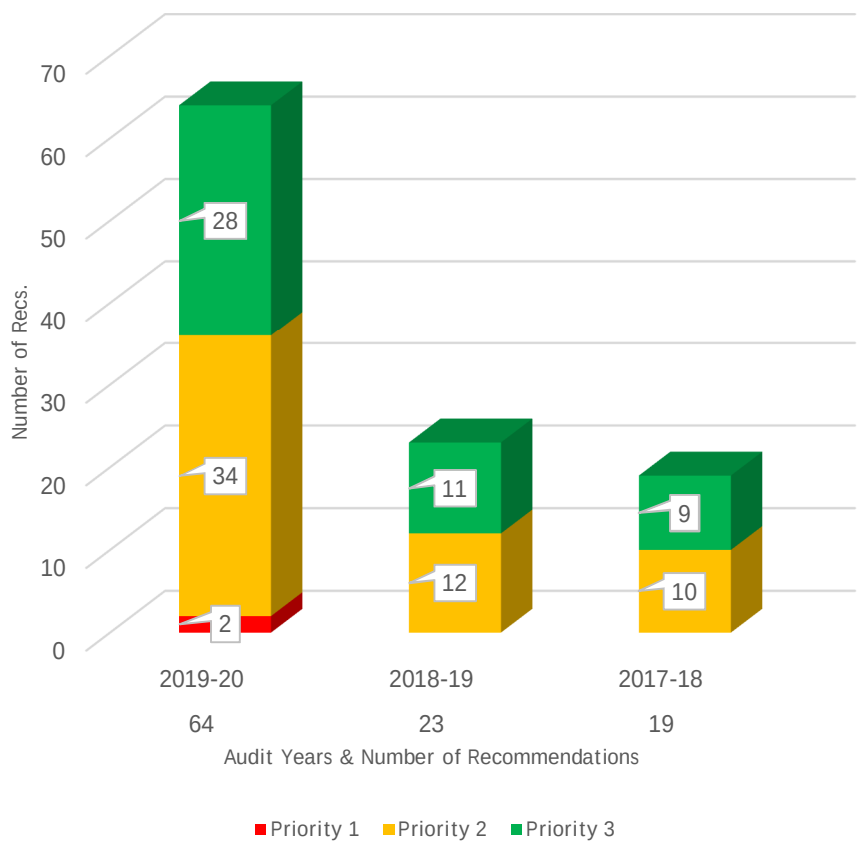
Fig. 3a - Report Assurance Ratings 2017-18 to 2019-20



	2019-20	2018-19	2017-18
	8	7	3
Advisory	3	1	0
Red	0	0	0
Amber-Red	0	0	0
Amber	2	0	0
Green-Amber	3	6	3
Green	0	0	0

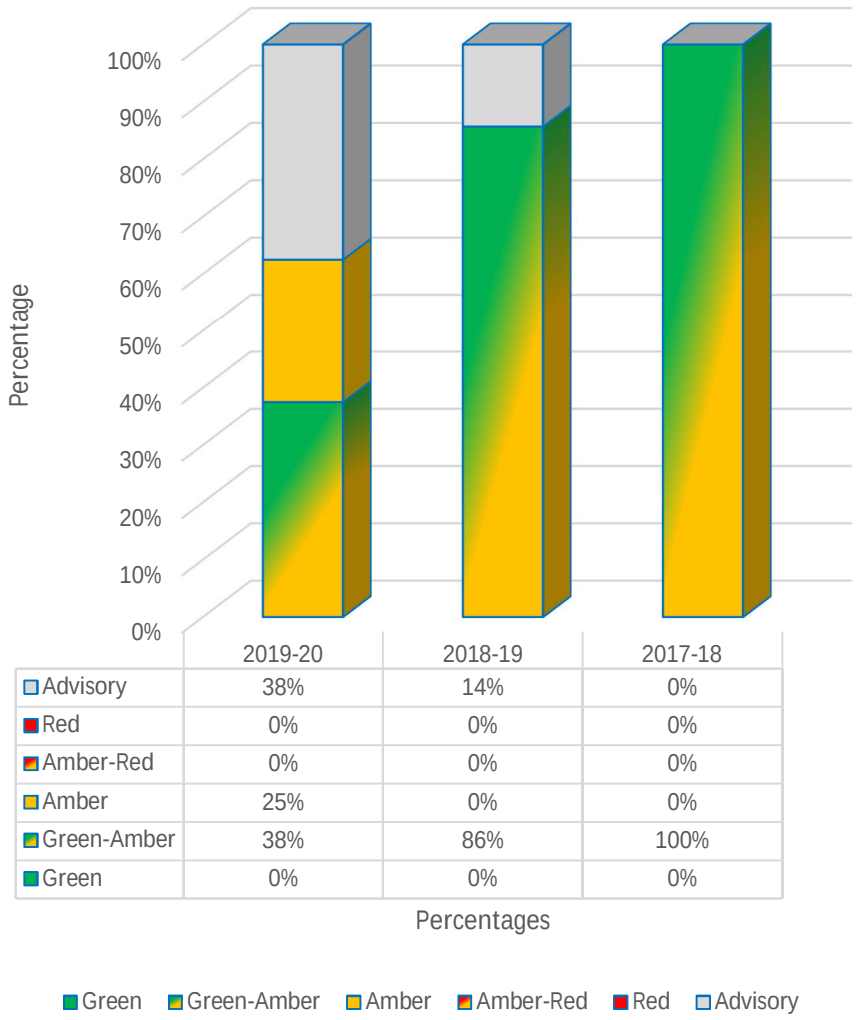
Source: Internal Audit analysis

Fig 3b. Recommendations by Priority - 2017/18 to 2019/20



Source: Internal Audit analysis

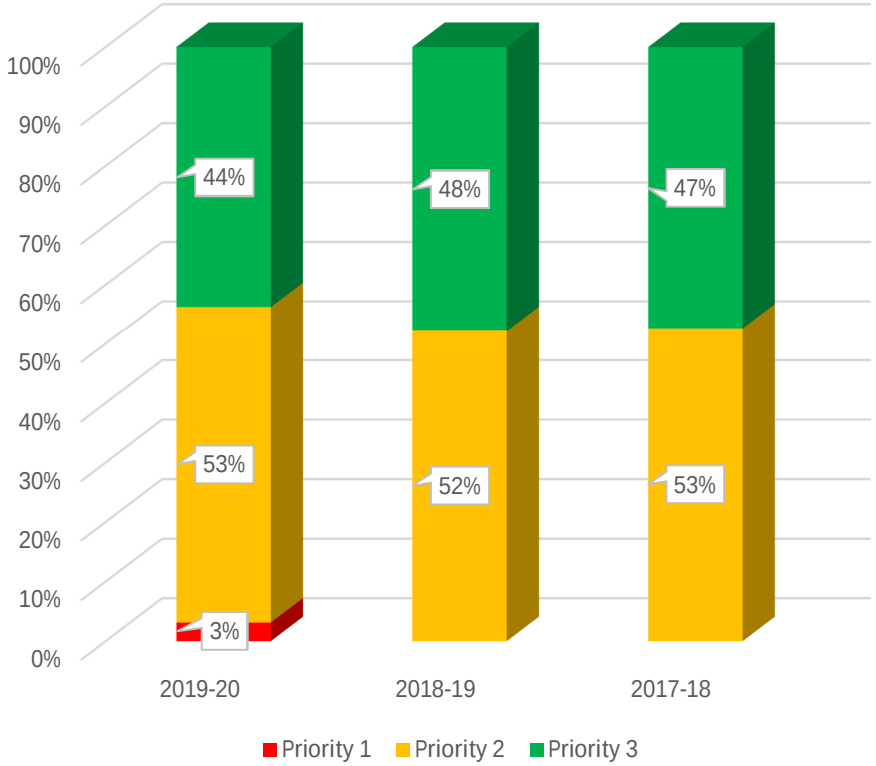
Fig 4a. Report Assurance Ratings %



	2019-20	2018-19	2017-18
Advisory	38%	14%	0%
Red	0%	0%	0%
Amber-Red	0%	0%	0%
Amber	25%	0%	0%
Green-Amber	38%	86%	100%
Green	0%	0%	0%

Source: Internal Audit analysis

Fig 4b. Recommendations by Priority Rating %



Source: Internal Audit analysis

2.20 The graphs in Figures 3 a/b and 4 a/b give a broad indication of the direction of travel for audit assignments' assurance ratings. Since BDO's appointment there has been a greater proportion of 'amber' rated reports, however comparisons between years are limited due to the change in service provision for internal audit and the differences in 'scoring' systems. The overall percentage of recommendation priorities appears consistent for the last three years with a roughly equal proportion of "Priority 2" and "Priority 3" recommendations raised.

Completion of the audit plan

2.21 Our findings are based upon and limited to the results of the internal audit work performed as set out in the Internal Audit Strategy and Plan approved by the Audit & Risk Committee in February 2019.

2.22 The Internal Audit plan agreed by the Audit & Risk Committee provided for £40,995 (excl. VAT) of internal audit activity in 2019/20. Table 2 (across) shows that assignments have been completed within the planned number of days and budget, with the exception of the Fitness to Practise review which required more time to complete than planned. There is a protocol in place for the addition of / deferral of audits assignments from the plan. All material changes are agreed by the Audit & Risk Committee.

2.23 Internal audit work was performed in accordance with BDO Internal Audit methodology which conforms to the Public Sector Internal Audit Standards. The Public Sector Internal Audit Standards require the annual report to include the results of the Internal Audit function's quality assurance and improvement programme. Details of our method and quality assurance programme are outlined in Appendix B.

Table 2: Internal Audit assignments conducted 2019-20

Assignment	Work type	Planned budget £	Actual cost £	Completion status
1. Assurance Map	Advisory	£5,600	£5,600	Complete
2. Quality Assurance	Audit	£4,600	£4,600	Complete
3. Procurement Project Assurance – Part 1 Review	Advisory	£1,100	£1,100	Complete
4. Transfer of Social Workers to social Work England	Audit	£4,800	£4,800	Complete
5. Fitness to Practise	Audit	£8,650	£9,550	Complete
6. Fraud Risk Assessment	Audit	£6,500	£6,500	Complete
7. Business Continuity Planning	Audit	£4,100	£4,100	Complete
8. Procurement Stage 2	Advisory	£2,300	£2,300	Complete
9. Risk Management Workshop	Advisory	£2,445	£2,445	Complete
10. Induction	Service Delivery	£3,000	£3,000	Complete
11. Internal Audit Plan and Strategy	Service Delivery	£3,300	£3,955	Complete
12. Audit Charter	Service Delivery	£600	£600	Complete
13. Internal Audit Follow-up	Service Delivery	£2,600	£2,600	Complete
14. Audit Committee, and Client Liaison	Service Delivery	£4,200	£4,406	Complete
15. Annual Report	Service Delivery	£1,200	£1,200	Complete
TOTAL		£54,995	£56,756	

3. Summary of findings from assignments undertaken in the year

1. Quality Assurance — Assessment: G A

Introduction

3.1 The objective of the review was to provide assurance on whether the quality assurance function set up by the HCPC currently provides an effective and value-adding second line of defence assurance service to the organisation. This review also sought to assist the organisation in further developing the quality assurance function by providing recommendations for future development.

3.2 The key considerations for the review related to whether:

- there are appropriate governance arrangements for central QA Department is appropriately structured to provide a common and consistent approach to QA activities. This includes whether the QA function has the right positioning within the organisation to carry out its role effectively;
- QA staff have an appropriate level of skills and training to effectively carry out QA activity;
- there is an overarching QA methodology and framework in place which clearly sets out HCPC's approach to its QA activities, including management oversight and reporting; and
- recommendations and actions arising from QA activities are monitored and followed up adequately.

Key conclusions

3.3 The audit highlighted 15 recommendations:

Priority 1	Priority 2	Priority 3
-	7	8

3.4 Our overall assessment was that HCPC has made good progress in establishing a central Quality Assurance Department, but it is still in its developmental phase. The bringing together of the QA teams from the respective directorates is a positive step towards further developing a central QA function that can support a consistent approach to providing an effective second line of defence assurance service to the organisation. It also bodes well that the QA Department has inherent knowledge of the regulatory areas, the organisation's processes and established working relationships with the Business.

3.5 The Department has developed structured frameworks for the QMs and their respective teams to follow when undertaking audits that have been devised with the Head of QA, involving input from the respective heads of service for the departments. A new Quality Assurance Development Manager post has been recruited to further develop the ISO and non ISO audit QA framework and to clearly define and document the working arrangements between ISO and non ISO activity. The Department had also initiated a framework of management and quality checks of outputs from QA activity. There was also an established system of reporting to Management, through the Operational Management Team (OMT), through to the Senior Management team's bi weekly meetings and the Audit Committee around overall QA activity.

3.6 Our review did, however, highlight areas for improvement in order to support the function in further developing the QA function to ensure that it continues to meet the needs of the organisation. Our recommendations once implemented would provide a strong second line of defence for the organisation. The following were the key themes for improvement which reflected the relative newness of the centralised QA function:

- the function should develop an audit charter which sets out its overall approach to delivering its QA activities;
- more detail should be provided to the Audit Committee on progress of the QA work programme, the outcomes from individual reports and the implementation of recommendations;
- as part of developing the new framework for ISO and non ISO related activity the following should be taken into consideration; clearly define and outline the separation of assurance activities being undertaken by the QA and Governance Departments and considerations should be given to ownership, reporting, methodology and accountabilities for delivery;
- Performance reporting can be further enhanced to include metrics to monitor the quality of QA activities and performance of the Department;
- there is scope for improving the presentation of the QA reports, particularly including overall assurance levels for reviews and priority levels for recommendations;
- at the time of the review, whilst there are individual trackers, there was not a mechanism in the form of a central recommendation tracker for monitoring the implementation of recommendation arising from QA reviews. We understand that Management is currently working on this improvement;
- although, staff within the QA function have good knowledge and expertise in the areas they audit and there has been initial training on audit approach, techniques and best practice from other regulators, there is scope to enhance existing training to provide ongoing refresher training including case studies of audit areas across the regulatory areas and sampling methodologies; and
- recommendations within the reports can be more specific and targeted to the individual issues highlighted within the report.

Management's Response and Action

3.7 The recommendations were accepted by management and an action plan agreed.

2. Transfer of Social Workers to social Work England	Assessment:	G	A

Introduction

3.8 The objective of the review was to provide assurance that the project has been managed satisfactorily so far and that HCPC would be ready for a successful transfer in December 2019.

3.9 The key risks with this area of activity were whether:

- legal agreements are in place and cover the key risks to HCPC;
- the project has been planned and delivered according to plan so far, and in accord with project management good practice, including governance, oversight, planning, reporting, and adequate management of risks and resolution of issues;
- arrangements for registration, education and FtP data transfers are sound, well-rehearsed and secure;
- the arrangements for live FtP case transfers during the transfer period are sound in principle and thus do not pose a risk to public protection or prolong the FtP process unnecessarily;
- HCPC are fully ready for the transfer date, have adequate contingency arrangements and communication plans in place should the transfer date be deferred or the switchover fails in some way.

Key conclusions

3.10 The audit highlighted 3 recommendations:

Priority 1	Priority 2	Priority 3
-	-	3

3.11 We concluded that the Transfer to SWE project was being managed and governed in line with good practice for a project of this size. Overall, the project was being managed effectively and key project documents, in particular, the project plans were in place as expected to provide structure to the project through to go-live.

3.12 From our experience the following are a number of aspects to consider moving forward

- Plans and progress should continue to be monitored closely as the 2nd December gets closer it may be beneficial to have shorter, but more frequent, progress update reports and meetings to ensure issues are picked up quickly and communication is increased.
- Given the timescales remaining it would be appropriate to schedule additional Project Board meetings if any 'Red' issues are flagged as part of progress monitoring.
- The contingency plans should continue to be refined to ensure they are detailed and specific enough during cutover as more detail emerges.
- Ensure there are clear planned communications and contact points during the cutover period which will help resolve issues quickly.

Management's Response and Action

3.13 The recommendations were accepted by management and an action plan agreed.

3. Fitness to Practise — Assessment: A

Introduction

3.14 The objective of the audit was to provide assurance that the controls around the FtP end to end processes are appropriate and adequate in their design and is applied as intended in practice.

3.15 The key risks with this area of activity were whether:

- the procedures and controls around FtP processes effectively support HCPC's statutory obligations in protecting the public, that is, the controls in place from the point a concern is raised, the triage process, investigations process and hearings tribunal process;
- the procedures and controls around Interim Orders effectively support HCPC's statutory obligations in protecting the public;
- management and processing of FtP cases are complete, rigorous and in accordance with statutory and legislative requirements;
- FtP cases are processed in a timely manner meeting both set statutory and administrative timescales;
- there are adequate management quality checks at key stages of the FtP process;
- there is a robust programme of quality assurance of FtP cases;
- there is ongoing, accurate management and performance reporting around FtP case activity.

Key conclusions

3.16 The audit highlighted 14 recommendations:

Priority 1	Priority 2	Priority 3
-	13	1

3.17 Overall our end-to-end sample testing of the FtP process confirmed that the individual tasks within each stage of the FtP process were completed effectively. This was confirmed when we reviewed in detail processes such as at triage, the Investigating Committee Panel (ICP) stage and post ICP stage, the Protection of title (POT) process, declarations of character cases and miscellaneous cases. In all areas, supporting documentation was comprehensive and had been maintained to demonstrate compliance with the process steps. This was also highlighted when we reviewed the completion of FtP cases. Where interim orders are required, we also found that these are adequately risk assessed and interim order applications are consistently approved. In addition, the FtP process is monitored by quality assurance audits, which are undertaken by a QA Team who have knowledge of the process and apply recognised assurance and automation tools. This is complemented by quality assurance reports which are distributed to SMT. The Audit Committee receive an overview of the progress against the recommendations from the audit and Council receive a summary of this information in the organisational performance report.

3.18 The Quality Assurance (QA) team, who undertake FtP audits, have all worked in the FtP field previously and therefore have a sound knowledge of how the function works. The QA team work with the FtP team to identify which audits should be undertaken in line with risks. The risks are identified by the Head of FtP, The FTP QA manager and the Head of QA. In addition the QA plan is not rigid and can be updated via regular quarterly meetings between the Head of QA, the FtP QA Manager, the Head of FtP and, when required, the Executive Director of Regulation.

3.19 We noted that the triage process was identified to be sound in that it allowed for only the more relevant and pertinent cases to be considered and thus escalated to the next stage. This helps ensure that resources, even when low are focusing on those cases that are most relevant. We also noted that HCPC

routinely and consistently acknowledged all concerns that were raised to them which is important as it allowed complainants to be made aware that their concerns were being dealt with. Declaration of health and character cases we tested were also all dealt with in a timely manner. This helps to ensure that registrants are able to practice in a timely manner.

3.20 However, we found there were a number of issues identified within the FtP processes and these generally centred on the common theme that as management were aware timescales were not being consistently adhered to across the various process stages - from triage through to case completion. A key factor that management cited for delays in the FtP processes was that staff resources have been limited and there have been a number of staff vacancies at different stages within the process.

3.21 In addition, the FtP end to end process needs to be developed in light of the following issues:

- Timescales had not been met in some areas of the FtP processes;
- Although management checks are in place in the form of the quality assurance reviews there was no specific reporting on the organisation's ability to meet the required timescales for the aforementioned FtP processes;
- In one case sent to the Panel the case had to be put on hold due to insufficient information being presented in the 'bundle' pack. This caused a delay in the decision that was made. We understand that this was an isolated issue;
- Information sent to the Audit Committee and Council with regards to recommendations from QA audits did not include how many cases' recommendations had been completed, were in progress and still outstanding and had passed the implementation date;
- FtP management do not respond to the QA team in a timely manner and therefore the FtP tracker is not up to date.

Management's Response and Action

3.22 The recommendations were accepted by management and an action plan agreed.

4. Fraud Risk Assessment — Assessment: A

Introduction

3.23 The objective of the review was to assess the Heath and Care Professions Council's (HCPC) exposure to the risk of fraud and the existing controls for managing fraud risk.

3.24 The key risks with this area of activity were whether:

- HCPC's strategy for managing their fraud risk was appropriately designed; and
- There were adequate controls in place for preventing, deterring and detecting fraud (specifically within the main fraud risk areas).

Key conclusions

3.25 The audit highlighted 13 recommendations:

Priority 1	Priority 2	Priority 3
2	5	6

3.26 Overall, HCPC has a low direct exposure to fraud (where HCPC themselves will be the victim), though, HCPC's exposure is higher in relation to reputational damage as a result of a registrant committing fraud in order to gain registration, for example using false qualifications or ID documents. It is acknowledged that this is an inherent risk to regulators and is minimised through the verification procedures for registering professionals and conducting fitness to practise investigations. For example, areas of good practice included registrant due diligence, specifically in relation to verifying identity documents, references and academic/professional qualifications. Having such robust due diligence procedures allows HCPC to identify individuals who are not suitable and potentially attempting to gain registration using false information/documents.

3.27 There were three main key areas for improvement we noted during our review:

- Strategic Approach: There was a weakness in HCPC's strategic approach to managing the risk of fraud. Instead the approach to combatting fraud has been managed independently by each department with no clear oversight. The risk of fraud was not specifically included, or referenced within the strategic risk register, which is reviewed by the Audit Committee on a quarterly basis. The lack of an explicit reference may result in the risk of fraud not being specifically assessed, giving the Council false assurance that the risk is being effectively managed. It should also be noted that the Audit Committee last reviewed the entire Risk Register and Risk Treatment Plan (which does include fraud and bribery more explicitly) in November 2017. In order to adopt a more strategic approach to managing fraud risk, we have recommended that the risk of fraud is more explicitly referenced within the strategic risk register. This will ensure that the risk of fraud is more effectively monitored by the Audit Committee and demonstrate a clear tone from the top.
- Fraud Awareness: With regards to raising fraud awareness, HCPC did not have a fraud policy and there was no fraud awareness programme across HCPC. The risk of fraud was not covered at induction or as part of an annual refresher training. A lack of fraud awareness may result in staff not being able to detect or report instances of fraud, resulting in continued losses or public protection risks, but the lack of awareness will also fail to discourage individuals from committing fraud. We have recommended that the HCPC develop an anti-fraud policy and a fraud awareness programme. This could be delivered via eLearning.

- Fraud Response: HCPC does have a fraud response plan process map, however there was no standalone fraud response plan policy – the fraud response process map, is linked to the Whistleblowing Policy. The Whistleblowing Policy did provide guidance on how to report concerns, but did not provide any detailed guidance on how investigations will be undertaken. Without clear guidance investigation may be mismanaged. For example, at the initial referral stage the fraud response process map includes a decision as to whether evidence needs to be isolated or duplicated but also needs to explain about the handling and maintaining the chain of evidence, as evidence may rendered inadmissible if handled incorrectly. This in turn may jeopardise any criminal prosecution or applications for recovering losses to fraud. Although, it is acknowledged that HCPC has access to trained investigators within the fitness to practise department who could advise on such matters. We have recommend that HCPC develop a fraud or serious incident response plan in order to address this weakness.

Management's Response and Action

3.28 The recommendations were accepted by management and an action plan agreed.

5. Business Continuity Planning — Assessment: G A

Introduction

3.29 The objective of the audit was to provide assurance over the design and effectiveness of the key controls operating around the business continuity management process.

3.30 The key risks with this area of activity were whether:

- A Business Continuity Strategy has been defined, which is aligned with the Corporate Business Plan.
- An effective risk assessment process is in place that ensures key systems were identified and included within the plan.
- A BCP is in place and sufficient to enable business critical elements of the plan to be backed up and running within required timeframes to prevent significant business disruption.
- Adequate third party management practices existed to ensure that the levels of controls expected by the organisation were being adhered to by the provider.
- The BCP and/ or IT DRP have been tested for robustness and are kept up-to-date.
- Preparedness of staff resulting in the BCP being implemented correctly in the event of an incident.
- Adequate backup and restore provisions are in place to ensure the availability of information required to resume processing.
- The organisation's disaster recovery plan enables the recovery of IT processing capabilities in the event of a disaster.

Key conclusions

3.31 The audit highlighted 10 recommendations:

Priority 1	Priority 2	Priority 3
-	7	3

3.32 Overall, our review of the business continuity arrangements confirmed the business continuity plan was generally well developed to ensure that the organisation is equipped to respond effectively and efficiently in the event of a disaster. Business continuity roles and responsibilities had been well defined and it was clear that there was an awareness of the business continuity arrangements from discussions with relevant stakeholders. The key risks in the event of a disaster had been defined with HCPC's top 10 organisational risks which also included the risks to critical business systems that would cause significant impact to HCPC. The Shadow Planner applications serves as an effective tool to host the business continuity plan and contains key information such as invocation procedures, key contacts and suppliers and assembly points. The plan had been tested at least annually either through a live incident or desktop exercise which showed that the business continuity plan was effective in minimising the impact of the incident. In terms of the IT disaster recovery arrangements, there were daily backup schedules to ensure that data is consistently backed up and HCPC uses the third party Azure to deliver the disaster recovery solution which has also been tested on an annual basis.

3.33 However, our audit identified a number of areas for improvement with regards to the business continuity arrangements. These related to aligning the business continuity plan to HCPC corporate objectives, explicitly defining the business impact analysis, maintaining an up to date list of suppliers, formalising the training that is administered to staff and aligning the IT disaster recovery arrangements such as backup frequency to the requirements of the operational processes.

Management's Response and Action

3.34 The recommendations were accepted by management and an action plan agreed.

4. Summary of other assurance assignments undertaken in the year

6. Assurance Map – Advisory — Assessment: N/A

Introduction

4.1 The purpose of developing the assurance map is to understand the control, governance and management oversight environment operating at HCPC. If the assurances are strong, then it is likely that HCPC's senior management and the Board could:

- reasonably rely on the information provided to it about the performance of its core functional areas;
- that the 'delivery' systems are working to ensure that the same, if not better performance can continue into the future, and
- the risks to achieving business objectives are reasonably mitigated.

Key conclusions

4.2 Currently HCPC has an array of assurances provided to management across most of the key areas of the business and no area has been assessed as not having any assurance activity in place. Assurances in place are thought to be well designed, most notably the first line of defence. It has been noted however that there are some existing gaps in fraud awareness and corruption, in addition to finance and budgets.

4.3 The Quality Assurance (QA) function as a second line of defence within HCPC has been in a place for a number of years but has been a centralised function since June 2018. . The QA team have been undertaking audits in heavily regulated areas that have been based on risk and agreed with the Heads of the regulatory departments. In addition, to the QA team undertaking ISO audits to give business areas assurance on areas that are not so heavily regulated such as HR.

4.4 Areas that worked well:

- It was identified that the core regulatory functions of HCPC, namely Registration, Fitness to Practise (FTP), Education, and Policy & Standards have a good coverage of the three lines of defence in place. This is mainly attributable to the fact that they are core regulatory functions and are therefore under constant scrutiny by a number of independent bodies on an annual basis. The prescribed legislation also determines the first line of defence for the core functions.
- Likewise, for the management systems functional areas, it was identified that there was once again a good coverage of the three lines of defence within the following areas: risk management, performance management and strategy & planning. This is mainly assisted via good controls and policies at the operational level, allowing sufficient information and decision making through to the SMT, Committees and subsequently the Council with a good selection of external assurance providers providing additional independent assurance to the HCPC.
- With respect to the non-regulatory departments, there were sufficient controls in place and oversight covering all three lines of defence in the areas of payroll and IT. The payroll function is outsourced which helps to prevent fraud and allows a segregation of duties to be imposed at both the operational first line of defence and at the second line of defence in reviewing payroll runs made on a monthly basis. The IT function has had some independent assurance work undertaken by the previous internal audit team within the past two years with a good level of controls set at the operational level.

4.5 Key gaps in assurance:

- Other finance staff/members of the budget holders' respective teams were not well informed on current budget situations for their teams. Therefore, as an example, for succession planning, this could prove to be an issue if someone else had to take over that budget.
- The procurement function of HCPC has a procurement support team in place. However there was no centralised procurement system in place as of yet. It was expected that Delta e-sourcing system would go live in quarter three. Where there is no procurement system in place this can cause a number of issues when ordering goods and services with a risk of HCPC not achieving value for money on their purchases. In addition to this, there is not an up to date approved supplier list, which can, once again, result in HCPC wasting both time and resources when procuring goods and services. There has not been any training for those staff in departments who are responsible for procuring goods and services and there is therefore a risk that they do not follow the Procurement Manual that is currently in place, leading to inconsistencies in procurement across the teams.
- The culture within HCPC seemed to be one that is not fraud aware, there was no evidence of formal, systematic fraud & corruption, anti-money laundering or bribery training in place. Although HCPC does not deal with vast amounts of money, there are risks to fraud in areas such as registration and FtP.

Management's Response and Action

4.6 Management accepted the report and will continue to implement recommendations in a timely and effective manner.

7. Procurement – Stage 1 Assessment: N/A

Introduction

4.7 HCPC was in the process of procuring the provisions of legal services for their Fitness to Practise (FtP) regulatory function. The current provider of this service is Kingsley Napley (KN) and was selected via the official journal of the European Union (OJEU) procurement framework.

4.8 The current contract commenced on 1st April 2014 via the OJEU tendering process during the 2013/14 financial year. For the 2019/20 financial year the contract with KN was extended for an additional year at an additional cost of approximately £4.8million. The contract was not subject to tender for the 2019/20 financial year mainly due to the uncertainty around the transfer of social workers to the new regulator - Social Workers England (SWE). It is anticipated that the move of social workers to SWE will take place in December 2019, and will therefore reduce the number of cases that are processed by the Investigating Committee in making a 'case to answer' decision and thus move to the final hearing stage.

4.9 The service being procured was with respect to instructing external legal services. The successful supplier will be expected to act on behalf of HCPC when a FtP case has been reviewed by the Investigating Committee panel and they have reached a 'case to answer' decision. The supplier will be required to prepare the case for final hearing. This will include taking witness statements, attendance at preliminary or case management meetings and undertaking advocacy before a final hearing panel.

4.10 HCPC are looking to procure a supplier for a period of one year with the option to extend for a further year should contract performance and the working relationship work well.

Key conclusions

4.11 Our assessment confirmed that the process for procuring the new provider of FtP legal services is generally sound with a few minor improvements required.

Management's Response and Action

4.12 Management accepted the report and will continue to implement recommendations in a timely and effective manner.

8. Procurement – Stage 2 Assessment: N/A

Introduction

4.13 HCPC was in the process of procuring the provisions of legal services for their Fitness to Practise (FtP) regulatory function. The current provider of this service is Kingsley Napley (KN), who were selected via the Official Journal of the European Union (OJEU).

4.14 The Kingsley Napley contract commenced on 1st April 2014 via during the 2013/14 financial year. For the 2019/20 financial year the contract with KN was extended for an additional year at an additional cost of approximately £4.8million. The contract was not subject to tender for the 2019/20 financial year mainly due to the uncertainty around the transfer of social workers to the new regulator - Social Work England (SWE). It is anticipated that the move of social workers to SWE will take place in December 2019, and will therefore reduce the number of cases that are processed by the Investigating Committee in making a 'case to answer' decision and thus move to the final hearing stage.

4.15 The service being procured was with respect to providing external legal services. The successful supplier will be expected to act on behalf of HCPC when a FtP case has been reviewed by the Investigating Committee panel and they have reached a 'case to answer' decision. The supplier will be required to prepare the case for final hearing. This will include taking witness statements, attendance at preliminary or case management meetings and undertaking advocacy before a final hearing panel.

4.16 HCPC are looking to procure a supplier for a period of one year with the option to extend for a further year should contract performance and the working relationship work well.

4.17 We reviewed the first stage of the procurement process in Q1 of the 2019/20 financial year. We found a few minor areas where improvements could be made to the process such as ensuring that the procurement time table is complied with. At the time of completion of the audit work the Invitation to Tender (ITT) document had just gone live.

Key conclusions

4.18 Our assessment confirmed that the process for procuring the new provider of FtP legal services is generally sound with a few minor improvements required.

Management's Response and Action

4.19 Management accepted the report and will continue to implement recommendations in a timely and effective manner.

A Definitions

Possible Annual Opinions	
1	There is an adequate and effective system of governance, risk management and internal control to address the risk that management's objectives are not fully achieved.
2	There is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and internal control. OR There is some risk that the system of internal control, governance and risk management will fail to meet management's objectives – some areas there are adequate and effective systems of governance, but there are also some specific areas of significant risk. Significant improvements are required in specific areas to improve the adequacy and / or effectiveness of governance, risk management and internal control.
3	There is considerable risk that the system of internal control, governance and risk management will fail to meet management's objectives. Significant improvements are required to improve the adequacy and / or effectiveness of governance, risk management and internal control.
4	The systems have failed or there is a real and substantial risk that the systems of internal control, governance and risk management will fail to meet management's objectives. Immediate action is required to improve the adequacy and / or effectiveness of governance, risk management and internal control.

Individual assignment assurances	
(Green)	Overall, there is a sound control framework in place to achieve system objectives and the controls to manage the risks audited are being consistently applied. There may be some weaknesses but these are relatively small or relate to attaining higher or best practice standards.
(Green-Amber)	Generally a good control framework is in place. However, some minor weaknesses have been identified in the control framework or areas of non-compliance which may put achievement of system or business objectives at risk.
(Amber)	Weaknesses have been identified in the control framework or non-compliance which put achievement of system objectives at risk. Some remedial action will be required.
(Amber-Red)	Significant weaknesses have been identified in the control framework or non-compliance with controls which put achievement of system objectives at risk. Remedial action should be taken promptly.
(Red)	Fundamental weaknesses have been identified in the control framework or non-compliance with controls leaving the systems open to error or abuse. Remedial action is required as a priority.

Individual assignment recommendation ratings	
Priority ranking 1:	There is potential for financial loss, damage to the organisation's reputation or loss of information. This may have implications for the achievement of business objectives and the recommendation should be actioned immediately.
Priority ranking 2:	There is a need to strengthen internal control or enhance business efficiency.
Priority ranking 3:	Internal control should be strengthened, but there is little risk of material loss or recommendation is of a housekeeping nature.

B Internal Audit Quality Assurance

Quality assurance processes and procedures	
Procedures	Our audit procedures were designed to ensure the service we deliver is of the highest standard and complies with the Public Sector Internal Audit Standards (PSIAS). We utilise specially designed internal audit software Pentana to conduct our work and all reports are subject to review by a senior manager (Stage 1) and director or partner (Stage 2). All reports are also checked for proofing errors at draft and final report stage by another staff member.
Knowledge Library	Our audit testing programmes, and good practices we find are imported into our Knowledge Library. The Knowledge Library is part of our Pentana audit workflow system and enables auditors to see examples of best practice across our client base. This enhances the quality of our audit work – understanding the features of best practice in the areas under audit and also auditing techniques applied. It also includes some standardised reporting templates.
Professional training, CPD and development	Staff are suitably professionally qualified or working towards qualification. There is a full programme of continuing professional development and training provided by BDO LLP and to specific members of the BDO LLP relating to internal audit, risk management and governance.
Quality assurance improvement programme (QAIP)	The BDO LLP has an internal audit Quality Assurance Improvement Programme (QAIP). Such a programme is a requirement of PSIAS and international internal auditing standards. It ensures that any issues identified by the quality processes are assigned actions and resolution is monitored. Specific improvements required are directed to the relevant person – generic changes to processes are recorded and tracked using the firm's internal audit quality group.
Customer satisfaction survey	We have online satisfaction surveys. These are available on a periodic 'per client' or 'per assignment' basis.
BDO client care programme	Firm-wide satisfaction survey which benchmarks our service against the firm and the industry.
Hot review	Peer review of a selection of audits to ensure each client receives the same high standards of audit work.
Cold review	The BDO LLP Risk Advisory Services Group conducts an internal 'cold review' of its internal audit working practises, reports and files annually. The review is conducted annually and was last conducted in January-February 2020. The findings feed into the QAIP.
External review	BDO LLP's internal audit work was subject to an external quality review in 2015 (both BDO LLP & legacy Moore Stephens LLP). The next review is in 2020/21

C Limitations

Limitations	
Opinion	Our opinion is based on the work undertaken as part of the Audit Strategy and Plan. The work addressed the key risk areas agreed for each individual internal audit assignments as set out in our individual assignment terms of reference. There might be weaknesses in the system of internal control that we are not aware of because they did not form part of our programme of work, were excluded from the scope of individual internal audit assignments or were not brought to our attention. As a consequence the reader should be aware that our opinion may have differed if our programme of work or scope for individual reviews was extended or other relevant matters were brought to our attention.
Internal control systems	Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.
Future periods	Our assessment of controls relating to National Lottery Heritage Fund is for the year end of the year 2019-20. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.
Management's responsibilities	It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems. We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected, and our examinations as internal auditors should not be relied upon to disclose all fraud, defalcations or other irregularities which may exist.

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