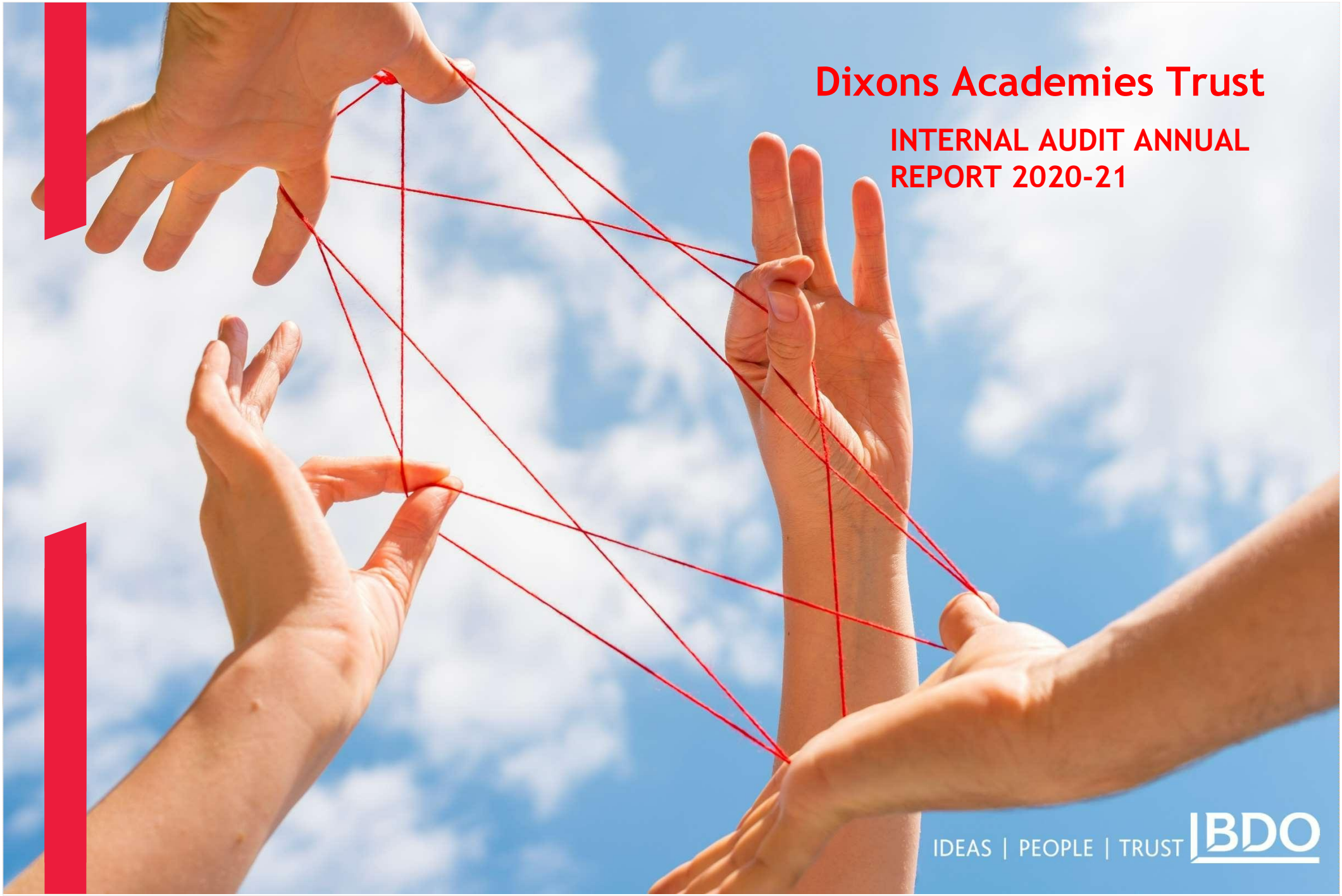

Dixons Academies Trust
INTERNAL AUDIT ANNUAL REPORT 2020-21
IDEAS | PEOPLE | TRUST
BDO

CONTENTS

EXECUTIVE SUMMARY

Our role as internal auditors is to provide an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. Our approach, as set out in the firm's Internal Audit Manual, is to help the Organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Responsibilities

BDO LLP has been appointed as internal auditors to Dixons Academies Trust (Dixons) to provide the Board (via the Audit Committee), the Chief Executive and other managers with assurance on the adequacy of the following arrangements:

- Risk Management
- Corporate Governance
- Internal Control

Responsibility for these arrangements remains fully with Management, who should recognise that internal audit can only provide 'reasonable assurance' and cannot provide any guarantee against material errors, loss of fraud. Our role at Dixons is also aimed at helping Management to improve risk management, governance and internal control, so reducing the effects of any significant risks facing the organisation.

Our risk evaluations and tests are designed to ensure that controls are sound both in design and effective in operation. Our conclusions are based on samples selected from the year's transactions to date. However, our conclusions should not be taken to mean that all transactions have been properly authorised and processed.

EXECUTIVE SUMMARY

Audit Approach

We have reviewed the control policies and procedures employed by Dixons to manage risks in business areas identified by Management set out in the 2020-21 Annual Internal Audit Plan, as approved by the Audit Committee. This report is made solely in relation to those business areas and risks reviewed in the year and does not relate to any of the other operations of the Organisation.

Our approach complies with best professional practice, in particular, Public Sector Internal Audit Standards and the Chartered Institute of Internal Auditors' Position Statement on Risk Based Internal Auditing.

We discharge our role, as detailed within the audit planning documents agreed with Dixons Management for each review, by:

- Considering the risks that have been identified by Management as being associated with the processes under review
- Reviewing the written policies and procedures and holding discussions with Management to identify process controls
- Evaluating the risk management activities and controls established by Management to address the risks it is seeking to manage
- Performing walkthrough tests to determine whether the expected risk management activities and controls are in place
- Performing compliance tests (where appropriate) to determine that the risk management activities and controls have operated as expected during the period.

The opinion provided on page 9 of this report is based on historical information and the projection of any information or conclusions contained in our opinion to any future periods is subject to the risk that changes may alter its validity.

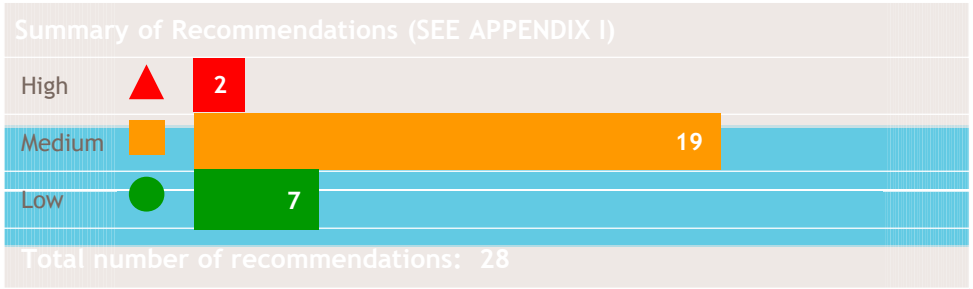
During 2020-21 BDO LLP has reviewed and evaluated Dixons's processes in the following areas:

- Credit Cards and Expenses
- Health and Safety
- Human Resources
- It General Controls (ITGC)
- Follow-up

EXECUTIVE SUMMARY

Recommendations

To assist Management in addressing our findings, we categorise our recommendations according to their level or priority. The recommendations made in the reviews totalled 28.



Our initial draft reports are sent to the key officer responsible for the area under review in order to gather management responses. In every instance there is an opportunity to discuss the draft report in detail. Therefore, any issues or concerns can be discussed with Management before finalisation of the reports.

Our method of operating with the Audit Committee is to agree reports with Management and then present and discuss the matters arising at the Committee meetings.

Management have been conscientious in reviewing and commenting on our reports. For the reports which have been finalised, Management have responded positively. The responses indicate that appropriate steps to implement our recommendations are being put in place.

EXECUTIVE SUMMARY

Relationship with external audit

All of our final reports are available to the external auditors through the Audit Committee papers and are available on request. Our files are also available to external audit should they wish to review working papers in order to place reliance on the work of Internal Audit.

Background

The purpose of this review was to provide the Audit Committee with assurance that Dixons Academies Trust (Dixons) has relevant mechanisms in place to ensure that recommendations are implemented in line with appropriate timescales. We considered whether recommendations from previous internal audits reports had been appropriately implemented in line with their due dates. Recommendations from one BDO report were also followed up (credit cards and expenses) as part of this review.

Methodology

In order to ascertain the status of the 12 recommendations followed up on, interviews were held with the responsible recommendation owners. Where it was confirmed by management that recommendations had been implemented, evidence was sought to verify that this was the case. We have not conducted detailed sample testing in the areas reviewed but have sought evidence on the controls put in place by management to be able to mark a recommendation as implemented.

Results

Of the 12 recommendations we reviewed we were able to verify that 10 (83%) of these had been fully implemented when analysed against detail outlined in our initial recommendation and the agreed management response. We have outlined in Appendix IV the status of the recommendations.

Conclusion

Dixons has made good progress in implementing the recommendations made by internal audit.

REVIEW OF 2020-21 WORK

Details of the reviews completed to date have been reported to the Audit Committee throughout the year and have been discussed with consideration and scrutiny of management responses and timescales proposed.

For the purpose of this annual report, we set out below our summary assessment of the effectiveness of the risk management arrangements in each of the audit areas reviewed.

Reports Issued	Overall Report Conclusions				
				Design	Operational Effectiveness
Credit Cards and Expenses	-	6	1	Moderate	Limited
Health and Safety	-	5	4	Moderate	Moderate
Human Resources	2	1	1	Moderate	Limited
It General Controls (ITGC)	-	7	1	Limited	Limited
Follow-up	-	-	-	10/12 (83%) recommendations marked as implemented	

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	Finding	Recommendation	Management response
	Credit card ownership Cardholders are required to sign a declaration which states the terms of use for corporate credit cards. The declaration states where there is failure to comply with the policy, the credit card disciplinary action. Records of returned signed declarations are recorded on the master list of credit cards; through testing we identified; There were two cardholders that had not returned a signed declaration. There is a risk that if evidence of signed declarations is not held for all cardholder, in the event of credit card misuse there is not appropriate evidence which confirms the cardholders acceptance of the terms of use of the corporate credit card.	It is recommended; Where staff are allocated a credit card, finance should ensure that there is evidence of a signed declaration held from An annual review should be undertaken to confirm that there is a signed declaration in place.	Signed declarations will be obtained for the 2 missing documents and an annual review will be undertaken

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	Finding	Recommendation	Management response
	Credit Card Limits There is a corporate credit card located at each academy within the Trust, each with a monthly limit of £5,000 and a single transaction limit of £1,000. We selected a sample of 15 credit card payments across the Trust across different months (in the last 12 month period) and looked to obtain evidence to confirm that the process outlined within the credit card policy had been followed. Testing identified; There were three of the cards reviewed from our sample which had transactions that exceeded the £1,000 spend limit, in these instances; The credit card limit had not been applied in a timely manner. A request had been submitted to increase the spend limit, however there was no evidence to confirm authorisation of the increase. Additionally, through review of the 15 credit card monthly transactions we noted instances where the payment appeared to have been split into two or more individual transactions that when aggregated amounted to over the £1000 threshold. In all instances an approval form was in place. There is a risk that if credit card limits are not applied correctly or there is a lack of audit trail which confirms limits have been increased, spend may not be made in line with the policy.	It is recommended; That where credit card limits are increased, there is an appropriate audit trail in place to ensure the tracking of credit card spend can be monitored appropriately. Credit card limits should be reviewed periodically to ensure that they are correct. Card holders should have the message re-iterated about limits and not splitting expenditure to avoid them. Finance should also look out for where this may be	Evidence will be retained and filed where credit card limits have been increased. Limits will be reviewed periodically. Card holders have been reminded re the message of not splitting expenditure and going forwards this will be monitored monthly and addressed where necessary.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	Finding	Recommendation	Management response
	Credit Card use in line with Policy The credit card policy states: "There are some types of expenditure which are prohibited such as:- The purchasing of gifts for staff Cash withdrawals IT Equipment (Both capital and consumables) Capital spend (Incl furniture) Licenses or subscriptions" We did a high level review as part of our testing (due to restrictions in available data to perform full analytics) and noted some expenditure which appeared to misalign with the policy. This included subscriptions to Amazon Prime, purchases of flowers for staff awards, membership subscriptions and the purchase of furniture, all of which fall under capital expenditure. We do note that these instances had a signed approval form in place, suggesting that card holders and budget holders were comfortable with the expenditure. However, expenditure not allowed or in alignment to the credit card policy should not be incurred without a specific rational which is recorded. Using the credit card may result in reduced value for money and additional expense.	We recommend that the restrictions on use are re-iterated to staff members as a priority. We also recommend that where there are exceptions to the use of cards for items noted as not allowed, the approval forms specifically record the rational behind the purchase.	Credit card usage is being reviewed and monitored monthly now. Any exceptions to the policy will be questioned and reasons recorded in the documentation. There should be no Amazon subscriptions going forwards as an Amazon account has been set up.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	**Finding**	**Recommendation**	**Management response**
	Approval for expenditure The credit card policy states: The cardholder must also sign the Credit Card Usage Form prior to any transactions being processed." As part of our review of the sample of credit card transactions we noted: Seven of the fifteen card expenditure reviewed had exceptions where approval was obtained after the purchase was made. For expenses, the policy states: Any purchase made on behalf of the academy must be approved by the budget holder prior to purchase. Our testing noted exceptions in c20 of 30 expense claims reviewed where approval had not been obtained prior to purchase. Without prior approval before expenditure is incurred, the budget holders ability to monitor and manage the budget is reduced, and the Trust may end up incurring additional costs and reduced value for money.	We recommend that the message regarding the timeliness of approval is reconfirmed to relevant individuals. As part of Finance's check, where approval has been obtained after the expenditure was incurred this should be fed back and where the breach continues to occur this should be escalated as required.	The process will be reiterated to credit card holders where necessary following the monthly review.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	Finding	Recommendation	Management response
	Expense Policy The expense policy outlines the types of expenses that cannot be submitted and reimbursed through the expense process. The policy states that expenses such as classroom equipment or line or equipment rental will not be reimbursed. Reasonable expenses which arise from attending meetings, training or conferences or made on behalf of the academy are acceptable.	It is recommended; That the expense policy is updated to state that where there are exceptional urgent circumstances occur this will be allowed. Where exceptional items are expensed, approval should still be obtained and recorded.	Partially agreed. The expense policy should not be updated but where exceptional expenses are claimed for these should be accompanied by a note explaining and authorizing the exception.
	there were instances where expenses had been approved and processed that were not in line with the policy. These instances included; An expense claim for mobile phones which is prohibited within the policy, however it was identified that these mobiles were purchased as a result of remote working and the need to deal with safeguarding cases. Three professional memberships were claimed, in line with the policy the trust will only reimburse two memberships and any additional professional membership claims will need to be claimed as a tax deduction on the employee's tax assessment return. Other purchases not in line with policy included: purchase of mice, plates and forks, marketing cost (Facebook), classroom equipment and purchase of sweets and postage. For mileage claims made, our sample showed inconsistency in the evidence provided with missing receipts or some receipts not detailing VAT. There is a risk that the Trust will not obtain best value in instances where items are purchased directly and expenses rather than processed through procurement process.	which are not allowed to be claimed through the expenses process and where Finance identify these areas, they should be rejected or a record should be maintained as to why the exception was allowed.	

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Credit Cards and Expenses			
Sig.	**Finding**	**Recommendation**	**Management response**
●	**Formal Monitoring** [illegible] for a credit card usage form, appropriateness of spend and where full receipts and evidence are not attached they will be returned to the budget holder. Before expenses are processed, they are checked by the finance team to ensure that there is appropriate authorisation and all claims include a corresponding receipt. However, we noted that there is no formal monitoring/ oversight/ commentary consistently completed of overall expenditure on cards and expenses. This helps to ensure the levels are appropriate and consistent across the Trust. It also helps to present opportunities to identify where alternative suppliers may be required to support expenditure being incurred through different measures, where enhanced value for money could be obtained. There is a risk that if the use of credit cards and expense submissions is not monitored appropriately, management may be unable to sufficiently identify any trends in expenditure and identify areas for improvement.	It is recommended that the monitoring of [illegible] Discussion of credit card spend and expense claims at monthly management account meetings. Analysing credit card spend and expense claims at each academy and across the Trust.	Credit card spend is monitored monthly and [illegible] will be reviewed regularly in future.
■	**Claim form completion** Both the credit card and the expenses process require forms to be completed and signed off as part of the approval process. We noted across our sample testing for both credit cards and expenses, incompleteness in the forms submitted (with missing dates, nominal code allocations/ expense type allocation, and signed approval in some instances). Without completeness of information and documented clarity over dates of approval and sign off, the audit trail is reduced and the ability to oversee and monitor the process is restricted. Additionally, claims may be misallocated if detail on the required coding is not completed.	It is recommended that as part of Finance's review, where there is information missing, claimants are asked to complete and resubmit. The required standard of form completion should also be re-iterated to staff members.	Where receipts are missing, these transactions won't be processed and the credit card will be put on stop until the receipts have been forwarded to Finance.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health & Safety			
Sig.	Finding	Recommendation	Management response
	Staff training - Trust Mandatory and role-specific H&S training is managed and monitored through Smart Log. Smart Log generates compliance reports that show the level of training completed across all staff in an academy. These compliance reports [redacted] However, walkthrough of Smart Log identified that compliance reports do not include training/certification completed outside of Smart Log. These modules are managed by staff themselves and certificates are uploaded upon completion. As such, there is a portion of training (including mandatory training, for example legionella awareness and IOSH) that does not form part of the statistics regularly monitored and reported. There is a risk that monitoring and reporting of staff H&S training completion is not consistent or comprehensive.	We recommend that a database/spreadsheet is used to record and monitor training that is required to be completed outside of [redacted] reporting should include all training required to be undertaken by staff.	A spreadsheet will be developed to record and monitor training, including due dates and dates of completion. This will be rolled out to OBMs and Campus Managers [redacted] Estates Implementation Date: End of Term 1
	Training assignment - D6A and Trust Training is assigned by relevant line managers at the time of induction of the staff member. We performed sample testing on three roles, namely science lab technician, fire warden and site assistant to confirm that relevant role-specific training had been assigned to staff in these roles at both academies. We identified that the science lab technician at D6A was not assigned COSHH awareness training. Moreover, there is no documented guidance that lists the training that staff within each role is required to complete, in order to support line managers in assignment of training in a consistent manner. There is a risk that role-specific training in not assigned to staff in a consistent manner.	We recommend that: The identified staff member at D6A is assigned relevant training Training requirements for each role is documented and communicated to staff	The identified staff member at D6A has now been assigned the relevant training. A spreadsheet detailing role specific training will be developed and rolled out to OBMs, Campus Managers and Head of HR. Responsible Officer: Gill Prout, Head of Estates Implementation Date: End of Term 1

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health and Safety			
Sig.	Finding	Recommendation	Management response
	Risk Assessments - DKA Risk assessments (RAs) are completed by staff and reviewed by line managers. The RA forms are uploaded on Smart Log. During sample testing, we noted that for all of the three Risk Assessment forms at DKA, the review date was not input to evidence review by the OBM and one of the three forms also did not identify the due date/regularity of review. It is noted that a similar finding had also been previously raised by auditors as part of the H&S audit in 2019-20. There is a risk that Risk Assessments are not reviewed in a timely manner and [illegible]	We recommend that review due dates and completion are captured on Risk Assessment forms consistently.	Review due dates and completion will be captured on risk assessments and signed appropriately. The Risk Assessment Register will be reviewed and updated to reflect risk assessments completed, date completed, by whom and next review date. Responsible Officer: Gill Prout, Head of Estates and Eddie Laughlin, OBM, DKA Implementation Date: End of Term 1
	Smart Log Access - D6A There are different levels of Smart Log user access provided to staff based on role. These are Company Admin, Local Admin, Departments Admins, Site team, and Standard users. We reviewed the access rights reports from Smart Log for both academies to confirm, for a sample of three roles, whether access rights align with roles. We identified a Site Assistant at Dixons Sixth Form who had Standard user access while they should have been assigned Site team access that allows access to specific locations and to update checks and upload documents. There is a risk of incorrect assignment of user access rights to staff that may result in them being unable to fulfil their responsibilities.	We recommend that: The identified Site assistant is provided appropriate access Management implement periodical review (say, bi-annually or annually) of user access rights to ensure these are appropriate and align with staff roles	The identified Site Assistant has now been provided with the appropriate access. A check and test has been created on Smartlog for the review bi-annually of user access rights to ensure that access is appropriate and aligns with staff roles. Responsible Officer: Michael Hirst, Campus Manager Implementation Date: Completed

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health and Safety			
Sig.	**Finding**	**Recommendation**	**Management response**
●	**RIDDOR procedure - Trust** There is an established process in place around RIDDOR. This is done via a platform called RIVO. As assessment of the incident is completed by the competent person at the Local authority prior to reporting to the regulator, HSE. We however, found that there is not a formally documented RIDDOR procedure that formalises the Trust's approach to identifying, recording and reporting RIDDOR. There is a risk that in the absence of a documented procedure, there could be inconsistencies in the manner in which RIDDOR is managed by staff.	We recommend that management establish a formal RIDDOR procedure document or alternatively, include RIDDOR within existing procedures relating to incident management.	A formal procedure will be developed to formalize the Trust's approach to identifying, recording and reporting RIDDOR and rolled out across the Trust. Responsible officer: Gill Prout, Head of Estates/Michael Hirst, Campus Manager Implementation Date: End of Term 1
■	**Compliance checks - DKA and D6A** On Smart Log, there is a section called 'Checks and tests' used to create and monitor H&S compliance checks at each academy, such as fire alarm testing, PAT testing, First Aid box check, etc. Compliance reports indicate level of completion of checks and highlight any overdue tasks. Review of compliance checks at both academies noted some discrepancies: Dixons Kings • COSHH does not appear as a check Dixons Sixth Form • Fire Alarm, fire extinguisher and PAT testing checks state 'No certificate' while certificates are required to be uploaded in order to be compliant • Plant/Equipment servicing and Fire Evacuation Drill do not appear as checks There is a risk that compliance monitoring and reporting is inconsistent across academies. Also, the risk of non-compliance is heightened in the absence of a check on Smart Log.	We recommend that a standard list of compliance checks is used by all academies for reference and all relevant checks are added.	A full review of statutory and regulatory compliances checks will be completed. A standard list of compliance checks is already in place and this will be reviewed against Smartlog to ensure all checks are included on Smartlog for every academy. Responsible officer: Gill Prout, Head of Estates/Michael Hirst, Campus Manager (responsibility for Compliance) Implementation Date: End of Term 1

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health and Safety			
Sig.	Finding	Recommendation	Management response
	H&S Group meeting - DKA The Trust H&S Committee meet three times a year. All academies are required by the Trust to hold H&S Group meetings three times a year to discuss H&S matters. There is an established terms of reference for the group, including responsibilities, membership and standard agenda of topics discussed. The H&S Group meet to discuss risk register, accidents/incidents/RIDDOR, audit and action plans, and training. The outcome from these group meetings is also used to inform Trust-wide H&S reporting. We noted that at Dixons Kings Academy, although H&S is discussed at weekly SLT meetings, there are no formal H&S Group meetings held during the year. It is noted that a similar finding had also been previously raised by auditors as part of the H&S audit in 2019-20. There is a risk that Trust-wide established process is not being followed and there is insufficient formal review and discussion of H&S matters at the academy.	We recommend that regular H&S Group meetings are held by Dixons Kings Academy and outcome from these meetings reported, as required by the Trust.	Academy H&S Group meetings will be reinstated at DKA and lead by the OBM. All three meetings for the academic year will be scheduled in advance in line with the Individual Academy H&S Terms of Reference. Meetings will be scheduled for September 2021, February and June 2022. Responsible officer: Eddie Laughlin, OBM Implementation date: End of Term 1

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health and Safety			
Sig.	Finding	Recommendation	Management response
	Board and LGB reporting During our review, we noted that there is limited reporting around H&S to Board. A consolidated percentage of Smart Log compliance is reported, along with other key performance indicators relating to academy performance. There is no supporting narration or distinction between training and statutory compliance to allow Board to understand areas of concern or gain assurance. Also, there is no information around incidents/near-misses/RIDDOR reporting; completion of actions arising from FRAs/RAs or lessons learnt reported to Board. The last H&S Annual Report presented to Trust Board was in 2018-19 which comprises of the above information. It is noted that H&S does not form a standard agenda item on LGB meeting agendas. It is noted that a similar finding had also been previously raised by auditors as part of the H&S audit in 2019-20. There is a risk of insufficient reporting to Board and LGB on health & safety matters.	We recommend that: A comprehensive H&S report is presented to Board on an annual basis that highlights H&S matters relating to each academy and at least includes compliance levels, staff training, incident management and reporting, lessons learnt and progress against actions arising from Fire and other H&S risk assessments. H&S forms part of the standard agenda of items discussed at LGB meetings each term and this includes outcome from H&S Group meetings.	A comprehensive H&S report will be presented to the board on an annual basis. The report will include information relating to compliance levels, staff training, incident management and reporting, lessons learnt etc. H&S will form part of the standard agenda items discussed at LGB meetings each term and this includes outcome from H&S Group meetings. Responsible Officer: Gill Prout, Head of Estates Implementation date: H&S report to be presented to the Board on 09 September. The Individual Academy H&S Group Meetings Terms of Reference have now been amended to reflect the requirement to provide outcomes from H&S Group meetings to the LGB meetings each term.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Health and Safety			
Sig.	Finding	Recommendation	Management response
	Lessons learnt As noted in this report, the issues below have been previously highlighted by auditors as part of the H&S Audit completed in 2019-20. The audit had focussed upon two other academies. • Review of risk assessments • H&S Group meetings • Board and LGB reporting There is a risk that lessons learnt and improvements made following external reviews are not effectively communicated across the Trust to allow all academies to consider and implement them, where relevant.	We recommend that action taken and improvements made following external reviews are widely communicated to all academies	Agreed. The audit report and findings will be shared with the Executive, Principals and the Trust H&S Group meeting scheduled. Responsible officer: Gill Prout, Head of Estates Implementation date: End of Term 1

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	Finding	Recommendation	Management response
	Authority to Recruit The Recruitment policies and procedures in place state that the Principal or Head of school is responsible for providing the authority to recruit. For the sample of ten new starters examined as part of the audit, we were unable to obtain evidence to demonstrate that each role was approved by the Principal or Head of School. Discussions with management confirmed that previously the authority to recruit was often provided verbally, however, this process has recently been strengthened so that the approval is provided within the iTrent HR and Payroll system; therefore evidence is not retained within individual HR personnel files. There is a risk that where formal records are not held, there is a lack of audit trail to demonstrate that approvals have been obtained.	Where approval to recruit has been obtained, all records should be held within individual HR personnel files so that evidence is easily accessible.	Authority to recruit forms part of the process within the recruitment portal in iTrent. When HR are adding requisitions an automatic workflow is sent to the Principal / Senior Leader to authorise. This can be evidenced within the requisition at any time. With regards to formal approval evident in the HR file, the new starter checklist includes a sign off section following all relevant checks, which also includes confirming the position / salary / start date. Spot checks will be carried out centrally across academies throughout the academic year. ***Responsible Officer: L. Sharp*** ***Implementation Date: Immediate***

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	**Finding**	**Recommendation**	**Management response**
▲	**Recruitment and Selection** To ensure a fair and transparent recruitment process, hiring staff are required to shortlist applications received and score interviews that take place, maintaining records throughout the process. As part of the audit, we examined a sample of ten new starters recruited in the past 12 months and sought to confirm the Trust's recruitment processes were consistently applied. However, we noted the following issues; McMillan: • For two of the new starters (20%), we were not provided with evidence of shortlisting to confirm that applicants were considered and assessed appropriately • For one new starter (10%), we were not provided with evidence of the interview and assessment process; as a result we were unable to confirm that at least one member of staff on the interview panel had received Fair Recruitment training	We recommend that management ensure that evidence of the recruitment process, including shortlisting, interview notes and scoring should be obtained by the hiring manager and held centrally by the HR Team.	In the previous 12 months prior to the audit, there has been a change in staff. Samples without evidence in most cases was prior to those currently in role. However, fair recruitment training has been delivered to relevant staff, updated shortlisting matrix is used and all internal adverts are now advertised via iTrent. Further developments of iTrent in the Autumn term will see shortlisting carried out within the HR system. This will allow central HR visibility for all roles. The new starter checklist also includes sign off to include interview notes for those appointed. In line with the Trust Retention policy, recruitment docs are held for 6 months and then destroyed for *Responsible Officer: L. Sharp* *Implementation Date: 31 January 2022*

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	**Finding**	**Recommendation**	**Management response**
▲	**Recruitment and Selection Cont…** Trinity: • For one new starter (10%), we were not provided with evidence of the job description and person specification in place for the role • For two of the new starters (20%), we were not provided with evidence to [illegible]		
	• For three of the new starters (30%), we were not provided with evidence of shortlisting to confirm that applicants were considered and assessed appropriately • For two of the new starters (20%), we were not provided with evidence of the interview and assessment process; as a result we were unable to confirm that at least one member of staff on the interview panel had received Fair Recruitment training. In addition, we also examined a sample of ten internal promotions and TLRs awarded within the past 12 months. However, we noted the following issues; McMillan: • For four role changes (40%), we were not provided with evidence to demonstrate the role was appropriately advertised • For four of the role changes (40%), we were not provided with copies of the applications / letters of interest submitted in relation to the role • For five role changes (50%), we were not provided with evidence of shortlisting • For four role changes (40%), we were not provided with evidence of the interview and assessment process or feedback provided; as a result we were unable to confirm that at least one member of staff on the interview panel had received Fair Recruitment training.		

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	Finding	Recommendation	Management response
▲	**Recruitment and Selection Cont…** Trinity: • For three role changes (30%), we were not provided with evidence to demonstrate the role was appropriately advertised • For one role change (10%), we were not provided with copies of the applications / letters of interest submitted in relation to the role • For five role changes (50%), we were not provided with evidence of shortlisting • For three role changes (30%), we were not provided with evidence of the interview and assessment process or feedback provided; as a result we were unable to confirm that at least one member of staff on the interview panel had received Fair Recruitment training. cannot be evidenced, there is a risk the Trust is unable to evidence that a fair and transparent recruitment and selection process has been followed. In addition, there is a risk the Trust is unable to evidence that fair recruitment principles have been embedded into the interview and assessment process through the delivery of training to staff on the interview panel.		

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	**Finding**	**Recommendation**	**Management response**
▲	**Pre-employment Checks** Pre-employment checks must be carried out once an offer of appointment is made in line with the Safer Recruitment policy; all offers are made subject to a successful enhanced DBS check and satisfactory references. [redacted] However, we identified the following exceptions; McMillan: • For one new starter (10%), we were not provided with evidence of the DBS check; therefore, we were unable to confirm a satisfactory DBS check was conducted prior to the start date • For one new starter (10%), we note that the DBS letter was dated after the employee start date • For one new starter (10%), we were only provided with evidence for one satisfactory reference; therefore, we were unable to confirm two satisfactory references were obtained. • For two new starters (20%), we note that one or more of the references were dated after the employee's start date Trinity: • For one new starter (10%), we note that the DBS letter was dated after the employee start date • For one new starter (10%), we note that one reference was dated after the employee's start date We were not provided with evidence to demonstrate that a risk assessment or Children's Barred list check was completed to compensate for instances where a satisfactory DBS or references could not be obtained prior to the employee start date.	We recommend that management ensure that an enhanced DBS check is performed and two satisfactory references are obtained for all new recruits prior to the their start date; [redacted] measures in the Safer Recruitment policy have been consistently applied. Where an enhanced DBS check or references cannot be obtained prior to the start of employment, there should be a clear audit trail to evidence management has actively chased the items prior to the start date and suitable compensating measures should be put in place to mitigate this e.g. risk assessments.	In the previous 12 months prior to the audit, there has been a change in staff. Samples without evidence in most cases was prior to those currently in role. However, spot checks will continue to [redacted] line with policy. All academies are using a DAT SCR template / supporting guidance to ensure that there are no gaps. ***Responsible Officer: L. Sharp*** ***Implementation Date: Immediate***

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: Human Resources			
Sig.	Finding	Recommendation	Management response
▲	**Pre-employment Checks continued…** Although not required by law, OFSTED state that all schools must conduct an enhanced DBS check for all staff. Therefore if DBS checks are not conducted for all members of staff prior to their start dates, there is a risk that the Trust may fail to comply with OFSTED requirements and may not make suitable and safe recruitment decisions. Furthermore, if two satisfactory references are not obtained in line with the Trust's procedures, there is a risk of individuals being hired who may not meet the requirements of the role or align to the Trust's values.		
●	**Central oversight** Each academy has HR Administrators who are tasked with inputting the HR [illegible] providing the interview panel with the relevant documentation. As noted in findings raised, there could be further benefit from introducing enhanced oversight and monitoring of compliance with Trust procedures whilst Administrators become comfortable with the required controls. Without period review of compliance with required processes, key controls may not be undertaken as required.	We recommend that the central HR function perform period sample testing of the completion of key controls to obtain assurance over compliance.	Sample testing will continue across all academies to ensure key controls are undertaken. The current HR model for the Trust is also under review with a view building capacity and capabilities for the Trust. Responsible Officer: L Sharp Implementation Date: Immediate

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: ITGC			
Sig.	Finding	Recommendation	Management response
	IT Purchasing Procedures Good practice standards relating to IT controls (such as COBIT) highlight the [illegible] infrastructure and also to ensure that change activities (such as the acquisition of devices and applications) are subject to rigorous controls. Budgets for IT spend have been developed for the Trust. However, there would appear to be considerable local discretion at individual academy level regarding such expenditure. Acquisitions are not always made with the involvement (or even knowledge) of the Trust's IT Services function. There is a risk that IT services, solutions and infrastructure purchased by individual academies does not support the strategic direction adopted by the Trust as a whole, leading to inefficient processes in terms of support, licensing and intra-operability. Such acquisitions could also undermine security arrangements and expose the Trust to cyber security and data protection compliance risks.	Management should develop purchasing policies and procedures to ensure all IT-related spend within the [illegible] transparent manner. IT acquisitions should be subject to change management controls that are designed to assess their impact on both the individual academy and the Trust as a whole. The purchasing policies and procedures should be explicitly integrated with relevant information security and data protection policies and standards (e.g. Data Protect Impact Assessments).	Agreed. A new purchasing and asset post has been appointed to in July and will support this recommendation.
	Data Protection Officer The requirements associated with the role of Data Protection Officer (DPO) are set out in the UK General Data Protection Regulation (GDPR) and guidance notes issued by the Information Commissioner's Office (ICO). These include the requirement to ensure that the DPO has sufficient independence and any other tasks they perform do not result in a conflict of interest. The Trust has appointed a DPO who also holds the role of Head of HR. The HR function is responsible for processing significant amounts of personal data (e.g. staff records). As such, the Head of HR currently holds a position within the Trust that leads her to determine the purposes and the means of the processing of personal data. This officer may also manage competing objectives that could result in data protection taking a secondary role to business interests. There is a risk that the Trust will be unable to demonstrate that its DPO is sufficiently independent to perform this role. This could result in the imposition of fines and public censure in the event of an investigation by the ICO (even if the cause of the investigation did not).	Management should consider appointing another individual with sufficient experience and expertise to perform the role of DPO.	Role under discussion as part of organisational review. A request for a link governor will be made at the next TB meeting.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: ITGC			
Sig.	Finding	Recommendation	Management response
	Information Security Responsibility Good practice standards relating to information security (such as ISO 27001) [illegible] unambiguous responsibility for information security within an organisation. No individual within the Trust has been formally assigned responsibility for information security. We note, however, that a proposed structure for a future-state IT function does include the role of 'Cyber Security Lead'. There is a risk that information security may not receive the focused and pro-active attention it requires to ensure that the Trust's data and systems are resilient to a loss of confidentiality, integrity and availability.	Management should appoint an individual with responsibility for information/cyber security across the [illegible] to demonstrate the necessary technical skills to perform this role as well as sufficient authority to ensure compliance.	Post to be advertised and expected in post by December.
	IT Strategy and Performance Measurement Good practice standard relating to IT operations (such as ITIL) and IT controls state that organisations should develop an information technology strategy. Progress towards achieving strategic goals should be regularly reported and monitored by senior management. A strategy has been developed for the IT Services function. It was created in 2019. However, this strategy does not explicitly align itself with the business strategy adopted by the Trust. We understand that no defined business strategy was in place when the IT Services Strategy was written. Although Critical Success Factors (CRFs) and Key Performance Indicators (KPIs) have been defined, and do reflect the strategic goals, these are not used by senior management to monitor progress towards achieving these goals. They appear to be only used as internal metrics and for benchmarking purposes. There is a risk that the direction of information technology within the Trust may not be sufficiently well-defined or understood within the Trust. This may result in a lack of commitment to the strategic goals by senior management and decisions being made that undermine ongoing efforts or create sub-optimal outcomes.	IT management and senior Trust management should agree a strategy that is clearly aligned to the business and educational strategic goals of the Trust. The strategy should assess the current capabilities and limitations of information technology within the Trust, conduct a gap analysis between these capabilities and the strategic goals and define a plan to bridge this gap. Performance against this plan should constitute a key element of senior management's and other key stakeholders' ongoing assessment of the IT functions. Meaningful and achievable CSFs and KPIs should be agreed that enable this monitoring to take place. Significant IT spend and other initiatives relating to information technology should always be taken with reference to the IT Strategy.	Agreed. The IT strategy is under redraft to align and reporting mechanisms for IT as part of the exec meeting structure will be agreed.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: ITGC			
Sig.	Finding	Recommendation	Management response
	Back-up Procedures Good practice standards relating to information security and IT controls strongly emphasise the need to establish robust back-up arrangements for an organisation's data and other information assets. With respect to the potential loss of personal data, this is also a requirement of the GDPR. Robust back-up arrangements have been established for the majority of systems and data held centrally. However, we were unable to confirm that all locally-sourced IT systems, especially Cloud-based solutions, are backed up with the same degree of rigour. There is a risk that data may be lost, corrupted or subject to additional recovery costs due to the lack of robust back-up arrangements.	Management should ensure that all of the Trusts data and systems are subject to formal back-up procedures, monitoring controls and recovery testing.	Plan in place for Cyber lead to take forward when appointed.
	Information Security Policies Good practice standards relating to information security and IT controls stress the need to define and implement robust security policies that clearly express the requirements of senior management and reflect good practice. There is no Trust-wide information security policy in place. An Online Safety Policy and Acceptable Use of Information Technology document has been created, which addresses some aspects of an information security policy. In addition a draft Data Access and Password Policy has been created, but this only applies to systems supported by the IT Services team and has not yet been approved. There is a risk that actions may be taken by individuals or functions within the Trust that threaten the confidentiality, integrity and availability of the Trust's information services and data due to a lack of clear direction with respect to security.	Management should define and implement an information security policy that reflects the circumstances of the Trust, its risk appetite and recognised good practice. The policy should be equally applicable to all central functions and constituent academies. The policy should be owned by a member of the senior management team, reviewed regularly and define responsibility for ensuring compliance.	Draft policy ready for approval.

REVIEW OF 2020-21 WORK

The table below summarises the conclusions from the internal audits completed in the year.

Audit: ITGC			
Sig.	Finding	Recommendation	Management response
	IT Asset Management Procedures Good practice standard relating to IT operations and IT controls highlight the need to establish strong procedures over the management of information technology assets. Starting in October 2020, the IT Services function has established a limited asset disposal and reuse. A more comprehensive process is planned to be implemented by July 2021. An IT Asset Management Policy has been defined, but is still in draft form. However, the Trust lacks a fully comprehensive asset register for IT infrastructure and applications. The effectiveness of these procedures is limited by the purchasing practices highlighted Finding One. There is a risk that the value of IT assets, in terms of their contribution to the effectiveness of the IT services they support, may be over- or under-estimated. Outdated equipment may no longer be supported by manufacturers and appropriate security patches may no longer be supplied. Unanticipated support costs may be incurred. Opportunities to rationalise or exploit existing capabilities may be lost.	Management should ensure that a register of all IT assets, whether supported by the IT Services function or not, is established and that robust procedures are established to ensure [illegible] management procedures should include clear interfaces to IT procurement procedures. The asset register should include non-tangible items such as software licenses as well as physical infrastructure.	Procedures written and ready for roll out. Additional capacity agreed to implement.
	Incident Management Procedures Good practice guidelines relating to information security and IT controls set out the need to manage potential and actual information security incidents in a consistent and controlled manner, i.e., in line with established procedures. There is currently no formal incident management procedure in place. However, work is reasonably far advanced on the design of one and plans exist to implement this by the end of August 2021. This is associated with service levels that will allow senior management to track performance in this area. There is a risk that a security-related incident will not be managed in line with the expectations of senior management or accepted good practice, this may result in the loss of data confidentiality, integrity and availability and/or the failure to identify the root cause of the issue.	Management should ensure that the draft incident management procedure is implemented and associated key performance indicators are reported to senior management.	Procedures in place to implement and associated reporting to action.

ANNUAL STATEMENT OF ASSURANCE

Report by BDO LLP to Dixons

As the internal auditors of Dixons we are required to provide the Board, via the Audit Committee and the Chief Executive with an opinion on the adequacy and effectiveness of Dixons' risk management, governance and internal control processes.

In giving our opinion it should be noted that assurance can never be absolute. The internal audit service provides Dixons with reasonable assurance that there are no major weaknesses in the internal control system for the areas reviewed in 2020-21. Therefore, the statement of assurance is not a guarantee that all aspects of the internal control system are adequate and effective. The statement of assurance should confirm that, based on the evidence of the audits conducted, there are no signs of material weaknesses in the framework of control.

In assessing the level of assurance to be given, we have taken into account:

- All internal audits undertaken by BDO LLP during 2020-21
- Any follow-up action taken in respect of audits from previous periods for these audit areas
- Whether any significant recommendations have not been accepted by Management and the consequent risks
- The effects of any significant changes in the organisation's objectives or systems
- Matters arising from previous internal audit reports to Dixons
- Any limitations which may have been placed on the scope of internal audit.

Opinion

In our opinion, based on the reviews undertaken, and in the context of materiality:

- The risk management activities and controls in the areas which we examined were found to be suitably designed to achieve the specific risk management, financial and internal control frameworks and governance arrangements for the period under review.
- Based on our sample testing, financial and internal control frameworks and governance arrangements were operating with sufficient effectiveness to provide reasonable, but not absolute assurance that the related risk management, control and governance objectives were achieved for the period under review.

This view is given with the exception of the credit cards, HR and ITGC reviews where limited assurance was given.

PROGRESS AGAINST OPERATIONAL PLAN

Proposed Audit	Planned Days	Actual Days	Status
Credit Cards and Expenses	4-6	5	Finalised
Health and Safety	5-7	7	Finalised
Human Resources	5-7	7	Finalised
It General Controls (ITGC)	5-7*	6.5	Finalised
Follow-up	3	3	Finalised

*Changed from 8-10 as agreed with management.

AUDIT PERFORMANCE

AUDIT	DEBRIEF MEETING	DRAFT REPORT	MGT RESPONSES	FINAL REPORT
Credit Cards and Expenses	19 November 2020	16 December 2020	1 February 2021	2 February 2021
IT General Controls (ITGC)	6 May 2021	21 May 2021	22 June 2021	25 June 2021
Health and Safety	1 July 2021	9 July 2021	6 September 2021	6 September 2021
Human Resources	12 July 2021	3 August 2021	6 September 2021	6 September 2021
Follow-up	7 September 2021	8 September 2021	16 September 2021	16 September 2021

On average:

- Reports were issued in draft within 10 working days of completion of our fieldwork and a debrief meeting with management.
- Initial responses were received within 24 working days of the draft report being issued.
- Final reports were issued within one working day of management responses being received.

APPENDIX I - DEFINITIONS

LEVEL OF ASSURANCE	DESIGN of internal control framework		OPERATIONAL EFFECTIVENESS of internal controls	
	Findings from review	Design Opinion	Findings from review	Effectiveness Opinion
Substantial 	Appropriate procedures and controls in place to mitigate the key risks.	There is a sound system of internal control designed to achieve system objectives.	No, or only minor, exceptions found in testing of the procedures and controls.	The controls that are in place are being consistently applied.
Moderate 	In the main there are appropriate procedures and controls in place to mitigate the key risks reviewed albeit with some that are not fully effective.	Generally a sound system of internal control designed to achieve system objectives with some exceptions.	A small number of exceptions found in testing of the procedures and controls.	Evidence of non compliance with some controls, that may put some of the system objectives at risk.
Limited 	A number of significant gaps identified in the procedures and controls in key areas. Where practical, efforts should be made to address in-year.	System of internal controls is weakened with system objectives at risk of not being achieved.	A number of reoccurring exceptions found in testing of the procedures and controls. Where practical, efforts should be made to address in-year.	Non-compliance with key procedures and controls places the system objectives at risk.
No 	For all risk areas there are significant gaps in the procedures and controls. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Poor system of internal control.	Due to absence of effective controls and procedures, no reliance can be placed on their operation. Failure to address in-year affects the quality of the organisation's overall internal control framework.	Non compliance and/or compliance with inadequate controls.

Recommendation Significance	
High 	A weakness where there is substantial risk of loss, fraud, impropriety, poor value for money, or failure to achieve organisational objectives. Such risk could lead to an adverse impact on the business. Remedial action must be taken urgently.
Medium 	A weakness in control which, although not fundamental, relates to shortcomings which expose individual business systems to a less immediate level of threatening risk or poor value for money. Such a risk could impact on operational objectives and should be of concern to senior management and requires prompt specific action.
Low 	Areas that individually have no significant impact, but where management would benefit from improved controls and/or have the opportunity to achieve greater effectiveness and/or efficiency.

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