A Meeting of the Care Inspectorate Audit and Risk Committee is to take place from **10.30 am to 1.00 pm on Thursday 19 May in rooms 0.18/0.24, Ground Floor, Compass House, Dundee**

AGENDA	
1.	Welcome
2.	Apologies for Absence
3.	Declaration of Interests
4.	Minute of Meeting held on 10 March 2022 (paper attached)
5.	Action Record of meeting held on 10 March 2022 (paper attached)
6.	Matters Arising
	Internal Audit Items
7.	Internal Audit Report 2021/22 – Follow Up Report – Report No: ARC-09-2022 7.1 Update on Complaints Resource Model and Capacity Tool (verbal update)
8.	Annual Internal Audit Plan 2022/23 – Report No: ARC-10-2022
9.	Internal Audit 2021/22 Annual Report - Report No: ARC-11-2022
10.	Internal Audit Review: Workforce Planning - Report No: ARC-12-2022
11.	Internal Audit Review: Scrutiny and Assurance - Report No: ARC-13-2022
12.	Internal Audit Review: Corporate Planning - Report No: ARC-14-2022
	External Audit Items
13.	None for this meeting.

	Items for Discussion
14.	Strategic Risk Register Monitoring – Report No: ARC-15-2022
15.	Presentation: Assurance Mapping for 2022/23
16.	Draft Audit and Risk Committee Annual Report to the Board 2021/22 – Report No: ARC-16-2022
	S H O R T B R E A K
17.	Digital Programme Update - Report No: ARC-17-2022
18.	Presentation: Cyber Security Plan
19.	Senior Information Risk Officer Annual Report 2021-22 - Report No: ARC-18-2022
20.	Shared Service Review Board (verbal update)
	Items for Information
21.	Horizon Scanning - CIPFA Audit Committee Update
	Standing Items
22.	Audit and Risk Committee Narrative to the Board and Publication of Committee papers
23.	Schedule of Committee Business 2022-23 (paper attached)
24.	Any Other Competent Business
25.	Close of Business and Date of Next Meeting: Thursday 11 August 2022 at 10.30 am (Annual Report and Accounts only – meeting extended to all Board members)

Minutes

Meeting	Audit and Risk Committee
Date	10 March 2022
Time	10.00 am
Venue	Held by Teams Videoconference
Present	Bill Maxwell (Convener) Gavin Dayer Rona Fraser Paul Gray Rognvald Johnson
In Attendance	Edith Macintosh, interim Chief Executive (iCE) Jackie Mackenzie, Executive Director of Corporate and Customer Services (EDC&CS) Kevin Mitchell, Executive Director of Scrutiny and Assurance (EDS&A) Gordon Mackie, Executive Director of IT and Digital Transformation (EDIT&DT) Craig Morris, interim Executive Director of Strategy and Improvement (iEDS&I) Kenny Dick, Head of Finance and Corporate Governance (HFCG) Fiona McKeand, Executive and Committee Support Manager (E&CSM) David Archibald, Henderson-Loggie John Boyd, Grant Thornton Jacqui Duncan, Equalities Professional Adviser *(item 10)* Claire Brown, Executive and Committee Support Officer
Apologies:	Paul Edie, Board Chair

Item **Action**

1.0 WELCOME

The Convener welcomed everyone to the meeting.

2.0 APOLOGIES FOR ABSENCE

There were no apologies.

3.0 DECLARATION OF INTERESTS

There were no declarations of interest.

4.0 MINUTE OF PREVIOUS MEETING HELD ON 18 NOVEMBER 2021

The Committee reviewed and **approved** the minute of the meeting held on 18 November 2021 as an accurate record.

5.0 ACTION RECORD OF MEETING HELD 18 NOVEMBER 2021

The Committee reviewed and agreed the action record and noted under item 9 of the previous meeting that a Board Development Event would be organised to provide all Board members with more information on the arrangements for care governance in the Care Inspectorate.

6.0 MATTERS ARISING

The Convener advised that discussions would be held with the Board Chair to identify a new member to take the vacant seat on the Committee. Recruitment was currently underway for three new Board members. The Committee indicated the need for its membership to reflect a good gender balance, and this would be taken into account in discussions with the Chair.

INTERNAL AUDIT ITEMS

7.0 INTERNAL AUDIT ON FOLLOW-UP REVIEWS – REPORT NO: ARC-01-2022

The internal auditors presented the report which set 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.

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

Overall, the Care Inspectorate had made good progress in implementing the thirteen recommendations followed up, with eight having been fully implemented. The report outlined the action plans for each of the six internal audit reviews in question, the current progress and revised implementation dates and the “red/amber/green” ratings for each.

The Executive Director of Corporate and Customer Services assured the Committee that management was addressing the outstanding recommendations as a matter of priority. Management was also closely monitoring and reviewing any risks associated with delays in implementation, although it was noted that almost all were rated as low priority recommendations.

The Committee noted the report and that members would be provided with information on progress with outstanding recommendations. There were no changes required to the implementation dates put forward by management.

8.0 INTERNAL AUDIT PLAN 2021/22 PROGRESS REPORT – REPORT NO: ARC-02-2022

The internal auditors presented the Committee with a report on progress with the annual internal audit plan.

Members were advised of the deferral of the Workforce Planning and Scrutiny and Assurance reviews, which linked in with the work around the Care Inspectorate's new corporate plan. In light of this, management had requested that fieldwork be deferred on these three reviews until April 2022, and they would then be submitted to the May Committee meeting.

Management had also requested the internal review of IT strategy be carried over to the 2022/23 and so this would be added to the draft annual internal audit plan.

The Committee asked if the deferrals would impact on the number of contracted audit hours for 2022/23 and were advised that there would be no change in the number of days overall but there would be some viring of hours from the current year.

The Executive Director of Corporate and Customer Services advised the Committee that pressures of work had affected the ability to meet the original fieldwork timeframes. In recognition of the importance of internal audit in terms of good governance, audit scopes would be agreed in good time with lead officers and the Committee would be kept informed of any changes and the reasons for these.

9.0 DRAFT ANNUAL INTERNAL AUDIT PLAN 2022/23 – REPORT NO: ARC-03-2022

The internal auditors presented the draft annual internal audit plan for 2022/23 to the Committee for its approval. The Committee was also invited to comment on the topics to be covered during the coming year.

Members were advised that the content of the plan was in line with the three-year strategic internal audit plan, with two exceptions that had previously been noted by the Committee, namely the deferral of the IT Strategy review and the inclusion of work around Shared Services. This had resulted in a slight increase to the number of audit hours, which was outlined in the plan.

There was discussion on the subject of staffing, particularly around issues with recruitment and retention, and whether consideration should be given to including this in the plan. Members were advised that the internal audit review on scrutiny and assurance would focus on target-setting processes

and ability to deliver inspection activities and this would assist in highlighting any recruitment challenges in this particular area. The interim Chief Executive advised the Committee that the HR team would also be producing a report on work they had carried out on the process for inspector recruitment, which would have more detail on the issues and where improvements could be made.

There was also some discussion on the proposed review on complaints and clarity about whether this was in relation to registered services or complaints about the Care Inspectorate. It was agreed that the auditors and management would discuss this further to consider which area of complaints should be the focus, and to report back to the Committee.

In respect of the proposed audit on business continuity, the Committee recommended that cyber security be considered as part of this. The Executive Director of IT and Digital Transformation assured members that the cyber security plan contained a number of actions and that an update on these would be provided to the May meeting of the Committee to give assurance on the work that was being carried out in this area.

EDIT&DT

The Committee **approved** the proposed annual programme of internal audit activity for 2022/23, subject to further discussions between the auditors and management on complaints.

10.0 INTERNAL AUDIT REVIEW: EQUALITY AND DIVERSITY – REPORT NO: ARC-04-2022

The internal auditors presented the report of the audit on Equality and Diversity, which the Committee was invited to note and accept. The audit had reviewed the systems and procedures in place to integrate equality into the day-to-day working activities of the Care Inspectorate which allowed the organisation to meet the legislative and regulatory requirements of the Equalities Act and to examine future plans to enhance existing arrangements.

The Committee was pleased to note the very positive report, with an overall level of assurance of “Good”, and each of the four internal audit objectives being scored the same. The review made one recommendation that the composition of the Corporate Equality Group be reviewed to determine if senior manager/director level membership would be beneficial. Members were advised that this recommendation was agreed and the Group membership would be considered by the Operational Leadership Team in March 2022.

The interim Chief Executive highlighted the leadership of the Equalities Professional Adviser in her role of encouraging, engaging and enabling colleagues to adopt the organisation’s equality and diversity policies and principles in practice.

The Committee was advised that an annual progress report was also being presented to the Board on 22 March which would reflect some of what was in the internal audit report.

E&CSM/ Equalities Professional Adviser (EPA)

There was discussion on the equalities training provided for staff, which was part of the Care Inspectorate's core learning programme, and it was agreed to consider this being extended to Board members as part of a Board Development Event.

EPA/ HoCPC

It was agreed that the positive work on equalities and diversity be promoted more widely and that the Equalities Professional Adviser would follow this up with the Head of Corporate Policy and Communications after the Board had discussed the annual progress report in a couple of weeks' time.

EXTERNAL AUDIT ITEMS

11.0 ANNUAL AUDIT PLAN 2022/23– ANNUAL ACCOUNTS

The external auditor presented the draft annual audit plan for 2022/23 which provided the Committee with an overview of the planned scope and timing of the external audit of Care Inspectorate. The key areas covered the risk-based audit approach, materiality, audit fees and audit timeline.

The Committee noted the draft plan and would await the outcome of the external audit in due course.

ITEMS FOR DISCUSSION

12.0 STRATEGIC RISK REGISTER MONITORING – REPORT NO: ARC-05-2022

The Head of Finance and Corporate Governance presented the quarterly report on risk monitoring and advised the Committee that there had been no significant change to the strategic risk position since last reported to the Board in December 2021.

The Committee noted that there were three strategic risks that remained above target level, namely financial sustainability, ICT data access and security and digital transformation.

In trying to mitigate the risk in respect of financial sustainability, the Committee was informed that discussions were continuing with the sponsor team around a letter of comfort to cover the budget deficit and also a further request for a three-year settlement in order to assist with financial planning.

In respect of ICT data access and cyber security, members were advised by the Executive Director of IT and Digital Transformation that a security plan was in place and an update report would be brought to the May Committee meeting, as outlined earlier. There were also plans in place

for external revalidation and testing which it was anticipated would help in lowering the risk.

In respect of digital transformation, the Committee was advised that the risk related to funding of Stage 2. The Board had approved the business case to be submitted to the Scottish Government at the end of March and, once final reviews had been undertaken, involving the member/officer Assurance and Advisory Group, this would be shared with Board members.

The Committee noted the strategic risk position and agreed to draw this to the attention of the Board.

13.0 DIGITAL PROGRAMME UPDATE - REPORT NO: ARC-06-2022

The Executive Director of IT and Digital Transformation presented the report which updated the Committee on recent progress of the Digital Programme. The report focussed on Stage 1, which covered Complaints and Registrations and The Register and outlined the delivery progress, along with the latest programme finances.

Members noted that good progress was continuing to be made and that work was being undertaken for the move into Stage 2 of the programme, noting that this had the support of the member/officer Assurance and Advisory Group. The Committee was also advised of the transition of services to the IT operational support team and that the digital team would continue to support the organisation through this large and complex business change.

The Committee noted the report.

14.0 NATIONAL FRAUD INITIATIVE UPDATE – REPORT NO: ARC-07 2022

The Head of Finance and Corporate Governance presented the report which advised the Committee of the outcome of the Care Inspectorate's participation in the National Fraud Initiative (NFI) 2020/21 exercise. The Committee was invited to review the management response to the NFI self-appraisal document.

Members were pleased to note that no instance of fraud or errors had been identified following investigation of the data matches, which were explained within the report. The Committee took assurance from this that the Care Inspectorate's internal controls in place for payroll, purchasing and payments were operating effectively.

The Committee noted the report and response to the self-appraisal document.

15.0 SHARED SERVICE REVIEW BOARD – REPORT NO: ARC-08-2022

The Committee received the update report on the work of the Shared Service Review Board, which the Head of Finance and Corporate Governance explained had met twice since the November Committee meeting. At those meetings, the SSRB had reviewed a report 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.

Members noted a drop in the percentage of debt collected and it was agreed that the Head of Finance and Corporate Governance would check this and respond to the Committee directly.

The Committee was pleased to receive these performance details and were reassured of the continued oversight of the implementation of the shared service.

ITEMS FOR INFORMATION

16.0 HORIZON SCANNING

The Committee noted the CIPFA Audit Committee Update, issue 37.

STANDING ITEMS

17.0 AUDIT AND RISK COMMITTEE NARRATIVE TO THE BOARD AND PUBLICATION OF COMMITTEE PAPERS

The Committee agreed the following matters should be included in its summary report to the Board meeting of 22 March 2022:

- The progress reports that would be provided in respect of the outstanding internal audit recommendations, and continued review of any impact on risk
- The Committee's approval of the annual internal audit plan, subject to further discussion between internal auditors and management on the scope of the audit on complaints and if this should cover registered services and/or complaints against the Care Inspectorate
- The very positive internal audit on the Care Inspectorate's equality and diversity policies and procedures and the plan to extend training in this area to Board members
- The actions being taken to try to mitigate the high level strategic risks identified in the risk monitoring report
- The Committee's reassurance that the internal controls for payroll, purchasing and payments were operating effectively, as an outcome of the National Fraud Initiative exercise
- The Committee's continued oversight of the performance of the shared services between the Care Inspectorate and Scottish Social Services Council.

18.0 SCHEDULE OF COMMITTEE BUSINESS 2022-23

The Committee reviewed the schedule of business for the new cycle and noted that the internal audit reviews that would be brought to the May meeting, namely Scrutiny and Assurance and Workforce Planning. **E&CSM**

It was agreed to add an update report on cyber security to the May meeting.

19.0 AOCB

There was no other business.

20.0 CLOSE OF BUSINESS AND DATE OF NEXT MEETING

The date of the next meeting was noted as Thursday 19 May 2022 at 10.30 am, to be held at Compass House, Dundee.

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
10 March 2022					
9.0	**DRAFT ANNUAL INTERNAL AUDIT PLAN 2022/23 – REPORT NO: ARC-03-2022**	Update on actions in cyber security plan to be provided to the May meeting.	EDIDT	For Committee meeting on 19.5.22	Presentation to Committee on 19.5.22 **Completed**
10.0	**INTERNAL AUDIT REVIEW: EQUALITY AND DIVERSITY – REPORT NO: ARC-04-2022**	• Equalities learning and development session to be co-ordinated for all Board members • Look at ways of promoting the CI's work on equalities and diversity more widely.	ECSM AND Equalities Professional Adviser (J Duncan) HoCPC and J Duncan	Board Development in Autumn 2022 (Sept or Nov) Ongoing activity	Arrangements underway for BDE on 17/11/22 **Completed** **Completed**
18.0	**SCHEDULE OF BUSINESS 2022-23**	Update Schedule to include update on cyber security action plan for May meeting	ECS&M	Immediate	**Completed**

Agenda item 5

Senior Leadership Team (SLT)

iCE	Interim Chief Executive		
EDCCS	Executive Director of Corporate and Customer Services	G-T	Grant-Thornton (external auditors)
EDSA	Executive Director of Scrutiny and Assurance	H-L	Henderson-Loggie (internal auditors)
iEDSI	Interim Executive Director of Strategy and Improvement		
EDIDT	Executive Director IT and Digital Transformation		
HFCG	Head of Finance and Corporate Governance	HoCP&C	Head of Corporate Policy and Communications
HLS	Head of Legal Services	ECSM	Executive and Committee Support Manager

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 7
Report No: ARC-09-2022

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 January 2022 and reported to the Audit and Risk Committee in March 2022. 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 May 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**

Agenda item 7
Report No: ARC-09-2022

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.

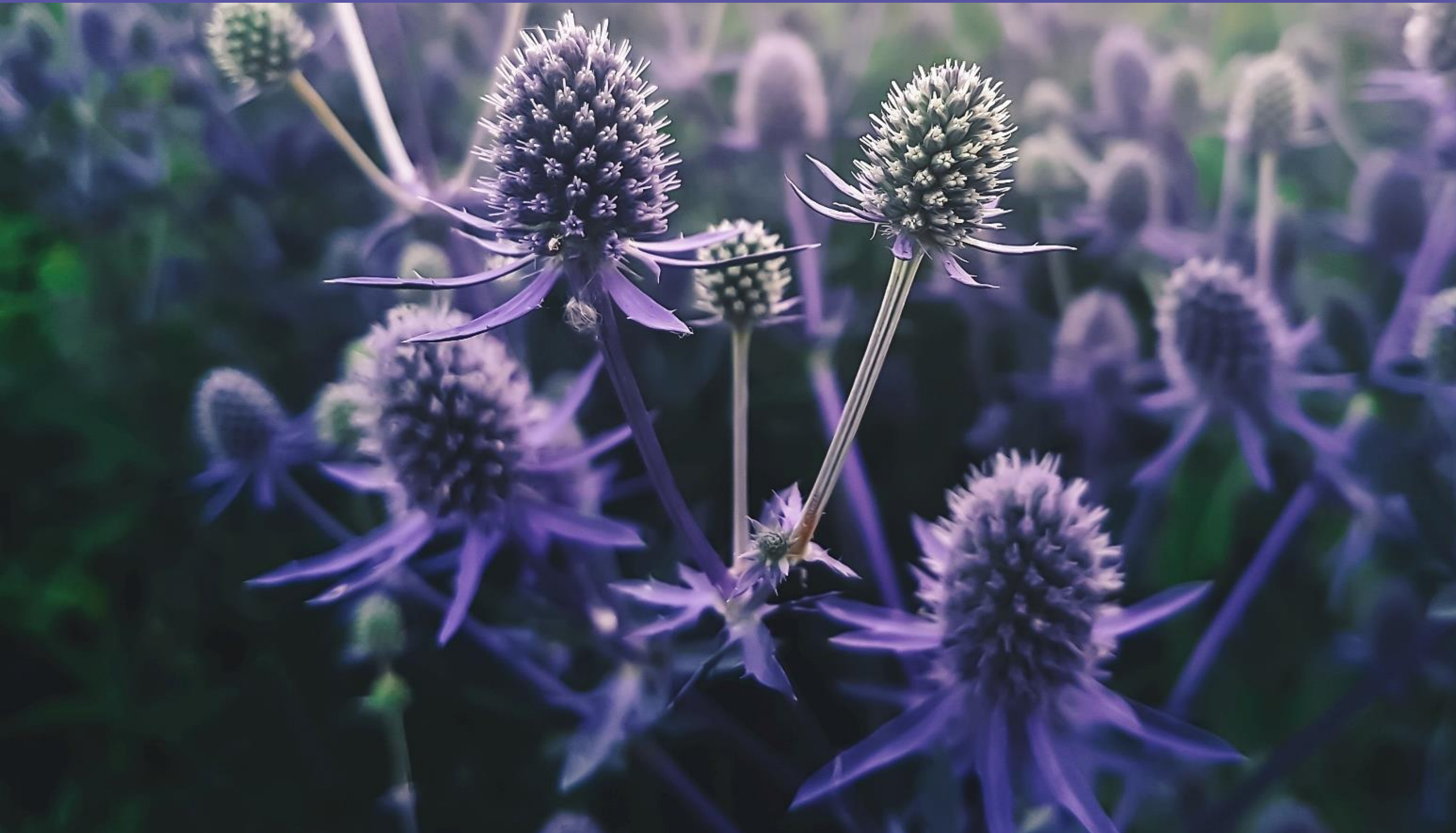
Agenda item 7
Appendix 1

Care Inspectorate

Follow Up Reviews

Internal Audit report No: 2022/12

Draft issued: 16 May 2022
Final issued: 16 May 2022



Henderson Loggie

Contents

		Page
Section 1	Introduction and Background	1
Section 2	Objectives of the Audit	1
Section 3	Audit Approach	1
Section 4	Overall Conclusion	2 - 3
Section 5	Acknowledgements	3

Appendices

Appendix I	Updated Action Plan – Follow Up review 2019/20	4 - 5
Appendix II	Updated Action Plan – Recruitment and Retention	6
Appendix III	Updated Action Plan – Risk Management	7 - 8

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 February 2022. 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)

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 some progress in implementing the recommendations followed-up as part of this review. One of the five recommendations followed-up, which had reached their original agreed completion date, was assessed as ‘fully implemented’, with four (80%) remaining 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	1	1	-	-	-	-
	3	1	-	1	-	-	
Total		**2**	**1**	**1**	**-**	**-**	**-**
Recruitment and Retention 2019/20	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	-	1	-	-	-
Total		**1**	**-**	**1**	**-**	**-**	**-**
Risk Management (report 2021/01)	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	2	-	2	-	-	-
Total		**2**	**-**	**2**	**-**	**-**	**-**
Grand Totals		**5**	**1**	**4**	**-**	**-**	**-**

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	Description
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	Description
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 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	**Update at May 2022:** Recovery tests of cloud hosted applications completed. **Fully Implemented**	**a) Complete** **b) Complete** **c) Complete**

Follow Up Reviews

Original Recommendation	Grade	Responsible Officer for Actions	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
Complaints (Continued) **2.2 Resource Capacity** The new digital solution to replace PMS is currently under development. The complaints team should use the review to investigate options to improve the reliability of time recording and reporting for complaints work. This would allow improved planning and highlight any anomalies. The current resourcing model for complaints management may need to be reviewed to manage workload pressures for staff and to ensure key performance indicators can be achieved.	**2**	Systems / Development Accountant (Capacity Tool) Head of Finance & Corporate Governance	a) 30 September 2019 (Capacity Tool) b) 31 January 2020 (update Resource Model)	**Update at February 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.	**Update at May 2022:** Progress report will be provided to the meeting. **Partially Implemented**	**a) 31 months over original completion date** **b) 27 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 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.	**Update at May 2022:** A revised plan for reviewing and updating the Strategic Workforce Plan to align to the new Corporate Plan, published in May 2022, was agreed by SLT in April 2022. **Revised Implementation date:** The development of the Strategic Workforce Plan will be completed over May to November 2022. This extended timescale will enable us to take cognisance of emerging developments impacting on the future role, function and structure of the Care Inspectorate, including the establishment of the national care service and outcome of education reform. It will also ensure we are able to integrate the learning from our 2022 employee survey and reflect the themes identified through the action planning process. **Partially Implemented**	**24 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 **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 February 2022:** 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.	**Update at May 2022:** Procedure note is on the agenda for the Operational Leadership Team meeting of 26 May and will then go to the Strategic Leadership Team on 8 June 2022 for final sign off. **Revised implementation date:** 8 June 2022 **Partially Implemented**	**17 months over original completion date**

Follow Up Reviews

Original Recommendation	Grade	Management Response	Responsible Officer for Action	Original Agreed Completion Date	Previous Updates	Current Progress	RAG Ratings
Internal audit report 2021/01 – Risk Management (Continued) **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 February 2022:** Work on developing the training content is continuing and the revised implementation date of 31 March 2022 is still achievable.	**Update at May 2022:** Work on developing the training content is continuing and the revised implementation date of 31 March 2022 is still achievable. Training content is closely linked to the procedure note and will therefore be finalised following SLT approval of procedure note on 8 June 2022. **Revised implementation date:** Training pack to be ready for delivery by 30 June 2022 **Partially Implemented**	**15 months over original completion date**

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN T: 01224 322 100 F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB T: 01382 200 055 F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF T: 0131 226 0200 F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 8
Report No: ARC-10-2022

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 second draft of the Internal Audit Annual Plan for 2022/23 is attached as Appendix 1. The Committee considered the first draft at the March 2022 meeting of the Committee and the second draft includes timings for the agreed internal audit assignment The Plan 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, objectives and timing 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 2022/23.

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

Agenda item 8
Report No: ARC-10-2022

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 8
Appendix 1

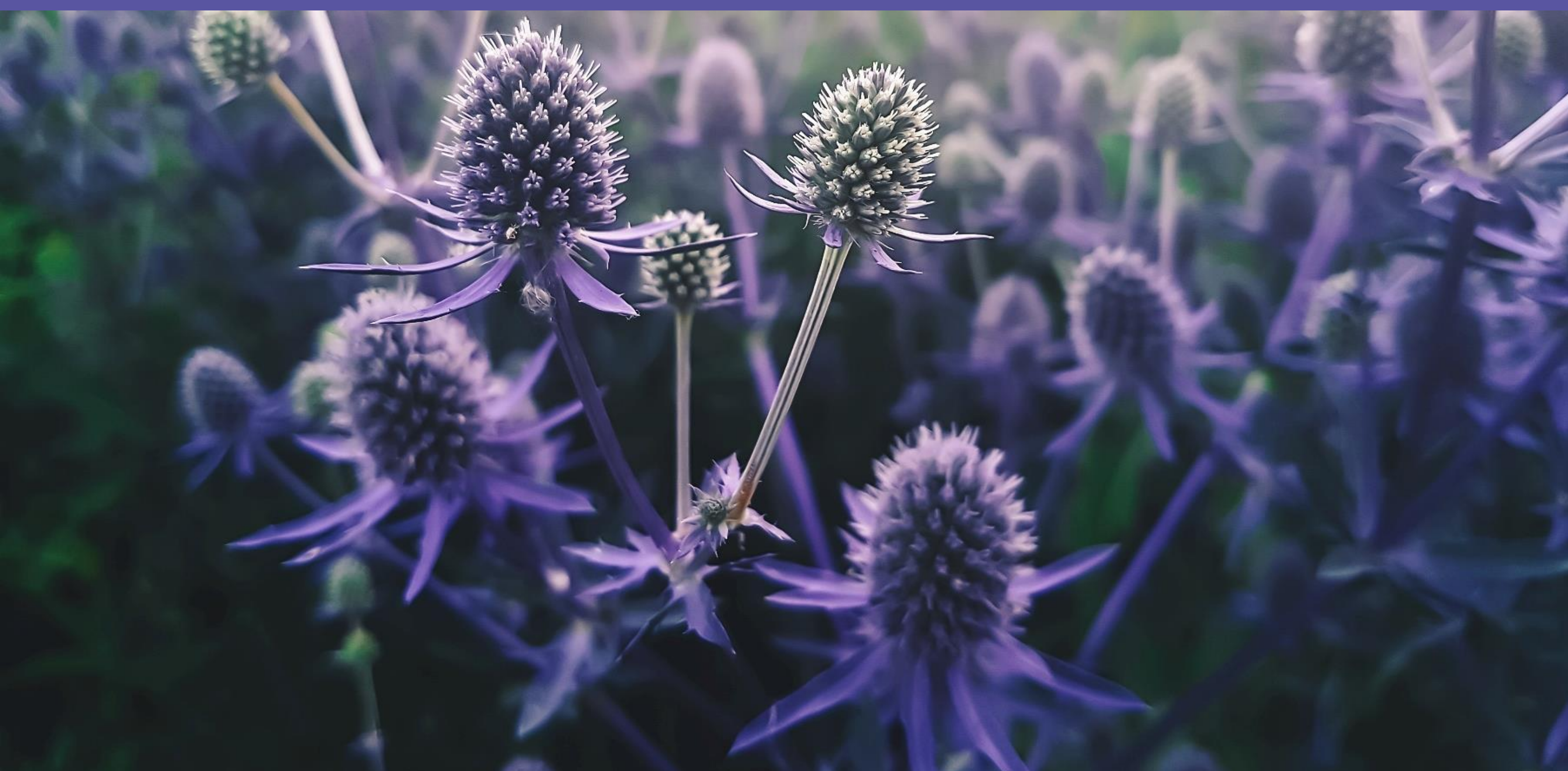
Care Inspectorate

Internal Audit Annual Plan 2022/23

Internal Audit Report No: 2023/01

Draft issued: 18 February 2022

Final issued: 16 May 2022



Henderson Loggie

Contents

		Page
Section 1	Introduction	1
Section 2	Strategic Plan 2020 to 2023	2 - 3
Section 3	Outline Scope and Objectives	
	• Complaints	4
	• Shared Services	5
	• Payroll	6
	• Procurement and Creditors / Purchasing	7 - 8
	• Business Continuity	9
	• Performance reporting and KPIs	10
	• Partnership working	11
	• Change management	12
	• Data Protection	13
	• IT Strategy	14
	• Follow-Up Reviews	15

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

	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	July 2022
Audit & Risk Committee Meeting:	September 2022
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.

Audit Assignment:	Shared Services
Priority:	High
Fieldwork Timing	December 2022
Audit & Risk Committee Meeting:	March 2023
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.

Audit Assignment:	Payroll
Priority:	Medium
Fieldwork Timing	November 2022
Audit & Risk Committee Meeting:	March 2023
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	September 2022
Audit & Risk Committee Meeting:	November 2022
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.

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.

Audit Assignment:	Business Continuity
Priority:	Medium
Fieldwork Timing	August 2022
Audit & Risk Committee Meeting:	September 2022
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.

Audit Assignment:	Performance Reporting & KPIs
Priority:	Medium
Fieldwork Timing	September 2022
Audit & Risk Committee Meeting:	November 2022
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.

Audit Assignment:	Partnership Working
Priority:	Medium
Fieldwork Timing	January 2023
Audit & Risk Committee Meeting:	March 2023
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 Deputy Chief Executive / Director of Strategy & Improvement, Director of Scrutiny & Assurance and the Chief Inspectors 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.

Audit Assignment:	Change Management
Priority:	Medium
Fieldwork Timing	September 2022
Audit & Risk Committee Meeting:	November 2022
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.

Audit Assignment:	Data Protection
Priority:	Medium
Fieldwork Timing	August / September 2022
Audit & Risk Committee Meeting:	November 2022
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.

Audit Assignment:	IT Strategy
Priority:	Medium
Fieldwork Timing	July 2022
Audit & Risk Committee Meeting:	September 2022
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.

Audit Assignment:	Follow-Up Reviews
Priority:	Various
Fieldwork Timing	July 2022, October 2022, January 2023 and April 2023
Audit & Risk Committee Meeting:	August 2022, November 2022, February 2023 and May 2023
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.

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN T: 01224 322 100 F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB T: 01382 200 055 F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF T: 0131 226 0200 F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 9
Report No: ARC-11-2022

Title:	**COVER REPORT: ANNUAL INTERNAL AUDIT REPORT 2021/22**	
Author:	*David Archibald, Partner in MHA Henderson Loggie*	
Appendices:	1.	Internal Audit Report: Annual Internal Audit Report 2021/22
Consultation:	**n/a**	
Resource Implications:	**None**	

Executive Summary:	
The Annual Internal Audit Report for 2021/22 is attached as Appendix 1. This report summarises the internal audit work performed during the year and provides a positive overall opinion on the Care Inspectorate's arrangements for risk management, control and governance. It also confirms that, in our opinion, the Care Inspectorate has proper arrangements in place to promote and secure Value for Money. The audit work conducted during 2021/22 did not identify any significant control weaknesses. In general, procedures were operating well in the areas selected, but a few areas for further strengthening or improvement were identified, and action plans have been agreed to address these issues.	
The Audit and Risk Committee is invited to:	
1.	Accept the Internal Audit Annual Report for 2021/22.

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:

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

Agenda item 9
Appendix 1

Care Inspectorate

Annual Report to the Board and Chief Executive on the Provision of Internal Audit Services for 2021/22

Internal Audit report No: 2022/013

Draft issued: 16 May 2022

Final issued: 17 May 2022

Henderson Loggie

Contents

		Page
Section 1	Annual Report and Opinion	1 - 2
Section 2	Reports Submitted	3 - 4
Section 3	Summary of Results and Conclusions	5 - 23
Section 4	Time Spent - Budget v Actual	24
Section 5	Operational Plan for 2022/23	25 - 27

Annual Report and Opinion

Introduction

1.1 We were appointed in January 2020 as internal auditors of the Care Inspectorate (CI)) for the period 1 April 2020 to 31 March 2023, with the option to extend for a further two 12-month periods. This report summarises the internal audit work performed during 2021/22.

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

1.3 The work undertaken in the year followed that set out in the Annual Plan for 2021/22 with the exception of the planned review of IT Strategy which was deferred into the 2022/23 programme at the request of management.

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

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

Public Sector Internal Audit Standards (PSIAS) Reporting Requirements

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

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

Public Sector Internal Audit Standards (PSIAS) Reporting Requirements

1.7 Self-assessment is undertaken through:

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

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

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

Significant Issues

1.10 There were no issues identifying significant internal control weaknesses noted from the internal audit work carried out during the year. In general, procedures were operating well in the areas selected, but a few areas for further strengthening or improvement were identified, and action plans have been agreed to address these issues.

Opinion

1.11 In our opinion the Care Inspectorate has adequate and effective arrangements for risk management, control and governance. Proper arrangements are in place to promote and secure Value for Money. This opinion has been arrived at taking into consideration the work we have undertaken during 2021/22 and also from our collective knowledge of the organisation obtained since our appointment in 2020/21.

Reports submitted

Number	Title	Overall Grade	Recommendations	Priority 1	Priority 2	Priority 3
2022/01	Annual Plan 2021/22	**N/A**	N/A	N/A	N/A	N/A
2022/02	Compliance with Legislation	**Satisfactory**	5	-	-	5
2022/03	Financial Sustainability	**Good**	-	-	-	5
2022/04	Follow Up – August 2021	**N/A**	8 of 10 recommendations required further action	-	2	6
2022/05	Fraud prevention, detection and response	**Good**	1	-	-	1
2022/06	Follow Up – November 2021	**N/A**	7 of 8 recommendations required further action	-	2	5
2022/07	Equality and Diversity	**Good**	1	-	-	1
2022/08	Follow Up – February 2022	**N/A**	5 of 13 recommendations required further action	-	1	4
2022/09	Scrutiny & Assurance	**Satisfactory**	3	-	-	3
2022/10	Workforce planning	**Satisfactory**	3	-	-	3
2022/11	Corporate planning	**Good**	-	-	-	-
2022/08	Follow Up – May 2022	**N/A**	4 of 5 recommendations required further action	-	-	4

Overall gradings are defined as follows:

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

Recommendation grades are defined as follows:

Priority	Definition
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.

Grading for recommendations from internal audit reporting issued by the Care Inspectorate's previous internal auditors Scott-Moncrieff (Follow Up Reviews only) are as follows:

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

Summary of Results and Conclusions

2022/01 – Annual Plan 2021/22

Final Issued: 3 March 2022

The purpose of this document was to present, for consideration by the Audit and Risk Committee, the annual operating plan for the year ended 31 March 2022. The plan was based on the proposed allocation of audit days for 2021/22 set out in the ANA and Strategic Plan 2020 to 2023. The outline scope, objectives and audit approach for each audit assignment to be undertaken, arrived at following discussion with the Executive Management Team were set out in the report.

2022/02 – Compliance with Legislation

Final Issued – 1 September 2021

Overall grade: Satisfactory

The scope of this audit was to carry out a review of the arrangements in place within the Care Inspectorate (CI) to identify and monitor compliance with applicable legislation.

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

Strengths

- There is a suitable framework, and sufficient dedicated resource, established for the CI to remain up to date with new and up-coming legislation that may impact upon the organisation. This takes the form of research by the Legal team and Policy team, as well as the CI's involved in Scottish Government consultations (such as the current consultation around the National Care Service review).
- Management interviewed through sample testing of legislative areas demonstrated that they are aware of the legal obligations placed upon CI, and any associated reporting requirements in their area.
- There is an effective internal network established to communicate key requirements or new changes to management and to the Board, where necessary.
- The Legal team provide training and ongoing support for staff, which supplements the mandatory requirement to complete training on key legislative areas such as Health and Safety, Equality and Diversity, and GDPR.
- A process for updating policies has been established and governance arrangements are in place to ensure that they are reviewed by key stakeholders before publication and implementation.
- The current governance arrangements are effective in reporting on legislative requirements through the Senior Leadership Team (SLT); Board Sub-Committees and then the Board. No non-compliance has been reported to the Board during the review period.
- Management have identified the need to have a holistic view on legislative compliance arrangements and have begun to structure future arrangements in this manner through the development of a Table of Legislative Requirements.

The objective of this audit was to obtain reasonable assurance that:	Grade
1. A framework is in place to identify relevant legislation and upcoming legislation that will affect the Care Inspectorate and the wider care sector in Scotland.	Satisfactory
2. Staff are provided with training on areas of key legislation, including refresher training where appropriate.	Good
3. Policies, processes and systems have been put in place to ensure that legislation is being complied with.	Satisfactory
4. There are appropriate monitoring and reporting processes to identify any areas of legislative non-compliance and to undertake appropriate action regarding these, with non-compliance being reported upwards to the Board or to a standing committee of the Board.	Good
Overall Level of Assurance	**Satisfactory**

2022/02 – Compliance with Legislation (Continued)

Weaknesses

- We were unable to identify a resource modelling tool to provide management with a platform to identify current resource and forecast ongoing resource requirements against significant pieces of legislative change. Currently, most legislative obligatory work is subsumed into an individual or team's role. However, we noted some legislative requirements require multi-disciplinary and cross-team support, such as the Climate Change Emergency Response, which will result in increased workloads and potentially longer working hours.
- The CI's Legal Handbook, which is provided to Inspectors during training, should be version controlled in line with good practice, and should provide detail on the responsible manager for updating the document; when it was last subject to review; and when it is next due for review.
- The number of published Equality Impact Assessments (EQIAs) was limited and there is currently no dedicated website which brings together all EQIAs to demonstrate their consideration when updating new policies, published strategies, or projects. Management within OD, HR and Equalities are currently reviewing the current arrangements to strengthen controls in this area.
- There are two published policies on the CI public website that require to be updated to reflect the current version of each policy: Fraud Policy (May 2016) and Zero Tolerance Policy (May 2016). Both have been updated in 2021 and 2019, respectively.

2022/03 – Financial Sustainability **Final Issued – 1 September 2021** **Overall grade: Good**

The scope of this audit was to review the long-term financial planning arrangements which the Care Inspectorate has put in place to ensure financial sustainability, supporting effective planning and business decision making in the medium to long term.

In particular, the objectives of the audit were to review the current financial strategy to ensure that it is adequate and is flexible enough to address the impact of the Covid-19 pandemic to ensure that the Care Inspectorate delivers its core functions in line with the Scottish Regulators' Strategic Code of Practice and remains financially viable.

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

Strengths

- A draft Financial Strategy 2022-28, covering the financial years 2021/22 to 2027/28, was considered and approved by the Board in June 2021;
- The Financial Strategy 2022-28 was prepared against the backdrop of the Covid-19 pandemic and the ongoing uncertainty over the implications for the Care Inspectorate associated with the Adult Social Care Review (including the creation of a national care service) and the implications for delivering on the Scottish Government 'Promise' for early years and young people's services;
- The covering paper which accompanied the Financial Strategy 2022-28, clearly sets out the purpose of the financial strategy and specifically confirms that "The financial strategy is therefore a key enabler of the corporate plan", and also sets out the four financial strategy objectives which underpin the strategy;
- The importance of aligning the Financial Strategy with the overarching Corporate Plan is demonstrated by the focus around objective 4, with a clear recognition of the need to align the financial strategy with other key strategies such as the estates strategy, people strategy and digital strategy;
- The financial planning approach adopted aligns with the consistent messaging by Audit Scotland around the need to take a medium to long term view of the resources required to deliver core objectives;
- There is ongoing dialogue between the Care Inspectorate and the Sponsor Team and Health and Finance Business Partner through scheduled quarterly meetings;

The objective of this audit was to obtain reasonable assurance that:	Grade
1. The Care Inspectorate has developed a five-year financial strategy, which includes medium and long-term financial forecasts which underpin the organisation's strategic outcomes as set out in the Corporate Plan 2019 to 2022.	Good
2. The organisation is engaged with the sponsor department in Scottish Government and with other key stakeholders to help shape its financial strategy.	Good
3. Risks to the successful achievement of the financial strategy have been identified and are being managed in line with the Care Inspectorate's risk management policy.	Good
4. The strategy has been updated following an assessment of the impact of Covid-19 on financial forecasts to reflect potential changes in demand around registration, inspection and the work required to improve care standards across Scotland.	Good
5. Robust scenario planning and forecasting has been undertaken, which includes sensitivity analysis, to fully understand the impact of Covid-19 on the Care Inspectorate financial strategy.	Good
Overall Level of Assurance	**Good**

2022/03 – Financial Sustainability (Continued)

Strengths (Continued)

- Maintaining an effective dialogue with the Scottish Government through ongoing liaison meetings is listed as a specific mitigating action against Risk 2 – Financial Sustainability on the strategic risk register;
- The Financial Strategy states that the financial risks will be included in strategic, directorate, department, team and project risk registers as appropriate and monitored through existing risk management processes;
- The covering report which accompanied the draft Financial Strategy at the June 2021 Board meeting set out the policy context which the strategy should be considered within. These included expectations around social care staffing models and child contact centre regulation, the impact of the introduction of a National Care Service and also the policy implications arising from the COVID-19 pandemic;
- The Financial Strategy 2022-2028 sets out in detail the assumptions which underpin the budgeted figures for each financial year; and
- Scenario planning and sensitivity analysis has been conducted to demonstrate the impact which different levels of Grant in Aid and potential revisions in fee levels could have on budgeted income levels moving forwards. In addition, analysis of potential pay awards and changes to pension contributions has also been modelled to ensure that the impact of any potential changes in these key areas are set out at the outset.

Weaknesses

- There were no control weaknesses identified during our review

2022/05 – Fraud prevention, detection and response **Final Issued – 10 November 2021** **Overall grade: Good**

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

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

Strengths

- The Counter Fraud, Bribery and Corruption Framework was refreshed in 2020/21 and was approved by the Board in June 2021;
- The framework adopted contains a Counter Fraud, Bribery and Corruption Policy; a Counter Fraud, Bribery and Corruption Strategy; a Formal Action Policy; and a Counter Fraud Services: Financial Crime Response Plan;
- The development of the Counter Fraud, Bribery and Corruption Strategy has been informed by the Scottish Government and NHS Scotland Strategy;
- The Counter Fraud Services (CFS): Financial Crime Response Plan sets out the way in which the Care Inspectorate will work in partnership with CFS to implement, maintain and develop the Strategy and associated Financial Crime Action Plan;
- Our review of the Counter Fraud Bribery and Corruption Framework and the Customer Services Contract confirmed that, in our view, the policy and procedural framework in place is clearly set out, sufficiently detailed and is in line with good practice;
- The Counter Fraud, Bribery and Corruption Policy sets out the general responsibilities placed on all Care Inspectorate employees around reporting of suspected fraud, bribery or corruption; responsibilities around fraud awareness training; the need to comply with the financial regulations and the Procurement Policy; to record gifts and hospitality; and to make annual declarations of interest;
- The policy also sets out the role of the Counter Fraud Champion (CFC) and the Fraud Liaison Officer (FLO) explains that the Executive Director of Corporate and Customer Services is the designated CFC, and the Head of Finance and Corporate Governance is the designated Fraud Liaison Officer;

The objective of this audit was to obtain reasonable assurance that:	Grade
Fraud 1. Anti-fraud policies and procedures exist within the Care Inspectorate that are in line with best practice.	**Good**
2. Clear leadership, roles and responsibilities have been set out for implementation of the anti-fraud framework.	**Good**
3. There is a process in place to assess the nature and extent of the Care Inspectorate's exposure to potential external and internal risks of fraud.	**Good**
4. Anti-fraud policies and procedures are embedded and understood throughout the organisation through appropriate training and communication.	**Good**
5. The organisation has put in place a process to monitor and review procedures designed to prevent fraud and make improvements where necessary.	**Good**
6. There are clear procedures for employees and Board members to raise concerns or whistleblow if they believe there has been fraud or other wrongdoing within the organisation.	**Good**
7. Appropriate procedures are in place for the investigation and reporting of a fraud.	**Good**

2022/05 – Fraud prevention, detection and response (Continued)

Strengths (Continued)

- We are comfortable that the arrangements which are being developed in partnership with CFS will provide a suitable mechanism to evaluate and manage the relative risks around fraud, bribery and corruption in order to direct future fraud prevention activity efficiently and effectively. This will also allow the work of CFS to complement the work of internal audit in the future;
- The Care Inspectorate have identified procurement fraud as a high risk area and proactively compared anti-fraud arrangements with the Northern Ireland anti-fraud prevention standards;
- The organisation utilises Microsoft365 for email services, which contains a security feature called ATP which operates in a similar way to Mimecast, by employing email search and threat analysis as part of the incoming email filtering. The application and monitoring of this protection reduces, but cannot eliminate entirely, the risk of external threats which could lead to fraudulent activity by an external party;
- The Care Inspectorate website contains a dedicated Whistleblowing page with links to relevant guidance;
- The Financial Crime Action Plan describes in detail the background responsibilities and the process to be followed in circumstances where fraud or bribery is suspected;
- Anti-bribery and anti-corruption policies and procedures are enshrined within the Counter Fraud Bribery and Corruption Framework described under Objective 1, rather than as standalone documents;
- The Counter Fraud, Bribery and Corruption Policy states unequivocally that the Care Inspectorate expects all Board Members, employees and those acting as its agents to conduct themselves in accordance with the nine general principles set out in the Ethical Standards in Public Life etc. (Scotland) Act 2000;
- The Counter Fraud, Bribery and Corruption Policy states that the Audit and Risk Committee is responsible for overseeing and monitoring the effectiveness of our counter fraud, bribery and corruption arrangements; and
- The Counter Fraud, Bribery and Corruption Framework includes specific information around bribery and corruption and makes reference to the different types of crime which could be committed under the Bribery Act 2010.

The objective of this audit was to obtain reasonable assurance that:	Grade
Bribery 8. Anti-bribery and anti-corruption policies and procedures exist within the Care Inspectorate that are proportionate to the bribery risks it faces and to the nature, scale and complexity of its activities.	**Good**
9. An appropriate individual or group has been assigned to deliver the message of zero tolerance to bribery and corruption and that there is an appropriate level of involvement from senior management in the development of the bribery procedures.	**Good**
10. Bribery prevention policies and procedures are embedded and understood throughout the Care Inspectorate through internal and external communication, including an appropriate training programme.	**Good**
11. The organisation has put in place a process to monitor and review procedures designed to prevent bribery by persons associated with it and make improvements where necessary.	**Good**
Overall Level of Assurance	**Good**

2022/05 – Fraud prevention, detection and response (Continued)

Weaknesses

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

2022/07 – Equality and Diversity **Final Issued – 25 January 2022** **Overall grade: Good**

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

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.

The objective of this audit was to obtain reasonable assurance that:	Grade
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**
Overall Level of Assurance	**Good**

2022/07 – Equality and Diversity (Continued)

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.

2022/09 – Scrutiny and Assurance

Final Issued – 16 May 2022

Overall grade: Satisfactory

This audit examined the ways in which the fundamental risks which impact on the Scrutiny & Assurance function are being managed.

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

Strengths

- A new role of Service Manager – Methodology was created with a team of five supporting (and further resource planned). This role has responsibility for developing all of the quality frameworks and other tools to support scrutiny activities;
- There are a range of quality frameworks in place for children and adult Services. The quality framework for Care Homes for adults and older people has been recently updated, with extensive testing conducted and a lessons learned exercise from the COVID-19 pandemic informing the way forward;
- Lessons learned in relation to Infection Prevention and Control (IPC) have been added to the framework for care homes for adults and will be added to the other quality frameworks by July 2022;
- The core assurances have been strengthened and are now based on the Hull early indicators of concern;
- Bespoke quality frameworks are in place for Strategic Inspections, with the approach for Adult Services refined during the COVID-19 pandemic. This approach is built around national outcomes and integration principles, although it was noted that this approach has yet to be tested;
- We confirmed that there is an embedded quality framework for Adult Services with good feedback received on the implementation of the framework;
- For Justice services quality assurance arrangements are currently under review due to the Scottish Government review of the national framework for justice;
- To effectively embed protection procedures across the organisation guidance has been developed on individual responsibilities around protection. Sessions will be delivered by the Protection Group and OWD to explain how the new procedures will operate in practice;

The objective of this audit was to obtain reasonable assurance that:		Grade
1.	An effective Quality Assurance Framework is in place for scrutiny and assurance activity.	Good
2.	Child and adult protection procedures are adequately aligned to the Care Inspectorate Public Protection Policy.	Good
3.	The scrutiny and improvement methodology remains fit for purpose in meeting identified need for registration; complaints and enforcements in regulated care.	Satisfactory
4.	Progress in delivering the Involvement Strategy 2018-21 and action plan is monitored effectively and learning has been fed into the next iteration of the Strategy.	Good
5.	There are effective processes in place to ensure compliance with the Scottish Regulators Strategic Code of Practice.	Good
6.	There is an agreed approach setting out how the Care Inspectorate will engage with a range of partners to support improvement in the quality of care and support and measures are in place to demonstrate the impact of this partnership activity.	Satisfactory
Overall Level of Assurance		**Satisfactory**

2022/09 – Scrutiny and Assurance (Continued)

Strengths (Continued)

- The terms of reference for the Protection Group were reviewed in late 2021 and this allowed the focus of the group to be expanded beyond adults and regulated care services;
- A new framework is being developed for recording evidence which spans registration, complaints and enforcement activity;
- The Involvement Outcomes Action Plan 2018 – 2021 set out a programme of involvement activities over a three-year period. The delivery of the Outcomes Action Plan is monitored through regular team meeting and huddles;
- At the time of our audit fieldwork work was ongoing to co-create an interim Improvement Strategy 21-22, with Involvement and Equalities staff forming part of a multi-disciplinary team within the wider Improvement function;
- Reporting on Involvement activity occurs twice a year through the publication of the Involve magazine. In addition, updates on Involvement activity are provided quarterly through the Executive Director Report and via the Corporate Plan KPIs (Key Performance Indicators) reporting structure, which is monitored by the Board;
- The application of the Scottish regulators' strategic code of practice plays an important part in enforcement activity and therefore the need to make sure that staff understand the requirements of the Code is an integral part of induction processes;
- A list of external partners is maintained, which the Care Inspectorate engages with. This includes local authorities as well as care providers. On the instruction of Scottish Ministers, relevant bodies were instructed to come together in a National Organisations Integration Huddle. Our review of the February 2022 meeting of this Huddle demonstrates the active participation of the Care Inspectorate in engaging with a wide range of partners to progress improvement activity collaboratively; and
- A review of enforcement procedures had been undertaken and a work on developing a comprehensive revision of these was nearing completion, including a new structure to enforcement decision-making and audit of decisions taken. These also included a new level of authority for enforcement action and quality assurance of decision-making. It was also intended to strengthen executive oversight of the highest profile enforcements based on recent experience.

2022/09 – Scrutiny and Assurance (Continued)

Weaknesses

- There is a need for dedicated resource to be made available for larger more complex enforcement activity in order to ensure that there is sufficient time and space available to carry out all of the necessary background work to underpin decisions and any subsequent legal challenge or complaints raised. Input is required from the Accountable Officer in specific enforcement cases;
- The high vacancy levels have impacted on the delivery of the Inspection Plan, with a risk based approach adopted which focuses on priorities one and two. There remains a determination to ensure that the intelligence led approach is supplemented by the inspection of all services which have not been inspected in the previous two years. However, this cannot be achieved unless the true scale of the task can be estimated in order to plan and monitor the deployment of resources effectively; and
- There has been significant investment in improvement activity in recent years but there is a perception that the time is right to review the impact of this activity and to explore the potential for more targeted improvement support at Service Level to drive and sustain improvements together with the Chief Inspectors.

2022/10 – Workforce Planning

Final Issued – 12 May 2022

Overall grade: Satisfactory

The overall objective of this audit was to gain assurance that there are effective processes in place to assess the workforce needs of the organisation to meet strategic priorities and to confirm that there has been appropriate progress made against Care Inspectorate's Strategic Workforce Plan.

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

Strengths

- Despite the changing expectations, pressures, and challenges facing the organisation as a direct consequence of the COVID-19 pandemic, some progress was achieved in delivering the 2019-2022 Strategic Workforce Plan;
- Good progress was made in relation to Objective 1 - Attract and retain people with talent and experience from a range of sectors and all walks of life. Actions completed were reflective of the environment for which staff were operating at that time. For example, improved recruitment frameworks, supporting the workforce and implementing a coaching framework, building of Quality Improvement capacity, joint working with the trade unions, and improved induction programmes, and achieved Bronze in the Stonewall LBGT+ Charter;
- There is an operational framework for monitoring current under or over utilisation of staff. A monthly staffing meeting involving Human Resource (HR), Finance, the Scrutiny and the Assurance management team and planning team takes place to review staffing levels, planned, and anticipated vacancies, and sickness absence levels. The group monitor capacity to anticipate future challenges and risks;
- The current strategic workforce plan includes a range of metrics designed to monitor and report on progress against the action plan. The current corporate plan (2019 – 2022) includes two relevant Key Performance Indicators (KPIs). These are frequently reviewed by management and reported to the Board via Performance Reports; and
- Given management business continuity arrangements, we have identified the succession planning arrangements as reasonable while acknowledging work is in progress to establish a formal succession planning framework and process under the revised Strategic Workforce Plan 2022-2025 that is to be approved during 2022.

The objective of this audit was to obtain reasonable assurance that:	Grade
1. Appropriate progress has been made against the Care Inspectorate's Strategic Workforce Plan.	Satisfactory
2. There is appropriate management information and Board oversight to identify areas of potential under or over-utilisation of staff, including the use of capacity tools, and proportionate action is taken where any such instances are identified.	Satisfactory
3. Workforce management performance metrics are in place to identify emerging workforce challenges and risks and to address them in a way which supports achievement of strategic and operational objectives.	Satisfactory
4. Appropriate succession planning arrangements are in place for key members of staff.	Good
Overall Level of Assurance	**Satisfactory**

2022/10 – Workforce Planning (Continued)

Weaknesses

- There was absence of progress reporting on the Strategic Workforce Plan to the SLT and Board over 2021/22.The Board's forward planning also noted absence of reporting of the draft Strategic Workforce Plan or progress reports over 2022 to ensure their awareness of arrangements and to set expectations for delivery;
- Assurance reporting on staff utilisation should also be provided to the Board, or its relevant sub-committee, for scrutiny and review of any issues, risks, and action planning; and
- Management should consider metrics relating to staff retention such as attrition and turnover, retention rates, time to hire and tenure rates, as well as internal mobility rates to allow for trend analysis and timely identification of challenges and actions.

2022/11 – Corporate Planning **Final Issued – 13 May 2022** **Overall grade: Good**

Strengths

- In order to ensure alignment with the ambitions of the Scottish Government, two separate meetings were held with the Scottish Government Sponsor Branch to discuss the general priorities described in the new Corporate Plan 2022 – 2025 and the alignment with the future direction of travel for the care sector in Scotland;
- A Corporate Plan Consultative Group was in place and this allowed input from a variety of stakeholders from all Directorates around the content and format of the Corporate Plan;
- Consultation was also held with our Inspection Volunteers and a number of external stakeholders to ensure that it reflected the entirety of the Care Inspectorate's work;
- The Corporate Plan 2022 makes specific reference to the National Performance Framework and sets out the way in which the Care Inspectorate will aim to support the achievement of national outcomes over the next three years;
- Work to develop the more detailed operational plans, which will underpin the Corporate Plan 2022 – 2025, commenced in late March 2022, immediately after approval;
- The Head of Corporate Policy and Communications demonstrated a comprehensive understanding of the need for further work in this area to ensure that there is clarity in the messaging across the organisation regarding the way in which operational activity at Directorate or team level contributes to the delivery of the four strategic outcomes set out in the Corporate Plan 2022 – 2025;
- Key priorities are set out for each of the four strategic outcomes in the Corporate Plan 2022 – 2025 and these are supported by tailored KPIs and KOIs;
- The Corporate Plan 2022 – 2025 lists the key plans and strategies which will help the Care Inspectorate deliver on the agreed key priorities;
- The draft Corporate Plan 2022 – 2025 was presented to the December 2021 meeting of the Board to capture feedback and to enhance ownership of the key priorities set out within the Plan and the performance measures designed to track delivery;

The objective of this audit was to obtain reasonable assurance that:	Grade
1. The Corporate Plan is aligned with the ambitions and aims of the sponsor department within the Scottish Government and is therefore aligned with the future direction of travel set out for the care sector in Scotland.	Good
2. Linkages between the Corporate Plan and operational plans are clearly defined and communicated across the organisation	Good
3. Operational planning effectively supports the achievement of the strategic outcomes in the Corporate Plan.	Good
4. Delivery of the Corporate Plan and the supporting key strategies, plans and programmes is appropriately monitored.	Good
5. There is effective linkage between planning and financial budgeting at all levels.	Good
Overall Level of Assurance	**Good**

2022/11 – Corporate Planning (Continued)

Strengths (Continued)

- Work was ongoing at the time of our audit to develop targets for the KPIs and KOIs. Once these are developed this will allow quarterly reporting to the Board to compare the actual position against the target position; and
- The Accounting and Procurement Manager was represented on the Corporate Plan Consultative Group and we were advised that work has already commenced to consider how the 2023/24 budget will connect to the Corporate Plan 2022 – 25

Weaknesses

Although a number of pieces of work still require to be completed to embed actions to deliver the key priorities at Directorate and Team level, and to agree on targets for the KPIs and KOIs in the Corporate Plan 2022 – 2025, these are issues which have already been identified by management and plans are already in place to address them. Therefore there are no control weaknesses identified from our review.

2022/04, 2022/06, 2022/08, and 2022/12 – Follow Up Reviews

Final Issued – August 2021, November 2021, February 2022, May 2022

The Internal Audit Plan for 2021/22 included time for a follow-up of the recommendations made in Internal Audit reports issued during 2021/22 and reports from earlier years where previous follow-up identified recommendations as outstanding. This work was reported at each meeting of the Audit and Risk Committee. The objective of each of our follow-up reviews was to assess whether recommendations made in previous reports had been appropriately implemented and to ensure that, where little or no progress had been made towards implementation, that plans were in place to progress them.

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

CI had made good progress in implementing the recommendations followed-up during the year, with 11 of the 15 recommendations reviewed categorised as ‘fully implemented’ by May 2022. Four recommendations were assessed as ‘partially implemented’ at May 2022. Revised dates have been agreed to provide a target for full implementation of the four outstanding recommendations.

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

From Original Reports			*From Follow-Up Work Performed*				
Area	Rec. Priority	Number Agreed	Fully Implem-ented	Partially Implem-ented	Little or No Progress Made	Not Past Agreed Completion Date	Considered But Not Implemented
Follow Up Review 2019/20	1	-	-	-	-	-	-
	2	2	2	-	-	-	-
	3	2	1	1	-	-	
Total		**4**	**3**	**1**	**-**	**-**	**-**
Recruitment and Retention 2019/20	1	-	-	-	-	-	-
	2	1	1	-	-	-	-
	3	1	-	1	-	-	-
Total		**2**	**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, Detection and Response	1	-	-	-	-	-	-
	2	-	-	-	-	-	-
	3	1	1	-	-	-	-
Total		**1**	**1**	**-**	**-**	**-**	**-**
Grand Totals		**15**	**11**	**4**	**-**	**-**	**-**

Time Spent - Actual v Budget 2021/22

	Report number	Planned days	Actual days billed	Days to fee at May 2022	Days to spend / WIP	Variance
Operations						
Scrutiny & Assurance	2022/09	6	-	6	-	-
Staffing Issues						
Workforce planning	2022/10	5	-	5	-	-
Financial Issues						
Financial sustainability	2022/03	6	6	-	-	-
Fraud prevention, detection and response	2022/05	5	5	-	-	-
Organisational Issues						
Compliance with legislation	2022/02	4	4	-	-	-
Corporate planning	2022/11	5	-	5	-	-
Equality and Diversity	2022/07	5	5	-	-	-
Information and IT						
IT Strategy	N/A	6	-	-	-	6
Other Audit Activities						
Management and Planning	2022/01	4	3	1	-	-
Follow-up Reviews	2022/04, 2022/06, 2022/08 & 2022/12	5	4	1	-	-
Total		**51**	**27**	**18**	**-**	**6**

Operational Plan for 2022/23

5.1 Following our appointment as internal auditors for the period 1 April 2020 to 31 March 2023, with the option to extend for a further two 12-month periods, we prepared an Audit Needs Assessment and Strategic Plan for 2020 to 2023 (internal audit report number 2021/03, issued July 2020).

5.2 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.

5.3 An extract from the revised Operational Plan, in relation to 2022/23, is shown below.

Approved Allocation of Audit Days

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

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

Key

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

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

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN — T: 01224 322 100 — F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB — T: 01382 200 055 — F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF — T: 0131 226 0200 — F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP — T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 10
Report No: ARC-12-2022

Title:	**COVER REPORT: INTERNAL AUDIT ON WORKFORCE PLANNING**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Workforce Planning
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:	
The internal audit report on Workforce Planning is attached as Appendix 1. The overall level of assurance is "Satisfactory". There were four internal audit objectives and assurance of "Satisfactory" was provided against three of these objectives with the fourth objective being "Good". Three priority 3 recommendation were made. All three recommendations will be taken forward by management within the timescale indicated in the management responses.	
The Committee is invited to:	
1.	Accept the Internal Auditor's report on Workforce Planning.

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:

Agenda item 10
Report No: ARC-12-2022

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
Satisfactory

Care Inspectorate

Workforce Planning

Internal Audit report No: 2022/10

Draft issued: 11 May 2022

2nd Draft issued: 12 May 2022

Final issued: 12 May 2022

Henderson Loggie

Contents

		Page
Section 1	**Management Summary**	
	• Overall Level of Assurance	1
	• Risk Assessment	1
	• Background	1
	• Scope, Objectives and Overall Findings	2
	• Audit Approach	2
	• Summary of Main Findings	3
	• Acknowledgements	3
Section 2	**Main Findings and Action Plan**	**4 - 11**

Level of Assurance

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

Gradings are defined as follows:

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

Action Grades

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

Management Summary

Overall Level of Assurance

Satisfactory	System meets control objectives with some weaknesses present.

Risk Assessment

This review focused on the controls in place to mitigate the following risks on the Care Inspectorate Strategic Risk Register:

- Risk number 1 – Delivery of Strategy (residual risk score: 8)
- Risk number 3 – Workforce Capacity (residual risk score: 6)

Background

As part of the Internal Audit programme at the Care Inspectorate for 2021/22 we carried out a review of the Workforce Planning within the organisation.

The Audit Needs Assessment (ANA) identified this as an area where risk can arise and where Internal Audit can assist in providing assurances to the Board and the Chief Executive that the related control environment is operating effectively, ensuring risk is maintained at an acceptable level.

The Care Inspectorate's Strategic Workforce Plan 2019-2022 was approved by the Board in June 2019 and published in November 2019 after taking on board feedback from the Senior Management Team, Executive Group, the Board, and Partnership Forum.

The current approach to workforce planning is structured against a range of short-, medium-, and long-term activities as follows:

- Short term operational planning relating to capacity planning against operational plans, headcount projections and staffing requirements, and recruitment;
- Medium term annual planning relating to staffing requirements to deliver plans or programmes, annual budget setting, review of Learning and Development priorities, performance management arrangements, recruitment planning
- Longer term, three-year strategic planning in relation to aligning staffing to corporate planning and priorities and workforce skill development.

Management are currently in the process of developing the 2022-2025 Strategic Workforce Plan and have supporting methodology and timescale established for its delivery in September to October 2022. Activities to support its development include management reviewing the Care Inspectorates workforce profile and operating environment, defining future needs in alignment to the Corporate Plan 2022-2025, identifying gaps and actions to address issues identified, and consult on the draft plan. A stakeholder plan and governance framework is also established.

This audit examined the progress made in delivering the objectives set out in the Care Inspectorate's Strategic Workforce Plan 2019-2022. We also examined the way in which future workforce needs are assessed and then built into succession planning arrangements, training, and development activity and financial plans.

Scope, Objectives and Overall Findings

The overall objective of this audit was to gain assurance that there are effective processes in place to assess the workforce needs of the organisation to meet strategic priorities and to confirm that there has been appropriate progress made against Care Inspectorate's Strategic Workforce Plan.

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**	**Actions already in progress**
		No. of Agreed Actions			
1. Appropriate progress has been made against the Care Inspectorate's Strategic Workforce Plan	**Satisfactory**	0	0	1	✓
2. There is appropriate management information and Board oversight to identify areas of potential under or over-utilisation of staff, including the use of capacity tools, and proportionate action is taken where any such instances are identified	**Satisfactory**	0	0	1	✓
3. Workforce management performance metrics are in place to identify emerging workforce challenges and risks and to address them in a way which supports achievement of strategic and operational objectives	**Satisfactory**	0	0	1	✓
4. Appropriate succession planning arrangements are in place for key members of staff.	**Good**	0	0	0	✓
Overall Level of Assurance	**Satisfactory**	**0**	**0**	**3**	
		System meets control objectives with some weaknesses present.			

Audit Approach

Human Resources, OWD, and other relevant staff were interviewed, and relevant documentation was be reviewed to obtain evidence that the above objectives are being met.

Summary of Main Findings

Strengths

- Despite the changing expectations, pressures, and challenges facing the organisation as a direct consequence of the COVID-19 pandemic, some progress was achieved in delivering the 2019-2022 Strategic Workforce Plan;
- Good progress was made in relation to Objective 1 - Attract and retain people with talent and experience from a range of sectors and all walks of life. Actions completed were reflective of the environment for which staff were operating at that time. For example, improved recruitment frameworks, supporting the workforce and implementing a coaching framework, building of Quality Improvement capacity, joint working with the trade unions, and improved induction programmes, and achieved Bronze in the Stonewall LBGT+ Charter;
- There is an operational framework for monitoring current under or over utilisation of staff. A monthly staffing meeting involving Human Resource (HR), Finance, the Scrutiny and the Assurance management team and planning team takes place to review staffing levels, planned, and anticipated vacancies, and sickness absence levels. The group monitor capacity to anticipate future challenges and risks;
- The current strategic workforce plan includes a range of metrics designed to monitor and report on progress against the action plan. The current corporate plan (2019 – 2022) includes two relevant Key Performance Indicators (KPIs). These are frequently reviewed by management and reported to the Board via Performance Reports; and
- Given management business continuity arrangements, we have identified the succession planning arrangements as reasonable while acknowledging work is in progress to establish a formal succession planning framework and process under the revised Strategic Workforce Plan 2022-2025 that is to be approved during 2022.

Weaknesses

- There was absence of progress reporting on the Strategic Workforce Plan to the SLT and Board over 2021/22.The Board's forward planning also noted absence of reporting of the draft Strategic Workforce Plan or progress reports over 2022 to ensure their awareness of arrangements and to set expectations for delivery;
- Assurance reporting on staff utilisation should also be provided to the Board, or its relevant sub-committee, for scrutiny and review of any issues, risks, and action planning; and
- Management should consider metrics relating to staff retention such as attrition and turnover, retention rates, time to hire and tenure rates, as well as internal mobility rates to allow for trend analysis and timely identification of challenges and actions.

Acknowledgment

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

Main Findings and Action Plan

Objective 1: Appropriate progress has been made against the Care Inspectorate's Strategic Workforce Plan

Workforce planning is a process of analysing the current workforce, determining future workforce needs, identifying gaps between the workforce currently available and the future needs of the Care Inspectorate, and implementing solutions to that the Care Inspectorate can accomplish its mission, goals, and Corporate Plan. This is not a linear process, but one that is iterative requires review and monitoring to ensure there is the right people with the right skills at the right time and cost.

As noted earlier, the Care Inspectorate has a Workforce Strategic Plan 2019-2022 established and is in the process of reviewing this plan for the period 2022-2025 to align to its newly published Corporate Plan 2022-2015. Our review of the steps to be taken for this review noted it is in line with good practice as set by the CIPD.

Our current audit reviewed the progress made against the current Strategic Workforce Plan that was published in November 2019. The plan set six priorities as follows:

1. Attract and retain people with talent and experience from a range of sectors and all walks of life
2. Build career paths that encourage a breadth of experience and depth of expertise
3. Develop confidence and skilled leaders who are inspiring and empower others
4. Aim to be an inclusive employer of choice with effective systems to support talent management and progression
5. Develop cost-effective and flexible reward structures that support the organisation to attract, retain, and develop the very best talent, and
6. Strive to create a healthy working environment and actively encourage health working lives to enable their staff to flourish and achieve their full potential for the benefit of themselves and the organisation.

Under these priorities, the organisation set 42 objectives for delivery over the three-year period. A framework was established to review delivery on a quarterly basis by management and it was initially agreed that an annual progress report be submitted to the Board and the Senior Leadership Team (SLT) in December/ January each year.

However, these priorities and objectives were set before the COVID-19 pandemic that consequently impacted on management priorities and capacity. Management reported that work became more reactive in response to the emerging crisis with resources frequently assigned to new or changing priorities. This resulted in reduced capacity to deliver the Strategic Workforce Plan and more sporadic delivery of the plan that would normally be the case. With management reprioritisation, reporting on progress was also impacted and SLT agreed to delay 2020 reporting to a more appropriate time.

Workforce Planning

Objective 1: Appropriate progress has been made against the Care Inspectorate's Strategic Workforce Plan (Continued)

Despite the changing expectations, pressures and challenges facing the organisation as a direct consequence of the COVID-19 pandemic, some progress was achieved in delivering the 2019-2022 Strategic Workforce Plan. Progress of the actions are monitored by the Head of Organisation & Workforce Development. Review of the latest paper to the SLT noted the following:

- 16 (38%) actions have been completed;
- 11 (26%) actions are in progress; and,
- 15 (26%) actions have been delayed.

Closer review noted good progress was made in relation to Objective 1 and actions completed were reflective of the environment for which staff were operating, such as recruitment, supporting the workforce and implementing a coaching framework, building of Quality Improvement capacity, joint working with the trade unions, and improved induction programmes, and achieved Bronze in the Stonewall LBGT+ Charter. Delayed objectives relating to developing confident and skilled leaders, career paths, inclusion initiatives, and review of pay and grading structures and retention strategies will be reviewed in context of the Care Inspectorate's new operating environment, revised Corporate Plan, and new Strategic Workforce Plan during 2022.

By way of context, it is important to note that there have been a number of vacant posts within the OWD function, and we were advised that business case had been submitted for the recruitment of a Senior OWD Business partner which will add additional expertise around strategic delivery.

Workforce Planning

Objective 1: Appropriate progress has been made against the Care Inspectorate's Strategic Workforce Plan (Continued)				
Observation	**Risk**	**Recommendation**	**Management Response**	
There was absence of progress reporting on the Strategic Workforce Plan to the SLT and Board over 2021/22. Review of the Care Inspectorate's Board Forward Plan from March 2022 minutes published on the public website also noted absence of the review on the new Strategic Workforce Plan during 2022. There is also absence of planning of reporting progress of its implementation.	Board's awareness to the risks to delivering the Strategic Workforce Plan and therefore its new Corporate Plan.	**R1** Progress reports on the implementation of the Strategic Workforce Plan should be provided to the SLT and Board, either directly or via the relevant sub-Committee, at least on an annual basis. The Board's forward plan should document when the draft Strategic Workforce Plan is to be reviewed and reference an annual review of progress made in delivering the plan.	The original delivery of the Strategic Workforce Plan included a commitment to report annually to Strategic Leadership Team, the Board and Audit and Risk Committee. Due to Covid-19 pressures this was not implemented as planned. This commitment will be implemented as part of the new Strategic Workforce Plan with timescales for monitoring and reporting on progress and delivery. **To be actioned by:** Head of OWD **No later than:** 31 December 2022	
			Grade	**3**

Workforce Planning

Objective 2: There is appropriate management information and Board oversight to identify areas of potential under or over-utilisation of staff, including the use of capacity tools, and proportionate action is taken where any such instances are identified

Operationally, we noted arrangements from the monitoring of current under or over utilisation is established. A monthly staffing meeting involving Human Resource (HR), Finance, the Scrutiny and the Assurance management team and planning team takes place to review staffing levels, planned, and anticipated vacancies, and sickness absence levels. The group monitor capacity to anticipate future challenges and risks. They also plan recruitment and targeted recruitment activities and timescales.

The Head of HR also meets with the Chief Inspectors every 6 weeks to discuss recruitment plans, staffing, and employee relations or capacity issues.

There is a capacity management tool in place for all inspection teams. The tool is used by inspection staff to capture inspection activity, sick leave, and other staff activities e.g., development time (70 hours pa), one to one meetings and team meetings (one day per month) and admin (two days per month). Data from the tool is monitored monthly and reported to the Scrutiny and Assurance management team. This information is used to inform anticipated recruitment requirements.

Inspection of quarterly performance reporting in March 2022 noted the Board does have awareness of current risks and issues. For example, the Board receives frequent performance reports relating to information on staff absences and level of investment in learning and development for staff. the percentage of staff absences and level of investment in learning and development. Updates on recruitment projects and other programmes from the Strategic Workforce Strategy are also reported via the Chief Executive's Report.

This is an area that management are aware is to be improved. The HR team are planning to provide quarterly reports to SLT on absence, turnover, vacancies, temporary staff from June 2022.

The review of the Strategic Workforce Plan will also include a more detailed review of workforce capacity and over/ under utilisation through production of a thematic workforce profile and analysis. This should provide a detailed analysis of the under or over utilisation across the organisation. However, consideration will then be made on then aligning current utilisation to future needs. This is to be completed by management review of emerging themes from the employee survey, align workforce needs from a gap analysis against the corporate plan, and review of the external operating environment. A joint strategic/ operational leadership team meeting is scheduled for Summer 2022 to allow for further work to be completed in response to the employee survey action plan. Using the recent employee survey results to understand key challenges reported by staff will support a robust process and more informed discussion by SLT/OLT. This review work was underway at the time of our audit.

Workforce Planning

Objective 2: There is appropriate management information and Board oversight to identify areas of potential under or over-utilisation of staff, including the use of capacity tools, and proportionate action is taken where any such instances are identified (Continued)			
Observation	**Risk**	**Recommendation**	**Management Response**
The governance arrangements for reporting on staff utilisation should be established and agreed with the Board or relevant sub-committee to ensure at least annual review by members. We were unable to evidence a specific report on staff under or over utilisation to the Board over the last 12 months. This was mainly due to the HR Report due for reporting in December 2021 being delayed until June 2022 due to changes in the team's management structure during Quarter 1 2022.	Timely support and decision making by the Board on issues relating to staff utilisation and risks to delivery of the Strategic Workforce Plan.	**R2** Assurance reporting on staff utilisation should also be provided to the Board or its relevant sub-committee for scrutiny and review of any issues, risks, and action planning.	Staff utilisation will be a key quality assurance priority for the Audit and Risk Committee and form part of a scheduled timescale of reporting. This will be a shared organisational responsibility between Scrutiny and Assurance and Corporate and Customer Services directorates. **To be actioned by:** Head of Human Resources and Head of Finance and Corporate Governance **No later than:** 31 October 2022 **Grade** **3**

Workforce Planning

Objective 3: Workforce management performance metrics are in place to identify emerging workforce challenges and risks and to address them in a way which supports achievement of strategic and operational objectives

The current strategic workforce plan includes a range of metrics designed to monitor and report on progress against the action plan. The current corporate plan (2019 – 2022) includes two relevant Key Performance Indicators (KPIs), as summarised below:

- KPI 4: % staff absence 4.1% (Target 3.6%: Range 2.4% to 5.7%)
- KPI 6: Level of investment in learning and development for our workforce 3.6 hours on average per employee (Benchmark 3.0 hour).

These are frequently reviewed by management and reported to the Board via Performance Reports.

The new corporate plan (2022 – 2025) includes a strategic objective specifically focussing on the Care Inspectorate's workforce titled 'Our people are skilled, confident, and well supported to carry out their roles'. Our review noted a range of new and updated quantitative and qualitative metrics have been established to support effective monitoring and reporting as follows:

- Percentage of staff completing core learning.
- Percentage staff experiencing/making positive change as a result of development input.
- Percentage of internal and external candidates reporting a positive recruitment experience.
- Percentage of volunteers that describe an inclusive experience when working with the Care Inspectorate.

Staff absence and "Days per quarter that inspection volunteers and care experienced people are involved in our work" will also be monitored. The targets were still to be agreed, however the purposes and timescales for their development had been established. As management develop the new plan and performance indicators, they should be aware of setting realistic targets and expectations given the ongoing pandemic and wider social economic issues.

Workforce Planning

Objective 3: Workforce management performance metrics are in place to identify emerging workforce challenges and risks and to address them in a way which supports achievement of strategic and operational objectives (Continued)				
Observation	**Risk**	**Recommendation**	**Management Response**	
Acknowledging the work in progress to revise the Strategic Workforce Plan and related performance indicators, we noted absence of workforce performance indicators relating to attrition and turnover, retention rates, time to hire and tenure rates, as well as internal mobility rates.	Challenges in relation to staff retention are not identified on a timely basis.	**R3** Management should consider metrics relating to staff retention such as attrition and turnover, retention rates, time to hire and tenure rates, as well as internal mobility rates to allow for trend analysis and timely identification of challenges and actions.	Reporting: Work is ongoing to provide quarterly reports to the Senior Leadership Team on absence, turnover, vacancies, temporary staff from June 2022. The Corporate Plan (2022-2025) performance framework has two metrics aligned to attrition and turnover of the organisational workforce. Strategic Workforce Plan: We will review our approach to monitoring this data to ensure we have a robust approach to identify emerging workforce challenges and risks as well as understand the impact of interventions taken to address these risks in the short, medium, and long term. **To be actioned by:** Head of Human Resources and Head of OWD **No later than:** 31 August 2022	
			Grade	**3**

Workforce Planning

Objective 4: Appropriate succession planning arrangements are in place for key members of staff.

Work started in 2020 to develop succession planning for business-critical roles. The original timeline noted two phased of identifying key roles and a talent pool over 2020. However, this work was delayed due to the COVID-19 pandemic.

As part of business continuity arrangements, however, management identified business critical roles and agree short term successor/ cover arrangements to provide continuity in the event of extended staff absence or during recruitment where existing postholders have left employment.

Succession planning will be progressed as part of the delivery of the new strategic workforce plan. Given management business continuity arrangements, we have identified the arrangements as reasonable while acknowledging work is in progress to establish a formal succession planning framework and process.

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN T: 01224 322 100 F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB T: 01382 200 055 F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF T: 0131 226 0200 F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 11
Report No: ARC-13-2022

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

Executive Summary:	
The internal audit report on Scrutiny and Assurance is attached as Appendix 1. The overall level of assurance is "Satisfactory". There were six internal audit objectives and assurance of "Satisfactory" was provided against two of these objectives with the remaining four objectives rated as "Good". Three priority 3 recommendation were made. All three recommendations will be taken forward by management within the timescale indicated in the management responses.	
The Committee is invited to:	
1.	Accept the Internal Auditor's report on Scrutiny and Assurance.

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:

Agenda item 11
Report No: ARC-13-2022

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
Satisfactory

Care Inspectorate

Scrutiny and Assurance

Internal Audit report No: 2022/09

Draft issued: 11 May 2022

Final issued: 16 May 2022

Henderson Loggie

Contents

		Page
Section 1	**Management Summary**	
	• Overall Level of Assurance	1
	• Risk Assessment	1
	• Background	1
	• Scope, Objectives and Overall Findings	2
	• Audit Approach	2
	• Summary of Main Findings	3 - 4
	• Acknowledgements	4
Section 2	**Main Findings and Action Plan**	**5 - 13**

Level of Assurance

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

Gradings are defined as follows:

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

Action Grades

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

Management Summary

Overall Level of Assurance

Satisfactory	System meets control objectives with some weaknesses present.

Risk Assessment

This review focused on the controls in place to mitigate the following risks on the Care Inspectorate Strategic Risk Register:

- Risk number 1 – Delivery of Strategy (residual risk score: 8)
- Risk number 3 – Workforce Capacity (residual risk score: 6)
- Risk number 4 – Partnership Working (residual risk score: 8)

Background

As part of the Internal Audit programme at the Care Inspectorate for 2021/22 we carried out a review of the Scrutiny and Assurance function within the organisation. This is a collective term for the areas of:

- Registration;
- Complaints; and
- Enforcement (Regulated Care)

The Audit Needs Assessment (ANA) identified this as an area where risk can arise and where Internal Audit can assist in providing assurances to the Board and the Chief Executive that the related control environment is operating effectively, ensuring risk is maintained at an acceptable level.

In developing the ANA the specific areas identified for internal audit scrutiny were around performance management, capacity planning (including challenges around recruitment, retention and succession planning), staff development.

This review has been conducted against a backdrop of significant change and heightened political and media interest in the activity of Scrutiny and Assurance throughout the COVID-19 pandemic.

In accordance with Section 54 of the Public Services Reform (Scotland) Act 2010 (the 2010 Act), the Care Inspectorate must prepare a plan for carrying out inspections in line with best regulatory practice and the agreed budget. The agreed plan must set out arrangements for inspections to be carried out (including inspections of those services subject to self-evaluation). It may make different provision for different purposes. In preparing the plan, the Care Inspectorate must have due regard to guidance issued by the Scottish Ministers. The plan is kept under review and is revised periodically to reflect new and emerging risks. Ministerial approval is required for this plan and any updates made to the plan after initial approval. Scottish Ministers approved the Scrutiny, Assurance, and Improvement Plan for 2020-21 in February 2020. A revised plan for 2020-21 was submitted for consideration in October 2020 which outlined the way in which the Care Inspectorate planned to respond effectively to the Covid-19 pandemic. Scottish Ministers approved this updated plan in November 2020.

This Scrutiny and Assurance Plan for 2021/22 was published in August 2021 and takes cognisance of the accumulated knowledge developed over the preceding 12 months, including revised approaches to scrutiny and assurance developed during the pandemic.

Scope, Objectives and Overall Findings

This audit examined the ways in which the fundamental risks which impact on the Scrutiny & Assurance function are being managed.

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

Objective	Findings				Actions already in progress
The objective of our audit was to ensure that:		**1**	**2**	**3**	
		No. of Agreed Actions			
1. An effective Quality Assurance Framework is in place for scrutiny and assurance activity.	**Good**	0	0	0	✓
2. Child and adult protection procedures are adequately aligned to the Care Inspectorate Public Protection Policy.	**Good**	0	0	0	✓
3. The scrutiny and improvement methodology remains fit for purpose in meeting identified need for registration; complaints and enforcements in regulated care.	**Satisfactory**	0	0	2	
4. Progress in delivering the Involvement Strategy 2018-21 and action plan is monitored effectively and learning has been fed into the next iteration of the Strategy.	**Good**	0	0	0	
5. There are effective processes in place to ensure compliance with the Scottish Regulators Strategic Code of Practice.	**Good**	0	0	0	✓
6. There is an agreed approach setting out how the Care Inspectorate will engage with a range of partners to support improvement in the quality of care and support and measures are in place to demonstrate the impact of this partnership activity.	**Satisfactory**	0	0	1	✓
Overall Level of Assurance	**Satisfactory**	**0**	**0**	**3**	
		System meets control objectives with some weaknesses present.			

Audit Approach

Through interviews with the Executive Director of Scrutiny and Assurance, and other key staff who are involved in the management and operation of the Scrutiny and Assurance function, we assessed the extent to which the above objectives were being met.

Summary of Main Findings

Strengths

- A new role of Service Manager – Methodology was created with a team of five supporting (and further resource planned). This role has responsibility for developing all of the quality frameworks and other tools to support scrutiny activities;
- There are a range of quality frameworks in place for children and adult Services. The quality framework for Care Homes for adults and older people has been recently updated, with extensive testing conducted and a lessons learned exercise from the COVID-19 pandemic informing the way forward;
- Lessons learned in relation to Infection Prevention and Control (IPC) have been added to the framework for care homes for adults and will be added to the other quality frameworks by July 2022;
- The core assurances have been strengthened and are now based on the Hull early indicators of concern;
- Bespoke quality frameworks are in place for Strategic Inspections, with the approach for Adult Services refined during the COVID-19 pandemic. This approach is built around national outcomes and integration principles, although it was noted that this approach has yet to be tested;
- We confirmed that there is an embedded quality framework for Adult Services with good feedback received on the implementation of the framework;
- For Justice services quality assurance arrangements are currently under review due to the Scottish Government review of the national framework for justice;
- To effectively embed protection procedures across the organisation guidance has been developed on individual responsibilities around protection. Sessions will be delivered by the Protection Group and OWD to explain how the new procedures will operate in practice;
- The terms of reference for the Protection Group were reviewed in late 2021 and this allowed the focus of the group to be expanded beyond adults and regulated care services;
- A new framework is being developed for recording evidence which spans registration, complaints and enforcement activity;
- The Involvement Outcomes Action Plan 2018 – 2021 set out a programme of involvement activities over a three-year period. The delivery of the Outcomes Action Plan is monitored through regular team meeting and huddles;
- At the time of our audit fieldwork work was ongoing to co-create an interim Improvement Strategy 21-22, with Involvement and Equalities staff forming part of a multi-disciplinary team within the wider Improvement function;
- Reporting on Involvement activity occurs twice a year through the publication of the Involve magazine. In addition, updates on Involvement activity are provided quarterly through the Executive Director Report and via the Corporate Plan KPIs (Key Performance Indicators) reporting structure, which is monitored by the Board;
- The application of the Scottish regulators' strategic code of practice plays an important part in enforcement activity and therefore the need to make sure that staff understand the requirements of the Code is an integral part of induction processes;
- A list of external partners is maintained, which the Care Inspectorate engages with. This includes local authorities as well as care providers. On the instruction of Scottish Ministers, relevant bodies were instructed to come together in a National Organisations Integration Huddle. Our review of the February 2022 meeting of this Huddle demonstrates the active participation of the Care Inspectorate in engaging with a wide range of partners to progress improvement activity collaboratively; and
- A review of enforcement procedures had been undertaken and a work on developing a comprehensive revision of these was nearing completion, including a new structure to enforcement decision-making and audit of decisions taken. These also included a new level of authority for enforcement action and quality assurance of decision-making. It was also intended to strengthen executive oversight of the highest profile enforcements based on recent experience.

Summary of Main Findings (Continued)

Weaknesses

- There is a need for dedicated resource to be made available for larger more complex enforcement activity in order to ensure that there is sufficient time and space available to carry out all of the necessary background work to underpin decisions and any subsequent legal challenge or complaints raised. Input is required from the Accountable Officer in specific enforcement cases;
- The high vacancy levels have impacted on the delivery of the Inspection Plan, with a risk based approach adopted which focuses on priorities one and two. There remains a determination to ensure that the intelligence led approach is supplemented by the inspection of all services which have not been inspected in the previous two years. However, this cannot be achieved unless the true scale of the task can be estimated in order to plan and monitor the deployment of resources effectively; and
- There has been significant investment in improvement activity in recent years but there is a perception that the time is right to review the impact of this activity and to explore the potential for more targeted improvement support at Service Level to drive and sustain improvements together with the Chief Inspectors.

Acknowledgment

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

Main Findings and Action Plan

Objective 1: An effective Quality Assurance Framework is in place for scrutiny and assurance activity.

The Scrutiny & Assurance Directorate assumed responsibility for methodology from the Strategy & Improvement Directorate in February 2021. A new role of Service Manager – Methodology was created with a team of five inspectors supporting (and further resource planned up to six inspectors). This role has responsibility for developing all of the quality frameworks. This includes inspection notebooks and report templates. The focus for the last year has been on regulated activities with a particular focus on adults. This has led to a review of frameworks based on the learning from the COVID-19 pandemic.

For Children and Young People one of the key drivers around quality assurance is The Promise, which impacts on the 'Quality Framework Children and Young People in Need of Care and Protection, which was revised in August 2019. Part of the promise has a specific focus on listening and acting upon what children and young people tell bodies such as the care inspectorate. This has been particularly pertinent in investigating historic child abuse cases in residential schools and the methodology is being looked at to ensure that this remains fit for purpose around foster care. The review of the methodology is designed to ensure that any changes made do not undermine quality whilst remaining responsive to the needs of Children and young people.

The draft quality framework developed for Early Learning and Childcare (ELC), School Age Children and Childminders was issued in March 2021. It was published on 22 March 2022 following extensive testing and will be formally launched on 1 June 2022. The testing undertaken on the new quality framework means that there is more clarity around expectations. There is uncertainly around where ELC will sit in future with the outcome of a Scottish Government consultation dictating the direction of travel for the new inspection body for the 2023/23 shadow year. There is a proposal for a single / shared inspection framework for ELC.

There are a range of quality frameworks in place for Adult Services. The quality framework for Care Homes for adults and older people has been recently updated, with extensive testing conducted and a lessons learned exercise from the COVID-19 pandemic informing the way forward. This testing included input from Nurse Directors and this also informed the development of a self-evaluation toolkit. Lessons learned in relation to Infection Prevention and Control (IPC) will be added to the other quality framework by July 2022. The core assurances have been strengthened and are now based on Hull early indicators of concern . This has led to the development of key questions which are then supplemented by supplementary intelligence-led questions. This assessment framework is designed to achieve consistency of questioning and lines of enquiry for care homes, with work planned to apply this approach to other settings in future.

Bespoke quality frameworks are in place for Strategic Inspections, with the approach for Adult Services refined during the COVID-19 pandemic. This approach is built around national outcomes and integration principles, although it was noted that this approach has yet to be tested. The framework will be utilised during 2022 across a range of settings, with the initial focus around physical disabilities and the 2023 focus shifting to mental health.

We confirmed that there is an embedded quality framework for Adult Services with good feedback received on the implementation of the framework. Six core questions are set out in the quality framework, with quality indicators underpinning these questions. Some of these indicators have been prioritised for Inspectors to focus on. Core assurances are now more transparent because these were not previously shared with care providers. For Justice Services, quality assurance arrangements are currently under review due to the Scottish Government review of the national framework for justice.

Based on the work conducted, we are comfortable that there is an effective quality assurance framework in place, recognising that government expectations and changes in the operating environment will drive the need for further change and revision of quality assurance methodologies in the short to medium term.

Scrutiny and Assurance

Objective 2: Child and adult protection procedures are adequately aligned to the Care Inspectorate Public Protection Policy.

The expectations placed on different inspection setting by different parts of government was highlighted as a key change in the last two years. Two new policy directives are due in May 2022 for ELC but these are not fully implemented. In addition, there remain challenges around the short term nature of ring-fenced funding for Adult Support and Protection. The lead in time, culture shift and learning curve for staff involved is challenging to deliver with only short term funding.

In order to effectively embed protection procedures across the organisation guidance has been developed on individual responsibilities around protection. Team Managers will conduct spot checks of QA activity prior to individual one to one discussions with staff. This is included in the recently revised Protection Procedure. It is intended that Team managers will record quality assurance activity and report quarterly to Service Managers, who in turn will report emerging themes and actions to the Chief Inspectors. The first of these reports are expected in June 2022.

Sessions will be delivered by the Protection Group and OWD to explain how the new procedures will operate in practice. Our triangulation of evidence presented confirms that the new Protection Procedures have been developed through the Protection Group, with a focus on collaboration with the SSSC in particular. A shared Protection Policy has been developed with the SSSC and was nearing finalisation at the time of our fieldwork. This will replace the existing Child and Adult Protection Policy. The shared nature of this new policy document has meant that some of the Care Inspectorate specific detail has been lost. As a result, this detail has now been embedded in detailed quality assurance procedures, which have been developed specifically for the Care Inspectorate. Following consultation with a sub group of the Protection Group there will be further consultation on the use of protection logs across the organisation and this will be informed by an all staff survey. The key question asked is around staff confidence and understanding of the quality assurance procedures across all staff groups. Moving forward, training will be delivered in conjunction with OWD.

A meeting of the Protection Group is scheduled in May 2022 and this will consider the outcomes from the staff survey before submitting the final policy and procedures to the Executive Director for Scrutiny and Assurance, Chief Inspectors and Service Managers to consider in advance of sign off by the Executive Team.

The terms of reference for the Protection Group were reviewed in late 2021 and this allowed the focus of the group to be expanded beyond adults and regulated care services. This group will act as the advisory body, rather than as a delivery body, for protection across the organisation. The Protection Group meets quarterly and maintains an action log. There are sub groups of the main Protection Group, which also meet regularly.

Notwithstanding the ongoing work to finalise the Protection Policy and Procedures we are comfortable that there is adequate alignment between the policies and procedures and that the new protection arrangements will strengthen collaboration both internally and with the SSSC.

Scrutiny and Assurance

Objective 3: The scrutiny and improvement methodology remains fit for purpose in meeting identified need for registration; complaints and enforcements in regulated care.

A new framework is to be introduced for recording evidence which spans registration, complaints and enforcement activity. It has already been recognised that the increased volume of enforcement activity will necessitate a review of how this is reflected within the new Quality assurance procedure to specifically define who is involved. We were advised by the Chief Inspectors that there have been more than 30 improvement notices served in recent years, with four proposals to cancel. This has been delivered without any dedicated resource to deliver enforcement activity, which can be complex and time-consuming. We were advised that large scale investigations progressed under adult care and protection have tripled. These investigations are led by local authorities.

Oversight teams have been placed in every local authority in relation to care homes in order to provide advice. This requires team managers and inspectors to meet at least twice a week.

There has also been a significant expansion in local authority nursery provision in recent years, which also increases the existing workload. This has been exacerbated by high vacancy levels in the last two years and challenges in recruiting staff with the correct skillset. We were advised that although there is a Workforce Strategy in place, this does not reflect the age profile of the experienced staff required to take up inspection roles. This has been recognised by the chief inspectors who highlighted the need to develop a tailored recruitment approach to showcase the care inspectorate as an exemplar employer for their target demographic.

Scrutiny and Assurance

Objective 3: The scrutiny and improvement methodology remains fit for purpose in meeting identified need for registration; complaints and enforcements in regulated care. (Continued).				
Observation	**Risk**	**Recommendation**	**Management Response**	
There has been significant investment in dedicated improvement and methodology resource which has not been matched in relation to enforcement activity. Enforcement is in line with the scheme of delegation and the rationale for decisions is set out within an email from the Chief Inspectors to the Executive Director of Scrutiny and Assurance. However, there is a need for dedicated resource to be made available for larger more complex enforcement activity in order to ensure that there is sufficient time and space available to carry out all of the necessary background work to underpin decisions and any subsequent legal challenge or complaints raised.	There is a risk that staff involved in larger more complex enforcement activity do not have the capacity to deliver both their routine responsibilities and the additional enforcement workload.	**R1** Consideration should be given to the creation of a protocol which would define the circumstances in which an Executive Group should be convened to take forward larger and more complex enforcement activity, which meets the criteria set.	This recommendation is **agreed**. A comprehensive revision of our enforcement procedures was completed just as this audit was concluding. The new procedures were approved by the Strategic Leadership Team (SLT) on 13 April 2022. These include strengthened executive oversight of high profile enforcements based on recent experience. The SLT will consider how to meet the need for additional dedicated resource for enforcement. **To be actioned by:** Executive Director of Scrutiny & Assurance / SLT **No later than:** 31 December 2022	
			Grade	**3**

Scrutiny and Assurance

Objective 3: The scrutiny and improvement methodology remains fit for purpose in meeting identified need for registration; complaints and enforcements in regulated care. (Continued).

Observation	Risk	Recommendation	Management Response
The high vacancy levels have impacted on the delivery of the Inspection Plan, with a risk based approach adopted which focuses on priorities one and two. The pressure on the system means that the plan is now much more fluid and therefore it is now extremely difficult to estimate the number of inspections which will be conducted in any given year. There remains a determination to ensure that the intelligence led approach is supplemented by the inspection of all services which have not been inspected in the previous two years. This is required to sustain improvements over time. However, this cannot be achieved unless the true scale of the task can be estimated in order to plan and monitor the deployment of resources effectively.	Without a true picture of the scale of registration, complaints and enforcement activity it is not possible to effectively plan ahead or set meaningful targets.	**R2** Consideration should be given to the development of a new resource model which would build a more coherent picture of the demands placed on every aspect of the Scrutiny and assurance function. This model will underpin staff resourcing and will inform target setting for reporting to the Board.	This recommendation is **agreed**. The work is already underway led by the Head of Finance and Corporate Governance and involving the Operational Leadership Team (OLT). The terms of reference and scope of the work was agreed by the Strategic Leadership Team on 11 May 2022. **To be actioned by:** Executive Director of Corporate & Customer Services / Head of Finance and Corporate Governance **No later than:** 30 December 2022 **Grade** 3

Scrutiny and Assurance

Objective 4: Progress in delivering the Involvement Strategy 2018-21 and action plan is monitored effectively and learning has been fed into the next iteration of the Strategy.

The Public Services Reform (Scotland) Act 2010 sets out the duty of user focus. The Involvement Outcomes Action Plan 2018 – 2021 set out a programme of involvement activities over a three-year period. This action plan was intentionally designed to ensure flexibility in responding to the needs of stakeholders. This ingrained flexibility was designed to allow Involvement activity to flex and adapt to keep pace with the changing landscape in terms of equalities and community empowerment, while remaining responsive to stakeholder needs. The delivery of the Outcomes Action Plan is monitored through regular team meeting and huddles. The delivery of the EDI strategy is connected to the wider work of Involvement, with Equality Outcome 2 highlighting the issues for people who are care experienced and younger, older, disabled or minority ethnic, and families and carers of people experiencing care, who may face barriers to effective participation and engagement. Reporting of this activity was reported as part of the Equalities Mainstreaming Report April 2019 - March 2021.

The Involvement and Equalities team are part of the Strategy and Improvement Directorate. The driver for this structural change was the stated intention to "*consolidate our core purpose to carry out scrutiny and support improvement in care, ensuring that involvement is at the heart of all we do. We are also focussed on strengthening communities and reducing inequalities, working in collaboration with external partners to enable us to hear the experiences of care experienced people from a wider audience*". The health and social care landscape is evolving rapidly with many external influences and pressures shaping the way in which involvement feeds into the current and future activity of Scrutiny and Assurance staff. At the time of our audit fieldwork work was ongoing to co-create an interim Improvement Strategy 21-22, with Involvement and Equalities staff forming part of a multi-disciplinary team within the wider Improvement function. The Involvement Strategy came to an end in October 2021, and the Interim Quality Improvement Strategy 21-22 was developed to drive both Quality Improvement (QI) and Involvement activity through to 2022. We were advised that the aspiration for the next iteration of the Quality Improvement Strategy is to align it with the three-year timeline set out within the Corporate Plan. This demonstrates a commitment to the development of innovative, quality improvement and involvement practices, which are designed to increase the opportunities to widen and strengthen the impact of improvement of outcomes for people who experience care.

Reporting on Involvement activity occurs twice a year through the publication of the Involve magazine. In addition, updates on Involvement activity are provided quarterly through the Executive Director Report and via the Corporate Plan KPIs (Key Performance Indicators) reporting structure, which is monitored by the Board.

Examples of the types of activity which are being progressed to build on the learning from previous strategy delivery are:

- Development of a 3-year Quality Improvement and Involvement Strategy 2022/25 - which will build on the Interim Strategy for Quality Improvement, Involvement and Equalities support. This will utilise the Care Inspectorate's Intelligence Model to identify priorities, themes, and topics and listen to the voices of people who experience care using an asset-based approach.
- The Promise Workstream 2 – 'Participation, engagement and listening'. This will involve a review of the existing Inspection Volunteer scheme and will examine ways in which participation can be developed within the Care Inspectorate.
- Scottish Approach to Service Design - This is a framework to guide how the Care Inspectorate will help to support the design of user-centred public services. This workstream will focus on the mechanisms required to agree on and support a set of core ideas and intentions, which will require to be embedded within the Care Inspectorate approach to service design.

From the work conducted we are comfortable that the development of the Interim Quality Improvement Strategy 21-22 has reflected learning from previous delivery and that the next iteration of the strategy will continue this good practice.

Scrutiny and Assurance

Objective 5: There are effective processes in place to ensure compliance with the Scottish Regulators Strategic Code of Practice.

One of the Chief Inspectors has responsibility for oversight of the national registration scheme. This is necessary to allow business to operate. The duty to avoid stifling the growth of capacity and growth is embedded within the Scottish Regulators Strategic Code of Practice ('the Code'). Therefore, if a care home provider sought to open a care setting on the same street as an existing provider then although the views of the relevant local authority would be sought, the default position is to seek the expansion of capacity (as reflected in the Code).

After the registration process is completed, there are standard processes in place to ensure that the newly registered provider establishes effective links with the relevant local authority and health and social care partnership.

The application of the Code plays an important part in enforcement activity and therefore the need to make sure that staff understand the requirements of the Code is an integral part of induction processes.

Any proposed refusal of registration is progressed via the legal Team , who act as gatekeepers in ensuring consistent application with the Code.

Education days have been delivered with the Directors Nursing from NHS Boards, the Scottish Government Sponsorship Branch, and the Oversight Team for COVID-19 to improve the understanding of the Code and of legislative requirements.

Scrutiny and Assurance

Objective 6: There is an agreed approach setting out how the Care Inspectorate will engage with a range of partners to support improvement in the quality of care and support and measures are in place to demonstrate the impact of this partnership activity.

The Quality Improvement and Involvement Interim Strategy 2021-22 continues to reflect the same vision, values and strategic objectives set out in the Improvement Support Strategy 2019-2022 but has been recalibrated and reprioritised to reflect the changed landscape since the 2019 launch of the Improvement Support Strategy 2019-2022. The Interim strategy states that "*As we move through an evolving Covid-19 landscape and the recommendations from the Independent Review of Adult Social Care start to come forward, further priorities for quality improvement and involvement support will be identified. We will follow good practice in quality improvement and involvement practices through both our understanding of social care and building on established improvement alliances*".

The interim strategy maintains a focus on the following three strategic objectives:

- **Strategic Objective 1.** Grow person-led innovation – testing out, supporting, and spreading innovative practice and influencing policy will support the development of world-class care and develop models of care fit for the future.
- **Strategic Objective 2.** Grow person-led QI capacity and capability – integral to the core purpose of our work; we have a duty to support improvement in care.
- **Strategic Objective 3.** Grow person-led involvement and equalities – Ensure people's voices are heard and equity across all our work to reduce inequalities in social care, particularly for the most disadvantaged groups and communities.

A list of external partners is maintained which the Care Inspectorate engages with. This includes local authorities as well as care providers. On the instruction of Scottish Ministers, relevant bodies were instructed to come together in a National Organisations Integration Huddle. Our review of the February 2022 meeting of this Huddle demonstrates the active participation of the Care Inspectorate in engaging with a wide range of partners to progress improvement activity collaboratively. These partners include National Services Scotland (NSS), Health Education Scotland (HES), Scottish Government and SSSC. This Huddle is supported by a Joint Account Management Group, which also contains Care Inspectorate representation through the Interim Head of Improvement. This subgroup allows direct interaction with local authorities and also the Chief Officers in Health and Social Care Partnerships.

We were advised that alliances have been developed through Practice Groups, with work underway to develop a specific Quality Improvement Practice Group. This will allow a direct link to Inspectors, which will feed into the ongoing work to develop the Skills Matrix and will also create a feedback loop which will allow Inspectors to question and capture the outcome of improvement activity. The approach taken is to impart the improvement methodology in the care setting and then withdraw. Impact is measured through the data collected. Three new key performance indicators on Improvement activity will be incorporated into the new Corporate Plan.

Scrutiny and Assurance

Objective 6: There is an agreed approach setting out how the Care Inspectorate will engage with a range of partners to support improvement in the quality of care and support and measures are in place to demonstrate the impact of this partnership activity. (Continued).

Observation	Risk	Recommendation	Management Response	
There has been significant investment in improvement activity in recent years but there is a perception that the time is right to review the impact of this activity and to explore the potential for more targeted improvement support at Service Level to drive and sustain improvements together with the Chief Inspectors.	Without evaluation of impact the improvement activity may not deliver optimal results.	**R3** A review should be conducted to assess the impact of the current programme of improvement activity and as part of this exercise the benefits of implementing more targeted improvement support at Service Level should be explored in collaboration with the Chief Inspectors.	This action is agreed. **To be actioned by:** Director of Strategy and Improvement **No later than:** 30 December 2022	
			Grade	**3**

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN T: 01224 322 100 F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB T: 01382 200 055 F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF T: 0131 226 0200 F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 12
Report No: ARC-14-2022

Title:	**COVER REPORT: INTERNAL AUDIT ON CORPORATE PLANNING**
Author:	*Kenny Dick, Head of Finance and Corporate Governance*
Appendices:	1. Internal Audit Report: Corporate Planning
Consultation:	**n/a**
Resource Implications:	**None**

Executive Summary:	
The internal audit report on Corporate Planning is attached as Appendix 1. The overall level of assurance is "Good". There were five internal audit objectives and assurance of "Good" was provided against all of these objectives. No recommendations have been made.	
The Committee is invited to:	
1.	Accept the Internal Auditor's report on Corporate Planning.

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:

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 12 - Appendix 1

LEVEL OF ASSURANCE
Good

Care Inspectorate

Corporate Planning

Internal Audit report No: 2022/11

Draft issued: 11 May 2022

Final issued: 13 May 2022

Henderson Loggie

Contents

		Page
Section 1	**Management Summary**	
	• Overall Report Grade	1
	• Risk Assessment	1
	• Background	1
	• Scope and Objectives	2
	• Audit Approach	2
	• Summary of Main Findings	3
	• Acknowledgements	3
Section 2	**Main Findings and Action Plans**	**4 - 6**

Level of Assurance

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

Gradings are defined as follows:

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

Action Grades

Priority 1	Fundamental issue subjecting the organisations to material risk which requires to be addressed by management and the Audit and Risk Committee as a matter of urgency.
Priority 2	Issue subjecting the organisations to significant risk, and which should be addressed by management as a priority.
Priority 3	Matters subjecting the organisations to minor risk or which, if addressed, will enhance efficiency and effectiveness.

Management Summary

Overall Level of Assurance

Good	System meets control objectives.

Risk Assessment

This review focused on the controls 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. (Residual Risk score: 8)
- Strategic risk 3 - We are unable to deliver our Corporate Plan objectives due to a lack of workforce capacity. (Residual Risk score: 6)

Background

As part of the Internal Audit programme at the Care Inspectorate ("CI") for 2021/22, we carried out a review of corporate planning 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.

This review has been conducted against a backdrop of continued uncertainty around, for example, the development of a National Care Service and the way in which the Care Inspectorate will play into any new structure, and ongoing education reforms. The Board meeting in August 2021 approved the decision to create a new Corporate Plan rather than simply updating the existing 2019 – 2022 Corporate Plan. This decision took into the account the uncertainty around the future role of the Care Inspectorate and any associated changes in the priorities of the organisation arising from the changes introduced by Scottish Government.

The timing of approval of the new Corporate Plan 2022 - 2025 '*Care. It's what we do*' coincided with the completion of the audit fieldwork. Therefore, a number of the aspects of the scope set out for this review had not yet been implemented, such as the development of the targets associated with the suite of corporate key performance indicators (KPIs) and Key Outcome Indicators (KOIs) linked to the Corporate Plan or the development of the operational plans which underpin the overarching Corporate Plan.

Therefore, our assessment is based on the plans in place to deliver these aspects now that the Corporate Plan has been finalised and published on 9 May 2022.

Scope, Objectives and Overall Findings

The scope of this audit was to consider whether the Care Inspectorate's corporate planning process is working effectively, particularly in relation to the linkages between the Corporate Plan and the detailed operational plans which support the delivery of the strategic objectives set out in this overarching document.

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**	**Actions already in progress**
		No. of Agreed Actions			
1. The Corporate Plan is aligned with the ambitions and aims of the sponsor department within the Scottish Government and is therefore aligned with the future direction of travel set out for the care sector in Scotland	**Good**	0	0	0	
2. Linkages between the Corporate Plan and operational plans are clearly defined and communicated across the organisation	**Good**	0	0	0	✓
3. Operational planning effectively supports the achievement of the strategic outcomes in the Corporate Plan.	**Good**	0	0	0	✓
4. Delivery of the Corporate Plan and the supporting key strategies, plans and programmes is appropriately monitored.	**Good**	0	0	0	✓
5. There is effective linkage between planning and financial budgeting at all levels.	**Good**	0	0	0	✓
Overall Level of Assurance	**Good**	**0**	**0**	**0**	
		System meets control objectives.			

Audit Approach

Through discussions with key staff we documented the corporate planning process, covering the setting of the strategic vision, values and priorities. We also examined the way in which the new Corporate Plan connects upwards to national priorities and downwards into operational planning; budgeting; implementation; monitoring and control

Summary of Main Findings

Strengths

- In order to ensure alignment with the ambitions of the Scottish Government, two separate meetings were held with the Scottish Government Sponsor Branch to discuss the general priorities described in the new Corporate Plan 2022 – 2025 and the alignment with the future direction of travel for the care sector in Scotland;
- A Corporate Plan Consultative Group was in place and this allowed input from a variety of stakeholders from all Directorates around the content and format of the Corporate Plan;
- Consultation was also held with our Inspection Volunteers and a number of external stakeholders to ensure that it reflected the entirety of the Care Inspectorate's work;
- The Corporate Plan 2022 makes specific reference to the National Performance Framework and sets out the way in which the Care Inspectorate will aim to support the achievement of national outcomes over the next three years;
- Work to develop the more detailed operational plans, which will underpin the Corporate Plan 2022 – 2025, commenced in late March 2022, immediately after approval;
- The Head of Corporate Policy and Communications demonstrated a comprehensive understanding of the need for further work in this area to ensure that there is clarity in the messaging across the organisation regarding the way in which operational activity at Directorate or team level contributes to the delivery of the four strategic outcomes set out in the Corporate Plan 2022 – 2025;
- Key priorities are set out for each of the four strategic outcomes in the Corporate Plan 2022 – 2025 and these are supported by tailored KPIs and KOIs;
- The Corporate Plan 2022 – 2025 lists the key plans and strategies which will help the Care Inspectorate deliver on the agreed key priorities;
- The draft Corporate Plan 2022 – 2025 was presented to the December 2021 meeting of the Board to capture feedback and to enhance ownership of the key priorities set out within the Plan and the performance measures designed to track delivery;
- Work was ongoing at the time of our audit to develop targets for the KPIs and KOIs. Once these are developed this will allow quarterly reporting to the Board to compare the actual position against the target position; and
- The Accounting and Procurement Manager was represented on the Corporate Plan Consultative Group and we were advised that work has already commenced to consider how the 2023/24 budget will connect to the Corporate Plan 2022 – 25

Weaknesses

Although a number of pieces of work still require to be completed to embed actions to deliver the key priorities at Directorate and Team level, and to agree on targets for the KPIs and KOIs in the Corporate Plan 2022 – 2025, these are issues which have already been identified by management and plans are already in place to address them. Therefore there are no control weaknesses identified from our review.

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 Corporate Plan is aligned with the ambitions and aims of the sponsor department within the Scottish Government and is therefore aligned with the future direction of travel set out for the care sector in Scotland

In order to ensure alignment with the ambitions of the Scottish Government, two separate meetings were held with the Scottish Government Sponsor Branch to discuss the general priorities described in the new Corporate Plan 2022 – 2025 and the alignment with the future direction of travel for the care sector in Scotland.

The initial meeting was held in January 2022 in order to discuss the outcomes arising from the consultation process on the draft Corporate Plan 2022 – 2025. The second meeting in March 2022 allowed the opportunity for discussion on the key objectives.

The Corporate Plan 2022 – 2025 and the Scrutiny and Assurance Plan are interlinked and since the Scrutiny and Assurance plan requires ministerial approval, the Corporate Plan 2022/25 was also presented to the Minister prior to publication.

A Corporate Plan Consultative Group was in place and this allowed input from a variety of stakeholders around the content and format of the Corporate Plan, recognising that this document would build on the previous iteration of the Corporate Plan 2019 – 2022, which has understandably been impacted by the COVID-19 pandemic.

We noted that the Corporate Plan 2022 makes specific reference to the National Performance Framework and sets out the way in which the Care Inspectorate will aim to support the achievement of national outcomes over the next three years.

In addition, The Promise is specifically listed as one of the key documents which underpins the new Corporate Plan.

Corporate Planning

Objective 2 - Linkages between the Corporate Plan and operational plans are clearly defined and communicated across the organisation

We were advised that the work to develop the more detailed operational plans, which will underpin the Corporate Plan 2022 – 2025, commenced in late March 2022, immediately after approval. This will entail an examination of the themes for each Directorate and a template was being developed to link strategic objectives, key priorities and performance metrics together. There was a clear understanding that further work was required to connect the Corporate Plan to the operational plans.

Although there is a linkage between the Corporate Plan 2022 – 2025 and the Scrutiny and Assurance Plan for 2022/23, there is an aspiration going forward that these linkages will be even more transparent.

Objective 3 – Operational planning effectively supports the achievement of the strategic outcomes in the Corporate Plan.

At the stage of our audit fieldwork there had been consideration of how the Corporate Plan 2022 – 2025 would connect with existing Directorate or teams level plans but work was yet to commence on this aspect. However, the Head of Corporate Policy and Communications demonstrated a comprehensive understanding of the need for further work in this area to ensure that there is clarity in the messaging across the organisation regarding the way in which operational activity at Directorate or team level contributes to the delivery of the four strategic outcomes set out in the Corporate Plan 2022 – 2025. Effective communication of these messages across the organisation is recognised as a vital component of the rollout of the Corporate Plan 2022 – 2025 and the creation of the 'golden thread' between strategic outcomes and day to day or transformational operational activity.

The Corporate Plan 2022 – 2025 sets out the Vision, Mission and values for the Care Inspectorate. These are designed to underpin all activity carried out by the organisation and the document states that "*Our values are under regular review in consultation with staff to ensure they remain relevant and reflective of our work and purpose*".

Corporate Planning

Objective 4 – Delivery of the Corporate Plan and the supporting key strategies, plans and programmes is appropriately monitored.

Key priorities are set out for each of the four strategic outcomes in the Corporate Plan 2022 – 2025 and these are supported by tailored KPIs and KOIs (which capture some of the more qualitative aspects of performance which rely on external feedback). Specific effort has been directed towards developing their softer qualitive measures so that progress in working towards Scottish Government aspirations around the delivery of outcomes can be tracked. The suite of KPIs and KOIs was developed by the Intelligence Team with a view to capturing the right data which will demonstrate the impact of delivery against the key priorities. This work was supported by the Corporate Plan Consultative Group, which met monthly from September 2021 onwards to help shape the KPIs and KOIs. The membership of this group included the Convenor of the Audit and Risk Committee.

A Board Development session was held in October 2021 to gather the Board's views on the development of the new Corporate Plan. Internal and external consultation took place throughout October, November and December. The draft Corporate Plan 2022 – 2025 was developed and presented to the December 2021 meeting of the Board to capture feedback and to enhance ownership of the key priorities set out within the Plan and the performance measures designed to track delivery. A second round of consultation then took place with key stakeholders on the draft corporate plan in January, February and March 2022. The Corporate Plan 2022 – 2025 lists the key plans and strategies which will help the Care Inspectorate deliver on the agreed key priorities. This includes strategies around workforce, finance and digital transformation.

Work was ongoing at the time of our audit to develop targets for the KPIs and KOIs. Once these are developed this will allow quarterly reporting to the Board to compare the actual position against the target position.

Objective 5 – There is effective linkage between planning and financial budgeting at all levels.

The Accounting and Procurement Manager was represented on the Corporate Plan Consultative Group and we were advised that work has already commenced to consider how the 2023/24 budget will connect to the Corporate Plan 2022 – 25. This approach has largely been dictated by a timing issue in relation to announcements around the spending review.

Going forward there will be a need to manage operational budgets in a way which will ensure that funding is directed to the delivery of key priorities. This will include both business as usual and developmental/innovation activity.

Henderson Loggie

Aberdeen 45 Queen's Road AB15 4ZN — T: 01224 322 100 — F: 01224 327 911
Dundee The Vision Building, 20 Greenmarket DD1 4QB — T: 01382 200 055 — F: 01382 221 240
Edinburgh Ground Floor, 11-15 Thistle Street EH2 1DF — T: 0131 226 0200 — F: 0131 220 3269
Glasgow 100 West George Street, G2 1PP — T: 0141 471 9870

Henderson Loggie LLP is a limited liability partnership registered in Scotland with registered number SO301630 and is a member of PrimeGlobal, a global association of independent accounting firms, the members of which are separate and independent legal entities. Registered office is: The Vision Building, 20 Greenmarket, Dundee, DD1 4QB. All correspondence signed by an individual is signed for and on behalf of Henderson Loggie LLP. Reference to a 'partner' is to a member of Henderson Loggie LLP. A list of members' names is available for inspection at each of these addresses.

AUDIT AND RISK COMMITTEE MEETING 19 MAY 2022

Agenda item 14
Report No: ARC-15-2022

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 22 March 2022.	
The Committee is invited to:	
1.	Consider the current risk monitoring position highlighting any issues that should be brought to the attention of the Board at its meeting of 16 June 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

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 14
Report No: ARC-15-2022

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 22 March 2022. It is likely this risk will remain high until there is more known about National Care Service implications and more work has been completed in conjunction with the Sponsor Department on the 2023/24 spending review.

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 43.5 FTE. It is expected to start 46 new Inspectors from the current recruitment campaign.

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

The risk score has reduced from 16 (high) to 15 (high). This reflects the early impact of a programme of work to improve security.

The target level for this risk is low and our tolerance has been set at medium. This risk therefore exceeds target and tolerance levels. It is expected that the risk will reduce to medium (within tolerance level) by the end of 2022/23. It is worth noting that this aim will be subject to investment requests to support the decommissioning of our Practice Management System (PMS) and the shift of Enforcements process and related archive data away from the PMS legacy platform.

This risk has been above target and tolerance levels for nine 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 risk register has been updated to reflect the current position with controls in place and planned further action.

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

Agenda item 14
Appendix 1

SUMMARY STRATEGIC RISK REGISTER: 2022/23 (as at 19 May 2022)

No.	Risk Area	Strategic Outcome/ Principle	Lead Officer	Raw Score (LxI)	Raw Grade	Residual Score (LxI)	Initial Residual Grade	Current Residual Grade
1	Delivery of Strategy	SO 1,2,3	CE	16	High	8	Medium	Medium
2	Financial Sustainability	P 6	EDCCS	16	High	16	Medium	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	15	High	High
6	Digital Transformation	P 1 to 7	EDIDT	20	Very High	15	High	High
7	Shared Service Governance	P 6	EDCCS	16	High	6	Medium	Medium

Agenda item 14
Appendix 1

SCORING GRID

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

IMPACT

Black = Very High

Red = High

Amber = Medium

Green = Low

White = Very Low

Lead Officers

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

Agenda item 14
Appendix 2

Strategic Risk Register Monitoring

Date	for Audit & Risk Committee 19 May 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 2022 – 25 in place with supporting operational plans and performance measures and under continuous review ii. Regular Sponsor liaison meetings iii. Regular meetings with the Minister for mental health and wellbeing and other Ministers iv. Attendance at Strategic Scrutiny Group v. Horizon scanning through our policy team vi. Scrutiny and Assurance Plan agreed by Minister vii. Attendance at key national forums viii. Attendance at meetings related to the NCS	Further Actions: i. A new Corporate Plan 20 22-25 published May 2022. New performance measures have been developed and they will be reviewed annually. ii. Strengthening use of risk and intelligence to inform our work. iii. A full business case for stage 2 of business and digital transformation is being prepared and this is critical to the development of our intelligence capability iv. Improvement and involvement support strategy being reviewed and to come to Board in September 2022	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 v. Ongoing review and development of	Further Actions i. Full business case for Stage 2 of Business and Digital Transformation being developed ii. Early engagement of 23/24 spending review and reviewing baseline budget requirements	Appetite: cautious Target: medium Tolerance: high Above target for 4 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.											savings and income generation options	iii. Early consideration of National Care Service financial implications following any announcement by SG		
3	**Workforce Capacity** **What is the Potential Situation?** We are unable to deliver our Corporate Plan objectives due to a lack of workforce capacity. **What could cause this to arise?** We do not have an effective strategic workforce plan to support the delivery of our corporate plan objectives; we do not have effective workforce planning at directorate and team level; there is ineffective monitoring of workload and capacity; we fail to recruit and retain staff in sufficient numbers and with the required skillset, we have an inefficient organisation structure and/or job design; there are ineffective staff learning and development plans; our reward offer is uncompetitive; we do not adequately address the aging demographic of a significant element of our workforce. **What would the consequences be?** Inability to provide the desired level of scrutiny, assurance and improvement support Reduction in the quality of care and protection for vulnerable people across Scotland Reputational damage with reduced public and political confidence Possible reduced SG funding Lack of ability and credibility to positively influence change such as SG policy development and to drive innovation	4	4	16	H	2	3	6	M	Med	↔	In Place: i. Strategic workforce plan ii. Workload and capacity monitoring iii. Staff learning and development plan iv. LEAD process v. Recognised job evaluation system vi. Regular salary benchmarking	Further Actions: i. Implement Strategic Workforce Plan actions ii. Develop succession planning iii. Strengthen use of risk and intelligence iv. Recruitment strategy review v. Pay and grading review	Appetite: cautious Target: medium Tolerance: medium At target level Rating: Green Response: Accept	EDS&I & EDCCS
4	**Partnership Working** **What is the Potential Situation?** The Care Inspectorate collaborative working with our key scrutiny and delivery partners is compromised and we are not able to: • participate in, or progress, work which would help deliver our strategic objectives • deliver public service scrutiny in a joined up and collaborative way • deliver our agreed scrutiny and improvement plan **What could cause this to arise?** Scrutiny and delivery partner strategies are not aligned well enough to our own; our ability to fully resource our own or our partners' strategic priorities; unexpected changes in environment (PESTEL); unclear, misaligned or incomplete individual and joint plans; collaborative work does not have or adhere to legal underpinning; inadequate or deficient Information Technology; inaccurate or inappropriate information sharing. **What would the consequences be?** Reputational damage; loss of confidence and credibility, unable to fulfil statutory obligations; damage to relationship with scrutiny and delivery partners.	4	4	16	H	2	4	8	M	Med	↔	In Place: i. Wide consultation and regular meetings at Senior level inter-organisation meetings ii. Effective external comms strategy in place iii. Membership of National Strategic Scrutiny Group iv. MoUs or agreed protocols in place with all relevant partners v. Chief Executive and Directors monitor and carefully manage relationships with scrutiny and delivery partners vi. Deputy Chief Exec has specific role to promote parentship working with other scrutiny/public	Further Actions: i. Continuing engagement with Scottish Government officials and others on the development of a National Care Service and educational reform. ii. Development of an overarching scrutiny & assurance strategy with strong focus on collaborative scrutiny	Appetite: cautious Target: medium Tolerance: High At target level Rating: Green Response: Accept	EDS&A

Agenda item 14
Appendix 2

												bodies/provider groups vii. Inspection Plan for 2022-23 includes ongoing commitment to collaborative scrutiny			
5	**ICT Data Access & Cyber Security** **What is the Potential Situation?** Our systems or data are compromised due to cyber security attack. **What could cause this to arise?** Low overall maturity in security policy, procedure and controls. Lack of security awareness training, failure to invest in the controls and infrastructure to limit, detect and respond quickly to threats. **What would the consequences be?** Serious disruption to business and operational activities, we are held to ransom or face significant fines, potential loss of intelligence, impact on public / political confidence, loss of reputation, additional recovery costs, increased risk of fraud, additional scrutiny overhead.	5	4	20	VH	3	5	15	H	High	⬇	In Place: i. ICT security protocols and monitoring of compliance with the protocols ii. Trained ICT staff iii. Physical security measures iv. Business Continuity plans in place v. Cyber Essentials+ certification in place vi. Routine penetration testing vii. Cyber Security Maturity baselined and 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. xi. Established regular vulnerability testing xii. Established Information Security Working Group supporting org-wide security consultation xiii. Regular updates to Leadership teams on progress on Cyber Security improvements xiv. Communication plans in place to maintain Security awareness and engagement across organisation xv. Plans established to support recovery of key systems	Further Actions: i. Implementation of cyber security action plan (plan will take approx. 18 months to implement) 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. Additional DR plan testing vi. Implement additional security controls and reporting capabilities vii. Two factor authentication to be introduced November / December 21 viii. Partial roll-out of two factor authentication (450/630 employees) – target completion by end Q1 ix. Projects designed to reduce infrastructure security risks x.	Appetite: cautious Target: low Tolerance: medium Has exceeded tolerance for 9 months. Risk reduced from 16 to 15 May 22. Working towards a medium risk score by end of 2022/23 Rating: Red Response: Treat	EDIT&D

Agenda item 14
Appendix 2

6	**Digital Transformation** **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. Board agreement for stage 2 Business case in February 2022 ii. Business Justification Gate (SG Digital Directorate) successfully passed iii. Health Check exercised to validate submission iv. Formally submitted the business case to SG (April 2022) v. Established regular dialogue with the National Care Service (NCS) implementation team	Further Actions: i. Planned session with Minister to outline Digital Transformation journey forecast for June 2022 ii. Ongoing dialogue with NCS implementation teams (health, data, finance and other sponsor branch departments) iii. Prepare contingency paper to outline the risks to the organisation if no or reduced funding occurs in relation to our at Risk systems. iv. Implement programme governance arrangements v.	Appetite: cautious Target: low Tolerance: medium Has exceeded tolerance for 9 months Rating: Red Response: Treat	EDIT&D
7	**Shared Service Governance** **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 19 MAY 2022

Agenda Item 17
Report Number: ARC-17-2022

Title:	**DIGITAL PROGRAMME UPDATE**
Author:	*Gordon Mackie, Executive Director of IT, Transformation and Digital*
Appendices:	None
Consultation:	**n/a**
Resource Implications:	**No**

<table>
<tr><td colspan="8">EXECUTIVE SUMMARY</td></tr>
<tr><td colspan="8">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.</td></tr>
<tr><td colspan="8">The Committee is invited to:</td></tr>
<tr><td>1.</td><td colspan="7">Note the information contained in the report on Digital Programme Update.</td></tr>
<tr><td>Links:</td><td>Corporate Plan Outcome Key principles</td><td>1-7</td><td>Risk Register – Y/N</td><td>Y</td><td>Equality Impact Assessment - Y/N</td><td colspan="2">N</td></tr>
<tr><td>For Noting</td><td>X</td><td>For Discussion</td><td></td><td>For Assurance</td><td></td><td>For Decision</td><td></td></tr>
</table>

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.

1. 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 PROGRAMME DEVELOPMENTS

2.1 Overall Progress

Registrations and The Register continues to make good progress. Since the last reporting period we have focused the delivery of the improved communications log functionality and scoping and designing new functionality for managing provider data:

- Support has been handed over completely to IT Service Operations. This follows sign-off of comprehensive documentation of standard operating processes to ensure delivery of business as usual.
- Communications log will provide a major enhancement to the functionality around the management of communications within the registration application. This was a complex change to add functionality and the delivery team were able to deliver additional functionality and resolve minor bugs providing even more usability.
- Provider data is a significant programme of work. We scoped the functionality required as well as the design to deliver in collaboration with the operational champions. The plan for delivery was presented to the Programme Board on 20 April which will commence on completion of the communications log sprints.
- Move towards agreeing organisational ownership of the applications.

The number of providers using the Registrations Application and The Register continues to rise and is currently over 7,100 services out of approximately 11,000 services on The Register. The statistics show high levels of use in maintaining registration information while the feedback from those users remains strongly 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 the continued prioritisation of work based on their immediate business requirements.

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-19 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 as required and is suing the opportunity to consider the "hybrid" approach to returning to office use.

2.3 The Complaints App Update

As previously report, the focus has been on the delivery of registration, the register and the functionality used internally. The digital team has 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 two years. The average rate of registration has been around 30 new services registered per month vs 80 pre-Covid-19. 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 positive.

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

Since the last update we have continued to work 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 App. 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 our Register and Registration App 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 an 11-week (2x3 and 1x5 week sprints) delivery that aims to deliver a redesign of our comms log that will provide real improvements that has been guided and agreed with our Operational Champions group and wider operational staff. At the time of preparing this report, it was forecasted to be released on 5 May 2022.

We are currently working on refining the provider requirements following agreement for this significant programme of work with the Programme Board on 20 April 2022. This is a significant and complex set of enhancements that touches many areas of our Register and Registration App and, as such, required Programme Board discussion and approval following the approval of the Operational Champions.

Budgets have now been agreed to extend the fixed term contract staff up to 31 October 2022. However, we have ongoing recruitment challenges in key operational leadership posts.

2.6 Support

Support/Hypercare has transitioned to IT Service Operations in March 2022. This follows sign-off of comprehensive documentation of standard operating processes to ensure delivery of business as usual.

As of 21 April, there were three defects to be resolved, which will be managed through the standard process to closure, and none of which are high priority.

2.7 Registration and Register usage

We have seen an increase in numbers 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	16 Feb 2022	April 2022	Increase
Registration Applications Created	3,530	3,811	**+281**
Variation requests (in flight)	2,474	2,832	**+358**
Voluntary Cancellation Requests	864	1,050	**+186**
Inactive Service Requests	438	471	**+33**
Illegal Service cases opened	49	60	**+11**
New Services Registered	416	474	**+58**
Change of Detail Requests	3,997	4,897	**+900**
Change Of Details Self Service	**1,643**	**2,000**	**+357**

Since go live **10,629** 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 low.

2.8 Programme Communication Channels

Our Senior Stakeholder Group continues to meet monthly, which 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.

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.

Regular reviews of the continued role and involvement of the Operational Champion group have been 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 with regular reviews planned.

3 EXTERNAL ASSURANCE ASSESSMENTS

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

4 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 actual cost for stage 1 which was completed in 2021/22 is £4.999m, £0.011m 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. Work on enhancing the new applications, funded from our approved 2022/23 budget, is continuing ahead of our business case for stage 2 being submitted to Scottish Government.

5 NEXT STEPS

Complete and release the Communication log improvements forecast for release in May 2022.
Recruit to fill vacant key operational leadership posts.
Complete the design of provider, with development forecast for Q2 and Q3.
Continue to prioritise delivery in partnership with operational colleagues.
Continue to support the organisation through this large and complex business change.

6 OTHER IMPLICATIONS AND/OR DIRECT BENEFITS

6.1 People Who Experience Care

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

6.2 Customers (Internal and/or External)

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

Agenda Item 19
Report No: ARC-18-2022

Title:	**SENIOR INFORMATION RISK OWNER (SIRO) ANNUAL REPORT - FINANCIAL YEAR 2021-22**
Author:	*Rachel Mitchell Information Governance Lead and DPO*
Appendices:	1. Overview of Information Governance Improvement Plan 2. Summary of revised deliverables Financial Year 21-22 3. SIRO Report 4. Projected deliverables Financial Year 22-23
Consultation:	Head of Intelligence (Deputy SIRO) Executive Director of ICT, Digital and Transformation (SIRO)
Resource Implications:	N/A

EXECUTIVE SUMMARY	
This SIRO report is submitted to the Audit and Risk Committee for them to note the work completed in Financial Year 2022-23. The statistical data for the year is also provided showing that work has returned to pre-pandemic levels and there are no exceptions that require further analysis or comment. The Information Governance team has now completed its initial improvement plan with updates provided in the report and a new workplan is submitted for noting for the financial year ahead.	
The Committee is invited to:	
1.	Note the work completed to date and the forward work plan
2.	Note the SIRO report

Links:	Corporate Plan Outcome	Y	Risk Register	Y	Equality Impact Assessment	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 (see Reasons for Exclusion)
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.

Agenda Item 19
Report No: ARC-18-2022

SENIOR INFORMATION RISK OWNER (SIRO) REPORT: FINANCIAL YEAR (FY) 2021-2022

1.0 INTRODUCTION

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

The deliverables envisaged have now been achieved and a summary of deliverables is provided at Appendix 2. We have now moved into Stage 3, Consolidation.

This paper provides a summary of progress against the original plan, a SIRO report on deliverables for Financial Year 2021-2022 (see Appendix 3) and a plan for future projects and projected deliverables (see Appendix 4).

2.0 IMPROVEMENT PLAN: SAFER AND MORE SECURE

2.1 Records Management Plan

2.1.1 The Records Management Plan (the Plan) submission is a statutory requirement for all Scottish public authorities under the Public Records Scotland Act 2011. Due to the pandemic, the cycle of submission and assessment was protracted for our latest submission. However, the assessment of the Plan by the Keeper of the National Records was completed in December and is now published[1].

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

2.2 Maturity Modelling and Benchmarking

2.2.1 The Care Inspectorate needs to know how well it is performing in terms of information and data management against external benchmarks that reflect statutory requirements.

Our strategy was to have this based on the Plan as referenced in 2.1, which is independently assessed by the Keeper of the National Records, and which covers not only records management, but also data protection and information security.

[1] Care Inspectorate Records Management Plan Assessment Report 2021

As explained above, the initial and final assessments of the Plan were delayed, with the final assessment not being received from NRS until December. This was then assimilated into the OneTrust platform as a maturity model and the first baseline will be run to show the position at the end of the financial year and will then be run at the end of each quarter.

A sample of the maturity report can be seen as part of the SIRO report at Appendix 3.

- ✓ *This activity supports the Corporate Plan values of Fairness, Integrity and Efficiency.*
- ✓ *This activity supports the Corporate Plan principle of Well Governed.*
- ✓ *This activity supports Strategic Outcome 3 - People's rights are respected.*

2.3 Information Asset Management

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

i. Statutory; for example, the need to protect and manage personal data (Data Protection Act (DPA) 2018/UK General Data Protection Regulation (UK GDPR).
ii. Cyber Security; for example, the prevention of successful malware attacks (Cyber Essentials Certification).
iii. Government Security Policy Framework – Mandatory Requirements 3, 5 and 6.
iv. ISO 27001:2005, which is the international standard for an information security management system.

The Care Inspectorate adopt the principles of all of the above in their policies and procedures.

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

There has been further progress this year as we have refreshed information assets and their processes on the OneTrust platform updating this with Information Asset Owners (IAOs) and Business Process Owners (BPOs) from within the business functions for new and existing processing activities.

This now gives us an Information Asset Register and the ability to download a report on personal data through a Record of Processing Activity as required by law[2].

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

2.3.2 We now have a verifiable list of IAOs which is updated as roles and personnel change, who have all been trained to understand their responsibilities. This also gives us an accountable person in each functional area who is responsible for information risk management.

2.4 Information Risk Reporting

2.4.1 The underpinning framework for information risk reporting has been finalised on the OneTrust platform and aligned to the organisational risk framework as signed off by the Board. This framework and the quarterly risk reporting template has also been reviewed and agreed by the SIRO in March. The first quarterly risk report for IAOs will be issued at the end of Quarter 1 2022-2023 along with a SIRO information risk register, and then on a rolling basis.

2.5 SIRO Report to Committee

2.5.1 The SIRO report is provided at Appendix 3.

2.6 Other Developments This Financial Year

2.6.1 Hard Copy Indexing Project

This year has seen the commencement of the hard copy indexing project which was a stage two improvement plan priority (see Appendix 1) which has run since 18 October 2021 and will finish on 16 May 2022.

The initial phase was to improve the metadata for hard copy records management system in IM Connect which is hosted by our supplier Iron Mountain.

The second phase was to look at anomalies and strange boxes labels that were found while carrying out the phase one task and identifying those boxes that were labelled miscellaneous, archiving or not labelled at all. The boxes were recalled and then indexed.

The current phase was to work through boxes newer than 2015 on a prioritised basis to recall and index them at file level and/or mark them for destruction. We prioritised the Scrutiny and Assurance records and ensured that they were more easily retrievable by adding metadata or where possible master data such as Care Service number which provides unique identifiers.

By the end of the project, we assess that we have digitally amended the metadata on IM Connect for 7,588 boxes out of 7,591 boxes onboarded to Iron Mountain (99.96%). We have also indexed to file level approximately 55% of RICE (Registration, Inspection, Complaints, Enforcement) boxes less than five years old and anticipate approximately 94% completion rate by the close of the indexers contract on 16 May 2022.

The benefits of this work are:

- **Making it easy to do the right thing -** allows better search outcomes for scrutiny, assurance and statutory purposes; reduces resource time; improves outcomes.

- **Records Management Plan -** This is one of the key areas of improvement in our Records Management Plan under the Public Records Scotland Act 2011 to the Keeper. This is part of evidence we submitted under Element 5 (Retention Schedule), **Element 6 (Destruction Arrangements),** Element 7 (Archiving and Transfer Arrangements) and **Element 10 (Business Continuity & Vital Records).**

- **Corporate Policies -** Supports our IG Policy and Review and Retention Schedule requirements.

- **Lowers risk -** meeting our statutory obligations for destruction under the UK General Data Protection Regulation and Public Records Scotland Act (2011).

- **Cost savings -** Improved metadata allows better risk-based decision making over destruction of obsolete records that are assessed to be over their retention period with cost savings. This destruction work will commence next financial year.

2.6.3 Training

This year has seen the commencement of Information Governance (IG) induction training for all new inspectors. This will hopefully improve their understanding of records management, statutory requests and data protection matters; particularly when a Data Protection Impact Assessment may be required.

This training has been recorded and uploaded to the Learning Management System (LMS) and other colleagues are directed to it for a refresher on IG matters as required.

2.6.4 OneTrust

After the initial delays due to the pandemic, the IG team has made a great effort in the last six months of this year and all enquiries, statutory and operational, internal and external, are now managed through the OneTrust platform.

This is in addition to:
- Data Protection Impact Assessments
- Security breaches
- Risk
- Maturity modelling

which have all been imported, created or improved over the last year.

We will work with IT colleagues to better embed Technology Assets into the platform and their associated risk assessments going forward.

2.6.5 Cyber Essentials Accreditation

In December 2021, we achieved recertification to the Cyber Essentials Plus standard. Achieving the Cyber Essentials standard involves an annual self-assessment exercise, where we record what security controls that we have in place. An assessor then reviews and checks our record of self-assessment.

The Plus assessment involves an independent, on-site third-party inspection of our security controls. The scrutiny involved includes a series of tests, spanning three to five days to check that the security controls on our computers are as effective as they should be.

3.0 IMPLICATIONS AND/OR DIRECT BENEFITS

3.1 Resources

3.1.1 There are no additional resources for the activities required in the form of staff for the Information Governance team if we maintain the current resourcing levels.

3.2 Sustainability

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

3.3 Policy

3.3.1 The Policy team has confirmed that there are no implications in this regard.

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

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

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

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

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

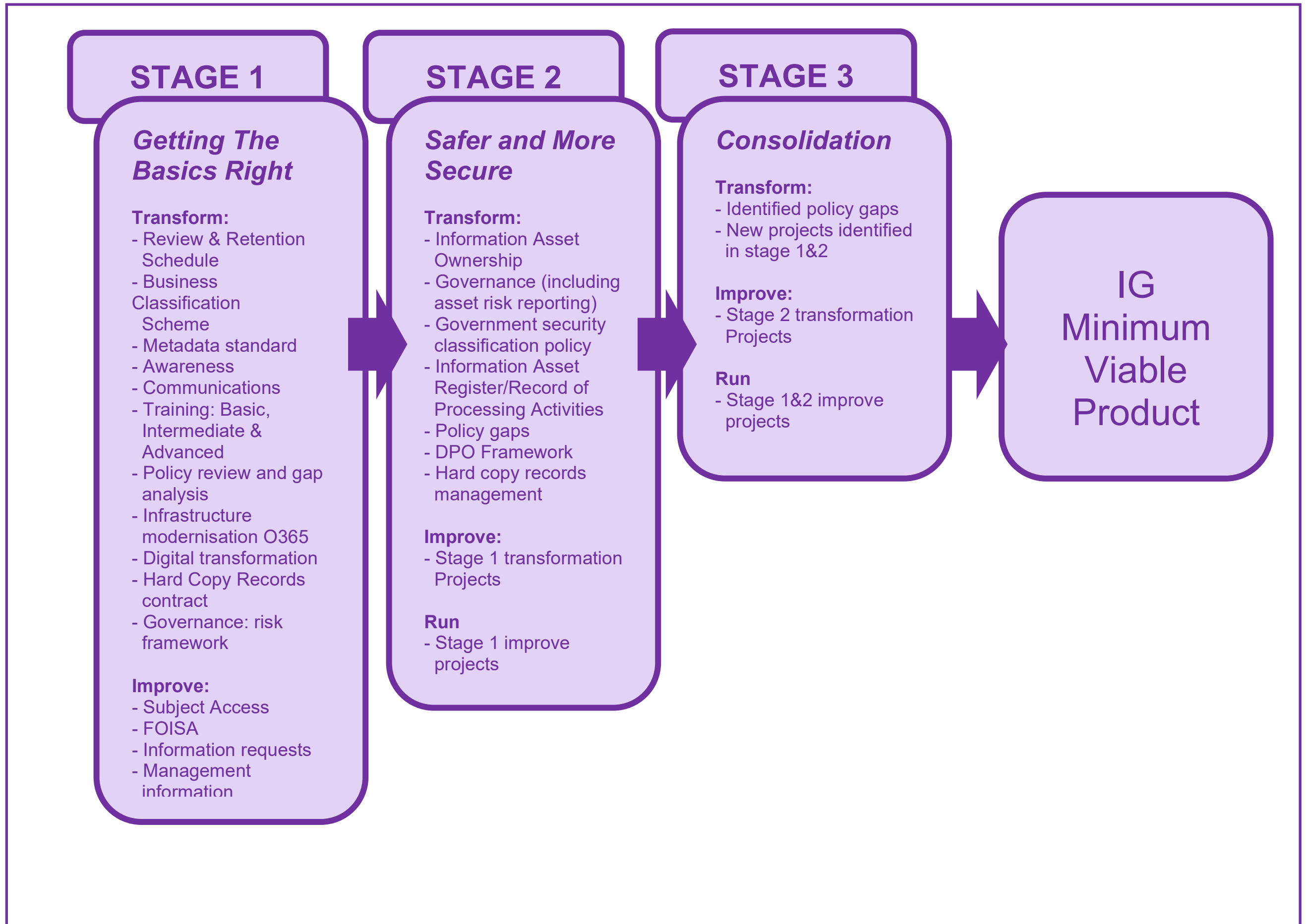
One of the Information Governance team's mantras is 'if we all do a little, we achieve a lot'. This is the approach here through education, training, and the implementation of robust and repeatable processes we will start to change the culture across the senior management in the organisation in performing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

4.0 NEXT STEPS

The Committee is asked to note the work completed to date, the forward work plan and the SIRO report.

Agenda item 19
Appendix 1

Overview of Information Governance (IG) Improvement Plan



Agenda item 19
Appendix 2

Summary of Revised Deliverables

Deliverable	Original Target Date	Revised date 21/22 Plan	Date Delivered	Notes
Records Management Plan Submission	Q1 20-21 (30/04/20)	Q2 20-21 (31/07/20)	Q2 20-21 (24/07/20)	-
NRS Records Plan Initial Assessment	Q2 20-21 (31/07/20)	Q4 20-21 (31/09/20)	Q4 20-21 (18/03/21)	-
Records Management Plan Resubmission	-	Q1 21-22 (31/05/21)	Q2 21-22 (26/08/21)	Delayed due to late receipt of initial assessment
Records Management Plan Sign off by the keeper		Q3 21-22 (30/09/21)	Q4 21-22 (08/12/21)	
FOISA statistics	Completed Quarterly	-	-	-
Maturity Modelling: Baseline	Q4 20-21 (31/03/21)	Q2 21-22 (30/09/21)	Q1 22-23 (31/5/22)	Delayed due to late receipt of Keeper's report.
Maturity Modelling: First Quarterly Report	Q1 20-21 (30/06/21)	Q3 20-21 (31/12/21)	Q1 22-23 (10/7/22)	
IAO training	Q2 21-22	Completed	-	-
Quarterly Risk Reporting	Q1 20-21 (30/06/21)	Q3 21-22 (31/12/21)	Q4 21-22 (14/3/22)	First report will be issued at the end of Q1 22-23

Agenda item 19
Appendix 3

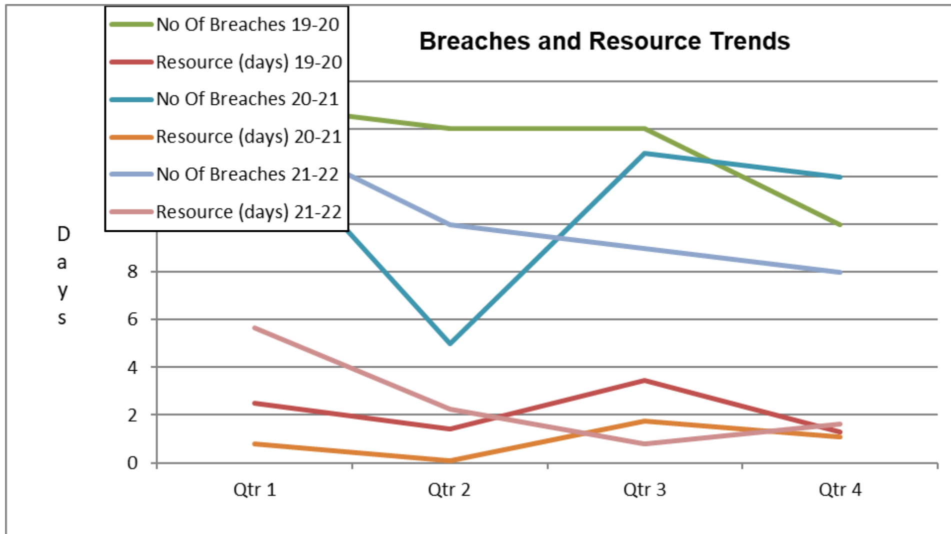
SIRO Report to the Audit and Risk Committee

This will be in a dashboard format for next FY 2022-2023 and will be complete with maturity measures and risk profiles from OneTrust.

The first 'right to be forgotten' request was received under The Data Protection Act 2018 and UK GDPR; a complainant's data was deleted as a result.

a) Breaches

Figure 1: Breaches and Resource Trends to Financial Year 21-22



There has been a constant reporting level of breaches. There are no key anomalies this year.

b) Freedom of Information Scotland Requests

Figure 2: FOISA numbers and complexity FY 2021-2022 (as submitted to OSIC)

Financial Year 2021-22: Quarters	Number	Average Completion Time	Number Late
Q1	38 (25)	3.1 (3.4)	4(12)
Q2	33 (29)	5.8 (5.6)	1(2)
Q3	24 (41)	4.7 (6.6)	4(4)
Q4	38 (31)	3.0 (3.9)	4(8)

The numbers of FOISA requests have remained high but the complexity has reduced which can be seen by the hours for completion. The number late has also stayed constant this year. This is mainly due to the time for Care Inspectorate colleagues to reply to us with data requested due to delays for absence or leave, or a lack of understanding of the importance of the deadline. The latter will hopefully improve as we are training inspectors on the importance of Statutory request as part of their new IG induction.

Agenda item 19
Appendix 3

c) Subject Access Requests

Figure 2: SAR numbers and complexity FY 2021-2022 (FY20-21)

Quarter	Number	Time Per SAR	Number late
Q1	1 (6)	1 (18)	0 (2)
Q2	8 (8)	2.6 (4)	3 (3)
Q3	8 (10)	2.5 (3)	1 (4)
Q4	5 (11)	1.8 (10)	1 (2)

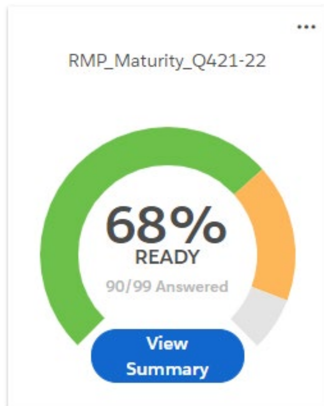
The number of SARs has remained within expected numbers this year and there are no exceptional issues to report.

d) End of Year Maturity

The dashboard has been developed on the OneTrust platform and the scoring is just being adjusted by the One Trust developers. A baseline will then be run to show maturity as at the end of FY 21-22. This will then be run each quarter.

The following shows sample data:

i. The assessment looks at the 15 elements of the Records management Plan and calculates an overall maturity score:



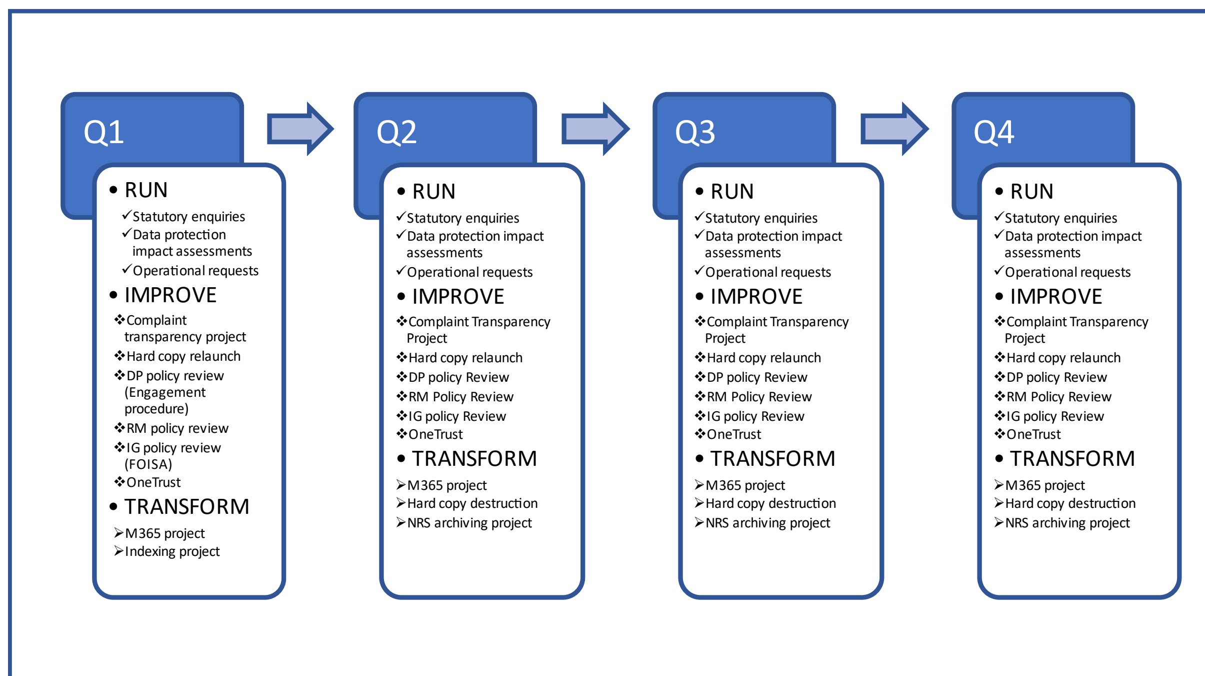
ii. Each element is then broken down and a gap analysis is provided depending on the answers given:

This will allow us to measure maturity at the start of each financial year and at the end of each quarter to plot maturity over time. The gap analysis will be used to inform both an action plan and the information governance risk register.

Agenda item 19
Appendix 4

Projected Deliverables Financial Year 22-23

Deliverable	Projected Target Date
Phase 2 Microsoft 365 project	This project is currently under development with IT colleagues. Deliverables will be identified and agreed organisationally. This project will run until the end of Financial Year 2022-23.
Information policy library review and production of timetable for refresh and process for ongoing monitoring.	This project will run until the end of Financial Year 2022-23.
Hard copy relaunch and refresh/production of associated guidance and training.	This project will run until the end of Financial Year 2022-23.
Hard copy destruction project	This project will run until the end of Financial Year 2022-23.
Process mapping, DPIAs and Risks: Continuing the improvement of the OneTrust data protection management and reporting by IAO functional area.	This project will run until the end of Financial Year 2022-23.
Transfer to National Records Scotland Project planning and commencement	This project will start in quarter 2 and run to the end of the Financial Year 2022-23.
IT Technology Asset management on OneTrust	Project to be scoped and timescales to be agreed with IT colleagues expected to run until the end of the Financial Year 2022-23



Agenda item 25

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	✓	✓	✓	✓	✓
Final Annual Internal Audit Plan 2022/23	✓				
Internal Audit 2021/22 Annual Report	✓				
Internal Audit Plan 2022/23 Progress Report			✓	✓	✓
Draft Annual Internal Audit Plan 2023/24					✓
Audit Assignments					
Workforce Planning	✓				
Corporate Planning	✓				
Scrutiny and Assurance	✓				
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		✓	✓		

Agenda item 25

REPORT/TOPIC	**19 May 2022**	**11 Aug 2022**	**8 Sept 2022**	**17 Nov 2022**	**9 March 2023**
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)*					
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) *(normally first meeting of new cycle – but for 2022/23 will go to Sept meeting to align with new Corp Plan)*			✓		
Strategic Risk Register Monitoring	✓		✓	✓	✓
Digital Programme Update	✓		✓	✓	✓
Cyber Security Action Plan - Presentation	✓				
SIRO Report (Information Governance) (*Annual report)*	✓				
Assurance Mapping (presentation)	✓				
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					✓