Head of Internal Audit
Annual Report and Opinion
2020-2021

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Contents

1. Introduction

1.1 The Annual Reporting Process

1.2 The Public Sector Internal Audit Standards (Performance Standard 2450) state that the Chief Audit Executive, referred to in this report as the Head of Internal Audit, must deliver an annual internal audit opinion and a report that can be used by the organisation to inform its governance statement.

1.3 The annual report must incorporate the opinion, a summary of the work that supports the opinion, an explanation about any limitations on the scope, details of other internal or external assurance or activity that may have been relied on when forming the opinion, a statement about conformance with the Public Sector Internal Audit Standards and the results of Internal Audit's Quality Assurance and Improvement Programme.

2. Head of Internal Audit Annual Opinion 2020/21

2.1 In reaching my opinion this year I have taken the following into consideration:

- Outcomes of the internal audit and anti-fraud activity undertaken during the year, which forms the primary basis for the opinion.
- The significant issues with the Council's Statement of Accounts.
- Assurance from third parties such as the Council's external auditors, Investors in People, the Social Care Institute for Excellence (SCIE) and the Chartered Institute of Public Finance & Accountancy (CIPFA).
- The significant improvement in the implementation of management actions that were agreed during the course internal audit activity.
- The Council's risk awareness and risk culture which has matured further in 2020-21.
- The fact that none of the internal audit assignments were rated as 'No assurance' for the third consecutive year and one audit received 'Substantial Assurance'.
- The impact on the authority from the outbreak of Covid-19 which has affected many aspects of service provision, governance, risk management, internal control, financial resilience, and ways of working.

2.2 **Head of Internal Audit Annual Opinion 2020/21**

Primarily on the basis of the audit and anti-fraud activity undertaken during the year, but also taking into account external assurances and other relevant matters including the significant issues with the closure of the Council's accounts, it is my opinion that I can provide **Limited** assurance that the Council has adequate systems of governance, risk management and internal control.

idering the opinion readers should note the following

- This opinion is based solely upon the areas taken into consideration and identified above.
- Assurance can never be absolute, neither can internal audit's work be designed to identify or address all weaknesses that might exist.
- Responsibility for maintaining adequate and appropriate systems of governance, risk management and internal control resides with the Council's management and not internal audit.

3. The Basis of the Annual Opinion

3.1 The outcome of the audits undertaken during the year by Internal Audit form the primary basis of the annual audit opinion over the adequacy and effectiveness of the governance, risk and control framework.

3.2 As agreed at the May 2020 Audit Committee, a revised opinion scale has been utilised from the 1 April 2020. The scale is as follows:

Table 1 - 2020/21 Audit Opinion Definitions

Opinion	Definition
Substantial	A sound system of governance, risk management and control exist, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and/or control to effectively manage risks to the achievement of objectives in the areas audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and/or control is inadequate to effectively manage risks to the achievement of objectives in the areas audited.

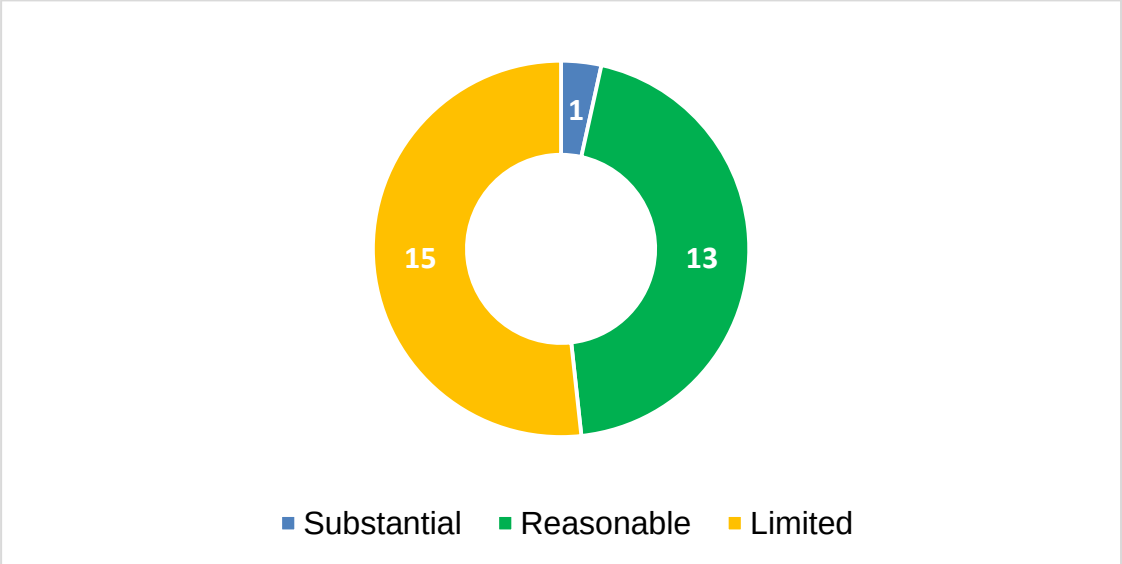
3.3 A risk-based internal audit plan was agreed with the Audit Committee in July 2020. The changing public sector environment and emergence of new risks necessitates re-evaluation of the audit plan throughout the year. During 2020/21, regular reports have been presented to the Audit Committee to highlight progress made towards the delivery of the audit

plan, along with details of any significant amendments to the plan. Whilst there were no significant amendments, several planned audits were deferred at management's request or because of resourcing challenges and these audits may be moved into the 2021/22 internal audit plan

4. Internal Audit 2020/21

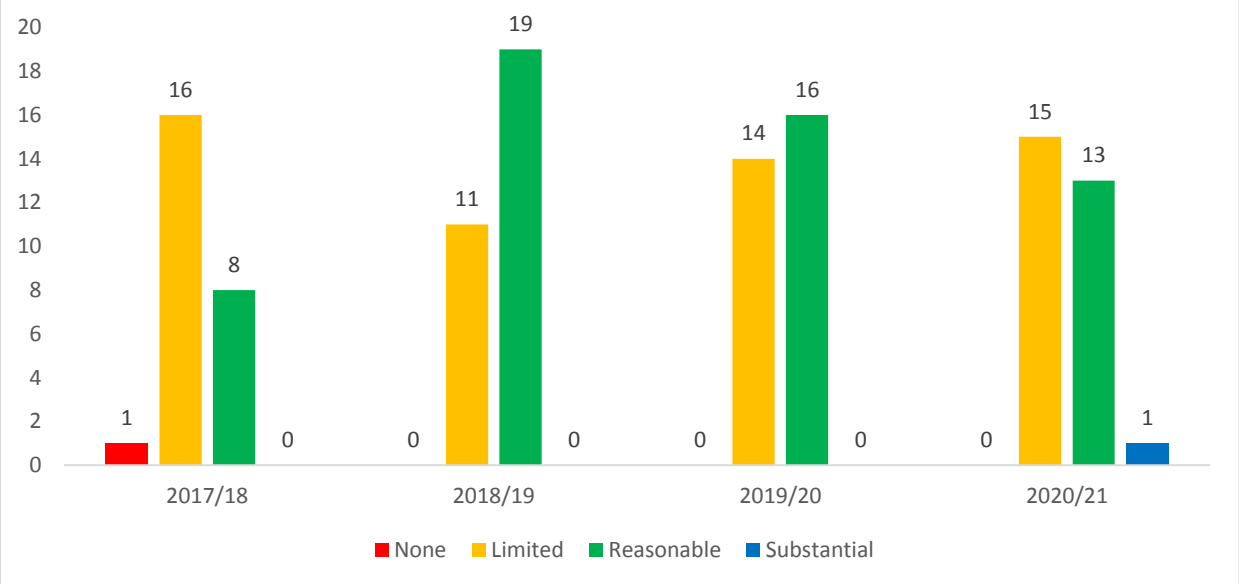
4.1 The following chart and table summarise the outcomes of the internal audit assurance reviews completed in 2020/21:

Chart 1 – Balance of Assurance Opinions for 2021/22



4.2 To provide some comparison the following chart includes data from the previous 3 years (excluding schools):

Chart 2 –Comparison of Assurance Opinions from 2017/18 to 2020/21



4.3 This chart does show that there has been a decline in reasonable assurance opinions (-6) and an increase in limited assurance opinions (+4) since 2018/19. However, opinion comparisons across years should be treated with some caution as internal audit must select its audit activity based on risk and therefore it does not examine the same systems each year making comparison between years more challenging.

Table 2 - Summary of Internal Audit Outcomes for 2020/21.

Audit Title	**Assurance Opinion**
Treasury Management	Substantial
DSP Tool Kit	Reasonable
Payment Controls for Temporary Accommodation	Reasonable
Creditors	Reasonable
IT Remote Working	Reasonable
Debtors and Income Recovery	Reasonable
Local Community Fund	Reasonable
New Town Hall Contract	Reasonable
Management of Complaints	Reasonable
General Ledger	Reasonable
Discretionary Housing Payments	Reasonable
Overview and Scrutiny functions	Reasonable
Drugs and Alcohol Services – Contract Monitoring	Reasonable
Emergency Hardship Payments (Resident Support Scheme)	Reasonable
IR35 Off Payroll Engagements	Limited
Back up Schedules and Protection (IT Audit)	Limited
Control and Monitoring of Parking Permits	Limited
Acquisition of Properties for Temporary Accommodation	Limited
Capital Programme Governance	Limited
Financial Assessments of Contributions to Social Care	Limited
PCI DSS Governance	Limited
Corporate Governance	Limited
Cyber and Network Security (IT Audit)	Limited
Deputyships and Appointeeships	Limited
Pensions Administration	Limited
Staff Declarations of Interest	Limited
Housing Allocations and Lettings	Limited
Contract Monitoring of Grouped Schools PFI Contract	Limited
Place Directorate Governance	Limited

4.4 In total, 1 substantial assurance opinion, 13 reasonable assurance opinions and 15 limited assurance opinions have been given. Summaries of the finalised reports with limited assurance opinions up to April 2021

have previously been provided to the Audit Committee. Summaries of finalised reports issued since the April 2021 Audit Committee are shown at Appendix A.

4.5 It is pleasing to report that Treasury Management has achieved the highest assurance opinion and is the first area of the Council to achieve this rating in four years. Reasonable assurance opinions have also been offered in other key areas for the Council including the management of the new Town Hall build, the overview and scrutiny function, creditors, debtors and income recovery. It's also positive that the Council has not received a 'No assurance' opinion since 2017/18. There are areas for improvement including some governance arrangements, pension administration, cyber & network security and housing allocations. The Council has responded to internal audit's recommendations and provided updates to the Audit Committee on progress made to rectify the issues identified in areas that received limited assurance.

4.6 In addition to assurance activity the internal audit team have delivered some advisory work including multiple grant certifications related to the supporting families programme and Covid-19 activity and an advisory review of the ethical culture framework. A summary of the outcome of the ethical culture framework advisory review follows.

Ethical Culture Framework

4.7 During 2020/21 Internal Audit reviewed the framework the Council has in place to build and maintain a strong ethical culture. During the review we identified good practice which included a strong tone from the top articulated through Tower Values; a good framework for training and development such as the introduction of a new appraisal process and an e-learning package for all staff, and the introduction of performance reporting for the Divisional and Corporate Leadership Teams. Areas for development included improved compliance with the mandatory learning programme and My Annual Reviews; more staff need to complete their annual declarations of interest; key policies and procedures were not regularly reviewed; the staff code of conduct was not aligned to Tower Values and key milestones and success measures needed to be more clearly defined to support the achievement of the desired culture.

4.8 The levels of maturity for each area were assessed in accordance with five agreed categories (Immature (low) to Continuous Improvement (high)):

- Immature
- Aware
- Defined
- Mature
- Continuous Improvement

4.9 Based upon our work, interviews and review of evidence provided we concluded the following:

Tone from the Top	**Defined** - Values and ethics are addressed at Cabinet and Corporate Leadership Team level, and the organisation has begun to identify actions to proactively address ethics and organisational culture.
Policies and Procedures	**Defined** - The organisation has begun to outline a framework of key policies and procedures relevant to its ethical objectives, but key policies are out of date.
Training and Development	**Aware** - Some appropriate ethical training has been identified, however, there are also gaps that the organisation has identified. Compliance with training is inconsistent.
Measurement, accountability & continuous improvement	**Aware** - Some measurement of data is collected, with limited management information and analysis produced. Some key assurance functions may provide reports to an appropriate level in the organisation. There is inconsistency in the implementation of recommendations. However, this is may be largely aligned to meeting legislative standards rather than defined organisational ethical objectives.

4.10 Management have received the report and have responded appropriately.

5. Other Sources of Assurance and Relevant Matters

External Audit and the Statement of Accounts

5.1 At the time of drafting this report (June 2021) Deloitte have been unable to complete their audit of the 2018/19 or 2019/20 financial statements. There have been significant issues with the Council's 2018/19 and 2019/20 statement of accounts, and it has taken many months for these issues to be investigated and resolved with some significant issues still outstanding.

5.2 In April 2021, Deloitte reported the following to the Council's Audit Committee

> *As our audits are in progress, we are not yet in a position to conclude. We report in this document on uncorrected misstatements, together with other actual or possible misstatements where we are not able to quantify the amount of the misstatement. Whilst these matters are individually immaterial, in concluding our audit we will need to consider whether they may be*

material in the aggregate. If this was the case and they remained unadjusted, this would result in the qualification of our opinion.

In our July 2019 report, we said that our value for money conclusion for 2018/19 would be qualified as improvements in children's' services, following an earlier assessment by Ofsted that services were inadequate, were not in place for the whole of 2018/19. In this document we report that we expect both the 2018/19 and 2019/20 value for money conclusions will also be qualified due to weaknesses in financial reporting arrangements and explain the background to this judgement.

5.3 The Council has developed an action plan, additional resources have been sourced to complete the plan and produce a revised set of accounts, and a dedicated finance improvement team has been created for additional support. Progress has been regularly reported to the Council's Statutory Officers, the Mayor, Cabinet Members and the Audit Committee. It is anticipated the audits for the 2018/19 and 2019/20 accounts will be completed in 2021. To support improvement moving forward a Finance Improvement Board has been created and is chaired by the Interim Corporate Director of Resources (s151 Officer). The Board will monitor, challenge, and support the delivery of the Finance Improvement Plan.

5.4 The Council is in the progress of producing a draft set of accounts for 2020/21. Due to amended regulations, laid by the Secretary of State for Housing, Communities and Local Government, the publication date for the accounts has be moved from 31 July to no later than 30 September 2021.

Investors in People – Silver Award

5.5 In December 2020, the Council was accredited with the Investors in People Silver Award. The assessor commented in his reports that almost a third of the elements were met at the Gold level and the organisational development plans, if implemented as intended, would enable the Council to achieve Gold in the future.

5.6 The key strengths recognised included a good momentum on the people agenda despite the Covid-19 pandemic; the new appraisal process "My Annual Review was successfully launched; a revised and updated organisational change policy and toolkit was put in place; survey results revealed a friendlier culture; improvement in supporting wellbeing and inclusion were recognised; there were improved internal communications; there was also clear improvements in learning and development and more positive relationships between line management and their staff. The next assessment is due in December 2023.

Social Care Institute for Excellence (SCIE) and the Chartered Institute of Public Finance & Accountancy (CIPFA)

5.7 Towards the end of 2020, SCIE and CIPFA were commissioned to undertake a finance and practice review of the London Borough of Tower Hamlets Adult Social Care Service with a view to exploring the drivers for behind its high net expenditure and to propose recommendations to bring these costs into line with the budgets required for a sustainable medium term financial strategy. The subsequent report identified numerous challenges faced by the service including the comparatively late introduction of charging and financial assessment for social care services; an unusually complex case-load; high community expectations and dependency on the Council's services; high attrition rates in senior Service management posts and amongst senior posts in the Council's finance department, and the disruption caused by the Covid-19 pandemic. The authors commented:

> *Despite these challenges the Council is starting to make progress and has implemented a range of new initiatives to embed a strength-based philosophy and manage practice decisions. The Service has also developed a number of initiatives to control costs and has embarked on programmes to deliver significant costs savings. All of these initiatives have started to yield benefits but have not had the fully desired impact*.

5.8 The report authors identified 10 key areas for improvement which included the need for a clearer strategic vision and strategy; action to address the weaknesses in core data held on Mosaic; the need to align change and improvement initiatives; the need to develop grounded plans to deliver savings; embedding strength-based practice; a programme to educate and raise awareness of the benefits and objectives of strength-based thinking and to strike a "new deal" with the community; sourcing project and change management support; embedding stronger business discipline; improving the reporting and monitoring of budgets and ensuring that changes to working practices are seen through and sustained. The authors made a series of recommendations that need to be developed into a clear project plan with timelines and responsibilities. The recommendations have been reported to CLT accepted by the Corporate Director and an action plan is being developed, although its delivery is reliant on additional resources being made available.

Risk Management

5.9 During 2020/21 risk management has been a key feature of the Council's response to the Covid-19 pandemic. Bespoke risk registers were created and actively managed by the Bronze, Silver and Gold command groups with the frequency of activity stepped up or down as the risks fluctuated. These registers provided clear operational and strategic oversight of risks and their mitigating actions.

5.10 In addition to the bespoke risk registers, a concerted effort was made by all directorates to update their respective business as usual risks, remove out of date and immaterial risks, and review the registers on a more regular basis (at least quarterly).

5.11 A summary of other activities that have taken place during 2020-2021 follows:

- The Risk Management Strategy was updated and approved by the Audit Committee in July 2020.
- Each Directorate nominated a Risk Champion to lead on risk in their respective Directorates. The Risk Champions meetings were reconstituted.
- The Corporate Leadership Team were requested to ensure risk management features at least quarterly on their Divisional Leadership Team meeting agendas.
- The Directorate Risk Registers for Place, Health Adults and Community, Children's and Culture, Governance and Resources have all been reviewed and actions identified to update and/or close out of date active risks.
- Training has been provided to Senior Business Support Officers enabling them to support Directorates in updating risks on JCAD (the Council's risk management software).
- Both the Joint Health and Safety Committee and the Civil Contingencies Board have received regular risk reports in their respective areas.
- The Audit Committee has been regularly presented with the Corporate Risk Register as well as the Place and the Resources directorate risk registers and a rolling timetable to review the other directorates has been agreed.

5.12 Risk management remain an important feature of good governance and the Council's approach to risk management has matured during 2020/21 which has been demonstrated through the proactive risk management during the response to Covid-19 pandemic. The current risk management arrangements are reasonable but there is some room for improvement to better integrate risk management into the day to day operations and culture of the Council and this will be a key focus of work during 2021-2022.

6. Implementation of Agreed Management Actions

6.1 In each instance where it was identified that the control environment was not strong enough or was not complied with sufficiently to prevent risks to the organisation, Internal Audit have obtained an agreed management action plan to address the weaknesses identified and improve the system of control and compliance.

6.2 As a result of the pandemic, and a freeze on recruitment, internal audit resources were limited during the year and therefore only a sample of audits were followed up. Of the 10 follow up audits that were completed we were able to confirm that of the 61 high priority issues/ recommendations raised 42 were fully implemented, 17 were partially implemented and 2 had not been implemented. Of the 34 medium priority issues/recommendations raised,18 were fully implemented, 13 were partially implemented and 3 had not been implemented. Further details are available in Table 2.

Table 2 – Implementation of Agreed Management Actions

	High Priority	**Medium Priority**
Number of Agreed Management Actions Followed Up	61	34
Number of Management Actions Fully Implemented	42	18
Number of Management Actions Partially Implemented	17	13
Number of Management Actions Not Implemented	2	3
% Fully Implemented	69%	53%
% Partially Implemented	28%	38%
% Not Implemented	3%	9%

6.3 Overall, this shows a good response to agreed actions and a significant improvement on previous years. 97% of the high priority actions and 91% of the medium priority actions we reviewed have either been fully or partially implemented. This is a significant improvement in comparison to previous years; in November 2019 we reported implementation rates of 66% for high priority and 60% for medium priority actions.

7. Anti-Fraud and Corruption

7.1 During 2020/21 the Corporate Anti-Fraud Team consists of the following sub teams:

- Intelligence
- Social Housing
- Corporate Investigations
- Blue Badge

7.2 There is also an investigator in the Insurance Service who examines the integrity of insurance claims to eliminate fraudulent submissions and repudiate inappropriate claims.

7.3 In addition to investigating referred cases, the Corporate Anti-Fraud Team undertakes activity to support the Council in reducing its fraud and corruption risks, this includes coordinating the Council's participation in the National Fraud Initiative, a biennial proactive data matching exercise run by the Cabinet Office in which each local authority must participate, along with a number of initiatives to raise awareness of the council's anti-fraud and corruption culture. Progress on this activity has been regularly reported to the Audit Committee.

7.4 The Covid-19 pandemic significantly impacted on the team's ability to progress investigations. In line with the Council's strategy during the pandemic, only essential services were in operation. To minimise the risk to the investigators and the public, interviews, foot patrols and visiting were stopped, although desktop investigations have continued throughout. As a result, outcomes in comparison to previous years are reduced. As restrictions ease during 2021/22, the backlog of investigation and Court work will be cleared. Most Court cases are being relisted for hearings in late 2021 and 2022.

7.5 During 2020/21, 20 corporate/internal referrals in respect of alleged fraud or code of conduct breaches were received. This included referrals received via the Council's whistleblowing procedure. 263 referrals were received in respect of suspected social housing fraud matters, and 222 cases were reviewed as part of a Pro Active data match in respect of Parking / Blue Badge fraud. In addition, 64 insurance claims have been investigated.

7.6 The positive outcomes achieved following the investigation of the above matters includes the following:

- £17,000 has been awarded to the Council in costs and compensation
- 21 insurance claims were repudiated or discontinued with a reserve value of £196,041
- 22 Social Housing properties were recovered.
- 4 Right to Buy applications have been stopped.
- 212 Blue Badges were cancelled.
- 22 Blue Badges were seized.

7.7 Initial matches from the biennial National Fraud Initiative (NFI 2020) data matching exercise were received by the Council in February 2021. The 'potential' fraud matches have been reviewed using the recommended prioritisation filters. For the NFI 2020 exercise the total number of matches received so far is 11,653, of these 2,890 were considered high or medium risk. To date, a total of 331 have been reviewed and resolved. Detailed reports about the current NFI arrangements and progress made have regularly been provided to the Audit Committee.

7.8 The Corporate Anti-Fraud team also included detailed reviews of No Recourse to Public Funds applications, and the Corporate Anti-Fraud

Manager has been an active member of the London Borough's Fraud Investigation Group.

8. Schools

8.1 During 2020/21, due to the Covid-19 pandemic and the resulting impact on schools, we did not complete our normal school audit programme. We will reinstate our programme of school audits in 2021/22.

9. Scope limitations

9.1 Internal Audit does not audit the Council's annual statement of accounts and this opinion does not cover the associated financial statements and disclosures. The Council's external auditors (Deloitte) are responsible for the audit of the annual statement of accounts and reporting whether, in their opinion, they present a true and fair view of the financial position of the Council. At the time of preparing this report neither the 2018/19, 2019/20 nor 2020/21 accounts have been audited.

9.2 The internal audit plan cannot address all risks across the Council and the plan represents our best use of the available resources. The annual opinion draws on the work carried out by Internal Audit during the year on the effectiveness of managing those risks identified by the Council and covered by the audit plan. Not all risks fall within our audit plan.

10. Internal Audit Performance

10.1 During the year the Internal Audit service carried three vacancies. We were unable to recruit to these vacancies due to a freeze on recruitment. As a result, the audit plan first agreed with the Council in July 2020 has not been delivered in full. In total 14 audits have not been delivered or were deferred into 21/22 at management's request. As part of the planning process for 2021/22 we have considered which of the undelivered audits can be carried forward into 2021/22 but resource limitations remain. We will increase the size of the 2021/22 plan as more resources are made available through recruitment and sourcing an external delivery partner.

10.2 The Internal Audit plan for 2020/21 was agreed with the Audit Committee in July 2020. We aim to achieve 90% completion of the plan to draft report stage by 30th May 2021. As at 30th June 2021, 69% of the audit plan was complete to at least draft report stage (after deferrals and additions have been taken into account).

10.3 Continuous development in the quality of the internal audit service remains a key objective. In order to obtain feedback from the organisation, when final reports are issued a 'Customer Satisfaction Survey' is issued to all officers who receive the report. Respondents are requested to provide an opinion as to the effectiveness of the audit and the relevancy of the audit recommendations provided.

10.4 For 2020/21, out of the 22 satisfaction surveys sent out for final reports (including Tower Hamlets Homes) 18 completed surveys were received. All 18 surveys have reported back positive outcomes indicating that the recommendations made in the internal audit report will lead to improvement in the control environment.

10.5 To further improve the internal audit service, we sought the views of management across the Council through a short perception survey. Recipients were asked to grade internal audit (using a 4-point scale ranging from strongly disagree to strongly agree) on the following statements:

1. I understand the role and importance of Internal Audit and how it helps the Council accomplish its objectives?
2. Internal Audit activity is aligned with the strategies, objectives and risks of the Council?
3. Internal Audit consistently demonstrates competence and due professional care?
4. Internal Audit is objective and independent?
5. Internal Audit adds value with the work they deliver?
6. Internal Audit is insightful, proactive and future focussed?
7. Internal Audit promotes and supports organisational improvement and transformation?
8. Internal Audit provides accurate, objective, clear, concise, constructive, complete and timely reports that meet your needs?
9. Internal Audit consistently demonstrates integrity?
10. Internal Audit enables the sharing of good practice and experience across the Council?
11. Internal Audit demonstrates quality and continuous improvement in internal audit practice?
12. Internal Audit has provided an effective service for the Council in the last 12 months?

10.6 There were 35 responses in total. The results were reported in detail to the Audit Committee in January 2021. In summary I am pleased to report the following:

- 80% or more of respondents ‘strongly agreed’ or ‘agreed’ with statements 1, 2, 3 ,4 ,5, 7 & 9.
- 74% to 77% of respondents ‘strongly agreed’ or ‘agreed’ with statements 6, 8,11 and 12; around 20% of respondents disagreed with these statements or did not respond.

- The lowest percentage of ‘strongly agreed’ and ‘agreed’ was for statement 10 which scored 63%, 34% disagreed and 3% did not respond.

10.7 Whilst most responses were positive there remains room for improvement. In 2021/2022 we will seek to improve how insightful, future focused and proactive we are, our reporting, how we share good practice and our Quality Assurance and Improve Programme. We will also deliver a series of workshops and update our Intranet content to better explain the role of Internal Audit and how we support the organisation in achieving its objectives.

10.8 This is the first time such a survey has been undertaken and we will repeat this survey each year to measure our performance and progress and report the results to the Corporate Leadership Team and the Audit Committee.

11. Internal Audit’s Independence

11.1 During the year the Head of Internal Audit was also responsible for the Council’s Risk Management and Insurance services. To manage the risk to organisational independence both the Risk Management and Insurance functions have been previously audited by the audit contractor and each audit was sponsored by the Divisional Director for Finance, Procurement and Audit; the outcomes of these audits have been reported to the Audit Committee. These services will be separately audited again in 2022/23. In all other respects Internal Audit has operated independently of the organisation and there were no compromises of Internal Audit’s independence in its operation this year.

12. Conformance with the Public Sector Internal Audit Standards and the Quality Assurance and Improvement Programme

12.1 During 2020, a self-assessment of Internal Audit’s compliance with the Public Sector Internal Audit Standards was undertaken. The self-assessment concluded that out of the 56 areas of compliance, there were two standards where the current internal audit practices were only partially conforming; in all other respects, the service was complaint with the Public Sector Internal Audit Standards.

Areas of partial conformance	Planned action
Adequacy of resources.	Resources remain a challenge but will be supplemented through a contract with an external provider.
Coordination with other assurance providers.	We have committed to coordination with other assurance providers where applicable. Assurance Mapping to be conducted in 2021/22 to develop this

	approach further.

12.2 An action plan has been developed to address the areas of partial conformance and progress against this plan will be reported to the Audit Committee.

12.3 The self-assessment confirmed that we are fully complying with the Code of Ethics. A further self-assessment against the standards will be undertaken during 2021/22 and the service will be subject to an independent External Quality Assessment in 2022/23. The results of which will be reported to the Corporate Leadership Team and the Audit Committee.

12.4 Some work is required to be fully compliant with the standards. Whilst there are standards that require further work, I am of the view that the level of compliance does not impact on my ability to provide an annual opinion over the Council's arrangements for governance, risk management and control.

Appendix A

Summaries of Finalised Internal Audits

Assurance level	Significance	Directorate	Audit title
Limited	Extensive	Resources and Children and Culture	Grouped Schools PFI – Contract Monitoring
Limited	Extensive	Place	Place Directorate Governance
Reasonable	Extensive	Governance	Management of Complaints
Reasonable	Extensive	Governance	Overview and Scrutiny Functions
Reasonable	Extensive	Resources	Management of Discretionary Housing Payments
Reasonable	Extensive	Health, Adults and Community	Management of Drugs and Alcohol Services Contracts
Reasonable	Moderate	Place	Contract Monitoring of Resident Support Scheme Administration

Limited / Reasonable Assurance

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Grouped Schools PFI – Contract Monitoring	June 2021	This audit provided assurance that there are robust client side policies and procedures in place for an effective monitoring of the Grouped PFI contract. The following good practices and issues were reported: • An independent company was appointed by the main contractor to carry out regular health and safety reviews of PFI schools. Monthly performance meetings are held between the Council, the main contractor and its sub-contractors to cover the statutory matters. Regular contract monitoring meetings are also occurring and a system of raising contract payments is in place that ensures that regular invoices are generated, issued and paid. The following exceptions were also reported. **Procedural guidance and clarity of roles and responsibilities** • The Grouped Schools PFI Contract is a self-monitoring contract which requires the contractor to monitor various aspects delivered by its subcontractors, to rectify these issues and report them to the Council. The Council retains overall responsibility to monitor the contract and also to ensure that the provider have robust monitoring processes in place. During our review we were able to find clear Council guidance (Toolkit and Handbook) for its contract managers to assist and support them in fulfilling their duties, however no procedures had been produced for the Groups School PFI contract which was an area of weakness acknowledged by the Council's Contract Management team. **Financial Planning and Engagement** • The Council's Finance team adopt a Business Partner model in supporting all its budget holders. During our interviews and review of evidence, we identified that there is a lack of financial planning and modelling with regards to the Schools PFI contract,	Extensive	Limited

		for example we were provided with evidence that previous calculations of funding allocations and cost liabilities were based on out of date and inaccurate information regarding pupil numbers and hours of use. There was an acknowledgement from the Finance team that they needed to become more engaged with the Contract Management team and to improve the financial management arrangements of the contract to ensure accurate and complete information is available to aid the annual agreement exercise on future funding allocation and expenditure commitments. **Annual Survey Scores** • While the annual survey with schools received a response rate of 100% and we found that there is monthly reporting of the issues raised, no year on year comparison or analysis is completed to highlight areas of improvement or concern. The survey provides valuable feedback from the schools that should be fully utilised in producing clear, measurable action plans aimed at improving the service delivery and performance of the contractor. **Funding** • We attempted to review the robustness of the audit trail of two funding remittance advices c£5m from the Department for Education (DfE), but limited evidence was provided to us in order to complete this test. Through discussions with the Finance team, we are aware that they have experienced a number of staff changes and resource issues in recent months and the need to increase level of support and engagement on all finance matters regarding the Grouped Schools PFI Contract monitoring arrangements was recognised. **Internal Management Reporting** • There was no evidence that any internal management reporting withing the Council's governance structure occurs to provide information on the service performance and delivery of the PFI		

		Schools Contract to those charged with governance. **Timeliness of Invoicing Schools** • There is regular invoicing for additional expenditure outside the normal contract terms, which requires more scrutiny and supporting documentation prior to payment. We reviewed a sample of eleven Authority Change Requests (ACRs) for evidence of accuracy, supporting documentation, approval and payment. Our results showed that all were completed correctly and accurately with costs and appropriate signatures in place. At the time the audit testing was performed in February, these ACRs had not yet been issued to the schools for payment, however this was completed by year end in March. **Health and Safety Follow Up** • As at March 2021, the current follow up position on Health and Safety recommendations made by the company appointed and information from the Head of School Building and Development indicated that action was being taken to address long standing recommendations, although some actions remain open from audits completed in 2019 and were dated for completion in October 2020, yet were still outstanding with no revised completion date agreed. All findings and recommendations were discussed and agreed with the Head of Finance, Children and Culture and the Head of School Buildings and Development in April 2021, and the final report was issued in June 2021 to Corporate Directors, Children and Culture and Interim Corporate Director, Resources.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Place Directorate Level Governance	June 2021	This audit sought to provide assurance that there is a robust governance structure in place within the Place Directorate to support effective decision making. The following good practices and issues were reported: • Performance is routinely reported and monitored at both CLT and DLT meetings. Finance and HR related performance is discussed routinely. The Place Structure Chart is clear and appropriately documented. However, the following exceptions were reported. • We interviewed four senior management team members (Heads of Service and a Divisional Director) and found that there is a lack of understanding of key decision making amongst senior management, and the Officer Key Decision process is not formally documented within any guidance. The Scheme of Delegation for Place Directorate also does not state who can sign/authorise FP1s for key decisions and Officer Authority forms for key officer decisions. There is a risk that Key Decisions and Key Officer Decisions will not be identified and the correct process followed, and appropriate approval will not be sought. • There are no opportunities to raise a Declaration of Interest (DoI) at Place operational level or Directorate Leadership[Team (DLT) meetings, and compliance with the submission of annual DoIs is low, therefore there is an increased risk of decisions being made by individuals where there is a conflict of interest. • We were advised that divisional management meetings attended by the Heads of Service and the Divisional Director we interviewed are not adequately documented; minutes and actions are not consistently being recorded and there is a lack of understanding amongst some Divisional Directors of governance	Extensive	Limited

		arrangements, structure and reporting. This results in poor governance and oversight of operational performance. • Key Place Directorate Board meetings (Lower Lea Valley Area Board, Quarterly Strategic Meeting and the Regeneration Board) do not specify the quorum, or document whether quorate, DoIs are not made at the start of meetings and meetings and actions are not always adequately documented resulting in an increased risk of actions not being followed up or completed. Furthermore the appropriate members of a board meeting as set out in the ToR are not always in attendance. • DoIs are not made at the start of Corporate Leadership Team (CLT) and Divisional Leadership Team (DLT) meetings, and these meetings and the actions from meetings are not adequately documented. All findings and recommendations were discussed and agreed with the Corporate Director (Place) and the Senior Executive Support Officer (Place) in February 2021, and the final report was issued in June 2021.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Management of Complaints	June 2021	This audit reviewed systems for recording, investigating, responding, controlling and monitoring customer complaints in line with the Council's current policies and procedures. The Council has two stage complaints policy – stage 1 is investigated by the service directorate and stage 2 by the corporate complaints officers. During 2019/20, the Council received 4,071 stage 1, and 348 stage 2 complaints. For the first six months of 2020/21 there were 1,218 stage 1 and 37 stage 2 complaints. The following good practices and issues were reported:- • The Council has a clear Complaints Policy which was approved by the CLT in August 2018. Clear policies and procedures were in place to guide both officers and members of the general public. A dedicated electronic system is in place for the recording and management of complaints. • An annual report was presented to CLT on key issues raised from complaints management process highlighting any service improvements required to avoid repetitive complaints in the same service areas. • All complaints recorded in the complaints management system have completion data recorded and a completion target date for monitoring purposes. Testing of Stage 1 complaints covering the period April 2019 to September 2020 showed that in 38 Stage 1 cases, there were no completion dates or completion data recorded. This was due to staff from different parts of the Council, who have not used the IT system properly. • In order to ensure that targets set for completing stage 1 and stage 2 Complaints are met, the monitoring control needed to be improved. Testing confirmed that in one case, the Stage 1 process was	Extensive	Reasonable

		undertaken outside of iCasework system. It was noted that 6 out 20 Stage 1 complaints and 8 out of 10 Stage 2 complaints were not acknowledged within 2 working days of receipt of complaint. In one case, the date of receipt for Stage 2 request recorded on the system did not match the date of receipt set out in the acknowledgement email and only 2 out of 10 Stage 2 acknowledgement emails included a target date for the response. • Audit noted that four Stage 1 responses were not signed-off by the relevant Divisional Directors (or Heads of Service) as required by procedures. Therefore, the Divisional Director may not have an opportunity to review and quality check the responses before they had been sent out. • A review of 10 Stage 2 complaints which had not been upheld at stage 1, but subsequently upheld at stage 2, showed that in 6 cases, the initial investigation had not been adequately undertaken by the responsible service area as the corrective actions had not been followed-up, the response did not address all of the issues raised or the correct assessment procedures were not followed resulting in Ombudsman investigation. • It was noted the Ombudsman, in his Annual Review letter 2020 (dated 22/07/2020), confirmed 100% compliance with Ombudsman recommendations. However, the Ombudsman reported that in six cases, remedies were not completed within the agreed timescales, requiring the Ombudsman to chase the Council on several occasions in order to record compliance. Four of these cases included personal remedies for complainants, of which three were over 30 days late. All findings and recommendations were agreed with the Divisional Director Customer Services and final report was issued to all Corporate Directors.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Overview and Scrutiny Functions	June 2021	This audit reviewed the systems and controls for management of the Overview and Scrutiny (O&S) functions of the Council. The requirement for local authorities in England to establish Overview and Scrutiny committees is set out in sections 9F to 9FI of the Local Government Act 2000 as amended by the Localism Act 2011. Our review found that the Divisional Director Strategy, Policy and Performance was the officer designated by the local authority under this section to be known as the authority's "scrutiny officer". The following good practices and issues were reported:- • The Council has defined clear roles and responsibilities for the Overview & Scrutiny Committee, which are included within the Council's Constitution. A revised version of the O&S Toolkit was issued in 2020. The purpose of this toolkit is to support Members, Council officers and partner agencies in getting involved with the O&S functions. Scrutiny members have also been provided with a copy of the Councillors workbook on Scrutiny written by the LGA that has been designed as a learning aid for elected councillor's and serves as good practice. • In March 2019 the Centre for Public Scrutiny was commissioned to undertake a Taking Stock Reflection and Review session of O&S. Following that review several improvements were suggested to the way that O&S operated and how the service could make a difference and improve their performance. • A detailed Checklist and process map for prioritising Scrutiny Topics has been developed and is included within the O&S Toolkit. The O&S chair, its three Sub-Committee chairs and scrutiny leads attended a virtual workshop on 08/10/2020 to discuss the work programme for the	Extensive	Reasonable

		2020/21. • Members of the Executive with key responsibilities as well as report authors are requested to attend O&S in order that members can directly raise questions or seek points of clarification on any of the issues contained within their reports being presented. The following issues were highlighted:- • O&S is a critical governance function and often complex topics are discussed, the Committee's effectiveness may be improved if a comprehensive skills analysis was undertaken and appropriate development opportunities are identified in order to better support committee members, particularly for topics such as Treasury Management, budgets and the Council's Accounts. • Management indicated that due to the pandemic, a different approach was taken to plan the work programme for 2020/21 for the O&S of the committee and its sub-committees to manage the uncertainty in membership this created, and the reduced number of committee meetings. Our testing showed that although a Scrutiny work plan had been developed at a virtual Scrutiny away day, there was insufficient evidence that the Scrutiny work programme for 2020/21 had been developed in accordance with statutory guidance and the topic prioritisation process map contained within the Scrutiny Toolkit. • During 2020/21, amid the pandemic, recommendations made and agreed for challenge sessions were not formally tracked or followed up to ensure they have been implemented. All findings and recommendations were greed with the Divisional Director of Strategy, Policy and Performance and final report was issued to the Chief Executive.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Management of Discretionary Housing Payments	June 2021	This audit sought to provide assurance that systems for managing the DHP Grants were sound and secure. The Child Support, Pension and Social Security Act 2000 makes provision for relevant authorities to make payments by way of financial assistance ("discretionary housing payments") to person's housing who: i) are entitled to housing benefit or council tax benefit, or to both; and, ii) who appear to such an authority to require some further financial assistance (in addition to benefits to which they are entitled) in order to meet housing costs. These additional payments are discretionary and do not fall under the normal housing benefit rules. The current total grant budget for Discretionary Housing Payment (DHP) for 2020/21 is £1,927,869 with grant expenditure of £1,927,445,69. During the audit we identified following areas of good practice and issues:- • The DHP Strategy Guide 2020 sets out the basis for all decision making and considers the impacts resulting from the Covid-19 Pandemic. A standard DHP application form and the Financial statement are available on the Tower Hamlets website. Out testing confirmed that in line with policy, DHPs were awarded where there was entitlement. In all 20 cases tested, the DHP payment set-up on Northgate system was in accordance with the DHP award amount set out in the DHP Award letter. • However, the DHP Policy document did not sufficiently detail all key stages, processes, procedures and approval requirements e.g. how does the delegated officer approve the DHP within the HB system and the level of management checks, quality reviews and monitoring undertaken to check the accuracy of payments. In addition, the DHP	Extensive	Reasonable

		Policy document required updating.		
		• Our testing showed that in 1 of the 20 DHP application forms reviewed, the declaration had not been signed and dated by the applicant. For applications submitted digitally, the system of obtaining consent from applicants to share personal data for prevention and detection of fraud needed to be reviewed by Management and Information Governance. • Testing confirmed that in 4 out of 10 cases sampled, the reason for DHP payment was not specified in the Award Letter and hence in these cases there was no clear audit trail. • Audit testing had shown that the current approved Scheme of Delegation for the Resources Directorate delegates the approval of DHPs either to the Corporate Director, Resources or to the Benefits Manager. We noted that none of the DHPs awarded in our audit sample could be confirmed as approved by one of these two officers. We were informed that approval by these two officers will not be practical and hence the Scheme of Delegation needed to be reviewed to reflect the practicality of the function. • Testing confirmed that where overpayments had occurred there was no evidence of quality checks/reviews by senior officers/managers of the DHP awards. • Testing confirmed that the Benefits Risk Register requires updating as a number of documented risks did not have the required control measures in place. All findings and issues were agreed with the Head of Revenues and final report was issued to the Corporate Director, Resources.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Management of Drugs and Alcohol Services Contracts	April 2021	This audit was designed to provide assurance that the systems and controls for monitoring the three contracts for Treatment, Recovery and Outreach work were sound and secure. The total contract value over 7 years is £29m. The total annual value of the 3 contracts is £4.1m and included Performance By Results (PBR) element. During the audit we identified the following areas of good practice and issues:- 1. Contract specifications reflected Council objectives and outcomes. Specifications contained a suite of key performance indicators. The method for monitoring the performance of the contract delivery was clearly set out in the specifications. Quarterly contract review meetings were held with each provider. The meetings were minuted, followed a pre-set agenda and included clearly marked decisions and action points. Actions were followed up at the next meeting. 2. The providers submitted performance reports in advance of each quarterly review meeting. The reports were analysed and reviewed by the client team prior to the meeting with the providers. The contract included measures for addressing poor contract performance. The quarterly performance reports were RAG rated and in cases, where the KPIs were not achieved, clear explanations of the lag was given, and remedial action documented. 3. However, the existing contract monitoring and management can be made more effective by completing the Council's contract management handbook and by drawing up a risk register. Due to Covid-19 situation annual monitoring visits/audits to the providers were not carried out, neither was there any checking/monitoring remotely.	Extensive	Reasonable

		4. In order to ensure that all necessary issues are reported , the Commissioning manager needed to specify the headings and format for the quarterly narrative reports from the providers. 5. A decision by the Interim Head of Service in consultation with the Divisional Director to pay the full PBR element for quarter 1 in light of the problems achieving targets under pandemic restrictions had not been documented. 6. Contract overpayment was made as incorrect invoices totalling £48,804 were received from the provider delivering the treatment and recovery contracts in respect of the payment by results element for quarter 1. The control mechanism did not pick up these incorrect invoices for return to the provider and invoices were receipted and paid. The overpayment now requires to be recouped. All findings and issues were reported to the Divisional Director Community Safety and final report was issued to the Corporate Director, Health, Adults and Community.		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Administration of Resident Support Scheme – Contract Monitoring	May 2021	This review tested the systems for monitoring the Resident Support Scheme service delivered under a Deed of Variation to the Council's Welfare Resilience Framework contract awarded in August 2017. The main framework contract is a call off arrangement for the processing of Housing Benefits and Council Tax reduction claims when employed Council staff are at capacity. The Deed of Variation was entered into in December 2018, total value being £124,931. During the audit we identified the following areas of good practice and issues:- 1. The contract (Deed of Variation) has been signed and sealed and has Key Performance Indicators. Regular monthly management reports are provided by the contractor, which show the number, type and value of awards made in the previous month. Various other details of the awards are also included. Monthly reports also include performance on some agreed KPIs. 2. However, in accordance with Council procedures, in procuring this service, there should have been advice sought from the Head of Procurement to ensure that the variation to the existing contract was the correct method to follow to demonstrate good value for money. Instead a variation was agreed by the then officers within Resources where this service was then provided without advice from Head of Procurement. It should be noted that the current Management Team within Place Directorate where this scheme is now managed, did not have any input in this procurement. 3. Testing showed that orders were raised retrospectively when invoices from the supplier were received. This negates the control a purchase order affords, namely approval to spend has been obtained, future financial commitment is recognised, risk of duplicate payment is reduced. The Council's procurement rules require that an official purchase order be raised once a contract has been awarded.	Moderate	Reasonable

		4. The contract has been running for 2 years, but there has been no contract monitoring. We were informed that this is partly due to the new priorities arising from the pandemic and the fact that recruitment to project officer roles in the summer of 2020 was unsuccessful. Even so, there is no evidence of any contract monitoring between December 2018 and March 2020, the start of the pandemic. Therefore there is risk that not all contract objectives are being achieved or that the contractual arrangement provides value for money. All findings and issues were discussed with the Divisional Director and final report was issued to the Corporate Director, Place and Head of Revenues.		