Head of Internal Audit
Annual Report and Opinion
2021-2022

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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 2021/22

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 ongoing issues with the Council's Statement of Accounts.
- Assurance from third parties such as the Council's external auditors, and results from other assessments such as Lexcel's Independent Legal Assessment, LGA's Corporate Peer Challenge Revisit, and SEND Local Area Inspection Review.
- The consistency in the implementation of management actions that were agreed during internal audit activity.
- The Council's risk awareness and risk culture has continued to be an area of focus and matured further in 2021-22.
- The fact that none of the internal audit assignments were rated as 'No assurance' for the fourth consecutive.
- The ongoing impact on the authority resulting from Covid-19 which has affected many aspects of service provision, governance, risk management, internal control, financial resilience, and ways of working.

2.2 When concluding my opinion for 2021/22, I have considered the following:

Head of Internal Audit Annual Opinion 2021/22

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.

sidering 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 previously agreed by the Audit Committee in May 2020, the revised opinion scale has continued to be used throughout 2021/22. The scale is as follows:

Table 1 - 2021/22 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.

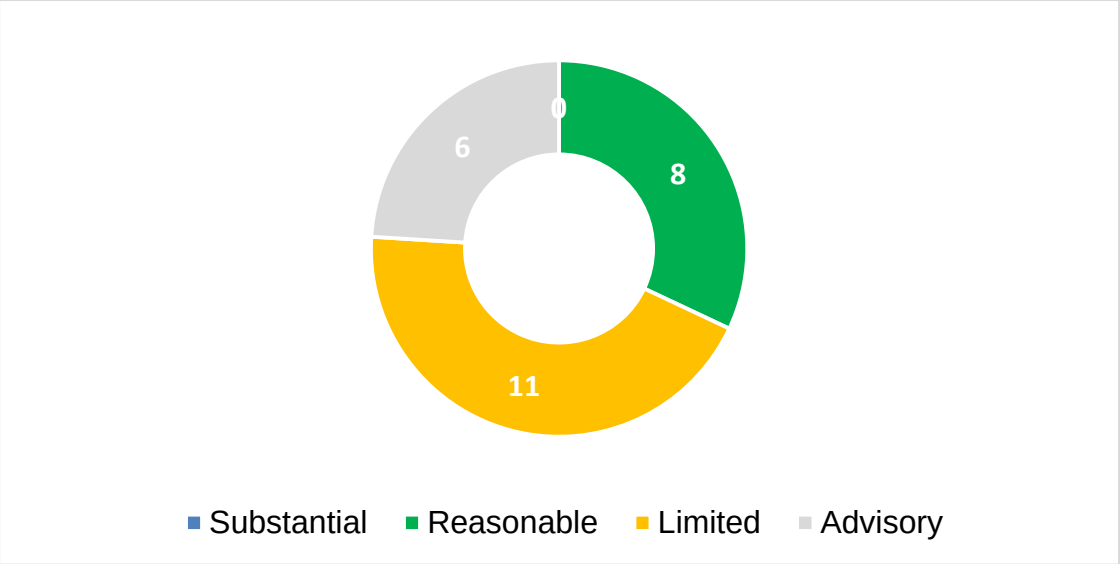
3.3 A risk-based internal audit plan was agreed with the Audit Committee in July 2021. The changing public sector environment and emergence of new risks necessitates re-evaluation of the audit plan throughout the year. During 2021/22, regular reports have been presented to the Audit

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 2022/23 internal audit plan accordingly.

4. Internal Audit 2021/22

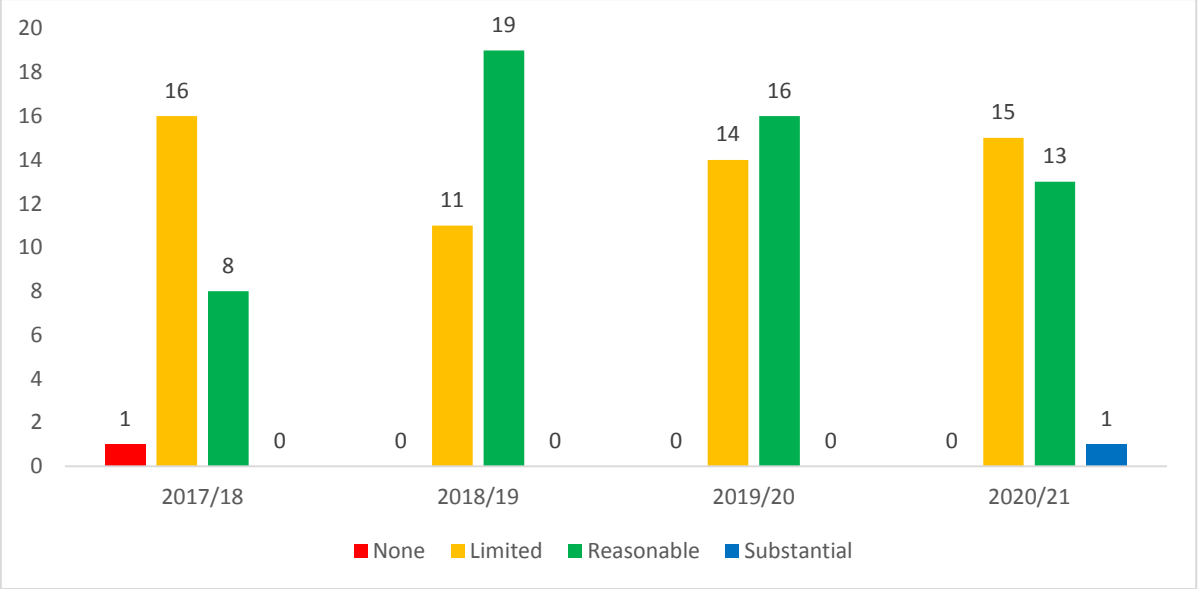
4.1 The following chart and table summarise the outcomes of the internal audit assurance reviews completed in 2021/22:

Chart 1 – Balance of Assurance Opinions for 2021/22



4.2 To provide some comparison the following chart includes data from the previous 4 years (excluding schools):

Chart 2 – Comparison of Assurance Opinions from 2018/19 to 2020/21



4.3 This chart does show that there has been a decline in reasonable assurance opinions and an increase in limited assurance opinions 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. Furthermore, when collating the Annual Internal Audit Plan and discussing areas of focus with management, we are often directed to areas of heightened risk, where improvements are required and therefore, adverse opinions are generated until agreed improvement recommendations are implemented.

Table 2 - Summary of Internal Audit Outcomes for 2021/22.

Audit Title	**Priority**	**Assurance Opinion**
Multi-Agency Safeguarding Hub (MASH)	1	Reasonable
Contract Services Improvement Plan (Children & Culture)	1	Reasonable
IT Project Governance and Management	1	Reasonable
Empty Property Rates and Inspection	2	Reasonable
Creditors	1	Reasonable
Highway Repairs and Maintenance Contract (Draft)	1	Reasonable
Property Disposals (Draft)	1	Reasonable
Control and Monitoring of Agency Staff – Matrix Contract Management	1	Reasonable
Control and Monitoring of Agency Staff – Directorate Level Compliance		Limited
Commissioning and Management of Placements Looked After and Leaving Care Children (Draft)	1	Limited
New Council House Building Programme Contract Audit (Draft)	1	Limited
Adults Safeguarding Board Case Reviews – Improvement Plan (Draft)	1	Limited
SQL Database Management	2	Limited
IT Access Control Management	-*	Limited
Purchase Cards	1	Limited
Management of Commercial Waste	1	Limited
Management of Security Breaches & Incidents	1	Limited
Management of Failed Visits to Service Users (Draft)	1	Limited
SLA for Traded Services with Schools (Draft)	1	Limited
Management and Contract of S106 Planning Obligations	1	TBC – Draft report being collated
GLL Contract Management – Consultancy Review	-*	N/A - Advisory
Supporting Stronger Families Grant – Monthly	1	N/A - Advisory

Audit Title	Priority	Assurance Opinion
Grant Certification audits		
COVID-19 Government Grants Certification Audits	1	N/A - Advisory
Business Continuity Plans - Testing – Consultancy Review	-*	N/A - Advisory
Finance Improvement Plan – review of procedures and testing	1	N/A - Advisory
Management of Freedom of Information – Consultancy Review	1	N/A - Advisory

**Additional management requests raised during the period.*

4.4 In total, 8 reasonable assurance opinions and 11 limited assurance opinions have been given. Summaries of the finalised reports with limited assurance opinions up to March 2022 have previously been provided to the Audit Committee. Summaries of finalised reports issued since the March 2022 Audit Committee are shown at Appendix A.

4.5 In addition to those that have been delivered as per table 2 above, due to the ongoing challenges that Council has faced during 2021-22, primarily as a result of the ongoing response to the Covid-19 pandemic, the Internal Audit Plan had to remain flexible. This was to ensure that as a resource, Internal Audit was used in an efficient and effective way. This meant changes to the proposed plan occurred throughout the year to cover other areas and / or management requests which were informed by a greater risk or urgency, to provide necessary value and insight at the right time for the Council. Table 3 below summarises those deferrals or cancellations to the plan to enable this collaborative approach to occur.

Table 3 - Summary of Deferrals/Cancellations from the Internal Audit Plan for 2021/22.

Audit Title	Priority	Rationale for Deferral / Cancellation
Corporate Governance Improvement Plan	1	Deferred at the request of the Chief Executive to align to the Council's Governance Improvement Plan timetable.
Client Management of Waste Functions	1	Cancelled at the request of management due to a service restructure being underway.
Management and Monitoring of Council's Contribution to Climate Change Agenda	2	Currently at fieldwork stage, agreement with management to report as part of 2022/23 Internal Audit Plan and corresponding Annual Head of Internal Audit Report for 2022/23.
Mobile Device Management	2	Currently at fieldwork stage, and whilst management are expediating information requests, expectation is this will not be completed to inform

		this Annual Internal Audit Report and will inform the opinion for 2022/23.
NNDR Business Support Grants	2	Cancelled due to being a priority 2 audit to accommodate additional requests outlined above.
Data Protection and Privacy	2	Cancelled due to being a priority 2 audit to accommodate additional requests outlined above. Will be considered as part of 2022/23.
Delivery of IT Strategy and Architecture	2	Deferred to 2022/23 at management's request whilst the IT Strategy continues to be developed.

4.6 As a result of the changes above, this enabled Internal Audit, in addition to assurance activity, to deliver a number of pieces of advisory work to support the Council in developing its governance, risk, and internal control environment, including:

- multiple grant certifications related to the supporting families programme and Covid-19 activity.
- advisory reviews on areas such as Contract Management, Business Continuity Testing and Freedom of Information Request Management.
- supporting key process and procedure changes that derive from the Council's Finance Improvement Plan to ensure they are fit-for-purpose, effectively designed and mitigate the risks they are designed to do so.

Whilst these advisory pieces of work have not been assigned an assurance opinion, they have indicatively provided further insight and supported the conclusions for 2021-22, primarily by not identifying significant issues, but also, providing practical solutions to key operational areas for the Council during 2021-22.

5. Other Sources of Assurance and Relevant Matters

External Audit and the Statement of Accounts

5.1 From 1 September 2018 Deloitte LLP was appointed as the Council's external auditor, this was following the decision of the Council to opt into the Public Sector Audit Appointments Limited (PSAA) arrangement. The PSAA Board appointed Deloitte to audit the accounts of the Council for a period of five years (2018/19 to 2022/23).

5.2 At the time of drafting this report (May 2022) Deloitte have still been unable to complete their audit of the 2018/19, 2019/20, and 2020/21 Statement of Accounts. 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, the Statement of – with some queries still being investigated to conclude.

5.3 The Council developed an action plan, additional resources were sourced to complete the plan and produce a revised set of accounts, and a dedicated finance improvement team has been created for additional support. To support this improvement, a Finance Improvement Board was created and chaired by the Interim Corporate Director of Resources (s151 Officer). Throughout 2021/22, the Board has monitored, challenged, and supported the delivery of the Finance Improvement Plan. Internal Audit has also been in embedded in this process, performing specific reviews over process redesigns and improvements suggested to ensure they mitigate the risks posed and address the recommendations that derived from the initial review. Progress has been regularly reported to the Council's Statutory Officers, the Mayor, Cabinet Members, and the Audit Committee.

5.4 Whilst it is not expected that the draft opinions presented by Deloitte to the Audit Committee in January 2022, being qualified for both years, will change, it is anticipated the audits for the 2018/19 and 2019/20 accounts will be reported as complete in June 2022. Subsequently, this will mean that Deloitte will be able to commence their audit of the 2020/21 Statement of Accounts, as planned, in July 2022. It is not expected that any qualifications will re-occur as the Council has taken action to ensure that such matters from 2019/10 and 2019/20 have been addressed.

5.5 The Council is in the process of producing a draft set of accounts for 2021/22. Deloitte will be producing their Audit Plan in June 2022, with the audit due to commence in July 2022 (alongside their audit of 2020/21) to be completed by October 2022, to comply with the amended statutory deadline of 30 November 2022.

<u>Lexcel Independent Legal Assessment</u>

5.6 The Council were subject to an independent assessment of their legal services during 2021/22. This was conducted against the Lexcel Standards, The Law Society's practice quality mark for client care, compliance, and practice management. To assess the Council against these, an assessment was conducted via electronic and virtual means, and in accordance with the submitted Assessment Plan, Lexcel Scheme Rules, and Assessment Guidance Notes as modified by The Law Society's temporary COVID19 procedures.

5.7 The visit covered all sections of the standard were covered and was conducted through three distinct elements, being:

1. A desktop assessment of all management documentation, with all documents supplied securely via electronic means.
2. Case files for review were selected from open and closed matter lists.
3. Interviews were held with key staff members.

5.8 The results of this assessment did not highlight any major areas of concern In Legal Services, however, there were some minor areas for improvement, these were around independent fee earner file reviews,

Annual Risk Review, HR Induction Records for new staff and Lexcel Compliance training for new staff. The findings indicated a slight slippage in process rather than a fundamental breakdown of quality systems. To counter this, the Assessor recorded a high number of Areas of Good Practice in Legal Services, and these are spread across all areas of practice.

5.9 As a result, the Assessor recommended that Legal Service be re-accredited with the Lexcel Standard.

LGA Corporate Peer Challenge Revisit

5.10 Following a full Corporate Peer Challenge (CPC) visit by the LGA in June 2018, a follow up visit was conducted in September 2021. Drawing on their knowledge from the previous CPC, the peer review team met with Members, Officers, Partners, and residents, alongside a review of a range of key documents and information to consider progress since 2018.

5.11 The peer review team shared their final findings as part of a report shared with the Council in 2021. It acknowledged that the Council continued to make good progress on its improvement journey. It highlighted the Mayor's understanding of community needs and that, alongside Cabinet Members, there was provision of a stable and community focused political leadership. It also acknowledged good member-officer relationships, as well as strong and cohesive Senior Leadership Team.

5.12 The peer review team found partners are strongly committed to the ambitions of the borough. The findings recognised how partnership working came to the fore during the pandemic and continues to strengthen for the benefit of residents. The Council's response to the pandemic was praised by the peer review team along with the progress made to improve services for our communities and how the Council continually strive to improve the lives of residents in as many ways as is possible.

5.13 The findings also acknowledged several areas of priorities highlighted by stakeholders as important. Taking forward the recommendations of the Black, Asian and Minority Ethnic (BAME) and the Poverty Commissions was highlighted along with community safety, with a focus on dealing with gangs, knife crime, domestic violence, and the safeguarding of children. They also suggested job opportunities for young people and access to good quality employment at all levels, and the promotion of good employment practices to go with them.

5.14 The report stated the need for the Council to continue work to reduce heath inequalities such as diabetes, child obesity and mental health and that climate change and pollution needs serious attention due to the rising levels of asthma. They highlighted the benefits of local traffic calming schemes and stated for some there is a perceived lack of youth provision and accommodation. The peer team acknowledged existing plans in place to address these issues.

5.15 The report highlighted six key recommendations to shape the future priorities of the Council. These included areas such as: ensuring a clear understanding of the Mayor's priorities for all, and focus on delivering within clear timescales; to continue work to close previous years' accounts; to continue to improve and embed Council governance arrangements, including decision-making and scrutiny, the TOWER values and ongoing compliance with the Constitution; and the continued efforts to return to normal working practices following the COVID—19 pandemic.

5.16 The LGA Peer Revisit report can be found on the Council's website. And the actions which were outlined to Cabinet at its meeting in February 2022 will continue to be delivered as planned. Delivery against these actions will be monitored through existing boards such as the Performance Improvement Board. If Cabinet identify the need to undertake further work to implement the peer team's recommendations, then this will be taken forward.

SEND Local Area inspection 2021

5.17 During late June and July 2021, Ofsted, and the Care Quality Commission (CGC) conducted a joint inspection of the local area of Tower Hamlets to judge the effectiveness of the area in implementing the special education needs and / or disabilities (SEND) reforms as set out in the Children and Families Act 2014.

5.18 Inspectors spoke with children and young people with SEND, parents and carers, and local authority and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff, and governors about how they are implementing the SEND reforms. Inspectors looked at a range of information about the performance of the area, including the area's self-evaluation. Inspectors met with leaders for health, social care, and education. They reviewed performance data and evidence about the local offer and joint commissioning.

5.19 As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, the inspection determined that a Written Statement of Action is required because of significant areas of weakness in the area's practice. HMCI has also determined that the local authority and the area's clinical commissioning group are jointly responsible for submitting the written statement to Ofsted.

5.20 Within the findings outlined in the letter issued by DfE following the completion of the inspection, a number of strengths were identified, alongside areas for further improvement, it was fair to say that the DfE considered the self-evaluation completed by the Council and its partners to be an honest assessment of the areas that required improvement.

5.21 There were four key areas of weakness highlighted - quality of education, health, and care plans, waiting times for speech and language therapy

provision, waiting times for ASD assessment and comprehensive engagement and communication with parents and carers were going to be the areas where the partners would be focussing their efforts.

5.22 The Council, working with its health colleagues, developed a joint Written Statement of Action, which was submitted to DfE and NHS England prior to the 24 December 2021 deadline. This accepts the findings and outlines the improvement plan to address such weaknesses, with progress already underway. The Written Statement of Action was accepted as "fit-for-purpose" in setting out how the Local Area will tackle the weaknesses identified in the published inspection letter.

5.23 A SEND Improvement Board was already operational within the Council prior to the inspection and its results, therefore, progress against this plan has been, and will continue to be regularly reviewed by the Board. Further reporting will be escalated up to the Children and Education Scrutiny Sub-Committee as required.

Risk Management

5.24 During 2021/22, risk management has continued to be a key feature of the Council's response to the Covid-19 pandemic. Bespoke risk registers have been 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.

5.25 At the end of March 2022, these risk registers were retired as a result of Gold meetings concluding, and the number of risks on the risk register thankfully reducing. There were three risks, which due to their rating, were moved onto JCAD (the Council's risk management software) to be managed as part of business as usual.

5.26 In addition to the bespoke risk registers, efforts have continued to be 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).

5.27 A summary of other activities that have taken place during 2021/22 follows:

- The Corporate Leadership Team were requested to ensure risk management features at least quarterly on their Divisional Leadership Team meeting agendas. Regular reporting has gone monthly for the likes of Resources, and Children's & Culture, as a result.
- 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. These continue to be reported on a cyclical basis to

each Audit Committee meeting, along with the Corporate Risk Register.

- Both the Joint Health and Safety Committee and the Civil Contingencies Board have continued to receive regular risk reports in their respective areas.

5.28 Risk management remains an important feature of good governance and whilst the Council's approach to risk management has continued to mature during 2021/22, which has been demonstrated through the continuation of good 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 2022-2023.

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, a previous freeze on recruitment, and more recently, failure to recruit into roles, internal audit resources were limited during the year and therefore only a sample of audits were followed up. Of the 13 follow up audits that were completed we were able to confirm that of the 29 high priority issues/recommendations raised 11 were fully implemented, 14 were partially implemented and 4 had not been implemented. Of the 43 medium priority issues/recommendations raised,17 were fully implemented, 20 were partially implemented and 6 had not been implemented. Further details are available in Table 4.

Table 4 – Implementation of Agreed Management Actions

	High Priority	**Medium Priority**
Number of Agreed Management Actions Followed Up	29	43
Number of Management Actions Fully Implemented	11	17
Number of Management Actions Partially Implemented	14	20
Number of Management Actions Not Implemented	4	6
% Fully Implemented	38%	39%
% Partially Implemented	48%	47%

% Not Implemented	14%	14%

6.3 Overall, this shows a reasonable response to agreed actions, but a slight fall on the previous year's performance. For 2021/22, 86% of the high priority actions and 86% of the medium priority actions we reviewed have either been fully or partially implemented. This is a slight deterioration in comparison to previous year when we reported implementation rates of 97% for high priority and 91% for medium priority actions.

7. Anti-Fraud and Corruption

7.1 During 2021/22 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, the Internal Audit and Fraud Prevention 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 were reduced. As restrictions eased during 2021/22, the number of referrals has fluctuated, and the backlog of investigation and Court work continues to be cleared. Most Court cases were relisted for hearings in 2021/22 and continue to be scheduled as we move through 2022/23.

7.5 During 2021/22, 24 corporate/internal referrals in respect of alleged fraud or code of conduct breaches were received. These included referrals received via the Council's whistleblowing procedure. 187 referrals were received in respect of suspected social housing fraud matters. In addition, 61 insurance claims have been investigated.

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

- 124 insurance claims were repudiated or discontinued with a reserve value of £77,730.
- 35 Social Housing properties were recovered.
- 4 Right to Buy applications have been stopped.
- 13 Blue Badges were cancelled because of National Fraud Initiative matches being followed up.
- 43 Blue Badges were seized.

7.7 Initial matches from the biennial National Fraud Initiative (NFI 2020/21) data matching exercise were received by the Council in February 2021. The 'potential' fraud matches have been reviewed using the recommended prioritisation filters, with services instructed to review selected cases. For the NFI 2020/21 exercise the total number of matches received so far is 12,617 and of these 2,890 were considered high or medium risk. To date, a total of 1,031 have been reviewed, with 936 closed with no issue, 88 identified as errors, and seven cases identified where fraud may have occurred, and appropriate actions have been taken to resolve. Detailed reports about the current NFI arrangements and progress made have regularly been provided to the Audit Committee.

7.8 The Internal Audit and Fraud Prevention 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 Like in 2020/21, due to the Covid-19 pandemic and the resulting impact on schools, we did not complete our normal school audit programme during 2021/22. However, this was reinstated for 2022/23, and audits on the selected schools commenced from April 2022 and will inform the opinion of the Head of Internal Audit for 2022/23.

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 had been signed off as 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 previous freeze on recruitment and more recently, difficulties in attracting suitable candidates for the roles. As a result, and building on lessons learnt in 2020/21, when similar resource constraints were present, but the Internal Audit Plan size or approach was not considered in detail (alongside the impact of the COVID-19 pandemic), a revised planning approach was undertaken for 2021/22.

10.2 A Draft Internal Audit Plan for 2021/22 was agreed with the Audit Committee in July 2021. This plan had Priority 1 and Priority 2 audits and it was intended that all Priority 1 audits would be completed with the existing resource availability and Priority 2 audits would be subject to filling of vacancies. However, due to continual recruitment issues combined with the delay in procuring an audit partner, the audit plan was subsequently revised and reported to the Audit Committee in December 2021. We aimed to achieve 90% completion of the revised plan to draft report stage by 30th May 2022. As at 31st May 2022, 84% of the audit plan was complete to at least draft report stage (after deferrals and additions have been considered). It is expected by the end of June 2022, this target will have been met and exceeded.

10.3 Continuous development in the quality of the internal audit service remains a key objective. 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 2021/22, out of the 25 satisfaction surveys sent out for final reports (including Tower Hamlets Homes) 15 completed surveys were received. All 15 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 Last year, to identify any improvements for the Internal Audit service, we sought the views of management across the Council through a short perception survey. During 2021/22, we have taken on board feedback received to further improve how we engage with stakeholders across the Council. This has included, how insightful, future focused and proactive we are, our reporting, how we share good practice and our Quality Assurance and Improve Programme.

10.6 This was the first time such a survey had been undertaken and we will repeat this survey as part of 2022/23 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 2020/21, 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.

12.2 We have reviewed this self-assessment for 2021/22, and concluded that there has been no change to the outcomes from the 2020/21, with the same two standards where it was felt internal audit practices were only partially compliant, being:

Areas of partial conformance	Planned action
Adequacy of resources.	Resources remain a challenge but will be supplemented through a contract with an external provider following the completion of the current re-procurement.
Coordination with other assurance providers.	In the prior year, we committed to coordination with other assurance providers where applicable. It was planned that Assurance Mapping would be conducted in 2021/22 to develop this approach further. However, due to resourcing constrains this has not been formally conducted and remains on our action plan to complete to fully comply with this standard.

12.3 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.

12.4 The self-assessment confirmed that we are fully complying with the Code of Ethics, and this has not changed for 2021/22. The service will be subject to an independent External Quality Assessment in 2022/23, planned for Q3. The results of which will be reported to the Corporate Leadership Team and the Audit Committee.

12.5 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	Corporate	Purchase Cards
Limited	Extensive	Resources	IT Access Control Management
Limited	Extensive	Resources	SQL Management
Reasonable	Extensive	Resources	Creditors
Reasonable	Extensive	Children and Culture	Multi Agency Safeguarding Hub
Reasonable	Extensive	Children and Culture	Contract Services Improvement Plan
Reasonable	Moderate	Resources	Empty Property Rates and Inspections
Not Applicable	Extensive	Corporate	Business Continuity Plans Testing - Consultancy Audit

Limited / Reasonable Assurance

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
Control and Monitoring of Purchase Cards	May 2022	This audit sought to provide assurance over the systems in place for controlling and monitoring payments made by using the Council's Corporate Purchase Card facility. The total amount procured using payment cards between April 2021 and March 2022 was £626,000. There were some 6500 purchase card transactions during the year. The following areas of good practice were reported: • Procurement retained copies of all Purchase Card application forms along with the completed NatWest User Agreement Form, to ensure a full audit trail. • Monthly Purchase Card expenditure reports were issued to all designated Directorate Officers with budget responsibility. The report highlighted monthly expenditure for each card user, non-reviewed transaction, and non-approved transactions. • Where leavers were notified to procurement, evidence showed that the bank was notified, and the cards had been duly cancelled. The following key issues and risks were reported: • Although there were procedures in place which were available to staff on the Intranet, these procedures were out of date, dating back to 2017 and did not reflect the current practices that are now in operation. • Testing of 30 purchase card applications (10 new and 20 existing applications) showed that 4 applicants had not physically signed the form agreeing to the terms and conditions for the card use; 5 had no signature of the approving officer; 6 did not have the signature of Budget holder or Agresso Approver for the cost centre; and 3 had no Finance Officers' signature. • We identified 8 cardholders whose purchase cards were showing as	Extensive	**Limited**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		"Active" within the IT system (SDOL), had left the Council. Two of these had left in 2017 and 2019, respectively. Although it was confirmed that there were no card transactions after the leaving dates, the Active users on the IT system needed to be reviewed. • Card holders are required to retain Receipts to preserve audit trail and to enable the approving officer to approve the transaction. However, testing showed that Receipts for purchase card transactions were not being retained by the card holders and uploaded onto the SDOL system. Some 21% of total receipts had not been uploaded. This has therefore, weakened the checking and approval control. In addition, if receipts were not kept, this would undermine the VAT return and claim for the Council. • As part of our testing, we looked at transactions from a Value for Money perspective as well as compliance with the CEO's directive on non-essential expenditure for purchases made. We identified a number of these transactions that we considered not to be Value for Money, nor complying with the directive on non-essential expenditure. These were referred to Directorates for further assessment. • Transactions should only be approved by the Budget holder, or the approver set up on Agresso with the responsibility for the Cost Centre. Our review showed that those Services without a purchase card allocated to them, requested Business Support Transaction Hub to make the purchase on their behalf, and to code the expenditure to the appropriate Cost Centre. However, these arrangements and required controls were not reflected in the Purchase Card User Guidance Manual. *All findings and actions were agreed with the Interim Head of Procurement and Final report was issued to the Director of Finance, Procurement and Audit and all Corporate Directors.*		
Management of IT Access Control	May 2022	The purpose of this audit was to provide assurance that adequate controls were in place to allow appropriate access to the Council's IT network. Ensuring that access to data is restricted to authorised persons is of vital	Extensive	**Limited**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		importance to LBTH. In the event of an information security breach, the Council must be able to demonstrate that it had put in place appropriate procedural and technological security measures and access controls to manage these risks. Our key findings from this audit include the following: • We found that the Council's domain password policy (via system settings) is not appropriate and non-compliant with the Council's Access Control Policy. • Our sample testing identified that the starters' access was granted on an average of three days after an employee joining the Council. • We found that there is no formal, documented, or operational monitoring and reporting controls in place to govern the Council's approach to access, authentication, and password management activities to ensure the security of Council's IT network and access to their information systems, as required by the Council's Access Control Policy. • We found that the Council's Access Control Policy was last reviewed in in July 2020 and is due a review. We also identified some gaps in the policy when compared with good practice. • Our analysis of Domain Administration Accounts identified one duplicate account for existing domain user accounts, four generic accounts and 29 service accounts. No documented business reason was provided to support the existence of the generic and service accounts. • We found that there are no formal arrangements in place for reviewing domain or privileged administrator access accounts on Active Directory, on a regular basis. • Our sample testing identified that the leavers' access was revoked on an average of seven days after an employee left the Council. *All findings and actions were agreed with the Director of IT and final report*		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		was issued to the Corporate Director – Resources.		
SQL Management	June 2022	The purpose of this audit was to review the Council's SQL Server database infrastructure and provide an assessment of the effectiveness of internal controls and operating efficiency of the database servers in storing business data, and access to confidential customer data stored. The following areas of good practice were identified during our review: • Through our testing we confirmed that multi-factor authentication (MFA) was used for external access into the Council's servers, through Microsoft Windows Virtual Desktop (WVD). • The Council uses Azure Blob (Binary Large Object) Storage for its backup solution. We confirmed, through review of backup logs, that all 12 SQL servers, are backed up daily, with a Full Backup performed for System Databases and User Databases. The following key findings and risks were reported: • Our testing of a random sample of 10 SQL users found 4/10 (40%) instances where SQL accounts belonged to a former employee, with one of the four flagged being a third-party user account. In addition, there was no proactive regular monitoring of the SQL user accounts which would mean any unauthorised access or anomalies/errors regarding user activity may not be detected / rectified. In addition, our analysis of the SQL user listing noted that there was no clear distinction between internal and external user accounts. • We found that the Council's domain password policy (via system settings) is not appropriate and non-compliant with the Council's Access Control Policy. The same finding and corresponding recommendation were raised in the Access Control Management audit report and therefore not included in this report. • Through discussions held with management, we noted that the Council	Extensive	**Limited**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		does not make use of SQL database encryption such as TDE or 'Always On' encryption for specific databases which contain sensitive data. Exploring such encryption mechanisms for relevant databases may support a greater level of protection where sensitive datasets are held. • The latest SQL vulnerability assessments carried out for TOW-AZS-P-SQL02 (Tribal EIS and Synergy databases) in March 2022 reported two high and seven medium risk findings, which were yet to be addressed by the Council. If such findings are not rectified in a timely basis, this could impair the infrastructure and systems susceptibility to attacks. Since the report, management are progressing actions with the relevant vendors to resolve the issues. *All findings and actions were agreed with the Head of Business Applications and Governance Manager (IT) and final report was issued to the Director of IT and the Corporate Director – Resources.*		
Creditors Systems Audit	May 2022	The Creditors function involves processing of invoices for payment, including confirming that goods/services have been appropriately ordered and received and that invoices have been approved prior to making prompt payment. The council requires a purchase order to be raised and approved for all purchases, which must also be matched to the invoice, in addition to having a goods receipt note in place. Between April 2021 and December 2021, a total of some £643M of creditor payments were made by the Council. The following areas of good practices were identified during our review: • There were policies and procedure notes in place for the accounts payable system. These were reviewed bi-annually and were kept up to date. • There was an adequate segregation of duties in place throughout the payment process, due to the built-in controls and workflows within Agresso and Requisition to Pay (R2P) systems. The amendment to supplier data and the set-up of new suppliers within the system was	Extensive	**Reasonable**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		adequate. • Reconciliations between R2P and the Agresso were carried out daily. The reconciliations were signed and dated by the preparing officer and the reviewing officers. • Invoices held in suspense were investigated and cleared daily. The following key findings and risks were reported: • 4 out of the 20 invoices tested were not processed by the due date and there is the risk that the late payment could possibly result in financial penalties being levied against the Council. In one instance, an invoice had taken over 161 days to be paid. • Testing of a sample of 20 paid invoices showed that 5 invoices were received by the Council prior to the purchase orders being raised. The respective invoice values ranged from between £2,730 and £1.0m. We requested the Financial Systems team to run a report on the number of retrospective Purchase Orders raised for the whole of 2021/22 financial year to assess the extent of this practice. The report showed that there were 7,332 paid invoices with a total value of some £44M which were possibly issued in retrospect. This equates to 6.85% of total invoices paid. Raising of purchase orders in retrospect represents non-compliance with the Council's Financial Regulations and Procurement Procedures. • BACS payment run reconciliations were performed against the Agresso General Ledger System on a thrice weekly basis. Sample of 10 reconciliations were selected for testing, which showed that the reconciliations were carried out in a timely manner. However, these were not independently checked for accuracy and completeness. • A total of 10 CHAPS payments were tested to check whether these were processed in an appropriate manner. It was noted that due to requirements for staff to work remotely, CHAPS payments were		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		authorised via email. However, the current procedure for authorising CHAPS payments via email had not been documented in the Treasury Management procedures. Furthermore, the current Directorate list(s) of CHAPS Authorised Signatories required a review and update. • To test leavers had been removed from the IT system, we tested sample of 15 staff leavers. This showed that in 5 cases (33.3%), timely notifications were not received by the Financial Systems team from HR, resulting in delays of between 16 to 95 days in removing users access to Agresso. Of the remaining 10 leavers (66.6%), none were removed on the day of notification or the next working day. These delays ranged from 7- 40 days. • With regards to Credit Notes, there was currently no written policy/procedure on the management and monitoring of credit notes. Credit Notes report had only recently been re-introduced showing the current outstanding credit notes against each supplier. However, with the current Credit Notes report format, it is not possible to ascertain the value and age of credit notes tied up with suppliers. *All findings and actions were agreed with the Payments Manager and Head of Financial Systems. Final report was issued to the Director of Finance, Procurement and Audit and to the Corporate Director – Resources.*		
Management of Multi Agency Safeguarding Hub (MASH)	April 2022	This audit reviewed the adequacy and soundness of management control over the Multi-Agency Safeguarding Hub (MASH). The MASH was developed by the police, local authorities, and other agencies to co-locate safeguarding agencies and their data into a secure, research and decision-making unit. This was in response to the inability of agencies, on occasions to effectively share information which has been the comment of numerous Serious Case Reviews and public enquiries. The MASH in Tower Hamlets is the single point of entry for all referrals regarding safeguarding and welfare concerns for a child or young person (unborn to 17 years). The MASH receives contacts through a variety of methods such as telephone, email, and letter. These	Extensive	**Reasonable**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		contacts are made by professionals, members of the public and service users. The audit review identified the following areas of good practice: • There was an Information Sharing Protocol, which was revised In October 2021. • There was a detailed operational protocol to guide the MASH team. • Audit testing of a sample of 20 referrals showed that procedures concerning consent had been complied with in all cases. • The performance of the screening processes undertaken by the MASH team was measured, scrutinised, and reported on regularly. • The Service Head chairs quarterly MASH implementation meetings where detailed performance reports are reviewed with key partners. • Procedures require that each contact be screened, and a RAG rating applied. This was done in 19 cases in our sample of 20. The exception related to a request for information from another local authority. The following key issues were highlighted: • Procedures require that all contacts be recorded immediately on receipt using the multi-agency referral form. Audit testing of a sample of 20 contacts from a total of 16341 contacts received between October 2020 and September 2021, showed that in one instance a request for information was not loaded on MOSAIC as contact until 12 weeks after it had been received. • In another case, a request for information should have been responded to within 24 hours but was not responded to until 2 months after it had been received. The latter case had been identified by the MASH manager through their weekly monitoring. • In 6 of 19 cases, the letter to the referrer took more than the required 48		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		hours to be produced. In 3 cases, there was no letter to the referrer. • An annual report for the MASH activities and performance was not in place. The Service Manager advised that the first annual report for the MASH will be presented to the Partnership Board on 17 March 2022 to ensure oversight by the executive. *All findings and actions were agreed with the Service Head of MASH and Final report was issued to the Director Supporting Families and Corporate Director - Children and Culture.*		
Review of Contract Services Improvement Plan (Children & Culture)	April 2022	This audit reviewed the progress of the improvement plan for contract services which provide school catering and cleaning services on a trading basis. An improvement plan was put in place to make the service more financially viable as approved by the February 2019 Cabinet, in which the Service was predicting an annual year-end deficit of £1.4 million for 2018/19. This was due to issues such financial pressures arising from under-pricing and with high overheads; an inefficient Service structure; and a lack of consistent leadership to drive forward improvements. To reduce the service budget deficit and make the service more commercially viable and sustainable, eight key recommendations were presented for approval to bring the Service to a break-even position in future years. With the implementation of recommendations, total cost reductions of £1,679,954 were projected. The following areas of good practice were reported: • A Transformation Project was created with a detailed business case, cost savings proposals, project timetable, the finances and resources required to deliver the project, the project team, and the governance arrangements. • The business case comprised of a recurring annual cost reduction of £1.680m from 2019/20 and was subject to Cabinet approval in line with the financial reporting thresholds.	Extensive	**Reasonable**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		• Adequate working papers were maintained to demonstrate the methodology used in identifying the cost saving proposals. • Regular Project Highlight Reports were produced on the project's progress in relation to the project's milestones, costs savings delivered and the key risks and issues. The following issues and risks were reported: • Significant progress was made by Contract Services in delivering the required cost saving of £1.406M against planned savings of £1.677M. However, there is still the risk of on-going budget pressures and budget variances resulting in further trading deficit. There are further unavoidable cost pressures from key suppliers due to increased transport costs and inflationary increases, which would require additional growth bid which had yet to be made and approved. This would impact upon the Council's objective to make this service financially viable as a trading service. • To sustain the in-house school meals provision, a growth bid of £500k was required to cover the ongoing operational needs of the service. • Audit testing confirmed that the council needs to have clear strategy and governance for financial management and accounting for the traded services to its schools and other clients. For example, when a traded service makes a trading deficit, there was no clear Council policy in place around how that deficit will be funded and what course of action should the service take to reduce the deficit. • Although, the Interim Head of Contract Services has no formal responsibility/accountability for PDC, this budget was given to the officer to manage. In addition. Audit noted that the DLT was advised that the future commercial use of the PDC building was included in the Tower Hamlets Venues and Events Commercial Project. *All issues and actions were agreed with the Interim Head of Contract*		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		Services, Director of Commissioning and Culture and Head of Strategic Finance - Children and Culture. The Final report was issued to Corporate Director – Children and Culture.		
NNDR and Council Tax - Empty Rates and Inspections	May 2022	This audit sought to provide assurance around the adequacy and soundness of systems for granting empty property exemptions for business rates and council tax and for inspecting these properties as required on a regular basis. During the audit we identified areas of good practice which included the following: • Business ratepayers applying for mandatory/discretionary charity relief are required to sign a declaration to confirm that all information and evidence provided is true and accurate. • There were guidance notes on processing of discretionary relief and for inspectors who carry out inspections of these properties. Our findings and issues from this audit include the following: • <u>Processing of Applications</u> - Audit testing of a sample 5 organisations which were awarded charity relief showed that in 2 cases, completed check lists to verify the details of the applicants were not on file. In another case, the audit trail was poor as it was not clear how, why and by whom the initial decision not to grant discretionary relief was overturned. We noted that there was no system of management review or spot checks to monitor compliance with procedures • <u>Empty property rates and charity relief (NNDR)</u> - Audit found that inspections had been carried out for each property in the sample of 21 we tested. However, in 5 cases, the outcome of the inspection had not been recorded and hence there was no audit trail. • Furthermore, testing of a sample of 5 properties in receipt of charity relief showed that in 4 cases inspections had been conducted within the last 12 months. However, in 2 of these cases, the inspector had failed to record the outcome of this inspection. In 1 case, the inspection was still	Moderate	**Reasonable**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		queued in the inspector's workflow. • Council Tax exemptions - There were 5 cases in our sample of 20 where there was lack of progress in determining whether the exemption was still valid. • Billing - Void exemptions, where a change in occupancy or liability had been identified, had been treated correctly in 10 out 11 cases. In the 11th case the account had not been reverted to the Housing Association a year after the tenant had passed away. The Income Verification Team Leader commented that this oversight will be picked up in the next annual review. Bills had been issued or a liability raised in all other cases. *All findings and actions were agreed with the Head of Revenues and final report was issued to the Corporate Director Resources.*		
Testing of Business Continuity Plans (Consultancy Review)	May 2022	This consultancy review was requested by the Corporate Director - Health, Adults and Community (HAC) who chairs the Civil Contingency Board (CCB). The objective of the review was to test the robustness of a sample of the service level Business Continuity Plans (BCPs) to ensure that they meet the corporate requirements and clearly identify actions and work arounds needed when a serious or disruptive incident occurs. Under the Civil Contingencies Act, the Council is required to have Business Continuity (BC) arrangements in place to ensure that statutory services continue to be delivered. Business continuity is the responsibility of all managers across the Council to ensure that they have sound arrangements in place when a critical incident happens in their service area. The Civil Protection Unit (CPU) which is within the Health, Adults and Community Directorate (HAC) is responsible for promoting the Council's business continuity management and providing general support, administration, training, guidance etc. The following areas of good practice were identified: • There are currently clear policies and procedures in place, which are	Extensive	**N/A - Advisory**

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		published and communicated across the Council. Each Directorate has a BCP Champion whose role is to provide advice and guidance to BCP owners and represent the Directorate at the CCB. • The Council has implemented an IT system called ClearView to guide and document the formulation of BCPs in a systematic manner. The IT system allows each BCP owner to identify and document essential functions, essential resources, duration of time within which the function/service must be restored to continue providing the service, impact/risk assessments, internal dependencies, key suppliers, workarounds including manual work arounds when critical IT systems are not operating, people strategy etc. There is also a mobile App which provides an agile and virtual platform allowing an additional layer of resilience. • The CCB is provided with regular management reports including the status of service level BCPs such as services which have no BCPs, services which have live and up to date BCPs, any further actions required etc. These reports are also circulated to Directorate Champions more frequently. CPU also provides regular training sessions and advice to Plan owners, approvers and maintainers which is supplemented with guidance documents. • Children's Services have compiled their own schedule of statutory services which details the number of staff employed by each service, manual work arounds in place and number of staff required each day to provide a legal minimum public service. The schedule is appended to each BCP. The following key areas identified for improvement were highlighted: • Our review showed that of the 102 services which should have formulated and submitted their BCPs, 13 were live and up to date, 23 required some action to bring them up to date; 59 were significantly overdue for review and approval; and 7 BCPs had still not been complied		

Title	Date of Report	Comments / Findings	Scale of Service	Assurance Level
		and submitted. Where BCPs are not fully live, not developed at all and still require further review and approval, there is risk that the Council's objectives and priorities in relation to business continuity and resilience are not achieved. • Detailed testing of 17 BCPs, showed that in 12 cases (71%), services had either not documented manual work arounds at all or had not fully recorded manual workarounds within their BCPs. In these cases, there were either none or few documented contingencies which could be applied if access to essential resources was denied. As the Council procedures require approval to be provided after confirmation that manual work arounds had been identified and documented, there is a key control weakness in the approval process. • There is a requirement to test the BCPs on a regular basis. However, from our audit testing, there was no evidence that testing of BCPs, and any manual work arounds included within them was taking place. Hence there was no process for confirming the effectiveness and robustness of service BCPs. We were informed that once the plan documentation, approval and review processes were fully embedded, greater focus would be applied to ensuring that BCPs are tested. • Testing showed that whilst essential resources were documented within BCPs, these were not always being kept updated and there was risk that some key resources might have been omitted from the BCPs and that obsolete resources were included. • Testing of sample of BCPs also showed that although supplier contact details were included within the BCPs, these were sometimes incomplete or out of date. And hence needed to be properly reviewed. *All findings and actions were agreed with the Civil Protection Unit and the Chair of the Civil Contingency Board (Corporate Director HAC). The report was discussed at the May 2022 meeting of the Civil Contingency Board to ensure that all BCP Champions were aware of the issues and improvement*		

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		actions required. It is expected that these issues are reported back to their respective Corporate Directors, DLTs, SLTs and BCP owners so that immediate actions are taken to implement the agreed actions from this consultancy review to ensure that the BCP process becomes more embedded and effective across the Council.		