Queen Mary
UNIVERSITY OF LONDON

Internal Audit Recommendation Tracker

Outcome requested	Audit and Risk Committee is asked to **note** progress with the internal audit recommendations.
Executive Summary	Updates from lead officers have been provided. The full list of actions has been included for review.
	Key points for the Committee to note:
	i. 25 items have been progressed to completion. 13 items remain open and are being progressed, only 6 of which were due for completion at this time or are overdue.
	ii. A number of long standing actions have now been implemented including those relating to facilities payments to Barts Health NHS Trust (see SMDP07 on page 6), budget holder training (see BFM05 on page 6), and stakeholder engagement regarding suppliers (see PRO05 on page 10).
	The last column details the revised deadlines for items proposed by the responsible officers. Newly proposed deadlines **have been highlighted in red.** The Executive will provide any further updates at the meeting.
	KPMG will take over monitoring the completion of internal audit recommendations and we will use this as an opportunity to revise the format of the report.
QMUL Strategy:	Internal audit supports all areas of the strategic plan.
Strategic Risks:	Internal audit considers all risk areas.
Subject to prior and onward consideration by:	QMSE 19 September 2017
Confidential paper under FOIA/DPA:	No
Equality Impact Assessment:	Not required
Timing:	Regular report to Audit and Risk Committee
Author:	Sian Marshall, Assistant Registrar (Council and Governance)
Date:	13 September 2017
Senior Management/External Sponsor	Laura Gibbs, Chief Operating Officer

Outstanding Recommendations

Overdue and Due

Audit Plan Year	Audit Title Code	Auditor Priority	Agreed due by date	Finding / Risk / Recommendation	Management Response in Audit	Responsible Officer	Management Notes on progress	Status	Revised deadline proposed by Management Red = high priority
1617	RDD01	Amber	01/09/2017	**Timely update of student amendment data on SITS** We noted one transfer to writing up status request approved by the Deputy Dean at the start of February 2017 where the approved transfer date had not been updated on SITS at the time of testing, in March 2017. This delay was due to staff absence and a staff vacancy. The ten day target is not a service standard that is monitored against and failure to occasionally not make it does not have significant ramifications. However, there should be arrangements in place to ensure the task is covered in the event of unforeseen absences. Furthermore, the Research Degrees Office should undertake a termly review to determine performance and identify whether there are any common causes of delays which should be addressed.	**Accepted** We will develop a monthly data audit process to check changes to students 'enrolment status and projected end date arising from decisions made by RDPEB and decisions delegated to the Faculty Deputy Deans for Research (Research Degrees). The same data will inform our periodic process reviews.	Assistant Academic Registrar (Research Degrees)	Periodic checks are part of the RDO data audit plans, which will be implemented once student enrolment has been completed.	Overdue	**Proposed revised deadline: end of November**
1617	CAPP01	Amber	30/09/2017	**Project Process** We note QMUL uses both its own internal process (Gateway process) and also the external RIBA Plan of Work as a methodology for managing capital projects. The two methodologies differ in the type of information and stages required. The RIBA process is much more detailed in what should be included at each reporting stage while the governance structure approval process is aligned to the Gateway process. The variation between methodologies creates a number of risks: the reporting of progress of projects is more difficult when comparisons are not always like for like, it is more difficult for projects to be picked up when staff leave or are unavailable (i.e. sickness absence) and lessons learnt cannot be easily identified or applied to new projects using different methodologies. Should QMUL wish to continue to have the option of using more than one project methodology (i.e. using RIBA in addition to the internal Gateway process) it should define the circumstances in which it expects each one to be applied and ensure there is clear direction and guidance on how the RIBA process aligns to existing governance framework. Alternatively, it could consider how to incorporate more elements of the RIBA process in the existing Gateway process. This will ensure different projects can be compared and all stakeholders are clear of the slightly different reporting	**Accepted** It should be noted that gateway 0 – 2 align with RIBA Plan of Work Stages 0 -2 although the content of the papers could be updated to fully match the outcomes of RIBA Stages. Gateway 3 (Construction Decision) is subject to the approved procurement strategy and depending on a Traditional, Single or 2 Stage procurement route could be issued at either RIBA Stage 3 or 4. Gateway 3 covers approval for RIBA Plan of Works Stages 3 – 6 (refer to the attachment for the detail). Actions: Capital Projects will undertake a review of the current Gateway Papers (0 – 3). Following the review of existing Gateway Papers (0 – 3) where identified QMUL Estates & Facilities (Capital Projects) will liaise with relevant stakeholders before	Assistant Director of Estates & Facilities (Capital Projects), Head of Capital Development & Projects	This action will be delayed until the end of October due to the departure of the Assistant Director of Estates & Facilities (Capital Projects).	Overdue	**Proposed revised deadline: 31/10/2017**

				and milestone tracking that derive from the two processes.	tabling any recommendations to the Estates Strategy Board (ESB). Amending the Capital Projects Governance reporting process will require ESB approval. Therefore it is proposed to aim for September 2017 for any implementation of re-aligned Gateway Papers with the RIBA Plan of Works.				
1617	SCA01	Amber	30/06/2017	**Stage 1 complaints and informal complaints** There is limited data to support the tracking of stage one complaints and informal complaints and resolutions. In addition, there should be greater communication and information sharing between Departments and the Appeals, Complaints and Conduct Unit in regards to the initiation and outcomes of student complaints (both for formal and informal complaints). We recommend a process is put in place to track the level of informal and stage one complaints being made. These should be collated centrally to ensure there is a better understanding of emerging trends and themes arising through the complaints process. This will better help QMUL to share learning with the aim of reducing future complaints and improving the student experience.	**Accepted** We had provided schools and institutes with templates and guidance on the complaints process and visited each of them individually last year, offering to do further training but this was not taken up. Luke Vulpiani (Assistant Academic Registrar, Appeals, Complaints and Conduct) will undertake a process review of the complaints tracking process with recommendations for schools, institutes and ARCS.	Deputy Academic Registrar	It was agreed that a process improvement project would not be undertaken for this area of work; however, Luke Vulpiani (Assistant Academic Registrar, Appeals, Complaints and Conduct) and the student casework team continue to advise schools and institutes on complaint handling processes. It is evident that complaint handling is working well at local level as just 14 reached the institutional level stage in 2016-17 (for comparison, the student casework team has handled 300 appeal cases and 230 assessment offences in the same period). Additional recommendations for best practice in logging informal and stage one complaints will be circulated to schools and institutes during autumn 2017, with a requirement to report cases to ARCS at the end of each term.	Overdue	**Proposed revised deadline: Dec-17**
1617	SCA02	Amber	30/06/2017	**Complaint Stages and Timelines** QMUL has three formal stages within the complaints process compared to two formal stages within the OIA good practice framework. QMUL's complaints policy requires a formal stage one complaint form and a formal written outcome letter. In practice, formal stage one complaint forms and formal stage one outcome letters are not always consistently applied. In four of ten complaints tested, stage one was bypassed and the complaint proceeded directly to stage two. In two of six stage one complaints tested the stage one complaint form was not completed. Furthermore, we note that five of ten complaints tested were not resolved within the 90 days target outlined by the OIA good practice framework. Of the five complaints tested that were resolved within 90 days, four bypassed stage 1. We recommend: • QMUL consider whether there is the opportunity to streamline the process and remove bottlenecks. QMUL could consider whether there is the possibility to modify stage one complaint level into an informal resolution stage or combine two stages. By streamlining the process the University will benefit by decreasing the administrative burden, and increase student satisfaction	**Accepted** Stage one is sometimes bypassed, often this is where the complaint would be better handled centrally. Also, agreed that the form may not always be completed - this is usually to assist the student. We are keen to work towards decreasing the administrative burden and to increase student satisfaction through quicker resolution of cases. It is often the case that a complaint at stage one may be easier to resolve quickly, by the time the complaint reaches stage two it may have become more complex. We wish to promote informal resolution at local level wherever possible, and will work with schools, institutes and professional services directorates in order to	Deputy Academic Registrar	ARCS is considering making revisions to the number of stages in the complaints process, bearing in mind the emphasis on local resolution and the requirement in the OIA's good practice framework's for a final review stage. The Education Quality and Standards Board will review the complaints policy in light of these suggestions at its meeting in September 2017.	Overdue	**Proposed revised deadline: Dec-17**

				through quicker resolutions. • If a formal stage one is determined necessary we recommend the Appeals, Complaints, and Conduct Unit issue formal guidance to departments on the standardised process to follow including requiring standard complaint forms and issuing standard outcome letters. We recommend the departments are required to follow the standard process to drive consistency throughout the formal stages.	facilitate a more streamlined approach. We will look again at aligning the informal and stage 1 processes and advise schools and institutes of best practice, including formal guidance and template letters. It may be possible to fold this work in with the project on recording complaints, or to follow with a further process review. We will finalise the review of this work by June 2017 to coincide with QMUL's Senate, should any policy modifications be required.				
1213	SMDP06	Amber	01/08/2013	**Partner payments for placement students** Whilst we confirmed that the College was prepared to withdraw funding from the Health Service Bodies (including BHT) in the event that standards fell, we could not identify a specific framework against which providers were assessed. There is a risk that if student numbers were withdrawn from a provider, the deemed lack of transparency over the process could lead to tensions in the partnerships. A formalised framework for assessing suppliers could also reduce the risks of conflicts of interest arising in decisions on partner placement numbers arising from the number of staff that hold joint roles within the SMD and BHT. It is recommended that: - The SMD define standards expected of the Health Service Bodies in receipt of funding for supporting placement students under the Service Increment For Teaching (SIFT) arrangement and benchmark the performance of the difference partners against these criteria. - The SMD inform partners on a timely basis where they are under-performing against the criteria and ultimately use performance as a determinant for allocations	**Accepted** Action is already in place, to be augmented by agreed quality metrics and backed up with clear accountability for resources disbursed for the support of Education in partner Trusts. This will be managed by the SMD's Dean for Education	Dean for Education	**Update August 2017:** SLAs in place except Barts, BHR, ELFT and Moorfields SLAs are outstanding. Barts have agreed their SLA but insist on HEE signing it too. I have asked them to identify someone at HEE for this task. BHR are close to finalising. All agreements should be signed off by December 2017. **Update January 2017:** The SLA has been sent out to Trusts and we await the return of signed agreements. A revised clause has been agreed with one organisation and another has raised late queries and these are being worked through.	Overdue	**Proposed revised deadline: Dec-17**
1617	ANW05	Green	31/08/2017	**Review of training and competency records** Training and competency records are not centrally stored and monitored. While the responsibility for training and competency lies with the project licence holders, which is also clearly communicated in the BSU policy, the ELH is ultimately responsible for all staff working on animal research projects being adequately trained. A central record of staff training and competency records should be held to provide assurance to the ELH that staff working on animal research projects being adequately trained. This could be done on the current ARMIS system.	**Accepted** The PPL holder is responsible for ensuring training and competency of the person licence holders working under their Project licence. We are looking to move to a central record keeping system.	Director of Biological Services	An amended job description has been submitted to HR for regrading; the main focus of this role is the responsibilities of Named Training and Competency Officer (NTCO) as required under the Act. This will facilitate the move to a centralised system, along with clearer reporting lines. We are currently investigating available software systems and will need to seek the funding for this.	Overdue	**Proposed revised deadline: Dec-17**

Not Yet Due

Audit Plan Year	Audit Title Code	Auditor Priority	Agreed due by date	ARC meeting to report progress to	Finding / Risk / Recommendation	Management Response in Audit	Responsible Officer	Management Notes on progress	Status	Revised deadline proposed by Management Red = high priority
1617	SLLF01	Amber	31/10/2017	November 2017 ARC	**Risk management process** SLLF uses the appropriate channels for risk identification, recording and escalation in line with the QUML Risk Management Policy. However, we noted that review and updating of the risk register is only performed annually, while the QMUL policy requires that risk registers are updated bi-annually and are subject to regular review. We recommend the register is formally updated in line with the QMUL policy (i.e. at least bi-annually) to help make the register more of a management tool to help identify risks to the delivery of the school's key objectives.	**Agreed** SLLF to consider adding standing item to Executive Committee or other appropriate committee agenda (committee system may be reviewed following separate review process).	Head of Admin/Head of School		Not yet due	
1617	RDD02	Green	01/11/2017	November 2017 ARC	**Monitoring use of supervision log** The supervision log, on MySIS, is used by PGR students and their supervisors as a tool for successful supervision and as a means to evidence supervision. The importance of the supervision log is outlined to students in the PGR code of practice and as part of a student's induction and to supervisors as part of their training, however there is no formal process in place for monitoring the use of the supervision log. We recommend that use of the supervision log is monitored by the Research Degrees Office on at least a termly basis, to assess whether the tool is being used and whether there are specific faculties within QMUL that are using it more effectively than others. A report should be run on a quarterly basis and students making little or no use of the log inadequate supervision, as defined by the PGR code of practice, should be reminded of the requirement to fully use the log.	**Accepted** A report is under development summarising engagement by each student with the supervision log. This will be circulated to schools/institutes three times each year so that they can follow up with individual students. Any schools/institutes with low levels of engagement will be reported to RDPEB by the RDO.	Assistant Academic Registrar (Research Degrees)	In progress The timing of the report is to be aligned with the timing of the student engagement immigration compliance monitoring exercise co-ordinated by Registry in ARCS.	Not yet due	
1617	SLLF02	Green	30/11/2017	November 2017 ARC	**Key committee terms of reference** We obtained and reviewed terms of reference for the School Board, Senior Executive Committee and the four subcommittees at SLLF. When the terms of references are next due for review the school should consider including the following: • The purpose of the committee; • The membership of the committee;	**Agreed** Include in review of committee structure or at start of first meeting of each committee in new academic year.	Head of Admin/ Head of School/ Chairs of Committees		not yet due	

					• The committee quorum; • The minimum frequency of meetings; • If applicable, the committee's responsibility for oversight of other groups or committees; and • Any other College or groups or committees to which the committee is required to report and at what frequency.					
1617	SLLF03	Green	31/10/2017	November 2017 ARC	**SLLF risk registers** We reviewed the School risk register and sampled six risks to ensure control activities were operating as stated and were documented in a way that is SMART (i.e. specific, measurable, agreed-upon, reasonable and time bound). Whilst we confirmed the SLLF risk register was prepared in-line with University guidelines, one of the risk register items sampled was not fully complete, with mitigating controls missing. We also noted that while control activities are ongoing as documented on the School risk register, the some actions identified are not SMART (in these instances not defining timescales for completion and metrics for measurement. The School should ensure that the information relating to each risk is complete and that when control activities are documented that they are SMART.	**Agreed** Include in next review of risk register. Where SMART objectives or actions are not applicable, ensure this is made clear within the entry.	Head of Admin/ Head of School/ Committee members as appropriate		Not yet due	

Implemented

Audit Plan Year	Audit Title Code	Auditor Priority	Agreed due by date	Finding / Risk / Recommendation	Management Response in Audit	Responsible Officer	Management Notes on progress	Status
1213	SMDP07	Amber	implemented	**Partner payments for placement students use of facilities** We identified that certain partners are being paid significantly more for use of facilities by placement students than other partners, which creates a risk that the College is not getting value for money in its medical placements. Two areas merit special attention. - PCTs (Tower Hamlets and City & Hackney) together provide only three medical student placements and yet have a combined facilities charge of £509k (the equivalent charge for three placements from the other partners combined would be just £138k). - The BHT facilities charge is £31.8m, which represents £78k per placement compared to an average of £15k for the other non-PCT partners who combined provide 51% of the total placement numbers. It is recommended that: - Facilities payments to SIFT partners are monitored in the context of placement numbers and where these are significantly higher for certain institutions, the College should consider re-negotiating the fees and the allocation of any students to these partners.	**Accepted** New tariffs from the DoH deal with this issue which is a legacy issue that has been out of the SMD's hands.	Dean for Education	**Complete:** Barts funding transition has been implemented and the additional (non qualified) fte is being reduced by 15% each year for 5 years until 0. This will complete by 2022/23. In the meantime, we are trying to identify additional work BHT can perform to increase their fte (eg deliver more clinical skills tutors, breast examiner tutors etc)	Overdue
1213	BFM05	Amber	Implemented	**Budget holder training** There is scope for improving the training for budget holders with 43% of budget holders perceiving not to have received sufficient training to perform their role. This is supported by 40% of budget holders who do not view their budgets are realistic. There is also no training for Finance Managers on how to explain accounting matters. It is recommended that: - Mandatory training is introduced for budget holders on budget setting and monitoring. - Staff should not be allowed to take on the responsibilities of being a budget manager until they have completed basic training in budget setting and budget monitoring. - Training is introduced for Finance Managers on how to explain accounting matters to non-finance professionals. - The College should consider the potential for using e-Learning software to track attendance and achieve efficiencies in recurring training programmes.	**Accepted** Budget holder training will be re-introduced and a programme developed. The Finance Director approval will be required before a new budget holder is appointed Training needs will be assessed as an integral part of the staff appraisal process. With regards to e-Learning, this should be should be considered in the wider context of the HR strategy on staff development, rather than in isolation in the finance department.	Deputy Director of Financial Management	Training has been organised with the Centre for Academic and Professional development starting in December 2017.	Overdue

1516	HAS01	Amber	Implemented	**Health and safety policy** We have reviewed the health and safety policy as presented to the Health and Safety Advisory Group on 2 December 2015. Our review focused on compliance with the Health and Safety at Work Act 1974, HSE - HSG65 and OHSAS 18001 as well as other areas of good practice. In order to bring the policy in line with good practice the policy should document; • How compliance with the policy will be measured; • How the College will co-operate with other organisations which share the same workspace; • How the College ensures contractors and other personnel working at, but not employed by the School meet the requirements of the Health and Safety policy; and • The legal requirements which the College is required to fulfil.	**Accepted** Management has produced a detailed action plan setting how the policy will be updated. This includes timescales for each element through to August 2017.	Zarah Laing, Director of Health and Safety	Closed-all actions are completed as a part of the H&S Action Plan.	Due
1617	FM01	Amber	Implemented	**Review of school/institute financial performance** We note school/institute level financial results are discussed at meetings between the respective finance partner and the school's/institute's senior management team. While the finance partners, who participate at the monthly school/institute level review meetings, can escalate instances of underperformance to the central finance team at the management account review meeting (attended by the finance partners, the DoF, deputy interim DoF, the Head of Reporting & Financial Planning and other central finance staff members). However there is variability in how Schools record review meetings. SMD for example fully minutes each meeting with an action log. Other schools do not have minute of complete action logs. To improve oversight of school/institute financial performance at university level, we recommend that for all school/institute financial review meetings there is a rolling action log completed and maintained.	**Accepted** Monthly Faculty meetings to include an action log.	Deputy Director of Finance (Financial Management)	The Finance Business Partners have implemented this for the 2017/18 academic year.	due
1617	ANW01	Amber	Implemented	**Reporting to Council** While reporting processes to the HO, the ELH and senior management at BSU are well developed robust, there is currently no report made to Council on the QMUL's compliance with its duties in relation to Animal Welfare. Due to the highly political nature of the subject matter and the fact the ELH is delegated, we recommend QMUL ensures the reporting structure is revised to include reporting to Council. This could take the form of exception reporting or more likely an annual update on ongoing research, any changes in processes and controls in place or incidents or concerns which have been addressed during the year.	**Accepted** Going forward, we will report annually to QMSE, and by exception to Council. NB Council have also requested a summary of how BSU is scrutinised internally and externally. This will provide further assurance and visibility to Council in this area. We will ensure that QMUL compliance with its duties in this area is included with the legal compliance register.	Director of Biological Services	Animal welfare has been added to the legal compliance register and an update on compliance provided as part of the annual reporting process.	Due

1617	SHC01	Amber	Implemented	**Water Supply – Hot/Cold Labelling** Mandatory element 2.19 *states all premises must be provided with hot and cold water to appropriately marked taps.* Four of five student bedroom sinks sampled and two of five student bedroom shower facilities did not have hot and cold water taps labelled. To comply with mandatory element 2.19 of the code QMUL should ensure there is a process in place for regularly checking residences to check hot and cold water taps are appropriately labelled.	**Accepted** This recommendation is acknowledged and agreed. Immediate action has commenced to ensure that all taps are marked red for hot or blue for cold as appropriate. Where the problem relates to a mixer tap on a shower or basement steps will be taken to ensure that this too is clear.	Campus Maintenance Manager (Residences)	Checks for any recurrence of this issue elsewhere in the housing stock have been conducted and an effective process of ensuring compliance is in place with effect from 31/05/17	Due
1617	SHC02	Amber	Implemented	**Kitchen Facilities and Cooking Equipment** Mandatory element 2.30 *states where provided, all kitchen facilities must be maintained in good order and repair with all equipment supplied in good working order. Facilities for the preparation, cooking and storage of food must be appropriate to the number of students using the facilities in accordance with local authority published standards. Users' instructions must be available.* For one kitchen in our sample of five, the stove top temperature gauge including off position was worn off and replacement signage was illegible. To comply with mandatory element 2.30 of the code QMUL should ensure there is a process in place for regularly checking residences to confirm the temperature settings on stove tops are eligible.	**Accepted** This recommendation is acknowledged and agreed. Immediate action has commenced to order decals from the manufacturer to replace the worn lettering and these will be fitted on all effected appliances. If for some of the hobs this does not work the hobs will be replaced. Regular routine checks will be conducted to ensure no recurrence of this safety problem.	Campus Maintenance Manager (Residences)	The stoves in the sample checked have been rectified and going well beyond this, a large scale programme of hob replacement to ensure the problem is dealt with absolutely will be completed by the end of 30/06/17.	Due
1617	SHC03	Amber	Implemented	**Fault/ Defect Notification and Rectification** Mandatory element 3.2 *states the Higher Education Establishments must provide students with information on how to report a defect or fault, including out of office hours procedure and expected response times from the service.* As part of our checks on two residences we noted that the signage for reporting faults was out of date. The e-mail address and phone number provided are automatically forwarded to the Estates Helpdesk which is the appropriate contact. However the signage directs students to report faults to the Building Maintenance Office which is not the most appropriate office and does not operate 24/7. Students should be directed to report faults in person to the Student Reception office which operates 24/7. To comply with mandatory element 3.2 QMUL should refresh signage across residences so the correct information on how to report faults is communicated to students.	**Accepted** This recommendation is acknowledged and agreed. Immediate action has commenced to create professional looking labels to fix on existing signage over the top of any incorrect information or numbers. This will be followed up by full reprints of signage.	Head of Security & Emergency Planning	Following the effective temporary fix, a review of all mandatory signage was undertaken and the programme of replacement was completed by 28/07/17	Due

1516	HAS02	Green	Implemented	**Health and safety advisors and health and safety managers** The current health and safety policy does not distinguish between the roles and responsibilities of the health and safety advisors and the health and safety managers, rather it includes their responsibilities as part of the Health and Safety Directorate Group. Given there are separate roles for health and safety managers and health and safety advisors, the College should ensure that the health and safety policy reflects this. As such, separate roles and responsibilities should be outlined for both advisors and managers.	**Accepted** Section 2.5.8 of the policy will be updated to better define HSD's position within the QMUL.	Zarah Laing, Director of Health and Safety	Closed- H&S Policy has been updated accordingly.	Due
1516	ROR03	Green	Implemented	**Consistency of project documentation** As part of testing ten industry projects, we found that documentation for one project showed inconsistent overhead recovery rates (the costing form showed 55%, the contract announcement showed 50%). This was because £27,000 of directly allocated staff costs had not been included on the final contract announcement. We recommend that the officer preparing the contract carries out a final review of all project documentation to ensure it is consistent throughout. This will ensure that decisions are being made with reference to accurate information.	**Accepted** Unfortunately this can happen – When we cost (Industry) we would maximise, where possible, to achieve the highest residual for QMUL and this would be reflected in the costing/ quote. If this has been achieved and the amount is over the threshold it could be that an internal arrangement has been made for the additional monies to be used to support the project for additional activities (Conferences, studentship etc).	Dr Sally Burtles, JRMO	Update August 2017: With the introduction of the new Research Management system all overheads recovered for projects are clearly visible within the system. Where internal arrangements have been agreed to re allocate any funds that have been achieved over and above the QMSE overhead target, this is documented within the system for transparency purposes. An adjusted budget is also created within the system to show the new breakdown and both budgets are available for audit purposes.	Due
1415	ROR06	Green	Implemented	**Measures of overhead recovery** Currently overhead recovery is reported in terms of overheads recovered (total award less directly incurred costs) as a percentage of direct staff costs. Although this provides a uniform measure on an aspect of overhead recovery it is not a true measure of the overheads recovered in relation to overheads consumed. We recommend that an additional measure of overhead recovery is introduced that is calculated as the overheads recovered as a % of the full economic cost of the overheads for a project. Overheads recovered would be calculated as award total less full economic cost of directly incurred and attributable costs. This is documented further in Appendix B.	**Accepted** Historically overheads were awarded as a percentage of direct staff involvement at a rate of 46%. This was seen as the accepted level of overheads for non-commercial studies which attracted overheads. Whilst the methodology of costing changed with the introduction of FEC this rate was still retained by the University as a target/acceptable to achieve for this type of research. All costings are presented in the FEC format but it is expected that for commercial studies we should achieve a minimum the full direct and indirect cost recovery ie100% overhead. QMUL Financial Management team are	Pardeep Dhoofer, Head of Reporting and Financial Planning	Extensive work has been done in the last 6 months on improving the accuracy of overhead reporting, working closely with JRMO and involving Faculties on the Research Grant Management System. This will be reviewed again at the next JRMO / Finance joint working group this month.	Overdue

		<td style="background:green"></td>	<td style="background:green"></td>			currently involved in an exercise to agree the way we account and distribute the overhead element of research studies.			
1213	PRO05	Green	Implemented	**Stakeholder Engagement** Our discussion with stakeholders around the College found that there was a desire to be more informed when key tenders which affect all departments are taking place. There is currently no formal route in place for the Schools or Professional Service departments to provide feedback on suppliers. We recommend that: - The Schools and Professional Service departments are consulted when considering suppliers to be part of a framework or when a re-tender is in progress. This could involve holding an annual survey to engage stakeholders or developing voting tools to allow stakeholders to have a say in who the key suppliers are for activities undertaken by the Schools; such as travel companies or furniture suppliers. - As part of a performance review of suppliers, the Procurement Team should request feedback from the users every six months on key suppliers.	**Accepted** We will 1 - Ensure there is appropriate stakeholder representation on tender exercises designed for common use of goods or services across QM 2 - Design a suitable user feedback mechanism that will complement the actions to carried out in recommendation no	Head of Procurement	Feedback is now obtained through contract review meetings between internal stakeholders and procurement. This ensures that any issues and queries are taken forward and resolved. Additionally, the procurement main page on the intranet requests any generic feedback direct to the Head of Procurement (http://qm-web.finance.qmul.ac.uk/purchasing/)	Overdue
1415	ROR05	Green	Implemented	**Charity research overhead rebate** During our review we noted that when reviewing the recovery rates achieved on research projects funded by charities the College does not take into account the central government22% rebate on overhead costs for conducting charity funded research. By not taking into account this additional contribution could make charity funded research look like it is achieving a lower recovery on overheads than it actually is. We recommend that when reviewing recovery rates in relation to charity funded research the 22% rebate from central government should be included to demonstrate the true financial position of the research.	**Accepted** There is no mechanism within the current costing tool to recognise the national charity support contribution to individual studies and therefore it does appear that these are under achieving in comparison to direct overhead bearing studies We will request that finance shows the HEFCE Charity support fund income as a separate line in the Faculty and School accounts One the Research Grants Management System is implemented (July 2016) we ensure this information is captured and can be reported on.	Gerry Collins, Contracts and Costing Manager and Manesh Patel, IT Management Accounts	Update August 2017. RGMS costing and application system was launched in May 2017. The overhead recovery analysis is in line with QMSE current rules. This recovery is based on DI staff. There is no functionality in the system that will show a 22% potential rebate on competitive charities.	Due

1617	RDD03	Green	Implemented	**Action reminders** We noted two instances in our request to transfer to writing up status testing and one instance in our interruptions sample where there were delays in the process due to delayed action/responses from student supervisors and department admin. We also noted one extension where further information was requested by the December Research Degrees Board however this was not provided by the supervisor until to the end of February. We recommend that RDO and schools and institutes develop appropriate mechanisms to ensure delays in processing requests are identified and addressed.	**Accepted** Sign-off of requests is properly the responsibility of schools/institutes. RDO and schools and institutes will develop appropriate mechanisms to identify and address delays (the online workflow in MySIS for transfer to writing up status already provides this). The development of a general reminder process for the PGR SITS online workflows to identify outstanding tasks will be explored.	Assistant Academic Registrar (Research Degrees)	An automatic reminder system for online PGR student process workflows has been implemented. Staff roles within these processes receive automatic email messages and reminders to alert them to outstanding actions in MySIS.	Due
1617	RDD04	Green	Implemented	**Document retention on shared drive** We noted two instances in our student extensions sample testing where the student extension confirmation emails sent by the RDO could not be located, as the member of staff who had sent the emails had left the team. We recommend that RDO takes appropriate steps to ensure copies of request outcomes messages are retained. This will ensure that the information is easily accessible when student amendments are being subsequently reviewed.	**Accepted** The policy is that request outcomes messages are printed and retained in student files. Members of staff have been reminded that copies of confirmation emails must be filed and in future will copy all such emails to the generic Research Degrees mailbox.	Assistant Academic Registrar (Research Degrees)	Members of staff have been reminded that paper copies of confirmation messages must be filed.	Due
1617	SLLF04	Green	Implemented	**Budget Monitoring** We obtained the budget reports for the year to date and chose three lines items where performance was lower than expected. As meetings discussing financial performance are not minutes and no action logs are kept, there was no evidence that financial underperformance was discussed and corrective actions identified and monitored. We recommend that when budget reports are reviewed there is discussion of adverse variances and that corrective actions identified are tracked. This will provide assurance to the Faculty and University that the School is undertaking appropriate scrutinising of financial information.	**Agreed** Head of Admin/ Head of School and Resources Manager meet monthly to review budget statements, log and monitor actions.	Head of Admin/ Head of School/ Resources Manager	Meetings have been introduced.	due

1617	FM02	Green	Implemented	**In year budget reforecasting** There is a routine reforecasting process built into the annual plan called Forecast 1. This is primarily to take account of actual student numbers but is also used as an opportunity to update for other changes. While there may be instances where a reforecasting exercise is appropriate it making it a routine exercise can create issues. Reforecasting can potentially undermine financial monitoring, as budget holders are not held accountable against pre-set targets for the first part of the year and it can reduce the robustness of the initial budget cycle if budget holders know there is second window. Additionally, there is an issue of additional management time being away from other activities. QMUL should consider the value of including a routine reforecast into its annual financial cycle. There should be the opportunity to complete the exercise when there are significant issues with an original budget. Not completing a reforecasting exercise annually will free up management time and better help create an environment where budget holders are held to account against the initially agreed budget to promote the achievement of pre-set financial targets.	**Accepted** As part of the 2017/18 budget process QMSE and the Finance Director agreed there will not be a Forecast 1 in 2017/18. Results will be reported against budget and a full year out-turn will be updated on a monthly basis.	Finance Director	Implemented.	Due
1617	FM03	Green	Implemented	**Financial modelling** The budget setting process could be improved by performing more financial modelling to assess the sensitivity of the budget to underlying key drivers, to set realistic targets and feed back insights to the strategic decision making process, as it can identify how baseline projections and new initiatives impact the financial plan. We understand Cognos does not have the appropriate functionality for financial modelling, which results in limited scenario planning performed. If it is not financially or practically viable to upgrade the system we recommend QMUL consider whether there are any workarounds or alternatives to allow for increased scenario planning.	**Accepted** We will develop our financial models to incorporate sensitivity analysis and this will be included in the 2018/19 budget process.	Deputy Director of Finance (Financial Management)	Update August 2017: we will be migrating from our existing Cognos platform to a more flexible Cognos solution during 2017/18. We have recruited a new Cognos and Systems accountant to the team (starting September 2017) who has significant experience in the new Cognos tool. In the meantime, we are developing scenario and metric based planning approaches in Excel.	Due
1617	FM04	Green	Implemented	**Budget reports** Review of the financial performance reports prepared by the finance partners for schools and institutes has shown that a commentary on the figures and variance analysis is not always provided. As school senior management may not have specific expertise in finance, commentary on the financial results is essential to highlight areas of underperformance. We therefore recommend to reiterate the importance of narrative comments as part of the budget reports provided to schools/institutes.	**Accepted** Monthly financial reports to include commentary.	Deputy Director of Finance (Financial Management)	Implemented.	Due

1617	ANW02	Green	Implemented	**AWERB meetings** We have reviewed the AWERB terms of reference and meeting minutes to assess whether the responsibilities under the ASPA are effectively discharged of at QMUL and found the following improvement opportunities: Meeting minutes were not available for one of five meetings held in 2016/17 and the QUARTZY electronic repository system is no longer used for record keeping as stated in the ToR. Additionally, AWERB minutes do not show evidence of retrospective reviews completed. The ToR state that retrospective reviews are to be undertaken for all projects although we note that the HO licence does not mandate this requirement. AWERB should either be completing reviews as directed by its TOR or consider updating the TOR to reflect current practice.	**Accepted** We will ensure all meeting minutes are maintained as good practice however we note that only records for ASPA for 2c research, projects not currently undertaken at QMUL, need to be maintained. When we have finalised using the new Lab Archives then we will update the ToR.	Director of Biological Services	Administrative support for minute taking has been provided. The TOR has being fully updated by mid-September. Regular retrospective reviews conducted via QMUL's Animal Welfare and Ethical Review Body will be documented going forward.	Due
1617	ANW03	Green	Implemented	**BSU policy** The BSU policy sets out clear expectations relating to the roles and responsibilities of all licence holders and named persons required under the ASPA however it does not provide guidance on the submission of the mandatory annual return for all project licences. Furthermore it refers to systems not currently in use at QMUL, such as the QUARTZY electronic repository system, which has been replaced by lab archives. These update should be made when the policy is next due for review.	**Accepted** We need to state that the annual returns are mandatory. We currently annually send out an emails outlining that year's process and timeline. When we have finalised using the new Lab Archives then we will update the ToR.	Director of Biological Services	Complete.	Due
1617	ANW04	Green	Implemented	**ARMIS system records** A monthly stock take of animals is performed to confirm numbers per ARMIS. However, no records are kept. While this is not a HO requirement, records of the monthly stock take could be kept with relatively low administrative burden. We recommend QMUL implement a process for evidencing monthly stock takes. This could mean keeping all records or alternatively creating a proforma sign off sheet that is completed, signed off as part of the monthly process and stored.	**Accepted** We will develop a sign off sheet that is signed by the manager to state completed; rather than keep all this paperwork	Director of Biological Services	A sign off sheet is now provided and completed by the managers.	Due
1617	CAPP02	Green	Implemented	**Document Retention** As part of our review Estates were able to provide all information relating to the three projects reviewed. However there is no central storage in place to maintain project documentation or an expectation on exactly what information should be kept and how it should be filed. This is exacerbated by the fact that QMUL uses more than one project methodology and these require different types of information. Going forward we recommend there is clear guidance on what information should be held for capital projects, where and how it should be filed. This will ensure that complete audit trails are maintained for capital projects and can be easily identified.	**Accepted** QMUL Estates & Facilities (Capital Projects) acknowledge that the existing electronic filing structure can be improved. We also concur that "guidance on what information should be held for capital projects, where and how it should be filed" should be implemented. Actions: Capital Projects are currently reviewing the electronic filing structure and document control process, as well as developing a user guide for staff. Training will be rolled out to project	Assistant Director of Estates & Facilities (Capital Projects), Head of Capital Development & Projects	The new electronic filing system/format has been completed and the staff manual for the filing system will be completed in September 2017.	Due

					managers and regular auditing of filing systems and templates will be implemented.			
1617	CAPP03	Green	Implemented	**Initial Budget Information** At the first Project Board (PB) meeting for the Neuron Pod project there was no breakdown of the costing of the project. We note a total budget was recorded and an action minute for the external consultant to provide a budget breakdown for the next PB meeting. We have confirmed that the current financial position is in line with the total budget and the breakdown was subsequently used to track budget variations. QMUL should ensure detailed budget information is reported to the first PB meeting to cover a new project. This will ensure that financial performance can immediately be monitored on an ongoing basis against original budgets and ensure that any variances in areas at the start of the projects are identified in a timely manner.	**Accepted** QMUL Estates & Facilities (Capital Projects) concur that when available "QMUL should ensure detailed budget information is reported to the first PB meeting to cover a new budget." Actions: It will be reinforced to all Project Managers that full Budget Information and approvals should be presented to all Project Boards.	Assistant Director of Estates & Facilities (Capital Projects), Head of Capital Development & Projects	Action competed. The need for accurate cost plans and cash flow forecasts from project inception has been reiterated to all Senior project managers.	Due
1617	SHC04	Green	Implemented	**Snow and ice clearance policies** Desirable element 3.8 states *Policies on snow and ice clearance should specify expected clearance times and should be displayed in a communal area and/or on the appropriate website where residences are part of a campus environment. Residences in urban areas should display advice regarding the Local Authorities responsibilities.* QMUL has a policy on how to handle and remove snow and ice. However there is no policy on snow and ice removal with expected clearance times and Local Authority responsibilities that is communicated to students either via signage in communal areas or on the website. This is not a mandatory element of the code but QMUL should consider whether it needs to update its policy and communicate this so expected clearance times and the Local Authority responsibilities are communicated.	**Accepted** This recommendation is acknowledged and agreed. Updates to clarify the policy relating to the clearance of snow and ice will be incorporated into the 17/18 redraft of the Residents Handbook.	Head of Housing Services	Updated Snow and Ice clearance received from the Facilities Management team and incorporated into the Residents' Handbook for 17/18. Annual updates scheduled. Links to local authorities' snow and ice clearance policies and procedures have been added to the residences website under 'Policies and Procedures – Health and Safety'.	Due