Meeting	Audit Committee
Date and time	Tuesday 03 March 2026 at 16.30 p.m.
Location	Microsoft Teams

Governance Officer
24 February 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.

16:30 – 17:00 **0) CREATIVE SESSION – GOVERNANCE RESPONISIBILITY**

Session delivered by Roger Sendall, University Secretary, UHI

ITEMS FOR DECISION

17:00 – 17:15 **1) CYBER SECURITY UPDATE**
Report by ICT Services Manager

17:15 – 17:20 **2) MINUTES**

a.) Minutes of the Meeting of Audit Committee held on 08 September 2025
b.) Confidential Note (CN-01-092025) of Audit Committee held on 08 September 2025
c.) Confidential Note (CN-02-092025) of Audit Committee held on 08 September 2025
d.) Confidential Note (CN-03-092025) of Audit Committee held on 08 September 2025
e.) Confidential Note (CN-04-092025) of Audit Committee held on 08 September 2025
f.) Confidential Note (CN-05-092025) of Audit Committee held on 08 September 2025
g.) Confidential Note (CN-06-092025) of Audit Committee held on 08 September 2025
h.) Confidential Note (CN-07-092025) of Audit Committee held on 08 September 2025

17:20 – 17:25 **3) OUTSTANDING ACTIONS - INTERNAL & EXTERNAL AUDIT**

a. Audit Committee Action List
b. External Audit (Deloitte) – Recommendation List
c. Internal Audit (WBG) – Recommendation List

17:25 – 17:45 **4) INTERNAL AUDIT**
Report by the Director of Finance and Estates

a. Internal Audit (BDO) Follow Up Final Report 24-25
b. Internal Audit (BDO) Staff Wellbeing Final Report
c. Internal Audit (BDO) Incidents Management Draft Report
d. Internal Audit (BDO) Annual Report 2024-25 – to follow
e. Internal Audit (WBG) Progress Report February 2026

ITEMS FOR DISCUSSION

17:45 – 18:00 **5) BUSINESS CONTINUITY (CONFIDENTIAL)**
Report by the Director of Finance and Estates

18:00 – 18:15 **6) RISK REGISTER UPDATE (CONFIDENTIAL)**
Report by the Director of Finance and Estates

18:15 – 18:25 **7) KPI MATRIX**
Report by Operations and Commercial Manager

18:25 – 18:30 **8) STRATEGIC PLANNING 2026/27**
Report by Governance Officer

a.) Terms and Conditions – Audit Committee
b.) Standing Orders
c.) Scheme of Delegation
d.) Code of Good Governance 2025-26

FOR NOTING

18:30 – 18:30 **09) AOCB**

10) DATE AND TIME OF NEXT MEETING
Audit Committee Meeting 02 June 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.

Audit Committee

Subject/Title:	Cyber and Information Security Update
Author: [Name and Job title]	Martin Robinson, ICT Services Manager
Meeting:	Audit Committee
Meeting Date:	03/03/26
Date Paper prepared:	23/02/26
Brief Executive Summary of the paper:	This paper provides an overview of the governance controls and on-going activity across UHI in response to cyber and information security threats. The UHI approach can be summarised as risk prioritisation; continual review of controls; monitoring their effectiveness and new threats; and external assurance that these controls are appropriate. The paper also provides an overview of the working groups and committees responsible for cyber security as well as highlighting current high-level risks and impact.
Action requested: [Approval, recommendation, discussion, noting]	Noting
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 to reduce risk of exposure and / or loss of corporate or personal data; or disruption of core business services due to a cyber or information security incident.
Resource implications:	N/A
Risk implications:	N/A
Equality and Diversity implications:	N/A
Consultation: [staff, students, UHI & Partners, External] and provide detail	N/A

Status – [Non confidential]	Non confidential
Freedom of Information Can this paper be included in "open" business* [Yes]	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

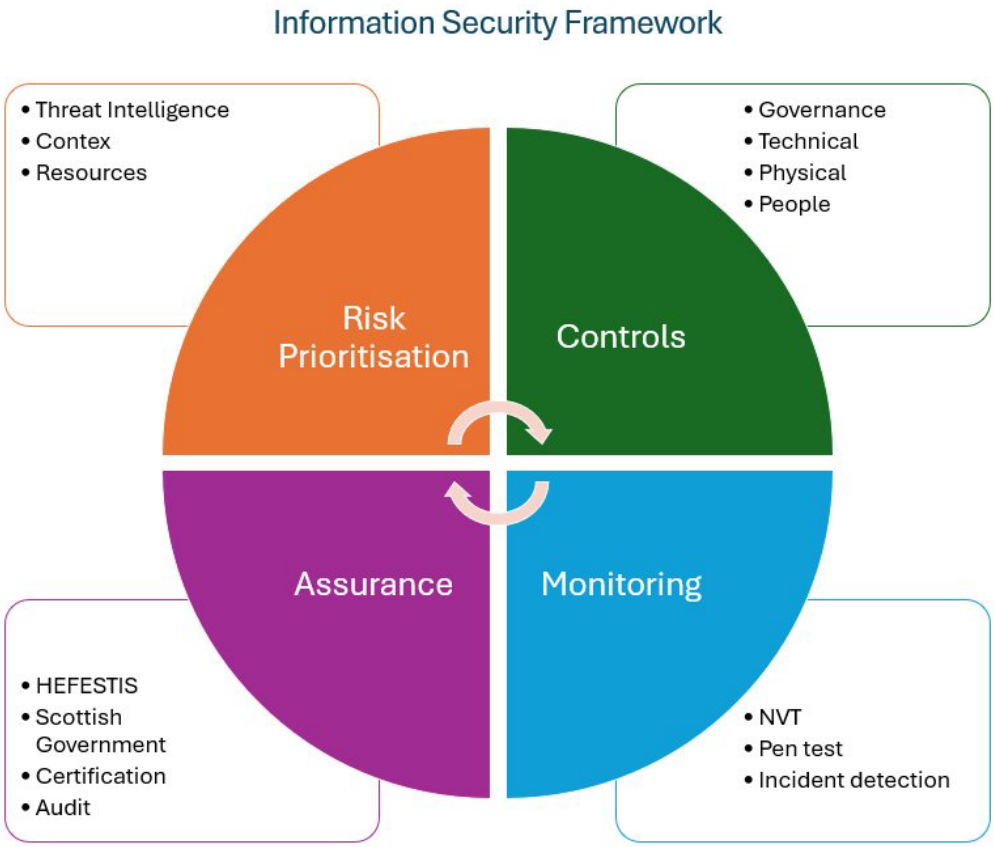
Information Security Management

The UHI Partnership, whilst made up of 11 Partner institutions, shares one UHI communication network. Therefore, cyber and information security is a collaborative exercise across the Partnership to ensure the appropriate controls and systems are in place to mitigate the risk of external threats and the loss of data.

There are governance and technical groups regularly reviewing risk, potential threats and best practice to, in turn, ensure the controls we have in place are appropriate.

The UHI approach to information security can be summarised via four interconnected elements:

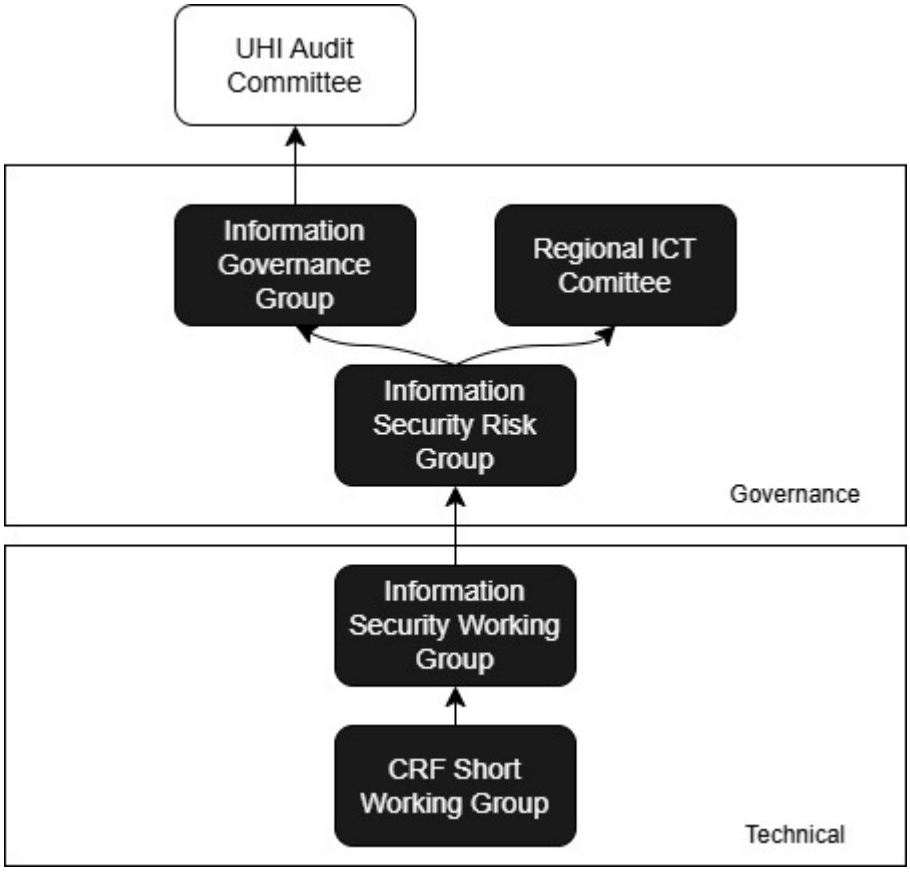
- Risk Prioritisation: to target or highlight new risks to mitigate
- Controls: the review and updating of the policies and systems in place to maintain a secure environment
- Monitoring: actively testing the controls in place as well as reviewing external incidents of highlighted vulnerabilities to adapt controls
- Assurance: Cyber Essentials Plus certification, audits, and external expert overview.



Governance and Technical Groups

UHI Inverness is a key member of the governance and technical groups contributing to the management of information security. With the Vice-Principal Student Experience and the Information Development Manager being members of the Information Governance Group, the ICT Manager is a member of the other governance groups

and members of the ICT Services team are involved in both the working groups and various short-life technical working groups. Therefore, we are actively contributing to the UHI wide governance of information management and security, the policies and procedures reviewed, as well as updating and introducing new technical controls.



The UHI Inverness role in Cyber Security is both to contribute to these Partnership groups as well as taking responsibility for the controls and application within our own setting, as, for example, only our own HR or Estates team can manage physical security or staff employment checks.

In addition, many controls and processes are implemented differently or are initiated locally. For example, UHI Inverness first implemented geographic login controls which are now in place across the Partnership and currently have stricter control on staff travel than other partners.

UHI also subscribes to the HEFESTIS shared service organisation for information security services, receiving a part time Chief Information Security Officer (CISO). The CISO-Share Office actively monitors security incidents, new threats, and best practice, supporting the UHI in monitoring their risk exposure and review and implementation of controls.

Controls and Certification

UHI adheres to the Scottish Government cyber security guidelines for further and higher education institutions with regards to both Cyber Essentials Plus certification and reviewing its Information Security risk profile against the UK wide NCSC Cyber Assessment Framework, this replaces the Cyber Resilience Framework (CRF) v2.

Cyber Essential Plus certification, which both validates the cyber security position as well as auditing the institution to verify that the appropriate systems and technical controls are in place, was successfully achieved in February 2025 with on-going activity to renew this currently.

Though it should be noted that the Cyber Essential certification is stricter and more difficult to achieve which may lead to review of approach. For example, students use their own devices to access their studies, and it would not be possible to prevent access or manage these devices to meet certain criteria if this was to be necessary.

The NCSC CAF is “a tool to help organisations assess and improve their cyber security and resilience, managing cyber risks and protecting essential services from cyber threats“ Some of the current highest risks in the information security risk register are about potential staff behaviors as well as supplier security, which demonstrates that information security needs to be prevalent across the organisation and is not just an IT area of responsibility.

Risk	Gross	Residual
Accidental misuse of email results in personal and sensitive data being shared with unauthorised recipients.	20	12
An internal or external rogue actor intentionally compromises university information systems and data and disrupts access and/or exfiltrates data.	16	12
Weak technical controls lead to institutional, personal, and sensitive data and/or services being disrupted, corrupted, lost, stolen, or misused through serious and inappropriate access of IT systems or data by external actors.	25	12
Threat actors gain access to the university's systems and data through compromising a supplier.	16	12
Staff have a poor awareness of information security threats and data protection issues and how these relate to their professional work and the impact that has on the safety and security of the organisation.	16	9

Appendix B provides more information and documents the approach to the management of risk across the UHI Partnership, which emphasises the need for collective ownership and the need to consistently implement security controls across the Partnership due to the interlinked nature of our ICT systems and services.

Information Security Management Systems (ISMS)

UHI Inverness as part of its Information Security Policy has an Information Security Management System, based on the ISO 27001 standard. This maps the controls in place both UHI wide and locally to manage information security. Of the 37 controls documented in this ISMS, 9 controls are shared UHI controls (such as acceptable use, password control, third-party access) with the rest being UHI Inverness policies and procedures. Many of these are also technical controls (such as administrative rights and patching) whilst others cover a wide range of departments in the College. Including Estates for physical security, HR for recruitment, Finance and data protection.

External Verification

In addition to Cyber Essential Plus, UHI Inverness was audited in the summer of 2025 for Cyber Security and was given a substantial level of assurance for the controls in place. The minor issues raised were around dates both within papers and the helpdesk system, rather than raising any issues related to cyber or information security.

Impact on Staff and Students

As raised above, the controls needed to comply with Cyber Essential Plus certification, as well as to reduce the risk exposure of the College and wider UHI, do have an impact on staff, students and researchers.

There are controls on personal devices accessing information, locked down controls on college devices and a restricted availability of software and applications. The most common impact is the inability to download software without prior approval as well as the need to use personal devices to access corporate data.

Where possible, the college does address these problems to avoid significant business impact. For example, researchers can be provided non-corporate devices to test software with less risk, and a secondary internet connection and network is in place to allow computing courses on cyber security and ethical hacking to be possible. That is, the college is aware that there is a clash between providing a certified secure environment and the educational and research needs of the college but actively looks to find pragmatic solutions to reduce any impact.

Finally, there is a high cost to cyber and information security. The amount of staff time spent working on information security is ever increasing. More staff time reviewing existing services to make them more secure and addressing new vulnerabilities means less time available for value added services and customer support.

Artificial Intelligence (AI)

AI is a rapidly evolving threat and defence in cyber security. Cyber terrorists are using AI to look to expose weaknesses and support both technical and social attack methods, and in return AI is now starting to be used to support cyber security defences too, such as analysing patterns in data, responding to new phishing alerts and proactively responding to new threats. Such solutions are not currently in place in UHI as the governance and management of such systems would be highly challenging, and likely expensive initially.

With regards to information security and potential exposure of corporate and personal data, AI is a risk as any information put into common online tools is then incorporated into its database and potentially available outside the UHI environment. The UHI Generative AI Policy prohibits staff and researchers from using AI to input college records, personal data, student work, research data, copyright materials or any potentially sensitive or commercial information.

The Digital Learning Leader supports staff in the use of AI and has created training content in how to use it responsibly. In addition, an all-staff notice was recently issued reminding staff to not use AI tools with college or personal data.

UHI | INVERNESS

Subject/Title:	Outstanding Actions – Internal & External Audit
Author: [Name and Job title]	Ludka Orlowska-Kowal Governance Officer
Meeting:	Audit Committee
Meeting Date:	03 March 2026
Date Paper prepared:	24 February 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
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)	

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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. To date, the previous internal auditors BDO, have provided the Committee with the final copy of their follow up report 2024-25. Any outstanding actions from the follow up report will be discussed with the new internal auditors WBG regarding further monitoring and implementation.

The Committee were provided with the following action lists:

- Audit Committee action list
- External Audit (Deloitte) – Recommendation List
- Internal Audit (WBG) – Recommendation List

Progress update:

- Audit Committee action list:
  - ✓ 10 actions complete
  - ✓ 5 actions outstanding
- External Audit (Deloitte) – Recommendation List
  - ✓ 4 actions complete
  - ✓ 4 actions outstanding (from December 2025)
- Internal Audit (WBG) – Recommendation List
  - ✓ 9 actions complete
  - ✓ 1 action outstanding

Audit Committee Action List

ITEM 03.a

Action	Academic Year	Status	Finding	Recommendation	Recommendation Significance	Implementation Date	Responsible Officer	Status as at 03 June 2025	Comments
1	2023/24	Complete	**Sale of Longman Site:** The sale of Longam Site took place on 15 December 2023.	The Chair of Board asked the Audit Committee to take the responsibility for monitoring the future sales of the site for the next 2 years, until 15 December 2025.	Low	15/12/2025	Estates and Campus Services Manager & GO	Still being monitored with no changes to report.	
5	2024/25	Complete	**Student Attendance KPI:** New measure to be added to the KPI report for new AY.	Student attendance monitoring measure to be added to the KPI Matrix report.	Low	08/09/2025	Operations and Commercial Manager & TELs	Proposed	**Update at 24/02/2026:** Will not be added to the KPI as not a meaningful measure for Board level review. It is being monitored by the SJEC and reported to the LTR Committee.
8	2024/25	Ongoing	**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 is still to follow.
								Status at 08/09/2025	
10	08/09/2025 2025/26	Complete	**Attendance & quorum**	All future meetings to be streamlined.	Low	03/03/2026	Chair of the Board, Chair of Audit & GO	Proposed	
11	08/09/2025 2025/26	Complete	**BDO Internal Audit - Outsanding Reports:** The Committee suggested that the Director of Finance and Estates should contact BDO to escalate in an appropriate manner the delay in reports completion and to ask for an updated timeline.	BDO to be contacted in regard to outstanding internal reports to provide a clear timeline of the process.	Medium	03/03/2026	Director of Finance and Estates	Proposed	
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 timesclae from WBG.
13	08/09/2025 2025/26	Complete	**WBG Internal Audit - Calendar of Submission:** The Committee suggested that an annual cyber security report should be presented to the Committee and added to its Calendar of Submission, with the first update being presented in March 2026.	Annual Cyber Security Report to be added to the Calendar of Submission.	Low	03/03/2026	GO	Proposed	
14	08/09/2025 2025/26	Complete	**WBG Internal Audit - Annual Cyber Security Report:** The Committee suggested that an annual cyber security report should be presented to the Committee and added to its Calendar of Submission, with the first update being presented in March 2026.	Annual Cyber Security Report to be presented to the Committee by the ICT Services Manager in March 2026.	Low	03/03/2026	ICT Services Manager	Proposed	
15	08/09/2025 2025/26	Ongoing	**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.
16	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.	The reporting and approval route of the financial recovery plan in 2020 to be checked.	Low	03/03/2026	GO	Proposed	**Update at 24/02/2026:** Discussed by Board on 12/03/2020 and Audit Committee on 10/03/2020, 02/06/2020 & 15/09/2020. Monitored by the Chairs Committee. Agreed by the Board on 30/04/2020.
17	08/09/2025 2025/26	Ongoing	**SFC's Summary - University of Dudee:** The Chair would welcome a lesson learnt report, based on the Gillies's report, specifically written for UHI Inverness to provide assurance purposes to the Board.	Lesson learnt report, based on the Gillies's report, specifically written for UHI Inverness to provide assurance purposes to the Board, to be presented to the Committee.	Medium	03/03/2026	Director of Finance and Estates	Proposed	

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	
19	08/09/2025 2025/26	Complete	**Draft Fraud Annual Report:** The Committee welcomed the report and positively commented on good findings and their underpinning data presented within its body.	Fraud risk to be added to college's main Risk Register.	Low	03/03/2026	Director of Finance and Estates	Proposed	
20	08/09/2025 2025/26	Complete	**Closed Meeting with Auditors:** The Chair suggested the Committee should meet with auditors on a biannual basis to maximise opportunities for feedback and improvements.	Closed session meetings with the auditors to be scheduled on a biannual basis going forward.	Low	03/03/2026	GO	Proposed	
								Status at 09/12/2025	
21	09/12/2025 2025/26	Complete	Joint Audit & FGP Committee	Savings plan to be put in place.	Medium	03/03/2026	Director of Finance and Estates	Proposed	**Update at 13/01/2026:** On the head of every policy, procedure and guidance it states the following: "Inverness College is known as UHI Inverness". The Quality tries to ensure the consistency of this approach by scrutinising documents at Policy & Procedure Review Panel meetings. This approach will be continued ging forward.

External Audit (Deloitte) Recommendation List

ITEM 03.b

Action	Reporting Year	Status	Finding	Recommendation	Recommendation Significance	Management Response	Implementation Date	Responsible Officer	Client status as at 03 June 2025 (Fully Implemented/ Partially Implemented/ Not Implemented/ Superseded/ Not Due For Implementation)	Comments
1	2023/24	Complete	**No fixed asset register:** UHI Inverness does not hold and maintain a Fixed Asset Register. This creates a risk that College assets are not being correctly recorded or accounted for.	It is recommended that a fixed asset register is created and maintained going forward.	High	Work is now almost completed on producing the college fixed asset register, with current year and prior years information having now been collated. Final checks are now being made and the fixed asset register will be fully completed by the end of June 2025.	31 June 2025	Director of Finance and Estates	Not implemented - ongoing. For reassurance purposes Deloitte can provide compliance confirmation to the Committee.	**Update at 03/06/2025:** Sample of physical verification/ownership can be provided only when an asset has been purchased. Depending on the purchase date this could create problems. **Update at 08/09/2025:** Draft of fixed asset register has been completed, showing assets from 2023/24 and prior years. 24/25 now to be added and checked to estates fixed asset register. **Update at 09/12/2025:** A fixed asset register has been created and maintained in 2024/25 and going forward.
2	2023/24	Complete	**Information provided to valuer:** UHI Inverness does not keep floor plans and site plans of the land and buildings that have been revalued. This prevents the audit team from verifying the inputs that are used in the revaluation calculation. UHI Inverness sent these measurements to Shepard's (external valuer) in 2019 when they were first engaged and have not maintained them since.	It is recommended that floor plans are maintained annually and provided to the College's external valuer ahead of each valuation per the rolling valuation cycle.	Medium	Floor plans will be provided to the college valuer prior to the next revaluation exercise taking place.	31 June 2025	Director of Finance and Estates	Not implemented - ongoing. Floor plans have been requested from GTFM and will be updated once reived to reflect recent departmental moves.	**Update at 08/09/2025:** Floor plans have been requested from GTFM, action will be completed for next valuation in 2027/28. **Update at 09/12/2025:** The floor area plans will be provided for next valuation in 2 years time.
3	2023/24	Complete	**NPD creditor agreement:** We noted that the College has not retained the original NPD service concession agreement.	It is recommended that the College seek to source a copy of the original NPD service concession agreement and retain this going forwards.	Medium	The college will attempt to source a copy of the original NPD agreement.	31 June 2025	Director of Finance and Estates	Not implemented - ongoing. The Principal will check detailed progress with the Director of Finance and Estates.	**Update at 08/09/2025:** Information and documents have been located, will provide this to Deloitte.
4	2023/24	Complete	**Retention of grant agreements for deferred capital grants:** We noted that the College have not retained the original grant agreements for many of the capital grants.	It is recommended that the College looks to source original grant income documentation from the relevant party and moving forward, we would suggest that they retain any relevant documentatior	Medium	Copies of future deferred capital grants will be held on file going forward.	31 June 2025	Director of Finance and Estates	Not implemented - ongoing. The Inventory process has started to list the grant and the agreement.	**Update at 08/09/2025:** Copies of grant agreements are now being kept by Finance department. **Update at 09/12/2025:** External Auditors now retain a copy of all new deferred grant documents from 2024/25.
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 fo	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 is used rather than when it is delivered. This creates a risk of understatement of expenditure and under accrua	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		

Internal Audit (WBG) Recommendation List

Action	Reporting Year	Status	Finding	Recommendation	Recommendation Significance	Management Response	Implementation Date	Responsible Officer	Comments
1	09/12/2025 2024/25	Complete	**Student Support Funds 2024/25 Audit:** Payment Made to Student Marked as Did Not Start	We recommend that the College complete its investigation to confirm how the DNS record was able to progress through to payment and raise the issue with Tribal/SITS if required. The College should also review the configuration of system controls and introduce additional checks where necessary, such as exception reporting for DNS students prior to payment runs, to ensure that similar errors cannot occur in future.	Medium	Initial investigations by the MIS Manager and Admissions, Enrolment and Funding found no reason as to why the student who was DNS pulled through in to the payment run as system configuration should not allow this. At the time of writing the issue has been escalated to UHI Executive Office MIS. If following their investigation it remains unresolved it will be escalated further to SITS/Tribal. Whilst awaiting advice and/or resolution additional checks will be implemented to cross checks student's status prior to payment runs being completed and SITS message buffers will be stored for reference.	23/09/2025	Admissions, Enrolment and Funding Manager	**Update at 28/01/2026:** Ongoing.
2	09/12/2025 2024/25	Complete	**Student Support Funds 2024/25 Audit:** Delays in Submission of Childcare Invoices	We recommend that the College strengthen the administration of childcare payments by introducing clearer expectations and deadlines for students in relation to invoice submission, supported by regular reminders. The College should also consider implementing monitoring controls, such as monthly checks or exception reports, to identify and follow up on any missing invoices promptly.	Low	The childcare support process relies on Childcare Providers to provide students with invoices on time, it may therefore be outwith the students control as to when these are submitted. However, to mitigate this monthly reminders will be issued to students, and the notification letter to Childcare Providers will be reviewed and updated to ensure that timely submission is highlighted.	23/09/2025	Admissions, Enrolment and Funding Manager	**Update at 28/01/26:** Monthly email reminders being sent to students, improvement in timesheets coming in on time.
3	09/12/2025 2024/25	Complete	**Student Support Funds 2024/25 Audit:** Inconsistencies in Care Experienced Student Records	We recommend that the College implement a process to reconcile care experienced status recorded at enrolment with the information provided on funding applications. Any discrepancies should be investigated and resolved before FES2 returns are finalised.	Low	Students can self select their Care Experienced status at the time of enrolment, this is only verified if the student makes a funding application. An additional step will be introduced to the funding process for the Admissions, Enrolment and Funding team to check and update students' enrolment records (SCS, MCI and STUA - which populate the FES 2 records), where there is a discrepancy between what the student has stated at enrolment, on their funding application and the evidence provided.	01/10/2025	Admissions, Enrolment and Funding Manager	**Update at 28/01/2026:** Team now checking all SITS fields CE data is captured against Assessment Look -up list.
4	09/12/2025 2024/25	Complete	**Credits Audit 2024/25:** Incorrect Credits	We recommend that the College enhance its reconciliation procedures between planned course hours, attached credits on progression reports, and the figures submitted in FES returns by introducing an additional review step or developing an automated check to ensure consistency and accuracy.	Medium	The Course Information Sheets relating to the Access to Nursing Course stated 770 planned hours, equating to 19.25 credits. There are optional units on this course. The Progression Board information indicated that all students were attached to 19 credits and the adjustment was made. For 2025/26 a new process is being introduced where the Course Information Sheets are locked for editing. This means that any amendments made by the course team will need to be advised to the Academic Administration Team, who will make any necessary updates on the course records in SITS. Course INS811A1 is the Part Time Highers & Nationals Programme which has been discontinued in 2025/26. The errors arose due to incorrect coding where students had transferred from Full Time study to Part Time. Whilst the Full Time and Part Time Highers course will no longer be continuing, further training will be provided to the Academic Administration Teams, which will be overseen by the Head of Registry & Quality and the MIS Manager, to ensure that student transfers are accurately recorded.	01/10/2025	Head of Registry and Quality	
5	09/12/2025 2024/25	Complete	**Credits Audit 2024/25:** Fundable students	We recommend that the College strengthen enrolment data input controls by ensuring that mandatory fields such as start dates cannot be left blank and that validation rules are in place to prevent funding flags being incorrectly applied. Exception reports should be run and checked periodically throughout the year to ensure accuracy of data input.	Low	Whilst there are no automated validation checks in SITS, staff have access to an Enrolment Dashboard where data can be checked. Further training will be provided to the Academic Administration and Admissions, Enrolment and Funding Teams, which will be overseen by the Head of Registry & Quality and the MIS Manager. The MIS Manager will oversee the exception reporting along with the Academic Administration Manager.	01/10/2025	Head of Registry and Quality & Management Information Systems Manager	**Update at 06/01/2026:** We have implemented the following to resolve this: •The enrolment dashboard now has a tab on it detailing required by dates so that we can ensure any discrepancies with the CBO can be updated. This is checked monthly •The Course Information Sheets are completed by May (with sessions held between AA team and DCL to ensure a greater accuracy level) and then CBO data input at an earlier stage before courses commence in August. This is particularly relevant to start and end dates plus credits/planned hours. •Withdrawals data is pulled monthly to identify any anomalies and resolve them. •There is a greater focus from all teams on data accuracy as the teams have become more familiar with SITS and the processes/requirements •Information Systems Manager pulls various reports and circulates so that data anomalies are resolved timeously
6	09/12/2025 2023/24	Complete	**Credits Audit 2024/25:** Fee Waiver: Source of Finance	The College should ensure that the Source of Finance coding on the FES 2 is correct. We also recommend that the College staff take care when matching the fee waiver code from the fee waiver form to the FES 2	Medium	A review of the Fee Waiver process will be undertaken by the Accountant, Head of Registry & Quality and the MIS Manager to address the following: - How to minimise the impact of students self-selecting the incorrect Fee Waiver code at enrolment. - Improvements are required in the collection and storage of Fee Waiver evidence and forms. - Fee Waiver information relating to the student's source of finance requires to be reviewed and updated in line with the information provided by the student. - Where no Fee Waiver documentation has been provided and no form submitted the source of funding should be updated to Self-Financing and the student invoiced accordingly. - Where the student has more than one enrolment the Fee Waiver information requires to be checked on all records, and where the student has transferred after the required date the subsequent record updated to College Borne Fee Waiver.	01/10/2025	The Accountant	
7	09/12/2025 2023/24	Complete	**Credits Audit 2024/25:** Fee Waiver: 1 per Student	We recommend that the College introduce a more robust process for the approval of fee waivers, requiring a secondary review by a separate member of staff to ensure this issue does not arise again.The College should only be claiming one full time fee waiver per student.	Medium	A review of the Fee Waiver process will be undertaken by the Accountant, Head of Registry & Quality and the MIS Manager to address the following: - How to minimise the impact of students self-selecting the incorrect Fee Waiver code at enrolment. - Improvements are required in the collection and storage of Fee Waiver evidence and forms. - Fee Waiver information relating to the student's source of finance requires to be reviewed and updated in line with the information provided by the student. - Where no Fee Waiver documentation has been provided and no form submitted the source of funding should be updated to Self-Financing, and the student invoiced accordingly. - Where the student has more than one enrolment the Fee Waiver information requires to be checked on all records, and where the student has transferred after the required date the subsequent record updated to College Borne Fee Waiver.	01/10/2025	The Accountant	
8	09/12/2025 2023/24	Complete	**Credits Audit 2024/25:** Fee Waiver: Fee Waiver Documentation	We recommend that the College ensure that fee waiver forms are held in a centralised location either electronically or physically, ensuring easy access for audits or any internal reviews.	Medium	A review of the Fee Waiver process will be undertaken by the Accountant, Head of Registry & Quality and the MIS Manager to address the following: - Improvements are required in the collection and storage of Fee Waiver evidence and forms. - Fee Waiver information relating to the student's source of finance requires to be reviewed and updated in line with the information provided by the student. - Where no Fee Waiver documentation has been provided and no form submitted the source of funding should be updated to Self-Financing.	01/10/2025	The Accountant	
9	09/12/2025 2024/25	Complete	**Education Maintenance Allowance Audit 2024/25:** Absence of Retained Evidence of Student ID	We recommend that staff are reminded that evidence used to confirm student eligibility is not only checked by them but is also consistently stored on file. We also recommend that periodic checks be introduced to confirm compliance.	Low	An additional cross check of evidence received and stored will be included in the process going into 2025/26.	15/09/2025	Admissions, Enrolment and Funding Manager	**Update at 28/01/2026:** Team cross checking evidence is stored before making offers.
10	09/12/2025 2024/25	Ongoing	**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	

INVERNESS COLLEGE
FOLLOW UP -25

INTERNAL AUDIT REPORT - FINAL

DECEMBER 2025

IDEAS | PEOPLE | TRUST

Contents

DISTRIBUTION LIST		
FOR ACTION	MANAGEMENT TEAM	
FOR NOTING	NIALL MCARTHUR	DIRECTOR OF FINANCE AND ESTATES
FOR INFORMATION	MEMBERS OF	AUDIT COMMITTEE

REPORT STATUS	
LEAD AUDITOR(S):	EWAN GALBRAITH
DATES WORK PERFORMED:	09/07/2025 - 16/12/2025
DRAFT REPORT ISSUED:	07/01/2026
DRAFT REPORT RE-ISSUED:	09/02/2026
MANAGEMENT RESPONSES RECEIVED:	12/02/2026
FINAL REPORT ISSUED:	18/02/2026

Executive Summary

BACKGROUND

As part of the provision of continual assurance over the design and effectiveness of controls, and closure on control gaps, we have undertaken a review to assess the degree of implementation of the recommendations made in prior years in accordance with the Annual Internal Audit Plan.

If recommendations are not implemented on a timely basis, weaknesses identified through internal audits in control, risk management and governance activities will remain in place. Furthermore, a reluctance or inability to implement recommendations reflects poorly on management's commitment towards maintaining a robust internal control and governance environment. Therefore, confirmation of the implementation status of recommendations is a key determinant of our annual opinion over your governance, risk, and internal control framework.

SCOPE

In accordance with the -25 Internal Audit Plan, we have considered the implementation status of all open recommendations raised from the work carried out by BDO which were due to be implemented by July 2025 and identified those not due for implementation (nine recommendations). This resulted in a total of 16 recommendations to be followed up. The recommendations relate to nine audit areas, as shown in the tables below.

METHODOLOGY

During our testing, we followed up on all recommendations that had a target completion date on or before 31 July 2025. Additional actions became due in the interim period, but we were not provided with evidence for these.

Management's Internal Audit recommendation progress was reviewed to establish the degree of implementation achieved. Where it was confirmed that the recommendation had been implemented, evidence was sought, and testing was undertaken to verify the ongoing operation of the recommended controls. Where Management's response in the Internal Audit report differed from the original recommendation, we tested the agreed management actions.

RECOMMENDATIONS FOLLOWED UP

YEAR	AUDIT	RECOMMENDATIONS FOLLOWED UP			
		HIGH	MEDIUM	LOW	TOTAL
2019/20	Cash Handling	-	1	1	2
2020/21	Workforce Planning	-	1	-	1
2020/21	Finance System Upgrade	-	4	-	4
2021/22	Staff Recruitment	-	1	-	1
2021/22	Procurement	-	1	1	2
2022/23	Strategic Planning	-	1	-	1
2023/24	Professional Development	-	2	-	2
/25	Fraud Strategy	-	2	-	2
/25	Core Financial Controls		1	-	1
TOTAL		0	14	2	16

Executive Summary

Status of recommendations as of JULY 2025

The table below outlines the implementation status of the recommendations followed up:

Audit Area	Action Significance Rating	STATUS AT JULY 2025					
		Fully implemented	Being implemented	Not implemented	Superseded	Not Due For Implementation	Total
Recommendations from 2019/20							
Cash Handling	Medium	1	-	-	-	-	1
	Low	1	-	-	-	-	1
Recommendations from 2020/21							
Workforce Planning	Medium	-	1	-	-	-	1
Finance System Upgrade	Medium	2	2	-	-	-	4
Recommendations from 2021/22							
Staff Recruitment	Medium	-	1	-	-	-	1
Procurement	Medium	-	1	-	-	-	1
	Low	-	1	-	-	-	1
Recommendations from 2022/23							
Strategic Planning	Medium	-	1	-	-	-	1

Executive Summary

Audit Area		STATUS AT JULY 2025					
	Action Significance Rating	Fully implemented	Being implemented	Not implemented	Superseded	Not Due For Implementation	Total
Recommendations from 2023/24							
Professional Development	Medium	-	2	-	-	1	3
Recommendations from /25							
Fraud Strategy	Medium	-	2	-	-	2	4
	Low	-	-	-	-	1	1
Core Financial Controls	Medium	-	1	-	-	-	1
	Low	-	-	-	-	2	2
Cyber Security	Low	-	-	-	-	3	3
TOTAL		4	12	-	-	9	25

CONCLUSION

We found that of the 16 recommendations followed up in July 2025:

- 4 (25%) are fully implemented
- 12 (75%) either remain in the process of being implemented and/or no evidence was provided at the time of follow-up

The results above highlight that the number of fully implemented recommendations has fallen when compared to the previous follow up (50%). Continued work is needed by management to ensure Internal Audit recommendations are completed on time to strengthen the overall internal control framework across the organisation.

Detailed information on the status of each being implemented recommendations and management updates are provided on the following slides.

STATUS OF RECOMMENDATIONS

Recommendation Status

WORKFORCE PLANNING - FINDING 2			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
We recommend identifying critical roles and preparing a documented succession plan.	HR Manager Nicola Quinn	Whilst we do not necessarily have a 'list' of critical roles - I must re-iterate some of the comments made (please see report) A documented succession plan procedure as outlined above will be formalised.	April 2021
BDO UPDATE JULY 2025			**STATUS**
Management noted that in July , two VPs developed a confidential spreadsheet accessible only by the EMT, which identifies business-critical roles and succession planning options, guiding structural changes and development opportunities, while increasing notice periods for these roles and implementing skills matrices and professional development programmes as part of the Talent Management Framework. Internal Audit has been provided with the Skills Matrix Templates, and guidance for managers and staff has been developed and shared with staff. However, this recommendation will be fully implemented when Succession Planning Spreadsheets for Business-Critical Roles are provided to Internal Audit, along with evidence of regular review and senior authorisation of plans. If access to the already developed spreadsheets is not possible, Internal Audit requires evidence of the process.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
These spreadsheets are completed but cannot be shared due to their confidential nature.		Head of HR	Completed

Recommendation Status

FINANCE SYSTEM UPGRADE - FINDING 3			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	SMT still to allocate	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.	June 2021
BDO UPDATE JULY 2025			**STATUS**
Internal Audit reviewed the Project Progress Report Template and noted that it requires changes and necessary approvals to be included in the progress reports prepared by the project manager. We found that the Project Management Guidance shows an absence of specific documents related to change management. We will mark this recommendation as fully implemented once templates for change forms are provided within the Project Management Resources.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
Ongoing.		Head of Commercial Operations	March 2026

Recommendation Status

FINANCE SYSTEM UPGRADE - FINDING 4			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.		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.	June 2021

Recommendation Status

BDO UPDATE JULY 2025	STATUS
This recommendation is being implemented as we noted that the Project Initiation Plan requires identification of the project team, including key roles and responsibilities. Furthermore, project tasks and actions need to be listed clearly, including by whom they will be completed and the timeline for completion. We noted that the Project Management Guidance includes the core responsibilities of project sponsors, project managers, and the project team. However, this recommendation will be fully implemented when the Project Management Guidance is updated to clearly reflect how changes to the project team will be documented.	**BEING IMPLEMENTED**

REVISED MANAGEMENT RESPONSE	ACTION OWNER	COMPLETION DATE
Ongoing.	Head of Commercial Operations	March 2026

Recommendation Status

STAFF RECRUITMENT – FINDING 4			SIGNIFICANCE
Recruitment & Selection Training 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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	HR Manager and HR Business Partners Nicola Quinn	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 Tor 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 provided to all staff who may be involved in the hiring process.	2022-23 Academic Year

Recommendation Status

BDO UPDATE JULY 2025	STATUS
Management advised us that the Human Resources (HR) and Professional Development (PD) teams are collaborating to develop line manager training on HR Policies and Procedures, which began in -2025 and will continue in 2025-2026, including Staff Recruitment and Selection, and has been added to HR's Quality Enhancement Plan (QEP) for 2025-2026. This recommendation will be fully implemented when evidence can be provided that all staff involved in the hiring process have received anti-bias training, and that the completion of this training is monitored and reported.	**BEING IMPLEMENTED**

REVISED MANAGEMENT RESPONSE	ACTION OWNER	COMPLETION DATE
Ongoing.	Head of HR	July 2026

Recommendation Status

PROCUREMENT - FINDING 2			SIGNIFICANCE
Non-Contracted Spend 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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	Assistant Principal Finance & Audit Roddy Ferrier	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.	31/10/2022
BDO UPDATE JULY 2025			**STATUS**
Internal Audit has been informed that the legal services contract is still pending. This recommendation will be fully implemented once the Legal Services Contract Strategy is launched and approved.			**BEING IMPLEMENTED**

REVISED MANAGEMENT RESPONSE	ACTION OWNER	COMPLETION DATE
A new framework agreement is now in place for Legal Services through APUC, which the college will use to procure legal services going forward.	Director of Finance & Estates/ APUC	February 2026

Recommendation Status

PROCUREMENT - FINDING 4			SIGNIFICANCE
Training 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.			LOW
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	Assistant Principal Finance & Audit Roddy Ferrier	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.	August 2023
BDO UPDATE JULY 2025			**STATUS**
Internal Audit has been advised that several procurement training sessions have been undertaken with staff and that further training sessions will be arranged in the 2025-26 Academic Year. This recommendation will be fully implemented when evidence is provided to Internal Audit of the training sessions that have been conducted to date and the college's plans to provide this training to all relevant staff. Evidence of the training materials used in the training should also be made available to Internal Audit.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
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.		Director of Finance & Estates/ APUC	Completed

Recommendation Status

STRATEGIC PLANNING - FINDING 1			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
We recommend that the College updates the KPI matrix to include the three KPIs.	The Principal Vice Principal Operations & External Relations	We will include the research KPI and extend the coverage of the CO2 KPI once a mechanism for measurement has been agreed for each.	31 July
BDO UPDATE JULY 2025			**STATUS**
Management noted that engagement with Innovate UK will be included in the 2025-26 Key Performance Indicator (KPI) Measurement once the Principal agrees on a target with Research Directors. Additionally, carbon dioxide (CO2) emissions monitoring has been refined to cover utilities and waste, with plans to expand to staff and student travel, requiring further development and initial benchmarking. This recommendation will be fully implemented once the target or benchmark for engagement with Innovate UK has been agreed upon, and Internal Audit is provided with evidence of regular reporting on the CO2 emissions KPIs.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
Being monitored but not included in the KPI matrix because it's a small measure.		Vice Principal Operations & External Relations	Completed.

Recommendation Status

PROFESSIONAL DEVELOPMENT- FINDING 1			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	Professional Development Manager	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 August

Recommendation Status

BDO UPDATE JULY 2025	STATUS
Management advised us that the current mandatory training, including Health & Safety courses and external training on PREVENT and Trauma Informed Practice, has a completion deadline of 31 July 2025, with compliance reports to be compiled and circulated in August, while the transition to the SafetyHub platform in 2025-26 aims to streamline monitoring and reminders, addressing the current complexity and time-consuming nature of compliance checking across different platforms. We noted that there is ongoing work to migrate the mandatory training from iHASCO and Brightspace towards SafetyHub, however, the recommendation will be marked as fully implemented when evidence of successful migration and regular reporting on training completion through the SafetyHub platform is provided.	**BEING IMPLEMENTED**

REVISED MANAGEMENT RESPONSE	ACTION OWNER	COMPLETION DATE
Now fully implemented.	Professional Development Manager	Completed

Recommendation Status

PROFESSIONAL DEVELOPMENT- FINDING 2			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
We recommend that the Professional Development team works in close partnership with HR to create a structured follow-up system for PRD completion. This should include: 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.	Professional Development Manager	1. We recognise that staff professional development is initiated in different ways and at different times and the PRD is just one mechanism. To help provide oversight we will explore moving the PRD into Microsoft forms. This will mean that development requests will be pulled out and automatically sent to the PD team for actioning. 2. Even exceptions to the standard process (those not coming through as a PD1) are pre-approved and documented. No PD requests are actioned without pre-approval by the PD manager. We will keep records of approval of courses & bookings by adding another column to our spreadsheet to show this approval process.	01 August
BDO UPDATE JULY 2025			**STATUS**
Management informed us that the transition of Performance Review and Development (PRD) forms to Microsoft Forms has not been possible, prompting a review of the Ciphr Human Resources (HR) system to potentially facilitate PRD completion within the system for efficient data extraction and follow-up by the Professional Development (PD) team, as the current manual process remains very time-consuming. This recommendation will be fully implemented when the College can ensure that all professional development activities are uploaded and the required evidence is provided.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
Ongoing.		Professional Development Manager	July 2026

Recommendation Status

FRAUD STRATEGY- FINDING 1			SIGNIFICANCE
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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	Director of Finance Estates	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.	July 2025
BDO UPDATE JULY 2025			**STATUS**
We noted that the Finance Procedure Manual now specifically references the college's participation in the National Fraud Institute (NFI). However, the Anti-Fraud and Corruption Policy (version available through the UHI Inverness website) was last updated in December 2023 and does not include information related to the Fraud Response Plan or NFI involvement. A draft Fraud Response Plan was provided in February 2026 for review, which includes sections on the involvement of the NFI with the college and incorporates the Fraud Response Plan. The recommendation will be fully implemented once evidence of policy approval and publication is provided.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
Policies now provided and fully implemented.		Director of Finance Estates	Completed

Recommendation Status

FRAUD STRATEGY- FINDING 2			SIGNIFICANCE
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 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.			MEDIUM
RECOMMENDATIONS	**ACTION OWNER**	**MANAGEMENT RESPONSE**	**TARGET COMPLETION DATE**
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.	Director of Finance Estates	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.	July 2025
BDO UPDATE JULY 2025			**STATUS**
Internal Audit was informed that the Fraud Response Plan was completed and is scheduled to be presented at its next meeting on 02 September 2025. However, we were not provided with evidence to demonstrate the corresponding actions. A draft Fraud Response Plan was provided in February 2026 for review, which includes sections on the Prevention of Further Loss and Press Release Publicity. As noted, the updates to the Anti-Fraud and Corruption Policy are not available to view on the website, nor does the review frequency reflect any changes made in 2025. This recommendation will be fully implemented when the amended Anti-Fraud and Corruption Policy is approved and published.			**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE		**ACTION OWNER**	**COMPLETION DATE**
Anti Fraud & Corruption policy approved and sent to BDO		Director of Finance Estates	Completed.

Recommendation Status

CORE FINANCIAL CONTROLS - FINDING 1	SIGNIFICANCE
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 . 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.	MEDIUM

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	TARGET COMPLETION DATE
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. • 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 College updates the Financial Regulations to ensure they align with its accounting policies with respect to the capitalisation and depreciation. • The College updates the Finance Procedures Manual to include processes around maintaining the Fixed Asset Register and the existing asset disposal process.	Professional Development Manager	We accept there needs to be consistency in the format of the skills matrices so will develop a common template to support this. This will come through our PPRP process. However, the development of the content and the discussions around this needs to sit with each individual line manager and their team. This is an on-going process which may be added to during the course of an academic year and therefore would not be appropriate to come through our PPRP process.	1: September 2025 2: July 2025

Recommendation Status

BDO UPDATE JULY 2025		STATUS
Internal Audit has been advised that a draft fixed asset register (FAR) has been compiled and that management will liaise with Estates to reconcile the draft FAR with the asset register maintained by Estates. This recommendation will be fully implemented when evidence is received that revised asset disposal forms have been updated with information from the FAR, and the draft FAR includes unique asset numbers, descriptions of assets, and details of the depreciation method and rate per asset class.		**BEING IMPLEMENTED**
REVISED MANAGEMENT RESPONSE	**ACTION OWNER**	**COMPLETION DATE**
Fixed asset register completed, and approved by external audit.	Director of Finance & Estates	Completed

Appendix I: Definitions

RECOMMENDATION STATUS	MEANING
●	Fully Implemented
■	Being Implemented
▲	Not Implemented
■	Superseded
▬	Not due for implementation

BDO 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 II: Staff interviewed

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

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BDO

INVERNESS COLLEGE
STAFF WELLBEING
INTERNAL AUDIT - FINAL REPORT

OCTOBER 2025

LEVEL OF ASSURANCE:	
DESIGN	MODERATE
EFFECTIVENESS	MODERATE

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CONTENTS

DISTRIBUTION LIST		
FOR ACTION	GEORGIE PARKER	VICE PRINCIPAL
	NICOLA QUINN	HEAD OF HUMAN RESOURCES (HR)
FOR INFORMATION	AUDIT COMMITTEE	MEMBERS

REPORT STATUS	
LEAD AUDITOR(S):	JAASI PHELPS-NYAKAIRU BENNET LE RICHE
DATES WORK PERFORMED:	10/02/2025 - 16/09/2025
ADDITIONAL DOCUMENTATION RECEIVED:	19/09/2025
DRAFT REPORT ISSUED:	20/10/2025
MANAGEMENT RESPONSES RECEIVED:	23/02/2026
FINAL REPORT ISSUED:	23/02/2026

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	5
L	5	8
TOTAL NUMBER OF FINDINGS: 7		13

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

✓ The College may not have a referral procedure in place.

BACKGROUND AND SCOPE

In accordance with the 2024-25 Internal Audit Plan, Internal Audit undertook a review of staff wellbeing within Inverness College. The College uses a dedicated Human Resources (HR) SharePoint and dedicated Staff Wellbeing Sharepoint to host staff wellbeing information, policies and guidance, all accessible to staff.

BACKGROUND AND SCOPE CONTINUED

There is an Employee Assistance Programme in place offering mental health resources and wellbeing guidance materials. The College also offers financial support options, including a salary advance scheme.

Wellbeing materials are distributed to staff via the HR SharePoint, and staff wellbeing workshops have been utilised. The last ad-hoc survey conducted by the College on staff wellbeing was in 2020, focusing on the topic of working from home. The College have also used other ad-hoc pulse surveys and topic-specific surveys.

HR provides quarterly Key Performance Indicator (KPI) reporting to the Executive Management Team (EMT) and the Board on matters such as starters, leavers, turnover, and absences. There is a Staff Wellbeing Group in place, that meets every two months and shares updates to the Health, Safety and Wellbeing Committee quarterly.

There is a standalone Staff Wellbeing Policy and Guidance created the Staff Wellbeing Group in conjunction with HR, which went through the College approval process, being reviewed by the Policy and Procedure Review Panel (PPRP) and approved by the Board of Management. Policies are reviewed every three years. There is additionally a Promoting Attendance Policy and Procedure and a Special Leave Policy and Procedure.

The College's Professional Development Team tracks and monitors manager training modules which include Promoting Attendance, iHasco core training, and optional role-specific modules.

The staff wellbeing initiatives in place include Optima Health, which provides guidance materials Able Futures, which offers confidential one-to-one support for up to nine months and NHS Highland's Occupational Health and Wellbeing, accessible via manager referrals or through pre-employment health questionnaires, with defined forms, Service Level Agreements (SLAs), and KPIs in place.

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

PURPOSE

The purpose of this review was to provide assurance over the design and operational effectiveness of the key controls in relation to staff wellbeing in the following areas:

- Policies and practices
- Referral procedures
- Staff engagement
- Support and discussion framework
- Governance and training

CONCLUSION

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

The College has demonstrated the Staff Wellbeing Group, made up of staff volunteers, can influence staff wellbeing policies through escalation of wellbeing matters to the Health, Safety and Wellbeing Committee. There is a variety of wellbeing services available to staff, including confidential support lines. Additionally, managers have access to optional training on supporting neurodiverse employees and fostering an inclusive culture.

However, the audit identified two findings of medium significance and five of low significance. The findings relate to the Promoting Attendance Policy not being consistently followed, with return-to-work forms often incomplete. We also noted that the Salary Advance Scheme has missing eligibility requirements the Reasonable adjustment form needs clearer sign-off requirements, and there is an absence of a consistent all-staff survey on wellbeing. Additionally, the Staff Wellbeing Group's action section lacks due dates and is inconsistently completed, and the Promoting Attendance Training does not align with the Promoting Attendance Policy, showing discrepancies in definitions of short-term and long-term absences, and omitting the Policy requirement for employees to provide work-related updates during long-term absence reviews.

EXECUTIVE SUMMARY

SUMMARY OF GOOD PRACTICE

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

- The College uses an external provider, Able Futures, to offer confidential and consistent mental health support, available to all staff. This service is part of a comprehensive set of wellbeing services, including Optima Health for wellbeing guidance accessible to all staff on the SharePoint, and NHS Highland's Occupational Health and Wellbeing Service, which is available to staff following a manager's referral. These options provide staff with multiple avenues to address their wellbeing.
- The College has in place a Staff Wellbeing Group made up of staff who have volunteered. This group gathers feedback on staff wellbeing issues and hold bi-monthly meetings to discuss these matters, including updates on training opportunities and attendance rates for optional courses. This group has the ability to influence existing wellbeing policies through escalation of wellbeing matters to the Health, Safety and Wellbeing Committee and promoting the wellbeing initiatives to staff.
- The College has a Remote Working Charter in addition to the current staff wellbeing policies to directly communicate with staff about their wellbeing and privacy when working from home.
- There are staff workshops in place such as sewing, active listening, and cooking amongst a variety of other workshops to encourage staff wellbeing, both physically and mentally.
- The wellbeing initiatives in place are clearly communicated to staff and include general physical and mental wellbeing guidance, a confidential mental health call service, and NHS assistance when necessary. The initiatives are clearly signposted with a SharePoint providing guidance for access to Optima Health and Able Futures.
- The manager training on Promoting Attendance clearly outlines how to set attendance targets, refer employees to Occupational Health, and engage with HR regarding staff wellbeing matters. Managers also have access to optional training on staff wellbeing through Optima Health, which includes topics like support for neurodiverse employees, creating an inclusive culture, and offering flexibility.

SUMMARY OF FINDINGS

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

- **Promoting Attendance:** Internal Audit selected a sample of 15 absent and returned staff from June 2024 to May 2025 out of a population of 332, to confirm alignment with the Promoting Attendance Policy and Procedure. Of the sample, 13 (87%) were considered not in alignment with the Policy. Of these: two did not have a return-to-work form and were missing an absence report. Eleven employees had no return-to-work meeting evidenced.
- **Salary Advance Scheme:** We found that the Salary Advance Scheme Request form does not define or communicate clear conditions for the refusing of a request for example, a request may be refused if the staff member has not completed their probationary period.
- **Reasonable Adjustments Approval:** We found the Reasonable Adjustment form does not clearly designate who is responsible for the 'employer's signature' and does not require a line manager's signature.
- **Staff Feedback Surveys:** Management advised us that there are no consistently performed surveys on staff wellbeing. We found that the Staff Wellbeing Group discussed the need for an all-staff survey which includes stress as a topic in their 17 January 2025 bi-monthly meeting, but we were not provided with evidence of any follow up actions identified.
- **Staff Wellbeing Group:** We found that the Staff Wellbeing Group previous action section does not include completion dates for actions, and not all fields are consistently completed. Additionally, the minutes from the Staff Wellbeing group meetings have a missing summary of issues to be reported or escalated to the Health, Safety, and Wellbeing (HSWB) Committee.
- **Promoting Attendance Training:** We found that the Promoting Attendance Training does not align with the Promoting Attendance Policy with differences in absence timing and missing information from the policy. Additionally, we noted that the training is delivered via workshops and currently does not have clear due dates with timing still ~~in~~ under consideration, as advised by management.

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DETAILED FINDINGS

DETAILED FINDINGS

RISK: THERE MAY NOT BE EFFECTIVE ARRANGEMENTS IN PLACE TO MANAGE ABSENCE AND RETURN TO WORK.

FINDING 1 – PROMOTING ATTENDANCE	TYPE
It is important that absence policies are current, clear, and applied consistently. Policies should be regularly reviewed and updated, setting out clear roles and responsibilities to ensure reliable management information, fair absence management, staff wellbeing support, and a reduction of legal and employee relations risks. The College has a Promoting Attendance Policy defining short and long-term absence, setting absence triggers, and assigning responsibilities to HR, line managers, and staff. Internal Audit selected a sample of 15 absent and returned staff from June 2024 to May 2025 out of a population of 332, to confirm alignment with the Promoting Attendance Policy and Procedure which requires absence is appropriately qualified as short or long term, formal review meetings with managers, and the completion of a return-to-work form. Of the sample, we noted that 13 (87%) were considered not in alignment with the Of these: • *Employee ID: 10143 did not have a return-to-work form. The recorded system (Ciphr) showed that leave began on 8 April 2024, however the formal review meetings between the employee and their manager noted the absence began on 18 March 2024.* • *Employee ID: 12289 did not have an absence report in Ciphr for 20 September 2024 - 4 October 2024 and no return-to-work form was submitted for the absence on 6 September 2024. Additionally, the line manager did not inform the employee in the given evidence that time off was available with a hospital note, requiring the employee to perform their own escalation to be granted reasonable paid time off, having previously paid back the time via Time Off In Lieu (TOIL).* • *Employee IDs 12155, 748, 12303, 9509, 2428, 677, 12005, 9188, 2489, 12183, and 10532 did not have a return-to-work meeting evidenced, which is required for submission to HR for any absence according to the Promoting Attendance Policy.*	EFFECTIVENESS AND DESIGN 
IMPLICATION	**SIGNIFICANCE**
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.	MEDIUM

DETAILED FINDINGS

RISK: THERE MAY NOT BE EFFECTIVE ARRANGEMENTS IN PLACE TO MANAGE ABSENCE AND RETURN TO WORK.

FINDING 1 – PROMOTING ATTENDANCE			TYPE
RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. 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.	HR	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 Cipher system . IN THE INTERIM, regular spot checks will be implemented for a sample of absences to ensure necessary documents are completed.	April 2026
2. Line managers should receive regular refresher training, such as annually, on the Promoting Attendance Policy and Procedure.	HR and PD Teams	Our HR Business Partners work 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

DETAILED FINDINGS

RISK: A FRAMEWORK MAY NOT HAVE BEEN ESTABLISHED WHICH ALLOWS FOR SUPPORT AND DISCUSSION AROUND PERFORMANCE, WELLBEING AND DEVELOPMENT.

FINDING 2 - STAFF FEEDBACK SURVEYS	TYPE
It is important that staff are given regular opportunities to provide feedback and that feedback received is analysed to ensure key areas are clearly highlighted for management to address and act on, promoting staff satisfaction and wellbeing. UHI Inverness conducts ad-hoc staff surveys with various focuses such as pulse surveys, stress indicator surveys, and a working from home survey (2020), which was the last comprehensive all staff survey. There are no consistently performed surveys, such as an annual all-staff listening survey with a clear template. We found that the Staff Wellbeing Group discussed the need for an all-staff survey, including stress as a topic, in its 17 January 2025 bi-monthly meeting, however there was no evidence of agreed actions to address this. Additionally, Management advised us that no specific Key Performance Indicators (KPIs) are currently in place for staff wellbeing.	DESIGN
IMPLICATION	**SIGNIFICANCE**
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.	MEDIUM

DETAILED FINDINGS

RISK: A FRAMEWORK MAY NOT HAVE BEEN ESTABLISHED WHICH ALLOWS FOR SUPPORT AND DISCUSSION AROUND PERFORMANCE, WELLBEING AND DEVELOPMENT.

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. 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.	VP, CO&ER, Health, Safety and Sustainability and HR.	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
2. Future survey responses should be used as KPI benchmarks to judge the effectiveness of actions taken to address identified issues.	VP, CO&ER, Health, Safety and Sustainability and HR.	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.
3. Questions about experiences on Optima Health and Able Futures are included in annual surveys to ensure staff utilising the service are satisfied.	VP, CO&ER, Health, Safety and Sustainability and HR.	AS ABOVE.	AS ABOVE.

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE CLEAR AND PRACTICABLE POLICIES AND PRACTICES IN PLACE FOR THE WELLBEING OF STAFF.

FINDING 3 - SALARY ADVANCE SCHEME	TYPE
It is important that the staff wellbeing policies and procedures, including the salary advance process must be clear and include set thresholds and qualifying criteria. This ensures all staff have an equal opportunity for salary advances and prevents approvers from acting with discrimination. There is a Salary Advance Scheme within UHI Inverness, available for all staff via the HR SharePoint. The application process is monitored by Finance and HR, allowing staff to request a salary advance within set thresholds. However, we found that the Salary Advance Scheme Request form which covers the employee details, amount request, repayment period and more recent payslip, does not define or communicate clear conditions for the refusing of a request for example, a request may be refused if the staff member has not completed their probationary period.	DESIGN
IMPLICATION	**SIGNIFICANCE**
Without clear guidelines, there is a risk that an authoriser could make incorrect or discriminatory decisions, posing legislative risk.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. 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.	HR	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.

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT ENCOURAGE STAFF TO BE OPEN ABOUT THEIR MENTAL HEALTH AND WELLBEING.

FINDING 4 - REASONABLE ADJUSTMENTS APPROVAL	TYPE
It is important that there is a clear process for employees to receive reasonable adjustments at work. This process should include a clear approval structure to ensure all relevant staff are informed of adjustments. Managers who need to be involved should be prepared for adjustments in advance to maintain operational efficiency and foster collaboration. The College has established a reasonable adjustments process, available to staff via the HR SharePoint, which includes a form the employee and their line manager must complete to outline any restricted duties. However, we found that the form does not clearly specify who is responsible for the 'employer's signature'. Additionally, it does not require a line manager's signature, even though the line manager is expected to complete part of the form.	DESIGN
IMPLICATION	**SIGNIFICANCE**
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.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. The Employer's Signature section is clearly defined, specifying the department and position to ensure a consistent process.	HR Team	RA FORM HAS BEEN UPDATED.	January 2026
2. The line manager section requires a sign off to confirm that line managers have thoroughly reviewed the form before its approval.	HR Team	RA FORM HAS BEEN UPDATED.	January 2026

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE A CLEAR GOVERNANCE STRUCTURE FOR DELIVERING AND REPORTING ON WELLBEING.

FINDING 5 – STAFF WELLBEING GROUP	TYPE
It is important Staff Wellbeing oversight includes clear action schedules and designated owners to ensure actions are consistently completed within an appropriate timeframe and to a suitable standard. UHI Inverness has a Staff Wellbeing Group made up of staff volunteers across the College that oversees staff wellbeing matters and sets actions to address issues. The meetings minutes include a section for previous actions that include meeting (date), action, owner, and status/update to monitor these actions. However, we found that the section does not include completion dates for actions, and not all fields are consistently completed. Additionally, we noted that the minutes from the Staff Wellbeing Group meetings, which occur every two months, have a missing summary of issues to be reported or escalated to the Health, Safety, and Wellbeing (HSWB) Committee.	EFFECTIVNESS AND DESIGN
IMPLICATION	**SIGNIFICANCE**
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.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. 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.	N/A	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
2. 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.	N/A	As above.	N/A
3. Any issues to be escalated to the Health, Safety, and Wellbeing committee should be clearly summarised in all Staff Wellbeing Group minutes of meetings.	N/A	As above.	N/A

DETAILED FINDINGS

RISK: THE COLLEGE MAY NOT HAVE A CLEAR GOVERNANCE STRUCTURE FOR DELIVERING AND REPORTING ON WELLBEING.

FINDING 6 – PROMOTING ATTENDANCE TRAINING	TYPE
It is important that manager training aligns with relevant staff wellbeing policies and is tracked and reported clearly and promptly. When training matches policies, managers apply procedures consistently, ensuring staff receive fair and timely support. UHI Inverness has a Promoting Attendance Policy and managers receive training through the Promoting Attendance Training. We found discrepancies between the training and the Policy. The training defines short-term absence as 'two weeks or less' for stress/anxiety and 'four weeks or less' for other reasons, while long-term absence is 'more than two weeks' and 'more than four weeks'. The Policy, however, defines short-term as 'less than two weeks' and 'less than four weeks', and long-term absence as 'two weeks or more' and 'four weeks or more'. Additionally, the training also omits the Policy requirement for employees to provide work-related updates during long-term absence reviews. Furthermore, we noted that the training is delivered via workshops but currently does not have clear due dates, with timing still under consideration, as advised by management.	EFFECTIVNESS AND DESIGN
IMPLICATION	**SIGNIFICANCE**
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.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that: 1. The training information is updated to align with the Promoting Attendance Policy.	HRBP	UPDATED.	28/01/2026
2. 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.	HRBP/PD	AGREE.	End AY.

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OBSERVATIONS

OBSERVATIONS

OBSERVATION 1 – SALARY ADVANCE SCHEME REVIEW PERIOD
The Salary Advance Scheme document states it is 'reviewed regularly by EMT' but does not clarify how regular this is, i.e. monthly, quarterly, annually.
OBSERVATION 2 – PROMOTING ATTENDANCE POLICY
According to the version control, the Promoting Attendance Policy is scheduled for review in March 2025, which is over eight years after the previous review by an HR manager on 20 December 2016. This exceeds the maximum interval of three years between reviews as stated in the Policy. Review of the policy was not confirmed due to the timing of the audit as the evidence was provided on 21 February 2025.
OBSERVATION 3 – STAFF SURVEY
We conducted a staff survey to understand staff awareness and experience of wellbeing policies and initiatives. Only 3 of the 8 staff (37.5%) surveyed provided a response. The survey highlighted consistent awareness of the Employee Assistance Program (EAP) – Optima Health, which provides confidential support calls, but revealed communication and confidence gaps in relation to awareness and understanding of the other wellbeing resources available. One staff member was only aware of the EAP and staff development days, unaware of the Occupational Health and Able Futures resources, and a separate employee showed no awareness of the staff wellbeing workshops available. While one staff member recognised strong existing structures, one employee believed this could be improved via a wellbeing drop-in session, and one employee called for clearer, more targeted support and better awareness of wellbeing resources.

APPENDICES

APPENDIX I: BACKGROUND

In accordance with the 2024-25 Internal Audit Plan, Internal Audit undertook a review of staff wellbeing within Inverness College. The College established a Staff Wellbeing Group in 2020 to support the shift to remote work during COVID. The group included the Principal, departmental managers, and volunteer staff from academic and professional services, met every two months, and reported to the Health, Safety and Wellbeing Committee, which met quarterly.

The Staff Wellbeing Group, in conjunction with HR, created a standalone Staff Wellbeing Policy and Guidance through the College approval process, which was reviewed by the Policy and Procedure Review Panel (PPRP) and approved by the Board of Management. The Staff Wellbeing Policy covers roles and responsibilities, promotes wellbeing initiatives and sets out how the College supports a healthy working environment. The Staff Wellbeing Guidance supports the Policy, describing wellbeing initiatives (such as Optima Health and Able Futures) and advises on stress management and referrals. There is also a Promoting Attendance Policy and Procedure covering absence notification, short- and long-term absence management, return-to-work steps and occupational health referrals. Additionally, the Special Leave Policy and Procedure cover types of leave, conditions, and the application process. Furthermore, there is a Salary Advance Scheme in place to grant staff salary advances of up to one month's basic net salary for financial assistance, with a cap of £10000 in a 12-month period.

In June 2024, EMT approved supporting guidance after consultation with staff and union colleagues through the Joint Consultation Committee. The PPRP approved both the Staff Wellbeing Guidance and Policy. Policies are reviewed every three years, with earlier reviews considered where needed. There is also a Promoting Attendance Procedure on the HR SharePoint, within a wellbeing sub-folder, and it was communicated to staff via 'Wee Connect'.

The College uses a dedicated HR SharePoint and a decicated Staff Wellbeing Sharepoint to host staff wellbeing information, policies and guidance, accessible to all staff. 'Wee Connect' provides weekly updates and signposts to new and revised staff wellbeing policies. The Staff Wellbeing site follows the structure of the 8 pillars of wellbeing and is the output of a project from the Staff Wellbeing Group. There is also an Employee Assistance Programme in place which offers mental health support and wellbeing guidance, this includes a confidential phone line, access to confidential wellbeing and counselling practitioners and guidance amongst a variety of matters such as advice for carers, and guidance on financial stress. The University additionally provides financial support options, including a salary advance scheme.

Staff wellbeing materials are distributed to staff via a HR SharePoint and 'Wee Connect' communications and staff wellbeing workshops have been utilised with inconsistent frequency. The most recent ad-hoc all-staff wellbeing survey was carried out in 2020, with questions related to 'working from home'. The College additionally used ad-hoc pulse surveys and topic-specific surveys on topics such as stress, no smoking zones, and campus fitness classes. Managers and staff use the Health and Wellbeing Risk Assessments to identify and address issues related to staff wellbeing, agree actions and assign owners and due dates ensuring accountability and resolution of the issues.

The College's HR Team provides quarterly KPI reporting to the Executive Management Team (EMT) and the Board on matters such as starters, leavers, turnover, and absences. For absences, HR works with line managers to support staff, conduct absence review meetings and offer occupational health advice. The Staff Wellbeing Group meets every two months and escalates issues to the Health, Safety and Wellbeing Committee which meets quarterly.

In terms of training, there is induction training that directs staff to Student Services, and the HR SharePoint for staff wellbeing resources. Staff conference and development days, made up of two annual development days along with an individual day for each team which can be utilised as workshops, also include staff wellbeing content and workshops.

The Professional Development Team tracks and monitors manager training modules which include Promoting Attendance, iHasco core training, and optional role-specific modules. The iHasco training relating to staff wellbeing was reported to the Health Safety and Wellbeing Committee on a quarterly basis.

The College has in place several staff wellbeing initiatives. These include Optima Health, which provides guidance materials, Able Futures, offering confidential one-to-one support for up to nine months, and NHS Highland's Occupational Health and Wellbeing, accessible via manager referrals or through pre-employment health questionnaires. These services come with defined forms, Service Level Agreements (SLAs), and Key Performance Indicators (KPIs).

APPENDIX II: DEFINITIONS

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

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

APPENDIX III: TERMS OF REFERENCE

EXTRACT FROM TERMS OF REFERENCE
PURPOSE
The purpose of this review is to provide assurance over the design and operational effectiveness of the key controls in relation to staff wellbeing in the following areas: • Policies and practices • Referral procedures • Staff engagement • Support and discussion framework • Governance and training
KEY RISKS
1. The College may not have clear and practicable policies and practices in place for the wellbeing of staff. 2. The College may not have a referral procedure in place. 3. The College may not encourage staff to be open about their mental health and wellbeing. 4. There may not be effective arrangements in place to manage absence and return to work. 5. A framework may not have been established which allows for support and discussion around performance, wellbeing and development. 6. The College may not have a clear governance structure for delivering and reporting on wellbeing. 7. The College may not have appropriately trained managers.
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	AUDIT LEAD
NICOLA QUINN	HEAD OF HR	KEY CONTACT
CLAIRE FRASER	HR BUSINESS PARTNER	KEY CONTACT

APPENDIX V: LIMITATIONS AND RESPONSIBILITIES

MANAGEMENT RESPONSIBILITIES

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

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

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

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

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

LIMITATIONS

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

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

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

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

FOR MORE INFORMATION:

CLAIRE ROBERTSON, DIRECTOR AND HEAD OF RISK ADVISORY SERVICES – SCOTLAND

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INVERNESS COLLEGE
INCIDENTS MANAGEMENT
INTERNAL AUDIT - DRAFT REPORT

FEBRUARY 2026

LEVEL OF ASSURANCE:	
DESIGN	MODERATE
EFFECTIVENESS	MODERATE

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CONTENTS

DISTRIBUTION LIST		
FOR ACTION	GEORGIE PARKER	VICE PRINCIPAL
	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:	TBC
FINAL REPORT ISSUED:	TBC

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	5
L	2	2
TOTAL NUMBER OF FINDINGS: 4		7

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 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 and two of low 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. Additionally, evidence of completion for Duty Manager Training was not provided. 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. Finally, there is an absence of a formal action plan for implementing security recommendations.

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 named 'Policies and Procedures' on the staff intranet, accessible by the safeguarding team, containing relevant policies and forms. Access to this folder is restricted to specific roles, ensuring confidentiality.
- The College has a policy for new students related to safeguarding, which involves joint risk assessments with Police Scotland or the National Health Service (NHS) before enrolment. 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 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 (23%) , four incidents had no suitable follow-up actions, including issues with outdated camera equipment that were not addressed, highlighting gaps in security and incident management.
- **Incidents Management Training Programmes:** The College's incident management training programme includes Duty Manager Training for all 50 duty managers, but evidence of completion for the 2024-25 training was not provided. Additionally, 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.
- **Enhancing Preparedness and Compliance: Addressing Security Recommendations:** Despite Police Scotland's engagement and recommendations on security vulnerabilities, the College does not maintain an action plan for timely implementation.
- **Absence of Formal Action Plan Process for Incident Management:** We found that the Health, Safety & Wellbeing Committee (HSWC) conducts quarterly reviews to monitor and report health and safety incidents across relevant departments. However, we noted that there is no process in place to maintain formal and regular action plans to address underlying issues related to incidents.

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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 A'CCB65 A15 04-02-25_Redacted'* 2. *For the sample reference number 'ACCB91 A310 14-01-25_Redacted'* Additionally, for four (23%) out of 17 incidents sampled, there were no suitable follow-up actions recorded on the system: 1. *ACCB91-A309 06-01-25* 2. *ACCB97 A1 03-12-24_Redacted, the note on the system mentioned that 'CCTV footage was reviewed but was not clear enough to identify the student, likely due to outdated camera equipment. A task was set to review the footage by 10 December 2024, but the images remained insufficient for identification.' However, we noted that the absence of follow-up on the outdated camera equipment issue is concerning, as it leaves gaps in security and incident management. Upgrading the equipment and establishing protocols for handling unclear footage would help prevent similar occurrences in the future.* 3. *ACCB113-A2 26-02-25, and* 4. *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 and outdated security equipment may compromise safety and security, potentially resulting in reputational damage and regulatory scrutiny.	MEDIUM

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 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.			
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.			

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. We noted that the training programme for incident management includes Duty Manager Training for all 50 duty managers within the College, 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. However, we were not provided with evidence of completion for the Duty Manager training conducted in 2024-25 to verify if staff responsible for incident management are suitably trained and aware of the timescales and information to be retained. 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 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.	MEDIUM

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
We recommend that the College should ensure robust tracking the completion of Duty Manager training and maintaining records of training completion.			

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.			
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.			

DETAILED FINDINGS

RISK: 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.

FINDING 3 - ENHANCING PREPAREDNESS AND COMPLIANCE: ADDRESSING SECURITY RECOMMENDATIONS	TYPE
It is important that the College thoroughly evaluates the potential changes required due to the Terrorism (Protection of Premises) Act 2025 to prevent inadequate campus operations, safety measures, and insufficient adjustments to policies and procedures. Regarding Police Scotland's engagement with the College, we noted that several meetings and visits took place, including the Counter Terrorism Security Advisor (CTSA) Monthly Bridge call, where discussions covered the current terror threat, local concerns, and government guidance. On 17 August 2023, Police Scotland's Prevention and Interventions/Architectural Liaison Officer provided feedback to the College, identifying security vulnerabilities and recommending signage and access control measures. However, the College currently lacks a process to maintain an action plan, which is crucial for implementing these recommendations within the expected timeframe.	DESIGN AND EFFECTIVENESS 
IMPLICATION	**SIGNIFICANCE**
Without a process to maintain an action plan for the recommendations provided by Police Scotland, the College may be vulnerable to potential security incidents.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
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.			

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 4 - ABSENCE OF FORMAL ACTION PLAN PROCESS FOR INCIDENT MANAGEMENT	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. We found that the Health, Safety & Wellbeing Committee (HSWC) conducts quarterly reviews to monitor and report health and safety incidents across relevant departments such as Business and Creative Industries, Care, Arts, Sport & Humanities, Construction & Engineering, and Estates. However, we noted that there is no process in place, in line with best practice, to maintain formal action plans on a quarterly basis to address underlying issues related to incidents. The Committee should then have oversight of the suitability of these actions and ensure they are completed.	DESIGN
IMPLICATION	**SIGNIFICANCE**
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.	LOW

RECOMMENDATIONS	ACTION OWNER	MANAGEMENT RESPONSE	COMPLETION DATE
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.			

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 Lead. 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 safeguarding committee 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 Safeguarding department 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 2021-2025. 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 the Curriculum Leader, manages safeguarding concerns with five additional staff members. 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 the safeguarding team, containing relevant policies and forms. Staff can report concerns via email to the safeguarding mailbox, 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 admin support, with confidential matters handled by three staff members.

The College has a policy for new students related to safeguarding, involving joint risk assessments with police or the National Health Service (NHS) before enrolment. The National Prevent Referral Form is used to report concerns about individuals at risk of radicalisation, with responses provided where possible.

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, and disciplinary actions are reviewed for potential sharing.

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 Progression Manager, who maintains disciplinary policies and procedures. The code of conduct is accessible on SharePoint, and the Progression Manager tracks the disciplinary process to ensure completion. Disciplinary actions must be completed within ten working days, with serious incidents handled by Senior Management. The College uses the ASSNET system for recording incidents, with a process for tracking disciplinary actions, investigation outcomes, and incident closure.

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 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, 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 Progression Manager and Team, with oversight by a short-life working group (SLWG) set up to manage low-level vandalism and misconduct. Recommendations from this group are 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. 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.

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 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	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

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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UHI Inverness

2025/26 Internal Audit Progress Report

February 2026

Progress Update

The following table summarises the progress against the 2025/26 Internal Audit Plan.

Area	Planned Days	Status	Provisional start date for visit	Provisional date for issue of Draft Report	Date for reporting to Audit Committee
Mandatory Funding Audits	12	Complete	Complete	Complete	Complete
Budgetary & Financial Reporting	6	Complete	Complete	6 March 2026	2 June 2026
Staff Recruitment & Retention	6	On track	30 March 2026	17 April 2026	
Follow Up Review	3				
Student Recruitment	6	On track	1 June 2026	19 June 2026	September 2026
Freedom of Information	5	On track			
Audit Management	4	Notes: The Annual Report for 2025/26 will be presented to the September 2026 Audit Committee.			
Total	**42**				

Performance Measures
AY: 2025-2026

Performance Measures- EMT & Board of Management

Measures - Linked to Profile and Actual sheets

AY Start	01 Aug 2025
Today	24 Feb 2026
Period Month	January
No.Periods YTD	6

Key:

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

	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
1	HE Active applications (next AY - Measure from Dec - Jul)	Monthly	1,418	1,400.0	1,200	1,093	**91.1%**	1,145	-52
2	FE Active applications (next AY - Measure from Dec - Jul)	Monthly	2194	2,300.0	400	543	**135.8%**	435	108
3	FE Credits	Monthly	27085	26,442	24,000	26,371	**109.9%**	26,374	-3
4	Apprenticeship starts	Monthly	409	382	236	295	**125.0%**	243	52
5	Apprentices in Learning (average in year)	Monthly	705	675	675	746	**110.5%**	677	69
6	Apprenticeship Income (excluding T&A)	Monthly	£1,398,960	£1,300,000	£696,000	£909,864	**130.7%**	£747,891	£161,973
8	Commercial Short Course Income	Monthly	£72,508	£75,000	£37,500	£85,545	**228.1%**	£26,989	£58,556
9	HE enrolments (head count)	Monthly	2,074	2,100	2,000	2,167	**108.4%**	2,092	75
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	1,400.0	1,446.9	**103.4%**	1286	161
13	GA Programmes - New Enrolments	Monthly	191	130	130	115.0	**88.5%**	200	-85
14	Senior Phase Enrolments	Annual	574	564	564	542.0	96.1%	574	-32
18	Early Satisfaction & Engagement Survey (ESES)	Annual	95.7%	96%	96.0%	96.0%	**100.0%**	95.70%	0.30%
23	ESES % Response Rate	Annual	61.0%	60%	60.0%	63.0%	**105.0%**	61.0%	2.00%
32	Modern Apprenticeship successful outcomes (contract year)	Monthly	63.2%	75%	75.0%	68.5%	91.3%	65.70%	2.80%
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 workir	Monthly	98.0%	97.0%	97.0%	100%	**102.9%**	99%	0.83%
36	Learning Support appt offered for within 6 - 20 working days	Monthly	100.0%	97.0%	97.0%	86%	**88.8%**	100%	-13.83%
37	PLSP - completed and accepted by student (within 10 days of meeting)	Monthly	-	85.0%	85.0%	81.5%	95.9%		

40	Sickness levels	Quarterly	3.63%	2.98%	3.04%	2.60%	**85.5%**	4.10%		-1.50%
41	- Short Term	Quarterly	1.53%			1.31%		1.65%		-0.34%
42	- Long Term	Quarterly	2.10%			1.29%		2.45%		-1.16%
43	% Staff turnover	Quarterly	2.35%	2.45%	2.64%	3.95%	**149.6%**	1.90%		2.05%
44	PRD completion - full or review	Quarterly	44%	75%	125.0%	66%	**52.6%**	68%		-2.20%
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	80	81	101.25%	80		1
48	Number of RIDDOR reportable accidents and illness	Monthly	5		2	4	**2**	4		
49	% of staff completed mandatory IHASCO (H&S) Trg	Quarterly	84%	80%	80.0%	80.0%	**99.9%**	78%		1.95%
59	Room Occupancy - Frequency %	Monthly	40.2%	38.0%	37.8%	33.9%	89.5%	40%		-6.14%
60	CO2 Emissions on Utilities (gross) Tonnes	Monthly	561	532	286	280	97.8%	301		-21
61	CO2 Emissions on Waste - Tonnes	Quarterly	0.821	0.780	0.380	0.262	68.8%	0.4		-0.14
62	Estates reactive task completion rate %	Monthly	95%	96%	96%	96.0%	100.0%	95%		1.0%
63	GTFM % reactive task completion rate	Monthly	95%	96%	96%	96.7%	**100.7%**	95%		1.7%
64	Total % of Capital expenditure budget committed (Aug - March)	Monthly	100%	100%	75.0%	100.0%	133.3%	100%		

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Subject/Title:	Strategic Planning 2026-27
Author: [Name and Job title]	Ludka Orlowska-Kowal Governance Officer
Meeting:	Audit Committee
Meeting Date:	03 March 2026
Date Paper prepared:	24 February 2026
Brief Executive Summary of the paper:	This paper provides the Board of Management with an update on agreed and proposed actions at the Board Away Day on 04/02/2026. Following documents need reviewing: • Terms of Reference of the Audit Committee • Standing Orders • Scheme of Delegation • Code of Good Governance 2025-26 The Committee are asked to review and propose changes to the above documents that would reflect the actual current scope and remit of the Audit Committee.
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

The Committee is asked to review and propose changes to the attached documents that would reflect the actual current scope and remit of the Audit Committee.

Executive Summary

The Chair of the Board requested at the last Board Away Day in February for all Committees to review the current scope and remit of the individual Committees and reflect any changes in the governance documents. A Strategic Day will take place in May 2026, date/time tbc, to review all feedback received and propose amendments to the governance documents.

The Audit Committee is asked to review the attached documents and provide feedback to the Governance Officer during and after the meeting. Sections related to the Audit Committee had been highlighted with pages listed below.

Progress update:

- Item 08.a - Terms of Reference of the Audit Committee
- Item 08.b – Standing Orders – page 4 (page 109 of the combined document)
- Item 08.c – Scheme of Delegation - Pages 6 & 7 (pages 139 & 140 of the combined document)
- Item 08.d – Code of Good Governance 2025/26 – pages 7, 8 & 9 (pages 155, 136 & 157 of the combined document)

The Audit Committee members are asked to provide verbal and/or written feedback in regard to the documents above and the highlighted sections by Tuesday 31st March 2026. All feedback gathered will be shared with the Committee Chair in early April 2026 and then will be presented at the Strategic Day in May 2026.

Any changes within the governance documents relating to the Audit Committee will be presented to the Committee at the June meeting for consideration and approval. Once approved by the Committee the updated documents will be presented to the Board of Management for comments and approval.

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Audit Committee
Terms of Reference

Membership

Not less than 5 members of the Board of Management.

At least one member of the Committee should have recent and relevant experience in finance, accounting or auditing.

Co-opted members can sit on the Committee.

Board members not eligible for appointment are the Chair of the Board, the Principal, members elected by the teaching and non-teaching staff of the college and the persons appointed by the Students Association.

No member of the Finance and General Purposes Committee shall also be amember of the Audit Committee

The Chair of the Board and the Principal may be invited to attend meetings.

The Vice Chair of the Committee or another nominated member of the Committee, may deputise in the absence of the Chair.

A member of the Executive Management Team may deputise in the Principal's absence.

Membership of the Committee should satisfy the requirements of the SFC Code of Audit Practice, and/or other appropriate guidance, as may be directed by the Board of Management.

Quorum

Three members of the Committee entitled to vote upon the items before the meeting.

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Frequency of Meetings

The Committee will meet no less than four times each year.

Remit

The Committee has overall strategic responsibility for developing, monitoring and enhancing the following aspects of the College's operations, and to advise the Board appropriately on:

1. The comprehensiveness, reliability and integrity of assurance of the governance and management of the College.
2. The comprehensiveness, reliability and integrity of assurance of the risk management and business continuity of the College.
3. The comprehensiveness, reliability and integrity of the College's financial management and other internal control and management systems.
4. The effectiveness of arrangements for safeguarding the assets of the College and the public funds at its disposal.
5. The economy, efficiency and effectiveness of the College's activities, including value for money.
6. The effectiveness of the corporate governance and conduct of theCollege operations.
7. All aspects of the provision of an effective Internal audit service.
8. All aspects of the provision of an effective External audit service
9. Public interest disclosure (whistle-blowing) arrangements.

Specifically, the Audit Committee shall:

1. Monitor, develop, enhance and review the contents of the risk register maintained by the College.
2. Receive, consider and discuss the reports submitted by the College's Internal Auditors and progress reports from College Management on the Internal Audit recommendations.
3. Jointly with the Board's Finance and General Purposes Committee support, challenge and enhance the development and implementation of the annual report of the College's external auditors and the associated College financial statements on which that report is based.

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4. Support, challenge and enhance the development of an annual report for the Board of Management which once approved will be shared with the Head of Internal Audit at University of the Highlands and Islands.
5. Sit privately without any non-members present for all or part of the meeting if it so decides. The Committee will meet privately with the internal and external auditors at least annually.
6. The Audit Committee shall conduct its business in accordance with the requirements of any guidance and/ or codes of practice issued from time to time by the SFC and/ or any other relevant statutory or regulatory authority, as directed by the Board of Management.
7. The Audit Committee will observe that the University of the Highlands and Islands are provided with appropriate updates and access to all papers and business to ensure that they are appraised of all aspects being monitored by the Committee.

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Standing Orders of the Board of Management of Inverness College UHI

Lead Officer	Chair of the Board of Management
Review Officer	Governance Officer to the Board of Management
Date first approved by BoM	Mar 2017
First Review Date	Mar 2020
Date review approved by BoM	Mar 2020
Next Review Date	June 2025
Date review approved by BoM	October 2025
	October 2028
Equality impact assessment	N/A
Further information (where relevant)	

Reviewer	Date	Review Action/Impact
Gov Officer & Information Development Officer	16 September 2024	Amendments made: formatting, new college logo and changes made to role titles only.
Gov Officer	18 November 2024	Trade union information added to 3.2 & 3.3 as per CDN guidelines.

Gov Officer	24 June 2025	Section 3.2 updated to clarify attendance roles for staff and students when attending Committee and Board meetings.
Gov Officer	07 Oct 2025	All Articles of Governance approved by the Board of Management on Tuesday 7th October 2025.

Preamble

Paragraph 11 of Schedule 2 to the Further and Higher Education (Scotland) Act 1992 "Schedule 2", a Board may regulate its own proceedings and those of any Committee appointed by it.

The purpose of these Standing Orders is to ensure the orderly and effective conduct of the meetings of the Board of Management ("the Board") and of Committees of the Board ("Committees"). They shall apply to all meetings of the Board and its Committees and shall, subject to a resolution by the Board for their suspension, remain in force unless and until they are varied or revoked as hereinafter provided.

The Standing Orders were adopted by the Board on 24th June 2025 and come into effect on that date. They replace all other Standing Orders previously adopted by the Board, which are hereby revoked.

1 Meetings of the Board and Committees

1.1 The Board shall hold at least four Board and Committee meetings within each academic year for the performance of its functions and at such times, places and frequency as the Board determines.

1.2 The Governance Officer shall produce an annual programme of meetings which shall be presented to the Board for approval.

1.3 Extraordinary meetings of the Board and Committees may be called on the instructions of the Chair or by agreement by a majority of the members entitled to vote at such a meeting.

1.4 Board and Committee meetings shall be called giving no less than five working days' notice. Where extraordinary meetings are called and, exceptionally, due to the urgency of the business five working days' notice cannot be given, notice will be given as soon as is reasonably practicable and giving no less than 2 working days' notice.

2 Quorum and Voting Rights

2.1 The quorum for a meeting of the Board shall be no less than one half of the members entitled to vote at such a meeting or for a meeting of a Committee, no less than three of the members entitled to vote at such a meeting.

2.2 If a meeting does not have a quorum of members present 15 minutes after its scheduled start time or falls below having a quorum of members present part

way through, the Chair must either adjourn the meeting to a new date and time, or proceed with the agenda, ensuring that any decisions are taken by members at the next meeting of the Committee or Board, whichever is the sooner.

2.3 If the Chair of the Board or Committee is not present at any meeting, the Vice Chair (where this office exists) shall assume that role. Where a Vice Chair is not available, members shall elect from amongst themselves a Board member who is entitled to vote as the Chair of that meeting.

2.5 A question on which a vote is required shall be determined by a majority of votes of the members of the Board present and voting on the question and, in the case of an equal division of votes, the Chair of the meeting shall have a second or casting vote.

2.6 Only matters identified on the agenda as requiring a decision shall, if consensus is not possible, be decided by vote.

2.7 In exceptional circumstances, such as for matters requiring urgent attention, and when the approval of the Board or Committee is required, decisions can be taken, with the prior agreement of the Chair, by written procedure. That is, decisions can be taken without calling a physical meeting of the Board or Committee. In such circumstances for a decision to be deemed to be taken:

- the Governance Officer shall email all Board or Committee Members outlining the decision required, together with relevant briefing information
- a quorum, as defined in 2.1 of these Standing Orders, must have replied to the email
- the Governance Officer shall ensure that a deadline for response is clearly specified, and Board members shall endeavour to respond within that timeframe
- any decisions taken in this way shall be homologated at the next relevant meeting of the Board or Committee.

2.8 Where a proposal is amended, voting will take place on the amendment against the proposal, or the series of amendments, in the order of the last amendment first, until a single amendment is put against the proposal. Thereafter, voting will take place upon the proposal amended. All members have a single vote.

2.9 No-one shall be entitled to ender his or her dissent from any decision, except at the meeting at which it has been passed; but any member not present may at the next meeting have his or her dissent recorded.

2.10 No proposal nor any amendment to any such proposal, shall be moved if it involves a reconsideration of any question or proposal which has been decided or adopted by the Board at any time within the preceding six months unless:

- it is moved by the Chair
- in addition to being signed by the mover, it is signed by at least one third of the total members of the Board.

3 Attendance at Board and Sub Committee Meetings

3.1 The Governance Officer shall have oversight of all Board and Committee meetings in order to ensure meetings are conducted in accordance with legislation, terms and conditions of grant (including in relation to its Financial Memorandum with UHI as the Regional Strategic Body, the Scottish Public Finance Manual, the Code of Good Governance for Scotland's Colleges), the Board's Scheme of Delegation and these Standing Orders, and in order to ensure a record is kept of proceedings.

3.2 It shall be a matter for the Board or Committee to determine which College employees and students (with the exception of the staff, student and trade union Board Members who shall be invited to attend all meetings of the Board and Committees they are a member of) or other individuals should be invited to attend any Board or Committee meeting or any part of it in an advisory capacity in order to ensure that the Board or Committee has the required advice to fulfil its functions. It will be noted that no staff or students will attend the Audit Committee meetings. Where invited to do so by the Chair at the meeting, these employees or individuals may contribute to the discussion but may not vote or contribute to any decision being taken.

3.3 The Board may decide to meet privately without the Principal or any Executive Management Team members being present. In these circumstances the Governance Officer to the Board shall be present at the meeting unless requested by the Chair to leave. Where the Governance Officer to the Board is requested to leave, there must be a clear and specific reason for this recorded in the minutes and the Chair shall ensure that appropriate arrangements are made for recording the discussion and any decisions taken at the meeting in the minutes. Staff, trade union and Student Board members are permitted to attend such meetings unless they have a conflict of interest in relation to the matter being discussed.

4 Agenda

4.1 The Governance Officer in consultation with the Chair shall prepare the draft agenda. Other Board members may place an item or paper on the agenda for discussion by submitting this to the Governance Officer to the Board no later than 10 working days in advance of the meeting (except in the case of an extraordinary meeting where only the urgent business notified at the time the meeting was requested will be placed on the agenda). The Governance Officer shall ensure that all items placed on the agenda fall within the remit of the Board or Committee.

4.2 All matters for consideration by the Board or Committee shall be clearly identified on the draft agenda as to whether it is for decision, discussion or noting.

4.3 The order of business shall be:

- Apologies for absence
- Declarations of any Potential Conflicts of Interest in relation to any agenda items
- Approval of the minutes of the previous meeting
- Matters arising

- All other business with those items of business requiring a decision or discussion taking precedence over items of business for noting
- Date of the next meeting(s)

4.4 All business at Board and Committee meetings shall be conducted through the Chair by members indicating to the Chair that they wish to speak. The Chair shall be heard without interruption.

4.5 The Chair shall be responsible for the general conduct of the meeting to preserve order and to ensure that every member has the opportunity to contribute.

5 Board and Committee Papers

5.1 Board and Committee papers may be submitted by the Principal, a Board or Committee member, a member of the Executive Management Team or the Governance Officer to the Board.

5.2 The Governance Officer shall ensure the circulation of papers to Board or Committee members at least 5 working days prior to the meeting. Where this timescale is not possible, the Governance Officer shall advise members of this and advise of the reason for the delay and when papers might be expected.

5.3 The Governance Officer shall be responsible for ensuring that Board papers are timeously published on the College's website, with the exception of those papers which are marked confidential.

6 Minutes of Board and Committee Meetings

6.1 In addition to recording the decisions and basis of decisions of all business on the agenda, the minutes shall include a record of those members present and any individuals in attendance, for all or part of the meeting.

6.2 Draft minutes shall be prepared for the Chair's agreement normally within five working days of the meeting and shall be labelled "draft".

6.3 Once agreed by the Chair, minutes shall be circulated to members normally within ten working days of the meeting and shall be labelled "agreed for circulation".

6.4 The minutes shall be considered for approval by the Board or Committee at its next meeting and the Chair of the meeting shall thereafter sign the minute which shall be labelled "final version".

6.5 The Governance Officer shall be responsible for ensuring that a signed final version of the minutes is securely retained.

6.6 The Governance Officer shall be responsible for ensuring that the final version of the minutes of each Board and Committee meeting is timeously published on the College website.

6.7 In the event that extraordinary business is being transacted and additional meetings are being arranged, the timescales for preparing minutes shall be adjusted to ensure their availability for approval at the next meeting.

6.8 Where a Committee meets infrequently, draft minutes shall be circulated by email to all Members who will be required to confirm their approval or otherwise of the draft within eight weeks of the meeting having taken place. The meetings shall thereafter be confirmed by the Chair of the meeting, labelled as "final version" and signed as soon as is practicable.

6.9 All Committee minutes will be submitted to the Board for information at the next scheduled meeting of the Board, regardless of whether the minutes are labelled as draft, agreed for circulation or final version.

7 Establishment of Committees and Sub-Committees

7.1 As provided for in Schedule 2, the Board may establish Committees, and a Committee may establish sub-committees. References in these standing Orders include sub-committees.

7.2 A Committee shall consist of at least five Board members appointed by the Board. One of these Members shall be elected as Chair of the Committee. The Board may also wish to elect a Vice Chair of each Committee.

7.3 Each Committee shall review its remit biennially unless there is an urgent matter to be considered and shall submit any proposed changes to the Board for approval.

8 Appointment of Vice Chair

A Vice Chair shall be appointed by the Board from amongst its members.

In the absence of the Chair, the Vice Chair shall have the authority the Chair would have under these Standing Orders.

9 Suspension of Standing Orders

These Standing Orders may be suspended when at least two-thirds of the members' present entitled to vote agree to such a motion.

Approved by the Board of Management – 7th October 2025

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Scheme of Delegation of the Board of Management of Inverness College UHI

Lead Officer	Chair of the Board of Management
Review Officer	Secretary to the Board of Management
Date first approved by BoM	Mar 2017
First Review Date	Mar 2020
Date review approved by BoM	March 2020
Date review approved by BoM	October 2025
Next Review Date	October 2028
Equality impact assessment	N/A
Further information (where relevant)	

Reviewer	Date	Review Action/Impact

Gov Officer & Information Development Officer	July 2025	To comply with the updated Code of Governance the whole document has been drafted anew. The new Code of Good Governance had been re-formatted in terms of sections listed and the previous Scheme of Delegation did not map correctly onto the new Code. No sections of the Scheme of Delegation have been removed but have been rearranged to mirror the updated Code document. Tracked document was confusing with too many sections moved; for clarity the Gov Officer & Information Development Officer decided to create a brand new document that includes all information form the previous document but has also taken the updated Code into consideration. The Secretary to the Board has been replaced with Governance Officer.

Preamble

UHI Inverness is at the heart of the community, serving the interests of the community, students, employers, governments and their agencies and other stakeholders.

Colleges receive substantial public funding and operate in an increasingly commercial and enterprising way. Boards are expected to innovate, pursue new opportunities and take measured risks in delivering what is best for their stakeholders.

It is right and proper that the highest standards of governance and propriety are expected of our board and those individuals who serve them.

Scotland's colleges have produced a Code of Good Governance which we endeavour to follow. It outlines the principles of good governance and promotes accountability and continuous improvement in how colleges are governed.

The role of the Board of Management is:

- to lead the college and set its strategic direction and values.
- ensure effective management and financial controls to support the student experience with a framework of public accountability and transparency.
- deliver high quality learning outcomes.

Key to the overall role of the Board is the leadership of the Chair, the support given to and by the Principal, and the frankness and openness of mind with which issues are discussed re tackled by all board members.

Individual board members have a duty at act on serious concerns about the governance of their body. Guidance is available in The Guide for Board Member in the College Sector.

Principles

Section A: Leadership and Strategy

- The Board is collectively responsible for setting, demonstrating and upholding the values and ethos of the organisation.
- Every board member must ensure they are familiar with, and their actions comply with the provisions of the board Code of Conduct.

- The principles of public life will be the basis of all decisions and behaviours of board members. They apply individually and collectively. The are:

  Duty/Public Service
  Selflessness
  Integrity
  Objectively
  Accountability and Stewardship
  Openness
  Honesty
  Leadership
  Respect

- The Board is responsible for determining the college's vision, strategic direction, educational character, values and ethos.
- The Board will develop and articulate a clear vision for the college. This will be a formally agreed statement of its aims and desired outcomes which will be sued as the basis for this overall strategy and planning process.
- The Board is responsible for formulating and agreeing strategy by identifying strategic priorities and providing direction within a structured planning framework.
- The Board will ensure effective engagement with all relevant stakeholders in the development of its outcome agreement and monitor performance in achieving the agreed outcomes.
- The Board will contribute constructively to the development of the outcome agreement led by the Regional Strategic Board (RSB) and support the RSB to monitor performance in achieving the agreed outcomes.
- The Board must ensure that a comprehensive performance measurement system is in place which is clearly linked to the regional strategic framework and identifies key performance indicators.
- The Board will demonstrate high levels of corporate social responsibility by ensuring it behaves ethically and contributes to economic development while seeking to improve the quality of life of the local community, society at large and its workforce.
- The Board will exercise its functions with a view to improving economic, cultural and social wellbeing in the locality of the college.

- The Board will provide leadership in equality and diversity.
- The Boad will seek to reflecting ins membership, the make-up of the community through offering maximum opportunity of membership to a range of potential members and removing potential barriers to membership, in partnership with the RSB (as appropriate).

Section B: Quality of the Student Experience

- The Board will have close regarding to the voice of its student and the quality of the student experience.
- The Board will lead by example in relation to openness, by ensuring that there is meaningful on-going engagement and dialogue with students, HISA, and as appropriate staff and trade unions in relation to the quality of the student experience.
- The Board must consider the outcome of student surveys and other student engagements and monito action plans that could impact on the quality of the student experience.
- The Board will have regard to the Framework for the Development of Strong and Effective College Students
- The Board will encourage a strong an autonomous student's association an ensure the students' association is adequately resourced.
- The Board will ensure the student's association operates in a fair and democratic manner and fulfils its responsibilities.
- The Board will review the written constitution of the HISA at least every five years.
- The Board will seek to foster good relationship and ensure it works in partnership with external bodies to enhance the student experience, including employability and the relevance of learning to meet industry needs.
- The Board will ensure appropriate mechanisms are in place for the effective oversight of the quality and inclusivity of the learning experience in the college.

Section C: Accountability

Accountability and Delegation

- The Board will ensure delivery of its agreed contribution to the region's outcome agreement.
- The Board will ensure it fulfils its statutory duties and other obligations on it and the terms and conditions of its grant are met.

- The Board will create and maintain a publicly disclose a current register of interests of all Board members.
- The Board will ensure its' decision making processes are transparent, properly informed, rigorous and timely and appropriate and effective systems of financial and operational control, quality, management of staff, risk assessment and management are established, monitored, continually improved and appropriately impact assessed.
- This includes:

  the prompt production, dissemination and online publication of board/committee agendas, minutes and papers to the public.

  Every board meeting and committee meeting will have a well-structured agenda circulated timeously in advance.

  all key records documenting decisions made by the Board and its sub-committees will be retained as corporate records.

  The quorum for each meeting will be set in line with good practice and preferably at 50%o or higher of non-executive members. When considering the quorum, the Chair may be considered as a non-executive member.

- As a minimum, the Board are required to have committees for Audit, Remuneration, Finance and Nominations/Appointments.
- The board will ensure every board committee has a specific member of the management team to provide objective, specialist advice to support it to discharge its remit, including explanation of the matters under discussion and the possible implications of different options.
- The Board will put in place procedures to ensure effective working relationships and constructive dialogue amongst the Board as a whole and ensure effective reporting and two-way communication takes place between the committees and the Board. The Board will ensure discussions and decision of every committee are accurately recorded and reported to the Board, no later than the next meeting of the Board.

Risk Management

- The Board is responsible for the overall management of risk and opportunity. It will set the risk appetite for the college and will ensure there is an appropriate balance between risk and opportunity, and this is communicated via the Principal to the college's management team.
- The Board will ensure sound risk management and internal control systems are in place and maintained. It will ensure there is a formal on-going process for identifying, reporting evaluating and managing the college's signification risks and review the effectiveness of risk management, business continuity planning and internal control systems.

Audit Committee

- The Audit Committee will support the Board and the Principal by reviewing the comprehensiveness, reliability and integrity of assurances including the college's governance, risk management and interna control framework. The Scottish Government Audit and Assurance Committee Handbook promotes the development of an assurance framework to aid the committee in fulfilling its role Audit and Assurance committee handbook
- The Audit Committees work is defined by its terms of reference. It will have engagement with internal and external auditors and must work with management and auditors to resolve any issues in relation to financial reporting.
- The Audit Committee will promptly pursue recommendation arising from audit reports and will monitor their implementation.
- The membership of the Audit Committee will not include the Board Chair, the Principal, nor executive members of the college management team. The majority of members will be non-executive. The role of the college executive is to attend meeting at the invitation of the committee Chair and to provide information for particular agenda items.
- The Audit Committee members will meet with the internal and external auditors without the executive team present at least annually.
- At least one member of the Audit Committee will have recent relevant financial or audit experience.

Renumeration Committee

- All members will undertake the on-line training module for Remuneration Committees provided by the College Development Network within one month of appointment.

- The Board will put in place a formal procedure for setting the remuneration of the Principal by a designated committee of non-executive members.
- The Board Chair cannot be the Chair of the Remuneration Committee (but they can be a member of it).

Financial and Institutional Sustainability

- The Board will ensure compliance with its Financial Memorandum either with the Scottish Funding Council (SFC) or the RSB depending on which body is funding it.
- The Board will ensure:
  funds are used economically, efficiently and effectively as possible:
  effective monitoring arrangements are in place;
  college staff report relevant financial matters to it.
- The Board will ensure all members are aware of their responsibilities under Chairty legislation and for complying with relevant provisions as set out by the Office of the Scottish Chairty Regulator Guidance and Good Practice for Chairty Trustees

Staff Governance

- The Board as the employer, is responsible for promoting positive employee relations and for ensuring effective partnership between recognised trade unions and management.
- The Board will comply with the nationally agreed college sector Staff Governance Standard
- The Board will comply with collective agreements placed on it through national collective bargaining for colleges.

Section D: Effectiveness

The Board Chair

- The chair is responsible for leadership of the board and ensuring its effectiveness in all aspects of its role. The chair is responsible for setting the boards' agenda an ensuring that adequate time is available for discussion of all agenda items, particularly strategic issues. The chair must promote a culture of openness and debate by:
  - Encouraging the effective contribution of all board members:

  - Fostering constructive challenge and support to the Principal, executive team and fellow board members;
  - Effective team-working;
  - Positive relations between board members.
- The chair will engage with the Principal and the Governance Officer in a manner which is both constructive and effective.
- The Board and it's committees will have the appropriate balance of skills, experience, independence an knowledge of the college to enable them to discharge their respective duties and responsibilities effectively.

Senior Independent Member

- The Board must appoint one of the non-executive member to be the Senior Independent Member to provide a sounding board for the Chair and to serve as an intermediary for the Principal, other board members and the Governance Officer when necessary.
- The Senior Independent Member will also be available where contact through the normal channels of Chair, Principal or Governance Officer has failed to resolve an issue or for which such contact is inappropriate.
- The Senior Independent Member is responsible for holding annual meeting with Baord members, without the Chair to appraise the Chair's performance and provide the Chair with relevant feedback. Further guidance on the role can be found in The Guide for Board Members in the College Sector

Board Members

- Each board member is collectively responsible and accountable for all board decisions. Board members must make decision in the best interests of the college and as a whole rather than selectively or in the interest of a particular group.
- Staff and student board members are full board members and bring essential and unique, skills, knowledge and experience to the board. They must not be excluded from board business unless there is a clear conflict of interest in common with all board members.
- All board members , as charity trustees, including staff and student board members, have legal duties and responsibilities under the Charities Act 2005. This includes registering any personal interests that could be seen as conflicting with the interests of the college. The objective test for judging if there is a conflict of interest is:
  "…..whether a member of the public, with knowledge of the relevant facts, would

reasonably regard the interest as so significant that it is likely to prejudice your decision making in your role as a member of a public body"

Principal and Chief Executive

- The Board will appoint the Principal, as Chief Executive of the college, securing approval for the appointment and terms and conditions of the appointment from the RSB if necessary.
- The Board will ensure there is an open and transparent recruitment process for the appointment. Students and staff will have an opportunity to contribute to the recruitment process.
- The Board will delegate to the Principal, as Chief Executive, authority for the academic, corporate, financial, estate and human resource management of the college, and will ensure the establishment of such management functions are undertaken by and under the authority of the Principal.
- The Board will ensure there is a clear process in place to set and agree personal performance measures of the Principal. This process will seek the views of students and staff. The Chair on behalf of the Board, will monitor, review and record the Principal's performance, at least annually, against the agree performance measures.
- The Principal as a Board member shares responsibility for good governance with the Chair and all other members of the Board, supported by the Governance Officer. The Principal also enables good governance through supporting effective communication and interaction between the Board and the rest of the college including staff and students.
- The Board will provide a constructive challenge to the Principal and the executive team and hold them to account.

Governance Officer

- The Board will appoint a Governance professional who is responsible to it and reports directly to the Chair in their governance professional capacity. The Governance professional may be a member of the senior management team in their governance professional capacity, but they cannot hold any other senior management team position at the same time. The appointment and removal of the governance professional is a decision for the Board.

- All Board members will have access to the Governance Officer who has an important role in advising the Board, the committees and individual Board members and supporting good governance.
- The distinctive governance professional role includes:
  facilitating good governance and advising board members on:
  the proper exercise of their own powers, including in relation to relevant legislation
  The Boards's compliance with its Financial Memorandum, the Code of Good Governance, its Standing Orders and Scheme of Delegation
  Their behaviour and conduct in relation to the Board's Code of Conduct.
- Providing clear advice to the Chair and the Board/committees on any concerns the Governance Officer may have that Board members have not been given:

  sufficient information
  information in an appropriate form
  sufficient time to monitor, scrutinise or make informed and rigorous decisions in an open and transparent way.

- The Governance Officer is responsible for attending all Board and Committee meetings. Where they are unable to attend, they retain overall responsibility and will arrange cover with a person who is fully able to discharge the role effectively.
- The Governance Officer has the unambiguous right to speak at Board and Committee meeting to convey any concerns they may have about governance. This extends to someone substituting for the Governance Officer.
- The Governance Officer is also responsible for reporting any unresolved concerns about the governance of the body to the relevant funding body e.g. SFC or the RSB.
- The Board will ensure the Governance Officer:
  has suitable skills, knowledge and behaviours to carry out their role effectively
  Receives appropriate induction, and if new to the role, is mentored by a more experienced governance professional for at least their first year.
  has adequate time and resources available to undertake their role effectively.
- The Board will ensure arrangements are in place to deal with a Governance Officer's potential or real conflict of interest.

Board Member Appointment, Induction and Training

- The Board is responsible for ensuring appropriate arrangements are in place for the conduct of student elections and nominations, and elections and nominations of staff members to the Board. The Board will have regard to the current ministerial guides on the appointments.
- The Chair will ensure that new Board members receive a formal induction on joining the board, tailored in accordance with the individual and collective needs. The Governance Officer will support the Chair in the provision of relevant induction for new Board members.
- The Board will ensure all Board members undertake appropriate training and development in respect of their governance role. The Governance Officer will support the Chair in the provision of relevant opportunities which will be tailored to meet Board members skills and needs. The Governance Officer will retain records of all development activities for Board members including the Chair.
- The Board will ensure that all new committee members will receive a committee induction and have their specific training needs assessed and met.

Board Evaluation

- The Board will ensure appropriate mechanisms are in place to evidence extensions to the term of office of board appointments.
- The Board will put in place an effective, robust self-evaluation process to ensure its effectiveness is reviewed annually. This will be an externally facilitated review, and the Board will determine the timing for this.
- The Board will share its self-evaluation (including externally facilitated evaluation) and Board development plan (including review on previous year's plan) with its funding body (SFC or RSB) and publish them on-line.
- The Board will agree a process for evaluation the effectiveness of the Board Chair and the Committee Chairs. The evaluation of the Board Chair will normally be led by the Senior Independent member.
- The Board will ensure all Board members are subject to appraisal of their performance, conducted at least annually, normally led by the Chair of the Board.
- The performance of the college Chair will also be evaluated by the RSB, as they are appointed by the University Court and are accountable to them.

Section E: Relationships and Collaboration

Partnership Working

- The Board will work in partnership to secure the coherent provision of high quality fundable further and higher education in their localities.
- The Board will ensure effective consultation, local and regional planning will follow the principles of effective collaborative working: mutual respect; trust and working towards commonly agreed outcomes.
- The Board will ensure effective partnership working with local and national bodies including businesses, public an third sector organisation to develop commonly agreed priorities following the principles of effective collaborative working.
- The Board will encourage and support effective partnership working and collaboration within and across regions to address local needs and meet national priorities and specialisms.

CODE of GOOD GOVERNANCE for SCOTLAND'S COLLEGES

THE CODE OF GOOD GOVERNANCE FOR SCOTLAND'S COLLEGES

2025-2026

CONTENTS

1. BACKGROUND

The original *Code of Good Governance for Scotland's Colleges* was published in December 2014. The Code is reviewed and updated annually by the Good Governance Steering Group. This is the edition for the 2025-26 session.

Colleges Scotland will act as custodian for any future reviews in liaison with the Good Governance Steering Group and in keeping with the way that the Code was created, the broad range of stakeholders who developed the Code will be engaged fully with any revisions. CDN will take responsibility for the production and dissemination of the Code document.

This Code refers to regional colleges, assigned colleges and regional strategic bodies.

2. FOREWORD

Colleges in Scotland thrive in the heart of their communities, serving the interests of those communities, students, employers, governments and their agencies and other stakeholders. They have an essential and valuable role in Scottish society. Colleges deliver 68 million hours of learning each year, and 95% of these learning hours lead to a recognised qualification. Across Scotland colleges employ 14,000 staff and deliver education, skills and training to 248,900 students and 14,830 apprentices. .

Colleges receive substantial public funding and also operate in an increasingly commercial and enterprising way. We value the significant contribution college board members make to governing our colleges and regional strategic bodies, and to their stewardship of taxpayer's money, ensuring its efficient and effective use.

Boards are expected to innovate, pursue new opportunities and take measured risks in delivering what is best for their stakeholders.

Against this background, it is right and proper that the highest standards of governance and propriety are expected of our boards and those individuals who serve them. This Code of Good Governance codifies the principles of good governance for learners and learning that already exist in our colleges and promotes accountability and continuous improvement in how colleges and regional strategic bodies are governed.

The Code is based on key principles and has been written in a way that is mandatory and anticipates compliance. All colleges that receive funding from the Scottish Funding Council (SFC) or from a regional strategic body must comply with the Code as a term and condition of grant. Exceptions should be rare and must be explained publicly.

In addition to demonstrating good governance, colleges and regional strategic bodies must also ensure compliance with their statutory and other obligations. The governance professional role is vital in providing guidance to the board on its legal and other obligations.

Colleges have an important individual and collective role to play in promoting economic, social, and cultural well-being. We expect this Code to provide the essential underpinning to help discharge that role to the highest standards possible.

Dr David C. Watt OBE
Chair of the Good Governance Steering Group

3. CODE OF GOOD GOVERNANCE FOR SCOTLAND'S COLLEGES

Governance and the Code

Corporate governance:

- is the way in which organisations are directed and controlled within a legislative and regulatory framework
- defines the distribution of rights and responsibilities among the different stakeholders and participants in the organisation
- determines the rules and procedures for making decisions on corporate affairs including the process through which the organisation's objectives are set
- provides the means of achieving those objectives and monitoring performance.

Scotland's colleges refer to colleges either funded by SFC or by a regional strategic body for the provision of education. Such colleges can be incorporated or non-incorporated. The overarching purpose of good governance for Scotland's colleges is to:

- lead the college, region or regional strategic body and set its strategic direction and values
- ensure effective management and financial controls to support the student experience within a framework of public accountability and transparency
- deliver high quality learning and outcomes.

The *Code of Good Governance for Scotland's Colleges* has been developed and is owned by the college sector. Colleges are required to comply with it as a condition of grant from either SFC or their regional strategic body. It establishes standards of good governance practice for all boards and provides the essential foundations for compliance within the legislative framework.

Boards must not only follow the letter but also the spirit of the Code to ensure good governance. Boards must think deeply, thoroughly and on a continuing basis about their overall tasks and the implications of these for the roles of their individual members. Key to this is the leadership of the chair, the support given to and by the principal, and the frankness and openness of mind with which issues are discussed and tackled by all board members.

Statement of Compliance with Good Governance

Each board must state its adoption of the Code in the corporate governance statement contained in its annual financial statement. The chair, on behalf of the board, is expected to report as to how the principles have been applied by the board. Where, for whatever reason, a board's practice is not consistent with any principle of the Code, it should make this known to SFC or, if it is an assigned college, the regional strategic body. This should be done immediately they become aware of an inconsistency and, without exception, in advance of publishing the information. An explanation for that inconsistency must be clearly stated in its corporate governance statement. Boards will be expected to offer a clear rationale for exceptions in the context of their college's operational model and to identify mitigations.

Individual board members have a duty to act on serious concerns about the governance of their body. Information on who board members can approach is included in *The Guide for Board Members in the College Sector* available from the College Development Network.

4. PRINCIPLES

Section A: Leadership and Strategy

Conduct in Public Life

A.1 Every college and regional strategic body must be governed by an effective board that is collectively responsible for setting, demonstrating, and upholding the values and ethos of the organisation.

A.2 Every board member must ensure that they are familiar with, and their actions comply with the provisions of their board's Code of Conduct.

A.3 The *Nine Principles of Public Life in Scotland*, which incorporate the seven Nolan principles, must be the basis for board decisions and behaviour. These key principles, which apply individually and collectively, are:

- Duty/Public Service
- Selflessness
- Integrity
- Objectivity
- Accountability and Stewardship
- Openness
- Honesty
- Leadership
- Respect

Vision and Strategy

A.4 The board is responsible for determining their institution's values, vision, strategic direction, educational character, , and ethos. Regional strategic bodies must also determine the regional strategy for colleges assigned to them. The board of an assigned college must have regard to the strategy determined by the regional strategic body. Board members have a collective leadership role in fostering an environment that enables the body to fulfil its mission and meet Scottish Government priorities, for the benefit of students and the community it serves.

A.5 The board must develop and articulate a clear vision for the region or college. This should be a formally agreed statement of its aims and desired outcomes which should be used as the basis for its overall strategy and planning processes.

A.6 The board provides overall strategic leadership of the region or college. The board is responsible for formulating and agreeing strategy by identifying strategic priorities and providing direction within a structured planning framework.

A.7 The board (except in the case of assigned college boards) is responsible for overseeing the negotiation of its funding agreement with SFC, to meet the needs of the college or region and make best use of available funding, consistent with national strategy.

A.8 The roles and responsibilities of the boards of assigned colleges should be undertaken in the context of the roles and responsibilities of their regional strategic body.

Performance

A.9 The board must ensure that a comprehensive performance measurement system is in place which is clearly linked to the regional strategic framework and identifies key performance indicators. It must ensure that it scrutinises performance measures and reports these on their website in a manner that is both timely and accessible to stakeholders. This will allow the board to determine whether or not the vision and mission of the region or the college are being fulfilled and that the interests of stakeholders are being met.

Corporate Social Responsibility

A.10 The board must demonstrate high levels of corporate social responsibility by ensuring it behaves ethically and contributes to economic development while seeking to improve the quality of life of the local community, society at large and its workforce.

A.11 The board must exercise its functions with a view to improving economic, cultural and social wellbeing in the locality of the college or region. It must have regard to social and economic needs and social inclusion.

A.12 The board must provide leadership in equality and diversity.

A.13 The board must seek to reflect in its membership, the make-up of the community through offering maximum opportunity of membership to a range of potential members and removing potential barriers to membership, in partnership with its regional strategic body, as appropriate.

Section B: Quality of the Student Experience

Student Engagement

B.1 The board must have close regard to the voice of its students and the quality of the student experience should be central to all board decisions.

B.2 The board must lead by example in relation to openness, by ensuring that there is meaningful on-going engagement and dialogue with students, the students' association and as appropriate staff and trade unions in relation to the quality of the student experience. Consultation is essential where significant changes are being proposed.

B.3 The board must consider the outcome of student surveys and other student engagements and monitor action plans that could impact on the quality of the student experience.

B.4 The college board must have regard to the Framework for the Development of Strong and Effective College Students' Association in Scotland. It must put in place robust partnership procedures (e.g. partnership agreement) to work together to achieve change and which are supported by regular and open communications.

B.5 The college board must encourage a strong and autonomous students' association and ensure that the students' association is adequately resourced.

B.6 The college board must ensure that the students' association operates in a fair and democratic manner and fulfils its responsibilities.

B.7 The college board should review the written constitution of its students' association at least every five years.

Relevant and High-Quality Learning

B.8 The board must seek to secure coherent provision for students, having regard to other provision in the region or college's locality. The board must be aware of external local, national and international bodies and their impact on the quality of the student experience, including community planning partners, employers, skills development and enterprise agencies and employer bodies. The board must seek to foster good relationships and ensure that the body works in partnership with external bodies to enhance the student experience, including employability and the relevance of learning to industry needs.

Quality Monitoring and Oversight

B.9 The board must ensure appropriate mechanisms are in place for the effective oversight of the quality and inclusivity of the learning experience in the college or region. The board must ensure that the college works in partnership with sector quality agencies and other appropriate bodies to support and promote quality enhancement and high-quality services for students.

Section C: Accountability

Accountability and Delegation

C.1 The board is primarily accountable to its main funder, either SFC or its regional strategic body. Through the chain of funding, the body is ultimately responsible to the Scottish Ministers who are accountable to the Scottish Parliament.

C.2 The board must ensure delivery of its agreed outcomes or in the case of an assigned college, its agreed contribution to the region's agreed outcomes.

C.3 The board must ensure it fulfils its statutory duties and other obligations on it, and that the terms and conditions of its grant are being met.

C.4 Scottish Ministers have powers to suspend or remove by order any or all board members of an incorporated college (except the principal) or a regional board for serious or repeated breaches of a term and condition of grant.

C.5 The board also has a wider accountability to a range of stakeholders including students (both current and prospective), its staff, the wider public, employers and the community it serves, for the provision high quality education that improves people's life chances and social and economic well-being.

C.6 Incorporated colleges and regional boards must maintain and publicly disclose a current register of interests for all board members. Board members have a personal responsibility to ensure any changes to their register of interests are notified timeously to the governance professional and to declare any specific conflicts of interest in the business of the meeting prior to the commencement of each meeting of the board and its committees and withdraw from meetings as appropriate.

See section D.6 for the 'objective test' for judging if there is a conflict of interest.

C.7 The board must ensure that its decision-making processes are transparent, properly informed, rigorous and timely, and that appropriate and effective systems of financial and operational control, quality, management of staff, risk assessment and management are established, monitored, continuously improved and appropriately impact assessed. This includes:

a) the prompt production, dissemination and online publication of board/committee agendas, minutes and papers to the public
b) every board meeting and every committee meeting having a well-structured agenda circulated timeously in advance
c) the retention of all key documentation which help justify the decisions made by the board and its committees
d) setting quorum for board and committee meetings in line with good practice and preferably at 50% or higher are non-executive members. A board should satisfy itself that adequate arrangements are in place to ensure that decisions it has delegated to a committee are taken with a non-executive majority. When determining a quorum, the chair of the board may be considered to be a non-executive member. (see Annex 1 for the definition of non-executive)

C.8 The board may delegate responsibilities to committees for the effective conduct of board business. As a minimum the committees required are Audit, Remuneration, Finance and Nominations/Appointments. Delegation of responsibilities from and matters reserved to the board and its committees must be set out in a scheme of delegation including the functions delegated by the board to the chair, committees, the principal and the governance professional (and any other members of staff).

Incorporated college boards and regional boards have no powers to delegate functions to an individual board member (except the chair who has no authority to act out with their delegated powers).

C.9 The board must ensure every board committee has a specified member of the management team to provide objective, specialist advice to support it to discharge its remit, including by explaining in an accessible way the matters under discussion and the possible implications of different options.

C.10 The board must consider and have in place procedures to ensure effective working relationships and constructive dialogue amongst the board as a whole and ensure there are effective reporting and two-way communications between committees and the board. The board must ensure that discussions and decisions of every committee are accurately recorded and reported to the board, no later than the next meeting of the board.

Risk Management

C.11 The board of a college or a regional body is responsible for the overall management of risk and opportunity. It must set the risk appetite of the body and ensure there is an appropriate balance between risk and opportunity and that this is communicated via the principal to the body's management team.

C.12 The board must ensure that sound risk management and internal control systems are in place and maintained. It must ensure there is a formal on-going process for identifying, reporting, evaluating and managing the body's significant risks and review the effectiveness of risk management, business continuity planning and internal control systems.

Audit Committee

C.13 The Audit Committee must support the board and the principal by reviewing the comprehensiveness, reliability and integrity of assurances including the body's governance, risk management and internal control framework. The Scottish Government Audit and Assurance Committee Handbook promotes the development of an assurance framework to aid the Committee in fulfilling this role. See Audit and Assurance Committee Handbook

C.14 The scope of the Audit Committee's work must be defined in its terms of reference and encompass all the assurance needs of the board and the principal. The Audit Committee must have particular engagement with internal and external audit, and must work with management and auditors to resolve any issues in relation to financial reporting.

C.15 The Audit Committee must promptly pursue recommendations arising from audit reports and must monitor their implementation.

C.16 The membership of the Audit Committee cannot include the board chair or the principal and, in line with the Audit and Assurance Committee Handbook, 'executive members of the organisation should not be appointed to the Audit and Assurance Committee', and the majority of members must be non-executive. The role of the college executive is to attend meetings at the invitation of the committee chair and to provide information for particular agenda items.

C.17 The Audit Committee terms of reference must provide for the committee to sit privately without any non-members present for all or part of a meeting if they so decide. The Audit Committee members should meet with the internal and external auditors without the executive team present at least annually.

C.18 At least one member of the Audit Committee should have recent relevant financial or audit experience.

Remuneration Committee

C.19 It essential that members of the Remuneration Committee understand their role and responsibilities. Members must undertake the online training module for Remuneration Committees provided by College Development Network within one month of appointment.

C.20 The board must have a formal procedure in place for setting the remuneration of the principal by a designated committee of non-executive members. The board may wish to supplement this by taking evidence from a range of sources. In particular, staff and students should have a role in gathering and submitting evidence in relation to the college principal to the relevant committee.

C.21 The board chair cannot be the chair of the Remuneration Committee (but they can be a member of it).

Financial and Institutional Sustainability

C.22 The board is responsible for ensuring the financial and institutional sustainability of the body. The board must ensure compliance with its Financial Memorandum (either with SFC or the regional strategic body, depending on which is funding it), including in relation to incorporated colleges and regional boards, relevant aspects of the Scottish Public Finance Manual.

C.23 The board must ensure that:

- funds are used as economically, efficiently and effectively as possible
- effective monitoring arrangements are in place
- college staff report relevant financial matters to it.

C.24 For colleges that are charitable organisations, board members are also charity trustees. The board of a college that is a charity must ensure its members are aware of their responsibilities under charity legislation and for complying with relevant provisions as set out by the Office of the Scottish Charity Regulator. See OSCR Guidance and Good Practice for Charity Trustees (02.04.25)

Staff Governance

C.25 The college board as the employer, is responsible for promoting positive employee relations and for ensuring effective partnership between recognised trade unions and management.

C.26 The board must have a system of corporate accountability in place for the fair and effective management of all staff, to ensure all legal obligations are met and all policies and agreements are implemented and identify areas that require improvement and to develop action plans to address them.

C.27 The college board must comply with collective agreements placed on it through national collective bargaining for colleges.

Section D: Effectiveness

The Board Chair

D.1 The chair is responsible for leadership of the board and ensuring its effectiveness in all aspects of its role. The chair is responsible for setting the board's agenda and ensuring that adequate time is available for discussion of all agenda items, particularly strategic issues. The chair must promote a culture of openness and debate by:

- encouraging the effective contribution of all board members
- fostering constructive challenge and support to the principal, executive team and fellow board members
- effective team-working
- positive relations between board members.

The chair must engage with the principal and the governance professional in a manner which is both constructive and effective.

D.2 The board and its committees must have the appropriate balance of skills, experience, independence and knowledge of the body to enable them to discharge their respective duties and responsibilities effectively.

Senior Independent Member

D.3 The board must appoint one of the non-executive members to be the senior independent member to provide a sounding board for the chair and to serve as an intermediary for the principal, other board members and the governance professional when necessary (see Annex 1 for the definition of 'non-executive'). The senior independent member should also be available where contact through the normal channels of chair, principal or governance professional has failed to resolve an issue or for which such contact is inappropriate. The senior independent member is also responsible for holding annual meetings with Board members, without the Chair, to appraise the Chair's performance and provide the Chair with relevant feedback

Further information on the role of the senior independent member can be found in The Guide for Board Members in the College Sector.

Board Members

D.4 Each board member is collectively responsible and accountable for all board decisions. Board members must make decisions in the best interests of the college and/or region as a whole rather than selectively or in the interests of a particular group.

D.5 Staff, student and trade union board members are full board members and bring essential and unique, skills, knowledge and experience to the board. Staff, student and trade union board members must not be excluded from board business unless there is a clear conflict of interest, in common with all board members.

D.6 Where the college is a charity, all board members, as charity trustees, including staff, student and trade union board members, have legal duties and responsibilities under the Charities Act 2005. This includes registering any personal interests that could be seen as conflicting with the interests of the body. The 'objective test' for judging if there is a conflict of interest is:

"… whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your decision making in your role as a member of a public body".

Principal and Chief Executive

D.7 The college board must appoint the principal as chief executive of the college, securing approval for the appointment and terms and conditions of the appointment from the regional strategic body if necessary.

D.8 The college board must ensure there is an open and transparent recruitment process for the appointment. Students and staff must have an opportunity to contribute to the recruitment process.

D.9 The college board must delegate to the principal, as chief executive, authority for the academic, corporate, financial, estate and human resource management of the college, and must ensure the establishment of such management functions are undertaken by and under the authority of the principal.

D.10 The college board must ensure a clear process is in place to set and agree personal performance measures for the principal. This process should seek the views of students and staff. The chair, on behalf of the board, should monitor, review and record the principal's performance, at least annually, against the agreed performance measures.

D.11 The principal, as a board member, shares responsibility for good governance with the chair and all other members of the board, supported by the governance professional. The principal also enables good governance through supporting effective communication and interaction between the body and the rest of the college including staff and students.

D.12 The board provides strategic direction for the region and/or college, and the chair provides leadership to the board. The principal provides leadership to the staff of the body.

D.13 The board must provide a constructive challenge to the principal and executive team and hold them to account.

Governance Professional

D.14 The board must appoint a governance professional who is responsible to it and reports directly to the chair in their governance professional capacity. The governance professional may be a member of the senior management team in their governance professional capacity, but they cannot hold any other senior management team position at the same time. The appointment and removal of the governance professional is a decision of the board.

D.15 All board members must have access to the governance professional who has an important governance role in advising the board, the committees and individual board members and supporting good governance. The distinctive governance professional role includes:

- facilitating good governance and advising board members on:
  - the proper exercise of their powers, including in relation to relevant legislation
  - the board's compliance with its Financial Memorandum, the Code for Good Governance, its Standing Orders and Scheme of Delegation
  - their behaviour and conduct in relation to the board's Code of Conduct.
- providing clear advice to the chair and the board/committees on any concerns the governance professional may have that board members have not been given:
  - sufficient information
  - information in an appropriate form
  - sufficient time to monitor, scrutinise or make informed and rigorous decisions in an open and transparent way.
- attending and providing support to every board meeting and every meeting of every board committee. Where the governance professional is unable to attend, while the governance professional retains overall responsibility, proper arrangements must be made to cover the role with a person who is fully able to discharge the role effectively.
- having an unambiguous right to speak at board and committee meetings to convey any concerns they may have about governance. This extends to someone substituting for the governance professional.
- reporting any unresolved concerns about the governance of the body to the relevant funding body (i.e., SFC or the regional strategic body).

D.16 The board must ensure the governance professional:

- has suitable skills, knowledge and behaviours to carry out their role effectively
- receives appropriate induction, and if new to the role, is mentored by a more experienced governance professional for at least their first year
- has adequate time and resources available to undertake their role effectively.

D.17 The board must ensure arrangements are in place to deal with a governance professional's potential or real conflicts of interest.

Board Member Appointment, Induction and Training

D.18 For boards with responsibility for board appointments, the board must ensure a formal and open procedure is in place for recruiting and selecting new non-executive board members. Boards must have regard to current Ministerial Guidance on board appointments.

D.19 The board is responsible for ensuring appropriate arrangements are in place for the conduct of student elections and nominations, and elections and nominations of staff and trade union members to the board.

D.20 The chair must ensure that new board members receive a formal induction on joining the board, tailored in accordance with their individual and collective needs. The governance professional should support the chair in the provision of relevant induction for new board members.

D.21 The board must ensure all board members undertake appropriate training and development in respect of their governance role. The governance professional should support the chair in the provision of relevant training and development opportunities for board members, which should be tailored to meet board members skills and needs. The governance professional must keep records of the development activity of board members, including the chair.

D.22 The board must ensure that new committee members receive a committee induction and have their specific training needs assessed and met.

Board Evaluation

D.23 Extension of the term of office of board appointments requires evidence and the board must ensure appropriate mechanisms are in place to support this.

D 24 The board must keep its effectiveness under annual review and have in place a robust self-evaluation process. There should also be an externally facilitated evaluation of its effectiveness every three to five years. The board should determine the timing for this externally facilitated review as part of the annual effectiveness review. The board is not required to conduct a self-evaluation of its effectiveness in the same year as an externally facilitated evaluation. The board must send its self-evaluation (including an externally facilitated evaluation) and board development plan (including progress on previous year's plan) to its funding body and publish them online.

D.25 The board must agree a process for evaluating the effectiveness of the board chair and the committee chairs. The evaluation of the board chair should normally be led by the senior independent member.

D.26 The board must ensure all board members are subject to appraisal of their performance, conducted at least annually, normally by the chair of the board.

D.27 The performance of regional college chairs will also be evaluated by the Scottish Government, as regional college chairs are appointed by the Scottish Ministers and are personally accountable to them.

D.28 The performance of assigned, incorporated college chairs will also be evaluated by the regional strategic body, as they are appointed by the regional strategic body and are personally accountable to them.

Section E: Relationships and Collaboration

Partnership Working

E.1 The board must work in partnership to secure the coherent provision of high quality fundable further and higher education in their localities.

E.2 The board must ensure effective consultation, local and regional planning and must follow the principles of effective collaborative working: mutual respect, trust and working towards commonly agreed outcomes.

E.3 The board must ensure effective partnership working with local and national bodies including businesses, public and third sector organisations to develop commonly agreed priorities following the principles of effective collaborative working.

E.4 The board must encourage and support effective partnership working and collaboration within and across regions to address local needs and meet national priorities and specialisms.

ANNEX 1

References and Definitions

- "**college**" means a college funded by either SFC or a regional strategic body.
- "**incorporated college**" means a college with a board of management under part 1 of the Further and Higher Education (Scotland) Act 1992.
- "**assigned** college" means a college assigned to a regional strategic body.
- "**board**" means the governing body of the college or to the regional strategic body.
- "**body**" means the organisation in question, i.e., a college or regional strategic body.
- "**principal**" includes where appropriate in the context, the chief officer or equivalent person of a regional strategic body.
- '**non-executive**' means a member who is not the chair of the board and who does not otherwise hold a specific position on the board i.e., is not a student member or a staff or trade union member; and in the case of a college board, is not the principal; and in the case of a regional board is not the chair of an assigned college.
- The reference to a non-executive majority under C.7(d) reflects the underlying governance principle of ensuring an appropriate degree of independence and objectivity in all board decision-making. A board quorum should always require a non-executive majority. When determining a quorum, the chair of the board may be considered to be a non-executive member.
- The Court of the University of the Highlands and Islands (UHI) is the Regional Strategic Body (RSB) for the region and is the only RSB in Scotland.

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