A Meeting of the Care Inspectorate Audit and Risk Committee is to take place from **10.30 am to 12.30 pm on Thursday 18 November 2021** by Teams video-link

AGENDA	
1.	Welcome
2.	Apologies for Absence
3.	Declarations of Interest
4.	Minute of Meeting held on 9 September 2021 (paper attached)
5.	Action Record of meeting held on 9 September 2021 (paper attached)
6.	Matters Arising
	Internal Audit Items
7.	Internal Audit Plan Follow-Up Report – Report No: ARC-25-2021
8.	Audit Report: Fraud Prevention, Detection and Response - Report No: ARC-26-2021
	External Audit Items None for this meeting.
	Items for Discussion
9.	Proposals for Care Inspectorate Care Governance Arrangements: Report No: ARC-27-2021
10.	Strategic Risk Register Monitoring – Report No: ARC-28-2021
11.	Digital Programme Update - Report No: ARC-29-2021

12.	Shared Service 12.1 Final report of Member/Officer Oversight Group – Report No: ARC-30-2021 12.2 Shared Service Review Board – verbal update from meeting held 8 November 2021
	Items for Information
13.	Horizon Scanning 13.1 CIPFA Audit Committee Update – Issue 36 13.2 Audit Scotland Report: Community empowerment: Covid-19 update | Audit Scotland
	Standing Items
14.	Audit and Risk Committee Narrative to the Board and Publication of Committee papers
15.	Schedule of Committee Business 2021-22 (paper attached)
16.	AOCB
17.	**PRIVATE ITEM (Members and Officers Only)** Draft Collation of Learning from the Pandemic and Key Changes Taken Forward – Report No: ARC-31-2021
18.	Close of Business and Date of Next Meeting: Thurs 10 March 2022 at 10.30 am (to include Committee Effectiveness and Development Review)
	PRIVATE SESSION (Members and Internal Auditors Only) Private discussion between Committee members and Internal Auditors. This has been arranged as a separate meeting.

Minutes

Meeting: Audit and Risk Committee

Date: 9 September 2021

Time: 10.30 am

Venue: Held by Teams Videoconference

Present: Bill Maxwell, Convener
Gavin Dayer
Paul Gray
Rona Fraser

In Attendance: Peter Macleod, Chief Executive (CE)
Kevin Mitchell, Executive Director of Scrutiny and Assurance
Jackie Mackenzie, Executive Director of Corporate and Customer Services (CCS)
Kenny Dick, Head of Finance and Corporate Governance (HFCG)
Claire Brown, Executive Support Officer (ESO)
Gordon Mackie, Executive Director of IT and Digital Transformation (iEDIDT)
Stuart Inglis, Internal Auditor, Henderson Loggie (IA)
John Boyd, External Auditor, Grant Thornton (EA)

Apologies: Anne Houston, Committee member
Ronnie Johnson, Committee member
Edith Macintosh, Executive Director of Strategy and Improvement (EDSI)
Fiona McKeand, Executive and Committee Support Manager (ECSM)
Kenny McClure, Head of Legal Services (HLS)
David Archibald, Henderson Loggie

Item **Action**

1.0 WELCOME

The Convener welcomed everyone to the meeting.

2.0 APOLOGIES FOR ABSENCE

Apologies were received as noted above.

3.0 DECLARATION OF INTERESTS

There were no declarations of interest.

4.0 MINUTES OF PREVIOUS MEETINGS

4.1 MEETING HELD ON 20 MAY 2021

The Committee approved the minute as an accurate record.

4.2 MEETING – 12 AUGUST 2021

The Committee approved the minute as an accurate record.

5.0 ACTION RECORD OF MEETINGS HELD 20 MAY & 12 AUGUST 2021

The Committee reviewed and agreed the action record.

6.0 MATTER ARISING

There were no matters arising.

7.0 INTERNAL AUDIT PLAN FOLLOW-UP REPORT - REPORT NO: ARC-18-2021

The internal auditors briefed the Committee on the Management Summary of the document. The report assessed the status of all internal audit recommendations from previous audits which had not been formally evaluated as fully implemented.

Recommendations categorised as 'Partially Implemented' or 'Little or no progress' would be carried forward and evaluated as part of future follow up reviews. Where the previous implementation date had elapsed, a revised implementation date had been proposed by management.

The Committee noted the pace of progress that had been made in implementing the recommendations followed-up as part of this review. Overall, two (20%) of the 10 recommendations followed-up were assessed as 'fully implemented', with seven (70%) classified as 'partially implemented' and one (10%) classified as 'little or no progress'.

The Chief Executive proposed that a meeting be held with the Convenor, senior officers and internal auditors to look at the outstanding issues in detail and provide a substantial report on how these will be resolved for the next Audit and Risk Committee in November. He also proposed that the outstanding action relating to the Health, Safety and Wellbeing Audit be adjusted to state that management would produce a more comprehensive report

summarising key learning for the Care Inspectorate from the experience of delivering through the pandemic and implications for future strategy and operations. A draft of this report would be considered at the proposed meeting of the Strategic Leadership Team and Convenor prior to it coming to the November Committee meeting potentially the full Board thereafter.

CE and Directors

The Committee **agreed** the above proposals and **approved** the Follow-up progress report, including the proposed amended target dates for completion of outstanding actions.

8.0 AUDIT REPORT: FINANCIAL SUSTAINABILITY – REPORT NO: ARC-19-2021

The internal auditors presented the audit report on the review of the long-term financial planning arrangements which the Care Inspectorate has put in place to ensure financial sustainability, supporting effective planning and business decision making in the medium to long term.

In particular, the objectives of the audit had been to review the current financial strategy to ensure that it was adequate and was flexible enough to address the impact of the pandemic to ensure that the Care Inspectorate delivered its core functions and remained financially viable.

The overall level of assurance was reported as “Good” and no recommendations were made.

The Chief Executive commended the Executive Director of Corporate and Customer Services, the Head of Finance and Corporate Governance and their team for securing funding from the Scottish Government and the possibility of converting the current loan into a grant (£650k), whilst noting that there was no room for complacency in the current environment. It was recommended that this be reviewed on a regular basis.

The Committee noted the very positive outcomes of this audit and asked for their thanks to be conveyed to the staff involved.

9.0 AUDIT REPORT: COMPLIANCE WITH LEGISLATION - REPORT NO: ARC-20-2021

The Committee received the report on the audit review of the organisation’s arrangements for ensuring effective compliance with legislative requirements.

The overall level of assurance was reported as “Satisfactory”. There were four control objectives, two were identified as “Good” and two are identified as “Satisfactory”. Five priority 3 recommendations were made, and management responses were provided for each of them.

The Executive Director of Corporate and Customer Services advised the Committee that the legal services team was working on a business case for a Compliance Officer post to be created. The Committee endorsed the potential value of such a post.

The Committee noted the report and **approved** the proposed management actions in response.

10.0 AUDIT REPORT: SHARED SERVICES 2 – REPORT NO: ARC-21-2021

The Committee received the report of the audit review which had been commissioned to provide additional assurance on the implementation of the new Shared Services agreement with the Scottish Social Services Council (SSSC).

The Committee was pleased to note that the overall level of assurance was "Good". There were six control objectives all six were identified as "Good". There were no recommendations.

It was noted that the meetings of the Member Officer Oversight Group, had been very valuable however it would be appropriate now to bring it towards a conclusion.

The Committee thanked management, in particular the Head of Finance and Corporate Governance/Head of Shared Service, for the huge amount of work that had been done in bringing the Shared Services to this positive outcome. It was agreed that a strong focus needed to be maintained on ensuring the arrangements bedded in well and the full benefits were drawn from them. It was recognised that requirements might well change and develop as the implications of the National Care Review unfolded.

The Committee agreed:

- that a final meeting of the Member Officer Oversight Group should take place in October and produce a final report for the November Audit and Risk Committee. **HFCG**

- that the further internal audit review which was provisionally scheduled in the 22/23 Internal Audit Plan should be retained. **Henderson -Logie**

- that a new Standing Item should be added to Audit and Risk Committee agendas titled 'Shared Service Governance update' with a report from management to the ARC reporting on the regular governance meetings being scheduled between CI and SSSC Chief Executives and senior leaders. **ECSM**

11.0 ANNUAL REPORT AND ACCOUNTS

11.1 DRAFT ANNUAL REPORT AND ACCOUNTS 2020/21

The Convenor thanked officers for a revised draft of the Annual Report and Accounts, now updated to take account of the points raised in the Committee's previous detailed discussion of a prior draft at its August meeting. The revised draft was **approved** for submission to the Board without any further revisions.

11.2 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND FOR THE FINANCIAL YEAR ENDED 31 MARCH 2021

The external auditor briefed the Committee on the outcomes of the 2021 external audit. The Committee was pleased to note that the organisation was in receipt of a clean audit, with the auditors proposing to issue an unmodified audit opinion. There was discussion around some minor recommendations for strengthening arrangements for treating pension fund liabilities and dilapidations provisions.

The auditors thanked the Head of Finance and Corporate Governance and his team for their co-operation in ensuring an effective audit in what was a particularly challenging year.

The positive external audit report was noted by the Committee, and the management response to the minor recommendations identified were endorsed.

11.3 DRAFT LETTER OF REPRESENTATION

The Committee **approved** the draft Letter of Representation.

12.0 DRAFT AUDIT AND RISK COMMITTEE ANNUAL REPORT TO THE BOARD

The Committee thanked officers for an updated draft of this report and **approved** it for submission to the Board.

13.0 STATEGIC RISK REGISTER MONITORING

The Committee discussed strategic risk 3 (Workforce Capacity), as management had identified this as an area of continuing pressure.

The Executive Director of Corporate and Customer Services updated the meeting on the ongoing issues in the recruitment of inspectors. Twenty-nine had been recruited from the most recent campaign and a new campaign had started. However, the organisation remained short in key areas. Difficulties were also being experienced in recruiting and retaining IT specialists, with a number joining then leaving to take up higher paid roles elsewhere. Ensuring sufficient staff capacity was a

rising risk for the Business Transformation programme. Alternative ways of attracting staff were being explored by HR and updates would continue to be provided on the changing situation.

It was also highlighted that recruitment was acutely difficult within the social care more generally at the moment, creating a very challenging environment for the Care Inspectorate's recruitment.

The Committee agreed that the Risk Register rating should remain unchanged for now, but the Convenor would be advised of any immediate increase to the risk.

14.0 DIGITAL PROGRAMMME UPDATE

The Executive Director of IT and Digital Transformation presented the report on progress with the digital programme, noting that the pandemic continued to have an impact on the delivery team. It was expected to face further challenges due to the large and complex nature of the work involved. However, the team continued to make progress in a very challenging time. The registration App was released in March and currently processing registrations of 7000 users and 5000 services.

The Committee was advised of a potential data breach connected to the implementation of the App. This had been identified and resolved quickly, and reassurance was given that no actual breach occurred. Working with colleagues in Information Governance, a report had been submitted to the Information Commissioner who had confirmed that correct protocols had been followed.

The Committee noted with approval that an Operations Champions Group had been set up and was providing a valuable ongoing dialogue between digital staff and operational staff. Challenges were arising as systems were being deployed in practice but these were being worked through and resolved.

The Committee noted the good progress being made in taking forward implementation of the first phase of the digital programme, despite challenging circumstances, and noted that work continued on preparing the Business case for Phase 2, for submission to Scottish Government later this year.

15.0 HORIZON SCANNING

The Committee noted the information contained in the CIPFA Audit Committee Update – Issue 35 – which had been emailed to members in advance of the meeting. Current and previous updates were readily available to all in the Committee Sharepoint folder.

16.0 AUDIT COMMITTEE NARRATIVE TO THE BOARD AND PUBLICATION OF COMMITTEE PAPERS

The following items were agreed to be included in the narrative to the Board at its meeting on 23 September 2021.

- Highlight continuing concerns regarding Strategic Risk 3, stemming from recruitment and staffing issues for inspectors and digital staff.
- Note the outcomes of the internal audit, with a note of their overall ratings.
- Note the clean external audit, with Grant-Thornton intending to issue an unmodified opinion
- Recommendation that the Board approves the Annual Report and Accounts.
- Agree to the Committee papers being published once approved by the Board.

17.0 SCHEDULE OF COMMITTEE BUSINESS 2021/22

The Committee noted its schedule of business.

18.0 AOCB

18.1 PROPOSED AUDIT COMMITTEE CHAIRS NETWORK GROUP

Bill noted that he had been consulted on a proposal to set up a Networking Group for Convenors of Audit and Risk Committees in non-departmental public bodies. It was **agreed** that there would be value in the Care Inspectorate participating in such a group if it became established.

DATE OF NEXT MEETING

The date of the next meeting was noted as Thursday 18 November at 10.30 am by Teams video-conference.

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
23 September 2021					
10.0	**AUDIT REPORT: SHARED SERVICES 2 – REPORT NO: ARC-21-2021**	Add new Standing Item to Committee agendas titled 'Shared Service Governance update with a report from management on the regular governance meetings between CI and SSSC	ECSM EDCCS/HFCG	Immediate and recurring	**Completed**
		A final meeting of the Member Officer Oversight Group to take place in October and produce a final report for the November Audit and Risk Committee	EDCCS/HFCG	Immediate	Meeting on 18.10.21

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

AUDIT AND RISK COMMITTEE MEETING 18 November 2021

Agenda item 7
Report No: ARC-25-2021

Title:	**COVER REPORT: INTERNAL AUDIT ON FOLLOW UP REVIEWS**
Author:	*David Archibald, Partner in Henderson Loggie*
Appendices:	1. Internal Audit Report: Follow Up Reviews - November 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 August 2021 and reported to the Audit and Risk Committee in September 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 Committee is invited to:	
1.	Accept the Internal Audit report on Follow Up Reviews as at November 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 18 November 2021

Agenda item 7
Report No: ARC-25-2021

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:

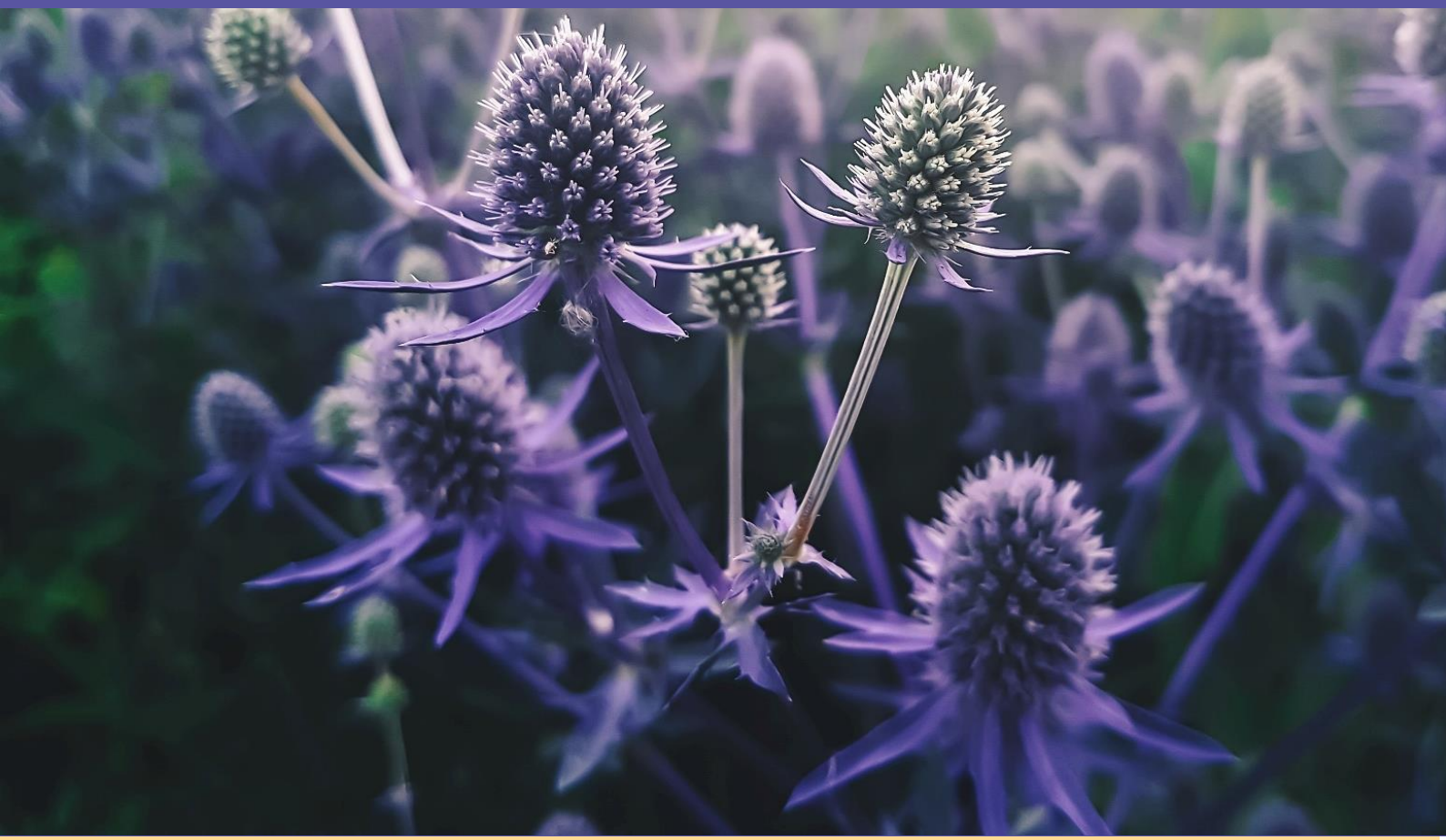
Reasons for Exclusion	
a)	Matters relating to named care service providers or local authorities.
b)	Matters relating to named persons which were they to be discussed in public session, may give rise to a breach of the Data Protection Act 2018 or General Data Protection Regulation 2016/679.
c)	Matters 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.

Agenda item 7
Appendix 1

Care Inspectorate

Follow Up Reviews

Internal Audit report No:	**2022/06**
Draft issued:	**9 November 2021**
Final issued:	**10 November 2021**



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 2021/22 audit programme to conduct follow-up work to assess the progress made in taking forward the recommendations made in Internal Audit reports issued during 2019/20, 2020/21 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 Follow Up review report issued in September 2021. 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)
- Complaints (issued in April 2019)
- Recruitment and Retention (issued in December 2019)
- Risk Management (issued in August 2020)
- Health, Safety and Wellbeing during the COVID-19 Pandemic (issued in May 2021)

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, one (13%) of the eight recommendations followed-up, which had reached their original agreed completion date, was assessed as 'fully implemented', with seven (87%) classified as 'partially implemented'.

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. Priority**	**Number Agreed**	**Fully Implem-ented**	**Partially Implem-ented**	**Little or No Progress Made**	**Not Past Agreed Completion Date**	**Considered But Not Implemented**
Follow Up Review 2019/20	1	-	-	-	-	-	-
	2	2	-	2	-	-	-
	3	1	-	1	-	-	
Total		**3**	**-**	**3**	**-**	**-**	**-**
Recruitment and Retention 2019/20	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	-	1	-	-	-
Total		**1**	**-**	**1**	**-**	**-**	**-**
Risk Management (report 2021/01)	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	3	-	3	-	-	-
Total		**3**	**-**	**3**	**-**	**-**	**-**
Health, Safety and Wellbeing	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	1	-	-	-	-
Total		**1**	**1**	**-**	**-**	**-**	**-**
Grand Totals		**8**	**1**	**7**	**-**	**-**	**-**

Overall Conclusion (continued)

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.

Gradings for recommendations from 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
Internal Audit Report – Follow Up Review 2019/20 (Scott Moncrieff)

Original Recommendation	Grade	Responsible Officer for Actions	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
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 August 2021** A Disaster Recovery (DR) capability and readiness assessment was conducted in Q1, as planned. This exercise identified a need to upgrade specific technology components, prior to exercising DR tests. Taking a risk based approach, a project has been established to replace infrastructure components, with DR built-in by design. This programme will include the DR testing of remote access to systems and is expected to complete by the end of Q3 (31 December 2021). In parallel, a 3rd party organisation has been engaged to assist the Care Inspectorate IT team to identify modern alternative recovery options. This will support an investment proposal for new technologies to support DR plans that align with BCP recovery objectives. This exercise will complete by the end of Q2. A DR test schedule for cloud-based business applications is expected to complete by the end of Q4. **Revised Implementation date:** b) 31 December 2021 c) 31 March 2022	**Update at November 2021** b) The DR testing of remote access to systems remains on track to be completed by 31 December 2021. c) The DR test schedule for cloud-based business applications remains on track to be completed by 31 March 2022 It should be noted that this work has identified other improvements that can be made to our DR capability and we are currently seeking investment and off-setting savings to implement these improvements. **Partially Implemented**	**a) Complete** **b) 25 months over original completion date** **c) 31 months over original completion date**

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 2021:** a) **Capacity tool:** Meeting is now arranged for September 21. Implementation date for capacity tool to be aligned to resource model work below so 31 October 2021 is recommended. **Revised Implementation date:** 31 October 2021 b) **Resource Model:** No further work has been possible on this at this stage. Revised date of 31 October 2021 recommended. This will still permit consideration as part of the budget setting process. **Revised Implementation date:** 31 October 2021	**Update at November 2021:** Time recording data has been extracted from the new complaints application that was implemented part way through 2018/19. Focus has been on 2019/20 the first full year that the new application has been used and which was largely unaffected by pandemic conditions. Average times for complaints are unrealistically low and the reasons for this are being investigated. The resource model and capacity tool are reliant on realistic average complaints time and this work cannot be progressed until the issue with time recording data is understood. If there is an underlying problem with the recording of Inspector time then it will not be possible to update the resource model or develop a capacity tool until the issue is resolved and sufficient time elapsed with corrected time recording in place to allow meaningful analysis. A revised implementation date will be dependent on the investigation of the time recording accuracy issue. **Revised Implementation date:** The issue should be investigated and understood by 31 December 2021. The Committee will be advised of what further progress is possible at its March 2022 meeting. **Partially Implemented**	**a) 25 months over original completion date** **b) 21 months over original completion date**

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 August 2021:** a) **Capacity tool:** Meeting is now arranged for September 21. Implementation date for capacity tool to be aligned to resource model work below so 31 October 2021 is recommended. **Revised Implementation date:** 31 October 2021 b) **Resource Model:** No further work has been possible on this at this stage. Revised date of 31 October 2021 recommended. This will still permit consideration as part of the budget setting process. **Revised Implementation date:** 31 October 2021	**Update at November 2021:** Time recording data has been extracted from the new complaints application that was implemented part way through 2018/19. Focus has been on 2019/20 the first full year that the new application has been used and which was largely unaffected by pandemic conditions. Average times for complaints are unrealistically low and the reasons for this are being investigated. The resource model and capacity tool are reliant on realistic average complaints time and this work cannot be progressed until the issue with time recording data is understood. If there is an underlying problem with the recording of Inspector time then it will not be possible to update the resource model or develop a capacity tool until the issue is resolved and sufficient time elapsed with corrected time recording in place to allow meaningful analysis. A revised implementation date will be dependent on the investigation of the time recording accuracy issue. **Revised Implementation date:** The issue should be investigated and understood by 31 December 2021. The Committee will be advised of what further progress is possible at its March 2022 meeting. **Partially Implemented**	**a) 25 months over original completion date** **b) 21 months over original completion date**

Appendix II - Updated Action Plan

Internal Audit Report - Recruitment and Retention (Scott Moncrieff)

Original Recommendation	Grade	Responsible Officer for Actions	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
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 2021:** Progress around the SWP has slowed down due to the pandemic and during the last quarter we have picked back up on the strategic priorities and aligned those to the OWD workplan as we felt that we could now pick up on some of the strands of work now the workforce was stepping back from working in a pandemic response environment. The Corporate Plan is being refreshed over the next 3 months and alongside that there will be a refresh of the SWP as one of the key changes mooted to the Corporate plan is the inclusion of a strategic priority around workforce. It is anticipated that there will be a stronger focus on the KPI and metrics around workforce and workforce planning. This will be picked up by the new Head of Service when they are appointed.	**Update at November 2021:** A SMART action plan and relevant KPIs to underpin the Strategic Workforce Plan was developed and agreed in December 2019. In early 2020, the actions were integrated into relevant workplans for delivery. As already noted in previous updates, progress against the plan has been delayed due to the pandemic. Delays to delivery have also made it challenging to report against the KPIs confirmed in the action plan. **Revised Implementation date:** The Strategic Workforce Plan will be reviewed and updated alongside the review of the Corporate Plan by 30 April 2022. **Partially Implemented**	**17 months over original completion date**

Appendix III - Updated Action Plan
Internal Audit Report - Risk Management (Henderson Loggie)

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
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 August 2021:** Meeting arranged with Scrutiny and Assurance Directorate Management Team to discuss revised risk appetite approach. Linking Strategic Risk Register to Directorate Risk registers implementation date revised to 30 September 2021. **Revised Implementation Date:** 30 September 2021	**Update at November 2021:** Work on this is progressing with several directorate meetings taking place. Strategy and Improvement, Scrutiny and Assurance and Customer and Corporate Services directorates are well advanced. A meeting with the newer Digital and IT directorate is to be arranged. **Revised implementation date:** For all directorate risk registers to be in the corporate format and linked to the strategic risk register a date of 31 December 2021 is proposed. **Partially Implemented**	**9 months over original completion date**

Follow Up Reviews

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
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 August 2021:** Procedure note partially complete. A revised implementation date of 30 September 2021 should be achievable. **Revised Implementation Date:** 30 September 2021	**Update at November 2021:** The work associated with implementing R1 above is informing the development of a procedure note which is partially completed. The procedure note will quickly follow on from the work to link directorate risks to strategic risks. **Revised implementation date:** A date of 31 January 2022 is proposed. **Partially Implemented**	**11 months over original completion date**

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
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 August 2021:** Reliant on completion of procedure note and getting diary time for training. 30 November 2021 is a realistic implementation date. HoFCG had attended directorate meetings and provided interim advice and support as the directorate risk registers are worked on. **Revised Implementation Date:** 30 November 2021	**Update at November 2021:** The work undertaken to link directorate risks to strategic risks has involved training senior managers on the use of the corporate style risk registers and applying our Risk Policy and Risk Appetite Statement. Refresher training and review of directorate risk registers will take place following the Audit and Risk Committee's annual review of strategic risk and upon the introduction of the new Corporate Plan. Training will also be provided to new senior managers as part of their induction process. **Revised Implementation Date:** The content of this training will be developed by 31 March 2022 and then delivered as appropriate. **Partially Implemented**	**9 months over original completion date**

Appendix IV - Updated Action Plan

Internal Audit Report 2021/09 – Health, Safety and Wellbeing during the COVID-19 Pandemic (Henderson Loggie)

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
Internal audit report 2021/09 – Health, Safety and Wellbeing during the COVID-19 Pandemic **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.	**3**	Agreed. This will become an element of our lessons learned work.	Head of Customer Service	30 June 2021	**Update at August 2021:** Due to a communications issue in the allocation of this action there has been a delay in taking this forward. A revised implementation date of 30 November will now be achievable. **Revised implementation date:** 30 November 2021	**Update at November 2021:** This action is now completed. **Fully Implemented**	**Completed**

Henderson Loggie

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AUDIT AND RISK COMMITTEE MEETING 18 NOVEMBER 2021

Agenda item 8
Report No: ARC-26-2021

Title:	**COVER REPORT: INTERNAL AUDIT ON FRAUD PREVENTION, DETECTION AND RESPONSE**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Fraud prevention, detection and response
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The internal audit report on Fraud prevention, detection and response is attached as Appendix 1. The overall level of assurance is "Good". There are eleven control objectives. All eleven are identified as "Good". One priority 3 recommendation has been made and the management response confirms this recommendation will be implemented.
The Committee is invited to:
1. Accept the Internal Auditor's report on Fraud prevention, detection and response.

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 18 NOVEMBER 2021

Agenda item 8
Report No: ARC-26-2021

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.

LEVEL OF ASSURANCE
Good

Care Inspectorate

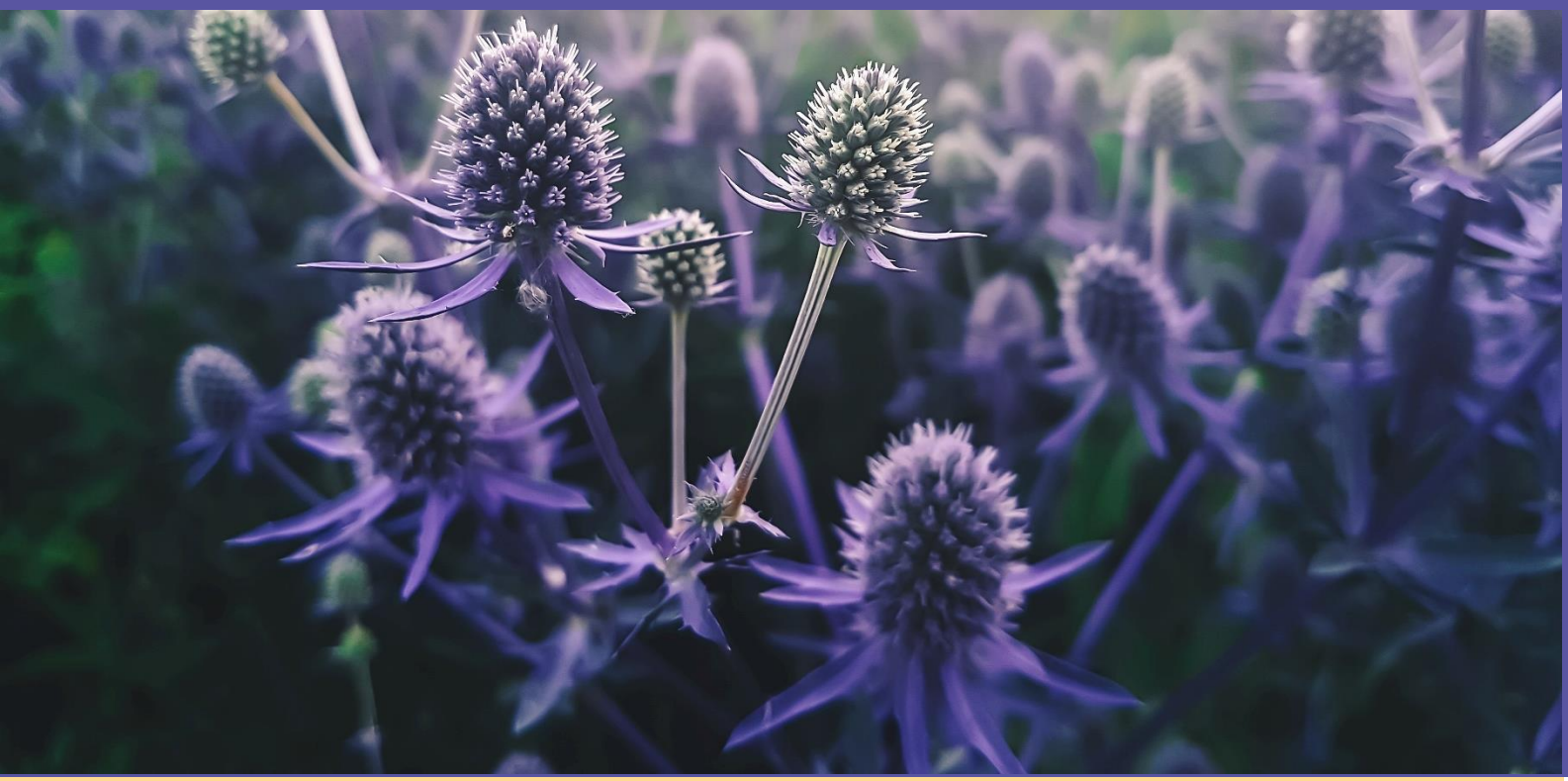
Fraud prevention, detection and response

Internal Audit report No: 2022/05

Draft issued: 9 November 2021

2nd Draft issued: 10 November 2021

Final issued: 10 November 2021



Henderson Loggie

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	Fundamental issue subjecting the organisations to material risk which requires to be addressed by management and the Audit and Risk Committee as a matter of urgency.
Priority 2	Issue subjecting the organisations to significant risk, and which should be addressed by management as a priority.
Priority 3	Matters subjecting the organisations 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 as at September 2021:

Risk 1 – Delivery of Strategy - We are unable to fulfil our core purpose due to external factors (Residual Risk Grade – Medium)

Background

The Care Inspectorate has developed a Counter Fraud, Bribery and Corruption Framework, which is a series of inter-related documents designed to prevent and detect fraud, bribery or corruption and to take robust action where it is suspected.

A joint agreement has been entered into with the SSSC to partner with the NHS Counter Fraud Services (CFS) and a formal partnership agreement is in place for each organisation which sets out the contractual agreement.

The latest Fraud and Irregularity report for 2020/21 was published by Audit Scotland in July 2021. This document highlights a number of emerging fraud risks which have emerged during the COVID-19 pandemic as working patterns changed and the way in which controls were applied also changed. The report highlights the fact that a number of the significant frauds perpetrated against public sector bodies during financial year 2020/21 were frauds which are already well publicised. However, the failure to consistently apply strong controls to minimize the risk of fraud left these organisations vulnerable to fraudulent activity, which in some cases remained undetected for some time.

Fraud prevention, detection and response

Scope, Objectives and Overall Findings

The scope of this audit was to carry out a review of the organisation-wide anti-fraud framework in place within the Care Inspectorate and also the arrangements in place to ensure compliance with the Bribery Act 2010. We also review the progress made in developing an effective working relationship with NHS Counter Fraud Services in terms of implementing a framework for both fraud prevention and fraud investigation activity.

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

Objective	Findings			
The objective of our audit was to ensure that:		1	2	3
		No. of Agreed Actions		
Fraud 1. Anti-fraud policies and procedures exist within the Care Inspectorate that are in line with best practice.	**Good**	-	-	-
2. Clear leadership, roles and responsibilities have been set out for implementation of the anti-fraud framework.	**Good**	-	-	-
3. There is a process in place to assess the nature and extent of the Care Inspectorate's exposure to potential external and internal risks of fraud.	**Good**	-	-	-
4. Anti-fraud policies and procedures are embedded and understood throughout the organisation through appropriate training and communication.	**Good**	-	-	-
5. The organisation has put in place a process to monitor and review procedures designed to prevent fraud and make improvements where necessary.	**Good**	-	-	1
6. There are clear procedures for employees and Board members to raise concerns or whistleblow if they believe there has been fraud or other wrongdoing within the organisation.	**Good**	-	-	-
7. Appropriate procedures are in place for the investigation and reporting of a fraud.	**Good**	-	-	-
Bribery and corruption 8. Anti-bribery and anti-corruption policies and procedures exist within the Care Inspectorate that are proportionate to the bribery risks it faces and to the nature, scale and complexity of its activities.	**Good**			
9. An appropriate individual or group has been assigned to deliver the message of zero tolerance to bribery and corruption and that there is an appropriate level of involvement from senior management in the development of the bribery procedures.	**Good**			

Fraud prevention, detection and response

Objective	Findings			
The objective of our audit was to ensure that:		**1**	**2**	**3**
		No. of Agreed Actions		
10. Bribery prevention policies and procedures are embedded and understood throughout the Care Inspectorate through internal and external communication, including an appropriate training programme.	**Good**			
11. The organisation has put in place a process to monitor and review procedures designed to prevent bribery by persons associated with it and make improvements where necessary.	**Good**			
Overall Level of Assurance	**Good**	**-**	**-**	**1**
		System meets control objectives.		

Audit Approach

Through discussions with Head of Finance & Corporate Governance, the procurement team and the intelligence manager in NHS Counter Fraud Services, and through review of the partnership agreement and associated policy and procedural framework around fraud and bribery prevention, we considered the extent to which the above objectives have been met.

Summary of Main Findings

Strengths

- The Counter Fraud, Bribery and Corruption Framework was refreshed in 2020/21 and was approved by the Board in June 2021;
- The framework adopted contains a Counter Fraud, Bribery and Corruption Policy; a Counter Fraud, Bribery and Corruption Strategy; a Formal Action Policy; and a Counter Fraud Services: Financial Crime Response Plan;
- The development of the Counter Fraud, Bribery and Corruption Strategy has been informed by the Scottish Government and NHS Scotland Strategy;
- The Counter Fraud Services (CFS): Financial Crime Response Plan sets out the way in which the Care Inspectorate will work in partnership with CFS to implement, maintain and develop the Strategy and associated Financial Crime Action Plan;
- Our review of the Counter Fraud Bribery and Corruption Framework and the Customer Services Contract confirmed that, in our view, the policy and procedural framework in place is clearly set out, sufficiently detailed and is in line with good practice;
- The Counter Fraud, Bribery and Corruption Policy sets out the general responsibilities placed on all Care Inspectorate employees around reporting of suspected fraud, bribery or corruption; responsibilities around fraud awareness training; the need to comply with the financial regulations and the Procurement Policy; to record gifts and hospitality; and to make annual declarations of interest;
- The policy also sets out the role of the Counter Fraud Champion (CFC) and the Fraud Liaison Officer (FLO) explains that the Executive Director of Corporate and Customer Services is the designated CFC, and the Head of Finance and Corporate Governance is the designated Fraud Liaison Officer;
- We are comfortable that the arrangements which are being developed in partnership with CFS will provide a suitable mechanism to evaluate and manage the relative risks around fraud, bribery and corruption in order to direct future fraud prevention activity efficiently and effectively. This will also allow the work of CFS to complement the work of internal audit in the future;
- The Care Inspectorate have identified procurement fraud as a high risk area and proactively compared anti-fraud arrangements with the Northern Ireland anti-fraud prevention standards;
- The organisation utilises Microsoft365 for email services, which contains a security feature called ATP which operates in a similar way to Mimecast, by employing email search and threat analysis as part of the incoming email filtering. The application and monitoring of this protection reduces, but cannot eliminate entirely, the risk of external threats which could lead to fraudulent activity by an external party;
- The Care Inspectorate website contains a dedicated Whistleblowing page with links to relevant guidance;
- The Financial Crime Action Plan describes in detail the background responsibilities and the process to be followed in circumstances where fraud or bribery is suspected;
- Anti-bribery and anti-corruption policies and procedures are enshrined within the Counter Fraud Bribery and Corruption Framework described under Objective 1, rather than as standalone documents;
- The Counter Fraud, Bribery and Corruption Policy states unequivocally that the Care Inspectorate expects all Board Members, employees and those acting as its agents to conduct themselves in accordance with the nine general principles set out in the Ethical Standards in Public Life etc. (Scotland) Act 2000;
- The Counter Fraud, Bribery and Corruption Policy states that the Audit and Risk Committee is responsible for overseeing and monitoring the effectiveness of our counter fraud, bribery and corruption arrangements; and
- The Counter Fraud, Bribery and Corruption Framework includes specific information around bribery and corruption and makes reference to the different types of crime which could be committed under the Bribery Act 2010.

Summary of Main Findings (Continued)

Weaknesses

- The Counter Fraud Bribery and Corruption Framework contains a raft of information around the definitions of fraud, bribery and corruption and sets out the responsibilities and actions required in specific circumstances. However, the intelligence led approach described under Objective 3, below, presents an opportunity to bring together all of the fraud prevention, detection and response documentation in one single place which can act as a single reference point for managers, staff and Board members.

Acknowledgement

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 - Anti-fraud policies and procedures exist within the Care Inspectorate that are in line with best practice.

The Counter Fraud, Bribery and Corruption Framework was refreshed in 2020/21 and was approved by the Board in June 2021.

The framework adopted contains a Counter Fraud, Bribery and Corruption Policy; a Counter Fraud, Bribery and Corruption Strategy; a Formal Action Policy; and a Counter Fraud Services: Financial Crime Response Plan.

The Policy, Strategy and Financial Crime Response Plan set out the way in which the Care Inspectorate will:

- take all reasonable steps to prevent fraud;
- ensure that processes are in place to detect fraud wherever possible;
- investigate fraud where it is detected or reported; and
- pursue appropriate formal action against those involved in fraudulent or corrupt activities.

The development of the Counter Fraud, Bribery and Corruption Strategy has been informed by the Scottish Government and NHS Scotland Strategy and with support from CFS in compiling the framework to set out the approach to prevention, detection and response.

The Counter Fraud Services (CFS): Financial Crime Response Plan sets out the way in which the Care Inspectorate will work in partnership with CFS to implement, maintain and develop the Strategy and associated Financial Crime Action Plan. This is supplemented by a formal Customer Services Contract which sets out the contractual obligations placed on both parties.

Our review of the Counter Fraud Bribery and Corruption Framework and the Customer Services Contract confirmed that, in our view, the policy and procedural framework in place is clearly set out, sufficiently detailed and is in line with good practice.

Fraud Prevention, detection and response

Objective 2 - Clear leadership, roles and responsibilities have been set out for implementation of the anti-fraud framework.

The Counter Fraud, Bribery and Corruption Policy states that the Chief Executive has overall responsibility for the maintenance and operation of the framework. The Chief Executive is supported in discharging these duties by the Executive Director of Corporate and Customer Services, Head of Finance and Corporate Governance, Head of Legal, Head of Human Resources, CFS and by the lead of the outsourced internal audit service.

Section 7 of the Counter Fraud, Bribery and Corruption Policy sets out the general responsibilities placed on all Care Inspectorate employees around reporting of suspected fraud, bribery or corruption; responsibilities around fraud awareness training; the need to comply with the financial regulations and the Procurement Policy; to record gifts and hospitality; and to make annual declarations of interest. The overarching intention to ensure that all stakeholders uphold a positive counter fraud, bribery and corruption culture is also included with the general duties placed on all parties. The Policy also sets out the specific responsibilities around fraud, bribery and corruption for all managers and aligns specific responsibilities to the Chief Executive, the Executive Director of Corporate and Customer Services, the Audit and Risk Committee, both internal and external audit and to CFS.

The policy also sets out the role of the Counter Fraud Champion (CFC) and the Fraud Liaison Officer (FLO) explains that the Executive Director of Corporate and Customer Services is the designated CFC, and the Head of Finance and Corporate Governance is the designated Fraud Liaison Officer.

The Financial Crime Action Plan details the Care Inspectorate's responsibilities in respect of cooperating with the proactive and counter fraud programmes of work developed by CFS. The Plan also describes the way in which the Care Inspectorate and CFS will work together to coordinate work around fraud, bribery and corruption and describes the specific role of CFS in helping the Care Inspectorate to prevent, detect and investigate suspected fraud, bribery or corruption. The Plan contains a useful flowchart which can be used as an aide memoire to guide staff and/or board members dealing with reports of potential fraud, bribery & corruption, theft or other financial irregularity.

From our review of the framework documentation, it is our view that the roles and responsibilities around fraud, bribery and corruption have been clearly set out in a way which can be readily understood by all relevant parties.

Fraud Prevention, detection and response

Objective 3 - There is a process in place to assess the nature and extent of the Care Inspectorate's exposure to potential external and internal risks of fraud.

Our discussions with the Head of Finance & Corporate Governance and the procurement team confirmed that risks around exposure to potential external and internal risks of fraud are regularly considered and are informed by the Technical Bulletins issued by Audit Scotland (which highlight significant public sector frauds), the National Fraud Initiative (NFI) activity and by specific quarterly reviews of procurement related risks which are considered by the procurement Development Group. This group includes the Head of ICT, the Head of Communications, the Head of Finance & Corporate Governance and senior members of the Procurement team.

We were advised by CFS that the introduction, in England and Wales, of Cabinet Office Government Functional Standard GovS 013 : Counter Fraud, resulted in new requirements being placed upon the bodies covered by the standards and meant the introduction of 12 components where compliance can be evaluated to assess whether the organisation is countering fraud and corruption effectively. The approach is focused on the documentation of anti-fraud practices, qualifications; and the consistent application of an agreed approach.

Work is currently ongoing in two Scottish Health Boards to examine the implications of adopting the Cabinet Office Government Functional Standard GovS 013 : Counter Fraud in a learning environment. This involves the completion of an exercise to work through the various standards in order to identify any potential barriers to implementation in Scotland. The outcome of this pilot activity will then feed up into a consultation exercise involving all Fraud liaison officers in Scotland, with a view to launching the standards in Scotland from April 2022 to allow assessment / self-assessment.

The approach envisaged by CFS is that the introduction of the standards will be conducted on a partnership basis, given that the application of the standards is not yet mandatory in Scotland (unlike the position in England and Wales).

The partnership agreements between CFS and NHS Health Boards will be reviewed in April 2022, and we were advised by CFS that a subsequent discussion will be required with the Care Inspectorate around the implications which the adoption of the Cabinet Office standards would have on existing governance arrangements and practices. This would also require consideration by senior management and by the Board before any of the components could be implemented. One of the key components of the standards is a Fraud, Bribery and Corruption Risk assessment which is undertaken in line with the professional standards already in place in England and Wales. We were advised that CFS are currently in the process of obtaining Cabinet Office accreditation. There are three levels of fraud risk assessment available and CFS have taken the view that rather than conducting a high level risk assessment of the organisation, the preferred approach going forward will be to conduct a series of detailed fraud risk assessments in order to build a picture of the relative risk across the organisation. The approach will be intelligence led in terms of the specific focus for the risk assessment activity and therefore CFS have already been in dialogue with internal audit in order to share information which will allow the risk assessments to be conducted effectively in key parts of the organisation (such as procurement and staff related fraud).

Therefore, we are comfortable that the arrangements which are being developed in partnership with CFS will provide a suitable mechanism to evaluate and manage the relative risks around fraud, bribery and corruption in order to direct future fraud prevention activity efficiently and effectively. This will also allow the work of CFS to complement the work of internal audit in the future.

The Care Inspectorate have identified procurement fraud as a high risk area and proactively compared anti-fraud arrangements with the Northern Ireland anti-fraud prevention standards.

Fraud Prevention, detection and response

Objective 4 - Anti-fraud policies and procedures are embedded and understood throughout the organisation through appropriate training and communication.

The Formal Action Policy has been specifically developed as a reference document for all staff to be aware of and have access to. Following approval of the framework steps were taken to highlight the existence of this document to staff so that they are aware of the agreed approach and understand what to do if they suspect fraud, bribery or corruption. Targeted training has already been delivered by CFS to Finance and Procurement staff, due to the specific nature of the fraud risks relating to both of these areas. CFS advised that they can provide training sessions on demand to meet identified need and that the fraud risk assessments will help to shape a programme of training activity in future years.

Observation	Risk	Recommendation	Management Response	
As highlighted under Objective 1 the Counter Fraud Bribery and Corruption Framework contains a raft of information around the definitions of fraud, bribery and corruption and sets out the responsibilities and actions required in specific circumstances. The framework is available to staff on the intranet and work is planned to raise the profile of the work with CFS and to highlight the existence of the dedicated Fraud page on the intranet to staff. However, the intelligence led approach described under Objective 3 presents an opportunity to bring together all of the fraud prevention, detection and response documentation in one single place which can act as a single reference point for managers, staff and board members. There is also an opportunity to publish the framework on the public facing website to showcase the anti-fraud approach which has been taken and to act as a deterrent.	Without readily accessible information on fraud, bribery and corruption, managers, staff and Board members may be unclear on their respective responsibilities and the correct steps required to adequately discharge those duties.	**R1** – Steps should be taken to further develop the fraud intranet page as a central repository for all Anti-Fraud, Bribery and Corruption documentation, including links to external sources such as the CFS website and other pertinent information published by audit Scotland, CIPFA and Scottish Government. This information should be made available on the staff intranet and also on the public facing website to act as a deterrent and to demonstrate the zero tolerance stance which the Care Inspectorate has taken around fraud, bribery and corruption.	This recommendation is accepted. This fits with plans to provide regular communication to staff on fraud. **To be actioned by:** Head of Finance & Corporate Governance **No later than:** 31 December 2021	
			Grade	**3**

Fraud Prevention, detection and response

Objective 5 - The organisation has put in place a process to monitor and review procedures designed to prevent fraud and make improvements where necessary.

As highlighted under Objective 1, above, the Counter Fraud Bribery and Corruption Framework was approved by the Board in June 2021. Although the framework does not contain a set date for the review of the framework, section 8.4 of the Counter Fraud, Bribery and Corruption Policy states that "*In order to keep abreast of key changes we undertake ongoing reviews of national issues and developments. Information from a range of sources is obtained and used in keeping our plans up to date, including from CFS, Audit Scotland, CIPFA Better Governance Forum and Scottish Government*".

The partnership with CFS is still developing but it is clear from the work already progressed that CFS will be an importance source of advice and support in determining whether the existing Counter Fraud Bribery and Corruption Framework remain fit for purpose. The work outlined under Objective 3, in relation to the adoption of the Cabinet Office standards and the implementation of Fraud, Bribery and Corruption Risk assessments will also play a pivotal role in directing the work of CFS and in determining the effectiveness of the established framework.

Therefore, we have concluded that the current partnership approach adopted is sufficiently robust to ensure that procedures are regularly reviewed and that required improvements can be identified and taken forward as deemed necessary.

The organisation utilises Microsoft365 for email services, which contains a security feature called ATP which operates in a similar way to Mimecast, by employing email search and threat analysis as part of the incoming email filtering. The application and monitoring of this protection reduces, but cannot eliminate entirely, the risk of external threats which could lead to fraudulent activity by an external party.

Fraud Prevention, detection and response

Objective 6 - There are clear procedures for employees and Board members to raise concerns or whistleblow if they believe there has been fraud or other wrongdoing within the organisation.

The Care Inspectorate website contains a dedicated Whistleblowing page which provides links to the document 'Raising concerns in the workplace: Guidance for employers, social service workers and social work students'. This document is a joint SSSC / Care Inspectorate publication issued in 2019 (review date not stated). The Whistleblowing web page also contains a link to the document 'Whistleblowing: Guidance to Support the Code of Conduct' which sets out the whistleblowing arrangements for staff and volunteers. Links to all of these documents are also available via the staff intranet.

The Financial Crime Response Plan states that "*Guidance has been issued by Audit Scotland to organisation's recommending actions to be taken when staff suspect that fraudulent activity is being perpetrated. This guidance takes the form of booklets for managers and staff entitled 'Don't turn a blind eye'. Further information is also available on www.whistleblowing.org.uk."* Appendix 3 of the Financial Crime Response Plan also sets out the various ways in which concerns can be raised around suspected fraud, bribery and corruption. It also describes the way in which those who report any suspicions will be kept informed of subsequent action taken. Appendix 3 also signposts to the Counter Fraud Services hotline and online reporting services, which are powered by Crimestoppers. This offers access 24 hours a day and seven days a week, with complete anonymity and confidentiality.

Objective 7 - Appropriate procedures are in place for the investigation and reporting of a fraud.

The Financial Crime Action Plan describes in detail the background responsibilities and the process to be followed in circumstances where fraud or bribery is suspected. Appendix 3 of the Financial Crime Action Plan also sets out the reporting requirements and the respective roles and responsibilities around escalation to CFS and potential onwards reporting to the Procurator Fiscal.

We also noted that Appendix 2 of the Financial Crime Action Plan sets out a Human Resources Protocol. We would highlight this is an example of good practice because the existence of such guidance assists greatly in avoiding a scenario whereby an internal disciplinary process could potentially compromise an ongoing CFS investigation and potentially any subsequent criminal proceedings.

Details of action taken and investigations of any suspected fraudulent or corrupt acts are reported annually in the Annual Fraud, Bribery and Corruption Report to the Audit and Risk Committee annually.

We confirmed that a Fraud Register is in place in order to record any incidents of fraud identified. In addition, the appointed external auditors are required to report significant frauds to Audit Scotland annually as part of ongoing collation of fraud data across all public bodies in Scotland. This data feeds into the annual reporting by Audit Scotland around fraud and irregularity.

Fraud Prevention, detection and response

Objective 8 - Anti-bribery and anti-corruption policies and procedures exist within the Care Inspectorate that are proportionate to the bribery risks it faces and to the nature, scale and complexity of its activities.

Anti-bribery and anti-corruption policies and procedures are enshrined within the Counter Fraud Bribery and Corruption Framework described under Objective 1, rather than as standalone documents.

A monthly review of expenditure transactions is conducted. In order to minimise the risk of fraud the creation of supplier masterfiles is strictly controlled. The supplier list is reviewed quarterly and if an account has not been used for 13 months, then it will be deactivated on the system. Only two members of the Procurement team have the authority to set up a new supplier in the iProcurement function within SEAS. There is ongoing monitoring of non-compliant or "maverick" spend through the budget monitoring process. We were advised that the level of noncompliant spend identified in 2020/21 was 3%.

One of the key risk areas identified relates to requests for changes in standing supplier details and a process is in place to ensure that a member of the Transaction team calls the contact number held on the financial system to verify that the requested change is legitimate. The call made is recorded on the phone system to provide an audit trail. If the change is verified as bona fide then the request is passed to the procurement team who action the changes on the creditor Masterfile.

The use of Scottish Government frameworks is the preferred route to market in order to minimise the risk of procurement related fraud or corruption. Recent amendments to the financial procedures mean that declarations of interest are required even for transactions down to a value of £1,000. This ensures that before any member of staff has the opportunity to scope the required specification, or take part in a tender evaluation panel, they are required to declare any interest in the procurement exercise.

Government procurement cards (GPC) have also been introduced to manage the risk around procurement fraud and the Head of Finance & Corporate Governance or the Accounting and Procurement Manager have the delegated authority to approve the issue of a GPC.

The Counter Fraud, Bribery and Corruption Policy states unequivocally that the Care Inspectorate expects all Board Members, employees and those acting as its agents to conduct themselves in accordance with the nine general principles set out in the Ethical Standards in Public Life etc. (Scotland) Act 2000.

Fraud Prevention, detection and response

Objective 9 - An appropriate individual or group has been assigned to deliver the message of zero tolerance to bribery and corruption and that there is an appropriate level of involvement from senior management in the development of the bribery procedures.

The Counter Fraud, Bribery and Corruption Policy states that the Audit and Risk Committee is responsible for overseeing and monitoring the effectiveness of our counter fraud, bribery and corruption arrangements. In addition, a Counter Fraud Champion and Fraud Liaison Officer are in place.

We confirmed that the development of the Counter Fraud, Bribery and Corruption framework had involved appropriate input from senior management and had received Board approval.

Objective 10 - Bribery prevention policies and procedures are embedded and understood throughout the Care Inspectorate through internal and external communication, including an appropriate training programme.

The Counter Fraud, Bribery and Corruption Framework includes specific information around bribery and corruption and makes reference to the different types of crime which could be committed under the Bribery Act 2010.

As highlighted under Objective 2, above, Section 7 of the Counter Fraud, Bribery and Corruption Policy sets out the general responsibilities placed on all Care Inspectorate employees around reporting of suspected fraud, bribery or corruption; responsibilities around fraud awareness training; the need to comply with the financial regulations and the Procurement policy; to record gifts and hospitality; and to make annual declarations of interest. Targeted training has already been provided which included coverage of bribery and corruption.

Fraud prevention, detection and response

Objective 11 - The organisation has put in place a process to monitor and review procedures designed to prevent bribery by persons associated with it and make improvements where necessary.
As highlighted above, bribery and corruption are integrated into the overarching Counter Fraud, Bribery and Corruption Framework. As highlighted under Objective 5, above, we have concluded that the current partnership approach adopted with CFS is sufficiently robust to ensure that procedures are regularly reviewed and that required improvements can be identified and taken forward as deemed necessary.

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AUDIT AND RISK COMMITTEE MEETING 18 NOVEMBER 2021

Agenda item 9
Report No: ARC-27-2021

Title:	**CARE GOVERNANCE IN THE CARE INSPECTORATE**	
Author:	*Kenny Dick, Head of Finance and Corporate Governance*	
Appendices:	1.	Draft Terms of Reference Clinical and Care Governance Group
	2.	Driver Diagram
	3.	Terms of Reference Former Quality and Strategy Committee
	4.	Principles of Clinical and Care Governance
Consultation:	N/A	
Resource Implications:	None	

Executive Summary:	
This report provides an update on progress and initial thinking about Care Governance in the Care Inspectorate.	
The Committee is invited to:	
1.	Note this update.
2.	Provide comment on "Current Thinking" (Section 3) and "Next Steps" (Section 6)

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

AUDIT AND RISK COMMITTEE MEETING 18 NOVEMBER 2021

Agenda item 9
Report No: ARC-27-2021

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 GOVERNANCE IN THE CARE INSPECTORATE

1.0 INTRODUCTION

1.1 As reported to the Board on 17 June 2021, the Chief Nurse had been progressing work to develop a Clinical and Care Governance framework to assist in bringing together clinical and care concerns through a focused group, to inform our work including future quality improvement programmes and build on existing processes in place (eg CPD, professional registration).

1.2 Two Locum Advisers, Linda Pollock and Bob Parry, initially worked with the Chief Nurse and more recently have continued dialogue with staff, held meetings and roundtable discussions on the development of a Care Governance framework and what that might look like for the Care Inspectorate.

1.3 It should be noted that internal stakeholders view "Care Governance" as more appropriate to the work of the Care Inspectorate with its focus on scrutiny and quality improvement of social care. References to "clinical" are no longer used.

1.4 This paper is intended as an initial overview of the intention to take forward a review and deliver a framework which focuses on systems and processes which demonstrates to internal and external stakeholders the effectiveness of our work, promotes our work, identifies good practice and enables quality improvement to be focused where it is needed the most based on data/information from scrutiny and other avenues which forms our intelligence. The role of Chief Nurse role will be pivotal in influencing and contributing to this from a strategic perspective.

2.0 UPDATE ON PROGRESS

2.1 Clinical and Care Governance Group

The Chief Nurse, as reported to the Board on 17 June 2021, set out in the "Next Steps" section of her report:

- Progress the Clinical and Care Governance (CCG) group with an agreed term of reference and processes.

Terms of Reference (Appendix 1) for the group were drafted but not agreed.

As can be seen from the draft Terms of Reference the focus at this time was on clinical and care governance within registered care services:

"To have an overview of matters related to clinical care governance in respect of clinical/health care being delivered by care services regulated by the Care Inspectorate"

2.2 Subsequent work by Locum Advisers

The emphasis has shifted from care governance in the services we regulate to care governance within the Care Inspectorate. Section 2.2.1 to 2.2.3 below summarise the findings and approach recommended. However, we are clear this evolving area of work will also relate strongly to the external focus of the organisation.

2.2.1 Care Governance Definition

Social Work Scotland provide a widely accepted definition of care governance:

"*A robust system for assuring high standards in the delivery of safe, personalised and effective health and social care services*"

A definition of care governance in the Care Inspectorate context is proposed:

"*Care Governance is a process by which accountability for the quality of the functions of our role are monitored and a shared culture of continuous improvement is embedded in order to fulfil our strategic outcomes. This provides assurance to the Board*"

This definition has been developed through the work done by the group to date and in close consultation with staff members. This proposal will be consulted on with internal and external groups as appropriate to ensure a clear understanding and to ensure clarity of purpose.

2.2.2 Creation of a Care Governance Committee

The Locum Advisers were commissioned to support the Chief Nurse in identifying the purpose and remit of a Care Governance Committee and they undertook, inter alia, round table presentations as part of the consultation and facilitation process with Care inspectorate staff.

Following initial discussions with Care Inspectorate staff, potential benefits of creating a Care Governance Committee were identified. These benefits are reflected in section 3.2 below.

A group has also been meeting to discuss our approach to care governance and live issues as they arise under the working title Care Governance Committee. The Locum Advisers have recommended consideration of Board member involvement. The Terms of Reference for this committee are still being developed and will be done so in consultation with colleagues. The business of the Care Governance Committee will be regularly reported by the chief executive to the Audit and Risk Committee and any salient points highlighted.

2.2.3 Drivers for Change

A "Driver Diagram" (Appendix 2) that provides a useful summary of the rationale for the proposals which have been adapted from previous versions in consultation with staff.

3.0 CURRENT THINKING

The work of the locum advisers has been invaluable in stimulating debate and thinking about how we can build on and improve our governance framework to incorporate principles, issues and priorities identified by the locum advisers' work. Our current, evolving position is set out in sections 3.1 to 3.2 below.

3.1 Care Governance

We believe that the Social Work Scotland definition of care governance is appropriate and central to this definition is delivery of health and social care services. We do not deliver care services but we do apply scrutiny to the care governance of the services we regulate.

The proposed definition substitutes fulfilling our strategic outcomes for the delivery of care and in doing so it is difficult to differentiate from a possible definition of corporate governance.

Therefore, creating a new definition of care governance for the Care Inspectorate context is likely to cause confusion between care governance in the generally accepted context of the services we regulate and with our own corporate governance framework.

However, the locum advisers did point to NHS Education Scotland (NES) who have an Education and Research Committee. Education is the key function of NES and Scrutiny and Improvement is the key function of the Care Inspectorate.

We are considering the Care Inspectorate taking a similar approach to build on the governance we already have in place to develop a better integrated and more focussed approach to the governance of our scrutiny and quality improvement work. This would sit within and be complimentary to our existing overall corporate governance framework

3.2 Potential Scrutiny and Quality Improvement Governance Framework

If, following further discussion and consultation, we adopted a Scrutiny and Quality Improvement governance framework, this would allow a cross organisational approach to the governance of scrutiny and quality improvement activity. This can incorporate the principles of care governance (Appendix 4) but focus these principles on the delivery of our scrutiny and improvement activity as opposed to the delivery of care. This framework would incorporate the work undertaken by the recently constituted Care Governance Committee including

that envisaged by the Chief Nurse's draft Terms of Reference of the scrutiny of services focussed Clinical and Care Governance Group.

As noted above we have effective governance in place already, so this requires us to consider how we can improve on what we are already doing. The Scrutiny and Quality Improvement governance framework could include areas to focus on such as: the analysis and management of risks to people who experience care at service, provider and sector levels; developing our use of our data and intelligence; identification, planning and delivery of the education and development needs of our scrutiny and improvement workforce aligned to professional registration requirements; engaging with people who experience care; developing and monitoring the implementation of the Scrutiny and Improvement Plan; directing and monitoring methodology development; our quality assurance and continuous improvement processes.

3.3 Creation of a new Committee

Our current governance structure of a Board with a single Audit and Risk Committee was the result of a relatively recent governance review. There is overlap between the proposal for Board member involvement in the Care Governance Committee and our former Quality and Strategy Committee (Terms of Reference attached as Appendix 3). In the context of developing the Care Governance Committee and potentially re-focussing this to a Scrutiny and Quality Improvement Governance Committee we need to consider if either option would be an officer only committee (akin to our Health & Safety Committee) or if Board member involvement is required.

This does come at a very opportune time as we recently agreed to review our governance structures below Board level looking at the operation of the Strategic Leadership Team (SLT), Operational Leadership Team (OLT) and the various decision-making groups that support these teams.

The creation of a new scrutiny and quality improvement governance framework will be factored into the work to consolidate the operation of SLT, OLT and the various supporting groups.

A new scrutiny and quality improvement governance framework may result in the need for a new Committee of the Board but it may also be possible to deliver this within our existing Board and Audit and Risk Committee structure. This will be considered as we progress this work.

4.0 IMPLICATIONS AND/OR DIRECT BENEFITS

4.1 Resources

There are no resource implications associated with this update report.

4.2 Sustainability

There are no sustainability implications associated with this update report.

4.3 Government Policy

There are no government policy implications associated with this update 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.

5.0 CONCLUSION

5.1 The work of the locum advisers and the engagement they have had with staff from across the Care Inspectorate has been invaluable in stimulating thinking at a very opportune time. This work and much of the principles and thinking behind the recommendations made will underpin and be incorporated into our review of our governance structure below Board and Committee level. The aim is to provide further assurance to the Board and more widely about the quality of our core work.

6.0 NEXT STEPS

6.1 Further consideration of the development of the arrangements referred to in this report at the joint SLT and OLT meeting on 17 December 2021.

6.2 Report to 10 February 2022 Board meeting on final recommendations including any necessary changes to our governance structures.

Agenda item 9
Appendix 1

Clinical and Care Governance Group

Terms of Reference

Membership:

Chief Nurse (Chair)

Chief Inspector, Adult Services

Head of Intelligence

Head of Improvement Support

Head of OWD

In Attendance:

Other officers at the request of the group Chair (or in the Chair's absence, its deputy Chair)

Frequency of Meetings:

At least every 6 weeks

Reports to:

SLT (by way of minutes and Annual Report or reports on individual issues)

Purpose

The purpose of the Clinical and Care Governance Group (CCG) is to provide oversight and assurance to SLT and the Board that registered services are clinically safe and are of high quality. To help identify poor performance and address this, developing a proactive and informed approach to strategy, improvement, and support. This fits with our strategic objective

'Poor quality care will be addressed quickly'

Definition

For purposes of the Care Inspectorate Clinical Governance is defined as:

A quality improvement framework based around the clinical and care governance domains which enables the Care Inspectorate to work proactively to improve health and clinical need outcomes for people experiencing care, to share, support and sustain good practice and improvement, and to respond appropriately and timeously to areas identified with high clinical or health risks.

Remit

To ensure that the Care Inspectorate is able to meet the following strategic outcomes – in the relation to clinical and health needs :

Strategic outcome 1 – People experience high-quality care

Strategic outcome 2 – People experience positive outcomes

Strategic outcome 3 – People's rights are respected

To:

- have an overview of matters related to clinical care governance in respect of clinical/health care being delivered by care services regulated by the Care Inspectorate, and to do so having regard to the key domains based around clinical and care governance:
    1. Risk assessment & management
    2. Informed & transparent decision making
    3. Leadership & management of staff
    4. Training, education & development
    5. Data, information sharing & intelligence
    6. Public & stakeholder feedback
    7. Fostering cultures of transparency & openness

- consider such matters both as they relate to individual care services regulated by the Care Inspectorate and across the sector as a whole.

- make recommendations to SLT as to actions which the Care Inspectorate should take in order to improve clinical care governance across the regulated care sector or in specific areas of that sector.

- provide, via the Chief Inspector, Adult Services, advice as to the adequacy or otherwise of clinical care governance arrangements or aspects thereof in respect of individual regulated care services, and to advise on appropriate actions or measures which may be necessary to support (or in appropriate cases, compel) registered care services to address any deficiencies in clinical care governance arrangements.

- consider and make recommendations as appropriate on the education and training required of Care Inspectorate inspectors.

- to agree, direct and support improvement through a triage mechanism to proactively support regulated services where there are indicators of distress

- to monitor improvement on any areas of concern.

- to report any concerns to appropriate lead agency where applicable.

Agenda item 9
Appendix 1

Procedure

Meetings will be chaired by the Chair of the group ("The Chair") or in the event that the Chair is absent or otherwise unavailable, its deputy Chair ("the deputy Chair").

The Chair or in the event that the Chair is absent or otherwise unavailable, the deputy Chair, shall circulate an agenda at least 7 days in advance of each meeting. Members may at their own instance, or at the request of any other member of Care Inspectorate staff, request that items be added to the agenda for any meeting. It shall be for the Chair or deputy Chair as may be appropriate to decide whether any requested item should be added to a meeting agenda. The Group may agree at its first or at any subsequent meeting that there shall be an item or items which shall appear on the agenda for every meeting.

Administrative support, including, but not limited to, arranging meetings, preparing agendas and taking minutes of meetings shall be provided by (**whom**?). Minutes will be agreed by email following each meeting, and upon agreement and approval by the Chair or deputy Chair, shall be shared with the SLT.

The Group will compile an annual report of its activities for submission to SLT, and in addition, shall submit to the SLT *ad hoc* reports on such matters as seem to it appropriate, and shall, in addition, promulgate information, including information about its activities, to the wider staff group, via the Care Inspectorate's intranet.

These Terms of Reference may be reviewed and revised by the Group at any time and shall be so reviewed, and if appropriate, revised, at intervals of no more than two years.

Version Control

Version	Section/Paragraph/ Appendix	Description of Amendments	Date	Author/ Amended by

Aim
In order to achieve this Aim…

Primary Driver
We need to ensure…

Secondary Driver
Which requires…

Change Ideas
Ideas to ensure this happens…

To have robust care governance structures & processes to monitor & assure the quality of the functions of the organisation

CARE GOVERNANCE is a process by which accountability for the quality of the functions of our role are monitored and a shared culture of continuous improvement is embedded in order to fulfil our strategic outcomes. This provides assurance to our Board.

Primary Driver	Secondary Driver	Change Ideas
Care Governance at the heart of all we do	Care Governance Committee	Agreed understanding and definition for the Care Inspectorate of care governance Improving staff understanding of care governance
The organisations values based approach is exhibited in what we do	Professional Assurance Framework	The people who experience our services are assured their voices are heard through robust processes
Continuous and targeted quality improvement	Quality review processes based on learning and outcomes from our scrutiny and improvement support work	Develop a methodology and review process that is supported by agreed data that support legislative requirements
Skilled and competent workforce	A learning and development framework for all staff	Learning needs analysis, personal development plans to meet individual and organisational needs that demonstrate evidence of relevant knowledge, competencies and skills

5. QUALITY & STRATEGY COMMITTEE

5.1 Terms of Reference

5.1.1 To monitor and consider developments and events both internal and external to the Care Inspectorate having regard to the policy, planning and resources framework determined by Scottish Ministers, the principles of Better Regulation and the Care Inspectorate's statutory obligations and to make recommendations to the Board as to the overall strategic direction of the Care Inspectorate in terms of paragraph 1.4.1(b) hereof.

5.1.2 To request, receive and consider reports on, any aspect of the Care Inspectorate's scrutiny activity identifying themes and trends in all areas of the Care Inspectorate's work, seek to influence the health, care and learning landscape, and to report thereon to the Board, making appropriate recommendations.

5.1.3 To monitor the quality of all of the Care Inspectorate's work (including, but without prejudice to the generality of the foregoing, its handling of complaints made to the Care Inspectorate, whether about regulated care services, or about the Care Inspectorate), and ensure that appropriate mechanisms are in place and implemented to promote regular review of its activities, approaches and methodologies and that those mechanisms enable it to identify learning from all of its work (including, but without prejudice to the generality of the foregoing, its work in handling complaints) and opportunities to promote and maintain continuous improvement in all of the Care Inspectorate's activities.

5.1.4 To identify evidence of the impact of continuous improvement in all of the work of the Care Inspectorate areas and where appropriate, make proportionate and prioritised recommendations to the Board, taking account of risk and resources.

5.1.5 To provide leadership in the development and promotion of efficient, effective, economic and intelligence-led use of public resources in the areas falling within its remit

5.2 Membership

5.2.1 The Quality & Strategy Committee shall comprise the Chair and not less than five nor more than seven of the currently appointed members of the Care Inspectorate's Board.

5.3 Quorum

5.3.1 The quorum of the Quality & Strategy Committee shall be the Chair of The Care Inspectorate or any substitute, as provided for in terms of Standing Order 20 of The Care Inspectorate's Standing Orders and in addition not less than three members of the Committee.

5.4 Frequency

5.4.1 The Quality and Strategy Committee shall meet at least 4 times per year.

5.5 In Attendance

5.5.1 Chief Executive
Executive Director, Scrutiny & Assurance
Executive Director, Strategy & Improvement
Executive Director, Corporate & Customer Services
Chief Inspector - Strategic Scrutiny (as Executive Adviser on Social Work)
Head of Legal Services
Other officers as appropriate

5.6 Equality and Diversity

5.6.1 The Care Inspectorate is committed to promoting equality and diversity. The Committee will at all times conduct its business in a way which reflects good practice in relation to equality and diversity and which complies fully with the requirements of the Equality Act 2010.

Extract from Reservation of Powers and Scheme of Delegation
Approved by Board: 30 March 2017

Agenda item 9
Appendix 4

Five Key Principles of Clinical and Care Governance

1. Clearly defined governance functions and roles are performed effectively.

2. Values of openness and accountability are promoted and demonstrated through actions*.

3. Informed and transparent decisions are taken to ensure continuous quality improvement.

4. Staff are supported and developed.

5. All actions are focused on the provision of high quality, safe, effective and person-centred services.

Clinical and Care Governance Framework (Scottish Government)

*in the Care Inspectorate context work undertaken would fit with all our values.

AUDIT AND RISK COMMITTEE MEETING 18 NOVEMBER 2021

Agenda item 10
Report No: ARC-28-2021

Title:	**STRATEGIC RISK REGISTER MONITORING REPORT**	
Author:	*Kenny Dick, Head of Finance and Corporate Governance*	
Appendices:	1.	Summary Strategic Risk Register
	2.	Strategic Risk Register Monitoring Statement
Consultation:	N/A	
Resource Implications:	None	

Executive Summary:
The Strategic Risk Register monitoring position is presented for the Audit and Risk Committee's consideration. There has been no significant change to the strategic risk position since the Board meeting held on 23 September 2021.
The Committee is invited to:

1.	Consider the current risk monitoring position, highlighting any issues that should be brought to the attention of the Board at its meeting of 16 December 2021.

Links:	Corporate Plan Outcome		Risk Register - Y/N	Y	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

AUDIT AND RISK COMMITTEE MEETING 18 NOVEMBER 2021

Agenda item 10
Report No: ARC-28-2021

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.
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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 REGISTER MONITORING REPORT

1.0 INTRODUCTION

1.1 The Care inspectorate's Strategic Risk Register is reviewed at each meeting of the Audit and Risk Committee and the Board. This report highlights changes in the risk position or risk management issues to the Audit and Risk Committee to assist with this review.

2.0 STRATEGIC RISK REGISTER REVIEW

2.1 Strategic Risk 1 – Delivery of Strategy

The is no change to the residual risk score which remains at 8 (medium).

This risk is at its target level.

2.2 Strategic Risk 2 - Financial Sustainability

The is no change to the residual risk score which remains at 9 (medium).

This risk is at its target level.

2.3 Strategic Risk 3 - Workforce Capacity

There is no change to the residual risk score which remains at 6 (medium).

Inspector vacancies have reduced from the 53 FTE previously reported to the Committee to a current position of 37 FTE vacancies. It is expected to start 10 new Inspectors in January 2022. The remaining 27 vacancies are expected to remain unfilled for the rest of the 2021/22 financial year.

The previously reported difficulties in recruiting and retaining staff for digital and business transformation work remains a challenge but the position has eased as we have been able to fill key roles.

This risk is at its target level.

2.4 Strategic Risk 4 - Partnership Working

There is no change to the residual risk score which remains at 8 (medium).

This risk is at its target level.

2.5 Strategic Risk 5 – ICT Data Access and Security

There is no change to the residual risk score which remains at 16 (high).

The target level for this risk is low and our tolerance has been set at medium. This risk therefore exceeds target and tolerance levels.

The "controls in place" and "further actions" sections of the risk monitoring have been updated (updates are in highlighted in red text). Further actions viii) two factor authentication and ix) addressing legacy infrastructure risks when completed are likely to reduce the risk likelihood score to a 3 and the residual risk score will reduce from 16 to 12 but this still results in a grade of "High".

This risk has now exceeded tolerance for four months.

2.6 Strategic Risk 6 - Digital Transformation

There is no change to the residual risk score which remains at 15 (high).

The target level for this risk is low and our tolerance has been set at medium. This risk therefore exceeds target and tolerance levels.

The submission of the business case to the Board has been delayed from the previously reported September 2021 to February 2022 to allow the inclusion of market oversight requirements to be included.

The identified further actions are intended to reduce the risk to at least the tolerance level. This risk has now exceeded tolerance for four months.

2.7 Strategic Risk 7 – Shared Service Governance

The is no change to the residual risk score which remains at 6 (medium).

This risk is at its target level.

3.0 RESIDUAL RISK TOLERANCE RATING

3.1 The residual risk to risk tolerance rating highlights how long there has been a mismatch between the residual risk score compared to the Board's stated risk tolerance level. The table below shows the basis of this rating:

Rating	Descriptor
Green	Residual risk is at or lower than the tolerance level.
Amber	Residual risk has been higher than the stated risk tolerance for up to six months.
Red	Residual risk has been higher than the stated risk tolerance for more than six months.

The Audit and Risk Committee may decide to rate as "Red" a risk that has been different to the stated tolerance for less than six months if this is considered appropriate.

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 10
Appendix 1

SUMMARY STRATEGIC RISK REGISTER: 2021/22 (as at 18 November 2021)

No.	Risk Area	Strategic Outcome/ Principle	Lead Officer	Raw Score (LxI)	Raw Grade	Residual Score (LxI)	Initial Residual Grade	Revised Residual Grade
1	Delivery of Strategy	SO 1,2,3	CE	16	High	8	Medium	Medium
2	Financial Sustainability	P 6	EDCCS	16	High	9	Medium	Medium
3	Workforce Capacity	SO 1,2,3	EDSI & EDCCS	16	High	6	Medium	Medium
4	Partnership Working	SO 1,2,3 P 5	EDSA	16	High	8	Medium	Medium
5	ICT Data Access & Cyber Security	P 6	EDIDT	20	Very High	16	High	High
6	Digital Transformation	P 1 to 7	EDIDT	20	Very High	15	High	High
7	Shared Service Governance	P 6	EDCCS	16	High	6	Medium	Medium

Agenda item 10
Appendix 1

SCORING GRID

LIKELIHOOD					
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic

IMPACT

Black = Very High

Red = High

Amber = Medium

Green = Low

White = Very Low

Lead Officers

CE	Chief Executive
EDS&A	Executive Director Scrutiny & Assurance
EDCCS	Executive Director Corporate & Customer Services
EDS&I	Executive Director Strategy & Improvement
EDIDT	Executive Director ICT and Digital Transformation

Agenda item 10
Appendix 2

Strategic Risk Register Monitoring

Date	for Audit & Risk Committee 18 November 2021														
Risk		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 / Target / Tolerance	Risk Owner
1	**Delivery of Strategy** **What is the Potential Situation?** We are unable to fulfil our core purpose due to external factors **What could cause this to arise?** Change to macro environment adversely impacts together with an inability to influence or react / adapt appropriately; ineffective leadership and/or decision making in adapting to the change; insufficient capability or capacity to manage the changes required. **What would the consequences be?** Inability to provide the desired level of scrutiny, assurance and improvement support. Reduction in the quality of care and protection for vulnerable people across Scotland. Reputational damage with reduced public and political confidence. Possible reduced SG funding. Lack of ability and credibility to positively influence change such as SG policy development and to drive innovation.	4	4	16	H	2	4	8	M	Med	⇔	In Place: i. Corporate Plan in place with supporting operational plans and performance measures and under continuous review ii. Regular Sponsor liaison meetings iii. Meetings with Cabinet Secretary and other Ministers iv. Strategic Scrutiny Group v. Chief executive attends SG remobilisation recovery group chaired by Cabinet Secretary vi. Horizon scanning through our policy team vii. Scrutiny and Assurance Plan agreed by Minister viii. Attendance at national forums	Further Actions: i. Planning for a review of the current Corporate Plan 2019-22 towards the 2022-25 Corporate Plan including further development of performance monitoring is underway with a draft Corporate Plan intended to be considered by the Board in December 2021 and approved by Board in March 2022 ii. Strengthening use of risk and intelligence to inform our work. A full business case is being prepared for stage 2 of business and digital transformation and this is critical to the development of our intelligence capability	Appetite: cautious Target: medium Tolerance: high At target level Rating: Green Response: Accept	CE
2	**Financial Sustainability** **What is the Potential Situation?** Funding level fails to increase in line with inflation, external cost pressures and additional demands **What could cause this to arise?** Inability to influence and agree sufficient funding with the Scottish Government; financial planning not aligned to corporate, operational & workforce plans, unexpected additional or changes to demands; insufficient data or information to accurately cost activities; potential costs arising from Covid 19 public inquiry. **What would the consequences be?** Resulting in adverse impact on our ability to deliver the scrutiny and improvement plan, reputational damage, reduced confidence in care and protection arrangements, reduced future funding, reduced ability to influence change and policy development.	4	4	16	H	3	3	9	H	Med	⇔	In Place: i. Medium term budget and financial strategy are regularly reviewed ii. Monthly budget monitoring iii. Positive working relationships maintained with SG iv. Regular liaison meetings with SG Health Finance v. Ongoing review and development of savings and income generation options	Further Actions i. Full business case for Stage 2 of Digital Transformation being developed	Appetite: cautious Target: medium Tolerance: high At target level Rating: Green Response: Accept	EDCCS

Agenda item 10
Appendix 2

3	**Workforce Capacity** **What is the Potential Situation?** We are unable to deliver our Corporate Plan objectives due to a lack of workforce capacity. **What could cause this to arise?** We do not have an effective strategic workforce plan to support the delivery of our corporate plan objectives; we do not have effective workforce planning at directorate and team level; there is ineffective monitoring of workload and capacity; we fail to recruit and retain staff in sufficient numbers and with the required skillset, we have an inefficient organisation structure and/or job design; there are ineffective staff learning and development plans; our reward offer is uncompetitive; we do not adequately address the aging demographic of a significant element of our workforce. **What would the consequences be?** Inability to provide the desired level of scrutiny, assurance and improvement support Reduction in the quality of care and protection for vulnerable people across Scotland Reputational damage with reduced public and political confidence Possible reduced SG funding Lack of ability and credibility to positively influence change such as SG policy development and to drive innovation	4	4	16	H	2	3	6	M	Med	⇔	In Place: i. Strategic workforce plan ii. Workload and capacity monitoring iii. Staff learning and development plan iv. LEAD process v. Recognised job evaluation system vi. Regular salary benchmarking	Further Actions: i. Implement Strategic Workforce Plan actions ii. Develop succession planning iii. Strengthen use of risk and intelligence iv. Recruitment strategy review v. Pay and grading scoping review	Appetite: cautious Target: medium Tolerance: medium At target level Rating: Green Response: Accept	EDS&I & EDCCS
4	**Partnership Working** **What is the Potential Situation?** The Care Inspectorate collaborative working with our key scrutiny and delivery partners is compromised and we are not able to: • participate in, or progress, work which would help deliver our strategic objectives • deliver public service scrutiny in a joined up and collaborative way • deliver our agreed scrutiny and improvement plan **What could cause this to arise?** Scrutiny and delivery partner strategies are not aligned well enough to our own; our ability to fully resource our own or our partners' strategic priorities; unexpected changes in environment (PESTEL); unclear, misaligned or incomplete individual and joint plans; collaborative work does not have or adhere to legal underpinning; inadequate or deficient Information Technology; inaccurate or inappropriate information sharing. **What would the consequences be?** Reputational damage; loss of confidence and credibility, unable to fulfil statutory obligations; damage to relationship with scrutiny and delivery partners.	4	4	16	H	2	4	8	M	Med	⇔	In Place: i. Wide consultation and regular meetings at Senior level inter- organisation meetings ii. Effective external comms strategy in place iii. Membership of National Strategic Scrutiny Group iv. MoUs or agreed protocols in place with all relevant partners v. Chief Executive and Directors monitor and carefully manage relationships with scrutiny and delivery partners	Further Actions: i. Positive positioning of the Care Inspectorate in relation to transformation arising from the Feeley review recommendations, including structure and governance arrangements ii. Consolidating new partnership arrangements developed during the pandemic and exploring any opportunities for new partnerships	Appetite: cautious Target: medium Tolerance: High At target level Rating: Green Response: Accept	EDS&A
5	**ICT Data Access & Cyber Security** **What is the Potential Situation?** Our systems or data are compromised due to cyber security attack. **What could cause this to arise?** Low overall maturity in security policy, procedure and controls. Lack of security awareness training, failure to invest in the controls and infrastructure to limit, detect and respond quickly to threats. **What would the consequences be?** Serious disruption to business and operational activities, we are held to ransom or face significant fines, potential loss of intelligence, impact on public / political confidence, loss of reputation, additional recovery costs, increased risk of fraud, additional scrutiny overhead.	5	4	20	VH	4	4	16	H	High	⇔	In Place: i. ICT security protocols and monitoring of compliance with the protocols ii. Trained ICT staff iii. Physical security measures iv. Business Continuity plans in place v. Cyber Essentials+ certification in place vi. Routine penetration testing vii. Cyber Security Maturity baselined and	Further Actions: i. Implementation of cyber security action plan (plan will take approx. 2 years to implement) ii. Increase organisational cyber security awareness and testing iii. Enhance ICT staff cyber security awareness and technical training	Appetite: cautious Target: low Tolerance: medium Has exceeded tolerance for 4 months Rating: Amber Response: Treat	EDIT&D

Agenda item 10
Appendix 2

												improvement plan in progress viii. Agreed a temporary (18 month) IT Officer post to focus on security work ix. Specific budget allocated to security x. Security compliance included in the monthly IT Operations report and therefore regularly reviewed and discussed.	iv. Re-run cyber security assessment v. Introduce security vulnerability testing vi. Build and test of IT DR plans vii. Implement additional security controls and reporting capabilities viii. Two factor authentication to be introduced November / December 21 ix. Funding for additional spend to address legacy infrastructure risks has been agreed		
6	**<u>Digital Transformation</u>** **What is the Potential Situation?** We do not get agreement and funding to proceed to digital transformation programme Stage 2. **What could cause this to arise?** SG do not prioritise our business case against other competing funding pressures. There is a significant delay in the business case and/or funding being agreed. Changed SG priorities due to Adult Social Care Review / National Care Service. **What would the consequences be?** We are unable to fully modernise and move to a digitally enabled comprehensive intelligence led approach. Our core business is reliant on end-of-life legacy systems with best endeavours support model. Staff dissatisfaction and negative impact on morale. Reputational damage and adverse public opinion. May result in long term increased unplanned costs. May compromise our ability to collaborate effectively with other organisations.	4	5	20	VH	3	5	15	H	Med	⟷	In Place: i. Draft comprehensive business case prepared and is currently in review cycle ii. Agreement to undertake business justification gate (SG Digital Directorate) iii. Awareness raising with Minister and Sponsor iv. Digital member /officer oversight group established	Further Actions: i. Business case presented for approval to February 2022 Board meeting ii. Develop contingency plans for reduced or no additional funding. iii. Full programme governance arrangements	Appetite: cautious Target: low Tolerance: medium Has exceeded tolerance for 4 months Rating: Amber Response: Treat	EDIT&D
7	**<u>Shared Service Governance</u>** **What is the Potential Situation?** The new shared service governance arrangements are ineffective **What could cause this to arise?** There is a lack of clarity over the services to be delivered, the standard of service delivery required and the consequences of service failure. Resources are not aligned to service delivery or standards. There is insufficient or ineffective reporting on performance, cost and risk. There is a lack of clarity on accountability and responsibility for decision making. **What would the consequences be?**	4	4	16	H	2	3	6	M	Med	⟷	In Place: i. joint shared services strategy ii. Management agreement iii. Specifications of Service. iv. Risk register and risk management process. v. Performance measures and service standards vi. Regular meetings of Review Board	Further Actions: i. Finalise reporting to Review Board ii. Develop assurance maps for Service Review Board iii. Annual report to governing bodies	Appetite: Cautious Target: Medium Tolerance: Medium At target level Rating: Green Response: Accept	EDCCS

	Failure to secure best value through ineffective deployment of resources and ineffective procurement, non-compliant statutory reporting, employee relations and health & safety issues, customer dissatisfaction, strained SSSC/CI working relationship, failures in physical, cyber and information security, failure to deliver legal obligations and reputational damage										vii. Regular meetings of shared service oversight group viii. Internal audit positive review of arrangements			

AUDIT AND RISK COMMITTEE MEETING 18 November 2021

Agenda Item 11
Report Number: ARC-29-2021

Title:	**DIGITAL PROGRAMME UPDATE**
Author:	*Gordon Mackie, Executive Director of IT, 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.	Note 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 of progress in maintaining the Registration application and associated features post Go-Live (March 2021).

2.0 PROGRAMME DEVELOPMENTS

2.1 Overall Progress

Registrations and The Register continues to make good progress. Since the last reporting period we have made very good progress on the Hypercare issues & also been successful in recruiting a number of resources who are experienced and are settling well into the team and overall this has had a positive impact on our progress.

In September and October 2021, we undertook a review of functionality to assess how much of the planned functional scope has been delivered and to identify if any there were any significant outstanding requirements. The review confirmed 95% functionality has been delivered. This has enabled forward planning up to the end of March 2022. The review also confirmed that of the 5% not delivered there was nothing material to stop the application from functioning.

This review was achieved through collaborative engagement with the Operational Champions, operational colleagues, and the Senior Stakeholder Group.

As a result of the concerted efforts of the team over the last three months, the level of issues associated with go-live of a complex system, experienced by our operational colleagues (reported last quarter) has reduced significantly.

The programme has focussed on the following areas;

- Hypercare - We have seen a longer period of hypercare being in place than would be expected. However, the delivery and service have worked closely together, and the result is the numbers continue to reduce.
- Data fix issues – due to the nature and size of the data migration we continue to address data fix issues. The scale of the errors within the legacy system prior to transfer to the new register meant whilst we did extensive cleansing, there would always have been residual errors requiring manual updates. We are managing via a mix of planned “data fixes” and manual updates by operational colleagues to ensure the best quality data is available within the app. We expect data fix issues to persist for some time and will continue to prioritise work on solutions to reduce impact internally and externally.
- We have made significant progress on passing the day-to-day support of the application to IT Service Operations. We now have IT Operations responding to any initial issues raised from operational colleague and ensuring this work is successfully triaged.
- A **Functionality Review** was undertaken to assess how much of the planned functional scope has been delivered and to identify any significant outstanding business requirements to enable forward planning to 31 March 2022

The complaints app has had minimal work completed since the last report. We are however, working closely with the Service Manager, Complaints, to ensure to plan their prioritised work based on their immediate business requirements and this will be planned into our forward-looking work plan that is focussed up till 31 March 2022.

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 2020 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 team has been impacted by “COVID” and “COVID fatigue”. Team members have been affected personally as well as family members over the last 20 months. There has also been an impact for 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.

The Digital team continues to support the Care Inspectorate's overall response to the Covid-19 pandemic when required.

2.3 The Complaints App Update

As previously report, the main focus has been on the delivery of registration, the register and the functionality used internally and externally. The digital team have now begun preliminary discussions with the Complaints leadership team and as part of these discussions we will look to update our forward-looking delivery plan to the end of the current financial year.

2.4 Registration Phase 1

As previously reported, Phase 1 of the Registration app (the digitised application form) went live on 28 January 2020. The average since go-live has been around 60 new services registered per month vs 80 pre-Covid. The feedback from applicants, in the main, continues to be very positive.

2.5 Registration Phase 2 (including the Register) – Progress Post Go live

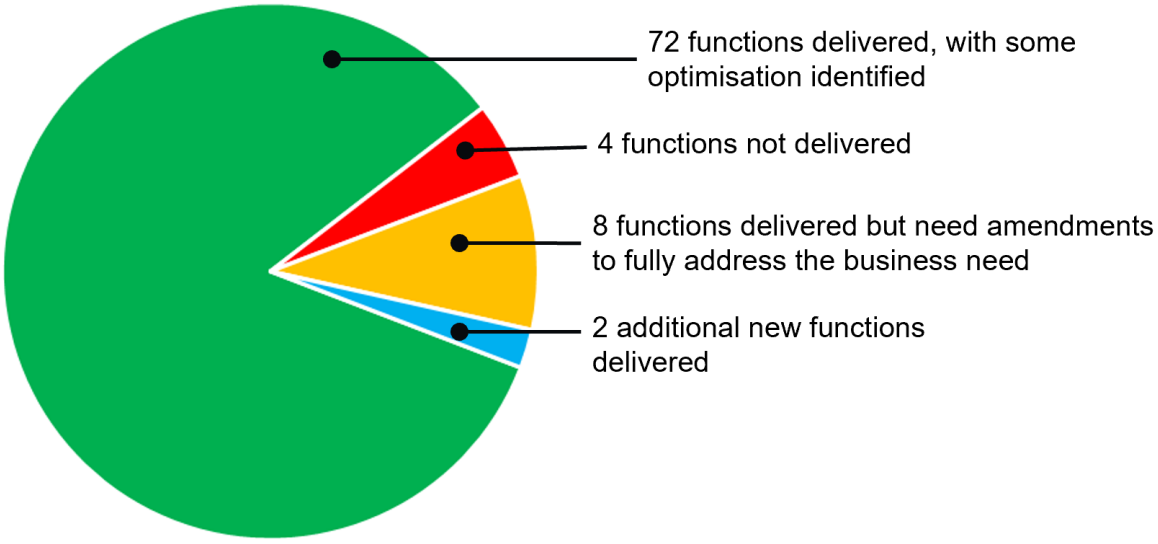
Since the last update we have continued to work through to fix known bugs along with optimising functionality that has already been delivered.

Functionality review

The purpose of the review was to assess how much of the planned functional scope has been delivered and to identify any significant outstanding business requirements. This review was requested by the August 2021 programme board to assure colleagues delivery and progress being made was as expected.

It followed after some challenge from operational colleagues around the delivery of the new app.

The review was carried out over six weeks, nine workshops and involved 27 staff representing a cross section of operational and business colleagues. We asked them to assess 84 functions as part of the registration and register delivery.



This review identified that 95% of the functionality for Registration and the Register (ten separate areas of functionality linked to the register) has been delivered. The review highlighted the need for a small number of new changes, some areas although delivered would benefit from further optimisation. As previously stated, the review also confirmed that of the 5% not delivered there was nothing material to stop the application from functioning

This resulted in a delivery plan up to 31 March 2022 which was welcomed by Operational Champion's and the Senior Stakeholder Group.

Hypercare

Hypercare has been beneficial to help us work with operational colleagues to meet business requirements. It was always to be expected we would see challenges as a of the complex changes we were introducing. Hypercare helped us manage this in a structured way.

"Hypercare" is a term we use to provide support to our operational colleagues and our external stakeholders through our contact centre. This allows our staff to log issues and provide feedback to the digital team. We categorise these areas as:

- Incident/Defect – erroneous behaviour of the app software
- Change request – for new functionality for the app
- Service Request – for IT to carry out a standard operation for a user
- Data Fix – requires technical staff to update the data held by the system to correct a processing error or resolve a data quality issue
- User Guidance – where the issue can be addressed by appropriate advice to the user including updating procedures, guidance, and reference material.

As at 28/10/2021 - 2264 Hypercare issues have been logged since 23 March 2021. To date, we have resolved and closed 96% of all issues raised which is a decrease in the in the backlog of outstanding tickets in the last quarter.

There are currently 65 issues overall recorded as to be resolved. We are reviewing how we record and report all areas as they include guidance issues, requests for change and new functionality requests. This number of actual issues is only a fraction of this total

The breakdown of issues is as follows;

Category	Live Numbers
Incident/Defect	14
Change requests	0
Service Requests	4
Data Fix	36
User Guidance	10
TBA	1
Total	65

**TBA are issues that were just logged but are yet to be categorised.*

As of September 2021, the IT service team has now taken over hypercare. They triage the issues and make sure actions are allocated to the appropriate team for resolution.

Registration and Register usage

We have seen a big uptake in terms of users and applications to Register, Vary conditions, and change of detail requests since the last report and continue to see the numbers grow. Rather than go with a big communications message we have pointed service providers to the application at point of need. This has meant we have managed numbers accessing the portal and prevented any surge in use and limited ongoing support calls.

Application Type	May 2021	28 October 2021	Increase
Registration Applications Created	170	3041	+2871
Variation requests (in flight)	578	1900	+1322
Voluntary Cancellation Requests	99	575	+476
Inactive Service Requests	31	366	+335
Illegal Service cases opened	3	37	+34
New Services Registered	17	305	+288
Change of Detail Requests	228	2550	+2322
Change Of Details Self Service	107	1152	+683

Since go live **8086** external users (Providers and new applicants) have logged into the Portal to use the new functions. The use of the application, portal and associated functions continues to grow, and the volume of issues raised has been very low.

Data Migration

As part of the Hypercare Data Fix work identified above, we identified and resolved one specific impact of migration related to services migrated as inactive, for which a single fix cleared 14 issues and prevented a further 150 cases from encountering problems. However, no other significant issues have been raised as a result of bugs in the migration. As previously reported to the Audit and Risk Committee, it was not feasible for migration to resolve all PMS data quality issues, but the rate at which these surface as issues remains low enough to continue be handled via the support desk on a case-by-case basis.

Programme Communication Channels

Our Senior Stakeholder Group continues to meet fortnightly and supports the work of our digital team. The Operational Champions continue to work closely with the digital team in agreeing the priorities for the delivery of additional functionality for the Register and Registration App. As previously reported, they were crucial to agreeing and signing off the findings of the functionality review.

All communications (internal and external) are agreed and signed off by Operational Champions and where necessary the Senior Stakeholder Group, this has included close working with the Communications team to ensure our colleagues and external stakeholders are informed and updated on changes.

A review of the continued role and involvement of the Operational Champion group was carried out in conjunction with the digital team, Senior Stakeholder Group and Operational Champion's. The positive impact the group has had on planning, decision making, ownership and overall delivery has shown the value of the group and it has been agreed to continue the role of Operational Champion's to the end of March 2022. This will be reviewed on an ongoing basis.

3.0 EXTERNAL ASSURANCE ASSESSMENTS

There is no planned external assurance during the next reporting period.

4.0 PROGRAMME FINANCES

The budget position for business transformation and the IT 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

Continue to deliver on key focus areas as agreed with operational colleagues.

Continue to prioritise delivery in partnership with operational colleagues.

Transition services to IT business as usual- Supported Service (ongoing).

Continue to support the organisation through this large and complex business change. Move more towards organisational ownership.

6.0 OTHER IMPLICATIONS AND/OR DIRECT BENEFITS

6.1 People Who Experience Care

By investing in our IT 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 IT 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 11
Appendix 1

ACTION RECORD

Meeting:	**Member/Officer Assurance and Advisory Group – Digital Transformation Programme**
Date/Time/Venue	1 November 2021 at 10.00am – 11.00am by Teams video-call
Present:	Anne Houston (Board member and Chair of Group); Paul Gray (Board member); Gordon Mackie (Executive Director of IT, Transformation and Digital) Peter Macleod (Chief Executive)
In Attendance:	Louise Bremner (Business Transformation Support Officer)
Apologies:	

Agenda item 11
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**	Noted as accurate.			
3.0	**Exception reporting**	None			

Agenda item 11
Appendix 1

Number	Item	Discussion Points	Action	By Whom	By When/ Completed
4.0	**Registrations and the Register update**	GM opened by providing members with an overview of delivery. It was noted that application stability has remained high since delivery in March and that a functionality review had been undertaken. GM reminded members that at the last meeting of the group, the team were going through a period of challenge from operational colleagues. GM continued to advise that good progress has been made with the Operational Champions and that members feel they are adding value and that this message has been conveyed to Senior Stakeholders. It was noted that the Partnership Forum had provided some favourable feedback in relation to the app. It was noted that the fixed term contractors within the team had been extended to March 2022. Members were informed that work is underway to establish the team on a permanent basis and that all vacancies except one have been filled.			

4.0	**Registrations and the Register update**	AH noted the major shift in staffing within the team and queried what had made the big difference and if there is any read over to vacancy issues within other areas of the Care Inspectorate. GM advised that commitment was sought from candidates on the posts and that recruitment was also tailored to compliment current personnel. PM added that he believes the full and frank discussion that SLT members had (that members were advised of at the previous meeting of the group) helped shift some of the other dynamics in the way people were feeling and that colleagues are already seeing the benefits of recruitment with some staff already in post. An update was then provided on current stats, stats from August and October were shown with GM highlighting that significant inroads had been made. It was noted that a focussed team worked on data issues and daily updates were provided to operational colleagues. Several enduring fixes had been put in place and it was now at a BAU level. GM added that one of the biggest criticisms was that the data numbers fluctuated between 150 – 170 however it was noted that a lot of work had been done on this and that change requests and service requests would be removed from the overall numbers which would reduce them further. It was noted that the Service Desk are now doing the triaging on all tickets.			

4.0	**Registrations and the Register update**	PG advised that he was very pleased to see the progress on data but queried what led to the requirement for such a high number of data fixes and what is leading to the requirement for data fixes now? It was noted that previously with PMS there was no structure to data in terms of validation and where you could put data. Stricter validation is now in place in the app. GM advised that he would share an overview of the areas that were done. PG queried if there is a story to be told about the quality of data and that with the introduction of the app that the organisation is being provided with higher quality data. It was noted that GM agreed with PG's suggestion and added that an admin tool is being built to allow business support colleagues to fix certain fields. The big issue is who owns data in the organisation as this is seen as ICT at present. GM added that part of this is to get colleagues to own this as an application. PM added to discussions and advised that he felt this was an opportunity for himself and his leads to talk about system leadership in the context of data. An initial meeting to be arranged before the end of year.	GM to share overview of the areas undertaken. LB to arrange initial meeting date to discuss system leadership.	GM LB	ASAP ASAP

4.0	**Registrations and the Register update**	Discussions moved on and an update was provided on the functionality review. It was noted that this was conducted following a request from the Programme Board and assessed how much of the planned functional scope had been delivered and identified any significant outstanding business needs. The review was conducted over 6 weeks and assessed delivery of 84 functions. Members were informed that 72 functions had been delivered, 8 functions delivered but amendments were required. 2 additional functions were delivered, and 4 functions were not delivered. It was noted that 95% of functionality has been delivered. PG queried to what extent is the word sprint used in general discussion and how much do these technical terms mean to colleagues? GM advised that the team have worked with the Board, Senior Stakeholders and Operational Champions so they are all well briefed on the language used and prior to the pandemic, plans were in place to run agile overview sessions with Senior Stakeholders. PG then went onto query the figure of 95% functionality and stated that it depends on what the 5% is.			

Agenda item 11
Appendix 1

Number	Item	Discussion Points	Action	By Whom	By When/ Completed
		It was noted that GM subscribed to this comment but advised that the remaining 5% doesn't stop any functionality happening.GM to send latest figures on numbers of users and services to members.			
5.0	**Phase 2 Business Case update**	GM provided a brief update on the phase 2 business case and advised members that he would be holding a session with his leads on 03/11/21 to do some further work on the business case. It was noted that work would be required on the investment funding profile and the delivery profile. GM added that the additional element of Market Oversight has never been done before and is a big ask. It was noted that work needed to be done on costs for implementation and ongoing costs for the organisation. In addition, the team were looking at whether external support was required to achieve the tight February timescale. AH queried if GM had a roadmap of how this would be achieved? It was noted that GM was meeting with his colleagues this week and would come back with a realistic view of timings.	GM to share stage 2 business case roadmap.	GM	ASAP
6.0	**AOCB**	GM advised that he has been working on the IT and Transformation strategy. It was noted it is draft format and GM would like to share for comment.	LB to share draft IT and Transformation strategy to members for review.	LB	10/11/21

AUDIT AND RISK COMMITTEE MEETING 18 November 2021

Agenda item 12.1
Report No: ARC-30-2021

Title:	**NOTE OF MEETING - SHARED SERVICE MEMBER OFFICER WORKING GROUP**
Author:	*Bill Maxwell, Chair of Shared Service MOWG*
Appendices:	1. Note of Meeting 25 October 2021
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The Shared Service Member Officer Working Group oversees the development and implementation of the new shared service arrangements principally between the Care Inspectorate and SSSC. Appendix 1 provides a note of the meeting of 25 October 2021. The Group reviewed the implementation of the new shared service governance arrangements and that these were now agreed and operating. It was concluded that there was no requirement for future meetings of the Group as it has fulfilled its purpose.
The Committee is invited to:
1. Agree the cessation of the Shared Services Member / Officer Working Group.

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 18 November 2021

Agenda item 12.1
Report No: ARC-30-2021

Reasons for Exclusion	
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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 12.1
Appendix 1

MEMBER OFFICER WORKING GROUP – SHARED SERVICES

25 OCTOBER 2021 - MEETING VIA TEAMS

Present:

- Bill Maxwell (Board Member)
- Rognvald Johnson (Board Member)
- Rona Fraser (Board Member)
- Jackie MacKenzie (Executive Director Corporate & Customer Services)
- Kenny Dick (Head of Finance & Corporate Governance)

1. Shared Services Update

It was confirmed that all the required documentation was agreed, in place and operating.

It was noted that reference has already been made to the Management Agreement to confirm the employing organisation of the HR Adviser (Transactions) post.

Two favourable internal audits had been completed.

2. Service Review Board

The Group considered an early draft of the Shared Service Quarterly Performance Review Report that will be submitted to the first meeting of the Service Review Board (SRB) on 8 November 2021. This first meeting of the SRB will consider performance for quarters 1 and 2. Future meetings will consider performance on a quarterly basis.

The Performance report sets out:

- highlights / lowlights for the quarter for each area of service delivery
- the performance measures for the quarter for each area of service delivery
- staff changes during the quarter
- provides an update on development activity completed in the quarter
- how a Service Improvement Plan is to be developed and then progress against this plan included in future reports
- resources used by the CI and SSSC

The Group agreed the report was comprehensive and clearly set out the performance of shared services for the quarter.

A verbal update on the outcome of the SRB meeting on 8 November will be provided to the Audit and Risk Committee on 18 November 2021.

3. Risks

The Group reviewed the Shared Service Risk Register and noted there was no significant change to the risk position since the last meeting on 20 May 2021.

The continued use of shared systems (particularly finance and payroll / HR Management Information System) was previously identified as an emerging risk. However, the Scottish Government Shared Service Programme has provided clear guidance that the CI and SSSC should continue to use the SEAS system ahead of migrating to a new Enterprise Resource Planning (ERP) system over the next two years. The Head of Shared Services is liaising with the SG Shared Service Programme about a potential move of payroll / HR system to the new Scottish Government ERP.

4. Cessation of Group

The Group agreed that the purpose of the short life working group has been served and there was no need for further meetings.

It was noted:

- The SRB now has a set of meetings planned
- Shared Service governance is included on the strategic risk register and provides a route to escalate issues to Audit and Risk Committee / Board if required.
- An internal audit to review the shared service arrangements in practice is planned for 2022/23.

Agenda item 15

AUDIT AND RISK 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	✓	✓	✓	✓	✓
Internal Audit Plan 2021/22 Progress Report					✓
Draft Annual Internal Audit Plan 2022/23					✓
Audit Assignments *(timings as agreed with management)*					
Health, Safety and Wellbeing	✓				
Freedom of Information (Scotland) Act - FOISA	✓				
Shared Services	✓		✓ *(2)*		
Financial Sustainability			✓		
Fraud prevention, detection and response				✓	
Compliance with Legislation			✓		
Corporate Planning					✓
Equality and Diversity				*Postponed to March 2022*	✓
IT Strategy					✓
Scrutiny and Assurance *(date to be confirmed)*					✓
Workforce Planning					✓
Private Meeting with Internal Auditors				✓	
External Audit Items					
Combined ISA260 Report to those charged with Governance and Annual Report on the Audit *(External Audit Annual Report to the Board and the Auditor General for Scotland for the financial year ended 31 March 2021)*		✓	✓		
Progress on the Audit of Financial Statements `		✓	✓		

Agenda item 15

REPORT/TOPIC	20 May 2021	12 Aug 2021	9 Sept 2021	18 Nov 2021	10 March 2022
Annual Audit Plan 2020/21– Annual Accounts					✓
Private Meeting with External Auditors					✓
Care Inspectorate Items					
Draft Annual Report and Accounts and External Audit Report		✓	✓		
Draft Audit and Risk Committee Annual Report to the Board	✓	✓	✓		
Strategic Risk Register 2021/22 (draft pre-Board)	✓ (for BDE on 2 June)				
Strategic Risk Register Monitoring	✓		✓	✓	✓
Digital Programme Update	✓		✓	✓	✓
SIRO Report (Information Governance) (*Annual report, as agreed by Committee on 5.3.2020 - but Committee to be notified of any serious IG breaches)*	✓				
Shared Service – final report of Member/Officer Working Group				✓	
Care Governance Arrangements for the Care Inspectorate				✓	
Lessons Learned (Private item)				✓	
Standing Items					
Shared Service Governance update *(agreed to add as new standing item at committee meeting held 9/9/2021)*				✓	✓
Horizon Scanning (Audit Scotland & CIPFA publications)	✓		✓	✓	✓
Audit and Risk Committee Narrative to the Board	✓		✓	✓	✓
Schedule of Committee Business	✓		✓	✓	✓
Annual Review of Committee Effectiveness					✓