A Meeting of the Care Inspectorate **Audit and Risk Committee** is to take place at **10.30 am** on Thursday 20 May 2021 by Teams video-link

AGENDA	
1.	Welcome
2.	Apologies for Absence
3.	Declarations of Interest
4.	Minute of Meeting held on 4 March 2021 (paper attached)
5.	Action Record of meeting held on 4 March 2021 (paper attached)
6.	Matters Arising 6.1 Chief Executive Update
	Internal Audit Items
7.	Annual Internal Audit Report 2020/21 – Report No: ARC-09-2021
8.	Internal Audit Plan Follow-Up Report – Report No: ARC-10-2021
9.	Audit Report: Health, Safety and Wellbeing – Report No: ARC-11-2021
10.	Audit Report: Freedom of Information (Scotland) Act (FOISA) – Report No: ARC-12-2021
11.	Audit Report: Joint Review of Shared Service - Report No: ARC-13-2021
	External Audit Items
12.	External Audit update (verbal update)
	Items for Discussion and/or Decision
13.	Strategic Risk Review – Report No: ARC-14-2021

14.	Draft Audit Committee Annual Report to the Board – Report No: ARC-15-2021
15.	Digital Programme Update - Report No: ARC-16-2021
16.	Senior Information Risk Officer Annual Report – Report No: ARC-17-2021
	Items for Information
17.	Horizon Scanning • CIPFA Audit Committee Update *(link to Sharepoint folder circulated to members by email)*
	Standing Items
18.	Audit Committee Narrative to the Board and Publication of Committee papers
19.	Schedule of Committee Business 2021-22 (paper attached)
20.	AOCB
21.	Close of Business and Date of Next Meeting: Thursday 13 August 2021 at 10.30 am. This meeting is a single item meeting to consider the Draft Annual Report and Accounts and is open to all Board members.

Minutes

Meeting: Audit and Risk Committee

Date: 4 March 2021

Time: 10.30 am

Venue: Video-conference

Present: Bill Maxwell, Convener
Gavin Dayer
Paul Gray
Ronnie Johnson
Anne Houston
Rona Fraser

In Attendance: Peter Macleod, Chief Executive (CE)
Gordon Mackie, interim Executive Director of IT and Digital Transformation (iEDIDT)
Jackie Mackenzie, Executive Director of Corporate and Customer Services (EDCCS)
Kevin Mitchell, Executive Director of Scrutiny and Assurance (EDSA)
Kenny Dick, Head of Finance and Corporate Governance (HFCG)
Fiona McKeand, Executive and Committee Support Manager (ECSM)
David Archibald, MHA Henderson-Loggie (H-L)
John Boyd, Grant-Thornton (G-T)
Kenny McClure (Effectiveness and Development session only)

Apologies: Edith Macintosh, Executive Director of Strategy and Improvement and Deputy Chief Executive (EDSI)

Item **Action**

1.0 WELCOME

The Convener welcomed members, officers, staff and auditors to the meeting and in particular to Board member Rona Fraser who was attending her first meeting as a new member of the committee. The Convener recorded thanks to member Keith Redpath for his service to the work of the committee.

2.0 APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

3.0 DECLARATIONS OF INTEREST

There were no declarations of interest.

ITEMS FOR DISCUSSION

4.0 MINUTE OF MEETING HELD ON 19 NOVEMBER 2020

The minute of the meeting held on 19 November 2020 was **approved** as an accurate record.

5.0 ACTION RECORD OF MEETING HELD ON 19 NOVEMBER 2020

The Committee noted that all of the actions from the previous meeting had been completed.

6.0 MATTERS ARISING

6.1 UPDATE ON IFRS 16 "LEASES"

Further to the report submitted to the Committee at its previous meeting, the Head of Finance and Corporate Governance informed members that IFRS16 had been postponed until the 2022/23 financial year.

INTERNAL AUDIT ITEMS

7.0 INTERNAL AUDIT PLAN 2020/21 PROGRESS REPORT – REPORT NO: ARC-01-2021

The internal auditor presented the report on progress of planned internal audit activity in 2020/21 against the 2020/21 Annual Internal Audit Plan. The report showed that delivery of the plan was on track and that reports on three of the remaining assignments would be brought to the May meeting of the Committee.

A delay of the audit of Publicity and Communications had been requested by management, which would require a change to the reporting timeframes. The rationale for the delay was to allow for the appointment to the new post of Head of Corporate Communications and Policy, the recruitment to which was currently underway.

The Committee raised concern with the number of reports that were planned for the May meeting, and whether this would be placing a degree of pressure on auditors and staff in order to achieve the reassurance the Committee sought. The internal auditor explained that

much of the groundwork for the audits had already been completed and were spread across a range of contributors, thus reducing any undue pressure.

The Committee noted the good progress being made with the internal audit plan.

8.0 INTERNAL AUDIT PLAN FOLLOW-UP REVIEW – REPORT NO: ARC-02-2021

The internal auditors presented the regular follow-up review, which outlined the progress made on live internal audit actions since reported to the previous meeting of the Committee in November 2020.

The Committee was invited to approve any further revisions to implementation dates put forward by management.

The review highlighted those internal audit recommendations that had not been fully implemented as well any new recommendations. At the previous meeting, the Committee had requested a Red/Amber/Green system be introduced to the review report, and which had now been implemented. This would help to demonstrate any gaps since original implementation dates were set and provide management with the opportunity to set out the rationale as to why a recommended action had taken longer to complete.

The Committee welcomed this new step and acknowledged the impact of COVID-19 on some of the recommendations. Members stressed the need to ensure that any recommendations that were no longer relevant were not being carried over and that focus was given to those that were of highest risk.

The Committee was assured that the review report categorised those recommendations that had been considered but not implemented, and which demonstrated that due consideration had been given by management, with a clear rationale as to why any had not been implemented, notably when matters had been overtaken by events.

As a result of the discussion on this matter, the Chief Executive recommended a meeting be convened with members, the internal auditors, the Executive Director of Corporate and Customer Services and the Head of Finance and Corporate Governance, in order to go through the recommendations in more detail as the organisation emerged from COVID, and to provide an additional level of assurance in alignment to the output of the review of the strategic risks. The Committee agreed to a meeting being set up on a date before the next meeting in May. **ECSM**

The Committee noted the report and agreed no further revisions to implementation dates were required.

9.0 DRAFT ANNUAL INTERNAL AUDIT PLAN 2021/22 – REPORT NO: ARC-03-2021

The internal auditors presented the draft Internal Audit Annual Plan for 2021/22, which represented year two of the three year Strategic Plan, approved by the Committee at its September 2020 meeting. The scope and objectives for each audit assignment to be undertaken during the coming year were outlined, together with the audit approach.

The Committee was invited to comment on the audit approach and to approve the proposed annual programme of internal audit activity for 2021/22.

Members' attention was drawn to the proposed change to the Publicity and Communications review, the rationale for which had been explained to the Committee earlier in the meeting under item 7.

The Committee expressed the need for clarity on which internal audits were cyclical and asked if this was taken account of in the priority listing, in comparison to those that were particularly high risk. The internal auditors confirmed that audit plans were firmly aligned to the organisation's strategic risk register.

The Committee **approved** the draft annual internal audit plan for 2021/22.

10.0 REVIEW REPORT: ORGANISATIONAL DEVELOPMENT – REPORT NO: ARC-04-2021

The internal auditor presented the report on the review of the organisational and workforce development (OWD) function, which had concluded an overall level of assurance of "Satisfactory". Two recommendations had been made and the Committee was invited to accept the report and agree the management response to both recommendations.

The audit had highlighted the good work being done by the OWD team and positive responses had been recorded especially in the relation to the extensive training programme that had been developed for staff.

The Committee consider the content of the report and had some discussion on the LEAD system, the challenges of goal and objective setting for staff and the regularity of one-to-one meetings between managers and their individual team members, the latter of which the Committee deemed especially important during COVID, to ensure that staff wellbeing was at the forefront. Assurance was given that these meeting were being held, though not formally recorded on the LEAD system. It was acknowledged that there was opportunity now to review, refresh and relaunch LEAD and the Committee supported a

proposal from the Chief Executive for the Strategic Leadership Team to consider this in more detail, to encompass a brief audit and communication to staff.

The Committee noted the report and the management response to the recommendations.

11.0 SHARED SERVICE ASSIGNMENT PLAN – REPORT NO: ARC-05-2021

The internal auditors presented the proposed scope for the additional joint assignment plan on Shared Services, which had been agreed with senior management of the Care Inspectorate and Scottish Social Services Council. The Committee had no further questions and **approved** the scope.

EXTERNAL AUDIT ITEMS

12.0 EXTERNAL AUDIT UPDATE

The update from the external auditors was presented under item 13.

13.0 DRAFT EXTERNAL AUDIT PLAN

The external auditors presented the draft external audit plan which would be submitted to the Care Inspectorate and Audit Scotland by 31 March 2021.

The main aspects of the plan were fully explained to the Committee, which covered materiality, financial statement audit risks, smaller body arrangements and the audit fee. It also included other audit matters that would be summarised for the Committee's awareness.

The Committee **agreed** the draft plan and noted the timescale for submission of the final plan to Audit Scotland.

ITEMS FOR DISCUSSION

14.0 PUBLICATION OF SUB-COMMITTEE MEETING PAPERS – REPORT NO: ARC-06-2021

The Chief Executive introduced the report which outlined the current arrangements for publication of Committee papers, whereby the approved minutes and brief narrative featured on the Care Inspectorate website, incorporated into the published Board papers.

For the purposes of transparency, it was planned to establish a separate website page for publication of all Audit and Risk Committee meeting papers, excluding those taken in private.

The Committee was invited to consider whether committee papers ought to be published retrospectively and/or going forward from April 2021 only.

The Committee **agreed** that, although not meeting in public, the non-private papers of the Audit and Risk Committee meetings should be published on a separate landing page of the Care Inspectorate website, effective from the next committee cycle starting in May 2021. **ECSM**

15.0 STRATEGIC RISK REGISTER MONITORING – REPORT NO: ARC-07-2021

The Head of Finance and Corporate Governance presented the revised Strategic Risk Register for the Committee's consideration and noted that there had been no significant change to the strategic risk position since the Board meeting held on 17 December 2020.

There had been a full Board session on the annual review of the strategic risk register a few days prior to the Committee meeting. The output from the session would be considered in more detail by the Senior Leadership Team and a revised and updated draft register would be presented to the May meeting of the Committee.

The Committee noted the report and the planned next steps.

16.0 DIGITAL PROGRAMME UPDATE - REPORT NO: ARC-20-2020

The interim Executive Director of IT and Digital Transformation presented the report which provided the Committee with an update on the progress of the Digital Programme. It also outlined the latest programme finances and overall progress including the impact of the COVID-19 response.

The main aspects of the update covered the delivery of the new register and registration, planned for mid-March. End to end testing had successfully concluded the previous week and a technology framework assessment undertaken by the digital assurance office had resulted in an amber/green rating, demonstrating the good work that had been carried out by the digital team over the previous six months.

A report from the Advisory and Assurance Group, comprising officers and Board members, was also provided and it was noted that, due to the required extension of the six month lifespan of the group, its terms of reference would need to be reviewed at its next meeting and submitted to the Board for approval.

The Committee welcomed the update, noting good progress and preparedness for Phase 2 of the digital programme.

ITEMS FOR INFORMATION

17.0 HORIZON SCANNING – INCLUDING AUDIT SCOTLAND AND OTHER PUBLICATIONS

The Committee noted the two relevant reports published recently by Audit Scotland. These were:

- NHS in Scotland 2020 – which outlined the response to the pandemic by the NHS in Scotland and presented an overview of its financial and operational performance for 2019/20
- COVID-19: What it means for public audit in Scotland – which outlined Audit Scotland's response to COVID-19, its approach to audit during the pandemic and its assessment of the pandemic's impact on public bodies.

STANDING ITEMS

18.0 AUDIT COMMITTEE NARRATIVE TO THE BOARD

The Committee agreed that its narrative to the Board should cover:

- The Committee's approval of the internal audit plan and the scope of the assignment plan on Shared Services
- The Committee's agreement to meet with internal auditors and senior officers to discuss in more detail the recommendations from previous audits
- The discussion of the internal audit review on OWD
- The agreement to the draft external audit plan
- The development of the revised strategic risk register for further consideration by the Committee in May, prior to Board
- The good progress made with the digital programme and the extension of the member/officer working group
- The agreement to publish non-private Committee papers on the Care Inspectorate website

19.0 SCHEDULE OF COMMITTEE BUSINESS 2021/22

The Committee noted the schedule of business for 2021/2022. **ECSM**

17.0 AOCB

There was no other competent business.

18.0 DATE OF NEXT MEETING

The date of the next meeting was noted as Thursday 21 May 2021 at 10.30 am, the venue to be confirmed.

The Committee members and external auditors entered private discussion.

Signed:

Bill Maxwell, Convener

Agenda item 5

Audit and Risk Committee
Action Record - Rolling

Item No	Item Title/ Report No	Action	Responsibility	Timescale	Status/ Comments
4 March 2021					
8.0	**internal Audit Plan Follow-up Review – Report No: ARC-02-2021**	Arrange meeting with internal auditors, EDCCS, HFCG, Convener and committee members to "deep dive" recommendations in more detail. *(refer to minute)*	ECSM	By w/c 3 May	**Completed** Meeting held 30.4.21
1.0	**Publication Of Sub-Committee Meeting Papers – Report No: ARC-06-2021**	Non-private papers of the Audit and Risk Committee meetings to be published on a separate landing page of the Care Inspectorate website, effective from the next committee cycle starting in May 2021	ECSM	Following meeting on 20 May and each meeting thereafter	**Completed** Webpage set up

CE	Chief Executive		
EDCCS	Executive Director of Corporate and Customer Services	G-T	Grant-Thornton
EDSA	Executive Director of Scrutiny and Assurance	H-L	Henderson-Loggie
EDSI	Executive Director of Strategy and Improvement		
IEDITD	Interim Executive Director IT, Transformation & Digital	HFCG	Head of Finance and Corporate Governance
HLS	Head of Legal Services	ECSM	Executive and Committee Support Manager

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 7
Report No: ARC-09-2021

Title:	COVER REPORT: ANNUAL INTERNAL AUDIT REPORT 2020/21
Author:	*David Archibald, Partner in MHA Henderson Loggie*
Appendices:	1. Internal Audit Report: Annual Internal Audit Report 2020/21
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The Annual Internal Audit Report for 2020/21 is attached as Appendix 1. This report summarises the internal audit work performed during the year and provides a positive overall opinion on the Care Inspectorate's arrangements for risk management, control and governance. It also confirms that, in our opinion, the Care Inspectorate has proper arrangements in place to promote and secure Value for Money. The audit work conducted during 2021/21 did not identify any significant control weaknesses. In general, procedures were operating well in the areas selected, but a few areas for further strengthening or improvement were identified, and action plans have been agreed to address these issues.
The Audit and Risk Committee is invited to:
1. Accept the Internal Audit Annual Report for 2020/21.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**For Decision**	**x**

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 7
Report No: ARC-09-2021

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A *(see Reasons for Exclusion)*
Disclosure after:

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

AUDIT • TAX • ADVISORY

Agenda item 7
Appendix 1

Care Inspectorate

Annual Report to Board and the Chief Executive on the Provision of Internal Audit Services for 2020/21

Internal Audit Report No: 2021/12

Draft issued: 13 May 2021

Final issued: 14 May 2021

Now, for tomorrow

mha HENDERSON LOGGIE

Contents

Annual Report and Opinion

Introduction

1.1 We were appointed in January 2020 as internal auditors of the Care Inspectorate (CI)) for the period 1 April 2020 to 31 March 2023, with the option to extend for a further two 12-month periods. This report summarises the internal audit work performed during 2020/21.

1.2 An Audit Needs Assessment (ANA), based on the areas of risk that the CI is exposed to, was prepared as part of our internal audit programme for 2020/21 (internal audit report 2021/02), with the final version issued in November 2020. Audit needs were assessed and prioritised through discussion with members of the Executive Group and the Chair of the Audit and Risk Committee. We also conducted a desktop review of Care Inspectorate documents, including previous internal and external audit reports. The assessment covered the main areas where the Care Inspectorate is exposed to risk which can be managed through internal control, and which therefore should be considered for examination by internal audit. Following on from the Audit Needs Assessment a Strategic Plan was formulated to cover the period 1 April 2020 to 31 March 2023.

1.3 The work undertaken in the year followed that set out in the Strategic Plan for 2020/21 with the exception of the planned reviews of Publicity and Communications (which was deferred until 2021/22 at the request of management) and Access to ICT Systems (which was removed from the internal audit programme at the request of management).

1.4 The reports submitted during the year are listed in Section 2 of this report and a summary of results and conclusions from each assignment is provided at Section 3.

1.5 An analysis of time spent against budget is shown at Section 4.

Public Sector Internal Audit Standards (PSIAS) Reporting Requirements

1.6 The CI has responsibility for maintaining an effective internal audit activity. You have engaged us to provide an independent risk-based assurance and consultancy internal audit service. To help you assess that you are maintaining an effective internal audit activity we:

- Confirm our independence;
- Provide information about the year's activity and the work planned for next year in this report; and
- Provide quality assurance through self-assessment and independent external review of our methodology and operating practices.

Public Sector Internal Audit Standards (PSIAS) Reporting Requirements (continued)

1.7 Self-assessment is undertaken through:

- Our continuous improvement approach to our service. We will discuss any new developments with management throughout the year;
- Ensuring compliance with best professional practice, in particular the PSIAS;
- Annual confirmation from all staff that they comply with required ethical standards and remain independent of clients;
- Internal review of each assignment to confirm application of our methodology which is summarised in our internal audit manual; and
- Annual completion of a checklist to confirm PSIAS compliance. This is undertaken in April.

1.8 External assessment is built into our firm-wide quality assurance procedures. PSIAS requires an independent review of our approach against the agreed standards and therefore our internal audit service was included in the independent assessment process this year in order to fulfil this requirement. The independent review, conducted in March 2019, concluded that the firm's policies and procedures relating to internal audit were compliant with the PSIAS in all material respects.

1.9 The results of our self-assessment are that we are able to confirm that our service is independent of the CI and complies with the PSIAS.

Significant Issues

1.10 The audit work conducted during 2021/21 did not identify any significant control weaknesses. In general, procedures were operating well in the areas selected, but a few areas for further strengthening or improvement were identified, and action plans have been agreed to address these issues.

1.11 Our follow up activity (Reports 2021/03, 2021/06, 2021/08 & 2021/11 – Follow Up Reviews) confirms that management have taken steps to implement the agreed internal audit recommendations, but a number of the agreed actions have still to be completed. In May 2021, a meeting was convened with the Chair of the Audit and Risk Committee, which was attended by senior managers from the CI, including the Chief Executive. This meeting allowed detailed discussion on the work being undertaken to progress outstanding internal audit actions, recognising that a number of these recommendations have been outstanding for some time. This demonstrates that there is active engagement to monitor delivery and on that basis we have taken the view that these historic issues should not impact on the overall internal audit opinion.

Opinion

1.12 In our opinion the Care Inspectorate has adequate and effective arrangements for risk management, control and governance. Proper arrangements are in place to promote and secure Value for Money. This opinion has been arrived at taking into consideration the work we have undertaken during 2020/21 including the follow-up of recommendations made by the Care Inspectorate's previous internal auditors.

Reports Submitted

Report Number	Title	Overall Grade	Recommendations	Priority 1	Priority 2	Priority 3
2021/01	Risk Management	**Satisfactory**	4	0	0	4
2021/02	Audit Needs Assessment and Strategic Plan 2020 to 2023	N/A	N/A	N/A	N/A	N/A
2021/03	Follow-Up Reviews August 2020	N/A	9 of 13 recommendations required further action	0	4	5
2021/04	Cash and Bank	**Good**	0	0	0	0
2021/05	Annual Plan 2020/21	N/A	N/A	N/A	N/A	N/A
2021/06	Follow-Up Reviews November 2020	N/A	11 of 13 recommendations required further action	3	3	5
2021/07	Organisational Development	**Satisfactory**	2	0	1	1
2021/08	Follow-Up Reviews February 2021	N/A	9 of 11 recommendations required further action	3	3	3
2021/09	Health, Safety and Wellbeing during the COVID-19 Pandemic	**Good**	2	0	0	2
2021/10	FOISA	**Good**	0	0	0	0
2021/11	Follow-Up Reviews	N/A	9 of 9 recommendations required further action	3	3	3
2021/12	Annual Internal Audit Report	N/A	N/A	N/A	N/A	N/A

Overall gradings are defined as follows:

Good	System meets control objectives.
Satisfactory	System meets control objectives with some weaknesses present.
Requires improvement	System has weaknesses that could prevent it achieving control objectives.
Unacceptable	System cannot meet control objectives.

MHA Henderson Loggie Recommendation grades are defined as follows:

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee.
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Gradings for recommendations from internal audit reports issued by the CI's previous internal auditors Scott-Moncrieff (Follow-Up Reviews only) are as follows:

Grade 5	Very high risk exposure, major concerns requiring immediate senior attention that create fundamental risks within the organisation.
Grade 4	High risk exposure, absence / failure of key controls that create significant risks within the organisation.
Grade 3	Moderate risk exposure, controls are not working effectively and efficiently and may create moderate risks within the organisation
Grade 2	Limited risk exposure, controls are working effectively, but could be strengthened to prevent the creation of minor risks
Grade 1	Minor risk exposure, will improve the efficiency or effectiveness or a general housekeeping point

Summary of Results and Conclusions

Report 2021/01 – Risk Management

Final Issued – August 2020

The scope of this audit was to consider whether there were corporate policies and procedures in place to adequately assess risk and minimise the possibility of unexpected and unplanned situations developing.

The table opposite notes each separate objective for this review and records the results.

Strengths

- A comprehensive Risk Policy is in place which clearly articulates the Care Inspectorate's approach to risk management and the responsibilities of the EG, the Board and the Audit and Risk Committee in identifying, assessing, and monitoring the mitigation of risks;
- Risk management is a standing agenda item for each meeting of the EG and all Directorate Management Team (DMT) meetings;
- The SRR is maintained centrally by the Corporate and Customer Services Directorate who apply updates following EG meeting for presentation and discussion at the subsequent Audit and Risk Committee and Board meetings;
- The regular EG meetings have risk as a standing agenda item and this ensures ample opportunity for Directors to discuss the identified risks; the scoring of the risks; and the mitigating actions and controls in advance of each meeting of the Audit and Risk Committee and the Board;
- Risk management, and the review of each Directorate's risks, is also a standing item agenda at the DMT meetings;

The specific objective of this audit was to obtain reasonable assurance that:	Assurance
1. There is a process in place to provide reasonable assurance to Board Members and to the Chief Executive in relation to the declaration on risk management arrangements required for the financial statements.	**Satisfactory**
2. The process in place applies good practice in risk management including meeting the specific requirements around risk set out within the SPFM.	**Satisfactory**
3. Key risks have been identified and are being appropriately controlled, mitigated, reported and discussed at appropriate levels of management and in Board and relevant Committees.	**Satisfactory**
Overall Level of Assurance	**Satisfactory**

Report 2021/01 – Risk Management (continued)

- There is an annual review of the effectiveness of risk management process and its application as part of the Care Inspectorate's Code of Corporate Governance;
- The Care Inspectorate is progressing work to develop an assurance map to enhance existing governance arrangements; and
- From our review of the Board and Audit and Risk Committee meetings it was clear that there is a full discussion around risk management and that comprehensive information is provided with transparency around the management of key risks.

Opportunities for Improvement

- The current approach in place at Directorate level does not always map across directorate risks to the Corporate Plan or to the risks identified within the SRR, where applicable;
- There is no defined or suggested approach in place for consistently identifying and managing risks at Directorate level and this means that there is a lack of consistency and transparency in the approach for managing directorate risks;
- There is no defined training or guidance in place to support staff and managers in applying the agreed risk management processes within the Care Inspectorate; and
- Although risk appetite levels have been set for the risk categories these are not currently linked to the risk scoring matrix in a way which would allow identification of instances where residual risk is above the risk appetite level set by the Board.

Report 2021/02 – Audit Needs Assessment and Strategic Plan 2020 to 2023

Final Issued - November 2020

The purpose of this document was to present for consideration by the Audit and Risk Committee the Audit Needs Assessment (ANA) and the Strategic Plan for the period 2020 to 2023. A comprehensive ANA based on the areas of risk that the CI is exposed to was prepared during the Summer of 2020. A Strategic Plan to cover the normal three-year internal audit cycle from 2020/21 to 2022/23 was then formulated and the final iteration was approved at the 19 November 2020 meeting of the Audit & Risk Committee.

Report 2021/04 – Cash and Bank

Final Issued – November 2020

The scope of this audit to review the key internal controls in place within the CI over the recording of cash, cheque, credit / debit card, direct transfer and direct debit payments received for regulatory fees and GIA onto the finance system. The audit covered the systems in place within the CI for its handling, banking, recording and reporting of income received with a focus on:

- overall arrangements including policies and procedures;
- cash flow management;
- banking arrangements; and
- Grant in Aid drawdown process.

The table opposite notes each separate objective for this review and records the results.

The specific objective of this audit was to obtain reasonable assurance that:	Assurance
1. Revenue collected by the Care Inspectorate is accurately and timeously recorded	**Good**
2. All monies received are banked intact and in a timely manner	**Good**
3. Regular reconciliations are carried out between actual receipts and amounts recorded in the organisation's finance system	**Good**
Overall Level of Assurance	**Good**

Strengths

- There are defined procedures and processes in place for the identification and recording of CI income;
- CI are part of the Government Banking system and use the Oracle Financial system;
- There are regular sweeps conducted of the bank accounts to identify new payments received;
- There are regular transfers of balances between the RBS and the Santander accounts into the main CI Nat West bank account;
- Debtor reports are in place to identify and pursue overdue payments relating to the CI;
- There were reconciliation procedures in place to ensure that all amounts received into the bank accounts have been correctly entered into the Oracle finance system;
- There is a documented approach in place to identify the CI net cashflow position to ensure that the monthly GIA drawdown meets with the SPFM requirements; and
- There is effective cash monitoring in place, and we noted that the CI revised its budget position for the 2020/21 financial year in September 2020 and is forecasting a £0.854m underspend.

Report 2021/04 – Cash and Bank (continued)

Weaknesses

The audit did not identify any control weaknesses which require any remedial actions to be undertaken by the CI.

Report 2021/05 – Annual Plan 2020/21

Final Issued - November 2020

The purpose of this document was to present, for consideration by the Audit and Risk Committee, the annual operating plan for the year ended 31 March 2021. The plan was based on the proposed allocation of audit days for 2020/21 set out in the ANA and Strategic Plan 2020 to 2023

The outline scope, objectives and audit approach for each audit assignment to be undertaken, arrived at following discussion with the Executive Group were set out within the report.

Report 2021/07 – Organisational Development

Final Issued – February 2021

The scope of this audit was to consider whether the Care Inspectorate is making best use of its staff and developing their skills and expertise to meet the current and future needs of regulated bodies and other stakeholders. This review has a specific focus on training and personal development planning.

The table opposite notes each separate objective for this review and records the results.

Strengths

- A Learning and Development Policy was published in May 2020, which sets out the guiding principles which underpin learning and development activity.
- Our review of the Training Needs Analysis process confirmed that this is logical and is aligned to the budget cycle to ensure that sufficient funding is available to meet identified training needs.
- Training needs are identified based on organisational priorities, role and team priorities as well as individual development goals agreed through the LEAD process.
- Quarterly meetings are held between the OWD team and key internal stakeholders and commissioners of learning and development activities to capture emerging and changing priorities.
- A Lifelong Learning Group (LLG) has been established, which functions as a sub-group of the Partnership Forum.
- A proactive redesign of the standard format of the corporate induction day commenced prior to the outbreak of the COVID-19 pandemic, with a virtual, streamlined corporate induction framework introduced in August 2020.
- Work is ongoing to further develop the evaluation approach to include assessment of how learning is applied over time and its impact on employee performance and behaviours.
- A wide range of resources are available to staff to support participation in LEAD.

The specific objective of this audit was to obtain reasonable assurance that:	Assurance
1. the organisation's approach to training, including induction training, is clearly informed by an assessment of where there are skills / knowledge / performance gaps	**Good**
2. the organisation has a systematic approach to evaluating its training to ensure that it is achieving the desired impact	**Good**
3. there is a systematic approach for translating business objectives into actions / tasks for members of staff.	**Requires Improvement**
4. a systematic approach is utilised to communicate personal objectives and performance expectations to staff.	**Requires Improvement**
5. a systematic process is used to provide feedback to staff on their performance and to agree on any action(s) to improve performance.	**Satisfactory**
6. there is a systematic approach for ensuring that the Care Inspectorate makes full use of the skills and knowledge of its staff	**Good**
Overall Level of Assurance	**Good**

Report 2021/07 – Organisational Development (continued)

- A standard report is available which is designed to collate development goals which feed into the TNA process and the development of the learning and development programme.

Weaknesses

- There is a need for more detailed step by step guidance to allow managers and staff to fully utilise the capability of the current system, which is viewed by the managers interviewed as cumbersome and overly bureaucratic.
- The current guidance around goal setting does not equip managers with all of the information they need to inform the discussions required to agree goals with staff and to record these on LMS.
- The impact of the COVID-19 pandemic and the requirement for home working has resulted in a loss of focus and momentum which requires to be rectified through active collaboration between OWD and senior leaders once the perceived challenges around the LEAD process and LMS system, and the associated guidance material, are worked through and resolved.

Report 2021/09 – Health, Safety and Wellbeing during the COVID-19 Pandemic **Final Issued – May 2021**

The scope of our audit was to undertake a review of the work that been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic (2020/21). We also reviewed the steps taken to ensure the wellbeing of Care Inspectorate staff

The table opposite notes each separate objective for this review and records the results.

Strengths

- A governance framework for business continuity and recovery planning was established with clear remits established for Gold, Silver and Silver Tactical Response Command groups, who had clear communication and reporting frameworks established for intelligence gathering (Appendix 1).
- While taking steady progress to respond to the crisis as it unfolded, management worked in an agile manner around business continuity and recovery planning without deferring from the need to evidence final decisions made through an audit trail, such as meeting action logs, Decision logs, and Policy Change Logs. This provided assurance that the reporting made to the Board was accurate and reports on decisions made were transparent.
- A Route map to Business Recovery group was established in the Summer 2020 to determine service recovery requirements based on the Scottish Government four phase to recovery planning. Each directorate currently has its own roadmap for remobilisation tied with the current review of the revised Care Inspectorate Corporate Plan due for approval by the Board in the Summer 2021.
- Conscious to capture lessons learned and positive practices adopted during the pandemic into future ways of working, the Future Working Group was also established and will run until March 2022.
- There was strong partnership working as noted with Public Health Scotland and Healthcare Improvement Scotland, as well as other regulatory bodies, NHS Scotland Health Boards, and Health and Social Care Partnerships. Relationships and review of work being completed elsewhere to ensure joined up approaches were maintained through Chairs of Non-Territory Board meetings as noted in the Chair of the Board reports.

The specific objectives of this audit were to obtain reasonable assurance that:	**Assurance**
• The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included: • Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and • Adequate communication and testing of the business continuity/ contingency plans.	**Good**
• Specific activity has been undertaken to identify the wellbeing needs of staff and to implement a framework of wellbeing activity to meet the needs of staff at all levels across the organisation.	**Good**
Overall Level of Assurance	**Good**

Report 2021/09 – Health, Safety and Wellbeing during the COVID-19 Pandemic (continued)

Strengths (Continued)

- The Care Inspectorate continued to play a pivotal role in providing the Scottish Government up to date picture of the status of events within care homes and as physical inspection resumed, fortnightly reports provide clarity over arrangements and in line with new COVID-19 legislation.
- Publications on the Care Inspectorate public website ensured that lessons learned and new ways of working throughout the pandemic are available to all stakeholders.
- Health and safety of the workforce and service users was evidenced in all reporting reviewed. This included:
    - The reassessment of Scrutiny and Assurance work in March 2020 and reprioritisation of inspections to those identified as high risk or with COVID-19 outbreaks.
    - All Care Inspectorate staff completed a COVID-Age assessment to self-identify their risk category and prompt Ill Health Risk Assessments with line management. There are set criteria to who can volunteer to complete physical inspections agreed with the Director of Public Health.
    - All offices have remained closed throughout and remote working default until Phase 4 of the route to recovery (Current aim is July 2021). All offices open to the Care Inspectorate were COVID-19 risk assessed in line with Public Health Scotland and HSE requirements.
    - The Estates, Health and Safety team also have scenario planned the opening of offices and social restricted working arrangements at 2m, 1.5m, and 1m.
- Provider Updates using eForm registration details ensured that all registered bodies and newsletter subscribers were kept abreast of operational changes within the Care Inspectorate.
- Regulated bodies also had direct contact from inspectors and relationship managers. In some cases, there was daily correspondence depending on circumstances and use of new Near Me technology.

Report 2021/09 – Health, Safety and Wellbeing during the COVID-19 Pandemic (continued)

Strengths (Continued)

- Risk assessment, staff absences information, staff survey, and management feedback were used to inform a Wellbeing Plan that has reviewed needs of staff, management, and Board members, throughout the pandemic and for which learnings are being brought into future programmes around culture development.

Opportunities for Improvement

The two recommendations identified should revolve around the opportunity to provide additional transparency in relation to the following:

- The governance and reporting framework into the Gold and Silver command groups was not identified in documentation provided to allow transparency around workstreams and their roles and responsibilities. For example, several groups were identified through our discussions with management rather than through the documented group structure. Therefore, it is recommended that the business continuity governance arrangements be mapped, and roles and responsibilities of key groups identified, so that there is improved clarity around defined roles and responsibilities, and

- The action log, used to minute key decisions from the Future Working Group, does not fully adopt good practice to ensure that actions and target dates are specific, measurable, attainable, realistic, and time-bound (SMART). There were instances where descriptions and timelines reviewed were worded in such a way that they required specific management knowledge to fully understand the actions required.

Report 2021/10 – Freedom of Information (Scotland) Act 2002 (FOISA)

Final Issued – 13 May 2021

The scope of this review was to assess the arrangements in place within the Care Inspectorate for dealing with requests for information under the Freedom of Information (Scotland) Act 2002 (FOISA) in order to meet the requirements placed on the organisation as a public body. The Act gives a general right of access to all types of recorded information held by public authorities, sets out exemptions from that right and places a number of obligations on public authorities. Any person who makes a request to a public authority for information is entitled to receive that information, subject to exemptions. As set out within the Act, the Care Inspectorate must adopt and maintain a publication scheme setting out the information routinely made publicly available. Subject access request requests under the Data Protection Act do not fall under the scope of this review.

The table opposite notes each separate objective for this review and records the results.

Strengths

- The Model Publication Scheme, produced by the Scottish Information Commissioner, has been adopted in its entirety;
- There is a dedicated Freedom of Information page within the Information and Data section on the Care inspectorate website;
- The Freedom of Information Policy is supported by a comprehensive Information Governance Email Box – Requests for Information - Standard Operating Procedure (SOP);
- A detailed step by step guide has been produced for the use of the RMS system used to log requests, which contains screenshots and guidance on how to navigate and populate the various screens;
- A RAG rating system is deployed in order to direct enquiries effectively;
- The daily team huddle providing the opportunity for collective support and a focus on wellbeing;
- Weekly workload reports set out the key tasks for the week and explicitly cross reference to the priority which the task supports;
- The Information Governance team have previously attended team meetings to raise awareness around the input which is required from managers across the Care Inspectorate in order to allow requests to be actioned in a timely fashion;

The specific objectives of this audit were to obtain reasonable assurance that:	Assurance
The organisation has established a publication scheme which sets out the information which will be published.	**Good**
The responsibility and approach for dealing with FOISA requests has been formally documented.	**Good**
Requests for information under the Act are promptly transferred to the appropriate part of the organisation for action and procedures ensure that requests are actioned in a timely fashion.	**Good**
Monitoring of performance to ensure that requests are dealt with within the statutory timescales and to make sure that the information provided is accurate and up to date before it is published or released.	**Good**
There are arrangements in place to report compliance with the requirements set out within the Act on at least an annual basis.	**Good**
Overall Level of Assurance	**Good**

Report 2021/10 – Freedom of Information (Scotland) Act 2002 (FOISA) (Continued)

Strengths (Continued)

- A comprehensive Quarterly dashboard is produced, which is shared with the Director of Executive Director of Strategy and Improvement and Deputy Chief Executive and the Head of Risk and Intelligence;
- There is a clear focus on maintaining effective internal and external engagement with a Memorandum of Understanding in place with key partners;
- Weekly workload meetings focus on data extracted from the RMS system, which allows tracking of performance against the 20-day target;
- Quarterly reports are produced which summarise FOISA statistics (and Subject Access Request data) required by the Scottish Information Commissioner. This sets out how many responses were responded to on time, how many missed the target deadline, how many exemptions were applied and how many requests were refused.

Opportunity for further development

- The current Freedom of Information Policy is dated 2011 and although we confirmed with the Information Governance team that this document remains fit for purpose, the contact details within the document would benefit from periodic refresh to ensure that they remain up to date. However, we recognise that any future focus on policy development is only achievable with the correct balance of workload across the Transform, Run and Improve workstreams, with the recent activity understandably focused on the increased Run activity which has coincided with the COVID-19 pandemic. Therefore, we have not included a formal recommendation on this point.

2021/03, 2021/06, 2021/08 and 2021/11 – Follow-Up Reviews

Final Issued – August 2020, November 2020, February 2021, May 2021

The Internal Audit Plan for 2020/21 included time for a follow-up of the recommendations made in Internal Audit reports issued during 2020/21 and reports from earlier years where previous follow-up identified recommendations as outstanding. This work was reported at each meeting of the Audit and Risk Committee. The objective of each of our follow-up reviews was to assess whether recommendations made in previous reports had been appropriately implemented and to ensure that, where little or no progress had been made towards implementation, that plans were in place to progress them.

For the recommendations made in each of the reports followed-up we ascertained by enquiry or sample testing, as appropriate, whether they had been completed or what stage they had reached in terms of completion and whether the due date needed to be revised.

CI had made progress in implementing the recommendations followed-up during the year, with eight of the 17 recommendations reviewed categorised as 'fully implemented' by May 2021. Seven recommendations were assessed as 'partially implemented' at May 2021 and two actions were categorised as 'Little or no progress'. Work has continued to progress the 'partially implemented' recommendations but there have been delays due to the impact of the COVID-19 pandemic and competing priorities. Revised dates have been agreed to provide a target for full implementation of the nine outstanding recommendations.

Our combined findings from the Follow-up reviews conducted throughout the year have been summarised below:

Report 2021/11 – Follow-Up Reviews (continued)

From Original Reports			*From Follow-Up Work Performed*				
Area	**Rec. Grade**	**Number Agreed**	**Fully Implemented**	**Partially Implemented**	**Little or No Progress Made**	**Not Past Original Agreed Completion Date**	**Considered But Not Implemented**
Follow up Review 2019/20	**4**	-	-	-	-	-	-
	3	7	5	2	-	-	-
	2	4	2	2	-	-	-
	1	-	-	-	-	-	-
Total		**11**	**7**	**4**	**-**	**-**	**-**
Recruitment and Retention 2019/20	**4**	-	-	-	-	-	-
	3	1	-	1	-	-	-
	2	1	-	1	-	-	-
	1	-	-	-	-	-	-
Total		**2**	**-**	**2**	**-**	**-**	**-**
Risk Management (report 2021/01)	**1**	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	4	1	1	2	-	-
Total		**4**	**1**	**1**	**2**	**-**	**-**
Grand Total		**17**	**8**	**7**	**2**	**-**	**-**

Time Spent - Actual v Budget

	Report number	Planned days	Actual days billed	Days to fee at May 2021	Days to spend / WIP	Variance
Reputation						
Publicity and Communications	N/A	5	-	-	-	5
Health, Safety and Wellbeing	2021/09	6	-	6	-	-
Staffing Issues						
Organisational Development	2021/07	6	6	-	-	-
Financial Issues						
Cash, Bank & Treasury management	2021/04	4	4	-	-	-
Organisational Issues						
Risk Management	2021/01	5	5	-	-	-
FOISA	2021/10	5	5	-	-	-
Information and IT						
ICT data access and cyber security	N/A	6	-	-	-	6
Other Audit Activities						
Management and Planning	2021/05	4	3	1	-	-
External audit						
Attendance at Audit & Risk Committee						
Follow-up reviews	2021/03 2021/06 2021/08 2021/11	5	4	1	-	-
Audit Needs Assessment	2021/02	3	3	-	-	-
Total		49	30	8	-	11

Revised Operational Plan for 2021/22

5.1 Following our appointment as internal auditors for the period 1 April 2020 to 31 March 2023, with the option to extend for a further two 12-month periods, we prepared an Audit Needs Assessment and Strategic Plan for 2020 to 2023 (internal audit report number 2021/05, issued November 2020).

5.2 The annual operating plan for 2021/22 shows two changes to the allocation set out in the original Strategic Plan. Following discussion with the CI Executive Group, and the Audit and Risk Committee at the meeting in February 2021, the following planning amendments been agreed:

- The Publicity and Communications review, originally -planned for 2020/21, will now be undertaken in 2021/22*;* and
- The review of ICT Data Access and Cyber Security is no longer required following a separate consultancy exercise commissioned by CI. These 6 days have been marked as contingency days in the revised 2021/2022 operational plan shown below, pending management decision on the appropriate use for these days.

5.3 An extract from the revised Operational Plan, showing the proposed allocation of audit days for 2021/22, is shown below.

Proposed Allocation of Audit Days for 2021/22

	Category	Priority	Planned 21/22 Days
Reputation			
Publicity and Communications	Gov	M	5
Health, Safety and Wellbeing	Gov	H	
Operations			
Scrutiny & Assurance	Perf	M	6
Complaints	Perf	M	
Staffing Issues			
Workforce Planning	Perf	M/H	5
Organisational development	Perf	H	
Staff recruitment and retention	Perf	M	
Payroll	Fin	M	
Travel and expenses	Fin	L	
Estates and Facilities			
Building maintenance	Fin/Perf	L	
Asset management	Perf	L	
Financial Issues			
Financial Sustainability	Fin	H	6
General ledger	Fin	L	
Procurement and creditors / purchasing	Fin	M	
Debtors/ Income	Fin	L	
Cash, Bank & Treasury management	Fin	L/M	
Fraud prevention, detection, and response	Fin/Gov	M	5
Organisational Issues			
Risk Management	Perf	M	
Business Continuity	Perf	M	
Corporate Governance	Gov	L	
Compliance with legislation	Gov	M	4
Corporate Planning	Perf	L/M	5
Performance reporting / KPIs	Perf	M	
Partnership Working	Gov/Perf	M	
FOISA	Gov/Perf	M	
Equality and Diversity	Gov	M	5
Change Management	Perf	M	

Proposed Allocation of Audit Days (Continued)

	Category	Priority	Planned 21/22 Days
Information and IT			
ICT data access and cyber security	Perf	H	
Data protection	Gov	M	
Digital transformation	Perf	M	
IT strategy	Perf	M	6
Other Audit Activities			
Contingency			6
Management and Planning			4
External audit liaison			
Attendance at Audit & Risk Committee		Various	
Follow-up reviews			5
			_____
Total			**62**
			====

Key

Category: Gov – Governance; Perf – Performance; Fin – Financial

Priority: H – High; M – Medium; L – Low

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AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 8
Report No: ARC-10-2021

Title:	**INTERNAL AUDIT ON FOLLOW UP REVIEWS**
Author:	*David Archibald, Partner in MHA Henderson Loggie*
Appendices:	1. Internal Audit Report: Follow Up Reviews - May 2021
Consultation:	n/a
Resource Implications:	None

Executive Summary:

The internal audit report on Follow Up reviews is attached as Appendix 1.

This is a recurring review which sets out the progress made since the previous Follow Up reviews conducted in February 2021 and reported to the Audit and Risk Committee in March 2021.

This report examines the status of all internal audit recommendations which have not been formally evaluated as fully implemented. Where a recommendation has been categorised as fully implemented then evidence has been obtained from management to demonstrate that all aspects of the original recommendation have been implemented.

Any recommendations categorised as 'Partially Implemented' or 'Little or no progress' will be carried forward and will be evaluated as part of future follow up reviews. Where the previous implementation date has elapsed then a revised implementation date has been agreed with management.

The Audit and Risk Committee is invited to:	
1.	Accept the Internal Audit report on Follow Up Reviews as at May 2021.
2.	Approve any further revisions to implementation dates put forward by management.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**For Decision**	**x**

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 8
Report No: ARC-10-2021

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A *(see Reasons for Exclusion)*
Disclosure after:

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

AUDIT · TAX · ADVISORY

Care Inspectorate

Follow-Up Reviews

Internal Audit Report No: 2021/11

Draft Issued: 13 May 2021

Final Issued: 14 May 2021

Now, for tomorrow

mha HENDERSON LOGGIE

Contents

Management Summary

Introduction and Background

We have been appointed as Internal Auditors of the Care Inspectorate for the period from 1 April 2020 to 31 March 2023, with the option to extend for a further two 12-month periods. At the request of management we have included time in the 2020/21 audit programme to conduct follow-up work to assess the progress made in taking forward the recommendations made in Internal Audit reports issued during 200/21, 2019/20 and in reports from earlier years where the previous follow-up exercise, conducted by the previous internal auditors in February 2020, identified recommendations as outstanding.

This report builds on the last formal Follow Up review report issued in August 2020. We have reviewed all of the recommendations which were not closed off as completed in relation to the following reports:

- IT Healthcheck (issued in May 2018)
- Business Continuity Planning (issued in April 2019)
- Complaints (issued in April 2019)
- Payroll (issued in April 2019)
- Financial Sustainability (issued in October 2019)

In addition, we have followed up the recommendations which had reached their agreed implementation date, which have not been subject to formal follow up previously, for the following reports:

- Recruitment and Retention (issued in December 2019)
- Risk Management (issued in August 2020)

Objectives of the Audit

The objective of each of our follow-up reviews is to assess whether recommendations made in previous internal audit reports have been appropriately implemented and to ensure that, where little or no progress has been made towards implementation, that plans are in place to progress them.

Audit Approach

For the recommendations made in each of the reports listed above we ascertained by enquiry or sample testing, as appropriate, whether they had been completed or what stage they had reached in terms of completion and whether the due date needed to be revised. Action plans from the original reports, updated to include a column for progress made to date, are appended to this report.

At the request of the Audit and Risk Committee a RAG rating system has been introduced to provide a visual indicator of the status of the recommendation in relation to the original agreed implementation date. In the appendices shown from page 4 onwards, recommendations which are completed or are less than six months past the original agreed implementation date are shown as green, with recommendations which are more than six months but less than 12 months past their original agreed implementation date shown as amber. Any recommendation which is more than 12 months over the original agreed implementation date is shown as red.

Overall Conclusion

The Care Inspectorate has made limited progress in implementing the recommendations followed-up as part of this review. Overall, none (0%) of the 9 recommendations followed-up, which had reached their original agreed completion date, were assessed as 'fully implemented', with seven (78%) classified as 'partially implemented' and two (22%) classified as 'little or no progress'.

Any recommendations categorised as 'partially implemented', 'little or no progress' or 'Not past original agreed completion date' will be subject to further follow-up at a later date.

Our findings from each of the follow-up reviews has been summarised below:

From Original Reports			*From Follow-Up Work Performed*				
Area	**Rec. Grade**	**Number Agreed**	**Fully Implem-ented**	**Partially Implem-ented**	**Little or No Progress Made**	**Not Past Original Agreed Completion Date**	**Considered But Not Implemented**
Follow up Review 2019/20	**4**	-	-	-	-	-	-
	3	2	-	2	-	-	-
	2	2	-	2	-	-	
	1	-	-	-	-	-	-
Total		**4**	**-**	**4**	**-**	**-**	**-**
Recruitment and Retention 2019/20	**4**	-	-	-	-	-	-
	3	1	-	1	-	-	-
	2	1	-	1	-	-	-
	1	-	-	-	-	-	-
Total		**2**	**-**	**2**	**-**	**-**	**-**
Risk Management (report 2021/01)	**1**	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	3	-	1	2	-	-
Total		**3**	**-**	**1**	**2**	**-**	**-**
Grand Total		**9**	**-**	**7**	**2**	**-**	**-**

The grades, as detailed below, denote the level of importance that should have been given to each recommendation within the internal audit reports.

Gradings for recommendations from Scott Moncrieff internal audit reports are as follows:

Grade 4	Very high risk exposure major concerns requiring immediate senior attention that create fundamental risks within the organisation.
Grade 2	High risk exposure absence / failure of key controls that create significant risks within the organisation.
Grade 2	Moderate risk exposure controls are not working effectively and efficiently and may create moderate risks within the organisation
Grade 1	Limited risk exposure controls are working effectively, but could be strengthened to prevent the creation of minor risks or address general house keeping issues.

Overall Conclusion (continued)

Gradings for recommendations from MHA Henderson Loggie internal audit reports are as follows:

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee.
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Acknowledgements

We would like to thank all staff for the co-operation and assistance we received during the course of our reviews.

Appendix I - Updated Action Plan
Follow Up Review 2019/20 (Scott Moncrieff)

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Update	Current Progress	RAG Rating
IT Healthcheck (Continued) **3.1 ICT Disaster recovery and business continuity plans** We recommend that the Care Inspectorate develops and implements a risk-based programme of testing for UT disaster recovery and business continuity plans. The outcomes of these tests should be formally documented and identify lessons learned. Plans should be updated as appropriate following completion of tests. We recommend that IT disaster recovery and business continuity plans are subject to review on at least an annual basis. We also recommend that business impact analyses are revisited. This should be used as the basis of agreeing a priority restart order for the network and business applications.	**3**	Senior Service Delivery Manager and Head of Finance & Corporate Governance	(a) 31 December 2018 (b) 30 September 2019 (c) 31 March 2019	**Update at November 2020:** Position unchanged from August 2020 update. **Revised Implementation date:** The revised implementation date is dependent on entering Phase 4 of the Covid-19 measures as set out in the Scottish Government Covid-19 Routemap. **Update at February 2021:** Position unchanged from November 2020 update. Part a) of the original recommendation has been completed but parts b) and c) remain ongoing. **Revised Implementation date:** The revised implementation date is dependent on entering Phase 4 of the Covid-19 measures as set out in the Scottish Government Covid-19 Routemap.	**Update at May 2021:** A DR capability and readiness assessment is planned, using an independent agency to provide assurance to the Audit and Risk Committee that the approach is comprehensive. The output of this review will determine the plans that are required to align with BCP priorities. This exercise will complete by the end of Q1 and will lead on to the development of a DR schedule. **Revised Implementation date:** DR capability and readiness assessment to be completed by 30 June 2021 Development of a DR schedule – Date to be confirmed once the DR capability and readiness assessment is finalised. **Partially Implemented**	**a) Complete** **b) 19 months over original completion date** **c) 25 months over original completion date**

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG rating
Complaints **2.1 Resource Requirements** Work should be undertaken to update the resourcing model based on more realistic data through, for example, the use of daily recorded hours over a period.	**2**	Systems / Development Accountant (Capacity Tool) Head of Finance & Corporate Governance	a) 30 September 2019 (Capacity Tool) b) 31 Jan 2020 (update Resource Model)	**Update at August 2020:** There has been no further progress on this due to Covid-19. **Revised Implementation date:** 30 November 2020 **Update at November 2020:** Not yet due for completion. **Revised Implementation date:** 30 November 2020 **Update at February 2021*:*** There has been no further progress since previous report. **Revised Implementation date:** 31 May 2021	**Update at May 2021*:*** a) **Capacity tool**: HoFCG to meet with the Service Manager Complaints to discuss revised requirements for a capacity tool now that the new Complaints App has been running for more than a year with new manager dashboard functionality. This meeting to be arranged prior to 30 June 2021. **Revised Implementation date:** 30 September 2021 b) **Resource Model**: This work has been delayed due to pandemic but has now been prioritised with a revised implementation date of 30 June 2021. **Revised Implementation date:** 30 June 2021 **Partially Implemented**	**a) 19 months over original completion date** **b) 15 months over original completion date**

Recommendation	Grade	Responsible Officer For Action	Agreed Completion Date	Previous Updates	Current Progress	RAG Rating
Complaints (Continued) **2.2 Resource Capacity** The new digital solution to replace PMS is currently under development. The complaints team should use the review to investigate options to improve the reliability of time recording and reporting for complaints work. This would allow improved planning and highlight any anomalies. The current resourcing model for complaints management may need to be reviewed to manage workload pressures for staff and to ensure key performance indicators can be achieved.	**2**	Systems / Development Accountant (Capacity Tool) Head of Finance & Corporate Governance	a) 30 September 2019 (Capacity Tool) b) 31 January 2020 (update Resource Model)	**Update at February 2021*:*** There has been no further progress since previous report. **Revised Implementation date:** 31 May 2021.	**Update at May 2021*:*** a) **Capacity tool**: HoFCG to meet with the Service Manager Complaints to discuss revised requirements for a capacity tool now that the new Complaints App has been running for more than a year with new manager dashboard functionality. This meeting to be arranged prior to 30 June 2021. **Revised Implementation date:** 30 September 2021 b) **Resource Model**: This work has been delayed due to pandemic but has now been prioritised with a revised implementation date of 30 June 2021. **Revised Implementation date:** 30 June 2021 **Partially Implemented**	**a) 19 months over original completion date** **b) 15 months over original completion date**

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Rating
Payroll **1.1 Policies and Procedures** We recommend that relevant policies and procedures are created for the new payroll system together with related guidance and instruction where necessary. A timetable for embedding new policy and procedures should be agreed and management should seek to ensure that key control issues have been considered and are addressed fully. This should include clear guidance, written procedures and documented controls in respect of key Payroll processes, covering, for example: Payroll access and authorised usage; Control over starters, leavers and amendments; Rules for changing standing data; Levels of authority; Details of any reconciliations, checks and sign-offs to be undertaken. The policy, procedures and any associated guidance and desk instruction should be formally approved, reviewed on an annual basis to ensure they remain relevant and be readily accessible to staff.	**3**	Senior HR Adviser (Workforce Information)	31 March 2020	**Update at August 2020:** The original date was not achieved due to competing workload pressures and this has been further impacted by the covid-19 position. The work already completed for the payroll manual was used to develop documented business continuity processes for payroll for use during the covid-19 lockdown. This will be further developed to produce the payroll manual as per the internal audit recommendation. **Revised implementation date:** 30 November 2020 **Update at February 2021:** Further progress has been made since previous report and I would estimate work is 80% complete. Delay due to Covid pressures and difficulty in arranging a payroll course. **Revised implementation date:** 31 March 2021	**Update at May 2021:** Staff vacancies and other priorities in HR has meant limited further progress has been made since the position was last reported to Audit and Risk Committee. Revised implementation date is 30 June 2021. **Revised implementation date:** 30 June 2021 **Partially Implemented**	**13 months over original completion date**

Appendix II - Updated Action Plan

Recruitment and Retention (Scott Moncrieff)

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Rating
1.1 Policies and Procedures A SMART action plan and relevant KPIs to underpin the Strategic Workforce Plan will be developed and shared widely across the organisation. The actions will be integrated into relevant workplans for delivery.	**3**	Head of Organisational and Workforce Development (OWD)	30 April 2020	**Update at August 2020:** The action plan and KPIs (with covering report) were drafted for the Executive Group in March 2020. Due to the pandemic and refocus however the EG meetings were replaced by the Gold Group which focused on the decisions around the pandemic response. While the action plan is integrated into workplans already being progressed and reflected in our Strategy and Improvement Directorate Routemap to recovery, it has not been shared more widely across the organisation to get buy in. When the new operational leadership team (OLT) meets in September 2020 a paper will be tabled to generate ideas on how to engage staff and share more widely. **Revised Implementation Date:** 20 December 2020 **Update at November 2020:** Not yet due yet. **Revised Implementation Date:** 20 December 2020	**Update at May 2021:** Remaining on track to meet revised implementation date. **Revised Implementation Date:** 31 August 2021 **Partially Implemented**	**12 months over original completion date**

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Rating
1.1 Continued				**Update at February 2021:** In order to support our ongoing pandemic response the Senior Leadership Team have set out key priorities for delivery between now and the end of March 2021. Elements of the Strategic Workforce Plan work have paused to refocus resources into supporting the workforce through the pandemic. This has focused on; a) Supporting staff health and wellbeing b) Inducting new staff and staff redeployed to other roles well c) Providing key learning and development support to key staff groups supporting the pandemic d) Supporting managers to support their staff through good management and the LEAD process The Strategic Workforce Plan's action plan and the relevant KPIS have been reviewed during this period and will be progressed in line with our pandemic response and organisational priorities. **Revised Implementation Date:** 31 August 2021		

Follow Up Reviews

Recommendation	Grade	Responsible Officer For Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Rating
4.1 Provision of Management Information As raised under MAP 1.1 and 2.1, key performance indicators should be developed for the Strategic Workforce Plan and any recruitment and retention strategies. Management information should be available to all senior management in a timely, structured and appropriate manner to support scrutiny and measure progress against strategic plans. When data is provided as the result of a specific request, quality assurance activities should be performed by a second person to ensure the accuracy of the data.	**2**	Head of Human Resources (HR)	30 April 2020	**Update at November 2020:** The Care Inspectorate have agreed the metrics and these will be reported to the SLT for the first time in November 2020. Agreement is still awaited from the SSSC but the decision has been taken to press ahead with the Care Inspectorate agreed metrics. **Revised Implementation Date:** 30 November 2020 **Update at February 2021:** The position has been revised due to Covid. SLT have been receiving since November 2020 two key HR reports: 1. Monthly HR Overview 2. Monthly Key cases Gold has been re-convened and it has been agreed the focus should be on providing weekly information on the Inspection workforce and who is available to inspect. **Revised Implementation Date:** 31 July 2021	**Update at May 2021:** Quarterly reporting of the agreed metrics is planned to start from Quarter 1 of 2021/22. Remaining on track to meet revised implementation date. **Revised Implementation Date:** 31 July 2021 **Partially Implemented**	**12 months over original completion date**

Appendix III - Updated Action Plan
Risk Management (MHA Henderson Loggie)

Follow Up Reviews

Recommendation	Grade	Management response	Responsible Officer For Action	Original Agreed Completion Date	Previous Progress Reported	Current Progress	RAG Rating
Internal audit report 2021/01 – Risk Management **R1** The risks identified within the Directorate risk registers should be aligned with the Corporate Plan and linked to the risks contained within the SRR, where applicable to do so.	**3**	Agreed. This will be contained within the procedure note as per recommendation 2 below. Executive Directors will then be requested to update the directorate risk registers in line with the new procedure note. The Executive Director Corporate and Customer Services will oversee this process.	Executive Director Corporate and Customer Services	31 January 2021	**Update at November 2020:** Not Past Original Agreed Completion Date **Update at February 2021:** Covid priorities and progressing the new shared service arrangements has limited progress on implementing the agreed actions arising from the recommendations of the Risk Management audit. **Revised Implementation Date:** 31 August 2021 **Little or No Progress**	**Update at May 2021:** Risk management has been developed to enhance our approach to risk appetite, risk targets and risk tolerance. The strategic risk register is currently being reviewed to reflect this. The developments to our risk management approach are intended to better support and embed a consistent approach to the management of risk throughout the organisation. HoFCG is meeting all directors individually to discuss the strategic risk position and a revision of directorate risk registers. On track to achieve the revised implementation date of 31 August 2021. **Revised Implementation Date:** 31 August 2021 **Partially Implemented**	**3 months over original completion date**

Follow Up Reviews

Recommendation	Grade	Management response	Responsible Officer For Action	Original Agreed Completion Date	Previous Progress Reported	Current Progress	RAG Rating
Internal audit report 2021/01 – Risk Management (Continued) **R2** Consideration should be given to development of a procedure note which provides examples of the way in which risks should be articulated on the face of the relevant risk register (whether strategic, directorate or team) and demonstrates the way in which associated risk actions to mitigate risk and controls should be documented in order to achieve further consistency, transparency and alignment to the SRR.	**3**	Agreed. Procedure notes will be developed in line with this recommendation. Procedure notes and risk identification templates were issued at directorate level in 2017. However, these are now out-of-date and there has been no follow through to check consistent application. The recommended update of procedure notes provides an opportunity to address this.	Executive Director Corporate and Customer Services	30 November 2020	**Update at November 2020:** Not Past Original Agreed Completion Date **Update at February 2021:** Covid priorities and progressing the new shared service arrangements has limited progress on implementing the agreed actions arising from the recommendations of the Risk Management audit. **Revised Implementation Date:** 28 February 2021 **Little or No Progress**	**Update at May 2021:** Procedure note has been delayed pending the agreement by the Board of the new risk appetite statement. This is a key element of our revised approach to risk. HoFCG is meeting all directors individually to discuss the strategic risk position and a revision of directorate risk registers and this will inform the development of the procedure note. **Revised Implementation Date:** Request a revised implementation date of 31 July 2021. **Little or No Progress**	**5 months over original completion date**

Follow Up Reviews

Recommendation	Grade	Management response	Responsible Officer For Action	Original Agreed Completion Date	Previous Progress Reported	Current Progress	RAG Rating
Internal audit report 2021/01 – Risk Management (Continued) **R3** The Care Inspectorate should develop and implement initial and refresher training in how to apply general risk management principles and in particular applying its own risk management policy. This training should focus on the consistent application of the procedural note outlined above in **R2**.	**3**	Agreed.	Executive Director Corporate and Customer Services	31 January 2021	**Update at November 2020:** Not Past Original Agreed Completion Date **Update at February 2021:** Covid priorities and progressing the new shared service arrangements has limited progress on implementing the agreed actions arising from the recommendations of the Risk Management audit. **Revised Implementation Date:** 30 April 2021	**Update at May 2021:** This recommendation is dependent on the completion of the procedure note referred to in **R2** above. **Revised Implementation Date:** Request a revised implementation date of 31 August 2021 **Little or No Progress**	**3 months over original completion date**

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AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 9
Report No: ARC-11-2021

Title:	**COVER REPORT: INTERNAL AUDIT ON HEALTH, SAFETY AND WELLBEING**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Health, Safety and Wellbeing
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The internal audit report on Health, Safety and Wellbeing is attached as Appendix 1. The overall level of assurance is "Good". The two control objectives were identified as "Good" and two "priority 3" (minor risk) recommendations made. There is a management response agreeing to take forward both recommendations.
The Audit and Risk Committee is invited to:
1. Accept the Internal Auditor's report on Health, Safety and Wellbeing.
2. Agree the management response to the two recommendations made.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**For Decision**	

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A *(see Reasons for Exclusion)*
Disclosure after:

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 9
Report No: ARC-11-2021

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

Agenda item 9
Appendix 1

Care Inspectorate

Health, Safety and Wellbeing during the COVID-19 Pandemic

Internal Audit Report No: 2021/09

Draft issued: **10 May 2021**

Final issued: **13 May 2021**

LEVEL OF ASSURANCE	Good

Contents

Level of Assurance

In addition to the grading of individual recommendations in the action plan, audit findings are assessed and graded on an overall basis to denote the level of assurance that can be taken from the report. Risk and materiality levels are considered in the assessment and grading process as well as the general quality of the procedures in place.

Gradings are defined as follows:

Good	System meets control objectives.
Satisfactory	System meets control objectives with some weaknesses present.
Requires improvement	System has weaknesses that could prevent it achieving control objectives.
Unacceptable	System cannot meet control objectives.

Action Grades

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee.
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Management Summary

Overall Level of Assurance

Good	System meets control objectives.

Risk Assessment

This review focused on overarching health, safety, and wellbeing arrangements including business continuity arrangements during the COVID-19 pandemic and the following strategic risk:

Risk 10 - Failure to maximise and be seen to maximise our ability to protect staff and our stakeholders from the impacts of the COVID 19 virus. (Residual risk rating: 10)

Background

As part of the Internal Audit programme at the Care Inspectorate for 2020/21, we carried out a review of the organisation's health, safety, and wellbeing arrangements for managing the workforce during the response to national restrictions brought about by the global COVID-19 pandemic and planning for the recovery of services. Our Audit Needs Assessment identified this as an area where risk can arise and where Internal Audit can assist in providing assurances to management and the Audit and Risk Committee that the related control environment is operating effectively, ensuring risk is maintained at an acceptable level.

As the independent regulator and scrutiny body for social care, the Care Inspectorate is responsible for assuring the quality of care across Scotland. When the COVID-19 pandemic escalated in Scotland, in March 2020, all Care Inspectorate offices were closed. The scrutiny and improvement work at regulated bodies also ceased until arrangements were established to ensure the safety of Care Inspectorate staff and that of the people at the regulated bodies.

With a workforce headcount of 599 (September 2020) and offices spread across 14 offices around Scotland, consideration had to be made around national and local COVID-19 restriction requirements for returning to offices. The risk to the individual experiencing COVID-19 related disease was also assessed to identify and protect the most vulnerable in the workforce and workforce planning for when physical inspections of care facilities resumed (late Spring/ Summer of 2020).

The Strategic Workforce Development Plan, approved by the Board in 2019, also set a clear commitment to create a positive environment which supports a sense of wellbeing at work for staff, as well as improved engagement, empowerment, and performance. This commitment continued with the implementation of Wellbeing plans for the organisation throughout the pandemic.

Scope, Objectives and Overall Findings

The scope of this audit was to undertake a review of the work that been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic (2020/21). We also reviewed the steps taken to ensure the wellbeing of Care Inspectorate staff.

The table below notes the objectives for this review and records the results:

Objective	Findings			
The specific objectives of this audit were to obtain reasonable assurance that:		**1**	**2**	**3**
1. The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included: • Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and • Adequate communication and testing of the business continuity/ contingency plans.	**Good**	-	-	2
2. Specific activity has been undertaken to identify the wellbeing needs of staff and to implement a framework of wellbeing activity to meet the needs of staff at all levels across the organisation.	**Good**	-	-	-
Overall Level of Assurance	**Good**	**-**	**-**	**2**
		System meets control objectives.		

Audit Approach

An assessment of the key processes and internal controls was performed with reference to relevant good practice guidance. We obtained and reviewed business continuity planning in place to continue Care Inspectorate operations during the COVID-19 pandemic and considered whether they covered all the Care Inspectorate's activities and locations.

We also reviewed the approach on how plans were communicated to regulated bodies, such as Care Homes, and other stakeholders. We originally scoped to test plans, however, during the review it was noted that decision making was agile. We therefore reviewed the decision-making process of these plans and communications of planning with stakeholders and governance arrangements identified.

We also reviewed plans for offices to reopen as lockdown restrictions ease, including the review of office risk assessments completed. As there was resumption of Scrutiny and Improvement inspections, we also assessed the effectiveness of the process for completing individual risk assessments.

We also discussed the way in which the wellbeing needs of staff had been assessed and activity developed and delivered to meet these needs.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Summary of Main Findings

Strengths

- A governance framework for business continuity and recovery planning was established with clear remits established for Gold, Silver and Silver Tactical Response Command groups, who had clear communication and reporting frameworks established for intelligence gathering (Appendix 1).
- While taking steady progress to respond to the crisis as it unfolded, management worked in an agile manner around business continuity and recovery planning without deferring from the need to evidence final decisions made through an audit trail, such as meeting action logs, Decision logs, and Policy Change Logs. This provided assurance that the reporting made to the Board was accurate and reports on decisions made were transparent.
- A Route map to Business Recovery group was established in the Summer 2020 to determine service recovery requirements based on the Scottish Government four phase to recovery planning. Each directorate currently has its own roadmap for remobilisation tied with the current review of the revised Care Inspectorate Corporate Plan due for approval by the Board in the Summer 2021.
- Conscious to capture lessons learned and positive practices adopted during the pandemic into future ways of working, the Future Working Group was also established and will run until March 2022.
- There was strong partnership working as noted with Public Health Scotland and Healthcare Improvement Scotland, as well as other regulatory bodies, NHS Scotland Health Boards, and Health and Social Care Partnerships. Relationships and review of work being completed elsewhere to ensure joined up approaches were maintained through Chairs of Non-Territory Board meetings as noted in the Chair of the Board reports.
- The Care Inspectorate continued to play a pivotal role in providing the Scottish Government up to date picture of the status of events within care homes and as physical inspection resumed, fortnightly reports provide clarity over arrangements and in line with new COVID-19 legislation.
- Publications on the Care Inspectorate public website ensured that lessons learned and new ways of working throughout the pandemic are available to all stakeholders.
- Health and safety of the workforce and service users was evidenced in all reporting reviewed. This included:
    - The reassessment of Scrutiny and Assurance work in March 2020 and reprioritisation of inspections to those identified as high risk or with COVID-19 outbreaks.
    - All Care Inspectorate staff completed a COVID-Age assessment to self-identify their risk category and prompt Ill Health Risk Assessments with line management. There are set criteria to who can volunteer to complete physical inspections agreed with the Director of Public Health.
    - All offices have remained closed throughout and remote working default until Phase 4 of the route to recovery (Current aim is July 2021). All offices open to the Care Inspectorate were COVID-19 risk assessed in line with Public Health Scotland and HSE requirements.
    - The Estates, Health and Safety team also have scenario planned the opening of offices and social restricted working arrangements at 2m, 1.5m, and 1m.
- Provider Updates using eForm registration details ensured that all registered bodies and newsletter subscribers were kept abreast of operational changes within the Care Inspectorate.
- Regulated bodies also had direct contact from inspectors and relationship managers. In some cases, there was daily correspondence depending on circumstances and use of new Near Me technology.
- Risk assessment, staff absences information, staff survey, and management feedback were used to inform a Wellbeing Plan that has reviewed needs of staff, management, and Board members, throughout the pandemic and for which learnings are being brought into future programmes around culture development.

Opportunities for Improvement

The two recommendations identified should revolve around the opportunity to provide additional transparency in relation to the following:

- The governance and reporting framework into the Gold and Silver command groups was not identified in documentation provided to allow transparency around workstreams and their roles and responsibilities. For example, several groups were identified through our discussions with management rather than through the documented group structure. Therefore, it is recommended that the business continuity governance arrangements be mapped, and roles and responsibilities of key groups identified, so that there is improved clarity around defined roles and responsibilities, and

- The action log, used to minute key decisions from the Future Working Group, does not fully adopt good practice to ensure that actions and target dates are specific, measurable, attainable, realistic, and time-bound (SMART). There were instances where descriptions and timelines reviewed were worded in such a way that they required specific management knowledge to fully understand the actions required.

Acknowledgements

We would like to take this opportunity to thank the staff at the Care Inspectorate who helped us during our audit.

Main Findings and Action Plan

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans.**

Business Continuity and Recovery Governance Arrangements

From the onset of the global COVID-19 pandemic in March 2020, management worked at pace to ensure that business continuity arrangements were ratified and established. This included the implementation of the operational and governance management framework via the Gold, Silver, and Silver Tactical Command groups as follows:

- **Gold Command** (Executive Leadership Team) met twice a day. It was responsible for the strategic decision-making. Members included the Chief Executive, four Directors, and management from the Communications directorate.
- **Silver Command** (Operational Leadership Team) met weekly. It was responsible for implementing actions and for bringing matters which may require a policy decision.
- **Silver Tactical Response Group** was established to review emerging intelligence and the impact of practice within the social care sector. It moved from being held daily to meeting three times a week in June 2020.

In good practice, all decisions ratified by the Gold group between march and August 2020 were logged on a Decision Log. Changes to Care Inspectorate policies were retained on a separate Policy Log. Review of the logs provided assurances around when decisions were made and when changes in policies were implemented, noting timely execution of changes. Our review of Chief Executive reporting to the Board from March 2020 against the logs also noted full transparency in the actions taken by management. The logs were presented to the Audit and Risk Committee as part of assurance reporting in November 2020 in line with good practice.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

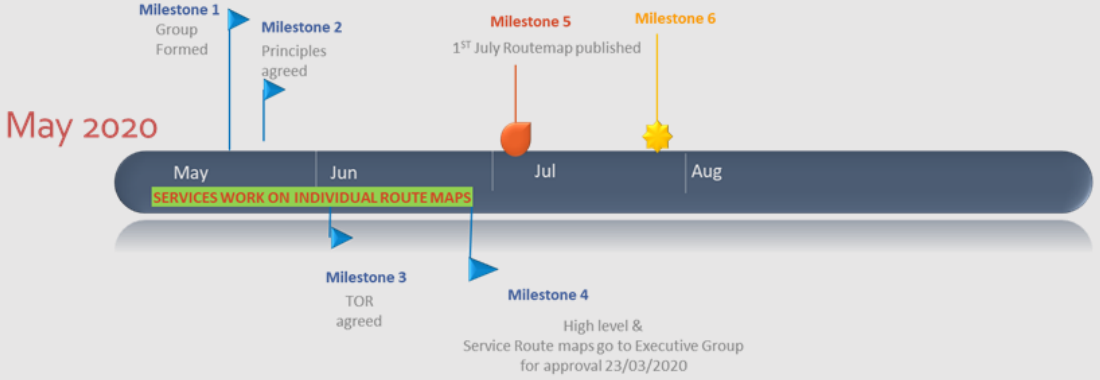
Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Governance arrangement to gather emerging intelligence and reporting to the groups above from external agencies was also defined by management (see Appendix 1 for a diagram of the intelligence gathered and from who). Information was also gathered from Chief Executive and Chair of the Board meetings with peers from other Boards, ensuring the Care Inspectorate remained central to the gathering and supply of key information around the status of its registered regulated bodies, particularly care homes. Business continuity arrangements were reported in the report titled "The Care Inspectorate's role, purpose and learning during the COVID-19 pandemic (published on 21 August 2020)".

While the Gold and Silver groups were disbanded at the end of August 2020, the continuation of the pandemic and national restrictions over the end of 2020 and 2021 meant that the Gold Group and Silver Tactical Response Group were reinstated in October 2020 and continued to be operational at the time of our audit fieldwork. The Operational Leadership Team (OLT) was re-established and chaired by the Head of Organisation and Workforce Development (OWD).

Conscious the business continuity planning was to also review recovery arrangements, the New Normal Working Group, also known as the Route Map to Business Recovery Group, was approved by the Gold Group on 4 June 2020. This was a short-term group set up to plan for a return to the office in September 2020. It stopped meeting when it was clear that enforced absence from the office would be for a longer period. It brought together management from across key functions to collectively identify solutions to a range of challenges to recovering services. The terms of reference (May 2020) detail its duties that are to provide direction, leadership, and ultimately a 'Route map to Business Recovery'. It met once per week and joint-chaired by Interim Executive Director of IT, Transformation and Digital and Director of Customer and Corporate Services. During the first period of national lockdown between March and August 2020, its work included developing a route map to safely restart operations in line with the Scottish Government's four phase national route map to recovery. The following timeline and milestones for developing the route map to recovery was as follows:



Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

The route map included review of the following:

- Office arrangement, such as who can use them and how (access and hotdesking),
- Longer term working from home arrangements, such as what this will look like, equipment, homeworking contracts,
- Delivery, attendance, participation at business events and/or including organisational travel,
- Communications and engagement, such as the communication required to convey changes the response to business recovery and obtaining staff views at every stage, and
- Identify associated risks, issues, and improvements in supporting the organisational to restart and recover from the Covid-19 global pandemic.

The phased plans include:

- **Scrutiny and Assurance:** a small number of inspections in selected care homes were permitted in Lockdown stages but only where there was an existing COVID-19 outbreak or where risk was high rated (see below for further details). There are plans for full resumption by Phase 4.
- **Test and protect:** Ensuring staff were tested regularly before and after inspections at high-risk care homes or care facilities.
- **Office closure status:** There had been planning for reopening of offices to take place in Phase 3 for critical functions only and all who are not prevented from doing so in line with all social distancing guidance available by Phase 4 (September 2020). However, this was not executed as infection rates began to rise in September 2020. No staff were in offices at the time of audit (April 2021).
- **Home/ remote working arrangement:** default has been to work from home which will be encouraged in Phase 4.
- **Business travel and visits out with Care Inspectorate offices:** essential travel only and business travel will be permitted only by Phase 4.
- **Business meetings**: virtual meetings will be the default, and
- **Recruitment arrangements:** any outstanding recruitment and support for induction started in Phase 2 and have continued throughout the 2020/21.

During 2020, Phase 4 was not achieved as COVID-19 infection rates began to rise again in September 2020. A second national lockdown was imposed from 26 December 2020 to 26 April 2021. At the time of audit, the recovery planning was under review on the back of social distancing requirements easing and there was an aim for staff to return to Care Inspectorate offices in July 2021. However, management reported that as the full effects of the National Vaccination Programme remained uncertain, and with increases of new COVID-19 variants, planning had to remain agile and in line with Scottish Government national guidance.

Each Directorate is responsible for their own roadmaps. Progress is monitored through the OLT and Executive Team via the Gold Group.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

A second group titled the 'Future Working Group' has also been established to draw on the work from the Route Map to Recovery Group. It first met on 7 April 2021 and has a twofold approach to future working and will review (i) short term planning for opening offices possibly from July 2021 and (ii) medium to long term planning for how the Care Inspectorate will work in the future as management do not envisage a return to working practices that were in place pre pandemic. The group will take a holistic approach to the review of the impact on policy, health and safety, employee wellbeing, training and development needs, technology requirements, environment, and sustainability. The Future Working Group is chaired by the Head of Finance and Corporate Governance and is scheduled to meet monthly until 31 March 2022. The Terms of Reference for the Future Working Group is due to be considered and ratified by the OLT in May 2021, with a specific focus on the following key issues:

- In the short to medium term, examine work patterns and physical work locations as Covid restrictions may ease or tighten, and
- In the medium to long term, establish future work models and identify the changes required to support this.

Meetings have a set agenda covering discussions and decisions on arrangements within estates, policy changes required, sustainability, resources, technology, staff, and communication directorates. Minutes are kept as an action log that is reviewed at each meeting as a standing agenda point.

Through the review of minutes to the Board, it was noted that governance arrangements and decision making have remained transparent throughout the pandemic. However, there are some specific areas where some additional clarity would ensure organisational knowledge retention and support any future review of lessons learned as noted in the following recommendations for Objective 1.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:
- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Observation	Risks	Recommendation	Management Response	
The audit was unable to evidence terms of reference for the Gold, Silver and Silver Tactical groups to fully understand their remit and reporting lines, and to ensure that the Board was aware of the governance arrangements established during the COVID-19 pandemic. The wider governance arrangements were also not documented in papers reviewed to provide clarity around the wider business continuity governance and reporting framework. Governance arrangements noted in discussions were complex and names of groups changed. Several groups with roles in implementing operational responses were identified, such as: • Intelligence Development Group (stopped meeting in August/ September 2020) • COVID-19 Flexible Response Team (temporary team in the emergency response that disbanded in June 2020), • Wellbeing Group (see Objective 2), and the • Winter Planning Group (being renamed to the Cross Directorate Response group, that currently meets weekly). With the exception of the Wellbeing Group, we were not sighted on documentation which detailed all key workstreams and the roles these various groups had in business continuity and recovery.	Reporting arrangements are not transparent impacting on potential duplication of effort or inefficiencies in reporting impacting timely decision making.	**R1** Management should document the governance framework which was established for the response and recovery during the COVID-19 pandemic for future review of any lessons learned.	Agreed. This will become an element of our lessons learned work. **To be actioned by:** Head of Customer Service **No later than:** 30 June 2021	
			Grade	**3**

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included: • **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and** • **Adequate communication and testing of the business continuity/ contingency plans. (continued)**				
Observation	**Risks**	**Recommendation**	**Management Response**	
The Future Working Group meeting action log detailed actions stemming from agenda points. Our review of the action log noted some actions without target dates and timescales were generalised rather than specific dates (using terminology such as "ongoing"). Some of the actions were also not specifically defined to provide clarity on the outcome required.	Organisational knowledge retention and reliance then on management insight impacting efficient delivery of action outcomes.	**R2** The action tracker for the Future Working Group should adopt S.M.A.R.T. good practice to support organisation knowledge retention and ensure effective monitoring of delivery.	Agreed **To be actioned by:** Head of Finance & Corporate Governance **No later than:** 19 May 2021 (Date of next Future Working Group meeting)	
			Grade	**3**

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Recovery of Scrutiny and Assurance

In March 2020, all non-essential scrutiny and assurance activity was stopped. However, the Care Inspectorate played a pivotal role in providing the Scottish Government, and other partnership organisations, up-to-date information on the status of its registered regulated bodies and the impact that COVID-19 had on service users, particularly within care homes.

The Scrutiny and Assurance Directorate reported its immediate response detailing inspection arrangements based on risk criteria in the report titled "Coronavirus (COVID-19)-Immediate Response" that was approved by the Gold group on 31 March 2020. Initially, Scrutiny Inspectors telephoned services, however, this later evolved to also including Near Me video conferencing that allowed walkthroughs and scrutiny of the service environment to take place remotely.

Staff were supported by guidance and enforcement criteria for the following:

- Adult care and complaint team management engagement arrangements by inspectors,
- Relationship manager responsibilities in the Adult and Child and Young People teams,
- Procedure for monitoring COVID-19 outbreaks and staffing issues, and
- Instructions and guidance for staff managing alerts to COVID-19 outbreaks within the service.

All regulated bodies that are inspected by the Care Inspectorate must register on the Digital Portal where key information is provided, including details on the principal office address and person for correspondence. This information allowed the Care Inspectorate to create an eForms account for correspondence on key requirements to 12,197 registered care services. eForms was adapted to flag whether regulated bodies were open or closed and to enable more efficient reporting to the Scottish Government.

From May 2020, the Care Inspectorate was required to report inspection activity and findings to Scottish Government fortnightly was set out in Coronavirus (Scotland) (No.2) Act 2020. As it was not possible to resume the original programme of physical inspections, management revised the inspection priorities for services rated high-risk. The criteria for rating services as high risk was approved by Public Health Scotland:

- intelligence which gives the Care Inspectorate cause for concern or suggests there are areas requiring further exploration. Intelligence may come from notifications or from a failure to comply with the notification system, and from complaints or relevant information provided by other bodies,
- inspection history, particularly where the last inspection identified significant areas for improvement and where they need to assess the extent to which improvements have been made,
- services which have not been inspected since registration with the Care Inspectorate, and
- inspection frequency timescales.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

The evidence examined demonstrates that the workforce adapted quickly to agile ways of working to ensure scrutiny and assurances continued and reporting on outcomes was consistent. The Chief Executive reported that up to 31 May 2020, there was over 19,000 contacts made by 300 inspectors and over 600 virtual meetings held (Board Report, June 2020).

The Care Inspectorate further revised its Scrutiny Assurance and Improvement Plan for 2020-21 (originally approved by Scottish Ministers in February 2020) in Quarter 3 2020 for the period until March 2021, and, more recently within the report titled "Coronavirus – COVID 19, supporting, safeguarding and assuring – re-purposing our scrutiny responses" was approved by the Gold Group on 31 March 2021.

Reports detailed arrangements for all services relating to:

- Alternatives to on-site inspections such as using Near Me digital meeting technology,
- Complaint management, that has continued to operate with complaint advisers working remotely,
- Registration and variations,
- Arrangements for care homes for adults,
- Housing support and care at home arrangements,
- Regulated care services for children and young people,
- Suspension of strategic scrutiny suspension that required working with Health and Social Care Partnerships (HSCPs) and extensive travel for Care Inspectorate staff,
- Suspension of joint inspection of services for children suspension due to the travel requirements and need to be working onsite for periods of time,
- Joint inspections of health and social care integration. Nine partnership inspections have been completed over 2020/21 and discussions were underway on revised models of working at HSCPs,
- Justice scrutiny. The postponed report on justice social work services was published on 23 February 2021 and work is ongoing with publishing the biennial report on serious incident reports and the refresh of related guidance.
- Suspension of adult supervision and protection inspections that was impacted by the availability of HSCP personnel, and
- Adult Initial Case reviews and Significant case reviews (adults) that progressed in October 2020.

Additional business continuity and forward planning arrangements for other regulated bodies was documented and published on the organisation's public website:

- Delivering care at home and housing support services during the COVID-19 pandemic (September 2020), and
- Early learning and childcare: role, purpose and learning during the COVID-19 pandemic in 2021 (September 2020).

There is currently a review of arrangements as national restrictions change and a review of the Care Inspectorates' Corporate Plan for 2021 is scheduled for Board consideration/approval in June 2021.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Health and Safety Recovery Planning

Arrangements taken forward by the Estates, Health and Safety team over 2020/21 were documented as an integral part of the Health and Safety Annual Report submitted to the Board in December 2020, as documented below:

- The closure of all the offices except for emergency, essential access. Risk assessments for when offices were closed or open were documented (see table below)
- Worked with the Health and Improvement Team to identify and provide necessary Personal Protective Equipment for Scrutiny and Assurance staff. (this was completed to allow physical inspections to take place. Initially protective gowns were also provided together with masks and gloves, however, as the pandemic progressed Public Health Scotland approved that this was no longer required to be worn by Scrutiny Inspectors)
- Preparation of a new risk assessment and associated process for safe emergency inspection of care homes. (As agreed with Public Health Scotland, this was risk assessed based on service risk priority, Scrutiny Inspector risk category, and completion of negative COVID-19 testing before inspection)
- Delivery of a live online Display Screen Equipment event and assessments for staff.
- Provision of new ICT equipment, desks, and chairs to enable staff safe working from home.
- Adapting DSE assessments to be completed online via Teams.
- Completed a staff workforce survey specifically around COVID-19 and the mental health and wellbeing of colleagues.
- Incorporated COVID-19 into the specific ill health risk assessment and ensured completion for staff shielding with an underlying health condition or with a COVID age greater than 70.
- Developed specific risk assessments to allow essential tasks to be completed safely in Compass House and other offices.
- Developed a path for recovery and a return to offices in line with Scottish Government guidance (see recovery plan below).
- Worked with Landlords to develop office specific risk assessments and guidance for staff (see below).
- Each office COVID-19 safe with the introduction of sanitiser, signage, additional cleaning, and other measures such as the reintroduction of hand towels in Compass House (complete as far as the offices the Estates, Health and Safety Team could access during 2020/21).

Health, Safety, and Wellbeing during the COVID-19 Pandemic

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- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Office Risk Assessments

During the first lockdown, the Estates and Health & Safety team completed an Office Recovery Plan, an Excel workbook that considered arrangements for the reopening of 14 offices after the first national lockdown in September 2020 (recently updated for July 2021). It considered different scenarios on staff numbers based on national / local social distancing requirements, such as at 2m, 1.5m, and 1m. It also tracked if risk assessments from landlords had been received or documented by the Estates, Health and Safety team. Any issues requiring attention prior to office use, such as water treatment or access to the building, were also identified. This has allowed tracking of arrangements and intelligence around social distancing measures within offices in line with good practice.

There are two sets of Office COVID-19 Risk Assessment guidance established for Care Inspectorate offices – for when they are closed and when they reopen and detailed instructions in line with the SG COVID-19 Occupational Risk Assessment Guidance (September 2020). They adopted a consistent format and instructions were transparent.

We obtained office COVID-19 guidance and risk assessments for offices when they were open and closed, as noted in the table below:

Office	Guidance	Risk Assessment	Signed	Dated	Review date present
Aberdeen Open	Yes	Yes	Yes	9/9/20	No
Aberdeen Closed	Yes	Yes	Yes	16/11/20	No
Dundee (Compass House) Open	Yes	Yes	Yes	4/9/20	No
Dundee (Compass House) Closed	No	Yes	Yes	16/11/20	No
Dunfermline Open	Yes	Yes	Yes	9/9/20	No
Dunfermline Closed	Yes	Yes	Yes	16/11/20	No
Elgin Closed	Yes	Yes	Yes	16/11/20	No
Hamilton	Yes	Yes	Yes	9/9/20	No
Hamilton Closed	Yes	Yes	Yes	16/11/20	No
Inverness Closed	No	Yes	Yes	13/10/20	No
Selkirk Closed	No	Yes	Yes	16/11/20	No
Stirling Closed	Yes	Yes	Yes	16/11/20	No

Health, Safety, and Wellbeing during the COVID-19 Pandemic

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- **Appropriate business continuity/ contingency plans in place covering all the Care Inspectorate's activities and locations; and**
- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Office Risk Assessments (continued)

There was also landlord risk assessment guidance established for Selkirk, Dunfermline, Hamilton, Oban, and Stirling. As noted above not all 14 offices identified yet had risk assessments documented. The risk was discussed with management who noted this was a timing issue and the offices were owned by third parties and had not been open since March 2020 to allow inspection, such as the Scottish Government in Edinburgh. There were therefore no risk assessments evidenced for Dumfries, Oban (visited in April 2021 and due for completion), Paisley, Lerwick, Stornoway, and Edinburgh at the time of audit (April 2021). Risk assessments are planned to be completed when the Care Inspectorate is provided notice that these offices are to reopen and before staff are to return to these offices. All risk assessments will be revised when there is a change is COVID-19 related guidance.

Individual Risk Assessments

All staff assessed their COVID-Age using a tool recommended by the Scottish Government. Depending on their risk category, they were to complete an Ill Health Risk Assessment with their line manager. The Covid-age category and Ill Health Risk Assessment were reported to the Estates, Health, and Safety team. There were 93 employees identified as high-risk and who have ill health risk assessments established at the time of audit. The assessments are to be kept on record for as long as necessary, such as until the end of the pandemic, and revised only if there is a change in their health or conditions.

Inspector and Scrutiny & Assurance Risk Assessments

The Gold Group Decision Log presented to the Audit and Risk Committee (November 2020) detailed that risk assessment for inspectors going into care homes was based on inspectors confirming that they were COVID-19 free and were to confirm via a negative test result afterwards and before they enter another care home. If an inspector were to decline COVID-19 testing, they were unable to undertake physical inspections. They were also unable to volunteer to go on inspections if they had any underlying health issues or were shielding as specified in health guidance or were living with someone with any underlying health issues or shielding. All inspectors received Covid training and are to complete regular lateral flow tests, use personal protective equipment, and face masks.

Care Homes were also only inspected after consent from the Director of Public Health and only inspected without consent when the risk was so high that warranted overriding the Director of Public Health. From June 2020, only a Chief Inspector required to agree the risk assessment.

Overall, management identified early the needs of the workforce and wider stakeholder requirements around their scrutiny and assurance work. Through agile decision making and robust audit trails around actions taken by management. We were able to evidence that the health and safety needs of the Care Inspectorate workforce were considered in planning, but also the needs of service users of the regulated bodies and assurances to their families and wider stakeholders, such as the Scottish Government and other healthcare regulatory bodies.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 1: The work that has been undertaken to allow Care Inspectorate operations to continue during the COVID-19 pandemic has, as far as possible, minimised the impact on the service delivery to regulated bodies. This included:

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- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

Reporting arrangements -The Chief Executive reports to the Board provided details to the management arrangements as the impact of the COVID-19 pandemic emerged and detailed close links made with the Care Inspectorate and the Scottish Government and other organisations and forums, including Scottish Care, COSLA and CCPS, and public health protection authorities (see Appendix 1).

Further to this work, the Care Inspectorate's Chair of the Board also met frequently with fellow Chairs from non-territorial NHS Boards, HIS, and SSSC to understand their responses to the COVID-19 pandemic. Both the Chair of the Board and Chief Executive reported Care Inspectorate arrangements with the Cabinet Secretary for Health and Wellbeing.

Direct Communications with regulated bodies - Provider Updates were generated by the Communications team. They were issued to all registered regulated bodies and to 4,305 readers who had signed up to receive the updates. The Communications Team reported 278 Provider Updates have been provided over the year. In Quarter 3 2020, a Survey of Readers was completed to ensure the information provided was useful and the frequency suitable. On review of feedback, the Provider Updates were tailored each for the following key Regulated body providers and there is a weekly schedule established for one publication per week:

- Childminders – each Tuesday
- Children and Young people – each Tuesday, and
- Adult and Older Persons – each Thursday.

Inspector directed communications - Up to 31 May 2020, there was over 19,000 contacts made by the 300 inspectors and over 600 virtual meetings. This included training around the use of "Near Me" video calls. In June 2020, all care homes in Scotland were contacted directly, and sometimes daily depending on their individual circumstances.

Website communications - All communications are published on the dedicated Care Inspectorate COVID-19 website and included all publication noted earlier.

Business Continuity Plan Testing

As noted earlier in this report, management were required to be agile in the decision-making process in response to the pandemic and issues as they emerged. While testing of business continuity and recovery planning was not completed, in the traditional sense, real time events meant that decisions were made, assessed by relevant groups (see governance section), ratified, and communicated to relevant stakeholders. Where change was required, such as in the inspectorate risk assessment process, then these changes were reviewed, approved, and documented in the Gold Group's Decision Log.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

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- **Adequate communication and testing of the business continuity/ contingency plans. (continued)**

An initial recommendation from the Gold Group was to quickly establish a working group to support the wellbeing of the Care Inspectorate workforce. In April 2020, the Wellbeing Group was formed – a weekly group accountable to Silver group and the Head of Organisation and Workforce Development (OWD), who was both the lead for wellbeing planning and part of the Silver group membership.

The group connected staff from all levels and directorates to raise awareness around key concerns and emerging issues from their area of work. Including members from Human Resources and the Estates, Health and Safety team who were able to share intelligence based on emerging trends and themes relevant to wellbeing identified through a range of sources including risk assessments, covid age risk assessments, volunteer and shielding lists, sickness absence data, and other workforce metrics. The OWD team also brought insight from training, induction, employee engagement, and employee relations with the Trade Unions.

Duties of the Wellbeing Group were to:

- Identify emerging issues and challenges for staff in relation to their wellbeing,
- Develop and deliver timely and focussed interventions to support the wellbeing of staff during the pandemic,
- Take account of the different challenges experienced by staff, including:
    - Working from home
    - Physical and mental health
    - Psychological wellbeing
    - Vulnerable groups
    - Groups requiring additional support, including working parents, employees with caring responsibilities and line managers.
- Share intelligence and feedback to gold and silver groups, and
- Ensure links with existing wellbeing work undertaken by HR, Health & Safety, and OWD, such as work on Healthy Working Lives.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 2: Specific activity has been undertaken to identify the wellbeing needs of staff and to implement a framework of wellbeing activity to meet the needs of staff at all levels across the organisation. (continued)

The Head of OWD also leads on employee relations with the Trade Unions (TUs) who they meet with every two weeks. There is also a quarterly partnership forum, where the TUs meet with the senior leadership team to share intelligence and information about any issues impacting on the workforce and any needs arising. These were considered throughout the pandemic with close working relationships continuing at the time of audit. The Workforce Wellbeing Champion Network was also set up by Scottish Government in response to the pandemic to promote and support the wellbeing of the health and social care workforce across Scotland. The 'wellbeing champion' role ensured the sharing of information across the Care Inspectorate. Both the Head of OWD and the Wellbeing Project Officer are members of the group.

Regular updates were shared by the Head of OWD with the Board to provide assurance and keep members informed on the effectiveness of the wellbeing strategy (September 2020 and December 2020). Links to the wellbeing resources were also shared for Board members to access and members of the Board were invited to attend the Wellbeing Group in October 2020.

Wellbeing Planning

Management responded in an agile manner to develop response strategies tailored to the needs of staff and risks. Wellbeing support did not target specific groups, instead remained under a legal obligation to ensure that the decisions made in response to the pandemic did not directly or indirectly discriminate against employees with protected characteristics. However, the following groups were identified as having increased vulnerabilities to wellbeing:

- Parents and carers,
- Managers supporting staff,
- Front line staff – adult care home inspectors,
- Staff with underlying health conditions, and
- Staff who were considered high risk (using the covid-age risk assessment tool).

Staff wellbeing was assessed initially through staff survey in June 2020. Results were used to inform activities and the development of the Wellbeing Plan 2020:

- What management set out to do,
- What they aim to achieve,
- Engagement with the workforce,

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 2: Specific activity has been undertaken to identify the wellbeing needs of staff and to implement a framework of wellbeing activity to meet the needs of staff at all levels across the organisation. (continued)

- Method of self-reflection and future planning arrangements
- How management will lead health and wellbeing for the organisation,
- A detailed action plan detailing specific actions, action owners, and specific target dates for the 31 August 2020.

The Wellbeing Plan was executed as follows:

Phase 1: During the first phase of the pandemic, management reported that staff were feeling overwhelmed by the changes and uncertainty. All staff worked from home and balancing home care or home-schooling responsibilities. Case numbers were rising and lockdown measures increasing. The Scrutiny and Assurance inspection activity had stopped and for many staff their job had changed and their role and purpose at that time was uncertain. Staff were supported by management through the following activities:

- Regular messaging around 'taking time for your wellbeing' was shared with staff and reinforced by the Senior Leadership Team.
- A wellbeing group (above) was set up with representation from across the organisation.
- A wellbeing page was created, pulling together resources available to staff.
- Wellbeing webinars were offered– mindfulness, working at home (physical impact), managers support.
- Live staff events where the wellbeing message was a key theme.
- The promotion of the Employee Assistance Programme increased.
- A temporary Wellbeing Project Officer role was also established in August 2020 within the OWD team to build capacity and support to deliver the increased workload associated with the wellbeing recovery plan and wider OWD programme.

Phase 2: As the pandemic continued into late 2020, staff reported struggling with what was happening. Management reported that motivation and burnout were themes across the workforce. Priority onsite inspections resumed and there was an increase in inspection activity. Support activities included:

- Regular messaging around 'supporting your wellbeing' was shared with staff and reinforced by the Senior Leadership Team.
- October 2020, a video blog was produced on the theme of burnout. The Wellbeing Officer spoke with the Director of Psychology at NHS Grampian, to examine what Burnout may feel like, how Covid-19 was impacting staff, and support required.
- December 2020, there was a focus on Loneliness and Isolation in recognition of the challenges staff faced during the festive period and with ongoing restrictions. A video blog was produced where a staff member spoke about this issue and signposted to resources and support available to all staff.
- January 2021, additional Support to Parents was provided in recognition of the challenges faced by school closures and included support, confirm key worker status, a parent Forum, webinars, and a video message from the Senior Leadership Team.

Health, Safety, and Wellbeing during the COVID-19 Pandemic

Objective 2: Specific activity has been undertaken to identify the wellbeing needs of staff and to implement a framework of wellbeing activity to meet the needs of staff at all levels across the organisation. (continued)

- For teams providing advice and support to care services, there was dedicated group support sessions. The debrief sessions, facilitated by an experienced therapist, allowed staff the opportunity to discuss issues, concerns or challenges, and strategies for self-care.

Phase 3: During 2021, and as the Scottish Government sets out how and when they plan to lift the current coronavirus restrictions over the Spring/ Summer 2021, management are reviewing the post-COVID-19 recovery arrangements. There is recognition of a need for reflection and the previous practices staff do not wish to return to, increased social anxiety, and challenges around change and resilience. Support activities included:

- Regular messaging around 'learning from the pandemic and continuing to support wellbeing' was shared with staff and reinforced by the Senior Leadership Team.
- Support for managers continued with a workshop on change and resilience and stress in the workplace.
- A staff learning event took place looking back over the past 12 months (What worked well, what could they have done better and what would they do differently next time).
- To empower staff and unpaid carers and to enhance personal resilience and self-care there was promotion of the Scottish Government Wellbeing Programme. The programme content is linked to the range of resources available on the National Wellbeing Hub.

A survey of staff in March 2021, impacted on two 'learning from the pandemic' workshops being held and led by Creative Huddle, an external organisation specialising in the design and facilitation of online workshops. The first workshop was attended by 118 employees representing all areas of the organisation and workforce. The second workshop was held with the Executive Directors and Heads of Service.

The audit evidenced a range of support established for the Care Inspectorate workforce, reinforce by a list of resources on the Care Inspectorate intranet. The OWD team also produced emails (now weekly) reinforcing key wellbeing messages.

Management report that there is a strong wellbeing agenda from the work completed over the pandemic. It will no longer be a stand-alone agenda item and there is planning for the work to be linked into cultural development work underway. A proposal detailing a programme of "Joy at Work" was underway at reporting and further work underway on using the employee voice in planning. This will comprise of learning events, employee surveys, focus groups, and wellbeing / culture events to encourage participation at all levels. The proposals for these programmes are due to be reported to the OLT in May 2021 and the terms of reference for the Wellbeing Group will be updated at that time.

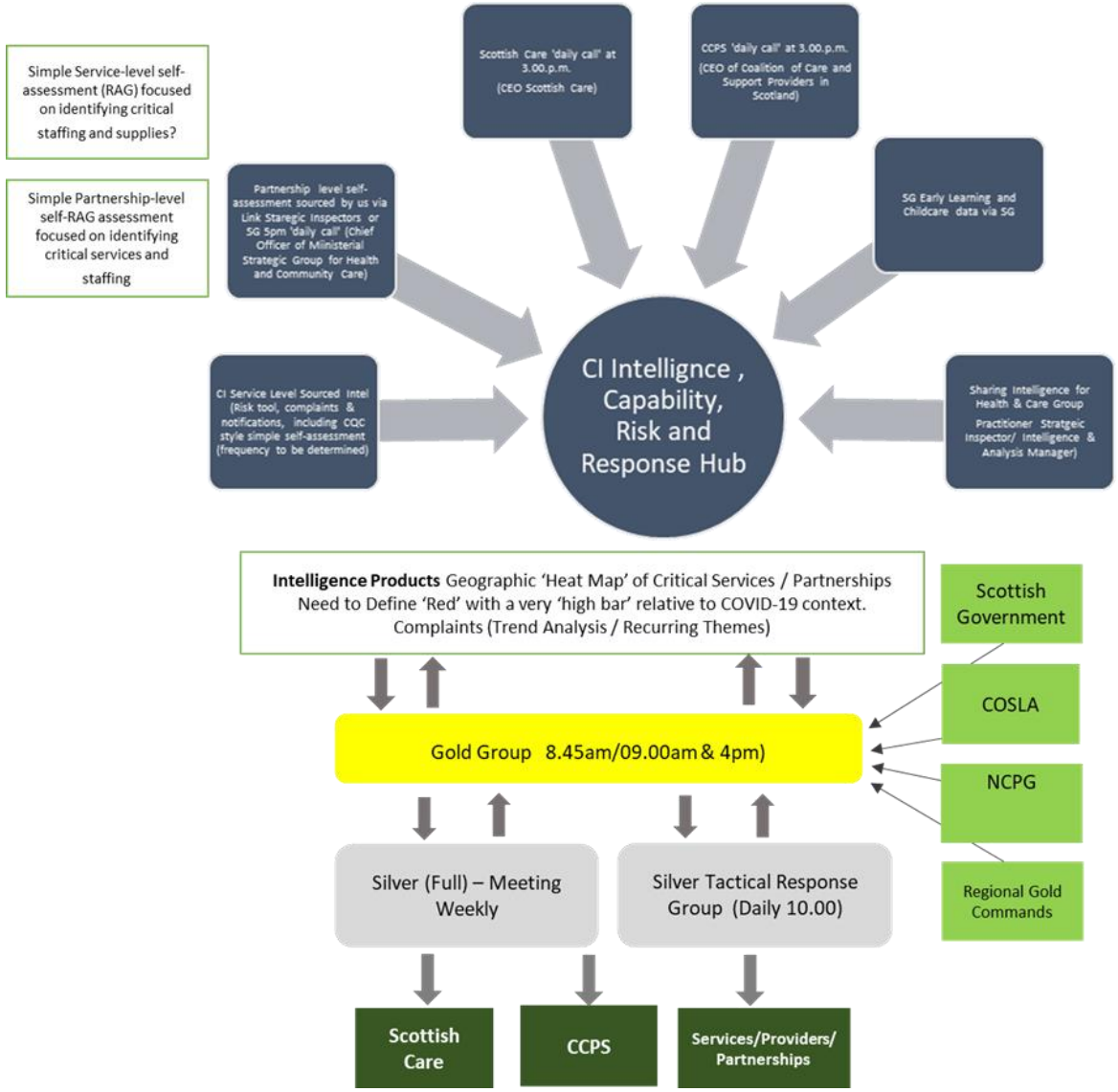
The aim is to launch this work, together with the revised Corporate Plan, after June 2021 when management are further informed on how the workforce will be working.

Appendix 1
External Stakeholder Communication Flows

Diagram detailing the flow of communications of the Care Inspectorate with its external partners during the first COVID-19 wave between March and July 2020. The Gold and Silver Groups were disbanded in August 2020, however, as the pandemic continued and number of cases increased, the Gold and Silver Tactical Response Groups resumed. Collaboration with external agencies remained at audit with the Gold Group and Silver Tactical Response Group remaining operational (April 2021).

Regulated bodies were risk rated. Scrutiny inspections were also reviewed to ensure infection control and staffing levels were included.

Roles and responsibilities of key individuals leading partnership communications are identified.



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AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 10
Report No: ARC-12-2021

Title:	**COVER REPORT: INTERNAL AUDIT ON FREEDOM OF INFORMATION (SCOTLAND) ACT 2002 (FOISA)**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report:
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The internal audit report on Freedom of Information (Scotland) Act 2002 (FOISA) is attached as Appendix 1. The overall level of assurance is "Good". All five control objectives were identified as "Good" and no recommendations were made. The report highlights that the team operate across three work streams: • Transform • Improve • Run The pandemic has had a significant impact on the volume of FOI requests and also the complexity of these requests. This has meant the focus has been on Run activity. This position will require to be monitored as the impact of the pandemic lessens to ensure there is sufficient resource to maintain an appropriate and sustainable balance across all three work streams.
The Audit and Risk Committee is invited to:
1. Accept the Internal Auditor's report on FOISA.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**For Decision**	

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 10
Report No: ARC-12-2021

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A *(see Reasons for Exclusion)*
Disclosure after:

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

Care Inspectorate

Freedom of Information (Scotland) Act 2002 (FOISA)

Internal Audit Report No: 2021/10

Draft issued: 13 May 2021

Final issued: 14 May 2021

LEVEL OF ASSURANCE	**Good**

Contents

Level of Assurance

In addition to the grading of individual recommendations in the action plan, audit findings are assessed and graded on an overall basis to denote the level of assurance that can be taken from the report. Risk and materiality levels are considered in the assessment and grading process as well as the general quality of the procedures in place.

Gradings are defined as follows:

Good	System meets control objectives.
Satisfactory	System meets control objectives with some weaknesses present.
Requires improvement	System has weaknesses that could prevent it achieving control objectives.
Unacceptable	System cannot meet control objectives.

Action Grades

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee.
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Management Summary

Overall Level of Assurance

Good	System meets control objectives.

Risk Assessment

This review focused on the controls in place to mitigate the following risks on the Care Inspectorate strategic risk register:

- Risk 10 – Failure to maximise and be seen to maximise our ability to protect staff and our stakeholders from the impacts of the COVID 19 virus. (residual risk rating: Red)

Although there is no specific risk shown on the strategic risk register in relation to Freedom of Information requests, the COVID-19 pandemic has resulted in a significant chance to the workload of the staff which deal with these requests and their ability manage competing priorities.

Background

As part of the Internal Audit programme at the Care Inspectorate (CI) for 2020/21 we carried out a review of the arrangements in place to deal with requests under the Freedom of Information (Scotland) Act 2002 (FOISA) . This was identified by the Executive Team (ET) as an area where risk can arise and where Internal Audit can assist in providing assurances to the Board and the Chief Executive that the related control environment is operating effectively, ensuring risk is maintained at an acceptable level.

The Freedom of Information (Scotland) Act 2002 (or "FOISA") came into force on 1 January 2005. Under FOISA, a person who requests information from a Scottish public authority which holds it is entitled to be given it by the authority subject to certain conditions and exemptions set out in the Act.

Freedom of Information (Scotland) Act 2002 (FOISA)

Scope, Objectives and Overall Findings

The scope of this review was to assess the arrangements in place within the Care Inspectorate for dealing with requests for information under the Freedom of Information (Scotland) Act 2002 (FOISA) in order to meet the requirements placed on the organisation as a public body. The Act gives a general right of access to all types of recorded information held by public authorities, sets out exemptions from that right and places a number of obligations on public authorities. Any person who makes a request to a public authority for information is entitled to receive that information, subject to exemptions. As set out within the Act, the Care Inspectorate must adopt and maintain a publication scheme setting out the information routinely made publicly available. Subject access request requests under the Data Protection Act do not fall under the scope of this review.

The table below notes each separate objective for this review and recorded the results:

Objective	Findings			
The objective of our audit was to:		**1**	**2**	**3**
		No. of Agreed Actions		
1. The organisation has established a publication scheme which sets out the information which will be published.	**Good**	0	0	0
2. The responsibility and approach for dealing with FOISA requests has been formally documented.	**Good**	0	0	0
3. Requests for information under the Act are promptly transferred to the appropriate part of the organisation for action and procedures ensure that requests are actioned in a timely fashion.	**Good**	0	0	0
4. Monitoring of performance to ensure that requests are dealt with within the statutory timescales and to make sure that the information provided is accurate and up to date before it is published or released.	**Good**	0	0	0
5. There are arrangements in place to report compliance with the requirements set out within the Act on at least an annual basis.	**Good**	0	0	0
Overall Level of Assurance	**Good**	**0**	**0**	**0**
		System meets control objectives.		

Audit Approach

Through discussion with the Information Governance Lead and the Information Governance Analyst we examined the publication scheme developed for the Care Inspectorate and documented the systems and processes which have been implemented to allow the organisation to meet the requirements set out within the Act. We then performed compliance testing to establish whether the agreed processes were operating effectively in practice.

Freedom of Information (Scotland) Act 2002 (FOISA)

Summary of Main Findings

Strengths

- The Model Publication Scheme, produced by the Scottish Information Commissioner, has been adopted in its entirety;
- There is a dedicated Freedom of Information page within the Information and Data section on the Care inspectorate website;
- The Freedom of Information Policy is supported by a comprehensive Information Governance Email Box – Requests for Information - Standard Operating Procedure (SOP);
- A detailed step by step guide has been produced for the use of the RMS system used to log requests, which contains screenshots and guidance on how to navigate and populate the various screens;
- A RAG rating system is deployed in order to direct enquiries effectively;
- The daily team huddle providing the opportunity for collective support and a focus on wellbeing;
- Weekly workload reports set out the key tasks for the week and explicitly cross reference to the priority which the task supports;
- The Information Governance team have previously attended team meetings to raise awareness around the input which is required from managers across the Care Inspectorate in order to allow requests to be actioned in a timely fashion;
- A comprehensive Quarterly dashboard is produced, which is shared with the Director of Executive Director of Strategy and Improvement and Deputy Chief Executive and the Head of Risk and Intelligence;
- There is a clear focus on maintaining effective internal and external engagement with a Memorandum of Understanding in place with key partners;
- Weekly workload meetings focus on data extracted from the RMS system, which allows tracking of performance against the 20-day target;
- Quarterly reports are produced which summarise FOISA statistics (and Subject Access Request data) required by the Scottish Information Commissioner. This sets out how many responses were responded to on time, how many missed the target deadline, how many exemptions were applied and how many requests were refused.

Opportunity for further development

- The current Freedom of Information Policy is dated 2011 and although we confirmed with the Information Governance team that this document remains fit for purpose, the contact details within the document would benefit from periodic refresh to ensure that they remain up to date. However, we recognise that any future focus on policy development is only achievable with the correct balance of workload across the Transform, Run and Improve workstreams, with the recent activity understandably focused on the increased Run activity which has coincided with the COVID-19 pandemic. Therefore, we have not included a formal recommendation on this point.

Acknowledgment

We would like to take this opportunity to thank the staff at the CI who helped us during the course of our audit.

Main Findings and Action Plan

Objective 1 - The organisation has established a publication scheme which sets out the information which will be published.

The Model Publication Scheme, produced by the Scottish Information Commissioner, has been adopted in its entirety.

In adopting the Single Model Scheme, the Care Inspectorate have produced a 'Guide to Information' which:

- allows you to see what information is available (and what is not available) in relation to each class;
- states what charges may be applied;
- explains how to find the information easily;
- provides contact details for enquiries and to get help with accessing the information; and
- explains how to request information that has not been published.

There is a dedicated Freedom of Information page within the Information and Data section on the Care inspectorate website. This provides contact details for the Information Governance team and detailed information on the following:

- How to make a request?
- How to word a request?
- What to do if you are unhappy with a response?
- What to do if you are unhappy with the Review Response

We were advised that work is planned to revisit the Publication Scheme in terms of the publication of FOISA responses in order to provide increased transparency going forward, which can be accessed by the press.

Freedom of Information (Scotland) Act 2002 (FOISA)

Objective 2 - The responsibility and approach for dealing with FOISA requests has been formally documented.

The current Freedom of Information Policy is dated November 2011, and although we confirmed with the Information Governance team that this document remains fit for purpose, the contact details within the document would benefit from periodic refresh to ensure that they remain up to date.

The Freedom of Information Policy is supported by a comprehensive Information Governance Email Box – Requests for Information - Standard Operating Procedure (SOP), which was published in March 2019 and last updated in March 2020. This SOP defines the purpose of the document as "*… to map out the process of how to administer the different requests for information to ensure that they are processed by Information Governance where appropriate or passed to the relevant department for actioning and to ensure that all enquiries are processed to meet both statutory and internal business deadlines*".

In line with good practice, the SOP contains three flowcharts which set out:

1. the triage process for dealing with requests for information received;
2. the process for dealing with all information requests; and
3. the reporting process.

The main software tool utilised to record information requests is RMS, and a detailed step by step guide has been produced, which contains screenshots and guidance on how to navigate and populate the various screens. This guide also sets out definitions to allow the sensitivity of the request to be categorised on a RAG rating scale which dictates the level of management input required from within the Information Governance team and outwith (for example from the Communications team).

Freedom of Information (Scotland) Act 2002 (FOISA)

Objective 3 - Requests for information under the Act are promptly transferred to the appropriate part of the organisation for action and procedures ensure that requests are actioned in a timely fashion.

The Information Governance team have three workstreams, Transform; Improve; and Run. The Run activity relates to the days to day activity including processing requests under the Act. It was clear from analysis of the reports provided, and our discussions with the Information Governance Lead and the Information Governance Analyst, that the COVID-19 pandemic has had a significant impact on the volume of requests and also the complexity of requests. This meant that during the period from March 2020 to October the entire Information Governance Team was focused solely on Run activity. A large proportion of the inquiries received were press related in relation to COVID-19 data held by the Care Inspectorate.

As highlighted under objective 2, above, a RAG rating system is deployed in order to direct enquiries effectively. Changes in the Coronavirus legislation meant that the process had to be adapted to cope with the need input by the Intelligence Lead and the press Lead for any COVID-19 related enquiries. We confirmed that this was a two-way process which required the Information Governance team to keep abreast of the daily Scottish Government briefings, via the Gold Group. The Information Governance Lead reviewed the Gold Group minutes and maintained a spreadsheet to capture discussions around the implications for information governance.

It was evident from our discussions that the workload which the Information Governance team have faced in the last 18 months, coupled with the nature of the data being examined, has been challenging for the entire team, with the daily team huddle providing the opportunity for collective support and a focus on wellbeing. This is supplemented by weekly workload report discussions every Monday, which allows a focus on worked completed in the preceding week and allows a weekly look ahead. This weekly workload reports sets out the key tasks for the week and the task explicitly cross references to the priority which it supports.

Work was undertaken in 2019, as part of a communications relaunch, which provided a platform for the Information Governance team to attend team meetings to raise awareness around the input which is required from managers across the Care Inspectorate in order to allow requests to be actioned in a timely fashion.

The need for ongoing contact with the relevant Inspector was highlighted as an important role for the Information Governance team, with the presumption of disclosure the default position when considering whether an exemption is appropriate. The source of the referral also has a bearing on the way in which requests are handled with referrals from Inspectors generally providing more clarity than those received from members of the public who may not realise the importance or the repercussions of avoiding ambiguity.
The need to create an enhanced focus on training, strategy and policy development was highlighted by the Information Governance Lead and while the creation of a new business support role within the team will free up some resource there is a need to monitor the ongoing workload of the Information Governance team to ensure that the Transform and Improve workstreams can be delivered alongside Run activity. However, we recognise that this focus on policy development is only achievable with the correct balance of workload across the transform, Run and Improve workstreams, with the recent activity understandably focused on the increased Run activity which has coincided with the COVID-19 pandemic (but is not entirely attributable to COVID related requests).

Objective 4 - Monitoring of performance to ensure that requests are dealt with within the statutory timescales and to make sure that the information provided is accurate and up to date before it is published or released.

As well as the weekly workload report mentioned above, a Quarterly dashboard is produced which is shared with the Director of Executive Director of Strategy and Improvement and Deputy Chief Executive and the Head of Risk and Intelligence. Our review of the three quarterly reports for the period 1 April 2020 to 31 December 200 confirmed that comprehensive information is provided on the following areas:

- the focus for the Information Governance on Run activity;
- the number of requests received;
- the average time it took to deal with requests;
- performance against the targets set by the Scottish Information Commissioner (which have been retained at the pre-COVID target level of 20 days for reporting purposes despite an increase in the allowed response time to 60 days implemented by the Scottish Information Commissioner);
- the percentage breakdown by department;
- completed requests by type;
- internal engagement; and
- external engagement.

It is clear from the Quarterly dashboard reporting that the increased Run activity has had a significant impact on transformation activity. We were advised that this transform activity is now a year behind the original delivery dates set.

The weekly workload meeting is focused on data extracted from the RMS on the previous Friday afternoon. This allows tracking of performance against the 20-day target suing a spreadsheet model. Requests are normally aligned to one particular member of the team but there are instances where the size of the requests necessitates a division of responsibility for different aspects of the request. A written summary report is submitted to the Director of Executive Director of Strategy and Improvement and Deputy Chief Executive and the Head of Risk and Intelligence weekly which flags any specific points which require to be actioned.

The relationship between the Information Governance team and the Legal team was highlighted as being of particular importance for dealing with more legally sensitive cases.

The importance of effective external engagement was also evident, and the level of ongoing external engagement is reflected in the Quarterly dashboard reports. In particular, the engagement though formal Memoranda of Understanding (MOU), and also through less formal routes, was highlighted, as was the relationship with the Scottish Information Commissioner to seek advice on how to deal with more complex requests. The Nursing and Midwifery Council and the SSSC are key partners where an MOU is in place to allow effective sharing of information.

Freedom of Information (Scotland) Act 2002 (FOISA)

Objective 5 - There are arrangements in place to report compliance with the requirements set out within the Act on at least an annual basis.

Quarterly reports are produced which summarise FOISA statistics (and Subject Access Request data) required by the Scottish Information Commissioner. This sets out how many responses were responded to on time, how many missed the target deadline, how many exemptions were applied and how many requests were refused.

Although there has been development of the digital platform there are some functionality issues with the RMS system which is utilised to log requests. Input is provided by an external consultant around reporting functionality, but we were advised that this arrangement was about to end. The RMS system does not have the inbuilt functionality to report directly to the Scottish Information Commissioner.

One of the key digital transformation projects progressed has been the movement of complaints information on to a new application. However, for older complaints there is a need to access information such as correspondence via the legacy PMS system. We were advised that work has been undertaken to migrate data relating to regulation to the new application but at the time of our fieldwork this functionality had not been activated. Inspection information is currently held on RMS. In addition, improvement notices relating to enforcement are held on the legacy system PMS. Therefore, while there is no imminent risk that the PMS and RMs systems will not be supported going forward there is a recognition that further work is required as RMS and PMS are phased out and this should deliver improved interrogation capability and reporting functionality moving forward.

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AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 11
Report No: ARC-13-2021

Title:	**COVER REPORT: INTERNAL AUDIT ON JOINT REVIEW OF SHARED SERVICES**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Joint Review of Shared Services
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The internal audit report on Joint Review of Shared Services is attached as Appendix 1. The overall level of assurance is "Satisfactory". Of the four control objectives, one control objective was identified as "Good" and the remaining three as "Satisfactory". Three recommendations are made. Two have been actioned already and the third relating to adding a shared service risk to the strategic risk register is subject to Board approval.
The Committee is invited to:
1. Accept the Internal Auditor's report on shared services.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**For Decision**	

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A *(see Reasons for Exclusion)*
Disclosure after:

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 11
Report No: ARC-13-2021

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

Care Inspectorate and SSSC

Joint review of Shared Service

Draft issued: **16 May 2021**

Final issued: **19 May 2021**

LEVEL OF ASSURANCE	**Satisfactory**

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Now, for tomorrow

Contents

Level of Assurance

In addition to the grading of individual recommendations in the action plan, audit findings are assessed and graded on an overall basis to denote the level of assurance that can be taken from the report. Risk and materiality levels are considered in the assessment and grading process as well as the general quality of the procedures in place.

Gradings are defined as follows:

Good	System meets control objectives.
Satisfactory	System meets control objectives with some weaknesses present.
Requires improvement	System has weaknesses that could prevent it achieving control objectives.
Unacceptable	System cannot meet control objectives.

Action Grades

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee (CI) and the Audit and Assurance Committee (SSSC).
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Management Summary

Overall Level of Assurance

Satisfactory	System meets control objectives with some weaknesses present.

Risk Assessment

There are currently no specific strategic risks on the risk registers of the Care Inspectorate or SSSC on the topic of shared services. This issue is address in recommendation 4 in the action plan below.

Background

At the request of management within the Care Inspectorate (CI) and the Scottish Social Services Council (SSSC) we have been asked to conduct a joint review of the shared service arrangements which apply from 1 April 2021. This review was not included within the Strategic Internal Audit Plan for either organisation, but this work has been commissioned in order to provide positive assurance on the arrangements which have been developed through joint working between the Executive Director of Customer and Corporate Services for the Care Inspectorate, the interim Director of Finance and Resources for the SSSC and the Head of Shared Services.

Latterly a Shared Service Member Officer Working Group has overseen the development and implementation of the new shared service arrangements from a purely Care Inspectorate perspective. The last meeting of this Group, held on 16 March 2021, received an update on the progress to date and set out the direction of travel around the suite of documentation which would be subject to independent review by internal audit. The list of documentation agreed for consideration as part of the internal audit review was as follows:

- Service specifications
- Development Plan
- Resource Plan
- Time recording
- Performance Framework
- Management Agreement (includes performance framework and charging regime)
- Shared service combined risk register
- Joint CI and SSSC shared service strategy

Scope, Objectives and Overall Findings

This review builds on the previous consultancy work conducted by CIPFA around Shared Services. The original scope for this review, which was agreed with the Executive Director of Customer and Corporate Services for the Care Inspectorate, the interim Director of Finance and Resources for the SSSC and the Head of Shared Services, in February 2021, had a specific focus around the Shared Service specification. However, following discussion with management, the revised focus for this review is around providing an assessment of the fitness for purpose of the following documents which will be submitted for consideration and approval by the next meetings of the Care Inspectorate Board and SSSC Council:

1. A joint CI and SSSC Shared Service Strategy;
2. The Shared Service Management Agreement;
3. The Performance Framework; and
4. The Shared Service combined risk register.

The table below notes each separate objective for this review and records the results:

Objective	Findings			
The objective of our audit was to assess whether:		**1**	**2**	**3**
		No. of Agreed Actions		
1. The joint CI and SSSC Shared Service Strategy is fit for purpose	**Good**	0	0	0
2. The Shared Service Management Agreement is fit for purpose	**Satisfactory**	0	0	1
3. The Performance Framework is fit for purpose	**Satisfactory**	0	0	1
4. The Shared Service combined risk register is fit for purpose	**Satisfactory**	0	0	1
Overall Level of Assurance	**Satisfactory**	**0**	**0**	**3**
		System meets control objectives with some weaknesses present.		

Audit Approach

Through review of the documentation submitted for review to date, and through discussion with management, we have formed a view regarding the four documents listed above, which will be submitted to the CI Board and SSSC Council. Although we have been presented with various iterations of the various shared service documents, since the concept of a joint internal audit review of the shared service arrangements was initially mooted, the findings below are based on the versions of the joint CI and SSSC Shared Service Strategy; Shared Service Management Agreement; Performance Framework; and Shared Service combined risk register, which were provided for audit review on 10 May 2021.

Summary of Main Findings

Strengths

- The joint CI and SSSC Shared Service Strategy defines what is meant by shared services; describes the shared services model to be adopted; and sets out the scope of the strategy. It also sets out a shared vision for shared services and describes the internal and external drivers for developing a sustaining a shared service model. This includes specific linkages to the characteristics and priorities set out within the SSSC Strategic Plan 2020-23 and the Care Inspectorate Corporate Plan 2019-22;
- The Strategy sets out four strategic aims for Shared Services and also describes the governance arrangements and performance monitoring arrangements which will allow oversight of the shared services arrangements for both partner organisations;
- The overarching joint CI and SSSC Shared Service Strategy is underpinned by the Shared Service Management Agreement, the Performance Framework; and the Shared Service combined risk register;
- In general the Shared Service Management Agreement document provides a detailed description of the way in which the Shared Service function will operate;
- The suite of performance measures set out in Appendix 2 cover all aspects of the shared service arrangements and are designed to feed into the quarterly reporting process.

Weaknesses

- Our review of the latest iteration of the Shared Service Management Agreement identified several areas where further clarification would improve the current wording and remove any room for misunderstanding or ambiguity;
- It is our view that the current body of performance measures included in Appendix 2 require to be revisited to ensure that there is improved clarity around the performance metrics themselves and the validity of the targets which will be utilised to determine whether acceptable performance levels are being achieved and whether improvement actions may be required;
- It is our view that the current Risk 1 should be reflected on the Strategic Risk registers of both the Care Inspectorate and the SSSC rather than on the Shared Service combined risk register.

Acknowledgment

We would like to take this opportunity to thank the staff at the CI and SSSC who helped us during the course of our audit.

Main Findings and Action Plan

Objective 1 - The joint CI and SSSC Shared Service Strategy is fit for purpose

The joint CI and SSSC Shared Service Strategy defines what is meant by shared services; describes the shared services model to be adopted; and sets out the scope of the strategy.

This document also sets out a shared vision for shared services and describes the internal and external drivers for developing and sustaining a shared service model. This includes specific linkages to the characteristics and priorities set out within the SSSC Strategic Plan 2020-23 and the Care Inspectorate Corporate Plan 2019-22. It also explains how the delivery of a Shared Services strategic approach ensures alignment with the Scottish Government's shared services agenda.

The three roles of Shared Support Services are clearly articulated as follows:

1. Ensuring and supporting good governance
2. Driving efficiency
3. Providing value, insight and proactive professional advice

The Strategy sets out four strategic aims for Shared Services and also describes the governance arrangements and performance monitoring arrangements which will allow oversight of the shared services arrangements for both partner organisations.

The overarching joint CI and SSSC Shared Service Strategy is underpinned by the Shared Service Management Agreement, the Performance Framework; and the Shared Service combined risk register. Therefore, the effectiveness of this document relies heavily on the effectiveness of the supporting documents. However, it is our view, that as a standalone document, the joint CI and SSSC Shared Service Strategy provides a comprehensive description of the high level Shared services framework which is fit for purpose.

Objective 2 - The Shared Service Management Agreement is fit for purpose

Our assessment of the Shared Service Management Agreement has raised a number of issues, around the current wording, which are set out below:

Section 17 – this section sets out the need for an annual review and the mechanisms for dealing with any disagreement on the way forward arising from this annual review process. However, there is a need for improved clarity around what is meant by "escalation to the organisation's respective governance bodies". It is not clear whether this refers to Council and the Board; the Audit and Assurance Committee and Audit and Risk Committee; the Service Review Board; or another governance body. In addition, there is no timeline provided for the appointment of the independent advisor which would be brought in if a consensus could not be reached. We feel that this would be useful given the likely tight timescales for presenting the outcome of any independent review through the escalation process to the governance bodies in advance of 1 April.

Section 21 – this section relates to the content of the shared service and makes specific reference to the fact that "Either organisation may make ad hoc requests for work not specifically covered by the specification of services or the annual development plan". It is our view that there is a need for improved clarity around the mechanisms which would be used to make requests not specifically covered by the specification of services and the annual development plan. In particular this should make it clear:

- Who should these requests be submitted to?
- When can they be submitted?
- Should there be a standard format for submitting any requests?

Section 24 – relates to the specifications of service and raises the same issue as Section 17 around a lack of clarity on what is meant by "respective Governance bodies" in this context.

Section 25 – this section relates to any proposed withdrawal from the shared service arrangements. However, it the current wording of this section does not make it clear how the six month notice period relates to the timing of the annual review process, which commences in September each year. So for example, it is not clear whether any decision to withdraw from the shared service arrangements, arising from the outcome of the annual review process, would necessitate an extension of the arrangement beyond 1 April in the year in question, to cover the element of the six month notice period, from the date of withdrawal, which extends beyond 1 April.

Section 33 – this section relates to the staff of the shared service and in particular the employment of staff. However, it is not clear what would happen in an instance where an employee has historically undertaken more work for the CI, for example, but the focus for the role going forward would necessitate more of the workload for the role being completed on behalf of the SSSC. It is currently not clear who would make the decision around the employment of a replacement member of staff in these circumstances.

Objective 2 - The Shared Service Management Agreement is fit for purpose (continued)

Section 35 – this section relates to performance of the shared service and specifically states that "*Any remedial action required as a result of under-performance will be agreed jointly and be the responsibility of the Head of Shared Services to deliver*." However, it is our view that a number of the performance metrics listed in Appendix 2 of the Shared Service Management Agreement are not measures of performance by the shared services functions and should therefore be reviewed. It is also apparent that a significant proportion of the performance metrics selected can only be collated annually and therefore this will have an impact on the quarterly reporting to identify and initiate improvement actions in year. This is covered in more detail under Objective 3, below.

In addition, we have been advised that discussions are ongoing with the Corporate Governance team within the SSSC around the Data protection wording within the agreement. Therefore, on the basis that this work is already underway we have not included any commentary around this specific point.

Objective 2 - The Shared Service Management Agreement is fit for purpose (continued)

Observation	Risks	Recommendation	Management Response	
In general the document provides a detailed description of the way in which the Shared Service function will operate. It is intended to set out "*a framework to guide both organisations in the conduct of the shared services and is intended to demonstrate their firm commitment to support and participate fully in the shared services between them and to work together with openness and transparency*". From our perspective, the current wording of the agreement does meet this overall objective. However, as highlighted under Objective 2 above, our review of the latest iteration of the Shared Service Management Agreement identified several areas where further clarification would improve the current wording and remove any room for misunderstanding or ambiguity.	Without clarity on the points raised above there is an increased risk for misunderstanding or ambiguity which could impact on the effective delivery of shared objectives should specific scenarios unfold over time.	**R1** The current wording of the Shared Service Management Agreement should be revisited, and consideration should be given on how the points raised above can be expanded on to ensure that the document is fit for purpose going forward.	This recommendation is agreed. The observations on current wording are very helpful. The Management Agreement will be revised to incorporate the points made. **To be actioned by:** SSSC: Interim Director of Finance & Resources CI: Executive Director of Corporate and Customer Services **No later than:** 19 May 2021 **Audit comment:** The proposed amendments have been made and are reflected in the updated Management Agreement which will be considered by SSSC Council and the CI Board.	
			Grade	**3**

Objective 3 - The Performance Framework is fit for purpose

It is our view that the performance management framework moving forward should be sub-divided into three distinct aspects:

1. The operational performance metrics which will be monitored internally within Shared Services.
2. The quarterly performance metrics which will be reported to the Executive Director of Customer and Corporate Services for the Care Inspectorate, the Director of Finance and Resources for the SSSC and the Service Review Board.
3. The annual performance metrics which will be included in an annual Shared services report which will summarises the performance delivery for each financial year.

Our review of the latest iteration of the performance measures, which have been proposed for inclusion as Appendix 2 within the Shared Service Management Agreement, relate solely to categories 2 and 3 listed above, and do not include any operational performance metrics for use by management within Shared services. Therefore our review of the performance measures is focused on the performance metrics which will be formally reported on a quarterly and annual basis in order to identify areas of "under performance", as described in the management agreement, and to allow improvement actions to be identified, agreed and implemented.

Our review of the current proposed performance measures identified the following issues:

Performance measure **CU01** - It is not clear what the distinction is between "a report" and "a paper" or what would constitute a sufficient level of accuracy "in the agreed format". In addition, it is not clear who would make the decision on whether the reports/papers are sufficiently accurate or are sufficiently aligned to the agreed format.

Performance measure **CU03** – The target of four out of five is an increase in the threshold previously utilised to gauge the level of satisfaction of both the Executive Director of Customer and Corporate Services and the Director of Finance and Resources. Therefore, there is a need to set out the rationale for any score of less than four provided in order to clearly articulate the issues and the improvement actions which are required in order to rectify these issues. This will provide enhanced clarity for all parties around what is, in essence, a subjective judgement based on the experiences of the previous three months for each service area covered by the shared service agreement.

Performance measure **CU04** – If the intention of the target is an improvement in the year on year survey results, then it is our view that an acceptable baseline performance level should be set. This will avoid a scenario whereby a marginal increase from a very low starting point is deemed a success by the current target set for this performance measure. There is also a need to clarify why this performance measure refers to a bi-annual survey when the Shared Service Management Agreement refers to an annual survey.

Objective 3 - The Performance Framework (which will form an appendix within the management agreement) is fit for purpose (Continued)

Performance measure **CU11** - The current wording states that "Shared Services provide Budget Managers with timely budget reports". However, the definition of what constitutes "timely" reporting is not set out.

Performance measure **IP42** – the current measure refers to a need to "…minimise the number of HSE interventions". However, the target set of zero interventions suggests that the intention is to eradicate altogether rather than minimising HSE interventions.

Performance measure **CU18** – The target states that 2021/22 will be the baseline year but it is not clear whether a year on year target increase will be set beyond 2021/22 against this baseline level or whether the baseline level of performance for 2021/22 will be adopted as a static benchmark.

HR performance measure on HR policies (no performance measure number provided) – this measure states that Quality of HR Policies delivered to the Director of Finance & Resources / Executive Director of Customer & Corporate Services is such that only minor amendments are required (Director's judgement). Whilst the wording of the measure acknowledges that there is a high degree of subjective judgement required it is not clear what an acceptable level of amendments would be and therefore this undermines the effectiveness of this performance measure as a tool to drive improved performance.

Performance measure **CU15** – It is not clear how a static target of 80% positive responses will drive the objective/result of "customers receive better service because we listen to them and improve feedback". It is also not clear what the level of response rate from students will be accepted as representative in order to make sure that the conclusion drawn are statistically sound.

Objective 3 - The Performance Framework is fit for purpose (Continued)				
Observation	**Risks**	**Recommendation**	**Management Response**	
The suite of performance measures set out in Appendix 2 cover all aspects of the shared service arrangements and are designed to feed into the quarterly reporting process. It is our view that the current body of performance measures included in Appendix 2 require to be revisited to take on board the comments provided above. This will ensure that there is improved clarity around the performance metrics themselves and the validity of the targets which will be utilised to determine whether acceptable performance levels are being achieved and whether improvement actions may be required.	Without a shared understanding of the performance metrics and targets there may be a lack of shared ownership which may undermine the effectiveness of the quarterly reporting to drive performance improvement.	**R2** The current wording of the performance measures for Appendix 2 of the Shared Service Management Agreement should be revisited and consideration should be given on how the points raised above can be integrated into the description of the performance metrics and the associated targets to ensure that the document is fit for purpose going forward.	This recommendation is agreed. **To be actioned by:** SSSC: Interim Director of Finance & Resources CI: Executive Director of Corporate and Customer Services **No later than:** 19 May 2021 **Audit comment:** The proposed amendments have been made and are reflected in the revised performance metrics in Appendix 2 of the updated Management Agreement which will be considered by SSSC Council and the CI Board.	
			Grade	**3**

Objective 4 – The Shared Service combined risk register is fit for purpose (Continued)

Observation	Risks	Recommendation	Management Response
Our review of the Shared Service combined risk register confirms that the layout of the risk register is logical and applies good practice in risk management. However, it is our view that the current Risk 1 should be reflected on the Strategic Risk registers of both the Care Inspectorate and the SSSC rather than on the Shared Service combined risk register. This risk resets with the partner organisations and therefore, given the importance of successful Shared Service delivery to both organisations, it is important that the risk of a failure to achieve this is reflected on the risk register so that the risks can be tracked by both organisations.	There is a risk that failure to recognise the mechanisms for receiving assurances around successful delivery of shared services on the Strategic Risk Registers of partner organisations will prevent effective oversight of ongoing risks for each organisation.	**R3** Consideration should be given to including the current Risk 1 from the Shared Service combined risk register within the Strategic risk registers of the care inspectorate and the SSSC.	This recommendation is agreed. The CI Board are to consider a revised risk register at a development meeting on 4 June 2021 with a view to agreeing a revised SRR at the Board meeting of 17 June. The Board had previously requested that a strategic risk on Shared Services was drafted for consideration of inclusion on the revised SRR for consideration at the 4 June development session. The report for the shared service arrangements going to Council in May 2021 will seek approval for the addition of this risk. **To be actioned by:** CI: Head of Finance & Corporate Governance SSSC: Interim Director of Finance and Resources **No later than:** CI: 17 June 2021 SSSC: 27 May 2021
			Grade **3**

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AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 13
Report No: ARC-14-2021

Title:	**STRATEGIC RISK REVIEW**	
Author:	*Kenny Dick, Head of Finance and Corporate Governance*	
Appendices:	1.	Draft Risk Appetite Statement
	2.	Risk Monitoring – Strategic Risk 9
Consultation:	N/A	
Resource Implications:	None	

Executive Summary:
This report sets out the process for agreeing a revised Strategic Risk Register for 2021/22. It presents a draft revised risk appetite statement for the Committee to consider with a view to recommending this for Board to approve at the Board meeting of 17 June 2021. It also provides an update on the current strategic risk monitoring position.

The Audit and Risk Committee is invited to:	
1.	Note the process for agreeing a revised strategic risk register.
2.	Consider the draft revised risk appetite statement (Appendix 1) and recommend the Board to approve this statement (suitably amended for Committee comments) at the Board meeting of 17 June 2021.
3.	Note the current risk monitoring position.

Links:	Corporate Plan Outcome		Risk Register - Y/N		Equality Impact Assessment - Y/N	N
For Noting		**For Discussion**		**For Assurance**		**For Decision**	**x**

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: This is a public report.
Disclosure after: N/A

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

STRATEGIC RISK REVIEW

1.0 INTRODUCTION

1.1 The annual detailed review of our strategic risks is underway. This report sets out the process for this annual review that will result in the revised strategic risk register being considered for approval at the Board meeting on 17 June 2021.

1.2 A draft revised risk appetite statement is presented in Appendix 1. The Committee is requested to consider and amend the draft revised statement as appropriate and recommend approval of the revised statement to the next meeting of the Board (17 June 2021).

1.3 The Care inspectorate's Strategic Risk Register is reviewed at each meeting of the Audit and Risk Committee and the Board. There has been no significant change to the strategic risk position except for strategic risk 9 "Staff Capacity" where the risk of reduced staff capacity adversely affecting performance has increased.

2.0 STRATEGIC RISK REVIEW PROCESS

2.1 Board Development Event – 2 March 2021

A Board development event was held on 2 March 2021 to consider the current risk management process. At this event it was agreed to:

- adopt the risk categories set out in the Treasury Orange Book
- adopt revised risk appetite definitions
- revise the risk appetite statement to align with the extended risk categories and the revised risk appetite definitions
- introduce risk targets
- change the way we view risk tolerance
- request the strategic leadership team to review each strategic risk to ensure it is properly expressed and is revised in accordance with the developments to our risk management process as described above.
- There would be a further Board development event to discuss the revised strategic risk register.

2.2 Strategic Leadership Team (SLT) Review

The SLT met to consider the strategic risk register on 21 April 2021. This meeting concluded that change was required to each strategic risk and that each risk owner would meet with the Head of Finance and Corporate Governance to discuss each risk in detail and to develop the risk to align to the revised risk management process. These meetings are arranged throughout May.

2.3 Follow up Board Development Event – 2 June 2021

The revised strategic risk register will be considered in detail at a Board Development Event on 2 June 2021. The strategic risk register will be amended for Board member comments.

2.4 Board Meeting – 17 June 2021

The revised strategic risk register, risk appetite statement and risk policy will be presented for Board approval at the meeting of 17 June 2021.

3.0 REVISED RISK APPETITE STATEMENT

3.1 Revised Risk Appetite Definitions

At the Board development in March 2021, it was agreed to adopt five risk appetite definitions as follows:

- Averse
- Minimalist
- Cautious
- Receptive
- Eager

It was considered that the three existing definitions of “Averse”, “Cautious” and “Open” was too restrictive.

The risk appetite statement has been revised to incorporate the new appetite definitions.

3.2 Risk Categories

At the Board development in March 2021, it was agreed to adopt the risk categories set out in the Treasury Orange Book. The current risk appetite statement contains five broad risk categories. The Treasury Orange Book breaks these categories down to more specific areas and it is expected that this will be beneficial when considering risk appetite at all levels throughout the Care Inspectorate.

The risk appetite statement has been revised to incorporate the new risk categories.

3.3 Draft Revised Risk Appetite Statement

The draft revised risk appetite statement is presented in Appendix 1.

The Committee is requested to review and comment on the draft revised statement. The Committee is further requested to recommend to the Board that draft risk appetite statement adjusted for Committee comments is approved.

4.0 Strategic Risk Monitoring

4.1 Strategic Risk Monitoring

The are no significant changes to the risk position for strategic risks 1 to 8 and strategic risk 10. The risk assessment for strategic risk 9 has increased from 12 (high) to 16 (high). Details are in section 4.2 below. There is no change to the residual risk score which remains at 16 (high).

4.2 Strategic Risk 9 – Staff Capacity

The likelihood score for this risk has increased from 3 (possible) to 4 (likely) due to a combination of:

- There are currently significant Inspector vacancies (44 FTE).
- Previous Inspector recruitment campaigns have not been as successful as hoped.
- There is a threat of industrial action associated with a collective grievance submitted by Inspectors with respect to their placing on the new Inspector pay grade following job evaluation.

The risk monitoring position is detailed in Appendix 2.

4.0 IMPLICATIONS AND/OR DIRECT BENEFITS

4.1 Resources

There are no resource implications associated with this report.

4.2 Sustainability

There are no sustainability implications associated with this report.

4.3 Government Policy

There are no government policy implications associated with this report.

4.4 People Who Experience Care

There are no direct benefits for people who experience care.

4.5 Customers (Internal and/or External)

There are no direct customer implications or benefits.

Agenda item 13
Appendix 1

CARE INSPECTORATE RISK APPETITE STATEMENT 2021-22

As a scrutiny body that supports improvement, we manage risk on a day-to-day basis. Through use of evidence and intelligence, we monitor and assess whether providers, community planning partners and health and social care partners are managing the different risks for people who experience care and their carers to deliver positive outcomes that meet the needs, rights and choices of individuals. We use this risk-based intelligence to inform how we best deploy our finite resources to scrutinise and support improvement across care services and the broader care sector.

As a regulator, we must ensure that we are managing the risks to our organisation in a highly effective way and set the standard that we expect of others. We need to do this in a way that balances safeguarding public protection and providing assurance on the quality of care with supporting the need for innovation in the way that services are planned, commissioned and delivered.

Risk Appetite Definitions

We classify our risk appetite using the table below:

Classification	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.

Receptive	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

Risk Categories

We consider our risk appetite across the risk categories described in the table below. When considering the risk associated with our activities, we use these risk categories to inform our risk appetite, risk target and risk tolerance.

Risk Category	Category Descriptor	Risk Appetite - Statement	Risk Appetite Descriptor
Strategy	Risks arising from identifying and pursuing a strategy, which is poorly defined, is based on flawed or inaccurate data or fails to support the delivery of commitments, plans or objectives due to a changing macro-environment (e.g., political, economic, social, technological, environment and legislative change)	We strive to ensure the strategies we identify and pursue are well defined and based on the best available information, but it is recognised that perfect information is not available and changes to the macro environment tend to be out with our control and can occur at a rapid rate. There is a balance to be struck between the perfect strategy and the need to deliver the intended outcome within an appropriate time scale. We will take risks in an informed, deliberate and thoughtful way with	**Receptive**

		quantitative and qualitative evaluation being an inherent part of our approach.	
Governance	Risks arising from unclear plans, priorities, authorities and accountabilities, and/or ineffective or disproportionate oversight of decision-making and/or performance	We strive to be an organisation that is recognised for excellent governance	**Cautious**
Operations Risks	Risks arising from inadequate, poorly designed or ineffective/inefficient internal processes resulting in fraud, error, impaired customer service (quality and/or quantity of service), non-compliance and/or poor value for money.	We are willing to consider all potential delivery options and choose one that is most likely to result in successful delivery while also providing an acceptable level of reward (best value, stakeholder satisfaction etc.). Rather than avoiding innovation, we are open to innovation if there are commensurate quality assurance processes, evaluation and robust internal controls. Efficiency is a very high priority to maximise our ability to pursue our strategic goals and achieve sustainability. Furthermore, efficiency is within our control and should be a focus for all business activities. We therefore have a receptive risk appetite for exploring best value / efficiency initiatives	**Receptive**

Legal	Risks arising from a defective transaction, a claim being made (including a defence to a claim or a counterclaim) or some other legal event occurring that results in a liability or other loss, or a failure to take appropriate measures to meet legal or regulatory requirements or to protect assets (for example, intellectual property).	We aim to reduce our risk of failing to meet our legal obligations to a managed position of being 'as low as reasonably practicable'. The tolerance for risk taking is generally minimalist and is limited to those events where there is little chance of any significant repercussion for the Care Inspectorate should there be a compliance failure	**Minimalist**
Property	Risks arising from property deficiencies or poorly designed or ineffective/ inefficient safety management resulting in non-compliance and/or harm and suffering to employees, contractors, service users or the public.	We strive to have well maintained properties that are fit for purpose. The safety of our staff, contractors, service users or other visitors to our properties is of high importance.	**Minimalist**
Financial	Risks arising from not managing finances in accordance with requirements and financial constraints resulting in poor returns from investments, failure to manage assets/liabilities or to obtain value for money from the resources deployed, and/or non-compliant financial reporting.	We operate within a tightly controlled and audited financial regime. We generally maintain a cautious risk appetite and our preference is for a relatively conservative approach. We are also willing to consider the benefits of any proposed course of action and in doing so, are prepared to accept the possibility of some limited financial loss.	**Cautious**
Commercial	Risks arising from weaknesses in the management of commercial partnerships, supply chains and contractual requirements, resulting in poor performance, inefficiency, poor value for money, fraud, and /or failure to meet business requirements/objectives.	We have established procurement strategy, policy and procedures. We also participate in a procurement and a counter fraud, bribery and corruption shared service. Within this context we are willing to take an element of risk to ensure Best Value from our commercial arrangements.	**Cautious**

People	Risks arising from ineffective leadership and engagement, suboptimal culture, inappropriate behaviours, the unavailability of sufficient capacity and capability, industrial action and/or non-compliance with relevant employment legislation/HR policies resulting in negative impact on performance.	We recognise that our staff are critical to the achievement of our strategic priorities. The support of our staff is key to making the Care inspectorate an inspiring and safe place to work.	**Cautious**
Technology	Risks arising from technology not delivering the expected services due to inadequate or deficient system/process development and performance or inadequate resilience.	We are currently engaged in a programme of digital transformation designed to improve the technology out staff rely on. However, we do still have legacy systems in operation. We are willing to consider options for improving our technology and progress the option most likely to deliver success and the most valuable benefits. In doing so we are willing to accept a higher level of risk	**Receptive**
Information	Risks arising from a failure to produce robust, suitable and appropriate data/information and to exploit data/information to its full potential.	We are striving to become more intelligence led and ensure we fully exploit the data / information available to us. In pursuit of this aim we are willing to accept a higher level of risk	**Receptive**
Security	Risks arising from a failure to prevent unauthorised and/or inappropriate access to the estate and information, including cyber security and non-compliance with General Data Protection Regulation requirements.	The tolerance for risk taking is generally minimalist and is limited to those initiatives or events where there is little chance of any significant repercussion for the Care Inspectorate should there be a security failure	**Minimalist**

Project / Programme	Risks that change programmes and projects are not aligned with strategic priorities and do not successfully and safely deliver requirements and intended benefits to time, cost and quality	We are concerned that our projects and programmes are and remain aligned to our strategic priorities throughout the project / programme lifecycle. We do recognise that projects and programmes may be complex and realising benefits to time cost and quality is not a given, but we do expect robust governance that manages this risk	**Minimalist**
Reputational	Risks arising from adverse events, including ethical violations, a lack of sustainability, systemic or repeated failures or poor quality or a lack of innovation, leading to damages to reputation and or destruction of trust and relations.	We understand that reputational risk is of critical importance to the work we do. We therefore aim to be open, transparent and proportionate in our scrutiny and improvement work as issues arise. This is of significance across all our regulatory activities and the use of evidence and professional judgement and evaluation must be underpinned by sound and consistent approaches to risk assessment and quality assurance. The Care Inspectorate's risk appetite allows for decisions to be taken that have the potential to expose the Care Inspectorate to additional scrutiny from e.g., Government or media but only where appropriate steps have been taken to minimise any adverse exposure	**Cautious**

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Appendix 2

Risk Register Monitoring

Date	12 May 2021 for 20 May Audit & Risk Committee														
Risk	Changes to previous version are in red text.	Raw Likelihood	Raw Impact	Raw Score	Raw Grade	Residual Likelihood	Residual Impact	Residual Score	Residual Grade	Risk Velocity	Movement	Key Controls	Further Actions	Risk Appetite / Tolerance	Risk Owner
9	**<u>Staff Capacity</u>** **What is the Potential Situation?** We are not operating with sufficient staff to deliver our planned inspection and complaints activity. **What could cause this to arise?** Difficulties in recruiting staff, staff deployment to other activities, staff absence. **What would the consequences be?** An impact on our ability to achieve our Inspection and Complaints targets	4	4	16	H	~~4~~ 3	4	~~1~~ 6	H	Low	⇔	Performance report in place and reported quarterly to Board. Managers are reviewing capacity on a month to month basis Inspections are being prioritised according to the level of risk and intelligence we hold and in line with our Revised Scrutiny, Assurance & Improvement Plan 2020-21 approved by Ministers on 5.11.20 Staff overtime arrangements in place	Back-to back recruitment processes continue although numbers recently recruited have been less than we had hoped for. Together with higher-than-normal staff absences, this remains a high risk. HR are leading a dedicated project team involving external consultants and a cross-directorate group of staff to focus on recruitment.	Appetite: averse Tolerance: Low Rating: Red	EDS&A

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 14
Report No: ARC-15-2021

Title:	**COVER REPORT: DRAFT AUDIT AND RISK COMMITTEE ANNUAL REPORT TO BOARD 2020/21**	
Author:	*Kenny Dick, Head of Finance and Corporate Governance*	
Appendices:	1.	Draft Audit and Risk Committee Annual Report to Board 2020/21 and appendices
	2.	Draft 2020/21 Governance Statement
	3.	Significant Issues Letter
Consultation:	N/A	
Resource Implications:	No	

Executive Summary:	
The first draft of the Audit Committee's Annual Report to the Board is attached at Appendix 1. This covering report highlights areas that the Committee may wish to consider and details the timetable for the agreement of the report prior to its submission to the Board along with the 2020/21 Annual Report and Accounts on 23 September 2021.	
The Committee is invited to:	
1.	Consider and provide comments on the draft Audit and Risk Committee Report to the Board (Appendix 1)
2.	Consider and provide comments on the draft Governance Statement (Appendix 2)
3.	Note the Convener of the Audit and Risk Committee will write to the Director of Health Finance and Governance stating there have been no significant issues of a wider nature in 2020/21. This will be accompanied by the draft Governance Statement.
4.	Note the timetable for submitting this report to the Board (Section 4).

Links:	Corporate Plan Outcome			Risk Register Number		EIA Y/N	N
For Noting	**x**	**For Discussion**	**x**	**For Assurance**		**For Decision**	

COVER REPORT DRAFT AUDIT AND RISK COMMITTEE ANNUAL REPORT TO BOARD 2020/21

1.0 INTRODUCTION

1.1 The Scottish Government Audit Committee Handbook identifies an Audit Committee Annual Report as best practice.

1.2 There needs to be effective communication between the Audit and Risk Committee and the Board. The Care Inspectorate already recognises this through consideration of Audit and Risk Committee Minutes at Board meetings and a narrative summary of key points from Committee meetings.

1.3 The Annual Report enhances this communication by providing the Audit and Risk Committee's conclusions from the work it has done during the year, an overall assessment of the Care Inspectorate's governance and risk management framework and identifying priorities for the year ahead.

2.0 SPECIFIC ISSUES

This is the first draft of the report and is intended for Committee Members' consideration and discussion. The document as a whole is for the Committee to review but, this section draws Members' attention to specific areas of the draft Audit and Risk Committee Annual Report. There will be further opportunities to revise this report before submission to the Board on 23 September 2021.

2.1 Annual Report and Accounts (Section 7.1)

Section 7.1 of the draft Audit and Risk Committee Annual Report has been prepared to show the Audit and Risk Committee to have the opinion:

"the annual report and accounts taken as a whole is true and fair, balanced and understandable and provides the information necessary for stakeholders to assess the Care Inspectorate's performance and strategy".

It is not possible at this stage to confirm this opinion. This will need to be confirmed when this report is finalised at the 9 September 2021 meeting of the Committee.

2.2 Annual Governance Statement (Section 7.2)

The Annual Governance Statement is an integral part of the Annual Report and Accounts and is a statement that requires specific attention from the Audit and Risk Committee.

The first draft of the Annual Governance Statement is presented for the Committee to review as Appendix 2. The Committee should note this draft will be submitted to the Director of Health Finance and Governance to underpin the

Scottish Government governance statement provided by the Principal Accountable Officer (the Scottish Government Permanent Secretary). The letter requesting this information is attached as Appendix 3.

Areas highlighted in yellow on the Statement are to be updated to include 2020/21 information.

2.3 Audit Committee Developments (Section 9)

The narrative is a draft for the Committee to review.

2.4 Self-Assessment, Effectiveness and Development Review (Section 10)

The narrative is a draft for the Committee to review with a view to ensuring this accurately reflects the Committee's approach to effectiveness and development.

2.5 Priorities for 2021/22 (Section 11)

The narrative is a draft for the Committee to review with a view to ensuring the Board is informed of the Audit and Risk Committee's priorities for 2021/22. There may be other priorities the Committee would like to include in this section.

2.6 Audit Committee's Formal Opinion

The narrative here is the text that was submitted to the Board in last year's (2019/20) report.

This opinion is expressed as the opinion of the Audit and Risk Committee Convener, but it is important that the Committee as a whole is content with this opinion.

3.0 TIMETABLE

3.1

20 May 2021 First draft of Audit & Risk Committee Annual Report to the Board (including draft Annual Governance Statement)	The Committee is requested to take an initial overview of the report and suggest areas where the report can be improved. Comments and feedback from the Audit & Risk Committee will be incorporated into the next iteration of the report.

30 June 2021 Audit and Risk Committee Convener submits "Significant Issues that are Considered to be of Wider Interest" letter along with the draft governance	The Committee is requested to note the letter will be submitted based on the annual fraud disclosure (Section of the Committee Annual Report to Board) and the draft governance statement as amended for Committee comments will be submitted along

statement to the Director of Health Finance and Governance.	with this letter. Copy of the letter submission request is attached as Appendix 2).

12 August 2021 **(A&R Committee open to all Board members)** Second draft of Audit & Risk Committee Annual Report to Board and initial review of the Annual Report and Accounts.	The Committee is requested to review the report as revised for Committee comments from the 20 May meeting. Comments and feedback from the Audit & Risk Committee will be incorporated into the next iteration of the report.

9 September 2021 **(A&R Committee)** Final Draft of Audit & Risk Committee Annual Report to Board, final review of the Annual Report and Accounts and consideration of external Auditor's Report	The Committee is requested to agree the report as being ready for submission to the Board. The report includes the Audit and Risk Committee's recommendation that it is appropriate for the Accountable Officer to sign the Accounts and the Annual Governance Statement. The draft Annual Report and Accounts and the External Auditor's Report will be available at this meeting to inform these recommendations.

23 September 2021 **(Board)**	The Board considers the Annual Report and Accounts approval pack. This includes the Audit & Risk Committee Annual Report to the Board.

4.0 IMPLICATIONS AND/OR DIRECT BENEFITS

4.1 Resources

There are no resource implications associated with this report.

4.2 Sustainability

There are no sustainability implications associated with this report.

4.3 Government Policy

There are no government policy implications associated with this report.

4.4 People Who Experience Care

There are no direct benefits for people who experience care.

4.5 Customers (Internal and/or External)

There are no direct customer implications or benefits.

Agenda item 14
Appendix 1

BOARD MEETING 23 September 2021

Agenda item XX
Report No: B-XX-2020

Title:	AUDIT COMMITTEE ANNUAL REPORT TO BOARD 2020/21
Author:	*Bill Maxwell, Audit and Risk Committee Convener*
Appendices:	1. Committee Terms of Reference 2019/2020
Consultation:	
Resource Implications:	None

Executive Summary:
In accordance with the Audit and Assurance Committee Handbook, the Audit and Risk Committee prepares an annual report to the Board. This report presents a summary of the work of the Audit and Risk Committee during 2020/2021 and provides the Committee's opinion on the assurance that this work provides. The report also provides the outcome of the Committee's consideration of the 2020/2021 Annual Report and Accounts including the Annual Governance Statement. Following this consideration, the Committee recommends that the Board approves the 2020/2021 Annual Report and Accounts.

The Board is invited to:	
1.	Approve the 2020/2021 Annual Report and Accounts.
2.	Agree that it is appropriate for the Chief Executive to sign the Annual Report and Accounts at all appropriate points within the document.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**		**For Decision**	**X**

Agenda item 14
Appendix 1

AUDIT COMMITTEE ANNUAL REPORT TO BOARD 2020/21

1.0 INTRODUCTION

1.1 The purpose of this report is to provide evidence to the Board as to how the Audit and Risk Committee has fulfilled its remit, and how effectively it has discharged its responsibilities.

The report details the following:

- Summary of the Audit and Risk Committee's activities relating to the financial year 2020/2021.
- An opinion on the adequacy and effectiveness of the Care Inspectorate's framework of governance, risk and control and how the organisation has secured best value.
- The Committee's priorities for 2021/2022.

Furthermore, this report underpins the Board's own opinions in the Annual Governance Statement in the Annual Report and Accounts.

2.0 REMIT AND MEMBERSHIP OF THE AUDIT COMMITTEE

2.1 Remit

The Audit and Risk Committee meets at least four times per year. The main purpose of the Audit and Risk Committee is to review and maintain oversight of the Care Inspectorate's corporate governance, particularly with respect to financial reporting, system of internal control and risk management. The Committee's responsibilities also include oversight of the internal audit arrangements; engagement with the external auditors and their work; oversight and evaluation of the management of risks and business continuity planning; and to advise the Board on the development of performance measures which support the implementation of the Corporate Plan. The Committee's current remit is attached in Appendix 1. This was reviewed at the Committee's annual effectiveness and self-evaluation session on 4 March 2021.

2.2 Membership

The Board appoints non-executive Board members to the Audit and Risk, Committee. During 2020/2021 the following Board members served on the Audit and Risk Committee:

Gavin Dayer	
Rona Fraser	
Paul Gray	
Anne Houston	
Rognvald Johnson	
Bill Maxwell	Convener
Keith Redpath	

Where appropriate, the Committee augments the skills and experience of its members by seeking advice from internal and external auditors, and senior management.

3.0 RISK AND INTERNAL CONTROL

3.1 Internal Audit Reports

The Care Inspectorate's Internal Auditors, MHA Henderson-Loggie, presented three reports for consideration by the Audit and Risk Committee. 2021/22 was the first year of MHA Henderson-Loggie's engagement and significant time was devoted to an audit needs assessment and the development of the strategic internal audit plan.

MHA Henderson-Loggie use a system for categorising assurance levels. Each internal audit report provides an overall level of assurance and an assurance level for each control objective as follows:

Good	System meets control objectives.
Satisfactory	System meets control objectives with some weaknesses present.
Requires improvement	System has weaknesses that could prevent it achieving control objectives.
Unacceptable	System cannot meet control objectives.

In addition to the above control assessments, MHA Henderson-Loggie assign management action grades to demonstrate risk exposure. These are graded in terms of priority and are colour coded as follows:

Priority 1	Issue subjecting the organisation to material risk and which requires to be brought to the attention of management and the Audit and Risk Committee.
Priority 2	Issue subjecting the organisation to significant risk and which should be addressed by management.
Priority 3	Matters subjecting the organisation to minor risk or which, if addressed, will enhance efficiency and effectiveness.

The following reports were considered by the Committee:

Report	Committee Date	Control Objective Assurance Level	Management Action Risk Exposure
Risk Management	10 September 2020	**Control objectives:** 3 Satisfactory **Overall Assurance:** Satisfactory	4 Priority 3
Cash, Bank & Treasury Management	19 November 2020	**Control objectives:** 3 Good **Overall Assurance:** Good	No actions
Organisational Development	4 March 2021	**Control objectives:** 3 Good 1 Satisfactory 2 Requires Improvement **Overall Assurance:** Satisfactory	1 Priority 2 1 Priority 3

The Internal Audit Annual Report 2020/2021 was considered at the Committee's May 2021 meeting. The overall opinion of internal audit was expressed in this report as:

"In our opinion, The Care Inspectorate has a framework of controls in place that provides reasonable assurance regarding the organisation's governance framework, effective and efficient achievement of objectives and the management of key risks". *(will be adjusted to reflact MHA Henderson-Loggie Annual Report)*

3.2 Implementation of Audit Recommendations

Throughout the year, the Committee monitored management's progress towards implementing audit recommendations. This is achieved by reviewing the recommendations in follow up reports prepared by the internal auditors which summarise progress on completed actions at each meeting of the Committee.

The final follow-up report considered during 2020/2021 at the Committee on 4 March 2021 set out the position on the completion of management actions as at 28 February 2021.

There were 13 management actions brought forward from internal audits performed in previous years. Of these 7 (54%) were fully implemented and 6 (46%) were partially completed. The Committee was informed of progress and sought reasons and justification for revised completion date requests and subsequently approved these.

There were 6 new management actions agreed as a result of internal audit work performed in 2020/2021. Of these 1 (17%) was fully implemented during the year, 3 (50%) were not completed by the original due date and revised

implementation dates are agreed for 2021/22. The agreed implementation dates for the remaining 2 (33%) management actions are in 2021/2022.

The Committee has carefully considered all reports by the Internal Auditors and considers these to be comprehensive.

3.3 Committee Opinion

Overall, the Committee is of the view that the system of internal controls and management of risks associated with these is effective.

4.0 EFFECTIVENESS OF INTERNAL AUDIT

The Audit and Risk Committee is responsible for monitoring and reviewing the effectiveness of the internal audit function. The Audit and Risk Committee reviews the effectiveness of internal controls and receives reports from the Internal Auditors.

MHA Henderson-Loggie were appointed as internal auditors from 1 April 2020. The first year of MHA Henderson-Loggie's engagement required a detailed audit needs assessment to be completed. The audit needs assessment underpins the three-year Strategic Internal Audit Plan (2020-23) and both the assessment and strategic plan were considered by the Committee at its meeting of 10 September 2020. The annual Internal Audit Plans for 2020/21 and 2021/22 were considered at the Committee meetings of 19 November 2020 and 4 March 2021, respectively.

The review of annual and strategic audit plans strives to ensure a strong relationship between the planned internal audits, the strategic risk register and the Care Inspectorate's duty to provide best value.

5.0 ENGAGEMENT WITH EXTERNAL AUDIT

Grant Thornton, our external auditors are appointed by the Auditor General for Scotland.

The Committee engages regularly with external audit. The Committee considers the results of external audit work and the implementation of actions against audit recommendations. In March 2021, the Committee considered and subsequently approved the External Audit Plan for the 2020/2021 Annual Report and Accounts submitted by Grant Thornton. The Committee also monitors co-ordination and engagement between internal and external audit to ensure there is no unnecessary duplication of audit work.

6.0 RISK MANAGEMENT FRAMEWORK

A report on strategic risks is a standing item on the Committee agenda providing a facility for the Strategic Leadership Team to escalate any issues pertaining to risk including identifying any emerging issues.

Work on revising the strategic risk register and our risk appetite statement was started in 2020/21 and will continue into 2021/22.

This work will incorporate the implementation of the management actions identified in the internal audit report on Risk Management (overall assurance level of "Satisfactory"). The Strategic Risk Register is published on the Care Inspectorate's website.

The Committee monitor changes in the strategic risk position at each meeting and consider the Strategic Risk Register in full twice per year.

7.0 ANNUAL REPORT AND ACCOUNTS

7.1 Annual Report and Accounts 2020/2021

The Committee considered the draft 2020/2021 Annual Report and Accounts in detail at a meeting specifically arranged for this purpose in August 2021. This meeting was open to all Board members to attend.

The draft 2020/2021 Annual Report and Accounts were considered again in conjunction with the external auditor's report and management letter at the Audit and Risk Committee meeting of 9 September 2021.

Following this detailed review of the draft document and consideration of the external auditor's report, the external auditor's unmodified opinion and letter to those charged with governance, the Audit and Risk Committee consider the annual report and accounts taken as a whole is true and fair, balanced and understandable and provides the information necessary for stakeholders to assess the Care Inspectorate's performance and strategy.

7.2 Annual Governance Statement

The Committee has a specific responsibility to consider the Annual Governance Statement which is contained within the Annual Report and Accounts at section 3.3. The Committee is content the statement addresses all pertinent issues.

The Committee is of the opinion that the Statement fairly reflects the adequacy and effectiveness of the Care Inspectorate's governance and risk framework for the year ended 31 March 2020 and up to the date of approval of the Annual Report and Accounts.

7.3 Recommendation

The Committee recommends that the Board approves the Annual Report and Accounts for the year ended 31 March 2021 and the incorporated Governance Statement.

8.0 FRAUD, IRREGULARITY, WHISTLEBLOWING

8.1 Reported in 2020/2021

The Care Inspectorate's whistleblowing policy enables staff, in confidence, to raise concerns about any matters of possible improprieties and to be protected in doing so. There is also a Counter Fraud and Corruption Framework in place.

The Care Inspectorate has entered into an agreement with NHS National Shared Services Counter Fraud Service to support our efforts in the prevention, detection and investigation of fraud, bribery and corruption.

The Committee has not received any reports detailing fraud, irregularity or whistleblowing.

9.0 OTHER MATTERS

9.1 Pandemic Response

The Committee had oversight of the Care Inspectorate pandemic response through the addition of a specific Covid 19 strategic risk to the strategic risk register and the position was monitored throughout the year.

The Committee sought assurance that the Care Inspectorate had established and maintained effective arrangements for how it adopted its key decisions made during the pandemic and the ability to explain the rationale behind these decisions. The Committee considered a report by management at its meeting of 19 November 2020 and the Committee agreed this report provided this assurance.

9.2 Digital Programme

The Committee considered reports on the progress of the Digital Programme at each meeting of the Committee during 2020/21.

9.3 New Shared Service Governance Arrangements

The Committee recognises the drive to improve the governance and operational arrangements associated with the delivery of shared services between the Care Inspectorate and SSSC. The Committee ensured it was kept informed of progress throughout the year via a series of updates from senior managers on the progress towards agreeing new operational and governance arrangements for the delivery of shared services involving the Care Inspectorate and SSSC.

A member / officer short life working group with the Convener of the Audit & Risk Committee and another Committee member being the Board member representatives was set up during the year to maintain oversight of the process when it became clear progress was not as swift as originally anticipated.

10.0 SELF ASSESSMENT, EFFECTIVENESS AND DEVELOPMENT REVIEW

In March 2021, the Audit and Risk Committee undertook its annual self-assessment exercise using the Scottish Government's checklist as contained in the Audit and Assurance Handbook for public bodies. Individual assessments informed the Committee's discussion, following which it was agreed that the Committee's approach was largely compliant.

The following areas were identified for improvement and/or further development, including amendments to the remit of the Committee. These were reported to the Board at the annual Board Governance Review on 18 June 2020 and included the following:

- a more explicit role in reporting to Board on the Care Inspectorate's annual accounts and detail of the Committee's remit in reviewing accounting policies
- inclusion of Best Value within the Committee's terms of reference
- the ability for the Committee to co-opt, with the approval of the Board
- specific induction and training on audit for Committee members
- an improved committee administration process through scheduled pre-meeting reviews of final reports by the Convener, lead officer and secretariat.

11.0 PRIORITIES FOR 2021/22

In addition to ensuring effective oversight of internal audit, the Committee has agreed the following priorities for 2021/2022:

1. Further development of assurance mapping
2. Close monitoring of change management including the development of the new transformation business case and the subsequent implementation based on the approval of funding. A member/officer oversight group was set up in 2020/21 which will continue into 2021/22 to ensure there is a focus on digital transformation and the development of the stage 2 business case.
3. Consideration of the effectiveness of financial planning and budget monitoring and the risks to the organisation's financial sustainability.
4. Consideration of the impact of COVID-19 on the role and the work of the Care Inspectorate in the medium to long term.

12.0 AUDIT AND RISK COMMITTEE'S FORMAL OPINION

As Convener of the Audit and Risk Committee, I am satisfied that the frequency of meetings, the breadth of the business undertaken and the diversity of attendees supported by senior officers has allowed the Committee to fulfil its remit. It is important that attendance at meetings of the Committee is maximised to ensure a continued mix of skills appropriate to ensuring an effective Audit and Risk Committee.

The Audit and Risk Committee's review of effectiveness has highlighted some areas for development and I am satisfied that these have all been taken forward effectively.

The Audit and Risk Committee continues to engage formally and regularly with our internal and external auditors. This has ensured the Committee is able to fully understand the effectiveness of our assurance and risk functions and to be advised of any emerging risks.

The Audit and Risk Committee has carefully considered the effectiveness of controls and risk management. There is nothing material to the work of the Care Inspectorate which has been highlighted to the Board over the past year. We will continue to focus on challenging the effectiveness of internal controls and the robustness of risk management processes going forward.

I would pay tribute to the commitment of members of the Audit and Risk Committee and to all attendees. I am especially grateful to those who prepare reports and for the quality of professional advice given by senior management, particularly the Head of Finance and Corporate Governance and the Executive Director of Corporate and Customer Services. I am also extremely grateful to Fiona McKeand, Executive and Committee Support Manager, for her continued guidance and support.

13.0 IMPLICATIONS AND/OR DIRECT BENEFITS

13.1 Resources

There are no resource implications associated with this report.

13.2 Sustainability

There are no sustainability implications associated with this report.

13.3 Government Policy

There are no government policy implications associated with this report.

13.4 People Who Experience Care

There are no direct benefits for people who experience care.

13.5 Customers (Internal and/or External)

There are no direct customer implications or benefits.

Agenda item 14
Appendix 2

3.3 Governance Statement

Introduction

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Care Inspectorate's policies, aims and objectives. I am also responsible for safeguarding the public funds and assets assigned to the Care Inspectorate, in accordance with the responsibilities set out in the Memorandum to Accountable Officers for Other Public Bodies.

This annual governance statement explains the Care Inspectorate's governance and risk management framework.

Governance framework

Organisation structure

The Board is the governing body responsible for ensuring that the Care Inspectorate fulfils its aims and objectives, for promoting the efficient and effective use of staff and other resources and for identifying and managing risk.

The Board must approve the making, revision or revocation of standing orders, the code of conduct for members, the reservation of powers and scheme of delegation, and financial regulations. It must approve the annual report and accounts, budget, corporate plan, risk register and risk management strategy for each financial year.

The Board is also responsible for the approval of the appointment of internal auditors to the Care Inspectorate.

The Board oversees how the Care Inspectorate conducts its business to ensure operation in accordance with the principles of Better Regulation and Best Value.

The Board comprises the Chair and 10 members. The Chair and eight of the members are appointed by Scottish Ministers through the public sector appointment process. The Convener of the Scottish Social Services Council and the Chair of Healthcare Improvement Scotland also sit on the Board. It is a statutory requirement that appointments to the Board must have at least one member who uses or has used a care service and at least one member who cares for, or has cared for, a person using care services. The Board remains ultimately responsible and accountable for all the decisions taken in its name, whether directly or through its Audit and Risk Committee. The Board meets in public at least four times per year.

Board committees

The Board has one standing committee:

Audit and Risk Committee

This committee consists of a Convener and a minimum of four to a maximum of six Board members. Executive officers can be in attendance but are not members of the committee. The committee meets at least four times per year.

The committee makes recommendations to the Board with respect to the financial reporting arrangements of the Care Inspectorate, the external and internal audit arrangements, ensuring that there is sufficient and systematic review of internal control arrangements of the organisation, including arrangements for risk management and business continuity planning. The committee is also responsible for advising the Board on the development of the strategic performance management framework and the arrangements for securing Best Value.

Board members and attendance
Board members are subject to the Ethical Standards in Public Life (Scotland) Act 2000 and the Care Inspectorate Code of Conduct which has been approved by Scottish Ministers.

The Board and its committee review their effectiveness at least annually. There is a Board member performance appraisal process in place and from this each Board member has a development plan. Board and committee thematic development events are also regularly arranged and attended by Board members.

Board meetings are held in public and the minutes of each meeting are available on our website https://www.careinspectorate.com/index.php/publications-statistics/35-corporate-annual-reports-accounts/corporate-board-meeting-papers

Board Member Attendance at Meetings and Events 1 April 2020 to 31 March 2021

Board Member	Board	Audit		Appeals Sub Committee	Board Development Events	Total
Number of Meetings and Events						
	Attended	Member	Attended	Attended	Attended	Attended
Paul Edie, Chair		No				
Naghat Ahmed		No				
Sandra Campbell		No				
Gavin Dayer		Yes				
Rona Fraser		Yes				
Paul Gray		Yes				
Anne Houston		Yes				
Rognvald Johnson		Yes				
Bill Maxwell		Yes				
Keith Redpath		Yes				
Carole Wilkinson		No				

Accountable Officer
The Care Inspectorate's Chief Executive, Peter Macleod, is the designated Accountable Officer taking up this responsibility with effect from 7 January 2019. The Accountable Officer is personally responsible to the Scottish Parliament, for securing propriety and regularity in the management of public funds and for the day-to-day operations and management of the Care Inspectorate.

The detailed responsibilities of the accountable officer for a public body are set out in a memorandum from the Principal Accountable Officer of the Scottish Administration which is issued to the Chief Executive on appointment and updated from time to time.

Executive Directors
The Executive Directors support the Chief Executive in his Accountable Officer role through the formal scheme of delegation. In addition to the Chief Executive, the Executive Directors for the financial year 2020/21 comprised:

- Edith Macintosh, Executive Director of Strategy and Improvement and Deputy Chief Executive
- Gordon Mackie, Interim Executive Director IT, Transformation and Digital
- Kevin Mitchell, Executive Director of Scrutiny and Assurance
- Jacqueline MacKenzie Executive Director of Corporate and Customer Services (from 1 November 2020)
- Gordon Weir, Executive Director of Corporate and Customer Services (to 9 August 2020)

Each of these officers has responsibility for the development and maintenance of the governance environment within their own areas of control.

Internal audit
The Care Inspectorate's internal audit function has been contracted out. Internal audit forms an integral part of the Care Inspectorate's internal control and governance arrangements. The internal audit service operates in accordance with public sector internal audit standards and undertakes an annual programme of work approved by the Audit and Risk Committee. The Audit and Risk Committee reviews and approves the three-year Strategic Internal Audit Plan on an annual basis.

Each year our internal auditors provide the Audit and Risk Committee with assurance on the whole system of internal control. In assessing the level of assurance to be given for 2019/20, our internal auditors consider:

- All reviews undertaken as part of the 2020/21 internal audit plan.
- Matters arising from previous reviews and the extent of follow-up action taken.
- The effect of any significant changes in the Care Inspectorate's objectives or systems; and
- The proportion of the Care Inspectorate's review needs covered to date.

The internal auditor's overall opinion for 2020/21 was:

"the Care Inspectorate has a framework of controls in place that provides reasonable assurance regarding the organisation's governance framework, effective and efficient achievement of objectives and the management of key risks."

Whistleblowing
Our employee Staff Code of Conduct Policy and associated Whistleblowing Guidance informs and encourages staff to raise serious concerns about wrongdoing or alleged impropriety. The policy is consistent with, and makes explicit references to, the Public Interest Disclosure Act 1998.

Risk and risk management
The Care Inspectorate has a risk management policy. The main priorities of this policy are the identification, evaluation and control of risks which threaten our ability to deliver our objectives. The policy provides direction on a consistent, organised and systematic approach to identifying risks, the control measures that are already in place, the residual risk, the risk appetite and action that is necessary to further mitigate against risks.

Risks identified are maintained on a Strategic Risk Register and addressed in the preparation of the Corporate Plan. The Corporate Plan has been developed to show clear links between risks identified on the Risk Register and the Care Inspectorate's strategic outcomes. As a result, the risks identified become embedded in managers' work plans for the year. The Board has agreed a risk appetite statement to underpin the Care Inspectorate's approach to risk management and control.

System of internal financial control
Within the Care Inspectorate's overall governance framework, specific arrangements are in place as part of the system of internal financial control. This system is intended to ensure that reasonable assurance can be given that assets are safeguarded, transactions are authorised and properly recorded, and material errors or irregularities are either prevented or would be detected within a timely period.

The Care Inspectorate's system of internal financial control is based on a framework of financial regulations, regular management information, administrative procedures (including segregation of duties), management supervision and a system of delegation and accountability. Development and maintenance of the system is the responsibility of managers within the Care Inspectorate. In particular, the system includes:

- Financial regulations.
- Comprehensive budgeting systems.
- Regular reviews of periodic and annual financial reports which indicate financial performance against forecasts.
- Setting targets to measure financial and other performance.
- The preparation of regular financial reports which indicate actual expenditure against the forecasts.
- Clearly defined capital expenditure guidelines.
- Scheme of delegation.

Information security
The Care Inspectorate has a duty to ensure that the personal information entrusted to it is safeguarded properly.

We have information governance policies and procedures in place to ensure we handle data responsibly and comply with data protection and freedom of information laws. We also have a procedure to respond to suspected data breaches. In the year to 31 March 2021 there were 53 data security incidents which were:

- 39 data breaches
- 14 near misses

A near miss is where an incident is reported to the information governance team, but the incident was prevented, or it did not meet the definition of a personal data breach under GDPR.

However, no breaches reached the threshold for reporting to the Information Commissioner's Office.

Counter Fraud, Bribery & Corruption
The Care Inspectorate has a Counter Fraud, Bribery and Corruption Framework, including a counter fraud and corruption policy, strategy and response plan together with a formal action plan. We also maintain a fraud and corruption risk register to document the controls in place to mitigate fraud.

We have an agreement with NHS Counter Fraud Services (CFS) to provide fraud prevention, detection and investigation services.

Review
The effectiveness of our governance framework is reviewed annually as part of the preparation of this Governance Statement. Individual policies and procedures that contribute towards the overall governance framework are also subject to periodic review.

This review is informed by:
- The views of the Audit and Risk Committee on the assurance arrangements.
- The opinions of internal and external audit on the quality of the systems of governance, management and risk control.
- 'Certificates of assurance' supplied by Executive Directors following a review of the governance arrangements within their specific areas of responsibility.
- Regular formal monitoring of progress against corporate plan, business plan and budget.
- Feedback from managers and staff within the Care Inspectorate on our performance, use of resources, responses to risks, and the extent to which in-year budgets and other performance targets have been met.
- Integrated formal reviews of the effectiveness of the Board and its committee.
- Periodic staff surveys.

Developing the governance framework
The following developments were identified for 2021/22:

- We will continue to develop our risk management framework and adapt our processes to suit the recently constituted Strategic Leadership Team (SLT) and Operational Leadership Team (OLT).
- We will build on the assurance mapping work already undertaken.
- Our testing and review of our Business Continuity Management System will continue.
- We will develop a new Corporate Plan for 2021 to 2024.
- Aligned with the new Corporate Plan we will continue the development of the Strategic Performance Management Framework.
- We are reviewing our cyber security during 2021/22.
- We will submit a business case for stage 2 of our Transformation Programme and will ensure that appropriate governance arrangements are in place to support the delivery of stage 2 objectives.
- We continue to work with the Scottish Social Services Council (SSSC) to review our shared services and the governance arrangements. We will seek final approval from the SSSC Council and our Board in early 2021/22.

Impact of Pandemic

When the COVID-19 pandemic took hold in Scotland in early March 2020, we acted quickly to change our approach to scrutiny and improvement support and implement different approaches in order to keep people safe in the face of the escalating pandemic.

Given the evident risk that our staff could transmit or spread COVID-19 in services, we took the decision, with advice from directors of public health that it would have been untenable to carry on business as usual and continue with onsite scrutiny interventions at that time.

Our governance our response included:

- The introduction of Gold and Silver management teams that met very frequently. The Gold and Silver teams maintained comprehensive policy and decision logs to ensure we could manage the pace of developments.
- Adjusted and suspended some of our key performance measures.
- Included the impact of Covid 19 as risk on our Strategic Risk Register
- Agreed a revised Inspection Plan with the Minister.
- A concerted and sustained effort to ensure the health, safety and wellbeing of our staff, people who experience care, care workers and other stakeholders.

Certification
The Care Inspectorate's governance framework has been in place for the year ended 31 March 2021 and up to the date of signing of the accounts.

It is my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the Care Inspectorate's systems of governance. The annual review has provided sufficient evidence that the Care Inspectorate's governance arrangements have operated effectively and that the Care Inspectorate complies

with all relevant laws, regulations, guidance and generally accepted best practice in all significant respects.

AUDIT AND RISK COMMITTEE 20 MAY 2021

Agenda Item 15
Report Number: ARC-16-2021

Title:	**DIGITAL PROGRAMME UPDATE**
Author:	*Gordon Mackie, Executive Director of ICT, Transformation and Digital*
Appendices:	1. Action record of Member/Officer Assurance and Advisory Group meeting
Consultation:	**n/a**
Resource Implications:	**No**

EXECUTIVE SUMMARY	
This report provides the Audit and Risk Committee with an update on recent progress of the Digital Programme. The report is focussed on Stage 1, which covers Complaints and Registrations and The Register The report outlines the delivery progress and gives update on latest programme finances and overall progress including the impact of the COVID-19 response.	
The Audit and Risk Committee is invited to:	
1.	Notes the information contained in the report on Digital Programme Update.

Links:	Corporate Plan Outcome Key principles	1-7	Risk Register – Y/N	Y	Equality Impact Assessment - Y/N	N	
For Noting	**X**	**For Discussion**		**For Assurance**		**For Decision**	

If the report is marked Private/Confidential please complete section below to comply with the Data Protection Act 2018 and General Data Protection Regulation 2016/679.

Reason for Confidentiality/Private Report: N/A
Disclosure after: N/A

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

DIGITAL PROGRAMME UPDATE

1.0 INTRODUCTION

1.1 Background

This report updates the Audit and Risk Committee on progress on Stage 1 of the Digital Programme.

The scope of Stage 1 covers:

- Complaints
- Registration: Phase 1 (the external facing application form)
  Registration: Phase 2 (developing the app to support our internal registration business processes, the Register and associated updates)

1.2 Purpose

This report provides an overview and analysis of the programme, the achievements to date, a financial analysis, and an update on the current position on meeting the requirements and recommendations of the external assurance assessments, including our recent Digital First and Gateway reviews and preparation for our Go Live Gate review.

2.0 PROGRAMME DEVELOPMENTS

2.1 Overall Progress

The Digital Programme has continued to make progress in the backdrop of the ongoing pandemic, which at times has been challenging. The focus of the programme over the last period has been completing Registrations and The Register work along with preparing for our Go Live assurance assessments via Scottish Government Digital directorate.

The “Go Live” gate process for Digital First was concluded in March 2021. The outcome of the assessment was confirmation that the Digital Assurance Office was satisfied we were able to go live with our Public Beta Register, associated functionality and final stages to grant registration to place a service on the Register.

December 2020, the Strategic Leadership Team (SLT) recognised current operational pressures (as was), mounting pressure on us as an organisation from many external sources which were expected to run into January 2021(this was pandemic related). This, along with the pandemic continuing to grow and case numbers rising, resulted in a discussion around the delivery of Phase 2 of Registrations and The Register. We supported this approach and aimed to go live in early March 2021. As a result of a robust testing process, we identified an issue which we required to resolve before we could go live. As a result, we agreed with the business a two month extension which meant a new go live date was agreed of 23 March 2021.

The complaints app has had minimal work completed since the last report. We are working closely with the Service Manager, Complaints, to ensure the prioritisation of work based on their immediate business needs. We are also working closely with colleagues in the complaints team to address some service availability issues which have arisen. This will resolve short term challenges as well as outstanding areas known to the team.

The Digital team released into production the full functionality of creating a service on the register and the provider and internal actions associated with the register:

- Data migration of all active services to generate The Register
- Grant and refuse a registration
- Variation of conditions
- Cancellation
- Change of details (update by provider option as well as request for approval by inspector)
- Illegally operating services case log
- Inactive services

Inflight registration cases continue to be progressed by business support colleagues with the digital team supporting access “by proxy” to ensure the applicant/provider has limited duplication of effort into the new system.

All changes and updates of progress continue to be reported to the Programme Board. There have also been regular updates to the Digital Transformation Programme Member/Officer Assurance and Advisory Group (action note of latest meeting is at appendix 1.)

2.2 Direct and Indirect Impact of the COVID-19 Response

All aspects of Care Inspectorate activity, including digital, have been impacted by the COVID-19 pandemic. In mid-March there was a decision to require all staff to work remotely. The Digital team has always had a mixture of team members who have partially worked from home but given this affected the whole team there was some adjustment required to support staff to operate as effectively as possible in a constant remote working basis and this has had an understandable impact on overall productivity.

The Digital team has supported the Care Inspectorate’s overall response to the COVID-19 pandemic. The re-purposing of the organisation has required changes and developments in our e-forms to support the revised notifications process.
To date, the Digital team has undertaken over 100 hours of such work.

The team has been impacted by “COVID fatigue”. This impacts the team by not having the support of in-room discussions and access to all parts of the team, testers, business analysts, developers and product owner. Whilst “MS Teams” has been a useful tool for communication it cannot replace the benefits of face-to-face team problem solving sessions.

2.3 The Complaints App Update

The Complaints App initially went live in March 2019. End to end functionality was delivered by August 2019.

During the last nine months there has been minimal new functionality work being undertaken with only service activity work being scheduled.

The digital team will now engage with the business over May/June to ensure that any current business requirements can be agreed and activity planned to ensure this work is then undertaken.

2.4 Registration Phase 1

As reported at the last meeting of the Audit and Risk Committee, Phase 1 of the Registration app (the digitised application form) went live on 28 January 2020. During the pandemic we have seen the volumes of new registration applications drop. The general feedback from users continues to be very positive. The Registration app has over 1000 applications which have been started since launch 10 months ago. Of the 1000, over 400 have been completed and submitted to be processed to grant registration (or refuse).

2.5 Registration Phase 2 (including the Register) – Progress

The full release of registration and the register including all associated functionality went live on 23 March 2021. This reduced by a significant amount, the risk of PMS and therefore the register failing.

It should be noted that this has been one of the biggest and complex changes the Care Inspectorate has delivered in the last number of years. This has meant that for operational colleagues that in the short to medium term has brought some degree of impact to their day-to-day activity. The digital team has remained close to all operational teams supporting them through this period and will continue to do this until we move the delivery out of hypercare into business-as-usual footing.

These are the processes underway since go live (below) – a number of these are “inflight” cases where Care Inspectorate business support teams have transferred from PMS into the new app. This reduces the burden of duplication of effort from the applicant/provider. Illegally operating services is a new function created to support operational colleagues. That function was not available in PMS.

Application Type	Count
Registration Applications Created	170
Variation requests (in flight)	578
Voluntary Cancellation Requests	99
Inactive Service Requests	31
Illegal Service cases opened	3
New Services Registered	17
Change of Detail Requests	228
Change Of Details Self Service	107

The programme board was tasked with confirming go live agreement. This was subject to agreement by the Digital First to go live following the "Go live" gate assessment. This was conducted in early March and resulted in nine recommendations.

The timing of the "Go Live" gate meant that the actions classed as critical were planned or underway but not completed by the time the assessment concluded.

They included user testing, confirmation of go live criteria for decision making and appropriate call off options. The report highlighted;

Recommendation	Action	Met/not Met
4.1 Planning	That Programme Board requires the PT and business representatives to bring forward pre-defined criteria from which the Go-Live decision will be derived. The criteria should be authorised by the SRO and business lead.	**Met**
4.2 Governance	That the business owners, in conjunction with the PT, establish a backlog management process that reflects the full scope of functionality delivered through the Gold Build, the functionality planned in future releases. The process should also accommodate new requirements being added.	**Met**
4.8 Testing	That the project determines the aspects of testing, which could be deemed prejudicial to a Go-Live decision and include these within the overall Go-Live criteria.	**Met**
4.8 Testing	That project undertakes end-to-end testing.	**Met**

These recommendations were classified as

Critical	The recommendation requires to be actioned before the project can be given approval by the Digital Assurance Office to move to the next stage of the project.
Essential	The project should take action to address the recommendation before the next Technology Assurance Review or by a timeline specified by the report.
Recommended	Potential improvements can be made and the project should plan this activity into their future work to a timeline specified by the report.

The programme board convened on 22 March and was given a presentation by the digital team on progress to go live to assist with their decision making. All criteria had been met and the Programme board agreed go live. There was a discussion as part of this decision making on having a slight further delay, but the balance of opinion at the board was to go live.

Testing was carried out to ensure the functionality was fit for purpose. A summary report was provided to the programme board detailing how we met all test criteria for go live.

Test Phase	Overall Tests Run	Overall Pass	Overall Fail	Overall Not Run	Defects outstanding	Exit Criteria	Go/No Go	Notes
System and Migration Testing	5238	100%	0%	0%	23 - P3 Defects 4 - P4 Defects	0 High Level Defects 0 Medium Level Defects	Go	
User Acceptance Testing (including End to End)	399	78%	10%	12%	3 Low priority	0 High Level Defects 0 Medium Level Defects	Go	Some tests were not executed due to unavailability of UAT users, however the functionality has all been covered by the remaining UAT Testers. Therefore the Overall Pass seems to be lower.
Penetration Testing	187	95%	5%	0%	1 High - fixed awaiting retest 1 Medium - fixed awaiting retest	0 High Level Defects 0 Medium Level Defects	Go	Risk Assessment carried out and agreement in place to address.
Accessibility Testing	51	94%	6%	0%	3 Low priority	0 High Level Defects 0 Medium Level Defects	Go	
Performance Testing	100%	100%	100%	100%	No defects	0 High Level Defects 0 Medium Level Defects	Go	Average performance time is 1.2 second

Data Migration

The existing register held on PMS had nearly 18,000 registered services including those cancelled in the past five years, which had to be migrated onto the new service. This was done using a migration software tool to encode the translation. This was configured and extensively tested over twelve weekly cycles each which ran a test migration on a copy of production data. A tool was developed to check automatically the 2,500,000 data values generated by each trial. The data in PMS suffered from many quality issues which the migration had to accommodate: initial tests raised over 250,000 issues, which were iteratively addressed and retested until under 100 remained, all of which were trivial (eg capitalisation and extra spaces in text).

It was not feasible to resolve all PMS data quality issues, so some remain in the new register to be raised and resolved on a case-by-case basis through the support desk. However no significant issues have been raised as a result of bugs in the migration.

Public Beta Go live

Register (Public Beta) Go-Live exit criteria

#	Criteria	State	Notes
	Development		
1	Dev complete for all Register Public Beta work	GO	
2	GOLD Build ready to deploy	GO	18/2/21 Gold Build declared
3	Code freeze in place	GO	
	Testing		
4	Disability testing completed	GO	Webusability testing
5	Accessiblity completed	GO	WCAG2 compliant
6	Pen test completed and risk assessments are accptable for 2 issues	GO	Retest complete and Ras in place
7	UAT & E2E Complete	GO	
8	No P1 or P2 bugs	GO	P3 and P4 in backlog to be addressed
9	Data Migration testing completed	GO	NES support to deliver
10	Performance testing completed	GO	
11	Test Closure Report completed and signed off	GO	
	Business Readiness		
12	Comms Plan	GO	underway
13	Users received guidance / demos on Register system	GO	To be provided tthrough BRG
14	Practice area available	GO	
15	Accepted workarounds signed off by business	GO	
16	Hypercare plan communicated, training completed, resources in place	GO	Final ServiceNow categories to be confirmed 22/3
	Governance		
17	IT/OPS support	GO	
18	Rollback Plan confirmed and approved	GO	
19	Run book started	GO	
20	Business sign off confirmed (CI, BS and Intel team)	GO	
21	CAB Approval	GO	
22	Digital First Critical Actions Completed	GO	
23	Programme Board sign off	GO	
24	SRO Sign off	GO	

The Programme board confirmed go live on Monday 22 March 2021.

Post Go live

Digital team has been working since go live in close partnership with colleagues from across the business to support this change. This involves a range of communication channels to support collaboration and prioritisation of any subsequent updates to either fix bugs or add new functionality.

Given how large and complex this change was for business colleagues it was important that there were very clear and transparent communication channels in place.

Programme Communication Channels

Business Readiness Group – meets weekly with wide membership from across the organisation including inspectors, TM's, intelligence team, communication team, business support colleagues. Supports guidance, organisational communications including surgeries and Teams live events.

Senior Stakeholders meetings/reports – Chief Inspectors and Head of Customer Service, weekly meeting face to face to consider range of issues including communication needs of wider teams, issues and themes arising. Includes weekly report including details of hyper care statistics and release planning.

Business Stand ups – key stakeholders meet with digital team. Initially daily and now three times a week to raise key themes arising for the wider organisation.

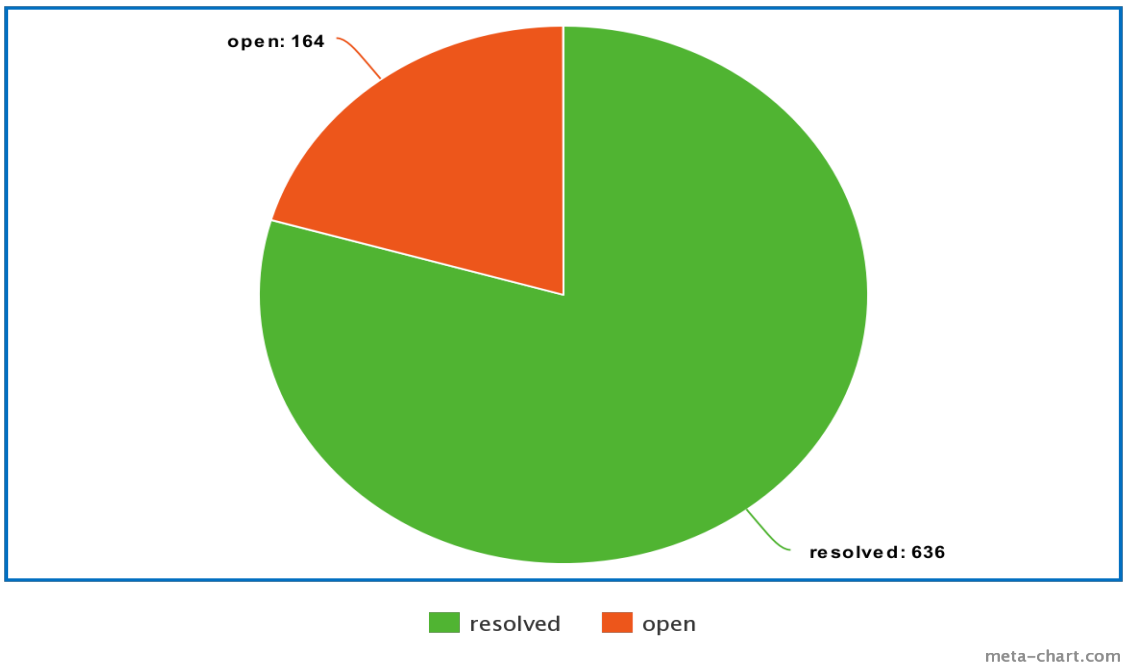
Weekly communication meetings – Weekly meetings are held with Communication colleagues to ensure all areas are kept informed with the latest internal and external communication. A dedicated intranet page to update staff on the latest developments with an area for demos of functionality and guidance as well as weekly reports including details of hypercare statistics.

Hypercare

"Hypercare" is a term we use to provide support following identification of any issues post go live. We categorise these as being:

- Bugs – where something is not working
- Changes - to process
- Edits - to assist understanding or flow within the app
- Information – where would respond with a FAQ style response
- Business decision – where it is business rules that are needed, require updated or followed.

As at 30/4/2021 - 800 Hypercare tickets logged of which:



Release History Post Go live

We have been working with our colleagues since go live to make additional releases to ensure we can respond to bug fixes in a timely manner, and we have also released agreed additional functionality to enhance the Register and Registration Application.

3.0 EXTERNAL ASSURANCE ASSESSMENTS

The Digital Assurance Office (DAO) team in Scottish Government agreed to our request for a "Go Live" assessment. This was caried out by two external assessors over 10 days. Four days reviewing evidence submitted and six days interviewing and report writing.

The process is assessed against the Scottish Government Digital Directorates Technology Assurance Framework. This is an aggregation of the digital standards under nine separate headings.

4.0 PROGRAMME FINANCES

The budget position for business transformation and the ICT modernisation is managed within the core Care Inspectorate budget monitoring process. The original programme total costs were estimated at £4.988m over the four years to 2020/21.

The latest estimates are for costs of £5.335m which is £0.347m more than originally anticipated. As the Care Inspectorate did not receive all the funding it requested (£2.3m compared to our request of £3.2m), additional funds have been allocated from within existing budgets and from the general reserve. We intend to fund £0.712m of non-recurring development in 2020/21 from our reserves.

5.0 NEXT STEPS

The digital team will continue to work closely with operational colleagues and respond to any urgent need for action as we continue through the hypercare period.

The plan is to exit hypercare by end of May 21. Generally, hypercare would be for a shorter period, but given the size and complexity of this change, we want to fully ensure this new service is ready to hand over to a business as usual state and therefore have extended it by an additional month.

Post exiting hypercare there will continue to be work delivered on Registrations and The Register (like there was on complaints initially) as we work with the business to add additional functionality and address any issues that arise from using the new service in live operations.

6.0 OTHER IMPLICATIONS AND/OR DIRECT BENEFITS

6.1 People Who Experience Care

By investing in our ICT and digital capabilities, staff will be well equipped to deliver our outcomes for people experiencing care in Scotland.

6.2 Customers (Internal and/or External)

Modernising our ICT and digital capabilities will have a positive impact on both the internal and external customer experience. This will result in more timely and better quality information being available to support the scrutiny and delivery of care.

Agenda item 15
Appendix 1

ACTION RECORD

Meeting:	**Member/Officer Assurance and Advisory Group – Digital Transformation Programme**
Date/Time/Venue	10 May 2021 at 9.30 – 10.30am by Teams video-call
Present:	Anne Houston (Board member and Chair of Group); Paul Gray (Board member); Peter Macleod (Chief Executive); Gordon Mackie (Executive Director of IT, Transformation and Digital)
In Attendance:	Louise Bremner (Business Transformation Support Officer)
Apologies:	

Agenda item 15
Appendix 1

Number	Item	Discussion Points	Action	By Whom	By When/ Completed
1.0	**Welcome/Matters Arising**	AH welcomed all members to the meeting.			
2.0	**Action Record**	Action record noted as accurate. AH enquired about the outstanding actions and was advised that GM would redraft the second paragraph on section 4.0 on the CI digital vision from the December action record to make PG's point clearer. LB to send link to AH & PG to highlight the dedicated intranet area for Registrations and the Register information.	GM to redraft the paragraph and run by AH and PG. LB to send link to AH & PG to highlight the dedicated intranet area for Registrations and the Register information.	GM LB	Action Complete Action Complete

3.0	**Exception Reporting**	GM opened by providing members with an update on progress following Registrations and the Register going live on 23 March 2021. It was noted that a fortnightly maintenance window has been established and that some data issues have been encountered but none with any material impact. Members were informed that 880 tickets have been logged, 703 have been resolved and that there are 177 unresolved at this stage. It was noted that of the 177, this has been broken down into 30 issues which the Digital team are now focussing on. Members were presented with a table detailing the number of tickets being raised on a week by week basis to provide an understanding of the number of tickets and their current status. It was noted that we are not on the downward slope yet however a number of the issues are in the moderate bracket of P3s & P4s with only a few P2s which are currently being worked on. GM advised that there is now an issue log so that the team can define how many tickets relate to what issue. GM continued by stating that the introduction of this phase of the app has been a very complex change for the organisation. It was noted that the team have worked closely with the business and that weekly senior stakeholder meetings are in place. A daily meeting is held with key stakeholders from the business to explore the			

3.0	**Exception Reporting**	themes and challenges. This meeting has now been reduced to 3 times a week. The Business readiness group also meet once a week. PG queried how confident are we that the tickets do not relate to people wanting it to be different as opposed to something that is wrong or needs to be fixed? GM advised that there is a design bucket and anything that is not seen to be part of the minimal viable product will be placed into that bucket and would be reviewed with the business in time. Members were informed that within the last week, the team have been delving further into the tickets so to gain a much better understanding of the issues. AH queried whether there have been any major surprises through that process? GM advised that the organisation really does not understand change and that their experience of designing systems is at the low end. It was noted that there had been some surprises however no material problems and that these have been down to the maturity of the people that we are working with in terms of their experience of change. It was noted that over the next few weeks, it is hoped that the hypercare backlog will start to shrink and this is what the focus is on. Part of the challenge has been that some fast follows have			

3.0	**Exception Reporting**	been agreed and in addition to this the team have been supporting hypercare. Some of the fast follows have been delivered and the focus is now on reducing the hypercare backlog which will hopefully bring up confidence in the system. The 3 main themes of hypercare are as follows: Change of details – challenges around data input and the mandatory information requested. This will be resolved by reducing the number of mandatory fields to assist our providers. Portal access – challenges around setting up new accounts. The team have been very responsive on this matter and have contacted providers directly to assist. Communications log – there are tweaks and changes required in order to make the log better and more effective and there is a workshop with the business this week to explore that. It was noted that the next steps are to continue to work with the business to ensure there is alignment on approach and to reduce the hypercare issues. A detailed plan for moving from hypercare to BAU has been drawn up and the team maintain regular contact with management on progress. GM added that the team continue to be open and transparent with the organisation and that it has been challenging especially when delivering a			

3.0	**Exception Reporting**	complex and large change under the current pandemic. It was noted that this has been a large and complex change for the organisation however small green shots can be seen and it is about bedding the new service into the organisation. PG queried if there are any reflections on the current business impact and anything that could be done to encourage the organisation to recognise the worth of what has been introduced. PM advised that there had been some push back and that a discussion has been arranged with SLT which will be critical in terms of moving forward. There has been some slowing down in the business as we have had to work through how registrations work as have providers. It was noted that some resistance is an inevitable part of the change programme and that the change has meant people having to work harder during difficult times and that colleagues have found the demands on their time more intense. It is hoped that following the SLT meeting that we can reunite all of the teams towards common purpose. AH queried if there is confidence that the SLT are on board as they will be able to push down in a constructive way. It was noted that the main piece of work is on the organisational structure of the Scrutiny and Assurance Directorate and this is the focal point of where the cultural approach lies.			

3.0	**Exception Reporting**	GM added that we are much more open and transparent around change and will face into the issues posed whilst supporting the business. It was noted that surgery sessions have been introduced. This involves a small group of operational team members and small group of the delivery team and allows for collaboration. The surgery allows the team to understand what their pain points are and can provide some additional help and guidance in a very small group. By going to SLT it is hoped to agree the realignment of where we are and where we are going. AH queried if champions within the business could be identified as this could aide with confidence in the system if you have a few champions that are really onboard. It was noted that this is currently done through the business stand up where there a number of representatives from key areas of the business. It was noted that in terms of communications to the organisation that these would now be reduced and focus would be placed on the champions and allowing them to agree the prioritisation of the work.			

5.0	**Stage 2 Business Case**	GM opened by advising members that the business case had taken longer than anticipated given the pandemic and the challenges experienced over Christmas with the new variant and subsequent lockdown. It was noted that the business case was sent to some senior managers at the end of April and the feedback received has been collated. A framework has been created which will allow information to be captured and will provide a tool that allows us to know exactly what feedback we have had and whether it has been addressed or if it is felt it is not appropriate at this point to address it for a number of different reasons. The SLT will be provided with an overview of the business case on Wednesday. GM advised that unless there is anything fundamental or material that should come out of that meeting that he would share that update with AH and PG. It was noted that there is a Scottish Government business justification gate. It is proposed this will be done early June before presenting the business case to the full board so that there is assurance around the business case at some external level. GM believes the business case will be presented at the August Board. It was noted that the business case would be informally shared with Scottish Government sooner rather than later. It	GM to share SLT update information with AH & PG.	GM	ASAP

5.0	**Stage 2 Business Case**	would then be formally presented post the Board in August/September. PM advised that we need to be mindful of the Feeley review and the new parliament to be formed. It was noted that the approach that has been taken for the Feeley review is that time has been dedicated with Kevin Mitchell (Executive Director of Scrutiny and Assurance) plus 2 Chief Inspectors to feed into the teams at Sponsor branch. PM continued to inform members that at the SLT meeting on Wednesday there will be a full presentation from the consultant who is working with HIQA. It was noted that there would be discussion around the structure of the organisation and whether it is going to be fit for purpose going forward. It was noted that there needs to be some thought about the shape of the organisation whatever that may be. It was noted that PG feels the interactions with the Feeley review are very important. In terms of the time tabling for the business case PG discussed with members if some flex should be built into the timetable to allow the team a fraction of elbow room. PM agreed that it is about judging the timeframe correctly and having something to offer that helps to shape and influence.			

		Finally, GM advised that he would aim to formally submit the business case to the Scottish Government in August/September but that this would be dependent on direction, speed of the new government and approach to Feeley. It was noted that the group agreed with this approach.			
6.0	**AOCB**	AH confirmed that Paul Edie sent an emal to confirm that this group should continue.			

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 16
Report No: ARC-17-2021

Title:	**SENIOR INFORMATION RISK OWNER (SIRO) ANNUAL REPORT - FINANCIAL YEAR 2020-2021**	
Author:	*Information Governance Lead*	
Appendices:	1.	Overview of Information Governance Improvement Plan
	2.	Summary of revised deliverables.
	3.	SIRO Report
Consultation:	Head of Risk and Intelligence Executive Director of Strategy and Improvement	
Resource Implications:	N/A	

EXECUTIVE SUMMARY	
This paper outlines the work completed to date by Information Governance to deliver the transformation required to make our data 'Safer and More Secure'. Due to the impact of the pandemic, particularly with the increase in Freedom of Information (Scotland) Act requests, some deliverables have had their deadlines extended into Financial Year 2021-2022. Good progress has been made in establishing and implementing our new information governance tool (OneTrust), as well as improving our information asset management. A summary SIRO report is provided which gives an overview of the tasks completed this Financial Year 2020-2021	
The Audit and Risk Committee is invited to:	
1.	Note the work completed to date and the forward plan.
2.	Note the SIRO Report

Links:	Corporate Plan Outcome	Y	Risk Register - Y	Y	Equality Impact Assessment	N

For Noting	x	For Discussion		For Assurance		For Decision	

Reason for Confidentiality/Private Report: *(see Reasons for Exclusion)* N/A
Disclosure after: N/A

AUDIT AND RISK COMMITTEE MEETING 20 MAY 2021

Agenda item 16
Report No: ARC-17-2021

Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters relating to terms and conditions of employment; grievance; or disciplinary procedures relating to identified members of staff.
d)	Matters involving commercial confidentiality.
e)	Matters involving issues of financial sensitivity or confidentiality.
f)	Matters relating to policy or the internal business of the Care Inspectorate for discussion with the Scottish Government or other regulatory or public bodies, prior to final approval by the Board.
g)	Issues relating to potential or actual legal or statutory appeal proceedings which have not been finally determined by the courts.

Agenda item 16
Report No: ARC-17-2021

SENIOR INFORMATION RISK OWNER (SIRO) REPORT: FINANCIAL YEAR (FY) 2020-2021

1. INTRODUCTION

The Information Governance (IG) lead has built on the work delivered to date to make the Care Inspectorate information and data 'Safer and More Secure' as detailed in Stage 2 of our improvement plan: see Appendix 1 for an overview of the plan.

The reporting cycles and training to inform the SIRO Information Risk Report, have not yet embedded to provide an end of year report as originally reported to the Audit and Risk Committee on 3 March 2020.

Both deliverables have been delayed due to the COVID-19 pandemic as the IG team had to cease all improvement and transformation work from Quarter (Q)1 FY 2020-2021 to Q2, due to the volume and complexity of Freedom of Information (Scotland) Act (FOISA) requests.

This paper provides a summary of progress to date against the original plan and outlines a revised timetable for the SIRO Information Risk Report. A summary of revised deliverables is provided at Appendix 2.

2. INFORMATION RISK WORKPLAN

2.1 Maturity Modelling and Benchmarking

As reported in March 2020, the Care Inspectorate needs to know how well it is performing in terms of information and data management against external benchmarks that reflect statutory requirements.

It was planned to have a maturity tool by 31 March 2021 based on:

- The NHS Data Security and Protection toolkit
- The Information Commissioners Office Data Protection Self-Assessment
- The National Records Scotland (NRS) – Records Management Plan

The initial assessment of the Care Inspectorate Records Management Plan (RMP) from NRS was delayed and not received until mid-March 2021 due to their pandemic response. This requires further clarification and engagement before formal re-submission (projected 31 May 2021). It is therefore expected that the maturity modelling and benchmarking assessment will be fully up and running around the end of Q3 FY 2020-2021, with the first report on progress being issued to the SIRO at the end of Q4 FY 2020-2021.

- ✓ *This activity supports the Corporate Plan values of Fairness, Integrity and Efficiency.*

- ✓ *This activity supports the Corporate Plan principle of Well Governed.*
- ✓ *This activity supports Strategic Outcome 3 - People's rights are respected.*

2.2 Statutory Compliance

2.2.1 Records Management Plan (RMP)

As explained above, the RMP review by the NRS was delayed. It is expected that the plan will be signed off before the end of Q3 FY2020-2021. At that point elements of the plan will be incorporated into our maturity modelling.

In addition, any records management risks associated or identified via the plan will be incorporated into the information risk reporting (see 2.4.1). The plan will then be reviewed in its entirety on an annual basis.

- ✓ *This activity supports the Corporate Plan value(s) of Integrity and Efficiency.*
- ✓ *This activity supports the Corporate Plan principle(s) of Well Governed, Co-Operation and Collaboration.*
- ✓ *This activity supports Strategic Outcome(s) 3 - People's rights are respected.*

2.2.2 Freedom of Information Scotland Act 2002 (FOISA)

The Office of the Scottish Information Commissioner has a statutory function as outlined in the Act (S43) in terms of upholding good practice of the Law. They discharge this function in part by asking all Public Bodies to submit statistics in relation to their responses relative to the act the full return with narrative is included at Appendix 3 in the SIRO Report.

- ✓ *This activity supports the Corporate Plan value(s) of Fairness, Integrity and Efficiency.*
- ✓ *This activity supports the Corporate Plan principle(s) of Well Governed, Customer Focussed, Co-Operation and Collaboration.*
- ✓ *This activity supports Strategic Outcome(s) 2 People experience positive outcomes and 3 - People's rights are respected.*

2.3 Information Asset Management

As outlined in our last report, there are many reasons for good information asset management:

i. Statutory; for example, the need to protect and manage personal data (Data Protection Act (DPA) 2018/General Data Protection Regulation (GDPR) 2016).
ii. Cyber Security; for example, the prevention of successful malware attacks (Cyber Essentials Certification).

iii. Government Security Policy Framework – Mandatory Requirements 3, 5 and 6.
iv. ISO 27001:2005, which is the international standard for an information security management system.

The most important reason for good information asset management is to 'make it easy for our staff to do the right thing'.

There has been good progress this year as the Information Asset Register has been incorporated into the OneTrust platform. We are now updating this with Information Asset Owners (IAOs) and Business Process Owners (BPOs) from within the business functions and when up to date it will give us a baseline assessment as to what personal data is captured and where, in order that any risks or compromise can be identified and managed. This also details our Record of Processing Activity as required by law[1].

2.3.1 Information Asset Owners (IAOs)

Each Information Asset needs to have an owner and the roles these owners undertake within the Care Inspectorate have been identified and will be refreshed continually. Training is planned for the end of Q1 FY2021-2122.

2.4 Information Risk Reporting

2.4.1 Information Risk Identification and Management

To date information risks have been identified in an ad hoc manner, as a result of Data Protection Impact Assessments or other activities. It has been challenging to manage them effectively due to the existing manual and time consuming processes.

In Q3 2020-2021 work commenced in embedding the risk identification and management data into the OneTrust platform. To date we have embedded some IG risks into the platform which are associated with particular information assets and their processing activities. They are identified when a Data Processing Impact Assessment is conducted and ownership is then automatically allocated to the accountable IAO and BPO. The risks can then be managed on the platform and reported upon. The latter is still being developed to make it as simple as possible and less resource intensive, whilst still being robust enough to show when and how risks are mitigated for SIRO oversight.

The OneTrust platform also allows technology assets and third party suppliers to be easily documented, risk assessed and reported upon in the same way.

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1 ROPA is required to be held under Article 30 of the UK GDPR and DPA 2018 to document processing activities related to personal and special category data.

Work has commenced with IT (ICT and Digital Transformation Directorate) and will be commencing with Procurement (Corporate and Customer Services Directorate) to embed these risk categories in the same platform which will give a holistic risk approach. Finally, we will also look in Q2 to embed Equality Impact Assessments (EQIAs).

2.4.2 Risk Reporting

Due to resource constraints[2] the improvement and transform work in IG has had been slower than expected for Q1-2, FY2021-2022, but it is anticipated that the first quarterly risk reporting will be up and running for IAOs and the SIRO by start of Q3 and thus the first reports will be available at the end of Q3 for the risk owners and the SIRO.

2.5 SIRO Report to Committee

The SIRO report is provided at Appendix 3.

2.6 The Committee is invited to

1. Note the work completed to date and the forward plan.
2. Note the SIRO report.

3.0 IMPLICATIONS AND/OR DIRECT BENEFITS

3.1 Resources

There are no additional resources for the activities required in the form of staff for the Information Governance team if we maintain the current resourcing levels. As previously mentioned we are currently in a recruitment process for the IG analyst and any delay to that recruitment and onboarding will affect the delivery times outlined.

3.2 Sustainability

Whilst all factors, including social and environmental have been considered, there is no evidence to support the sustainability agenda.

3.3 People Who Experience Care and Customers (Internal and/or External)

This activity supports the Corporate Plan values of Fairness, Integrity and Efficiency.

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2 IG Analyst resignation and subsequent recruitment – projected 6 week team resource impact. .

The data in relation to Information Assets and risks will be better managed and its integrity will be understood. Any risks to our data will be identified and reported in a transparent fashion to the IAOs and SIRO.

This directly effects the People Experiencing Care and our Customers including: Care Service Managers, Contractors and our staff. Their data is saved on multiple assets. The new Information Asset Register and Record of Processing Activity will start to make sure that all data storage is optimised and associated risks are reduced for data, processes, third party vendors and technology.

This activity supports the Corporate Plan principle of Well Governed, Co-Operation and Collaboration, Decision Making through Engagement, Empowerment and Development.

One of the Information Governance team's mantras is 'if we all do a little, we achieve a lot'. This is the approach here through education, training and the implementation of robust and repeatable processes we will start to change the culture across the senior management in the organisation in performing their role as Information Asset Owner. This will filter down to all staff and the importance of good information governance for all of our data subjects, including people who experience care, and our customers should improve as a result.

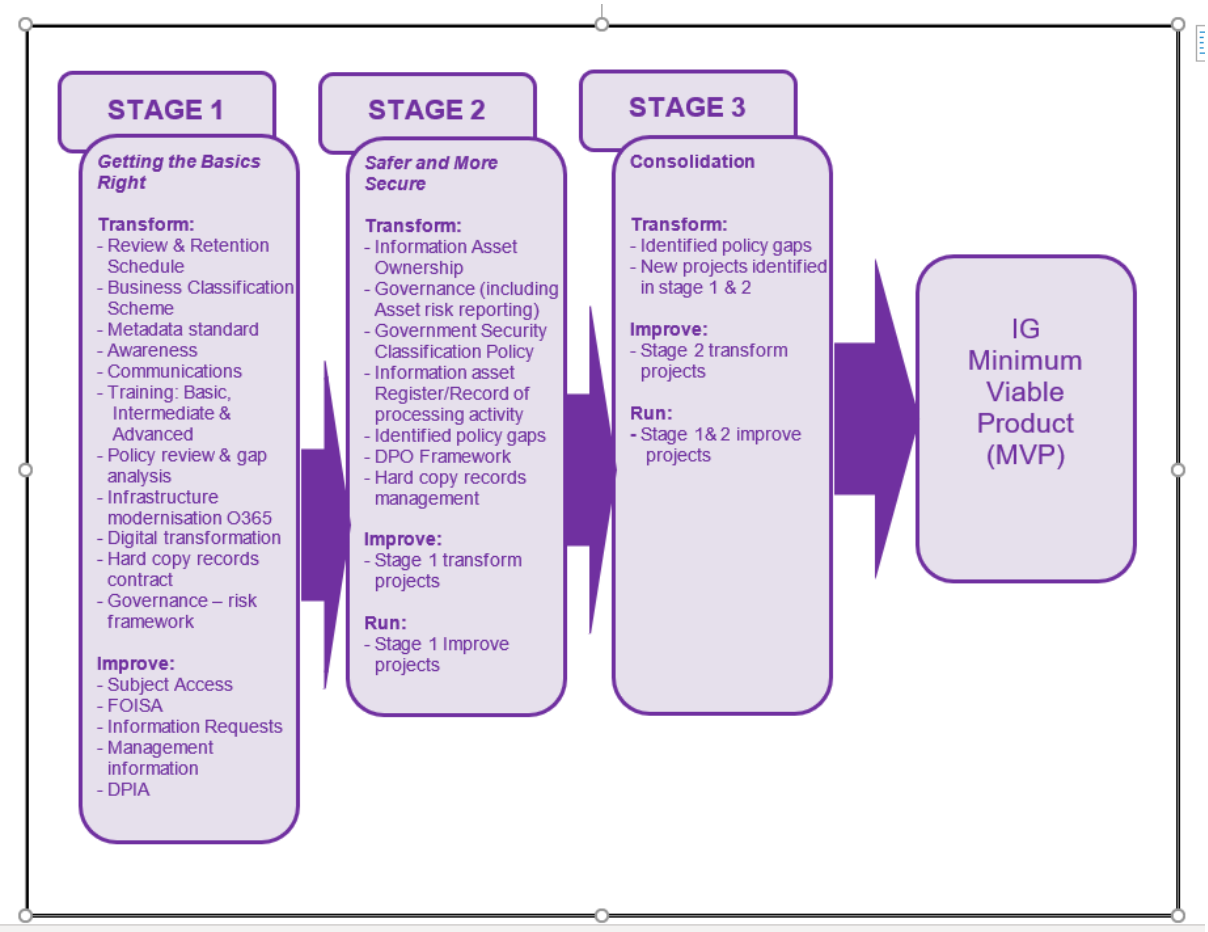
4.0 CONCLUSIONS/NEXT STEPS

The Audit and Risk Committee is asked to note the work completed to date and the forward plan.

The Committee is also asked to note the SIRO report at Appendix 3.

Agenda item 16
Appendix 1

Appendix 1: Overview of Information Governance (IG) Improvement Plan



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Appendix 2

Appendix 2: Summary of Revised Deliverables

Those in red/italics are outstanding:

Deliverable	Original Target Completion/Implementation Date	Revised Completion date
Maturity Modelling: Baseline	Q4 2020-2021 31/03/2021	*Q2 2021-2022 30/09/2021*
Maturity Modelling: First Quarterly Report	Q1 2020-2021 (30/06/2021)	*Q3 2020-2021 (31/12/2021)*
Records Management Plan Submission	Q1 2020-2021 (30/04/2020)	Q2 2020-2021 (31/07/2020)
NRS Records Plan Initial Assessment	Q2 2020-2021 (31/07/2020)	Q4 2020-2021 (18/03/2021)
Records Management Plan Resubmission	-	*Q1 2021-2022 (31/05/2021)*
Records Management Plan Sign off by the keeper		Q3 2021-2022 (30/09/2021)
FOISA statistics	Completed Quarterly	-
IAO training	Q2 2021-2022	-
Quarterly Risk Reporting	Q1 2020-2021 (30/06/2021)	*Q3 2020-2021 (31/12/2021)*

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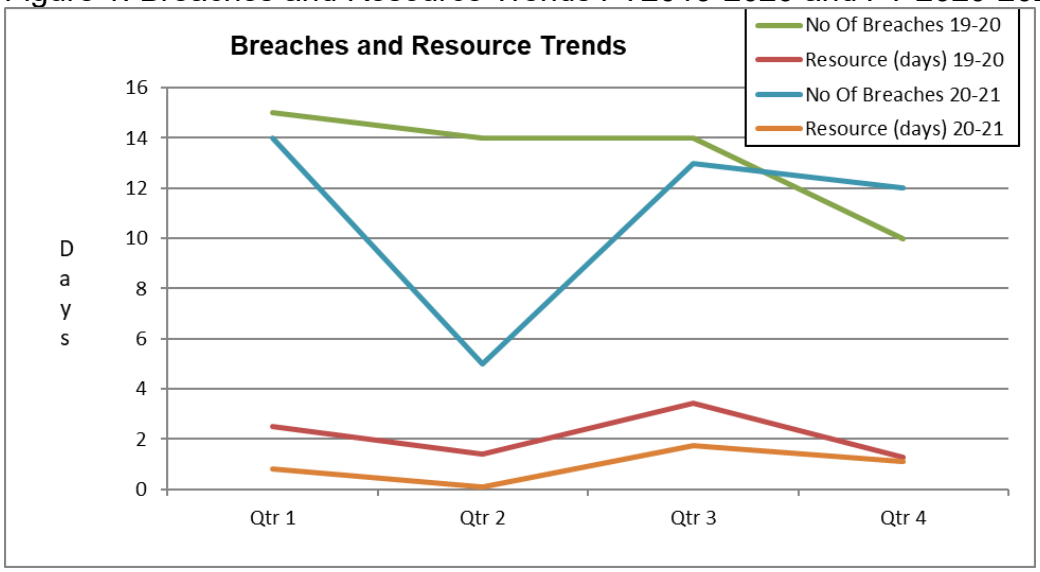
Appendix 3

Appendix 3: SIRO Report

This will be in a dashboard format for next FY 2021-2022 and will be complete with maturity measures and risk profiles

a) Breaches

Figure 1: Breaches and Resource Trends FY2019-2020 and FY 2020-2021



The number of reported breaches remains fairly consistent in the Care Inspectorate but as can be seen in Q2 2020-2021 this dropped considerably. There is no explanation for this except that reporting could have reduced during the peak of the pandemic.

The majority of our breaches relate to incorrect email addressing with 75% attributed to this in 2019-2020 as compared to only 43% in 2020-2021. It can be assumed that the drop in 2020-2021 can be attributed to the drop in reporting.

b) Freedom of Information Scotland Requests

This year has continued to be dominated by FOISA requests. However, whilst the number has remained high at the close of the financial year, the complexity has started to reduce back to normal levels which can be seen in the average completion time figures below.

Figure 2: FOISA numbers and complexity FY 2020-2021 (as submitted to OSIC)

Financial Year 2020-2021: Quarters	Number	Average Completion Time	Number Late
Q1	25	3.4	12
Q2	29	5.6	2
Q3	41	6.6	4
Q4	31	3.9	8

In Q3 we had 41 FOISA requests taking on average 6.6 hours. Q3 FY2019-2020 we had 21 which took an average of 1.9 hours. This demonstrates how both the complexity and volume changed this FY. The volume late in Q1 was mainly as a result of the team and the organisation deciding how best to answer FOISA requests based on new data sets with a fast-changing environment; trying to maintain transparency and protect privacy.

c) Subject Access Requests (SARs)

Figure 2: SAR numbers and complexity FY 2020-2021

Quarter	Number	Hours	Time Per SAR	Number late
Q1	6	105.75	18	2
Q2	8	35.25	4	3
Q3	10	26.5	3	4
Q4	5	50	10	2

Unlike FOISA requests SARs do not show any real patterns as they vary from the simple to the highly complex. In Q1, one SAR took a total of 92 hours.

Agenda item 19

AUDIT COMMITTEE

Schedule of Committee Business 2021/22

REPORT/TOPIC	20 May 2021	12 Aug 2021	9 Sept 2021	18 Nov 2021	10 March 2022
Internal Audit Items					
Internal Audit Report 2021/22 – Follow Up Report	✓	✓	✓	✓	✓
Annual Internal Audit Report 2020/21	✓				
Internal Audit Plan 2021/22 Progress Report					✓
Draft Annual Internal Audit Plan 2022/23					✓
Audit Assignments					
Scrutiny and Assurance					
Workforce Planning					
Financial Sustainability					
Fraud prevention, detection and response					
Compliance with Legislation					
Corporate Planning					
Equality and Diversity					
IT Strategy					
Health, Safety and Wellbeing	✓				
Freedom of Information (Scotland) Act - FOISA	✓				
Shared Services	✓				
Private Meeting with Internal Auditors				✓	
External Audit Items					
Combined ISA260 Report to those charged with Governance and Annual Report on the Audit		✓	✓		
Progress on the Audit of Financial Statements `		✓	✓		
Annual Audit Plan 2020/21– Annual Accounts					✓

Agenda item 19

REPORT/TOPIC	20 May 2021	12 Aug 2021	9 Sept 2021	18 Nov 2021	10 March 2022
Private Meeting with External Auditors					✓
Care Inspectorate Items					
Draft Annual Report and Accounts and External Audit Report		✓	✓		
Combined ISA260 Report and Annual Report on the Audit		✓	✓		
Draft Audit Committee Annual Report to the Board	✓	✓	✓		
Strategic Risk Register 2021/22 (draft pre-Board)	✓ (to BDE on 2 June)				
Strategic Risk Register Monitoring	✓		✓	✓	✓
Digital Programme Update	✓		✓	✓	✓
SIRO Report (Information Governance)	✓		✓		
Best Value Report			✓		
Standing Items					
Horizon Scanning (Audit Scotland & CIPFA publications)	✓		✓	✓	✓
Audit Committee Narrative to the Board	✓		✓	✓	✓
Schedule of Committee Business	✓		✓	✓	✓
Annual Review of Committee Effectiveness					✓