Meeting	Audit Committee
Date and time	Tuesday 02 June 2026 at 04.30 p.m.
Location	Microsoft Teams

Governance Officer
26 April 2026

AGENDA

The timings on this agenda are indicative only and may extend beyond times highlighted.

Welcome and Apologies

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

ITEMS FOR DECISION

16:30 – 16:35 **1) MINUTES**
a.) Minutes of the Meeting of Audit Committee held on 03 March 2026
b.) Closed Session Note (CSN-01-032026) of Audit Committee held on 03 March 2026
c.) Confidential Note (CN-01-032026) of Audit Committee held on 03 March 2026
d.) Confidential Note (CN-02-032026) of Audit Committee held on 03 March 2026

16:35 – 16:45 **2) OUTSTANDING ACTIONS - INTERNAL & EXTERNAL AUDIT**

a. Audit Committee Action List
b. External Audit (Deloitte) – Recommendation List
c. Internal Audit (WBG) – Recommendation List
d. Internal Audit (WBG) - Follow Up tracker from BDO

16:45 – 16:55 **3) POLICIES FOR APPROVAL**
Report by the Principal

a) Data Protection Policy

16:55 – 17:15 **4) INTERNAL AUDIT**
Report by the Director of Finance and Estates

a. Internal Audit (BDO) Incidents Management Final Report
b. Internal Audit (BDO) Annual Report 2024-25
c. Internal Audit (WBG) Budgetary & Financial Reporting Final Report
d. Internal Audit (WBG) Annual Plan 2026-27

ITEMS FOR DISCUSSION

17:15 – 17:25 **5) EXTERNAL AUDIT (incl. updates and audit plans)**
Report by the Director of Finance and Estates

17:25 – 17:40 **6) RISK REGISTER UPDATE (CONFIDENTIAL) – to follow**
Report by the Director of Finance and Estates

17:40 – 18:00 **7) FINANCIAL REPORT (CONFIDENTIAL)**
Report by the Director of Finance and Estates

18:00 – 18:10 **8) ANNUAL REVIEW OF BUSINESS CONTINUITY – (CONFIDENTIAL) – to follow**
Report by Director of Finance and Estates

18:10 – 18:20 **9) KPI MATRIX**
Report by Operations and Commercial Manager

18:20 – 18:25 **10) COMMITTEE & CHAIRS EVALUATION**
Report by Governance Officer

FOR NOTING

18:25 – 18:30 **11) AOCB**

12) DATE AND TIME OF NEXT MEETING
Audit Committee Meeting 01 September 2026 at 16.30 p.m.

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 only be considered for inclusion in the agenda in advance of the start of the meeting.

UHI | INVERNESS

Subject/Title:	Outstanding Actions – Internal & External Audit
Author: [Name and Job title]	Ludka Orlowska-Kowal Governance Officer
Meeting:	Audit Committee
Meeting Date:	02 June 2026
Date Paper prepared:	26 May 2026
Brief Executive Summary of the paper:	This paper provides the Board of Management with an update on all outstanding actions: • Audit Committee Action List • External Audit (Deloitte) – Recommendation List • Internal Audit (WBG) – Recommendation list • Follow Up Tracker (BDO)
Action requested: [Approval, recommendation, discussion, noting]	Discussion and Noting.
Link to Strategy: Please highlight how the paper links to, or assists with:: □ compliance □ partnership services □ risk management □ strategic plan □ new opportunity/change	Governance Compliance
Resource implications:	Yes / No **If yes, please specify**:
Risk implications:	Yes / No **If yes, please specify:** Operational: Organisational:
Equality and Diversity implications:	Yes/No **If yes, please specify:**
Student Experience Impact:	Yes/No If yes, please specify:

Consultation: [staff, students, UHI & Partners, External] and provide detail	N/A
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

Purpose of the report

To provide the Audit Committee with an update on all outstanding actions: committee actions and from internal and external auditors.

Executive Summary

The Audit Committee oversees and monitors the progress of all received recommendations from internal and external auditors as part of their ongoing audit work for the college.

The Committee were provided with the following action lists:

- Audit Committee action list
- External Audit (Deloitte) – Recommendation List
- Internal Audit (WBG) – Recommendation List
- Follow Up Tracker &BDO)

Progress update:

- Audit Committee action list:
  - ✓ 3 actions complete
  - ✓ 3 actions outstanding
- External Audit (Deloitte) – Recommendation List
  - ✓ 5 actions outstanding (from December 2025) with 31st June 2026 completion date
- Internal Audit (WBG) – Recommendation List
  - ✓ 1 action complete
  - ✓ 0 action outstanding
- Follow Up Tracker (BDO) – Recommendation List
  - ✓ 23 actions complete
  - ✓ 24 actions outstanding (a list of outstanding actions has been shared with WBG who will review all with the Director of Finance and Estates and update their status before the next Committee meeting in September 2026)

Audit Committee - Action list at 26/05/2026

ITEM 02.a

Action	Academic Year	Status	Finding	Recommendation	Recommendation Significance	Implementation Date	Responsible Officer	Status as at 03 June 2025	Comments
8	2024/25	Complete	**Business Continuity:** A number of BDO reports still outstanding.	Detailed update to be provided in regard to the outstanding BDO reports missing from the report in June 2025.	Medium	08/09/2025	Director of Finance and Estates	Proposed	**Update at 08/09/2025:** Evidence is still being requested and reviewed by BDO in regard to all outstanding reports and the follow up tracker. **Update at 24/02/2026:** Two final reports - Staff Wellbeing and Follow Up 2024/25 have been submitted in the final format, Incidents Management in draft and Annual Report 2024/25 are still to follow.
								Status at 08/09/2025	
12	08/09/2025 2025/26	Ongoing	**WBG Internal Audit - training session:** There are plans for audit training being delivered to the Committee on an annual basis.	Committee training sessions organised by the WBG to be planned for 2025/26.	Low	03/03/2026	GO & WBG	Proposed	**Update at 24/02/2026:** Awaiting timescale from WBG.
15	08/09/2025 2025/26	Complete	**Risk Register Update:** The Chair would welcome an up-to-date version of the financial recovery plan first introduced by the EMT in 2020, with staff development process, sector analysis, core savings and additional savings for investment included. The Governance Officer has been asked to check the reporting and approval route of the financial recovery plan in 2020.	An up-to-date version of the financial recovery plan first introduced by the EMT in 2020 to be presented to the Committee.	Medium	03/03/2026	Principal & EMT	Proposed	**Update at 24/02/2026:** The draft plan will be completed on 27/02/2026.
18	08/09/2025 2025/26	Ongoing	**SFC's Summary - University of Dudee:** Discussion about the college's and EO's response to the report, objectivity and accountability aspects and the need for a separate session for the Board to review the report, lessons learnt, and key findings took place.	Separate session to be organised for the Board to review the Gillies report and discuss key findings.	Medium	03/03/2026	GO & Chair of the Board	Proposed	
								Status at 09/12/2025	
22	03/03/2026 2025/26	Ongoing	**KPI Matrix:** The Committee asked for reassurance that currently monitored KPIs are the correct ones and will be able to alert the college early enough to any future risks, especially in regard to the financial situation.	The financial forecast KPIs to be added to the matrix reviewed by the Audit Committee.	High	02/06/2026	Head of Operations and Business Performance	Proposed	**Update at 26/05/2026:** Meeting scheduled for Thursday 28/05/2026 to discuss the design of KPI Matrix going forward.
23	03/03/2026 2025/26	Complete	**BDO - Outstanding Internal Reports:** The Committee expressed concerns about the delays to the completion process of a number of outstanding reports still to be submitted by BDO.	The Committee to be informed of the progress of all outstanding BDO reports.	High	02/06/2026	Director of Finance and Estates	Proposed	

External Audit - Action List

ITEM 02.b

Action	Reporting Year	Status	Finding	Recommendation	Recommendation Significance	Management Response	Implementation Date	Responsible Officer	Comments
5	2024/25	Ongoing	**Lack of journals review:** UHI Inverness does not have evidence of review of journals posted. This creates a risk that College journals are not being correctly reviewed and recorded or accounted for.	It is recommended that the college implement a review process for journals which includes evidence of the reviews performed.	High	The College will implement review process on a monthly basis signed by DOF&E	31 June 2026	Director of Finance and Estates	
6	2024/25	Ongoing	**Review of property impairment assessment:** We note that there is no official impairment review process at the College during the years where a full revaluation does not take place. The creates a risk that the value of the College is overstated.	We recommend that the completed impairment assessment paper should be presented to the Audit Committee for review and approval.	High	The College will present the impairment assessment for review to the Audit committee at its next meeting.	31 June 2026	Director of Finance and Estates	
7	2024/25	Ongoing	**Lack of expenditure cut off control:** We noted instances where the College records expenditure when it is used rather than when it is delivered. This creates a risk of understatement of expenditure and under accrual.	We recommend that the College implements a control that ensures all expenditure is recorded when it is delivery rather than when the goods are used.	Medium	The College will ensure expenditure is recorded correctly as noted in the recommendation.	31 June 2026	Director of Finance and Estates	
8	2024/25	Ongoing	**Lack of Income completeness review:** UHI Inverness have a budget review process to ensure that all non recurrent income is included in the actual monthly results, however there is no process to ensure that all unbudgeted nonrecurrent income is included. This creates a risk that non-recurrent income may be understated.	We recommend the College clearly document its existing process for engaging budget holders during monthly/quarterly reviews to identify additional or unbudgeted non-recurrent income.	Medium	The College will document the existing process for budget holders to identify nonrecurrent income and ensure it is claimed by the year-end.	31 June 2026	Director of Finance and Estates	
9	2024/25	Ongoing	**Lack of Accrual Completeness review:** We noted that there is no formal review of the year-end accruals file which includes manually prepared schedules such as "PECOS order accruals". No formal independent review can be evidenced to show preparer or sign off for these manual entries before they are input into the financial statements working paper. This creates a risk of omissions from accruals.	We recommend the College implements a formal review control for the year-end accrual file and clearly documents the preparer and approval sign-off of the manual entries before they are inputted into the financial statements.	Medium	This will be included in the year-end task list.	31 June 2026	Director of Finance and Estates	

WBG Internal Audit - Action List at 26/05/2026

ITEM 02.c

Action	Reporting Year	Status	Finding	Recommendation	Recommendation Significance	Management Response	Implementation Date	Responsible Officer	Comments
10	09/12/2025 2024/25	Complete	**Education Maintenance Allowance Audit 2024/25:** Incomplete Coverage of EMA Spot Checks	We recommend that the College strengthen its monitoring of EMA spot checks by introducing a formal process to ensure that checks are distributed across both the August to March and April to July periods.	Low	The EMA Spot Checks Process will be updated so that the initial sample will be undertaken for applications received for the August to March spot check and a sample of payments made for the April to July spot check. The spot checks will be a mix of a sample selected from applications awarded and not awarded.	01/11/2025	Head of Registry and Quality	

Follow Up Tracker BDO - Action List

ITEM 02.d

#	Reporting Year	Audit	Finding Reference (per report)	Finding	Recommendation	Recommendation Significance	Management Response	Implementation Date	Responsible Officer	Client status as at July 2025 (Fully Implemented/ Partially Implemented/ Not Implemented/ Superseded/ Not Due For Implementation)	Client comments	BDO status as at July 2025	BDO Summary of testing / Comments	Example of evidence to be provided	Status as at October 2025	Status as at March 2026
1	2019/20	Cash Handling	2	It is important that there is a procedure in place to monitor and investigate variances in cash takings. During testing we found that there were variances in takings that were not investigated as they were below £10; however, there is no ongoing monitoring of trends in variances and that the investigation process for variances was not documented. There is annual analysis of the net figure which for the year ended 31 July 2019 amounted to £340.57 over. There is a risk that there may be patterns in variances which are going unchecked and hence remedial action may not be taken.	It is our recommendation that the College develops a procedure for monitoring and investigating variances in cash takings. The procedure should detail the variance tolerance level, the arrangements for monitoring variances to highlight any trends, and the remedial action which may be taken to address any identified issues such as re-training or disciplinary action. The existing banking procedures should be updated to include a section which refers to the procedure for monitoring and investigating variances.	**Medium**	Original Agreed January 2021 Finance Procedures are currently under review with the new Shared Finance Team. This process may change when we return to normal operating. October 2022 Commencing mid October 2022	Within one calendar month of lockdown ending.	Morag Jarvis	July 2025 - fully implemented	Updated Cash handling procedure, includes details of investigation and monitoring of variances. This has been added to the Finance Procedure Manual.			Financial Procedure manual, financial regulations and procurement strategy have been approved, but variance analysis and investigation has not been incorporated. College has advised this is being updated. This recommendation will be fully implemented once variance analysis, investigation and remedial action is included	Further evidence requested - copy of fin procedure manual, regulations and strategy.	Fully Implemented
2	2019/20	Cash Handling	4	It is important that cash handling procedures are fully documented to provide staff with guidance on processes. During our review we found that there were areas not covered by the procedures: - The procedures do not make it clear who may operate tills in each department or what the training arrangements are for till operation; and - There is no documented procedure for maintaining a float. There is a risk that staff may not be aware of the cash handling processes which increases the likelihood of errors.	We recommend that the Banking Process and Procedures document is updated to include the following areas: - Which members of staff may operate the till in each department and what the training arrangements are for till operators; and - The procedure for maintaining a float including the arrangements for picking up, counting, storing and dropping off the float.	**Low**	Original Agreed January 2021 Finance Procedures are currently under review with the new Shared Finance Team. This process may change when we return to normal operating. October 2022 Finance procedures to be reviewed by Team Leader by end of November 2022	Within one calendar month of lockdown ending.	Morag Jarvis	Fully implemented	July 2025 - Finance Procedure Manual updated to include all recommendations			Financial Procedure manual and financial regulations have been approved, but till operation by department is not included. College has advised this is being updated. This recommendation will be fully implemented once authorization for till operation by department is stated clearly in financial regulations or procedure manual.	Further evidence requested - screenshots of online portal to indicate who is on the till.	Fully Implemented
3	2020/21	Workforce Planning	2	Succession Planning It is good practice to identify critical roles and have a succession plan to support a smooth transition in the event a key member of staff was to become unavailable or leave. The College has not identified critical roles and does not have a documented succession plan. There is a risk the College loses key skills and experience if a key member of staff were to leave.	We recommend identifying critical roles and preparing a documented succession plan.	**Medium**	Original Whilst we do not necessarily have a 'list' of critical roles - I must re-iterate some of the comments made: • We review our staffing in line with our annual curriculum plan and set our annual staffing budget accordingly. Anticipating future skill need / development of skill sets to support future curriculum developments. • Managers continually monitor staff numbers to ensure that sufficient resources are attached to each department to ensure curriculum and support service levels can be met. • Skills gaps are filled either through redeployment of staff from other areas of the College or, where necessary, through external recruitment in line with the budget. • A review and approval process has been established to ensure that appointments, both internal and external, are managed in line with available budgets, curriculum and service demand and strategic objectives. • Development opportunities are made available for staff internally in preparation for promoted posts when vacancies become available. Staff have been provided with learning and development support to help them achieve that. For example, through trainee roles/programmes, CMI training for new line managers and those aspiring to become, and secondment opportunities.	Apr-21	HR Manager Nicola Quinn	Fully implemented	A spreadsheet was developed by the 2 VPs in July 2024. This is confidential and can only be accessed by the EMT. This identifies business critical roles and succession planning options. The VPs use this information to guide decision making and work with their direct reports to ensure that any structural changes, and identification of development opportunities are in line with this succession plan. In addition, business critical roles have had their notice periods increased. Skills matrices are in place across a number of departments and are being piloted in others, as part of our Talent Management Framework. Our programme of professional development also complements the wider work we undertake to oversee effective succession planning.			Staff Recruitment and Selection Procedure has been approved addressing management talent attraction, but does not clearly identify critical roles. This recommendation will be fully implemented when the procedure is updated to identify critical roles and a direct succession plan for these.	Further evidence requested: Skills Matrix - has it been rolled out? Confirmation if fully implemented and stage it is currently at. **Mgt response: A common skills matrix template for professional services staff has been developed. Training for Professional Services managers on the implementation of skills matrices with their teams is underway and matrices will be in full use in 2025/26. Utilisation of skills matrices will be added to QEPs to enable regular monitoring.**	Fully Implemented
4	2020/21	Finance System Upgrade	1	Project Management Methodology It is important that an organisation has a documented project management methodology to ensure that projects are run efficiently, effectively and consistently. There is no documented Project Management Methodology in place at Inverness College. As a result there is no agreed process for managing projects. There is a risk that projects are not effectively manages, as no project management methodology is in place.	We recommend the College prepares a project management framework and that all people responsible for managing projects are trained in the methodology. We recommend the methodology includes and considers the following: • Includes templates for Business Cases, project plans, risk registers, monitoring, project evaluation • Gateway process • Outlines expected approval required of key documents • Change management process • Monitoring timelines, costs and risks through the project • Project evaluation and Lessons learned when the project is completed • Risk Management • Scalability, considers requirements for projects of differing sizes	**Medium**	Original It has been discussed with the Quality Manager and her manager which is SMT level. It has been agreed that the Quality team will create a Policy and Procedure for Project Management. This will be drafted and be put to the BOM to approve in June 2021. October 2021 There may be a larger payroll/HR system project to be progressed, in which case some of this paperwork could be worked on in tandem or slightly before. October 2022 Recommend that this be closed.	Jun-21	ICT Manager	Fully implemented	A standard project management process has been developed under the leadership of the ICT Manager. This has been piloted on the Sustainable Construction Centre project. The process has worked well and has been rolled out as standard for large projects. Project planning guidance is accessible by all staff in the Quality SP site. This guidance and the associated templates are used to manage projects across the organisation.			College has advised it is currently starting work on a project management methodology, this recommendation will be updated when the methodology is launched and approved.	Further evidence requested: copies of documents within the folder. Project planning res - not able to access the hyperlink - send documents instead.	Fully Implemented
5	2020/21	Finance System Upgrade	2	Project Evaluation Following a projects completion it is good practice to assess whether the objectives have been achieved and identify whether there are any lessons to be learned. The College does not require evaluation of a project on its completion. Due to time constraints there has been no project evaluation for the Finance System Upgrade project. There is a risk that project objectives have not been realised and lessons to be learned are not being captured.	We recommend as part of the College's project management methodology, following a projects completion, there is a requirement to evaluate the project. This should include consideration of whether the objectives of the project have been achieved, and whether there are any lessons to be learned or actions to take forward.	**Medium**	Original Evaluation is that the project has delivered an updated Finance System that works in terms of what it was supposed to deliver in that the Finance Service has an updated ledger and Finance reporting is now being modelled so that the College Finance Service can monitor college finances in a much more coherent way. I consider this complete. As far as the wider issue of evaluation - can be included as part of Policy and Procedures. October 2021 Project is complete and the upgrade is working (the only issues affecting us are arising from the Cyber Incident) and no further action is being considered. October 2022 The response of no further action being undertaken at 31 October 21 was accepted by Committee. If this was not minuted then it can go back to Committee and agree to take off Follow Up.	Jun-21	Director of Finance (Shared) Roddy Ferrier	Fully implemented	As above			College has advised it is currently starting work on a project management methodology, this recommendation will be updated when the methodology is launched and approved.	Further evidence requested: documentation - project guide and templates.	Fully Implemented
6	2020/21	Finance System Upgrade	3	Change Forms The project Terms of Reference (ToR) outlined events that would require a Change form to be submitted; change in scope, change in estimates and changes to the schedule. The ToR did not outline acceptable tolerance for changes or the level of authority required to approve a Change Form. One Change Form was completed when additional key documentation was added to the ToR. This form was approved by the College's Finance Project Facilitator, however the form was not dated or signed. The project was originally agreed to be completed on the 1st of April 2020 but was not completed until the 31st of May 2020, 8 weeks later and a Change Form was not completed. There is a risk that changes to the project are nor appropriately documented and approved.	The College's Project Management Methodology should outline the expected process to follow when there are changes to a project and the required level of approval for a change. It may be useful to create a Change Form template. Project Managers should ensure Change Forms are completed appropriately when necessary.	**Medium**	Original I can see this some measure. I don't consider the delay here a large issue. The main thing is that it delivered in time to process the budget for 2020-21. However bigger projects can often get out of control without clear change parameters. See Quality Review re Procedure and time parameters. This should be combined. We also probably need to progress a Project Register. October 2021 Project is complete and the upgrade is working (the only issues affecting us are arising from the Cyber Incident) and no further action is being considered. October 2022 Recommend that this be closed.	Jun-21	SMT still to allocate	Fully implemented	See above. New process in place. **Update at 06/02/2026:** I can see this some measure. I don't consider the delay here a large issue. The main thing is that it delivered in time to process the budget for 2020-21. However bigger projects can often get out of control without clear change parameters. See Quality Review re Procedure and time parameters. This should be combined. We also probably need to progress a Project Register.			College has advised it is currently starting work on a project management methodology, this recommendation will updated when the methodology is launched and approved.	Further evidence requested: documentation - project guide and templates.	Fully Implemented
7	2020/21	Finance System Upgrade	4	Defining Responsibilities Roles and responsibilities should be defined and documented at the outset of a project to ensure understanding and accountability. The project team was outlined in the Terms of Reference, however there was no detail of their expected responsibilities, including who had overall responsibility at Inverness College for the project. Additionally, governance and reporting mechanisms were not documented. It was not clear how regularly management, SMT and the Board should be updated on progress of the project. There is a risk that individuals were not aware of their responsibilities.	We recommend the College's project management methodology outlines the requirement for key roles and responsibilities, governance and reporting mechanisms to be documented in project planning documentation. Where there are changes to the project team throughout the project's implementation, it should be decided and clearly documented who will be taking over their responsibilities	**Medium**	Original Not accepted per this project - this was a small project. Only if there were problems of the project not being delivered would I advise the Board. I verbally updated the SMT but not recorded dates or anything. The back end of this project was being delivered at the same time budget collation for 2020-21 was taking place. Generally, I have been satisfied with the outcome. This also was being delivered with Finance Recovery and new Finance management. The SMT was dealing with Financial Recovery Plan; a Finance Director resigned; an Interim Finance Director was trying to find her feet; by the time the current Finance Director commenced in May the project was near complete. For larger projects there may be something here, but the reality is that sometimes in organisations other issues take precedence. Project Management Methodology can be combined with the work Quality will be doing on this. October 2021 Project is complete and the upgrade is working (the only issues affecting us are arising from the Cyber Incident) and no further action is being considered. October 2022	Jun-21	SMT still to allocate	As above	See above. New process in place.			College has advised it is currently starting work on a project management methodology, this recommendation will be updated when the methodology is launched and approved.	Further evidence requested: documentation - project guide and templates.	Fully Implemented
8	2021/22	Staff Recruitment	4	It is important all staff involved in recruitment receive regular training to ensure they have sufficient awareness and understanding of the process and can adhere to set procedures. There is currently no formal or structured training provided on the staff recruitment process. We note support is provided to hiring managers by the HR Business Partners, and there is a range of guidance and templates available to staff regarding the recruitment process. There is a risk that staff may not have the suitable knowledge of the recruitment and selection process, which may prevent the College from compliance with employment regulations or adhering to a fair and consistent selection process.	We recommend regular training sessions are provided to all staff who may be involved in the hiring process, and that anti-bias training is included as part of these sessions. Staff should be required to attend refresher staff recruitment training sessions every three years, or sooner if there are changes to policy. We also recommend that training attendance is recorded and monitored on an ongoing basis.	**Medium**	Our new on-line recruitment system (i-Recruit) is now in place. i-Recruit is a recruitment management system that has provided a new improved service for candidates and recruiting managers. Due to the COVID-19 pandemic, the HR team have continued to support recruiting managers on all aspects of the process. Due the College's Financial Recovery Plan, HR phased in the system and processes, as vacancies arose. As noted, there is a range of guidance available to recruiting managers on all aspects of the recruitment processes, which includes an extensive set of guidance for managers and interview guidance and assessment templates. This is made available on the HR SharePoint site. The HR team continue to support recruiting managers on all aspects of the process. The HR Manager and HR Business Partners have already commenced discussions in regard to the reviewing and revising the HR support provided for line managers which includes tailored training and guidance of key HR policies and procedures, including Staff Recruitment and Selection. Management would therefore agree with the recommendation of regular training sessions are	2022-23 Academic Year	HR Manager and HR Business Partners Nicola Quinn	Not DUE FOR IMPLEMENTATION until 25/26	HR and PD Teams are working together to develop line manager training on HR policies and procedures. The first of these sessions were rolled out in 24/25 and will continue into 25/26. This will include Staff Recruitment and Selection and has been added to HR's QEP for 25/26. **Update at 06/02/2026:** Action being implemented.			The College has advised HR and PD Teams are working together to develop line manager training on HR policies and procedures. This recommendation will be fully implemented when this training program is approved and launched with a schedule and monitoring.	Further evidence requested: evidence that training has been delivered and materials used for the session. **Mgt Update: This has been added to the HR Team's QEP for 2025/2026.**	To be fully implemented in July 2026
9	2021/22	Procurement	2	It is good practice to have contracts in place with key suppliers and to ensure favourable terms and value for money is achieved. Review of the Spend Analysis report prepared by the Procurement Team identified the College had 7 suppliers with a total spend of £50,000 or more where there is no contract in place. This is the threshold for a public contract under the Procurement Reform (Scotland) Act 2014. The College also lists a legal services provider as a key supplier on its contract register, despite there not being a contract in place and the College already has a contract in place with another supplier to provide legal services. In addition, as there is no contract in place between the College and the legal service provider, no contract performance management is being performed by the College on this key supplier. There is a risk that the College has unfavourable terms with key suppliers and is not achieving value for money with its spend.	We recommend that the College ensures contracts are in place with all key contracts, including those with a total spend of over £50,000. Additionally, we recommend the College ceases to procure legal services from the legal services supplier where there is no contract in place, until it establishes a contract between itself and the provider or uses the other legal services provider where there is a contract in place.	**Medium**	The 7 Suppliers will be investigated and where contracts are required the Procurement Team will add these onto the forward contracting plan. Mini competition exercise is about to be undertaken for the legal service provider.	31-Oct-22	Assistant Principal, Finance & Audit Roddy Ferrier	**Partially implemented**	Most contracts now in place, legal services contract still outstanding. The 7 Suppliers will be investigated and where contracts are required the Procurement Team will add these onto the forward contracting plan. Mini competition exercise is about to be undertaken for the legal service provider. **Update at 06/02/2026:** A new framework agreement is now in place for Legal Services through APUC, which the college will use to procure legal services going forward.			College has advised that the Legal Services Draft Contract Strategy is being reviewed and will be tendered with a revised framework implemented by December 2024. This recommendation will be fully implemented when the Legal Services Contract Strategy is launched and approved.	Further evidence requested: Has the strategy been approved? Evidence and approval documents.	Fully Implemented
10	2021/22	Procurement	4	It is important for procurement training to be provided regularly to staff to ensure they receive appropriate support and guidance to discharge their duties effectively. The provision of many of the College's procurement training sessions have been significantly disrupted by COVID-19. Although the PECOS and Financial Regulations awareness training has continued to be delivered into 2022, many other training sessions, such as contract management training and procurement awareness training have not been delivered since 2018. There is a risk that the College is not providing regular procurement training to its staff.	We recommend that the College provides the additional training sessions to relevant staff included within its training schedule, such as the contract management, procurement tips and procurement awareness training sessions as soon as practicable, and that the training schedule is updated to record the training that is delivered.	**Low**	When staff development days resume, we will continue to provide procurement training. We will review the induction process for new starts to ensure they are provided with procurement training.	Aug-23	Assistant Principal, Finance & Audit Roddy Ferrier	Fully implemented	First part of procurement training undertaken with staff, further training sessions to be arranged in 2025/26 Academic Year. When staff development days resume, we will continue to provide procurement training. We will review the induction process for new starts to ensure they are provided with procurement training. **Update at 06/02/2026:** Procurement training was undertaken during 2024/25 as noted above and further training is being held at the college staff development day on 18 February 2026.			College has advised that training programme has been delayed to the new year, this recommendation will be updated once the programme has been approved and launched.	Further evidence requested: how is the roll out being monitored and its relevance.	Fully Implemented
11	2022/23	Strategic Planning	1	**KPIs** It is important that strategic objectives have accompanying KPIs in place to ensure that progress against objectives is effectively monitored. Internal Audit conducted a sample test of 15 strategic objectives outlined in the College's subsidiary strategies and found 2 objectives to have KPIs outlined in the sub-strategy that did not appear in the KPI extract provided to Internal Audit. Consequently, these KPIs are not being monitored by the College. The KPIs identified were: 1.The Research & Innovation Strategy "Increased engagement with Innovate UK KPI; and 2.The Environmental Sustainability Strategy "Annual carbon emissions reduction" KPI. We note that the College does report on CO2 emissions on utilities and is in the process of developing mechanisms for measuring other sources of carbon emissions. There is a risk that strategic objectives are not being appropriately monitored through measurable success indicators.	We recommend that the College updates the KPI matrix to include the three KPIs.	**Medium**	We will include the research KPI and extend the coverage of the CO2 KPI once a mechanism for measurement has been agreed for each.	1.31 January 2024 2.31 July 2024	1.The Principal 2.Vice Principal, Operations & External Relations	Partially implemented	Research KPI - Engagement with Innovate UK to be included in 2025-26 KPI measurement once Principal has agreed a target with Research Directors. CO2 Emissions measurement has been refined and CO2 Emissions on Utility and CO2 Emissions on waste are monitored and reported. Further development of CO2 emission monitoring and reporting is to evolve to include staff and student travel etc. This requires further work and initial benchmarking. **Update Feb 2026:** Innovate UK is reported through Audit Committee and given the small measure it is not included in the matrix.			CO2 Emissions on utilities have been implemented. This recommendation will be fully implemented once the KPI's "Increased engagement with Innovate UK", and "Annual carbon emissions reduction" have been included into the KPI matrix.	Further evidence requested: screenshots of all 3 measures being added to the KPI Matrix.	Fully Implemented

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12	2023/24	Professional Development	1	**Managerial oversight in training compliance and resolution approach** 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.	We recommend that: 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.	**Medium**	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	01-Aug-25	Head of Professional Development	Fully implemented	The current list of mandatory training includes H&S courses (on the iHASCO platform) and training on PREVENT & Trauma Informed Practice (on external platforms). All have a completion date of 31/7/2025. Reports on H&S training compliance will be compiled by the H&S team and reports on external training compliance will be compiled by the Professional Development team during August. These will be circulated to EMT and individual managers for verbal follow-up. These reports will be repeated during semester 1 and lack of compliance followed up by email to the individual staff members. The iHASCO training platform will be removed from service at the end of July and replaced by SafetyHub. This change will require considerable administrative work. It is intended that mandatory training currently held on Brightspace and external training			College has advised they are moving Information Security & GDPR onto the iHasco system to enable accurate recording and reporting by the end of Jan '25 and will establish a new process for documented follow up at that point. This recommendation will be fully implemented when this process is complete and approved. **Update at Feb '26:**There was a delay in the implementation of the new SafetyHub platform for mandatory training and we are still awaiting the upgrade that will enable UHI Inverness to upload our own training packages and streamline compliance checking. In the meantime, reporting on compliance with mandatory training	Further evidence requested: evidence what's been moved over to the new system or what cannot be?	Fully Implemented
13	2023/24	Professional Development	2	**Professional Learning and Development Request Form (PD1 form)** 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. 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.	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: 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. Ensure that any exceptions to the standard process are pre-approved and documented with justification and evidence to maintain transparency and accountability.	**Medium**	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. 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.	01-Aug-25	Head of Professional Development	Partially implemented	1. It has not been possible to move PRD forms to Microsoft forms. We are currently reviewing the Ciphr HR system to see if it might be possible for PRDs forms to be completed within the system. This would enable key information to be extracted and followed up by the PD team. 2. Fully implemented & evidence uploaded to BDO in Dec 2024. **Update Feb 2026:** No further action has been taken to implement a new HR system that potentially may facilitate the completion of PRD forms within the system. All professional development activities,			(1) College has advised the current Ciphr HR system does not allow for online completion of PRDs or monitoring of development actions therefore this recommendation cannot be fully implemented. (2) Fully implemented & evidence uploaded to BDO in December 2024.	Not applicable - see O14	To be fully implemented in July 2026
14	2023/24	Professional Development	3	**Review of role-based training matrix approval process** 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.	We recommend that: 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.	**Medium**	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.	01-Aug-25	Head of Professional Development	Fully implemented	A common skills matrix template for professional services staff has been developed. Training for Professional Services managers on the implementation of skills matrices with their teams is underway and matrices will be in full use in 2025/26. Utilisation of skills matrices will be added to QEPs to enable regular monitoring.			College has advised they have a working group developing a common template and approach to skills matrices to include in the PPRP process, this recommendation will be updated when this development is launched and approved.	Further evidence requested: copy of the matrix and evidence of training taking place. Screenshot of actions added to QEPs and stage the process is at.	Fully Implemented
15	2024/25	Fraud Strategy	1	**Policies and procedures** It is important that the fraud policies and procedures are clearly documented, and members of an organisation should be aware of how to detect and respond to fraud. Whilst there is an Anti-Fraud and Corruption policy in place, it was noted that: ► It does not include the College's Fraud response plan. ► There is no reference made to the College's involvement with the National Fraud Institute and related activities and reporting. The Finance manual documents the processes within the College that help detect and prevent fraud, however it was noted that the manual has not been reviewed since 2022. It should also be mandatory for all staff to read the policies and procedures on induction and when they are updated.	We recommend that: ○ The Anti-fraud policy be updated to include the fraud response plan. ○ The College's involvement in the National Fraud Institute should be documented in the Anti-Fraud policy. ○ The Finance Manual should be reviewed and updated ○ Staff should be made aware of any changes to policies and procedures, and it should be mandatory to read and understand them.	**Medium**	The anti-fraud policy will be updated with the fraud response plan & NFI involvement, the finance manual will also be updated with these details and staff will be made aware of changes to these policies.	31-Jul-25	Director of Finance & Estates	Fully implemented	Template & Guidance for Managers & Guidance for Staff documents have been included in evidence. The anti-fraud policy will be updated with the fraud response plan & NFI involvement, the finance manual will also be updated with these details and staff will be made aware of changes to these policies. **Update at 06/02/2026:** Updated Anti-Fraud and corruption policy approved at audit committee on 8 September 2025.				Further evidence requested: a copy of approved fraud strategy .	Fully Implemented
16	2024/25	Fraud Strategy	2	**Fraud Response Plan** An organisation should have a Fraud response plan in place that shows the step-by-step process to notify management and those charged with governance of instances of fraud and how to respond to limit losses. Whilst the College has developed a draft Fraud response plan that outlines how they will respond to fraud and the processes in place to investigate cases of fraud, it was noted that the document has been in draft since early 2024 and has not been approved by the Audit committee or the Board of Management. Also, the Fraud response plan could be enhanced to include how the College would respond to any reputational damage and manage press, and publicity should they be affected by a fraud incident.	We recommend that: ○ The fraud response plan be presented to and approved by the Audit committee and the board of management and then made accessible to staff. ○ The response plan include information on how to respond to and mitigate reputational damage and manage press and publicity that may be caused by fraud.	**Medium**	The fraud response plan will be presented to Audit committee and Board for approval.	30-Jun-25	Director of Finance & Estates	Fully implemented	Fraud response plan completed and is being presented to Audit Committee at its next meeting on 2 September 2025. **Update at 06/02/2026:** Fraud response plan was approved at audit committee on 8 September 2025.				Further evidence requested: a copy of approved response plan.	Fully Implemented
17	2024/25	Fraud Strategy	3	**Fraud training and staff awareness** It is important that an organisation provides adequate training to staff to effectively detect and respond to potential instances of fraud, to protect the College from potential financial losses and reputational damage. The College currently does not have any specific anti-fraud training that would make staff aware about the different types of fraud, common red flags, and how to respond to and report fraud within the College. Whilst there is Information Security and GDPR training that covers cyber fraud, there is limited communication around other types of fraud. The College should consider also including anti-money laundering and anti-bribery training.	We recommend the College develops an anti-fraud, anti-bribery and anti-money laundering training programme that includes: ○ Educating staff on what fraud is, including different types of fraud such as financial, cyber, and identity fraud. ○ Recognising red flags and early warning signs ○ Providing clear instructions on how to report suspected fraud, including who to contact and what information to provide. ○ Use of real-life examples to illustrate how fraud can occur and the impact it can have on the College. ○ Ensuring staff understand their legal obligations and the ethical importance of preventing fraud. Also consider preparing an annual Fraud Newsletter that details new fraud trends that can be communicated to staff to improve their awareness.	**Medium**	Fraud training will be developed and staff will be made aware and encouraged to complete the training.	30-Sep-25	Director of Finance & Estates	**Partially implemented**	Investigating inclusion of iHASCO fraud module, which can be delivered to all staff.				Further evidence requested: confirmation that the module is also available to staff on the new system SafetyHub.	TBC
18	2024/25	Fraud Strategy	4	**Fraud risk assessments** It is important for the College to identify, record and assess general and specific fraud risks that may affect the College, so that management and Board are aware of any gaps in its prevention, detection and response controls. Whilst there are controls in place, such as around payroll fraud and expenses fraud, the College would benefit from taking a more holistic approach to managing fraud risks that can then be reviewed regularly to add any new emerging fraud risks and add new controls. This would enable management to have oversight over what are the main risks to the organisation and what is being done to respond to these. The failure to prevent fraud offence under the Economic Crime and Corporate Transparency Act (ECCTA) does not apply to the College, however its principles may be applied as good practice. There is an expectation to have clearly documented fraud risk assessment and established procedures to prevent and detect fraud.	We recommend that the College carry out a fraud risk assessment that includes identifying areas where fraud could occur, considering both internal and external fraud risks; evaluation of the likelihood and impact of identified risks, and assessing existing controls to determine their effectiveness in preventing or detecting fraud.	**Medium**	The college will carry out a fraud risk assessment.	30-Sep-25	Director of Finance & Estates	**Partially implemented**	A draft risk assessment document is being prepared and will be presented to audit committee on 2 September 2025. **Update Feb 2026:** Ongoing.				Further evidence requested: copy of the approved draft risk assessment document.	TBC
19	2024/25	Fraud Strategy	5	**Fraud reporting** Management should be aware of any cases fraud that are affecting or may have affected an organisation so that they can respond by implementing procedures to mitigate against these instances in the future and understand the risk profile of the organisation. The Audit Committee has oversight over fraud risk as part of their terms of reference, however there are no updates provided to Committee around the effectiveness of the College's anti-fraud controls or instances of potential or actual fraud. Given that fraud risks have not been added to the risk register, there is limited oversight and scrutiny in relation to fraud risks.	We recommend that the Audit committee receive: ○ A regular update on any new and emerging fraud risks. ○ The outcomes and actions from the National Fraud Initiative (NFI) report. ○ A statement that there has been no instances of fraud detected during the period.	**Low**	An update report will be completed for the audit committee on an annual basis, the first one being for the AY 2024/25.	30-Sep-25	Director of Finance & Estates	Fully implemented	An annual fraud report is being drafted for the audit committee on 2 September 2025				Further evidence requested: copy of the approved annual fraud report.	Fully Implemented
20	2024/25	Core Financial Controls	1	**ABSENCE OF FIXED ASSET REGISTER IN PLACE** It is important for the College to maintain efficient and consistently applied financial procedures. The College's Finance Regulations state that the Director of Finance & Estates is responsible for keeping a full register of properties owned or occupied by the College. Additionally, when transferring equipment between departments, the transfer must be recorded, a copy sent to the Director of Finance & Estates, and inventories updated accordingly. Management informed us that the College does not have a formal fixed asset register to track its fixed assets. They advised that while they can calculate essential information such as the original acquisition cost and accumulated depreciation at the year-end, this is noted in the fixed assets working papers from the College's accounts preparation for the year ended 31 July 2024. These papers included asset additions from 2023-24 and as far back as 2019-20. Although individual departments like Information Technology (IT) and Estates maintain their own fixed asset registers, these are not integrated into a comprehensive system. Currently, all fixed assets are only noted in the Net Book Value (NBV) of the financial statements. Furthermore, Management advised us that asset disposals must first be authorised by the department's budget holder and then sent to the finance department for further approval from the Director of Finance & Estates via an 'Asset Disposal Authorisation Form', this process is absent from the Procedure Manual, however, it is documented within the Asset Disposal Form. We reviewed one form for the disposal of five CEA TOP 250 High Frequency (HF) welders ('TIG and MMA'), the only disposal for the year, and noted that the completed form followed the correct process, with approval given via signature and date by the Budget Holder, Executive Management Team (EMT) Manager for Budget Holder, and the Director of Finance & Estates. Details of the disposal, including the method, location, and estimated proceeds, are shown on the form. However, the original purchase details and depreciation of the assets being disposed of were recorded as 'Unknown'. Finally, Internal Audit identified that the documentation of the College's capitalisation and depreciation process as outlined within the Financial Regulations does not align with the College's accounting policies as outlined within its financial statements. The accounting policies outline that grouped items of a total value of £30,000 or more are capitalised, the Financial Regulations outline that grouped items of a total value of £5,000 or more may be capitalised. In addition, while the accounting policies outline the estimated useful life key asset types will be depreciated against (e.g. equipment, fixture and fittings), these are not documented within the Financial Regulations.	We recommend that the College: Establish a formal Fixed Asset Register to retain all relevant details such as asset number, description of the asset, NBV, purchase date, acquisition cost, depreciation method and rate, accumulated depreciation and disposal information. Conduct a physical verification of all existing fixed assets to create a baseline for the register. Train staff on fixed asset management procedures and perform periodic reviews to ensure accuracy and compliance.	**Medium**	We are in the process of completing the fixed asset register and will carry out the checks noted in the recommendation.	30-Sep-25	Director of Finance & Estates	Fully implemented	Draft FAR compiled as of July 2025. To liaise with Estates and reconciled to their asset register. 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. **Update at 06/02/2026**: Fixed asset register now in place - audited by Deloitte as part of their external audit of the college financial statements for 2024/25.			Draft FAR	Further evidence requested: copy of the draft FAR document.	Fully Implemented
21					Prioritise the correction and completion of asset disposal forms immediately. Ensuring all purchase details and depreciation information are accurately recorded should be addressed as soon as possible to maintain precise financial records.		The asset disposal forms will be revised as soon as possible.	31-Jul-25	Director of Finance & Estates	Work in Progress	Process added to Finance Procedure Manual - Forms to be updated with information from FAR for any future disposals			Finance Procedure Manual - Draft V1 July 2025	Further evidence requested: copy of the Finance Procedure manual.	Fully Implemented
22					The College updates the Financial Regulations to ensure they align with its accounting policies with respect to the capitalisation and depreciation.		The financial regulations will be updated as soon as possible.	31-Jul-25	Director of Finance & Estates	Fully implemented	Finance Regs updated to agree with accounting policies			Financial Regulations at 19.12.2023 V1.1 ALJ 25.07.2025	Further evidence requested: copy of the Financial Regulations document.	Fully Implemented
23					The College updates the Finance Procedures Manual to include processes around maintaining the Fixed Asset Register and the existing asset disposal process.		The financial procedures manual will be updated as soon as possible.	31-Jul-25	Director of Finance & Estates	Fully implemented	Finance Procedure Manual updated with audit recommendations			Finance Procedure Manual - Draft V1 July 2025	Further evidence requested: copy of the Finance Procedure manual.	Fully Implemented
24	2024/25	Core Financial Controls	2	**REVIEW OF BANK RECONCILIATION AND FINANCE PROCEDURE MANUAL PRACTICES** It is important that the College completes bank reconciliations to ensure the accuracy and integrity of financial records, identify discrepancies between bank statements and internal records, mitigate the risk of fraud, and comply with financial reporting standards. Furthermore, the College's financial policies and procedures must clearly define directions for all processes and be effectively communicated to staff. During our review, we selected a sample of three month-end bank reconciliations. None of these samples had a sign-off review from the Accountant, as required by the Manual. After discussing with the Accountant, we learned that monthly bank reconciliations do not undergo a review because each daily reconciliation is reviewed by the Accountant. Therefore, if the month-end banking reconciles, a review is deemed unnecessary. Furthermore, the College has a Finance Procedure Manual, last updated in November 2024, which is available to the Finance team and saved in their Finance SharePoint area. Management advised that the Manual is updated as needed by any member of the Finance Team when there is a change in process. However, we noted that the Manual is missing version control details, such as who updated it, when it was last updated, and the next review date or cycle. Although Management stated the document is updated as required, it is good practice to have a minimum review period to ensure information remains current. We also found that processes for payroll, debtor, and creditor reconciliations are not documented, although Management advised that these reconciliations are performed monthly.	We recommend that the College should: Update the Manual to reflect that daily reconciliations are signed off by the Accountant for all bank reconciliations.	**Low**	The financial procedures manual will be updated as soon as possible.	30-Aug-25	Director of Finance & Estates	Fully implemented	FPM updated with audit recommendations			Finance Procedure Manual - Draft V1 July 2025	Further evidence requested: copy of the Finance Procedure manual.	Fully Implemented
25					Establish version control for the Finance Procedure Manual, including details on who updated it and the next review date or cycle. This will ensure that the manual remains current and reliable for all financial processes.		The financial procedures manual will be updated with version control.	30-Aug-25	Director of Finance & Estates	Fully implemented	Version control added to end of FPM			Finance Procedure Manual - Draft V1 July 2025	Further evidence requested: copy of the Finance Procedure manual.	Fully Implemented
26					Clearly define frequency and process for payroll, debtor, and creditor reconciliations within the Manual. This will help maintain consistency and accuracy in financial operations.		The financial procedures manual will be updated with details on reconciliations.	30-Aug-25	Director of Finance & Estates	Fully implemented	FPM updated with audit recommendations			Finance Procedure Manual - Draft V1 July 2025	Further evidence requested: copy of the Finance Procedure manual.	Fully Implemented
27	2024/25	Core Financial Controls	3	**ABSENCE OF MONTH END CHECKLIST/TIMETABLE** It is important that management oversight is consistently performed across all financial processes and all issues are identified in a timely manner. During testing, we noted that the College does not maintain a month-end checklist or timetable. It is good practice to have a checklist or timetable which outlines all month end activities, who they are to be completed by and when they are to be completed.	We recommend that the College should: Establish a month-end checklist which outlines all of the monthly tasks to be completed, who they are to be completed by and when they are to be completed. A review should be undertaken each month to confirm that all activities have been completed, and the checklist should be signed off to confirm this.	**Low**	Monthly checklist will be produced which outlines all of the monthly tasks to be completed.	30-Sep-25	Accountant - Mo Jarvis	Fully implemented	Monthly checklist created and included process in FPM - to be implemented from 1st August 2025			Finance Monthly Checklist	Further evidence requested: copy of the monthly checklist.	Fully Implemented
				PROMOTING ATTENDANCE:	The College investigates whether return to work forms can be made mandatory for completing an absence report on the Ciphr system (e.g., software control), and in the interim period, or if not possible, regular spot checks should be implemented for a sample of absences to ensure necessary documents are completed.	**Medium**	THE HR TEAM ARE EXPLORING WITH OUR HR SYSTEM PROVIDER whether return to work forms can be made mandatory for completing an absence report on the Ciphr system . IN THE INTERIM, regular spot checks will be implemented for a sample of absences to ensure necessary documents are completed.	April 2026	Head of HR							

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28	2024/25	Staff Wellbeing	1	There is a risk that inconsistent handling of absences can lead to unfair treatment, grievances and appeals under the Equality Act, payroll and leave errors, and poor staff wellbeing outcomes. Inaccurate or incomplete records undermine management information and decision-making, weaken the College's ability to manage absence effectively, and increase reputational and legal risks.	Line managers should receive regular refresher training, such as annually, on the Promoting Attendance Policy and Procedure.	Medium	Our HR Business Partnerswork together to support the different departments at the College. Our HR Business Partners will continue to work with the line mangers to advise on strategies for reducing sickness absence on an individual, departmental, and organisational basis. As noted, the HR and Professional Development teams have worked together to develop a manager training package specifically on key HR Policies and Procedures. The first sessions have been rolled out, one of which focused on UHI Inverness's Promoting Attendance Policy and Procedure.	Ongoing	HR and PD Teams								
29	2024/25	Staff Wellbeing	2	STAFF FEEDBACK SURVEYS There is a risk that staff wellbeing issues are not addressed due to the limited scope of surveys, resulting is wellbeing issues not being recognised. Additionally, there is a risk that the lack of consistent feedback on specific topics results in management being unaware of the effect of actions taken to address issues.	UHI Inverness implements consistent scheduled surveys, including areas advised by the Staff Wellbeing Group (e.g., an annual all staff survey). Feedback from surveys should be collated and analysed, resulting in SMART objectives set and a 'you say, we did' approach should be adopted to ensure employees are aware of the steps being taken to address any identified issues.	Medium	The College launched a Wellbeing Survey to all staff in late 2025. This was a short and anonymous survey designed to help us understand the workplace stressors affecting our staff. The survey was delivered via the Health and Safety Executive (HSE) and supports our ongoing commitment to staff wellbeing. The results will help us identify what we are doing well, highlight areas where we can improve, and shape future wellbeing initiatives and resources that truly support our staff. A draft action plan has been created by our Health. Safety and Sustainability Manager.	TBA	VP, COBER, Health, Safety and Sustainability and HR.								
					Future survey responses should be used as KPI benchmarks to judge the effectiveness of actions taken to address identified issues.	Medium	With reference to the Wellbeing Survey above, this will provide a benchmark and track changes over time.Ideally this will be conducted annually to assess progress and guide ongoing interventions.	Conducted annually	VP, COBER, Health, Safety and Sustainability and HR.								
					Questions about experiences on Optima Health and Able Futures are included in annual surveys to ensure staff utilising the service are satisfied.	Medium	With reference to the Wellbeing Survey above, this will provide a benchmark and track changes over time.Ideally this will be conducted annually to assess progress and guide ongoing interventions.	Conducted annually	VP, COBER, Health, Safety and Sustainability and HR.								
30	2024/25	Staff Wellbeing	3	SALARY ADVANCE SCHEME Without clear guidelines, there is a risk that an authoriser could make incorrect or discriminatory decisions, posing legislative risk.	The Salary Advance Request Scheme clearly defines the conditions for refusal to ensure a fair approval process for staff. These conditions should be outlined in an eligibility checklist for approving requests.	Low	SCHEME DOCUMENT UPDATED TO REFERENCE THAT COMPLETION OF PROBATIONARY PERIOD IS A REQUIREMENT. WHILST THE COLLEGE ARE not currently promoting this scheme, it is in place and will consider any requests received.	January 2026	Head of HR								
31	2024/25	Staff Wellbeing	4	REASONABLE ADJUSTMENTS APPROVAL There is a risk that the reasonable adjustment forms may be inaccurately completed or left incomplete. This could result in adjustments not being made, line managers being unaware of changes, or unclear approval authority and processes.	The Employer's Signature section is clearly defined, specifying the department and position to ensure a consistent process.	Low	RA FORM HAS BEEN UPDATED.	January 2026	Head of HR								
					The line manager section requires a sign off to confirm that line managers have thoroughly reviewed the form before its approval.	Low	RA FORM HAS BEEN UPDATED.	January 2026	Head of HR								
32	2024/25	Staff Wellbeing	5	STAFF WELLBEING GROUP There is a risk that staff Wellbeing Group actions are not consistently tracked or completed, resulting in issues not being addressed in a timely manner, being ignored, or compounding over time.	The Staff Wellbeing Group reviews the previous actions tracked via the meeting minutes regularly, such as monthly, to ensure all fields are completed for each action where a field is deemed not relevant, this should be completed as n/a.	Low	Management do not agree with this recommendation. This is an informal group which is attended by Volunteers and has no hierarchical structure, the Principal facilitates these discussions as chair, and he reports into the Health Safety and Wellbeing Committee verbally each month. Introducing the below would begin to formalise this as a committee with minutes - which it is not intended to be.	N/A	N/A								
					During the review, any outstanding or urgent items are highlighted with a RAG (Red, Amber, Green) status and action owners should be contacted for updates.	Low	Management do not agree with this recommendation. This is an informal group which is attended by Volunteers and has no hierarchical structure, the Principal facilitates these discussions as chair, and he reports into the Health Safety and Wellbeing Committee verbally each month. Introducing the below would begin to formalise this as a committee with minutes - which it is not intended to be.	N/A	N/A								
					Any issues to be escalated to the Health, Safety, and Wellbeing committee should be clearly summarised in all Staff Wellbeing Group minutes of meetings.	Low	Management do not agree with this recommendation. This is an informal group which is attended by Volunteers and has no hierarchical structure, the Principal facilitates these discussions as chair, and he reports into the Health Safety and Wellbeing Committee verbally each month. Introducing the below would begin to formalise this as a committee with minutes - which it is not intended to be.	N/A	N/A								
33	2024/25	Staff Wellbeing	6	PROMOTING ATTENDANCE TRAINING There is a risk that Managers may misclassify absence length, apply the wrong process stage, delay escalation, or miss required updates during long-term reviews. This can lead to inconsistent case handling, weaker support for employees, and poorer return-to-work planning.	The training information is updated to align with the Promoting Attendance Policy.	Low	Updated.	28/01/2026	HRBP								
					Clear due dates and frequency are established for the training, and alternative methods are provided for staff unable to attend workshops such as one-on-one sessions, online meetings, or session recordings.	Low	Agree.	End of AY 2025/26	HRBP/PD								
34	2024/25	Incidents Management	1	EVALUATING INCIDENT MANAGEMENT AND SUPPORT SERVICES IN THE ASSNET SYSTEM If the College fails to systematically record and address incidents on the ASSNET system, it risks neglecting the emotional and psychological needs of victims, which could lead to increased distress and dissatisfaction among affected individuals. Additionally, inadequate follow-up actions and outdated security equipment may compromise safety and security, potentially resulting in reputational damage and regulatory scrutiny.	We recommend that the College ensure all incidents, where appropriate, include a record of recommended support services for victims, such as counselling or psychological support. Additionally, the College should establish a mechanism to review and update protocols to guarantee that follow-up actions are consistently documented in the system and executed in line with policy and procedures.	Medium	N/A	N/A	N/A								
					We recommend that the College implement a procedure to include additional comments on the system, detailing the steps being taken to resolve issues that require follow-up.	Medium	N/A	N/A	N/A								
35	2024/25	Incidents Management	2	INCIDENT MANAGEMENT TRAINING PROGRAMMES There is a risk that staff responsible for incident management may not be adequately trained or aware of the necessary procedures and timescales. Additionally, inconsistent reporting and absence of specific training completion statistics may lead to non-compliance, hindering the College's ability to effectively manage incidents and adhere to good governance.	We recommend that the College should ensure robust tracking the completion of Duty Manager training and maintaining records of training completion.	Medium	N/A	N/A	N/A								
					We recommend that the College's PDT ensure a clearer reporting system to accurately track the number of staff who are required to do the mandatory PREVENT duty training and have actually completed. Additionally, the College should enhance communication efforts to remind staff of the importance of submitting their completion certificates by the deadline to ensure 100% compliance.	Medium	N/A	N/A	N/A								
					We recommend that the College develop a standard format for quarterly reports on incident management training submitted by the PDT to the HR committee. These reports should consistently include specific statistics on required training completion to facilitate effective monitoring and compliance verification.	Medium	N/A	N/A	N/A								
36	2024/25	Incidents Management	3	ENHANCING PREPAREDNESS AND COMPLIANCE: ADDRESSING SECURITY RECOMMENDATIONS Without a process to maintain an action plan for the recommendations provided by Police Scotland, the College may be vulnerable to potential security incidents.	We recommend that the College develop a structured process to maintain an action plan for implementing the recommendations provided by Police Scotland. The action plan should include clear descriptions, timelines, and assigned responsibilities to ensure accountability and progress. The College should also incorporate regular review sessions to assess the effectiveness of implemented measures and make necessary adjustments.	Low	N/A	N/A	N/A								
37	2024/25	Incidents Management	4	ABSENCE OF FORMAL ACTION PLAN PROCESS FOR INCIDENT MANAGEMENT There is a risk that without a process to maintain formal and regular action plans, the College may fail to effectively address underlying issues related to incidents, potentially compromising safety and wellbeing across departments.	We recommend that the College implement a formal process to develop and maintain regular action plans for the quarterly HSWC to monitor and report on health and safety incidents. The action plan should include clear descriptions, timelines, and assigned responsibilities to ensure accountability and progress. These plans should also include specific measures to tackle the root causes of incidents, ensuring a proactive approach to health and safety management.	Low	N/A	N/A	N/A								

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Board of Management

Subject/Title:	Policy Approval – Data Protection Policy
Author: [Name and Job title]	Quality
Meeting:	Audit Committee
Meeting Date:	June 2025
Date Paper prepared:	11th May 2025
Brief Summary of the paper:	Audit Board Committee are asked to approve the reviewed **Data Protection Policy**. This was the standard 3-year review of the document, and the following updates have been made: • Update to include new legislative reference. • Some language amendments made but context remains unchanged.
Action requested: [Approval, recommendation, discussion, noting]	Approval
Link to Strategy: Please highlight how the paper links to, or assists with:**:** • compliance • partnership services • risk management • strategic plan • new opportunity/change	Compliance
Resource implications:	No **If yes, please specify**:
Risk implications:	Yes **If yes, please specify:** Operational: Organisational: Policies review and development required to ensure compliance with legislation and awarding body regulations.
Equality and Diversity implications:	Yes **If yes, please specify:** Policy Equality Impact Assessment included
Consultation: [staff, students, UHI & Partners, External] and provide detail	PPRP – March 2025 EMT Approval – March 2025

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

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DATA PROTECTION POLICY

PL/GO/2023/001

Lead Officer	College Principal & Chief Executive
Review Officer	Information Development Manager
Date first approved by BoM	27 November 2009
First Review Date	25 May 2010
Date review approved by BoM	
Next Review Date	October 2026
Equality impact assessment	Yes

Reviewer	Date	Review Action/Impact
Information Development Manager	27.11.09	Amendments approved by BoM Audit Committee
Information Development Manager	25.05.10	Review approved by BoM Audit Committee
Information Development Manager	24.11.15	Review Approved by BoM Audit Committee
Information Development Manager	19.09.17	Review Approved by BoM Audit Committee
Information Development Manager	30.06.20	Review Approved by BoM

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Information Development Manager	Aug 2023	Update to legislative/policy & procedure references and included additional responsibility to the Principal & Chief Exec. Some language amendments made but the context remains the same.
Information Development Manager	March 2026	Update to include new legislative reference. Some language amendments made but context remains unchanged.

1. Policy Statement

UHI Inverness is committed to ensuring that the processing of personal data is only undertaken in the legitimate operation of ~~the college~~ it's business.

~~The college~~ UHI Inverness collects and uses information (data) about its staff, students and other individuals and bodies that it has contact with and aims to follow the 6 principles outlined within the UK Data Protection Act 2018, ~~and~~ the UK General Data Protection Regulation (GDPR) and the Data Use and Access Act 2025.

2. The Data Protection Principles

Personal data shall be:

a) Processed lawfully, fairly and in a transparent manner in relation to the data subject;

b) Collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall, in accordance with Article 89 (1), not be considered to be incompatible with the initial purposes;

c) Adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed;

d) Accurate and, where necessary, kept up to date, ~~;~~ every reasonable step must be taken to ensure ~~tha~~t personal data that ~~are~~ is inaccurate~~,~~ ~~having~~ regard~~ing to~~ the purposes for which ~~they~~ it is ~~are~~ processed, ~~are~~ is erased or rectified without delay;

e) Kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purpose in accordance with Article 89 (1) subject to implementation of the appropriate technical and organisational measures required by the Regulation in order to safeguard the

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rights and freedoms of the data subject;

f) Processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

3. Legislative framework/related policies/documents

3.1.1. Legislative framework includes~~:~~
3.1.2. UK General Data Protection Regulation
3.1.3. UK Data Protection Act 2018
~~3.1.3.~~3.1.4. The Data Use and Access (DUAA) Act 2025
~~3.1.4.~~3.1.5. The ~~Data Protection,~~ Privacy and Electronic Communications (Amendments etc.) (EU Exit) Regulations 2019
~~3.1.5.~~3.1.6. The Human Rights Act 1998
~~3.1.6.~~3.1.7. The Protection of Freedoms Act 2012
~~3.1.7.~~3.1.8. Freedom of Information (Scotland) Act 2002
~~3.1.8.~~3.1.9. Public Records Scotland Act 2011
~~3.1.9.~~3.1.10. Related policies, procedures and documents include:
~~3.1.10.~~3.1.11. Freedom of Information Policy
~~3.1.11.~~3.1.12. Public Interest Disclosure (Whistle Blowing) Policy
~~3.1.12.~~3.1.13. Information Security Policy
~~3.1.13.~~3.1.14. Information Security Incident Management Procedure
~~3.1.14.~~3.1.15. University Partnership IS Acceptable Use Policy
~~3.1.15.~~3.1.16. Records Management Policy (including the UHI Records Retention Policy)
~~3.1.16.~~3.1.17. Business Continuity Policy
~~3.1.17.~~3.1.18. Staff Recruitment & Selection Policy
~~3.1.18.~~ Protecting Vulnerable Groups (PVG) Scheme procedure for New & Existing Staff Procedure
~~3.1.19.~~ Protecting Vulnerable Groups (PVG) Admissions & Student Funding
3.1.19. Team Procedure
3.1.20. Secure Handling, Use, Storage and Retention of Disclosure Information Procedure
3.1.21 DP Guidelines for Staff

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4. Scope

4.1.1. Information/data is legitimately gathered and processed for a variety of reasons including the recruitment and payment of staff; the recruitment of students; the payment of student bursaries and discretionary funds; the organisation and administration of courses and programmes; student prize giving and graduation ceremonies; the monitoring of health and safety arrangements; the monitoring of equality; diversity and inclusion strands (i.e. age, disability, gender, sexual orientation,

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race, ethnicity and religion) particularly in respect of student admissions/staff recruitment and the monitoring of performance; procurement of goods and services (including the payment of contractors); achievement and assessment and compliance with statutory obligations; Government agencies and other relevant bodies.

4.1.2. ~~The college~~ UHI Inverness is registered as a data controller with the Information Commission~~er's Office~~ (IC) and endeavors at all times to maintain data in secure conditions. A general outline of the personal data UHI Inverness processes has been notified to the Information Commission~~er~~ and can be viewed via the ~~ICO~~ register at www.ico.org.uk under registration number Z7631145.

4.1.3. This Policy should be read in conjunction with other relevant documents and policies noted above in Section 3.

5. Responsibilities

5.1.1. **The ~~College~~ Board of Management** are responsible for the approval of the Data Protection Policy; overseeing the monitoring ~~the college's~~ UHI Inverness's compliance with the GDPR; directing the EMT to take any action necessary to mitigate information risk(s) and data security risk(s) as notified to the Board and/or its sub-committees.

5.1.2. **The ~~College~~ Principal & Chief Executive** has strategic responsibility for data protection and decision-making responsibility in relation to organisational risk(s) of a data protection and information security nature.

5.1.3. **The ~~College~~ Executive Management Team** are responsible for providing leadership and commitment to the embedding of the data protection principles; monitoring compliance with the UK GDPR and ensuring action is taken (where required) to ensure legal compliance with the ~~GDPR~~ data protection and associated legislation; and, on-going review of the Data Protection Policy.

5.1.4. **The Data Protection Officer** is responsible for:

- Review & revision of the Data Protection Policy and ~~for~~ ensuring the associated data protection guidance for staff ~~is~~ are regularly updated to ensure currency~~;~~.

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- Maintaining an organisation wide register of all personal data processing activities, in accordance with Article 30 of the GDPR~~;~~.
- Maintaining a register of all Subject Access Requests and personal data released in accordance with Article 15 of the GDPR~~;~~.

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- Developing and embedding organisational data sharing agreements, Controller/Processor and Controller/Controller processing agreements and maintaining a register of all current arrangements~~.~~;

Providing advice (where sought) with regard to data protection impact~~.~~ assessments and monitoring compliance with the controls introduced to mitigate risk;

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~~assessments and monitoring compliance with the controls introduced to mitigate risk.~~

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- Development & delivery of staff training on data protection matters;

- Provision of advice & guidance to college staff at all levels (including the Board of Management) on data protection matters and compliance with associated legislation;

Acting as the Data Controller on behalf of ~~the college~~ UHI Inverness which includes liaison with the IC on matters relating to the processing of personal data and cooperating with the IC as the Supervisory Authority;

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~~liaison with the ICO on matters relating to the processing of personal data and cooperating with the ICO as the Supervisory Authority;~~Upholding data subject's information rights and processing information rights requests within legal timescales;

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- Monitoring & reporting to EMT, Audit Committee, F & GP Committee and Board of Management (as appropriate) regarding ~~the college's~~ compliance with current data protection legislation and any information risks giving cause for concern~~.~~;

5.1.5. **All managers** are responsible for ensuring:

- Development and on-going maintenance of a departmental personal data register which includes all areas under their control;

The secure storage, access, control and management of the personal data processed within their functional area;

-

~~data processed within their functional area;~~

- Understanding their own personal responsibilities regarding the Information Asset Owner Guidelines;

- All staff they manage undergo training on data protection and

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information security on an annual basis.

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5.1.6. **All staff** are responsible for ensuring:

- The security of the personal data that they process;
- Compliance with both the data protection policy and the associated staff guidelines;

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- Any suspected data breach is notified to the ~~college~~ Data Controller or
ICT Manager immediately when they become aware of it;
- Annual completion of the compulsory staff training modules on data protection and information security;~~-~~
- The information rights of data subjects as outlined in current legislation are respected and can be fully exercised;~~-~~

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- Ensuring the departmental data register is updated to record any personal data processing being undertaking, to ensure it remains both current and accurate.

6. Information Rights

Current legislation provides the following rights to all data subjects:

6.1 The right to be informed (how their personal data is processed).
6.2 The right to access (the right to be given a copy of their own data).
6.3 The right to have personal data corrected if believed to be inaccurate
6.4 The right to have their data deleted (in certain circumstances).
6.5 The right to limit how their data is used (in certain circumstances).
6.6 The right to data portability (in certain circumstance).
6.7 The right to object to data processing (in certain circumstances).
6.8 Rights regarding automatic decision making and profiling.

7. Compliance

7.1.1. This policy will be audited regularly with reports going to the executive management team and Board of Management Audit Committee.

7.1.2. Compliance with this policy is the responsibility of all college staff. Any deliberate breach of the data protection policy may lead to disciplinary action being taken or access to the college's facilities being withdrawn or even criminal prosecution. Any questions or concerns about the interpretation of this policy should be addressed to the ~~college's~~ Data Controller.

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7.1.3. Any member of staff, student or other individual who considers that the policy has been breached in respect of personal data about them, should raise the matter with the ~~college's~~ Data Controller.

7.1.4. Complaints or concerns regarding personal data processing or exercising one's information rights should be directed to ~~T~~t he Data Controller who can be contacted by email: data.controller@inverness.uhi.ac.uk and quality.ic@uhi.ac.uk About us - Complaints handling

7.1.5. This policy does not form part of the formal contract of employment but it is a condition of employment that employees abide by the policy and adhere to the guidelines which follow. Failure to adhere to the policy can therefore result in disciplinary proceedings.

8. Monitoring

8.1.1. Appropriate procedures for monitoring and evaluation are the responsibility of the lead officer. These procedures will be subject to audit by the Quality Unit.

8.1.2. The Data Controller will maintain statistical data regarding the number of ~~enquiries and access to~~ ~~data~~ requests for personal data and information rights requests. Such information will be reported to the Audit Committee on an annual basis.

9. Review

9.1.1. This policy will be reviewed on a 3 yearly basis

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Equalities Impact Assessment (EIA)

ITEM 03.a.1

Policy/Procedure/Strategy	Data Protection Policy	Lead Officer	Principal & Chief Executive
New / Revised / Existing	Revised	Review Officer	Information Development Manager
Review Due	Oct 2026	Assessment Date	03/03/26

Step 1 – Aim

Aim of proposed activity/decision/new or revised policy or procedure:

To take account of recent changes in legislation

Who will be affected?	Who will be consulted?	Evidence Available:
All data subjects	N/A	Legislative changes

Step 2 – Potential Positive (P) / Negative (N) / Neutral (N/I) impact identified:

Area:	Age	Disability	Gender Reassignment	Marriage/ Civil Partnership	Pregnancy and Maternity	Race	Religion or Belief	Sex	Sexual Orientation
v	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I
Advancing Equality of Opportunity	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I
Promoting Good Relations	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I	N/I

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Equalities Impact Assessment (EIA)

ITEM 03.a.1

Step 3 – Consider the Environmental Sustainability Impact (including Potential Positive (P) / Negative (N) / Neutral (N/I) impact)
Neutral

Step 4 – Outline actions taken to ensure no detriment resulting from change
Policy updated to include reference to the Data Use and Access Act 2025.

Summary of EIA Outcome	
☐	No further action to be carried out
☐	Amendments or changes to be made
☐	Proceed with awareness of adverse impact
☐	Abandon process – stop and rethink

Completed EIA Forms to be sent to Quality.ic@uhi.ac.uk.

BDO

INVERNESS COLLEGE
INCIDENTS MANAGEMENT
INTERNAL AUDIT - FINAL REPORT

FEBRUARY 2026

LEVEL OF ASSURANCE:	
DESIGN	MODERATE
EFFECTIVENESS	MODERATE

IDEAS | PEOPLE | TRUST

CONTENTS

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RESTRICTIONS OF USE

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.

DISTRIBUTION LIST		
FOR ACTION	GEORGIE PARKER	VICE PRINCIPAL – CURRICULUM, OPERATIONS & EXTERNALS RELATIONS
	LINDSAY SNODGRASS	VICE PRINCIPAL – CURRICULUM, STUDENT EXPERIENCE AND QUALITY
FOR INFORMATION	MARTIN KERR	ESTATES AND CAMPUS SERVICES MANAGER
	MARK MCKERRAL	HEALTH, SAFETY AND SUSTAINABILITY MANAGER
	AUDIT COMMITTEE	MEMBERS

REPORT STATUS	
LEAD AUDITOR(S):	DEEPASRI SELVAM
DATES WORK PERFORMED:	22/05/2025 - 19/12/2025
DRAFT REPORT ISSUED:	06/02/2026
MANAGEMENT RESPONSES RECEIVED:	10/03/2026
FINAL REPORT ISSUED:	12/03/2026

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	2	4
L	0	0
TOTAL NUMBER OF FINDINGS: 2		4

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

- ✓ The College may not have documented or made available the policies and procedures for staff and students to manage and report incidents.
- ✓ The College is not taking remedial actions to address issues identified within incidents, resulting in repeated incidents or inappropriate student behaviours.

PURPOSE

The purpose of this review was to provide assurance on the design and operational effectiveness of key controls related to incidents management for staff and students in the following areas:

- Policies and Procedures
- Consistent Application
- Governance, Training and Awareness
- Lessons Learned and Actions Taken
- Preparedness for Martyn's Law

BACKGROUND AND SCOPE

In accordance with the 2024-25 Internal Audit Plan, Internal Audit undertook a review of incidents management for staff and students at Inverness College (the College). The College has established a framework of policies and procedures to ensure a safe and supportive learning environment. The UHI Inverness Safeguarding Policy provides staff with guidance on safeguarding and duty of care. The UHI Inverness Student Conduct Policy aims to foster a positive learning environment for all students, including apprentices, and aligns with the Strategic Plan 2021-2025. Additionally, the Student Disciplinary Procedure addresses breaches of conduct with potential outcomes ranging from verbal warnings to exclusion.

The College utilises email, telephone, or face-to-face discussions for incidents based on the nature of the follow-up required. Governance involves a structure to manage safeguarding and health and safety incidents. Safeguarding incidents are reported and monitored annually by the Research Committee. Health and safety incidents are reviewed by the Health, Safety and Wellbeing Committee (HSWC) quarterly, and reported to the Finance and General Purposes Committee (F&GP) bi-annually and the Board of Management annually. Student conduct and disciplinary incidents are monitored by the Progression Manager and Team, with oversight by a short-life working group (SLWG) set up to manage low-level vandalism and misconduct.

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

CONCLUSION

We can provide moderate assurance over both the control design and the control effectiveness of the College's arrangements in place regarding incidents management.

The College has demonstrated good practice by establishing clear and detailed policies and procedures for incident management to ensure a safe and supportive learning environment. It systematically reviews safety procedures and conducts risk assessments following incidents, sharing lessons learned to enhance decision-making. The College's safeguarding system includes a 'Policies and Procedures' folder on the staff intranet, accessible only to specific roles to ensure confidentiality. The governance structure ensures that safeguarding incidents are reported and monitored annually by the Learning, Teaching & Research Committee, while health and safety incidents are reviewed quarterly by the Health, Safety and Wellbeing Committee (HSWC), bi-annually by the Finance and General Purposes Committee (F&GP), and annually by the Board of Management.

However, the audit identified two findings of medium significance. These findings relate to the evaluation of incident management and support services in the ASSNET system. Gaps were noted in the recording of support services and follow-up actions for six (35%) out of 17 incidents. Regarding PREVENT duty training, it was noted that 53% of total staff and 61% of permanent staff completed it, but 100% completion could not be clearly verified in the email evidence.

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EXECUTIVE SUMMARY

SUMMARY OF GOOD PRACTICE

During the course of our review, we identified several areas of good practice:

- The College has established a framework of clear and detailed policies and procedures for incidents management, including the UHI Inverness Safeguarding Policy and Student Conduct Policy, to ensure a safe and supportive learning environment.
- Inverness College has a process in place for systematically reviewing safety procedures and conducting risk assessments following incidents, while sharing lessons learned within the safeguarding team to enhance decision-making and maintain an approach to managing safeguarding concerns.
- The College's safeguarding system includes a folder on the named 'Policies and Procedures' on the staff intranet, accessible by all staff and containing relevant policies and forms. Access to an area of this folder is restricted to specific roles, ensuring confidentiality. The
- The College has a policy for all students related to safeguarding, which involves joint risk assessments with Police Scotland or the National Health Service (NHS) before enrolment for specific cases. This includes the use of the National Prevent Referral Form to report concerns about individuals at risk of radicalisation.
- The governance structure in place ensures that safeguarding incidents are reported and monitored annually by the Learning, Teaching & Research Committee. Health and safety incidents are reviewed quarterly by the Health, Safety and Wellbeing Committee (HSWC), bi-annually by the Finance and General Purposes Committee (F&GP), and annually by the Board of Management.
- Police Scotland has held several meetings and visits, including the Counter Terrorism Security Advisor (CTSA) Monthly Bridge call with the Health, Safety and Sustainability Manager. These discussions focus on the current terror threat, local concerns, and government guidance. The College was also briefed by Police Scotland on the challenges posed by County Lines, a method of drug dealing exploiting children and vulnerable adults.

SUMMARY OF FINDINGS

Notwithstanding the areas of good practice identified, we also identified important areas for improvement:

- **Evaluating Incident Management and Support Services in the 'Assnet' System:** The Health, Safety and Sustainability Manager uses the 'ASSNET' system to manage health and safety incidents. Our review of 17 incidents from a total of 230 between 01 July 2024 and 09 July 2025 showed that 11 (65%) were satisfactorily addressed with recommended actions recorded and evaluated. However, two (12%) incidents lacked recorded support services for victims, such as counselling. Additionally (18%) , three incidents had no suitable follow-up actions.
- **Incidents Management Training Programmes:** In March 2025, the College required all staff to complete online PREVENT duty training and we noted that 53% of total staff and 61% of permanent staff completed it, but 100% completion could not be clearly verified, and while Professional Development Team (PDT) submits quarterly reports to the HR committee, these reports lack a standard format and consistent statistics.

DETAILED FINDINGS

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE ADOPTED A SYSTEMATIC PROCESS FOR RECORDING, EVALUATING, AND ADDRESSING INCIDENTS REPORTED, WHICH COULD LEAD TO REPUTATIONAL ISSUES AND REGULATORY ACTION.

FINDING 1 – EVALUATING INCIDENT MANAGEMENT AND SUPPORT SERVICES IN THE ASSNET SYSTEM	TYPE
It is important that the College adopts a systematic process for recording, evaluating, and addressing incidents reported to ensure comprehensive management and resolution of issues. This approach will help prevent potential reputational damage and regulatory action by demonstrating accountability and commitment to safety and support for all individuals involved. The Health, Safety and Sustainability Manager uses the 'ASSNET' system to manage health and safety incidents. Upon review, we selected a sample of 17 from a population of 230 incidents from 01 July 2024 to 09 July 2025. These were related to injury, illness, property damage, near misses, and violent incidents. We found that 11 (65%) out of 17 incidents were satisfactory in terms of recommended actions, which were recorded, evaluated, and addressed as demonstrated on the system. However, two (12%) out of 17 incident samples had minor exceptions. While some action was taken, there was no record in the system for the support services offered to the victims, such as counselling or psychological support, which is expected in line with the policy. These include: 1. *For sample reference number 'ACCB65 A5 04-02-25_Redacted'* 2. *For the sample reference number 'ACCB91 A310 14-01-25_Redacted'* Additionally, for three (18%) out of 17 incidents sampled, there were no suitable follow-up actions recorded on the system: 1. *ACCB91-A309 06-01-25* 2. *ACCB113-A2 26-02-25, and* 3. *ACCB114 A15 24-02-25_Redacted*	DESIGN AND EFFECTIVENESS
IMPLICATION	**SIGNIFICANCE**
If the College fails to systematically record and address incidents on the ASSNET system, it risks neglecting the emotional and psychological needs of victims, which could lead to increased distress and dissatisfaction among affected individuals. Additionally, inadequate follow-up actions may compromise, potentially resulting in reputational damage and regulatory scrutiny.	MEDIUM

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that the College ensure all incidents, where appropriate, include a record of recommended support services for victims, such as counselling or psychological support. Additionally, the College should establish a mechanism to review and update protocols to guarantee that follow-up actions are consistently documented in the system and executed in line with policy and procedures.	Health, Safety and Sustainability manager	THE COLLEGE ALWAYS PROVIDES FOLLOW UP SUPPORT TO STAFF AND STUDENTS FOLLOWING ANY SIGNIFICANT INCIDENT. THIS CAN INVOLVE DIFFERENT TYPES OF SUPPORT. THIS HAS ROUTINELY NOT BEEN INCLUDED IN ANY INCIDENT REPORTING BUT CAN BE INCLUDED IN FUTURE TO ENSURE COMPLETENESS.	01/08/26

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE ADOPTED A SYSTEMATIC PROCESS FOR RECORDING, EVALUATING, AND ADDRESSING INCIDENTS REPORTED, WHICH COULD LEAD TO REPUTATIONAL ISSUES AND REGULATORY ACTION.

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that the College implement a procedure to include additional comments on the system, detailing the steps being taken to resolve issues that require follow-up.	Health, Safety and Sustainability manager	We have replaced AssessNET with a custom system. We will develop it further to ensure this type of action is recorded.	01/08/26

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE A CLEAR FRAMEWORK FOR INCIDENTS MANAGEMENT, INCLUDING HANDLING, REPORTING, MONITORING STUDENT BEHAVIOUR, STAFF TRAINING, AND AWARENESS INITIATIVES, WHICH COULD LEAD TO INEFFECTIVE MANAGEMENT AND COMMUNICATION OF PROCEDURES.

FINDING 2 - INCIDENT MANAGEMENT TRAINING PROGRAMMES	TYPE
It is important that the College establish clear and up-to-date action plans for incident management, including health and safety incidents, to ensure effective handling, reporting, and monitoring, as deficiencies in these areas could impact the overall safety and wellbeing within the College. In March 2025, the College launched mandatory Government online PREVENT duty training for all staff. Staff are required to complete the training, download their completion certificate, and send it to the Professional Development team (PDT) for tracking and updating their CPD records in the Ciphr system by the deadline of 31 July 2025. The PDT produced a completion report in August 2025, which enabled managers and the team to follow up on any non-completion by staff members. We noted that 53% of total staff and 61% of permanent staff have completed the training, including those exempt however we are unable to confirm there is 100% completion of the training through the email evidence. Management has advised us that the responsibility for monitoring the completion of Prevent training, Duty Manager training, and ACT (Action Counters Terrorism) awareness training lies with the staff's line manager. PDT submits quarterly reports to the HR committee however, there is no standard format for these reports, and they do not consistently provide statistics on the completion of specific training. We were not provided with the necessary evidence, and therefore we were unable to verify this information.	DESIGN AND EFFECTIVENESS
IMPLICATION	**SIGNIFICANCE**
There is a risk that staff indirectly involved in incident management may not be adequately aware of PREVENT concerns. Additionally, inconsistent reporting and absence of specific training completion statistics may lead to non-compliance, hindering the College's ability to effectively manage incidents and adhere to good governance.	MEDIUM

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE A CLEAR FRAMEWORK FOR INCIDENTS MANAGEMENT, INCLUDING HANDLING, REPORTING, MONITORING STUDENT BEHAVIOUR, STAFF TRAINING, AND AWARENESS INITIATIVES, WHICH COULD LEAD TO INEFFECTIVE MANAGEMENT AND COMMUNICATION OF PROCEDURES.

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that the College's PDT ensure a clearer reporting system to accurately track the number of staff who are required to do the mandatory PREVENT duty training and have actually completed. Additionally, the College should enhance communication efforts to remind staff of the importance of submitting their completion certificates by the deadline to ensure 100% compliance.	Head of Professional Development	THE COLLEGE ARE CURRENTLY EXPLORING IMPROVED WAYS OF BEING ABLE TO RECORD AND REPORT ON COMPLETION RATES OF MANDATORY PD IN LIGHT OF NOT HAVING A SOPHISTICATED SYSTEM WHICH CAN DO THIS. WE HAVE PROVIDED EVIDENCE DURING THE AUDIT OF ALL MANAGERS BEING FULLY TRAINED IN PREVENT. WE HAVE ALSO PROVIDED EVIDENCE OF STAFF COMPLETION RATES OF PREVENT AND THIS IS NOW REPORTED TO EACH HR BOARD COMMITTEE MEETING. WE HAVE A SYSTEM IN PLACE OF SHARING NON-COMPLETION WITH MANAGERS FOR THEIR TEAMS AND THEY ARE REQUIRED TO FOLLOW THIS UP WITH INDIVIDUAL STAFF. REMINDERS TO COMPLETE PREVENT TRAINING ARE REGULARLY CIRCULATED TO ALL STAFF ON WEE CONNECT. WE WILL CONTINUE TO WORK ON FURTHER WAYS OF DEALING WITH THE NON-COMPLIANCE ASPECT OF THIS RECOMMENDATION.	9/3/2026
We recommend that the College develop a standard format for quarterly reports on incident management training submitted by the PDT to the HR committee. These reports should consistently include specific statistics on required training completion to facilitate effective monitoring and compliance verification.	Head of Professional Development	WE NOW INCORPORATE AN UPDATE ON ALL STAFF MANDATORY TRAINING COMPLETION IN QUARTERLY UPDATES TO THE HR COMMITTEE.	9/3/2026

OBSERVATIONS

OBSERVATIONS

OBSERVATION 1 - ASSESSMENT OF COMPLIANCE WITH STUDENT CONDUCT AND DISCIPLINARY PROCEDURES

To verify adherence to the Student Conduct and Disciplinary Procedure, we selected seven sample accounts from 64 disciplinary incidents from the 2024-25 academic year to review the management of student conduct and disciplinary incidents. However, the College declined to provide evidence for the selected samples due to GDPR purposes instead, provided examples of the procedure being followed at the time of the audit. Therefore, we were unable to provide full assurance that systems and processes were performed to the required standard.

OBSERVATION 2 - CHALLENGES IN ESTABLISHING TIMELINES FOR INCIDENT MANAGEMENT

The College has established a timeline for disciplinary actions, which must be completed within ten working days. However, there are no specific timelines for safeguarding incidents, which are prioritised and managed by the Safeguarding Leads. Health and Safety incidents are categorized as low, medium, or high, but lack timelines to ensure they are resolved promptly. Communication about incidents is conducted via email, telephone, or face-to-face, depending on the situation. While the disciplinary procedures, precautionary actions require discussion between the Access and Progression Manager and the Vice Principal before informing the student. There is no formal guidance on the frequency or method of communication for safeguarding or health and safety incidents. Overall, there is an absence of formal communication guidelines for such incidents. Management advised that it is not practical to have Service Level Agreements (SLAs) or formal communication guidelines for such incidents, as they are handled based on dynamic risk assessment. Critical incidents may require immediate actions, such as contacting the police, which cannot be documented within a fixed timescale, as it would overly generalise the process.

OBSERVATION 3 - REVIEW OF IHASCO TRAINING PROGRAMME REPORTING AND DOCUMENTATION PRACTICES

We noted that the iHASCO training programmes, which cover incident management, include core modules on health and safety and Display Screen Equipment (DSE), as well as role-specific modules such as Control of Substances Hazardous to Health (COSHH), Working at Height, Risk Assessment, and Manual Handling. These trainings are reported and monitored by the HSWC quarterly, the Finance and General Purposes Committee (F&GP) bi-annually, and the Board annually. However, we were not provided with evidence of training materials for the core training or the latest completion rates log for role-specific training, as management considered these items to be out of scope, as this was covered in the Health and Safety audit in 2023-24.

OBSERVATION 4 - ENHANCING PREPAREDNESS AND COMPLIANCE: ADDRESSING MARTYN'S LAW AND ACT TRAINING

Management has informed us that the guidance on training requirements for Martyn's Law is still being developed. It is anticipated that this guidance will align with the content of ACT (Action Counters Terrorism) Awareness Workshops. We were advised that the UHI partnership safeguarding committee, which the Inverness VP chairs, is actively discussing this matter, as reflected in their quarterly agenda under 'PREVENT Update' scheduled for 5 November 2024, 5 February 2025, and 15 May 2025. Additionally, Management advised us that Policies and procedures are being updated in response to Martyn's Law, with plans to report on necessary adjustments for compliance once the guidance is available. We were also informed that the ACT training is relatively new and still in the process of being rolled out. There is an established group, led by the Health, Safety and Sustainability Manager, that will be active during May 2025. One of the tasks this group will complete is to assess the required training and refresh frequency for ACT.

APPENDICES

APPENDIX I: BACKGROUND

Inverness College, a key academic partner within the University of the Highlands and Islands (UHI), has established a framework of policies and procedures to ensure a safe and supportive learning environment.

Policies and Practices: The UHI Inverness Safeguarding Policy, is led by the Vice Principal for Curriculum, Student Experience & Quality, with the EMT and Safeguarding Leads being responsible for its implementation. This policy is overseen by the Learning, Teaching & Research Committee and applies to all UHI partners. The UHI Inverness Safeguarding Procedure, provides staff with guidance on safeguarding and duty of care. It is also overseen by the Learning, Teaching & Research Committee and it outlines the responsibilities of Safeguarding Leads and Deputies, emphasising confidentiality and appropriate reporting. The UHI Inverness Student Conduct Policy aims to foster a positive learning environment and applies to all students, including apprentices. It is reviewed every three years. The policy supports the university's strategic commitment to a safe environment and aligns with the Strategic Plan 2021-2026. The UHI Inverness Student Criminal Offence Data Policy ensures a consistent approach to processing student criminal offence data, supporting compliance with UK General Data Protection Regulation (GDPR) and rehabilitation legislation. It is reviewed every three years. The UHI Inverness Student Disciplinary Procedure, covers breaches of the Student Code of Conduct and is reviewed every three years. It includes informal and formal stages, with potential outcomes ranging from verbal warnings to exclusion. The Student Code of Conduct outlines expected behaviour for students and is reviewed every three years. It addresses misconduct in both physical and online environments, with disciplinary actions ranging from warnings to permanent exclusion.

Consistent Application: The College has in place a structured communication system for incidents, utilising email, telephone, or face-to-face discussions based on the nature of the follow-up required. Formal meetings are recorded when applicable, depending on the personal data involved. The process for determining incident outcomes is tailored to the specific nature of each incident, ensuring that appropriate procedures are followed.

The safeguarding team, led by the Vice Principal – Curriculum, Student Experience and Quality, and a Curriculum Leader, manages safeguarding concerns with five additional staff members acting as safeguarding deputies. The team uses a Safeguarding Reporting Form to ensure a structured approach to safeguarding, with detailed information required for consultation and decision-making. The team has undergone training from the National Society for the Prevention of Cruelty to Children (NSPCC) and the Home Office. The college maintains strong links with external partners, participating in Multi-Agency Public Protection Arrangements (MAPPA) and employing Information Sharing Protocols (ISPs) to manage risks and ensure community safety. The college's proactive approach includes Protection of Vulnerable Groups (PVG) checks for external support staff and collaboration with Police Scotland, Social Work, and the National Health Service (NHS).

The College's safeguarding system includes a folder named 'Policies and Procedures' on the staff intranet, accessible by all staff, containing relevant policies and forms. Staff can report concerns via email to the safeguarding mailbox using the referral form, with immediate prioritisation of safeguarding issues. Police involvement may extend timescales, and a coloured flag system is used for managing actions. Incident recording is limited to safeguarding leads and admin support, with confidential matters handled by three staff members.

The College has a risk assessment template which is used by the safeguarding team and supported by the Access and Transitions team to support decision making.

The College works with the Police Scotland Prevent lead and has provided face-to-face PREVENT training to managers, with mandatory online training for all staff. The PLACE Referral Meeting Operating Protocol addresses child exploitation through a multi-agency approach, ensuring consistent standards and effective information sharing. Following incidents, safety procedures are reviewed, and risk assessments are conducted. Lessons learned from safeguarding incidents are shared within the safeguarding team.

For Health and Safety incidents, the Health, Safety and Sustainability Manager uses the ASSNET system to manage incidents, with trend analysis for low-risk incidents. System access is available to all staff, with line managers having administrative access.

The College's student conduct and disciplinary incidents are managed by the Access and Progression Manager, who maintains disciplinary policies and procedures. The code of conduct is accessible on SharePoint, and the Access and Progression Manager tracks the disciplinary process to ensure completion. Disciplinary actions must be completed within ten working days, with serious incidents involving support from Senior Management. The College uses the ASSNET system for recording incidents, with a process for tracking disciplinary actions, investigation outcomes, and incident closure. Disciplinary actions are reviewed for potential sharing and consistency of practice.

Governance: The College has in place a governance structure to manage safeguarding and health and safety incidents. Safeguarding incidents are reported and monitored annually by the Learning. Teaching and Research Committee. The Safeguarding Report, prepared by the Vice Principal for Curriculum, Student Experience & Quality, outlines the safeguarding disclosures received and the partnership efforts of UHI Inverness. Presented to the Learning, Teaching and Research Committee, the report highlights the college's commitment to safeguarding children and vulnerable adults, presents trend data, ensuring compliance with legislative requirements and managing risks associated with safeguarding duties.

Health and safety incidents are reported and monitored through the Health, Safety and Wellbeing Committee (HSWC), which meets quarterly. The Health, Safety & Wellbeing Committee reviews reports authored by the Health, Safety and Sustainability Manager, providing updates on health and safety issues across various sectors. These reports highlight changes in incidents, such as injuries, illnesses, near misses, and violence, across different areas of the college. Health and safety incidents are also reported to the Finance and General Purposes Committee (F&GP) bi-annually and the Board of Management annually.

Student conduct and disciplinary incidents are monitored by the Access and Progression Manager and Team. A stand alone short-life working group (SLWG) was set up to explore ways of managing low-level vandalism and low-level misconduct. Recommendations from this group were reported to the Executive Management Team (EMT) for discussion and implementation of an action plan for the next academic year, 2025-26.

Continued…

APPENDIX I: BACKGROUND

Preparedness for Martyn's Law: The College has in place several processes to prepare for Martyn's Law, despite its current application to England. The College is actively engaging with Police Scotland to assess the potential impact of Martyn's Law on campus operations in Scotland. This engagement involves discussions with the UHI Safeguarding Committee, where Martyn's Law is a topic of conversation and the UHI Prevent committee and the College's Heath and Safety committee. The Health, Safety and Sustainability Manager, along with the Estates and Campus Services Manager, are in communication with Police Scotland to seek guidance on the matter.

Management has indicated that guidance on training requirements for Martyn's Law is still under development. It is expected that this guidance will align with the content of Action Counters Terrorism (ACT) Awareness Workshops. These workshops cover essential topics such as understanding the current threat, identifying and reporting suspicious activity, and responding effectively to firearms or weapons attacks. Management has advised that policies and procedures are being updated in response to Martyn's Law, with plans to report on necessary adjustments for compliance once guidance is available. The College have formed a working group who will take this work forward to ensure preparedness for Martyn's Law.

Training and Awareness: We noted that the training programme for incident management includes Duty Manager Training, covering a range of responsibilities and daily duties. Initial training is provided when an individual becomes a Duty Manager, followed by periodic training on various topics, such as PREVENT. In March 2025, the College launched mandatory Government online PREVENT duty training for all staff. Management has advised us that the responsibility for monitoring the completion of Prevent training, Duty Manager training, and ACT (Action Counters Terrorism) awareness training lies with the staff's line manager. PDT submits quarterly reports to the HR committee.

The College ensures that policies and procedures for incident management are accessible to staff via Quality SharePoint and to students through the student intranet and the public website.

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 on the design and operational effectiveness of key controls related to incidents management for staff and students in the following areas:

- Policies and Procedures
- Consistent Application
- Governance, Training and Awareness
- Lessons Learned and Actions Taken
- Preparedness for Martyn's Law

KEY RISKS

1. The College may not have documented or made available the policies and procedures for staff and students to manage and report incidents.
2. The College may not have adopted a systematic process for recording, evaluating, and addressing incidents reported, which could lead to reputational issues and regulatory action.
3. The College may not have a clear framework for incidents management, including handling, reporting, monitoring student behaviour, staff training, and awareness initiatives, which could lead to ineffective management and communication of procedures.
4. The College is not taking remedial actions to address issues identified within incidents, resulting in repeated incidents or inappropriate student behaviours.
5. The College may not have evaluated the potential changes required due to the Terrorism (Protection of Premises) Act 2025, which could lead to inadequate campus operations, safety measures, and insufficient adjustments to policies and procedures.

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. 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.		
GEORGIE PARKER	VICE PRINCIPAL – OPERATIONS AND EXTERNAL RELATIONS	KEY CONTACT
LINDSAY SNODGRASS	VICE PRINCIPAL – CURRICULUM, STUDENT EXPERIENCE AND QUALITY	KEY CONTACT
MARTIN KERR	ESTATES AND CAMPUS SERVICES MANAGER	KEY CONTACT
MARK MCKERRAL	HEALTH, SAFETY AND SUSTAINABILITY MANAGER	KEY CONTACT
LOUISE MARTIN-THEYERS	ACCESS AND PROGRESSION MANAGER	KEY CONTACT
SUZANNE STEWART	DATA CONTROLLER	KEY CONTACT
LUDKA ORLOWSKA-KOWAL	GOVERNANCE OFFICER	KEY CONTACT

ITEM 04.a

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:

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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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INVERNESS COLLEGE

INTERNAL AUDIT ANNUAL REPORT 2024-25

MARCH 2026

IDEAS | PEOPLE | TRUST

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Restrictions of use

The matters raised in this report are only those which came to our attention during the course of 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.

ANNUAL STATEMENT OF ASSURANCE

REPORT BY BDO LLP TO Inverness College

As the internal auditors of Inverness College, we are required to provide the Board, via the Audit Committee, and other management with a view on the adequacy and effectiveness of Inverness College's risk management, governance and internal control processes.

In giving our view, it should be noted that assurance can never be absolute. The internal audit service provides Inverness College with reasonable assurance that there are no major weaknesses in the internal control system for the areas reviewed in 2024-25. Therefore, the statement of assurance is not a guarantee that all other aspects of the internal control system are adequate and effective. The statement of assurance should confirm that, based on the evidence of the audits conducted, there are no other signs of material weakness in the framework of control.

In assessing the level of assurance to be given, we have taken into account:

- All internal audits undertaken by BDO LLP during 2024-25;
- Any follow-up action taken in respect of audits from previous periods for these audit areas;
- Whether any significant recommendations have not been accepted by management and the consequent risks;
- The effects of any significant changes in the organisation's objectives or systems;
- The requirements of the Public Sector Internal Audit Standards; and
- Any limitations which may have been placed on the scope of internal audit (no restrictions were placed on our work).

CONCLUSION

In our view, based on the reviews undertaken during the period, and in the context of materiality:

- In the areas of Fraud Strategy, Core Financial Controls, Staff Wellbeing, Cyber Review, and Incidents Management, the risk management activities and controls we examined were found to be suitably designed to achieve the specific risk management, control, and governance arrangements. Based on our verification reviews and sample testing, the controls in these areas were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the related risk management, control, and governance objectives were achieved for the period under review.

REVIEW OF 2024-25 WORK

BACKGROUND

Our role as internal auditors is to provide an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. Our approach, as set out in BDO's Internal Audit Manual, is to help the organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes.

INTERNAL AUDIT PLAN 2024-25

BDO LLP has been appointed as internal auditors to Inverness College to provide the Board (via the Audit Committee), the Chief Executive and other managers with assurance on the adequacy of the following arrangements:

- Fraud Strategy
- Core Financial Controls;
- Staff Wellbeing;
- Cyber Review;
- Incidents Management; and
- Follow Up;

Responsibility for these arrangements remains fully with management, who should recognise that internal audit can only provide 'reasonable assurance' and cannot provide any guarantee against material errors, loss or fraud. Our role at Inverness College is also aimed at helping management to improve risk management, governance and internal control, so reducing the effects of any significant risks facing the organisation.

Our risk evaluations and tests are designed to ensure that controls are sound both in design and effective in operation. Our conclusions are based on evidence obtained during the course of our audit work, verification tests and samples selected from the year's transactions to date. However, our conclusions should not be taken to mean that all transactions have been properly authorised and processed or that all elements of systems have been tested.

REVIEW OF 2024-25 WORK

AUDIT APPROACH

We have reviewed the control policies and procedures employed by Inverness College to manage risks in business areas identified by management set out in the 2024-25 Annual Internal Audit Plan approved by the Audit Committee. This report is made solely in relation to those business areas and risks reviewed in the year and does not relate to any of the other operations of the organisation.

Our approach complies with best professional practice, in particular, Public Sector Internal Audit Standards and the Chartered Institute of Internal Auditors' Position Statement on Risk Based Internal Auditing.

We discharge our role, as detailed within the audit planning documents agreed with Inverness College's management for each review, by:

- Considering the risks that have been identified by management as being associated with the processes under review
- Reviewing the written policies and procedures and holding discussions with management to identify process controls
- Evaluating the risk management activities and controls established by management to address the risks it is seeking to manage
- Performing walkthrough tests to determine whether the expected risk management activities and controls are in place
- Performing compliance tests (where appropriate) to determine whether the risk management activities and controls are operating as expected.

The assurance statement provided on page 8 of this report is based on historical information and the projection of any information or conclusions contained in our assurance statement to any future periods is subject to the risk that changes may alter its validity.

COVERAGE

During 2024-25 BDO LLP has reviewed and evaluated Inverness College's processes in the following areas:

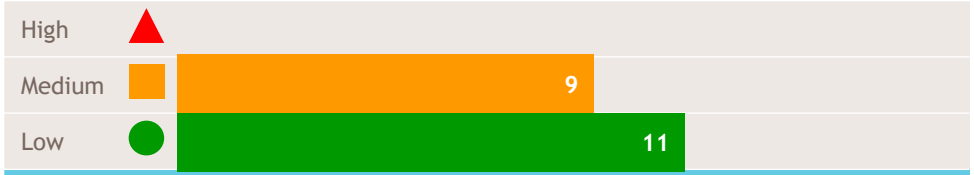
- Fraud Strategy
- Core Financial Controls
- Staff Wellbeing
- Cyber Review
- Incidents Management
- Annual Follow Up

REVIEW OF 2024-25 WORK

RECOMMENDATIONS

To assist management in addressing our findings, we categorise our recommendations according to their level or priority. The recommendations made in the completed reviews totalled 20.

SUMMARY OF RECOMMENDATIONS (SEE APPENDIX I)



TOTAL NUMBER OF RECOMMENDATIONS: 20

REPORTING MECHANISMS AND PRACTICES

Our initial draft reports are sent to the key officer responsible for the area under review in order to gather management responses. In every instance there is an opportunity to discuss the draft report in detail. Therefore, any issues or concerns can be discussed with management before finalisation of the reports.

Our method of operating with the Audit Committee is to agree reports with management and then present and discuss the matters arising at the Committee meetings.

MANAGEMENT ACTION ON OUR RECOMMENDATIONS

Management have reviewed and commented on our reports. For the reports which have been finalised, management have agreed responses. The responses indicate that appropriate steps to implement our recommendations will be put in place.

REVIEW OF 2024-25 WORK

RELATIONSHIP WITH EXTERNAL AUDIT

All our final reports are available to the external auditors through the Committee papers and are available on request. Our files are also available to External Audit should they wish to review working papers in order to place reliance on the work of Internal Audit.

FOLLOW UP

During the year we undertook independent exercises to assess the progress made by Inverness College in implementing internal audit recommendations made in previous years.

Implementation of recommendations is a key determinant of our annual opinion. If recommendations are not implemented on a timely basis then weaknesses in control and governance frameworks will remain in place. Furthermore, an unwillingness or inability to implement recommendations reflects poorly on management's commitment to the maintenance of a robust control environment. There were a total of 16 open audit recommendations across nine internal audit reports due to be implemented by 31 July 2025. Of the 16 recommendations, 4 (25%) were categorised as fully implemented, and 12 (75%) were categorised as partially implemented. The implementation rate shows some progress towards a commitment to ensuring internal audit recommendations are implemented in a timely manner to strengthen the overall internal control framework across the organisation.

SUMMARY OF WORK PERFORMED

Details of the completed internal audit reviews have been reported to the Audit Committee throughout the year and have been discussed at length with consideration and scrutiny of management responses and timescales proposed.

For the purpose of this annual report, we set out in the following pages our summary of recommendations and assessment of the design and effectiveness of the risk assurance for each of the audit areas reviewed.

REVIEW OF 2024-25 WORK

REPORTS ISSUED	OVERALL REPORT CONCLUSIONS - SEE APPENDIX I					
	▲	■	●	ADVISORY	DESIGN	OPERATIONAL EFFECTIVENESS
Fraud Strategy	0	4	1	0	MODERATE	MODERATE
Core Financial Controls	0	1	2	0	MODERATE	MODERATE
Staff Wellbeing	0	2	5	0	MODERATE	MODERATE
Cyber Review	0	0	3	0	SUBSTANTIAL	N/A
Incidents Management	0	2	0	0	MODERATE	MODERATE
Annual Follow Up	N/A	N/A	N/A	N/A	N/A	N/A

PERFORMANCE AGAINST OPERATIONAL PLAN

VISIT	DATE OF REVIEW	PROPOSED AUDIT	PLANNED DAYS	ACTUAL DAYS	STATUS
1	October 2024	Fraud Strategy	6	6	Completed
2	December 2024	Core Financial Controls	6	6	Completed
3	February 2025	Staff Wellbeing	5	7*	Completed
4	April 2025	Cyber Review	7	7	Completed
5	May 2025	Incidents Management	6	7*	Completed
6	July 2025	Annual Follow Up	3	5*	Completed

*The number of days incurred exceeded those billed because we received more evidence rather than management responses. This required us to reopen the file, conduct additional work, and complete quality assurance procedures again. Additionally, delays in receiving further evidence to complete the review necessitated extra time for review and continuous follow-up with key contacts regarding management responses.

AUDIT PERFORMANCE

AUDIT	COMPLETION OF FIELDWORK/DEBRIEF MEETING	DRAFT REPORT	FINAL MANAGEMENT RESPONSES	FINAL REPORT
Fraud Strategy	30/10/2024	20/11/2024	12/03/2025	12/03/2025
Core Financial Controls	23/12/2024	31/03/2025	30/06/2025	01/07/2025
Staff Wellbeing	16/09/2025	20/10/2025	23/02/2025	23/02/2025
Cyber Review	19/06/2025	22/07/2025	19/08/2025	20/08/2025
Incidents Management	19/12/2025	06/02/2026	10/03/2026	12/03/2026
Annual Follow Up	16/12/2025	09/02/2026	12/02/2026	18/02/2026

APPENDIX I: DEFINITIONS

LEVEL OF ASSURANCE	DESIGN OF INTERNAL CONTROL FRAMEWORK		OPERATIONAL EFFECTIVENESS OF INTERNAL 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.

FOR MORE INFORMATION:

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UHI Inverness

Internal Audit
2025-26

Budgetary & Financial Reporting
March 2026

Overall Conclusion

Strong

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A GRADING STRUCTURE 21
B ASSIGNMENT PLAN 23

The matters raised in this report came to our attention during the course of our audit and are not necessarily a comprehensive statement of all weaknesses that exist or all improvements that might be made.

This report has been prepared solely for UHI Inverness's individual use and should not be quoted in whole or in part without prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any third party.

We emphasise that the responsibility for a sound system of internal control rests with management and work performed by internal audit should not be relied upon to identify all system weaknesses that may exist. Neither should internal audit be relied upon to identify all circumstances of fraud or irregularity should there be any although our audit procedures are designed so that any material irregularity has a reasonable probability of discovery. Every sound system of control may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas that are considered to be of greatest risk and significance.

1 Executive summary

Overview

Purpose of review

The purpose of this review was to assess whether UHI Inverness (the College) has appropriate budgetary and financial reporting arrangements in place and that these have been embedded throughout the whole of the College. This review sought to provide assurance to the Board, via the Audit Committee, that the College's budgetary and financial reporting arrangements are timely and have sufficient controls in place.

This review formed part of our Internal Audit Plan 2025/26.

Scope of review

Our objectives for this review were to assess whether:

- There is appropriate control over the budgetary process within the College, with an appropriate member of management having ultimate responsibility for the process.
- Deviations from budget are identified and investigated at an early stage.
- The College has a set of comprehensive Financial Regulations to ensure that financial matters are managed professionally.
- Budget Holders are adequately trained and receive information regarding their budgets in a timely manner.
- The budget setting process is effectively linked to the operational planning process.
- Information outlined within the Management Accounts is timely and provides relevant information.

1 Executive summary

Budgetary processes are in line with good practice observed across our education client base.
The Board and Senior Management receive sufficient reporting of performance against budget and against plans throughout the year to enable informed decision making.

Our approach to this assignment took the form of discussion with relevant staff, review of documentation and where appropriate sample testing.

Limitation of scope

There was no limitation of scope.

1 Executive summary

Background

Financial Regulations

The College has a set of Financial Regulations in place, which were updated in August 2025 and are due to be reviewed in December 2026. The Regulations are supported by a set of Financial Procedures which are updated when required due to changes in processes. The Principal retains overall control of the budget while budget management activities are carried out by the Director of Finance & Estates with support from the Management Accountant, and individual Budget Holders.

The Director of Finance & Estates is responsible for the following elements of budget setting and financial management:

- Preparing annual, capital, and departmental budgets;
- Producing monthly management accounts and forecasts;
- Maintaining all financial systems;
- Supervising Budget Holders in financial planning, reporting, and audits; and
- Supplying reports on finances on a basis determined by Finance and General Purpose Committee.

Budget Holders are responsible to their Manager and the Director of Finance for managing income and expenditure within their allocated budgets. They must ensure spending remains within budget and follow financial procedures. Managers oversee the financial activity within their area and may delegate purchasing authority to named individuals.

Where budgets are devolved to individual Budget Holders within a department, those individuals remain accountable to their Manager for the effective use and oversight of their budget.

1 Executive summary

Budget Process

The College's budget-setting process begins with the preparation of an initial draft budget by the Director of Finance & Estates, in consultation with departmental Managers and Budget Holders. This draft is informed by a review of actual expenditure from the previous financial year (2024/25), historical trends, and prior year assumptions. The aim is to ensure that the proposed budget reflects operational needs and strategic priorities.

Once departmental inputs are consolidated, the Director of Finance & Estates prepares the final draft budget. This draft is presented to the Executive Leadership Team, and then the Finance and General Purposes Committee for review and then submitted to the Board of Directors for formal approval.

We reviewed the presentation of the draft 2025/26 budget and the approval from June 2025 and confirmed that it followed this process.

Management of Deficit

The College's approved budget for 2025/26 shows a predicted operating deficit of £792,000. This is due to sector wide issues around funding and increased cost pressures of staff and non-staff costs. The December 2025 Management Accounts show that the College were operating at a loss of around £2 million, against the budgeted deficit of the mentioned £792,000. Reasonings for this are outlined within the report presented to the Executive Management Team in February 2026. The key reasons include: the revised FE funding model resulting in less funding than budgeted, HE figures being under the budgeted target, and research grant funding cuts.

As a result of such a deficit at the December 2025 Management Accounts, the College are in the process of drafting a Financial Recovery Plan, these actions are expected to generate savings of up to £2.5 million, enabling the College to break even.

1 Executive summary

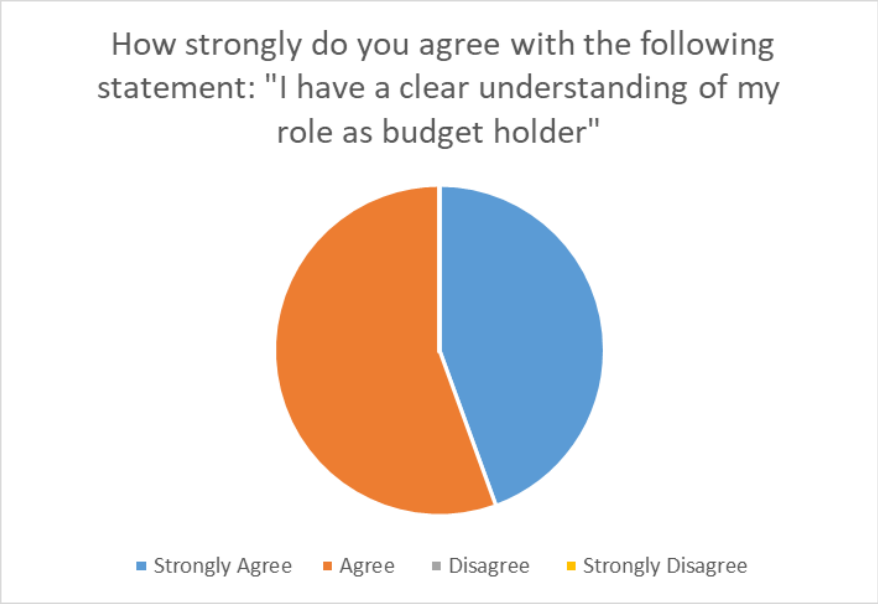
Management Accounts

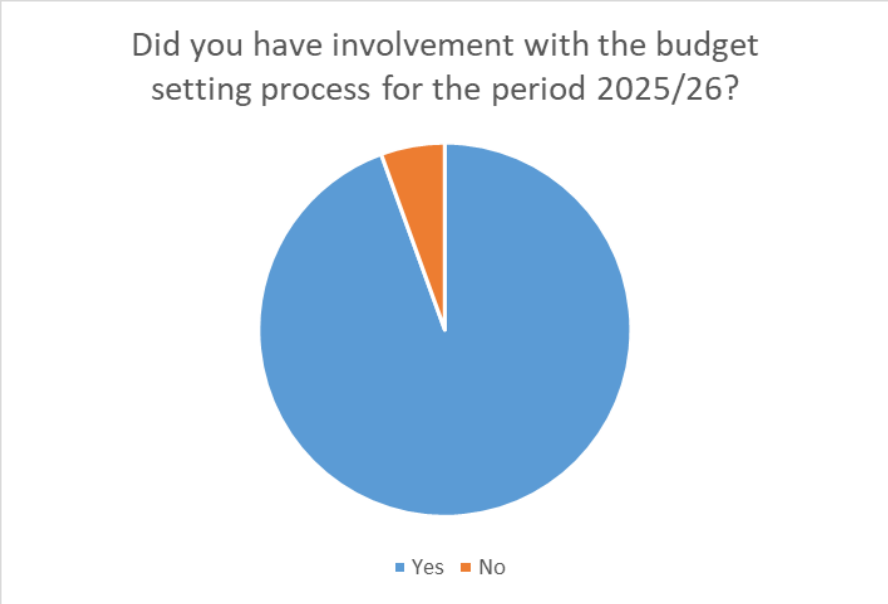
The Finance and General Purposes Committee meets on a quarterly basis and is updated on the financial position and provided a copy of the Management Accounts on a quarterly basis. We reviewed the Management Accounts from December 2025 and the quarterly reports to the Committee from September and November 2025. These reports included the key financial information and consistently covered the required items. We confirmed that the College has a clear process in place for monitoring its budget throughout the year.

1 Executive summary

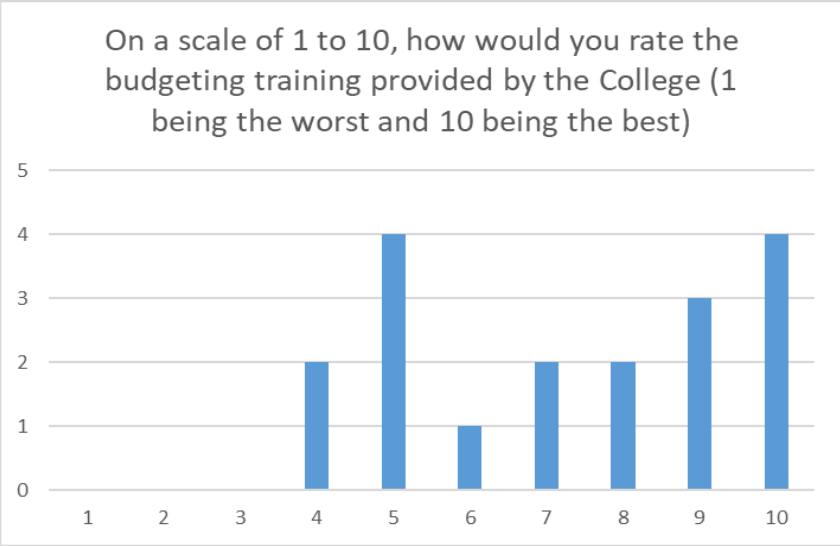
Budget Holder Questionnaire

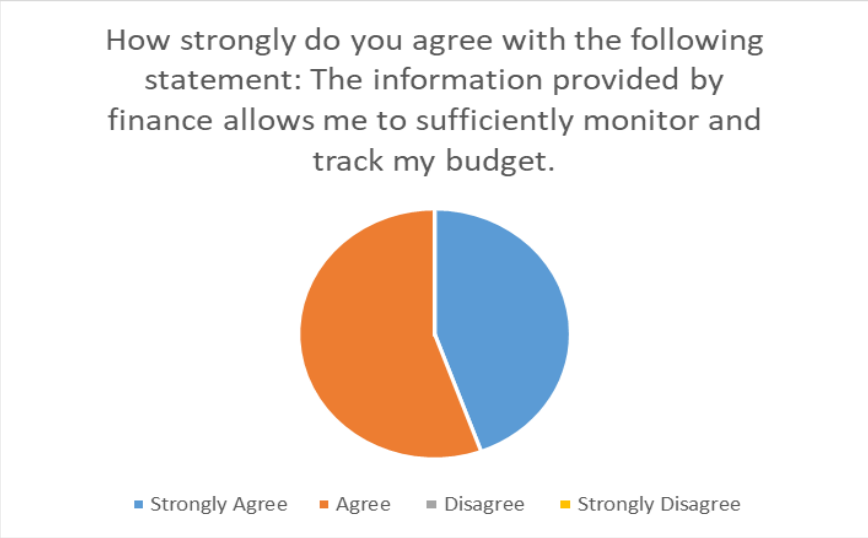
To gather feedback on the budget setting process and the support provided by the College, a questionnaire was sent to 30 Budget Holders across the College, to which we received 18 responses (60%). As a result of our survey, we have raised a recommendation surrounding the training and monitoring arrangements in place at the College. Please see **Section 3: Detailed Recommendations** for further information. We have summarised the results of the survey below:

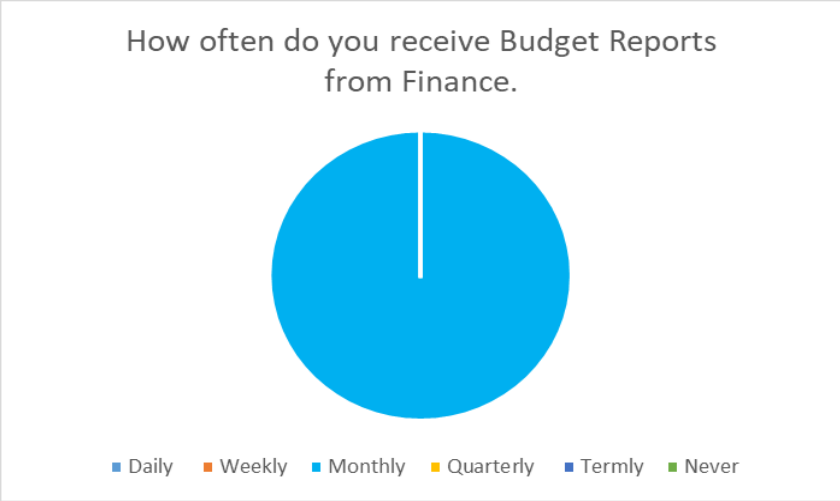


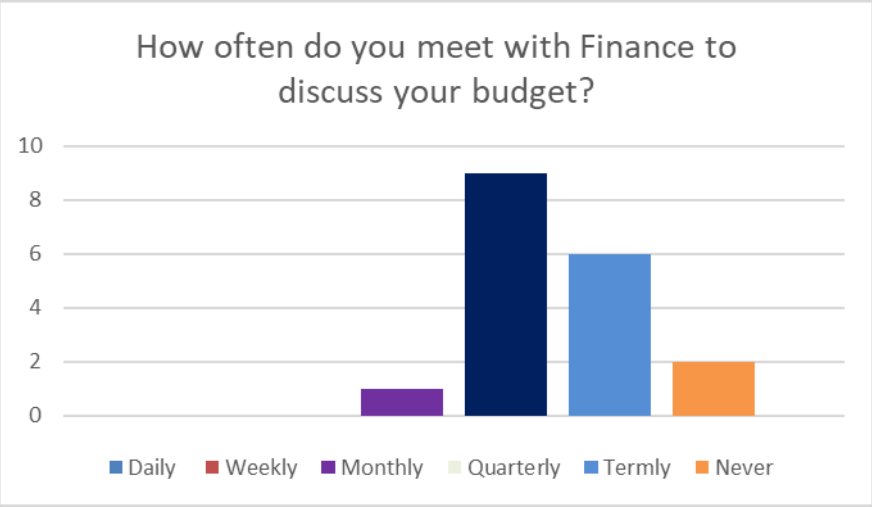


1 Executive summary









1 Executive summary

Work Undertaken

In line with each objective, we undertook the following work:

Objective 1: There is appropriate control over the budgetary process within the College, with an appropriate member of management having ultimate responsibility for the process.

- We reviewed the College's Financial Regulations to assess the structure of the budgetary team and confirm that there is a central point of control.
- We also reviewed the 2025/26 budget approval process to evaluate whether the budgeting procedures are adequate and were followed appropriately.

Objective 2: Deviations from budget are identified and investigated at an early stage.

- We reviewed the reports to the Executive Management Team minutes from November 2025 - February 2026 to assess if there are regular checks on actual financial position against the budget and if deviations are discussed.

Objective 3: The College has a set of comprehensive Financial Regulations to ensure that financial matters are managed professionally.

- We reviewed the Financial Regulations to assess if the budget-setting and monitoring processes are clearly outlined.

Objective 4: Budget holders are adequately trained and receive information regarding their budgets in a timely manner.

- We reviewed the results of a survey of Budget Holders to assess whether they receive adequate training related to their financial responsibilities.
- We also reviewed a sample of the departmental reports from October 2025, December 2025, and January 2026 to evaluate whether budget holders receive timely and sufficient information regarding their budgets.
- We reviewed a sample of termly meetings between Budget Holders and the Finance Team to assess whether there is appropriate monitoring of department budgets.

1 Executive summary

Objective 5: The Board and Senior Management receive sufficient reporting of performance against budget and against plans throughout the year to enable informed decision making.

- We reviewed the December 2025 management accounts to assess the frequency of their preparation and whether they sufficiently support decision-making.
- We reviewed the Executive Management Team and Finance & General Purposes Committee meeting minutes from November 2025 - February 2026 to determine whether Senior Management receives regular updates on their budget.

Objective 6: Information outlined within the Management Accounts is timely and accurate.

- We reviewed the December 2025 management accounts to assess the accuracy of the financial information provided.
- We reviewed the meeting minutes from the meetings the accounts were presented to assess whether the Management Accounts are reported in a timely manner to support effective financial planning.

Objective 7: Budgetary processes are in line with good practice observed across our education client base.

- We considered our wider education client base to assess whether the College's budgetary processes can be considered good practice.

1 Executive summary

Conclusion

Overall conclusion

Overall Conclusion: Strong
Following our review, we can provide a strong level of assurance surrounding the College's budget setting, monitoring, and reporting arrangements. This is highlighted as we have raised several good practice points, however, we have raised one low grade recommendation for improvement. Please see **Section 3: Detailed Recommendations** for further information.

Summary of recommendations

Grading of recommendations				
	High	**Medium**	**Low**	**Total**
Budgetary & Financial Reporting	0	0	1	1

As can be seen from the above table there were no recommendations made which we have given a grading of high.

1 Executive summary

Areas of good practice

The following is a list of areas where the College is operating effectively and following good practice.	
1.	Management Accounts are prepared by the College on a quarterly basis. Through our review of the Management Accounts and the month end procedures in place, we are satisfied that these arrangements are adequate. The College's Management Accounts are presented to the Finance & General Purposes Committee and to the Executive Management Team and we have confirmed that discussions and scrutiny of the Management Accounts takes place.
2.	The College aligns its budgeting process closely with the Curriculum Plan, helping to ensure that financial forecasts are directly supported by robust activity planning. Regular review of curriculum delivery hours against available staffing capacity further supports sustainable resource planning.
3.	The Financial Regulations, last approved in August 2025 and due for review in December 2026, provide a clear overview of the budget-setting and monitoring arrangements at the College.
4.	There are regular comparisons of actual v budget, through the College's management accounts and monthly budget reports. There are adequate explanations for significant deviations from budget and the Finance & General Purposes Committee are made aware of such deviations.

1 Executive summary

The following is a list of areas where the College is operating effectively and following good practice.	
5.	The Finance Team meet with Budget Holders three times per year to review budget performance, discuss any significant variances, address issues or risks, and agree on any required corrective actions.
6.	The Budgetary process is led by the Director of Finance & Estates who is responsible for overseeing the budget and updating the College's Executive Leadership Team.
7.	The College has a robust budget setting timetable in place, this clearly outlines the activities that must take place, details of who is responsible, and the deadlines.
8.	The College maintains a comprehensive set of Financial Procedures that detail each step of all finance-related functions, including every stage of the associated system processes.

2 Benchmarking

We include for your reference comparative benchmarking data of the number and ranking of recommendations made for audits of a similar nature in the most recently finished internal audit year.

Budgetary & Financial Reporting

Benchmarking				
	High	Medium	Low	Total
Average number of recommendations in similar audits	0	0	2	2
Number of recommendations at UHI Inverness	0	0	1	1

From the table above it can be seen that the College has a lower number of recommendations compared to those colleges it has been benchmarked against.

3 Detailed Recommendations

Budget Holder Training			
Ref.	Finding and Risk	Grade	Recommendation
1.	Budget Holders responsible for monitoring and managing budgets should be supported through clear financial reporting and appropriate training. From the 30 Budget Holders surveyed, we received 18 responses (60%). The average rating of the budgeting training provided by the College was 7.2 out of 10 (1 = very poor, 10 = very good), with 6 of these rating the training 5 or below. We also asked how often the Budget Holders meet with Finance and two respondents reported they never meet with Finance to discuss their budget. We note that the College has advised that training is planned to be delivered later this year; however, there is currently no confirmed date or defined content for this training. From our root cause analysis, we identified that the College do not have a formal, recurring	**Low**	We recommend that the College formalise and implement a structured budgeting training programme for all Budget Holders to address identified knowledge gaps and support more informed financial decision-making. The College should also ensure that all Budget Holders are formally scheduled to attend termly budget meetings, with attendance monitored and documented.

3 Detailed Recommendations

	training cycle for budget holders, nor is there a structured process to monitor or record meetings between budget holders and the Finance team. This creates a risk that Budget Holders may not have sufficient knowledge or confidence to effectively monitor and manage their budgets, potentially leading to inaccurate forecasting, overspending or underutilisation of funds.		
Management response			Responsibility and implementation date
			Responsible Officer: *Implementation Date:*

4 Observations

The following is a list of observations from our review	
1.	From our review of the December 2025 Management Accounts and the corresponding report, the College is currently reporting an operating deficit of £2.043 million. This is primarily due to ongoing sector-wide funding reductions and lower-than-budgeted Higher Education (HE) income.To address this deficit, the College has drafted a Financial Recovery Plan, which is expected to generate savings of approximately £2.5 million, bringing the College back to a break-even position.

5 Audit arrangements

The table below details the actual dates for our fieldwork and the reporting on the audit area under review. The timescales set out below will enable us to present our final report at the next Audit Committee meeting.

Audit stage	Date
Fieldwork start	16 February 2026
Closing meeting	25 February 2026
Draft report issued	6 March 2026
Receipt of management responses	11 March 2026
Final report issued	14 March 2026
Audit Committee	3 June 2026
Number of audit days	6

6 Key personnel

We detail below our staff who undertook the review together with the College staff we spoke to during our review.

Wbg			
Partner	Graham Gillespie	Partner & Head of Internal Audit	gg@wbg.co.uk
Director	Peter Clark	Director of Internal Audit	pcc@wbg.co.uk
Senior Manager	Scott McCready	Senior Internal Audit Manager	smc@wbg.co.uk
Auditor	Ailsa Gourlay	Internal Auditor	amg@wbg.co.uk

UHI Inverness			
Key Contact	Niall McArthur	Director of Finance & Estates	Niall.McArthur.ic@uhi.ac.uk
Wbg appreciates the time provided by all the individuals involved in this review and would like to thank them for their assistance and co-operation.			

Appendices

A Grading structure

For each area of review, we assign a level of assurance in accordance with the following classification:

Assurance	Classification
Strong	Controls satisfactory, no major weaknesses found, no or only minor recommendations identified.
Substantial	Controls largely satisfactory although some weaknesses identified, recommendations for improvement made.
Weak	Controls unsatisfactory and major systems weaknesses identified that require to be addressed immediately.
No	No or very limited controls in place leaving the system open to significant error or abuse, recommendations made require to be implemented immediately.

A Grading structure

For each recommendation, we assign a grading either as High, Medium, or Low priority depending on the degree of risk assessed as outlined below:

Grading	Classification
High	Major weakness that we consider needs to be brought to the attention of the Audit Committee and addressed by Senior Management of the organisation as a matter of urgency.
Medium	Significant issue or weakness which should be addressed by the organisation as soon as possible.
Low	Minor issue or weakness reported where management may wish to consider our recommendation.

B Assignment plan

Purpose of review

The purpose of this review is to assess whether the College has appropriate budgetary and financial reporting arrangements in place and that these have been embedded throughout the whole of the College. This review will seek to provide assurance to the Board, via the Audit Committee, that the College's budgetary and financial reporting arrangements are adequate.

This review forms part of our Internal Audit Pan 2025/26.

Scope of review

Our objectives for this review are to assess whether:

- There is appropriate control over the budgetary process within the College, with an appropriate member of management having ultimate responsibility for the process.
- Deviations from budget are identified and investigated at an early stage.
- The College has a set of comprehensive Financial Regulations to ensure that financial matters are managed professionally.
- Budget holders are adequately trained and receive information regarding their budgets in a timely manner.
- The budget setting process is effectively linked to the operational planning process.
- The College Board and Senior Management receive sufficient reporting of performance against budget and against plans throughout the year to enable informed decision making.

B Assignment plan

- Budgetary processes are in line with good practice observed across our education client base.
- Information outlined within the Management Accounts are timely and provides relevant information.

Our approach to this assignment took the form of discussion with relevant staff, review of documentation and where appropriate sample testing.

Limitation of scope

There is no limitation of scope.

Audit approach

Our approach to the review will be:

- Discussion with relevant management, finance staff and budget holders to establish the budgetary and financial control arrangements and their involvement in this process.
- Evaluating these arrangements to confirm their adequacy and whether they comply with current guidance and good practice.
- Review of documentation to confirm that policies and procedures are in place and that current arrangements comply with good practice.
- Appraisal of the adequacy of information provided to senior management for decision making.
- An overall review of the internal control environment to ensure all relevant controls are evident and being complied with.

Potential key risks

B Assignment plan

The potential key risks associated with the area under review are:

- There may be no central point of control for the budgetary process within the organisation.
- The College does not effectively monitor deviations between budgeted and actual income.
- The College may not comply with financial regulations and may not consider funding guidelines.
- Budget holders are inadequately trained and do not receive information regarding their budgets in a timely manner, resulting in an increased risk of bad decision making.
- The budget setting process may not effectively link to the operational planning process.
- The Board and Senior Management may not be provided with sufficient reporting of performance against budget and against plans throughout the year.
- Information reported within the management accounts does not provide timely information.
- Budgetary processes may not be in line with good practice observed across our education client base.

UHI Inverness

Internal Audit Plan 2026/27

May 2026

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Introduction

Background
Wbg Services LLP (Wbg) were appointed as Internal Auditors of UHI Inverness by the Audit Committee for two academic years until 31 July 2027. After this period, there is an option to extend for a further three 12-month periods, subject to the satisfactory agreement of both parties.

Internal Audit
The prime responsibility of the Internal Audit Service (IAS) is to provide the Audit Committee, the Principal and other Senior Management of the College, with an objective assessment of the adequacy and effectiveness of management's internal control systems.

The IAS objectively examines, evaluates and reports on the adequacy of internal control thus contributing to the economic, efficient and effective use of resources and to the reduction of the potential risks faced by the College.

The operation and conduct of the IAS must comply with the guidelines set down by the Institute of Internal Auditors, including the Global Internal Audit Standards (GIAS), and the Application Note regarding the adoption of GIAS in the UK Public Sector. The Application Note replaces the Public Sector Internal Audit Standards from 1 April 2025.

Terms of Reference – Internal Audit
The provision of the IAS by Wbg Services LLP is covered by the letter of engagement dated 23 July 2025.

Preparation of the Audit Plan
This Plan was developed following discussions with the Director of Finance & Estates.

Formal Approval
The original Audit Needs Assessment (ANA) was presented and approved by the Audit Committee on 8 September 2025. This document covers the Plan for 2026/27 and will be presented to the Audit Committee for discussion and approval on 2 June 2026.

Operational Plan

2026/27

Procurement

Audit area	High level indicative summary scope	Total number of days
Procurement	The purpose of this review is to conduct a review of the procurement process in place, from identifying procurement needs, through to appraising options and contracting with suppliers. Our objectives for this review are to assess whether: • An agreed procurement strategy and appropriate policies and procedures are in place to guide staff on making purchasing decisions. • Staff have been trained in procurement and receive appropriate procurement support. • Agreed procurement procedures are being consistently followed. • The Board obtains assurance that Value for Money is being obtained. • Contracts are appropriately sourced where relevant for all suppliers spend.	6

Estates Management

Audit area	High level indicative summary scope	Total number of days
Estates Management	The purpose of this review is to review the strategic and operational arrangements in place in respect of Estates Management at the College. We will also review the maintenance of the assets, the safety of the Estates and the processes to ensure compliance with safety legislation. Our objectives for this review are to assess whether: • The College's Estates Strategy supports the College objectives. • The College has appropriate arrangements in place to ensure that its estates are managed effectively. • There are robust procedures in place for ongoing maintenance and repair within the College. • Estates planning takes due consideration of the College's future plans for the curriculum. • The College is meeting its statutory obligations in relation to Estates Management.	6

Curriculum Planning

Audit area	High level indicative summary scope	Total number of days
Curriculum Planning	We will undertake a review of the suitability of the curriculum planning arrangements in place within the College. We will review the process from determining which courses to be run, the delivery methods, through to the approval of the plan. We will also review the processes surrounding timetabling and the methods adopted to assess the quality of the curriculum offered. Our objectives for this review are to assess whether: • The curriculum plan for the College is aligned with financial plans and objectives. • The curriculum plan involves sufficient input from Curriculum Departments and sufficient detail on how targets will be delivered. • There are sufficient controls in place surrounding the timetabling of the curriculum. • There are sufficient resources to deliver planned levels of curriculum. • There are robust methods in place for assessing the quality of the curriculum offered.	6

GDPR

Audit area	High level indicative summary scope	Total number of days
GDPR	The purpose of this review is to assess whether the College is complying with the requirements of the General Data Protection Regulation (GDPR) which came into force from May 2018. We will undertake a review of the processes in place to assess compliance. Our objectives for this review are to assess whether: | TheThe College is holding and managing its personal data in line with the GDPR. | The College has a robust Data Protection (GDPR) Policy and Procedure in place which covers all elements of data protection. | The College has documented plans in place to address any remaining areas of non-compliance. | There is sufficient reporting in place with regards to the College's ongoing compliance with the GDPR and potential breaches. | The College has provided training on GDPR to its staff, management, and Board members.	5

Follow Up

Audit area	High level indicative summary scope	Total number of days
Follow Up Review	The effectiveness of the internal control system may be compromised if management fails to implement agreed audit recommendations. Our follow up work will look to provide the Audit Committee with assurance that prior year recommendations are implemented within the expected timescales. Our objective for this review is to assess whether: | The College has appropriately implemented any outstanding internal audit recommendations made in prior years.	3

Funding Reviews

Audit area	High level indicative summary scope	Total number of days
SSF	Mandatory review of the Student Support Funds Return.	4
Credits	Mandatory review of the Credits Return.	5

Assignment Plans & Dates

Assignment Plans

A detailed assignment plan will be prepared for each audit undertaken, setting out the scope and objectives of the work, allocating resources and establishing target dates for the completion of the work. Each assignment plan will be agreed and signed off by an appropriate sponsor from the College.

Key Dates

Visit	Name	No. of audit days	Key College personnel	Provisional start date for visit	Provisional date of issue of draft report	Provisional date for reporting to Audit Committee
1	Mandatory Funding Audits	9	Director of Finance & Estates	31 August 2026	18 September 2026	December 2026
2	Procurement	6	Supply Chain Manager	11 January 2027	29 January 2027	March 2027
3	Estates Management	6	Director of Finance & Estates	22 March 2027	9 April 2027	June 2027
	Curriculum Planning	6	Director of Finance & Estates			
4	GDPR	5	Head of IT	12 April 2027	30 April 2027	June 2027
	Follow Up Review	3	Director of Finance & Estates			

Appendices

A – Summary of Internal Audit Input
B – Grading Structure
C – Key Performance Indicators
D – Training Topics
E – Audit Universe

A – Summary of Internal Audit Input

1 August 2025 to 31 July 2028		Operating Plan (No. Of days)		
System	**Audit Area**	**2025/26**	**2026/27**	**2027/28**
Financial Systems	Budgetary & Financial Reporting	6		
	Procurement		6	
Non-Financial Systems	Student Recruitment	6		
	Staff Recruitment & Retention	6		
	Estates Management		6	
	Curriculum Planning		6	
	Sustainability			6
Governance	Governance			5
Information Systems	Freedom of Information	5		
	GDPR		5	
	Business Continuity Planning			6
	Artificial Intelligence			6
	Total Days C/F	**23**	**23**	**23**

A – Summary of Internal Audit Input

1 August 2025 to 31 July 2028		Operating Plan (No. Of days)		
System	**Audit Area**	**2025/26**	**2026/27**	**2027/28**
	Total Days B/F	**23**	**23**	**23**
Mandatory	Credits Audit	5	5	5
	SSF Audit	4	4	4
	EMA Audit	3		
Required	Follow Up Review	3	3	3
	EMA days to be reallocated		3	3
	Audit Management	4	4	4
	Total Days	**42**	**42**	**42**

B – Grading Structure

For each area of review, we assign a grading in accordance with the following classification:

Assurance	Classification
Strong	Controls satisfactory, no major weaknesses found, some minor recommendations identified
Substantial	Controls largely satisfactory although some weaknesses identified, recommendations for improvement made
Weak	Controls unsatisfactory and major systems weaknesses identified that require to be addressed immediately
No	No or very limited controls in place leaving the system open to significant error or abuse, recommendations made require to be implemented immediately

For each recommendation we make we assign a grading either as High, Medium or Low priority depending upon the degree of risk assessed as outlined below:

Grading	Risk	Classification
High	High Risk	Major weakness that we consider needs to be brought to the attention of the Audit & Risk Committee and addressed by senior management of the College as a matter of urgency
Medium	Medium Risk	Significant issue or weakness which should be addressed by the College as soon as possible
Low	Low Risk	Minor issue or weakness reported where management may wish to consider our recommendation

C – Key Performance Indicators

For each area of review, we assign a grading in accordance with the following classification:

Performance Indicator	Target
Internal audit days completed in line with agreed timetable and days allocation	100%
Draft scopes provided no later than 10 working days before the internal audit start date and final scopes no later than five working days before each start date	100%
Draft reports issued within 10 working days of exit meeting	100%
Management provide responses to draft reports within 15 working days of receipt of draft reports	100%
Final reports issued within five working days of receipt of management responses	100%
Recommendations accepted by management	100%
Draft annual internal audit report to be provided by 31 August each year	100%
Attendance at Audit & Risk Committee meetings by a senior member of staff	100%
Suitably experienced staff used on all assignments	100%

D – Training Topics

As a firm we offer a wide range of training topics to our clients and we have listed below some of the topics which we would be able to offer UHI Inverness.

Topic	Summary
Risk Management	This can cover risk awareness, assessment of risks, responsibilities for monitoring risks, risk appetite and the scoring of risks. This is usually done as a workshop to ensure buy-in from management and committee members to the risk management process.
Role of the Board	This would cover the roles and responsibilities of Board members, including the Chair. This has been particularly useful when new Board members have been appointed and allows members to obtain some knowledge on what the expectation of a Board member is and what they should be looking out for.
Role of Internal Audit	We would provide a short session on what the internal audit function should be delivering to the College and the added value which we would bring.
Finance for Non-Financials	This is useful for committee members who do not have a finance background and covers areas such as the management accounts, budget reporting and the statutory accounts.
Fraud Awareness	We would cover the importance of a having a strong control environment and areas to be aware of in relation to fraud. We would discuss some real-life examples of where we have identified or been asked to investigate allegations of fraud and the results of these investigations.
Cyber Awareness	We would provide a cyber awareness session designed to help staff recognise and respond to common cyber threats. The training would be tailored to the education sector and assist in promoting a strong culture of cyber resilience across all levels of the College.

E – Audit Universe

We have set out below the auditable entities, processes, systems and activities, which support the development of the internal audit plan, and the Internal Audit coverage since 2024/25 Please see page 15 for colour key of assurance ratings. The assurance levels identified were those at the time of the review.

Area	2024/25	2025/26	2026/27	2027/28
Financial Systems	Core Financial Controls	Budgetary & Financial Reporting	Procurement	
Non-Financial Systems	Staff Welfare	Student Recruitment	Curriculum Planning	Sustainability
		Staff Recruitment & Retention	Estates Management	
Governance	Fraud Strategy			Governance
Information Systems	Cyber Security	Freedom of Information	GDPR	Artificial Intelligence
	Information Systems			Business Continuity Planning

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Audit Committee

Subject/Title:	Draft External Audit Planning Report – 2025/26
Author:	Niall McArthur – Director of Finance & Estates
Meeting:	Audit Committee
Meeting Date:	2 June 2026
Date Paper prepared:	25 May 2026
Brief Summary of the paper:	To provide the audit committee with the draft external audit planning report for the 2025/26 external audit.
Action requested: [Approval, recommendation, discussion, noting]	Approval

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 and approve the external audit planning report for 2025/26 prepared by Deloitte.

Purpose of report

To provide committee members with the draft external audit planning report for the 2025/26 external audit.

External Audit Planning Report for 2025/26

The draft external audit report for 2025/26 provided by our external auditors, Deloitte, is attached to this report. This is the fourth 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:

- Executive Summary – includes summary of audit fee for 2025/26, the materiality level for the audit, the scope of the audit, technology to be used during the audit, audit risks and the external and business changes that have impacted their audit plan.

- Section 1, External Audit Plan 2025/26 – this section includes further details on the level of materiality, significant risks, other areas of focus, wider scope work and the Audit timelines and communication plan.

- Section 2, Independence & Audit Fees – this section includes details of Deloitte's independence and the audit fee. In terms of the external audit fee, the total fee for the 2025/2026 audit is £33,780 (2025: £ 32,380), an increase of £1,400 or 4.3%. Additional fees would be discussed with the college for any work due to significant changes in scope if required.

- Section 3, How we use technology -now and in the future – this section includes the key technology and AI tools in their audit approach.

- Section 4, Responsibility statement - this section includes further details on Deloitte's respective responsibilities.

- Appendices – this includes the following areas:
    - Appendix 1: Our approach to materiality
    - Appendix 2: Scope of work and approach
    - Appendix 3: Significant risks and planned audit response
    - Appendix 4: Other areas of focus and planned audit response
    - Appendix 5: Wider scope
    - Appendix 6: Prior year audit adjustments
    - Appendix 7: Independence & fees
    - Appendix 8: Our other responsibilities explained
    - Appendix 9: Audit quality and our system of quality management
    - Appendix 10: We will report on information in your annual report
    - Appendix 11: Required communications

Deloitte.

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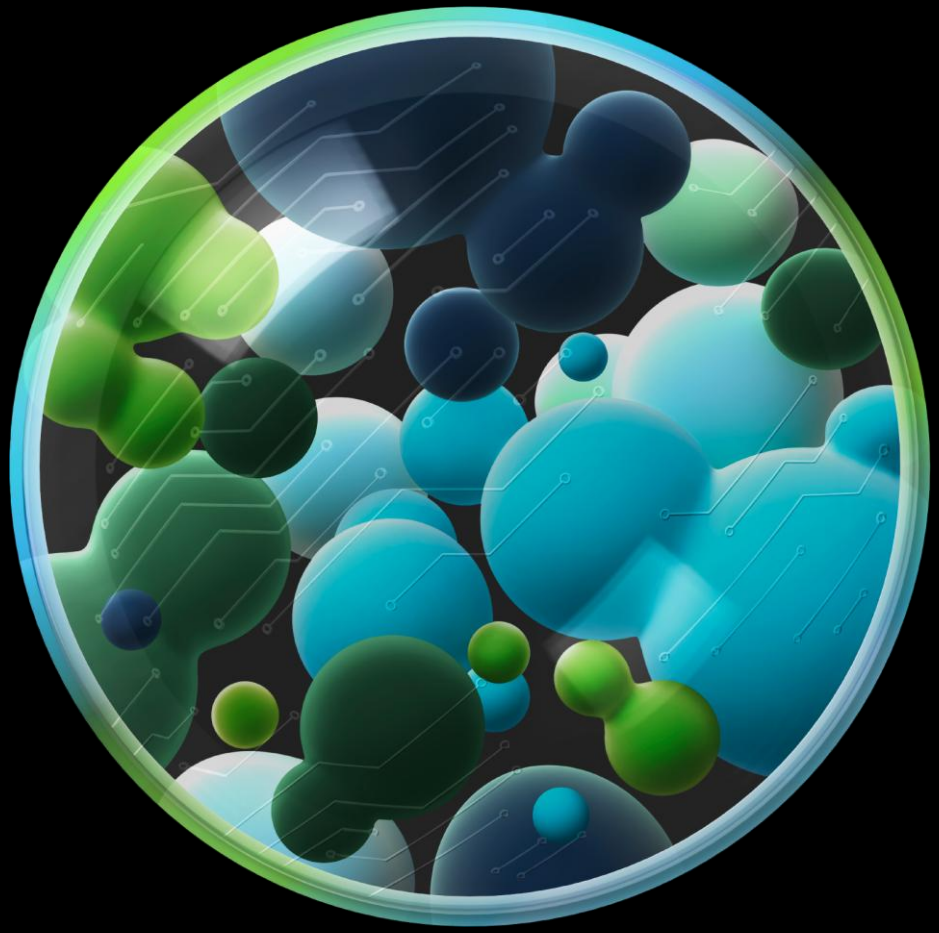

Inverness College

External audit 2026 planning report to the Audit Committee

2 June 2026 (issued on 26 May 2026)

Content

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Executive summary

I have pleasure in presenting our planning report to the Audit Committee ("AC") of Inverness College ("the College") for the 2025/26 audit. I would like to draw your attention to the key messages of this paper.

Proposed fee

The total fee for 2026 is £33,780 (2025: £ 32,380).

Additional fees would be discussed with you for any work due to significant changes in scope if required.

Materiality

2026: £616,000
2025: £618,000
Preliminary materiality is based on 2% of the forecast expenditure.

Scope

Our scope has remained consistent with the prior year and Sarah McGavin will continue as audit partner.

Technology being deployed on the audit

We have made significant investments in technology in recent years to increase audit quality, effectiveness, and the insight that we bring. We have summarised the key technology used during the year and those technologies, we plan to deploy in the current year audit on page 10.

Audit risks

We plan our audit of the financial statements to respond to the risks of material misstatement to transactions and balances and irregular transactions. Based on our initial risk assessment we have identified the following significant risks, which are presented in more detail on page 5:

- Operating within funding provided;
- Management override of controls

In the prior year, we identified property valuation as a significant risk. In the current year a desktop review will be performed, we do not expect significant movements in the inputs and the evaluation requires limited management judgment. Therefore, we have downgraded this to an area of audit focus. Additionally, we have identified the pension liability as an area of audit focus as detailed on page 6.

Our risk assessment is continually evolving and as a result our assessment may change. If any changes occur, we will inform the Audit Committee.

External and business changes that have impacted our audit plan

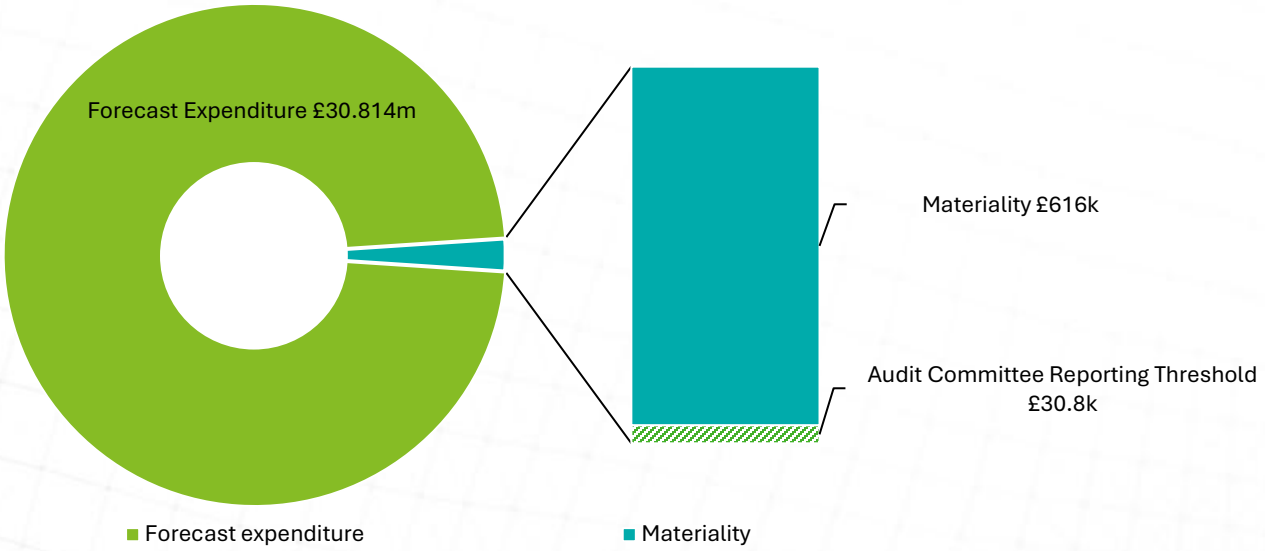
- We have updated our understanding of the College through discussions with management and have reviewed the initial relevant documentation. We have developed an efficient and effective audit plan that focuses on the most significant areas of importance and risk.
- Significant financial pressure persists at the College, stemming primarily from continuing operational cost increases, especially staff cost of living increases and lower growth than anticipated in Higher Education (HE) numbers. These combined factors heighten the risk to the College's financial sustainability, necessitating robust cost management strategies. Consistent with the prior year, financial sustainability remains a significant risk (wider scope). Our planned procedures will therefore specifically focus on obtaining and reviewing financial plans and forecasts.
- In 2026, the College changed internal auditors from BDO to WBG. While we do not place reliance on internal audit's work, we will liaise with new internal auditor as part of our audit process.

1. External audit plan 2026

1.1. Materiality

Our planned audit materiality is £616,000 (2025: £618,000), based on 2% of forecast expenditure, which is consistent with the prior year. We will report to you any changes from our planned materiality levels. **Appendix 1** provides further details on our approach to materiality.

The scope of our work is further detailed in **Appendix 2**.



We consider the metrics used by users of the financial statements, including forecast income and expenditure against actual performance.

Threshold for reporting misstatements: We will report to you all misstatements identified above **£30,800**.

1. External audit plan 2026 (continued)

1.2. Significant risks

Our significant risks for the current year audit are summarised below, with details of our planned audit response in **Appendix 3.** Risk assessment is a continuous process throughout the audit, and we will inform you of any changes to our assessment of significant risks.

Significant risks to our audit

Significant risks are those associated with the most significant and judgmental areas of our audit, and which have the greatest potential to cause a material misstatement to the financial statements.

Risk description	Fraud risk	Planned controls and audit approach	Level of judgement or estimation	Management paper expected	Expected to be included in the Audit Committee 's report	Expected to be a key audit matter in Deloitte audit opinion
Management Override of Controls	✓	DI	H	✗	✓	✗
Operating Within Funding Provided	✓	DI	L	✗	✓	✗

Key

- DI — Assess design & implementation of relevant controls
- OE — Test and rely on operating effectiveness sample testing of relevant controls
- S — Involvement of Deloitte specialists
- S — Significant judgement
- H — High degree of judgement
- L — Low degree of judgement

1. External audit plan 2026 (continued)

1.3. Other areas of focus



We have summarised below the other areas which we plan to include in our reporting to you. Details of our planned audit response are included in **Appendix 4.**

Other areas of focus

Other areas (with no identified significant risks) where we expect to provide further information on our audit approach and any findings we identify in future reports to the Audit Committee.

Risk description	Planned controls and audit approach	Level of judgement or estimation	Management paper expected
Valuation of pension schemes	S	L	✕
Property Valuation	DI S	H	✕

Key

- DI — Assess design & implementation of relevant controls
- OE — Test and rely on operating effectiveness sample testing of relevant controls
- S — Involvement of Deloitte specialists
- S — Significant judgement
- H — High degree of judgement
- L — Low degree of judgement

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1. External audit plan 2026 (continued)

1.4. Wider Scope

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: Financial management, Financial sustainability, Vision, leadership and governance, and Use of resources to improve outcomes.

As part of the 2024/25 audit, we did not classify Inverness College as a "less complex body" and as such performed procedures on all four wider scope areas. In our view this approach is still appropriate for the 2025/26 financial year.

Wider Scope Area	Significant risk identified
Financial Management	✕
Financial Sustainability	✓
Vision, Leadership & Governance	✕
Use of Resources to Improve Outcomes	✕

2025/26 Risk Assessment

Following initial wider scope planning procedures and discussions with management, we have performed an initial assessment on the wider scope risks as outlined in the table on the left.

For full wider scope considerations and planned audit response, please refer to **Appendix 5**

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 in **Appendix 5.**

1. External audit plan 2026 (continued)

1.5. Audit timelines and communication plan

The timeline and our planned reporting to you is summarised below.

We plan to perform the audit work in four phases. The four phases provide us the ability to communicate findings early and regularly throughout the audit process. 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.

Audit timeline and our Audit Committee reporting

March – July	August	October - November	December
Planning	**Pre Year end field work**	**Year end fieldwork**	**Reporting**
• Planning meetings to inform risk assessment and identify judgemental accounting issues • Discussion of fraud risk assessment • Discussion of the scope and timing of the audit • Understanding key business cycles and financial reporting changes	• Completion of planning procedures • Document design and implementation of key controls • Upload of journal uploads to Deloitte Data software • Review of Board and Audit Committee minutes • Wider scope procedures	• Year-end audit field work • Detailed review of annual accounts and report • Review of final internal audit reports (update)	• Year – end closing meeting • Final Audit Committee meeting - December • Issue final Audit Committee paper. • Issue audit report
Audit Plan	**Interim updates as required**		**Final Report**

2. Independence and fees



As part of our obligations under International Standards on Auditing (UK) 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 Inverness College.

Further details of our independence considerations are included in **Appendix 7**.



The expected fee for 2025/26 as communicated by Audit Scotland in January 2026 is analysed below :

Auditor Remuneration	£52,980
Audit Scotland Fixed Charges:	
Pooled Costs	(£6,420)
Sectoral Cap	(£12,780)
Total Expected Fee	**£33,780**

There are no non-audit fees.

3. How we use technology- now and in the future

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We have made significant investments in technology in recent years to increase audit quality, effectiveness and the insight that we bring. This has allowed us to build a suite of tools integrated with our Deloitte Omnia audit platform that embed the use of technology, analytics and AI to support collaboration, planning decisions, risk assessment, controls testing and substantive audit procedures.

Key Technology and AI Tools in Our Audit Approach

We have highlighted the benefits to you below of the existing and new tools implemented this year as well as future tools which we will consider using in the audit to enhance audit quality and effectiveness.

Currently in Use:
We are already utilising tools such as PairD (our proprietary GenAI tool), Journals profiling data analytics, and DataSnipper for efficient data extraction in our field work testing.

Introduced This Year:
For the current audit cycle, we are implementing Omnia Smart review which enhances our efficiency and quality of audit reviews.

Future Innovations:
Our strategic roadmap includes advanced capabilities such as AI Contract reader, Controls walkthrough automation for performing design and implementation of controls testing, and enhanced project management tools, among others, to continuously evolve our audit methodology and deliver superior value. We will monitor the applicability of future AI tools.

These technological advancements underscore our commitment to delivering high-quality, efficient, and insightful audits.

4. Responsibility statement

What we report

Our report is designed to establish our respective responsibilities in relation to the Annual 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.

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

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.

Our respective responsibilities

We are responsible for forming and expressing an opinion on financial statements prepared by management with oversight of those charged with governance, as detailed in our engagement letter. An audit does not relieve management or those charged with governance of their responsibilities. Auditing standards require us to only accept an audit engagement when the preconditions for an audit are present, including 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. 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.

Use of this report

This report has been prepared for the College, 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.

Deloitte LLP

Aberdeen | 26 May 2026

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

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Appendices

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Appendix content

Appendix 1: Our approach to materiality

Appendix 2: Scope of work and approach

Appendix 3: Significant risks and planned audit response

Appendix 4: Other areas of focus and planned audit response

Appendix 5: Wider scope

Appendix 6: Prior year audit adjustments

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Appendix 9: Audit quality and our system of quality management

Appendix 10: We will report on information in your annual report

Appendix 11: Required communications

Appendix 1

Our approach to materiality

Materiality is the threshold for misstatements that could influence users' economic decisions. **Performance materiality** is set lower, creating a buffer to reduce the risk that undetected errors, when aggregated, exceed overall materiality. **A trivial threshold** defines misstatements so small they are clearly inconsequential, requiring no accumulation or reporting

We consider the **metrics used by the users of the financial statements** to identify appropriate benchmarks to determine materiality. We will continue to monitor these metrics and will reassess materiality if there are significant variances from plan. We will report to you any changes to our planned materiality.

Based on the role of the College and audit focus of budgeted expenditure, we have selected expenditure as the most appropriate benchmark. Materiality has been set at £616,000 (PY £618,000) This represents 2% of forecast expenditure, in line with the prior year.

Benchmarks considered

Expenditure

Professional judgement

Audit materiality £616,000

Factors impacting determined materiality level

- Normal risk engagement, fourth year engagement, few prior year misstatements
- Continued pressure over expenditure and operating within resource limits

Threshold for reporting misstatements

We will **report all misstatements above £30,800** to you throughout the audit.

Performance materiality (PM)

70% of the materiality

This is set as a percentage of materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed materiality. We determine performance materiality with reference to factors such as the quality of the control environment and the historical error rate. The determined performance materiality is **70% of the materiality** which is in line with and supported by previous experience on Inverness College. Performance materiality determines the sample sizes selected in our substantive testing.

Appendix 2

ITEM 05.a

Scope of work and approach

We have the following key areas of responsibility under the Code of Audit Practice

Opinion on Financial Statements

We will conduct our audit in accordance with International Standards on Auditing (UK) ("ISA (UK)") and the Code of Audit Practice issued by Audit Scotland. The College will prepare its accounts in accordance with the Applicable law and UK Generally Accepted Accounting Practice (UK GAAP), FRS 102, Further and Higher Education (Scotland) Act 1992, and directions made thereunder by the Scottish Funding Council, the Charities and Trustee Investment (Scotland) Act 2005, and regulation 14 of The Charities Accounts (Scotland) Regulations 2006 (as amended).

Reporting on Other Requirements

Our responsibilities also include:

- an opinion on the regularity of expenditure and income;
- an opinion on the audited parts of the Remuneration and Staff Report;
- under the Code of Audit Practice to read the information included in the Performance Report and the Governance Statement, and opine whether they are consistent with the financial statements;
- in accordance with ISAs (UK) to read the other information accompanying the financial statements and report by exception any material misstatements we identify.

Our reporting will be addressed to Inverness College, the Auditor General for Scotland, and the Scottish Parliament.

Wider-scope requirements, including considering and reporting on Best Value arrangements

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 respect of:

- financial management
- financial sustainability
- vision, leadership and governance
- use of resources to improve outcomes.

As part of this wider-scope audit work, we also are required to consider whether there are appropriate organisation arrangements in place to secure Best Value in public services. Our approach to our wider-scope audit work is detailed on page 7.

Other Reporting Requirements

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.

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; or
- over £5,000.

Appendix 3

Significant risks and planned audit response

Management override of controls

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.

Key sources of judgement and estimation uncertainty are inherently the areas in which management has the potential to use their judgment to influence the Report and Financial Statements.

Risk identified and key judgements

This risk focuses on three key areas:

- journal entry testing to identify any unusual journal postings which may be indicative of potential management override;
- any transactions that are unusual or outside the normal course of business; and
- management judgement, including property valuation noted as an area of focus and estimates.

Deloitte planned response

In considering the risk of management override, we plan to perform the following audit procedures that directly address this risk:

- 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 Annual Report and Financial Statements;
- We use 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; and
- 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.

Appendix 3 (continued)

Significant risks and planned audit response (continued)

Operating within funding provided

In accordance with Practice Note 10 (Audit of financial statements and regularity 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 the 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 expenditure resource limits set by the Scottish Government. 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.

Risk identified and key judgements

- Expenditure incurred during the year, particularly around year end, is incomplete.
- Potential for management to “push” expenditure into proceeding periods by incorrectly recording prepayments and accruals values.

Deloitte planned 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 SFC and UHI;
- Perform focused testing of a sample of accruals and prepayments made at the year end; and
- Performing focused cut-off testing of a sample of invoices received and paid around the year end.

Appendix 4

Other areas of focus and planned audit response

Valuation of pension schemes

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).

Hymans Robertson 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.

Defined benefit pension balance

To respond to this area of focus, we will perform the following procedures:

- Obtain assurance from the auditor of the pension fund over the controls for providing accurate data to the actuary;
- Assess the independence and expertise of the actuary supporting the basis of reliance upon their work;
- Review and challenge the assumptions made by Hymans Robertson;
- 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 2026;
- Review the disclosures within the accounts; and
- Engage Deloitte's internal pensions experts to assist with the above procedures.

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Appendix 4 (continued)

Other areas of focus and planned audit response (continued)

Property Valuation

The College held £56.6m of property assets (land and buildings) at 31 July 2025.

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 five years for the purposes of the financial statements with an interim valuation after three years. Land and buildings were valued as at 31 July 2024 (full valuation) on the basis of depreciated replacement cost by the Colleges appointed external valuer. In a year with no revaluation, an impairment review will be performed by the Director of Finance & Estates.

Risk identified and key judgements

- Potential for management to exhibit poor judgement when performing a review of impairment indicators as part of the FY26 assessment.

Deloitte planned response

- We will test the design and implementation of key controls in place around the property valuation and impairment assessment performed by management; and
- We will engage early with the College, using our valuation specialists to challenge/test the assumptions applied by management in the valuations

Appendix 5

Wider Scope Risks



Our considerations of the significant risks and planned audit response at the planning stage against the four wider scope areas set out in the Code of Audit Practice is set out below:

Area	Significant Risks Identified	Planned Audit Response
Financial Management	None applicable for the 2025/26 audit.	We will review and assess the financial budget setting and monitoring processes and reports adopted by the Board and its Committees throughout the year. Our review of all internal audit plans and reports will also inform our work in this area.
Financial Sustainability	The ability of the College to function within constrained budgets amid increased expenditure. This risk directly impacts the broader financial sustainability of the College, necessitating close scrutiny of both the drivers of increased costs and the effectiveness of budgetary controls and strategic financial planning.	In addition to understanding the financial budgetary process, as noted above, our procedures will involve obtaining and reviewing the College's medium-to-long-term financial plans, forecasts, and scenario analyses, with a view to considering the strategies outlined for addressing future financial challenges. Concurrently, we will engage with senior management and the finance team to seek to understand the key drivers of increased expenditure and the specific actions being taken to manage these costs.
Vision, leadership and governance	None applicable for the 2025/26 audit.	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. We will continue to assess progress on the strategic plan, and assess governance arrangements at the College.
Use of resources to improve outcomes	None applicable for the 2025/26 audit.	We will 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 in the forthcoming years in recognition of the ongoing pressure.

Appendix 6

ITEM 05.a

Prior year audit adjustments

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

	Ref	Debit / (Credit) impact in £'000		
		Income statement	Net assets	Prior year reserves
Expenditure – Under Accrual Error	[1]	34.0	(34.0)	-
Expenditure – Cut off Error	[2]	24.6	(24.6)	-
Carryover of prior year misstatements	[3]	-	(34.0)	34.0
Total		**58.6**	**(92.6)**	**34.0**

[1] We identified three post year end payments relating to goods which were delivered in 2024/25, which were not accrued for at year end. The factual error is £5.4k and an extrapolated error of £28.6k with the total impact £34.0k.

[2] We identified two invoices relating to goods which were delivered in 2024/25, but were recorded in 2025/26 and were not accrued in the current period. The factual error is £2.7k and an extrapolated error of £21.9k with the total impact £24.6k.

[3]No allowance has been made in relation to the Goodwin case in the FY25 liability value. In our view an allowance should be made, as a past service cost. Based on available information, we believe the cost of this would be £34k which is consistent with what we reported in 2023/24. We note that this is a judgemental misstatement based on assumptions used by actuarial specialists.

Appendix 7

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 matter	Description
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 Inverness College and will reconfirm our independence and objectivity to the Audit Committee for the year ending 2026 in our final report to the Audit Committee .
Fees	Details of the proposed 2026 audit fee is detailed within **section 2** above. We will continue to assess the impact, if any, of additional incremental work required in relation to the completion of the audit and will report this to the Audit Committee in our final report to the Audit Committee .
Non-audit services	In our opinion there are no inconsistencies between the FRC's Ethical Standard and the company'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 as necessary. We have not provided, nor do we plan to provide any non-audit services. Where relevant, we will report the supply of non-audit services, to the Audit Committee in our final report to the Audit Committee .
Relationships	We have not identified any relationships with Audit Committee , its directors and senior management and its affiliates, or other services provided to other known connected parties that we consider may reasonably be thought to bear on our objectivity and independence, together with the related safeguards that are in place.

Appendix 8

Our other responsibilities explained - fraud

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 operating within resource limits, 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 judgement, 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.

Appendix 8 (continued)

Our other responsibilities explained - fraud

We will make the following inquiries, including of staff outside the finance function, regarding fraud and non-compliance with laws and regulations:

Management and other personnel:

- Whether management has performed an assessment of the risk that the financial statements may be materially misstated due to fraud, including the nature, extent and frequency of such assessments.
- Whether management has a process for identifying and responding to risks of fraud, including those specific to the sector.
- Whether management have communicated to those charged with governance regarding its processes for identifying and responding to the risks of fraud.
- Whether management have communicated 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.
- Whether there have been any allegations of fraud raised by employees or other parties.

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.

What are the views of those charged with governance on the most significant fraud risk factors affecting the entity.

Appendix 9

ITEM 05.a

FRC 2024/25 Audit Quality Inspection and Supervision report

We are proud of the continuing strength the results of our FRC inspections show.

In July 2025, the Financial Reporting Council ("FRC") issued individual reports on each of the six largest firms, including Deloitte, on Audit Quality Inspection and Supervision, providing a summary of the findings of its Audit Quality Review ("AQR") team for the 2024/25 cycle of reviews. We value the observations raised by both the FRC Supervision teams and the ICAEW Quality Assurance Department ("QAD"), both in identifying areas for improvement and also the ongoing focus on sharing good practice.

Results of our FRC inspections show that 95% (2023/24: 94%) of our public interest audits were rated as 'good or limited improvements' and that 90% (2024: 100%) of our audits reviewed by the ICAEW's QAD were assessed as good or generally acceptable.

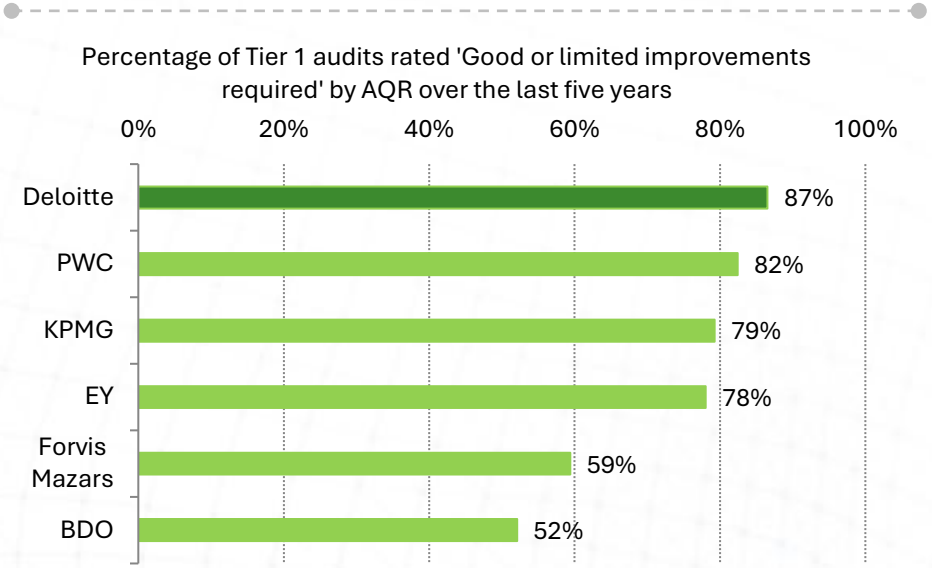
Over the last five years, our AQR results have consistently improved. This reflects our commitment to excellence, our mindset, behaviours, controls and processes. These are all critical to our achieving high-quality outcomes in the public interest

Consistent with our culture of continuous improvement, we are not complacent and recognise there is always more we can do. We put a significant level of investment, resource and effort into taking real-time actions throughout the year to address findings and to enhance our system of quality management (SoQM).

Overall, we have seen a reduction in the number of findings arising from regulatory inspections as well as a reduction in the number of findings where the root cause was direction, supervision or review. We are pleased to see the positive impact of actions taken over the last 12 months to address certain findings raised by the FRC and their associated root causes.

We welcome the breadth and depth of good practice points raised by the FRC and ICAEW, particularly in respect of accounting estimates and judgements, which includes robust procedures performed over impairment and asset valuations, revenue and effective group oversight. These have all been areas where we have taken specific actions to support the high-quality execution of audit work.

All the AQR public reports are available on the FRC's website.



Appendix 9 (continued)

FRC 2024/25 Audit Quality Inspection and Supervision report: overall comments

The boxes below detail the FRC's overall comments and Deloitte responses as published in the overview page of the 24/25 public report.

The AQR's 2024/25 Audit Quality Inspection and Supervision Report on Deloitte LLP:

"Deloitte has continued to maintain audit quality at the centre of its business, which has enabled it to improve further on last year's results."

"The percentage of audits inspected by the FRC requiring no more than limited improvements was 95%. This continues the pattern of improvement seen in the firm's results over recent years. The equivalent results for FTSE 350 audits inspected was 91%. The findings that contributed most to this year's inspection results related to the quality and consistency of the audit of valuation and impairment assessments and aspects of the audit of revenue. Certain aspects of these findings were recurring from previous inspection cycles. Our inspections also identified examples of good practice in these areas on other audits. The firm should continue to review the effectiveness of its actions to ensure greater consistency."

"The overall results profile for inspections by the ICAEW is 90% classified as good or generally acceptable. The firm's internal quality monitoring results show a year-on-year improvement."

Deloitte response to Audit Quality Inspection key findings

"Overall, we have seen a reduction in the number of findings arising from regulatory inspections as well as a reduction in the number of findings where the root cause was direction, supervision or review. We are pleased to see the positive impact of actions taken over the last 12 months to address certain findings raised by the FRC and their associated root causes."

Review of the firm's system of quality management (SoQM):

"Deloitte has an established SoQM structure, with robust governance, risk assessment, and second line monitoring processes. The firm is working on clarifying and strengthening its evidencing of quality risks and demonstrating that its assessment of the design and implementation of the responses to the risks is consistent and appropriate. This should continue to be a priority for the firm."

Deloitte response to review of SoQM

"We believe that an effective SoQM is crucial for the delivery of audit quality in every single engagement we deliver. We were pleased to issue our second conclusion on the effectiveness of our SoQM as of 31 May 2024, being satisfied that our SoQM provides the firm with reasonable assurance that the objectives of ISQM (UK) 1 are being achieved.

In the time since ISQM (UK) 1 was implemented our SoQM has continued to mature. As our SoQM embeds in our day-to-day operations, we are pleased to see the FRC have identified continued areas of good practice. We remain focussed on continuous improvement to refine and enhance our operations to ensure our approach to managing the quality of all engagements is consistent and strong. We have already taken action to address a number of the points raised by the FRC including adding further risks to our SoQM which map to existing responses and enhancing areas of our decision-making documentation.

The environment in which we operate is complex and continues to evolve. We remain focussed on identifying and investing in the changes required to continually improve and enhance the effectiveness of our SoQM."

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Appendix 10

We will report on information in your annual report

Your annual report contains detailed financial and non-financial information including discussion of the Board's strategy, business model, risks and prospects. This provides stakeholders with a holistic view of the performance of the Board and provides context for the Board's financial results and position as set out in the financial statements. We set out on this page the work we will perform in respect of this information and the matters we will report.

The performance report and accountability report

Our work includes:

- reading these reports and assessing whether they comply with the applicable requirements of the Scottish Public Finance Manual (SPFM) and FReM;
- considering whether the information presented is consistent with the financial statements, including cross-checking figures to the audited financial statements;
- assessing whether, in light of our knowledge and understanding obtained during the audit, these reports contain any material misstatements.

In our audit report we will give positive statements regarding the preparation of the reports in accordance with legal and regulatory requirements and consistency with the financial statements.

If we find material misstatements, we will require that these be corrected, otherwise we will have to report these.

Annual Governance Statement

We read the Annual Governance Statement and assess whether it meets the disclosure requirements, and whether it is misleading or inconsistent with information of which we are aware from our audit.

In our audit report, we report any exceptions identified in respect of these responsibilities.

Directors' remuneration report and fair pay disclosure

We will audit the parts of the directors' remuneration report and staff subject to audit, and state in our audit report whether they has been properly prepared in accordance with the requirements of the Public Finance and Accountability (Scotland) Act 2000.

Examples of matters that would cause us to report

- The Annual Governance Statement doesn't disclose significant control weaknesses identified in internal audit reviews.
- Risks to financial sustainability are not adequately disclosed in the Annual Report.
- Significant weaknesses in wider scope arrangements are not appropriately disclosed in the Annual Governance Statement.

Appendix 11

ITEM 05.a

Required communications



We have an obligation under the ISAs to communicate specific matters with you related to our audit. The table below highlights some of the required communications and their corresponding locations in our reporting. Additional required communications will be provided in future reports as we progress through the audit cycle.

Communication	Reference
Materiality	Section 1.1, Appendix 1
Scoping	Appendix 2
Identified significant risks	Section 1.2, Appendix 3
Areas of audit focus	Section 1.3, Appendix 4
Significant findings, misstatements, deficiencies, irregularities and/or non-compliance identified	Will be reported in the final report to the Audit and Risk Committee
Overview of the planned scope and timing of the audit Form, timing and content of communication with TCWG	Section 1.5
Auditor independence	Section 2, Appendix 7
Fees and non-audit services	Section 2, Appendix 7
Auditors' responsibilities	Section 4, Appendix 8
Audit quality and our system of quality management	Appendix 9

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Subject/Title:	KPI Matrix and Report YTD – Period 9 April 2026
Meeting and date:	Audit Committee 2 June 2026
Author:	Martin Whyte
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 2025-26 year-to-date KPI performance as at period 9, April 2026.

Main body of information

The KPI Matrix for 2025-26 accompanies the paper detailing the annual target, YTD target and actual performance along with a comparison against the same period last year. Narrative for in-scope measures is provided below. 'No change' in parenthesis following the RAG status for a measure confirms that the data has not changed since the previous KPI report.

YTD Summary

Thirty-six measures were in scope as at period 9, April 2026. Two measures that do not have an annual target are also reported; these are shaded blue.

Of the thirty-six measures:
Twenty-one are satisfactory / met (Green).
Ten are unsatisfactory / not yet met (Red),
Five are marginal / not yet met (Amber).

Comment on In-Scope Measures – YTD Period 9, April 2026.

HE Active Applications. Serial 1. 84.4% RED.

HE active applications at 1,139 are below the plan of 1,350 for this point in the year and are 141 fewer applications than the previous year. Weekly admissions meetings review HE application data, including 'no offers', 'offers', 'accepted offers', and their respective proportions. Percentage of offers that have been accepted are at a 7-year high of 75%. However, accepted offers are currently 74 fewer than last year (circa. -£410,000). Additional recruitment initiatives have been launched such as the 'Next Steps' attended stall in the atrium which is attracting interest and has added three HE applications so far. In addition, Business Solutions along with MIS colleagues have increased focus on GA applications, particularly activity to convert 'notes of interest' to named applicants.

FE Active Applications. Serial 2. 96.8%. AMBER.
FE active applications at 2,032 are 78 applications below the profiled expectation as at the end of April. Despite the lower number of applications, the number of accepted offers is 230 greater than the same point last year with 90% of offers accepted (78%).

FE Credits. Serial 3. 102.0%. GREEN.
The college has exceeded its FE Credit threshold with 26,725 FE Credits achieved against SFC threshold of 26,442. It is expected that there will be a small amount of additional credits to be added in the final weeks of the AY.

Apprenticeship Starts. Serial 4. 133.3%. GREEN.
The college achieved 313 new apprenticeship starts in the contract year (to March 2026). YTD performance is 25 greater than the same point last year. Modern apprenticeship recruitment from April – end of July 2026 relates to the new SDS contract year but the figures are reported in the current academic year KPI.

Apprentices in Learning. Serial 5. 106.2%. GREEN.
The average number of apprentices in learning is 717 against plan 675. The figure reflects increased recruitment over the past couple of years with many programmes being 4-year apprenticeships.
Note, the figure does not include apprentices studying at UHI Inverness through managing agents such as SNIPEF and SECTT which raises the average in learning to circa 1,000.

Apprenticeship Income. Serial 6. 115.5%. GREEN.
Apprenticeship Income YTD is £1,204,228 against plan of £1,043,000 and is £121,549 greater than the same point last year. This reflects the work undertaken by assessors and Business Solutions throughout the year to ensure that review claims are completed and claimed in a timely manner and the increased percentage of successful completions YTD (see serial 32).

Commercial Short Course Income. Serial 8. 195.5%. GREEN.
Short course income YTD is £123,205 against profile of £56,250. YTD short course income has exceeded the department target of £75,000. Green Skills Training funding is additional to the income reported in this measure. £65,000 Green Skills Training funding has been claimed for the academic year and will appear under 'Other Grant' funding rather than as Commercial Short Course Income.

HE Enrolments (head count). Serial 9. 100.9%. GREEN.

HE Enrolment head count was 2,119 against the annual target of 2,100 as at the end of period 9. Head count greater than target indicates that a larger proportion of HE students are undertaking part-time study than anticipated.

HE Enrolments (year one starts). Serial 10. 115.6%. GREEN. (no change)
Year one starts are 867 against planned 750. This is positive and reflects the increased recruitment. Increased year one starts provides an opportunity to retain students for two/three more years on undergraduate study and curriculum teams have been gathering 'intention to progress' information to inform expected retention data.

HE FTE (APC figures). Serial 11. 92.5%. RED.
HE FTE (APC figures) stand at 1,463 FTE against plan 1,581 FTE. Unfortunately, 118 FTE below APC target and 203 below budgeted target. Additional information concerning the impacts of the recruitment shortfall are included in the Director of Finance papers. HE Recruitment is 150 FTE greater than the same point last year.

GA Programmes – New Enrolments. Serial 13. 88.5%. RED. (no change)
There were 115 new enrolments to the GA programmes against plan 130. Last year saw 200 new GA enrolments. Overall, GA enrolments were 42 fewer than planned across all years with advanced entry to year 2 of some GAs below expectation.

Senior Phase Enrolments. Serial 14. 96.1%. AMBER. (no change)
We delivered 542 senior phase enrolments against planned 564. Last year we enrolled 574 on senior phase programmes. While below plan and last year's recruitment, the number is not a concern as FE delivery is on track and some senior phase options were curtailed. Senior phase applications received for 2026/27 study are greater than received for this year.

ESES. Serial 18. 100.0%. GREEN. (no change)
First survey of the year conducted in October returned 96% student satisfaction, 0.3 percentage points more than last year.

ESES% Response Rate. Serial 23. 105.0%. GREEN. (no change)
ESES response rate was 63% against 60% objective and 2 percentage points more than the previous year.

MA Successful Outcomes (contract year). Serial 32. 71.7%. RED.
Successful outcomes for the contract year ended March 2026 was 67.8% against plan 75%. This is an improvement of 1.4 percentage points on the same point last year. As mentioned previously, the timing of this objective does not coincide with the academic year and cycle of apprenticeship blocks. Business Solutions and curriculum monitor unit and qualification completions on an ongoing basis to ensure student progress is maintained. Successful outcomes as of the end of March was 67.8% against objective 75%.

FE Progression to Further FE Study. Serial 33. 103.8%. GREEN. (no change)
41.5% of FE students continued to further FE study in 2025-26. This exceeded the objective of 40% and was 1.9% greater than the previous year.

FE Progression to HE Study. Serial 34. 105.1%. GREEN. (no change)

36.8% of our HE students progressed from FE study. This exceeded our target of 35% and was 7.1% greater than the previous year. FE to HE progression is a key element of our student retention and HE growth plans.

Mental Health Support Appt. Serial 35. 103.0%. GREEN.
100% of requests received an appointment within 3-10 working days during the period. The counselling team continue to deliver a valuable and prompt service to our students. Note, UHI have notified us that from 2026/27 they will undertake student support activities for EO enrolled students (e.g. Nursing, Ophthalmology, Centre for History). This includes the provision of counselling services.

Learning Support Appt. Serial 36. 93.6%. RED.
Averaged across the AY, the team has delivered 90.8% of appointments within the timeframe against plan 97%. It is noted that they have achieved 100% in each of the past four months.
Note, UHI have notified us that from 2026/27 they will undertake student support activities for EO enrolled students (e.g. Nursing, Ophthalmology, Centre for History). This includes the provision of ASN and learning support services.

Sickness Levels. Serial 40. 102.3%. RED.
Sickness levels as an average YTD are 3.63% against plan 3.02% YTD which is the same as the same period last year. Absence rates for Q3 were 3.4% against 2.98% expectation. Q3 absence rate is 0.7 percentage points lower than Q3 2024/25. Head of HR and team have additional analysis.

PRD Completion – full or review. Serial 44. 108.0%. GREEN.
PRD completion rates as of Q2 (the period reported) are 27% against 25% objective. Note, the profile/target reporting has been moved by a quarter. HR report PRD completion data a full quarter behind to allow line managers time to upload PRD data to CIPHR after meetings have been completed.

Student FTE: Academic Staff Ratio. Serial 45. 111.5%. GREEN. (no change)
SSR is 22.3 as at the end of semester 1. This is better than the target however the ratio must increase to compensate for cost increases outstripping funding increases.

Number of Workplace Injuries. Serial 47. 110.5%. RED.
116 injuries YTD against planned 105. The HS&S Manager has seen an increase in reporting across all H&S matters with the more user-friendly SafePoint platform. There were 3 injuries reported in April. Note – 2-week academic holiday during the period. HS&S Manager monitors this closely.

RIDDOR Reportable Accidents & Illness. Serial 48. 200%. RED.
Six reportable incidents YTD. Two reported in March 26. One student spiked their leg with tree climbing footwear and attended hospital for stitches. Second student received minor burn from welding slag inside boot. Both departments have updated their activity RA following learning from the incidents. HS&S Manager deals with all RIDDOR cases.

% of Staff completed mandatory IHASCO Trg. Serial 49. 108.8%. GREEN.
87% of staff completed their allocated training within the period. This is 2 percentage points more than the same period last year.

Forecast Outturn Operational Surplus / (Deficit). Serial 53. 214.6%. RED.
Forecast outturn deficit circa. -£1,700,000 against budget deficit of -£792,000. Papers from the Director of Finance and Estates and other supporting papers have been provided with full details and analysis.

Room Occupancy – Frequency. Serial 59. 87.7%. RED.
Frequency of room usage is 37.2% YTD against planned 42.3%. This is 7.8 percentage points lower than the previous year.
Further analysis has been requested to identify if there are patterns emerging in certain rooms / timetable groups.

CO2 Emissions on Utilities (gross Tonnes). Serial 60. 104.7%. AMBER.
457 tonnes YTD against plan 436 tonnes. 21 tonnes more than plan and 38 tonnes more than for the same period last year.
Analysis has been requested from estates to understand the cause of variance between planned and actual.
Public body conversion factors have improved slightly which helps as does the replacement of lighting for LED bulbs.

CO2 Emissions on Waste – Tonnes. Serial 61. 76.5%. GREEN.
0.429 tonnes YTD against 0.560 tonnes planned. Emissions are 0.161 tonnes lower than the same point last year.

Estates Reactive Task Completion Rate %. Serial 62. 100.5%. GREEN
The team achieved 96.4% completion in the period against 96% expectation. Estates Supervisor monitors estates requests and completion rates.

GTFM % Reactive Task Completion Rate. Serial 63. 99.9% AMBER.
GTFM slipped below their objective delivering 95.9% against target 96%. Completion rates are a key part of the contract management discussions that take place each month.

Total % of Capital Expenditure Budget Committed. Serial 64. 100%. GREEN.
The full capital budget has been committed by 31 March.

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

Performance Measures
AY: 2025-2026
Performance Measures- EMT & Board of Management

Measures - Linked to Profile and Actual sheets

AY Start	01 Aug 2025
Today	25 May 2026
Period Month	April
No.Periods YTD	9

Key:

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

Serial	Measure	Measurement Frequency	Prior Year Actual	Current Year Target	YTD TARGET	YTD ACTUAL	YTD ACTUAL v TARGET RAG	Prior YTD ACTUAL	Variance - YTD vs Prior YTD
	Measure 1: CORE FE/HE OUTPUTS								
1	HE Active applications (next AY - Measure from Dec - Jul)	Monthly	1,418	1,400.0	1,350	1,139	**84.4%**	1,280	-141
2	FE Active applications (next AY - Measure from Dec - Jul)	Monthly	2194	2,300.0	2100	2,032	96.8%	2,132	-100
3	FE Credits	Monthly	27085	26,442	26,200	26,725	**102.0%**	26,908	-183
4	Apprenticeship starts	Monthly	409	382	237	316	**133.3%**	291	25
5	Apprentices in Learning (average in year)	Monthly	705	675	675	717	**106.2%**	689	28
6	Apprenticeship Income (excluding T&A)	Monthly	£1,398,960	£1,300,000	£1,043,000	£1,204,228	**115.5%**	£1,082,679	£121,549
8	Commercial Short Course Income	Monthly	£72,508	£75,000	£56,250	£123,205	**219.0%**	£66,200	£57,005
9	HE enrolments (head count)	Monthly	2,074	2,100	2,100	2,119	**100.9%**	2,106	13
10	HE enrolments (year one starts)	Annual	637	750	750	867	**115.6%**	637	230
11	HE FTE (APC figures) (from Oct)	Monthly	1,313.0	1,581.0	1,581.0	1,463.0	**92.5%**	1,313.2	150
13	GA Programmes - New Enrolments	Monthly	191	130	130	115.0	**88.5%**	191	-76
14	Senior Phase Enrolments	Annual	574	564	564	542.0	96.1%	574	-32
	MEASURE 2: SATISFACTION MEASURES								
18	Early Satisfaction & Engagement Survey (ESES)	Annual	95.7%	96%	96.0%	96.0%	**100.0%**	95.70%	0.30%
20	Student Satisfaction & Engagement Survey (SSES)	Annual	94.7%	95%	95.0%	95.0%	**100.0%**	94.70%	0.30%
23	ESES % Response Rate	Annual	61.0%	60%	60.0%	63.0%	**105.0%**	61.0%	2.00%
24	SSES % Response Rate	Annual	53.2%	55%	55.0%	53.0%	96.4%	53.2%	-0.20%
	Measure 3: RETENTION, SUCCESS & PROGRESSION								
32	Modern Apprenticeship successful outcomes (contract year)	Monthly	63.2%	75%	75.0%	53.8%	**71.7%**	57.10%	-3.30%
33	FE progression to further FE study	Annual	39.6%	40%	40.0%	41.5%	**103.8%**	39.60%	1.90%
34	FE progression to HE - actual	Annual	29.7%	35%	35.0%	36.8%	**105.1%**	29.70%	7.10%
35	Mental Health Support appt (non-emergency) offered for within 3 - 10 worki	Monthly	98.0%	97.0%	97.0%	100%	**103.0%**	98%	1.89%
36	Learning Support appt offered for within 6 - 20 working days	Monthly	100.0%	97.0%	97.0%	91%	**93.6%**	100%	-9.22%
37	PLSP - completed and accepted by student (within 10 days of meeting)	Monthly	-	85.0%	85.0%	87.7%	**103.1%**		
	Measure 4: HR								
40	Sickness levels	Quarterly	3.63%	2.98%	3.02%	3.63%	**120.3%**	3.63%	0.00%
41	- Short Term	Quarterly	1.53%			1.45%		1.65%	-0.20%
42	- Long Term	Quarterly	2.10%			2.19%		2.45%	-0.26%
43	% Staff turnover	Quarterly	2.35%	2.45%	2.59%	2.45%	**94.6%**	2.39%	0.06%
44	PRD completion - full or review (current quarter -2)	Quarterly	44%	50%	25.0%	27%	**108.0%**	34%	-7.00%
45	Student FTE:Academic Staff Ratio	Biannual	20.2	21	20.0	22.3	**111.5%**	21.7	0.6
47	Number of workplace injuries	Monthly	115	115	105	116	**110.5%**	105	11
48	Number of RIDDOR reportable accidents and illness	Monthly	5		3	6	**200.0%**	5	1
49	% of staff completed mandatory IHASCO (H&S) Trg	Quarterly	84%	80%	80.0%	87.0%	**108.8%**	85%	2.00%
	Measure 5: FINANCE								
53	Forecast Outturn Operational Surplus/(Deficit)	Quarterly	-£842,992	-£792,000	-£792,000	-£1,700,000	**214.6%**	-£967,000	-£733,000
	Measure 6: ESTATES & CAMPUS								
59	Room Occupancy - Frequency %	Monthly	40.2%	38.0%	42.3%	37.1%	**87.7%**	45%	-7.87%
60	CO2 Emissions on Utilities (gross) Tonnes	Monthly	561	532	436	457	104.7%	419	38
61	CO2 Emissions on Waste - Tonnes	Quarterly	0.821	0.780	0.560	0.429	76.5%	0.590	-0.16
62	Estates reactive task completion rate %	Monthly	95%	96%	96%	96.4%	100.5%	94.8%	1.6%
63	GTFM % reactive task completion rate	Monthly	95%	96%	96%	95.9%	99.9%	94.4%	1.5%
64	Total % of Capital expenditure budget committed (Aug - March)	Monthly	100%	100%	100.0%	100.0%	100.0%	100%	

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Subject/Title:	Committee & Chair Evaluation
Author: [Name and Job title]	Ludka Orlowska-Kowal Governance Officer
Meeting:	Audit Committee
Meeting Date:	02 June 2026
Date Paper prepared:	26 May 2026
Brief Summary of the paper:	Annual Audit Committee and Chair Evaluation Exercise
Action requested: [Approval, recommendation, discussion, noting]	The Committee is requested to individually undertake the Committee and Chair Evaluation Exercises which be made available to them via Microsoft Form Survey from beginning of July 2026.
Link to Strategy: Please highlight how the paper links to, or assists with:: • compliance • partnership services • risk management • strategic plan • new opportunity/change	The Code of Good Governance for Scotland's Colleges establishes standards of good governance practice for all boards and provides the essential foundations for compliance within the legislative framework. One of the five principles around which the code has been developed is effectiveness. Paragraph D24 states that "The board must agree a process for evaluating the effectiveness of the board chair and the committee chairs"
Resource implications:	
Risk implications:	Yes/No Operational: required for the proper Governance of the College
Equality and Diversity implications:	N/A
Consultation: [staff, students, UHI & Partners, External] and provide detail	

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

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As previously agreed, all future evaluations will be completed individually via an online survey. Members of the Audit Committee will be provided with access to these evaluations via the confidential Microsoft Forms Survey with emails being sent w/c 29th June 2026. Members are requested to complete this process by **5.00 p.m. on Friday 21 August 2026.**

Any actions highlighted as part of these evaluations will be brought to the Board of Management and feedback on the Chair will be discussed as part of the separate Board Member Evaluation Process.