ITEM 00

UHI | INVERNESS

Meeting	Audit Committee
Date and time	Tuesday 10 September 2024 at 4.30 p.m.
Location	Virtually – via Microsoft Teams

Governance Officer
02 September 2024

AGENDA

Welcome and Apologies
Declaration of Interests and/or any Statement of Connections or Transparency Statements.

CREATIVE SESSION – RISK REGISTER TRAINING

ITEMS FOR DECISION

1. MINUTES
a.) Minutes of the Meeting held on 04 June 2024
b.) Confidential Note CN-01-062024
c.) Confidential Note CN-02-062024
d.) Confidential Note CN-03-062024

2. OUTSTANDING ACTIONS
a. RECOMMENDATIONS LIST – INTERNAL AUDIT – to follow

3. INTERNAL AUDIT 2024/25
a.) Terms of Reference – Fraud Strategy
b.) Terms of Reference – Core Financial Controls – to follow
c.) Terms of Reference – Staff Wellbeing – to follow
d.) Terms of Reference – Cyber Review – to follow
e.) Terms of Reference – Incidents Management – to follow
f.) Internal Audit Report – Sustainability – Final Report
g.) Internal Audit Report – Professional Development – Final Report
h.) Internal Audit Report – Risk Management – Final Report
i.) Internal Audit Report – Health & Safety – Final Report
j.) Internal Audit Report – Follow Up Review – Draft – September 2024 – to follow

4. RISK REGISTER UPDATE (CONFIDENTIAL)
Report by Director of Finance and Estates

5. EXTERNAL AUDIT
Report by Deloitte

ITEMS FOR DISCUSSION

6. KPI MATRIX
Extract of KPI Matrix completed as at June 2024

7. ANNUAL COMPLIANCE REPORT – DATA PROTECTION
Report by Information Development Manager

8. DRAFT ANNUAL AUDIT COMMITTEE REPORT
Report by Governance Officer

9. FEEDBACK FROM COMMITTEE EVALUATION – to follow
Report by Governance Officer

ITEMS FOR NOTING

10. PUBLIC INTEREST DISCLOSURE UPDATE (CONFIDENTIAL)
Report by Governance Officer

11. AOCB

12. DATE OF NEXT MEETING – Joint Audit and F&GP Committee Meeting 09 December 2024 (subject to change)

If any member wishes to add an item of business to the Agenda, please inform the Chair and the Governance Officer as soon as possible. Additional items of business will be considered for inclusion in the agenda in advance of and at the start of the meeting.

UHI | INVERNESS

Item 02.

Outstanding Actions from Audit Committee Meetings

Item	Action	Responsibility	Timeline	ACTIONED
21 June 2023				
Risk Register Training	The Director of Corporate Governance, UHI will be asked to provide the Committee with the Risk Register presentation as part of a future creative space session.	GO	February 2024	**ONGOING**
12 March 2024				
Longman Site sold December 2023	Audit Committee will monitor for next two years any future sales of the site.	GO	December 2025	**ONGOING**
04 June 2024				
External Audit	Deloitte to provide a written plan for audit 2023/24, with risks and mitigation aspects from college and auditors perspective identified, alongside audit's timeframe.	Deloitte	September 2024	
External Audit	Deloitte to contact OSCR in regard to late financial statements and UHI Inverness being labelled as institution at risk in order to resolve it.	Deloitte	September 2024	**Superseded**

INVERNESS COLLEGE

Fraud Strategy

TERMS OF REFERENCE – Draft

August 2024

SIGN OFF			
ON BEHALF OF BDO LLP		ON BEHALF OF INVERNESS COLLEGE	
SIGNATURE:	Claire Robertson	SIGNATURE:	
TITLE:	Head of DRAS Scotland	TITLE:	
DATE:	23 August 2024	DATE:	

BACKGROUND

BACKGROUND

In accordance with the 2024-25 Internal Audit Plan, it was agreed that Internal Audit would undertake a review of Fraud strategy within Inverness College.

Fraud is referred to as the deliberate use of deception or dishonesty to disadvantage or cause loss (usually financial) - in simple terms, it's a crime in which some kind of deception is used for personal gain. As information systems increase in complexity and public finances tighten there is a risk that internal controls are compromised. This increases the risk of fraud, error and corruption.

The College has signed up to the National Fraud Initiative (NFI). The NFI helps organisations tackle fraud by conducting proactive data matching exercises designed to identify and prevent fraudulent activities. It operates under the oversight of the Public Sector Fraud Authority (PSFA) and is led by Audit Scotland in Scotland.

The College has an Anti-fraud & Corruption Policy in place which was approved in December 2023. The College's Financial regulations and Finance manual, amongst other documents set out its internal controls and processes to prevent and detect fraud. The College have not had any reported instances of fraud or potential fraud in the recent past.

The Fraud Response Plan is currently in draft, and management recognise the need for review and update of the document.

PURPOSE OF THE REVIEW

The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in relation to fraud strategy in the following areas:

- *Policy framework*
- *Risk assessment*
- *Detection and reporting*
- *Fraud response*
- *Training and communication*

EXCLUSIONS/LIMITATIONS OF SCOPE

The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review.

We are reliant on the honest representation by staff and timely provision of information as part of this review.

DETAILED SCOPE, RISKS & APPROACH

The table below and on the following pages outlines the areas which will be covered as part of this review, the key inherent risks associated with the areas under review and our high-level approach to test the design and operational effectiveness (where applicable) of the controls in place to mitigate the risks outlined:

SCOPE AREA	KEY RISKS	APPROACH
Policy framework	1. The College may not have appropriate policies in place which reflect current good practice in the prevention and detection of fraud	• We will assess whether the College has appropriate policies in place which reflect current good practice in the prevention and detection of fraud, such as an Anti-Fraud Policy, Whistleblowing Policy, Code of Conduct, and Declarations of Interest Policy which provide clear guidance to colleagues.
Risk assessment	2. The College may not have fully assessed the fraud risks presented by their activities	• We will assess how the College has assessed fraud risks, including whether a fraud risk assessment has been carried out and identified appropriate mitigating controls and responses to identified risk.
Detection and reporting	3. The processes in place for the detection and reporting of fraudulent activity are unclear. 4. Management may not have sufficient oversight of fraud risks and instances of fraud.	• We will assess whether there are clear processes in place for the detection of fraudulent activity, and that these have been appropriately documented. • We will review arrangements in place for management oversight over fraud risks within the College.
Fraud response	5. The College may not have established an adequate Fraud Response Plan, to investigate and respond appropriately to any reports of suspected fraud, resulting in inconsistent responses to fraud	• We will assess whether the College has established an adequate Fraud Response Plan to investigate and respond appropriately to any reports of suspected fraud, include the need for external reporting.
Training and communication	6. Staff may not receive appropriate training on fraud awareness resulting in instances not being reported 7. The College may not have a culture which promotes fraud awareness.	• We will confirm whether staff receive appropriate training on fraud, which includes red flags and reporting requirements. • We will review steps taken by management to promote zero tolerance to fraud within the College.

Sample sizes will be determined following the completion of our walkthroughs using our Internal Audit Methodology; for example, if a control is performed daily, we may select a sample of fifteen and if monthly a sample of two to three. Where possible full population testing will be conducted utilising data analytics. See the following page for further information. Internal Audit will bring to the attention of management any points relating to other areas that come to their attention during the audit. A closing meeting will be held to discuss findings emerging from the review prior to issue of the draft report. Once the report and recommendations have been agreed following discussions with management, a summary of the findings will be presented to the Audit Committee at its next meeting.

KEY CONTACTS, TIMELINE & LOCATION

KEY CONTACTS				
BDO LLP				
Claire Robertson	Head of Digital, Risk and Advisory Services - Scotland	Head of Internal Audit	T: 07583237579	E: claire.robertson@bdo.co.uk
Sowmya Menon	Internal Audit Manager	Engagement manager	T: 7436050151	E: sowmya.x.menon@bdo.co.uk
Henry Newman	Auditor	Auditor	E: henry.newman@bdo.co.uk	
Inverness College				
Georgie Parker	Vice Principal	Audit Sponsor	E: Georgie.Parker.ic@uhi.ac.uk	
Niall McArthur	Director of Finance & Estates	Audit lead	E: Niall.mcarthur.ic@uhi.ac.uk	
Mo Jarvis	Chief Accountant	Key contact	TBC	

The staff listed above will be contacted during the fieldwork to assist in completion of the assignment. All these staff will be contacted prior to fieldwork to agree the timing of our visit and should be issued with a copy of this terms of reference. It is important that staff involved with the assignment are notified. To assist us in planning the logistics of the assignment, including provision of documents and meeting organisation the above audit coordinator has been nominated.

PLANNED TIMELINE	
AUDIT ACTIVITY	DATE
SCOPING MEETING	23 August 2024
TERMS OF REFERENCE AGREED	TBC
DOCUMENTATION REQUEST DEADLINE	25 September 2024
FIELDWORK COMMENCEMENT	1 October 2024
END OF FIELDWORK	4 October 2024
CLOSING MEETING	10 October 2024
ISSUE OF THE DRAFT REPORT	24 October 2024
RECEIPT OF MANAGEMENT RESPONSES	31 October 2024
ISSUE OF FINAL REPORT	7 November 2024
AUDIT COMMITTEE DATE	TBC
By accepting this Terms of Reference document you are agreeing to the timing of this audit	

LOCATION

We plan to complete this work remotely as agreed with you. We will use a combination of conference calls, video conferencing facilities and emails. We will endeavour to limit the amount of time required of key colleagues via remote working and aim to perform these meetings on site.

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ALLOCATION & FEES

ALLOCATION

This is a 6-day allocation, split as follows:

AREA	DAYS
Planning	*0.5*
Fieldwork	*4.5*
Reviewing and Reporting	*1*

FEES

ACTIVITY	DAYS	RATE (£)	COST (£)
Total Estimated Cost of Review	6	£500	£3,000

BUDGET & ASSUMPIONS

We will charge fees for this assignment in line with our agreed Engagement Letter, including any subsequent changes agreed with you. Our fees for this engagement are set at £3,000 (excluding VAT), this includes planning, delivery, report writing and management review. This fee represents a total of 6 days on a blended day rate of £500. See the table to the left-hand side for a full breakdown of the fees.

The fees are based upon our estimate of the time required to complete the engagement. These costs have been calculated on the assumption that we will receive all information outlined on this page by the dates specified and that we will be granted access to all key personnel.

The allocation outlined to the left-hand side above is based upon our estimate of the time required to complete the engagement outlined within this document. If the scope of work changes, we will communicate with management any predicted over-or-underspend, before invoicing. In addition, we assume for the purposes of estimating the number of days of audit work that there is one control environment, and that we will be providing assurance over controls in this environment. If this is not the case, our estimate of audit day allocation may not be accurate.

TIMING CHANGES AND CANCELLATION

In accepting this Terms of Reference document, you are agreeing to the timing of this audit specified in this document. We will make every effort to accommodate timing changes or cancellation of the audit however any changes within 3 weeks of the start of the fieldwork may result in fees being charged in respect of the audit. Changes with more than 3 weeks' notice will be accommodated at no extra charge.

ACCESS TO INFORMATION & COLLEAGUES

Any unreasonable delay in gaining access to required information or key colleagues will place audit timings at risk and may result in additional fees to you. Any such charges would be notified to you and agreed at the time the issue is identified.

APPENDIX A: DOCUMENTATION REQUEST

Outlined below and on the following page is an initial information request relating to this audit. Timely receipt of this information is critical to ensure that the objectives of the audit are met and that the work is completed on time. We have provided an overview of what we require from you. If you can please ensure to present the requested documentation by **25 September 2024** that would be most appreciated. We have tried to be specific wherever possible; however, please do contact us as soon as possible if you are unsure about any of the information required. Please note that this is an initial request and is not exhaustive – further information requiring your attention (including meetings) will be required at the time of our fieldwork.

INITIAL DOCUMENTATION REQUEST LIST	SCOPE AREA
Anti-fraud & Corruption policy; Whistleblowing Policy; Code of Conduct; Declarations of Interest Policy	*Policy framework*
Fraud risk assessment (or any documentation as evidence of consideration of fraud risks), if available	*Risk assessment*
Financial regulations/ Finance Manual	*Detection and reporting*
Fraud response plan, if available	*Fraud response*
Anti-fraud training (content); Staff anti-fraud training completion rate	*Training and communication*

FOR MORE INFORMATION:

CLAIRE ROBERTSON, DIRECTOR

+44 (0)7583237579

Claire.robertson@bdo.co.uk

Freedom of Information (FOIA)

In the event you are required to disclose any information contained in this report by virtue of the Freedom of Information Act 2000 ("the Act"), you must notify BDO LLP promptly prior to any disclosure. You agree to pay due regard to any representations which BDO LLP makes in connection with such disclosure, and you shall apply any relevant exemptions which may exist under the Act. If, following consultation with BDO LLP, you disclose this report in whole or in part, you shall ensure that any disclaimer which BDO LLP has included, or may subsequently wish to include, is reproduced in full in any copies.

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UHI Inverness College Sustainability (Advisory)

August 2024

IDEAS | PEOPLE | TRUST

CONTENTS

DISTRIBUTION LIST		
For Action	Georgie Parker	Vice Principal - Operations and External Relations
	Mark McKerral	Health, Safety & Sustainability Manager
For Information	Members Of The	Audit & Finance Committee

Report Status	
Lead auditor(s):	Deepasri Selvam
Dates work performed:	20 - 24 May 2024
Additional documentation received:	18 June 2024
Draft report issued:	4 July 2024
Revised draft report issued:	12 August 2024
Management responses received:	23 August 2024
Final report issued:	23 August 2024

Executive Summary

BACKGROUND

UHI Inverness (the 'College') has an Environmental Sustainability Strategy in place for the academic years 2021/22 to 2025/26. As a Scottish Public Body identified by the Climate Change (Duties of Public Bodies Reporting Requirements) (Scotland) Order 2015, the College is obligated to submit annual Public Bodies Climate Change Duties Reports to the Scottish Government. The reporting requirements, initially published in 2015, were expanded by the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020.

The College's sustainability arrangements are relatively new and are currently being embedded into their operational practices.

Further detail on key processes in place at the College can be found at **Appendix I**.

PURPOSE

The purpose of this review was to provide management with advice on improvements that could be made to their sustainability planning arrangements in the following areas:

- Strategy
- Plan
- Policies and Procedures
- Staff & Student Engagement
- Governance
- Monitoring

SUMMARY OF GOOD PRACTICE

- The College has signed up to the Race to Zero campaign and adopted the Scottish Government's sustainable procurement guidelines. This is reflected in the College's procurement practices, which integrates social and environmental considerations. Sustainable procurement further involves environmental considerations, ethical supply chains, and life cycle assessment.
- The Equality Impact Assessment (EqIA) form is integrated into the policy development process for systematic sustainability evaluation. The form is a mandatory part of policy development, assessing the impact of policy changes on sustainability.
- A staff conference "Sustainably Bold, Ambitious and Creative" brought together staff to discuss sustainability in leadership, estates, procurement, learning, and teaching.
- The EAUC - The Alliance for Sustainability Leadership in Education (Roadmap on Net Zero) Action Plan supports the College's staff development in sustainability.
- Campus initiatives promote sustainability and aim to reduce energy and gas consumption.
- The Sustainability Working Group on Microsoft Teams facilitates staff engagement with sustainability objectives.

CONCLUSION

The review recognised that the College has only recently established formal processes relating to sustainability and these are yet to be fully embedded. The College has taken steps towards promoting sustainability within its practices.

Recommendations in this report will support the College in achieving its wider sustainability objectives and enhance the quality of monitoring and reporting of sustainability metrics.

Recommendations

Recommendations

Risk: The Environmental Sustainability Strategy may not be supported by appropriate plans that address environmentally sustainability across campuses

Finding 1 - UHI Inverness Environmental Strategy Review	Type
UHI Inverness has established an Environmental Sustainability Strategy aimed at reducing its environmental impact. This strategy is structured around four strategic objectives that are designed to be specific, measurable, and directly aligned with legislative mandates such as the Climate Change (Emissions Reduction Targets) (Scotland) Act 2019. The strategic objectives encompass leadership and governance, sustainable procurement, estates and campus operations, and curriculum teaching and learning. These objectives are tailored to ensure that the College can meet its goal of achieving net zero carbon emissions by 2040. ► As part of Strategic Objective 1: Leadership & Governance, the College must aim to develop 'a Sustainability Action Plan based on agreed targets'. An operational plan is crucial as it translates the strategic objectives into actionable steps across all campuses, ensuring that the strategy is not only a statement of intent but also a framework for tangible action and accountability. However, the College has not developed plans to operationalise its long-term sustainability goals across all its campuses, which is necessary for the effective execution and tracking of the College's sustainability objectives and the delivery of its strategy. ► As part of Strategic Objective 3: Estates & Campus Operations, the College will work with Inverness Campus Owners Association (ICOA) to develop and implement a Sustainable Travel Plan. This plan aims to maximise opportunities for staff and students to access sustainable travel options. It will also include actions to discourage unsustainable travel options. However, the College has not yet established mechanisms to monitor the use of sustainable versus unsustainable travel means or set measurable targets to enable ongoing reporting.	Design
Implication	
Without an operational plan, the College may encounter challenges in effectively executing and tracking progress against its sustainability objectives, which could lead to regulatory consequences. The operational plan is therefore essential to deliver the strategy successfully and to avoid any potential non-compliance with the requirements set forth by Scottish environmental legislation.	

Recommendations	Action Owner	Management response	Completion date
We recommend that UHI Inverness 1. Develops comprehensive annual plans for each campus to effectively implement their sustainability strategy. These plans should detail specific actions, timelines, and responsible parties to clearly demonstrate achievement of Strategic Objective 1: Leadership & Governance. *Continued overleaf*	Health, Safety and Sustainability Manager	Work is already underway to develop an annual sustainability action plan based on the sustainability strategy, which will encompass actions for both campuses.	December 2024

Recommendations

Risk: The Environmental Sustainability Strategy may not be supported by appropriate plans that address environmentally sustainability across campuses

Finding 1 - UHI Inverness Environmental Strategy Review			Type
Recommendations	Action Owner	Management response	Completion date
We recommend that UHI Inverness 2. Establish mechanisms to monitor and report on delivery of its Sustainability sub-strategy, including sustainable travel. This should include the introduction of performance indicators specific to staff travel. This will enable the EMT to conduct detailed analysis and ensure the College's travel practices align with its commitment to sustainability as per Strategic Objective 3: Estates & Campus Operations.	Health, Safety and Sustainability Manager	We will investigate what indicators we can reasonably extract from current systems with regard to sustainable travel. As systems are upgraded or replaced, we will ensure sustainability monitoring is built in.	April 2025

Recommendations

Risk: The College may not have adequate policies and procedures in place which support sustainable practices.

Finding 2 - Overdue review of policy and procedures	Type
It is important for the College to maintain robust policies and procedures that support sustainable practices, ensuring compliance with environmental regulations and demonstrating the College's commitment to sustainability. We found the College's Waste Management Policy and Procedure are key documents that articulate the College's commitment to responsible and sustainable waste management. The Staff Travel and Transport Procedure is also vital for mitigating the environmental impact of staff commuting, reflecting the College's initiative to sustainability and cost-efficiency in travel expenditures. Upon review, we noted the following: • The Waste Management Policy, approved by the Board of Management on 24 March 2016, is due for a triennial review or earlier if mandated by new legislation. At the time of the audit, review of the policy is overdue. • The Waste Management Procedure, approved by the Senior Management Team on 18 August 2014, was due for review in November 2018 and is currently overdue. • The Staff Travel and Transport Procedure, last approved by the Executive Management Team (EMT) in October 2021 was due for review in February 2023 and at the time of the audit, has not been updated. Moreover, we noted that both, the staff travel policy and procedure documents endorse using the most cost-effective mode of travel. However, these documents lack alignment with the College's sustainability objective around travel.	Effectiveness

Implication

The failure to review these documents as scheduled could result in the College's sustainable practices becoming outdated, potentially leading to non-compliance with current environmental legislation and regulations. This oversight may also hinder the College's ability to adapt to new sustainability challenges and technologies, thereby affecting its commitment to reducing its environmental impact.

Recommendations	Action Owner	Management response	Completion date
We recommend that UHI Inverness 1. Initiate the review process for both the Waste Management Policy and the Waste Management Procedure. This should involve assessing the current effectiveness of the policy and procedure, incorporating any new legislative requirements, and updating the documents to reflect best practices in waste management. *Continued overleaf*	Estates and Campus Services Manager	A review will be completed	April 2025

Recommendations

Risk: The College may not have adequate policies and procedures in place which support sustainable practices.

Finding 2 - Overdue review of policy and procedures			Type
Recommendations	Action Owner	Management response	Completion date
We recommend that UHI Inverness 2. Prioritises the review of the Staff Travel and Transport Procedure without further delay. This review should include an assessment of current travel practices against the latest environmental standards and HMRC guidelines. Additionally, we advise that the policy and procedure be updated to align with the sustainability objectives. This ensures that staff are not only cost-effective in their choices but also sustainable, contributing to the broader environmental goals of the organisation.	Finance and Estates Director	The staff travel & transport policy has been reviewed/ approved in Dec 23, and not due for review until 2026, but will review & update accordingly. The staff travel & transport procedure is due for review, so will review & update accordingly	December 2024

Recommendations

Risk: The College may not have appropriate governance structures in place to monitor performance against their sustainability related objectives.

Finding 3 - Exclusion of campus from performance monitoring	Type
It is important that the College has appropriate governance arrangements in place for ensuring that sustainability-related objectives are effectively monitored. UHI Inverness tracks and reports on its environmental performance using a Key Performance Indicator (KPI) matrix. This matrix records carbon dioxide emissions for the Beechwood Innovation Campus and the Balloch-School of Forestry, as well as waste output for these two campuses and the Burnett Road Campus. The matrix is in line with the Scottish Government's measurement criteria, with updates on carbon dioxide emissions from utilities made monthly and waste sent to landfill reported quarterly. However, upon review we noted that the current KPI matrix does not capture carbon dioxide emissions data for the Burnett Road Campus. This exclusion leads to a gap in the performance measurement for the College's sustainability efforts, as it does not provide a consistent outlook across all three campuses.	Design
Implication	
This exclusion could lead to an incomplete understanding of the College's overall environmental impact, potentially affecting the accuracy of sustainability performance monitoring.	

Recommendations	Action Owner	Management response	Completion date
We recommend that UHI Inverness 1. Revises its KPI matrix to include data from the Burnett Road Campus. This inclusion will provide a comprehensive view of the College's carbon footprint and waste output, ensuring consistency and that all campuses are accounted for in sustainability performance assessments. This change will also align future reports with the College's strategic objectives and enhance the integrity of environmental impact reporting.	Health, Safety and Sustainability Manager	This has already been completed. Burnett Road has been included in the 24-25 KPI matrix.	August 2024

Recommendations

Risk: The College may not monitor sustainability performance.

Finding 4 - Environmental Impact Reporting Process and Data Accuracy Review	Type
The College has established a process to monitor its environmental impact in line with the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020. This process includes collecting and checking data on transport, fuel, and accommodation usage, as well as electricity consumption, which is verified against utility bills. The finance team, together with the Health, Safety & Sustainability Manager, ensures the data is accurate and formatted correctly for the Scottish Government's requirements. Additionally, the College has a statutory obligation to monitor and report its environmental impact in compliance with the same amendment order. Accurate data collection and reporting are critical to fulfilling these duties. During our review, we identified a discrepancy in the waste data reported for one of the College's campuses, the Scottish School of Forestry. The Public Bodies Climate Change Duties Compliance Report for 2022-23 recorded 1 tonne of waste, whereas the document from the waste management contractor (NRS) reported 12 tonnes. The review of the College's compliance with climate change duties is currently an informal process led by the Health, Safety & Sustainability Manager and the Campus Supervisor. It is important to formalise this review to maintain consistent adherence to climate change reporting obligations.	Design
Implication	
Inaccurate reporting of data to the regulator would impact compliance with the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020 and could potentially result in penalties and fines. While the College is monitoring its environmental impact, the informal nature of the review process for the compliance report may lead to inconsistencies and potential non-compliance risks. A formalised review process would provide a structured approach, ensuring that the College's reporting is consistently accurate and meets the required standards.	

Recommendations	Action Owner	Management response	Completion date
We recommend that the College: 1. Implements a secondary verification process or spot check mechanism to review the alignment of reported figures with backup documentation, thereby minimising the risk of errors and omissions in environmental impact reporting.	Health, Safety and Sustainability Manager	A secondary verification process will be implemented.	November 2024

Observations

Observations

Observation 1 - Challenges in sustainability communication and policy compliance verification

The UHI Inverness Environmental Sustainability Sub-Strategy, while publicly accessible online, faces challenges in demonstrating active dissemination to staff and students due to the transition from iConnect to Connect+ in January 2024. This issue is combined by the Health, Safety & Sustainability Manager's inability to access iConnect archives and the Marketing team's peak workload, creating uncertainty in the timeline for record retrieval. Concurrently, the College's Waste Management Policy emphasises a commitment to sustainable practices, yet the verification of past compliance and engagement is hindered by the same archival issues, as the team awaits support during this busy period.

Appendices

Appendix I: Background

The College has adopted a dual-framework approach to sustainability, guided by the UHI Sustainability Strategy, which extends to 2030, and the more specific UHI Inverness Environmental Sustainability Sub-strategy for 2021-26. The overarching strategy was shaped through a collaborative process involving the Net Zero Acceleration Group and the Cross Partnership Group, with a sustainability manager playing a pivotal role in liaising with the UHI Green Champions network. The Cross Partnership Net Zero Strategy Implementation Group oversees the strategy, ensuring regular updates are communicated to the Partnership Council and the Scottish Government.

The Environmental Sustainability Sub-strategy, steered by the Principal and Chief Executive Professor, outlines the College's commitment to environmental stewardship. It provides a roadmap for the Board of Management, staff, students, and stakeholders, focusing on leadership, sustainable procurement, campus operations, and curriculum development. The strategy's effectiveness is measured against key performance indicators, such as carbon emissions reduction and waste management, aligning with the Race to Zero campaign and Scottish Government procurement guidelines. The strategy's formulation involved the Sustainability Working Group and carbon literacy training for leadership, with the Estates and Campus Management Department ensuring alignment with Scottish environmental targets. The Vice Principal – Operations and External Relations leads the initiative, with the strategy undergoing thorough review by the management team and consultations that included staff input.

The College's Sustainable Procurement Policy details the latest local and national developments, mandating the use of sustainable and ethical products and setting annual KPIs, with an Annual Procurement Report submitted for EMT approval. The Waste Management Policy commits to robust waste management practices, adhering to SEPA Zero Waste Regulations and the Waste (Scotland) Regulations 2012. Furthermore, the Estates and Campus Services Department monitors waste management, setting reduction targets and promoting recycling within the College community. The integration of the Equality Impact Assessment (EqIA) into policy development ensures sustainability is considered systematically, with the Policy and Procedure Review Panel (PPRP) providing governance.

Curriculum delivery at the College incorporates sustainability, with modules on sustainable practices embedded across courses and staff training modules designed to enhance sustainability-focused teaching methods. Campus initiatives aim to reduce energy and gas consumption, and a workshop demonstrates the College's collaborative approach to sustainability education. The EAUC Action Plan and the Sustainability Leaders Pack further support staff development, while the Sustainability Working Group on Microsoft Teams and the UHI Green Champions Network foster a culture of sustainability.

The College employs a structured KPI matrix to monitor sustainability performance, focusing on carbon dioxide emissions and waste output. Updated monthly, the matrix informs the EMT and the Board of progress against targets. Carbon emissions data is sourced from the facilities management company, GTFM, while waste data is provided quarterly by the waste contractor, NRS. Staff briefings on KPI reports encourage wider engagement, and the College's environmental impact monitoring complies with the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Amendment Order 2020.

Appendix II: Terms of Reference

Extract from terms of reference
Purpose
The purpose of this review is to provide advise management on improvements which could be made on their sustainability planning arrangements in the following areas: • Strategy • Plan • Policies and Procedures • Staff & Student Engagement • Governance • Monitoring
KEY Risks
1. The College's Environmental Sustainability Strategy may not align with the Scottish Government's environmental targets. 2. The Environmental Sustainability Strategy may not be supported by appropriate plans that address environmentally sustainability across campuses. 3. The College may not have adequate policies and procedures in place which support sustainable practices. 4. There may not be initiatives in place to engage staff and students. 5. The College may not have appropriate governance structures in place to monitor performance against their sustainability related objectives. 6. The College may not monitor sustainability performance.
Exclusions
The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review. This is an advisory engagement, therefore we will not be providing assurance on the control arrangements nor the operating effectiveness of these controls. We are reliant on the honest representation by staff and timely provision of information as part of this review.

Appendix III: Staff Interviewed

BDO LLP appreciates the time provided by all the individuals involved in this review and would like to thank them for their assistance and cooperation.		
Georgie Parker	Vice Principal – Operations and External Relations	Audit Sponsor
Mark McKerral	Health, Safety & Sustainability Manager	Audit Sponsor & Lead

Appendix IV: Limitations and Responsibilities

Management Responsibilities

The Board is responsible for determining the scope of internal audit work, and for deciding the action to be taken on the outcome of our findings from our work.

The Board is responsible for ensuring the internal audit function has:

- The support of the organisation's management team.
- Direct access and freedom to report to senior management, including the Chair of the Audit Committee.
- The Board is responsible for the establishment and proper operation of a system of internal control, including proper accounting records and other management information suitable for running the Company.

Internal controls covers the whole system of controls, financial and otherwise, established by the Board in order to carry on the business of the Company in an orderly and efficient manner, ensure adherence to management policies, safeguard the assets and secure as far as possible the completeness and accuracy of the records. The individual components of an internal control system are known as 'controls' or 'internal controls'.

The Board is responsible for risk management in the organisation, and for deciding the action to be taken on the outcome of any findings from our work. The identification of risks and the strategies put in place to deal with identified risks remain the sole responsibility of the Board.

Limitations

The scope of the review is limited to the areas documented under Appendix II - Terms of reference. All other areas are considered outside of the scope of this review.

Our work is inherently limited by the honest representation of those interviewed as part of colleagues interviewed as part of the review. Our work and conclusion is subject to sampling risk, which means that our work may not be representative of the full population.

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.

FOR MORE INFORMATION:

Claire Robertson, Director

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Level of Assurance:	
Design	Moderate
Effectiveness	Moderate

UHI Inverness

Professional Development Internal Audit Report

June 2024

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CONTENTS

Report Status	
Lead auditor(s):	Deepasri Selvam
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Draft report issued:	20/05/2024
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Final report issued:	21/06/2024

Executive Summary

Level of Assurance		
Design	Moderate	Generally a sound system of internal control designed to achieve system objectives with some exceptions.
Effectiveness	Moderate	Evidence of non compliance with some controls, that may put some of the system objectives at risk.

Summary of Findings			No. of agreed actions
H	0		
M	3		4
L	0		
TOTAL NUMBER OF Findings: 3			

Background and scope

In accordance with the 2023-24 Internal Audit Plan, it was agreed that Internal Audit would undertake a review of the professional development arrangements within Inverness College (the College).

The review focussed on professional development in specific areas such as guidance, training matrix, individuals, learning and teaching observations as well as monitoring processes.

Further detail on key processes in place at the College can be found at Appendix I.

Purpose

The purpose of this review was to provide management and the Audit & Risk Committee with assurance regarding the design and operational effectiveness of the key controls in place for Professional Development. To this end, we assessed whether there is guidance in place that outlines how professional development should be administered, ensuring it is complete and understandable. We also sought to determine if there is an up-to-date role-based training matrix for mandatory training.

We considered whether the training opportunities provided to staff align with the development objectives agreed upon for them and whether professional development reviews are completed by staff on an annual basis, including consideration of future professional development needs. Additionally, we examined how learning opportunities are identified and actioned following learning and teaching observations. Lastly, we reviewed whether records of professional development completed by staff are maintained and if mandatory training is completed by staff.

Conclusion

The audit identified three findings of medium significance, relating to review and update of the College's managerial oversight in training compliance and resolution approach, compliance of Professional Learning and Development Request Form (PD1 form), and review of role-based training matrix approval process.

We also noted some areas of good practice, such as the College's framework for staff development, which is underpinned by clear, accessible policies and procedures. Additionally, the establishment of development pathways for all roles and the annual Professional Review & Development process reflect commitment to staff progression and the enhancement of teaching quality, in line with the College's strategic objectives and sector standards.

As a result, we can provide moderate assurance over the design and operational effectiveness of the College's arrangements in place in relation to professional development.

Our testing did not identify any concerns surrounding the controls in place to mitigate the following risks:

- ✓ There may not be guidance in place which outlines how professional development is to be administered.
- ✓ Professional development reviews (PDR) may not include consideration of future professional development needs.
- ✓ Learning opportunities are not identified and actioned from learning and teaching observations.
- ✓ Records of professional development completed by staff are not maintained.

Executive Summary

Good practice

- **PRD framework documentation:** The College has a framework for the identification, management, and completion of staff development opportunities. This framework is supported by professional development policies and procedures, which are communicated across the College to ensure staff awareness and engagement with available development opportunities. The professional development policies and procedures are accessible to all staff members via the SharePoint. This site acts as a central repository for all relevant documentation, including the Professional Development and Professional Review & Development (PRD) policies, thereby ensuring transparency and ease of access.

- **Guidance:** Guidance documents for both managers and reviewees are provided to ensure clarity on responsibilities and expectations within the Professional Review & Development (PRD) process. Managers are guided on how to prepare for and conduct PRD meetings, complete the PRD form, and handle deferrals and queries. Reviewees are informed about the preparation required for the PRD meeting, including self-evaluation and the completion of Part A of the PRD form.

- **Pathways:** Development pathways are established for all roles within the College, including lecturers and professional services staff. These pathways are utilised annually to address the evolving needs of team members. Documentation of staff meetings and development discussions is maintained and uploaded to the HR system, ensuring transparency and the ability to track progress.

- **Learning and Teaching Review:** The Learning and Teaching Review (LTR) is a key component of the College's strategy to enhance the quality of education. It aligns with the UHI Learning and Teaching Enhancement Strategy and the Professional Standards for Lecturers in Scotland's Colleges. The LTR process encourages lecturers to engage in critical reflection on their teaching practices, fostering professional dialogue and continuous improvement. The LTR model is informed by best practices and research, focusing on peer-to-peer dialogue about learning and teaching.

Summary of key findings

- **Managerial oversight in training compliance and resolution approach:** The College's training compliance is managed through direct verbal communication to address non-compliance, without formal documentation or accountability for line managers.

- **Short-term development course requests:** The review of the Professional Development Team's PD1 form process for short-term development courses at the College identified that for 7 out of 10 samples, there was no PD1 Form and formal documentation was not provided to substantiate the alternate approval process that was followed.

- **Review of role-based training matrix approval process:** The College's Talent Management sub-strategy calls for departmental succession plans with skills matrices, yet these are not formally documented or approved through the PPRP process, relying instead on informal discussions between department managers and EMT line managers.

Detailed findings

Detailed findings

Risk: Mandatory training is not completed by staff.

Finding 1 - Managerial oversight in training compliance and resolution approach	Type
Within the College, there is a diverse range of roles and corresponding training requirements, which are managed through distinct skills matrices and coordinated by the Professional Development team. Line managers bear the responsibility for ensuring staff compliance with mandatory training modules. These modules, provided by iHASCO and Brightspace platforms, are important for maintaining the College's operational standards and safety protocols. The current approach to training compliance is characterised by direct verbal communication between managers and their team members, aimed at resolving non-compliance issues. While this method facilitates immediate action, it lacks formal documentation of individual non-compliance cases and places increased reliance on line managers without holding them accountable for their team members. Overall completion rates are reviewed by Health and Safety (H&S) Committee solely for iHASCO modules every during quarterly performance improvement meetings and discussions are had with the Executive Management Team (EMT), however there is no analysis of trends or recurring instances of non-compliance.	Design 
Implication	**Significance**
The absence of formal documentation for individual non-compliance cases may lead to gaps in accountability and hinder the ability to track and address recurring issues effectively. This could potentially result in non-uniform training standards and impact the College's compliance with regulatory requirements.	Medium

Recommendations	Action Owner	Management response	Completion date
We recommend that: 1. The College establish a process whereby training compliance is monitored and analysed on a regular basis, to identify recurring patterns and trends. There should be follow up with line managers on individual cases for iHASCO and Brightspace modules, where relevant. This process should complement the existing verbal communication strategy and provide a clear record that can be used for accountability and improvement purposes.	Professional Development Manager - Brightspace Health, safety & Sustainability Manager - iHASCO	We accept that any follow up to staff not completing mandatory training is done verbally by the line manager. This is effective and an avoids unnecessary administrative burden. The Principal also regularly communicates to all staff the importance of completing mandatory training. In addition, we will introduce a follow up email to be sent by line managers following their discussion with individuals. We will start to compare the reports of mandatory training completion (Brightspace modules, not just iHASCO H&S) from each semester to see any areas of continual non-compliance	1 August 2024

Detailed findings

Risk: Training opportunities assigned to staff do not align with the development objectives agreed for them.

Finding 2 - Short-term development course requests			Type
The Professional Development Team within the College is responsible for managing and approving staff requests for funding professional development activities through the Professional Learning and Development Request Form (PD1 form) process for short term development. This process ensures that activities are pre-approved, relevant to the staff's role, and aligned with the College's strategic objectives. Management explained that there will be cases where PD1 Forms are not required for certain types of courses/bookings. A sample of 10 staff who are to be enrolled to short term development courses was selected to verify compliance with the PD1 form process. Upon review of the sample provided and through discussions with management, we noted that for 7 of the 10 samples, there was no PD1 form prepared. While a narrative was provided to explain the process followed by the PD team in these instances, such as use of emails, internal discussions and approvals, there was no evidence provided at the time of the audit.			Effectiveness
Implication			**Significance**
Non-compliance with internal procedures and lack of documentary evidence to support staff enrolment to development courses may result in staff not being enrolled to appropriate courses or undue delays impacting staff career development.			Medium
Recommendations	**Action Owner**	**Management response**	**Completion date**
We recommend that the Professional Development team works in close partnership with HR to create a structured follow-up system for PRD completion. This should include: 1. Implement a tracking system to ensure that all professional development activities, especially those that do not follow the standard PD1 form process, are documented with appropriate evidence. 2. Ensure that any exceptions to the standard process are pre-approved and documented with justification and evidence to maintain transparency and accountability.	Professional Development Manager	1. We recognise that staff professional development is initiated in different ways and at different times and the PRD is just one mechanism. To help provide oversight we will explore moving the PRD into Microsoft forms. This will mean that development requests will be pulled out and automatically sent to the PD team for actioning. 2. Even exceptions to the standard process (those not coming through as a PD1) are pre-approved and documented. No PD requests are actioned without pre-approval by the PD manager. We will keep records of approval of courses & bookings by adding another column to our spreadsheet to show this approval process.	1 August 2024

Detailed findings

Risk: There may not be a role-based training matrix in place.

Finding 3 - Review of role-based training matrix approval process			Type
The Talent Management sub-strategy approved by Board states that 'Developing and implementing departmental succession plans, including skills matrices' form of the College's strategic objectives. However, role-based training matrices do not follow the College's formal Policy And Procedure Review Panel (PPRP) process and are typically reviewed and approved through informal discussions between department managers and their Executive Management Team (EMT) line managers. These discussions occur during one-on-one meetings and are not formally documented; therefore, no evidence could be provided at the time of the audit.			Design 
Implication			**Significance**
The informal nature of the review and approval process could lead to inconsistencies and a lack of transparency in how training needs are identified and addressed across the College. This may affect the quality of training and could potentially result in gaps in staff competencies.			Medium
Recommendations	**Action Owner**	**Management response**	**Completion date**
We recommend that: 1. The College formalises the review and approval process for role-based training matrices to ensure consistency and accountability across the board. This should involve the creation of clear documentation that captures the discussions and decisions made during the process.	Professional Development & Academic Administration & Quality Enhancement Lead	We accept there needs to be consistency in the format of the skills matrices so will develop a common template to support this. This will come through our PPRP process. However, the development of the content and the discussions around this needs to sit with each individual line manager and their team. This is an on-going process which may be added to during the course of an academic year and therefore would not be appropriate to come through our PPRP process.	1 August 2024

Appendices

Observations

Observation 1 - Discrepancy in PRD Form date

During our review process, we selected a sample of 15 Professional Development Review (PRD) forms to verify compliance. In our examination, we identified a date discrepancy in one PRD form, which was dated 06 April 2024 for which supporting evidence was provided on 26 March 2024, preceding the date on the form. Upon further inquiry, it was confirmed by the College that the form contained a typographical error, and the date of the form was in fact 06 March 2024. This was supported during a demonstration of the Cipher system, where the PRD was shown to be uploaded on the correct date.

Observation 2 - Professional Review and Development (PRD) reporting and system limitations

Professional Review and Development (PRD) completion is systematically reported, with an 83.9% rate achieved for the 2022-23 academic year, yet the reporting process is delayed by a lag due to paperwork timescales and a non-intuitive HR system that fails to exclude ineligible staff from the sample such as staff who are long-term absent, staff on maternity leave, staff on short term supply contracts, or staff on sabbatical. The current system's limitations necessitate manual follow-ups for non-compliance, which are facilitated by filtering the end-of-year PRD report by Directorate, allowing for targeted investigation into non-completions.

Appendix I: Background

As per the 2023-24 Internal Audit Plan, a review of the College's professional development arrangements was undertaken. The College's Talent Management Strategy, which is in line with the Professional Development (PD) Policy and Procedure, provides direction for the Board of Management in policy formulation, quality enhancement, and setting team objectives. This strategy comprises various aspects including workforce planning, talent attraction, and succession planning. The strategy is measured through Key Performance Indicators (KPIs) such as staff turnover and student-to-staff ratios, which are reviewed by Board committees.

The Quality team is responsible for managing the development of policies, ensuring a review process that involves consultation with staff, unions, and the executive team. Policies are approved by the full Board of Management and made accessible on the SharePoint. The Professional Review & Development (PRD) system is a crucial part of the professional development framework, facilitating one-to-one meetings between staff and line managers. It is reviewed annually to allocate days for development and mandatory training.

The PRD Procedure document provides a guide to the process, detailing preparation, training, and support for professional learning. The PRD Form for Lecturers serves as a self-assessment tool, aligning with GTCS standards and helping in reflection and planning for professional learning. Part A is completed by staff prior to their PRD meeting, and Part B by the line manager post-meeting, setting out a professional learning plan with actions and timelines. Similarly, the PRD Form for Professional Services staff aids in evaluating and planning professional development, with a focus on leadership, performance, and organisational targets. The form utilises the National Occupational Standards to support the PRD process.

The College's professional development approach is documented, guiding the approval process for further training as part of the annual review. Line managers identify training needs and complete a form detailing requirements and next steps, with a budget allocated for training opportunities. The Senior Management panel approves requests for further academic qualifications. Training needs and identification are managed by the PD team. HR provides reports on PRD completion to both the EMT and HR committees.

The PD1 form is used for short-term development requests, while the SD1 process is for long-term development, managed by the PD team in collaboration with line managers and staff members.

Lecturers must register with the General Teaching Council Scotland (GTCS) and adhere to the Professional Standards for Lecturers in Scotland’s Colleges. The HR team monitors GTCS registration compliance through report generation, with these standards informing the Professional Development Reviews (PDRs).

The Learning and Teaching Review (LTR) is an independent quality enhancement process overseen by the Quality team, distinct from the Talent Management strategy and the Professional Development (PD) team's remit. The LTR focuses on assessing the effectiveness of learning and teaching, learner engagement, and the application of resources and strategies through observation, student discussions, and professional dialogue. The sharing of LTR outcomes is at the discretion of the individuals reviewed. Should development needs arise from the LTR, they are addressed by line managers who arrange the necessary continuous professional development (CPD) or take alternative actions. The LTR Coordinator compiles an annual report that outlines effective practices and areas for development, for quality enhancement and staff development planning. This report is disseminated to relevant committees to guide training and provide direction. The LTR Report also clarifies that the LTR is not connected to the Professional Review & Development (PRD) process.

The College mandates that all new staff complete a corporate induction and associated training programmes, which are accessible on the Brightspace platform. New staff are automatically enrolled in these programmes through the HR system upon commencement of their employment. These programmes cover modules such as Information Security with GDPR, Corporate Parenting, Student Carers, Safeguarding, and Gender-based violence. Completion of these programmes, along with the understanding of the Safeguarding policy, is recorded and communicated back to the PD Team to ensure all staff meet the College's training and safety standards. All staff must complete mandatory training pertinent to their roles, with line managers responsible for overseeing their development across different functions.

Appendix II: Definitions

LEVEL OF ASSURANCE	DESIGN OF INTERNAL CONTROL FRAMEWORK		OPERATIONAL EFFECTIVENESS OF CONTROLS	
	FINDINGS FROM REVIEW	DESIGN OPINION	FINDINGS FROM REVIEW	EFFECTIVENESS OPINION
SUBSTANTIAL	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
MODERATE	In the main there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non compliance with some controls, that may put some of the system objectives at risk.
LIMITED	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
NO	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non compliance and/or compliance with inadequate controls.

RECOMMENDATION SIGNIFICANCE	
HIGH	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
LOW	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.
ADVISORY	A weakness that does not have a risk impact or consequence but has been raised to highlight areas of inefficiencies or potential best practice improvements.

Appendix III: Terms of reference

Extract from terms of reference
Purpose
The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in professional development in the following areas: • Guidance • Training Matrix • Individuals • Learning & Teaching Observations • Monitoring
KEY Risks
1. There may not be guidance in place which outlines how professional development is to be administered. 2. There may not be a role-based training matrix in place. 3. Training opportunities assigned to staff do not align with the development objectives agreed for them. 4. Professional development reviews may not be completed by staff on an annual basis. 5. Professional development reviews (PDR) may not include consideration of future professional development needs. 6. Learning opportunities are not identified and actioned from learning and teaching observations. 7. Records of professional development completed by staff are not maintained. 8. Mandatory training is not completed by staff.
Exclusions
The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review. Our work is inherently limited by sampling and therefore will not provide assurance over all professional development arrangements within the college. We are reliant on the honest representation by staff and timely provision of information as part of this review.

Appendix IV: Staff Interviewed

BDO LLP appreciates the time provided by all the individuals involved in this review and would like to thank them for their assistance and cooperation.		
Fiona Gunn	Professional Development Manager	Key contact
Lindsay Snodgrass	Vice Principal – Curriculum, Student Experience and Quality	Audit Sponsor

Appendix V: Limitations and Responsibilities

Management Responsibilities

The Board is responsible for determining the scope of internal audit work, and for deciding the action to be taken on the outcome of our findings from our work.

The Board is responsible for ensuring the internal audit function has:

- The support of the organisation's management team.
- Direct access and freedom to report to senior management, including the Chair of the Audit Committee.
- The Board is responsible for the establishment and proper operation of a system of internal control, including proper accounting records and other management information suitable for running the Company.

Internal controls covers the whole system of controls, financial and otherwise, established by the Board in order to carry on the business of the Company in an orderly and efficient manner, ensure adherence to management policies, safeguard the assets and secure as far as possible the completeness and accuracy of the records. The individual components of an internal control system are known as 'controls' or 'internal controls'.

The Board is responsible for risk management in the organisation, and for deciding the action to be taken on the outcome of any findings from our work. The identification of risks and the strategies put in place to deal with identified risks remain the sole responsibility of the Board.

Limitations

The scope of the review is limited to the areas documented under Appendix II - Terms of reference. All other areas are considered outside of the scope of this review.

Our work is inherently limited by the honest representation of those interviewed as part of colleagues interviewed as part of the review. Our work and conclusion is subject to sampling risk, which means that our work may not be representative of the full population.

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.

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The matters raised in this report are only those which came to our attention during our audit and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. The report has been prepared solely for the management of the organisation and should not be quoted in whole or in part without our prior written consent. BDO LLP neither owes nor accepts any duty to any third party whether in contract or in tort and shall not be liable, in respect of any loss, damage or expense which is caused by their reliance on this report.

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UHI Inverness

Risk Management

Internal Audit Report

August 2024

Level of assurance:	
DESIGN	Moderate
EFFECTIVENESS	Moderate

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CONTENTS

DISTRIBUTION LIST	
FOR ACTION AND INFORMATION	Niall McArthur

REPORT STATUS	
LEAD AUDITOR(S):	Hishaam Munawaree
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Executive Summary

Level of assurance: (see appendix iii for definitions)		
Design	Moderate	System of internal controls is weakened with system objectives at risk of not being achieved.
Effectiveness	Moderate	Non-compliance with key procedures and controls places the system objectives at risk.

Summary of findings (see appendix)			# Of agreed actions
H	0		
M	2		2
L	2		2
Total number of findings: 4			

Background

Risk management is fundamental to colleges to ensure potential threats are identified and analysed and steps are taken to prevent or minimise the impact of risks materialising.

The Scottish Funding Council's Financial Memorandum requires Inverness College (the College) to have an effective policy of risk management and risk management arrangements. It expects that each public sector organisation's internal control systems should include embedded arrangements for identifying, assessing, addressing, reviewing and reporting their risks.

Given the current economic uncertainty, balancing the budget in the education sector is becoming increasingly difficult. Funding from the Scottish Government is not increasing in line with inflation and costs are increasing. Colleges may not have the resources required to mitigate their risks to an acceptable level and therefore difficult decisions may need to be made about their risk appetite.

The College has a Risk Management Policy in place. The Policy is reviewed every three years with the Director of Finance maintaining responsibility as the policy owner.

Alongside the UHI Risk Register that is stored on the centralised Sharepoint for all colleges in the partnership, UHI Inverness also have their own Risk Register which is maintained in the form of a word document. This Risk Register is reviewed quarterly by the Executive Management Team (EMT) and Audit Committee.

The Director of Finance (DoF) has overarching responsibility for supporting the risk identification, management and governance arrangements at the College. Any updates to assessments and risk identification is then fed into quarterly reports to EMT and following their approval, to Audit Committee and the Board.

Purpose

The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in risk management in the following areas:

- Suitable risk strategy and policy
- Identifying risks
- Assessing risks
- Addressing risks
- Reviewing, reporting and monitoring risks
- Risk management training

Conclusion

As part of our review, we have identified four findings, two of which are of medium significance and two of low significance.

Overall, we found some areas of good practice, such as mechanisms for monitoring and reporting the risk register quarterly and assessments of risks.

However, we have raised findings regarding lack of procedural guidance in place for risk management activities and gaps in risk management training.

We have carried out a risk maturity assessment based on the information and documentation provided to us. This has been included in Appendix II. Our recommendations indicate what can be expected from the College in order to progress towards becoming more risk mature.

As a result of our audit, we have provided "Moderate" assurance over the design and operational effectiveness of internal controls.

Executive Summary

Summary of good practice

- **Accessibility of risk management policy:** The risk management policy for UHI Inverness is readily accessible for all employees, students and external readers on their website.
- **Regular reporting:** The Director of Finance updates and sends quarterly reports to the Executive Management Team as well as Audit Committee, ensuring a robust reporting schedule with appropriate oversight. This includes changes to risk scores, risks added/removed and any changes to mitigating actions.
- **Scoring of risks:** Risks are scored on likelihood and impact, as well as a gross and residual score being provided within the risk register, which aligns with good practice. Our testing of a sample of risks within the risk register revealed that the use of UHI Inverness' risk matrix was appropriately considered when scoring risks.

Summary of findings:

The three findings of medium significance have been summarised below:

- **Risk management policy and procedures**: Our review of the governance framework at the College identified that currently there is no clear alignment to strategic objectives or procedural guidance to document the processes in place for risk identification, training arrangements and escalation protocols. Also, there is need for a defined risk appetite.
- **Risk management training:** It was discovered that currently UHI Inverness have no identifiable training arrangements in place for risk management, including at induction, nor is management aware of when the most recent training had taken place for Board and staff.

Additionally, we identified opportunities for improvement during our review of the College's risk register and with respect to formalisation of risk identification.

Detailed Findings

Detailed Findings

Risk: The college may not have clearly documented risk management processes and procedures, including roles and responsibilities, escalation protocols and reporting

Finding 1 - Risk management policy and procedures	Type
Risk management policy UHI Inverness' Risk Management Policy was last revised in December 2023 by the Director of Finance. Upon review of this policy, we identified that whilst it outlines the college's approach to risk management, it does not explicitly state risk management objectives and how these align with the College's strategic objectives. Moreover, while the policy defines the College's general approach towards risk management which is that the number of areas exposed to high risk at any time would be minimised and balanced with a low-risk approach in other areas, and that high-risk areas will be very closely aligned to strategic priorities, the College's risk appetite statement(s) has not been formally defined to ensure there is clear alignment and understanding amongst Board and Executive management on what these areas of high and low risk are. **Risk management procedures** In the context of effective risk management, it is expected that the College's risk management processes are clearly documented, which would serve as a roadmap for all stakeholders. During our review, we noted that there were no documented process that: ► Details how risks are identified and escalated, managed, and reported. ► Defines roles and responsibilities, ensuring that each member of the organisation understands their part in the risk management framework. ► Provides a clear structure for managing risks, which is crucial for decision-making and strategic planning. As per the Risk Maturity Assessment (see Appendix III), in order for the College's risk management framework to be well-managed, risk management objectives should be defined and there is clarity over the risk level that is accepted within the organisation's risk appetite.	Design
Implication	**Significance**
The absence of clearly defined and aligned risk appetite and risk management objectives may result in inconsistency in application of the College's risk management approach. The absence of risk management procedures could lead to ambiguity and inconsistency in the application of risk management practices across the College.	Medium

Detailed Findings

Risk: The college may not have clearly documented risk management processes and procedures, including roles and responsibilities, escalation protocols and reporting

Recommendations	Action Owner	Management Response	Completion Date
We recommend that the College: ► Align its risk management objectives to its strategic objectives and that these are recorded within the Risk Management Policy. ► In consultation with the Board, defines its risk appetite and records this in the form of Board meeting minutes or within its risk management framework documents, ensuring it is considered during regular review of the risk register. We recommend that UHI Inverness documents its risk management procedures specific to its risk management arrangements and protocols, including: ► Detailed processes for risk identification, treatment, procedures for risk escalation and de-escalation, and monitoring and reporting. ► Review arrangements to ensure the procedures remain effective and are updated in line with any changes in the risk landscape or strategic direction of UHI.	Director of Finance & Estates	The Risk Management Policy will be updated, and the risk appetite will be defined in consultation with the Board. The risk management procedures will be updated, including the detailing of the various processes and a regular review to ensure they effective.	December 2024

Detailed Findings

Risk: The College may not be providing appropriate risk management training to relevant staff

Finding 2 - Risk management training	Type
Risk management training is crucial for empowering Board and staff with the knowledge and skills to identify, assess, and take adequate action to mitigate risks. Training would foster a proactive culture of risk awareness that can enhance decision-making and support the College in achieving its objectives. During our review, we were informed that the EMT and Board participated in some form of risk training in February 2023, but no evidence of or records in relation to content or attendance were provided during the audit. Furthermore, it was also noted that there has not been clear identification of which staff roles should receive training. This should be based on those that have been identified as being accountable for identifying and managing risks (*see finding 2*). As per the Risk Maturity Assessment (*see Appendix III*), in order for the College's risk management framework to be well-managed, relevant management should be trained in risk management techniques.	Design & effectiveness
Implication	**Significance**
There is a risk that staff may not be fully equipped to execute their role and responsibilities related to risk management, hence the college may not be adequately prepared to manage potential risks, which could lead to financial losses, reputational damage, or legal liabilities. Without proper training, staff may not recognise early warning signs of risk or may be of the appropriate actions to take in response to risk, leading to delayed or ineffective risk management.	Medium

Recommendations	Action Owner	Management Response	Completion Date
We recommend that management: • Conduct a needs assessment to determine which staff members require risk management training and the level of their training based on their roles and exposure to risk. • Ensure relevant staff and Board receive risk management training at the time of joining and refresher training thereafter on a regular basis. • Document risk management training requirements in the Risk management procedures (*see finding 1*).	Director of Finance & Estates	The audit committee members are to receive risk management training at the next audit committee meeting on 10 September 2024. We will also review which staff members require this training and ensure regular training is provided in the future. This will also be documented in the Risk management procedures	December 2024

Detailed Findings

Risk: The College may not have systematic processes in place to identify risks.

Finding 3 - Responsibility for risk identification			Type
Effective risk management requires a systematic approach to identifying risks that could impact an organisation's ability to achieve its objectives. This typically involves a collaborative effort across various levels of the organisation to ensure that all potential risks are captured and assessed. The policy states that recognition and management of risk is the responsibility of everyone who allocates and/or uses resources. During the audit, we had noted no formalised process for upward feedback of risks identified by the Heads of departments. However, subsequently it was explained by the Director of Finance and Estates that College's senior managers/ department heads report and highlight any risks in their areas to the relevant EMT member, which would then be reviewed and if appropriate, be included in the College risk register. These meetings may be held either fortnightly or monthly. As part of the review by EMT, there is also focus on monthly data information, which looks at a variety of different measures. If there are any risks associated with any of these areas or related areas, these are also included in the College risk register and actions to address these risks noted in a Data presentation spreadsheet. As per the Risk Maturity Assessment (see Appendix II), in order for the College's risk management framework to be well-defined, responsibilities for key risks should be allocated, including to those at management level. Risk management could also be written into the performance expectations of managers.			Design and Effectiveness
Implication			**Significance**
Where responsibilities in relation to risk management have not been defined and/or communicated effectively, there is a greater risk of exposure due to unidentified or unmanaged risks.			Low
Recommendations	**Action Owner**	**Management Response**	**Completion Date**
We recommend that management formalise the risk identification process and associated responsibilities with clear procedures for reporting risks from the departmental level to the EMT.	Director of Finance & Estates	The risk identification process and associated responsibilities will be formalised within the risk management procedures.	December 2024

Detailed Findings

Risk: The College may not have systematic processes in place for addressing risks

Finding 4 - Risk Register	Type
The risk register, a key tool in risk management, should be comprehensive and facilitate the active management of risks. We identified the following opportunities for improvement to strengthen the College's current approach: • Absence of Target Risk Score: Currently, UHI Inverness does not assign target risk scores to its risks. Target risk scores are instrumental in setting clear risk mitigation goals and measuring the effectiveness of risk responses. They should be set to align with the College's risk appetite (*see finding 1*). • Lack of Control Effectiveness Assessment: The risk register does not include an assessment of the effectiveness of the controls that have been implemented. Understanding the strength and performance of existing controls is crucial for identifying areas where additional measures may be required and for ensuring that controls are functioning as intended to mitigate risks. • Omission of Risk Categories: The risk register does not record the risk category for each risk. Categorising risks is a fundamental practice that aids in the organisation and prioritisation of risk management activities. It allows for a more structured approach to addressing risks and facilitates reporting and communication across the college.	Design
Implication	**Significance**
Without target scores, it is challenging to determine the desired level of risk the college is willing to accept after mitigation efforts are in place. The absence of control effectiveness assessments may lead to undetected weaknesses in risk management, and the failure to categorise risks can result in a lack of focus and prioritisation in addressing risks.	Low

Recommendations	Action Owner	Management Response	Completion Date
We recommend that UHI Inverness consider the following to improve their risk register format: • Each risk should be given a target risk score which aligns to the risk appetite for that category of risk to show what an acceptable level of risk is and where further mitigation is required. • For each risk, an assessment should be made of the effectiveness of controls in place e.g. effective, partly effective, ineffective. • Expected action completion dates should be consistently populated for all risks. • The risk category should be populated for each risk. Appendix I provides a template suggested for management to consider.	Director of Finance & Estates	As is noted in the executive summary on page 3 of the report, UHI Inverness use the partnership template for our risk register and so I will liaise with the risk management officer at UHI EO to discuss the potential for changes to this template.	September 2024

Observations

Observation 1 - KPIs
It was observed that the College's suite of KPIs does not currently include performance indicators directly relating to performance of risk management activities, for e.g. to measure the effectiveness of risk responses, monitor the occurrence of risks, or track deviations from expected risk levels. There is regular reporting of the risk register and changes to risk scores and mitigating actions, which ensures there is governance and oversight over risk management.

Appendices

Appendix I: Risk Register Template

Risk Ref.	Risk	Strategic Objective	Risk Category	Inherent Risk			Controls	Type	Control Effectiveness	Residual Risk			Risk Appetite	Target Risk			Actions	Action Owner / Deadline
				Probability	Impact	Score				Probability	Impact	Score		Probabili	Impact	Score		
1	College does not achieve allocated HE student number targets	Strategic Objective X	Strategy	5	4	20	Control 1	Preventative	Effective / Partial / Not Effective	3	4	12	Cautious	3	2	6	Action 1	Owner / Deadline
							Control 2	Detective	Effective / Partial / Not Effective								Action 2	Owner / Deadline

Appendix II: BDO Risk Maturity Assessment

	Risk Governance	Risk Identification and Assessment	Risk Mitigation and Treatment	Risk Reporting and Review	Continuous Improvement
Enabled	Risk management and internal control is fully embedded into operations. All parties play their part and have a share of accountability for managing risk in line with their responsibility for the achievement of objectives.	There are processes for identifying and assessing risks and opportunities on a continuous basis. Risks are assessed to ensure consensus about the appropriate level of control, monitoring and reporting to carry out. Risk information is documented in a risk register.	Responses to the risks have been selected and implemented. There are processes for evaluating risks and responses implemented. The level of residual risk after applying mitigation techniques is accepted by the organisation, or further mitigations have been planned.	High quality, accurate and timely information is available to operational management and directors. The board reviews the risk management strategy, policy and approach on a regular basis, e.g. annually, and reviews key risks, emergent and new risks, and action plans on a regular basis, e.g. quarterly.	The organisational performance management framework and reward structure drives improvements in risk management. Risk management is a management competency. Management assurance is provided on the effectiveness of their risk management on a regular basis.
Managed	Risk management objectives are defined and management are trained in risk management techniques. Risk management is written into the performance expectations of managers. Management and executive level responsibilities for key risks have been allocated.	There are clear links between objectives and risks at all levels. Risk information is documented in a risk register. The organisation's risk appetite is used in the scoring system for assessing risks. All significant projects are routinely assessed for risk.	There is clarity over the risk level that is accepted within the organisation's risk appetite. Risk responses appropriate to satisfy the risk appetite of the organisation have been selected and implemented.	The board reviews key risks, emergent and new risks, and action plans on a regular basis, e.g. quarterly. It reviews the risk management strategy, policy and approach on a regular basis, e.g. annually. Directors require interim updates from delegated managers on individual risks which they have personal responsibility.	The organisation's risk management approach and the Board's risk appetite are regularly reviewed and refined in light of new risk information reported. Management assurance is provided on the effectiveness of their risk management on an ad hoc basis. The resources used in risk management become quantifiably cost effective. KPIs are set to improve certain aspects of the risk management activity, e.g. timeliness of implementation of risk responses, number of risks materialising or surpassing impact-likelihood expectations.
Defined	A risk strategy and policies are in place and communicated. The level of risk-taking that the organisation will accept is defined and understood in some parts of the organisation, and it is used to consider the most appropriate responses to the management of identified risks. Management and executive level responsibilities for key risks have been allocated.	There are processes for identifying and assessing risks and opportunities in some parts of the organisation but not consistently applied in all. All risks identified have been assessed with a defined scoring system. Risk information is brought together for some parts of the organisation. Most projects are assessed for risk.	Management in some parts of the organisation are familiar with, and able to distinguish between, the different options available in responding to risks to select the best response in the interest of the organisation.	Management have set up methods to monitor the proper operation of key processes, responses, and action plans. Management report risks to directors where responses have not managed the risks to a level acceptable to the board.	The Board gets minimal assurance on the effectiveness of risk management.
Aware	There is a scattered, silo-based approach to risk management. The vision, commitment and ownership of risk management have been documented. However, the organisation is reliant on a few key people for the knowledge, skills and the practice of risk management activities on a day-to-day basis.	A limited number of managers are trained in risk management techniques. There are processes for identifying and assessing risks and opportunities, but these are not fully comprehensive or implemented. There is no consistent scoring system for assessing risks. Risk information is not fully documented.	Some responses to the risks have been selected and implemented by management according to their own perception of risk appetite in the absence of a board-approved appetite for risk.	There are some monitoring processes and ad hoc reviews by some managers on risk management activities.	Management does not assure the Board on the effectiveness of risk management.
Naïve	No formal approach developed for risk management. No formal consideration of risks to business objectives, or clear ownership, accountability and responsibility for the management of key risks.	Processes for identifying and evaluating risks and responses are not defined. Risks have not been identified nor collated. There is no consistent scoring system for assessing risks.	Responses to the risks have not been designed or implemented.	There are no monitoring processes or regular reviews of risk management.	Management does not assure the Board on the effectiveness of risk management.

Appendix III: Definitions

LEVEL OF ASSURANCE	DESIGN OF INTERNAL CONTROL FRAMEWORK		OPERATIONAL EFFECTIVENESS OF CONTROLS	
	FINDINGS FROM REVIEW	DESIGN OPINION	FINDINGS FROM REVIEW	EFFECTIVENESS OPINION
SUBSTANTIAL	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
MODERATE	In the main there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non compliance with some controls, that may put some of the system objectives at risk.
LIMITED	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
NO	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non compliance and/or compliance with inadequate controls.

RECOMMENDATION SIGNIFICANCE	
HIGH	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
MEDIUM	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
LOW	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.
ADVISORY	A weakness that does not have a risk impact or consequence but has been raised to highlight areas of inefficiencies or potential best practice improvements.

Appendix IV: Terms of reference

Extract from terms of reference
Purpose
The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in risk management in the following areas: • Suitable risk strategy and policy • Identifying risks • Assessing risks • Addressing risks • Reviewing, reporting and monitoring risks • Risk management training
Key risks
1. The college may not have clearly set out its strategic direction and objectives in relation to risk management. 2. The college may not have clearly documented risk management processes and procedures, including roles and responsibilities, escalation protocols and reporting. 3. The college may not have systematic processes in place to identify risks. 4. The college may not have systematic processes in place to assess risks. 5. The college may not have systematic processes in place for addressing risks. 6. The college may not have adequate reporting in place to management and the Board and its relevant sub-committees in relation to risk management activities. 7. The college may not be providing appropriate risk management training to relevant staff.
Exclusions/limitations of scope
The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review. Our work is inherently limited by sampling operational risk registers and monitoring arrangements and therefore will not provide assurance over all risk management processes within the college. We are reliant on the honest representation by staff and timely provision of information as part of this review.

Appendix V: Staff interviewed

BDO LLP appreciates the time provided by all the individuals involved in this review and would like to thank them for their assistance and cooperation.	
Niall McArthur	Director of Finance and Assets

Appendix VI: Limitations and responsibilities

Management responsibilities

The Audit Committee is responsible for determining the scope of internal audit work, and for deciding the action to be taken on the outcome of our findings from our work. The Committee is also responsible for ensuring the internal audit function has:

- The support of the management team.
- Direct access and freedom to report to senior management, including the Chair of the Audit Committee.

The Board is responsible for the establishment and proper operation of a system of internal control, including proper accounting records and other management information suitable for running the College.

Internal controls covers the whole system of controls, financial and otherwise, established by the Board in order to carry on the business of the College in an orderly and efficient manner, ensure adherence to management policies, safeguard the assets and secure as far as possible the completeness and accuracy of the records. The individual components of an internal control system are known as 'controls' or 'internal controls'.

The Board is responsible for risk management in the organisation, and for deciding the action to be taken on the outcome of any findings from our work. The identification of risks and the strategies put in place to deal with identified risks remain the sole responsibility of the Board.

Limitations

The scope of the review is limited to the areas documented under Appendix II - Terms of reference. All other areas are considered outside of the scope of this review.

Our work is inherently limited by the honest representation of those interviewed as part of colleagues interviewed as part of the review. Our work and conclusion is subject to sampling risk, which means that our work may not be representative of the full population.

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.

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The matters raised in this report are only those which came to our attention during our audit and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. The report has been prepared solely for the management of the organisation and should not be quoted in whole or in part without our prior written consent. BDO LLP neither owes nor accepts any duty to any third party whether in contract or in tort and shall not be liable, in respect of any loss, damage or expense which is caused by their reliance on this report.

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Level of Assurance:	
Design	Moderate
Effectiveness	Moderate

Inverness college

Health and Safety Internal Audit Report

June 2024

IDEAS | PEOPLE | TRUST

CONTENTS

REPORT STATUS	
LEAD AUDITOR(S):	Henry Newman and Abbi McCormack
DATES WORK PERFORMED:	27/11/2023 - 22/03/2024
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Executive Summary

LEVEL OF ASSURANCE:		
Design	Moderate	Generally, a sound system of internal control designed to achieve system objectives with some exceptions.
Effectiveness	Moderate	Evidence of non-compliance with some controls, that may put some of the system objectives at risk.

Summary of Findings		No. of agreed actions
H		
M	1	
L	2	
Total Number of Findings: 3		

Background & scope

In accordance with the 2023-24 Internal Audit Plan, it was agreed that Internal Audit would undertake a review of the health & safety arrangements within Inverness College.

The College has statutory obligations around the health & safety of its staff, students and visitors under the Health and Safety at Work Act 1972. Health & safety is also an important element of the overall corporate governance framework.

Inverness College has a Health and Safety Policy that outlines the College's commitment to developing a culture of competence and continuous improvement in health and safety management and practice. The Policy is available on the College's website.

At the time of scoping this review, the Health, Safety and Sustainability Manager was new in post.

The College uses AssessNET, to store risk assessments and accident and incident information.

Purpose

The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in risk management in the following areas:

- Policy
- Roles and Responsibilities
- Training
- Consistent Approach
- Risk Assessments
- Accidents and Near Misses
- Reporting

Conclusion

As part of our audit work, we identified three findings, one finding was assessed as medium risk relating to level of completion of staff training. Two were of low risk relating to completion of risk assessment forms and review and update of the H&S policy.

The audit also identified some areas of good practice relating to logging of accidents and near-misses, communication of training requirements and application of H&S procedures.

As a result, we are able to provide moderate assurance over the design and operational effectiveness of Inverness College's arrangements in place in relation to Health and Safety.

Our Testing did not identify any concerns surrounding the controls in place to mitigate the following risks:

- ✓ Health and safety roles and responsibilities may not be clearly documented and well understood.
- ✓ Lessons are not learned from accidents and near misses.
- ✓ Comprehensive health and safety risk assessments of key employee activities may not have been undertaken, with mitigation of key risks effectively planned for.

Executive Summary

Summary of good practice

- Accidents and near misses can be logged by any staff member of the organisation using the intranet system.
- Staff are notified of their training requirements and complete the training modules via the iHASCO software.
- Health and safety procedures are consistently applied throughout the university.

Summary of findings

The audit identified one finding of medium significance, summarised below:

- **Staff training completion** – We noted that there were staff who had not completed mandatory and other H&S-related training within the College's defined timescales.

The audit identified two findings of low significance relating to H&S risk assessment forms being completed inconsistently and the H&S policy which was out of date at the time of this audit.

Detailed Findings

Detailed findings

Risk : Health and safety policies and procedures may not have been communicated and required training not provided

Finding 1 - Training completion rates	Type
It is important that management monitor staff H&S training. iHASCO software provides the training modules and can produce reports that would allow management to monitor completion, follow up with employees to complete their training and ensure that staff training is up to date. Refresher training is required to be undertaken every two years. During the audit, we reviewed the training log generated by iHASCO and found: ► 11 staff with training 'not started' within the timescale defined by the College i.e. within three months of joining. One of these were enrolled in May 2022. ► Four teaching staff with training 'in progress' have not completed their training within three months of joining.	Design and Effectiveness
Implication	**Significance**
In the absence of adequate training, there is a risk that staff are unaware of how to manage H&S risks, prevent injury occurring or the correct procedure to follow if an incident occurs.	Medium

Recommendations	Action Owner	Management response	Completion date
We recommend that management ensure that core H&S training completion within mandated timelines is linked to staff performance management to motivate staff to complete training.	Health, Safety & Sustainability Manager	We will include a section on mandatory training within the Professional Review and Development (PRD) process that all staff complete with their line manager on an annual basis. This will create a formal opportunity to review and record progress, alongside less formal periodic reminders and reviews.	1 December 2024

Detailed findings

Risk: Comprehensive health and safety risk assessments of key employee activities may not have been undertaken, with mitigation of key risks effectively planned for.

Finding 2 - Incomplete risk assessments and actions	Type
Risk assessments are carried out by the College on activities and operations that are perceived to be hazardous. The risk assessment form includes measures currently in place to manage the risk and additional controls required. For recurring activities, risk assessments are reviewed and updated, where relevant. During the audit, we reviewed a sample of 10 risk assessments and noted the following: ► One hazard within the emptying fryers risk assessment did not show the risk rating due to a software issue which prevented it from displaying the risk rating ► One instance where the risk assessment form had no 'measures currently in place' for one of the hazards listed within the assessment. The risk assessment was for felling trees and the risk rating associated with it was high. It was explained by the Health, Safety and Sustainability Manager that the control was apparent from the hazard description, however the form was not used correctly. ► For one risk assessment relating to research for a funded project, an additional action was identified during review which was taking a volunteer buddy when lone working. Although the action was undertaken at the time of the activity itself, the action still shows as open as the staff member had not used the form correctly.	Effectiveness
Implication	**Significance**
Where risk assessments are not comprehensive or inconsistently recorded, there is a greater likelihood of misinterpretation of risks and controls by relevant staff resulting in potential harm.	Low

Recommendations	Action Owner	Management responses	Completion date
We recommend that: 1. Refresher training is provided to staff that perform risk assessments to reiterate key details that should be recorded in risk assessment forms and also, the importance of completing actions in a timely manner and retaining evidence of the same.	Health, Safety & Sustainability Manager, Professional Development	We will implement a programme of refresher training for those who are involved in creating or reviewing risk assessments.	1 March 2025

Detailed findings

Risk : There may not be appropriately documented health and safety policies, and procedures, and these may not be clear and well communicated.

Finding 3 - Delay in review of policy			Type
During the audit, we noted that the H&S policy has not been reviewed and updated in line with the College's standard timescale of one year. The policy had been last updated in June 2022, with a review date of October 2023. Management informed that the H&S policy has recently gone through a staff consultation process and is due to be presented to Board at the end of March 2024.			Effectiveness
Implication			**Significance**
There is a risk that policies are not reviewed and updated regularly resulting in out-of-date policies.			Low
Recommendations	**Action Owner**	**Management response**	**Completion date**
We recommend that the review process for the H&S policy is started earlier to allow for sufficient time to complete staff consultation and approval by committees and Board.	Health, Safety and Sustainability Manager	At the next review, we plan to increase the review period to two years. This will allow us to maintain our robust, but time-consuming, review and consultation process and avoid the need to start the next review within a few months of finishing the last.	1 April 2025

Observations

Observation 1 - Review of risk assessments

During our review of risk assessments, we observed that where risk assessments are prepared by managers, they would also be signed off by the manager. It was explained by the H&S Manager that the process allows managers to create and sign off risk assessments as they are ultimately responsible for the risk assessment. Any other staff who create risk assessments must pass them to their line manager for sign off.

Observation 2 - Near misses reporting

During our review, we observed that the Consolidated H&S report dated 6th September 2023 presented to Health, Safety and Wellbeing Committee did not state the number of near misses and instead stated "X near misses". It was explained by the Health, Safety and Sustainability Manager that this was an oversight and that a verbal update had been provided at the meeting. Subsequent reports had the numbers included.

Observation 3 - H&S incidents reporting

We reviewed the accidents and near misses log that the college maintains and found that the report was being used for all incidents that occur within the college and not just health & safety-related, including behavioural incidents. The Health, Safety and Sustainability Manager explained that they are responsible for triaging these to the appropriate departments to deal with and have found this centralised approach a more effective process as it allows an initial review of the record to check for completeness. It was also mentioned that an alternate member of staff has been identified to carry this out in the Health, Safety and Sustainability Manager's absence.

Appendices

Appendix I: Background

The Health and Safety Policies and procedures were first drafted in 2009 and have been updated regularly every year. According to the Health and Safety Manager the review and updating process can take 6 months due to having to go through multiple committees and staff consultations to complete. It is aimed to be reviewed yearly.

Risk assessments in the organisation all have the same format with an assessor, a reviewer and a manager sign off. Each risk assessment is then broken down into individual hazards with risk ratings, hazard information, measures currently in place to prevent the risk of injury and then any additional remedial controls required.

The accidents and near misses' report is generated using AssessNet. Incidents can be raised on the staff intranet page by any member of staff. These are then passed through to the log which can be accessed and reviewed by the health and safety manager. From this point the health and safety manager is responsible for raising lessons learned actions to be completed by the relevant members of staff. When these are actioned, the accident is classed as signed off/ completed.

Health and safety training is delivered by iHASCO, they provide training modules on DSE, fire safety, slips trips and falls and electrical safety. The iHASCO software collects information on completion rates and reports that to the health and safety manager. It also notifies the staff of when their training is due to expire. The health and safety training allows staff members three months allowance past the due date to start and finish their training requirements. Supply staff that work a low number of hours are not required to undertake the same core training modules.

The health and safety manager provides the board with Annual reports on health and safety. As well as this a quarterly report is provided too senior management that shows the figures of how many staff members have completed their required training and a breakdown of all accidents and near misses reported recently as well as any accidents that must be reported to RIDDOR.

APPENDIX II: DEFINITIONS

LEVEL OF ASSURANCE	DESIGN OF INTERNAL CONTROL FRAMEWORK		OPERATIONAL EFFECTIVENESS OF CONTROLS	
	FINDINGS FROM REVIEW	DESIGN OPINION	FINDINGS FROM REVIEW	EFFECTIVENESS OPINION
SUBSTANTIAL	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
MODERATE	In the main there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non compliance with some controls, that may put some of the system objectives at risk.
LIMITED	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
NO	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non compliance and/or compliance with inadequate controls.

RECOMMENDATION SIGNIFICANCE	
HIGH	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.
ADVISORY	A weakness that does not have a risk impact or consequence but has been raised to highlight areas of inefficiencies or potential best practice improvements.

Appendix III: terms of reference

Extract from the terms of reference
Purpose
The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in risk management in the following areas: • Policy • Roles and Responsibilities • Training • Consistent Approach • Risk Assessments • Accidents and Near Misses • Reporting
Key risks
1. There may not be appropriately documented health and safety policies, and procedures, and these may not be clear and well communicated. 2. Health and safety roles and responsibilities may not be clearly documented and well understood. 3. Health and safety policies and procedures may not have been communicated and required training not provided 4. Health and safety policies and procedures may not be consistently applied throughout the College 5. Comprehensive health and safety risk assessments of key employee activities may not have been undertaken, with mitigation of key risks effectively planned for. 6. Accidents and near misses may not be logged or reported. 7. Lessons are not learned from accidents and near misses 8. There may not be adequate, timely or sufficient management and Board reporting in place in relation to health and safety.
Exclusions
The scope of the review is limited to the areas documented under the scope and approach. All other areas are considered outside of the scope of this review. Our work is inherently limited by sampling and therefore will not provide assurance overall health & safety arrangements within the college. We are reliant on the honest representation by staff and timely provision of information as part of this review.

Appendix IV: Staff Interviewed

BDO LLP appreciates the time provided by all the individuals involved in this review and would like to thank them for their assistance and cooperation.		
Mark Mckerral	Health and Safety and Sustainability manager	Audit Lead
Georgie Parker	Vice Principal and external relations	Audit Sponsor

Appendix V: Limitations and Responsibilities

Management Responsibilities

The Board is responsible for determining the scope of internal audit work, and for deciding the action to be taken on the outcome of our findings from our work.

The Board is responsible for ensuring the internal audit function has:

- The support of the organisation's management team.
- Direct access and freedom to report to senior management, including the Chair of the Audit Committee.
- The Board is responsible for the establishment and proper operation of a system of internal control, including proper accounting records and other management information suitable for running the Company.

Internal controls covers the whole system of controls, financial and otherwise, established by the Board in order to carry on the business of the Company in an orderly and efficient manner, ensure adherence to management policies, safeguard the assets and secure as far as possible the completeness and accuracy of the records. The individual components of an internal control system are known as 'controls' or 'internal controls'.

The Board is responsible for risk management in the organisation, and for deciding the action to be taken on the outcome of any findings from our work. The identification of risks and the strategies put in place to deal with identified risks remain the sole responsibility of the Board.

Limitations

The scope of the review is limited to the areas documented under Appendix II - Terms of reference. All other areas are considered outside of the scope of this review.

Our work is inherently limited by the honest representation of those interviewed as part of colleagues interviewed as part of the review. Our work and conclusion is subject to sampling risk, which means that our work may not be representative of the full population.

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.

FOR MORE INFORMATION:

Claire Robertson, Director

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Claire.Robertson@bdo.co.uk

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The matters raised in this report are only those which came to our attention during our audit and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. The report has been prepared solely for the management of the organisation and should not be quoted in whole or in part without our prior written consent. BDO LLP neither owes nor accepts any duty to any third party whether in contract or in tort and shall not be liable, in respect of any loss, damage or expense which is caused by their reliance on this report.

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Audit Committee

Subject/Title:	Draft External Audit Planning Report – 2023/24
Author:	Niall McArthur – Director of Finance & Estates
Meeting:	Audit Committee
Meeting Date:	10 September 2024
Date Paper prepared:	3 September 2024
Brief Summary of the paper:	To provide the audit committee with the draft external audit planning report for the 2023/24 external audit.
Action requested: [Approval, recommendation, discussion, noting]	Discussion

Link to Strategy: Please highlight how the paper links to, or assists with:: ☐ compliance ☐ partnership services ☐ risk management ☐ strategic plan ☐ new opportunity/change	Risk Management Strategic Plan
Resource implications:	No **If yes, please specify**:
Risk implications:	Yes **If yes, please specify:** Financial Operational
Equality and Diversity implications:	N/A
Student Experience Impact:	None
Consultation: [staff, students, UHI & Partners, External] and provide detail	None
Status – [Confidential/Non confidential]	Non-Confidential
Freedom of Information Can this paper be included in "open" business* [Yes/No]	Yes

*If a paper should **not** be included within "open" business, please highlight below the reason.

Its disclosure would substantially prejudice a programme of research (S27)		Its disclosure would substantially prejudice the effective conduct of public affairs (S30)	
Its disclosure would substantially prejudice the commercial interests of any person or organisation (s33)		Its disclosure would constitute a breach of confident actionable in court (s36)	
Its disclosure would constitute a breach of the Data Protection Act (s38)		Other (Please give further details)	

Further guidance on application of the exclusions from Freedom of Information legislation is available via

http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp and

http://www.itspublicknowledge.info/web/FILES/Public_Interest_Test.pdf

Recommendation

For committee members to discuss the report.

Purpose of report

To provide committee members with the draft external audit planning report for the 2023/24 external audit.

External Audit Planning Report for 2023/24

The draft external audit report provided by our external auditors, Deloitte, is attached to this report. This is the second year of the five year contract we have with Deloitte, which was procured by Audit Scotland.

The key areas covered in their report are noted below:

- Planning report – this section includes the responsibilities of the Audit Committee, the external audit explained, a section on continuous communication and reporting, the audit materiality level, the scope of work to be carried out and the approach, highlights the significant risks in the audit, the wider scope requirements, reporting hot topics, audit quality, the purpose of the report and the responsibility statement.

- Technical and sector update – this section includes climate and sustainability reporting, FRC's corporate reporting highlights and any sector developments.

- Appendices – this includes prior year audit adjustments, other responsibilities explained and audit independence and audit fees.

Deloitte.

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Inverness College

Planning report to the Audit Committee on the 2023/24 audit
Issued on 03 September 2024 for the meeting on 10 September 2024

Contents

01 Planning report

02 Technical and sector update

03 Appendices

1.1 Introduction

The key messages in this report

Audit quality is our number one priority. We plan our audit to focus on audit quality and have set the following audit quality objectives for this audit:

- A robust challenge of the key judgements taken in the preparation of the financial statements.
- A strong understanding of your internal control environment.
- A well planned and delivered audit that raises findings early with those charged with governance.

I have pleasure in presenting our planning report to the Audit Committee ("the Committee") of Inverness College ("the College") for the 2023/24 audit. I would like to draw your attention to the key messages of this paper:

Audit plan

We have updated our understanding of the College including discussions with management and review of relevant documentation from across the College.

Based on these procedures, we have developed this plan in collaboration with the College to ensure that we provide an effective audit service that meets your expectations and focuses on the most significant areas of importance and risk to the College.

Key risks

We have taken an initial view as to the significant audit risks the College faces. These are presented as a summary dashboard on page 12.

Wider scope requirements

Reflecting the fact that public money is involved, public audit is planned and undertaken from a wider perspective than in the private sector. The wider-scope audit specified by the Code of Audit Practice broadens the audit of the accounts to include consideration of additional aspects or risks.

In carrying out our risk assessment, we have considered the arrangements in place for each area, building on any findings and conclusions from the previous auditor, planning guidance from Audit Scotland and developments within the organisation during the year. Our wider scope significant risks are presented on pages 12 to 16. As part of this work, we will consider the arrangements in place to secure Best Value (BV).

1.2 Introduction (continued)

The key messages in this report (continued)

Our commitment to quality

We are committed to providing the highest quality audit, with input from our market leading specialists, sophisticated data analytics and our wealth of experience.

Added value

Our aim is to add value to the College through our external audit work by being constructive and forward looking, by identifying areas of improvement and by recommending and encouraging good practice. In this way, we aim to help the College promote improved standards of governance, better management and decision making and more effective use of resources.

We have also shared our recent research, informed perspectives and best practice from our work across the wider public sector on pages 26 to 35 of this plan.

Pat Kenny
Associate Partner

1.3 Responsibilities of the Audit Committee

Helping you fulfil your responsibilities

Why do we interact with the Audit Committee?

- To communicate audit scope
- To provide timely and relevant observations
- To provide additional information to help you fulfil your broader responsibilities

As a result of regulatory change in recent years, the role of the Audit Committee has significantly expanded. We set out here a summary of the core areas of Audit Committee responsibility to provide a reference in respect of these broader responsibilities and highlight throughout the document where there is key information which helps the Audit Committee in fulfilling its remit.

Oversight of external audit

- At the start of each annual audit cycle, ensure that the scope of the external audit is appropriate.
- Implement a policy on the engagement of the external auditor to supply non-audit services.

Integrity of reporting

- Impact assessment of key judgements and level of management challenge.
- Review of external audit findings, key judgements, level of misstatements.
- Assess the quality of the internal team, their incentives and the need for supplementary skillsets.
- Assess the completeness of disclosures, including consistency with disclosures on business model and strategy and, where requested by the College, provide advice in respect of the fair, balanced and understandable statement.

Internal controls and risks

- Review the internal control and risk management systems (unless expressly addressed by separate board risk committee).
- Explain what actions have been, or are being taken to remedy any significant failings or weaknesses.

Oversight of internal audit

- Consider annually whether the scope of the internal audit programme is adequate.
- Monitor and review the effectiveness of the internal audit activities.

Whistle-blowing and fraud

- Ensure that appropriate arrangements are in place for the proportionate and independent investigation of any concerns raised by staff in connection with improprieties.

1.4 Our audit explained

What we consider when we plan the audit

Responsibilities of management

We expect management and those charged with governance to recognise the importance of a strong control environment and take proactive steps to deal with deficiencies identified on a timely basis.

Auditing standards require us to only accept or continue with an audit engagement when the preconditions for an audit are present. These preconditions include obtaining the agreement of management and those charged with governance that they acknowledge and understand their responsibilities for, amongst other things, internal control as is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Financial Reporting Council (FRC) guidance on good practice

The FRC, in its Review of Governance Reporting, issued November 2023, has identified good practice as including a clear statement describing the review undertaken, process and reporting of the outcome of the review of the effectiveness of risk management and internal control systems and clarity on what should be reported from the outcome of the review. This would include whether any weaknesses or inefficiencies were identified and explanations of what actions the board has taken, or will take, to remedy these.

Responsibilities of the audit committee

As explained further in the Responsibilities of the Audit Committee slide on page 5, the Audit Committee is responsible for:

- Reviewing internal financial controls and internal control and risk management systems (unless expressly addressed by a separate board risk committee or by the board itself).
- Monitoring and reviewing the effectiveness of the internal audit function; where there isn't one, explaining the absence, how internal assurance is achieved, and how this affects the work of external audit.
- Reporting in the annual report on the annual review of the effectiveness of risk management and internal control systems.
- Explaining what actions have been or are being taken to remedy any significant failings or weaknesses.

Our response

As stakeholders tell us they wish to understand how external audit challenges and responds to the quality of an entity's control environment, we are seeking to enhance how we plan and report on the results of the audit in response. We will be placing increased focus on how the control environment impacts the audit, from our initial risk assessment, to our testing approach and how we report on misstatements and control deficiencies.

1.5 An audit tailored to you

Overview of our audit plan

Identify changes in your business and environment

The College continues to face significant financial pressures, with rising costs not being matched by increased funding.

Scoping

Our scope is in line with the Code of Audit Practice issued by Audit Scotland. More detail is given on page 10

In our final report

In our final report to you we will conclude on the significant risks identified in this paper, report to you our other findings, and detail those items we will be including in our audit report.

Determine materiality

We will use a materiality level of £562,000 in planning our audit. This is based on forecast gross expenditure. We will report to you any misstatements above £28,000.

Further details on our materiality considerations are provided on page 9.

Significant risk assessment

We have identified significant audit risks in relation to the College. More detail is given on pages 12 to 16.

Quality and Independence

We confirm all Deloitte network firms and engagement team members are independent of the College. We take our independence, and the quality of the audit work we perform very seriously. Audit quality is our number one priority.

1.6 Continuous communication and reporting

Planned timing of the audit

As the audit plan is executed throughout the year, the results will be analysed continuously, and conclusions (preliminary and otherwise) will be drawn. The following sets out the expected timing of our reporting to and communication with you.

Planning	Interim	Year end fieldwork and wider scope	Reporting
• Introduction and Planning meetings • Discussion of the scope of the audit • Discussion of fraud risk assessment • Walkthrough of Business Processes	• Understanding of key business cycles • Discussion of audit fees • Carry out detailed risk assessments • Review of Board and Audit Committee papers and minutes • Review of the work performed by Internal Audit	• Audit of the Report and Financial Statements, including Governance Statement • Year-end audit field work • Complete wider scope procedures • Year-end closing meetings	• Reporting of significant control deficiencies • Final Audit Committee and Board • Submission of final Annual Audit Report to the Board and the Auditor General for Scotland • Submission of audited Report and Financial Statements to Audit Scotland
2023/24 Audit Plan	2023/24 Annual Audit Report		
August 2024	September 2024	October – November 2024	December 2024

Ongoing communication and feedback

1.7 Materiality

Our approach to materiality

Basis of our materiality benchmark

- The audit partner has determined materiality as £562,000 and performance materiality of £393,000, based on professional judgement, the requirement of auditing standards and the financial measures most relevant to users of the Annual Report and Accounts.
- We have used 2% of forecast gross expenditure as the benchmark for determining materiality and applied 70% as performance materiality. We have judged expenditure to be the most relevant measure for the users of the accounts.

Reporting to those charged with governance

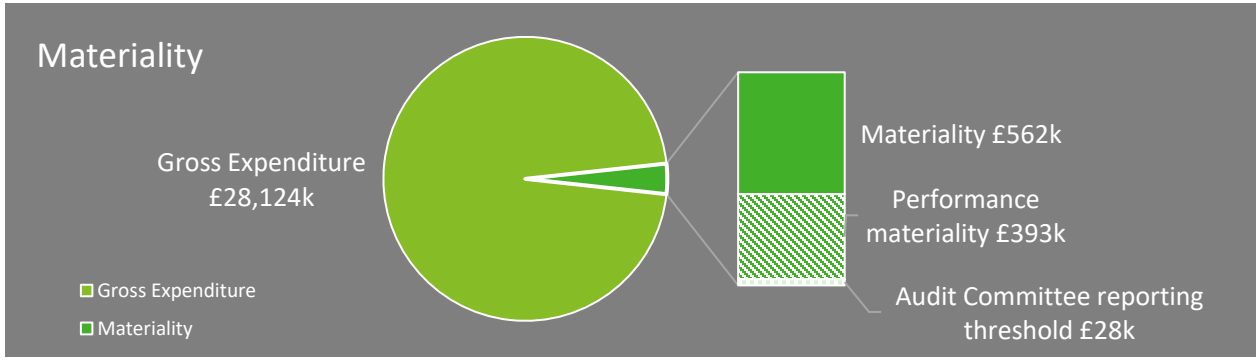
- We will report to you all misstatements found in excess of £28,000.
- We will report to you misstatements below this threshold if we consider them to be material by nature.

Our approach to determining the materiality benchmark is consistent with Audit Scotland guidance, which states that the threshold for clearly trivial above which we should accumulate misstatements for reporting and correction to the Audit Committee must not exceed £250,000.

Our Annual Audit Report

We will:

- Provide comparative data and explain any changes compared to prior year.
- Explain any normalised or adjusted benchmarks we use.
- Explain the concept of performance materiality and state what percentage of materiality we used for entity audits, with our rationale.



Although materiality is the judgement of the audit partner, the Audit Committee must satisfy themselves that the level of materiality chosen is appropriate for the scope of the audit.

1.8 Scope of work and approach

Our key areas of responsibility under the Code of Audit Practice

Auditors activity	Planned output	Proposed reporting timeline to the Committee	Audit Scotland/ statutory deadline
Audit of Annual Report and Accounts	Annual Audit Plan Independent Auditor's Report Annual Audit Report	10 September 2024 9 December 2024 9 December 2024	10 September 2024 31 December 2024 31 December 2024
Wider-scope areas	Annual Audit Plan Annual Audit Report	10 September 2024 9 December 2024	10 September 2024 31 December 2024
Consider and report on Best Value arrangements	Annual Audit Plan Annual Audit Report	10 September 2024 9 December 2024	10 September 2024 31 December 2024

1.9 Scope of work and approach

Our approach

Liaison with internal audit and local counter fraud

The Auditing Standards Board's version of ISA (UK) 610 "Using the work of internal auditors" prohibits use of internal audit to provide "direct assistance" to the audit. Our approach to the use of the work of Internal Audit has been designed to be compatible with these requirements.

We will review their reports and meet with them to discuss their work where necessary. We will discuss the work plan for internal audit, and where they have identified specific material deficiencies in the control environment, we consider adjusting our testing so that the audit risk is covered by our work.

Using these discussions to inform our risk assessment, we can work together with internal audit to develop an approach that avoids inefficiencies and overlaps, therefore avoiding any unnecessary duplication of audit requirements on the College's staff.

Approach to controls testing

Our risk assessment procedures will include obtaining an understanding of controls considered to be 'relevant to the audit'. This involves evaluating the design of the controls and determining whether they have been implemented ("D&I").

The results of our work in obtaining an understanding of controls and any subsequent testing of the operational effectiveness of controls will be collated and the impact on the extent of substantive audit testing required will be considered.

Promoting high quality reporting to stakeholders

We view the audit role as going beyond reactively checking compliance with requirements: we seek to provide advice on evolving good practice to promote high quality reporting.

We use and continually update Financial Reporting Standards ("FRS102") disclosure checklists in conjunction with the requirements of the Further and Higher Education SORP and FReM to support the College in preparing high quality drafts of the Report and Financial Statements, which we would recommend the College complete during drafting.

Other reporting prescribed by the Auditor General

In addition to the opinion on the financial statements, we are also required to provide an opinion on the following:

- The regularity of expenditure and income;
- Whether the audited part of the Remuneration and Staff Report has been properly prepared; and
- Whether the Performance Report and Governance Statement are consistent with the financial statements and have been properly prepared.

2.1 Significant risks

Significant risk dashboard

Risk	Fraud risk	Planned approach to controls	Level of management judgement	Management paper expected	Page no.
Risk 1 – Management override of controls	✓	DI	⚠	✗	13
Risk 2 – Property valuations	✗	DI	⚠	✓	14
Risk 3 – Operating within funding provided	✓	DI	⚠	✗	15
Risk 4 – Completeness and cut-off of income	✓	DI	⚠	✗	16

Level of management judgement

- ⚠ Limited management judgement
- ⚠ A degree of management judgement
- ⚠ Significant management judgement

Controls approach adopted

- DI Assess design & implementation

2.2 Significant risks

Risk 1 – Management override of controls

Risk identified	In accordance with ISA (UK) 240 management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the Report and Financial Statements as well as the potential to override the College's controls for specific transactions. The key judgments in the Report and Financial Statements are those which we have selected to be the significant audit risks – income recognition and operating within the funding provided. These are inherently the areas in which management has the potential to use their judgment to influence the Report and Financial Statements.
Our response	In considering the risk of management override, we plan to perform the following audit procedures that directly address this risk: • We will consider the overall control environment and 'tone at the top'; • We will test the design and implementation of controls relating to journals and accounting estimates; • We will make inquiries of individuals involved in the financial reporting process about inappropriate or unusual activity relating to the processing of journal entries and other adjustments; • We will test the appropriateness of journals and adjustments made in the preparation of the Report and Financial Statements. We will use Spotlight data analytics tools to select journals for testing, based upon identification of items of potential audit interest; • We will review accounting estimates for biases that could result in material misstatements due to fraud and perform testing on key accounting estimates as discussed above; • We will obtain an understanding of the business rationale of significant transactions that we become aware of that are outside of the normal course of business for the entity, or that otherwise appear to be unusual, given our understanding of the entity and its environment.

2.2 Significant risks

Risk 2 – Property Valuation

Risk identified	The College held £56.971m of property assets (land and buildings) at 31 July 2022 which decreased to £56.230m as at 31 July 2023. In 2023/24 the College will perform a full independent valuation of its estate as at 31 July 2024. The College is required to hold property assets within Property, Plant and Equipment at existing use value provided that an active market for the asset exists. Where there is no active market, because of the specialist nature of the asset, a depreciated replacement cost approach may be needed which provides the current cost of replacing an asset with its modern equivalent asset. The valuations are by nature significant estimates which are based on specialist and management assumptions, and which can be subject to material changes in value. The College's land and buildings are revalued every 5 years for the purposes of the financial statements with an interim valuation after 3 years. Land and buildings were valued as at 31 July 2022 (interim valuation) on the basis of depreciated replacement cost by the Colleges appointed external valuer. We are also aware that the College is faced with significant backlog maintenance which is likely to have an impact on the valuation and useful economic life of the buildings. There is therefore a risk that the carrying value of assets not revalued in the year is materially misstated.
Our response	• We will test the design and implementation of key controls in place around the property valuation and impairment assessment performed by management; • We will engage early with the College, using our valuation specialists to challenge the assumptions applied by management in the valuations. • We will test the inputs to the valuation and the key asset information provided by the College to the valuer back to supporting documentation. • We will use our valuation specialists, Deloitte Real Asset Advisory, to review and challenge the appropriateness of the assumptions used in the year-end valuation of the College's Land and Buildings.

2.3 Significant risks (continued)

Risk 3 – Operating within the funding provided

Risk identified	In accordance with Practice Note 10 (Audit of Annual Accounts of public sector bodies in the United Kingdom), in addition to the presumed risk of fraud in revenue recognition set out in ISA (UK) 240, auditors of public sector bodies should also consider the risk of fraud and error on expenditure. This is on basis that most public bodies are net spending bodies, therefore the risk of material misstatement due to fraud related expenditure may be greater than the risk of material misstatement due to fraud related to revenue recognition. We consider this fraud risk to be focused on how management operate within the funding available. The risk is that Inverness College could materially misstate expenditure in relation to year end transactions, in an attempt to align with its tolerance target or achieve a breakeven position. The significant risk is therefore pinpointed to the completeness of accruals and the existence of prepayments made by management at the year end and invoices processed around the year end as this is the area where there is scope to manipulate the final results. Given the financial pressures across the whole of the public sector, there is an inherent fraud risk associated with the recording of accruals and prepayments around year end.
Our response	We will evaluate the results of our audit testing in the context of the achievement of the limits set by the Scottish Funding Council (SFC). Our work in this area will include the following: • Evaluating the design and implementation of controls around monthly monitoring of financial performance and the estimated accruals and prepayments made at the year-end; • Obtain independent confirmation of the funding allocated to the College by the SFC and UHI; • Perform focused testing of a sample of accruals and prepayments made at the year-end; and • Performing focused testing of a sample of invoices received and paid around the year end.

2.4 Significant risks (continued)

Risk 4 – Completeness and cut-off of income

Risk identified	ISA (UK) 240 states that when identifying and assessing the risks of material misstatements due to fraud, the auditor shall, based on a presumption that there are risks of fraud in revenue recognition, evaluate which types of revenue, revenue transactions or assertions give rise to such risks. We have assessed the income streams for the College and concluded that the risk of a material misstatement due to fraud can be pinpointed to the non-recurrent funding as there is no judgement in respect of the recurrent grants from the SFC and UHI. We have pinpointed the non-recurrent funding risk to be in relation to: • Incorrect income cut-off recognition, as there is a risk that the College can manipulate its financial position around the year-end; • Incorrect recognition applied to grant income with conditions attached; and • Incorrect recognition where performance conditions are in place.
Our response	We will perform the following procedures: • Test the design and implementation of key controls in place around the recognition of non-recurrent funding; • Perform focused cut-off testing of a sample of invoices raised and income received around the year-end; • Test a sample of grants for any evidence of clawback of income where conditions of entitlement have not been met; and • Test a sample of grants with performance conditions to ensure income is recognised correctly in line with the outlined requirements.

2.5 Other areas of audit focus

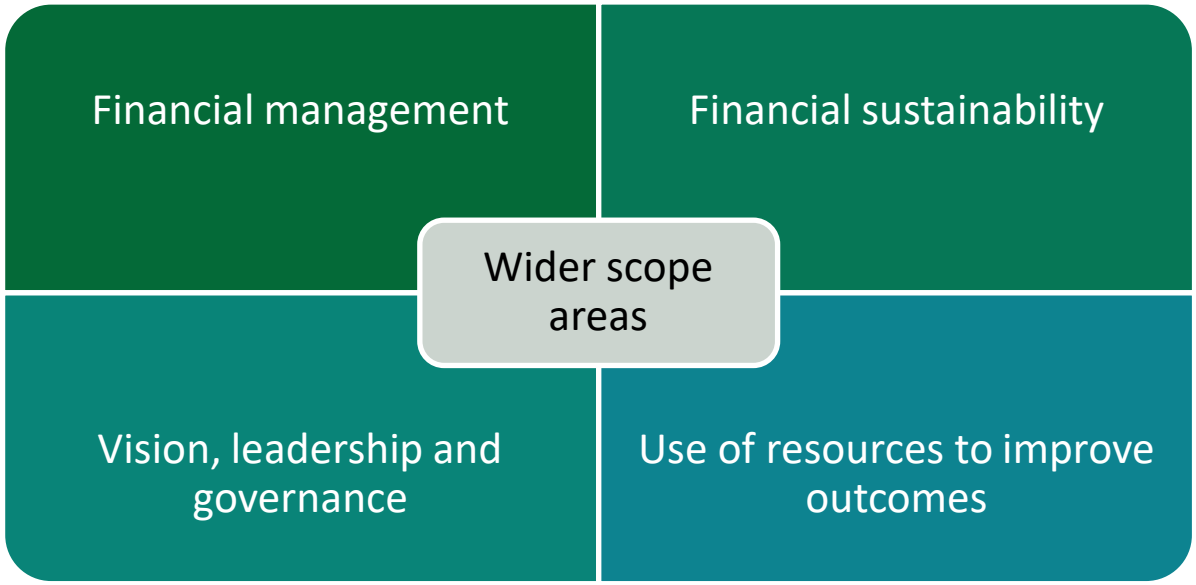
We have identified the below areas of audit interest, although do not consider these to be significant risks

Risk identified	**Pension Liability**
Summary	Retirement benefits to employees of the College are provided by the Highland Council Pension Fund (HCPF), which administers the Local Government Pension Scheme (LGPS) and managed by Highland Council, and the Scottish Teachers Superannuation Scheme (STSS), which is administered by the Scottish Public Pensions Agency (SPPA). The pension situation has transitioned from a state of liability to an asset position between the financial years 2021/22 and 2022/23. Following the updated actuarial valuation, the pension asset was valued at £4,890,0000 as of 31 July 2023. Hymans Robertson LLP are the College's appointed actuary, who produce a detailed report outlining the estimated liability at the year-end along with the associated disclosure requirements. The pension liability valuation is an area of audit focus due to the material value and significant assumptions used in the calculation of the liability. The valuations are prepared by a reputable actuary using standard methodologies and no significant changes in the membership of the scheme or accrued benefits are expected in the current year. As a result, we have not identified this as a significant risk.
Deloitte response	We will perform the following procedures to address the risk: • Engage early with the Pension Fund Auditor to ensure timetables are aligned to provide the required assurances; • Assess the independence and expertise of the actuary supporting the basis of reliance upon their work; • Review and challenge the assumptions made by Barnett Waddingham; • Obtain assurance from the auditor of the pension fund over the controls for providing accurate data to the actuary; • Assess the reasonableness of the College's share of the total assets of the scheme with the Pension Fund annual accounts and the Funds estimated asset position at 31 July 2024; • Review and challenge the calculation of the impact of the McCloud and Goodwin cases on pension liabilities; • Review the disclosures within the accounts against the FE SORP; and • Engage Deloitte's internal pensions experts to assist with the above procedures.

3.1 Wider scope requirements

Overview

Reflecting the fact that public money is involved, public audit is planned and undertaken from a wider perspective than in the private sector. The wider-scope audit specified by the Code of Audit Practice broadens the audit of the accounts to include consideration of additional aspects or risks in the following areas.



The Scottish Public Finance Manual (SPFM) explains that Accountable Officers have a specific responsibility to ensure that arrangements have been made to secure Best Value. Ministerial guidance to Accountable Officers for public bodies sets out their duty to ensure that arrangements are in place to secure Best Value in public services. As part of our wider scope audit work, we will consider whether there are organisational arrangements in place in this regard.

As part of our risk assessment, we have considered the arrangements in place for the wider-scope areas and have summarised the significant risks and our planned response on the following pages

3.2 Wider scope requirements (continued)

Significant risks

Area	Significant risks identified	Planned audit response
Financial sustainability	The financial environment in which the College operates is challenging, with the impact of declining student numbers, together with inflationary pressures and national pay negotiations continuing to exacerbate an already challenging financial position. This creates a risk that the College will not be able to develop viable and sustainable financial plans.	We will assess the development of the 2023/24 budget and the impact on the medium and longer term financial outlook.

3.3 Wider scope requirements (continued)

Other risks

Area	Risks identified	Planned audit response
Vision, leadership and governance	There is a risk around the effectiveness of the governance arrangements in place to ensure there is effective scrutiny, challenge and informed decision making.	We will review the work of the Board and its committees to assess whether the arrangements are operating effectively, including assessing whether there is effective scrutiny, challenge and informed decision making.
Use of resources to improve outcomes	As discussed under financial sustainability, there is a significant risk that the College does not have plans in place to manage its finances sustainably. Linked to this, there is a risk that performance management systems are not sufficient to demonstrate how resources are being directed to improve outcomes.	We will also review the performance reports presented to the Board against the College's strategic objectives to assess how the College is demonstrating the best use of resources to improved outcomes.

3.4 Wider scope requirements (continued)

Other requirements (continued)

Area	Requirements
National Fraud Initiative	The National Fraud Initiative (NFI) in Scotland is a biennial counter-fraud exercise led by Audit Scotland and overseen by the Cabinet Office for the UK as a whole. It uses computerised techniques to compare information about individuals held by different public bodies, and on different financial systems that might suggest the existence of fraud or error. All Colleges, including Inverness College, are participating in the 2023/24 NFI exercise. Participating bodies should have received matches for investigation from January 2024 and these required to be investigated by 30 September 2024. We will monitor the bodies participation and progress during 2023/24 and, where appropriate, include reference to NFI in our Annual Audit Report.
Anti-money laundering	We are required to ensure that arrangements are in place to be informed of any suspected instances of money laundering at audited bodies. Any such instances will be advised to Audit Scotland.
Fraud returns	We are required to prepare and submit fraud returns to Audit Scotland for all frauds at audited bodies: • Involving the misappropriation or theft of assets or cash which are facilitated by weaknesses in internal control. • Over £5,000.

3.5 Reporting hot topics

Ongoing macro-economic uncertainty

Reporting in times of uncertainty

Businesses face unprecedented uncertainty from a variety of sources, including stresses arising from energy supply and costs, inflation, foreign exchange volatility, commodity availability and pricing, global supply chain disruption, labour shortages and the impacts of climate change. Many of these issues are exacerbated by the ongoing conflict between Russia and Ukraine.

High-quality, transparent reporting that clearly explains the impact of these uncertainties on the College's financial position, performance and cash flows, as well as the College's response to these risks, remains as important as ever.

Impact of ongoing macro-economic uncertainty – Considerations

The current macro-economic uncertainty and the resulting challenges have a pervasive impact on the financial statements and need to be considered comprehensively across all account balances and disclosures, in particular those involving estimation or judgement.

Sources of uncertainty likely to impact College's operations and corporate reporting include:

- **High energy costs and risk of energy shortages**
- **Rising interest rates**
- **Rising levels of inflation**
- **Supply chain disruptions**
- **Continued pressures on labour supply and wages**

Impact of ongoing macro-economic uncertainty – Action

We expect all Colleges to have undertaken a comprehensive, evidence-based assessment of the risks relating to macroeconomic conditions including for example, higher energy costs, supply chain disruption, rising levels of inflation, commodity availability and labour shortages. Consideration should be given to how those risks affect both the operations of the College and the impact on the annual report and financial statements as a whole.

We expect Colleges to have considered the pressures throughout the value chain(s) in which they operate, including an assessment of the risks relating to suppliers and operations.

3.6 Reporting hot topics (continued)

Climate related risks

Deloitte view
The expectations of corporate reporting are increasing. While the focus is primarily on corporates, we highlight these areas where improved disclosures would help meet stakeholder expectations. This is also an area of interest from the Auditor General and Accounts Commission.

Accounting for and reporting of climate-related risks – Considerations

Stakeholder expectations

Stakeholders are clear that climate-related risks could be material to businesses in all sectors. In particular, stakeholders ask for clear, specific and quantified information that describes:

- how the impacts of physical and transition risks have been considered in preparing the financial statements;
- what climate-related assumptions and estimates were used to prepare the financial statements; and
- whether narrative reporting on climate risks and the accounting assumptions are consistent, or an explanation for any divergence.

Climate thematic reports

In July 2022, the FCA and FRC published **thematic reviews of Taskforce on Climate Related Financial Disclosures (TCFD) disclosures and climate-related impacts** reported in premium listed entities' financial statements. This follows up on the FRC's 2020 thematic review of climate-related considerations.

The FRC highlighted five broad areas for improvements in climate-change reporting in their thematic review:

- giving more **granular and company specific information** about the effects of climate change on different businesses, sectors and geographies;
- ensuring that the discussion of climate-related risks and opportunities is **balanced**;
- **linking climate-related disclosures**, such as the output of climate-related scenario analysis, with other relevant narrative disclosures in the annual report, such as the business model or strategy;
- explaining how **materiality** has been applied in deciding which climate-related information should be disclosed; and
- ensuring **connectivity between TCFD disclosures and the financial statements** to help investors understand the relationship between climate-related matters and judgements and estimates applied in the financial statements – for example, explaining clearly how different climate-related scenarios and the companies' own net zero commitments have been reflected in the financial statements.

The FRC report also includes disclosure examples and detailed expectations and can be found on the FRC's website here.

3.7 Reporting hot topics (continued)

Climate related risks

Accounting for and reporting of climate-related risks - Action

Governance

The impacts of climate change are a strategic issue that should be on the College agenda and integrated into decision making. We expect entities to have:

- Reviewed their governance, processes and controls for identifying, and responding to, climate-related issues;
- Completed a robust climate assessment including all physical and transition risks;
- Assessed the climate change assumptions used in judgements and estimates in the financial statements;
- Evaluated the appropriateness and consistency of information in the financial statements and narrative disclosures; and
- Prepared a management paper setting out management's climate risk assessment and consideration of the impacts of climate change on the financial statements.

Financial statements

Regarding financial statement disclosures, we expect entities to consider the transparency of information about the climate-related judgements and assumptions. Information should be entity-specific and avoid boilerplate explanations.

The financial statements should clearly disclose:

- What climate-related assumptions have been used in preparing the financial statements;
- How significant climate risks or net zero transition targets have been taken into account in preparing the financial statements;
- Which climate-related scenarios have been considered in sensitivity analysis of climate-related assumptions and how they affect judgements and estimates in the financial statements.

Narrative reporting

We expect the narrative accompanying the financial statements to include the following:

- An explanation of how climate is assessed as a strategic issue.
- Clarity of whether climate change represents a principal or emerging risk and how it is being managed.
- For climate-related targets and metrics, an explanation of how those targets and metrics fit into strategic targets/approach.

3.8 Reporting hot topics (continued)

Cyber risk

Area	Management actions	Impact on the financial statements and annual report	Impact on our audit
Cyber risk	The College's ICT team maintains an Operational Risk Register which is reviewed monthly. An IT Risk Log is also maintained, and the College's IT staff meet monthly to discuss cyber security.	Cyber risk is an increasing area of focus, including a focus for the Auditor General and Accounts Commission. We recommend considering whether any additional disclosure or explanations are appropriate, including discussion of principal risks and uncertainties, or in the Annual Governance Statement. The AGS requires disclosure of how risks to data security are managed and controlled, as well as of any serious information governance incidents.	We will obtain an understanding of the College and its internal controls in relation to cyber as part of our understanding of the College's IT environment. We will make specific enquiries to identify whether a cyber breach has occurred during the period, and evaluate the impact of any cyber incidents, including any potential liabilities arising or impacts on compliance with laws or regulation. We will review the disclosures made for consistency with our understanding from our audit work.

4.1 Audit quality

Our commitment to audit quality

Our objective is to deliver a distinctive, quality audit to you. Every member of the engagement team will contribute, to achieve the highest standard of professional excellence.

In particular, for your audit, we consider that the following steps will contribute to the overall quality:

We will apply professional scepticism on material issues and significant judgements by using our expertise in the sector and elsewhere to provide robust challenge to management.

We have obtained a deep understanding of your business, its environment and of your processes in income and expenditure recognition, payroll expenditure and fixed assets enabling us to develop a risk-focused approach tailored to the College.

Our engagement team is selected to ensure that we have the right subject matter expertise and industry knowledge. We will involve property specialists to support the audit team in our work on the valuation of property assets, IT specialists to support the audit team in our understanding of IT controls, and pension specialists to support the audit team in our work on the pension liability.

In order to deliver a quality audit to you, each member of the core audit team has received tailored learning to develop their expertise in audit skills, delivered by Pat Kenny (Associate Partner).

Engagement Quality Control Review

We have developed a tailored Engagement Quality Control approach.

We have developed a tailored Engagement Quality Control approach. Our dedicated Professional Standards Review (PSR) function will provide a 'hot' review before any audit or other opinion is signed. PSR is operationally independent of the audit team and supports our high standards of professional scepticism and audit quality by providing a rigorous independent challenge.

4.2 Audit quality (continued)

FRC Audit Quality Inspection and Supervision report

We are proud of our people's commitment to delivering high quality audits and we continue to have an uncompromising focus on audit quality. Audit quality is and will remain our number one priority and is the foundation of our recruitment, learning and development, promotion and reward structures.

In July 2024, the FRC issued individual reports on each of the six largest firms, including Deloitte, on Audit Quality Inspections providing a summary of the findings of its Audit Quality Review ("AQR") team for the 2023/24 cycles of reviews.

We greatly value the FRC reviews of our audit engagements and firm wide quality control systems, a key aspect of evaluating our audit quality.

In that context, we are pleased that the percentage of audits inspected by the FRC requiring no more than limited improvements was 94%, which shows a continued improvement on the prior year. The equivalent results for FTSE 350 audits inspected was 100%. One of the audits we inspected was found to require significant improvements. The findings that contributed most to this year's inspection results related to the audit of impairment assessments. We have previously identified key findings and examples of good practice in this audit area. We would review the effectiveness of its actions to ensure greater consistency.

The overall results profile for inspections by the ICAEW was 100% classified as good or generally acceptable These sets of results reflect the continuous investment we are making and our commitment to acting in the public interest to deliver confidence and trust in business through our high-quality audits.

We are also pleased that previous recurring findings relating to revenue and margin recognition and provisions were not identified as key finding in the current FRC inspection cycle, reflecting the positive impact of actions taken in previous years. We nevertheless remain committed to sustained focus and investment in these areas and more broadly to achieve consistently high-quality audits.

All the AQR public reports are available on its website: https://www.frc.org.uk/auditors/audit-quality-review/audit-firm-specific-reports

The AQR's 2023/24 Audit Quality Inspection and Supervision Report on Deloitte LLP

"In the 2023/24 public report, we concluded that the firm had made progress on actions to address our previous findings and made improvements in relation to its audit execution and firm-wide procedures. The firm has continued to show improvement, with an increase in the number of audits we assessed as requiring no more than limited improvements to 94% compared with 82% in the previous year and 83% on average over the past five years.

The area which contributed most to the audits' requiring improvement related to impairment assessments." We are pleased to see examples of good practice highlighted by the FRC in respect of our work on impairment and valuations. We remain focused on ensuring greater consistency of our work in this area.

4.3 Audit quality (continued)

Our commitment to audit quality and our system of quality management

Audit quality is at the heart of everything we do and our system of quality management (SQM) supports our execution of quality audits.

The FRC recently promulgated ISQM (UK) 1, a standard that sets out a firm's responsibilities to design, implement and operate a system of quality management for audits, reviews of financial statements, and other assurance or related services engagements.

Led by senior UK leadership, Deloitte UK's ISQM (UK) 1 implementation activities reached successful completion on 15 December 2022.

Deloitte UK performed its first annual evaluation of its system of quality management as of 31 May 2023. This evaluation was conducted in accordance with ISQM (UK) 1 and we concluded our SQM provides the firm with reasonable assurance that the objectives of the SQM are being achieved as of 31 May 2023.

For further details surrounding the conclusion on the operating effectiveness of the firm's SQM, including results of the monitoring activities performed, please refer to the disclosures within Appendix 5 of our publicly available transparency report.

4.4 Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to establish our respective responsibilities in relation to the Report and Financial Statements audit, to agree our audit plan and to take the opportunity to ask you questions at the planning stage of our audit. Our report includes:

- Our audit plan, including key audit judgements and the planned scope; and
- Key regulatory and corporate governance updates, relevant to you.

What we don't report

As you will be aware, our audit is not designed to identify all matters that may be relevant to the College.

Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.

Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the audit procedures performed in the audit of the financial statements and the other procedures performed in fulfilling our audit plan.

Use of this report

This report has been prepared for the Audit Committee, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent.

Other relevant communications

We will update you if there are any significant changes to the audit plan.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP

Glasgow | 03 September 2024

Technical and sector developments

ITEM 05.a

5.1 Climate and Sustainability reporting landscape in the Public Sector

Currently, there are a number of reporting frameworks that are being adopted by the public sector. However the climate and sustainability reporting landscape is changing and with change comes challenge and complexity. A summary of the **current status** of the reporting landscape in the public sector, and the likely **future** of reporting against sustainability and climate-related matters, including the challenges and next steps to consider, is noted below.

Current status | **Future landscape**

HM Treasury

In June 2021, the Financial Reporting Advisory Board (FRAB) as independent advisory board to HM Treasury, established a sustainability subcommittee (SSC) to consider how public sector annual reports and accounts can best reflect climate disclosure reporting matters.

In the March 2023 meeting, FRAB-SCC recommended that HM Treasury (HMT) ensure existing resources are publicised across the Public Sector, including **roll out of Taskforce for Climate-related Financial Disclosures (TCFD)-aligned reporting in a 3-phase approach.**

Phase 1 Application Guidance **applicable for 2023/24** annual reports and accounts – Governance disclosures, high level overview on Strategy, Risk Management and Metrics and Targets.

Phase 2 Application Guidance **applicable for 2024/25** annual reports and accounts) – qualitative focus on risk management with existing metrics and targets recommended disclosures with TCFD elements.

Phase 3 Application Guidance applicable for 2025/26 annual reports and accounts) - quntitative focus with strategy with expanded metrics and targets. The inclusion of scenario analysis and recommended disclosures with TCFD element and to align with the next round of greening government commitments 2025/30 (where possible).

2022 | 2023 | 2024

IPSASB / CIPFA

In 2022, **the IPSASB led a global consultation on advancing public sector specific sustainability reporting.** IPSASB has analysed the responses to the consultation and aims to publish the initial guidance by the end of 2023. IPSASB are looking to develop their guidance to follow the same approach as the International Sustainability Standards Board (ISSB), utilising the TCFD framework.

At its December 2022 meeting, the IPSASB commenced the scoping of public sector specific sustainability reporting. To do this, IPSASB set out to establish **Sustainability Task Force** to focus prioritise research on Sustainability-related, Climate-related & Natural Resources disclosures.

In April 2023, CIPFA **published a report on sustainability reporting in the public sector providing guidance, best practice and advice.** These recommendations draw on standards and frameworks already developed such as TCFD, GRI and ISSB as well as the work ongoing by IPSASB.

The IPSASB **aims to publish** initial guidance by the **end of 2023.**

What next?

- *It is likely that the TCFD framework will be the first sustainability reporting standard implemented for the public sector, notably for Central Government.*
- *Other relevant bodies (E.g. CIPFA and Department of Health & Social Care) to set their own reporting requirements for their respective sectors.*
- *Expect further clarity later this year when the IPSASB guidance is published.*

What about assurance?

In its March 2023 meeting, FRAB recognised the complexity of introducing formal assurance requirements, with plans to implement this only under early consideration by the National Audit Office (similar in the private sector). We recommend that public sector bodies develop a plan to meet the expected reporting requirements and consider what oversight and assurance will be required ahead of year-end.

Next steps

Based on the experiences of existing TCFD reporters, implementation of sustainability reporting frameworks and standards is known to be challenging and early planning is essential to help meet expected reporting requirements. Some key considerations in anticipation of increased focus for the public sector include:

- ***Granularity** – The need for more detail, specificity and granularity was a key theme from the regulator this year. Going beyond the headline of each recommended disclosure is now common practice.*
- ***Connectivity –** Within and between the narrative and financial statement disclosures. In the example of TCFD disclosures, significant focus has been placed on financial quantification of climate impacts and ensuring front and back half disclosures are consistent with each other.*
- ***Access to data –** All sustainability and climate reporting will require additional data, both in terms of quantity and crucially, quality of what is collected and reported. Currently some data may not be readily available or complete, and/or require challenge and oversight to obtain, measure and report.*

5.2 FRC's corporate reporting highlights

Findings of FRC monitoring work

The FRC's Annual Review of Corporate Reporting 2022/23 provides detail on the areas that gave rise to the highest number of queries during the Corporate Reporting Review (CRR) team's monitoring work. The Highlight section summarises the top 10 issues and included below are those issues with most relevance to the NHS

Area	Companies should ensure that…
Impairment of assets	**...key inputs and assumptions applied in impairment testing have been disclosed and explained**, including the relevant values and sensitivity analysis, where required. Additional disclosures are required where headroom is low, and heightened uncertainties over inflation, consumer demand and interest rates may drive a wider range of reasonably possible outcomes for future cashflows and discount rates. Users should be able to understand how assumptions are consistent with discussion of uncertainties elsewhere in the report. **...impairment testing methodology complies with IFRS**, particularly that the grouping of assets into cash generating units (CGUs) is appropriate, the treatment of inflation in the discount rate and cashflows is consistent; and cashflows in 'value in use' calculations reflect the current condition of assets, before any future enhancement expenditure.
Judgements and estimates	**...all significant judgements, including those applied in performing the going concern assessment, have been described.** It is not sufficient to list the matters requiring judgement. **...disclosures about estimates include values, sensitivities and explain significant changes.** Sources of estimation uncertainty with a significant risk of resulting in a material adjustment within one year should be clearly distinguished from other estimates. **...disclosures are reassessed every year** to confirm all relevant matters are captured, immaterial issues are not rolled forward and the assumptions and ranges of reasonably possible outcomes remain appropriate in the company's current circumstances.
Cash flow statements	**...a robust pre-issuance review has been performed.** We found fewer 'routine' errors this year but continue to identify many issues from basic consistency checks, comparing the cash flow statement to other information in the financial statements. Other common errors we find through our desktop reviews relate to classification, netting, and reporting non-cash movements in the cash flow statement.

5.2 FRC's corporate reporting highlights (continued)

Findings of FRC monitoring work

Area	Companies should ensure that…
Strategic Report	**...the strategic report provides a fair, balanced and comprehensive review** of the company's development, position, performance and future prospects. This should include unbiased discussion of positive and negative aspects of performance, a clear articulation of the effects of economic uncertainty on the business, and should address significant movements in the financial statements, including those in the cash flow and balance sheet
Financial instruments	**...material risks arising from financial instruments are adequately disclosed,** along with how these are managed. In particular, this includes risks driven by inflation and rising interest rates, and related hedging arrangements. **...information about banking covenants is provided** unless the likelihood of any breach is considered remote.
Revenue	**...accounting policies are provided for all significant revenue streams** and describe the methodology applied, including the timing of revenue recognition, the basis for recognising any revenue over time, and any significant judgements made in applying those policies. **...they describe inflationary features in customer contracts** and the corresponding accounting treatment.
Provisions and contingencies	...they provide **clear and specific descriptions of the relevant exposure,** including the basis for determining the best estimate of the relevant outflow, and the timeframe over which it is expected to crystallise. **...the calculation and presentation comply with IFRS.** Provisions should not be presented net of any reimbursement asset and a consistent approach should be taken in reflecting the effects of inflation in cash flows and discount rates.
Presentation of financial statements	**...company-specific information about material accounting policies and transactions** is disclosed. It is important that these explain how the policies apply to the company's particular circumstances. **...the financial statements are carefully reviewed.** Common issues we found this year included errors in the classification of intercompany receivables balances between current and non-current, and failure to disclose material impairments of receivables on the face of the income statement.
Fair value measurement	...fair value measurements use market participants' assumptions, and provide high quality disclosures. We find most issues in the disclosure of recurring Level 3 measurements, for which the significant unobservable inputs should be quantified and a sensitivity analysis given. **Companies should consider the need for specialist third party advice** where no internal expertise.

Sector developments

The State of the State report 2024 – Increased demand and lower funding

Background and overview

The 12th edition of Deloitte and Reform's report on the UK public sector was launched in January 2024. Since 2012, we have aimed to create an annual snapshot of what's happening across government and public services to serve as an evidence base for informed discussion.

This year's State of the State finds public attitudes are concerned with NHS waiting lists, immigration and the country's infrastructure – alongside the increased cost of living crisis from prior years.

After years of reacting to crises, the latest State of the State report finds officials across the public sector eager for reform and calling for bold decisions about the future of government and public services.

Some key findings:

- The public expects big government to continue – but could be in for a shock
- Government needs to prioritise, so its aspirations match its resources
- People want public services they can access and complain to when things go wrong
- Digital maturity comes with mature digital problems

Next steps

Full report is available at: The State of the State 2024 | Deloitte UK

Sector developments (continued)

Good practice in annual reporting – National Audit Office (NAO)

Background and overview

Effective annual reporting in the public sector is more important than ever. The COVID-19 pandemic and, more recently, the energy price crisis have resulted in extraordinary public spending interventions by the government to support the public and the economy. Making government spending transparent and understandable to those who fund it – taxpayers – is therefore critical. Annual reports must clearly tell the 'story' of how these monies have been spent and what has been achieved. Crucially, annual reports and accounts must give assurance on how effective outcomes are being secured and how the risk of fraud and loss to the public purse is being appropriately managed and controlled.

Good reporting equips stakeholders with information they can use to hold organisations to account. This is why high-quality annual reports and accounts are fundamental to effective accountability.

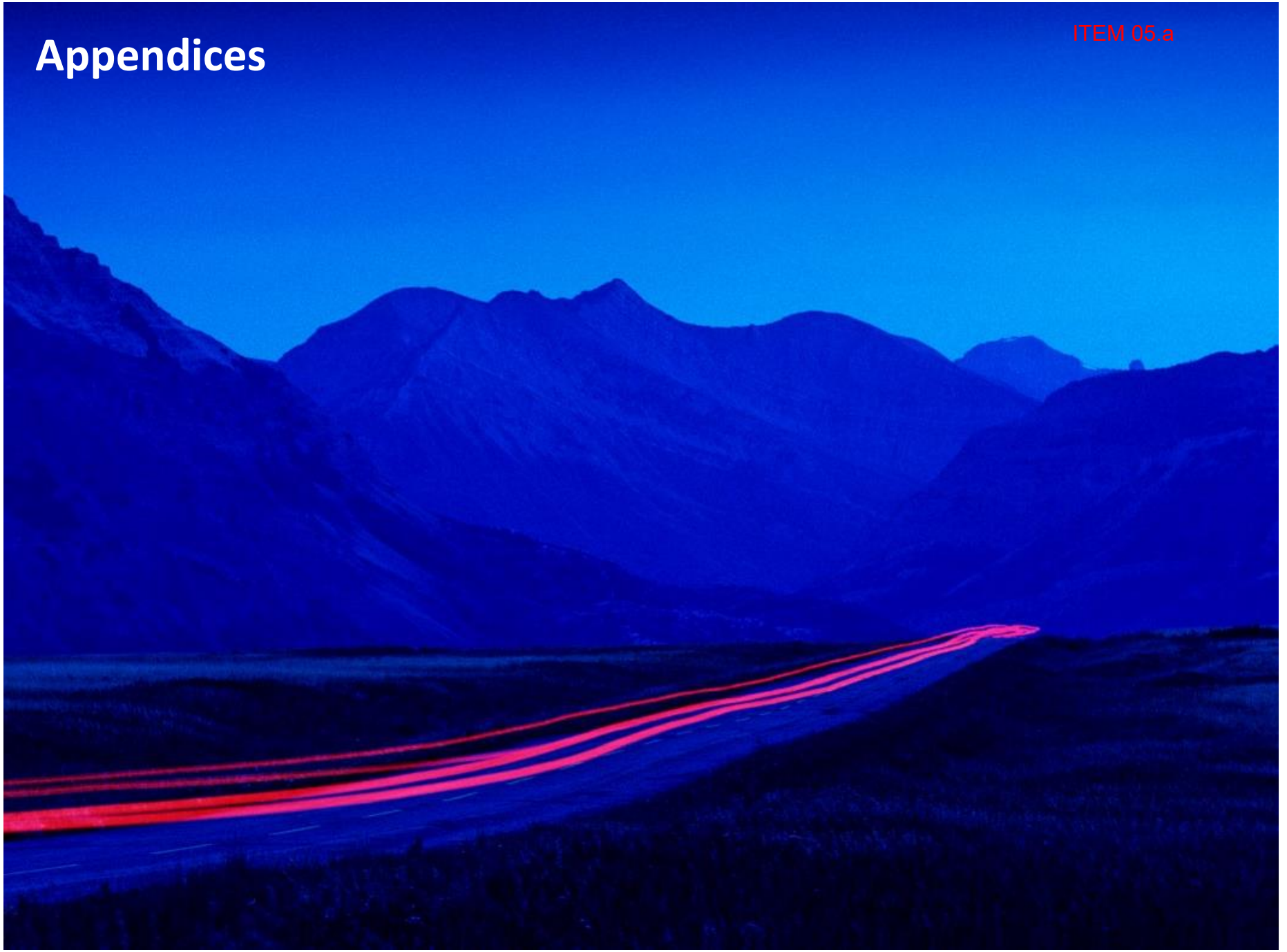
The NAO has published a guide setting out good practice principles that it believes underpin good annual reporting. These principles are grouped under: **Supporting accountability**, **Transparency**, **Accessibility**, and the need for the report to be **Understandable**. Against these principles, the guide highlights examples which demonstrate attributes of good-practice reporting, including:

- Joined-up reporting.
- A frank and balanced assessment of risks and opportunities facing an organisation.
- Understandable non-financial information.
- Linkage between financial and non-financial information.
- Accessibility considerations.

Next steps

The full guide has been shared with management for consideration as part of the preparation for the 2022/23 Annual Report and Accounts and is available at Good practice in annual reporting - National Audit Office (NAO) insight.

Appendices



Prior year audit adjustments

Uncorrected misstatements

The following uncorrected misstatements were identified in relation to the prior year audit:

		Debit/(credit) SOCNE £'000	Debit/(credit) in net assets £'000	Debit/(credit) prior year reserves £'000	Debit/(credit) Profit & Loss £'000	If applicable, control deficiency identified
Misstatements identified in current year						
Impairment of asset held for sale	[1]		(1,060)		1,060	
Non-current creditor	[2]		786		(786)	
Total			**(274)**		**274**	

Our other responsibilities explained

Fraud responsibilities

Your Responsibilities:

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

Our responsibilities:

- We are required to obtain representations from your management regarding internal controls, assessment of risk and any known or suspected fraud or misstatement.
- As auditors, we obtain reasonable, but not absolute, assurance that the financial statements as a whole are free from material misstatement, whether caused by fraud or error.
- As set out in the significant risks section of this document, we have identified risks of material misstatement due to fraud in completeness of income, operating within funding provided, property valuation, and management override of controls.
- We will explain in our audit report how we considered the audit capable of detecting irregularities, including fraud. In doing so, we will describe the procedures we performed in understanding the legal and regulatory framework and assessing compliance with relevant laws and regulations.
- We will communicate to you any other matters related to fraud that are, in our judgment, relevant to your responsibilities. In doing so, we shall consider the matters, if any, regarding management's process for identifying and responding to the risks of fraud and our assessment of the risks of material misstatement due to fraud.

Fraud Characteristics:

- Misstatements in the financial statements can arise from either fraud or error. The distinguishing factor between fraud and error is whether the underlying action that results in the misstatement of the financial statements is intentional or unintentional.
- Two types of intentional misstatements are relevant to us as auditors – misstatements resulting from fraudulent financial reporting and misstatements resulting from misappropriation of assets.

Our other responsibilities explained (continued)

Fraud responsibilities (continued)

We will make the following inquiries regarding fraud and non-compliance with laws and regulations:

Management and other personnel:

- Management's assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments.
- Management's process for identifying and responding to risks of fraud.
- Management's communication, if any, to those charged with governance regarding its processes for identifying and responding to the risks of fraud.
- Management's communication, if any, to employees regarding its views on business practices and ethical behaviour.
- Whether management has knowledge of any actual, suspected or alleged fraud affecting the entity.
- We plan to involve management from outside the finance function in our inquiries, in particular the Principal.
- We will also make inquiries of personnel who are expected to deal with allegations of fraud raised by employees or other parties.

Internal audit

- Whether internal audit has knowledge of any actual, suspected or alleged fraud affecting the entity, and to obtain its views about the risks of fraud.

Those charged with governance

- How those charged with governance exercise oversight of management's processes for identifying and responding to the risks of fraud in the entity and the internal control that management has established to mitigate these risks.
- Whether those charged with governance have knowledge of any actual, suspected or alleged fraud affecting the entity.
- The views of those charged with governance on the most significant fraud risk factors affecting the entity, including those specific to the sector.

Independence and fees

As part of our obligations under International Standards on Auditing (UK), we are required to report to you on the matters listed below:

Independence confirmation	We confirm the audit engagement team, and others in the firm as appropriate, Deloitte LLP and, where applicable, all Deloitte network firms are independent of the College and will reconfirm our independence and objectivity to the Audit Committee for the year ending 31 July 2024 in our final report to the Audit Committee.
Fees	The expected fee for 2023/24, as communicated by Audit Scotland in December 2023 is analysed below:

	£
Auditor remuneration	48,980
Audit Scotland fixed charges:	
• Pooled costs	(5,220)
• Audit support costs	-
• Sectoral cap adjustment	(11,990)
Total expected fee	**31,770**

There are no non-audit fees.

Non-audit services	In our opinion there are no inconsistencies between the FRC's Ethical Standard and the College's policy for the supply of non-audit services or any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary.
Relationships	We have no other relationships with the College, its directors, senior managers and affiliates, and have not supplied any services to other known connected parties.

Deloitte.

UHI | INVERNESS

Board of Management

Subject/Title:	KPI Report
Meeting and date:	Board of Management / Audit Committee September 24
Author:	Martin Whyte, Operations and Commercial Manager
Decision, Discussion or Noting:	Noting / Discussion
Link to Strategic Plan:	**Links to all strategic objectives**
Cost implications:	~~Yes~~ / No *(delete as applicable)* **If yes, please specify:**
Risk assessment:	~~Yes~~ / No *(delete as applicable)* **If yes, please specify:** Financial: Operational: Organisational:

Recommendation(s)

Note the performance measures for the year end.

The finance measures (serials 52-56, & 58) will be completed early/mid-September after year-end adjusting entries have been processed. Details will be provided in the Director of Finance and Estates report to F&GP committee.

Also, year end student success outcomes (serials 27-31) are slightly delayed as resit exam boards are still being convened. Year end student outcomes will be provided early/mid-September when the boards have concluded, and result verified. Details will be provided in the MIS Manager's report to committee.

Main body of information

The KPI RAG report for period 12, July 24, accompanies the paper and presents performance for each measure against the annual target.

Fifty-five performance measures are reported.
Twenty-four measures are satisfactory (Green).
Twelve are unsatisfactory (Red).
Five marginal (Amber).
Two measures (GA and Senior Phase enrolments) have been benchmarked this year and have no target.
Ten measures (finance and student outcomes) do not yet have end of year data.
Two measures, long/short term absence rates, are not in scope as they are a subset of the overall absence rate.

Commentary is provided below for a selection of the measures contained within the report. Measures that have been captured and reported in previous summaries and have not been revised since that report will not be commented upon here.

Comments on specific performance measures

HE Active Applications. Serial 1. RAG RED 88.9%.
HE active applications did not reach the target profiled. There has been an increase since the end of July, through Clearing and GA applications. MIS Manager report will reflect the up-to-date position.

FE Active Applications. Serial 2. RAG GREEN 99.2%.
FE applications fell 19 applications short of target as at the end of July. The data does not capture most of the apprenticeship recruitment as these students tend not to apply. There have been further FE applications in August. MIS Manager report will reflect the up-to-date position.

FE Credits. Serial 3. RAG GREEN 99.6%.
We have achieved our annual SFC Credits threshold. We ended the year 114 FE Credits behind our internal target. The FES Audit is due to take place where any final adjustments will be made, if applicable.

Apprenticeship starts (contract year). Serial 4. RAG AMBER 98.6%.
30 new starts were added in June and July. The position as at the end of July was 4 apprentices short of plan. August apprentice recruitment activity has been outstanding with the Business Solutions team, admissions, and curriculum teams ensuring that we met both our target and the wider UHI target of new contract starts imposed by SDS.

Apprenticeship Income (excluding T&A). Serial 6. RAG RED 90.7%.
£125k below target at year end. Delays in resulting and award completion has had an impact on claims and steps have been taken to address this issue. Business Solutions and curriculum are working together with oversight from the TELs and EMT to recover the shortfall.

Commercial Short Course Income. Serial 8. RAG RED 93.5%.
Commercial income fell £8.5k short of plan. Staff availability has impacted our ability to provide electrical and gas/oil courses which continued to the end of term.

HE APC FTE. Serial 11. RAG RED 88.8%.
Finished the year at 1,259.6 FTE against target 1,418. Full data available from the MIS Manager's report.

Research Income Less Expenditure. Serial 12. RAG RED 93.4%.
The net position at year end is £140k deficit, within the £150k objective. The measure remains red, as it is known that the research dept will have to defer some income to 24-25 which will increase the deficit. Outturn will be known once all adjusting entries have been processed.

Modern Apprenticeship Successful Outcomes (contract year). Serial 32. RAG AMBER 97.2%.

Overall performance for the year fell below the benchmark of 65%. Commentary for serial 6 applies to this measure.

Sickness Levels. Serial 40. RAG RED 118.2%.
2.98% against plan of 2.52%. The Head of HR's report will provide detail on the specific number of working days lost. It is worth noting that the percentage has reduced in each reporting quarter, with the absence rate being 2.4% in the last quarter.

% of Staff Completed Mandatory IHASCO Trg. Serial 49. RAG GREEN 99.1%.
Measure is marginally below 100% achievement, which translates as 80% of staff having completed all IHASCO training in the year. HS&S Manager will continue to monitor performance and encourage continued improvement in this measure.

CO2 Emissions on Utilities. Serial 60. RAG RED 115.2%.
85 tonnes over objective at year end. Disappointing that the excess increased in the final period. A substantial amount of construction, maintenance and similar activities have been underway through the summer repurposing rooms to create flexible and updated teaching spaces. This will have contributed to the excess emissions. HS&S Manager and Estates will continue to work with GTFM and colleagues to reduce output.

% Waste sent to landfill. Serial 61. RAG GREEN 70.5%.
Objective of no more than 15% of total waste is sent to landfill. This measure has been revised in year as our waste partner now disposes of landfill via waste to energy. The overall percentage disposed of rather than recycled is 10.6% which is a marked improvement on last year and on target. The measure will be revised for 24-25 to reflect the new method of disposal.

The information is accessible to all department managers and board members via SharePoint at: IN Management Information > Documents > KPI Matrix

Performance Measures
AY: 2023-2024
Performance Measures- EMT & Board of Management

Measures - Linked to Profile and Actual sheets

AY Start	01 Aug 2023
Today	28 Aug 2024
Period Month	July
No.Periods YTI	12

Key:

B = Not yet in scope	
R = Not Achieved	
A = Partially Achieved	
G = Achieved	

Serial	Measure	Measurement Frequency	2022/23 Actual	2023/24 Target	YTD Profile	YTD ACTUAL	YTD ACTUAL v PROFILE RAG
	Measure 1: CORE FE/HE OUTPUTS						
1	HE Active applications (next AY - Measure from Dec - Jul)	Monthly	1334	1,500.0	1,500	1,333	88.9%
2	FE Active applications (next AY - Measure from Dec - Jul)	Monthly	2049	2,300.0	2300	2,281	99.2%
3	FE Credits	Monthly	30569	26,657	26,657	26,543	99.6%
4	Apprenticeship starts (contract year)	Monthly	385	280	280	276	98.6%
5	Apprentices in Learning (average in year)	Monthly	651	650	638	664	102.1%
6	Apprenticeship Income (excluding T&A)	Monthly	£1,248,012	£1,348,050	£1,348,050	£1,222,884	90.7%
7	FWDF Income	2 monthly	£294,495	£150,000	£150,000	£317,153	211.4%
8	Commercial Short Course Income	Monthly	£137,191	£129,996	£129,996	£121,486	93.5%
9	HE enrolments (head count)	Monthly	1,986	1,986	1,986	1,904	95.9%
10	HE enrolments (year one starts)	Annual	523	670	670	697	104.0%
11	HE APC FTE (from Oct)	Monthly	1,251.8	1,418.0	1,418.0	1,259.6	88.8%
12	Research - Income less expenditure	Biannual	£195,223	£150,000	£150,000	£140,043	-93.4%
13	GA Programmes - New Enrolments (confirm monitoring period) (23/24 benchmark yr)	Review				92.0	
14	Senior Phase Enrolments (23/24 benchmark yr)	Review				667.0	
	MEASURE 2: SATISFACTION MEASURES						
18	Early Satisfaction & Engagement Survey (ESES)	Annual	95.3%	96%	96.0%	96.0%	100.0%
19	National Student Survey (NSS)	Annual	80.0%	83%	83.0%	82.0%	98.8%
20	Student Satisfaction & Engagement Survey (SSES)	Annual	93.0%	95%	95.0%	92.0%	96.8%
22	Post Graduate Taught Experience Survey (PTES) (previous AY)	Annual	96.0%	97%	97.0%	100.0%	103.1%
23	ESES % Response Rate	Annual		55%	55.0%	63.3%	115.1%
24	SSES % Response Rate	Annual		55%	55.0%	57.0%	103.6%
	Measure 3: RETENTION, SUCCESS & PROGRESSION						
25	College Retention Overall for FE	Annual	90.0%	90%	90%	91%	100.7%
26	College Retention Overall for HE	Annual	90.0%	90%	90%	89%	99.2%
27	FE FT Successful Outcomes	Annual	70.0%	70%	70%		
28	FE PT Successful Outcomes	Annual	86.0%	90%	90%		
29	Partial Success FE	Annual	4.0%	4%	4%		
30	HE FT Successful Outcomes	Annual	80.0%	80%	80%		
31	HE PT Successful Outcomes	Annual	75.0%	75%	75%		
32	Modern Apprenticeship successful outcomes (contract year)	Monthly	61.0%	65%	65.0%	63.2%	97.2%
33	FE progression to further FE study	Annual	33.8%	35%	35.0%	37.1%	106.0%
34	FE progression to HE - actual	Annual	10.0%	35%	35.0%	30.0%	85.7%
35	Mental Health Support appt (non-emergency) offered for within 3 - 10 working days	Monthly	83.0%	91.7%	91.7%	99%	108.5%
36	Learning Support appt offered for within 6 - 20 working days	Monthly	77.0%	91.7%	91.7%	96%	105.1%
	Measure 4: HR						
40	Sickness levels	Quarterly	2.80%	2.52%	2.52%	2.98%	118.2%
41	- Short Term	Quarterly				1.51%	
42	- Long Term	Quarterly				1.47%	
43	% Staff turnover	Quarterly	2.37%	3.35%	3.35%	2.38%	70.8%
44	PRD completion - full or review	Quarterly	84%	100%	75%	57%	75.3%
45	Student FTE:Academic Staff Ratio	Annual	22.8	24	24.0	21.7	90.4%
46	Lecturer utilisation % (% of deployable hours)	Annual	85.1%	80.0%	80.0%	79.8%	99.8%
47	Number of workplace injuries	Monthly	26	26	26	138	530.77%
48	Number of RIDDOR reportable accidents and illness	Monthly	1			3	
49	% of staff completed mandatory IHASCO (H&S) Trg	Quarterly	86%	80%	80.0%	79.3%	99.1%
	Measure 5: FINANCE						
52	Adjusted current ratio	Annual		1.7	1.7		
53	EBITDA as a % of income	Annual		-1.0%	-1.0%		
54	Staff costs as % of income (less NDP/capital allowances)	Annual		78.0%	78.0%		
55	Cash days in hand	Annual		62.0	62.0		
56	Income as a % of Expenditure	Annual		99.0%	99.0%		
57	Curriculum contribution (overall % - estimate)	Annual	41%	40.0%	40.0%	51.0%	127.5%
58	Analysis of aged debtors > 90 days	Quarterly		50.0%	50.0%	8.1%	16.2%
	Measure 6: ESTATES & CAMPUS						
59	Room Occupancy - Frequency %	Monthly	19.0%	35.0%	34.6%	35.8%	103.4%
60	CO2 Emissions on Utilities (gross) Tonnes	Monthly	553	553	553	638	115.2%
61	% waste sent to landfill	Quarterly	70.0%	15%	15.0%	10.6%	70.5%
62	Estates reactive task completion rate %	Monthly	96%	95%	95%	94.5%	99.5%
63	GTFM % reactive task completion rate	Monthly	93%	92%	92%	95.1%	103.4%
64	Total % of Capital expenditure budget committed (Aug - March)	Monthly	100%	100%	100%	100.0%	100.0%

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ITEM 07.

BOARD OF MANAGEMENT

Subject/Title:	Data Protection
Author: [Name and Job title]	Suzanne Stewart, Data Controller
Meeting:	Audit Committee
Meeting Date:	10th September 2024
Date Paper prepared:	27/08/24
Brief Summary of the paper:	Report provides a breakdown of annual data/security incidents reported and statistical data regarding Subject Access Requests. In addition, a summary of the compliance auditing that has been undertaken.
Action requested: [Approval, recommendation, discussion, noting]	Noting/discussion if felt necessary

Link to Strategy: Please highlight how thepaper links to, or assists with: □ compliance □ partnership services □ risk management □ strategic plan □ new opportunity/change	The content of this paper links to legal compliance regarding the processing times for subject access requests and for recording data breaches & information security incidents. By analysing incidents, we can see where the organisational risk exists in relation to how data breaches occur.
Resource implications:	Yes / **No** **If yes, please specify**:
Risk implications:	**Yes** / No **If yes, please specify:** Operational: Causes of data breaches, Organisational: Risk of holding third party data without knowing
Equality and Diversity implications:	Yes/**No** **If yes, please specify:**
Student Experience Impact:	**Yes**/No If yes, please specify: Data breaches often impact on students if their data has been shared inappropriately.
Consultation: [staff, students, UHI & Partners, External] andprovide detail	
Status – [Confidential/Non confidential]	

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Freedom of Information Can this paper be included in "open" business* [**Yes**/No]	

*If a paper should **not** be included within "open" business, please highlight below the reason.

Its disclosure would substantially prejudice a programme of research (S27)		Its disclosure would substantially prejudice the effective conduct of public affairs (S30)	
Its disclosure would substantially prejudice the commercial interests of any person or organisation (s33)		Its disclosure would constitute a breach of confident actionable in court (s36)	
Its disclosure would constitute a breach of the Data Protection Act (s38)		Other (Please give further details)	

Further guidance on application of the exclusions from Freedom of Information legislation is available via

http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp and

http://www.itspublicknowledge.info/web/FILES/Public_Interest_Test.pdf

Purpose of report

To inform the committee of actions taken to ensure on-going compliance with the UK Data Protection Act 2018 and the UK GDPR and any associated risks.

Data Breaches

Month	Incidents	Type	Summary
Aug	1	Email	Shared mailbox address subject to a third party organisation's data breach.
Sept	4	Email	A data sharing agreement was sent to a student by mistake.
		Email	A confidential attachment was sent by someone to the wrong recipient via the UHI Dropbox. Unfortunately, the password was also sent to the incorrect recipient by email.
		Email	Staff timesheets and rates of pay sent to the wrong recipient.
		Portal	Student personal learning support plan was sent to the wrong PAT in a different college. Investigation showed the right PAT was linked to the student. The cause was a system glitch!
Oct	1	Confidentiality Breach	Student sent an email to their PAT asking for the content not to be shared with the class. Staff member did not fully read the communication and read it out to the class.
Nov	2	Email Physical Record	Staff member's PDR Form was sent to payroll in error. Individual had been working on staff timesheets and took a short cut to attach the files. The system suggested a list of files and 7 files were highlighted and attached, instead of just 6.
Dec	3	Data Exposed	Student left copies of their birth certificate in a lap top bag. Next user of the bag had sight of them and reported the matter.
		Email	Expenses claim form sent to the wrong staff member. Individual had been processing expenses

			claims for both staff and sent the wrong form to the wrong person.
		Security Breach	Staff member breached the information security policy by allowing a student to use their staff device to sit an assessment when the staff member was already logged in to the network.
		Template	Misuse of a template letter led to a staff member receiving an invitation to an investigation meeting which contained another staff member's name.
Jan	0	N/A	
Feb	2	Email	Staff member sent email to a large group without using the BCC function. This resulted in everyone in the group knowing something about each other that they should not have known.
		Email	Staff member sent email to a colleague containing info about two students. One of the students was copied into the message in error (which exposed the data of the other student).
Mar	2	Social media	Student case study was posted on social media without the appropriate consent in place. It caused upset for the student that could have been avoided.
		Near Miss-Email	Three staff clicked on a dubious link in an email which compromised their network accounts. ICT acted promptly by resetting passwords and wiping the three laptops.
April	4	Near Miss	Email contained malicious link which a staff member clicked. Fortunately, the link had been disabled and no harm was done.
		Misuse of Image	Student signed consent authorising use of their image for limited purposes. This was not considered, and the image was used against the individual's wishes.
		Email	Email sent to the wrong colleague (shared same first name). Message was successfully recalled. The auto complete name function had not been turned off.
		MS Teams	Manager sent a message to the wrong colleague (shared same first name) containing data regarding the termination date of a staff member's employment.
May	0		
June	0		
Jul	2	Email	Communication was sent to a list of individuals and the BCC function was not used. All recipients became aware of others who had made complaints.
		Email	Communication sent to list of prospective students and BCC function was not used. Personal email addresses were exposed to all recipients.

Subject Access Requests Aug 23 - Jul 24

Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
3	2	5	7	5	15	6	7	3	9	4	1	**67**

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Breakdown of Statistics

Police	5
Public Authorities	1
Individual	4
3rd Party/Employment Reference	57
Total	**67**

Timescale for Responses

Days	Volume of Responses
1-5	65
6-10	
11-15	1
16-20	
21-40	1
Over 40	

One took 12 days for a response to be issued because the original consent to release personal data was not valid.

One took over 36 days to respond as the identity of the data subject had to be verified before data could be released.

Point to Highlight

One individual made a request for their personal data which highlighted our network was storing the data of third party organisation. A staff member is a Board member of another organisation and had been using their UHI network account for correspondence in that regard.

This resulted in the confidential board papers of the third party organisation being stored on our network. This was data for which were not the Data Controller.

Legal advice had to be sought regarding the situation. The cost was approximately £800.00.

The data was not released to the individual but was returned to the third party organisation. The data was then wiped from our network.

The situation took up a considerable amount of time to process as it involved the review of 1256 communications. Only 320 of them were within scope of the information request.

Action Taken Following Case Closure

- The data protection guidance for staff was updated to enhance the section regarding use of staff corporate email accounts.

- The Email Usage and Retention Policy was also enhanced to make it clear that staff should not use their corporate email address for the business of a third party organisation.

- The staff member was made aware of the situation and the impact the information request had on the organisation, both in terms of time and cost.

- It was noted and brought to the attention of the Governance Officer that some UHI Inverness board members were using email addresses in addition their UHI account to received board papers. This practice has since been stopped.

- Board members are asked to delete any emails from the Governance Officer that may have been sent to either their personal email account or their work email address.

Compliance Monitoring
Compliance monitoring takes place between April and June of each academic year. A risk-based approach is adopted to the review of systems and processes in place for managing personal data. The following departments were monitored:

Finance
The team is now in a sufficiently stable position to start to address their GDPR compliance. Some work is required to update the team's Personal Data Register. This is the starting point for the team to know what data they have stored where.

The college's Data Controller will schedule regular time over the coming year to meet with the team collectively (and individuals separately) to ensure the necessary work is taken forward as on-going work activity.

Admissions & Funding
The team's personal data register required some updating to record the legal basis relied upon for processing personal data. It is important that team members understand the requirements of the UK GDPR.

Team records management activities were reviewed. Information available on the team Sharepoint site was current. However, some work was required to review data held in the "Archive" folder. The relevant section of the UHI Records Retention and Disposal Policy was shared to assist with the process.

Some work was undertaken regarding the records management within the shared mailbox and individual mailboxes.

At the point of the monitoring activity, the processing of student disclosure records was in the final stages of moving to a secure online portal accessed via Disclosure Scotland.

Student Records
The new team manager has taken control of GDPR compliance. The team have a new Sharepoint area and time was taken to ensure it was populated with only current records. The old site now only holds guidance documents which are being updated and transferred to the new site as time allows. An additional site has been set up for any documents that need to be shared with academic staff to prevent inappropriate data access.

A new data register has been created. Feedback was given on how to enhance the layout to make it easier to navigate/update.

The data register is now on the monthly team agenda to ensure all understand the importance of keeping it current and managing the records retention.

Email retention of the shared mailbox and personal mailboxes required attention at the point of monitoring.

HR
The data register is up to date. Most processing in the department is static across the year.

A monthly review is undertaken regarding recruitment files and archived/leaver files. Any recruitment files past the retention period are deleted and/or shredded.

Both the HR Services and IC Recruitment mailboxes have been cleansed recently. Personal mailboxes within the team have a retention period of 12 months set up.

GTCS Membership
Staff membership numbers are currently recorded on Cipher. As staff members leave the organisation, they are advised it is their responsibility to notify the GTCS.

We discussed the point at which the HR team notify the GTCS regarding live investigations/disciplinary cases. So far, no such situation has arisen, but it was recognised as something the Team need to decide on.

Staff PVG checks are now all undertaken via the secure Disclosure Scotland portal.

Follow up meetings will take place before the end of October.

Departmental data registers will be called in by the end of September to ensure the central record is up to date.

ITEM 08.

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Subject/Title:	Draft Annual Audit Committee Report for the Academic Year 23-24
Author: [Name and Job title]	Ludka Orlowska-Kowal, Governance Officer
Meeting:	Audit Committee
Meeting Date:	10 September 2024
Date Paper prepared:	02 September 2024
Brief Summary of the paper:	To present the draft Annual Audit Committee Report for Academic Year 2023-24. The Committee should note that some areas within this report are not yet available and that the report indicates where this is the case.
Action requested: [Approval, recommendation, discussion, noting]	For discussion.
Link to Strategy: Please highlight how the paper links to, or assists with:: • compliance • partnership services • risk management • strategic plan • new opportunity/change	The Audit Committee is required, in accordance with Scottish Funding Council guidance to report annually to the Board of management. The report relates to the discussions and actions in relation to risk management Linked within the strategic plan, specifically managing our risks
Resource implications:	Not directly, but indirectly in relation to the management of risk

Risk implications:	Yes Operational: as outlined in the Risk register Organisational: as outlined in the Risk register
Equality and Diversity implications:	N/A
Consultation: [staff, students, UHI & Partners, External] and provide detail	No consultation carried out – report is a statement of work carried out by the Audit Committee throughout 2023-24.
Status – [Confidential/Non confidential]	Non-Confidential
Freedom of Information Can this paper be included in "open" business* [Yes/No]	Yes

*If a paper should **not** be included within "open" business, please highlight below the reason.

Its disclosure would substantially prejudice a programme of research (S27)		Its disclosure would substantially prejudice the effective conduct of public affairs (S30)	
Its disclosure would substantially prejudice the commercial interests of any person or organisation (S33)		Its disclosure would constitute a breach of confidence actionable in court (S36)	
Its disclosure would constitute a breach of the Data Protection Act (S38)		Other (please give further details)	
For how long must the paper be withheld? (express either as the time which needs to pass or a condition which needs to be met.)			

Further guidance on application of the exclusions from Freedom of Information legislation is available via

http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp and

http://www.itspublicknowledge.info/web/FILES/Public_Interest_Test.pdf

Audit Committee Annual Report to the Board of Management

Title	UHI Inverness Audit Committee Annual Report 2023-24
Introduction	The Audit Committee is required, in accordance with Scottish Funding Council guidance to report annually to the Board of Management. This report covers the work of the Audit Committee during the 2023-24 Academic Year.
Membership	The Membership of the Committee during the 2023-24 Academic Year was as follows: -

Member	**Designation**	**Membership Period**
Janette Campbell	Chair	October 2023-August 2024
Sally Blyth	Vice Chair	September 2023-August 2024
Innis Montgomery	Member of the Committee	September 2023-August 2024
Gillian Galloway	Member of the Committee	September 2023-August 2024
James Millar	Member of the Committee	September 2023-July 2024
Amy Goodbrand	Co-opted Member of the Committee	September 2023-August 2024
Michael Beveridge	Co-opted Member of the Committee	September 2023-August 2024

Meetings	3 meetings were held throughout the year and the attendance was as follows: -

	05 September 2023 Tina Stones, Chris O'Neil, Janette Campbell, Sally Blyth, Wendy Grindle, Gillian Galloway **14 March 2024** Janette Campbell, Sally Blyth, James Millar, Michael Beveridge, Innis Montgomery **04 June 2024** Janette Campbell, James Millar, Michael Beveridge, Innis Montgomery, Amy Goodbrand, Wendy Grindle • The Principal attended all three meetings. • Representatives from our Internal Auditors, BDO attended all three meetings. • Representatives from our External Auditor, Deloitte attended all three meetings. • The Joint Finance and Audit Director attended the meeting in September 2023. • The Director of Finance and Estates attended the meetings in March & June 2024. • The Vice Principal – Curriculum, Student Experience and Quality attended the meeting in June 2024. • The Information Systems Manager attended all three meetings.
Terms of Reference	The Terms of Reference were reviewed by the Committee on 14 March 2024 and were taken to the Board of Management on 26 March 2024. The Terms of Reference will next be due for review in March 2027.
Internal Audit	**Provider** Our Internal Auditors are BDO. Following a procurement exercise BDO were successfully appointed a new contract which commenced from 01 August 2022. This contract will be for a period of 36 months with 2 further 12-month extension options on mutual agreement.

Audit committee assessment of performance

As a result of the changes within management of the Finance Service, the annual review of the performance of BDO has yet to be carried out. The next scheduled review will take place in November 2024.

Review of internal audit plan

During 2023-24 our Internal Auditors BDO reviewed and evaluated our processes in the following areas:

- Risk Management
- Payroll
- Professional Development
- Health & Safety
- Sustainability

The outcomes of all reviews are presented to and discussed by Audit Committee, however the dates which the Internal Auditors carry out and complete their audit reports are not always aligned to this report due to the time lapse between the audit being carried out and it being presented to the Committee.

Audit Reports

The Committee made specific comments on the Internal Audit reports as follows (these comments refer to the audits which were taken to the Committee during the period September 23 – August 24 with some of the audits which were carried out by Internal Audit not being discussed within this Academic Year).

Risk Management Audit

Final report issued by BDO will be presented to the Committee on 10 September 2024.

	Payroll Audit The BDO provided their final Payroll report to the Committee on 14 March 2024. The audit highlighted one finding of low significance relating to the lack of audit trail and consistent processes in respect of monthly payroll reconciliations. Some areas of good practice had been recognised such as the establishment and communication of payroll policies and procedures, controls over system access and the segregation of duties in respect of payroll payments and amendments, and use of exception reporting to identify potential inaccuracies in pay. As a result BDO provided substantial assurance over the design and substantial assurance over the operational effectiveness of controls in place relating to payroll. **Professional Development Audit** Final report issued by BDO will be presented to the Committee on 10 September 2024. **Health & Safety Audit** Final report issued by BDO will be presented to the Committee on 10 September 2024. **Sustainability Audit** Final report issued by BDO will be presented to the Committee on 10 September 2024. **Closed Meeting** A closed meeting with internal auditors will take place on 10 September 2024.
External audit	**Deloitte** The Audit Committee is still awaiting the audit of the accounts for the year ending 31 July 2023. Joint Audit and Finance & General Purposes Committee meeting has been scheduled to take place on Tuesday 10th September 3pm.

	Once approved, the financial accounts report will be submitted for approval to the Board of Management on 01 October 2024. **Audit committee assessment of performance** The annual review of the performance of Deloitte for the year 2023/24 was not carried due to the audit delays. The next scheduled review will take place in November 2024. **Closed Meeting** The Audit Committee has scheduled a closed meeting with external auditors on 10 September 2024.
Other work done	**Risk Management** In December 2023 the Board of Management tasked the Audit Committee with the responsibility to monitor any future sales of the Longman Site for the duration of 2 years, until December 2025. The Committee discussed a possible risk, not currently on the register, in respect of the Shared Finance Service with North Highland College. The Committee was advised that following discussions with Finance staff and unions regarding a revised Finance Team structure it has been agreed on 26 February 2024 to no longer provide a shared finance service between Inverness and North Highland. The Finance Team is led by the Director of Finance & Estates, who reports to the Vice-Principal for Curriculum, Operations & External Relations. In March 2024 the HR Committee asked the Audit Committee to add two new risk to the Risk Register and monitor them in the future: • AI risk implications • Sexual Harassment Risk The Governance Officer has arranged for suitable Risk Register training to be provided to Committee members and this session will take place on 10 September 2024. The session will be delivered by Director of Corporate Governance and Deputy Secretary during Creative

	Space.
Opinion	The Audit Committee is of the opinion that the risk management of activities and controls in the areas examined by BDO were found to be suitably designed to achieve the specific risk management control and governance arrangements. The Audit Committee concurs with the (draft) opinion of BDO that (still to be included within report).
Circulation	Copy to the Auditors once approved by the Board of Management.
Conclusion	The Audit Committee is pleased to report to the Board of Management that in its opinion the College has adequate internal controls, procedures, and systems in place. Signed…… Chair, Audit Committee Date …….