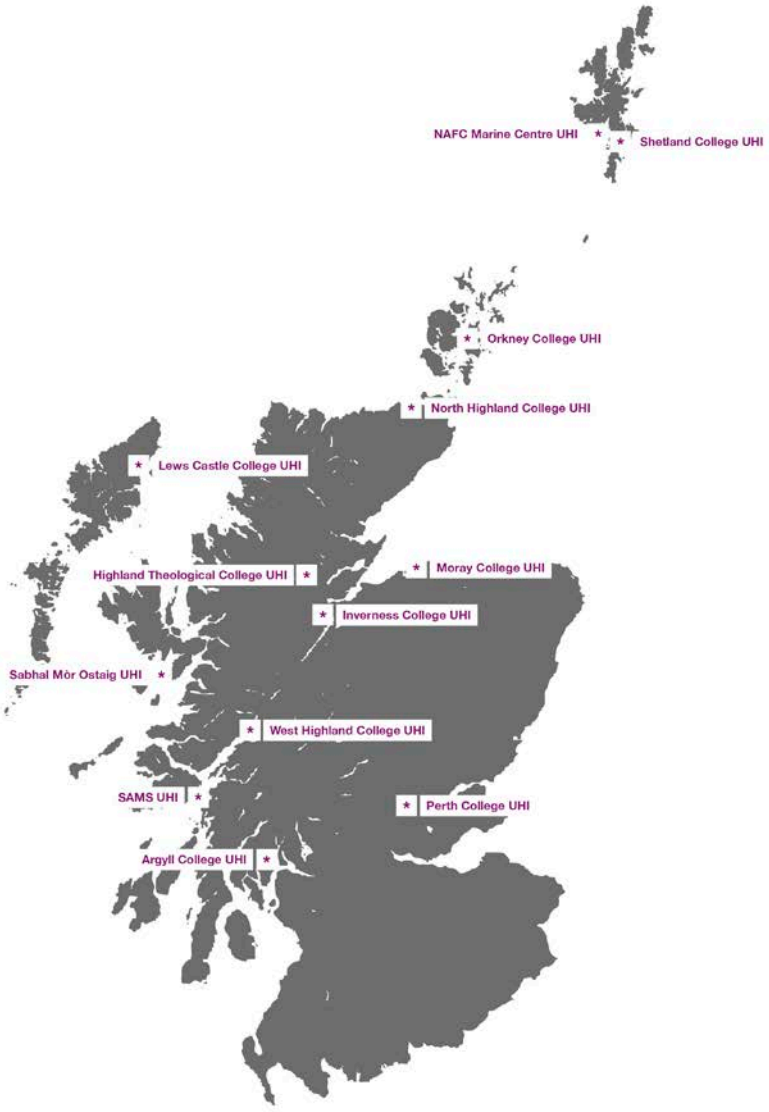
University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean



University of the Highlands and Islands Internal Audit Service

Annual Internal Audit Report 2013/14

02/09/2014

Internal Audit Annual Report

2013/14

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Appendices

Annual Internal Audit Report

2013/14

1. Introduction

1.1. UHI recruited an in-house Internal Auditor and established a Co-Sourced Internal Audit Service with Henderson Loggie Chartered Accountants in February 2009. This Annual Internal Audit Report provides a summary of the Internal Audit Service's activities since the 1st August 2013 for the financial year 2013/14.

1.2. The Internal Audit Terms of Reference require the Head of Internal Audit to give an annual opinion to Court and Principal and Vice Chancellor, through the Audit Committee, on the adequacy and effectiveness of UHI's arrangements for:

- risk management, control and governance; and for
- economy, efficiency and effectiveness (value for money)

1.3. The opinion is provided in section 7 of this report.

2. Responsibilities for Risk Management, Control, Governance and Value for Money

2.1. Within the University of the Highlands and Islands, responsibility for risk management, control and governance arrangements and the achievement of value for money rests with Court and management, who should ensure that appropriate and adequate arrangements exist without reliance on the UHI Internal Audit Service. The UHI Internal Audit Service has no executive role, nor does it have any responsibility for the development, implementation or operation of systems.

3. Role of Internal Audit

3.1. The UHI Internal Audit Service is responsible for providing an objective, independent appraisal of all the University of the Highlands and Islands activities, financial and otherwise. It provides a service to the whole organisation, including Court and all levels of management. It is not an extension of, nor a substitute for, good management, although it can have a role in advising management. The Internal Audit Service is responsible for evaluating and reporting to the University of the Highlands and Islands Court and the Principal and Vice Chancellor, through the Audit Committee, thereby providing them with assurance on the arrangements for risk management, control, governance and value for money. It remains the duty of management, not the internal auditor, to operate these arrangements.

3.2. The Head of Internal Audit is required to give an annual opinion to Court and the Principal and Vice Chancellor, through the Audit Committee, on the adequacy and effectiveness of the arrangements for risk management, control and governance and for economy, efficiency and effectiveness (value for money) within UHI, and the extent to which Court can rely on these.

3.3. Independence

3.4. The Internal Audit Service has no executive role, nor does it have any responsibility for the development, implementation or operation of systems. The Head of Internal Audit, subject to any guidance from the Audit Committee is solely responsible for the management and development of the University of the Highlands and Islands co-sourced Internal Audit Service.

3.5. For day-to-day administrative purposes only, the Head of Internal Audit reports to the UHI Principal and Vice Chancellor. The Head of Internal Audit also has right of access to the UHI Principal and Vice Chancellor.

3.6. The Institute of Internal Auditors International Standards for the Professional Practice of Auditing state that 'internal audit activity should be free from interference in determining the scope of internal auditing, performing work, and communicating results'.

3.7. Where there are differences of opinion between Internal Audit and management, Court (on the advice of the Audit Committee) should ultimately determine whether or not to accept audit recommendations, recognise and accept the risks of not taking action, and instruct management to implement recommendations.

4. Performance against the Internal Audit Plan

4.1. The University of the Highlands and Islands Internal Audit Plan for 2013/14 plan was prepared using a planning methodology in line with the Scottish Funding Council (SFC) guidance and current best practice from the Committee of University Chairmen (CUC), Institute of Internal Auditors (IIA), Higher Education Funding Council for England (HEFCE), the Council of Higher Education Internal Auditors (CHEIA) and also in the context of UHI's risk management infrastructure.

4.2. The Internal Audit Planning Methodology and proposed Internal Audit Plans were discussed and reviewed by the External Auditor.

4.3. The Audit Committee approved the Internal Audit Plan for 2013/14 at its meeting in September 2013. Progress with the audit plan was reviewed by the Audit Committee at each meeting during the year. During the year UHI has had to make preparations for a number of significant changes:

- Post-16 Education (Scotland) Act.
- Establishment of UHI as a Regional Strategic Body.
- Office of National Statistics reclassification of incorporated Colleges.
- New draft SFC Financial Memoranda.
- Revision of the UHI Articles of Association and reconstitution of Court and its respective committees.
- Establishment of the Further Education Regional Board

4.4. The above changes necessitate additional responsibilities being assumed by UHI and amend the governance and operational arrangements surrounding the UHI Academic Partners. During the year the Head of Internal has reviewed documentation and consultation papers on the Post 16 Education (Scotland) Act, the new SFC Financial Memoranda, as well as the new requirements that will apply to incorporated colleges subject to Office of National Statistics Reclassification e.g. the Scottish Public Finance Manual, Public Sector Internal Audit Standards, Directors Certificates of Assurance and Internal Control Checklist. The Head of Internal Audit has kept the Audit Committee informed of these changes and identified that the changes will widen the scope of internal

audit activity within UHI and increase the level of assurance required by the Audit Committee and Court.

4.5. The Head of Internal Audit has consulted with the Finance Directors Practitioners Group, liaised with the Further Education Regional Board Short Life Working Group and consulted Academic Partner Principals through the Vice Principal Further Education in order to plan the new partnership information and assurance requirements.

4.6. Preparation for the above changes has impacted delivery of the planned audits. Time allocated to reviewing Organisational Structures was directly allocated to liaising with the Further Education Regional Board Short Life Working Group and to identifying the new partnership information and assurance requirements. The planned audits of identification and management of research opportunities and succession planning were not able to be completed.

2013/14 Audit Plan	Audit risk score	Progress to date
Corporate Governance Framework - compliance with best practice	41	**Reported to Audit Committee 26 February 2014**
Organisational Structure - Committee and Court Organisation and Administration Monitoring of Executive Management, Delegated authority	40	Work carried out with the Further Education Regional Board Short Life Working Group to identify the new partnership information and assurance requirements. Full review of new structures in this area deferred to 2014/15 internal audit plan.
IT Asset Register and Software Licence Compliance	24	**Reported to Audit Committee 11 September 2014**
Identification and management of research opportunities	35	Initial Audit Planning meeting with Vice Principal Research carried out Scope and Objectives defined Field work underway unable to be completed during the year due to additional activities undertaken (See paragraph 4.6)
Student recruitment	32	**Reported to Audit Committee 6 June 2014**
Succession Planning	32	Deferred to 2014/15 internal audit plan (See paragraph 4.6)
Compliance with Legislation - Protecting Vulnerable Groups Scheme	30	**Reported to Audit Committee 6 June 2014**
Student Placements	23	**Reported to Audit Committee 11 September 2014**
Library Services	20	**Reported to Audit Committee 26 February 2014**
Risk Management		**Reported to Audit Committee 11 September 2014**

5. Summary of Internal Audit Work undertaken

5.1. The following paragraphs provide a summary of the Internal Audit work undertaken from the Internal Audit Plan 2013/14.

5.2. Scottish Code of Good HE Governance

5.3. An audit review was carried out to compare and assess UHI corporate Governance arrangements against best practice – the Scottish Code of Good HE Governance. The review concluded that the UHI Annual Report and Financial Statements (2012-13) record that the University had agreed to adopt the Scottish Code of Good Higher Education Governance as good practice for 2013-14 onwards. UHI will be required to report in the corporate governance statement of their annual audited financial statements (Annual Reports) that they have had regard to the Code, and that where an Institution's practices are not consistent with particular provisions of the Code an explanation should be published in that statement.

5.4. For the most part there was evidence to support that UHI had in place arrangements to demonstrate compliance with the Code. However, there were some areas identified where UHI could further increase the transparency surrounding its practices as well as some opportunities to improve practices to better demonstrate compliance with the Code.

5.5. Ten recommendations for improvement in control were identified, of which all were prioritised as Medium. Actions to improve compliance with the Scottish Code of Good HE Governance were agreed by management, with the final action due for implementation by 31 December 2015.

5.6. IT Asset Register and Software Licence Compliance

5.7. An audit review of the processes used to record UHI IT assets and ensure compliance with software licence requirements was carried out. The review concluded that there was no formal policy or procedures to ensure that the list of IT assets recorded on the LIS helpdesk software, which formed the basis of a UHI IT Asset Register, was complete, accurate and provided sufficient information for analysis. Furthermore, the processes being used for IT asset additions did not ensure that all IT assets were tagged or were entered onto the IT Asset Register. Audit sample testing identified that a significant proportion of items were not recorded on the IT Asset Register and that information about IT assets in the Register was not always accurate. There were no formal input or monitoring controls to ensure all asset additions or transfers in the IT Asset Register were accurate and complete.

5.8. There were no formal processes for IT hardware disposal. IT assets requiring disposal were removed by a specialist contractor periodically for destruction or recycling and it provided a list of all items that it had destroyed or recycled. The contractor provided a certificate of compliance with relevant legal requirements and was International Organisation for Standardisation registered. Some IT assets were passed on to Academic Partners and in these cases LIS advised that they wrote over all data and software to ensure that Data Protection legislation requirements had been met.

5.9. There were no policies or procedures that set out in detail how software licence terms and conditions should be identified, and outlined how controls should be put in place to ensure licence requirements were met.

5.10. Any software that departments wished to purchase would only be reviewed by LIS for appropriateness if it was funded from the LIS budget or if LIS was requested to review this. As a result, some software may have been purchased that was not best value for money or the most appropriate for UHI.

5.11. There was no central software register identifying software licences purchased, summarising key terms and conditions, and identifying what controls should be put in place to ensure that the risk of non-compliance with software licence requirements was

minimised. There was also no procedure to update software records when software was disposed of. The Protection Against Malicious Software Policy set out that users should not store or use unlicensed software, however there were no arrangements in place to identify, locate and remove un-licenced software.

5.12. Sixteen recommendations for improvement in control were identified, of which 11 were prioritised as Medium, and the remainder as Low priority. Fifteen actions to improve control were agreed by Management, one action was not agreed as the scope of the recommendation was considered too wide and was covered by other agreed actions. The final action was due for implementation by 31 December 2015.

5.13. Student Recruitment

5.14. An audit review of student recruitment was carried out. The review found that there was appropriate oversight of student recruitment activities at UHI through the Partnership Planning Forum and also in Academic Partners through review by their senior management or governing body. Roles and responsibilities for undertaking student recruitment activities were clear within the Executive Office and within Academic Partners, however some Academic Partners advised that the division of roles and responsibilities between Executive Office and Academic Partners were not clear.

5.15. A UHI Marketing and Communications Strategy and Plan was in place but this could be expanded upon. All Academic Partners involved in recruitment activity advised that they had a Marketing Strategy or were developing one (NAFC Marine Centre advised that it did not undertake recruitment activity). A formal annual student recruitment plan was in place at Executive Office. All Academic Partners involved in recruitment activity advised that they had either a formal or informal student recruitment plan or were developing one.

5.16. Student recruitment activity at Executive Office was planned, based on research, co-ordinated with Academic Partners and reviewed and monitored for economy, effectiveness and efficiency. Most Academic Partners had student recruitment activities designed to be economic, efficient and effective and underpinned with data, however some smaller or specialist Academic Partners had limited information, particularly about measuring the effectiveness of student recruitment activities.

5.17. Mechanisms for sharing best practice related mainly to the Marketing and Communications Practitioners Group conferences, with no formal process in place to consider what best practice could be shared and ensure this was done.

5.18. The knowledge and skills of staff undertaking student recruitment activities was formally considered, with training provided when necessary.

5.19. Appropriate processes were in place at Executive Office and in Academic Partners to deal with student recruitment complaints.

5.20. Six recommendations for improvement in control were identified, of which all were prioritised as Medium. Five actions to improve control were agreed by Management. For one recommendation no further additional action was proposed. The final agreed action was due for implementation by 31 December 2014.

5.21. Compliance with Legislation – Using disclosure information and the Protecting Vulnerable Groups Scheme

5.22. A review was carried out to assess whether UHI had effective arrangements in place for lawfully obtaining disclosure information under the Police Act 1997 and or the Protection of Vulnerable Groups (Scotland) Act 2007.

5.23. The review concluded that although there was a UHI PVG Scheme Policy in place, that this was not up-to-date or as comprehensive as required. Furthermore, there was no guidance over how Police Act 1997 disclosure checks should be applied.

5.24. The 'Code of Practice' produced by Disclosure Scotland sets out the requirements for registered bodies regarding the operating of the PVG Scheme. We noted a number of areas where the requirements of the Code were not being met.

5.25. Procedures were in place to consider whether a disclosure check was required, however the logic for requiring or not requiring these checks was not documented. In addition, when 'Authority to Recruit' forms highlighted the need for a disclosure check sometimes Human Resources staff overruled this based on their knowledge of the post and the disclosure legislation requirements but did not document their reasoning for this. Furthermore, procedures about how to process disclosure checks were not formally documented.

5.26. We reviewed a sample of staff to determine whether or not these staff required a disclosure check. We identified five staff that were employed prior to the PVG scheme and should require retrospective PVG checks. UHI staff who were employed prior to the introduction of the PVG Scheme in 2011 had not been systematically transferred onto the Scheme.

5.27. The UHI PVG Scheme Policy required staff to commence employment only once their Disclosure Scotland check had been received, however we found that all staff in post at 28 February 2014 who had disclosure checks had received these after they commenced employment.

5.28. Based on responses received to a questionnaire all but three Academic Partners appeared to have appropriate policies, procedures and controls in place to comply with Police Act 1997 and the Protection of Vulnerable Groups (Scotland) Act 2007 requirements, however there was no periodic process to obtain assurances from Academic Partners on compliance with this legislation.

5.29. Fifteen recommendations for improvement in control were identified, of which three were prioritised as High, nine as Medium, and the remainder as low priority. Actions to improve control were agreed by Management, with the final action due for implementation by 31 December 2014.

5.30. <u>Student Placements</u>

5.31. An audit review on Student Placements was carried out. The review concluded that Academic Council had approved a UHI Placement Learning Policy. The Policy defined the scope, process, role of academic staff and the role of UHI Careers Centre. It was found that the Policy had not been fully communicated or implemented and that there was a lack of clarity surrounding who had responsibility for monitoring compliance with it. The Policy did not define a clear management framework in terms of oversight and reporting structures within which placement activity would operate.

5.32. There was scope identified to further develop policy, guidance, processes and procedures for the planning, administration, management and monitoring of placement activity to assist in the effective management of risk.

5.33. There was an opportunity to improve record keeping processes to aid in the effective coordination and administration of placement activity across the partnership. Control could be further strengthened with a formalised process of monitoring across UHI to provide assurance that risks surrounding placement activity were being managed effectively and that the Placement Learning Policy and guidance was being complied with.

5.34. There were two high priority recommendations:

- Formalising the process for communication and implementation of the Placement Learning Policy. Measures to monitor compliance with the policy should be determined.

- Improve control by ensuring the use of a tripartite agreement between the UHI, Placement Provider and Student to define roles and responsibilities and govern placement activity.

5.35. Eighteen recommendations for improvement in control were identified, of which two were prioritised as High, Fourteen as Medium, and the remainder as low priority. In order to progress agreement to the recommendations identified. The report will be referred to the Quality Assurance Enhancement Committee (QAEC) for consideration alongside the QAEC Placement Review Group report. QAEC will receive both the QAEC Placement Review Group report and the internal audit report on 10 September 2014, and make decisions on the recommendations in the QAEC review group report. Relevant recommendations will be made to Academic Council for approval/action. An updated internal report will be provided to the Audit Committee with the management actions section fully completed.

5.36. Library Services

5.37. An audit review of UHI library services was carried out. The review concluded that there had not been a formalised partnership wide planning or review process to determine the needs of students and staff in relation to library resources required to support the University curriculum and research activities and inform purchasing. Furthermore, there was a lack of comprehensive reporting of library resource usage and expenditure to inform planning and monitoring. There was therefore a lack of evidence of processes to underpin demonstration that the UHI Executive Office expenditure on library resources provided value for money.

5.38. Academic Partner library services were provided by the 13 autonomous Academic Partners across a range of sites; they provide access to a range of physical and electronic materials. Academic Partners develop, fund, control and manage their own library services and provision. There were varying practices and different standards of service offered across Academic Partner Libraries such as: library opening hours; out-of-hours access; monitoring of the actual use of library services and end user feedback; the charging of library fines; and the provision of appropriate IT and other facilities and services for students.

5.39. There was insufficient evidence to conclude that there was equity of response at each Academic Partner site in terms of the availability of physical materials to meet the needs of students and staff in relation to the University curriculum. Furthermore, there was no effective process of post approval monitoring of library resources reading lists to ensure that the required core texts were purchased and made available whether electronically or via hard copies at appropriate Academic Partner Library sites. The findings identified a number of areas where further investigation was required to determine whether there could be opportunities to improve equity of response at each Academic Partner site and or service improvement through harmonisation or standardisation of practices.

5.40. Eleven recommendations for improvement in control were identified, of which seven were prioritised as Medium, and the remainder as low priority. Actions to improve control were agreed by Management, with the final action due for implementation by 31 December 2015.

5.41. Risk Management

5.42. An audit review on Risk Management was carried out. The review concluded that whilst UHI is continuing to embed its risk management processes there remains opportunities to further improve these by ensuring the regular completion and update of all risk registers and by more closely monitoring completion of actions to mitigate risk. The work of the two Risk Review Groups was providing a continuing impetus to improve risk management processes and was better enabling the provision of timely risk information to the Finance and General Purposes Committee, Higher Education Partnership Policy and Resources Committee and to Court.

5.43. In total, two recommendations for improvement in control were identified, of which both were prioritised as high priority. The High priority recommendations identified scope to improve control by:

- Reinforcing processes to ensure that the standard risk register templates were all completed as well as updated on a timely basis.
- The Executive Office Risk Review Group monitoring the implementation of further actions to mitigate risk. This could be assisted through the development of trend reports on residual risk that highlight by exception where residual risks are static for a period of time.

5.44. Actions have been agreed by Management, with the final action due for implementation by the 31 December 2014.

5.45. It was noted that there remained three agreed management actions outstanding from the previous internal audit review of risk management in 2013 these had been given revised action dates.

- There was scope to improve the transparency surrounding Court's risk appetite for each risk by requesting Court to review the High Level Risk Register and highlight by exception risks (for further review by the Risk Review Group) where the residual risk was not within its risk appetite. (High priority, revised action date 31 October 2014).
- There was scope to reinforce the importance of appraising senior staff on their risk management performance. (Medium priority, revised action date 30 September 2014).
- There was scope to improve control by reviewing and updating the Revised Process for Risk Identification and Management to reflect the role of the Risk Review Group, Programme and Project Board and recent changes to UHI management structures. (Low priority, revised action date 31 October 2014).

5.46. Implementation of all of the above actions will continue to be monitored and progress reported to the Audit Committee as part of the ongoing internal audit follow up process.

5.47. On conclusion of the assessment it is the Head of Internal Audit's opinion that UHI's risk maturity could be classified as 'Risk Defined'. The IIA describe the key characteristics of being risk defined as having the "strategy and policies in place and communicated. Risk appetite defined". The IIA suggest that in these circumstances Internal Audit's approach should be to "facilitate risk management / liaise with risk management and use management assessment of risk where appropriate".

6. Follow up of agreed management actions

6.1. As part of the normal Internal Audit process the Internal Audit Service follows up the implementation of agreed management actions to provide assurance to the Audit Committee that actions to improve control or further mitigate risk are being implemented on a timely basis.

6.2. The UHI Internal Audit Service records all agreed management actions to improve control in a follow-up database. The follow-up database is used to provide managers with reminders or updates on their agreed management actions. The Head of Internal Audit provides the Audit Committee with a follow-up report at each meeting which the Committee uses to closely monitor the implementation of agreed management actions.

6.3. The following table describes the categories used to prioritise recommendations to improve control.

Categorisation of recommendation	**Definition of category**
High	Inadequate systems and controls which if not addressed could expose the institution to significant financial, operational or reputational risk and adversely impact on implementation of its strategic plan.
Medium	Systems and controls which are not fully effective, and failure to improve them could adversely affect operational plans at departmental level.
Low	Good practice dictates that some enhancements to existing systems and controls are desirable.

6.4. The following table shows the total number of agreed management actions by Audit Year and priority.

Priority	**2008-9**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**Total**
High	17	7	33	5	7	**6**	**75**
Medium	26	34	78	40	51	**57**	**286**
Low	17	55	31	15	24	**14**	**156**
	60	**96**	**142**	**60**	**82**	**77**	**517**

6.5. The following table provides a summary of **all** the agreed management actions by audit since February 2009. It is important to note that the table includes agreed management actions that are **not** yet due for completion.

		High		*Medium*		*Low*				
Audit Ref	***Audit Title***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Total Completed***	***Percentage completed***
09-01	Risk Management 2009	3	3	4	4	3	3	10	10	100%
09-02	Review of the Strategic Delivery Body	4	4	3	3	6	6	13	13	100%
09-03	Curriculum Development and Review	1	1	5	5			6	6	100%
09-04	Business Continuity Planning	6	6	9	9	4	4	19	19	100%
10-09	Data Management Information Accessibility and Security	5	4	12	12	6	6	23	22	96%
09-06	Monitoring Academic Partners' financial position	3	3	5	5	4	4	12	12	100%
10-07	Student Fees			5	5	37	37	42	42	100%
10-19	Transparent Approach to Costing			3	3			3	3	100%
10-05	HR Payroll			3	3	3	3	6	6	100%
10-03	Research Business Planning and Development	1	1	7	7	4	4	12	12	100%
10-06	Student retention and management of withdrawals	2	2	4	4	2	2	8	8	100%
10-08	IT Network Vulnerability Test	10	10	21	21	13	13	44	44	100%
10-04	Business Transformation			3	3	4	4	7	7	100%
10-11	Risk Management 2010	1	1	1	1	1	1	3	3	100%
11-05	Health and Safety	3	3	3	3			6	6	100%
11-01	Procurement	3	3	6	6	1	1	10	10	100%
11-06	Project Management			11	11	2	2	13	13	100%
11-07	Compliance with Equality Law	2	1	5	4	1	1	8	6	75%
11-11	Risk Management 2011	1	1	3	3			4	4	100%

		High		Medium		Low				
Audit Ref	***Audit Title***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Total Completed***	***Percentage completed***
11-04	Strategic Planning	2	2	3	3	1	1	6	**6**	**100%**
11-03	IT Network Vulnerability Test - Follow Up	10	10	22	22	11	11	43	**43**	**100%**
12-08	Compliance with Freedom of Information Act			11	11	4	4	15	**15**	**100%**
12-09	Department of Diabetes and Cardiovascular Research	1	1	6	6	1	1	8	**8**	**100%**
12-06	Student Recruitment and Admissions			10	9	3	3	13	**12**	**92%**
12-10	Risk Management 2012	1	1	5	5	1	1	7	**7**	**100%**
12-04	Student Records Management	2	2	6	6	5	5	13	**13**	**100%**
12-04	Governance and Management of SDB	3	3	8	8	6	5	17	**16**	**94%**
13-04	UKBA Tier 4 Compliance	3	3	19	19	5	5	27	**27**	**100%**
13-19	North Highland College - sub contract Ballet West			4	2			4	**2**	**50%**
13-09	TRAC 2013			2	1	2	2	4	**3**	**75%**
13-07	Student Retention and Management of Withdrawals 2013			4	4	2	2	6	**6**	**100%**
13-08	Compliance with legislation - Bribery Act 2010			8	4	5	3	13	**7**	**54%**
13-02	Resource Allocation - EO budgetary control			1	1			1	**1**	**100%**
13-03	Planning - Continuing Student Numbers			1				1	**0**	**0%**
13-10	Risk Management 2013	2	1	6	5	5	4	13	**10**	**77%**
14-09	Library Services			8		4	1	12	**1**	**8%**
14-01	Scottish Code of Good HE Governance			10				10	**0**	**0%**
14-05	Student Recruitment			5				5	**0**	**0%**
14-07	Compliance legislation - Disclosure and PVG	2		10		3		15	**0**	**0%**
14-08	Student Placements	2		14		2		18	**0**	**0%**

		High		Medium		Low				
Audit Ref	***Audit Title***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Completed***	***Total***	***Total Completed***	***Percentage Completed***
14-11	Risk Management 2014	2						2	**0**	**0%**
14-03	IT asset register and software licence compliance			10		5		15	**0**	**0%**
	Total	**75**	**66**	**286**	**218**	**156**	**139**	**517**	**423**	**82%**
	Percentage Complete	**High 88%**		**Medium 76%**		**Low 89%**		**Total 82%**		

7. Annual opinion on the adequacy and effectiveness of the University of the Highlands and Islands arrangements for risk management, control and governance; economy, efficiency and effectiveness (value for money).

7.1. The Internal Audit Terms of Reference require the Head of Internal Audit to give an annual opinion to Court and the Principal and Vice Chancellor, through the Audit Committee, on the adequacy and effectiveness of UHI's arrangements for:

- risk management, control and governance;
- economy, efficiency and effectiveness (value for money).

7.2. It is important to note that:

- The opinion is based upon the internal audit work undertaken since the 1st August 2013 from the Internal Audit Plan 2013/14, summarised earlier in section five.
- Internal control can provide only a reasonable and not absolute assurance to management and Court regarding achievement of UHI's objectives.
- Responsibility for risk management, control and governance arrangements and the achievement of value for money rests with Court and management, who should ensure that appropriate and adequate arrangements exist without reliance on the UHI Internal Audit Service.
- Internal Audit reviews have a reasonable chance of detecting significant control weaknesses but cannot guarantee that fraud, error or non compliance will be detected.

7.3. Adequacy and Effectiveness of the University of the Highlands and Islands arrangements for Risk Management, Control and Governance

7.4. Findings

Risk Management

7.5. An internal Audit Review of Risk Management was undertaken during the year and a summary of the review was included in paragraph 5.41. Appendix A also includes the internal audit assessment on UHI's risk maturity.

7.6. Whilst UHI is continuing to embed its risk management processes there remains opportunities to further improve these by ensuring the regular completion and update of all risk registers and by more closely monitoring completion of actions to mitigate risk. The work of the two Risk Review Groups was providing a continuing impetus to improve risk management processes and is better enabling the provision of timely risk information to the Finance and General Purposes Committee, Higher Education Partnership Policy and Resources Committee and to Court.

7.7. In total, two recommendations for improvement in control were identified, of which both were prioritised as high priority. The High priority recommendations identified scope to improve control by:

- Reinforcing processes to ensure that the standard risk register templates were all completed as well as updated on a timely basis.
- The Executive Office Risk Review Group monitoring the implementation of further actions to mitigate risk. This could be assisted through the development of trend reports on residual risk that highlight by exception where residual risks are static for a period of time.

7.8. Actions have been agreed by Management, with the final action due for implementation by the 31 December 2014.

7.9. There remained three agreed management actions outstanding from the previous internal audit review of risk management in 2013 these had been given revised action dates.

- There was scope to improve the transparency surrounding Court's risk appetite for each risk by requesting Court to review the High Level Risk Register and highlight by exception risks (for further review by the Risk Review Group) where the residual risk was not within its risk appetite. (High priority, revised action date 31 October 2014).
- There was scope to reinforce the importance of appraising senior staff on their risk management performance. (Medium priority, revised action date 30 September 2014).
- There was scope to improve control by reviewing and updating the Revised Process for Risk Identification and Management to reflect the role of the Risk Review Group, Programme and Project Board and recent changes to UHI management structures. (Low priority, revised action date 31 October 2014).

7.10. Implementation of all of the above actions will continue to be monitored and progress reported to the Audit Committee as part of the ongoing internal audit follow up process.

7.11. On conclusion of the assessment it is the Head of Internal Audit's opinion that UHI's risk maturity could be classified as 'Risk Defined'. The IIA describe the key characteristics of being risk defined as having the "strategy and policies in place and communicated. Risk appetite defined". The IIA suggest that in these circumstances Internal Audit's approach should be to "facilitate risk management / liaise with risk management and use management assessment of risk where appropriate".

Control

7.12. During the year the Internal Audit Service has reviewed and tested many of UHI's internal controls based upon the Internal Audit Plan. A summary of the findings of these reviews is included in section 5.

7.13. All of the internal audits undertaken during the year had resulted in recommendations being made to improve control. The following table shows the categorisation of internal audit recommendations.

Categorisation of recommendation	**Definition of category**	**Number of recommendations made**	**Percentage of recommendations agreed by management**
High	Inadequate systems and controls which if not addressed could expose the institution to significant financial, operational or reputational risk and adversely impact on implementation of its strategic plan.	6	100%
Medium	Systems and controls which are not fully effective, and failure to improve them could adversely affect operational plans at departmental level.	59	97%
Low	Good practice dictates that some enhancements to existing systems and controls are desirable.	14	100%
	Total	79	97%

7.14. There were no significant internal audit recommendations that the Internal Audit Service consider had not received adequate management attention. The implementation of the agreed management actions corresponding to the recommendations will continue to improve UHI's internal control arrangements.

Governance

7.15. In August 2011 the Post Title Working Group commissioned with the approval of Court Capita Consulting to undertake a review to prepare an outline business case for a new UHI operating model. Following the Capita Consulting "Options for Change" report in January 2012 the Cabinet Secretary for Education and Lifelong Learning convened two meetings of the chairs and principals of UHI and its thirteen academic partners. The Cabinet Secretary subsequently announced, in the Scottish Parliament, the changes he proposed to make to regionalise further education provision in Scotland. In doing so, he asked Dr Michael Foxley, the then chair of West Highland College UHI, to establish and chair a working group to provide proposals of the governance changes required in UHI to ensure the effective and efficient operation of further and higher education in the Highlands and Islands. This group reported to the Cabinet Secretary on the 30 September 2012. The Report of the Governance Working Group was adopted by the University Court on the 31 October 2012. Since October 2012 arrangements were progressed to:

- Review the UHI Memorandum and Articles of Association
- Review the Court and establish an interim Shadow Court
- Establish a Further Education Regional Board as a Committee of Court
- Appointment Associate/Vice Principals and establish the Triumvirate

7.16. The final Scottish Code of Good Higher Education Governance was published on the 18 July 2013. As referenced earlier in paragraph 5.2, during the year an internal audit review to compare and assess UHI Corporate Governance arrangements against best practice (the Scottish Code of Good HE Governance) was carried out. The review found that for the most part there was evidence to support that UHI had in place arrangements to demonstrate compliance with the Code. However, there were some areas identified where UHI could further increase the transparency surrounding its practices as well as some opportunities to improve practices to better demonstrate compliance with the Code.

7.17. During the year there have been significant changes in government policy and strategy within the higher education and further education sector. These changes have been formalised in the Post 16 education Scotland Bill passed by parliament on the 26 June 2013 and received Royal Assent on the 7 August 2013. There has been substantial processes and significant effort expended in reviewing and evaluating UHI's governance structure and business model. Work in this area is still progressing and will be further consolidated as changes required as a result of the Post 16 Education (Scotland) Act are implemented.

7.18. Opinion

On the basis of the work carried out since 1 August 2013, the Head of Internal Audit concludes that where scope to improve controls was identified management actions have been agreed to address these. There is sufficient evidence of controls and procedures to provide reasonable assurance that UHI has adequate and effective arrangements for risk management, control and governance.

7.19. <u>Adequacy and Effectiveness of the University of the Highlands and Islands arrangements for economy, efficiency and effectiveness (value for money)</u>

7.20. Findings

7.21. The Scottish Funding Council Financial Memorandum mandatory requirements effective from the 14 October 2008, state that the 'institution must have a strategy for systematically reviewing management's arrangements for securing value for money. As part of its internal audit arrangements, the institution must obtain a comprehensive appraisal of management's arrangements for achieving value for money'.

7.22. At its meeting on the 23 June 2009, Court approved a Value for Money Strategy, as agreed by Finance and General Purposes Committee on 9 June 2009. On the 29 November 2011 Finance and General Purposes Committee approved a revised Value for Money Policy and Procedures.

7.23. The UHI Procurement Policy was approved by the Finance and General Purposes Committee at its meeting on the 30 August 2011, the purpose of the procurement policy was to provide details of UHI:

- Procurement leadership and governance;
- People;
- Procurement strategy and objectives;
- Approach to defining its supply needs, including the specification of goods and services;
- Sourcing strategy and use of collaborative procurement;
- Purchasing processes and systems, and
- Contract management.

7.24. The policy was further amended in November 2011 to include information on sustainable procurement.

7.25. UHI participates in the Advanced Procurement for Universities and Colleges (APUC) Procurement Capability Assessment. The Procurement Capability Assessment seeks to assist organisations in improving their structure, capability, processes and ultimately performance, by attaining the best standards that are appropriate to the scale and complexity of their business. The Assessment is independently assessed by APUC staff and identifies areas for improvement. To date UHI had completed two full assessments in February 2010 and April 2011 with a further interim assessment in December 2011. UHI had continued to demonstrate improved performance at each assessment.

7.26. In the course of the year Learning and Information Services have progressed a strategic initiative to establish a shared Learning and Information Service. A Learning and Information Services Shared Services Board was established in July 2011 to oversee this development. The Director of Learning and information Services was seconded to the project on a full time basis with the support of the Learning and information Services Development Programme Manager. In the course of 2013/14 A business plan was developed and reviewed by the Academic Partners and Court. Work remains ongoing to determine a delivery model within which the shared service can operate.

7.27. The University Court at its meeting on the 18 June 2013 had agreed in approving the 2013/14 budget that the following should take place:

I. A challenge exercise should be undertaken on the Executive Office budget involving representatives from the partnership.

II. A scoping and rapid identification of duplication and waste exercise should be undertaken with a view to agreeing efficiencies of delivery across the partnership.

7.28. A Budget Challenge / UHI Partnership Resources Dialogue process was defined with the following objectives:

- Greater understanding / increased transparency of how resources are used / linked to deliver UHI Strategy / Partnership Outcomes;
- Identification of potential areas of inefficiency, under investment or duplication in the use of resources or delivery of activities;
- Identification of areas that would benefit from greater co-ordination across the partnership (assist in the prioritisation of shared service activity); and
- Identification of use of resources / delivery of activities that do not contribute towards UHI Strategy / Partnership Outcomes.

7.29. The Head of Internal Audit reviewed documentation used to facilitate the first stage of Budget Challenge / UHI Partnership Resources Dialogue and observed the partnership challenge / dialogue on the proposed Executive Office 2014-15 Budget on the16 May 2014 at Eden Court. Initial early observations of the process were provided to the Higher Education Partnership Policy and Resources Committee (HEPPRC) on the 29 May 2014. The next stages of the Budget Challenge / UHI Partnership Resources Dialogue process are to be taken forwards in 2014/15.

7.30. The Internal Audit Service as a normal part of carrying out internal audit reviews seeks to identify any areas where there are opportunities to better demonstrate value for money and makes recommendations to improve control. A summary of the findings of these reviews is included in section 5.

7.31. Opinion

On the basis of the work carried out since 1 August 2013, the Head of Internal Audit concludes that UHI has in place a Value for Money Policy and Procedures which confirms UHI's commitment to achieving value for money from all of its activities, regardless of the method of funding. It further defines the scope, responsibilities, concept of value for money and approaches to assessing value for money to help promote and secure value for money within UHI.

There is sufficient evidence (subject to compliance with the Value for Money Policy and Procedures) that there are processes and procedures to provide reasonable assurance that UHI has adequate and effective arrangements to promote economy, efficiency and effectiveness (value for money).

8. Internal Audit Key Performance Indicators

8.1. The Internal Audit Terms of Reference require the Head of Internal Audit to implement measures to monitor the effectiveness of the Internal Audit Service. The Key Performance Indicators were discussed and agreed with the Secretary. They are derived from Key Performance Indicators suggested in the Committee of University Chairmen, Handbook for Members of Audit Committees in Higher Education.

Internal Audit Performance indicator	Target	Actual 2013/14
Percentage of audit work delivered by qualified staff.	60%	100%
Internal Audit Plan to be submitted by June each year.	June of each year	Final Audit Plan for 2013/14 approved by Audit Committee at its September 2013 meeting.
Follow-ups to be performed within 3 months of the last action date of recommendations made.	Within 3 months of the last action date of recommendation	Management are provided with regular updates on their agreed management actions and a follow up report is provided to each meeting of the Audit Committee.
Issue of draft reports within 30 days of work being completed.	30 working days	100%
Issue of final report within 10 working days of receipt of management responses.	10 working days	100%
Recommendations made compared with recommendations accepted.	80%	97%
Internal audit reviews that added value.	90%	100%
Internal audit attendance at audit committee meetings.	100%	100%
Issue of internal audit annual report.	September of each year	Report provided to September 2014 Audit Committee

9. Internal Audit Service Quality Assurance programme

9.1. The UHI Internal Audit Service is required through its Terms of Reference to perform internal audit work with due professional care, in accordance with appropriate professional auditing practice and with regard to Treasury and the Institute of Internal Auditors standards (see later paragraph 9.11).

9.2. The letter of agreement established between the University of the Highlands and Islands and the co-sourced internal audit partner Henderson Loggie affirms that the co-sourced internal audit partner will perform internal audit services in accordance with relevant professional standards and guidelines and in accordance with the Scottish Funding Council Financial Memorandum.

9.3. Compliance with the Institute of Internal Auditors, International standards requires the Head of Internal Audit to develop and maintain a quality assurance and improvement program that covers all aspects of the internal audit activity. The Institute of Internal Auditors International standards require that the Internal Audit Service Quality Assurance Programme must include both internal and external assessments.

9.4. The UHI Internal Audit Service has established a two tier approach to its quality assurance and improvement program:

- The ongoing process of monitoring the performance of internal audit activity.
- Internal Audit Annual Quality Assurance assessments. An internal review undertaken by the Principal and Vice Chancellor and the Chief Operating Officer and Secretary and an external evidence based peer review assessment.

9.5. Ongoing Performance Monitoring of Internal Audit Activity

9.6. The Head of Internal Audit manages the provision of the co-sourced Internal Audit Service on an ongoing basis. A monthly reporting process is in place to keep the Principal and Vice Chancellor informed of Internal Audit's progress. The Internal Audit Service has introduced Internal Audit Performance Questionnaires that are issued to management and staff at the conclusion of internal audit work. Feedback from management and staff on the performance of Internal Audit reviews is valued by the Internal Audit Service and helps enable the service provided to be improved and assists the Audit Committee in forming an opinion on the efficiency and effectiveness of the Internal Audit Service.

9.7. The table below presents a summary of the Internal Audit Performance Questionnaire responses received. The responses illustrate that on the whole 100% of the respondents were fully satisfied with the internal audit review process.

Internal Audit Performance Questionnaire	Fully Satisfied	Satisfied	Not Satisfied	Fully Dissatisfied	N/A
1. Were you given adequate notification of the audit?	100%	0%	0%	0%	0%
2. Were you adequately informed of the audit scope and objectives?	100%	0%	0%	0%	0%
3. Were the appropriate staff consulted for the audit area covered?	100%	0%	0%	0%	0%
4. Did the auditor display a professional, constructive and positive approach during the review?	83%	17%	0%	0%	0%
5. Did the auditor discuss key results/findings with you during the review?	83%	0%	0%	0%	17%
6. Were you given the opportunity to discuss the draft report with the auditor prior to finalisation?	83%	17%	0%	0%	0%
7. Was the report produced to a professional standard?	100%	0%	0%	0%	0%
8. Overall, were you satisfied with the review? Has it been worthwhile and added value to your work?	100%	0%	0%	0%	0%
Percentage Totals	**94%**	**4%**	**0%**	**0%**	**2%**

9.8. Annual Internal Audit Quality Assurance Reviews

9.9. In January 2009, the Institute of Internal Auditors launched its International Professional Practices Framework. This is a revised version of the IIA Standards and Guidance. The revised requirements state that the Internal Audit Service Quality Assurance Programme must include both internal and external assessments.

Internal Quality Assessment Reviews

9.10. The Committee of University Chairmen guide for members of Audit Committees in Higher Education provides useful templates to help in the annual evaluation of internal audit. The Principal and Vice Chancellor, Deputy Principal and the Chief Operating Officer and Secretary completed assessments in August 2014, which provide an independent internal evaluation of the Internal Audit Service. The UHI Internal Audit Service internal quality assessments are included in Appendix B.

External Quality Assessment reviews

9.11. The UHI Internal Audit Service participated in an external evidence based peer-reviewed assessment to provide independent external assurance to the Audit Committee over quality control of the UHI Internal Audit Service and to demonstrate compliance with the IIA standards.

9.12. The Council of Higher Education Internal Auditors (CHEIA), with the support of the Higher Education Funding Council England (HEFCE) leadership fund, piloted an internal audit 'self assessment' tool in 2006/07 which was developed by RSM Robson Rhodes; this was then rolled out from 2007/08. The self assessment tool provides a means of benchmarking service delivery against recognised best practice and helps to achieve and maintain an even higher quality internal audit service in the higher education sector.

9.13. The self assessment tool is a spreadsheet-based assessment comprising of 60 questions, against which the assessor is required to rate the audit service on a four point scale, from 'best practice' to 'potentially non-compliant'. To ensure consistency of completion the assessment requires a response to be provided to all 60 questions regardless of whether they best fit an individual institution's Internal Audit Service arrangements or not. Responses to these questions are then weighted and calculated to deliver percentage scores against six criteria: due professional care; strategy; methodology; people; independence and quality assurance. The tool can be completed in three ways, by self assessment, peer reviewed self assessment and finally by an evidence based peer-review process. The tool is in widespread use across the UK and Ireland as promulgated by HEFCE and CHEIA.

9.14. The questionnaire has remained the same since 2010 in January 2014 CHEIA reviewed the questionnaire and made a few minor amendments to the questionnaire, altering the text of some questions and substituting new questions.

9.15. The UHI Head of Internal Audit attended a meeting on the 25 July 2014 in Edinburgh with the Heads of Internal Audit of Newcastle University and the University of Strathclyde as well as the Partner of the Public Sector Group of Scott-Moncrieff to have an evidence based peer-review of the UHI Internal Audit Service undertaken. The following table presents the results of the assessment.

Assessment Criteria	**%**
Due professional care	87%
Strategy	86%
Methodology	89%
People	83%
Independence	90%
Quality assurance	77%
Overall average	**85%**

Key	
90% - 100%	Best Practice
60% - 90%	**Good Practice**
20% - 60%	Partially Compliant
0% - 20%	Potentially Non-Compliant

9.16. The results of the UHI Internal Audit Service evidence based peer-reviewed assessment show that the UHI Internal Audit Service represents **Good Practice**.

10. Conclusion

10.1. The co-sourced Internal Audit Service was established in February 2009. The Internal Audit Service is continuing to develop its role within the University of the Highlands and Islands and seeks to assist the University in progressing towards achievement of its objectives by providing independent, objective assurance on risk management, control and governance.

Appendix A - The Institute of Internal Auditors UK and Ireland - An approach to implementing Risk Based Internal Audit

Assessing the University's risk maturity -This assessment was made by reviewing the University of the Highlands and Islands's practices, processes and relevant supporting documentation such as the risk management strategy, policy and risk registers.

Risk Maturity	Risk naive	Risk aware	Risk defined	Risk managed	Risk enabled	Sample audit test	Summary of findings
Key characteristics.	No formal approach developed for risk management.	Scattered silo based approach to risk management.	Strategy and policies in place and communicated. Risk appetite defined	Enterprise approach to risk management developed and communicated.	Risk management and internal controls fully embedded into the operations.		
The organisation's objectives are defined.	Possibly.	Yes - but may be no consistent approach.	Yes ☑	Yes ☑	Yes ☑	Check the organisation's objectives are determined by Court and have been communicated to all staff. Check other objectives and targets are consistent with the organisation's objectives.	UHI's objectives are defined in the UHI Strategic Plan.
Management have been trained to understand what risks are, and their responsibility for them.	No	Some limited training.	Yes ☑	Yes ☑	Yes ☑	Interview managers to confirm their understanding of risk and the extent to which they manage it.	Managers were aware of risk and their responsibility for managing it. Whilst most managers were maintaining up to date risk registers for their areas of responsibility others were in the process of developing or had yet to develop risk registers. Arrangements were being developed to better formalise the process of

							identifying risk owners to ensure that they are notified and aware when risks were assigned to them.
A scoring system for assessing risks has been defined.	No	Unlikely, with no consistent approach defined.	Yes ☑	Yes ☑	Yes ☑	Check the scoring system has been approved communicated and is used.	Court has defined a scoring system for assessing risks this had been reviewed by the Risk Review Group. A partnership approach to risk scoring and recording had been developed through the Finance Directors Practitioners Group and this was being used in Executive Office and being implemented across the partnership.
The risk appetite of the organisation has been defined in terms of the scoring system.	No	No	Yes ☑	Yes ☑	Yes ☑	Check the document on which the controlling body has approved the risk appetite. Ensure it is consistent with the scoring system and has been communicated.	Court had defined its risk appetite and set risk score levels to determine the inclusion of risks on the high level risk register for its review and approval. The risk appetite has been reviewed by the Risk Review Group and efforts made to augment the process by seeking to develop a portfolio approach to risk management. The Risk Review Group recognised that at any one time UHI may be carrying a high level of risks in one or more parts of its business, however, UHI should ensure that the number of areas exposed to high risk at any time are minimised and balanced with a low risk approach in other areas. Court approved the formation of an Executive Office Risk Review

							Group to identify and review risks for inclusion on the high level risk register. This process has been augmented with a Partnership Risk Review Group which has a remit to identify and collate high level partnership risks.
Processes have been defined to determine risks, and these have been followed.	No	Unlikely	Yes, but may not apply to the whole organisation. ☑	Yes	Yes	Examine the processes to ensure they are sufficient to ensure identification of all risks. Check they are in use, by examining the output from any workshops.	A new standardised risk register template had been developed for use in Executive Office and Academic Partners to improve the monitoring, visibility and reporting of risk throughout Executive Office and the partnership. In accordance with the new process a separate risk register template were required to be completed by each Executive Office department, project and Academic Partner. The risk register template assists in determining risks by having controls to require the completion of set fields. A process of periodic horizon scanning has been implemented through the Partnership Risk Review Group to assist in forecasting longer term or emergent risks. The Executive Office Risk Review Group had identified at its March 2014 meeting that not all departments/projects were currently using risk registers and requested that new templates were completed. The majority of

							managers and projects were maintaining risk registers for their areas of responsibility. However, as identified by the Executive Office Risk Review Group there were still some risk registers templates that require completion. In most cases Academic Partners were still to complete risk register templates.
All risks have been collected into one list. Risks have been allocated to specific job titles.	No	Some incomplete lists may exist.	Yes, but may not apply to the whole organisation. ☑	Yes	Yes	Examine the Risk Register. Ensure it is complete, regularly reviewed assessed and used to manage risks. Risks are allocated to managers.	There was a potential risk that the High Level Risk Register may not be complete as not all departments and Academic Partners had completed their risk register templates.
All risks have been assessed in accordance with the defined scoring system.	No	Some incomplete lists may exist.	Yes, but may not apply to the whole organisation.	Yes ☑	Yes ☑	Check the scoring applied to a selection of risks is consistent with the policy. Look for consistency (that is similar risks have similar scores).	Risks were being assessed in accordance with the defined scoring system.
Responses to the risks have been selected and implemented.	No	Some responses identified.	Yes, but may not apply to the whole organisation ☑	Yes	Yes	Examine the Risk Register to ensure appropriate responses have been identified.	Review of the high level risk register and lower level risk registers highlighted that responses to risks had been recorded for risks. Many of the mitigating controls described required on-going commitment to provide mitigation. Where further actions to mitigate risk

							had been identified, for some actions a person responsible had not been recorded or a timescale allocated. A process to seek regular reports from all risk owners on the implementation of further actions to mitigate risk had not yet been implemented. The Risk Review Group had given consideration to developing a monthly sign off mechanism to ensure that risk reports and identified actions within risk templates were completed on time and identified that a workflow may provide an appropriate solution.
Management have set up methods to monitor the proper operation of key processes, responses and action plans (monitoring controls).	No	Some monitoring controls.	Yes, but may not apply to the whole organisation. ☑	Yes	Yes	For a selection of responses, processes and actions, examine the monitoring control(s) and ensure management would know if the responses or processes were not working or if the actions were not implemented.	An Executive Office Risk Review Group had been established and processes were in place to facilitate the review of the High Level Risks Register. However, there was an opportunity to implement more robust monitoring of risk registers to provide assurance that actions to mitigate risk were operating effectively and that further actions were being implemented on a timely basis. There was scope to further assist the monitoring of the implementation of actions to mitigate risk through the development of trend reports on residual risk that highlight by exception where residual risks are static for a

							period of time. The minutes of the Executive Office Risk Review Group were reported to the Finance and General Purposes Committee and Court together with the updated High Level Risk Register.
Risks are regularly reviewed by the organisation.	No	Some risks are reviewed, but infrequently.	Regular reviews, probably annually. ☑	Regular reviews, probably quarterly.	Regular reviews, probably quarterly.	Check for evidence that a thorough review process is regularly carried out.	Responsibilities for Committees to review risks at different levels throughout the UHI had been defined by Court. Processes were in place to facilitate the review of UHI's high level risks via the Executive Office Risk Review Group, Finance and General Purposes Committee and by Court itself. A Partnership Risk Review Group had been established to review Academic Partner risks registers. However, it was noted that some lower level risk registers were not being reviewed and kept up to date. The consequence of this may be a failure to identify, manage and report on risk on a timely basis.
Management report risks to directors where responses have not managed the risks to a level acceptable to Court.	No	No	Yes, but may be no formal process. ☑	Yes	Yes	For risks above the risk appetite, check that Court has been formally informed of their existence.	The current risk management process uses the initial risk assessment (the gross risk) to define when risk should be reported to the Executive Office Risk Review Group for review and approval. The Executive Office Risk Review Group had previously established a process where risk owners have been

							invited to explain their risks, actions being taken to mitigate their risks, the constraints and issues faced and identify any support needed to help manage risk. The Executive Office Risk Review Group was taking steps to develop a monthly sign off mechanism to ensure that risk reports and identified actions within risk templates were completed on time'. Court has been presented regularly with the High Level Risk Register and had noted its contents. There was a lack of transparency surrounding the risk appetite (the level acceptable to Court) for each risk. The Chief Operating Officer and Secretary had agreed to take forward an action that the new Court was to agree its approach to risk at an early stage.
All significant new projects are routinely assessed for risk.	No	No	Most projects.	All Projects. ☑	All Projects. ☑	Examine project proposals for an analysis of the risks which might threaten them.	Processes had been defined, communicated and implemented to help ensure that all new projects were assessed for risk. The Programme and Project Board reviewed Programme and Project risks. The Executive Office Risk Review Group remit was revised by the Finance and General Purposes Committee to include the review of the risk registers of large strategic projects to ensure an independent view could be fed

							back to the appropriate project board. Information on project risk was being reported to the Executive Office Risk Review Group.
Responsibility for the determination, assessment, and management of risks is included in job descriptions.	No	No	Limited. ☑	Most job descriptions.	Yes	Examine job descriptions. Check the instructions for setting up job descriptions.	Responsibilities for the management of risk were being routinely incorporated into all job descriptions for senior appointments.
Managers provide assurance on the effectiveness of their risk management.	No	No	No	Some managers. ☑	Yes	Examine the assurance provided. For key risks, check that controls and the management system of monitoring, are operating.	Risk Owners have attended meetings of the Executive Office Risk Review Group to explain the actions being taken to mitigate their risks.
Managers are assessed on their risk management performance.	No	No	No	Some managers. ☑	Yes	Examine a sample of appraisals for evidence that risks management was properly assessed for performance.	The Chief Operating Officer and Secretary had agreed to reinforce the importance of appraising senior staff on their risk management performance.
Internal Audit approach	Promote risk management and rely on alternative Audit Planning method	Promote enterprise- wide approach to risk management and rely on alternative Audit Planning	**Facilitate risk management / liaise with risk management and use management**	Audit risk management processes and use management assessment of risk as	Audit risk management processes and use management assessment of risk as		

		method.	**assessment of risk where appropriate.**	appropriate.	appropriate.	

Appendix B - UHI Internal Audit Service internal quality assessment - peer reviews

UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

2. Assess the strength of internal audit's understanding of the institution and its risk involvement.

Strong ☑ Adequate ☐ Needs improvement ☐

3. How strongly have the members of the internal audit team demonstrated an appreciation of the issues key to your role and responsibilities?

Strong ☑ Adequate ☐ Needs improvement ☐

4. Have members of the internal audit team consistently demonstrated independence in all their deliberations?

Yes ☐ No ☐ Not in post long enough to judge

5. Have members of the internal audit team been adequately supervised?

Yes ☑ No ☐

Comments

Work programme

1. Has effective co-operation been achieved between the internal auditors and your department, including avoidance of undue disruption to normal activities?

Yes ☑ No ☐

2. Is there a formal process to ensure that internal audit keeps you up to date with audit/project progress?

Yes ☑ No ☐

3. Has internal audit provided early identification and advice regarding contentious issues, problem areas and delays?

Yes ☐ No ☐ Not able to determine yet.

4. Has internal audit suggested how such issues could be resolved?

Yes ☐ No ☐ N/A as yet

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UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

5. Were such suggestions realistic, robust and presented clearly and on a timely basis?

Yes ☐ No ☐ N/A yet

6. How responsive has internal audit been to the institution's needs, including requests for special investigations?

Strong ☐ Adequate ☐ Needs improvement ☐ Not able to answer yet.

7. Are internal audit reports:

Relevant, clear and constructive?

Yes ☑ No ☐

Sufficiently detailed to provide assurance that the necessary audit work has been carried out to support the opinions/conclusions?

Yes ☑ No ☐

Sufficiently detailed to enable effective management action?

Yes ☑ No ☐

Issued on a timely basis?

Yes ☑ No ☐

8. Have internal audit findings been discussed with you prior to being tabled with the audit committee?

Yes ☑ No ☐

9. Has internal audit followed up recommendations to see if they have been implemented?

Yes ☑ No ☐

10. Do you have any major unresolved disagreements with internal audit?

Yes ☐ No ☑

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

5. Were such suggestions realistic, robust and presented clearly and on a timely basis?

Yes ☐ No ☐ N/A yet.

6. How responsive has internal audit been to the institution's needs, including requests for special investigations?

Strong ☐ Adequate ☐ Needs improvement ☐ Not able to answer yet.

7. Are internal audit reports:

Relevant, clear and constructive?

Yes ☑ No ☐

Sufficiently detailed to provide assurance that the necessary audit work has been carried out to support the opinions/conclusions?

Yes ☑ No ☐

Sufficiently detailed to enable effective management action?

Yes ☑ No ☐

Issued on a timely basis?

Yes ☑ No ☐

8. Have internal audit findings been discussed with you prior to being tabled with the audit committee?

Yes ☑ No ☐

9. Has internal audit followed up recommendations to see if they have been implemented?

Yes ☑ No ☐

10. Do you have any major unresolved disagreements with internal audit?

Yes ☐ No ☑

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

Overall performance

1. Has internal audit added value to the institution?

Yes ☑ No ☐

2. In what ways has internal audit added value to the institution?

Overall comments

Name C. MULHOLLAND
Position PRINCIPAL
Signed
Date

University of the Highlands and Islands
Oilthigh na Gàidhealtachd agus nan Eilean

UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

Internal Audit – Internal Quality Assessment Reviews

The Committee of University Chairmen guide for members of Audit Committees in Higher Education provides the following template to help in the annual evaluation of internal audit. The checklist should be completed by the head of finance and/or other senior managers and officers who have regular contact with the internal auditor.

Planning

1. Are internal audit's terms of reference sufficiently visible to everyone within the institution?

Yes ☑ No ☐

2. Has there been sufficient pre-planning and co-ordination by the internal auditors before the start of each phase of the internal audit or special project?

Yes ☑ No ☐

3. Has internal audit discussed its approach and major areas of audit focus with you?

Yes ☑ No ☐

4. Have you raised any major areas of concern that have not been reviewed by the internal audit team?

Yes ☐ No ☑

Comments
DIALOGUE WITH INTERNAL AUDITOR AROUND ANNUAL WORK PLAN IS VERY ROBUST.

Skills and experience

1. Do you consider that the internal audit team have sufficient expertise, professional experience, project management ability, interpersonal skills and seniority to effectively carry out the work required?

Yes ☑ No ☐

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UHI Internal Audit Service
Executive Office
Ness Walk
Inverness

2. Assess the strength of internal audit's understanding of the institution and its risk involvement.

Strong ☑ Adequate ☐ Needs improvement ☐

3. How strongly have the members of the internal audit team demonstrated an appreciation of the issues key to your role and responsibilities?

Strong ☑ Adequate ☐ Needs improvement ☐

4. Have members of the internal audit team consistently demonstrated independence in all their deliberations?

Yes ☑ No ☐

5. Have members of the internal audit team been adequately supervised?

Yes ☑ No ☐

Comments SUPERVISION THROUGH 1) MONTHLY DIALOGUE WITH VICE CHANCELLOR 2) REPORTING TO AUDIT COMMITTEE (A SUB-COMMITTEE OF COURT)

Work programme

1. Has effective co-operation been achieved between the internal auditors and your department, including avoidance of undue disruption to normal activities?

Yes ☑ No ☐

2. Is there a formal process to ensure that internal audit keeps you up to date with audit/project progress?

Yes ☑ No ☐

3. Has internal audit provided early identification and advice regarding contentious issues, problem areas and delays?

Yes ☑ No ☐

4. Has internal audit suggested how such issues could be resolved?

Yes ☑ No ☐

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5. Were such suggestions realistic, robust and presented clearly and on a timely basis?

Yes ☑ No ☐

6. How responsive has internal audit been to the institution's needs, including requests for special investigations?

Strong ☑ Adequate ☐ Needs improvement ☐

7. Are internal audit reports:

Relevant, clear and constructive?

Yes ☑ No ☐

Sufficiently detailed to provide assurance that the necessary audit work has been carried out to support the opinions/conclusions?

Yes ☑ No ☐

Sufficiently detailed to enable effective management action?

Yes ☑ No ☐

Issued on a timely basis?

Yes ☑ No ☐

8. Have internal audit findings been discussed with you prior to being tabled with the audit committee?

Yes ☑ No ☐

9. Has internal audit followed up recommendations to see if they have been implemented?

Yes ☑ No ☐

10. Do you have any major unresolved disagreements with internal audit?

Yes ☐ No ☑

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Overall performance

1. Has internal audit added value to the institution?

Yes ☑ No ☐

2. In what ways has internal audit added value to the institution?

Overall comments WELL ALIGNED WITH RISK MANAGEMENT AND QA/QE INITIATIVES/RESPONSIBILITIES IN OTHER DEPARTMENTS.

Name DR CRICHTON W. HANG.

Position DEPUTY PRINCIPAL + VP ACADEMIC.

Signed [signature]

Date 19/8/14.

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Internal Audit – Internal Quality Assessment Reviews

The Committee of University Chairmen guide for members of Audit Committees in Higher Education provides the following template to help in the annual evaluation of internal audit. The checklist should be completed by the head of finance and/or other senior managers and officers who have regular contact with the internal auditor.

Planning

1. Are internal audit's terms of reference sufficiently visible to everyone within the institution?

Yes ☑ No ☐

2. Has there been sufficient pre-planning and co-ordination by the internal auditors before the start of each phase of the internal audit or special project?

Yes ☑ No ☐

3. Has internal audit discussed its approach and major areas of audit focus with you?

Yes ☑ No ☐

4. Have you raised any major areas of concern that have not been reviewed by the internal audit team?

Yes ☐ No ☑

Comments
/

Skills and experience

1. Do you consider that the internal audit team have sufficient expertise, professional experience, project management ability, interpersonal skills and seniority to effectively carry out the work required?

Yes ☑ No ☐

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2. Assess the strength of internal audit's understanding of the institution and its risk involvement.

Strong ☑ Adequate ☐ Needs improvement ☐

3. How strongly have the members of the internal audit team demonstrated an appreciation of the issues key to your role and responsibilities?

Strong ☑ Adequate ☐ Needs improvement ☐

4. Have members of the internal audit team consistently demonstrated independence in all their deliberations?

Yes ☑ No ☐

5. Have members of the internal audit team been adequately supervised?

Yes ☑ No ☐

Comments Jason has been proactive in assessing the changing needs of the organisation for 14/15

Work programme

1. Has effective co-operation been achieved between the internal auditors and your department, including avoidance of undue disruption to normal activities?

Yes ☑ No ☐

2. Is there a formal process to ensure that internal audit keeps you up to date with audit/project progress?

Yes ☑ No ☐

3. Has internal audit provided early identification and advice regarding contentious issues, problem areas and delays?

Yes ☑ No ☐

4. Has internal audit suggested how such issues could be resolved?

Yes ☑ No ☐

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5. Were such suggestions realistic, robust and presented clearly and on a timely basis?

Yes ☑ No ☐

6. How responsive has internal audit been to the institution's needs, including requests for special investigations?

Strong ☑ Adequate ☐ Needs improvement ☐

7. Are internal audit reports:

Relevant, clear and constructive?

Yes ☑ No ☐

Sufficiently detailed to provide assurance that the necessary audit work has been carried out to support the opinions/conclusions?

Yes ☑ No ☐

Sufficiently detailed to enable effective management action?

Yes ☑ No ☐

Issued on a timely basis?

Yes ☑ No ☐

8. Have internal audit findings been discussed with you prior to being tabled with the audit committee?

Yes ☑ No ☐

9. Has internal audit followed up recommendations to see if they have been implemented?

Yes ☑ No ☐

10. Do you have any major unresolved disagreements with internal audit?

Yes ☐ No ☑

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Overall performance

1. Has internal audit added value to the institution?

Yes ☑ No ☐

2. In what ways has internal audit added value to the institution?

Overall comments

Excellent value add. Good range of activities undertaken focussing particularly on high risk areas

Name FIONA MARG

Position Chief Operating Officer / Secretary

Signed Fiona M Karg

Date 1/9/14