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Non-Executive Report of the: ***Audit Committee*** *28th June 2017*	
Report of: *Zena Cooke - Corporate Director - Resources*	***Classification:*** *Unrestricted*
2016/17 Head of Audit Report	

Originating Officer(s)	*Minesh Jani*
Wards affected	*All wards*

1. Summary

1.1 This report provides the annual internal audit opinion in accordance with the Public Sector Internal Audit Standards. The opinion supports the annual governance statement, which forms part of the annual statement of accounts required under the Accounts and Audit Regulations 2015.

1.2 The report concludes that the Council has a reasonably effective system of internal control which was in operation throughout 2016/17. The Head of Audit opinion is attached to this report at Appendices 7 and 8.

2. Recommendation

2.1 The Audit Committee is asked to note the content of the annual audit report, the summary of audits undertaken which have not been previously reported and the Head of Audit opinion.

2.2. The Audit Committee should consider and approve the Audit Charter and the Audit Strategy attached at Appendix 1.

3. Introduction

3.1 The purpose of this report is to meet the Head of Internal Audit annual reporting requirements set out in the Public Sector Internal Audit Standards. The Code advises that this report includes an opinion on the overall adequacy and effectiveness of the organisation's internal control

environment and presents a summary of the audit work undertaken to formulate the opinion.

3.2 This report is set out as follows:

- **Opinion and basis of opinion**
- **Summary of audit work undertaken in 2016/17**
- **Appendix 1 - Audit Charter and Internal Audit Strategy,** setting out the purpose, authority and responsibility of the Council's Internal Audit function, in accordance with the UK Public Sector Internal Audit Standards.
- **Appendix 2 - Audit Resources**
- **Appendix.3 -Summaries of reports not previously reported** Summaries of all audit reports are submitted to the CLT.
- **Appendix 4 – Follow Up Audits**
- **Appendix 5 – List of planned audits undertaken in 2016/17**
- **Appendix 6 – Summary Head of Audit Opinion**
- **Appendix 7 – Detailed Head of Audit Opinion**
- **Appendix 8 – Benchmarking club/headline**

4. Statement of Responsibility

4.1 The Council is responsible for ensuring its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The Council also has a duty under the Local Government Act 1999 to make arrangements to secure continuous improvement in the way in which it functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

4.2 In discharging this overall responsibility, the Council is also responsible for ensuring that there is a sound system of internal control which facilitates the effective exercise of the Council's functions and which includes arrangements for the management of risk.

5. Opinion

5.1 It is my opinion that I can provide reasonable assurance that the authority has an adequate system of internal control and that this was operating effectively during 2016/17. The basis for this opinion is set out below.

6. Basis of Opinion

6.1 The annual internal audit opinion is derived primarily from the work of Internal Audit during the year as part of the agreed internal audit plan 2016/17. A summary of that work is set out in paragraph 8 below. Internal Audit has been given unfettered access to all areas and systems across the Authority and has received appropriate co-operation. However, there have been delays in responding to Internal Audit enquiries and responding to draft audit reports. This matter has been raised with the Corporate Director, Resources and escalation routes have been developed to ensure timely response.

6.2 Internal audit work has been carried out in accordance with the Public Sector Internal Audit mandatory standards for Internal Audit in Local Government.

6.3 My opinion is primarily based on the work carried out by Internal Audit during the year on the principal risks, identified within the organisation's Assurance Framework.

6.4 In planning audit coverage and in forming the annual opinion, I have taken account of other sources of assurance, including the work of the External Auditors and other inspectors pertaining to or reported during 2016/17. Details of the other sources of assurances and the assurances obtained from the work of audit are attached at Appendices 6 and 7.

7 Audit Resources

7.1 The resources available to Internal Audit are set out in appendix 2 below. Internal Audit is provided in partnership with Mazars as part of Croydon Framework contract. An in-house team of four auditors works with resources provided under the Croydon framework arrangement.

7.2 The resources made available were adequate for the fulfilment of the Authority's duties although for the 2016/17 financial year, the resources had been increased in view of the Directions set out by the Secretary of State to support the work of the Council.

7.3 Productivity was maintained at planned levels. Sickness absence in the team was 21 days per person on average, compared with 3.6 days per person the previous year. This was due to a long term sickness for one member of staff.

7.4 During the year, there was an emphasis on carrying out risk based audits from the approved audit plan for 2016/17, which reflects the internal audit

strategy in providing assurance to the Council over its systems of internal control to manage risks. In addition, a number of specific pieces of audit work were commissioned by Corporate Directors. Details of the work done are attached at Appendix 4.

8 Summary of Audit Work

8.1 A list of the audits undertaken in 2016/17 is attached to main body of the report at Appendix 5 including the assurance levels assigned. Audit assurance is assigned one of four categories: Nil, Limited, Substantial and Full. Audits are also categorised by the significance of the systems. These are defined in Appendix 2.

8.2 Summaries of the finalised audit reports are reported quarterly to the CLT and the Audit Committee. Appendix 3 provides the summaries of those reports finalised in the period March to May 2017.

8.3 A summary of the audit assurance resulting from audit reports in 2016/17 is provided in the table below.

Audits 16/17		Full	Substantial	Limited	N/A	TBC
Significance	Extensive	5	48	24	4	8
	Moderate	-	25	2	-	-
	Low	-	-	-	-	-
	Total	5	73	26	4	8
	%	4%	63%	22%	4%	7%

8.4 The table shows that of 116 systems audits where we have issued audit reports, 67% of the systems audited achieved an assurance level of full or substantial. Full or substantial assurance means that an effective level of control was in place, although this does not mean the systems were operating perfectly. 22% of systems audited were rated as limited or nil assurance, 7% have their assurance levels yet to be confirmed; and 4% of audits did not require an audit opinion as these were consultancy audits.

8.5. Limited assurance means that there are controls in place, but that there are weaknesses such that undermine the effectiveness of the controls. In all cases actions are identified to rectify these weaknesses.

8.6. From the Internal Audit work during 2016/17 financial year, we identified risks in the Council's systems in a number of areas including Management of Markets, Management of Housing Allocations and Lettings, Establishment Control, Management of DBS checks, Troubled Families, Management of No Recourse to Public Funds cases, Management of Parking Permits, Management of Major Works and Procurement and Contract Monitoring.

Further information is provided at Appendix 7. Management have given commitment to implement our recommendations and this should in turn improve control environment in these areas.

8.7. From our Internal Audit work during 2016/17, we can provide an overall assurance that Tower Hamlets has a reasonably effective internal control framework with identified areas for improvement. In general, the key controls are in place and are operational. There is ownership of internal control at all management levels, which is evidenced by the positive response to audit recommendations.

9. Audit Performance

9.1. Internal Audit report three core performance indicators as part of Chief Executives performance monitoring and quarterly to the Audit Committee. The performance for 2016/17 is set out in the table below.

Performance Measure	2016/17	
	Target	Actual
Percentage of operational plan completed (to at least draft report stage) in the year	100%	97%
Percentage of priority 1 recommendations followed up that have been implemented by 6 month review date	100%	69% 48 out of 70
Percentage of priority 2 recommendations followed up that have been implemented by 6 month review date	95%	53% 42 out of 80

9.2. As at the 31st March 2017, 97**%** of the operational plan was completed in terms of days used. There were a few audits still in progress as at 31st March 2017 that have now been completed or are awaiting management comments.

9.3. Internal Audit's planned programme of work includes a check on the implementation of all agreed recommendations. This review is carried out six months after the end of the audit. For 2016/17 as a whole, 69% of priority 1 recommendations had been implemented against a target of 100%, and 53% of priority 2 recommendations had been implemented against a target of 95%. Appendix 4 lists the results of those follow up audits finalised since the last Audit Committee meeting. Corporate Directors are being regularly updated with the progress and performance of follow up audits and Internal Audit maintains a record of outstanding recommendations and carries out further checks on recommendations not complete at the six month review.

9.4. The budget outturn for the service is set out in Appendix 2. Internal Audit is benchmarked against a basket of authorities as part of the CIPFA benchmarking club. The results of benchmarking exercise for 2015/16 are attached at Appendix 8.

10. COMMENTS OF THE CHIEF FINANCE OFFICER

10.1. The Head of Internal Audit is required to provide an annual independent opinion on the adequacy of the systems of control in the authority from his work which is a vital part of the internal scrutiny activity of the organisation.

10.2 The Chief Finance Officer CFO must support the authority's internal audit arrangements and ensure that the audit committee receives the necessary advice and information, so that both functions can operate effectively. This report demonstrates that there has been wide ranging internal audit coverage across the authority. There are still some areas where a more timely response to audit reports and the implementation of recommendations arising from them is required however the escalation process that has been put in place is beginning to address this.

10.3 Any financial implications arising from the implementation of any individual audit recommendation are dealt with through the Council's usual budgeting and budget monitoring processes so there are no direct financial implications arising from this report.

11. LEGAL COMMENTS

11.1 A professional, independent and objective internal audit service is one of the key elements of good governance, as recognised throughout the UK public sector. In that regard, HM Treasury has adopted a common set of Public Sector Internal Audit Standards (PSIAS) from 1 April 2013. The PSIAS encompass the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF). The PSIAS is therefore addressed to Accounting Officers, Accountable Officers, board and audit committee members, heads of internal audit, internal auditors, external auditors and other stakeholders such as chief financial officers and chief executives.

11.2 Pursuant to the PSIAS the Chief audit executives are expected to report conformance on the PSIAS in their annual report and this report is confirming such conformance.

11.3 This report is also consistent with the Council's obligation under the Accounts and Audit Regulations 2015 to have a sound system of internal control which facilitates the effective exercise of the Council's functions and which includes arrangements for the management of risk. Further, the report is consistent with the Council's best value duty pursuant to section 3 of the Local Government Act 1999 and which requires the Council as a best value authority to "make arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness".

11.4 Finally, this report supports the annual governance statement, which forms part of the annual statement of accounts required under the Accounts and Audit Regulations 2015.

12. One Tower Hamlets

12.1 There are no specific one Tower Hamlets considerations.

12.2. There are no specific Anti-Poverty issues arising from this report.

13. Risk Management Implications

13.1. This report highlights risks arising from weaknesses in controls that may expose the Council to unnecessary risk. The risks highlighted in this report require management responsible for the systems of control to take steps so that effective governance can be put in place to manage the authority's exposure to risk.

14. Sustainable Action for a Greener Environment (SAGE)

14.1. There are no specific SAGE implications.

Appendix 1

Internal Audit Charter

Mission Statement

The Mission of LBTH Internal Audit Service is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

The Charter

This Charter sets out the purpose, authority and responsibility of the Council's Internal Audit function, in accordance with the UK Public Sector Internal Audit Standards.

The Charter will be reviewed annually and presented to the Audit Committee and to Corporate Management Team for final approval.

Purpose

Internal Audit is defined by the Institute of Internal Auditors' International Professional Practices Framework as "an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes."

In a local authority internal audit provides independent and objective assurance to the organisation, its Members, the Corporate Management Team (CMT) and in particular to the Chief Financial Officer to help him discharge his responsibilities under S151 of the Local Government Act 1972, relating to the proper administration of the Council's financial affairs.

In addition, the Accounts and Audit Regulations (2011) specifically require the provision of an internal audit service. In line with regulations, Internal Audit provides independent assurance on the adequacy of the Council's governance, risk management and internal control systems. Further information around the purpose of Audit is set out in the Council's Financial Regulations (D3) and Financial Procedures (CR4).

Authority

The Internal Audit function has unrestricted access to all Council records and information, both manual and computerised, cash, stores and other Council property or assets it considers necessary to fulfil its responsibilities. Audit may enter Council property and has unrestricted access to all locations and officers where necessary on

demand and without prior notice. Right of access to other bodies funded by the Council should be set out in the conditions of funding.

The Internal Audit function will consider all requests from the external auditors for access to any information, files or working papers obtained or prepared during audit work that has been finalised, which External Audit would need to discharge their responsibilities.

Responsibility

The Council's Head of Internal Audit (The Head of Audit and Risk Management) is required to provide an annual opinion to the Council and to the Chief Financial Officer, through the Audit Committee, on the adequacy and the effectiveness of the internal control system for the whole Council. In order to achieve this, the Internal Audit function has the following objectives:

- To provide a quality, independent and objective audit service that effectively meets the Council's needs, adds value, improves operations and helps protect public resources
- To provide assurance to management that the Council's operations are being conducted in accordance with external regulations, legislation, internal policies and procedures.
- To provide a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes
- To provide assurance that significant risks to the Council's objectives are being managed. This is achieved by annually assessing the adequacy and effectiveness of the risk management process.
- To provide advice and support to management to enable an effective control environment to be maintained
- To promote an anti-fraud, anti-bribery and anti-corruption culture within the Council to aid the prevention and detection of fraud
- To investigate allegations of fraud, bribery and corruption

Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas identified by the organisation as being of greatest risk and significance and rely on management to provide full access to accounting records and transactions for the purposes of audit work and to ensure the authenticity of these documents.

Where appropriate, Internal Audit will undertake audit or consulting work for the benefit of the Council in organisations wholly owned by the Council, such as Tower Hamlets Homes. Internal Audit may also provide assurance to the Council on third party

operations (such as contractors and partners) where this has been provided for as part of the contract.

Reporting

The UK Public Sector Internal Audit Standards require the Head of Internal Audit to report at the top of the organisation and this is done in the following ways:

- The Internal Audit Strategy and Charter and any amendments to them are reported to the Corporate Management Team (CMT) and the Audit Committee (AC). Both documents must then be presented to these bodies annually.
- The annual Internal Audit Plan is compiled by the Head of Internal Audit taking account of the Council's risk framework and after input from members of CMT. It is then presented to CMT and AC annually for noting and endorsement.
- The internal audit budget is reported to Cabinet and Full Council for approval annually as part of the overall Council budget.
- The adequacy, or otherwise, of the level of internal audit resources (as determined by the Head of Internal Audit) and the independence of internal audit will be reported annually to the AC. The approach to providing resource is set out in the Internal Audit Strategy.
- Performance against the Internal Audit Plan and any significant risk exposures and control issues arising from audit work are reported to CMT and AC on a quarterly basis.
- Any significant consulting activity not already included in the audit plan and which might affect the level of assurance work undertaken will be reported to the AC.
- Results from internal audit's Quality Assurance and Improvement Programme will be reported to both CMT and the AC.
- Any instances of non-conformance with the Public Sector Internal Audit Standards must be reported to CMT and the AC and will be included in the annual Head of Internal Audit report. If there is significant non-conformance this may be included in the Council's Annual Governance Statement.

Independence

The Head of Internal Audit (the Head of Audit and Risk Management) has free and unfettered access to the following:

- Chief Financial Officer (Corporate Director, Resources)
- Head of Paid Service
- Chair of the Audit Committee (AC)
- Monitoring Officer
- Any other member of the Corporate Management Team

The independence of the Head of Internal Audit is further safeguarded by ensuring that his annual appraisal is not inappropriately influenced by those subject to audit. This is achieved by ensuring that both the Head of Paid Service and the Chair of the Audit Committee contribute to, and/or review the appraisal of the Head of Internal Audit.

All Council and contractor staff in the Governance Service are required to make an annual declaration of interest to ensure that auditors' objectivity is not impaired and that any potential conflicts of interest are appropriately managed.

Internal Audit may also provide consultancy services, such as providing advice on implementing new systems and controls. However, any significant consulting activity not already included in the audit plan and which might affect the level of assurance work undertaken will be reported to the AC. To maintain independence, any audit staff involved in significant consulting activity will not be involved in the audit of that area for at least 12 months.

Due Professional Care

The Internal Audit function is bound by the following standards:

- Institute of Internal Auditor's International Code of Ethics
- Seven Principles of Public Life (Nolan Principles)
- UK Public Sector Internal Audit Standards.
- All Council Policies and Procedures
- All relevant legislation

Internal Audit is subject to a Quality Assurance and Improvement Programme that covers all aspects of internal audit activity. This consists of an annual self-assessment of the service and its compliance with the UK Public Sector Internal Audit Standards, ongoing performance monitoring and an external assessment at least once every five years by a suitably qualified, independent assessor.

A programme of Continuous Professional Development (CPD) is maintained for all staff working on audit engagements to ensure that auditors maintain and enhance their knowledge, skills and audit competencies. Both the Head of Audit and Risk Management and the Audit Manager are required to hold a professional qualification (CCAB or CMIIA) and be suitably experienced.

Internal Audit Strategy

This Strategy sets out how the Council's Internal Audit service will be developed and delivered in accordance with the Internal Audit Charter. The Strategy will be reviewed annually and presented to the Audit Committee and to Corporate Management Team for final approval.

Internal Audit Objectives

Internal Audit will provide independent and objective assurance to the organisation, its Members, the Corporate Management Team (CMT) and in particular to the Corporate Director, Resources to support him in discharging his responsibilities under S151 of the Local Government Act 1972, relating to the proper administration of the Council's financial affairs. It is the Council's intention to provide a best practice, cost efficient internal audit service.

Internal Audit's Remit

The internal audit service is an assurance function that primarily provides an independent and objective opinion on the degree to which the internal control environment supports and promotes the achievement of the council's objectives.

Under the direction of a suitably qualified and experienced Head of Internal Audit (the Head of Audit and Risk Management), Internal Audit will:

- Provide management and members with an independent, objective assurance and consulting activity designed to add value and improve the Council's operations.

- Assist the Audit Committee to reinforce the importance of effective corporate governance and ensure internal control improvements are delivered;

- Drive organisational change to improve processes and service performance;

- Work with other internal stakeholders and customers to review and recommend improvements to internal control and governance arrangements in accordance with regulatory and statutory requirements;

- Work closely with other assurance providers to share information and provide a value for money assurance service; and

- Participate in local and national bodies and working groups to influence agendas and developments within the profession.

Internal Audit must ensure that it is not responsible for the agreed design, installation and operation of controls so as to compromise its independence and objectivity. Internal Audit will however offer advice on the design of new internal controls in accordance with best practice.

Service Delivery

The Service will be delivered by the Council's internal audit team and the Council's strategic internal audit partner (currently Mazars) under the direction of the Council's Head of Internal Audit and Risk Management and supported by the Audit Manager.

To ensure that the benefits of the Internal Audit service are maximised and shared as best practice, Tower Hamlets will participate in the London Audit & Anti-Fraud Partnership to work with other local authorities on a shared service basis. This includes appropriate: resource provision, joint working, audit management & strategy and a range of value added services.

Internal Audit Planning

Audit planning will be undertaken on an annual basis and audit coverage will be based on the following:

- Discussions with the Council's Leadership Team (CLT) and Management;
- The Council's Risk Register;
- Outputs from other assurance providers;
- Requirements as agreed in the joint working protocol with External Audit. The Head of Internal Audit and Risk Management or his deputy will attend all Departmental Leadership Team meetings as part of the annual planning process to ensure that management views and suggestions are taken into account when producing the audit plan.

The Internal Audit Plan 2016/17 is composed of the following:

- **Risk Based Systems Audit:** Audits of systems, processes or tasks where the internal controls are identified, evaluated and confirmed through risk assessment process. The internal controls depending on the risk assessment are tested to confirm that they operating correctly. The selection of work in this category is driven by Departments' own risk processes and will increasingly include work in areas where the Council services are delivered with other organisations.

  Internal Audit planning is already significantly based on the Council's risk register. Internal audit will continue to have a significant role in risk management with audit

planning being focused by risk and the results of audit work feeding back into the risk management process.

- ***Key Financial Systems*****:** Audits of the Council's key financial systems where External Audit require annual assurance as part of their external audit work programme.

- ***Probity Audit (schools & other establishments*****):** Audit of a discrete unit. Compliance with legislation, regulation, policies, procedures or best practice are confirmed. For schools this includes assessment against the Schools Financial Value Standard.

- ***Computer Audit*****:** The review of ICT infrastructure and associated systems, software and hardware.

- ***Contract Audit*****:** Audits of the Council's procedures and processes for the letting and monitoring of contracts, including reviews of completed and current contracts.

- ***Fraud and Ad Hoc Work*****:** A contingency of audit days are set aside to cover any fraud and irregularity investigations arising during the year and additional work due to changes or issues arising in-year.

- ***Knowledge and Insight*****:** The Head of Audit and Risk Management, in conjunction with the Internal Audit and the Corporate Fraud teams, will use the knowledge and insight gained of the organisation and carry out reviews in specific areas.

Follow-up

Internal Audit will evaluate the Council's progress in implementing audit recommendations against set targets for implementation. Progress will be reported to management and to the Audit Committee on a quarterly basis. Where progress is unsatisfactory or management fail to provide a satisfactory response to follow up requests, Internal Audit will implement the escalation procedure as agreed with management.

Reporting

Internal audit reports the findings of its work in detail to local management at the conclusion of each piece of audit work and in summary to departmental and corporate management on a quarterly basis. Summary reports are also provided to the Audit Committee four times per year. This includes the Head of Internal Audit's annual report which contributes to the assurances underpinning the Annual Governance Statement of the Council.

Appendix 2

Internal Audit – Resources 2016/17

		Revised Plan	%	Outturn	%
	In-house staff days	1037	*62%*	994	*61%*
	Mazars	637	*38%*	629	*39%*
	Gross days	**1674**		**1623**	
less	Leave	118	*48%*	110	*46%*
less	Sickness absence	70	*28%*	70	*30%*
less	Non Operational Time	56	*24%*	56	*24%*
	Unproductive time	**244**		**236**	
Net productive days		**1,430**		**1,387**	

Internal Audit Budget 2016/17

	Budget £000	Actual £000	Variance £000
Salaries	**431**	**431**	**0**
Contract costs	**205**	**235**	**+30**
Running costs	**24**	**20**	**-4**
Central Recharges	**150**	**150**	**0**
Gross cost recharged	**810**	**836**	**+26**

*- includes the cost of three officers in the corporate fraud team.

Internal Audit Reports 2016/17 – Summary of Audit Reports

Assurance ratings

Level

	Level	Description
1	**Full Assurance**	***Evaluation opinion*** - There is a sound system of control designed to achieve the system objectives, and ***Testing opinion -*** The controls are being consistently applied.
2	**Substantial Assurance**	***Evaluation opinion*** - While there is a basically sound system there are weaknesses which put some of the control objectives at risk, and/ or ***Testing opinion*** - There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
3	**Limited Assurance**	***Evaluation opinion*** - Weakness in the system of controls are such as to put the system objectives at risk, and/or ***Testing opinion*** - The level of non-compliance puts the system objectives at risk.
4	**No Assurance**	***Evaluation opinion*** - Control is generally weak leaving the system open to significant error or abuse, and/or ***Testing opinion*** - Significant non-compliance with basic controls leaves the system open to error or abuse.

Significance ratings

Extensive	High Risk, High Impact area including Fundamental Financial Systems, Major Service activity, Scale of Service in excess of £5m.
Moderate	Medium impact, key systems and / or Scale of Service £1m- £5m.
Low	Low impact service area, Scale of Service below £1m.

Direction of Travel

Each audit summary presented at Appendix 2, shows the Direction of Travel for that audit. Each Direction of Travel is defined in the following Table.

⇨	Improved since the last audit visit. Position of the arrow indicates previous status.
⇦	Deteriorated since the last audit visit. Position of the arrow indicates previous status.
⇔	Unchanged since the last audit report.
⇕	Not previously visited by Internal Audit.

Appendix 3

Summaries of 2016/17 audit reports not previously reported

Assurance level	Significance	Directorate	Audit title
Limited	Extensive	Place	Market Vouchers Follow-Up
	Extensive	Place	Control and Monitoring of Right to Buy Valuations
	Extensive	Place	Highways Repairs and Maintenance – Follow Up Audit
	Extensive	Children's Services	Commissioning of SEN Placements
	Extensive	Resources	Pensions
	Extensive	Resources	Financial Assessments
	Extensive	Tower Hamlets Homes	THH Housing Insurance Claims Follow-Up
	Extensive	Tower Hamlets Homes	THH Management of Asbestos Follow-Up
	Moderate	Children's Services	St Luke's CoE Primary School
SUBSTANTIAL			
	Extensive	Resources	Debtors
	Extensive	Resources	Revenue and Capital Budgetary Control
	Extensive	Resources	General Ledger
	Extensive	Resources	Back Office Revenue Collection and Processing Follow-Up
	Extensive	Tower Hamlets Homes	Unauthorised Occupancy Follow-Up
	Extensive	Tower Hamlets Homes	Programme and Project Management Follow-Up
	Extensive	Children's Services	Adoption and Fostering Panels – Follow Up
	Extensive	Place	Penalty Charge Notices

Assurance level	Significance	Directorate	Audit title
	Extensive	Corporate	Asset Disposal
	Moderate	Children’s Services	Idea Store Watney Follow-Up
	Moderate	Children’s Services	Bonner Primary School
	Moderate	Children’s Services	Stephen Hawking Primary School
	Moderate	Children’s Services	Kobi Nazrul Primary School
	Moderate	Children’s Services	Wellington Primary School
FULL	Extensive	Place	Poplar Mortuary Follow-Up
	Extensive	Corporate	Transparency Code Compliance
N/A	Extensive	Resources	Independent Review of Pensions Statements

Limited Assurance

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Market Vouchers Follow-Up	April 2017	This follow-up audit has been undertaken as part of the 2016/17 agreed Internal Audit Plan. The Council operates 11 markets across the area, which is cumulatively open for 364 days each year. These include iconic markets such as Brick Lane, Columbia Road and Petticoat Lane. The responsibility for the management, control and enforcement of markets and other street trading activity now sits with the Place Directorate. A full systems audit of the Market Vouchers section was undertaken in September 2016 and was assigned Limited Assurance with three high priority recommendations and one medium priority recommendation raised. The objective of this follow-up audit was to assess whether the agreed recommendation at the conclusion of the original systems audit had been implemented. Our follow up review identified that of the three high priority and one medium priority recommendations made in the original audit report, one high priority recommendation has been fully implemented. The remaining three recommendations are partly implemented. The following issues were raised:- • A handheld machine is not yet in place to track Tower Hamlets Enforcement Officers (THEOs) daily movements. It was previously recommended that 10 spot checks be undertaken per month in respect of THEO activity. However, at the time of follow-up, only two per month were taking place. • There was not a formalised log of all training provided (and to verify attendance). Consequently, some e-mail trail evidence was provided which indicated some disagreement regarding the level of training that had been received to date. • Policies and procedures, although having been partly updated following the original audit, still omit the expected version history detail. Standard	Extensive	Limited ⟺

		Operating Procedures (SOPs) are still in the process of being updated. All findings and recommendations were agreed with the Markets and Enforcement Development Manager and reported to the Divisional Director Public Realm and Chief Executive (Interim Corporate Director, Communities, Localities and Culture).		

Management Comments

With regards to the recommendations, progress to achieve the desired outcomes are as follows:

- The PSI handheld logging and tracking system is now on course to be implemented within the street markets service by August 2017. This will enable the service to monitor markets officer's activities and movements throughout the borough. The current system in place records traders attendance and markets officers are tasked on a daily basis to specific markets. The market supervisor and manager makes random checks and sporadic visits to ensure compliance.

- The markets service has been reviewed and is currently going through a restructure. The restructure includes a new post of markets Audit & Business development Officer, responsible for spot checks and audits on street markets. We are waiting on a failure to agree to be resolved but early indications shows that the new structure will be agreed by August 2017 and recruitment will be enabled.

- An on-going training programme has been established including refresher training for markets officers for enforcement, statements preparation and court procedure. Further training in health & safety and personal safety has been carried out with further training sessions to follow. A record of officers who have received training is in place.

- The markets services review identified a number of changes that needed to take place in order for the service to develop into a business unit, therefore the new standard operations procedures will bear no resemblance to the new SOPs that are currently being written. Standard operating procedures are in place that mirror the THEO service. The new markets service SOP is being redesigned to reflect the new working practices. This will be completed in Mid-August.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Control and Monitoring of Right to Buy Valuations	March 2017	This audit examined systems for procuring, ordering, controlling and monitoring Right to Buy (RTB) valuations. It is the Council's responsibility to undertake valuations under the RTB legislation. Tower Hamlets Homes (THH) has the delegated functions to administer the RTB applications, including processing and checking of applications, ordering the valuations, preparing S125 Notices and referring cases to the District Valuer for determination. THH initiates valuation requests directly from an External Valuer, who then provides the valuation report to THH. LBTH Strategic Housing has responsibility for checking the Section 125 Notice and authorising the sale. There were 30 RTB completions in April 2016 generating £3,817,620. The following issues were raised :- • Our testing showed that the External Valuer had been paid £176,272 for RTB valuations covering the period October 2014 to June 2016. However, the procurement process undertaken by Asset Management in September 2014, assumed spend up to £25,000 and used a Level 2 procurement process, requiring three quotations. Audit was advised that the monitoring of valuation costs was THH responsibility, but the budget holder was Strategic Housing. As a consequence, there is a breach of the Council's Procurement Procedures. Competitive tendering was required for services over £25,000. We have, therefore recommended that a report is submitted to the Council's Section 151 Officer and the Monitoring Officer to regularise the expenditure. • Reliance was placed on one valuation company for RTB valuations, with no additional cross reference checks to ensure that valuations undertaken were consistent and in line with average median prices. • There was no system of sample checking the valuations provided by the External Valuer. Our testing of a sample of 20 valuations (for valuations undertaken during 2015), showed that in 10 cases the valuations were outside the median market prices for that area. • Audit testing showed that all four purchase orders issued by THH to the External Valuer covering the period 15th September 2015 to 29th June	Extensive	Limited

		2016,were issued in retrospect. This is breach of THH Financial Regulations and LBTH Financial Regulations and Procurement Procedures. • An examination of invoices paid to the External Valuer showed that of the 602 RTB Valuations invoiced, supporting RTB information was submitted by the company on 52 addresses only (8.63%). This brings into question the level and adequacy of checks undertaken by THH prior to the invoice being processed for payment. • The RTB Log maintained by LBTH officers was not been kept up to date. Testing of a sample 20 sales completed between November 2015 and April 2016 showed that one case was not recorded on the Log and 15 cases (78.94%) were not updated with the date of sales completion. All findings and recommendations were agreed with the Interim Divisional Director of Housing Strategy, Regeneration, Sustainability and Housing Options. Final Report was issued to the Corporate Director, Place.		

Management Comments

Recommendation 1

S151 report -. THH instructed to write the report regarding the breach of Procurement procedures and to seek approval for the expenditure for which there was not approval – the report is attached.

Recommendation 2

A procurement process has started which will award a 4 year contract for the provision of RTB valuations – it is expected that this contract will be completed in September 2017. Two companies will be procured as recommended.

Recommendation 3

THH now sends monthly RTB analysis data for asset management to view and challenge if required. The information is in summary version. Procedures covering sampling and checking of valuations carried out by the contracted Valuation company are to be formalised and written up.

These are now in place and complete

Recommendation 4

Strategic Housing Management team to formally write to the THH Interim Director of Finance, to ensure that THH purchase orders for RTB Valuations are raised prior to the RTB Valuations service request in accordance with Financial Regulations.

In addition, the THH Interim Director of Finance to be asked to ensure that invoices are approved for payment only after the valuation company has provided supporting documentation (e.g. valuation report) that the requisitioned service has been provided.

This action is now in place and complete

Strategic Housing Management team to instruct THH to provide monthly reconciliation statements of orders raised against invoices paid. Housing Strategy team to audit RTB valuations against payment in order to ensure no duplicate payments are processed. Advice to be sought from Place Finance team on the funding issues.

Action partially complete as THH are yet to provide monthly reconciliation statements of orders raised against invoices paid.

Recommendation 5

THH now sends monthly RTB analysis data for asset management to view and challenge if required. The information is in summary version. Procedures covering sampling and checking of valuations carried out by the contracted Valuation company are to be formalised and written up.

These procedures are now in place and complete

Recommendation 6

Strategic Housing Management team will instruct THH to provide monthly expenditure reports on RTB Valuation costs. Strategic Housing Management team to monitor the RTB valuation costs against the approved budget.

THH was instructed to provide monthly expenditure reports on RTB Valuation costs, and a monitoring regime is in place.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Highways Repairs and Maintenance – Follow Up Audit	April 2017	This follow up audit assessed the progress made in implementing the recommendations made in the original report finalised in October 2015. The contract for Carriageway & Footway Maintenance was awarded for a period of five years, starting from 01/10/2014. The anticipated spend for 2016/17 is £1.3M. Audit testing showed that ten of the fourteen high priority audit recommendations made in the Final Report had been progressed. However, the remaining four key high priority recommendations had not been implemented and embedded. In addition, the two medium priority recommendations had not been fully implemented. The key findings contributing to the assurance assigned are: • The procedures for monitoring the overdue jobs, selection criteria for post – inspections, and managing, controlling and monitoring of variations had not been documented. • No risk - assessment had been undertaken on the contract to identify critical areas for contract monitoring purposes. • There was not sufficient evidence to demonstrate on-site post– inspections and related outcomes. • Consistent practices had not been used by the contractor (e.g. provision of photographic evidence) to enable effective desk top post-inspection of jobs. • Robust KPIs had to be developed for monitoring the performance of the contractor and instigation of corrective actions, mainly where the quality of the jobs completed are not of the required standards. All findings and recommendations were agreed with the Divisional Director, Public Realm and final report was issued to the Corporate Director, Place.	Extensive	Limited

Management Comments

A review of the contract will be carried out by end of June 2017, in line with the Corporate Management Toolkit.

To accompany each element of the processes mapped, procedures will be updated and added by end of June 2017.

The Well Managed Highways Liability Risk (a code of Practice for well managed infrastructure) was launched on 14th March 2017. This long awaited document aims to provide a reference source and practical guidance on best practice in the management of highways liability risk exposures. In particular how to apply the principles of risk management and a risk based approach to highway liability claims exposure which will be beneficial to all levels of performance. Now that we have this guidance we have already started to review the current regime and frequencies of highways inspections. A system will be set up to monitor and review levels of frequency on a regular basis by end of July 2017.

From March 2017, a list of overdue works are now being produced and discussed at Monthly contract meetings. This will filter down to the weekly operational discussions, These discussions are minuted and comments are included on a report with actions. In addition, any repeat performance related issues that are not resolved in the monthly meeting are now being escalated to senior management in the quarterly meetings.
From March 2017, the highways engineer can run two reports (pending approval) that show all the jobs that have been issued or completed within the last week. These can inspected as part of the 20% sample checking system. This is to replace the use of the hand written notebook as they will update a spreadsheet with the findings.

The contractor was informed in March 2017, that all photos provided for post inspection purposes need to include the Job ID, date, time, location and the highways engineer will carry out the same process if an inspection takes place.

The Street works team currently carryout Coring and have already completed first trial on statutory undertakers and utilities, we have requested that this should be considered in the next trial.

With effect from April 2017, an agreed set of operational KPI's have been drawn up to measure performance at a local level in line with the audit recommendation. High level KPI's are now provided as set out in the contract and presented at Quarterly meetings but they do not provide the level of detail outlined in the recommendation. Reports are now produced at a local level by LBTH officers and given to senior managers in time for the Quarterly strategic meetings.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Commissioning of SEN Placements	March 2017	Every child who has special educational needs should have Special Education Needs (SEN) support to help them achieve their outcomes or learning objectives. SEN support means support that is additional to or different from the support generally made for other children of the same age. Section 14 of the Education Act 1996 places local authorities under a duty to secure sufficient schools for providing primary and secondary education in their area and to have particular regard to securing special educational provision for pupils who have SEN. In addition local authorities are under a duty to keep under review the arrangements they make for special educational provision (section 315 of the Education Act 1996). The Education and Inspections Act (2006) includes a duty on authorities to consider and respond to parental representations when carrying out their planning duty under section 14. Benchmarking data shows that Tower Hamlets had the highest number of placements in 2015 in respect of SEN of all the inner London councils, with 1,754 children who have significant educational needs. This amounts to an increase of 35% since 2007. The Council has six 'in-house' special schools with places for 486 children in the 2015/16 year, with the remainder of the SEN placements being placed in schools and other organisations both across the borough and outside. Current SEN placement fees for 2016/17 totalled £32,925,140 as at 04/01/17 compared to a total of £30,889,235 for 2015/16. It should also be noted that, at the time of audit fieldwork, a number of personnel changes were being made. Findings of this report will likely be taken forward by staff not originally involved with the audit fieldwork. This audit was undertaken as part of the 2016/17 agreed Audit Plan. The main weaknesses were as follows:- • There are concerns over the capacity to store, archive and recall all of the SEN documentation effectively. • Annual reviews of EHCPs and Statements of SEN are not being received from schools in a consistent manner and it was identified that there was an absence of robust monitoring over the completion of annual reviews. For four out of 20 SEN placement cases tested there was no evidence of the	Extensive	Limited ⇕

		required annual review taking place for each pupil. It is expected that the current Impulse database system, which has a limited reporting suite to help identify and monitor missed reviews, is to be replaced by a new system known as Tribal (but a deadline for implementation is yet to be confirmed). The SEN Team need to ensure that any system in place (whether database or manual control in the interim) has sufficient ability to enable management information to be produced efficiently as and when required. • There were no dates recorded indicating reviews or updates on the Terms of References (ToRs) for the Pre-Assessment Panel (PAP), Special Education Needs (SEN) Panel and the Protocol for the Joint Commissioning Panel. • There are concerns over whether the Council had sufficient policy in place concerning SEN for post-19 education. • There was not an annual plan in place to help guide the facilitation of review meetings (to be held between appropriate individuals of the school and professionals such as psychologists where possible). As stated above, for four out of 20 SEN placement cases tested, there was no evidence of the required annual review taking place. • Performance information is not currently required to be reported through the Council's governance structure (i.e. outside of the local team through the Service Head to the Directorate Management Team (DMT), Corporate Management Team (CMT) and ultimately up to Cabinet) with issues escalated accordingly. All the findings and recommendations were agreed with the Head of Pupil Services and Divisional Director, Education and Partnerships and reported to the Divisional Director, Resources and Corporate Director, Children's Services.		

Management Comments

- New interim leadership, management and team structure has been established to increase the capacity and capability of the SEN team. This includes the appointment of a new SEN Manager, 14-25 SEN/High Needs manager and additional SEN caseworkers from the 1 May 2017. A permanent restructure of the SEN Team will be completed by January 2018.

- Confidential documents removed from corridors and securely stored. Internal investigation into whereabouts of missing documentation has taken place, prior to follow up audit. A project plan was drafted in April/May 2017 to identify and implement an effective electronic document management system to record, process, store and archive all SEN documentation. This will be in place by the October 2017.

- Bespoke training sessions for the SEN Team on Information Governance is being devised and is planned for June/July.

- The migration to the new Tribal SEN Pupil Database along with the development of new reporting suite has assisted in establishing of a more robust recording and tracking system for annual review documentation. A new monthly reporting cycle to the Head of Service, including the monitoring of Annual Reviews will ensure that they are undertaken in line with statutory timescales.

- New guidance for schools and officers on the EHCP assessment process, thresholds and annual review is being drafted in consultation with school leaders and will be piloted from September 2017.

- Mapping of referral pathways and decision – making groups including Pre-Assessment Panel and Panel (TOR have not been updated since 2004 and therefore not statutorily compliant) has taken place. Simplification and streamlining underway, new TORs for both the Pre-Assessment and SEN Panels are being finalised and consulted upon. They will be implemented during May/June 2017.

- The appointment of the new 14-25 SEN/High Needs Manager has enabled LA to begin to develop its Post 19 SEN Policy and 'local offer' in line with the new statutory guidance issued in March 2017. This includes establishing a tracking system for young people aged 14 -25 to ensure the SEN Team, Children's and Adult Social Care provide these young people with coordinated transition plans as part of the 'Preparation for Adulthood' process. The revised policy and processes will in place by September 2017.

- Discussions re Joint Commissioning underway with the CCG, with a plan to jointly commission Speech and Language Therapy for schools from January 2018. A new protocol for joint commissioning will be developed in parallel with this work

- Development of joint CS and health SEND strategy underway, currently at the informal consultation stage, providing a mechanism to consider demand management as well as more effective use of resources. Due for publication in February 2018, to influence financial decisions for 2018-19 onwards

- SEND improvement board established, jointly chaired by LA and CCG to drive improvements and preparation for SEND Local Area Inspection
- Headteachers SEND board under development to improve governance of SEND

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Pensions	March 2017	This audit was undertaken as part of the 2016/17 agreed internal audit plan. The Pensions function is responsible for the administration of the Pensions scheme from the Council side, excluding the investment of the funds. Employees of the Council up to 75 years of age, who have a contract of more than three months duration, are entitled to join the Local Government Pension Scheme (LGPS). Decisions on delegated provisions are agreed by the Pensions Committee. The LGPS is a contributory scheme, whereby the employees contribute from their salary. The level of contribution is determined by whole time salary and contribution levels are set by the National Government. As at 31 December 2016, employees and employers contributions totalled £8,351m and £37,397m respectively. The audit was designed to provide assurance to management as to whether the systems of control around the Pensions system are sound, secure and adequate, and also to evaluate the potential consequences which could arise from any weaknesses in the internal control procedures. The main weaknesses were as follows:- • Examination of 20 out of 170 overseas individuals identified seven cases where the required life certificate form had not been returned, but these individuals were still being paid. In addition, no reminder letters were sent. • A sample of 20 leavers, from a total of 765 pension scheme leavers since April 2016, was tested. Two exceptions were identified, one where the same officer had undertaken and reviewed his own work, the other where the second officer is yet to review the work undertaken. • Examination of a sample of 20 retirements, tested from a total population	Extensive	Limited ⇦

		148 retirements since April 2016, identified that there were missing signatures on one AP1 form (payments voucher) and two payroll input forms. In three of the Final Pay calculations, not all pages had been scanned onto the individual's records and therefore evidence of the physical sign-offs could not be verified. • Examination of five transfers in, from a total of 19 transfers into the pension scheme since April 2016, identified that in one case a second officer review should have taken place in August 2016 but is yet to take place (as at end of January 2017). • Where the parameters for NI number, payroll number and the post number are found not to match (between the payroll system and pensions system), or there are any changes required to be made to employee addresses, hours, surname and first name, amendments and adjustments should be actioned by the Pensions Team. However, processing of these cases is known not to be up to date and there is also no review by a second officer of the changes subsequently made. This has the implication that confidential pensions information could be provided to the wrong locations or individuals may not receive accurate information regarding their pensions. • Three key reconciliations are performed between Altair and Agresso (covering refunds, lump sum payments, and transfers out). A fourth reconciliation is conducted between Altair and a manually maintained spreadsheet (within the Finance Department) which records details of transfer payments received. This acts as a double check that the expected transfer-in monies have been received. However, there is no evidence to suggest a second officer reviews any of these reconciliations on a monthly/quarterly basis. • Although procedures exist for the Pensions Team, as well as flow charts, some of these are now out of date and version controls are not sufficiently detailed. All findings and recommendations were agreed with the Pension Manager and Team Leader, and reported to the Corporate Director, Resources.		

Management Comments

The performance of the Pensions Team during 2016 was impacted by the prolonged absence of the Pension Manager and the diversion of one of the two team leaders to address weaknesses in the payroll system relating to auto-enrolment. In addition, a built up of work had been allowed to develop relating to the recording of monthly earnings from a growing number of external payroll providers. Since the introduction of CARE benefit in 2014, the volume of date required to calculate benefits has increased and reliance was being placed on manual processes. Starting from December 2016, steps have been taking to address the underlying problems with two interim appointments; a pension manager and pension officer. Although the backlog of earnings data has been cleared and technology solutions to capture this data have been identified, they have not yet been implemented. In addition, the diversion of pension staff time to resolve the inability of the Council's payroll system to handle auto-enrolment continues.

<u>Checks on Continued Entitlement to Pension</u>

The overseas life certificate exercise undertaken in Q1, 2016 was not followed through to the issue of reminders or the suspension of pensions. This exercise is undertaken annually and was repeated in Q1, 2017 from which 3 deaths were notified and 4 pensions suspended due to non replies. Also undertaken in Q4, 2016 was the matching of members records against the UK national death register. This identified 27 deaths which had not been notified to the pension team. These pensions have all been suspended and recovery action is being pursued with next of kin.

<u>Use of Workflows and Recording of Work Undertaken</u>

Bullet points 2-4 relate to the same issue, that the correct procedures for the use of Task Management Workflow have not been followed. Workflows are set up for each task within the pension administration system and guide staff through the process and record who does what and when. The design of workflows were reviewed with the software provider in December 2016 and significantly amended to record each stage of a calculation or task leading to greater accuracy in the recording of work and the performance of the team against KPIs. Staff have been shown how to use the new workflows and reminded of the need to record the work undertaken. Previously, in some instances tasks undertaken have not been signed off in workflow meaning that the tasks remain classified as outstanding even if the work (a review) has been undertaken. At a later date it is not possible to demonstrate task completion and by which team member. The absence of timely reviews of tasks shown as remaining outstanding within workflow has caused uncertainty as to whether work was checked or not and resulted in short cuts being taken to close workflows e.g. same individual recorded as both checking and completing calculations. In addition, to improving workflow processes, weekly task management reports are being issued to staff to remind them of outstanding work and to monitor that tasks are being completed in accordance with targets.

Scanning Paper Documents to Record Signatures

Where a computer record exists of the staff that completed and checked a task, there is no need to sign paper calculations and scan. The computer records provide sufficient, and superior, evidence of the work undertaken. Procedures notes will be amended to remove reference to scanning signatures were alternative records of work undertaken exist.

Pension / Payroll Interface Rejections (5th bullet point)

A considerable volume of data on earnings and changes in staff working arrangements passes from payroll to pensions each month. When the interface cannot find a matching record in the pension's administration system due to a mismatch in identification data, the interface file has to be amended to correct the identification headers and re-run to allow the interface to operate. In future, exception reports will be printed with a note of all manual adjustments. Changes will be verified by a second officer and reports will be scanned and saved.

The reference to delays in updating and amending members records relate to the recording of CARE benefits. These are now up to date.

Reconciliations between Pension Administration System and General Ledger

The comments regarding reconciliations of lump sums, refunds and transfers out are agreed and have been implemented. These reconciliations will be completed within a month and reviewed by a second officer (normally the Pension Manager). A schedule will be maintained of reconciliations undertaken, including data and names (preparer and checker). The checker will sign each reconciliation to evidence the review.

With regards to the transfers in reconciliation this is not a financial reconciliation as such, rather Pensions will only credit the transferred service once the transfer value has been received and require a means of identifying when funds are received. Workflow memos are established when a transfer request is made and delays in receiving funds are queried with the previous pension provider.

Procedure Notes

All procedures were reviewed prior to the Audit, but those that required no action were not amended. In future all procedures will be checked annually, with each review being evidenced by a name and date.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Financial Assessments	May 2017	This audit has been undertaken as part of the 2016/17 agreed Audit Plan to the review systems for carrying out financial assessments of service users to ensure that assessments are undertaken and charged for in accordance with the policy, procedures and regulations of Tower Hamlets Council (the Council). Financial assessments are undertaken for all persons in placements where care is required. A Financial Assessment is required to take place when an individual first enters into a placement as well as on an annual basis thereafter, at the start of each new financial year, as obligations for charging may differ if circumstances change. Individuals pay a set fee dependent on their income. Where individuals have savings between £14,250 and £23,250 they are expected to pay a notional charge (£1 for every £250 held between these limits). Where the individual has savings greater than £23,250 they are expected to pay the full cost of their placement. However, if an individual is sectioned under the Mental Health Act S117, there is no financial assessment required to take place and no payment is due on the placement provided. Prior to November 2015, the Financial Assessment Team gained information on a monthly basis from a Residential Care Panel. This information would feed through to the Financial Assessment Team to notify of any financial assessments that were required. This control has since been removed and the team are now notified through the Frameworki system directly. However, the findings within this audit should be considered in the appropriate context, in light of the various inter-dependencies to which the Financial Assessment Team works within. In particular: • the social work practitioners for whom the Financial Assessment Team rely on being notified of a client's permanent placement via a Frameworki outcome - before a Financial Assessment is carried out. • the Client Financial Affairs Team who manage the income for clients who fall under Appointeeship and Court of Protection (COP).	Extensive	Limited ⇕

		• the dependency on the Department of Work and Pensions (DWP) for information, updates to allowances and payments and supporting information with assessments. Consequently, it should be noted that the responsibility for implementing proposed actions may not fall directly within the powers delegated to the Financial Assessment Team specifically and will likely need to be considered at a wider/higher level within the Council to ensure that appropriate consideration of the risks be considered. Although this audit has been conducted with the assistance of the Financial Assessment Team, it is noted that dependency is on social work practitioners and the client to provide the required information (as per the above stated interface between the placing Practitioner, the Client Affairs Team and the DWP). The Financial Assessment Team can only work with the information that is provided and available and has no power or authority to require DWP or COP to hasten their work. The audit was designed to provide assurance to management as to whether the systems of control around the Financial Assessments system are sound, secure and adequate and to evaluate the potential consequences which could arise from any weaknesses in internal control procedures. The main weaknesses were as follows:- • There was no clear directive from the Local Authority about the course of action that will be taken when a client fails to disclose. Some assessments were therefore completed on previous declarations which did not account for any new changes in income because clients failed to submit revised benefit statements. • The scope for conducting any reconciliation of the care placements awarded against evidence of the financial assessments completed was entirely limited to the local Private and Voluntary (P&V) database currently used by the Financial Assessment Team, but which was due to be disbanded following the introduction of the Frameworki Financial Assessment module (a corporate decision). Therefore, it has not been possible to provide assurance that the Council is in a position to		

		transparently identify any instances where it may be losing income through an inability to confirm exceptions where social work practitioners do not request financial assessments to be performed. • Policies and procedures did not state a date of creation or an expected review timeframe by way of version history. It could also not be confirmed that the policies and procedures had been formally approved. • Formalised Key Performance Indicators (KPIs) were not produced and monitored in relation to financial assessments. All findings and recommendations were agreed with the Interim Business Partner (Health, Adults, Community Services & Children's Social Care), and reported to the Divisional Director of Finance and Procurement, Corporate Director Resources, and Corporate Director Adult Services.		

Management Comments

The findings of the report and the recommendations made have been accepted and a number of actions are being progressed. The management responsibility for the financial assessment team has been transferred to the Resources Directorate to strengthen the working arrangements, monitoring and oversight of the team's work.

Agreed Action for Recommendation 1

Action: For the FA Team to obtain access to the DWP Customer Information System, which would verify the client's income. This has been agreed with the Housing Benefits Team. (High, Aug 16)

Update: The full implementation of this recommendation was delayed due to systems access issues. Work is underway with the Housing Benefit Service to resolve this and full system access expected by the end of July 2017.

Agreed Action for Recommendation 2

Action: Financial Assessment Manager to explore the options available to verify on a regular basis by Adults Social Care Team Managers, that all long term permanent placements have been checked and that the Financial Assessment Team have been notified. Options to be considered and proposal to be put to the Adults' Services DMT and implemented (High, DMT Jan 2017, implementation April 17))

Update: The full implementation of this recommendation was delayed due to the appointment of the responsible senior manager. Manager now in post

and project team established to review and implement the changes required to ensure all placements are checked and the team are notified. The team includes representatives from Adults Social Care, Performance and Finance to take this forward. Full Implementation expected to be completed by Jan 2018

Agreed Action for Recommendation 3

Action: Financial assessment policies and procedures should be clearly dated and confirm details of when each will next be subject to review.
To strengthen control, a monitoring log may be implemented to record details of the policies in place, who is responsible for the update of each policy, when each was last updated and when each is due for review. By RAG (Red/Amber/Green) rating such a log, upcoming deadlines can be more easily identified so that mitigating action can be taken in a timely manner. (Medium, Jan to April 2017)

Update: The implementation of this recommendation was delayed due to the appointment of the responsible senior manager. Manager now in post and work underway and expected to be fully completed by September 2017

Agreed Action for Recommendation 4

Action: We accept KPIs would be a positive introduction to the work of the team. These would need to accommodate the external co-dependencies which impact on timeliness and quarterly activity. Options to DMT in January. To be overseen in Star Chamber performance review. To be overseen quarterly at Provider Services management team meetings. (Medium, developed quarter 3 and tested quarter 4 2016/2017, implemented 2017/18)

Update: The implementation of this recommendation was delayed due to the appointment of the responsible senior manager. Manager now in post and work underway to develop the options for quarter 3 and full implementation on quarter 4 2017/18.and expected to be fully completed by September 2017

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
THH Housing Insurance Claims Follow-Up	March 2017	A full systems audit on Housing Insurance Claims was undertaken in 2014/15, with the final report published in September 2015. This audit did not assign an opinion to the area, as it had followed the customer journey from beginning to end of the process in order to provide recommendations for improvements to the user experience. However, there were issues identified based on the audit findings and recommendations were raised on how to address these issues. This report presents the findings and recommendations of the follow up audit, conducted in November and December 2016; the objective was to assess whether the agreed recommendations at the conclusion of the internal audit had been implemented. Our follow up review showed that the one high priority recommendation and the six medium priority recommendations made at the conclusion of the original audit had not been fully addressed. Following our audit work, we have re-raised the original recommendations (either in part or in full) to enhance the control environment within this area. The areas of weakness are as follows: • THH does not adequately investigate claims in a timely manner, the relevant forms are not being completed. • Leaseholder and tenant handbooks have not been updated, the produced flowchart has not been made available to those who may need it and it is not made sufficiently clear to potential claimants that contractor-related claims should be directed to the responsible party. • The relevant insurance forms have not been updated. It could not be evidenced that staff have been trained regarding new procedures. • The new insurance claim handling process has not been agreed and procedure documents have not been updated and made available to staff. Review after a trial period has not been carried out and information available to tenants has not been updated.	Extensive	Limited *Direction of travel not applicable (as an opinion was not provided for original report).*

		• Letters of acknowledgement are not sent out and the Northgate system is not being properly updated by THH staff and contractors. Adherence to a 90-day target could not be tested. • Performance review cannot occur as reports have not been agreed and regular meetings are not held. • Contractor meetings are not attended by LBTH Insurance representatives and feedback on and monitoring of trends in claims is therefore not occurring. All findings and recommendations were agreed with the Head of Customer Access and Facilities (THH), and reported to the Chief Executive (THH).		

Management Comments

- THH does not adequately investigate claims in a timely manner, relevant forms are not being completed.

  Forms are completed in a timely manner by Repair inspectors and sent to LBTH insurance. Review meeting occurred with LBTH Insurance in April 2017 and this looked at how this could further improve. Since October 16 89% have been responded to within the time frame. (45 cases)

- Leaseholder and tenant handbooks have not been updated, the produced flowchart has not been made available to those who may need it and it is not made sufficiently clear to potential claimants that contractor-related claims should be directed to the responsible party.

  An updated process flow of the insurance process has been completed for internal use. This provides clarity in respect of contractor related claims LBTH have developed a claim flow that is yet to be published on the website. It's unlikely that handbooks will be updated with this information.

- Relevant forms have not been updated. It could not be evidenced that staff have been trained regarding new procedures.

  Updated forms have been completed but not placed on the website. Staff are aware of requirements for complete of the relevant forms, LBTH Insurance and THH met in April 2017 to review process and see further improvements in handling of information shared for the claim. The old form is still utilised as the updated forms have not been uploaded to our IT systems.

- The new insurance claim handling process has not been agreed and procedure documents have not been updated and made available to staff. Review after a trial period has not been carried out and information available to tenants has not been updated.

  The reviewed process has not been built on COMINO as THH is moving towards Northgate workflow, work around is in place on COMINO to reflect the new process. Process documents have been updated and circulated to only staff who are involved with the process, once developed on Northgate this will be available more widely. Information for tenants is not yet published.

- Letters of acknowledgement are not sent out and the Northgate system is not being properly updated by THH staff and contractors. Adherence to a 90-day target could not be tested.

  Acknowledgement letter are not sent from COMINO as per the current work around, the service area booking for the Inspector will confirm the appointment by telephone with the claimant. Appointments are recorded on Northgate. The 90 day adherence could be tested using this information.

- Performance review cannot occur as reports have not been agreed and regular meetings are not held.

  We have agreed with LBTH Insurance to send claim data to us on a monthly cycle. No regular cycle of meeting have been set up.

- Contractor meetings are not attended by LBTH Insurance representatives and feedback on and monitoring of trends in claims is therefore not *occurring.*

  THH will invite LBTH insurance to relevant contactor meeting once regular cycle of meeting between THH & LBTH Insurance occurs, invitation to meeting will depend on claims data shared.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
THH Management of Asbestos Follow-Up	Feb 2017	Tower Hamlets Homes (THH) manages approximately 22,000 rented and leasehold homes on behalf of LB Tower Hamlets. Approximately 50% of the stock is leasehold properties. THH is responsible for managing the maintenance and repair of the housing stock and this means managing the asbestos in each property. A full systems audit on Management of Asbestos was concluded in in February 2015 and the final audit report was issued in October 2015. This audit was assigned Substantial Assurance. Our follow up review identified that of the six medium priority recommendations made in the original audit report, one of these has been fully implemented, two recommendations are partly implemented and three are not implemented. Therefore, five further recommendations have been raised to address these issues, as follows: • THH should ensure that data is fully uploaded to Keystone, such that contractors can be encouraged to rely on the database without risk of false impression. Keystone log-in records should be used/reviewed to provide assurance that access is being made on a regular basis. • A monthly report of all works orders and inspections should be developed and scheduled, with statuses and reasons cited, that will be sent to the Health & Safety Co-ordinating Group for follow up. This should be used to mitigate the risk of both work orders and post inspections being amended/cancelled and going unnoticed. Northgate security configuration should be reviewed and options provided to control access to asbestos post-inspections. • The Asbestos Policy and Management Plan (including the planned inspections programme) should be completed in a timely manner and presented at the first available opportunity to the H&S Forum for approval. Reporting on the progress made against the agreed inspection programme should subsequently be communicated to senior management on a regular basis.	Extensive	Limited ⇦

		• As noted in Follow-Up Recommendation 3, the Asbestos Policy and Management Plan should be completed and presented to the H&S Forum at the first available opportunity for approval. On completion, the planned steps above should be taken to ensure that this document is adequately distributed and made available to staff. • Each month, a team member should undertake an independent 10% sample check in respect of entries made to the Keystone System, to help ensure that input errors are corrected. Evidence of these checks should be maintained. The findings should be reported to the Head of Service as part of the Performance Management Framework. All findings and recommendations were agreed with the THH Health and Safety Manager and THH Director of Asset Management and reported to the THH Director of Finance and THH Chief Executive.		

Management Comments

1. The Asbestos Register and access to it by all those who need it, continues to be developed, and this is addressed as part of the Asbestos Management Plan (AMP) and in our ongoing improvements with addressing asbestos matters.
2. This point has been answered previously in writing during the follow up audit. Reports on asbestos surveys and treatment works are run automatically on a weekly basis (not monthly), which means we can monitor more closely) and sent through to the Health and Safety Team (previously called the Health and Safety Co-ordinating Group). They consist of the following:
   - Orders out of target
   - Cancelled Orders; and
   - Variations.

   These reports are scrutinized by the Health and Safety Technical Officer and, as required, communicated with Mears our Partnering Contractor for follow up to ensure there are no gaps in the process.

‘Northgate security configuration should be reviewed’, we are unclear what this means in relation to the audit.

3. As previously reported during the follow up audit, the Asbestos Management Plan (AMP) has been in consultation and is now complete. We have provided the auditors with copies. However, as a result this of this audit and developing the AMP we have plans to proceed with important areas of work some of which were not covered in the original audit. These include:
   - Commissioning communal asbestos surveys
   - Addressing staff resourcing issues

- Ensuring our Asbestos Register is as up to date and accessible as necessary.

These actions will require additional funding from LBTH and in preparation for that we are presenting the AMP and an Asbestos proposals paper to our Executive Management Team in June.

In the meantime, we are continually reviewing and addressing our processes. The AMP ensures 100% post-inspection on all of the new Better Neighbourhoods projects going forwards and we are working towards a proportionate post-inspection regime for other areas of works.

Also, in the meantime, Health and Safety and Repairs have undergone Organisational Review with the Health and Safety Team moving to a corporate health and safety advisory, policy and reassurance role. The AMP requires the Health and Safety Team to carry out an independent audit of progress with the AMP on an annual basis. The first review will be in summer 2018. The operational function of managing various types of orders, variations etc. on Northgate repairs ordering system will be moving to the Repairs Team once the Organisational Review is completed in the near future.

4. As 3 above. This appears to be a repeated point in the Comments/Findings.

5. As explained in 2 above the Health and Safety Technical Officer is already carrying out this function and the follow up auditor was made of aware of this.

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
St Luke's CoE Primary School	March 2017	The audit was designed to ensure that the Head Teacher and the Governing Body have implemented adequate and effective controls over the administration and financial monitoring affairs of the school and to evaluate the potential consequences which could arise from any weaknesses in internal control procedures, including value for money issues and any equality issues. The key recommendations were as follows:- • All purchases / contracts over £10k should be approved by the Full Governing Body and minuted. • The Code of Practice for Financial Management and Delegations of Financial Authority also known as Scheme of Delegation should be presented to the Full Governing Body annually for review, sign-off and minuting. • The Curriculum Committee should meet every term in accordance with its Terms of Reference. Meetings should be minuted with signed copies provided to the School. • Declaration of Business Interest forms should be refreshed on an annual basis for both Governors and staff with financial responsibilities. A copy should be retained by the School. The School should also consider redesigning the form to enable the business interest of family members to be added. • Unpresented cheques over six months old should be cancelled and be removed / written back on the RM Finance system. • Staff expense forms should be dated to evidence that the purchase(s) have been pre-authorised. In addition, the £50 reclaim limit should not be exceeded. Should the £50 limit no longer be appropriate then subject to Full Governing Body approval this limit could be increased. • Assets should be updated onto Parago as soon as they are purchased. In addition, the School should carry out a full review in line with the planned timescale with the results of the check, and the list of assets marked for disposal, presented to the FGB for review and sign-off. This should be	Moderate	Limited ⇔

		formally minuted. Inventory checks should then be undertaken on an annual basis. • To help ensure that only overtime agreed at the time the work is undertaken is paid, a standard overtime claim form should be completed, by the member of staff, reviewed and then signed-off by the Head Teacher. • The School should maintain a signed copy of the Schools Financial Value Standards (SFVS), to help ensure that they are measuring performance / targets against the final version of the document. • The Financial Consultant and the Head Teacher should sign-off all the key documentations in the monthly reconciliations as evidence of being checked / reviewed. • The School should complete the identification all its current contracts and record them into one single Contracts Register. • The School should confirm the tax status (including the Inland Revenue tax code) of all self-employed individuals and also that the contractor holds suitable public liability insurance. • The School should ensure that goods / services provided are receipted to enable the Budget Holder to agree the purchases as part of the financial monitoring process. • All invoices should be paid within 30 days of the supply of the goods / service or receipt of the invoice. Where payment needs to be delayed, the invoice should be annotated accordingly. • To help ensure a consistent and transparent approach in collecting outstanding debt, the School should adopt a formal Debt Policy outlining the debt collection procedures. • All staff should complete a pre-employment medical questionnaire as part of the recruitment process and also supply details of two referees who can provide references. The information should be obtained before the member of staff commences employment at the School. • The School should consider developing a leaver's checklist to capture all the necessary checks and information into one comprehensive document for when a member of staff leaves. This should be kept in the member of staff's personnel file. • The School should ensure that an End of Journey Statement is produced and presented to the Full Governing Body for review and sign-off.		

		• The loan of School equipment form should be signed-off by the member of staff authorising the loan. All findings and recommendations were agreed with the School Business Manager and Head Teacher and reported to the Chair of Governors.		

Management Comments

The Education Finance Directorate have put the following systems and processes in place:-

- Internal audit reports on schools are now a regular item on the DMT agenda for discussion.
- Internal audit reports are used by schools Finance team to feed into systems to determine schools requiring priority support.
- Internal Audit assurance rating is used to target specific support to schools.

In addition, necessary intervention is put in place by Schools Finance to assist and support schools in improving governance, financial management and control in specific areas of business activities.

Comments:
The school have acted immediately and agreed to complete all actions with a defined timeframe.
The school and the governing body are fully committed to the recommendations made in the Audit report by:

- by tracking all actions within the timeframe provided in the report, including evidence of actions taken where appropriate
- confirming additional steps that the school are planning to take in light of the audit findings
- to take immediate action in mitigating exposure to risks arising from weaknesses in the control environment.

Schools Finance manager has provided additional support to schools, via a bursar service to review and support the school in its recommendations with additional signposting them to the guidance procedures to follow.
Additionally further action included:

- News bulletins are used to encourage good practices in schools to support operational procedures
- Termly director's Report to Governors includes good financial management practices to follow.
- Schools business managers forum included actions to improve their Audits through more self-assessment.
- Audit check list was circulated to primary's (keys areas to focus on)

It's proposed a member from schools finance, Audit, HR and Learning and Achievement will meet with the Head and Chair of Governors to support and ensure the recommendations are completed to a high standard

Substantial Assurance

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Debtors	April 2017	This audit was undertaken as part of the 2016/17 agreed internal audit plan. The Income and Debtors function is responsible for the invoicing, collection and recording of income received. A debtor is a person or organisation with an obligation to pay a debt to the Authority. The London Borough of Tower Hamlets implemented its general ledger system, Agresso, during the 2013/14 financial year. Agresso's accounts receivable function is fully integrated with the general ledger. As at 21/02/2017, the value of invoices raised since April 2016 was £98.2 million with £18 million outstanding (a collections rate of 82%). The audit was designed to provide assurance to management as to whether the systems of control around the Debtors system are sound, secure and adequate, and also to evaluate the potential consequences which could arise from any weaknesses in the internal control procedures. The main weaknesses were as follows:- • The Sundry Debt Policy did not have a version control history stated. This was previously raised in the 2015/16 Debtors audit. • A decision had not yet been made on how to manage debt recovery in respect of 'Meals in the Homes'. • For 4 out of 20 credit notes tested, the credit notes had been checked and approved by the same officer within the Account Receivables Team, although it should be noted that a separate individual had requested the credit note to be raised. Although this helped to demonstrate a partial segregation of duties, the expectation was for three individuals to be involved within this process (Requester, Budget Holder approval and Accounts Receivables approval). • Examination of 20 write-offs identified two instances (Invoice numbers: 40526623 and 3021897) where no evidence of reminder letters being sent could be provided. • Examination of 20 debtor invoices identified eight cases where there was a delay of over three months in respect of the Recovery Team taking the	Extensive	Substantial ⟺

		expected recovery action. • All invoices tested were found not to state the due date for the expected payment. • It could not be verified that the quarterly Sundry Debtors Forum had been attended by all expected members. • The date that both the preparer and the officer responsible for reviewing the reconciliations between the accounts receivables control account, the debtors control account and the suspense account with the general ledger are not included on the reconciliations (there is only one date present). It is therefore not possible to verify that reconciliations were reviewed in a timely manner by the second officer. All findings and recommendations were agreed with the Financial Systems Manager and reported to the Head of Revenue Services and Corporate Director of Resources.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Revenue and Capital Budgetary Control	March 2017	This audit was undertaken as part of the 2016/17 agreed internal audit plan and reviewed corporate systems for exercising sound Budgetary Control across the Council. At their meeting on 24 February 2016, the Council considered and agreed a Revenue Budget and Council Tax for 2016/17, a three-year Capital Programme from 2016/17 and the Housing Revenue Account (HRA) Budget for 2016/17 including setting rents and other charges. The net budget requirement for 2015-16 was restated to £350.3m; the 2016/17 budget has been set at £360.2m. The economic climate remains extremely challenging with the Government's austerity programme continuing until the end of the decade. The Medium Term Financial Plan (MTFP) indicates a balanced budget for 2016/17, but savings of £30m are still required to balance the budget in 2017/18. The audit was designed to provide assurance to management that the systems at corporate level for controlling and monitoring revenue budgets across the Council to meet the agreed objectives are sound, secure and effective, and also to evaluate the potential consequences which could arise from any weaknesses in the internal control procedures. The main weaknesses were as follows:- • Request forms for budgetary adjustments are not always being appropriately completed and retained. • Budget sign-off forms are not being completed for all directorates. • Budget holders were found not to be reviewing their budget forecasts to the expected monthly frequency. • Documented minutes/actions were not produced for Corporate Transformation Delivery Group (CTDG) meetings. All findings and recommendations were agreed with the Head of Financial Planning & Corporate Finance Partner and reported to the Corporate Director of Resources.	Extensive	Substantial ⇔

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
General Ledger	April 2017	This audit was undertaken as part of the 2016/17 agreed internal audit plan. The Council continues to use the Agresso general ledger system which was installed at the beginning of the 2013/14 financial year. The general ledger records all transactions that take place at LBTH, is updated on a daily basis and is also routinely backed up (stored remotely by IT). Access to the general ledger in the form of 'view only' is available to those staff with Agresso access, with only a limited number of staff having the ability to make uploads to the system. On a regular basis, a number of interfaces (information from the different departments, for example payroll figures) are uploaded onto the general ledger (with there being a total of 20 interfaces altogether). Interfaces that show any type of errors will be rejected and are not uploaded. The department responsible for that interface is then required to make the required changes before the interface can be attempted to be uploaded again. The audit was designed to provide assurance to management as to whether the systems of control around the general ledger are sound, secure and adequate, and also to evaluate the potential consequences which could arise from any weaknesses in the internal control procedures. The main weaknesses were as follows:- • There is no version control or supporting evidence which confirms approval of the Council's Financial Regulations and Closure of Accounts Guidance. • No evidence is retained to verify that the individual responsible for checking and confirming the full and appropriate upload of feeder systems onto the General Ledger has undertaken such reconciliation (although verbal assurance was obtained that this process takes place and is embedded as a standard operating practice). • There is no automated checking process in place in terms of the upload of data from the feeder systems to the Agresso system. A manual checking process is in place to help ensure the integrity of data uploads from the	Extensive	Substantial ⟺

		feeder systems. It was advised that the development of an automated system is on the Agilisys work plan to be delivered, but the timescale for the delivery of this functionality is not known. This was identified as part of the 2015/16 audit and progress has been made to implement an automated checking of the interfaces by Agilisys but is still in the 'proof of concept stage'. All findings and recommendations were agreed with the Financial Systems Manager and reported to the Corporate Director of Resources.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Back Office Revenue Collection and Processing Follow-Up	Feb 2017	Although the ex-Cashier's office (now the Revenues Processing and Reconciliation Office) is formally shut to the public, the existing system still allows for members of public to physically attend Albert Jacob House to collect emergency grants (such as for living expenses) which are paid in cash. A full systems audit on Back Office Revenue and Collection Processing was finalised in July 2016. This audit was assigned Substantial assurance. This report presents the findings and recommendations of a follow up audit and the objective was to assess whether the agreed recommendations at the conclusion of the original systems audit had been implemented. Our follow up review identified that the one high priority recommendation made in the original audit report had been fully implemented. Five of the seven medium priority recommendations had also been implemented. Of the remaining two medium priority recommendations, one had been partly implemented and one was not yet implemented. Following our testing, we have made a further two recommendations. The areas of weakness are as follows; • There is no second check/review of the weekly cash reconciliations. • There was an instance where there the expected initials were not evident in the postal order book (22/08/2016). Post audit this has been amended. All findings and recommendations were agreed with the Processing and Reconciliation Manager, and reported to the Service Head, Revenue Services and the Corporate Director of Resources.	Extensive	Substantial ⇔

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Unauthorised Occupancy Follow-Up	April 2017	Tower Hamlets Homes (THH) is responsible for the provision of 22,000 rented and leasehold homes on behalf of London Borough of Tower Hamlets (LBTH), with 50% of the stock relating to rented properties. The provision of tenancies for social housing and the methods used for recovering unlawfully sublet properties are under increased scrutiny as the demand for social housing far outweighs the supply. Under the Prevention of Social Housing Fraud Act 2013, the sub-letting of Council housing is now a criminal offence with the guilty facing criminal records, fines and prison sentences. Various methods or triggers are utilised by THH in order to detect suspicious cases of illegally occupied properties and tenancy fraud. Suspicious cases are referred to the Fraud Investigation Team based at LBTH with Legal Services providing assistance where necessary and undertaking prosecutions. Increasing prevention and the recovery of illegally occupied properties will help to ensure that social housing is only allocated to the residents of the borough most in need. A full systems audit on Unauthorised Occupancy was finalised in April 2016. This audit was assigned Substantial assurance. This report presents the findings and recommendations of a follow up audit and the objective was to assess whether the agreed recommendations at the conclusion of the original systems audit had been implemented. Our follow up review identified that, of the five medium priority recommendations made in the original audit report, two have been fully implemented. The remaining three recommendations were partly implemented (and have been re-raised). The areas of weakness are as follows: • Policies and procedures did not clearly confirm who had produced, reviewed and approved them, when they were produced or a date for future review. A version control history was therefore not evident. • It could not be verified whether a strategy was in place to identify and tackle instances of unauthorised occupancy by THH staff. • From a sample of five ongoing potential unauthorised fraud cases being investigated, one case had been ongoing since 2014. In one further case, there were gaps in respect of the expected review being pursued	Extensive	Substantial ⟺

		in a timely manner. All findings and recommendations were agreed with the Area Manager Neighbourhoods South (THH) and reported to the Director of Neighbourhoods (THH), Director of Finance (THH) and Chief Executive (THH).		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Programme and Project Management Follow-Up	April 2017	To ensure that its service improvement projects are properly managed and monitored, Tower Hamlets Homes (THH) had implemented a new delivery framework for 2016/17. The framework consisted of three work streams; Customers, Homes and Neighbourhoods, and Organisation, all of which support an overarching Programme Board. A final audit report was issued in July 2016, as a part of the 2016/17 agreed Internal Audit Plan, and focused on the three work streams. This audit was assigned Substantial Assurance with one medium recommendation being raised. This follow up audit was to show how far the team had come in implementing the medium priority recommendation that had been raised in the original full final audit report issued in July 2016. Our follow up review showed that the one medium priority recommendation made at the conclusion of the original audit (July 2016), had been implemented. Following our testing, we have not made any further recommendations to enhance the control environment within this area. A Full Assurance opinion could not be provided purely due to there being no new projects to test, however, the Head of Business Development (THH) reaffirmed that project initiation documents will be quality assured to ensue completeness as and when new projects are initiated. All findings and recommendations were agreed with the Head of Business Development (THH) and reported to the Director of Finance (THH) and Chief Executive (THH).	Extensive	Substantial ⟺

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Adoption and Fostering Panel Follow Up Audit	March 2017	This audit assessed the progress made in implementing the recommendations made at the conclusion of the original audit in November 2015. Out of 10 high priority recommendations tested, four had been fully implemented, three partly implemented and two recommendations had not been implemented. Our review found that a Constitution of Terms of Reference had been put in place for the Adoptions and Fostering Panels. We confirmed that all Panel members now have DBS checks; Panel member's forms were kept on file; Panel members identified not to have signed the Terms of Engagement from the original audit have now signed the Terms of Engagement; that a six monthly meeting took place with Panel members and the Agency Decision Maker to discuss what was working well and any issues with the effectiveness of the Panel; and that two separate rooms were being booked to cater for the sensitive needs of parents and other stakeholders. However, there were still areas where internal controls needed to be improved. A six monthly report on quality assurance needed to be produced; all application forms for Fostering needed to be checked for completion; clear recording of the timeframe for matching the child with suitable adopters to show why it took longer than expected.; and timely confirmation to Birth parents & prospective adopters within the required time period of 5 working days of the outcome of the decision made. All findings and recommendations were agreed with the Divisional Director, Children's Social Care and final report was issued to the Corporate Director, Children's Services.	Extensive	Substantial ⇔

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Penalty Charge Notices	March 2017	A Penalty Charge Notice (PCN) can be issued, by London Borough of Tower Hamlets (LBTH) employed Civil Enforcement Officers, for parking offences or for breaking traffic rules. The issue of PCNs is considered to be a legal case and can be subject to challenge at various stages by the recipient of the PCN. The PCN formally becomes a debt once a warrant is issued. LBTH works alongside contracted bailiffs to recover any monies that are due as a result of the issue of PCNs. The total number of PCNs issued in 2015/16 was 104,000, and year-to-date for 2016/17 is 78,000 (as at December 2016). The Council has a recovery rate of circa 70% on the total value of all PCNs issued. Annual gross income is between £8-9 million. £6 million was collected for the 2015/16 financial year in total. This audit was undertaken as part of the 2016/17 agreed internal audit plan and reviewed LBTH's systems and procedures for the processing and management of PCNs, including the effectiveness of debt recovery through the existing bailiff contract. The main weaknesses were as follows:- • Examination of 20 PCN monitoring sheets issued in the last 12 months, identified that for the PCNs issued on the 25/02/2016 for officer TH207, the supervisor had not signed to verify that they had checked the monitoring sheets and handheld machine matched. • Examination of 20 cases where PCNs had been either appealed or cancelled identified two cases where no information could be gained from the DVLA which, after six months, should have resulted in the PCN subsequently being cancelled. However, for PCN number TT23397901, no information could be found since 25/12/2015 but the case was still open. PCN number TT22204966 should have been closed six months after 23/12/2015 but was not cancelled until 22/07/2016. • Examination of 20 write offs (relating to the period 2012/13) which had been statute barred (meaning that is no longer viable for recovery action)	Extensive	Substantial ⇨

		identified one instance (PCN number TT10461258) where the debt had been written-off to a sum of £202. However, this had been paid between 28/09/2015 to 08/01/2016 in four instalments. This PCN had also been recorded as being written-off. • Examination of a random sample of 20 days from the past 12 months identified one instance where it could not be verified that two officers were present when they opened the cheques. This was for 27/06/2016 with seven cheque payments totalling a value of £592. • Examination of the suspense account identified that, in the 'Live' account, there were 40 PCNs and, for 30 of these, they were unable to be allocated to a correct account (identified by a 'TH' in front of the number). The PCN numbers recorded were in relation to when the Council used to use the 'Civica' system to record their PCNs whereas now Chipside is used. The information had been transferred from Civica onto Chipside but was now unable to be appropriately allocated and required removal from the account. All findings and recommendations were agreed with the Parking Appeals and Permits Manager and reported to the Operations Manager, Service Head Public Realm and Chief Executive.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Compliance Audit of Asset Disposal	May 2017	The Secretary of State issued Directions to the Council on 17th December 2014, which required drawing up a strategy and an action plan for securing the Authority's compliance with its best value duty in relation to Property. A Property and Disposal Action Plan was drawn up. One of the action points was to test compliance with revised procedures for the disposal of properties and this audit sought to undertake such tests for a sample of five recent disposals. Our testing found that the asset disposal procedures had been revised and approved by the Cabinet in April 2015 subject to amendments. Once received, the postal bids were kept securely in the safe and access was restricted to designated staff only. A log for opening the bids was in place. We also confirmed that the proceeds from the completed sales were found to be credited to the Authority's bank account on a timely basis. We were told that officers had been successful in obtaining the best consideration possible in disposing of the assets under S123 of the Local Government Act 1972. This was confirmed by Legal Services concluding the overriding duty for officers to secure best consideration reasonably obtainable has been achieved. However, during the compliance testing we noted that bidders did not always follow instructions provided to them when submitting their offers. Where this happened, Officers sought advice from Legal Services. For example, we noted that the disposal procedures approved by Cabinet have no provisions and controls around receipt of bids via emails. Disposal Procedures at para. 4.1, Step 6 (e) specifically state that 'offers must be returned to the Council's Service Head, Corporate Property and Capital Delivery in a plain sealed envelope marked 'OFFER' and identifying the property but not the name of the bidder'. Two bids were emailed directly to the Agent and two bids were emailed directly to the Service Head - Corporate Property and Capital Delivery. These bids were printed and brought to	Extensive	Substantial ⇕

		the bid opening meeting. At this meeting, legal advice was received from the		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		Interim Head of Legal Services & Deputy Monitoring Officer. Based on that advice, it was determined that the bids that had been received via email should be considered. All findings were agreed with the Divisional Director, Corporate Property and Capital Delivery and Major Programmes. Final report was issued to the Corporate Director, Place.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Idea Store Watney Follow-Up	April 2017	This follow-up audit has been undertaken as part of the 2016/17 agreed Internal Audit Plan. A full systems audit of the Idea Store Watney Market was finalised in October 2016. This follow-up audit was undertaken to provide assurance as to whether the two high and two medium priority recommendations raised at the time of the full audit have been subsequently implemented. The £4.5m Idea Store Watney Market opened on the 14 May 2013 and was jointly funded by the Big Lottery Fund and Tower Hamlets. It offers a wide range of services to the public over its three storey building including adults, youth and children's library facilities. The Idea Store Watney Market includes an integrated One Stop Shop and is open six days a week; Monday – Saturday. Our follow up review identified that the two high priority recommendations made in the original audit report had been partly implemented. One of the two medium priority recommendations had been partly implemented and one had not been implemented. Following our testing, we have made a further four recommendations. The areas of weakness are as follows; • Examination of five purchase orders, from a total of 43 (Since November 2016), identified that in one instance (PO 8090321) the delivery note was not signed and dated by the Idea Store Team Leader. In addition it was identified that, in one case (PO 8086114), a record of the delivery check was not maintained. • Watney Market Building User Group Meetings between Facilities Management (FM) and the Idea Store Manager were not held on a monthly basis. Only one meeting has taken place since the original audit (held on 1 March 2017).	Moderate	Substantial ⇔

		The Open Help Calls spreadsheet (which shows all outstanding and unresolved calls) was not produced on a monthly basis. The Auditor was only provided with the October and November 2016 spreadsheets. The November 2016 spreadsheet was not updated with to confirm progress and action taken against the outstanding items. • The Auditor conducted a physical check to verify whether five randomly selected Watney Market Idea Store assets were recorded in the Inventory Register. Testing identified, in three cases (Catalogue PC 6, Water Fountain 1st Floor and Staff PC-2), that the items were not recorded in the Inventory Register. • Inventory checks are not yet being performed (due to the recent implementation of the Inventory Register). All findings and recommendations were agreed with the Idea Store Manager, and reported to the Divisional Director Customer Services and the Corporate Director of Resources.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Bonner Primary School	March 2017	A full systems audit of Bonner Primary School was concluded, and a final audit report issued, in December 2015. This audit was assigned Limited Assurance. This report presents the findings and recommendations of a follow up audit and the objective was to assess whether the agreed recommendations at the conclusion of the original systems audit had been implemented. Our follow up review identified that of the six high priority recommendations, seven medium priority recommendations and three low priority recommendations made in the original audit report dated December 2015 (16 in total), 13 of these have been fully implemented and three recommendations remain outstanding (made up of one High, one Medium and one Low priority recommendation). A follow up recommendation has been raised against each the three outstanding issues. The key recommendations were as follows:- • Where the lowest quote is not accepted, formal approval should be obtained from the governors and formally minuted. • The School should ensure that all income is collected promptly and an End of Journey Statement is produced within four weeks of the trip (also being presented to the Full Governing Body for review and sign-off). • The School should update its Debt Management Policy to include procedures for long standing debt recovery. All findings and recommendations were agreed with the School Business Manager and Head Teacher and reported to the Chair of Governors.	Moderate	Substantial ⇨

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Stephen Hawking Primary School	March 2017	The audit was designed to ensure that the Head Teacher and the Governing Body have implemented adequate and effective controls over the administration and financial monitoring affairs of the school and to evaluate the potential consequences which could arise from any weaknesses in internal control procedures, including value for money issues and any equality issues. The key recommendations were as follows:- • Minutes of the Full Governing Body and sub-committee meetings should be sufficiently comprehensive, to reflect the detailed discussions and decisions made at the meetings. • The School's Financial Procedures and Scheme of Delegation should be consistent with the Financial Procedures Manual. Where the School requires different limits and/or requirements, guidance / approval should be sought from the Local Authority which should then be formally minuted at the Full Governing Body. • The Financial Procedures Manual should be approved and reviewed on an annual basis with the decision clearly minuted. • To enable the budget setting process and ongoing budget monitoring, the SDP should be updated to include financial costs. • Bank reconciliations should be undertaken on a monthly basis, as part of the month end financial processes. The reconciliations should be signed-off by the Head Teacher to evidence the independent review. • Authorisation should obtained from the Full Governing Body for higher value purchases of goods and services before the commitment is made, in accordance with the Financial Procedures Manual. • Purchase orders should raise and authorised, prior to a purchase being made. • The SFVS should be formally agreed and the decision minuted. The School should retain a signed copy of the SFVS to help ensure that they are measuring performance / targets against the final version of the document. • Policies should be implemented in relation to the safeguarding of students while accessing the internet. • Sub-Committee Terms of Reference should be updated to include the frequency of meetings. In addition, they should be reviewed on an annual	Moderate	Substantial ⇨

		basis, formally approved, and minuted by the Full Governing Body. • The Full Governing Body should formally approve and minute the disposal of assets. • The School should ensure the results of the annual inventory check is presented to the Full Governing Body for review and sign-off once the check is completed. This should be formally minuted in the meeting. The Full Governing Body should also approve and minute the disposal of assets. All findings and recommendations were agreed with the School Business Manager and Head Teacher and reported to the Chair of Governors.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Kobi Nazrul Primary School	March 2017	The audit was designed to ensure that the Head Teacher and the Governing Body have implemented adequate and effective controls over the administration and financial monitoring affairs of the school and to evaluate the potential consequences which could arise from any weaknesses in internal control procedures, including value for money issues and any equality issues. The key recommendations were as follows:- • Budget allocations should be accurately uploaded to the financial system following approval of the budget by Governors. The Head Teacher should review and sign a record of this being performed. Where subsequent amendments are required, approval from Governors/IEB should be sought and documented. • Payroll checks should be undertaken on a monthly basis. Once completed, the reconciliation should be independently reviewed and signed-off by the Head Teacher and documentation retained to evidence the process has taken place. • All unpresented cheques should be reviewed and followed up with the supplier after three months of issue, to ascertain the reason for non-presentation. All unpresented cheques over six months old should be cancelled where no response has been received and be removed / written back on the RM Finance system. • The Terms of Reference (ToR) for the Governing Body and Sub Committees should include the quorum requirements. • Purchase order forms should be raised for all purchases, where appropriate before an order is placed. In exceptional cases where verbal authorisation is sought, a retrospective purchase order should be raised and clearly noted and retained on file. • All Invoices should be paid in a timely manner (within 30 days). All findings and recommendations were agreed with the School Business Manager and Head Teacher and reported to the Chair of Governors.	Moderate	Substantial ⇨

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Wellington Primary School	Feb 2017	The audit was designed to ensure that the Head Teacher and the Governing Body have implemented adequate and effective controls over the administration and financial monitoring affairs of the school and to evaluate the potential consequences which could arise from any weaknesses in internal control procedures, including value for money issues and any equality issues. The key recommendations were as follows:- • Where required, specific reviews, sign-offs, approvals and decisions made by the Full Governing Body should be clearly minuted • Purchases should only be made once the Purchase Order has been raised and approved by the Head Teacher or a delegated officer as per the Scheme of Delegation. • The School Funds Account reconciliations should be reviewed and signed-off by the Head Teacher. • The audited School Funds Account should be presented for review and sign-off by the Full Governing Body, or the delegated committee and this should be clearly minuted. • The School should ensure that information is retained to support the full costing of the residential trips. The School should ensure an End of Journey Statement is produced and presented to the Full Governing Body for review and sign-off. • The School should ensure the results of the Annual Inventory Check are presented to the Full Governing Body for review once the check is completed. This should be formally minuted. • The School should renew and retain a copy of the current insurance policy and ensure the safe limit is not exceeded at any time. • The Full Governing Body meeting minutes should have Declarations of Pecuniary Interests as a standing item. All findings and recommendations were agreed with the School Business Manager and Head Teacher and reported to the Chair of Governors.	Moderate	Substantial ⇔

Full Assurance

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Poplar Mortuary Follow-Up	Feb 2017	A full systems audit on Popular Mortuary was undertaken as a part of the 2015/16 agreed Internal Audit Plan and the final audit report was issued in July 2016. This audit was assigned Substantial Assurance and two recommendations were raised (one medium priority recommendation and one low priority recommendation). A follow up audit was completed within the objective was to assess whether the agreed recommendations at the conclusion of the original systems audit had been implemented. This follow up audit was undertaken as part of the 2016/17 agreed Internal Audit Plan. Our follow up review showed that the medium priority recommendation made at the conclusion of the original 2015/16 audit had been fully implemented. Following our testing, we have not made any further recommendations to enhance the control environment within this area. All findings and recommendations were agreed with the Head of Environmental Health and Trading Standards and reported to the Chief Executive (Interim Corporate Director CLC).	Extensive	Full ⇨

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Transparency Code 2015 Compliance	March 2017	This follow up audit assessed the progress made in implementing agreed recommendations at the conclusion of the original audit in June 2016. Our testing showed that out of three high priority recommendations made in the original report, all three had been progressed and implemented. One medium priority recommendation was also implemented. The main issues covered in the report are as follows: • The Terms of Reference for the FOI Board were revised and taken to the FOI Board Meeting on 1st July 2016 for approval. However, we have noted that functions of the FOI Board have now transferred to the Corporate Strategic Information Governance Board. • In order to ensure that relevant data has been received for publication by the Information Governance Manager by set deadlines, a Transparency Programme Timetable for 2016/17 was developed and distributed to the FOI Board meeting on 1st July 2016. • Testing of local procedures showed that internal procedures for checking and redacting sensitive data have been developed to ensure that data sent to individual Finance Business Partners by Financial Systems manager are checked and submitted by specified deadlines. • The CMT meeting on 17 August 2016, considered the issue of publication of creditors spend data over £250. The CMT decided that the publication of data over £250 for general spend be implemented when the required software has been procured and installed. • Our review found that all procurement card spend is published separately from information on creditors payments over £500. Testing showed that information for spend over £500 is being published every month. All findings and recommendations were agreed with the Interim Divisional Director, Governance and final report was issued to all Corporate Directors.	Extensive	Full ⇨

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Independent Review of Pensions Statements	Nov. 2016	On 12th September 2016, it was brought to the attention of the Council that some employees had received the Annual Pension Statements of other active members of the Local Government Pension Scheme. As this event potentially represented a breach of the Data Protection Act, the incident was reported to the Information Commissioner's Office (ICO) on the 15th September 2016. The Council then liaised with the ICO to ensure that lessons were learnt and a repeat of the error is avoided in future. As part of this learning, an independent audit by Internal Audit was commissioned by the Interim Service Head, HR Transformation. From detailed audit testing and analysis, it was concluded that in order to produce annual statements, manipulation of sensitive data from two different data bases containing huge volume of personal data was required, which increased the risk of human error occurring. This together with other factors such as working against tight deadlines, an absence of internal checks, lack of control total reconciliations and possible lack of skills in spreadsheet use and analysis, may have contributed to the eventual data security breach. On the basis of our analysis, we alerted Management to re-consider immediately the extent of the security breach initially reported to the ICO. The Pensions Team sent Apology letters to 339 employees. However, audit analysis showed a number of cases where multiple employees' statements had been posted to a single address. It was of concern that these cases had not been identified and supervised correctly by the Pensions Team at the time when address mismatches were being investigated upon notification of the data security breach. For example, seventeen different employees' statements were sent to one address. In another case, nine employees' statements had been posted to a single address. These two addresses belonged to employees who were not in the Pensions Scheme. There were some twenty eight employees in our sample who appeared not to be on the Apology letter list. Therefore, it was important that the full extent of mismatched addresses was identified without further delay and Apology letters sent to those employees.	Extensive	N/A

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Independent Review of Pensions Statements		Another issue highlighted for remedial action was the methodology for preparing the annual pensions statements. This process was not automated on the pensions IT system, Altair (also known as ABS), although we understand that Altair has the facility to do so. Instead, the statements were prepared by using a number of manual intervention routines which required data to be exported on a spread sheet from Altair system and from Resource Link system which held HR data and then running VLOOKUP formulae to bulk match addresses and other details on the two data bases. To do this, 7 different versions of the spreadsheet were produced, each containing a huge volume of personal data from Altair and from Resource Link. From audit point of view, this is inefficient use of resources which increased the risk of errors, omissions, poor data quality and the resultant data security breach. We also highlighted from our testing that Altair was not regularly being updated with the most recent addresses of employees on pensions scheme. The address data on Altair was at least two years out of date. This, therefore, necessitated the bulk matching of addresses on Altair with those on Resource Link during the production of annual statements with unnecessary increased risk exposure to the Council. We made 11 recommendations within the audit report, all of which were agreed by the Interim Service Head, HR and WD and the Corporate Director, Resources. The audit report was provided to the ICO, who then determined not to levy any fines to the Council.		

Appendix 4

Follow Up Audits – List of Priority 1 Recommendations still to be implemented

Audit Subject	Recommendation	Service Head	Officer Name
Market Vouchers	The Street Markets and Enforcement Team should aim to implement the handheld loggers system for market vouchers as soon as practicable to assist in ensuring that the THEOs are undertaking their roles in line with policies and procedures. In addition, the attendance sheets should be more transparent and include tick boxes and/or narrative boxes to allow THEOs to indicate how they have verified all required information (including licence checks, identification checks of market traders as well as confirmation that market traders hold the required insurance). Management should aim to meet the target of 10 spot checks per month in respect of THEO attendance sheets.	Roy Ormsby, Divisional Director, Place	Roy Wayre – Markets Development Manager
Market Vouchers	When formal training begins in March 2017, a log/attendance sheet should be retained to detail all those officers who have attended, and to help identify any individuals who are yet to receive training.	Roy Ormsby, Divisional Director, Place	Roy Wayre – Markets Development Manager
Idea Store Watney Market	Once goods are received, delivery checks should be undertaken by the Idea Store Team Leader. When checks have been completed, the required form or delivery note should be signed, dated by the responsible officer and filed into the delivery folder.	Judith St John-Head of Idea Stores	Shaw Rahman Khan – Idea Store Manager

Audit Subject	Recommendation	Service Head	Officer Name
Idea Store Watney Market	Watney Market Building User Group Meetings between the Idea Store Manager and Facilities Management should be held on a monthly basis to discuss Health & Safety and all buildings related issues.	Judith St John- Head of Idea Stores	Ayo Alegbeleye –Senior Facilities Manager
THH Housing Insurance Claims	Insurance claims received by THH should be investigated by staff, CF2 forms completed and returned to the THH Contact Centre team, and passed to the LBTH Insurance team in a timely manner for processing. A timeframe should be established to be met for the investigation and CF2 report stages of the claims process to be completed, and performance against this target should be monitored on a monthly basis. A timeframe of 10-days is suggested, following discussion with the Head of Customer Access and Facilities.	Neil Isaac – Director of Finance	THH Senior Housing Advisor
Highways Repairs and Maintenance	It should be ensured that procedures for monitoring of overdue jobs, selection criteria for post – inspections, and managing and monitoring of variations are captured in the process maps. The process maps should be dated and version controlled with the name of the author and the date of next review to ensure procedures are being applied consistently.	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green
Highways Repairs and Maintenance	It should be ensured that written procedures for effective monitoring of various aspects of the contract are drawn up and distributed to staff. The Council's procedures and toolkits for contract monitoring should be used for this purpose.	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green
Highways Repairs and Maintenance	A list of jobs not completed should be produced from the source system (Mayrise). This list should be printed off and taken to the weekly meetings with the contractor for discussion as to why these jobs have not been completed in time. This list should be attached to the minutes of the meeting so that a complete audit trail is preserved. The minutes should clearly record key decisions and any penalties that should be raised for jobs not completed within the required time period.	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green

	The cumulative effect of any repeated non-performance incidences should be clearly recorded, discussed, escalated and reported to the contractor in accordance with LBTH Contract Monitoring toolkit and guidelines published in April 2016.		
Highways Repairs and Maintenance	In order to make the practice of approving payments on the basis of desk-top post inspections more effective, it should be ensured that standard procedures are drawn up for the contractor to follow when taking photographs. For example, each photograph should have location, date and time embedded; angle and distance for each pre and post completed jobs should be similar; each photograph should be clear; and each photograph should be such that it can be used as evidence in the event of dispute or insurance claim.	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green
Adoption and Fostering Panel	It should be ensured that applications which have been received without the essential sections being completed or other key details being deleted from the electronic documents should be sent back to the applicant for full completion.	Nasima Patel - Divisional Director, Children's Social Care	Tina Coburn Team Manager
Adoption and Fostering Panel	In order to ensure transparency the Service Manager Children's Social Care should record the reason why the timeframe for matching the child with suitable adopters took longer than expected.	Nasima Patel - Divisional Director, Children's Social Care	Tina Coburn Team Manager

Follow Up Audits – List of Priority 2 Recommendations still to be implemented

Audit Subject	Recommendation	Service Head	Officer Name
Market Vouchers	Once all policies, procedures and SOPs have been updated, version history details should be formally included.	Roy Ormsby, Divisional Director, Place	Roy Wayre – Markets Development Manager
Idea Store Watney Market	All assets within the Idea Store Watney Market should be included on the Inventory Register (whether electrical or non-electrical).	Judith St John- Head of Idea Stores	Shaw Rahman Khan – Idea Store Manager
Idea Store Watney Market	Inventory checks should be performed by an independent officer before December 2017.	Judith St John- Head of Idea Stores	Shaw Rahman Khan – Idea Store Manager
THH Unauthorised Occupancy	All policies and procedures should state a clear version history, to include information regarding:- - date when the document was last reviewed; - details of who reviewed and approved the document; and - confirmation of the next planned review date.	Neil Isaac – Interim Director of Finance,	Area Manager (Fraud lead) NHD South.
THH Unauthorised Occupancy	An unauthorised occupancy strategy should be implemented. The strategy should be presented for approval and agreed between LBTH and THH and cover both the identification and processes to tackle instances of unauthorised occupancy (whether this be by fraud or otherwise).	Neil Isaac – Interim Director of Finance,	Area Manager (Fraud lead) NHD South, input from LBTH Fraud Team.
THH Unauthorised Occupancy	Cases should be routinely reviewed on a monthly basis, with no gaps in action being taken wherever possible.	Neil Isaac – Interim Director of Finance,	Area Manager (Fraud lead) NHD South and LBTH Tenancy Fraud Team Leader.

Audit Subject	Recommendation	Service Head	Officer Name
THH Housing Insurance Claims	The online and physical copies of the leaseholder and tenants handbooks should be updated with dedicated headings and details on the different claims processes in place for both, so that claimants are informed of the process before making a claim and so leaseholders are aware of the need to contact Ocaso directly. The process involved in making a claim should be detailed, without providing information which might encourage or facilitate dishonest or unfounded claims. The flowchart that has been produced should be made available on the website in order to help tenants and leaseholders determine the course of action that they need to take, depending on their personal circumstances. Further to this; in all sources of information available to the public, it should be noted that any claims for damages caused by contractors should be made directly to the responsible party, not to the Council or to THH.	Neil Isaac – Director of Finance	Senior Housing Advisor
THH Housing Insurance Claims	The CF1 form should be amended to improve the clarity and ease of use, by including an explanatory front page, and a process flowchart to explain the different courses of action they should take, the processes which THH and LBTH follow, and the timeframe in which they should receive responses. The CF2 form should be updated with detailed guidance for the inspectors, whether from housing or repairs teams, as per the expectations of the Insurance team. The completed CF2 forms should include a detailed inventory of the items damaged, corroborated against the details of the claim as per the CF1, with officers challenging or confirming the claims made, and ensuring that photographic evidence is obtained where required. Both forms should also include details to make clear that if a contractor is responsible for the damage, the claimant should contact them directly and that THH and LBTH should not progress the claim further. Distributing claims forms should be restricted to the Contact Centre staff, as they are trained in the insurance claims process. Management should consider providing training in the new process and forms to be implemented, in order to embed the changes.	Neil Isaac – Director of Finance	Senior Housing Advisor

Audit Subject	Recommendation	Service Head	Officer Name
THH Housing Insurance Claims	The LBTH Insurance Team and THH should formally agree and confirm the new insurance claim handling process to be put in place, and update and finalise the new procedure documents to support the process. These should be made available to all relevant officers at THH and LBTH, and briefings should be held to update staff on the changes to the process. The template letters in place for housing insurance claims should also be updated to match the new procedure, and the date and time of the appointment booked should be confirmed via letter. The procedure should be reviewed following a trial period in order to establish the performance of the new process, and to determine whether any further changes are required. The information available to tenants and leaseholders should be updated to reflect the changes, in order to help prevent claimants coming to contact points without bringing the required information with them.	Neil Isaac – Director of Finance	LBTH Insurance Services THH – Repairs Inspector and Senior Housing Advisor
THH Housing Insurance Claims	Acknowledgement letters should be sent within two working days to claimants by THH once a completed CF1 form has been received. Claimants should be informed of the relevant contacts for their case at both THH and LBTH. Telephone calls should be used in the first instance in order to allow for timely and effective communications, with letters being sent following the calls, in order to confirm key information where necessary. The Northgate system should be updated by THH staff and contractors with all information as it is obtained, such that the claims process is not delayed by ambiguity (especially with regards to Decent Homes contractor work). The involvement of contractors should be established in the initial investigations, to prevent claims being progressed which should be directed to the responsible parties. Where claims are delayed beyond the LBTH Insurance team's internal target of 90 days, the claimant should be contacted to update them on the progress of their claim, and any reasons for the delay should be recorded.	Neil Isaac – Director of Finance	Senior Housing Advisor

Audit Subject	Recommendation	Service Head	Officer Name
THH Housing Insurance Claims	Performance reports should be produced by the LBTH Insurance Team and sent to the Head of ICT, Risk, and Contract Governance and the Customer Services Manager at THH, on a quarterly basis, to allow discussion and review of the performance. Regular meetings should be held to discuss the performance of the THH acknowledgement and investigation process, the LBTH claims process, and any issues identified. LBTH and THH management should establish what information is useful and relevant in order to facilitate this. It is recommended that the performance reports initially include details of new claims received, claims still open, and claims resolved in the recent period, the time taken to resolve claims, ratio of claims settled to those repudiated, reductions in pay-outs achieved, and details and analyses of customer complaints received, in addition to the information previously provided. Details of claims received relating to contractors should also be included, for discussion at the contractors meetings held by THH.	Neil Isaac – Director of Finance	LBTH Insurance Services THH Senior Housing Advisor and repairs Inspector
THH Housing Insurance Claims	A protocol should be evidenced, determining which parties are responsible for managing and coordinating claims relating to contractors, in order to prevent claimants being left without support by the Council and THH in dealing with any issues arising. Representatives of the LBTH Insurance Team should attend THH contractor meetings in order to address insurance claims, and provide performance information on contractor claims in order to identify any trends.	Neil Isaac – Director of Finance	LBTH Insurance Services THH Senior Housing Advisor
Back Office Revenue, collection and Processing	On a weekly basis a second officer should review the weekly cash balances in a timely manner.	Roger Jones – Service Head, Revenue Services	M COULTER - Processing and Reconciliation Manager
Back Office Revenue, collection and Processing	It should be reminded that officers should always sign the postal order book at the time of inputting the information.	Roger Jones – Service Head, Revenue Services	M INMAN / M COULTER - Processing and Reconciliation Manager

Audit Subject	Recommendation	Service Head	Officer Name
THH Management of Asbestos	THH should ensure that data is fully uploaded to Keystone, such that contractors can be encouraged to rely on the database without risk of false impression. Keystone log-in records should be used/reviewed to provide assurance that access is being made on a regular basis.	Neil Isaac – Interim Director of Finance	Head of Health and Safety Director of Asset Management is the main Duty Holder.
THH Management of Asbestos	A monthly report of all works orders and inspections should be developed and scheduled, with statuses and reasons cited, that will be sent to the Health & Safety Co-ordinating Group for follow up. This should be used to mitigate the risk of both work orders and post inspections being amended/cancelled and going unnoticed. Northgate security configuration should be reviewed and options provided to control access to asbestos post-inspections.	Neil Isaac – Interim Director of Finance	Systems & Data Manager
THH Management of Asbestos	The Asbestos Policy and Management Plan (including the planned inspections programme) should be completed in a timely manner and presented at the first available opportunity to the H&S Forum for approval. Reporting on the progress made against the agreed inspection programme should subsequently be communicated to senior management on a regular basis.	Neil Isaac – Director of Finance	Head of Health and Safety for Policy. Director of Asset Management as Duty Holder.
THH Management of Asbestos	As noted in Follow-Up Recommendation 3, the Asbestos Policy and Management Plan should be completed and presented to the H&S Forum at the first available opportunity for approval. On completion, the planned steps above should be taken to ensure that this document is adequately distributed and made available to staff.	Neil Isaac – Director of Finance	Head of Health and Safety responsible for Policy. Director Asset Management as Duty Holder.
THH Management of Asbestos	Each month, a team member should undertake an independent 10% sample check in respect of entries made to the Keystone System, to help ensure that input errors are corrected. Evidence of these checks should be maintained. The findings should be reported to the Head of Service as part of the Performance Management Framework.	Neil Isaac – Director of Finance	Health and Safety Team member.

Audit Subject	Recommendation	Service Head	Officer Name
Highways Repairs and Maintenance	It should be ensured that in accordance with the LBTH contract monitoring procedures and toolkits a set of clear KPIs and performance targets are developed	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green
Highways Repairs and Maintenance	Management reports should be produced on a periodic basis for senior management to enable them to make informed decisions.	Roy Ormsby Divisional Director, Public Realm	Liz Nelson Interim Head of Clean and Green

APPENDIX 5

List of Planned Audits Undertaken in 2016/17

Audit Description	Significance	Assurance
Law, Probity and Governance		
Registrars Office Follow-Up	Extensive	TBC
Corporate		
Systems Review Compliance Function	Extensive	N/A
Business Continuity Planning and Disaster Recovery	Extensive	Substantial (Draft)
Acting Up and Honoraria Payments	Extensive	Limited
Staff Hospitality and Gifts	Extensive	Substantial
Control and Monitoring of DBS checks	Extensive	Limited
Control and Monitoring of Declaration of Interests	Extensive	
Transparency Code Compliance Follow Up	Extensive	Full
Declarations of Interests	Extensive	Substantial
Management of Efficiency Programme	Extensive	Substantial
Adults Services		
ESW Petty Cash Follow Up	Extensive	Limited
Public Health Contract Monitoring F/Up - Smoking Cessation	Extensive	Substantial
Public Health Contract Monitoring F/Up - Health Promotion Sex Workers	Extensive	Full
Public Health Contract Monitoring F/Up - Healthy Start Vitamins	Extensive	Full
Public Health Contract Monitoring F/Up - Health Trainers NW	Extensive	Substantial
Troubled Families Compliance Testing	N/A	N/A
Domiciliary Care Procurement	Extensive	TBC
Children's Services		
Adopting and Fostering Panels	Extensive	Substantial
Missing Children – Follow Up	Extensive	Substantial
ESW Petty Cash Follow Up	Extensive	Limited
Norman Grove Children's Home	Extensive	Limited
Norman Grove Follow-Up	Extensive	TBC
Youth Offending Service	Extensive	Substantial
Quality Assurance Systems for Child Protection	Extensive	N/A
Commissioning of Special Education Placements	Extensive	Limited
Watney Market Idea Store Follow-Up	Extensive	Substantial

Schools		
Arnhem Wharf Primary School	Moderate	Substantial
Bonner School - Bethnal Green	Moderate	Substantial
Globe Primary School	Moderate	Substantial
Guardian Angels Primary School	Moderate	Substantial (Draft)
Kobi Nazrul Primary School	Moderate	Substantial
Marion Richardson Primary School	Moderate	Substantial
Old Palace Primary School	Moderate	Substantial
Olga Primary School	Moderate	Substantial
Redlands Primary School	Moderate	Substantial
St Agnes Primary School	Moderate	Substantial
St Anne's Primary School	Moderate	Substantial
St Elizabeth Primary School	Moderate	Substantial
St Luke's Primary School	Moderate	Limited
St Mary and St Michael Primary School	Moderate	Substantial
St Matthias Primary School	Moderate	Substantial
St Peter's London Docks Primary School	Moderate	Substantial
St Saviour's Primary School	Moderate	Substantial
Stewart Headlam Primary School	Moderate	Limited
Thomas Buxton Primary School	Moderate	Substantial
Wellington Primary School	Moderate	Substantial
William Davis Primary School	Moderate	Substantial
Woolmore Primary School	Moderate	Substantial
Harpley Inclusion Support Centre	Moderate	Substantial
Beatrice Tate Special School	Moderate	Substantial
Phoenix Special School	Moderate	Substantial
Cherry Trees Special School	Moderate	Substantial
Stephen Hawking Special School	Moderate	Substantial
Communities, Localities and Culture		
King George's Trust – Mile End Park	Extensive	Limited (Draft)
Street Lighting	Extensive	Limited (Draft)
Penalty Charge Notices	Extensive	Substantial
CCTV Control Room	Extensive	Limited (Draft)
Watney Market Idea Store	Extensive	Substantial
Brady Arts Centre and Kobi Nazrul Centre	Extensive	Limited
Market Vouchers Follow-Up	Extensive	Limited
Licence Applications Follow-Up	Extensive	TBC
Poplar Mortuary Follow-Up	Extensive	Full
Trading Standards Follow-Up	Extensive	Substantial
Bancroft Library Archiving	Extensive	Limited
Parking Permits	Extensive	Limited

Waste Contracts – Procurement	Extensive	Substantial
Repairs and Maintenance of Highways – Follow Up	Extensive	Limited
Risk Management Follow Up	Extensive	Limited
Pay by Phone Follow Up	Extensive	Substantial
Mayrol Community Infrastructure Levy - FU	Extensive	Substantial
Tower Hamlets Homes		
THH Estate and Caretaking Management	Extensive	Substantial
THH Housing Insurance Claims Follow Up	Extensive	Limited
THH Leaseholder Service Charges Follow Up	Extensive	Substantial
THH Management of SLAs Follow Up	Extensive	Full
THH Programme and Project Management	Extensive	Substantial
THH Estate Parking, Sheds and Garages	Extensive	Limited (Draft)
THH Management and Control of Voids	Extensive	Substantial
THH Financial Systems	Extensive	Substantial
THH Housing Rents	Extensive	Substantial (Draft)
THH Sickness Management	Extensive	TBC
THH Risk Management	Extensive	Substantial
THH Bancroft TMO Follow-Up	Extensive	Substantial
THH Programme and Project Management Follow-Up	Extensive	Substantial
THH Unauthorised Occupancy Follow-Up	Extensive	Substantial
THH Specialist Repairs Contracts Follow-Up	Extensive	TBC
THH Corporate H&S Follow-Up	Extensive	TBC
Development and Renewal		
Economic Benefits	Extensive	Limited (Draft)
Property Buy Back Programme	Extensive	TBC
Planning Permissions and Approvals	Extensive	Substantial
Asset Disposal – Compliance Audit	Extensive	Substantial
Lettings	Extensive	Limited
Right to Buy Valuations	Extensive	Limited
Risk Management – Follow Up	Extensive	Substantial
Resources		
Back Office Revenue Collection and Processing	Extensive	Substantial
VAT Follow Up	Extensive	Substantial
Council Tax	Extensive	Substantial
NNDR	Extensive	Substantial
Creditors	Extensive	Substantial

Debtors	Extensive	Substantial
General Ledger	Extensive	Substantial
Pensions	Extensive	Limited
Staff Recruitment	Extensive	Substantial
HR/Payroll	Extensive	Substantial
Back Office Revenue Follow-Up	Extensive	Substantial
Emergency Grant Funding Follow-Up	Extensive	Limited
Revenue and Capital Budgetary Control	Extensive	Substantial
Payroll Account Reconciliations Follow-Up	Extensive	Substantial
Housing and Council Tax Benefit	Extensive	TBC
Procurement Category Management	Extensive	N/A
Pensions Statement Review	Extensive	N/A
Tracing and Enforcement Agencies – Follow Up	Extensive	TBC
Treasury Management	Extensive	Substantial
Control of C&D Income – Follow Up	Extensive	Substantial
Control of Photocopying and Printing Contract	Extensive	Substantial
Management of Procurement Waivers	Extensive	Substantial
Risk Management Follow Up	Extensive	Limited
Financial Assessments	Extensive	Limited

Appendix 6

Head of Audit Opinion – Summary

Background

The purpose of this report is to meet the Head of Internal Audit annual reporting requirements set out in the Public Sector Internal Audit Standards. The purpose of this report is to:

a) Include an opinion on the overall adequacy and effectiveness of the organisation's internal control environment;
b) Disclose any qualifications to that opinion, together with the reasons for the qualification;
c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
d) Draw attention to any issues the Head of Internal Audit judges particularly relevant to the preparation of the statement on internal control;
e) Compare the work actually undertaken with the work that was planned and summarise the performance of the Internal Audit function against its performance measures and criteria; and
f) Comment on compliance with these standards and communicate the results of the Internal Audit quality assurance programme.

Therefore in setting out how it meets the reporting requirements, this report also outlines how the Internal Audit function has supported the Council in meeting the requirements of Regulation 4 the Accounts and Audit Regulations. These state that:

"The relevant body shall be responsible for ensuring that the financial management of the body is adequate and effective and that the body has a sound system of internal control which facilitates the effective exercise of that body's functions and which includes arrangements for the management of risk."

Head of Internal Audit Opinion on the Effectiveness of Internal Control 2016/17

This opinion statement is provided for the use of the Council in support of its Statement on Internal Control (required under Regulation 4(2) of the Accounts and Audit Regulations 2003) that is included in the statement of accounts for the year ended 31 March 2017.

Scope of Responsibility

The Council is responsible for ensuring its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. The Council also has a duty under the Local Government Act 1999 to make arrangements to secure continuous improvement in the way in which it functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

In discharging this overall responsibility, the Council is also responsible for ensuring that there is a sound system of internal control which facilitates the effective exercise of the Council's functions and which includes arrangements for the management of risk.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate risk of failure to achieve policies, aims and objectives; it can therefore **only provide reasonable and not absolute assurance of effectiveness**. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Council's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Internal Control Environment

The Internal Audit Code of Practice states that the internal control environment comprises three key areas, internal control, governance and risk management processes. Our opinion on the effectiveness of the internal control environment is based on an assessment of each of these three key areas.

Review of Effectiveness

The Council has responsibility for conducting, at least annually, a review of the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the authority who have responsibility for the development and maintenance of the internal control environment, and also by comments made by the external auditors and other review agencies and inspectorates in the annual audit letter and other reports.

Head of Internal Audit Annual Opinion Statement

My opinion is derived from work carried out by Internal Audit Services during the year as part of the agreed internal audit plan for 2016/17, including an assessment of the Council's corporate governance and risk management processes.

The internal audit plan for 2016/17 was developed to primarily provide management with independent assurance on the adequacy and effectiveness of the systems of internal control.

Basis of Assurance

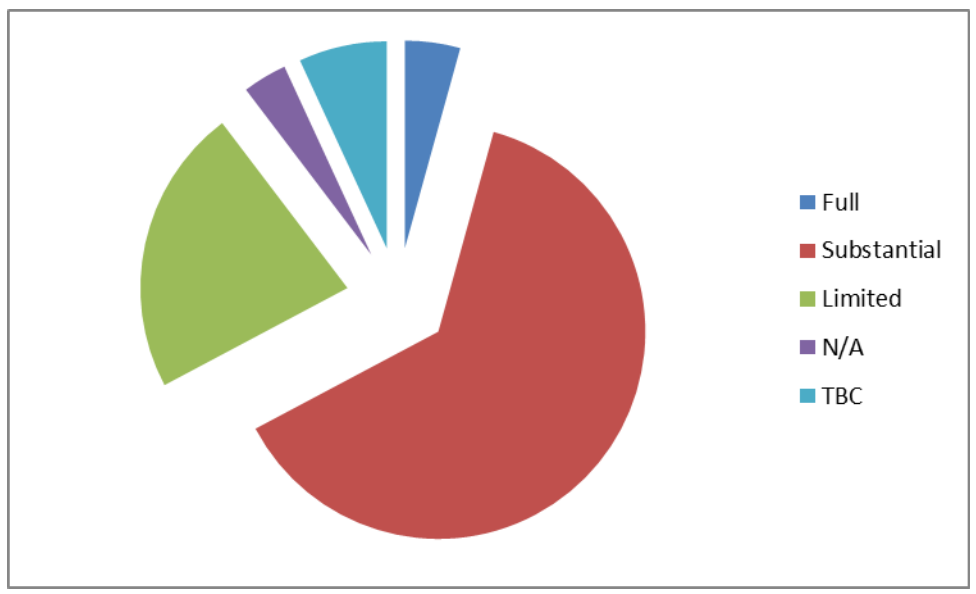
Audits have been conducted in accordance with the Public Sector Internal Audit Standards. The programme of work carried out during 2016/17 is at Appendix 5.

My opinion is limited to the work carried out by Internal Audit during the year on the effectiveness of the management of those principal risks, identified within the organisation's Assurance Framework, that are covered by Internal Audit's programme. Where principal risks are identified within the organisation's framework that do not fall under Internal Audit's coverage, I am satisfied that a reasonable system is in place that provides reasonable assurance that these risks are being managed effectively.

97% of Internal Audit work for the year to 31 March 2017 was completed in line with the operational plan. The percentage levels of assurance achieved for reports submitted in 2016/17 are depicted in Graph 1 below. This shows that 67% of the systems audited achieved an assurance level of full or substantial assurance, whereas 22% of systems audited achieved limited or nil assurance. This is an adequate performance by the council. There are currently 8 audits (7%) in progress which have assurance levels yet to be confirmed.

Internal Audit's planned programme of work also includes following-up all agreed recommendations. Given that 69% of priority 1 and 53% of priority 2 recommendations followed up had been implemented when the audit revisited the area, this is an area of concern and has been reported to the CMT and the Audit Committee previously. Stronger escalation procedures have been developed over the last year to improve on current performance and these have been agreed by the Corporate Management Team and the Audit Committee.

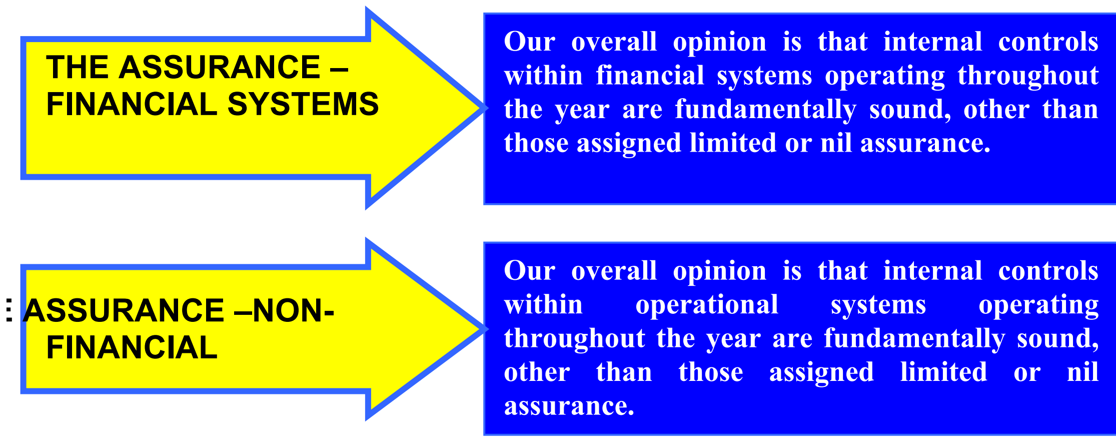
Graph 1 – Levels of Assurance for 2016/17



2016/17 Year Opinion

Internal Control

From the Internal Audit work undertaken in 2016/17, it is my opinion that I can provide a satisfactory assurance that the system of internal control that has been in place at the Council for the year ended 31st March 2017 accords with proper practice, except for any details of significant internal control issues as documented in the Detailed Report on **pages 82-93**. The assurance can be further broken down between financial and non-financial systems, as follows:



Risk Management

In my opinion, risk management within the Council continues to be embedded, with increased emphases on buy in from staff, Member and the Corporate Management Team. Embedding risk management within the culture is a lengthy process, continuing to improve the management information in the form of risk registers and reporting of risks and control will ordinarily assist this process. The Audit Committee will receive an annual Risk Management report in June 2017.

I would like to take this opportunity to formally record my thanks for the co-operation and support received from the management and staff during the year, and I look forward to this continuing over the coming years.

Minesh Jani – Head of Audit and Risk Management

June 2017

Appendix 7

DETAILED REPORT

Introduction

This section is a report detailing:

- any significant control failures or risk issues that have arisen and been addressed through the work of Internal Audit;
- any qualifications to the Head of Audit opinion on the Authority's system of internal control, with the reasons for each qualification;
- the identification of work undertaken by other assurance bodies upon which Internal Audit has placed reliance to help formulate its opinion;
- the management processes adopted to deliver risk management and governance requirements;
- comparison of the work undertaken during the 2016/17 year against the original Internal Audit plan; and
- a brief summary of the audit service performance against agreed performance measures.

Significant Control Issues

Internal Audit is required to form an opinion on the robustness of the internal control environment, which includes consideration of any significant risk or governance issues and control failures which have arisen during the financial year 2016/17. Key issues included the following which had all been responded by management:-

Control and Monitoring of Major Works

Major works are large 'one-off' projects. Where works are carried out on buildings in which leaseholder properties are located, the leaseholders are liable for a proportion of the costs incurred. The objective of this audit was to provide assurance on the effectiveness and adequacy of the systems and controls THH has put in place for the management and control of Major Works.

Audit testing found a number of key weaknesses in the systems of control for management and administration of Major Works. Key weaknesses included the timely issue of statutory S20 notices; independent review of S20 notices before being sent to the leaseholders; consultation meetings not always being held in a timely manner; key policies and procedures not up to date and not reviewed; lack of co-ordination and information sharing between teams creating inefficiencies to achieve targets; Resident Liaison Teams not being aware of which flats in the blocks have not yet been surveyed by the contractor; and reports produced by the contractors did not indicate whether residents require additional support, due to any disabilities or other needs. In addition, issues such as target timeframe not being set for reviewing the leaseholder accounts regularly in order to identify the status of arrears; leaseholder arrears for major works

not being appropriately actioned for recovery on a regular basis; weaknesses in procedures by the contractor responsible for visiting the property to identify any vulnerable residents; severe delays were found in the implementation of the 2014/15 Major Works Programme such that, in all cases tested, the works were still not 100% complete and a practical completion certificate was yet to be issued. Finally, due to the delays in the practical completion of the 2014/15 Major Works Programme, final accounts could not be sent to the Quantity Surveyors for checking. We were also informed that none of the blocks under the Major Works Programme 2014/15 had been audited as the breakdown of the final accounts had not been received from various contractors.

Management Comments from THH Director

Revised consultation procedures are now in place. Closer working with the leasehold teams and joint meetings occur each week to ensure information is shared and up to date. Meeting with both teams take place every Wednesday.

The internal program is now completed. Block surveys are now undertaken for external major works only and these are now achieved via consultant surveyors.

The process for identifying vulnerable residents for major works has been reviewed. We have identified the need to include housing staff to provide the information before surveys. Those residents identified as vulnerable and requiring works will be individually assessed by THH staff using the MOLESD form which is/will be signed and dated in line with the procedure. Contractors will not be required to undertake this task.

Final accounts are being actively managed through to completion. Future programs will be smaller in scale and will be more closely managed. Consultants have been instructed to ensure paperwork is properly signed and action reports on contractor progress are provided every month.

THH Corporate Health and Safety

Tower Hamlets Homes (THH) is responsible for ensuring a safe and healthy workplace in accordance with the Health and Safety at Work Act 1974. A new accident reporting system has recently been introduced, supplied by the firm Santia. Health and safety compliance is monitored via dashboard reporting and meetings of the bi-monthly Health and Safety Forum which is used to discuss and monitor actions from previous meetings, recent issues, and forward planning. This audit covered the administrative buildings and facilities, but did not cover the inspections or reviews of rented and leased streets, grounds or properties for which THH is responsible (as these are covered by other audits previously undertaken or planned for the future, in dedicated audits such as Gas Installation, Water Tests, Highways, and Grounds Maintenance).

The main points reported by this audit were as follows:-

- A tracker spreadsheet is maintained to monitor the training courses that have been attended by all staff. However, the log is incomplete and it is therefore not possible to know whether all staff have attended the necessary training for their roles. In addition, it was not possible to ascertain whether the appropriate training has been undertaken by the appointed fire marshals and first aiders.

- There is currently no schedule of inspections in place and therefore inspections may not be carried out at the required regular intervals which may lead to failure to identify and prevent incidents. In addition, there is not currently any formal procedure for raising healthy and safety issues and no log is currently kept of all issues that have been raised, thus providing no means of tracking progress or following up these issues.
- It was seen that investigation forms had only been completed by managers for five of the 20 cases that were tested. It was confirmed that an accident log is currently kept. However, this is incomplete and is not up to date.
- It was confirmed that health and safety reports are only sent to the Board on an annual basis.

Management Comments from THH Director

Work is ongoing to develop the incident reporting system. A meeting has been held with Santia, the organisation collecting incident information and compiling reports to ensure a full understanding of contract agreement and service delivery.
Incident investigations have been included in the dashboard presented to the Health and Safety Forum and EMT. Entries have been made on News & Views to raise awareness to the important of incident reporting.
A paper was presented to the Executive Management Team in July 2016 outlining a new governance structure and work is ongoing to develop the structure. The Health and Safety Forum will remain the strategic lead for THH and risk-based directorate meetings will be set up, commencing October 2016 to manage health and safety at a local level. Thereafter, the Health and Safety Forum will meet three monthly and all meetings will be co-ordinated to allow Directorates to report upwards.
Special groups are being set up to ensure high risk areas such as Fire Risk Assessment and Asbestos are managed effectively.

The new style dashboard has been drafted and presented to the August Health and Safety Forum and will, subsequently, be presented to the EMT. This provides a higher level report.

An Improvement Plan for THH Health and Safety will be developed in time for the October Forum

Establishment Control

This audit was designed to review the systems and processes in place, in order to provide assurance around the effective management of the Council's establishment levels and to evaluate the potential consequences which could result from any weaknesses in internal control procedures.

The following key issues were highlighted by this audit:-

- There is no requirement for service managers to review their establishment lists on a monthly basis and notify HR of any amendments required.
- A review of the establishment list obtained for March 2016 confirmed the concerns raised over the usefulness and completeness of the data including the fact that there are 102 posts that are detailed as being vacant for four or more years but there are no further details as to why they have been long-term vacant.
- The data held on both the Council's establishment list and the Agresso system is not reconciled on a consistent and timely basis, and we identified a number of variances between the two systems, including unfunded posts being present on the establishment list which is contrary to the Council's Financial Regulations.

- There is a need for the data held on the Comensura system to be reviewed against the establishment list and for the Council to re-classify people who are paid through the Comensura system but should not be included within the establishment list.
- From a sample of 20 employees tested, we were unable to obtain evidence that access approval forms in respect of the ResourceLink system had been completed in five cases.

Management Comments from Interim Service Head, HR and WD

A Project Officer has been commissioned to lead on the resourcing, establishment validation and data cleanse project as part of the One HR programme of service improvements. Work has already commenced on establishment cleansing and reconciliation of the data held by both HR and Finance within the respective Resourcelink and Agresso systems with the involvement of managers to ensure accuracy of data. Additionally, the project includes reconciliation between the Comensura system and establishment lists. The project is a standard agenda item at the monthly One HR Programme Board where its progress is monitored. This project will be completed by 31st March 2017.

Concurrently, there is a review of employees within the HR Service who have approval to access and update Resource link and for whom the relevant approval forms will be completed.

Control and Monitoring of Lettings

This audit was requested by the Chair of the Audit Committee. The audit involved an examination of the systems and controls in place for assessing, prioritising and approving applications to the Housing Register and the resulting lettings in order to ensure that decisions taken were in accordance with Council policy and statutory guidance. The Council's Housing Allocations Scheme and Lettings Policy were approved by the Cabinet on 10/04/2013 and progress against the Plan was subsequently reported to Cabinet in March 2015. Currently some 19,120 people were on the housing waiting list and for 2015/16, approximately 2,091 lettings had been made. A sample of 20 out of 121 lettings relating to LBTH during October to December 2015 was tested by Audit. The following issues were highlighted:-

- In determining the applicant's eligibility, only one proof of applicant's Identity was being accepted. This is not in compliance with the Council's lettings policy and procedures, which require two forms of identity proof.
- In 2 cases tested by Audit, management confirmed that these lettings did not meet the required standards and procedures as the applicants' eligibility and assessment could be open to challenge. Other case by case concerns identified by Audit were also referred to management for review.
- In 14 cases it was unclear what verification checks were being done on matters concerning overcrowding, home ownership, ASB and income over £85,000. Standard checklists were held on the system, but these were not adequate. There was no written guidance over verification checks to be made on the information given in the application form. Therefore, we could not provide assurance over the soundness of decisions reached.
- We could not establish complete audit trail in a number of cases. Therefore, decisions around determination of the applicant's eligibility, assessment and determination of priority groups were found to be not fully supported by valid evidence.
- There were no systematic management checks, reviews and monitoring, to provide assurance that policy and procedures were complied with by staff.
- We noted that the risk of fraud, irregularity and corruption in the lettings process had not been identified and assessed within the Team Plan. Consequently, controls to mitigate

these risks have not fully documented and it is possible, that fraudulent and irregular applications are processed and made eligible.

Management Comments from the Interim Service Head, Housing Strategy, Regeneration and Housing Options

Housing Options (Lettings) management have taken on board the findings of the Audit Report which has identified some good practices, and weaknesses which are being addressed. Most of those recommendations have either been implemented or are in the process of being implemented, including the following:

Detailed comments were provided to Audit on the specific cases and issues identified as part of this audit; also procedures and processes including standard letters which have been updated. Letters to housing applicants now require two forms of ID to be provided, one of which must be a photo ID.

Application checklist on Comino which has to be completed each time an application is made active has been updated. Staff have to now also confirm that they have checked whether an applicant is a homeowner, earns an income of more than £85K, and is guilty of bad behavior. Proof of ID and other important documents from One Stop Shop are being checked to make sure they have been duly certified by OSS staff. One Stop Shop manager has been reminded of this requirement. The revised housing application form is with Reprographics and incorporates recommendations made by Audit relating data sharing and other comments received from staff and housing association partners. Information has also been uploaded on the Homeseekers website reminding applicants of their obligations to be truthful.

The first round of spot checks, for cases offered and are active, will be started first week in December. A meeting has been set up for 11 January 2017 to discuss the findings with a view to improving processes and procedures further, as may be necessary. The draft procedure guide to complement the checklist staff have to complete has been circulated to Attainment & Assessment team and Applications & Admin team. The guide will be updated further if necessary, especially to address any issues identified from regular spot checks that will be carried out.

Staff have all completed their declaration of interest, and will form part of the induction for any new starters. The Lettings Team Plan has been updated and incorporates action to detect and prevent fraud.

The Council's Lettings Service will ensure all the recommendations are fully implemented and will look to continuously improve its policies and procedures and processes to make sure it provides full assurance by audit standard.

Management of Market Vouchers

The Council operates 11 markets across the area, which is cumulatively open for 364 days each year. A separate trading account is maintained for the management of markets, and the Council does not contribute to the costs of the markets from central funding. Total income generated from markets fees and charges in the 2014/15 financial year was £2,487,878 achieving an overall net budgetary surplus of £5,547. A balanced gross budget of £2,314,000 was set for 2015/16.

The following main issues were reported to management:-

- Reconciliations are not signed and dated following completion and to evidence independent peer review. In addition, any differences identified are not always investigated by the

responsible officers and therefore lost income may not be identified and allocated appropriately.

- THEOs are required, during their daily enforcement visits to verify the identification of the traders and ensure Public Liability Insurance has been renewed (where previous cover has expired). Exceptions were identified in the operation of this process.
- Spot checks are not being undertaken to supervise the work of the THEOs.
- Policy and procedure documents in respect of the administration of market vouchers are either not signed or not dated by the reviewing officer; there is no version history control used. Future review dates/responsible officers are also not identified.
- The Controlled Stationery Sheet, which is required to be completed as and when a new box of vouchers is commenced and completed, is facing delays in its completion due to resourcing constraints.
- Vouchers sold in 2014/15 are still located at the Market Services Office and are yet to be archived. These should have been archived in April 2015.

Management Comments from Service Head, Public Realm

Following a number of staff being absent from the workplace for a considerable time, staff have now returned and the markets structure in a more sustainably working position. The service is also under review looking at operational practices and procedures which will result in restructuring of the service.

Therefore with the increase of staffing level, the appointment of an interim manager and deployment of a team leader, THEO supervision is taking place on a more regular basis identifying poor working practices and placing in corrective measures.

Troubled Families Grant Verification

In April 2012, the Government launched the Troubled Families Programme: a £448m scheme to incentivise local authorities and their partners to turn around the lives of 120,000 troubled families by May 2015. The first programme worked with families where children were not attending school, young people were committing crime, families were involved in anti-social behaviour and adults were out of work. In June 2013, the Government announced plans to extend the Troubled Families Programme for a further five years from 2015/16 and to reach up to an additional 400,000 families across England. Aiming to target nearly 4,000 families in Tower Hamlets, the borough has been provided with a budget of £2,072,145.

The main issues identified by this review were as follows:-

- Key Performance Indicators (KPIs) have not been produced since November 2014 and comparisons have not been made against the expected targets.
- When PBR claims have been independently checked they are not signed-off to evidence that this check is conducted by the said officer.
- Criteria six, 'Health' is currently not being used by the Troubled Families Team to make PbR claims.
- Terms of Reference (ToR) for the Operational Steering Group and the Strategic Programme Board were not fit for purpose.
- During testing, it was identified that two claims had been put through for assurance, however, due to lack of supporting evidence, this should not have been the case.
- There was insufficient evidence maintained of training undertaken by staff.
- Information from third parties is not screened for accuracy.
- There is no evidence to support that budget monitoring is undertaken by the Children's and Families Board.

***Management Comments from the Service Manager, Youth Justice and Family Interventions*.**

This audit was conducted at the request of the Troubled Families Coordinator to test the manual data collection and evidence collection that the programme is still having to use in Tower Hamlets. This is due to significant delays in the development of an electronic data system. It is a condition of the national programme that any payment by results claims are audited on a regular basis. The programme team were under pressure to submit a PBR return and therefore the TF co-ordinator decided to test a small claim.

The audit process was very helpful in enabling the programme team to understand the breadth and depth of the programme demands. The process was very demanding because the programme team were working from static manual data rather than a live electronic system the two rejected claims were as a result of the fact that a time limited snapshot of data was accurate on the day of checking, but subsequent changes in the evidence (over a matter of days) had been missed.

Trying to run the TF programme on a manual system is almost impossible without a significant increase of resources. The programme is at significant risk as result of a historical lack of vision and strategic vision and leadership at a corporate level.

There is a WPA in place that reflects the work currently focussed on procuring and developing an electronic data system. It is a very late development in year five of an eight year programme. The programme is at a critical stage and at high risk of failure.

The learning from this audit has been incorporated in the development of the data system. It is unlikely that the programme will be ready to submit another PBR claim for approximately 6 months other than employment claims that demand a lower level of evidence of family 'turn around'. The new data system will contribute to the evidence needed in approximately 6 months. An external facing expert has been involved in the programme to advise and support the data system development on a pro bono basis. His expertise and advice has been invaluable to enable accurate planning and attention to risk.

The CEO will be receiving regular updates on the programme progress to enable to maintain sight of the programme risks.

Management and Control of No Recourse to Public Funds - Children's Services and Adults Services

No recourse to public funds' (NRPF) applies to migrants who are 'subject to immigration control', and as a result of this have no entitlement to certain welfare benefits, local authority housing, and homelessness assistance. 'No recourse to public funds' may be stamped on the visa of a foreign national living in the UK. Other groups of migrants who have NRPF include asylum seekers, refused asylum seekers, and migrants whose visas have expired.

The Council has a duty to provide support to those individuals who have No Recourse to Public Funds (NRPF) including providing accommodation to destitute adults and to safeguard and promote the welfare of children. The main concerns reported to Management were :-

1. Regular management information concerning NRPF such as caseloads and cases due for review is not regularly produced and escalated to management.

2. Of the 20 NRPF cases (both ASC and CSC) selected for testing, documentation was only provided in respect of the nine ASC cases. Consequently we are unable to provide assurance in respect of the CSC cases. For the ASC cases tested, a delay in the assessment was recorded

for four out of the nine cases. In addition, for all nine cases in which documentation was provided, none of the cases had been reviewed during the 2015/16 financial year.

3. The Council has not reviewed its NRPF subsistence rates to ensure they are appropriate and reflect current guidance.

The Council's NRPF policy and procedure documentation is not up to date and was last revised prior to the implementation of the Care Act 2014.

5. The cash office used for issuing NRPF subsistence payments has closed. A long term alternative method for issuing the payments had not yet been identified.

6. There are very few NRPF cases currently being administered by the ASC teams. As per current arrangements the Council's NRPF Panel only review the cases concerning the CSC Team but could look to include the NRPF cases assessed by the ASC teams to help ensure a more robust and consistent approach.

7. Delays have occurred with NRPF queries being communicated between the Council and the UKBA. A member of staff who would previously facilitate communication with the UKBA is no longer in post at the Council.

8. The Council has recently gained access to a portal through membership of the NRPF Network, but is not yet making effective use of the facility.

9. During the audit although budget information was provided by ASC, there was no indication that budget and performance monitoring information concerning NRPF for both ASC and CSC was being escalated through the appropriate reporting or governance structure.

10. No performance management information, such as caseload, is produced on a regular basis and reported through the governance structure.

Management Comments from the: Service Manager for Adults Social Care and Service Head, Children's Social Care

1- *Management information is available on a team basis and service areas are able to identify cases due for review. It is noted that there is a delay in conducting annual reviews across Adult Social Care. From a CSC perspective, Management Information is also available via monthly management information reports as well as from review on fwi (see comments below in relation to caseloads). As part of wider Quality assurance work that is being undertaken, a "Management Dashboard" is also being created for front line managers which will provide access to a suite of reports to facilitate review of team activities.*

2- *There is a delay in completing the annual reviews of all ASC cases which will include NRPF cases. Actions are currently being undertaken to reduce the period of delay. However, checks are in place to determine whether eligibility status has changed on a monthly basis when payments are collected by the Service User.*

3- *It is proposed that ASC adopts the No Recourse to Public Funds (NRPF) subsistence rates available through the NRPF portal which is managed by the LB of Islington. The rates are adopted across the majority of London Boroughs. Current subsistence rates vary across teams but the current recommended adult rate is £44pw.*

A joint meeting has also taken place between CSC and ASC to review subsistence rates. It is proposed that a joint paper is prepared by Case Officer and Project Manager to present to DMT for agreement. The most recent guidance is dated 2011.
http://towernet/staff_services/OneTH/services/20016/no_recourse/?view=Standard

An updated version has been requested and colleagues in Legal Services will undertake this piece of work. This has been taken forward by the Community Engagement, Quality and Policy Manager, Policy, Programmes and Community Insight Service.

4. *- Although the public facing cash office has closed, a back office function is still available to ASC and facilitates the cash provision. The Finance team is considering the options relating to a prepaid card solution. From a CSC perspective, payments continue on a business as usual basis.*

5. *It is recommended that both DMTs consider the potential benefits identified by the audit of having a joint panel. An ASC Service Manager will attend a panel to observe. CSC concur with this approach.*

6. *The volume of NRPF cases in ASC is low in comparison with CSC. Minimal delays are currently experienced by officers in ASC but officers in CSC are prepared to offer support to their colleagues in ASC if required in these instances.*

7. *Staff in ASC are encouraged to utilise access to the portal and it is recommended that the Council apply the subsistence rates as set out. From a CSC perspective, now that the IT issues are resolved and access for staff has been widened effective use is being made of NRPF Connect to expedite information re Service Users status and to increase the timeliness of completing assessments.*

9. *It is recommended to DMT that the monthly performance reports provided are commissioned to include activity and spend relating to NRPF. CSC concur with this.*

10. *From a CSC perspective, caseload activity is extrapolated from fwi. A Workload Weighting Matrix is also in place for the Assessment and intervention team where individual workload of team members (including the S/W for NRPF). All allocated Assessments are also regularly reviewed using the LBTH Assessment tracking tool that is sent to managers on a daily basis. All allocated cases (NRPF) are subject to regular review mechanisms with line management.*

Control and Monitoring of Disclosure and Barring Service (DBS) Checks

The objective of this audit was to provide assurance that there were sound systems in place within the Council for controlling, monitoring and managing DBS checks on employees who are required to have this clearance.

The Council's policy and guidance for managers of posts requiring DBS disclosure has been publicised on the Intranet. Through E-Bulk system, real time information is available to Human Resources (HR) Advisors for checking every employee requiring DBS and the status of the DBS check. The Human Resources and Workforce Development (HR and WD) Service provides monthly reports to Service Heads setting out the status of DBS checks for each employee that requires one. We highlighted a number of control weaknesses including the following issues:-

- Our review showed that a comprehensive database of all posts requiring DBS Checks was held within HR Resource Link system. However, a number of inconsistencies were reported, which needed to be addressed when the Establishment List is programmed for a review.
- The carrying out of risk assessments when disclosures are made is the responsibility of the line manager. From testing of 23 DBS certificates with disclosures, we identified delays of up to twelve months from the date the DBS Disclosure was received by HR to

the date HR notified the line manager to review the employee's DBS Disclosure to determine whether a risk assessment was required.

- The processes and controls for undertaking, recording and approving risk assessments by Directorate officers and notifying the results to HR promptly needed to be improved and strengthened to ensure that service users are adequately safeguarded under all circumstances. The quality of risk assessments required improvement and appropriate checks needed to be carried out by HR.

Management Comments from Interim Service Head, HR and WD

The HR Service maintains a comprehensive database of all posts that require DBS checks including the level and type of check. This database is held within HR Resourcelink (the HR and Payroll System) and details DBS information for every employee whose post has been deemed to require a DBS check by the relevant Divisional Director. The HR Service notifies the employee when their three-yearly DBS check is required in accordance with Council policy and records the results of the DBS check on receipt within Resourcelink.

Monthly management information reports are produced by the HR Service for Divisional Directors detailing those DBS checks in date, DBS applications undertaken, DBS checks approaching expiry (within 4 months) and those where employees have not arranged to visit the HR Service, on notification, for their ID verification and for the eBulk process to be progressed to obtain an up-to-date DBS check. If an employee who is required to renew their DBS check does not engage in the process they may be subject to disciplinary action which could include suspension from work.

DBS certificates are provided directly by the DBS to the applicant with the council receiving reports from the DBS notifying as to when a DBS check includes disclosure information which needs reviewing by the Line Manager. Where there is notification that there is a disclosure, the HR Service emails the line manager and the HR Business Partner to advise them that a risk assessment must be carried out.

A new risk assessment process has been implemented whereby dates of receipt of a disclosure are logged on Resourcelink to enable the tracking of progress for a risk assessment to be completed and relevant documentation submitted for uploading onto the system. The risk assessment forms will be maintained centrally and securely by the HR Advisers Team Leader who will ensure that all risk assessments are completed within a four week period of notification of disclosure. If the completed risk assessment is not submitted to the HR Advisers Team Leader within the four week period, the HR Advisers Team Leader will escalate to the relevant Divisional Director for notification. If a risk assessment is not completed, the Corporate Director/Divisional Director will be notified of the non-compliance by the manager which may lead to disciplinary action.

Only in exceptional circumstances can an individual commence work/or continue in their role without the full results of the DBS Disclosure being known and this can only be authorised by the Divisional Director, in consultation with an HR Business Partner. This must only be in situations where there is an urgent need to maintain service delivery and all reasonable steps have been taken to protect the safety of service users. Reasonable steps to protect service users include;

- *not allowing unsupervised access to children or vulnerable adults,*
- *allowing the applicant to start work in an alternative post or shadowing other employees.*

A waiver form, available on the intranet must be completed in ALL situations where an employee is allowed to commence/continue to work without knowledge of the outcome of a DBS check. This must be reviewed by the Line Manager at least monthly until the outcome of the check is received.

Completed Risk Assessment Forms are held centrally and securely within the HR Service with access to the information being strictly restricted, controlled and limited to those who are entitled to see the information as part of their duties.
An establishment validation exercise is currently being undertaken in which managers will confirm whether a DBS check is required for every post in their team. If a DBS check is required managers will confirm the level of check. On completion of the review, the HR Service will verify the information on DBS eligibility submitted by directorates so that each post is consistent in terms of the same DBS check level.

DBS policy and guidance is available for managers on the council's Intranet. The existing guidance has been reviewed to ensure it is in line with the current DBS Code of Practice and takes into account the recommendations made in the Ian Mikardo report as well as including the eBulk (electronic) process. The DBS Risk assessment form has been amended and incorporates a risk assessment methodology.

The guidance for managers on DBS checks has been strengthened to provide advice to managers on making decisions using disclosure information. Additionally, a risk assessment process for dealing with disclosures has been produced which incorporates guidance on the following areas:

- *Receipt of an unsatisfactory disclosure;*
- *Conducting a risk assessment meeting;*
- *Factors for management consideration when making a decision*
- *Risk assessment decision-making*
- *Roles and responsibilities of managers and HR within the risk assessment process*

Two new DBS Risk Assessment forms have also been produced to accompany the guidance within which the determining manager will:

- ✓ *Register details recorded on a DBS certificate if a risk assessment has previously been completed and is held on file;*
- ✓ *Record details if a new disclosure has been recorded on a DBS certificate for which there is no information held on file*

This guidance will be published once the contents have been considered by the Corporate Safeguarding Board on the 16th March 2017.

Guidance has also been produced which sets out the roles and responsibilities within the HR Service on receipt of a disclosure. This guidance includes the recording of receipt of a disclosure, monitoring the progress of decision-making by managers and the recording of the final outcome on receipt of a completed risk assessment form which will be retained securely and confidentially by the HR Advisers Team.

Management of Parking Permits

This audit sought to provide assurance to management that the systems for controlling, monitoring and issuing of all types of parking permits were sound, secure and adequate.

From our testing of a sample of twenty parking permits for residents, business and contractors permits, we highlighted the following issues which weaken the control environment in this area and increases fraud risk.

- Our review showed that a clear policy framework and scheme of delegation for officers setting out authority parameters within which to administer and issue parking permits was not in place. Although required by procedures, the management checks and audits carried out on parking applications were not effective.
- Our review of the terms and conditions for parking permits showed that there was no proper structure and that these were lengthy and loaded to capture a number of different situations emerging over a period of time rather than meeting specific business

objectives. In addition, the eligibility criteria and the documentary evidence required to support permit applications were not stringent enough to manage the risk of fraud, error and abuse. Testing identified permits were issued to ineligible applicants.

- There was no verification of online permit renewals and reproofing of documents for longstanding permits, which increased the risk of permits issued to ineligible applicants.
- Testing showed that necessary checks were not undertaken to ensure the validity of the application and the supporting documents for multi-parking permits.

Management Comments from Service Head, Public Realm

There is currently a review taking place of all policies with parking, and they will be presented to the Mayor for discussion over the next few months. There is also a review of the structure within parking, which will take account of the comments made in the report.

All the findings will be taken into account as part of the reviews, but any processes that we feel need to be brought forward will be prioritised to ensure robust systems are in place.

Financial Assessments

Financial assessments are undertaken for all persons in placements where care is required. A Financial Assessment is required to take place when an individual first enters into a placement as well as on an annual basis thereafter, at the start of each new financial year, as obligations for charging may differ if circumstances change. The audit was designed to provide assurance to management as to whether the systems of control around the Financial Assessments system are sound, secure and adequate. The following key control issues were highlighted:-

- There was no clear directive from the Council about the course of action that will be taken when a client fails to disclose. Some assessments were therefore completed on previous declarations which did not account for any new changes in income because clients failed to submit revised benefit statements.

- The scope for conducting any reconciliation of the care placements awarded against evidence of the financial assessments completed is entirely limited to the local Private and Voluntary (P&V) database currently used by the Financial Assessment Team, but which was due to be disbanded following the introduction of the Frameworki Financial Assessment module (a corporate decision). Therefore, it has not been possible to provide assurance that the Council is in a position to transparently identify any instances where it may be losing income through an inability to confirm exceptions where social work practitioners do not request financial assessments to be performed.

- Policies and procedures did not state a date of creation or an expected review timeframe by way of version history. It could also not be confirmed that the policies and procedures had been formally approved.

- Formalised Key Performance Indicators (KPIs) were not produced and monitored in relation to financial assessments.

Procurement and Contract Management/Monitoring Compliance

Audits on the Council's arrangements for procuring and monitoring of various contracts found that effective monitoring of compliance with procurement and contract monitoring procedures was required at Directorate and Corporate level to make the compliance and the category management functions more effective. During audits of various systems such as Right to Buy Valuations, Record of Corporate Director's Actions (RCDA), Treasury Management, Purchase Cards, Domiciliary Home Care and CCTV functions, it was found that various procurement non-compliance issues were not being identified promptly by either Management as first line of defence or various compliance functions as second line of defence. In addition, the procedures for tender evaluation and arrangements for managing, monitoring and reporting of the successful delivery of community and economic benefits needed to be improved.

The above matters have been raised in the Annual Governance Statement which includes an action plan to improve governance in this area.

Qualifications to the Opinion

Internal Audit has had unfettered access to all areas and systems across the authority and has received appropriate co-operation from officers and members.

Other Assurance Bodies

In formulating the overall opinion on internal control, I took into account the work undertaken by the following organisation, and their resulting findings and conclusion:

a) Audit Commission
b) Care Quality Commission
c) Ofsted

Ofsted Inspection

An inspection of services for children in need of help and protection, children looked after and care leavers and a review of the effectiveness of the Local Safeguarding Children Board was carried out in January and February 2017 and the final report issued in April 2017. The report rated Children's services in Tower Hamlets as inadequate. A copy of the report can be found at https://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/tower_hamlets/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

Risk Management Process

The principle features of the risk management process are described below:

Risk Management Strategy: The Council has established a Corporate Risk Management Strategy that sets out the Council's attitude to risk and to the achievement of business objectives and has been communicated to key employees. The policy:

- Explains the Council's underlying approach to risk management;
- Documents the roles and responsibilities of the Council, Cabinet and Directorates;
- Outlines key aspects of the risk management process; and
- Identifies the main reporting procedures.

Corporate Risk Register: This register records significant risks that affect more than one directorate. The register also includes major corporate initiatives, procurement and projects.

Directorate Risk Registers: Each directorate maintains its own register recording the major risks that it faces.

Corporate Risk Group: The Group identifies and oversees the management of corporate risk, and reviews directorate registers to identify emerging corporate risks.

Comparison of Internal Audit Work

The Operational Plan for 2016/17 was based on an Audit Risk Assessment. This assessment model takes into account four assessment categories for which each auditable area is scored to gauge the degree of risk and materiality associated with each area. Auditable areas were prioritised according to risk and a plan was prepared in consultation with Heads of Service, the Section 151 Officer and the Council's external auditors.

The Internal Audit plan was agreed at the start of the year and revised in December 2016. A summary of the revised plan is provided at Appendix 2 for information. The table compares the plan to the work actually completed during the year.

Internal Audit Performance

A table is provided at section 9 of the main body of report setting out the pre-agreed performance criteria for the Internal Audit service. The table shows the actual performance achieved against the targets that were set in advance.

Internal audit is subject to benchmarking exercise as part of the IPF Benchmarking Club. The results of these reviews are at Appendix 8.

External Audit continues to rely fully on the work undertaken by Internal Audit. This has resulted in the harmonisation of internal and external audit plans, so that external audit can place greater reliance on the work of internal audit. During the course of the year

we have worked closely with the External Auditors to ensure that this approach is followed.

Compliance with CIPFA Code of Internal Audit Practice

Internal Audit has comprehensive quality control and assurance processes in place to confirm compliance with the CIPFA standards. Assurance is drawn from:

- The work of external audit; and
- My own internal quality reviews.

External audit carried out a review of internal audit for the financial year 2009/10 and reported their findings in March 2010. The main conclusions of their review were: -

Internal Audit is compliant against the 11 code of the CIPFA code of Practice (applicable at the time);

The Internal Audit Service has appropriate governance arrangements, internal policies and sufficient resources to enable an independent, objective and ethical audit to be completed in line with the code.

That audit files contained sufficient information for an experienced auditor with no previous connection with the audit to re-perform the work and if necessary support the conclusions reached.

Minor recommendations were raised and were addressed.

Following the implementation of the Public Sector Internal Audit Standards in April 2013, Tower Hamlets will on a five year cycle, be subject to an independent peer review from the Head of Audit of another London borough. A peer review is planned for the next financial year. Findings from this review will be brought to the Audit Committee in due course.

APPENDIX 8

Benchmarking Club Results

1. Benchmarking Club Results

1.1. Internal Audit has participated in the Audit Benchmarking Club administered by the Institute of Public Finance (IPF) since 1999/2000. IPF is a division of the Chartered Institute of Public Finance and Accountancy (CIPFA).

1.2. The purpose of the benchmarking exercise is to provide comparative information which can form the basis upon which performance comparisons and value for money judgements can be made. Moreover, this information can also feed into the team planning process.

1.3. As part of the 2015/16 CIPFA benchmarking club the London Borough of Tower Hamlets was benchmarked against a range of Unitary Authorities selected either because the level of annual General Fund financial activity was similar, or annual total revenue, i.e., General Fund and HRA was similar. For the purpose of the benchmarking review the group with which LBTH internal audit was compared comprised 11 London Boroughs.

1.4. In terms of cost analysis, LBTH Internal Audit cost per audit day was £317 compared with the comparator group average of £390 per day. In comparison with the other London Boroughs, LBTH was a medium cost service. However, in terms of cost of the Audit service per million turnover, the group average was £606 against LBTH cost of £520, showing that the LBTH Audit service is relatively low cost as a whole.