A Meeting of the Care Inspectorate Audit and Risk Committee is to take place from **10.00 am to 1.45 pm on Thursday 10 March 2022** by Teams video-link

AGENDA	
1.	Welcome
2.	Apologies for Absence
3.	Declarations of Interest
4.	Minutes of Meeting held on 18 November 2021 (paper attached)
5.	Action Record of meeting held on 18 November 2021 (paper attached)
6.	Matters Arising
	Internal Audit Items
7.	Internal Audit on Follow-Up Reviews – Report No: ARC-01-2022
8.	Internal Audit Plan 2021/22 Progress Report – Report No: ARC-02-2022
9.	Draft Annual Internal Audit Plan 2022/23 – Report No: ARC-03-2022
10.	Internal Audit Review: Equality and Diversity – Report No: ARC-04-2022
	External Audit Items
11.	Annual Audit Plan 2022/23– Annual Accounts (paper attached)
	Items for Discussion
12.	Strategic Risk Register Monitoring – Report No: ARC-05-2022
13.	Digital Programme Update - Report No: ARC-06-2022

14.	National Fraud Initiative Update – Report No: ARC-07 2022
15.	Shared Service Review Board – Report No: ARC-08-2022
	Items for Information
16.	Horizon Scanning 16.1 CIPFA Audit Committee Update – Issue 37
	Standing Items
17.	Audit and Risk Committee Narrative to the Board and Publication of Committee papers
18.	Schedule of Committee Business 2021-22 (paper attached)
19.	Any Other Competent Businessf
20.	Close of Business and Date of Next Meeting: Thursday 18 May 2022 at 10.30 am at Compass House, Dundee
12.00 noon - 12.30pm	**PRIVATE SESSION (Members and External Auditors Only)** Private discussion between Committee members and External Auditors. Please join using the separate meeting link, running from 12 noon to 12.30 pm.
12.30 pm - 1.00pm	**LUNCH BREAK**
1.00 pm – 1.45 pm	**Committee Effectiveness and Development Review** (paper attached – Committee Terms of Reference) *Please re-join using the full Committee meeting link.* • Self-Assessment Exercise – using the Scottish Government Audit Handbook checklist (previously circulated via MS Forms) • Further action

Minutes

Meeting: Audit and Risk Committee

Date: 18 November 2021

Time: 10.30 am

Venue: Held by Teams Videoconference

Present: Bill Maxwell (Convener)
Gavin Dayer
Rona Fraser
Paul Gray
Rognvald Johnson

In Attendance: Peter Macleod, Chief Executive (CE)
Kevin Mitchell, Executive Director of Scrutiny and Assurance (EDSA)
Jackie Mackenzie, Executive Director of Corporate and Customer Services (EDCCS)
Gordon Mackie, Executive Director of IT and Digital Transformation (EDIDT)
Kenny Dick, Head of Finance and Corporate Governance (HFCG)
Fiona McKeand, Executive and Committee Support Manager (ECSM)
Stuart Inglis, Internal Auditor, Henderson Loggie (H-L)

Apologies: Anne Houston, Board member
Edith Macintosh, Executive Director of Strategy and Improvement (EDSI)
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 MINUTE OF PREVIOUS MEETING HELD ON 9 SEPTEMBER 2021

The Committee approved the minute of the meeting held on 9 September 2021 as an accurate record.

5.0 ACTION RECORD OF MEETING HELD 9 SEPTEMBER 2021

The Committee reviewed and agreed the action record, noting that all actions from the previous meeting had been completed.

In relation to the action under the Shared Service, the Chief Executive advised the Committee that the Shared Service Governance Review Board had met in recent days and had received a very positive performance report. Further information was provided under item 12.

6.0 MATTERS ARISING

There were no matters arising.

7.0 INTERNAL AUDIT PLAN FOLLOW-UP REPORT - REPORT NO: ARC-25-2021

The internal auditors presented the regular follow-up report, the purpose of which was to examine the status of all internal audit recommendations which had not been appropriately implemented and to ensure that plans were in place to progress them.

The Committee was invited to accept the report and to approve the further revisions to implementation dates put forward by management.

It was noted that, at the previous meeting of the Committee, it had been agreed to have further discussions between the internal auditors, the Strategic Leadership Team (SLT) and the Committee Convener to look in more detail at the recommendations that remained outstanding. Members' attention was drawn to the explanatory notes within the report which had been updated following the detailed discussions with management, along with revised implementation dates.

The Committee welcomed the more achievable implementation dates and sought assurance that these would be met and did not pose a significant additional level of risk to the organisation.

Members were advised that the detailed discussions had helped to realistically address the extent of the work and resources required and management was satisfied that there were no additional risks as a result of the modifications.

It was agreed that an interim update on progress of the outstanding audit recommendations to be prepared for the Convener in the lead up to the March meeting of the Committee. **H-L / SLT**

The Committee **approved** the revised dates.

8.0 AUDIT REPORT: FRAUD PREVENTION, DETECTION AND RESPONSE - REPORT NO: ARC-26-2021

The internal auditors presented the audit report on the review of fraud prevention, detection and response. The audit had looked at the Care Inspectorate's anti-fraud framework and the arrangements in place to ensure compliance with the Bribery Act 2010. The review had also looked at the progress being 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 very positive findings of the review provided a good level of assurance to the Committee that the organisation's systems met all control objectives, with one recommendation that all related documentation be collated into a single reference point for managers, staff and Board members.

Officers advised members that work would continue to ensure that a high standard of compliance and excellence was maintained.

The Committee accepted the report and recorded its thanks to all staff who had helped achieve the very strong audit outcome.

9.0 PROPOSALS FOR CARE INSPECTORATE CARE GOVERNANCE ARRANGEMENTS: REPORT NO: ARC-27-2021

The Chief Executive introduced the report, the purpose of which was to provide an update on progress and initial thinking about care governance within the Care Inspectorate, building upon the organisation's learning during the pandemic, particularly around clinical, health and wellbeing issues associated with adults and older people's care homes.

The report outlined plans to review and deliver a framework of systems and processes which would demonstrate how the Care Inspectorate ensures that it's work in evaluating and improving the quality of care provision is fully effective and reflective of current standards and expectations. The framework would enable the identification of good practice and how quality improvement would be focused where most needed, based on data/information from scrutiny and other avenues.

The proposed approach was to establish a new, officer-led care governance committee, whose remit would be to provide oversight and assurance to the Strategic Leadership Team and the Board that registered services are safe and provide high quality care, and that the inspectorate has the necessary skills, capacity and evidence to arrive at these judgements robustly. It would also help identify and address poor performance, developing a proactive and informed approach to strategy, improvement and support.

The Committee's views were sought on the proposals and next steps.

Members welcomed the opportunity to discuss care governance, noting that a holistic view should be taken of how care was delivered. They considered that part of any new governance framework should reflect the extent of the Care Inspectorate's expertise and set out where professional boundaries lie, eg when to seek advice from nursing, pharmacy and other healthcare colleagues. It was noted that inspection teams did regularly seek specialist clinical care advice both internally and externally.

The Committee raised the issue of the emotional impact of care, noting that any changes to a person's living environment could affect their emotional and mental wellbeing, and this was an area that care governance should also take into account.

There was discussion on the governance structure and whether there was a need for a new committee of the Board to be established to cover this work and provide assurance.

In summary, the Committee's further questions and comments covered:

- the need to ensure that there were appropriate up to date standards against which to evaluate and make decisions on the specific areas of care governance;
- the need to ensure there was the expertise within the staff of the Care Inspectorate and access to external specialist skills to undertake these evaluations effectively;
- the need to reconsider if an extra committee of the Board was required, but instead to develop a systematic process and action plan to ensure inspection and improvement work was focussed and effectively delivered;
- that a further iteration of the report on care governance should outline the benefits to people experiencing care;
- that consideration be given to how a person-centred approach could be factored into care governance.

The Chief Executive recommended that an annual report should be submitted to the Audit and Risk Committee, through the SLT, and that this would include an action plan. The Terms of Reference would also be modified.

The Committee agreed this as a way forward and noted that a future paper would be presented to the Board comprising an annual report on care governance from the Audit and Risk Committee, for Board endorsement. **HoFCG**

10.0 STRATEGIC RISK REGISTER MONITORING – REPORT NO: ARC-28-2021

The Strategic Risk Register monitoring position was presented for the Audit and Risk Committee's consideration, noting that there had been no significant change to the strategic risk position since the Board meeting held on 23 September 2021.

The Committee was invited to 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.

The Committee noted and agreed the current risk monitoring position.

11.0 DIGITAL PROGRAMME UPDATE - REPORT NO: ARC-29-2021

The Executive Director of IT and Digital Transformation presented the report which provided the Committee with an update on recent progress of the Digital Programme. The report focussed on Stage 1, which covered Complaints and Registrations and The Register. The report also outlined the delivery progress and information on the latest programme finances and overall progress including the impact of the Covid-19 response.

The Committee was also assured through the Member/Officer Advisory Group that good progress was continuing to be made.

Members acknowledged the point made in the report around Covid-19 "fatigue" amongst staff in the digital team and across the whole of the organisation. The Committee was assured that a further staff survey would consider this in more detail and that every effort was being given to ensuring proper support was in place for all colleagues.

The Committee noted the information contained in the report.

12.0 SHARED SERVICE

12.1 FINAL REPORT OF MEMBER/OFFICER OVERSIGHT GROUP – REPORT NO: ARC-30-2021

The Executive Director of Corporate and Customer Services presented the report of the meeting of the Shared Service Member/Officer Oversight Group held on 25 October.

The Group had been established to oversee the development and implementation of the new shared service arrangements between the Care Inspectorate and SSSC. At the meeting on 25 October, the Group agreed that the new shared service governance arrangements were operating satisfactorily and that two positive internal audits had been carried out. The Committee noted that the Shared Service Review Board had a full schedule of meetings planned, that the governance of the service was included on the strategic risk register with a "green" status, and that a further internal audit review was planned for 2022/23.

The Committee **agreed** that the Oversight Group had fulfilled its purpose and that it be drawn to a close.

12.2 SHARED SERVICE REVIEW BOARD – VERBAL UPDATE FROM MEETING HELD 8 NOVEMBER 2021

The Chief Executive reported on the first meeting of the Shared Service Governance Review Board, which had received a very positive report on service performance against various delivery points. The Committee would be regularly updated on the review board discussions.

13.0 HORIZON SCANNING

The Committee noted the two items which had been circulated for information, namely the quarterly CIPFA update and the Audit Scotland Report: Community Empowerment: Covid-19 Update.

14.0 AUDIT AND RISK 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 16 December 2021:

- the Committee's approval of the revised implementation dates outlined in the Internal Audit Follow-Up Report and the agreement to keep the Convener informed of progress;
- the positive report on the internal audit of fraud prevention, detection and response;
- the discussions on proposals for care governance within the Care Inspectorate and to reflect the Committee's comments in the next iteration of the report to the Board; **ECSM**
- the good progress being made with the digital programme and the continued assurance being provided through the Member/Officer Assurance and Advisory Group; and
- the positive first meeting of the Shared Service Review Board and the Committee's agreement to stand down the Member/Officer Working Group.

The Committee **agreed** that all papers, except for the private item, should be published on the Care Inspectorate website. **ECSM**

15.0 SCHEDULE OF COMMITTEE BUSINESS 2021-22

The Committee noted the schedule of business which included a deferral of the internal audit review on Equality and Diversity to the March 2022 meeting.

16.0 AOCB

The Committee agreed that the next meeting on 10 March 2022 should be extended to allow appropriate discussion time for the number of internal audit reports being presented on that date. **ECSM**

17.0 DRAFT COLLATION OF LEARNING FROM THE PANDEMIC AND KEY CHANGES TAKEN FORWARD – REPORT NO: ARC-31-2021

This item was for private discussion, in the presence of the internal auditors.

18.0 DATE OF NEXT MEETING

The date of the next meeting was noted as Thursday 10 March 2022 at 10.30 am.

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
18 November 2021					
7.0	**INTERNAL AUDIT PLAN FOLLOW-UP REPORT - REPORT NO: ARC-25-2021**	An interim update on progress with outstanding audit recommendations to be prepared for the Convener in the lead up to the March meeting of the Committee.	H-L / SLT	By end January/beg Feb 2022	Convener updated during agenda planning discussions in February **Completed**
9.0	**PROPOSALS FOR CARE INSPECTORATE CARE GOVERNANCE ARRANGEMENTS: REPORT NO: ARC-27-2021**	Paper to be presented to the Board comprising an annual report on care governance from the Audit and Risk Committee.	HFCG		Further update will be provided to A&RC meeting on 10.03.2022

Senior Leadership Team (SLT)

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

G-T	Grant-Thornton (external auditors)
H-L	Henderson-Loggie (internal auditors)

Agenda item 5

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

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 7
Report No: ARC-01-2022

Title:	**COVER REPORT: INTERNAL AUDIT ON FOLLOW UP REVIEWS**
Author:	*David Archibald, Partner in Henderson Loggie*
Appendices:	1. Internal Audit Report: Follow Up Reviews – February 2022
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 October 2021 and reported to the Audit and Risk Committee in November 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 March 2022.
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 10 MARCH 2022

Agenda item 7
Report No: ARC-01-2022

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.

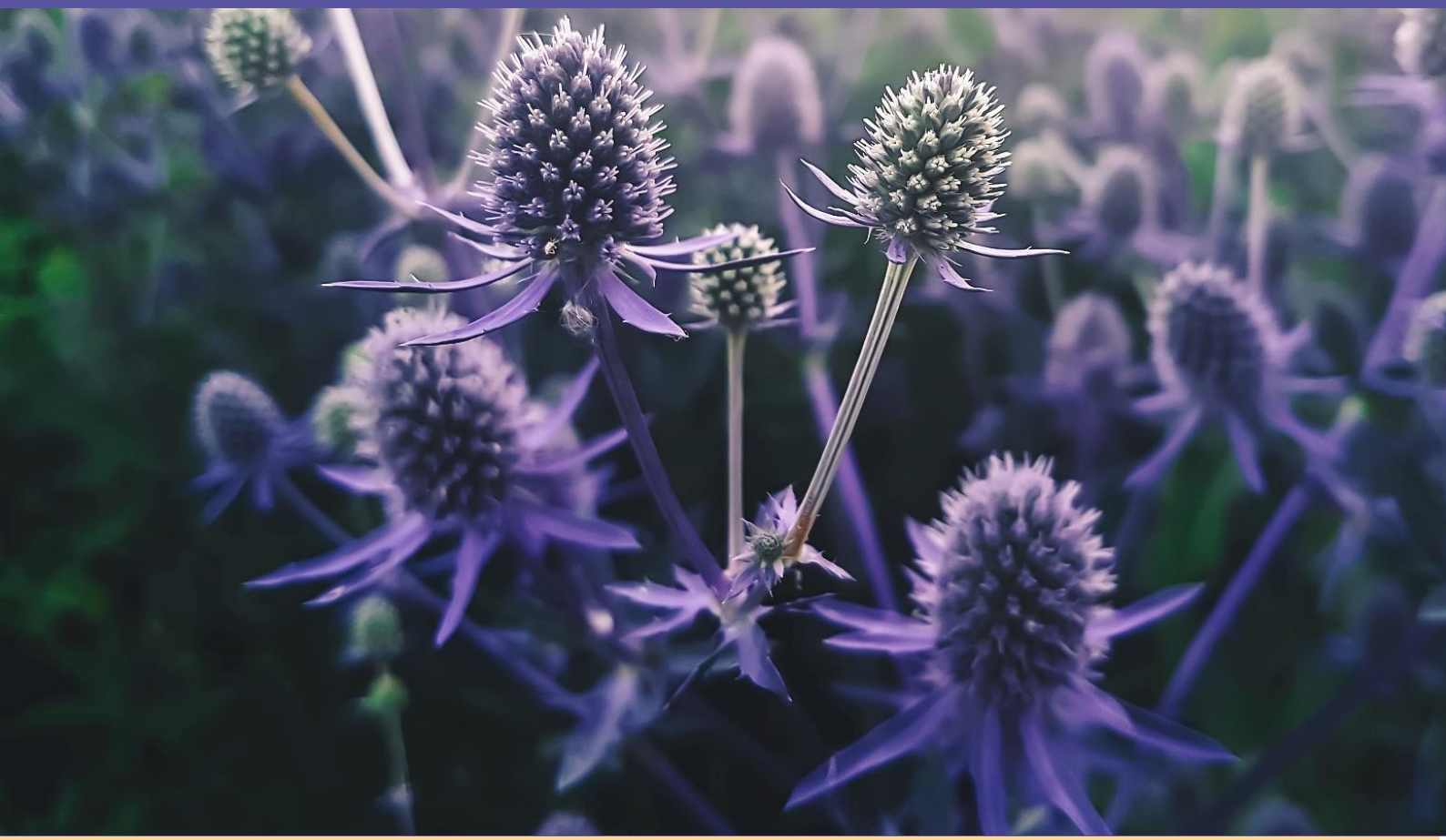
Agenda item 7
Appendix 1

Care Inspectorate

Follow Up Reviews

Internal Audit report No: 2022/08

Draft issued: 18 February 2022
2nd draft issued: 22 February 2022
Final issued: 28 February 2022



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 November 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)
- Compliance with legislation (issued in September 2021)
- Fraud prevention, detection and response (issued in November 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 good progress in implementing the recommendations followed-up as part of this review. Overall, eight (62%) of the 13 recommendations followed-up, which had reached their original agreed completion date, were assessed as 'fully implemented', with five (38%) 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	1	1	-	-	-
	3	1	-	1	-	-	
Total		**3**	**1**	**2**	**-**	**-**	**-**
Recruitment and Retention 2019/20	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	-	1	-	-	-
Total		**1**	**-**	**1**	**-**	**-**	**-**
Risk Management (report 2021/01)	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	3	1	2	-	-	-
Total		**3**	**1**	**2**	**-**	**-**	**-**
Compliance with legislation	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	5	5	-	-	-	-
Total		**5**	**5**	**-**	**-**	**-**	**-**
Fraud Prevention	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	1	-	-	-	-
Total		**1**	**1**	**-**	**-**	**-**	**-**
Grand Totals		**13**	**8**	**5**	**-**	**-**	**-**

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 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. **Revised Implementation date:** b) 31 December 2021 c) 31 March 2022	**Update at February 2022:** b) Since our last update we have completed a test recovery on the new Remote Access platform, as planned by 31 Dec 2021. c) Our plan to complete recovery tests of cloud hosted applications is progressing and on track to complete by 31 March 2022. The remaining works include test restores for our Inspections and Enforcement systems. Tests to restore components on our Registrations and Complaints systems have been completed. **Revised Implementation date:** c) 31 March 2022 **Partially Implemented**	**a) Complete** **b) Complete** **c) 34 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 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.	**Update at February 2022:** The concerns about the accuracy and reliability of the time recording data has been addressed. It has been identified that the follow up on complaints actions work is recorded along with Inspection activity i.e. not included in the times extracted from the Complaints application. The Service Manager responsible for Complaints is to establish if this information can be extracted from the Inspection time recording data. The Service Manager is also reviewing a sample of individual time recording records to confirm that the time recorded truly reflects actual time required. **Fully Implemented**	**Completed**

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 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.	**Update at February 2022:** We are still looking to pursue the update and refinement of the Complaints resource model and capacity tool but there is still significant work involved in this. I would suggest a progress report to each meeting of the Committee until such time as this action can be considered fully implemented. **Partially Implemented**	**a) 28 months over original completion date** **b) 24 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 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.	**Update at February 2022:** 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**	**21 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 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.	**Update at February 2022:** All directorates have reviewed their risk registers and linked these to the strategic risk register. Refining of directorate risk registers is continuing. **Fully Implemented**	**Completed**

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 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:** 31 January 2022	**Update at February 2022:** **Revised implementation date:** A date of 31 January 2022 is proposed. The procedure note has not been completed due to resource pressures (significantly more work on the draft budget than planned). **Revised implementation date:** A date of 31 March 2022 is proposed. **Partially Implemented**	**14 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 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.	**Update at February 2022:** Work on developing the training content is continuing and the revised implementation date of 31 March 2022 is still achievable. **Partially Implemented**	**12 months over original completion date**

Appendix IV - Updated Action Plan

Internal Audit Report 2022/02 – Compliance with Legislation (Henderson Loggie)

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Current Progress	RAG Ratings
Internal Audit Report 2022/02 – Compliance with Legislation **R1** For legislative obligations that require a multidisciplinary response or require substantial additional work, resource requirements should be modelled against current capacity and capability to (i) identify any gaps or (ii) any additional or specialist support needs. The CI already have a tool to map resource for development across the Shared Services developments which could be utilised to capture resource requirements for substantial projects. Medium to long term resource needs should also be forecasted to ensure that current delivery requirements remain sustainable.	**3**	It is recognised that principles and assumptions used in the shared service resource model can be applied more generally and we will seek to do so where appropriate. However, it cannot be transplanted elsewhere without some of the groundwork required to establish resources required for business as usual being developed. For example, Legal Services tends to be reactive to events in resource deployment. We will use the principles of the shared service and other resource models to establish the resource implications of compliance with legislation to assist with workload planning across different teams and disciplines. This will then be reflected in directorate, department and team plans.	Head of Finance & Corporate Governance	As and when needed to respond to legislative changes or team/ department re-design	**Update at February 2022:** This action is now completed. **Fully Implemented**	**Completed**

Follow Up Reviews

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Current Progress	RAG Ratings
Internal Audit Report 2022/02 – Compliance with Legislation **R2** Arrangements to develop compliance monitoring arrangement should be determined in mitigation for the role of the new Compliance Officer not being approved by SLT. The Table of Legislation should be version controlled so that there is only one working version, such as using SharePoint to allow multi-team input and to track additions. All responsible owners should be identified. Management should also consider enhancing the Table of Legal Requirements into a monitoring tool using Excel, for example, and developing a process for its ongoing management. As a monitoring tool, it can then be more effectively used to track other key information such as last review date; next review date; timetabling into management or Board review; and mapping against any assurance work completed, such as by internal or external audit. Using SharePoint will ease the completion of this task across the teams involved.	**3**	Version control will be incorporated into the Table of Legal Requirements (also referred to as the Table of Legislation). The identities of officers responsible for compliance with individual obligations will be refined so far as possible (it may not always be possible to identify the responsible officer in every case – for example the obligation to assess a new policy or procedure for impact - on, for example, island communities - lies with the author of the policy whose identity will vary). Consideration will be given to enhancing, within the scope of the resources and skills available to the Legal Team, the enhancement of the form and role of the Table of Legal Requirements.	Head of Legal Services	31 December 2021	**Update at February 2022:** Document now has version control front cover sheets which sets out when they need to be reviewed and who is responsible. Senior Solicitor has made a diary entry to begin a review in March. **Fully Implemented**	**Completed**

Follow Up Reviews

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Current Progress	RAG Ratings
Internal Audit Report 2022/02 – Compliance with Legislation **R3** Cl's Legal Handbook should be version controlled in line with good practice and should detail the responsible manager for updating; when it was last reviewed; and when it is next due for review.	**3**	The Legal Handbook will be updated to be version controlled and will name the manager responsible for updating, state when it was last reviewed and the date of the next review.	Head of Legal Services	31 December 2021	**Update at February 2022:** Document now has version control front cover sheets which sets out when they need to be reviewed and who is responsible. Senior Solicitor has made a diary entry to begin a review in March. **Fully Implemented**	**Completed**
Internal Audit Report 2022/02 – Compliance with Legislation **R4** Consideration should be given to the publication of EQIA for all new or revised policies and strategies in line with good practice. Consideration should be made to having a dedicated website that will allow ease of monitoring and ensuring they remain up to date. This step should be added to the Policy Review Methodology.	**3**	The Policy Review Methodology will be updated to reflect the role of the Equalities Professional Adviser and the requirement for EQIA's to be published. The Equalities Professional Adviser will continue to make improvements to the process in line with the Equality Impact Assessment Improvement Plan (which includes making changes to the website to ensure EQIA's are easy to find and the titles and dates of the EQIA's are clear).	Equalities Professional Adviser	8 October 2021	**Update at February 2022:** The website has been updated to make EQIA's easier to find . I also updated the policy review methodology and shared it with Kirstine. Both actions were complete by 8 October 2021. We have an agency worker working with us for 12 weeks, she started 17 January and we are making good progress with the Equality Impact Assessment Improvement Plan. **Fully Implemented**	**Completed**

Follow Up Reviews

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Current Progress	RAG Ratings
Internal Audit Report 2022/02 – Compliance with Legislation **R5 –** The following policies available on the public website should be updated to ensure they reflect the current version: • Fraud Policy, May 2016, and • Zero Tolerance Policy, May 2016	**3**	These policies will be replaced with current versions.	Fraud: Head of Finance & Corporate Governance Zero Tolerance: Head of HR	30 September 2021	**Update at February 2022:** Policies have been replaced with current versions. **Fully Implemented**	**Completed**

Appendix V - Updated Action Plan

Internal Audit Report 2022/05 – Fraud prevention, detection and response (Henderson Loggie)

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Current Progress	RAG Ratings
Internal Audit Report 2022/05 – Fraud prevention, detection and response **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.	**3**	This recommendation is accepted. This fits with plans to provide regular communication to staff on fraud.	Head of Finance & Corporate Governance	31 December 2021	**Update at February 2022:** This action is now complete. **Fully Implemented**	**Completed**

Henderson Loggie

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Care Inspectorate

Internal Audit Progress Report

Audit and Risk Committee 10 March 2022

Issued: 28 February 2022

Henderson Loggie

Internal Audit Progress Report
March 2022

Progress with the annual plan for 2021/22 is shown below.

Audit Area	Planned reporting date	Report status	Report Number	Overall Conclusion	Audit and Assurance Committee	Comments
Annual Plan 2021/22	February 2021	Draft 05/02/21 Final 03/03/21	2022/01	N/A	04/03/21 & 20/05/21	
Scrutiny and Assurance	May 2022					Fieldwork will be conducted in March and early April 2022.
Workforce Planning	March 2022					Fieldwork deferred at the request of management. Rescheduled for week commencing 11/04/22.
Financial Sustainability	September 2021	Draft 30/08/21 Final 01/09/21	2022/03	**Good**	09/09/21	
Fraud prevention, detection and response	November 2021	Draft 09/11/21 2nd Draft 10/11/21 Final 10/11/21	2022/05	**Good**	18/11/21	
Compliance with legislation	September 2021	Draft 27/08/21 Final 01/09/21	2022/02	**Satisfactory**	09/09/21	
Corporate Planning	March 2022					Fieldwork deferred at the request of management. Rescheduled for March / April 2022.

Audit Area	Planned reporting date	Report status	Report Number	Overall Conclusion	Audit and Assurance Committee	Comments
Equality and Diversity	March 2022	Draft 19/01/22 Final 25/01/22	2022/07	**Good**	10/03/22	
IT Strategy	May 2022					Review deferred into 2022/23 internal audit programme at the request of management.
Follow Up reviews – September 2021	September 2021	Draft 01/09/21 Final 01/09/21	2022/04	**N/A**	09/09/21	Two (20%) of the 10 recommendations followed-up, which had reached their original agreed completion date, were assessed as 'fully implemented', with seven (70%) classified as 'partially implemented' and one (10%) classified as 'little or no progress'.
Follow Up reviews – November 2021	November 2021	Draft 09/11/21 Final 10/11/21	2022/06	**N/A**	18/11/21	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'.
Follow Up reviews – March 2022	March 2022	Draft 18/02/22 2nd Draft 22/02/22 Final 28/02/22	2022/08	**N/A**	10/03/22	Eight (62%) of the 13 recommendations followed-up, which had reached their original agreed completion date, were assessed as 'fully implemented', with five (38%) classified as 'partially implemented'.

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.

Henderson Loggie

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AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 9
Report No: ARC-03-2022

Title:	**COVER REPORT: DRAFT ANNUAL INTERNAL AUDIT PLAN 2022/23**
Author:	*David Archibald, Partner in Henderson Loggie*
Appendices:	1. Draft Internal Audit Report: Annual Internal Audit Plan 2022/23
Consultation:	**n/a**
Resource Implications:	The audit days set out in the proposed annual plan form part of a three year plan which is in line with the number of audit days set out as part of the tender process finalised in early 2020, with the exception of the review of IT Strategy which has been deferred from the 2021/22 annual plan into the 2022/23 annual plan at the request of management.

Executive Summary:	
The draft Internal Audit Annual Plan for 2022/23 is attached as Appendix 1. This represents year three of the three-year Strategic Plan which was approved at the September 2020 meeting of the Audit and Risk Committee. The attached report sets out the outline scope and objectives for each audit assignment to be undertaken during 2022/23, together with the audit approach.	
The Committee is invited to:	
1.	Approve the proposed annual programme of internal audit activity for 2021/22.

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

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 9
Report No: ARC-03-2022

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

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

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

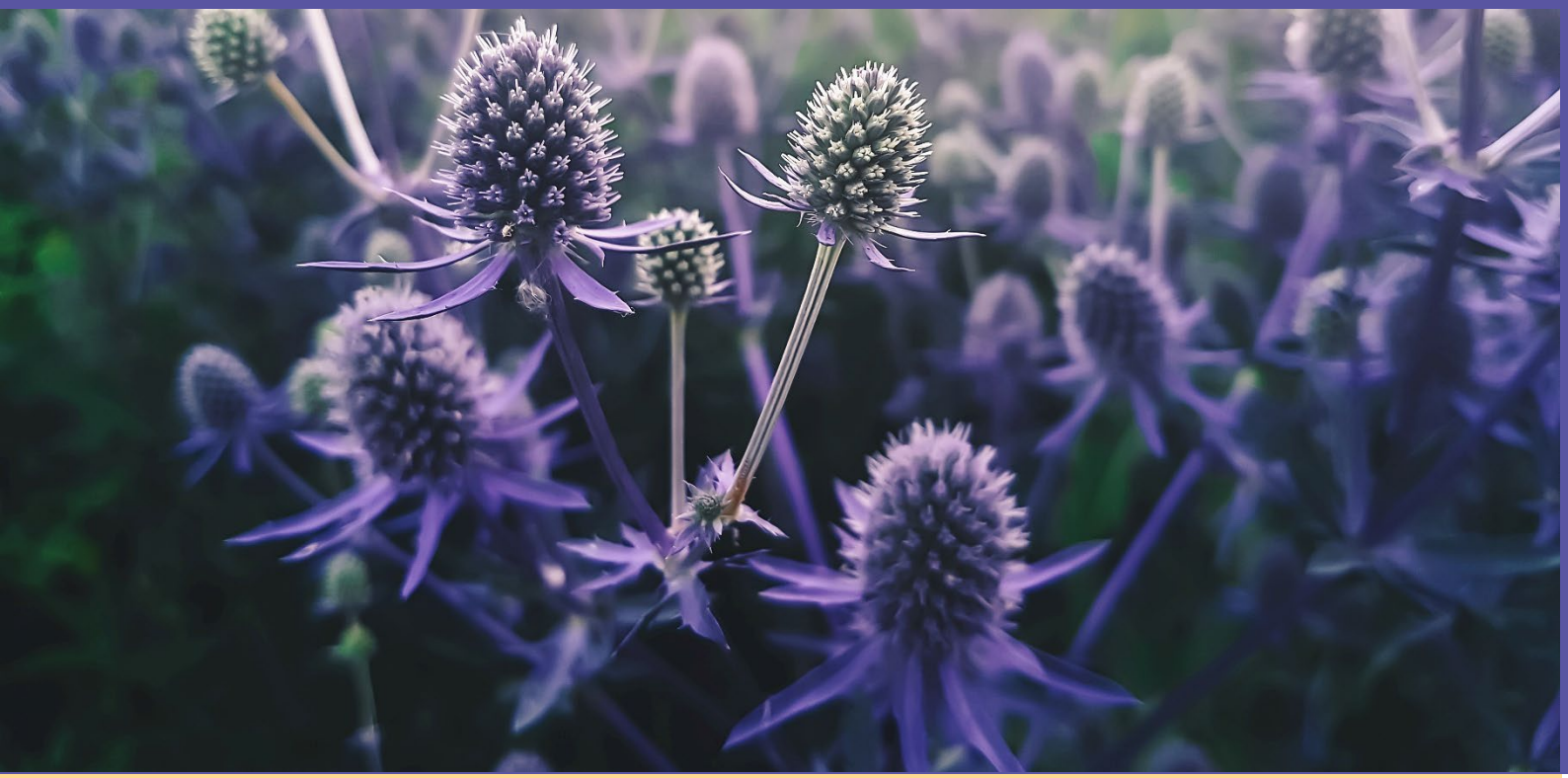
Care Inspectorate

Internal Audit Annual Plan 2022/23

Internal Audit Report No: 2023/01

Draft issued: 18 February 2022

Final issued:



Henderson Loggie

Contents

1. Introduction

1.1 The purpose of this document is to present to the members of the Audit and Risk Committee the annual internal audit operating plan for the year ending 31 March 2023.

1.2 Following our appointment as internal auditors in early 2020, audit needs were assessed and prioritised through discussion with members of the Senior Leadership Team and the Chair of the Audit and Risk Committee. We also conducted a desktop review of Care Inspectorate documents, including previous internal and external audit reports. The assessment covered the main areas where the Care Inspectorate is exposed to risk which can be managed through internal control, and which therefore should be considered for examination by internal audit. Following on from the Audit Needs Assessment a Strategic Plan was formulated to cover the period 1 April 2020 to 31 March 2023.

1.3 A copy of the Strategic Plan is included at Section 2 of this report which sets out the programme of internal audit activity for 2022/23. This proposed Annual Plan for 2022/23 represents year three of the three-year programme approved by the Audit and Risk Committee in September 2020 with no changes proposed in terms of topics or timing for the 2022/23 programme, with the exception of the IT Strategy review which has been deferred from the 2021/22 programme of work in to 2022/23 at the request of management .

1.4 At Section 3 of this report we have set out the outline scope and objectives for each audit assignment to be undertaken during 2022/23, together with the proposed audit approach. The outputs from all reviews listed in section 3 will be summarised in the Annual Internal Audit Report for 2022/23, which will form the basis of our overall opinion on whether the organisation has adequate and effective arrangements for risk management, control and governance and that proper arrangements are in place to promote and secure Value for Money.

1.5 As previously intimated, at the November 2020 meeting of the Audit & Risk Committee, a joint review of Shared Services was introduced into the 2020/21 internal audit programmes for the Care Inspectorate and SSSC at the request of management. A joint follow up review of the Shared Services arrangements has been built into the 2022/23 internal audit programme as an additional assignment. Therefore, the 2022/23 joint Shared Services Follow Up review is reflected in the revised Strategic Plan for 2020 to 2023 shown in section 2 below.

1.6 Internal audit also provides an independent and objective consultancy service specifically to help line management improve the Care Inspectorate's risk management, control and governance. Our audit service complies with Public Sector Internal Audit Standards (PSIAS).

2. Strategic Plan 2020 to 2023

	Category	Priority	Actual 20/21 Days	Actual 21/22 Days	Planned 22/23 Days
Reputation					
Publicity and Communications	Gov	M	5		
Health, Safety and Wellbeing	Gov	H	6		
Operations					
Scrutiny & Assurance	Perf	M		6	
Complaints	Perf	M			5
Shared Services	Perf	H	6		4
Staffing Issues					
Workforce Planning	Perf	M/H		5	
Organisational development	Perf	H	6		
Staff recruitment and retention	Perf	M			
Payroll	Fin	M			5
Travel and expenses	Fin	L			
Estates and Facilities					
Building maintenance	Fin/Perf	L			
Asset management	Perf	L			
Financial Issues					
Financial Sustainability	Fin	H		6	
General ledger	Fin	L			
Procurement and creditors / purchasing	Fin	M			6
Debtors / Income	Fin	L			
Cash, Bank & Treasury management	Fin	L/M	4		
Fraud prevention, detection, and response	Fin/Gov	M		5	
Organisational Issues					
Risk Management	Perf	M	5		
Business Continuity	Perf	M			5
Corporate Governance	Gov	L			
Compliance with legislation	Gov	M		4	
Corporate Planning	Perf	L/M		5	
Performance reporting / KPIs	Perf	M			5
Partnership Working	Gov/Perf	M			5
FOISA	Gov/Perf	M	5		
Equality and Diversity	Gov	M		5	
Change Management	Perf	M			5

Internal Audit Annual Plan 2022/23 - DRAFT

	Category	Priority	Actual 20/21 Days	Actual 21/22 Days	Planned 22/23 Days
Information and IT					
ICT data access and cyber security	Perf	H	6		
Data protection	Gov	M			5
Digital transformation	Perf	M			
IT strategy	Perf	M			6
Other Audit Activities					
Management and Planning)			4	4	4
External audit liaison)					
Attendance at Audit & Risk Committee)					
Follow-up reviews		Various	5	5	5
Audit Needs Assessment			3		
			_____	_____	_____
Total			**55**	**45**	**60**
			====	====	====

Key

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

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

3. Outline Scope and Objectives for 2022/23

Audit Assignment:	Complaints
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

As a Non-Departmental Public Body (NDPB), the Care Inspectorate must comply with the model Complaints Handling Procedure (CHP). The purpose of the model CHP is to provide a standardised approach to dealing with complaints to encourage public bodies to make best use of lessons learned from complaints made. Compliance with the model CHP is monitored by the Scottish Public Services Ombudsman.

The scope of this audit will be to carry out a review of the operation of the Care Inspectorate CHP process to provide assurances to the Chief Executive and the Board that the processes and their application meet the requirements of the model CHP.

Objectives

The objective of this audit will be to ensure that:

- The Care Inspectorate CHP is in line with the Scottish Public Services Ombudsman's model for public sector bodies;
- Adequate training and guidance have been provided to staff on dealing with complaints and decision reviews;
- There is a robust system to ensure 'lessons learned' are identified from complaint resolution and the outcomes from the decision review process and appropriate action is taken to make improvements if required;
- Steps have been taken to improve the customer experience and minimise the number of Stage 2 complaints through better first-time handling of initial complaints lodged; and
- Effective governance arrangements are in place, including regular reporting to the Chief Executive, senior managers and the Board, on the volume and outcome of complaints and decision review requests.

Our audit approach will be:

Key staff from within the Care Inspectorate will be interviewed to determine current working practices and the systems in place in relation to complaints and the decision review handling will be documented. The Care Inspectorate CHP will be reviewed to ensure that it is in line with the Scottish Public Services Ombudsman's requirements and model scheme. Compliance testing will be carried out to ensure that the CHP and decision review policies are being followed in practice.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Shared Services
Priority:	High
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	4

Scope

The scope of this review will be to review the way in which the Shared Services specification has been embedded and to review the extent to which the new arrangements introduced in 2021 are delivering the anticipated benefits in terms of service delivery.

Objectives

The specific objectives of our audit will be to obtain reasonable assurance that:

- The approved Performance Framework is being adhered to and mechanisms are in place to deal with any performance which drops below agreed target levels; and
- The Shared Service combined risk register is being updated and risks are being managed appropriately, with risks and mitigating actions/controls adequately reported to stakeholders;
- The Development Plan for activities not considered 'business as usual' is being monitored effectively and steps are being taken to ensure that there is sufficient resource available to achieve agreed development milestones;
- The Resource Plan is being kept up to date in order to track actual delivery against planned delivery to the Care Inspectorate; and
- The outcome of the annual review of Shared Services has been reported to senior management and to Board members and confirms that the agreed overall aims of the Shared Services arrangements are being delivered.

Our audit approach will be:

Through discussion with the Executive Director of Corporate and Customer Services and the Head of Shared Services, and through review of relevant documentation, we will assess compliance with the above objectives.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Payroll
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

This audit will consider the key internal controls in place over the Care Inspectorate's spend on staff costs of approximately £33.8m per annum.

Objectives

The objective of our audit will be to obtain reasonable assurance that systems are sufficient to ensure:

- correct calculation of gross pay and deductions;
- correct calculation of employer national insurance and superannuation contributions;
- overtime and other additional payments are properly authorised;
- approval and checking of changes to employee standing data;
- starters and leavers are properly treated and enter and leave the system at the correct dates; and
- proper authorisation, processing and recording of payments.

Our audit approach will be:

From discussion with Human Resources and Finance staff, and review of procedures documentation, we will identify the key internal controls in place within the Care Inspectorate's Human Resources / Payroll systems and compare these with expected controls. We will report on any areas where expected controls are found to be absent or where controls could be further strengthened.

Compliance testing will then be carried out to ensure that the controls in place are operating effectively, concentrating on starters, leavers and variations to pay.

Audit Assignment:	Procurement and Creditors / Purchasing
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	6

Scope

This audit will focus on the systems of internal control in place for the ordering of goods and services and the payment of invoices.

We will also consider whether the procurement strategy followed and procedures in place support best value purchasing across the Care Inspectorate in relation to non-pay spend.

Objectives

The specific objectives of the audit will be to ensure that:

- the Care Inspectorate's Procurement Policy, Strategy and procurement guidance are comprehensive, kept up-to-date and in line with the Procurement Reform (Scotland) Act 2014 ('the Act') and The Procurement (Scotland) Regulations 2016 ('the Regulations');
- procurement procedures ensure that:
  - areas of high spend across the Care Inspectorate are monitored appropriately;
  - opportunities for pooling of expenditure are identified in order to achieve best value; and
  - collaborative procurements and frameworks available to the Care Inspectorate are utilised where appropriate;
- purchase orders are completed for relevant purchases and are approved by members of staff with sufficient delegated authority prior to issue to suppliers, with the risk of unauthorised and excessive expenditure being minimised;
- the Care Inspectorate's procurement guidance on quotes and tenders are being complied with;
- all liabilities are fully and accurately recorded;
- all payments are properly authorised, processed and recorded; and
- appropriate controls are in place over the amendment of standing supplier data on the finance system.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Procurement and Creditors / Purchasing (Continued)

Our audit approach will be:

From discussions with Procurement staff, and a sample of budget holders, we will establish the procurement strategies, procedures and monitoring arrangements are in place within the Care Inspectorate. These will then be evaluated to establish if they follow recognised good practice.

Specifically, we will seek to establish whether the procurement procedures ensure that areas of high spend across the Care Inspectorate are monitored appropriately, identifying opportunities for pooling of expenditure in order to achieve best value, and ensuring that joint purchasing arrangements available to the Care Inspectorate are utilised where appropriate.

We will also document controls in place within the purchasing / payments system through interviews with Finance staff and also seek to establish whether the expected key controls are in place by reference to standard control risk assessment templates. We will also perform compliance testing where considered necessary to determine whether key controls are working effectively, including selecting a sample of items of expenditure from the financial ledger and testing to ensure compliance with the Care Inspectorate's Financial Regulations and Procedures.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Business Continuity
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

The scope of this audit will be to consider the systems in place to minimise significant disruption to operations including those affecting buildings, equipment or services.

Objectives

The overall objective of this audit will be to ensure that the Care Inspectorate's Business Continuity Plans are robust and reduce exposure to risks relating to major business continuity incidents.

The specific objectives of our audit will be to obtain reasonable assurance that:

- Business Continuity Plan are in place covering all of the Care Inspectorate's activities and locations, where appropriate;
- The Business Continuity Plan are workable, have been properly communicated to members of staff, and have been adequately tested; and
- The processes and procedures in place follow business continuity good practice.

Audit Approach

We will obtain a copy of the BCPs in place and considered whether they covered all of the Care Inspectorate's activities and locations, where appropriate.

The business continuity approach will be discussed with key staff involved with business continuity, and we will review evidence of how plans have been communicated to staff, the extent to which plans have been tested, and how assurance over the robustness of plans has been obtained.

An assessment of the key processes and internal controls will then be performed with reference to good practice business continuity guidance as set out in 'Good Practice Guidance 2018 Edition' from the Business Continuity Institute.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Performance Reporting & KPIs
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

This audit will consider the format, content and timeliness of performance management information, both financial and non-financial, provided to management; the Board and to external stakeholders.

Objectives

The objective of the audit will be to obtain reasonable assurance that:

- A performance management strategy has been devised in accordance with the key objectives of the organisation; this has been approved by the Board and is subject to regular review;
- Written policies and procedures relating to the performance management processes exist (including definitions of what each KPI measures and how it is calculated), and these policies and procedures are being adhered to by staff;
- Appropriate performance targets/ indicators are agreed annually, communicated and periodically reviewed to allow effective monitoring;
- There is independent, effective review and challenge of performance against targets to manage risk, support improvement and take action; and
- Performance information produced is complete, accurate, valid and timeous to allow for effective monitoring, decision making and reporting in line with senior management requirements.

Our audit approach will be:

A sample of managers and Board members will be interviewed, and the Care Inspectorate's performance management reports (both external and internal reporting), and management reporting procedures, will be reviewed to assess compliance with the above objectives. This will include performance reporting to the Sponsor Directorate within Scottish Government.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Partnership Working
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

This audit will review of the adequacy and effectiveness of the processes and procedures for partner engagement.

Objectives

The objectives of the audit will be to ensure that:

- There is a process in place to identify key external stakeholders and to align them with strategic objectives;
- There is regular dialogue between the Care Inspectorate and key external stakeholders to facilitate the delivery of national priorities;
- Effective governance arrangements are in place for effective stakeholder/partnership working – specifically scrutiny and accountability arrangements;
- An agreed set of measures and targets are in place to track progress and demonstrate the impact of stakeholder engagement, and there are effective arrangements in place for managing and reporting on partnership outcomes and actions, which are evidence-based; and
- The Care Inspectorate understands the collective resources required to deliver strategic priorities in partnership and coordinates effectively with stakeholders to direct funding, assets and staffing to partnership activity within a sustainable framework.

Our audit approach will be:

We will apply where applicable Audit Scotland's Best Value toolkit for Effective Partnership Working through discussion with the Senior Leadership Team, and also discussion with key external stakeholders, and review of supporting information, and form conclusions based on the evidence obtained on the effectiveness of the Care Inspectorate's partnership working arrangements.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Change Management
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

The scope of this audit will be to carry out a review of the change management controls in place within Care Inspectorate along with a review of the governance processes in place to oversee delivery of change management activity.

Objectives

The objectives of this audit will be to ensure that:

- the Care Inspectorate has established formal documented project management standards and policies, for change management activity, which reflect best practice;
- project teams and managers receive adequate project management training;
- all requests for new change management projects are supported by a detailed business case and, where approved, a feasibility study, project initiation document and detailed project plan are established;
- a functional specification is prepared which sets out users' requirements and a technical specification is prepared based on this;
- an outline testing plan with acceptance criteria is written at the functional specification stage and complied with during the implementation phase;
- for system changes, relevant staff are appropriately trained at the right time in the new system and operational guides, user manuals and support are supplied to system users;
- there are proportionate governance arrangements in place to allow effective oversight of change management activity; and
- post-implementation reviews are carried out by project teams to compare the actual costs and benefits are aligned with those originally articulated.

Our audit approach will be:

From discussion with the Interim Executive Director of Strategy and Improvement, and other relevant managers and staff, and through review of project documentation for a sample of recent change projects, we will consider whether the above objectives are being met.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Data Protection
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

The EU General Data Protection Regulation (GDPR), which came into force on 25 May 2018 and was enshrined in law as part of the Data Protection Act 2018 (DPA 2018), included an expanded definition of what personal data was, a greater number of specific responsibilities, and implemented significant fines for non-compliance. The EU GDPR no longer applies in the UK after the end of the Brexit transition period on 31 December 2020. With effect from 1 January 2021, the DPPEC (Data Protection, Privacy and Electronic Communications (Amendments etc) (EU Exit)) Regulations 2019 amended the EU GDPR to form a new, UK specific data protection regime that works in a UK context after Brexit to sit alongside the DPA 2018. This new regime is known as 'the UK GDPR'.

We will carry out a review of the Care Inspectorate's implementation of the Data Protection Act 2018, including the UK GDPR, to ensure that processes and procedures are in place to allow compliance with this.

Objectives

To obtain reasonable assurance that:

- appropriate action has been taken by the Care Inspectorate to comply with the Data Protection Act 2018, including the UK GDPR; and
- adequate procedures are in place for the ongoing monitoring of compliance with data protection legislation.

Our audit approach will be:

Through discussion with relevant managers and staff we will establish the action taken to date by the Care Inspectorate, and any further action planned, to implement the Data Protection Act 2018, including the requirements of the UK GDPR. The Information Commissioner's Office guidance will be used as the basis for this discussion, and any additional action required will be highlighted.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	IT Strategy
Priority:	Medium
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	6

Scope

This audit will include a review of processes for the development of the Digital Strategy within the Care Inspectorate. We will review the adequacy and effectiveness of the governance, processes and key controls over the definition, maintenance and delivery of the Digital Strategy to help the Care Inspectorate meet its business objectives.

Objectives

- An application architecture is in place that ensures that Care Inspectorate has a suite of compatible applications that are aligned to the Digital Strategy.
- An appropriate governance structure is in place that ensures that IT related projects, initiatives and requests are aligned to the Digital Strategy.
- All internal and external stakeholders have been identified and provided opportunities to provide input and inform the identification of requirements of the Digital Strategy.
- There is clear alignment of the Digital Strategy objectives with the Strategic Plan objectives.
- The Digital Strategy is regularly translated into operational plans that support delivery of business objectives.
- There is regular reporting to stakeholders on progress with achieving the digital strategy.
- Appropriate Key Performance Indicators and Key Risk Indicators are in place to measure and report progress of the digital strategy and associated risks.
- A formal process is in place to monitor future business, technology, infrastructure, regulatory, legal trends which are then fed into the Digital Strategy.

Our audit approach will be:

We will assess whether the above objectives have been met, through discussions with the Senior Service Delivery Manager and other key staff, and through review of relevant documentation.

Internal Audit Annual Plan 2022/23 - DRAFT

Audit Assignment:	Follow-Up Reviews
Priority:	Various
Fieldwork Timing	TBC
Audit & Risk Committee Meeting:	TBC
Days:	5

Scope

These reviews will cover reports from the 2022/23 internal audit programme and reports from earlier years that have either not already been subject to formal follow-up review or where previous follow-up identified recommendations outstanding.

Objectives

- To establish the status of implementation of recommendations made in previous internal audit reports and to confirm that the actions taken mitigated the identified weaknesses.

Our audit approach will be:

For the recommendations made in previous internal audit reports we will ascertain by enquiry or sample testing, as appropriate, whether they have been completed or what stage they have reached in terms of completion and whether the due date needs to be revised. A report will be produced for each meeting of the Audit and Risk Committee, with the final position for the whole year reflected in the Annual Internal Audit Report for 2022/23.

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AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 10
Report No: ARC-04-2022

Title:	**COVER REPORT: INTERNAL AUDIT ON EQUALITY AND DIVERSITY**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Equality and Diversity
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:
The internal audit report on Equality and Diversity is attached as Appendix 1. The overall level of assurance is "Good". There were four internal audit objectives and assurance of "Good" was provided against all four objectives. One priority 3 recommendation was made. This was to review the membership of the Corporate Equality Group to determine if senior manager / director level membership would be beneficial. This recommendation was agreed and the Group membership will be considered by the Operational Leadership Team in March 2022.
The Committee is invited to:
1. Accept the Internal Auditor's report on Equality and Diversity.

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 10 MARCH 2022

Agenda item 10
Report No: ARC-04-2022

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

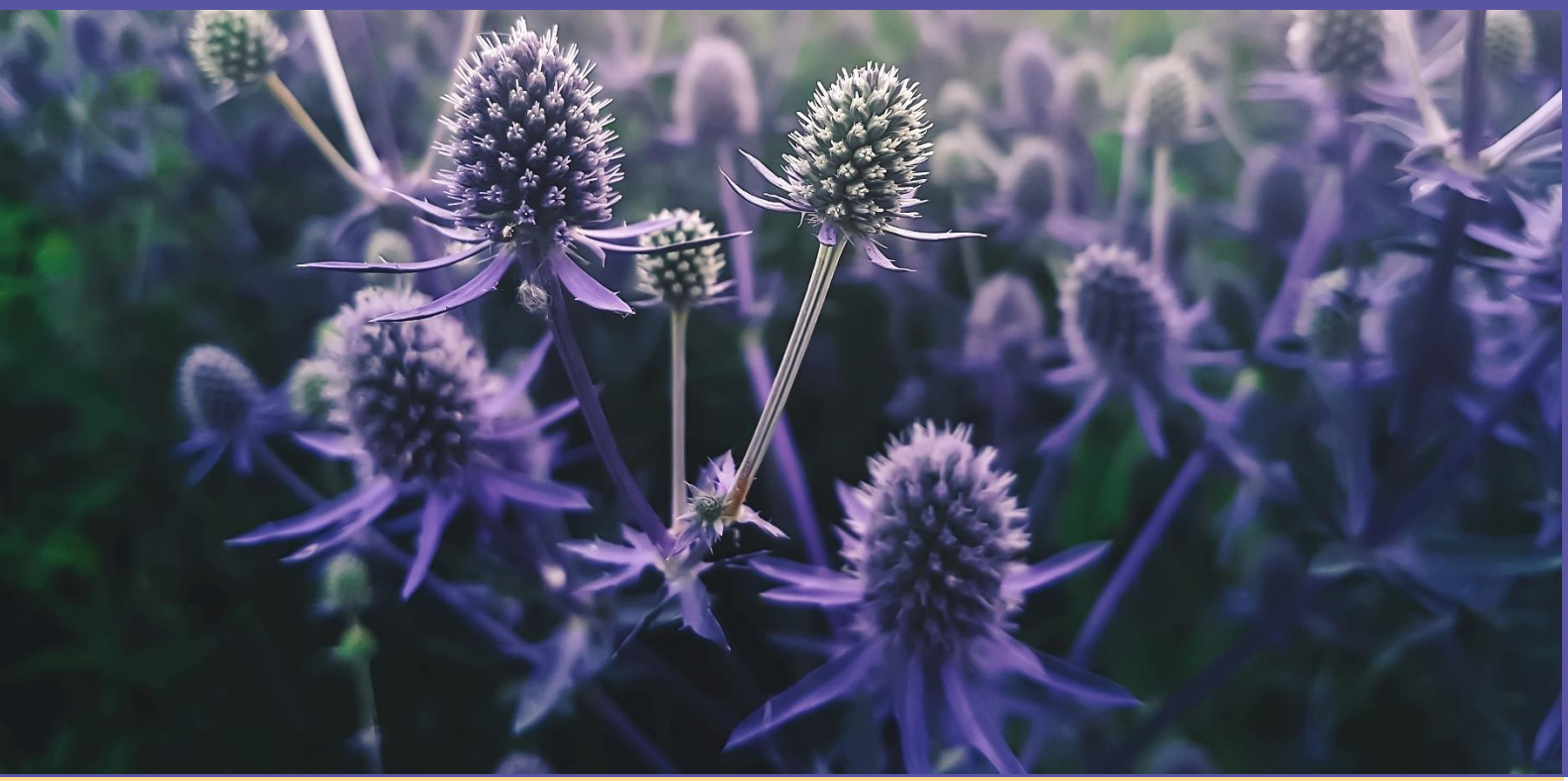
Care Inspectorate

Equality and Diversity

Internal Audit report No: 2022/07

Draft issued: 19 January 2022

Final issued: 25 January 2022



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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.

Equality and Diversity

Management Summary

Overall Level of Assurance

Good	System meets control objectives.

Risk Assessment

This review focused on the controls systems and procedures in place to integrate equality into the day-to-day working activities of the Care Inspectorate and the controls to mitigate against the following risks to the organisation as shown on the strategic risk register:

Strategic risk 1 - We are unable to fulfil our core purpose due to external factors.

Background

As part of the Internal Audit programme at the Care Inspectorate ("CI") for 2021/22, we carried out a review of equality and diversity arrangements. The Audit Needs Assessment, completed in September 2020, identified this as an area where risk can arise and where Internal Audit can assist in providing assurances to the Board of that the related control environment is operating effectively, ensuring risk is maintained at an acceptable level.

The Public Sector Equality Duty (PSED) sets out the requirements for public bodies, including NDPBs, to meet their obligations relating to the Equality Act 2010 that came into force in April 2011. This is often referred to as the 'General Duty' and required Scottish public authorities to have 'due regard' to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. The duty to eliminate discrimination in the area of employment, and also covers marriage and civil partnership.

The Equality Act also gives Scottish Ministers the power to impose specific equality duties through regulations. These duties require Scottish public authorities to:

- report on mainstreaming the equality duty;
- publish equality outcomes and report progress;
- assess and review policies and practices;
- gather and use employee information;
- publish information on board diversity and succession planning;
- publish gender pay gap information;
- publish statements on equal pay;
- consider award criteria and conditions in relation to public procurement; and
- publish required information in a manner that is accessible.

Equality and Diversity

Scope, Objectives and Overall Findings

The scope of this audit was to carry out a review of the systems and procedures in place to integrate equality into the day-to-day working activities of the Care Inspectorate which allow the organisation to meet the legislative and regulatory requirements of the Equalities Act and to examine future plans to enhance existing arrangements.

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		
1. The Care Inspectorate is taking reasonable steps to ensure compliance with its legal duties within the Equalities Act.	**Good**	-	-	-
2. Plans, policies, procedures and structures are in place to meet its equality duties.	**Good**	-	-	-
3. Monitoring and reporting of the Care Inspectorate mainstreaming activities is in place.	**Good**	-	-	-
4. Governance arrangements are in place to ensure that Care Inspectorate is meeting its requirements within Section 149 of the Equality Act on an ongoing basis.	**Good**	-	-	1
Overall Level of Assurance	**Good**	**-**	**-**	**1**
		System meets control objectives.		

Audit Approach

To assess whether these objectives were met we conducted meetings with key managers and staff within the Care Inspectorate who have responsibilities for equalities and their mainstreaming across the organisation.

The audit also reviewed the arrangements put in place to develop reporting on equalities and diversity against the good practice guidance issued by the Equality and Human Rights Commission and the Scottish Government. The review focused primarily on the systems and procedures in place.

Summary of Main Findings

Strengths

- The CI is meeting its legislative requirements under the Public Sector Equality Duty and has established appropriate systems for monitoring outcomes and progress of its EDI Strategy;
- Statement of intents that are signed by the Senior Leadership Team indicate strong alignment of outcomes from the EDI Strategy. The statement of intent is available on a newly published dedicated Equality and Diversity page on the CI website;
- There is dedicated resource in place to drive the CI EDI Strategy and monitor the status of outcomes;
- The Chair of the Board acts to champion equality through work on Board succession and Board member training;
- The CI approved its first EDI Strategy and plans across four years to strength arrangements to support its workforce;
- Assessment of arrangements against Equality Act Section 149, Specific Duties under the Equality Act 2010, and guidance Equality and Human Rights Commission and noted arrangements are reasonable were appropriate and in line with good practices;
- There are robust arrangements for the planning and monitoring of equality outcomes. Where there are weaknesses, such as in relation to issues arising from Equality Impact Assessment (EQIAs), there are plans established to address gaps and train staff;
- There are a suite of policies and procedures in place to support the application of its PSED, including its Equality and Diversity Policy; and
- Staff awareness on equality and diversity is monitored and there are actions in place to strengthen completion rates of equality and diversity related training.

Opportunity for Improvement

There is an opportunity to review the membership of the Corporate Equality Group to examine whether the inclusion of Director level representation would enhance decision making. We have been advised that the Equalities Professional Adviser will take this action to the 2 March 2022 meeting of the Operational Leadership Team who will review and examine the need for a Senior Manager/ Director level to attend the Corporate Equality group. Any change in the group's membership will take effect no later than September 2022.

Acknowledgment

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

Main Findings and Action Plan

Objective 1 - The Care Inspectorate is taking reasonable steps to ensure compliance with its legal duties within the Equalities Act

Equalities arrangements at the CI are led by the Director of Strategy and Improvement and the Involvement and Equalities Team. Within the team, there is a dedicated, full time, Involvement and Equalities Team Manager and an Equalities Professional Adviser. The Equalities Professional Adviser has a broad remit relating to the following:

- Leading and supporting the organisation to develop and implement the new Equality, Diversity, and Inclusion (EDI) strategy (April 2021).
- Delivering and reporting on the equalities programme of work, including the Mainstreaming Equalities report.
- Supporting and contributing to the Corporate Parenting Action Plan, UN Convention on the Rights of the Child (UNCRC), and Carer's priorities.
- Providing expert advice and guidance to internal and external stakeholders on EDI including participating in expert groups related to the work of the Care Inspectorate, including at a strategic level with Scottish Government (SG) colleagues.
- Ensuring that internal and external EDI support and advice is sector specific.
- Analysing data to identify trends that may have an impact on the outcome for people experiencing care to focus EDI support activity.
- Developing effective EDI support materials for use by inspectors and care services.
- Supporting the learning and development of all staff in the Care Inspectorate on EDI.
- Supporting the organisation when complex and challenging EDI situations arise.
- Co-ordinating and developing responses to requests for papers, briefings, correspondence and providing timely and accurate information.
- Contributing to delivering the Care Inspectorate's corporate plan.

The CI developed its first EDI strategy in March 2021, which was approved by the Board and published in April 2021. This provides a consolidation of intent, which is supported by a plan containing 36 actions spanning a four-year period. Actions listed with the plan relate to equality outcomes, corporate plan, specific duties, EDI performance indicators, the strategic workforce plan, Stonewall Diversity, LGBT Youth Scotland, Age Scotland, and Carer Positive. Progress in delivering actions is monitored by the Equalities Professional Adviser through ongoing review with action owners across the organisation, and outcomes will be reported to the Board annually each April from 2022 onwards.

The CI's commitment to EDI is highlighted on a new, dedicated equality and diversity page on the CI website which sets out the equality, diversity, and inclusion statement of intent by the Senior Leadership Team and contains a range of documents which describe how the organisation will meets its equality and diversity duties under each of the key headings noted above.

Equality and Diversity

Objective 1 - The Care Inspectorate is taking reasonable steps to ensure compliance with its legal duties within the Equalities Act (Continued)

In line with statutory requirements, the CI have published the Equalities Mainstreaming Report 2019-2021. The report includes:

- new equality outcomes and reported on progress against previous outcomes
- employee information
- information on board diversity
- gender pay gap information, and
- statement on equal pay

Board Succession Planning

In line with the Board Member Core Skills Framework – Public Appointments, the Chair of the Board is also committed to equality of opportunity and to developing and maintaining a diverse board. This has been demonstrated through their mentoring of one Board member and the investment in the CIPFA corporate governance training for all Board members. The Chair has been considering succession planning in terms of chairs for sub-committees, and how to build capacity among existing Board members to take these on.

CI have published information on gender for their Board members in their Equalities mainstreaming report, responsibilities in terms of the Gender Representation on Public Boards Act and have signed up to Partnership for Change.

Public Procurement

Equality criteria is considered during the procurement awards in the following ways:

- There is a sustainability question that references the Fair Work First Framework, which is weighted in the evaluation
- The terms and conditions of procurement detail the CI's values on anti-discrimination, and
- Suppliers to confirm they comply with the Equality Act 2010.

Staff Networks

The CI also supports several internal groups in supporting the workforce in embracing equality and diversity, as follows:

- Corporate Equality Group - Supports equalities mainstreaming, progress with the ED&I strategy/ equality outcomes, consultation groups for related work;
- LGBT Charter Group - Supports equalities mainstreaming, progress with the ED&I strategy/ equality outcomes, consultation groups for related work including the LGBT Charter action plan and the Stonewall Workplace Equality Index;
- Policy Review Group - Consultation group for people management policies, feedback used for Equality Impact Assessment (EQIAs); and
- Workstreams on corporate agendas around the Island Community Staff Consultation Group.

The CI is also represented on the First Minister's National Advisory Council on Women and Girls (NACWG); is working with Age Scotland to support their commitment to providing an age inclusive environment (ensuring fair working); and is a Carer Positive Engaged Employer.

Equality and Diversity

Objective 1 - The Care Inspectorate is taking reasonable steps to ensure compliance with its legal duties within the Equalities Act (Continued)

Supporting the workforce (Continued)

There is equality and diversity training available for staff and at the time of our audit fieldwork 49.6% of staff had completed the equality e-learning curriculum. Other training made available is also monitored for unconscious bias and is reviewed to consider the implications for BSL learning.

We reviewed the published arrangements against the Equality Act Section 149, Specific Duties under the Equality Act 2010, and guidance Equality and Human Rights Commission and have taken the view that the steps being taken by CI to comply with its legislative duties are reasonable and proportionate.

Equality and Diversity

Objective 2 – Plans, policies, procedures, and structures are in place to meet its equality duties.

The CI Corporate Plan 2019-2022 refers to the organisation's commitment to the Equality Act and achieving its equality outcomes via the principle of Diversity and Equality and its Strategic Outcome 3: People's rights are respected and world class care for all. This is progressed through planning under the EDI Strategy.

CI has established an Equality and Diversity Policy (June 2019) , which sets out the organisation's guiding principles, procedures, roles and responsibilities, whistleblowing arrangements, values over protected characteristics, and related policies. It is supported by Managers Guidance and is underpinned by the following policies:

- Legal timetable
- Corporate Parenting Planning
- Equalities Mainstreaming Plan, Outcomes Plan & Consultation Plans
- EQIA process and improvement plan
- Equal Pay Policy
- Dignity at Work Policy
- Disability Guidance for Managers
- Equalities training (3 curriculums) and induction content
- Unconscious bias training
- Training plan
- Policy tracker that details when policies are to be reviewed, and
- Procurement policies and guidance.

There are also associated HR Policies published on the staff intranet and procedures are in place for raising concerns (such as via whistleblowing or complaint management processes) (September 2021). HR policies also support any disciplinary arrangements, where required.

We reviewed these policies and through the work completed under Objective 1, above, noted that the structures established are reasonable and in line with requirements as set out in the Equality Act Section 149 and the Specific Duties under the Equality Act 2010.

The CI also has an Employee Monitoring Improvement Plan which describes the actions required to meet the CI's duty to gather employee information, such as information related to those with protected characteristics. By gaining more knowledge of their employees, CI will be better positioned to meet its equality duties by acting on any identified gaps in the support provided to these protected groups. Work was underway to survey staff at the time of our audit.

As reported in our Compliance with Legislation review (Internal Audit Report No: 2022/02), there is work underway to improve arrangements around management completed EQIAs and an improvement plan is being monitored by the Improvement Team. A new framework for ensuring EQIAs are completed is being reviewed with an aim for roll out in January 2022.

Equality and Diversity

Objective 3 – Monitoring and reporting of the Care Inspectorate mainstreaming activities is in place.

The latest Equalities Mainstreaming Report was reported, alongside the new EDI Strategy, to the Board in March 2021. The annual equalities progress report will be reported to the Board in April 2022. Management will publish the next iteration of the Equalities Mainstreaming Report in April 2023, in line with the regulatory deadline.

Other mainstreaming activities are monitored through business-as-usual activity, such as through discussion at the Senior Leadership Team (SLT) who review EQIAs and progress of key actions reports produced by the Director of Strategy and Improvement.

The Head of Improvement Support also ensures that there is ongoing consultation with the Operational Leadership team (OLT) on progress against equality outcomes; mainstreaming reporting; reporting on the gender pay gap; annual equalities progress report; and completion of EQIAs.

As noted above under Objective 1, the EDI Strategy Plan is monitored by the Equalities Professional Adviser through one to one meetings with action owners and the outcome of these discussions is reported to SLT.

Equality and Diversity

Objective 4 – Governance arrangements are in place to ensure that Care Inspectorate is meeting its requirements within Section 149 of the Equality Act on an ongoing basis. (Continued).

Observation	Risk	Recommendation	Management Response	
As noted above there are reasonable governance arrangements in place as described under Section 149 of the Equality Act. Our discussions with managers highlighted that the Corporate Equality Group acts as a focus/consultation group on the progress of actions relating to equalities mainstreaming and progress with the ED&I strategy/equality outcomes. However, it does not currently have the membership to allow it to act as a decision making forum. Therefore, approval of key actions currently requires to be reported and formally ratified through SLT.	Corporate Equality Group decision making may be delayed pending formal ratification of decisions by SLT.	**R1** The membership of the Corporate Equality Group should be reviewed to examine whether the inclusion of Director level representation could enhance the speed of decision making for issues which do not require to be elevated to SLT and also to enhance connectivity between the group and SLT.	The Equalities Professional Adviser will take this action to the 2 March 2022 meeting of the Operational Leadership Team who will review and examine the need for a Senior Manager/ Director level to attend the Corporate Equality group. Any change in the group's membership will take effect no later than September 2022. **To be actioned by:** Equalities Professional Adviser **No later than:** 31 September 2022	
			Grade	**3**

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Grant Thornton

Care Inspectorate

Financial year ending 31 March 2022

Draft External Audit Plan

Audit and Risk Committee

Draft 25 February 2022 for the Audit and Risk Committee on

10 March 2022

Your key Grant Thornton team members are:

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Contents

The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you as part of our audit planning process. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the organisation or all weaknesses in your internal controls. This report has been prepared solely for your benefit and Audit Scotland (under the Audit Scotland Code of Practice 2016). We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Plan overview

The audit plan sets out our risk based audit approach for Care Inspectorate. This draft plan outlines our initial risk assessment and is reported to those charged with governance (Audit and Risk Committee on behalf of the Care Inspectorate Board). Following completion of planning procedures we will submit a final copy of the plan to Audit Scotland.

Materiality

We have calculated planning materiality for Care Inspectorate using prior year gross expenditure as our benchmark:

- £809,000 planning materiality (2% expenditure)
- Performance materiality of £607,000 (75% of planning materiality
- Trivial is set at £40,480 (5% of overall materiality).
- Lower materiality of banding (£5,000) on Staff Remuneration Report

Financial statement audit risks

At planning, in accordance with the ISA's (UK) and FRC Practice Note 10 we have identified the following significant financial statement audit risks:

- Management override of controls (ISA UK 240)
- Risk of fraud in expenditure (cut-off) (FRC PN10)
- Risk of fraud in revenue (cut-off)(ISA 240)
- Risk of material misstatement in defined benefit pension scheme liabilities.

Wider Scope Audit – smaller body arrangements

In accordance with Audit Scotland's Code of Practice, we feel it is appropriate to continue to treat you as a smaller body under the Code. In 2021/22 we will consider Care Inspectorate's arrangements for ensuring financial sustainability as well as your governance arrangements in place to support disclosures contained within the annual governance statement included within your financial statements.

Other audit matters

We summarise other audit matters for Audit and Risk Committee awareness. This includes:

- In accordance with the Code and planning guidance we also complete and submit a number of deliverables in year including sharing intelligence with Audit Scotland.
- Notifying Audit Scotland of any identified frauds during the year.
- Consideration of going concern in accordance with Practice Note 10.

Our Audit Fee

Audit fees were shared by Audit Scotland with Care Inspectorate in December 2021. Our fee agreed with Management is £34,900. This includes £6,220 of Audit Scotland pooled costs and £1,280 contribution to Audit Scotland costs. The fee includes £500 increase on the Audit Scotland baseline fee associated with additional audit work over accounting estimates. We reserve the right to review our fee during the audit should significant delays be encountered and/or new technical matters arise.

Introduction

Purpose

This document provides an overview of the planned scope and timing of the external audit of Care Inspectorate (Care Inspectorate) for those charged with governance.

We are appointed by the Auditor General as the external auditors of Care Inspectorate for the 6 year period (2016/17 until 2021/22).

Respective responsibilities

Audit Scotland has issued a document entitled Code of Audit Practice ('the Code') dated 2016 covering this audit appointment period. This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. Our respective responsibilities, and that of Care Inspectorate are summarised in Appendix 1 of this plan. We draw your attention to this and the Code.

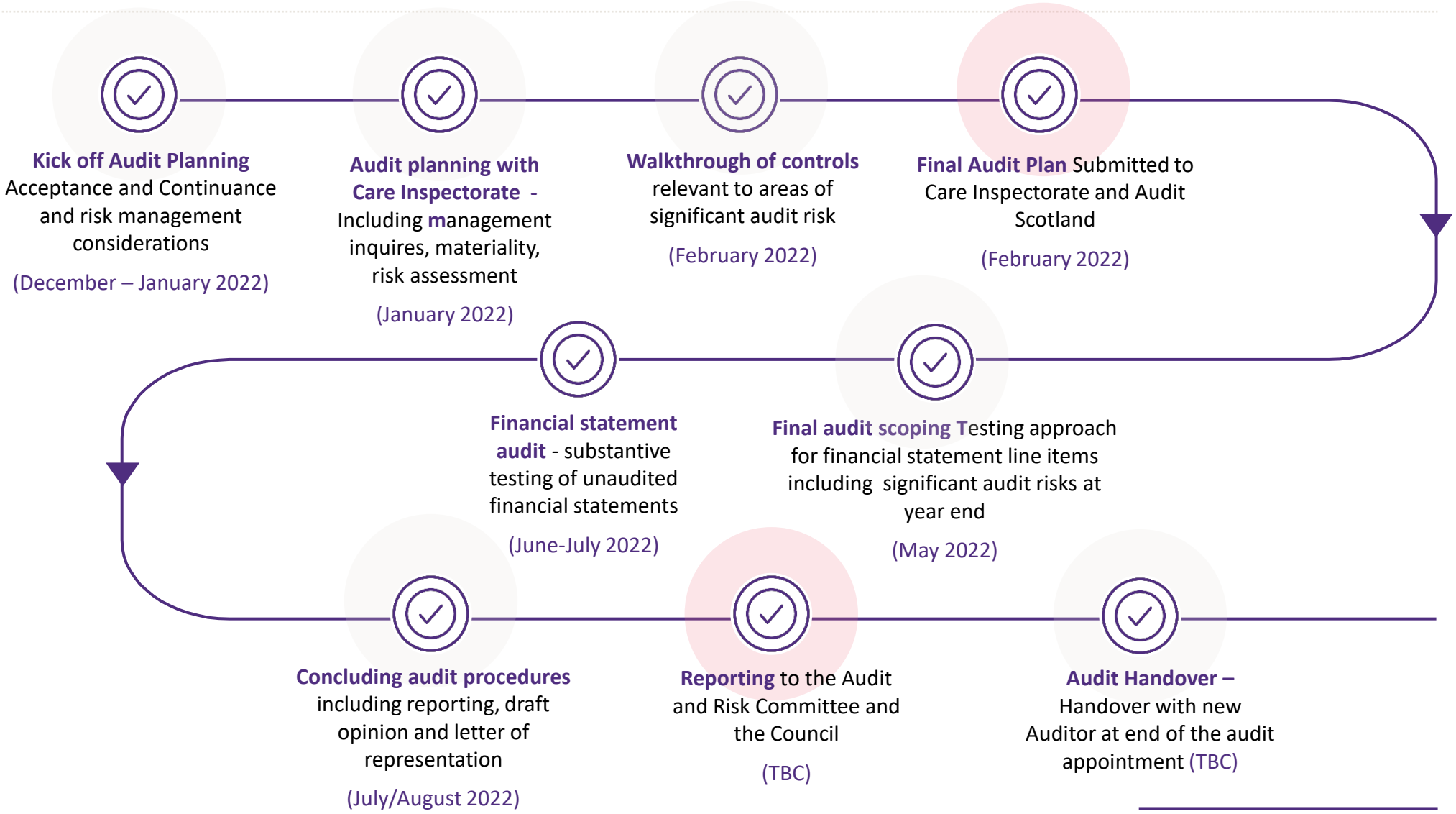
Scope of our audit

The scope of our audit is set in accordance with the Code and International Standards on Auditing (ISAs) (UK). We are responsible for forming and expressing an opinion on Care Inspectorate's financial statements that have been prepared by management with the oversight of those charged with governance (the Audit and Risk Committee).

The audit of the financial statements does not relieve management or the Audit and Risk Committee of your responsibilities. It is the responsibility of Care Inspectorate to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We will consider how Care Inspectorate is fulfilling these responsibilities.

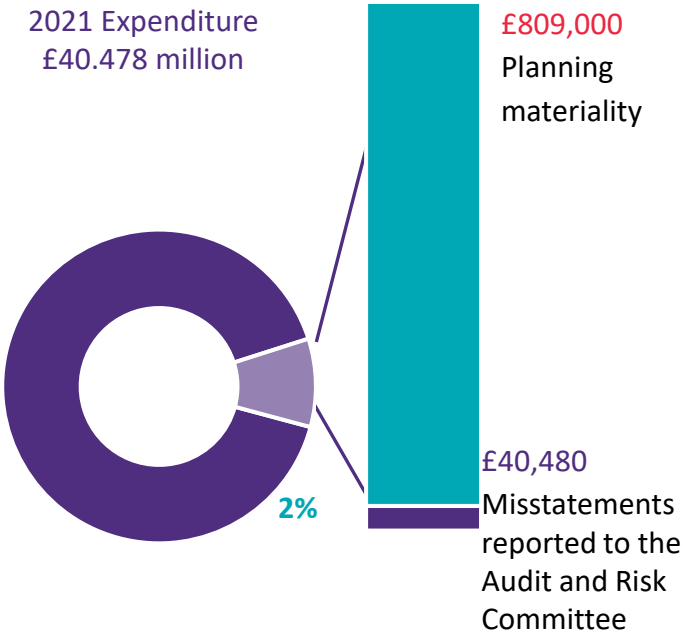
Our audit approach is based on a thorough understanding of Care Inspectorate and is risk based.

Audit approach



Materiality

Financial statement materiality is determined based on a proportion of the total operating expenditure. We have determined **planning materiality** to be £809,000 which equates to approximately 2% of your prior year total operating expenditure.



Performance materiality represents the amount set for the financial statements as a whole to reduce the probability that the aggregate of uncorrected and undetected misstatements exceed materiality. We use this to determine our testing approach to the financial statements. We have set this at 75% of planning materiality (£607,000) which is consistent with the rate used in the prior year. This is based on our understanding of Care Inspectorate including no material adjusted or unadjusted errors in the prior year and overall risk assessment.

Materiality reflects our professional judgement of the magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements.

On this basis we apply a separate **lower materiality level** to the Remuneration and Staff Report. This is set at 1 banding per disclosure in the financial statements (£5,000).

Under ISA 260 (UK) 'Communication with those charged with governance', we are required by auditing standards to report uncorrected omissions or misstatements other than those which are **'clearly trivial'** to those charged with governance. We have determined this threshold to be £40,480, being 5% of overall materiality.

We will update our materiality based on the unaudited 2021/22 financial statements when received. During the course of our audit engagement, we will continue to assess the appropriateness of our materiality.

Significant audit risks

Significant risks are defined by ISAs(UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement. (subject to conclusion of planning procedures)

Risk of fraud in revenue recognition (as required within Auditing Standards – ISA 240) **[completeness]**	ISA 240 requires us to consider the risk of fraud in Revenue. This is considered a presumed risk in all entities. Care Inspectorate receives Grant in aid funding through resource allocations direct from the Scottish Government and we consider the risk of management manipulation and fraud through this funding stream as limited. In addition, we consider the risk of material misstatement within other operating income to be low give its value (2021: £0.992 million). We therefore focus our significant risk of material misstatement on fees income, being fees charged to service providers (2021: £11.726 million). In the context of future years financial pressures and a projected surplus position in the current year, we consider the risk of understatement of revenue where Management may be incentivised to allocate revenue to future years. Our testing includes a specific focus on year end cut-off arrangements, where it may be advantageous for management to show an enhanced/different financial position in the context of reporting in-year to Scottish Government and the need to achieve the financial targets set. We therefore focus our testing on the occurrence of revenue recognised at year end including existence of receivables at the year end.
Risk of Fraud in Expenditure (as recommended in FRC Practice Note 10 for Public Sector entities) **[Occurrence]**	As set out in Practice note 10 (revised) which applies to public sector entities we consider there to be an inherent risk of fraud in expenditure recognition. Operating expenditure is understated or not treated in the correct period (risk of fraud in expenditure). As payroll expenditure is well forecast and agreeable to underlying payroll systems, there is less opportunity for the risk of misstatement in this expenditure stream. We therefore focus on material non-pay expenditure streams including property costs, administration costs and supplies and services. We consider the risk to be particularly prevalent around the year end and therefore focus our testing on cut-off of these expenditure streams. With forecast underspend we consider the risk to be overstatement of expenditure but will continue to monitor as part of our ongoing risk assessment. Our testing includes a specific focus on year end cut-off arrangements, where it may be advantageous for management to show an enhanced/different financial position in the context of reporting in-year to Scottish Government and the need to achieve the financial targets set in the current and future years.

Significant audit risks (continued)

Management Override of Controls (as required within Auditing Standards – ISA 240)

As set out in ISA 240 there is a presumed risk that management override of controls is present in all entities. Our risk focuses on the areas of the financial statements where there is potential for management to use their judgement to influence the financial statements alongside the potential to override Care Inspectorate internal controls, related to individual transactions.

Our work focuses on critical estimates and judgements as set out within the financial statements, including accounting policies. In addition, we specifically consider cut-off (expenditure and income) and the use of manual journals during the year, and in creating the financial statements where controls may be overridden by management.

IAS 19 Defined Benefit Pension Liabilities (valuation)

Care Inspectorate participates in the Tayside Pension Fund, a local government pension scheme (LGPS). The scheme is a defined benefit pension scheme and in accordance with IAS 19: Pensions, Care Inspectorate is required to recognise its share of the scheme assets and liabilities on the statement of financial position. Barnett Waddingham LLP provide an annual IAS 19 actuarial valuation of Care Inspectorate's net liabilities in the pension scheme. There are a number of assumptions contained within the valuation, including: discount rate; future return on scheme assets; mortality rates; and, future salary projections. Given the material value of the scheme liabilities and the level of estimation in the valuation, there is an inherent risk that the defined benefit pension scheme liability could be materially misstated within the financial statements. In particular, the assumptions applied in the valuation may not be appropriate resulting in material misstatement.

We will consider the work of the actuary, including the assumptions applied, using the work performed by PricewaterhouseCoopers (PwC) (commissioned on behalf of Audit Scotland to review actuarial assumptions proposed by LGPS actuaries), as well as local audit assessment. We will liaise with Audit Scotland as Auditors of the Pension Fund to provide assurances over the information supplied to the actuary in relation to Care Inspectorate, including assets held and confirm joint assurances in respect of employer and employee contributions in the year. We will review and test the accounting entries and disclosures made within Care Inspectorate's financial statements in relation to IAS 19.

On completion of audit planning procedures we will conclude the significant risks of material misstatement within our financial external audit plan. We will communicate significant findings on these areas as well as any other significant matters arising from the audit to you in our Annual Report to those Charged with Governance and the Auditor General for Scotland in concluding our audit in August 2022.

Other matters

Auditor Responsibilities

We have a number of audit responsibilities as set out in the Code and planning guidance:

- We audit parts of your Remuneration and Staff Report in your Annual Report and check whether these sections of your Annual Report have been properly prepared (opinion).
- We read the sections of your Annual Report which are not subject to audit and check that they are consistent with the financial statements on which we give an opinion (opinion).
- We carry out work to satisfy ourselves that disclosures made in your Annual Governance Statement are in line with requirements set out in FReM (opinion).
- We consider our other duties under the Code and planning guidance (2021/22), as and when required, including:
  - Supporting Audit Scotland in Section 22 reporting.
  - Participating in the Audit Scotland Central Government Sector group.
  - Notifying Audit Scotland of any cases of money laundering or fraud
  - Review of Technical guidance prior to issue by Audit Scotland.

Internal control environment

Throughout our audit planning and fieldwork we will continue to develop our understanding of the overall control environment (design) as related to the financial statements. In particular we will:

- Consider procedures and controls around related parties, journal entries and other key entity level controls.
- Perform walkthrough procedures on key controls around identified risk areas including: Scottish Government income, Income from fees and charges, payroll expenditure, material non-pay expenditure streams (disbursements, supplies and services costs, administration costs and property costs), journal entries and material areas of management estimate and judgement including defined benefit pension scheme liabilities.
- Our focus is design and implementation of controls only. We do place reliance on controls when it comes to our year end financial statement audit work.

Other material balances and transactions

Under International Standards on Auditing, "irrespective of the assessed risks of material misstatement, the auditor shall design and perform substantive procedures for each material class of transactions, account balance and disclosure". All other material balances and transaction streams will therefore be audited. However, the procedures will not be as extensive as the procedures adopted for the risks identified in this report.

Going concern assessment

As auditors, we are required to obtain sufficient appropriate audit evidence regarding, and conclude on:

- whether a material uncertainty related to going concern exists; and
- the appropriateness of management's use of the going concern basis of accounting in the preparation of the financial statements.

The Public Audit Forum has been designated by the Financial Reporting Council as a "SORP-making body" for the purposes of maintaining and updating Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (PN 10). It is intended that auditors of public sector bodies read PN 10 in conjunction with (ISAs) (UK).

PN 10 has recently been updated to take account of revisions to ISAs (UK), including ISA (UK) 570 on going concern. The revisions to PN 10 in respect of going concern are important.

In particular, PN 10 allows auditors to apply a 'continued provision of service approach' to auditing going concern, where appropriate. In considering going concern we will refer to Audit Scotland's Going Concern publication (December 2020). Within our wider scope work we will conclude on Care Inspectorate's arrangements to ensure financial sustainability.

Accounting estimates

Under ISA (UK) 540 auditors are required to understand and assess an entity's internal controls over accounting estimates, including:

- The nature and extent of oversight and governance over management's financial reporting process relevant to accounting estimates;
- How management identifies the need for and applies specialised skills or knowledge;
- How the entity's risk management process identifies and addresses risks relating to accounting estimates;
- The entity's information system;
- The entity's control activities in relation to accounting estimates; and
- How management reviews the outcomes of previous accounting estimates.

To ensure compliance with this revised auditing standard, we will be requesting further information from management and those charged with governance during our audit. Based on our knowledge of Care Inspectorate we have identified one material accounting estimates for which this is likely to apply being defined benefit pension scheme labilities.

Other financial reporting developments - Changes in the FReM for 2021/22

One of the changes to the FReM 2021/22 is to expanded requirements for Fair Pay Disclosures within the remuneration and staff report. This is in line with changes made to the FReM for 2021/22. The main changes are:

- A new requirement to disclose the percentage year on year changes in salary and allowances, and performance pay and bonuses, for the highest paid director and for the employees of the entity taken as a whole.
- total pay and benefits, and the salary component separately, for the 25th, 50th and 75th percentiles (previously just the median remuneration). This should be based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at 31 March 2022. For the purpose of this disclosure, pay and benefits excludes the value of pension benefits and severance payments.
- a summary for 2021/22 explaining:
    - whether movement in the ratios is attributable to a change in the highest paid director's remuneration or the employees, or a change in the body's employment models;
    - trends in the median pay ratio; and,
    - whether the body believes that the median pay ratio reflects the pay, rewards and progression policy for employees as a whole.

We will review Care Inspectorate's Remuneration and Staff report disclosures in the draft financial statements to evaluate whether the disclosers are complete, clear, concise, and free from material misstatement.

Wider Scope Audit – smaller body arrangements

For smaller bodies the Audit Scotland Code of Practice permits auditors to not apply the full wider scope audit. In our judgement, taking into account the nature of Care Inspectorate's operating activity and income and expenditure streams, we feel it is appropriate to continue to treat you as a smaller body under the Code. However, in accordance with Audit Scotland planning guidance, we will update our understanding of your arrangements for ensuring financial sustainability as well as your governance arrangements in place to support disclosures contained within the annual governance statement included within your financial statements.

Audit timeline

Client responsibilities

Where clients do not deliver to the timetable agreed, we need to ensure that this does not impact on audit quality or absorb a disproportionate amount of time, thereby disadvantaging other clients. Where additional resources are needed to complete the audit due to a client not meeting their obligations we are not able to guarantee the delivery of the audit to the agreed timescales. In addition, delayed audits will incur additional audit fees.

Our requirements

To minimise the risk of a delayed audit, you need to ensure that you:

- produce draft financial statements of good quality by the deadline you have agreed with us, including all notes, the Annual Report and the Annual Governance Statement
- ensure that good quality working papers are available at the start of the audit, in accordance with the working paper requirements schedule that we have shared with you
- ensure that the agreed data reports are available to us at the start of the audit and are reconciled to the values in the accounts, in order to facilitate our selection of samples for testing
- ensure that all appropriate staff are available (or as otherwise agreed) over the planned period of the audit
- respond promptly and adequately to audit queries.

Quality and adding value through the audit

Our overall approach for the audit is clear and upfront communication, founded on our public sector credentials and a methodology to ensure delivery of a quality audit.

The diagram opposite summarises our key approach to adding value to you throughout our audit.

Our methodology is risk based. We comply with Auditing standards and as a Firm we are regulated by the FRC. We taking findings on audit quality seriously and continue to invest as a Firm through our audit investment plan. The audit investment plan is supported by a specific national Public Sector audit plan.

We comply with Audit Scotland's quality arrangements including submitting an annual quality report over our Audit Scotland portfolio. As part of Audit Scotland's quality arrangements, ICAS review our work on a rotational basis. Audit Scotland's quality report can be found at www.audit-scotland.co.uk

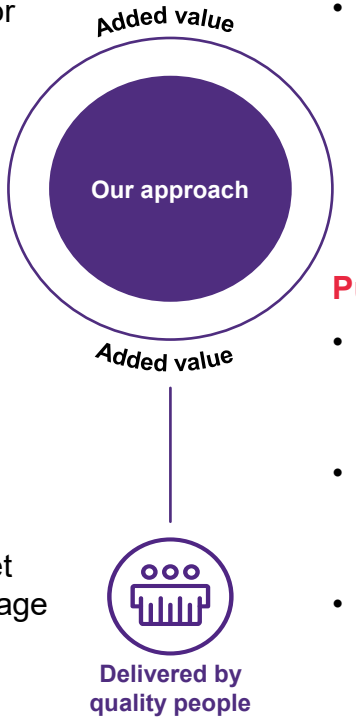
Our wider quality arrangements are set out in our annual transparency reports which are available on our website (www.granthornton.co.uk).

Project management

- Use of Inflo to track progress and deliverables throughout the audit
- Clear roles and ownership of responsibilities within our team
- Clarity over expectations and timetable
- Track record delivering public sector audits on behalf of Audit Scotland

Clear reporting

- Clear audit outputs at planning and within our final Annual Report
- Practical, risk based, recommendations for you to take forward
- Our judgements and conclusions set out transparently and in clear language
- Senior presence at Audit and Risk Committees to present our findings and support wider dialogue



Pragmatism and early attention of issues

- Accessible and proactive engagement team
- Working with you to reach the right solution – flexing the workplan, recognising Covid-19
- Audit director takes ultimate decision on technical matters, consulting with our technical experts

Public sector understanding

- Using our public sector insight to inform our audit and identify improvements you could make
- Regular meetings throughout the year sharing our observations and wider sector knowledge
- Wider scope conclusions to support you in considering key risks and the improvement actions to take

Audit Fees

Across all sectors and firms, the FRC has set out its expectation of improved financial reporting from organisations and the need for auditors to demonstrate increased scepticism and challenge and to undertake additional and more robust testing. This includes the revised ISA (UK) 540 (revised): Auditing Accounting Estimates and Related Disclosures.

As a firm, we are absolutely committed to meeting the expectations of the FRC over audit quality and public sector financial reporting. This includes, for Audit Scotland contracts, meeting the expectations of the Audit Scotland Quality Team and the ICAS quality framework.

Audit baseline fees were shared by Audit Scotland with LLTNPA in December 2021. Audit Scotland guidance allows auditors to set fees up to 20% above baseline fee where risks or issues identified may require additional audit procedures to be undertaken. To meet auditing standards, particularly in relation to ISA 540, we anticipate additional audit work over key accounting estimates. We therefore have agreed with Management to increase the baseline fee by £500.

Relevant professional standards

Audit Scotland set the baseline audit fee. We can increase the fee, from the baseline, for the inclusion of additional risks, new technical matters or specific client matters identified. We are required to consider all relevant professional standards, including paragraphs 4.1 and 4.2 of the FRC's Ethical Standard (revised 2019) which state that the Engagement Lead must set a fee sufficient to enable the resourcing of the audit with partners and staff with appropriate time and skill to deliver an audit to the required professional and Ethical standards.

Audit fees for 2021/22

Service	Fees £
External Auditor Remuneration	27,400
Pooled Costs	6,220
Contribution to Audit Scotland costs	1,280
Contribution to Performance Audit and Best Value	Nil
2021/22 Fee	**34,900**

Additional Fees (Non-Audit Services)

Service	Fees £
At planning stage we confirm there are no non-audit fees	Nil

Fee assumptions

In setting the fee for 2021/22 we have assumed that the Care Inspectorate will:

- prepare a good quality set of accounts, supported by comprehensive and well-presented working papers which are ready at the start of the audit
- provide appropriate analysis, support and evidence to support all critical judgements and significant judgements made in preparing the financial statements
- provide early notice of proposed complex or unusual transactions which could have a material impact on the financial statements.

Independence

Auditor independence

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant facts and matters that may bear upon the integrity, objectivity and independence of the firm or covered persons relating to our independence.

We encourage you to contact us to discuss these or any other independence issues with us.

We will also discuss with you if we make additional significant judgements surrounding independence matters.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention.

We have complied with the Financial Reporting Council's Ethical Standard (Revised 2019) and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements.

We confirm that we have implemented policies and procedures to meet the requirements of the Ethical Standard.

Our team complete annual fit and proper declarations including independence confirmations on a client by client basis as well as completing timesheets. The work of our Ethics team is overseen by the Ethics partner and all staff undergo ethics training in year.

Appendices

Responsibilities

The Code sets out auditor responsibilities and responsibilities of the audited body. Key responsibilities are summarised below. Please refer to the Code for further detail.

Care Inspectorate

Responsibilities include:

- Preparing financial statements that give a true and fair view
- Maintaining accounting records
- Establishing and maintaining systems of internal control
- Effective internal controls including controls to achieve objectives and secure value for money
- Establish arrangements for proper conduct of affairs including legality of transactions
- Arrangements for prevention and detection of fraud, error, irregularity, bribery and corruption
- Appropriate corporate governance arrangements and arrangements to monitor the effectiveness of governance

External Audit

Responsibilities include:

- Comply with professional engagement and ethical standards
- Provide an ISA compliant audit and opinion on the financial statements including regularity of transactions
- Demonstrate compliance with the wider scope public audit as detailed in the Code and applicable guidance
- Liaise with and notify Audit Scotland when circumstances indicate a statutory report may be required. This includes sharing awareness of current and/or sector issues
- Notify Audit Scotland of any known or suspected frauds greater than £5,000
- Contribute to relevant performance studies (as set out in the planning guidance for the year)

Communication

ISA (UK) 260 as well as other ISAS set out prescribed matters which we are required to report to those charged with governance (we assume this to be the Audit and Risk Committee on behalf of the Council). Our reporting responsibilities are set out below. We communicate all matters affecting the audit on a timely basis, to management and/or the Audit and Risk Committee.

Our communication plan	Audit Plan	Annual Report (considered our ISA 260 Report)
Respective responsibilities of auditor and management/those charged with governance	•	
Overview of the planned scope and timing of the audit, including planning assessment of audit risks and wider scope risks	•	
Confirmation of independence and objectivity	•	•
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	•	•
Significant matters in relation to going concern	•	•
Views about the qualitative aspects of Care Inspectorate's accounting and financial reporting practices, including accounting policies, accounting estimates and financial statement disclosures		•
Significant findings from the audit		•
Significant matters and issues arising during the audit and written representations that have been sought		•
Significant difficulties encountered during the audit		•
Significant deficiencies in internal control identified during the audit		•
Significant matters arising in connection with related parties		•
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		•
Non-compliance with laws and regulations		•
Unadjusted misstatements and material disclosure omissions		•
Expected modifications to the auditor's report or emphasis of matter		•

Fraud responsibilities

The term fraud refers to intentional acts of one or more individuals amongst management, those charged with governance, employees or third parties involving the use of deception that result in a material misstatement of the financial statements. In assessing risks, the audit team is alert to the possibility of fraud at Care Inspectorate.

As part of our audit work we are responsible for:

- identifying and assessing the risks of material misstatement of the financial statements due to fraud in particular in relations to management override of controls.
- leading a discussion with those charged of governance on their view of fraud. Typically we do this when presenting our audit plan and in the form of management and those charged with governance questionnaires.
- designing and implementing appropriate audit testing to gain assurance over our assessed risks of fraud
- responding appropriately to any fraud or suspected fraud identified during the audit.

As auditors we obtain reasonable assurance the financial statements as a whole are free from material misstatement, whether due to fraud or error.

We will obtain annual representation from management regarding managements assessment of fraud risk, including internal controls, and any known or suspected fraud or misstatement. We also make inquires of internal audit around internal control, fraud risk and any known or suspected frauds in year.

The primary responsibility for the prevention and detection of fraud rests with management and those charged with governance including establishing and maintaining internal controls over the reliability of financial reporting effectiveness and efficiency of operations and compliance with applicable laws and regulations.

It is Care Inspectorate's responsibility to establish arrangements to prevent and detect fraud and other irregularity. This includes:

- developing, promoting and monitoring compliance with standing orders and financial instructions
- developing and implementing strategies to prevent and detect fraud and other irregularity
- receiving and investigating alleged breaches of proper standards of financial conduct or fraud and irregularity.

Throughout the audit we work with Care Inspectorate to review specific areas of fraud risk, including the operation of key financial controls. We also examine the policies in place, strategies, standing orders and financial instructions to ensure that they provide a strong framework of internal control.

In addition, as set out in the Audit Scotland Code of Audit Practice we have a role in reviewing Care Inspectorate's arrangements in response to the National Fraud Initiative.

All suspected frauds and/or irregularities over £5,000 are reported to Audit Scotland by us as your auditors on a quarterly basis.

Anti-Money Laundering Arrangements

As required under the Money Laundering, Terrorist Financing and Transfer of Funds Regulations 2017 there is an obligation on the Auditor General (as set out in the planning guidance) to inform the National Crime Agency if he knows or suspects that any person has engaged in money laundering or terrorist financing. Should we be informed of any instances of money laundering at Care Inspectorate we will report to the Auditor General as required by Audit Scotland.

Accounting estimates and related disclosures

The Financial Reporting Council issued an updated ISA (UK) 540 (revised): *Auditing Accounting Estimates and Related Disclosures which* includes significant enhancements in respect of the audit risk assessment process for accounting estimates. The first year this impacted on was the 2020/21 financial year.

Introduction

Under ISA (UK) 540 (Revised December 2018) auditors are required to understand and assess an entity's internal controls over accounting estimates, including:

- The nature and extent of oversight and governance over management's financial reporting process relevant to accounting estimates;
- How management identifies the need for and applies specialised skills or knowledge related to accounting estimates;
- How the entity's risk management process identifies and addresses risks relating to accounting estimates;
- The entity's information system as it relates to accounting estimates;
- The entity's control activities in relation to accounting estimates; and
- How management reviews the outcomes of previous accounting estimates.

As part of this process auditors also need to obtain an understanding of the role of those charged with governance, which is particularly important where the estimates have high estimation uncertainty, or require significant judgement.

Specifically do Audit and Risk Committee members:

- Understand the characteristics of the methods and models used to make the accounting estimates and the risks related to them;
- Oversee management's process for making accounting estimates, including the use of models, and the monitoring activities undertaken by management; and
- Evaluate how management made the accounting estimates?

Additional information that will be required

To ensure our compliance with this revised auditing standard, we will be requesting again this year further information from management and those charged with governance during our audit for the year ended 31 March 2022.

Based on our knowledge of the Care Inspectorate, in particular prior year, we have identified only one material accounting estimate, being defined benefit pension scheme liabilities.

Care Inspectorate's Information systems

In respect of Care Inspectorate's information systems we are required to consider how management identifies the methods, assumptions and source data used for each material accounting estimate and the need for any changes to these. This includes how management selects, or designs, the methods, assumptions and data to be used and applies the methods used in the valuations.

If management has changed the method for making an accounting estimate we will need to fully understand management's rationale for this change.

Any unexpected changes are likely to raise the audit risk profile of this accounting estimate and may result in the need for additional audit procedures.

Financial accounting updates – International Financial Reporting standard 16: Leases

Following the previous deferrals of IFRS 16 *Leases* under the FReM, this accounting standard will now be implemented from 1 April 2022 .

The new standard brings significant changes for lessee accounting. Key points that bodies will need to consider on transition include:

- The need to recognise the cumulative effects of initially applying IFRS 16 on 1 April 2022 as an adjustment to the opening balances of taxpayers' equity. (This means prior year comparators will not need to be restated at 31 March 2023).
- The need to recognise the right-of-use asset for leases previously classified as operating leases at an amount equal to the outstanding lease liability.
- No adjustments are needed for leases for which the underlying asset is of low value (less than £5,000 new) or where the lease term ends on or before 31 March 2023.
- Assets where there is no or a below market rate peppercorn lease premium should be recognised as a right-of-use asset measured at current value in existing use or fair value as appropriate. Any difference between this and the lease liability will be recognised as part of the adjustment to the opening balances of taxpayers' equity.
- Irrecoverable VAT should not be included in the lease liability nor the value of the right of use asset.
- Existing finance lease and PFI liabilities that have an element based on an index or other rate will need to be reviewed and possibly amended as such variable payments are incorporated into the measurement of the lease liability under IFRS 16. (HM Treasury is expected to provide further guidance regarding the implementation of changes to accounting for PFI arrangements).

Impact on 2021/22

The 2021/22 financial statements will need to disclose the anticipated impact of adopting IFRS 16 from 1 April 2022.

We will consider the organisation's progress towards the implementation of IFRS 16 and the completeness and accuracy of disclosures within the financial statements of the impact of the adoption of the new standard.

Auditing developments

There are changes to the following ISA (UK):

- ISA (UK) 315 (Revised July 2020) 'Identifying and Assessing the Risks of Material Misstatement' - This will impact audits of financial statement for periods commencing on or after 15 December 2021.
- ISA (UK) 240 (Revised May 2021) 'The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements This will impact audits of financial statement for periods commencing on or after 15 December 2021.

A summary of the impact of the key changes on various aspects of the audit is included below:

Area of change	Impact of changes

Risk assessment	• The nature, timing and extent of audit procedures performed in support of the audit opinion may change due to clarification of:
	  • the risk assessment process, which provides the basis for the assessment of the risks of material misstatement and the design of audit procedures
	  • the identification and extent of work effort needed for indirect and direct controls in the system of internal control
	  • the controls for which design and implementation needs to be assess and how that impacts sampling
	  • the considerations for using automated tools and techniques.

Direction, supervision and review of the engagement	• Greater responsibilities, audit procedures and actions are assigned directly to the engagement lead, resulting in increased involvement in the performance and review of audit procedures.

Professional scepticism	• The design, nature, timing and extent of audit procedures performed in support of the audit opinion may change due to:
	  • increased emphasis on the exercise of professional judgement and professional scepticism
	  • an equal focus on both corroborative and contradictory information obtained and used in generating audit evidence
	  • increased guidance on management and auditor bias
	  • additional focus on the authenticity of information used as audit evidence
	  • a focus on response to inquiries that appear implausible

Area of change	Impact of changes

Fraud	• The design, nature timing and extent of audit procedures performed in support of the audit opinion may change due to:
	  • clarification of the requirements relating to understanding fraud risk factors
	  • additional communications with management or those charged with governance

Documentation	• The amendments to these auditing standards will also result in additional documentation requirements to demonstrate how these requirements have been addressed.

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 12
Report No: ARC-05-2022

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 16 December 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 22 March 2022.

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 10 MARCH 2022

Agenda item 12
Report No: ARC-05-2022

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

STRATEGIC RISK 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 position reported to the Board on 16 December 2021 at which the risk score increased from 9 (medium) to 16 (high).

This risk exceeds its target level and we are working with the Sponsor Department and Health Finance to reduce the risk level.

2.3 Strategic Risk 3 - Workforce Capacity

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

Inspector vacancies are currently 40.4 FTE. It is expected to start four new Inspectors in March 2022. A new Inspector recruitment campaign intended to fill the remaining vacancies started week commencing 21 February 2022.

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 & 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.

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 been above target and tolerance levels for seven months and therefore the tolerance rating is now Red.

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 Board considered the Stage 2 Business Case at its meeting of 10 February 2022. The business case is being further refined before submission to the Scottish Government.

The identified further actions are intended to reduce the risk to at least the tolerance level. This has been the position for seven months and therefore the tolerance rating is now Red.

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.

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Appendix 1

SUMMARY STRATEGIC RISK REGISTER: 2021/22 (as at 10 March 2022)

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	High	High
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

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Appendix 1

SCORING GRID

LIKELIHOOD	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
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

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 12
Appendix 2

Strategic Risk Register Monitoring

Date	for Audit & Risk Committee 10 March 2022														
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?**	4	4	16	H	4	4	16	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	Further Actions i. Full business case for Stage 2 of Digital Transformation being developed ii. Further discussion with Sponsor on Letter of Comfort and 22/23 financial position.	Appetite: cautious Target: medium Tolerance: high Above target for 2 months and at high end of tolerance level Rating: Amber Response: Treat	EDCCS

	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.											v. Ongoing review and development of savings and income generation options	iii. Early engagement of 23/24 spending review and reviewing baseline budget requirements		
3	**<u>Workforce Capacity</u>** **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	**<u>Partnership Working</u>** **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	**<u>ICT Data Access & Cyber Security</u>** **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.	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	Further Actions: i. Implementation of cyber security action plan (plan will take approx. 21 months to implement)	Appetite: cautious Target: low Tolerance: medium Has exceeded tolerance for 7 months	EDIT&D

	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.										iv. Business Continuity plans in place v. Cyber Essentials+ certification in place vi. Routine penetration testing vii. Cyber Security Maturity baselined and 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.	ii. Increase organisational cyber security awareness and testing iii. Enhance ICT staff cyber security awareness and technical training 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	Rating: Red Response: Treat	
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 7 months Rating: Red 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?** 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	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 vii. Regular meetings of shared service oversight group viii. Internal audit positive review of arrangements	Further Actions: i. Develop assurance maps for Service Review Board ii. Annual report to governing bodies	Appetite: Cautious Target: Medium Tolerance: Medium At target level Rating: Green Response: Accept	EDCCS

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda Item 13
Report Number: ARC-06-2022

Title:	**DIGITAL PROGRAMME UPDATE**
Author:	*Gordon Mackie, Executive Director of IT, Transformation and Digital*
Appendices:	None
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 focussed on hypercare, improving comms log functionality and scoping and designing new functionality for managing provider data:

- Hypercare - We have seen a longer period of hypercare being in place than would be expected. However, we continue to progress on passing the day-to-day support of the application to IT Service Operations, who have started to take over some support. Hypercare is on plan to complete this quarter, after which support will be handed over completely to IT Service Operations.

- Comms log - This will provide a major enhancement to the functionality around the management of communications within the registration application. We have a plan to delivery it in the next three, three-week sprints.

- Provider data is a significant programme of work. We are working through the scope and design with the development team, to produce a plan for delivery which will commence on completion of the comms sprints.

The number of providers using the Registrations Application and The Register continues to rise. The statistics show high levels of use in maintaining registration information while the feedback from those users is very positive.

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 24 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

Phase 1 of the Registration app (the digitised application form) has now been live for over 2 years. The average rate of registration has been around 30 new services registered per month vs 80 pre-Covid. However the number of variations is high at over 150 submitted per month plus over 500 changes of details per month. The feedback from applicants over the last six months 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 bugs along with optimising functionality that has already been delivered.

During the last three months we have been focusing on more significant areas of improvement to the Register and Registration App. We have made improvements based on the functionality review, Service now tickets and other forms of feedback. We have worked closely with the Operational Champions group from across the wider organisation to focus the delivery team on areas of priority for the people who use the Register and registration Application. We have worked together to agree a “backlog” of user requirements in the form of user stories that have been reviewed and refined. We have applied a prioritisation methodology to group the requirement into “Must have” areas and “Could have” areas.

Feedback has suggested two main areas require a more planned focused approach; these are the communication log that is used in all our App’s and our approach to registering, maintaining and updating our Provider data.

These areas were not in the scope of the original development of the Apps’ and have required significant consultation and planning with key stakeholders to agree the requirements. We have commenced a nine-week (3x3 sprints) delivery that aims to deliver a redesign of our comms log that will provide real improvements that has been guided and agreed with staff.

We are currently working on refining the Provider requirements for discussion with the Programme board. This a significant and complex area that touches many areas of our Register and registration application and as such requires programme board discussion and approval based on the approval of the Operational Champions.

Resourcing beyond the end of this quarter is a challenge. Budget has now been agreed to extend the fix term contract staff up to 31 October 2022.

Hypercare

We continue to work with operational and service team colleagues to achieve full handover to the service team, which is planned this quarter after which hypercare ends and support will then be handled as a service operation.

As at 21/02/2021 - 2289 Hypercare issues have been logged since 23 March 2021. To date, we have resolved and closed 98% of all issues raised which is a decrease in the in the backlog of outstanding tickets in the last quarter.

There are currently 46 issues overall recorded as to be resolved. The breakdown of issues is as follows;

Category	Live Numbers
Incident/Defect	13
Change requests	0
Data Fix	31
User Guidance	1
TBA	1
Total	46

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Tickets are categorised as follows:

- Incident/Defect – erroneous behaviour of the app software
- Change request – for new functionality for the app
- 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.
- TBA - issues that were just logged but are yet to be categorised.

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. We have managed numbers accessing the portal and prevented any surge in use and limited ongoing support calls.

Application Type	Oct 2021	16 Feb 2022	Increase
Registration Applications Created	3041	3530	+489
Variation requests (in flight)	1900	2474	+574
Voluntary Cancellation Requests	575	864	+289
Inactive Service Requests	366	438	+72
Illegal Service cases opened	37	49	+12
New Services Registered	305	416	+111
Change of Detail Requests	2550	3997	+1447
Change Of Details Self Service	1152	1643	+491

Since go live **9667** 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 steadily, and the volume of issues raised has been very low.

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 Champions. 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 Champions 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 2021/22 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.

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 14
Report No: ARC-07-2022

Title:	**NATIONAL FRAUD INITIATIVE UPDATE**	
Author:	*Gillian Berry, Accounting and Procurement Manager*	
Appendices:	**1.**	"The National Fraud Initiative 2018/19" (Prepared by Audit Scotland July 2020) report
	2.	National Fraud Initiative Scotland Self-Appraisal Checklist
Consultation:	There has been no formal consultation in the development of this report.	
Resource Implications:	**No**	

EXECUTIVE SUMMARY	
This report is to advise the Committee of the outcome of the Care Inspectorate's participation in the National Fraud Initiative (NFI) 2020/21 exercise and to give Committee an opportunity to review the management response to the NFI self-appraisal document.	
The Committee is invited to:	
1.	Note the content of this report.
2.	Review "The National Fraud Initiative 2018/19" (Prepared by Audit Scotland July 2020) report (Appendix 1).
3.	Review the management response contained in the self-appraisal checklist (Appendix 2).

Links:	Corporate Plan Outcome		Risk Register - Y/N		Equality Impact Assessment - Y/N		
For Noting	**x**	**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 *(see Reasons for Exclusion)*
Disclosure after:

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 14
Report No: ARC-07-2022

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.
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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.

NATIONAL FRAUD INITIATIVE UPDATE

1.0 INTRODUCTION

The National Fraud Initiative (NFI) in Scotland is a counter-fraud exercise led by Audit Scotland and is overseen by the Cabinet Office for the UK as a whole. It uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems that might suggest the existence of fraud or error.

1.1 The Cabinet Office conducts data matching exercises to assist in the prevention and detection of fraud. This is one of the ways in which the Minister for the Cabinet Office takes responsibility within government for public sector efficiency and reform. The Minister for the Cabinet Office is also the Chair of the Fraud, Error and Debt Taskforce, the strategic decision-making body for all fraud and error, debt and grant efficiency initiatives across government.

1.2 Data matching involves comparing sets of data, such as the payroll or benefits records of a body, against other records held by the same or another body to see how far they match. The data is usually personal information. The data matching allows potentially fraudulent claims and payments to be identified. Where a match is found it may indicate that there is an inconsistency that requires further investigation. No assumption can be made as to whether there is fraud, error or other explanation until an investigation is carried out.

1.3 The processing of data by the Cabinet Office in a data matching exercise is carried out with statutory authority under its powers in Part 6 of the Local Audit and Accountability Act 2014. It does not require the consent of the individuals concerned under the Data Protection Act 1998.

1.4 All bodies participating in the Cabinet Office's data matching exercises receive a report of matches that they should investigate, to detect instances of fraud, over or under payments and other errors, to take remedial action and update their records accordingly.

1.5 The Care Inspectorate is legally obliged to provide certain personal data about staff to Audit Scotland (or in practice, to the Cabinet Office) for the purposes of carrying out a data matching exercise that helps prevent and detect fraud.

This is our fourth round of participation and data was submitted covering the period 1 October 2018 to 30 September 2020.

2.0 NFI OUTCOMES

The data matching process produced three reports (2.1 to 2.3) where further investigation was required to determine whether there was any potential fraud or error. A further report (2.1.4) was provided for information.

The reports identified all matches and highlighted individual matches which were recommended for investigation. The 'recommended' filter assists organisations to optimise their time to review higher priority cases. The Care Inspectorate investigated all identified matches.

2.1 Payroll to Payroll

The purpose of this report is to identify individuals who may be committing employment fraud by failing to work their contracted hours because they are employed elsewhere or are taking long-term sickness absence from one employer and working for another employer at the same time.

There was one match identified which was investigated and no issues were identified.

2.2 Payroll to Payroll – Phone Number

The purpose of these matches is to identify fraudsters that may have changed their names or are using false identities to avoid detection. There is evidence to indicate they often keep the same phone number or email address for convenience or to facilitate the fraudulent activity.

There were two matches identified which were investigated and no issues were identified.

2.3 Duplicate Creditors by Invoice Amount and Creditor Reference

This report highlights possible duplicate payments more than £1,000 that may have arisen because of poor controls or fraudulent activity by suppliers and/or staff.

There were 89 matches identified which were investigated. Most matches related to staged payments, monthly, quarterly and annual recurring charges and no issues were identified.

2.4 Payroll to Pensions

The purpose of this report is to identify cases where employees have returned to employment after drawing a pension. Returning to employment whilst drawing a pension may require an abatement of pension.

This report is for information purposes only as the responsibility for investigating lies with the pension provider. There were seven matches identified.

3.0 NFI SELF APPRAISAL CHECKLIST

Audit Scotland has produced a report "The National Fraud Initiative 2018/19 (Prepared by Audit Scotland July 2020). The Audit Scotland NFI report is attached Appendix 1.

3.1 The report provides valuable information on the NFI and contains two specific recommendations which are relevant to the Audit and Risk Committee:

1. Audit Committees, or equivalent, leading the NFI should review the self-appraisal checklist at Appendix 2, Part A ensure that they are fully informed of the planning and the progress being made by their officers investigating the NFI 2020/21 exercise.
2. All participants in the NFI exercise should ensure that they maximise the benefits of their participation.
3. All participants should be aware of emerging fraud risks, eg due to Covid-19, and take appropriate preventative and detective action.

3.2 Officers have completed the self-appraisal checklist detailed in recommendation 1 and this is attached as Appendix 2 for the Audit and Risk Committee to review.

3.3 With respect to recommendation 2, the size of the Care Inspectorate comparative to local authorities and health boards means that we were able to investigate all data matches in the previous matching exercises without devoting a disproportionate amount of resource. We have considered the concerns set out in Appendix 3 and will apply the "how to work more efficiently" as appropriate. We do not use alternative matching services and do not intend to use the NFI flexible data matching service.

3.3 With respect to recommendation 3, we continue to review and assess fraud and risk through our contract with NHS Counter Fraud Services and have implemented additional internal controls in our procurement process to help minimise Covid-19 risk in our purchasing and procurement processes.

4.0 IMPLICATIONS AND/OR DIRECT BENEFITS

4.1 Resources

There are no direct resource implications arising from this report.

4.2 Sustainability

There are no direct sustainability implications arising from this report.

4.3 People Who Experience Care

Participation in the NFI provides assurance that the Care Inspectorate's internal controls are operating effectively and creates an opportunity to detect fraud or

error not prevented by these controls. This assists the Care Inspectorate in optimising the use of its resources to maximise the benefits of the work of the Care Inspectorate to people who experience care.

4.4 Customers (Internal and/or External)

This report directly relates to strategic theme 4, showing our commitment to measure, monitor and publish our outcomes from participation in NFI.

5.0 NEXT STEPS

The internal business processes developed for NFI participation ensured a seamless upload of data and allowed for a focus on investigating matches with higher risk or value. As the overall number of matches was not excessive, all identified matches were investigated.

Following investigation of the matches identified, no fraud or errors were identified. From this we can take assurance the internal controls we have in place for payroll, purchasing and payments are operating effectively.

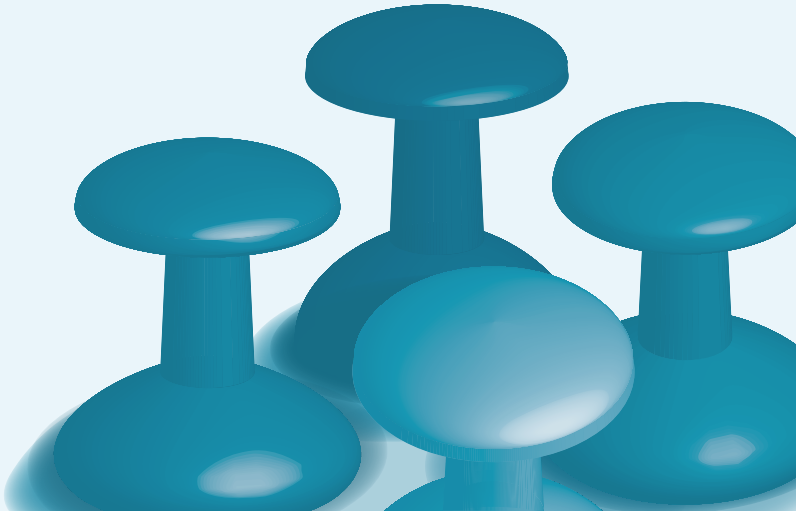
Agenda item 14
Appendix 1

National Fraud Initiative 2018/19

AUDIT SCOTLAND

Prepared by Audit Scotland
July 2020

Covid-19 raises risk of public-sector fraud



1. Covid-19

The Covid-19 pandemic has brought significant challenges across the public sector as bodies seek to deliver services for individuals, communities and businesses in an extremely difficult time. Since the start of the pandemic, the risk of fraud and error has increased as organisations become stretched and controls and governance are changing.

2. Outcomes

Since we last reported on the National Fraud Initiative (NFI) in Scotland in June 2018, outcomes valued at £15.3 million have been recorded. The cumulative outcomes from the NFI in Scotland since the first exercise 2006/07 are now £143.6 million. Across the UK, the cumulative total of NFI outcomes are now £1.93 billion.

3. Results

NFI outcomes in Scotland have fallen by £2.4 million to £15.3 million in the 2018/19 exercise, despite an increase in participating bodies. Reduced levels of outcomes could be due to less fraud and error in the system, strong internal controls or less effective detection of fraud and error.

4. Process

Most organisations demonstrate a strong commitment to counter-fraud and the NFI. Some could act more promptly and ensure that sufficient staff are in place to investigate matches, prevent frauds and correct errors.

Recommendations

1. Covid-19 risks

All participants should be aware of emerging fraud risks, eg due to Covid-19, and take appropriate preventative and detective action.

2. Maximise the benefits

All participants in the NFI exercise should ensure that they maximise the benefits of their participation.

They should consider whether it is possible to work more efficiently on the NFI matches by reviewing the guidance section within the NFI secure web application.

3. Self-appraisal checklist

Audit committees, or equivalent, and staff leading the NFI should review the NFI self-appraisal checklist.

This will ensure they are fully informed of their organisation's planning and progress in the 2020/21 NFI exercise.

4. Take action

Where local auditors have identified specific areas for improvement, participants should act on these as soon as possible.

1. Fraud risks associated with Covid-19

The Covid-19 pandemic has brought significant challenges across the public sector as bodies seek to continue to deliver services for individuals, communities and businesses in an extremely difficult time. This includes additional fraud risks that will be important for public bodies to identify and manage.

Good governance and sound controls are essential in such crisis situations. The risks include, but are not limited to:

public-sector staff working remotely

an increase in cyber-crime as more public-sector staff connect remotely

public-sector staff working under extreme pressure

an increase in phishing emails and scams trying to get staff working under pressure to click on links which allow fraudsters access to public-sector systems

government stimulus packages to support individuals and businesses being provided quickly with a lower level of scrutiny and due diligence than has previously been in place for similar schemes.

2. National Fraud Initiative outcomes

The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The NFI uses data sharing and matching to help confirm that services and payments are provided to the correct people.
An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents.

NFI outcomes

18/19

£15.3 million
NFI outcomes in Scotland from the 2018/19 exercise

These are split between outcomes for the 2018/19 exercise (£13.5 million) and late outcomes from the 2016/17 exercise (£1.8 million)

Since 06/07

£143.6 million
NFI outcomes cumulatively in Scotland since 2006/07

UK NFI outcomes
£244.7 million
from the 2018/19 exercise

£1.93 billion
cumulatively since 2006/07

The background of the NFI is contained in Appendix 1.

Trends in outcomes between 2016/17 and 2018/19 exercises

Outcomes in Scotland have fallen by £2.4 million to £15.3 million

Number of matches generated has fallen by 76,562 to 580,393

Number of participating bodies has increased by 11 to 124

The decrease in outcomes is partly down to immigration data not being included in the 2018/19 exercise due to restrictions placed on it by the Home Office following the recent review into the treatment of the Windrush generation. Following the review, the Home Office decided to temporarily suspend sharing immigration data until it had considered the findings of the review and reflected those findings in its policies and procedures. Reduced levels of outcomes and matches could be due to less fraud and error in the system, strong internal controls or less effective detection of fraud and error.

Having fewer matches provides some assurance there do not appear to be significant problems in the areas covered by the exercise. However, participants still benefit from the deterrent effect the NFI creates.

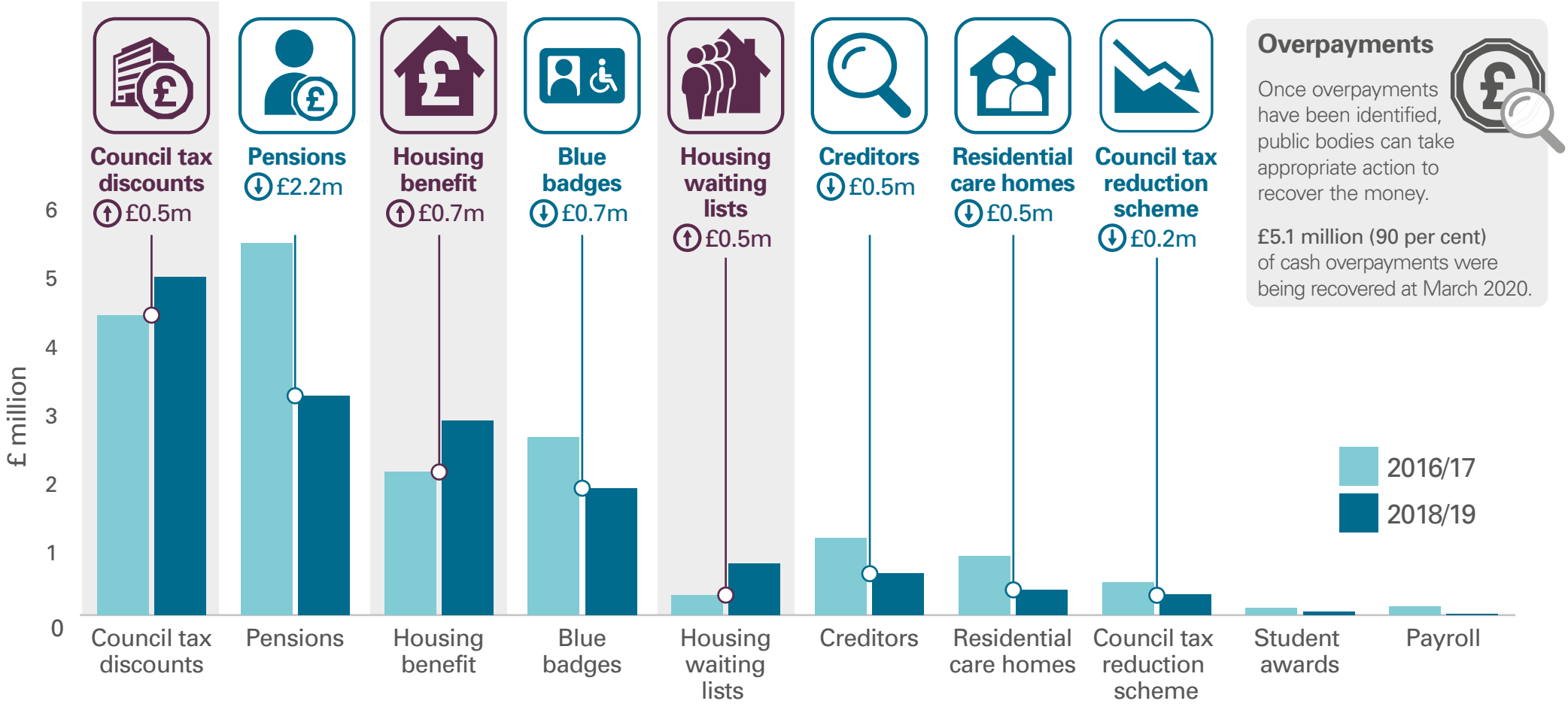
Although the main purpose of the NFI is to ensure funds and services are provided to the correct people, the review of NFI matches may also identify that a customer is entitled to additional services or payments.

Details of the Scottish NFI participants are on our FraudHub

3. Results

How the latest outcomes compare to the last exercise

The areas with significant changes are:



Overpayments

Once overpayments have been identified, public bodies can take appropriate action to recover the money.

£5.1 million (90 per cent) of cash overpayments were being recovered at March 2020.

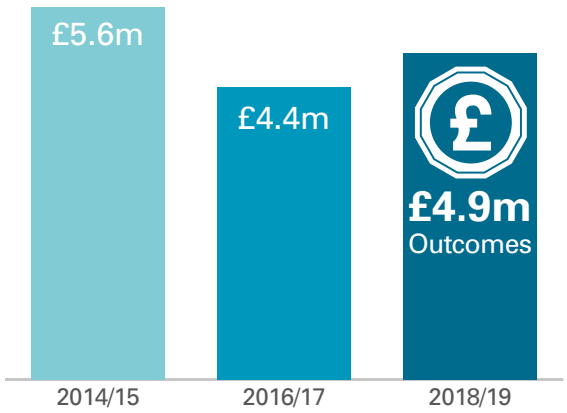
Council tax discounts

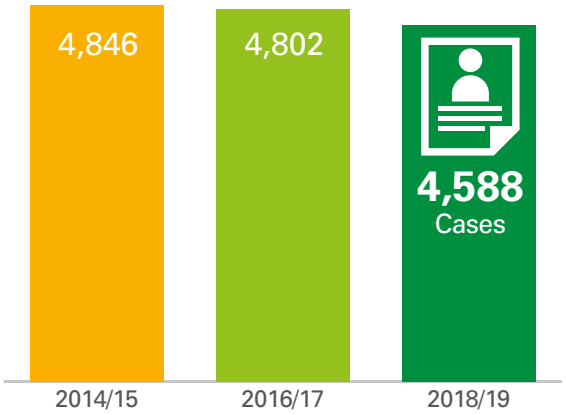
People living on their own, or with no countable adults in the household, are eligible for a 25 per cent single person discount (SPD) on their annual council tax bill.

£4.9 million
Total outcomes in 2018/19 exercise

£1,072
Average outcome

4,588
Cases





The 2018/19 NFI exercise found that the total council tax discount incorrectly awarded across Scottish councils totalled £4.9 million. This is an average outcome of £1,072 for each case compared with £916 per case in the 2016/17 NFI.

Five councils used alternative data matching or verification for SPD data matching during 2018/19.

Council tax data is matched to:

- ☑ Electoral register

Case study

East Dunbartonshire Council

An NFI match between a council tax reduction claimant and a pension recipient identified that a second undeclared adult was residing with the council tax reduction claimant.

Investigations identified that the pension recipient had been staying in, and jointly owned, the property since 1983. The pension recipient moved out of the property in 2013 and later returned in 2018.

As a result a council tax reduction overpayment of £2,200 plus a council tax SPD outcome of £9,800 were identified.

Pensions

For the Scottish Public Pensions Agency (SPPA) and councils that administer pensions, the NFI is an efficient and effective way of checking that they are only paying pensions to people who are alive.

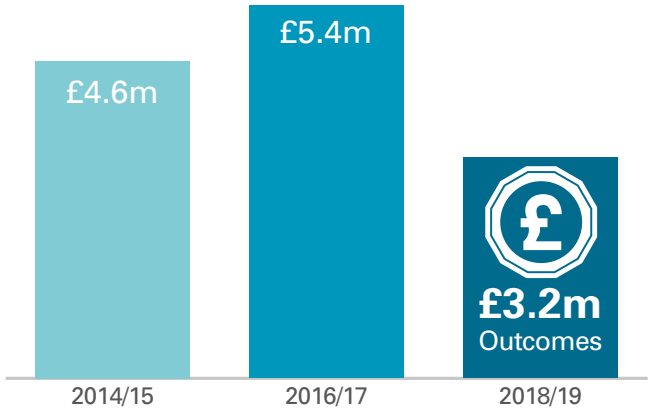
£3.2 million
Total outcomes in 2018/19 exercise

£2.2 million
Reduction on the 2016/17 NFI exercise

£32,600
Average outcome for each case

Pension outcomes have fallen due to the 'tell us once' reporting process having become more embedded over the last two years, and SPPA carrying out 6-monthly mortality screening.

Pension outcomes across the UK have fallen by 59 per cent from £143.7 million in 2016/17, to £59.1 million in 2018/19.



Note: Due to a formula error in the NFI computer system, pension outcomes in the 2016/17 exercise were overstated by £0.9 million. The figure has been adjusted accordingly.

Case study

Dundee City Council

An NFI match indicated that a pensioner had died. Investigations revealed that the pensioner had been living in Canada and had died in 2016.

A pension of just under £22,000 had been paid since the date of death. It was also established that the pensioner's widow has also since died. The overpaid pension has been partially offset against the widow's pension.

Pension data is matched to:

- Deceased person
- Payroll
- Housing benefits
- Injury benefits
- Amberhill data

Amberhill is a system used by the Metropolitan Police to authenticate documents presented for identity.

Tell us once

'Tell us once' is a service that lets you report a death to most government organisations when registering the death.

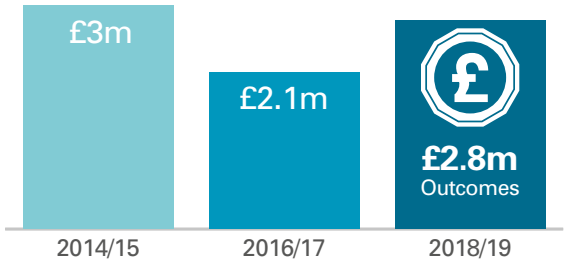
Housing benefit

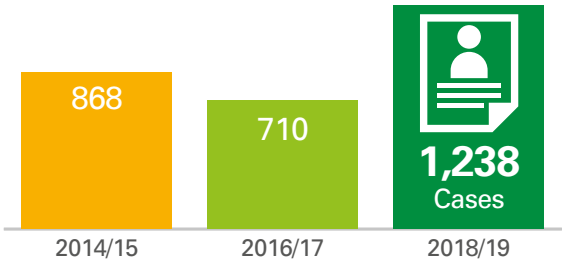
The NFI provides councils and the Department for Work and Pensions (DWP) with the opportunity to identify a wide range of benefit frauds and errors. Housing benefit helps people on low incomes pay their rent.

£2.8 million
Total outcomes in 2018/19 exercise

£2,292
Average individual value of overpayments

1,238
Cases





The value and number of housing benefit cases recorded with overpayments has risen from £2.1 million from 710 cases in the 2016/17 NFI, to £2.8 million from 1,238 cases in the 2018/19 NFI.

Although the number of benefit cases has risen, along with an increase in outcomes, the average individual value of overpayments has fallen from £2,923 in the 2016/17 NFI exercise to £2,292 in 2018/19.

One possible reason for the decline in the average value of individual overpayments of the 2018/19 outcomes is that the DWP and councils are now using real-time information (RTI) payroll and pension information, to help ensure any overpayments are picked up more quickly.

Housing benefit data is matched to:

- Student loans
- Payroll
- Pensions
- Housing benefits
- Housing tenants
- Right to buy (in England)
- Licences
- Deceased person
- Amberhill data

Case study

Renfrewshire Council

An NFI match resulted in a joint investigation by the council and the Department for Work and Pensions. This investigation identified that a benefit claimant had failed to declare their occupational pension since 2013, their earnings while working as a 'bank staff' employee and all of their bank accounts.

The undeclared occupational pension and earnings resulted in a housing benefit overpayment of £6,682.35 and a council tax reduction adjustment of £1,633.91.

The council has reported the matter to the Procurator Fiscal, for consideration of proceedings.

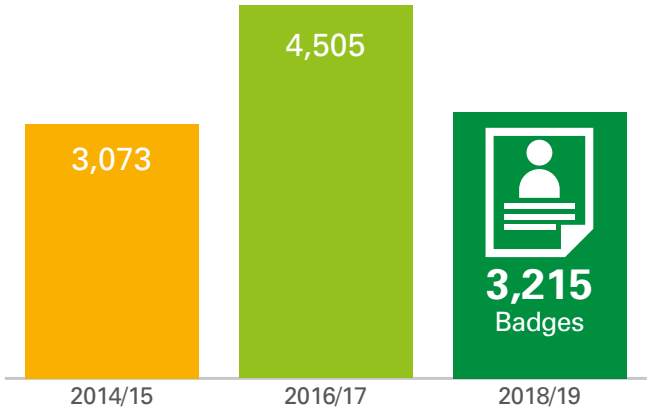
Blue badges

The blue badge parking scheme allows people with mobility problems to park for free at on-street parking meters, in 'pay and display' bays, in designated blue badge spaces, and on single or double yellow lines in certain circumstances.

£1.8 million
Total outcomes in 2018/19 exercise

3,215
Total number of blue badge outcomes in 2018/19 exercise

1,290
Decrease from NFI 2016/17 exercise



The 2018/19 NFI exercise identified 3,215 blue badge outcomes, which is a decrease of 1,290 (40 per cent) since the last exercise.

Badges are sometimes used or renewed improperly by people after the badge holder has died. It is an offence for an unauthorised person to use a blue badge.

Blue badge data is matched to:

- Deceased person
- Amberhill data

Housing waiting lists

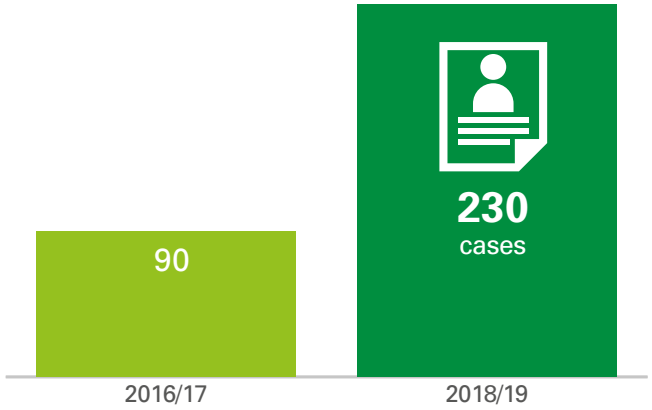
The aim of the NFI using housing waiting list data is to identify possible cases of waiting list fraud. This happens when an individual has registered on the waiting list but there are possible undisclosed changes in circumstances or false information has been provided. This was a new data set for the 2016/17 NFI exercise. Social housing provides affordable accommodation, allocated according to need. It usually provides a more secure, long-term tenancy when compared to private renting.

£0.7 million
Total outcomes in 2018/19 exercise

230
Cases

Councils identified 230 cases where applicants were removed from waiting lists. Stirling Council identified 185 (80 per cent) of these cases.

The estimated value of these cases is £0.7 million. This is based on a calculation of the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided a property.



Housing waiting list data is matched to:

- Waiting list
- Housing benefit
- Housing tenants
- Right to buy (in England)
- Deceased persons
- Amberhill data

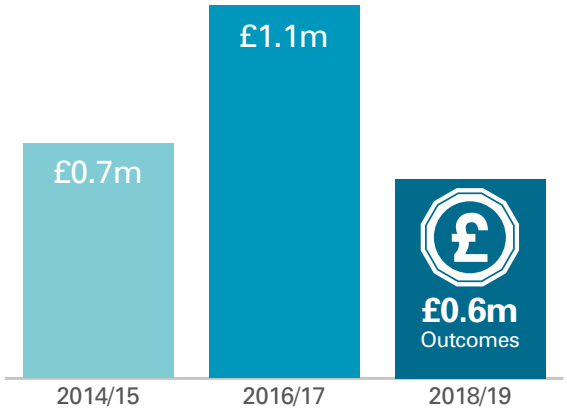
Creditors

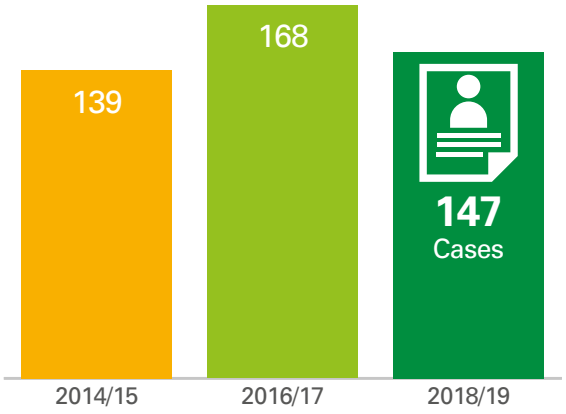
The NFI provides an efficient way to check for duplicate payments and that payments are only made to appropriate creditors. A creditor is a person or an organisation that a public body pays money to for a good or service.

£0.6 million
Total outcomes in 2018/19 exercise

100%
Recovery action is taking place

147
Cases





The 2018/19 NFI exercise has resulted in 147 creditor outcomes of £0.6 million compared to 168 outcomes worth £1.1 million in 2016/17. Recovery action is taking place for 100% of these overpayments.

Creditor data is matched to:

Creditor data

Payroll

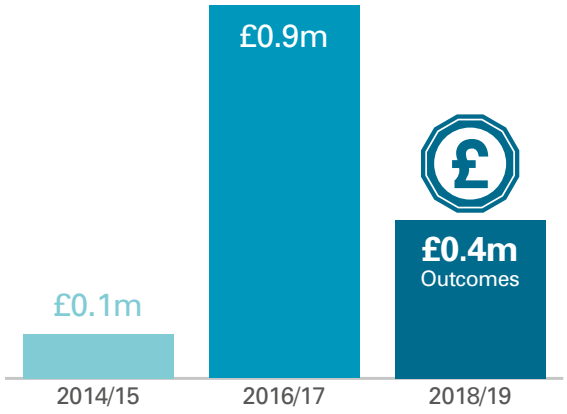
Payments to residential care homes

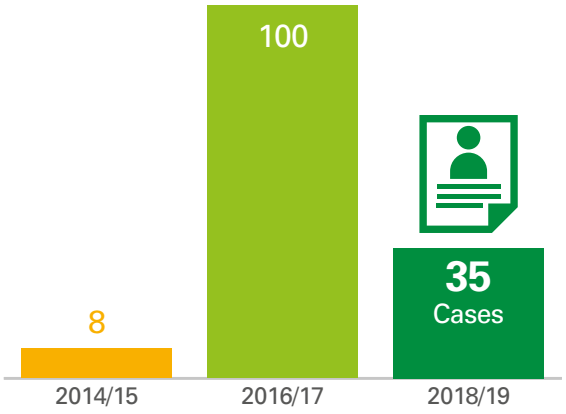
The NFI identifies cases where a care home resident has died, but the council may not have been notified and so continue to make payments.

£0.4 million
Total outcomes in 2018/19 exercise

71%
Overpayments are being recovered

35
Cases





Councils have identified 35 cases of overpayments valued at £0.4 million to care providers for residents who have died.

71 per cent of these overpayments are being recovered.

Despite the number of overpayments having fallen since 2016/17, the average value of overpayment has risen from £8,651 to £10,500.

Residential care home data is matched to:

Deceased persons

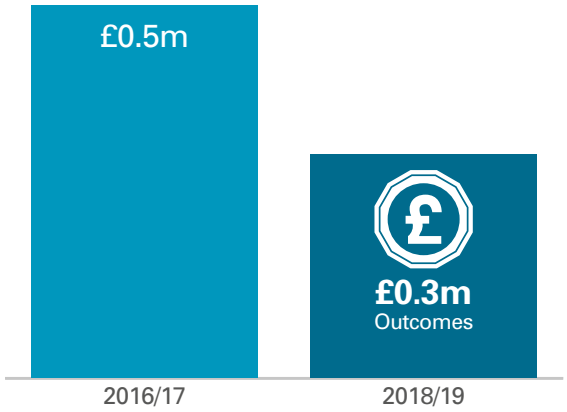
Amberhill data

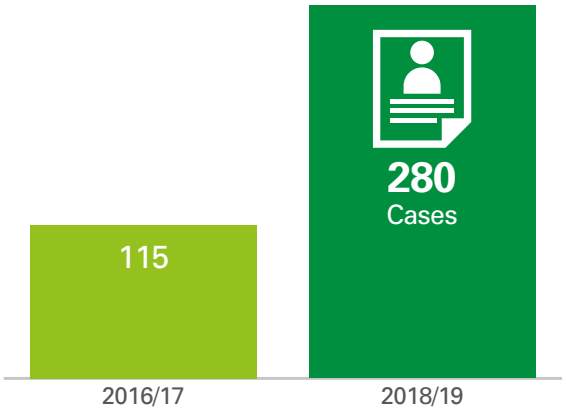
Council tax reduction

Council tax reduction helps those on low incomes to pay their council tax bills. The NFI provides councils with the opportunity to identify a range of council tax reduction frauds and errors.

£0.3 million
Total outcomes in 2018/19 exercise

280
Cases





The 2016/17 NFI was the first time council tax reduction data sets were included within the NFI.

Outcomes of £0.3 million were identified in the 2018/19 NFI, a fall of £0.2 million from the £0.5 million reported in 2016/17.

Councils have identified more than double the number of cases in 2018/19 but each with a smaller value, suggesting fraud and error is being picked up more quickly.

Council tax reduction data is matched to:

- Council tax reduction
- Payroll
- Pensions payroll
- Housing benefits
- Housing tenants
- Right to buy (in England)
- Licences
- Deceased persons
- Amberhill data

Other data matches

Payroll

£20,000
Total outcomes in 2018/19 exercise

8
Cases

The NFI also matches all participating bodies' employee payroll data as well as those of MSPs and councillors in order to identify cases of potential payroll fraud. The 2018/19 NFI identified eight cases valued at £20,000 compared to 13 cases valued at £0.1 million in the 2016/17 exercise.

Student awards

£50,000
Total outcomes in 2018/19 exercise

2
Case

The NFI provides the Student Awards Agency Scotland (SAAS) with matches identifying cases where individuals may not be eligible for student funding, for example, through identity fraud. The 2018/19 NFI exercise only identified two outcomes, a reduction of 3 from the 2016/17 exercise.

Past NFI exercises have identified larger outcomes in both payroll and student awards. This is partly due to immigration data not being included in the 2018/19 exercise.

Case study

Student Award Agency Scotland (SAAS)

An individual applied for student funding with a counterfeit Slovakian identity card. The applicant was awarded a tuition fee loan of £5,500.

The applicant was arrested, and facial recognition software identified a second false identity that had also been used by this individual.

The applicant made a full admission and is currently being detained in prison. It is expected that they will be deported from the UK following completion of their 12 month prison sentence.

4. Process

Matches benefiting other public bodies

One key benefit of a UK-wide data matching exercise is that it enables matches to be made between bodies and across national borders. Data provided by Scottish participants for the 2018/19 NFI exercise helped other public bodies, both within and outwith Scotland, to identify 884 outcomes worth £1.7 million. This is an increase of £0.6 million from 2016/17.

Local government

£854,760

415

2016/17
£520,948
232

Central government

£759,879

388

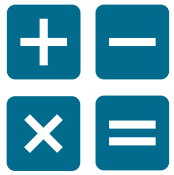
2016/17
£438,206
254

NHS

£120,408

75

2016/17
£155,566
77



Colleges

£12,672

6

2016/17
£7,073
5

Total

£1,747,719

884

2016/17
£1,121,793
568

Most of these outcomes relate to housing benefits, housing waiting lists and council tax reductions where, for example, payroll data from a health board may allow a council to identify a housing benefit overpayment.

Matches

For those public bodies taking part in the NFI which may not always identify significant outcomes from their own matches, it is important to appreciate that other bodies and sectors may do so.

Costs and benefits of participating in the NFI

£123,000+
Average outcome for each public body in Scotland for the 2018/19 NFI

£120 – £30,000
Estimated costs of NFI to public bodies

£213,750
Audit Scotland costs

Audit Scotland funds the cost of the NFI system and the biennial data matching for Scottish public-sector bodies

Participating bodies incur costs following up and investigating matches. Participating bodies also incur costs for pilot work and additional services such as the AppCheck[1] pre-application screening.

Many bodies do not keep separate records for NFI costs as it is just one of many counter-fraud activities they are doing. Those that did have records were able to estimate that their costs ranged from £120 to £30,000. This compares favourably with the average outcome for each public body in Scotland of over £123,000 for the 2018/19 NFI.

Overall, the £15.3 million of outcomes from the 2018/19 NFI outweigh the costs.

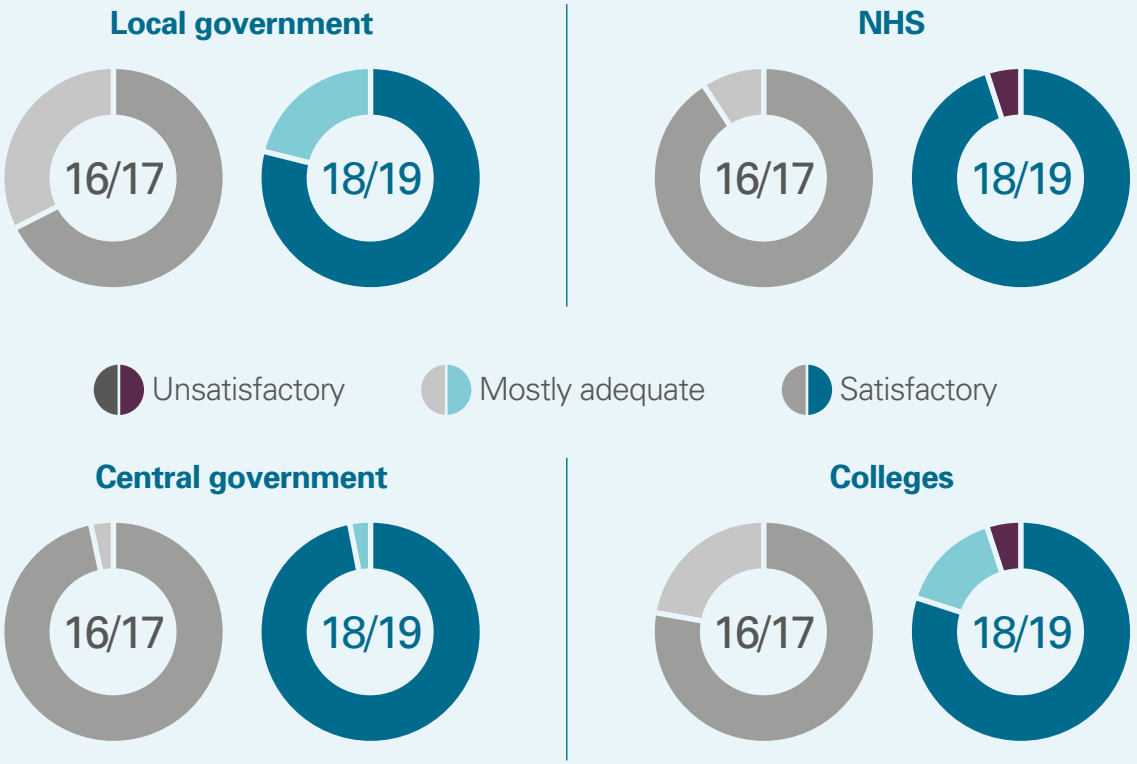
	No. of bodies reported	Cost range
Local government	4	£10,000 – £30,000
NHS	8	£120 - £6,000
Central government	10	£400 - £10,179
Colleges	7	£150 - £10,000

Note: 1. Appcheck is a data matching service used at point of applications for a service or benefit.

How bodies work with the NFI

External auditor review of NFI arrangements

A higher percentage of participating public bodies managed their roles in the 2018/19 NFI exercise satisfactorily compared to the 2016/17 NFI exercise.



Auditors reviewed each body's planning and progress with the NFI, and provided recommendations for improvement where appropriate.

Some bodies could be more pro-active in their approach to the NFI. All colleges were included in the 2018/19 exercise for the first time. Three colleges only submitted data after receiving several prompts from auditors. They cited resourcing and IT issues as the reasons. One of these colleges did not subsequently review any matches it received.

We recommend that all bodies use our checklist to self-appraise their involvement in the NFI before and during the 2020/21 NFI exercise.

NFI pilot activity – non-domestic rates

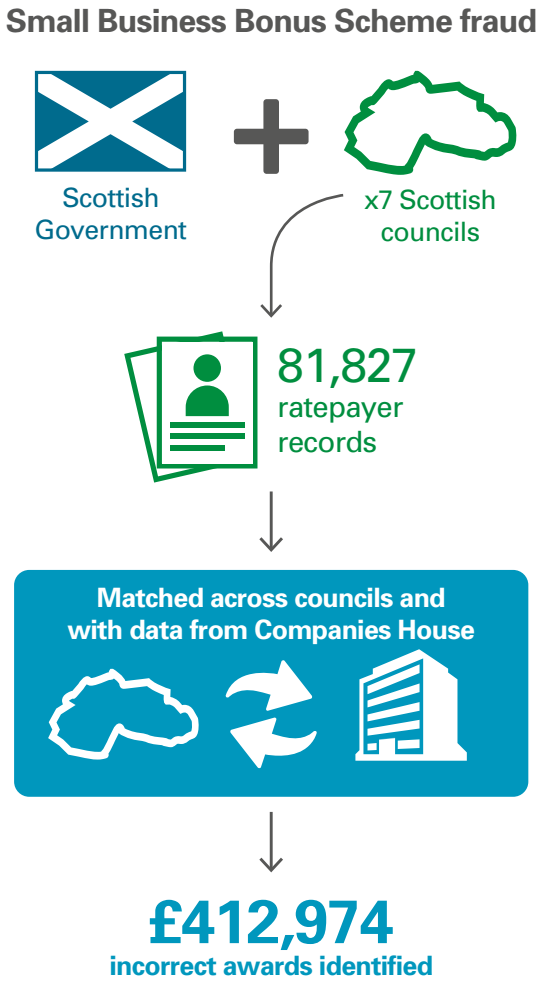
A pilot was undertaken with the Scottish Government and seven Scottish councils in order to help identify businesses inappropriately claiming Small Business Bonus Scheme (SBBS) relief. The SBBS assists small businesses in Scotland to pay their rates.

The seven participating councils provided 81,827 ratepayer records which were matched across councils and with data from Companies House in order to identify SBBS fraud. The pilot identified £412,974 in incorrect awards being identified.

If similar levels of incorrect awards were identified across all Scottish councils, the extrapolated value could be in the region of £1.9 million.

Some system weaknesses were also identified, and recommendations have been issued for improvements where appropriate.

Due to the success of this pilot, the Scottish Government is considering a national roll-out of this data matching exercise across all Scottish councils.



Future developments

The Covid-19 pandemic and the resulting emergency support packages have led to a greater risk of fraud.

Audit Scotland has been working with the Cabinet Office to identify, develop and promote data matching facilities to help address some of this increased fraud risk. Work will continue in this area into the 2020/21 NFI exercise.

The 2020/21 NFI is due to start in late summer 2020. Data sets have been reviewed following a period of consultation with participants.

Audit Scotland continues to work with the Cabinet Office in developing new ways to prevent and detect fraud. This includes piloting new data matching in respect of NHS patient prescription exemptions.

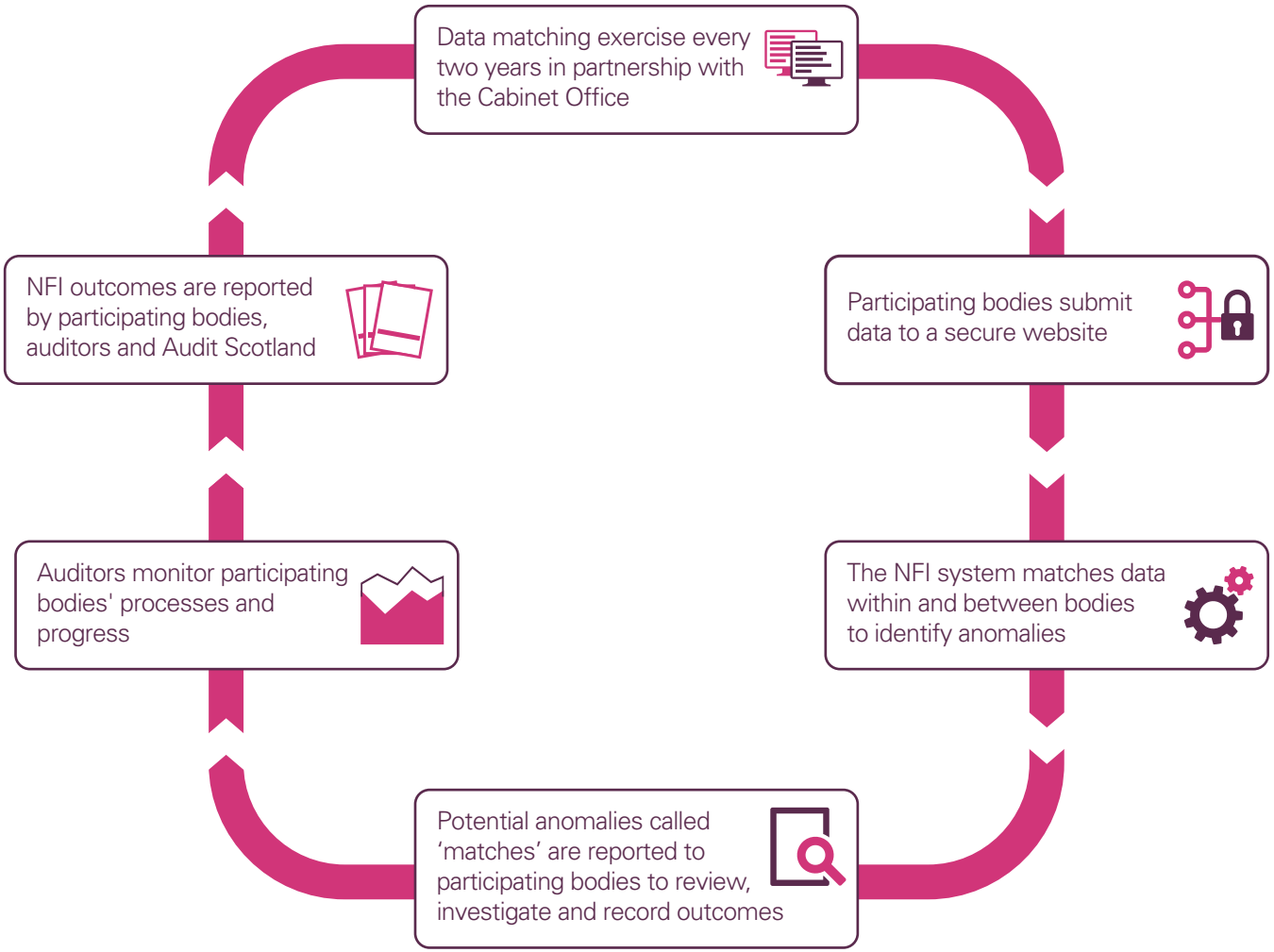
Audit Scotland continues to work with the Scottish Government in promoting and enhancing participation in the NFI across Scotland.

Appendix 1. Background to the NFI

The NFI is a counter-fraud exercise across the UK public sector which aims to prevent and detect fraud. The Cabinet Office oversees it and Audit Scotland leads the exercise in Scotland, working with a range of Scottish public bodies and external auditors. The NFI takes place every second year.

The NFI enables public bodies to use computer data matching techniques to detect fraud and error.

We carry out the NFI process under powers in The Criminal Justice and Licensing (Scotland) Act 2010. It is important for all parties involved that this exercise is properly controlled and data handled in accordance with the law. The Audit Scotland Code of Data Matching Practice includes a summary of the key legislation and controls governing the NFI data matching exercise.



Appendix 2. Estimation bases

The figures used in this report for fraud, overpayments and errors include outcomes already delivered (actual amounts participants have recorded) and estimates. Estimates are included where it is reasonable to assume that incidents of fraud, overpayments and errors would have continued undetected without NFI data matching.

Details of estimate calculations used in the report are shown below.

Data match	Basis of calculation of estimated outcomes
Council tax single person discount	Annual value of the discount cancelled multiplied by two years.
Housing	£93,000 per property recovered, based on average four-year fraudulent tenancy. Includes: temporary accommodation for genuine applicants; legal costs to recover property; re-let cost; and rent foregone during the void period between tenancies.
Housing benefit	Weekly benefit reduction multiplied by 21 weeks.
Pensions	Annual pension multiplied by the number of years until the pensioner would have reached the age of 85.
Payroll	£5,000 for each employee who is dismissed or resigns as a result of NFI matching, or £10,000 for each resignation or dismissal for employees who have no right to work in the UK.
Council tax reduction scheme	Weekly change in council tax discount multiplied by 21 weeks.
Housing waiting lists	£3,240 for each case based on the annual estimated cost of housing a family in temporary accommodation and the likelihood a waiting list applicant would be provided a property.
Residential care homes	Weekly cost of residential care multiplied by 14 weeks.
Social care/personal budgets	Monthly social care payment multiplied by three months. Monthly reduction in personal budget payment multiplied by three months.
Blue badges	Number of badge holders confirmed as having died multiplied by £575 to reflect lost parking and congestion charge revenue.
Other immigration	£50,000 for someone removed from the UK.

National Fraud Initiative 2018/19

This report is available in PDF and RTF formats, along with a podcast summary at:
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ISBN 978 1 913287 32 0

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National Fraud Initiative Scotland – Self Appraisal checklist

	Part A: for those charged with governance	Yes/No/Partly	Is action required?	Who by and when?
	Leadership, commitment and communication			
1	Are we aware of emerging fraud risks, eg due to Covid-19, and taken appropriate preventative and detective action?	Yes. We have contracted with NHS Counter Fraud Service. We've looked at high level fraud risk and held a workshop to drill down into specific fraud risks. We have a separate procurement risk register which is reviewed at least biannually. Additional controls have been implemented to prevent Covid-19 fraud.	No	
2	Are we committed to NFI? Has the council/board, audit committee and senior management expressed support for the exercise and has this been communicated to relevant staff?	Yes – all staff have been advised of our participation and a report on the findings is presented to Audit and Risk Committee.	Continued participation	Accounting and Procurement Manager to lead.
2	Is the NFI an integral part of our corporate policies and strategies for preventing and detecting fraud and error?	Yes. The Counter Fraud and Corruption Framework references participation in NFI as an initiative to help control the risk of fraud or error occurring.	No	
4	Have we considered using the point of application data matching service offered by the NFI team, to enhance assurances over internal controls and improve our approach to risk management?	Yes – this has been considered. Over the last four NFI exercises only one issue was identified from participation. Given the very low incidence of issues and the assurances gained	No	

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	Part A: for those charged with governance	Yes/No/Partly	Is action required?	Who by and when?
		through the internal and external audit reviews, it is felt that the risk of fraud or error is being managed through our existing internal controls.		
5	Are the NFI progress and outcomes reported regularly to senior management and elected/board members (eg, the audit committee or equivalent)?	Yes – a report is presented to Audit and Risk committee explaining the outcomes.	No further action except an outcome report being presented to Audit Committee after each NFI exercise.	Accounting and Procurement Manager to lead.
6	Where we have not submitted data or used the matches returned to us, eg council tax single person discounts, are we satisfied that alternative fraud detection arrangements are in place and that we know how successful they are?	n/a	No	
7	Does internal audit, or equivalent, monitor our approach to NFI and our main outcomes, ensuring that any weaknesses are addressed in relevant cases?	Yes - external audit reviewed our approach and outcomes. No issues were raised as a result.	No	
8	Do we review how frauds and errors arose and use this information to improve our internal controls?	In all instances where we identify fraud or error, we conduct a review with the objective of improving financial controls.	No	
9	Do we publish, as a deterrent, internally and externally the achievements of our fraud investigators (eg, successful prosecutions)?	n/a		

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	Part B:for the NFI key contacts and users	Yes/No/Partly /Not applicable	Is action required?	Who by and when?
	Planning and preparation			
1	Are aware of emerging fraud risks, eg due to Covid-19, and taken appropriate preventative and detective action?	Yes – NHS Counter fraud services delivered Fraud Training and the procurement risk register is reviewed and updated where required at least bi-annually.	No	
2	Are we investing sufficient resources in the NFI exercise?	Yes – we investigated all our hits from the NFI exercises.	No	
3	Do we plan properly for NFI exercises, both before submitting data and prior to matches becoming available? This includes considering the quality of data.	Yes – we have improved the data quality being uploaded which has resulted in fewer matches being identified for investigation.	No	
4	Is our NFI Key Contact (KC) the appropriate officer for that role and do they oversee the exercise properly?	Yes	No	`
5	Do KCs have the time to devote to the exercise and sufficient authority to seek action across the organisation?	Yes	No	
6	Where NFI outcomes have been low in the past, do we recognise that this may not be the case the next time, that NFI can deter fraud and that there is value in the assurances that we can take from low outcomes?	Yes – Audit and Risk Committee members discussed this at an earlier meeting and members gained reassurance from the exercise.	No	
7	Do we confirm promptly (using the online facility on the secure website) that we have met the	Yes – within the deadline.	No	

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	Part B:for the NFI key contacts and users	Yes/No/Partly /Not applicable	Is action required?	Who by and when?
	fair processing notice requirements?			
8	Do we plan to provide all NFI data on time using the secure data file upload facility properly?	Yes – this work was completed promptly for the 2020/21 exercise.	No	
9	Have we considered using the point of application data matching service offered by the NFI team to enhance assurances over internal controls and improve our approach to risk management?	Yes – this has been considered. Over the last four NFI exercises only one issue was identified from participation. Given the very low incidence of issues and the assurances gained through the internal and external audit reviews, it is felt that the risk of fraud or error is being managed through our existing internal controls.	No	
	Effective follow-up of matches			
10	Do all departments involved in NFI start the follow-up of matches promptly after they become available?	Yes – Finance and Human Resources did follow up promptly and within guidelines	No	
11	Do we give priority to following up recommended matches, high-quality matches, those that become quickly out of date and those that could cause reputational damage if a fraud is not stopped quickly?	The volume of matches is sufficiently low in number that we followed up all matches. We will consider prioritising for large volumes in future, if applicable.	No	
12	Are we investigating the circumstances of matches adequately before reaching a 'no issue' outcome, in particular?	Yes – all matches were investigated for the 2020/21 exercise.	No	
14	Are we taking appropriate action in cases where fraud is alleged	We have had no instances of fraud highlighted through	No	

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	Part B:for the NFI key contacts and users	Yes/No/Partly /Not applicable	Is action required?	Who by and when?
	(whether disciplinary action, penalties/cautions or reporting to the Procurator Fiscal)? Are we recovering funds effectively?	participation in the National Fraud Initiative to date. All instances of errors have been investigated and funds recovered. There were no instances of fraud or error identified in the 2020/21 exercise.		
15	Do we avoid deploying excessive resources on match reports where early work (eg, on recommended matches) has not found any fraud or error?	As the volume of matches is not excessive, all matches have been investigated. However, priority will be given to recommended matches where there is a large volume to be investigated.	No	
16	Where the number of high-risk matches is very low, are we adequately considering the medium and low risk matches before we cease our follow-up work?	Yes – all matches to date have been investigated.	No	
17	Overall, are we deploying appropriate resources on managing the NFI exercise?	Yes	No	
	Recording and reporting			
18	Are we recording outcomes properly in the secure website and keeping it up to date?	Yes	No	
19	Do staff use the online training modules and guidance on the secure website and do they consult the NFI team if they are unsure about how to record outcomes (to be encouraged)?	Yes – guidance used.	No	

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 15
Report No: ARC-08-2022

Title:	**SHARED SERVICE REVIEW BOARD UPDATE**	
Author:	*Kenny Dick, Head of Finance & Corporate Governance*	
Appendices:	1.	Note of Shared Service Review Board meetings (8 November 2021 and 1 February 2022)
	2.	Shared Service Performance
Consultation:	**n/a**	
Resource Implications:	**None**	

Executive Summary:
The Shared Service Review Board (SSRB) met on 8 November 2021 and 1 February 2022. The SSRB were provided with a report providing narrative on performance, highlights and lowlights for the quarter and details of resources deployed. The report also provided details of performance against the agreed performance measures. Appendix 1 is a note of the meetings of 8 November 2021 and 1 February 2022. Appendix 2 shows the performance measures for quarters 1 to 3.
The Committee is invited to:
1. Note the work of the Shared Service Review Board.

Links:	Corporate Plan Outcome		Risk Register Number		EIA Y/N	N	
For Noting		**For Discussion**		**For Assurance**	**x**	**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: N/A *(see Reasons for Exclusion)*
Disclosure after:

AUDIT AND RISK COMMITTEE MEETING 10 MARCH 2022

Agenda item 15
Report No: ARC-08-2022

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.

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SHARED SERVICE REVIEW BOARD (SSRB)

Monday 1 February 2022

Present: Peter MacLeod, Chief Executive, Care Inspectorate (PM) Chair, Jacqueline MacKenzie, Executive Director Corporate and Customer Services, Care Inspectorate (JM); Kenny Dick, Head of Shared Services, Care Inspectorate (KD), Lynn Murray (LM), Interim Director of Finance and Resources, SSSC, Edith Bankier, EPA to the Chair and Executive Director of Corporate and Customer Services, Care Inspectorate (EB).

	Item	Discussion	Actions/Decisions	By Whom	When
8 November 2021					
4.	Improvement Plan	KD advised the Improvement Plan would cover feedback received, common themes/issues and include timescales. It was hoped the Improvement Plan would be available for the next meeting.	1/2/22 - KD advised that he is intending to pull together the stand-alone Improvement Plan before 1 April 2022	KD	No later than 1 April 2022
5.	2022/23 Development Plan	KD requested any developments/significant projects should be fed into the Development Plan.	1/2/22 - KD advised that there is currently nothing new, however, NCS may bring additional projects, but not yet.		
6.	2022/23 Resource Plan	KD highlighted two issues effecting resources across both organisations in terms of shared services; the new HR team structure and VAT implications if we continued with time recording. They discussed possible joint approach to	1/2/22 - KD noted that the cost of the new HR structure and VAT was built into both budgets. KD also advised that a search is underway to see if a different process could be found for recording and it was		

	Item	Discussion	Actions/Decisions	By Whom	When
		securing technology to support time recording across both organisations.	hoped this would be available for year end		
7.	AOCB	The group discussed a proposed annual meeting between the respective CI Board and SSSC Council to review shared services. LG agreed to share background information with colleagues and PM to discuss with his Chair of the Board.	LG to share background papers and PM to discuss with his Chair of the Board around the proposal to hold an annual meeting. 1/2/22 - Annual Review of Shared Services Delivery meeting is scheduled to take place 6 May 2022 with a view to taking a report to both CI Board and SSSC Council. Attendees include both CEs, CI Chair, SSSC Convenor, both Directors and Head of Shared Services	LG/PM	Completed
1 February 2022					
1.	Welcome	PM welcomed everyone to the meeting.			
2.	Apologies for absence	LM extended apologies for LG			

	Item	Discussion	Actions/Decisions	By Whom	When
3.	Note from previous meeting 8 November 2021	Notes updates above and approved			
4.	Shared Service 2021/22 Q3 Report	KD provided an overview of the report contents advising that Q3 was quite steady with business as usual, however, there were still challenges around staffing etc. KD continued to advise that work levels are still good even though there is not full establishment due to quite a bit of staff turnover, however, performance had not declined since the previous report and had actually maintained or improved. Scoring was discussed, at length, with both Directors outlining their rationale behind their individual scores for each area. It was suggested that with that, once the Improvement Plan was in place and active, scores would be expected to improve. It was agreed that there was currently a good strong foundation in Service Delivery, with further improvements expected moving forward. Consensus is that the Review Board were content with how it's going, however, there is always room for improvement.	KD to prepare a report to go to CI Board and SSSC Council at end April	KD	By end April

Agenda item 15 – Appendix 1

	Item	Discussion	Actions/Decisions	By Whom	When
5.	AOCB	PM noted that overall, the teams are working well across both organisations and meeting targets. PM also asked that KD convey the appreciation of the Review Board to the Shared Services teams for all they do.	KD to advise teams of appreciation of Review Board	KD	ASAP

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APPENDIX 1(a) – CARE INSPECTORATE PERFORMANCE MEASURES

Care Inspectorate Shared Service Performance 2021/22

Area	Measures	Target	CI Q1 Result	CI Q2 Result	CI Q3 Result	CI Q4 Result	CI Annual Result
Shared Services	**SRB01** Reports & papers are accurate in format agreed by the officer responsible for the report/ paper and submitted to EMT/ SLT; Committee; Board/Council within agreed timescales.	100%	100%	100%	100%		
	SRB02 Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly). The rationale should be set out for any score of less than four in order to clearly articulate the issues and the improvement actions required.	5-point scale; score of 4 or more	4	4	4		
	SRB03 Positive feedback resulting from gathering and recording perceptions via annual survey. (Targeted surveys may also be undertaken).	5-point scale; score of 4 or more	n/a	n/a	n/a	n/a	
Accounting	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB04 Shared Services provide Budget Managers with budget reports to timescales agreed by the Executive Director of Corporate and Customer Services in the CI and Director of Finance and Resources in the SSSC that are in a format that is	80% positive responses	n/a	n/a	n/a		

	understandable and allows them to discharge the duties of a budget holder. (Annual survey).						
	SRB05 Agreed information provided to agreed timescales to allow draft Annual Report and Accounts to be submitted to the external auditors by the agreed deadline.	Compliance	Yes	n/a	n/a	n/a	Yes
	SRB06 we receive an unmodified audit opinion (for the areas of shared service responsibility) on our Annual Report and Accounts.	Compliance	n/a	Yes	n/a	n/a	Yes
	SRB07 Number of recommendations made by external auditors for shared services areas of responsibility in preparing the ARA.	0	n/a	2	n/a	n/a	2
Procurement	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	4	4		
	SRB08 Procurement & Commercial Improvement Programme (PCIP) (RAG rating).	Green	n/a	n/a	n/a	n/a	n/a
Property	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB09 We respond to Emergency, Medium and Low priority requests within agreed timescales.	100%	100% (no requests)	100%	100%		

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Health and Safety	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	4	4		
	SRB10 We mitigate the number of HSE interventions through provision, monitoring and reporting of training and risk assessments.	0	0	0	0		
Transactions	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB11 %age of Suppliers paid within 10 working days.	95%	99.3%	99.6%	99.1%		
	SRB12 %age of debt collected within 30 days.	80%	83%	68.1%	88%		
	SRB13 %age of annual and renewal fees collected by the fee due date.	80%	SSSC	SSSC	SSSC	SSSC	SSSC
	SRB14 Credit notes due to processing error as a %age of all invoices issued per quarter.	< 1%	0%	0%	0%		
	SRB15 %age of payments collected by automated means (direct debit, online direct debits, bacs, or automated telephone).	90%+	99.3%	99.2%	99.2%		
HR	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	4	4		

	SRB16 Quality of HR Policies delivered to the Director of Finance & Resources / Executive Director of Customer & Corporate Services in accordance with best practice, complying with all relevant legislation/ regulations and any other standards required by SSSC and CI that are included in the service specifications.	100%	n/a	100%	n/a		
	SRB17 Agreed schedule of HR metrics delivered in line with the timescales agreed with the Director of Finance & Resources/Executive Director of Customer & Corporate Services.	100%	n/a	n/a	n/a		
Payroll	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB18 % of staff paid accurately in quarter	98%	99.95%	99.36%	99.84%		
	SRB19 % of payrolls within last 12 months paid on time.	100%	100%	100%	100%		
Bursaries	**SRB20** Annual student satisfaction questionnaire.	80% positive responses in 2021/22 with year-on-year improvement	SSSC	SSSC	SSSC	SSSC	SSSC
	SRB21 Bursary payments paid to students accurately and on time.	100%	SSSC	SSSC	SSSC	SSSC	SSSC

Reception	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	n/a	n/a	n/a		

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APPENDIX 1 (b) – SSSC PERFORMANCE MEASURES

SSSC Shared Service Performance 2021/22

Area	Measures	Target	SSSC Q1 Result	SSSC Q2 Result	SSSC Q3 Result	SSSC Q4 Result	SSSC Annual Result
Shared Services	**SRB01** Reports & papers are accurate in format agreed by the officer responsible for the report/ paper and submitted to EMT/ SLT; Committee; Board/Council within agreed timescales.	100%	66.67%	76.47%	99.45%		
	SRB02 Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly). The rationale should be set out for any score of less than four in order to clearly articulate the issues and the improvement actions required.	5-point scale; score of 4 or more	3	3	3		
	SRB03 Positive feedback resulting from gathering and recording perceptions via annual survey. (Targeted surveys may also be undertaken).	5-point scale; score of 4 or more	n/a		n/a		
Accounting	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	5		
	SRB04 Shared Services provide Budget Managers with budget reports to timescales agreed by the Executive Director of Corporate and Customer Services in the CI and Director of Finance and	80% positive responses	n/a		n/a		

	Resources in the SSSC that are in a format that is understandable and allows them to discharge the duties of a budget holder. (Annual survey).						
	SRB05 Agreed information provided to agreed timescales to allow draft Annual Report and Accounts to be submitted to the external auditors by the agreed deadline.	Compliance	Yes	n/a	n/a	n/a	Yes
	SRB06 we receive an unmodified audit opinion (for the areas of shared service responsibility) on our Annual Report and Accounts.	Compliance	n/a	Yes	n/a	n/a	Yes
	SRB07 Number of recommendations made by external auditors for shared services areas of responsibility in preparing the ARA.	0	n/a	2	n/a	n/a	2
Procurement	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB08 Procurement & Commercial Improvement Programme (PCIP) (RAG rating).	Green	n/a	n/a	n/a	n/a	n/a
Property	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	3	3		
	SRB09 We respond to Emergency, Medium and Low priority requests within agreed timescales.	100%	100% (no requests)	100%	100% (no requests)		

Health and Safety	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	3	3		
	SRB10 We mitigate the number of HSE interventions through provision, monitoring and reporting of training and risk assessments.	0	0	0	0		
Transactions	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	4	4	4		
	SRB11 %age of Suppliers paid within 10 working days.	95%	99.8%	99.4%	99.9%		
	SRB12 %age of debt collected within 30 days.	80%	CI	CI	CI	CI	CI
	SRB13 %age of annual and renewal fees collected by the fee due date.	80%	71% affected by decision not to collect fees 2020/21	73% affected by decision not to collect fees 2020/21	74% affected by decision not to collect fees 2020/21		
	SRB14 Credit notes due to processing error as a %age of all invoices issued per quarter.	< 1%	0%	0%	0%		
	SRB15 %age of payments collected by automated means (direct debit, online direct debits, bacs, or automated telephone).	90%+	99.7%	99.8%	98.3%		

HR	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	3	3		
	SRB16 Quality of HR Policies delivered to the Director of Finance & Resources / Executive Director of Customer & Corporate Services in accordance with best practice, complying with all relevant legislation/ regulations and any other standards required by SSSC and CI that are included in the service specifications.	100%	100%	100%	100%		
	SRB17 Agreed schedule of HR metrics delivered in line with the timescales agreed with the Director of Finance & Resources/Executive Director of Customer & Corporate Services.	100%	67%	67%	100% Recently agreed estab and absence reporting to be included from Q4		
Payroll	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	3	3	3		
	SRB18 % of staff paid accurately in quarter	98%	100%	100%	100%		
	SRB19 % of payrolls within last 12 months paid on time.	100%	100%	100%	100%		

Bursaries	**SRB20** Annual student satisfaction questionnaire.	80% positive responses in 2021/22 with year-on-year improvement	n/a	n/a	n/a		
	SRB21 Bursary payments paid to students accurately and on time.	100%	100%	100%	n/a Transferred to D&I		
Reception	**SRB02** Director of Finance & Resources/ Executive Director of Customer & Corporate Services is satisfied with service provided (rated quarterly).	5-point scale; score of 4 or more	n/a	n/a	n/a		

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AUDIT AND RISK COMMITTEE

Schedule of Committee Business 2022/23

REPORT/TOPIC	19 May 2022	11 Aug 2022	8 Sept 2022	17 Nov 2022	9 March 2023
Internal Audit Items					
Internal Audit Report 2022/23 – Follow Up Report	✓	✓	✓	✓	✓
Internal Audit Plan 2022/23 Progress Report					✓
Draft Annual Internal Audit Plan 2023/24					✓
Audit Assignments					
Workforce Planning	✓				
Corporate Planning	✓				
IT Strategy					
Complaints					
Shared Services					
Payroll					
Procurement and Creditors / Purchasing					
Business Continuity					
Performance reporting and KPIs					
Partnership working					
Change management					
Data Protection					
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 2022)*		✓	✓		

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REPORT/TOPIC	19 May 2022	11 Aug 2022	8 Sept 2022	17 Nov 2022	9 March 2023
Progress on the Audit of Financial Statements `		✓	✓		
Annual Audit Plan 2022/23 – 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 2022/23 (draft pre-Board)	✓				
Strategic Risk Register Monitoring	✓		✓	✓	✓
Digital Programme Update	✓		✓	✓	
SIRO Report (Information Governance) (*Annual report)*	✓				
National Fraud Initiative Update					✓
Standing Items					
Shared Service Governance update				✓	✓
Horizon Scanning (Audit Scotland & CIPFA publications)	✓		✓	✓	✓
Audit and Risk Committee Narrative to the Board	✓		✓	✓	✓
Schedule of Committee Business	✓		✓	✓	✓
Annual Review of Committee Effectiveness					✓