Audit and Governance Committee Agenda

Wednesday, 10 December 2014
etc.venues, 8th Floor, Tenter House, 45 Moorfields, London EC2Y 9AE

Meeting starts: 10:00 am

1. Welcome, Apologies and Declarations of Interest

2. Minutes of 1 October 2014
   [AGC (10/12/14) 432)]

3. Matters Arising
   [AGC (10/12/14) 433) SG]

4. Regulatory & Register Management
   [AGC (10/12/14) Presentation) NJ]

5. Information for Quality (IfQ) Programme – Managing Risks
   [AGC (10/12/14) 434) NJ]

6. Internal Audit

   a. Progress report Audit 2014/15
      [AGC (10/12/14) 435) LY]

   b. IfQ audit report
      [AGC (10/12/14) 436) LY]

   c. Implementation of Recommendations – Progress Report
      [AGC (10/12/14) 437) SG]

7. External Audit

8. Risk

   a. Strategic Risk Register
      [AGC (10/12/14) 438) PR]

9. Whistle Blowing policy
   [AGC (10/12/14) 439) RH]

10. Resilience & Business Continuity Management
    [AGC (10/12/14) Presentation SG]

11. Action plan following review of AGC activities & effectiveness
    [AGC (10/12/14) 440) SH]

12. AGC Forward Plan
    [AGC (10/12/14) 441) SG]

13. Any Other Business

14. Session for members and auditors only

Close: 1:00 pm (Refreshments & Lunch Provided)
Next meeting: 10:00 am Wednesday, 18 March 2015 London

Audit and Governance Committee Paper

Paper Title	**DRAFT Minutes of the meeting 1 October 2014**
Agenda Item	**2**
Paper Number	[AGC (10/12/2014) 432]
Meeting Date	Wednesday, 10 December 2014
Author	Siobhain Kelly
For information or decision?	Decision
Recommendation	Members are asked to confirm the minutes as a true and accurate record of the meeting.

Members present
Rebekah Dundas (Chair)
Gill Laver
Jerry Page

External attendees
Catherine Hepburn – NAO
Nicholas Todd - NAO
Kim Hayes – DH
Lynn Yallop – PWC
James Hennessey - PWC

Staff in attendance
Sue Gallone – Director of Finance and Resources
Sam Hartley – Head of Governance and Licensing
Siobhain Kelly – Committee Secretary

Apologies
Dr Alan Thornhill

Attendance for specific items:
Nick Jones – Director of Compliance and Information
Juliet Tizzard – Director of Strategy and Corporate Affairs
Stacey Kennedy – Programme Support Officer
David Moysen – Head of IT

1. Welcome, Apologies and Declarations of Interests

1.1 The Chair welcomed all attendees, which included Catherine Hepburn and Nicholas Todd from the National Audit Office (NAO) plus James Hennessey and Lynn Yallop from Price Waterhouse Coopers (PWC).

1.2 Apologies had been received for Dr Alan Thornhill and there were no declarations of interest stated.

1.3 The Chair informed the committee that the Authority would still be running with 10 members instead of 12, as the new member appointments had not yet been made.

2. Minutes of the Meeting held on 11 June 2014

2.1 The Minutes of the meeting held on 11 June 2014 were agreed as a true record of the meeting and approved for signature by the Chair.

2.2 The Director of Finance and Resources drew the committee's attention to 8.7 in the minutes which related to the financial procedures being completed by this meeting, and stated that this would be addressed under the agenda item on audit recommendations.

3. Matters Arising

3.1 The Committee noted the status of the various matters arising and good progress made thus far.

3.2 The committee heard that seven members had now completed the online governance training and the cascade exercise (business continuity) would be completed in November due to resource constraints within the HR team.

4. Annual Report – Lessons Learned

4.1 The committee heard that merging the finance teams of the HFEA and the Human Tissue Authority (HTA) had, as a consequence, had an impact on year end.

4.2 The committee heard that there had been a comprehensive lessons learned document produced which would be for internal consumption only.

4.3 The Chair noted the Lessons Learned Report and thanked all staff that had contributed.

4.4 The committee heard that the HFEA would simplify the format and design of the annual report and accounts for 2014/15, so there would be better internal control of the content. The design of the cover could be managed by HFEA staff that already had the appropriate training.

4.5 The committee noted that an initial meeting with the NAO on lessons learned had been held and that the HFEA had committed to earlier audit dates and preparation of accounts for next year.

4.6 The committee agreed that the HFEA should ensure that all relevant external contacts are established earlier in the process and noted that extra resilience would be built in for next year.

4.7 The Chair thanked Jerry Page for liaising with Civil Service Pensions about delays in receiving pension data and welcomed any feedback that could be provided.

5. Strategy and Corporate Affairs – Update and Risks

5.1 The Chair congratulated the Director of Strategy and Corporate Affairs on behalf of the committee, on her appointment to this Director post. The committee noted the remit of this post which would now include responsibility for licensing and governance, business planning, policy, and communications (comms) and engagement.

5.2 The committee agreed that licensing is one of the main functions of the organisation, and that there were substantial statutory obligations to provide information under Freedom of Information (FOI) and Parliamentary Questions (PQs). Capacity has an impact on the accuracy and timely responses to these.

5.3 The committee noted that though the organisation would be considered small, interest in the HFEA and the sector regulated would be high. The nature, as well as the volume, would place additional pressure on the Executive.

5.4 The committee heard that though representations made against licensing decisions are rare, they would generally consume a lot of management and staff attention. The current representations process would be resuming in October.

5.5 The committee noted that there is a general risk around business planning and project management, mainly around projects being delivered on time with resource.

5.6 The committee noted there would be work for DH coming up on mitochondria which would consume scientific resources and on two new EU Directives. Recruitment from existing staff had taken place to fill gaps.

5.7 The committee noted that staff and member capacity would have an impact on sub committees. Currently the committees were still working effectively, largely due to the goodwill of members. Though this capacity issue should be addressed by the two pending member appointments, there would need to be further member appointments in the spring.

5.8 The committee noted that McCracken had highlighted concerns related to the HFEA's communication with professional stakeholders and the Information for Quality (IFQ) project had raised expectations in the sector.

5.9 The committee agreed that it would be challenging for Authority Members to have oversight over licensing issues, when access to the details needs to be restricted. However, the Head of Governance and Licensing informed the committee that the lessons learned report would be put before them once the representations process and any subsequent steps was concluded.

ACTION:

Action		Owner
5.10	Add Representations lessons learned to AGC forward planner	Head of Governance & Licensing

6. Compliance and Information – IFQ Programme – Governance and Risks

6.1 The committee noted that the Director of Compliance and Information was the Senior Responsible Officer and the Programme Manager had been with the HFEA for a year.

6.2 The committee noted the progress thus far which was set out in the paper and that the six-week consultation had just launched, with stakeholder engagement being central to the whole programme.

6.3 The committed heard that the options appraisal work had concluded and the business requirements work was ¾ complete.

6.4 The committee noted that market engagement with potential suppliers would take place before the official tender process began, and that there had been a lot of interest from suppliers (all on the government framework).

6.5 The SRO informed the committee that supplier engagement should enable the IFQ Programme Board to get a better indication of costs for delivery. The IFQ Board will make proposals to the Authority whilst working closely with DH and the NHS Information Centre (NHSIC).

6.6 A key challenge is migration of Register data to a new database and the Head of IT would be doing research into the best way forward.

6.7 The committee welcomed a member of internal audit attending the IFQ programme board meetings as a 'critical friend' and noted the contracts let and spend thus far that had been identified within the paper.

6.8 The committee heard that this programme would be funded from HFEA surplus and that by the end of next financial year, everything that needed to be implemented would be.

6.9 The committee agreed that a gateway review could be considered, in a light touch way, to provide assurance and approved of the involvement of the Crown Commercial Service (CCS). Jerry Page offered to provide advice on sourcing any gateway review.

ACTION

Action		**Owner**
6.10	Light touch gateway review to be discussed at IFQ programme board meeting.	Director of Compliance & Information

7. Information Assurance and Security

7.1 The committee received a paper on assurance and security. It was noted that there have been no serious incidents relating to the loss of personal data or breaches of confidentiality over the last year and patching had resolved recent bug issues.

7.2 The committed noted the records management system would be reviewed, information assets remained unchanged and information security training would be ongoing.

7.3 The committee noted that the information governance toolkit would be completed and AGC would be informed of the result annually.

7.4 The IT challenges of the proposed office move are being considered.

7.5 The committee noted that there would be internal conversations on information security between the Caldicott Guardian, SIRO and IT and the output would be presented to CMG and more formally to AGC annually.

8. McCracken Update

8.1 The committee noted that seven recommendations had been completed and two were in progress.

8.2 The committee agreed with the conclusion the Authority had drawn, that this work would now be core business and no further reporting would be necessary.

8.3 The committee was informed that there are conflicting demands on the finance resources shared with the HTA, but also synergies. This would be reported to the March meeting in more detail.

8.4 The Director of Finance and Resources assured the committee that further sharing in the finance teams would provide resilience rather than further efficiencies.

ACTION

Action		Owner
8.5	Add report on shared finance resources to AGC forward planner for March	Director of Finance & Resources

9. Risk – High Level Risk Register (HLRR)

9.1 The committee noted that the decision making risk had gone up and all other risks remained the same but the controls had changed.

9.2 The committee agreed that now that the corporate strategy was in place and the business plan agreed, this would need to filter down to individual operational plans.

9.3 The committee noted that the HLRR structure would be reviewed next and operational risks would flow from this. In addition this would continue to be a live document.

9.4 The committee agreed that though Grade A incidents (that had an impact on patients or babies born) were risks to clinics rather than the HFEA, this should be reflected in the detail of appropriate HFEA risks. On a human level, this could be the worst thing to happen to a patient and would matter greatly to the Authority.

9.5 The Chair informed the committee that the HLRR from June 2013 could now be published as more than a year had elapsed (in line with the Authority's publication policy).

ACTION

Action		Owner
9.6	Publish HLLR from June 2013	Committee Secretary
9.7	Finesse HLRR to reflect impact on HFEA from Grade A incidents at clinics	Head of Business Planning

10. Internal Audit – Draft plan – Internal Audit 2014/15 – Progress Report

10.1 The committee heard that the plan had developed to reflect current risks had priorities. The IFQ review was about to take place and Internal audit playing the role of critical friend on an ongoing basis would benefit to the IFQ programme. Particular attention would be given to data migration.

10.2 The committee agreed that internal audit sharing best practice and working with the HFEA as financial procedures are updated would be a suitable way to review this area.

10.3 The committee heard that NAO were meeting with internal audit to determine what level of reliance could be placed on internal audit work.

11. Implementation of Recommendations – Progress Report

11.1 The committee were informed that since the paper was written, a further recommendation had been completed thus ten recommendations were complete and 12 would be outstanding.

11.2 The committee heard that the older recommendations around standard operating procedures (SOPs) and policies would not be completed until the end of the year. The Information Governance policies would be complete by November.

11.3 The committee noted that the 2012/13 recommendations were completed and that there was progress with the newer recommendations.

12. External Audit

12.1 The committee noted the NAO planning report which included the timetable for 2015 work and maintenance of the previous fee. The committee also noted the risk factors identified.

13. Reserves Policy

13.1 The committee heard that the Director of Finance and Resources recommended that the Authority should have a cash reserve that would cover two months of costs (staff and accommodation), positive cash flow and other potential commitments such as legal fees. Kim Hayes, DH left the meeting for the discussion of this item and returned at the end.

13.2 The committee agreed that minimum reserves of £1.52m are required.

13.3 The committee were informed that there had been a dialogue with DH regarding setting a realistic minimum reserves figure in principle and that the amount would now be proposed to DH.

13.4 The NAO informed the committee that the principle of having a treasury management policy was good practice and that the agreed minimum level of reserves seemed prudent.

ACTION

Action		Owner
13.5	Review cash reserves annually – add to forward planner	Director of Finance & Resources
13.6	Conclude negotiations on minimum levels of reserves with DH	Director of Finance & Resources

14. Review of the activities and effectiveness of AGC

14.1 The Chair asked the committee to note that all committees with delegated powers should do this annual review, with a report back to the Authority in the spring.

14.2 The committee noted that the checklist would be the most proportionate way to do this. The Head of Governance and Licensing stated that there were outstanding actions from the previous review and efforts would be made to close these after the meeting.

14.3 The NAO stated that the checklist had been superseded and a newer one would be available shortly.

14.4 The committee agreed that it was not the role of AGC to manage risk, but to provide risk assurance to the Authority.

14.5 The committee discussed the benefits of having the Chief Executive at all meetings. At present risks are discussed with the relevant director.

14.6 The committee discussed moving to a three-meeting per annum model. External members, who were not Authority members of the committee, felt that continuity would be difficult to sustain. In addition, the HFEA would be going through a period of great change with IFQ and changes to Authority membership so regular meetings were necessary. The committee agreed to stay on a pattern of four meetings but to review again in six months.

14.7 The committee agreed that a closed session with members and auditors should be a standing item at the end of the agenda, to be used or not as required.

14.8 The Chair agreed that external members would benefit from attending an Authority meeting and having annual appraisals much in the same way as Authority members experience appraisals.

ACTION

Action		Owner
14.9	External members to attend an Authority meeting. Meeting dates to be forwarded.	Committee Secretary
14.10	Consider providing the Authority with AGC minutes as background to inform update from the AGC Chair	Head of Governance & Licensing

14.11	Consider the Chief Executive attending more than one AGC meeting per year	Head of Governance & Licensing
14.12	Add to the end of the agenda of each meeting a closed session for members and the auditors	Committee Secretary
14.13	Implement annual appraisals for external members	Head of Governance & Licensing
14.14	All AGC effectiveness actions to be added to a separate action plan	Head of Governance & Licensing

15. Forward Plan

15.1 The committee agreed to remove McCracken work which is now complete from the forward planner and move forward internal and external audit plans forward.

16. Any other Business

16.1 The committee noted there had been no actual or suspected fraud and no internal whistleblowing.

16.2 The committee also noted that the Director of Compliance and Information had informed the committee of the only contracts awarded.

Date of the next meeting:

Date: Wednesday, 10 December 2014

Time: 10:00 am

Location: etc.venues, Tenter House, 45 Moorfields, Moorgate, London EC2Y 9AE

I confirm this to be a true and accurate record of the meeting.

Chair _____

Date _____

Audit and Governance Committee Paper

Paper Title:	**Matters arising from previous AGC meetings**
Paper Number:	[AGC (10/12/2014) 433 SG]
Meeting Date:	1 October
Agenda Item:	**3**
Author:	Sue Gallone
For information or decision?	Information
Recommendation to the Committee:	To note and comment on the updates shown for each item.
Evaluation	To be updated and reviewed at each AGC.

Numerically:

- 13 items added from October 2014
- 11 closed.

Matters Arising from Audit and Governance Committee – actions from 19 March 2014 meeting				
INDEX (Date - Para)	**ACTION**	**RESPONSIBILITY**	**DUE DATE**	**PROGRESS TO DATE**
19/03/14 16.9	Ensure cascade calling staff exercise is completed for business continuity	Head of IT	July 2014	**Completed** Exercise planned to take place w/c 1 December 2014

Matters Arising from Audit and Governance Committee – actions from 11 June 2014 meeting			
ACTION	**RESPONSIBILITY**	**DUE DATE**	**PROGRESS TO DATE**
3.2 HFEA to monitor Authority members' completion of online information governance training	Executive Assistant to Chair and Chief Executive	20 September 2014	**Ongoing** Being monitored by Executive Assistant. As at 25 November 2014, 7+ Members had completed the training.

Matters Arising from Audit and Governance Committee – actions from 1 October 2014 meeting			
ACTION	**RESPONSIBILITY**	**DUE DATE**	**PROGRESS TO DATE**
5.10 Add Representations lessons learned to AGC forward planner	Director of Finance and Resources		**Completed**
6.10 Light touch gateway review to be discussed at IFQ programme board meeting	Director of Compliance and Information		**Completed** Agreed appropriate and planned after business case approval and before ITT issued, probably January 2015.
8.5 Add report on shared finance resources to AGC forward planner for March	Director of Finance and Resources		**Completed**
9.6 Publish HLLR from June 2013	Committee Secretary		**Completed**

Matters Arising from Audit and Governance Committee – actions from 1 October 2014 meeting			
ACTION	**RESPONSIBILITY**	**DUE DATE**	**PROGRESS TO DATE**
9.7 Finesse HLRR to reflect impact on HFEA from Grade A incidents at clinics	Head of Business Planning		**Completed**
13.5 Review cash reserves annually – add to forward planner	Director of Finance and Resources		**Completed**
13.6 Conclude negotiations on minimum levels of reserves with DH	Director of Finance and Resources		**Ongoing** Awaiting response from DH
14.9 External members to attend an Authority meeting. Meeting dates to be forwarded.	Committee Secretary		**Completed**
14.10 Consider providing the Authority with AGC minutes as background to inform update from the AGC Chair	Head of Governance and Licensing	December 2014	**Ongoing** Included in annual review of effectiveness action plan and will be completed once December AGC minutes signed by Chair.
14.11 Consider the Chief Executive attending more than one AGC meeting per year	Head of Governance and Licensing		**Completed** Included in annual review of effectiveness action plan and communicated to Chief Exec.
14.12 Add to the end of the agenda of each meeting a closed session for members and the auditors	Committee Secretary		**Completed**
14.13 Implement annual appraisals for external members	Head of Governance and Licensing	March 2015	**Ongoing** Included in annual review of effectiveness action plan
14.14 All AGC effectiveness actions to be added to a separate action plan	Head of Governance and Licensing		**Completed** See agenda item 11

Audit and Governance Committee paper

How this paper relates to our strategy	Setting standards	☐	Increasing and informing choice	☑	Demonstrating efficiency, economy and value	☑
Paper title	Information for Quality – managing risks					
Agenda item	**5**					
Paper number	[AGC (10/12/14) 434) NJ]					
Meeting date	10 December 2014					
Author	Nick Jones, SRO & Director of Compliance and Information					
For information or decision?	Information					
Recommendation	The Committee is asked to note this update					
Resource implications						
Implementation	In progress.					
Communication	Extensive stakeholder communication					
Organisational risk	Medium.					
Annexes	N/a					

1. Introduction

This report updates the Audit & Governance Committee (AGC) on the progress of the programme specifically in the areas covered by the AGC terms of reference.

2. Progress

Since the last meeting of the AGC the business requirements and feasibility review (BRFR) has been completed and the draft report/framework has been received. The review means we are clear as regards a range of aspects as we

edge towards procuring the necessary technical solutions: When finalised the review will clarify:

- The basis of the tender requirements, that is the outcomes we want suppliers to deliver;
- The sequence in which requirements are undertaken – we will want to order in a way that works both from a technical perspective and such that the benefits are visible to our stakeholders in a timely manner;
- The most appropriate balance between procuring the work from external suppliers.

As indicated in the previous paper to this Committee it was considered likely the HFEA's IfQ proposals would be subject to scrutiny by (the portfolio committee of) the Department of Health. We have received confirmation that (despite submitting and receiving approval for a business case at the outset of the programme) we are required to submit a new detailed business case prior to any tendering activity. Whilst this inevitably introduces an additional stage, we welcome the opportunity to expose our plans. Our path will be eased by the extensive user and system research that we can rely on – all in place due to the careful and methodical way that we have approached the discovery phase. Further, we are hopeful that our close working with the Health and Social Care Information Centre and Government Digital Service to date will also be helpful. We are finalising the business case which will be submitted in early December – and it is our hope that a decision will be communicated to us before the end of the financial year.

External and formal consultation on the programme has now completed. A gratifying number of responses (335) were received and 43 people attended two workshops (in Manchester and London). The Advisory Group is receiving reports from its 'expert' groups analysis of the findings, on 9 December 2014.

3. Governance

The IfQ programme board has continued to meet and has reported progress to the October and November meeting of the Corporate Management Group (CMG). In addition, the quarterly CMG risk management meeting in November considered a draft new high level risk register and in particular the capturing of risks to the business strategy of those activities captured within the IfQ programme. The draft register is subject to an agenda item at this meeting.

As reported to the previous meeting of the AGC, the IfQ programme is being developed within the context of a refreshed National Information Board (NIB) arrangement – with the HFEA members of the board. Since the last meeting the Board has published its strategy: *Personalised health and care 2020: a*

framework for action.(https://www.gov.uk/government/publications/personalised-health-and-care-2020). The framework is intended to:

- enable me to make the right health and care choices
- give care professionals and carers access to all the data, information and
- knowledge they need
- make the quality of care transparent
- build and sustain public trust
- bring forward life-saving treatments and support innovation and growth
- support care professionals to make the best use of data and technology
- assure best value for taxpayers

The IfQ programme is central to the HFEAs ability to fulfil these wider objectives, as appropriate to its functions.

A Government Gateway Review has been commissioned to take place on 24th March 2015 prior to contracts being let for implementation in April 2015.

The Authority will receive a detailed set of proposals at its January 2015 meeting requesting authority to proceed to implementation taking into account business case (and decision on approval by DH) and programme definition document setting out scope, budget and timeline, and the report and recommendations from the Advisory Group.

4. Internal Audit

The first Health Group internal audit report of the IfQ programme (with further reviews and reports to follow) is subject to a separate agenda item at this meeting. The SRO and programme team were impressed with the thoroughness and conduct of the review.

5. Report from the our tender panel

In accordance with Standing Financial Instructions the committee is requested to note that no contracts have been awarded since the last meeting:

Recommendation

The Committee is asked to note this report.

HFEA Internal Audit Progress Report 2014/15 - 10th December 2014

1) Purpose of paper:

This paper summarises progress to date against the 2014/15 Audit Plan which was agreed by the HFEA Audit Committee on 1st October 2014.

2) Summary of Progress

Reviews per 2014/15 IA plan	Audit scope per 2014/15 plan	Status	Findings				Overall report rating	Audit days per plan	Actual audit days
			Critical	High	Medium	Low			
IfQ	This review will provide assurance over the IfQ programme using PwC's 'Twelve Elements Top Down Project Assurance Model'. This approach provides a high-level analysis into the immediate and future risks that could affect the delivery of the IfQ programme, and will deliver recommendations and guidance around risk treatment.	Final report issued	0	1	6	1	**Moderate**	10	10
Standing Financial Instructions	This review will provide assurance over current standing financial instructions, including a comparison with HFEA's existing arrangement versus good/best practice. Results of this review will feed into the forthcoming management review of standing financial instructions.	Fieldwork completed 28/11/14						10	8
Internal Policies	We will review the HFEA register of policies and related documents and comment on: • Whether processes to determine the frequency and ownership of policy reviews, including version control, are effective and appropriate; • Whether revised/refreshed policies are subject to appropriate authorisation by the relevant forum; • Whether standing orders and committee terms	ToR agreed. Fieldwork to commence 26/01/15						12	1

Reviews per 2014/15 IA plan	Audit scope per 2014/15 plan	Status	Findings				Overall report rating	Audit days per plan	Actual audit days
			Critical	High	Medium	Low			
	of reference are refreshed on a sufficiently regular basis and are fit for purpose; • Whether policies are appropriately linked with other related policies, standing orders and committee terms of reference; and • Where a refresh to policy is made there are prompt communications to all relevant staff informing them of the policy update.								
Register of Treatments	HFEA is embarking on a significant IT project to improve clinical interfaces with fertility clinics. A high risk element of this project will be the data migration from the current Register of Treatment database to a new database which will be more user friendly and provide a more effective and efficient means of ensuring complete and accurate reporting. This will not be a compliance review; instead internal audit will attend key milestone project management meetings and provide challenge to the project team on progress against milestones and how risks are being mitigated, with a focus on the data migration element of the project. The output from internal audit will be external file notes giving updates from these meetings to the HEFA executive team and Audit Committee.	ToR being drafted						12	0
Audit Management	All aspects of audit management to include: • Attendance at liaison meetings and HFEA audit committees; • Drafting committee papers/progress reports; • Follow-up work; • Drafting 2015/16 audit plan; • Resourcing and risk management; and • Contingency.	N/A	-					10	4
							Total	**54**	**21**

3) Follow-up work

The HFEA performs its own follow-up work where it reviews the status of agreed audit actions prior to each Audit Committee.

As such, Internal Audit has been asked to provide independent assurance only over those agreed actions which relate to critical or high priority recommendations. This approach was agreed with the Director of Finance and Resources.

However, since there are no actions relating to critical or high priority findings remaining from 2013/14 reports, **we have not performed follow-up to date.**

4) Report Ratings - Definitions

The Department of Health have recently refreshed their ratings and definitions which apply to all HGIAS report. These are set out in the table below.

Substantial	In my opinion, the framework of governance, risk management and control is adequate and effective.
Moderate	In my opinion, some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	In my opinion, there are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
Unsatisfactory	In my opinion, there are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

Health Group Internal Audit

REFERENCE NUMBER: HFEA201415001
FINAL REPORT
HUMAN FERTILISATION & EMBRYOLOGY AUTHORITY
NOVEMBER 2014

Health Group Internal Audit provides an objective and independent assurance, analysis and consulting service to the Department of Health and its arms length bodies, bringing a disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes.

Health Group Internal Audit focuses on business priorities and key risks, delivering its service through three core approaches across all corporate and programme activity:

- Review and evaluation of internal controls and processes;
- Advice to support management in making improvements in risk management, control and governance; and
- Analysis of policies, procedures and operations against good practice.

Health Group Internal Audit findings and recommendations:

- Form the basis of an independent opinion to the Accounting Officers and Audit Committees of the Department of Health and its arms length bodies on the degree to which risk management, control and governance support the achievement of objectives; and
- Add value to management by providing a basis and catalyst for improving operations.

For further information please contact:

Bronwyn Baker

01132 54 5515 – 1N16 Quarry House, Quarry Hill, Leeds, LS2 7UE

INFORMATION FOR QUALITY

Overall report rating: Moderate

CONTENTS **PAGE**

Date fieldwork completed:	**17 October 2014**
1st draft report issued:	**26 November 2014**
Management responses received:	**28 November 2014**
Final report issued	**01 December 2014**

Report Author:	Saif Khan
Version №:	2
Date:	01/12/2014

Health Group
Internal Audit

Distribution List – Draft Report

Main recipient

Nick Jones

Cc:

Sue Gallone
Mike Arama
Lynn Yallop (Head of Audit)

Distribution List – Final Report

Main recipient

Nick Jones

Cc:

Sue Gallone
Mike Arama
Lynn Yallop (Head of Audit)

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1. Introduction

1.1 This review is being undertaken as part of the 2014/15 Internal Audit Plan which was approved by the Human Fertilisation and Embryology Authority's (HFEA) Audit Committee.

1.2 Information for Quality (IfQ) is a programme of work which aims to transform the way clinics provide information, the use to which the HFEA puts that information, and how HFEA publishes it through its website.

1.3 Under the original plan, a proof of concept (POC) was expected to have been delivered at the time of this review. However, the programme is currently at the feasibility stage and this includes business requirements clarification and undertaking market testing to explore suitable suppliers of technology solutions.

The programme includes the following five projects:

IfQ01 – Data dictionary project,
IfQ02 – Data submissions project,
IfQ03 – Transaction processing project,
IfQ04 – Data warehouse & reporting project, and
IfQ05 – Web publishing project

2. Review conclusion

2.1 The overall rating for the report is **Moderate** – some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

3. Summary of key findings

3.1 Defining the IT strategy

The IT strategy for the medium and long term has not been finalised. There is a lack of clarity on where IfQ will sit within this strategy and what the "to-be" IT landscape will look like to support the objectives of HFEA.

3.2 Delays in progress against original plan

Under the original plan, a proof of concept (POC) was expected to be delivered at this time. We understand that it was considered necessary to delay the POC as the requirements gathered were not detailed enough to perform a POC to a level that would provide the programme board the level of assurance it desired. It is currently unclear whether the initial high level indicative 24 month timeline for the completion of the programme forecasted in December 2013 still stands or whether there will be slippage to the target December 2015 delivery.

3.3 Programme budget appraisal

Approximately 40% of the overall anticipated programme costs have been spent to date since the revised forecast in December 2013. However, a business case for the programme is yet to be defined and will need to confirm the accuracy of the programme cost estimate of £1.4m. A lack of proper appraisal of the costs may impact accurate justification of the programme business case. Management has stated that appraisal of costs to date is being undertaken however at the time of our review formal evidence to support this could not be provided.

3.4 Risk management

Although risks that the programme faces, such as data migration and data quality issues have been defined and documented, the residual risks or assurance mitigations against these have not been captured.

3.5 Data migration

We acknowledge that the Authority is currently undertaking research to simulate data migration scenarios and the data quality issues are well understood. However, there are no formal controls to address the data quality issues and plans to ensure that data is migrated completely and accurately.

3.6 Stakeholder management

We noted that meetings were held where the needs and interests of different stakeholders' groups were taken into consideration. However, engagement with key operating teams such as IT should be strengthened to determine the expected change in systems landscape and the impact on skillsets, policies, procedures and controls.

3.7 Programme staffing and training

Whilst we acknowledge that the programme is in its early stages, some staff interviewed did comment on concerns with respect to the recent staff turnover and, in pockets, lack of adequate knowledge handover / domain knowledge.

3.8 Independent assurance

There is some independent assurance through Project Management Office (PMO) and Internal Audit (IA) but this can be further strengthen through independent external assurance at key stages of the programme that include the high risk areas such as data quality, Information Security, Disaster Recovery, Third parties and Compliance with regulations.

3.9 Positive Observations

In addition to the above findings, positive observations were also noted and shared with management. In particular, we observed that the initial engagement with stakeholders was conducted and the stakeholders have been mapped. We noted that forums and meetings were held where the needs and interests of different stakeholders' groups were taken into consideration. Whilst this is the case we recommend that the Authority maintains a clear view of the different stakeholder needs to ensure that they are not conflicting.

We also acknowledge that the current risks with regard to the programme, such as data migration and data quality issues are acknowledged. The programme also has an understanding of the challenges and issues that the Authority faces at the moment and these have been captured as risks and issues. We also noted that the programme has adequate governance structures in place.

Our recommendations focus on those where action to address these risks has, at this stage, not yet been documented. These actions, together with the impact on people, processes and budgets will be vital to the success of the implementation of IfQ. We recommend that the Authority continuously focuses on addressing and following up on action plans that have been put in place to manage and mitigate the risks.

During our fieldwork we noted a number of other observations that were not in scope but felt it was appropriate to bring to management's attention in order to add value to the programme as it progresses. These are detailed on Appendix A of this report.

4. Summary of Findings

4.1 The table below summaries the number of findings by rating:

Total Recs	High	Medium	Low
8	1	6	1

4.2 Section 2 of this report includes specific and detailed recommendations against observations and findings. However, the recommendations below are a useful summary encapsulating the common themes.

- Consider finalising the IT strattegy that supports the new business strategy and finalise the programme target operating model based on the wider IT strategy, this would enable the selection of the right suppliers.
- Formalise plans for each phase of the programme to reduce the risk of scope creep and/or significant extension to timelines.

- The programme budget needs to be revisited and a thorough appraisal of the programme costs must be conducted and this should be reflected in the business case.
- The business case and the scope of the functional requirements need to be finalised so that the programme can make decisions whether to proceed to next phases.
- The risk management process need to include strtategies on how the residual risks will be managed and addressed.
- A data migration and quality management plan should be in place, independent assurance needs to be conducted to ensure that the programme migrates the data successfully.
- The programme needs to ensure that there is independent assurance over the key programme risks.

4.3 Further analysis of each recommendation is provided in Sections 2 and 3.

5. Action Required

5.1 Public Sector Internal Audit Standards require you to consider the recommendations made in Section 2; and complete section 3 (Agreed Action Plan) detailing what action you are intending to take to address the individual recommendations, the owner of the planned actions and the planned implementation date. The agreed action plan will then form the basis of subsequent audit activity to verify that the recommendations have been implemented effectively.

5.2 Finally, we would like to thank Members and management for their help and assistance during this review.

2 Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
Medium	**1**	**The IT strategy needs to be updated and finalised**		
		We acknowledge that an overall vision and some business objectives have been set. However, an IT Strategy, aligned with business strategy, has not yet been formally documented. Our review showed that the current IT strategy has not been adequately defined but will be updated based on the programme implementation as well as consideration around infrastructure requirements and the target operating model. The data security and end point security requirements are still being defined as well. We also noted that a clear view of the regulatory requirements for data security is also not in place.	Lack of alignment of the programme to the organisational and IT strategy may lead to directing resources in a manner that is not effective and efficient.	The IT strategy needs to be defined upfront and the programme and changes within the IT environment need to be aligned to the wider IT strategy in order for IT to effectively meet business and regulatory needs.
Medium	**2**	**Delays in progress against original plan**		
		Under the original plan, a proof of concept (POC) was expected to be delivered at this time. However initial requirements gathered were not detailed sufficiently to progress with the POC to a level that could provide sufficient assurance to the programme board. Subsequently the programme approach, scope and timelines have since been revised to allow further work to be performed to	Lack of clearly defined plans will impact the progress of the programme against the original plan.	Develop detailed plans in conjunction with the key stakeholders for each phase of the programme, so that keys steps, dependencies and durations are captured earlier on and reduce the risk of scope creep and/or significant extension to timelines.

2 Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		capture detailed requirements. It is unclear at this stage whether a standalone POC will still take place or built into the implementation phase and whether the anticipated programme duration of up to 24 months for 2015 completion is still possible.		
High	**3**	**Current budget needs to be revisited**		
		The exact programme of work, costs and timelines will be confirmed in the business case that will be developed post completion of the 'Requirements gathering and Feasibility' phase. In February 2013, the outline business case anticipated the overall cost to be £0.6m (+/- 20%). By December 2013 the high level costs for the programme were expected circa £1.4m. We understand through discussions that the increase was largely due to the expansion of the programme's scope, following the technical appraisal and inclusion of changes to HFEA website & CaFC. The current budget of £1.4m should be revisited considering that the programme is still in the feasibility stage and that approximately 40% of the budget (£1.4m allocated from internal financial resources by the Director of Finance and approved by the Authority), has been spent to date.	Inadequate budgeting process and lack of reasonable budget assumptions would lead to potential overruns requiring further approval of extra budget resources. This in turn could lead to misdirecting of business resources severely impacting the success of the programme.	The programme budget needs to be revisited and a thorough appraisal of the programme costs must be conducted and this should be reflected in the business case. Furthermore, based on the correct programme costs appraisal, the business can make an informed decision on whether to undertake the programme or not. The earned value of the programme should be continously monitored and corrective actions taken.

2 Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
Medium	**4**	**Management of risks**		
		The current risks that the programme faces such as data migration and data quality issues have been documented. We also noted that risks registers and issue logs are maintained and there is adequate reporting to the CMG. However, the risk register does not formally capture the residual risk or the assurance obtained over those mitigation actions.	Lack of a comprehensive risk management approach may mean the programme may not fully address the identification and mitigation as well as monitoring of programme risks.	We recommend that a risk mitigation process that includes contingency plans and residual risks be documented. The trend of increase / decrease in risk profile over time should also be understood and there should be ongoing independent assurance over the management of program risks.
Medium	**5**	**Data Migration**		
		Data migration is acknowledged as a key risk and a key requirement to informing the POC and implementation phase. Subsequently on 21st July, 2014 the programme board agreed for IT to commence research on migration of the register data. The data migration strategy will be critical to informing: • Data quality standards; • Ensuring the data directory from source to target is mapped in line with requirements and linked to the data dictionary that has been produced via a separate programme. The data migration strategy should also include	Lack of a data migration strategy and execution plan/cut over plans to may mean that the programme goes live with erroneous data which would severely impact the business operations and the reputation of the Authority.	A data migration and quality management plan which includes formal controls around data migration and quality needs to be put in place. Independent assurance need to be given over the data migration and reconciliation.

2 Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		approach, data mappings, reconciliations and User Acceptance Testing (UAT) at key stages of the programme for all 'in-scope' system environments (circa 30+ systems to be replaced). We understand that the initial data migration strategy will be developed in December 2014.		
Medium	**6**	**Engagement with stakeholders**		
		We noted that advisory and expert groups are in place and that meetings were held where the needs and interests of different stakeholders' groups were taken into consideration. However engagement with key operating teams such as IT, who would be a key enabler for the programme, should be strengthened and engaged as soon as possible. Some stakeholders were unsure of their role post December 2014 as the programme looks to move into the next phase (implementation phase).	A lack of engagement by key internal stakeholders can lead to staff not buying into what is to be delivered and loss of their support.	Key internal stakeholders should be carefully managed and monitored throughout the lifecycle of the programme to encourage engagement and support.
Low	**7**	**Programme needs to be adequately staffed and team adequately trained.**		
		There have been a few changes in key programme team members in recent months. Whilst we acknowledge that the programme is in its early stages we came across some concerns, from staff interviewed, with respect	Key knowledge or experience may be lost through changes to personnel and programme may be	Formally consider training and introducing handover and induction arrangements when new employees are boarded on the programme.

2 Detailed Findings

IMPORTANCE	NO	FINDING/OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
		to the recent staff turnover. It was acknowledged by staff that the handover process /knowledge transfer is adequate although there were instances quoted where this could perhaps be improved and formalised further to enhance domain knowledge.	negatively impacted due to lack of key skills.	
Medium	**8**	**Independent assurance**		
		We noted that there is support and assurance provided by PMO and independent assurance over project management. However, however independent (external) assurance at key stages of the programme has not yet been considered in the plan. At a minimum, areas for consideration should include high risk areas including: • Data Migration and quality • Data Protection, compliance & Information Security • Disaster Recovery • Third parties • Compliance with regulations	Lack of independent assurance over these key areas of the programme may mean significant programme risks are not adequately managed on an ongoing basis.	The scope of work for programme assurance should be defned including assurance activities in relation to the pject phases and articulation of programme risks that the piece of external assurance addresses.

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

To be completed by Health Group Internal Audit as part of the recommendation follow-up process

№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
1	The IT strategy needs to be defined upfront and the programme and changes within the IT environment need to be aligned to the wider IT strategy in order for IT to effectively meet business and regulatory needs.	**M**	The strategy and IfQ can be worked up in parallel. An IT strategy is in development to take into account wider infrastructure developments (e.g. cloud hosting), office relocation, and the IfQ programme. CMG and SMT have considered 'first principle' proposals and the strategy will be worked up fully in the new year.	Nick Jones, 01/04/15		
2	Develop detailed plans in conjunction with the key stakeholders for each phase of the programme, so that keys steps, dependencies and	**M**	Yes, this will be defined in the programme definition.	Mike Arama, 01/04/15		

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

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№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
	durations are captured earlier on and reduce the risk of scope creep and/or significant extension to timelines					
3	The programme budget needs to be revisited and a thorough appraisal of the programme costs must be conducted and this should be reflected in the business case. Furthermore, based on the correct programme costs appraisal, the business can make an informed decision on whether to undertake the programme or not.	**H**	1) Yes, costs will be articulated in the new business case. 2) Earned value will be added to the programme Board reporting.	1) Mike Arama, 01/04/15 2) Mike Arama, 01/04/15		

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

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№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
	The earned value of the programme should be continously monitored and corrective actions taken.					
4	We recommend that a risk mitigation process that includes contingency plans and residual risks be documented. The trend of increase / decrease in risk profile over time should also be understood and there should be ongoing independent assurance over the management of program risks.	**M**	Yes, Gateway review booked for 26/03/15.	Nick Jones, 30/04/15		
5	A data migration and quality management	**M**	Yes, a third party has been commissioned to	Mike Arama, 31/01/15		

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

To be completed by Health Group Internal Audit as part of the recommendation follow-up process

№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
	plan which includes formal controls around data migration and quality needs to be put in place. Independent assurance need to be given over the data migration and reconciliation.		produce a data migration strategy and formal controls for the migration and reconciliation.			
6	Key internal stakeholders should be carefully managed and monitored throughout the lifecycle of the programme to encourage engagement and support.	**M**	Yes, internal stakeholders will be part of the new Programme communications plan.	Mike Arama, 31/03/15		
7	Formally consider training and introducing handover and induction arrangements when new employees are	**L**	Yes, formalised handover in place.	Helen Crutcher, 30/11/15		

3 Action Plan

Customer to provide details of planned action; owner and implementation date. Action taken will later be assessed by Health Group Internal Audit, and therefore the level of detail provided needs to be sufficient to allow for the assessment of the adequacy of action taken to implement the recommendation to take place.

To be completed by Health Group Internal Audit as part of the recommendation follow-up process

№	RECOMMENDATION	RATING	AGREED ACTION	OWNER & PLANNED IMPLEMENTATION DATE	OBSERVATIONS: RECOMMENDATION / AGREED ACTION IMPLEMENTED?	FURTHER ACTION REQUIRED?
	boarded on the programme					
8	The scope of work for programme assurance should be defned including assurance activities in relation to the programme phases and articulation of programme risks that the piece of external assurance addresses.	**M**	Yes, Programme Assurance will be detailed in the Programme Definition Document.	Mike Arama, 31/03/15		

4 Report Rating - Definitions

Substantial	In my opinion, the framework of governance, risk management and control is adequate and effective.
Moderate	In my opinion, some improvements are required to enhance the adequacy and effectiveness of the framework of governance, risk management and control.
Limited	In my opinion, there are significant weaknesses in the framework of governance, risk management and control such that it could be or could become inadequate and ineffective.
Unsatisfactory	In my opinion, there are fundamental weaknesses in the framework of governance, risk management and control such that it is inadequate and ineffective or is likely to fail.

Appendix A – Other Observations

OBSERVATION	RISK/IMPLICATION	RECOMMENDATION
Clarity of scope of next phases		
The programme is still in its early stages and key decisions are yet to be made over the direction, scope and approach for the next phases of the programme. We understand that the programme will be making a decision with regard to the direction and the next stages of the programme in December 2014. We noted that the scope is not yet defined and understood by both the programme team and the wider business. We also noted that the business case is not yet finalised to inform high level scope definition.	Lack of timely definition of programme scope may lead to unmanageable programme scope that may lead to lack of delivery of the programme. Furthermore if the scope is not robustly defined, there may be unmanageable change requests during the programme and after the programme has gone live to address some unforeseen business requirements.	The business case and the scope of the functional requirements need to be finalised to inform programme decisions and to avoid scope creep during the later stages of the programme. **Programme response:** We will ensure the scope of subsequent phases is articulated in accordance with *Managing Successful Programmes*.
Clarity of benefits		
We noted that the programme has defined broad benefits that the Authority would benefit from the IFQ programme but there is not specific and measurable benefits defined. We also noted that realisation plans that include the owners of the benefits are not in place. We acknowledge that the Authority is currently conducting workshops that would upskill the programme team on benefits management process.	Lack of clear articulation and measures and KPIs of benefits could lead to missed opportunities and insufficient monitoring of the success of the programme.	The program needs to establish a robust benefits management and benefits realisation plan in line with the benefits that have been defined in the business case. **Programme response:** We will ensure that clear benefits and a benefits realisation plan is in place in accordance with *Managing Successful Programmes*.

Appendix A – Other Observations

Change needs to be formally managed		
We noted that IfQ will drive a significant change within the organisation, with its business model having an impact on the culture and behaviours of the organisation. At this stage, there were no formal plans to manage these changes within the organisation during the rollout of the system The implementation of IfQ is expected to drive a significant change in the operations of the organisation and its interactions with business partners for the capture and processing of information. At this stage, there were no formal plans to manage these changes in the culture and behaviour of the organisation to facilitate a smooth rollout of IfQ.	Lack of formal change management and support from the internal stakeholders may impact the programme negatively.	We recommend that the new changes are managed in a formal and structured manner that would enable an environment where the programme would be embraced fully through enablement of highly motivated teams. **Programme Response:** We will ensure plans are in place to manage the change.
Current systems design documentation needs to be improved		
The programme aims to replace 30+ systems that are currently enabling business processes for the Authority. It came to our attention that there is no adequate system documentation of the current systems in terms of their technical functionality including coding. We also learnt that there is no adequate documentation of the current data sets and justification of why the current data items are collected. We acknowledge that there are some forms of spreadsheets with information about data items that individuals have completed over the years. We also understand that this knowledge rests with few individuals within the IT and the business teams.	There is risk with regard business continuity due to key-man dependency. This could impact the productivity and the assessment of the AS-IS state of the IT systems and the detailed definition of the requirements.	We recommend that documentation of the current systems designs is completed to ensure that there could be effective means of knowledge sharing and increase in productivity if there are new members on the programme. This would also enable smooth cutover processes during and post programme go-live. **Programme response:** We will ensure appropriate documentation for new systems rather than documenting existing systems which will be redundant within the next 12 months.

Audit and Governance Committee

Paper Title:		**Implementation of Audit Recommendations – Progress Report**
Paper Number :		**[AGC (10/12/14) 437) SG]**
Agenda Item:		**6c**
Meeting Date:		01 October 2014
Author:		Wilhelmina Crown
For information or decision?		Decision
Resource Implications:		As noted in the enclosed summary of outstanding audit recommendations
Communication		CMG
Organisational Risk		As noted in the enclosed summary
Recommendation to the Committee:		AGC is requested to review the enclosed progress update and to comment as appropriate.

Annexes		**Summary of Recommendations**		
Recommendation Source	**Status / Actions**	**2011/12 & 2012/13**	**2013/14**	**Total**
Internal – *DH Internal Audit*	*To complete*	*2*	*4*	***6***
	Complete	*-*	*5*	***5***
External Auditor – *NAO*	*To complete*	*-*	*2*	***2***
	Complete	*-*	*-*	***-***
COUNT		***2***	***11***	***13***

1. Report

1.1. This report presents an update to the audit recommendations paper presented to this committee in October 2014.

1.2. No new recommendations have been added since the last meeting of this Committee.

1.3. Recent updates received from Action Managers are recorded under a November heading in this document.

1.4. Five recommendations are noted as completed and the remaining eight are in hand.

1.5. The remaining outstanding recommendations are classified as (M) or (L) as low. None is classified as high.

1.6. Progress with the implementation of the remaining outstanding audit recommendations will be provided to future meetings of this committee and to CMG on a quarterly basis.

2. Recommendation

AGC is requested to review the enclosed summary of recommendations and updated management responses and to advise whether they have any comments or queries in respect of them.

2011 - 12	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
2011-12	Review of Supplier Maintenance	1	**Guidance for Supplier Maintenance:** Documentary guidance exists which sets out the financial authorities and responsibilities over procurement, purchasing and payment for goods and services. However, some of the detailed guidance needs to be updated. The HFEA Ordering and Payment Procedures are based on the Barclays Business Master system, which has been replaced by the Barclays Internet Banking system. The HFEA Financial Reporting Procedures do not reflect the current suite of management accounting reports.	L		HFEA Ordering and Payment Procedures should be updated to reflect the use of the Barclays Internet Banking system. HFEA Financial Reporting Procedures should be updated to reflect the current suite of management accounting reports.	Agreed. The Financial Procedures will be updated to reflect this and other recommendations arising from this audit, and also updates to the Authority's Fraud and Anti-Theft Policy. **June 2012 update:** The finance procedures have been revised in draft and presented to CMG. Recommendations from the meeting are due to be incorporated and finance training arranged for staff new to their financial responsibilities / who would like a refresher. **September 2012 update**: The Financial Procedures – the main document setting out procedures and processes for all staff – have been updated and are on the intranet. Revisions include reference to the Fraud and Anti-Theft Policy; changes in staffing; and enhancement of T&S information in line with DH policy. The detailed procedures in use by only the finance team have been substantially updated. The banking procedures refer to Barclays Internet banking. Some detailed procedures remain to be updated, it is anticipated this will be completed by end October. **November 2012 update:** The finance SOP on the HFEA's Ordering and Payment of goods and services has been updated to reflect the use of Barclays Internet Banking. The imminent delivery of the SAGE 200 project will radical transform the financial system and processes currently in place. It is therefore recommended that all other documents are reviewed after the new system is introduced. **March 2013 update:** The Sage 200 project is underway. The financial procedures and finance team SOPs will be subject to material revisions to reflect the forthcoming (1 April 2013) introduction of WAP (to facilitate online processing of purchase orders to payment). **June 2013 update:** Pending resolution of the technical problems with the new WAP system the revisions to the financial procedures were also delayed. The WAP system went live on 3rd June and revised summary financial procedures are to be presented to this meeting. Some of the individual detailed procedures will be completed subsequently. **Aug 2013 update**: Delayed due to finance team restructuring. In addition, an annual review of the existing suppliers database will be written into the standard operating finance documentations which is planned to be completed by November 2013 **Nov 2013 update** Now expected in Dec 2013 **Feb 2014 update** A review of time and availability resources has necessitated moing this piece of work back in Q1 of 2014-15. This rrecommendations relates to the updating of SOP's which are internal to finance staff only. **May 2014 update** Awaitng completion by Director of Finance and Facilities Internal audit planned in Q1 2014/15 to update this recommendation **September 2014 Update** Finance policies and SOPs to be updated. **November 2014 Update** As above. Financial controls audit is to look at existing policies to highlight "gaps" and any identifeid will be incorporated	*Head of Finance*	Apr-12 Jul-12 Oct-12 May-13 March / April 2013 Jul-13 Nov-13 Dec-13 Apr-14 Jun-14 Dec-14 Feb-15

2011 - 12	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
	Data Confidentiality	4	**Information Asset Register** A number of policies are in place that relate to the management of information, including: · Information Classification and Retention; · Records Management; and · Information Access. These policies do not reference HFEA's Information Asset Register (IAR) which is used to apply a security classification to information assets. HFEA use different security classifications to define the controls which are to be applied to data sets.	L	Polices related to information management may be applied without consideration of the security classifications documented in the IAR.	Management should review the policies related to information management to consider whether those policies require linking to the IAR.	**1. This is a good suggestion which we will progress during 2012.** **November 2012 update** In progress, a meeting has been arranged to initiate changes. **March 2013 update**: The OGSIRO has recently issued documents relevant to risk appetite and security for information assets. This needs to be taken account of in the review, which has been delayed. **June 2013 update**: Work delayed **Nov 2013 update** Now expected in Dec 2013 **Feb 14 update** - due to workload pressures, this has been delayed again. It is now firmly scheduled to be completed end March 2014 **May 14 update** Policies to be updated after IfQ changes - discussion to take place by end June 2014 to see if interim update possible **September 2014 Update** These policies form part of the Information Governance toolkit and are currently being reviewed. It is anticipated that the reviews will be completed by November 2014. **November 2014 Update** Work in progress	*Director of Finance / SIRO* *Head of IT*	**Nov-12** **Dec-12** **May-13** **Sep-13** **Dec-13** **Apr-14** **Dec-14** **Nov-14** **Jan-15**

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
P C W	PAYROLL & EXPENSES	1	**Arrangements for verification of mileage claims** There are no formalised arrangements for verification of expense claims relating to mileage. Individuals will submit claims for miles travelled that have to be authorised by line-managers in the normal way, but there are no arrangements for ensuring that claims are sufficiently detailed to identify start and end locations of journeys and individual mileages and to verify that these distances are reasonable on a sample basis. We were informed by management that introducing this type of control is something that they are looking to do in the near future	M	Individuals could inflate the number of miles they are claiming to have travelled, thereby resulting in financial loss to the Authority	Management should devise a control process whereby all mileage claims are suitably detailed and then a sample of journeys checked for reasonableness. The existence of such a process has a deterrent effect, which may mean that testing can be on only a small sample of claims	**Agreed (since the introduction of WAP).** **Testing for an upgrade to the WAP system with google map features is imminent and will help when it is rolled out.** **February update** Due to workload pressure, testing is delayed to April 2014 and roll out will be May 2014 **May update** Due to workload pressure, testing is delayed to June 2014 and roll out will be July 2014 **September 2014 Update** WAP testing continues and new queries were recently raised with Sicon. It is anticipated that depending on Sicon's availability when testing is completed, that the upgraded system will be rolled out before the end of September **November 2014 Update** Subject to confirmation, the upgrade to WAP is planned for week beginning 24/11/14. In addition, mileage on expense claims submitted in hard copy using our T&S form are sample checked. **Recommendation completed**	Finance & Accounting Manager	**December-13** **May-14** **July-14** **end Sept / Oct 14** **Complete**
	RISK MANAGEMENT	1	**The Authority does not have a formalised risk management strategy, policy or procedures**	M					
			The Authority has not documented a risk management strategy, policy or procedures. Information on areas such as risk appetite and the objectives of risk management are only set out within the Annual Governance Statement (AGS). Typically organisations will define a risk management strategy and framework and ISO 31000 "Risk Management – Principles and Guidelines" describes having a framework for implementing risk management. Related guidance from the Institute of Risk Management, The Public Risk Management Association and Association of Insurance and Risk Managers talks about an organisation describing its framework for supporting risk management by way of the risk architecture, strategy and protocols. This is seen as a way of communicating on risk issues and setting out the roles and responsibilities of the individuals and committees that support the process. The risk strategy should also set out the objectives that risk management activities in the organisation are seeking to achieve and the protocols and procedures by which the strategy will be implemented and risks managed. In practice, HFEA has a continuous process of monitoring and managing risk, and there is a structure of oversight and review in operation. However, the Head of Business Planning has a key role in driving these processes, including briefing new staff, determining tolerances for individual risks in the context of the overall statements in the AGS and monitoring top operational risks to identify any that need to be escalated to the HLRR. These conclusions are then subject to a degree of later		Reviewing the AGS may not effectively incorporate an appropriate review of the organisation's risk management appetite and strategy. In the absence of a formal strategy policies, procedures and risk management processes may not be clearly and consistently applied across the organisation, exposing the Authority to risks above its risk tolerance. In the event of a change in personnel, the process may be at greater risk of not continuing to operate satisfactorily.	The Authority should formalise a Risk Management Strategy, Policy and procedures that builds on the content of the AGS and provides guidance on the application of risk management across the Authority.	**Finding accepted. Draft Risk Management Policy to June 2014 AGC** **September 2014 Update** An advanced draft of the strategy went as planned to June AGC. Further work will follow over the next few months as we proceed to review our risk register in light of the new Strategy agreed at July Authority. **Plus any subsequent actions - to be completed by December 2014** **November 2014 Update** Risk policy is in place and will continue to be updated to reflect latest practice, as other work on the risk system is completed, as part of ongoing business as usual. It is therefore proposed that this item now be marked **'completed'**. **Recommendation Completed**	HoBP	**June 2014** **Complete** **December-14** **Complete**

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
		2	**Risks are significantly summarised within the HLRR and the supporting Assurance Framework has yet to be prepared**	M					
			We noted that the risks within the HLRR are summarised to a significant degree with a large number of contributory factors. For example: • The risk around decision making quality has a number of causes including decision-making apparatus, representation and appeals processes, workload pressures, governance transition programme and business/admin processes, practices and behaviours. Business/admin processes, practices and behaviours itself then refers to document management, risk and incident management, data security and finance processes. • The statutory and operational systems and delivery risk relates to operational delivery and business continuity being hampered by unreliability in, or excessive demand on, key statutory and infrastructure systems. Causes are reliability of a range of IT and non-IT systems, excessive demand on various processes, data integrity, records accuracy and behaviours. Whilst we can see how the underlying factors draw together into the overall risk, at this summarised level it becomes more difficult to evidence the alignment of controls and assurances against the overall risk. Each risk has a series of controls identified, but they are not directly aligned to each underlying cause of the overall risk and if every control in the organisation relevant to possible factors impacting the risk were listed the HLRR would be unmanageable. In some organisations, many of these causes and underlying controls would appear as risks within a risk management system in their own right, and of course in HFEA a number will be within the operational risk registers. However, we believe that what this highlights is the need for development of an Assurance Framework, as management have identified, that would sit behind the risk register and provide a more detailed level of information on individual controls, risk mitigations and sources of assurance within the business.		The HLRR may not provide sufficient detail to ensure that controls to address the broad nature of identified risks are adequate and that there is sufficient assurance over the continued, satisfactory operation of those controls	As intended, an Assurance Framework should be developed showing the alignment of controls, mitigating actions and sources of assurance relating to the risk of breakdown in areas underlying the high level risks.	**Accepted in part. We will need to approach this finding in a proportionate and manageable way. Our proposed actions are:** **1. To review our operational risk system to ensure it is being used fully and consistently across the organisation – the aim being to ensure operational risk is managed in a coherent and comparable way between all teams. This will help our overall risk assurance. The Head of Business Planning to start on this following Corporate Strategy work. For completion by the scheduled CMG review 11/ 14** **2. Revise the High Level Risk Register template to make more apparent the linkages and lines of sight between causes/sources of risks and the corresponding controls.** **Head of Business Planning – part of AGC paper for 06/14** **<u>September 2014 Update</u>** Most of this work will form part of the post-Strategy review of the whole content and lay-out of the risk register, but efforts have already been made to make the lines of sight more obvious, as indicated above. **3. Explanation of whole current risk system (all levels) to June AGC, for clarity (particularly for the newer members / attendees who will not be aware of all aspects of our risk management system). Head of Business Planning to work with CMG and members to consider this between 07/14 & 01/15** **4. Regarding the composite nature of our strategic risks, we will consider whether to break these down into smaller components when we review the high level risk register following the setting of our new strategy. (However, for the time being we are satisfied that the composite approach is sufficient and effective at the strategic risk level.) Head of Business Planning to work with CMG to assess usefulness and possibilities of RAM, inc resource implications To agree our approach by 12/2014** **<u>November 2014 Update</u>** A revised version of the high level risk register will be brought to the December AGC meeting for comment. This has been redesigned to take in the audit recommendations, as well as the HFEA's strategy.	HoBP	**February-15** **June-14** **Complete** **January-15** **December-14** **Complete**

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
							5. Risk Assurance Mapping – we will consider what other small organisations do, and review whether it would be worthwhile and feasible for the Authority to adopt a similar approach. Meanwhile, some of our other planned actions, listed in this report, will increase the amount of risk assurance built into our existing risk management processes. **September 2014 Update** Via a useful DH Risk Assurance Network meeting in July (the first one of an ongoing series), we have made a useful contact at the CCQ, who are also considering how to introduce risk assurance in a manageable and proportionate way. It is likely that we will be able to adopt some of their methodology, which they are kindly sharing with us as they continue to develop it. This work will be considered following the more urgent work to align all of our planning, performance measurement and risk documentation to the new strategy, and will form part of the future review of our operational risk management system (since the same managers will be central to assurance mapping). **November 2014 Update** Risk assurance mapping will be explored alongside the redevelopment of our operational risk system. The recent development of DH's risk and assurance network has already proved useful in this regard, and the CQC (also new to risk assurance as an activity) have kindly shared their process with us. It is likely that we will be able to adopt a very similar approach. Resource implications will remain an important factor in agreeing the detail of this, and this will be discussed in more detail at CMG (most likely in the new year).		**March-15**
		3	**Setting of tolerance for risk generally and for individual risks**	M					
			The Authority has stated that its tolerance for risk is medium. However, there is no direct linkage between this and individual risk tolerances. Tolerances for individual risks are determined by the Head of Business Planning as high, medium or low based on her general perspective and understanding of the business, and against the overall policy of the Authority that HFEA has an attitude to risk that is "proportionate and balanced" and an appetite that is "medium". These individual risk tolerances are then part of the information reviewed by CMG, AGC and the Authority. We also noted that the tolerance for the risk "Achieving organisational change alongside effective resource management" is stated in the HLRR as "high" notwithstanding the overall medium risk appetite.		There may be difficulty interpreting the Authority's risk tolerance into practical levels that determine whether to tolerate or take action on individual risks. Whilst practically there is a high level of review of actions against risks, it is still more difficult to articulate the link between the stated Authority tolerance and its application in practice. As a result, risks in excess of the Authority's tolerance may be accepted.	The Authority should consider whether it can refine its statement of risk tolerance by setting tolerance levels for key types of risk in terms of risk scores, for example licensing, regulation, provision of information etc.	**Accepted to some extent. The general point can be addressed in a proportionate way through the planned written policy (see response to rec. 1 above). This will include an explanation of our overall attitude to risk, our approach to setting individual risk tolerance levels (as opposed to overall organisational risk appetite), and an explanation of the roles of the Head of Business Planning, other Heads and Directors, and CMG, in relation to the setting of risk appetite and risk tolerances. It will also describe the practical limitations that exist in relation to setting meaningful numerical tolerance limits in relation to the areas suggested. We believe that this will usually not be applicable owing to the nature of the risks we encounter. NB: For information, since the ALB review period of uncertainty ended, we have lowered our overall risk appetite, as an organisation, from 'medium' to 'low'.** **September 2014 Update** This was addressed in the paper to June AGC describing the current risk system, and will be wrapped into further work on the policy. **November 2014 Update** See above update under risk item 1. It is also anticipated that taking a less composite approach, in the newly redesigned HLR register, will make tolerances easier and more meaningful to set in practice. This aspect will be kept under review, and the concepts of appetite and tolerance (which are not quite the same thing) will also continue to be a subject of discussion at meetings of CMG and at the DH risk and assurance network, which the ALBs intend to use for developing best practice in areas like tolerance, assurance, and so on. Given the long term nature of these developments, and the fact that the point is largely met, this point could now be marked as **'completed'** and incorporated into our business as usual quarterly reviews. **Recommendation Completed**	**HoBP**	The approach **June 2014** AGC paper (see rec. 1 response). **December-14** **Complete**

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
		4	**High Level Risk Register does not explicitly assign timescales to future actions or predict the likely residual risk once they are completed**	L					
			The High Level Risk Register contains a good level of detail on individual risks, including the causes and effects, current controls, tolerability and further controls required. We see this as good practice and beyond the level of detail that many organisations include. The same applies to having assigned individual risk tolerances. However, we also noted that there is no timescale explicitly attached to completing the identified actions by which risks will be reduced, nor any clear prediction of the expected residual risk once the actions have been taken or at a point in the future (e.g. by financial year end). Some organisations have incorporated such details into their risk registers in order to provide a clearer view of future expectations and to allow closer monitoring of the delivery of required actions.		Lack of clarity over timescales and the impact of identified actions may make it more difficult to monitor timely completion and to identify at an early stage whether the actions being taken are adequate.	Consider the benefits of including target completion dates for planned actions and an estimate of future residual risk once the actions are completed within the HLRR.	**Part accepted. We think there is value in adding target completion dates for planned actions. But estimating the impact on residual risk of each control seems disproportionate.** **Head of Business Planning to add target completion dates for each planned control when the risk register is next reviewed by CMG following the publication of our new strategy.** **September 2014 Update** The work to review the High Level Risk Register in line with the new Strategy is beginning now, and we will incorporate completion dates where relevant from that point on (and, where we already know such dates, some can be added immediately, ready for the next full CMG review on 10 September). **November 2014 Update** A revised version of the high level risk register will be brought to the December AGC meeting for comment. This has been redesigned to take in the audit recommendations, as well as the HFEA's strategy. A completion date for mitigating actions (where relevant) has been incorporated into the new structure, and so this recommendation can now be viewed as **'completed'.** **Recommendation Completed**	HoBP	**Target date: August 2014.** **October-14** **Complete**
	CORPORATE GOVERNANCE	1	**The Authority receives only a verbal update from committee chairs on the business undertaken by committees**	L					
			The Authority receives feedback on the activities of committees through verbal updates by the relevant chairs at the next Authority meeting. However, minutes of the meetings of committees are not circulated and whilst the verbal update is helpful in providing context and understanding of the work of committees it does mean that members of the Authority have no opportunity to consider matters discussed in advance of meetings to identify any questions. We also noted that on occasion committees can be dealing with sensitive matters that may subsequently appear in the press, and there is no formal mechanism for communicating such matters prior to the next meeting of the Authority, which could be after external reporting.		Authority members may not have a full understanding of the activities of committees, or may not have time to identify questions. Members may not be aware of key decisions taken in committees before they are reported in the press.	Consider circulating minutes from committee meetings for information as part of Authority papers to members, in addition to the verbal updates. Consider whether there would be any merit in having an additional communication channel for any key decisions likely to have significant external coverage.	**Head of Governance and Licensing (HoGL) to feed into annual review of committees, and take members' views on whether they would appreciate this approach, or have ideas for additional communication channels.** **November 2014 Update** Annual committee review has begun, including discussions on communications. On target to feed into review of SOs in new year.	HoGL	**Autumn 2014, with implementation in new year if agreed by members.** **January-15**
		2	**Some governance information on the website needs updating**	M					
			We noted that there are a number of governance items on the HFEA website that appear to require updating: • In the "About HFEA" section the link to provisions of the 1990 Act as amended by the 2008 Act (**www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH080211**) does not work, that legislation page seemingly having been archived, and the About HFEA section also still refers to having 22 members; • The section on Equality and Diversity refers to new guidance to public bodies due to be issued in 2010 and goes on to say that the Authority intends to overhaul and update its approach to equality issues as part of its preparation for the commencement of the new public sector duty, and makes mention of having considered an initial preliminary assessment at the open public meeting in Cardiff on 8th December 2010; and • On the website the "Our Public Events" sub sections are for the 2008 and 2009 Annual Conferences.		Users of the website may be confused by out of date information. Reputation may be impaired as a result of the perception of lack of attention to the quality of information on the web. There may be a perception that the Authority has not paid sufficient attention to its equality and diversity objectives.	Review the website and update any information that is out of date. In particular, update the equality and diversity section. Implement a mechanism for regular testing for broken links to third party information.	**Equality policy being refreshed in summer 2014, with updated documentation to go on website. Other website changes being factored into IfQ programme.** **November 2014 Update** Delayed due to member of staff allocated to project being re-deployed on IFQ01 project. Policy refresh to be conducted Q4. **Website** **September 2014 Update** All sections apart from the Equality and Diversity section of the website have now been fixed. The Equality and Diversity section has been delayed due to IFQ **November 2014 Update** No change	Equalities – HoGL IfQ Programme Manager transferred to Director of Strategy and Corporate Affairs	Equalities – by October 2014. **Now expected March 2015** **On implementation of IfQ programme** **March-15** **March-15**

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
		3	**There is no up to date register of policies and policies on counter-fraud and whistleblowing are overdue for review.**	M					
			We noted that per Standing Orders the Authority should maintain a register of policies for the purpose of monitoring the need for review and updating. However, we were unable to obtain such a register. We obtained copies of the policies for Counter-fraud and Whistleblowing and noted that these were respectively dated July 2010 and May 2012 despite containing references to being subject to annual review.		Policies may no longer be appropriate to current operations and/or reflect latest best practice.	A register of policies indicating the owner and scheduled date for review should be maintained and monitored to ensure timely review of all policies. The Counter-Fraud and Whistleblowing policies should be reviewed and updated if necessary.	**HoGL to create and maintain register of policies.** **September 2014 Update** Register created and policies that need to be udpated will be prioritised and scheduled. in discussion with policy owners. **November 2014 Update** Closed - register is created and now work ongoing with IA on Internal Policy review to ensure all policies up to date. **Head of Finance to update Counter-fraud policy.** **September 2014 Update** Finance policies and SOPs to be updated. **November 2014 Update** Have not commenced review of the Fraud Policy. This will be done by the end of Jannuary 2015 **Head of HR to update Whistleblowing policy. Whistleblowing policy updated already by Head of HR and communicated to all staff, awaiting sign-off expected.** **September 2014 Update** SMT agreed have agreed an updated policy. A paper of the updated policy was presented to the Staff Forum and CMG in September and to AGC in December. **November 2014 Update** The whistleblowing policy was agreed by SMT and CMG and will be presented to AGC in December.	HoGL HoF HoHR	May-14 December-14 Complete July-14 December-14 January-15 May-14 December-14 Complete
		4	**There are no formalised succession planning or induction arrangements and there is likely to be more change in members in the future than in recent years**	L					
			We understand that there are no formalised arrangements for succession planning and induction of new members. It is likely that there will be more change in membership in the future which raises the question of whether there should be succession planning to ensure that there is some continuity within all committees. In addition, consideration could be given to whether members should be able to serve their full terms on one committee, or if some rotation to introduce fresh perspective may be appropriate in certain circumstances. We are aware that induction has been undertaken, for example members observing a clinic inspection, but in light of possibly more significant change going forwards more formalised planning for induction may be appropriate. There is currently no induction pack of information nor any plans for the activities that should be undertaken as part of induction. This could also extend to thinking about induction to committees where new members may be asked to input to decisions on matters that are quite complex.		Key knowledge or experience may be lost through changes to membership. Whilst an element of change may be beneficial, normal timescales and flow of business may be interrupted in the event of significant change whilst new members find their feet. The experience of new members joining the Authority may not be wholly positive.	Formally consider the implications of forthcoming changes in membership and develop succession, handover or induction arrangements as appropriate. An information pack for new members with specific additions if necessary for those joining particular committees plus a plan/timetable for meetings with key staff and the opportunity to attend clinic events may help both expedite induction and create a positive experience for new members.	**Chief Executive (CEx) has begun liaising with DH reps regarding recruitment of two new members, following appointment of new Chair. HoGL to run recruitment process and any revision of committee membership, steered by Chair. New members and any changes to committee structure to be in place by September 2014. HoGL and Head of HR to create induction pack and programme for new members. Induction pack/programme to be ready on appointment.** **September 2014 Update** Interviews for new members occuring in August 2014. Appointments expected by end September 2014. Induction pack/programme to be ready on appointment. **November 2014 Update** New members now appointed. Induction documentation drafted and to be sent w/c 17 Nov. Training being planned for early 2015. Discussion regarding committee membership/succession planning in w/c 17 Nov. **Recommendation Completed**	HoGL	September 2014. December-14 Complete

2013 - 14	Title	Section	Findings	Grade	Risk / Implication	Recommendation	Management Response	Action Manager	Date
NAO	Annual Report & Accounts	5	**Remuneration Report**	L					
			As with the Annual Report, whilst the requirements of the Companies Act 2006 as interpreted by the FReM had broadly been addressed, there were a minor number of disclosures missing or that required amendment. Total employer pension contributions for HFEA as a whole were also inaccurate			HFEA should obtain up-to- date declarations of interest for the Senior Management Team (who are disclosed in the Remuneration Report) as they do for Non-Executives	**September 2014 update** Update planned for November 2014, with requirement to notify changes as they occur. **November 2014 Update** Declarations of interest for SMT will be obtained in January, alongside those for Authority Members	HoF	November-14 January-15
		6	**Intra-Government balances**	L					
			Significant discrepancies were identified in the categorisation of intra-government balances. The disclosures in the latest draft Accounts have now been corrected			Finance should review categorisation of suppliers and customers to ensure that this corresponds with the information reported in the DH Consolidation return	**September 2014 update** Comparison will take place when DH request future consolidations **November 2014 updated** This will take effect when Decembers' hard close commences in Jan-15	HoF	January-15

Audit and Governance Committee paper

Strategic delivery	**Setting standards**	☐	**Increasing and informing choice**	☐	**Demonstrating efficiency, economy and value**	☑
Paper title	Strategic Risk Register 2014 – 2015					
Agenda item	**8 a**					
Paper number	AGC (10/12/14) 438					
Meeting date	10 December 2014					
Author	Paula Robinson, Head of Business Planning					
For information or decision?	Information and comment.					
Recommendation	The Committee is asked to note the redesigned risk register (still a work in progress) and to comment on the risks and the new structure.					
Resource implications	No direct resource implications.					
Implementation	Continually in progress.					
Communication	Quarterly review by CMG and AGC. The Authority last commented on the risk register at its May 2014 meeting. The last CMG review was in November.					
Organisational risk	Medium					
Annexes	Annex A – HFEA Strategic Risk Register 2014/15					

The HFEA's High Level Risk Register will be published on the HFEA website after a time delay of twelve months, as specified in the HFEA's policy on the publication of Authority and Committee papers.

Audit and Governance Committee paper

How this paper relates to our strategy	**Setting standards**	☑	**Increasing and informing choice**	☐	**Demonstrating efficiency, economy and value**	☑
Paper title	Updated Public Interest Disclosure ("Whistleblowing") policy					
Agenda item	**9**					
Paper number	[AGC (10/12/2014) 439]					
Meeting date	10 December 2014					
Author	Rachel Hopkins, Head of Human Resources					
For information or decision?	Decision					
Recommendation	The Committee is asked to agree the updated policy.					
Resource implications						
Implementation	Updated policy to be published with immediate effect					
Communication	Updated policy will be published on the Intranet. Staff communication via Insider article, all staff meeting, and email. Promotion also via CSL e-learning module.					
Organisational risk	Low					
Annexes	Annex A – Public Interest Disclosure ("Whistleblowing" Policy)					

1. Purpose

1.1. This paper is to confirm that the annual review of the HFEA Whistleblowing Policy has been undertaken and to set out the updated policy which includes a number of minor amendments that have been proposed and agreed.

2. Background

2.1. The HFEA is committed to ensuring that staff have access to, and a clear understanding of, our public interest disclosure (whistleblowing) policy. The policy is to be reviewed each year to ensure that details are up to date and this review has been undertaken.

2.2. It should be noted that Public Concern at Work (PCAW) – the whistleblowing charity – has issued a Code of Practice which includes details of what any policy whistleblowing policy should include. The HFEA policy has therefore been updated to reflect the code of practice.

2.3. Staff Forum have commented and agreed the policy (with one suggested amendment which has been incorporated). Our Corporate Management Group (CMG) agreed the updated policy at its September meeting.

2.4. The updated policy is being sent to Audit and Governance Committee for final sign off.

3. Action

3.1. Audit & Governance Committee is asked to review and agree the updated policy (attached at Annex A)

Human Fertilisation & Embryology Authority

Public Interest Disclosure ("Whistleblowing") Policy

In this policy:

1. Introduction

In accordance with the Public Interest Disclosure Act 1998, and the corporate values of integrity, impartiality, fairness and best practice, this policy intends to give employees a clear and fair procedure to make disclosures which they feel are in the public interest ("whistleblowing") and will enable the HFEA to investigate these disclosures promptly and correctly.

2. Aim

To outline what constitutes a Public Interest disclosure, and to provide a procedure within the HFEA to deal with such disclosures

3. Scope

This policy applies to all employees, both permanent and fixed term and also Authority members.

4. Responsibility

The HR department is responsible for ensuring that all staff have access to this policy.

Managers and Senior Executives are responsible for ensuring that any public interest disclosure is dealt with immediately, and sensitively, and confidentially.

5. Principles

- Employees who raise their concerns within the HFEA, or in certain circumstances, to prescribed external individuals or bodies will not suffer detriment as a result of their disclosure, this includes protection from subsequent unfair dismissal, victimisation or any other discriminatory action.

- The Public Interest Disclosure Act 1998, (more widely known as the 'Whistleblowers' Act) protects 'workers' from suffering any detriment where they make a disclosure of information while holding a reasonable belief that the disclosure tends to show that:

  (a) a criminal offence has been committed, is being committed or is likely to be committed,
  (b) a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
  (c) A miscarriage of justice has occurred, is occurring or is likely to occur,
  (d) The health and safety of any individual has been, is being or is likely to be endangered,
  (e) The environment has been, is being or is likely to be damaged, or
  (f) Information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

- It should be noted that disclosures, which in themselves constitute an offence, are not protected.

- HFEA's policy is intended to ensure that where a member of staff, including temporary or contractual staff, have concerns about criminal activity and/or serious malpractice e.g. fraud, theft, or breaches of policy on Health and Safety, they can be properly raised and resolved in the workplace. Such matters must be raised internally in the first instance. Please refer to the paragraph on gross misconduct in the Authority's Disciplinary Policy, and also the Authority's Fraud and Anti-Theft Policy.

- HFEA seeks to foster a culture that enables staff who witness such malpractice to feel confident to raise the matter in the first instance in the knowledge that, once raised, it will be dealt with effectively and efficiently. The HFEA will not tolerate the victimisation of individuals who seek to bring attention to matters of potentially serious public concern, and will seek to reassure any individual raising a concern that he or she will not suffer any detriment for doing so. If an individual is subject to a detriment for raising a concern the HFEA will seek to pursue an appropriate sanction.

- Frivolous or vexatious claims which fall outside the protection of the Act or such other provisions as may be held to protect them (e.g. HFEA's codes of conduct, confidentiality clause etc) may be considered acts of misconduct and subject to disciplinary action.

6. Procedure

Internal Disclosure

6.1 HFEA staff who become concerned about the legitimacy or public interest aspect of any HFEA activity or management of it should raise the matter initially with their line manager. If a member of staff feels unable to raise the matter through their line manager they may do so through the HR Department.

6.2 It will be the responsibility of the line manager to record and pursue the concerns expressed; consulting such other parts of the Authority; (e.g. HR, SMT) as may be necessary, including where appropriate consideration as to whether external expert assistance is required.

6.3 The identity of the individual making the disclosure will be kept confidential if the staff member so requests unless disclosure is required by law.

6.4 In other than serious cases, the line manager will normally be responsible for responding to the individual's concern. They must maintain appropriate records and ensure that they provide the individual raising the concern with:

- An explanation of how and by whom the concern will be handled
- An estimate of how long the investigation will take
- Where appropriate, the outcome of the investigation
- Details of who he/she should report to if the individual believes that he/she is suffering a detriment for having raised the concern
- Confirmation that the individual is entitled to independent advice.

6.5 Should a member of staff feel that they are not satisfied that their concern has been adequately resolved, they may raise the matter more formally with the Chief Executive.

6.6 Any member of staff wishing to make a disclosure of significant importance may approach the Chief Executive in the first instance. Matters of significant importance include, but are not restricted to, criminal activity e.g. fraud or theft, or other breaches of the law; miscarriage of justice; danger to health and safety; damage to the environment; behaviour or conduct likely to undermine the Authority's functions or reputation; breaches of the *Seven Principles of Public Life* (Annex A) and attempts to cover up such malpractice.

6.7 The matter of significant importance may have taken place in the past, the present, or be likely to take place in the future.

6.8 Concerns may be raised either in writing or at a meeting convened for the purpose. A written record of meetings must be made and agreed by those present. In serious cases or in any case where a formal investigation may be required, line managers concerned should consult the Head of HR and SMT, unless they are implicated. Line managers must not take any action which might prejudice any formal investigation or which might alert any individual to the need to conceal or destroy any material evidence.

6.9 Where an individual has reason to believe that the concerns about which he / she intends to make a disclosure are condoned or are being concealed by the line manager to whom they would ordinarily be reported, the matter may be referred directly to the Head of HR r who will determine in conjunction with the Chief Executive the need for, and the means of, investigation. In exceptional circumstances, the Head of HR may take the disclosure directly to the HFEA Chair. Any such approach should be made in writing, clearly stating the nature of the allegations.

6.10 Unless inappropriate in all the circumstances, investigations will normally be undertaken by the following posts:

Allegation against	*Investigated by*
Directors	Chief Executive
Chief Executive	Chair
Member	Chair
Audit Committee Member	Audit Committee Chair
Chair	Department of Health*
Deputy Chair	Chair

*Via Senior Sponsor at the DH (currently Paul McNaught, Director, Health Science and Bioethics (tel. 0207 210 6304 / paul.macnaught@dh.gsi.gov.uk)

6.11 Individuals under contract to the HFEA for the delivery of services should raise any issues of concern in the same way, via the appropriate line manager.

6.12 Once investigations and follow up actions as appropriate have been concluded, a written summary of the matter(s) reported and concluding actions taken should be forwarded to the Chair of the Authority (the Chair) for inclusion in the central record of issues reported under this

policy. The anonymity of the individual who made the disclosure should be preserved as far as possible.

External Disclosure

6.13 The HFEA recognises that there are circumstances where the matters raised cannot be dealt with internally and in which an individual may make the disclosure externally and retain the employment protection of the Act. Ordinarily such disclosure will have to be to a person or regulatory body prescribed by an order made to the Secretary of State for these purposes.

6.14 Prescribed bodies under the Act include the Comptroller and Auditor General of the National Audit Office (NAO), who are the external auditors to the Authority. The Act states that disclosure to the NAO should relate to "the proper conduct of public business, fraud, value for money and corruption in relation to the provision of centrally-funded public services."

6.15 The NAO have a designated whistle blowing hotline which can be used in confidence on 020 7798 7999. Further information about this service and other bodies prescribed under the Act is available via the NAO's website: http://www.nao.org.uk/contact-us/whistleblowing-disclosures/

6.16 In these circumstances the worker will be obliged to show that the disclosure is made in good faith and not for personal gain, that he or she believed that the information provided and allegation made were substantially true, and that they reasonably believed that the matter fell within the description of matters for which the person or regulatory body was prescribed.

6.17 Unless the relevant failure of the employer is of an exceptionally serious nature, the worker **will not** be entitled to raise it publicly unless he/she has already raised it internally, and/or with a prescribed regulatory body and, in all the circumstances, it is reasonable for him / her to make the disclosure in public.

6.18 If a member of staff is unsure of their rights or obligations and wishes to seek alternative independent advice**,** Public Concern at Work is an independent organisation that provides confidential advice, free of charge, to people concerned about wrongdoing at work but who are not sure whether or how to raise the concern (telephone 020 7404 6609 or 020 3117 2520, email: whistle@pcaw.org.uk), or visit their website at http://www.pcaw.org.uk/.

6.19 Where matters raised from external disclosure procedures are (as appropriate) subsequently investigated and resolved internally, a written record of the matters raised and actions taken should be forwarded to the Chair for inclusion in the central record of issues referred under this policy. The anonymity of the individual who made the disclosure should be preserved as far as possible.

Information held on the HFEA Register

Under Section 31 of the Human Fertilisation and Embryology Act 1990 ("the Act"), the HFEA is required to keep a register containing certain categories of information. The Act prohibits disclosure of data held on the HFEA register, subject to a number of specified exceptions. Disclosure of information which is not permitted by an exception may constitute a criminal offence.

7. Notes

7.1 This policy will be reviewed by the Audit and Governance Committee annually.

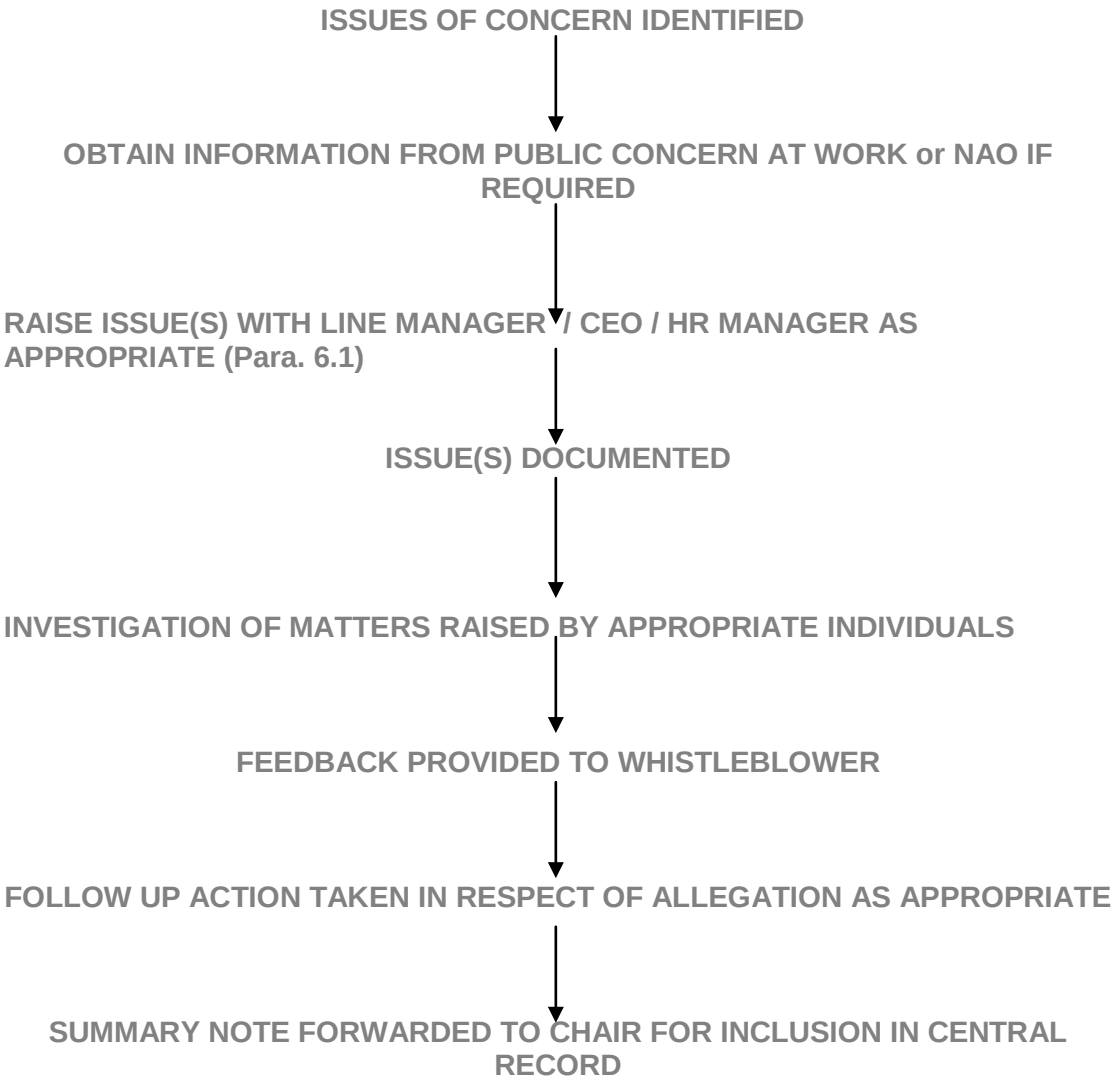
7.2 An anonymised summary of issues raised under this whistleblowing policy and remedial actions taken will be forwarded annually to the Authority for information.

7.3 The role of the HFEA as a regulatory body:

Under the provisions of the Public Interest Disclosure Act 1998 employees of an organisation are able to disclose publicly (under certain circumstances) their concerns about legitimacy or public interest aspects of the organisation within which they work. Although the Act requires that concerns be raised internally in the first instance, there are provisions for disclosure to be made to a regulatory body. The HFEA is itself one such regulatory body.

The procedure for dealing with a public interest disclosure from a member of staff of one of the licensed centres for which the HFEA is the regulatory body is not covered by this policy and prior to any separate procedure being issued, guidance must be sought from the Director of Compliance and Information.

8. Procedure Diagram



Procedures for **external disclosures** will depend upon the procedures of the body to whom disclosures are made. **Public Concern at Work** or the **NAO** will be able to provide information in this respect. Where matters raised from external disclosure procedures are (as appropriate) subsequently investigated and resolved internally, a written record of the matters raised and actions taken should be forwarded to the Chair for inclusion in the central record of issues referred under this policy.

The identity of the individual making the disclosure will be kept confidential if the staff member so requests unless disclosure is required by law.

The Seven Principles of Public Life (as recommended by the Nolan Committee)

Selflessness

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations which might influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards or benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interests.

Leadership

Holders of public office should promote and support these principles by leadership and example.

These principles apply to all aspects of public life.

ANNEX A

Doc Name and Reference number:	HR003 Public Interests Disclosure
TRIM number:	
Latest Version No:	3
Release date:	Xx December 2014
Author:	(Rachael Henry) / Rachel Hopkins
Approved by:	Staff Forum / CMG / AGC
Next review due:	1 December 2015
Total pages:*	9

Version/revision control

Version	Changes	Updated by	Approved by	Release date
1	New Policy	Rachael Henry	Rachel Hopkins	1st July 2010
2	Revisions/updates	Rachael Henry	CMG/AGC/Staff Forum	10th May 2012
3	Revisions and updates	Rachel Hopkins	Staff Forum, CMG, AGC	TBC December 2014

Audit & Governance Committee Paper

How this paper relates to our strategy	Setting standards	☐	Increasing and informing choice	☐	Demonstrating efficiency, economy and value	☑
Paper Title	Annual Review of AGC Activities and Effectiveness – action plan					
Agenda Item	**11**					
Paper Number	[AGC (10/12/2014) 440]					
Meeting Date	10 December 2014					
Author	Sam Hartley, Head of Governance and Licensing					
For information or decision?	Information					
Recommendation	Committee members are invited to note the action plan resulting out of the committee's annual review of effectiveness in October 2014					
Resource Implications	Negligible					
Implementation	According to the action plan					
Communication	Results will be put direct to Authority, along with those for all committees					
Organisational Risk	Low					
Evaluation	This is part of a continuing review of effectiveness by AGC that culminates in this more formal annual report					
Annex	A: Action plan B: NAO checklist for Audit Committees – completed					

Introduction

1. The Committee conducted its annual review of effectiveness at its last meeting in October. The results of that discussion have been written into the NAO good practice self-assessment checklist, and is attached at Appendix B.

Action plan

2. There are actions arising out of the review of effectiveness, and these are captured within the document. For clarity (and for monitoring purposes) those actions are detailed in Appendix A, with owners and expected timescales.

Recommendations

3. The Committee is asked to note the completed checklist and appendix B, and the action plan at Appendix A, with progress against actions.

	Action	Expected benefit	Owner	Expected completion	Open/closed?
1	Keep with plan to hold four meetings per year, and re-visit proposal for three meetings per year in six months' time.	Consistency; evaluation; proportionality	Director of Finance & Resources	March 2015	Open
2	Ensure an action plan is kept in order to follow up on reviews of effectiveness.	Monitoring and improvement	Head of Governance & Licensing	December 2015	Closed
3	Ensure Accounting Officer attends June meeting of the committee every year, as a minimum.	Accountability; transparency	Chief Executive	June 2015	Open
4	Circulate committee minutes to all Authority members once signed off to ensure visibility of work carried out by committee.	Communication; shared learning; raising profile	Secretary to the Committee	From sign-off after December meeting	Open
5	Arrange for external members to attend Authority meeting as observers	Communication; learning; raised profile	Head of Governance & Licensing	March 2015	Open
6	Arrange for external members to observe an inspection	Communication; learning; raised profile	Head of Governance & Licensing	March 2015	Open
7	Arrange for members to have an annual appraisal with the Chair, adhering to the Authority member appraisal timescales	Learning & development	Chair of AGC	March 2015	Open
8	The committee must have time and space for discussions with Internal Audit only, which could be at the end of a meeting. It was noted that this was unlikely to be necessary, but would be built in to the consideration of agendas in future nevertheless.	Accountability; effectiveness; scrutiny	Secretary to the Committee	December 2015	Closed

9	Institute formal annual report to Authority board	Accountability; communication	Head of Governance & Licensing	March 2015	Open
10	Give thought to improving communication from external appeals committees to AGC/Authority board, while maintaining independence of those committees.	Scrutiny; assurance; communication	Head of Governance & Licensing	March 2015	Open

Appendix B: NAO's Audit Committee self-assessment checklist – completed

National Audit Office

GOOD PRACTICE

The Audit Committee self-assessment checklist

2nd edition January 2012

Financial Management and Reporting

Our vision is to help the nation spend wisely.

We apply the unique perspective of public audit to help Parliament and government drive lasting improvement in public services.

The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Amyas Morse, is an Officer of the House of Commons and leads the NAO, which employs some 860 staff. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of more than £1 billion in 2011.

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Contents

Introduction

1 This Checklist[1] has been designed to help Audit Committees in central government assess how well they apply good practice. The criteria we have used are derived largely from the Audit Committee Handbook (March 2007)[2] published by HM Treasury.

2 The Handbook highlights five good practice principles which aim to answer the following key questions:

- **Principle 1: The Role of the Audit Committee** – Does the Audit Committee effectively support the Board and the Accounting Officer by reviewing the completeness of assurances to satisfy their needs, and by reviewing the reliability and integrity of these assurances?
- **Principle 2: Membership, Independence, Objectivity and Understanding** – Is the Audit Committee suitably independent and objective, and does each member have a good understanding of the objectives, priorities and risks of the organisation, and of their role on the Audit Committee?
- **Principle 3: Skills** – Does the Audit Committee contain or have at its disposal an appropriate mix of skills to perform its functions well?
- **Principle 4: Scope of Work** – Is the scope of the Audit Committee suitably defined, and does it encompass all the assurance needs of the Board and Accounting Officer?
- **Principle 5: Communication** – Does the Committee engage effectively with Financial and Performance Reporting issues, and with the work of internal and external audit? And does the Audit Committee communicate effectively with the Accounting Officer, the Board, and other stakeholders?

3 For each principle, we have developed a series of Good Practice Questions to help Audit Committees conclude whether they are meeting these principles. These are set out in **Section I** of this checklist.

4 In addition, the role of the Chair and the provision of appropriate secretariat support are key for an effective Audit Committee. The Handbook details Good Practice Questions on these two roles. **Sections II** and **III** of this checklist include questions that will enable the Audit Committee to determine if they currently meet this guidance.

1 This Checklist was originally published in November 2009 and has been updated (January 2012) to reflect the requirement for departments, their executive agencies and arm's-length bodies to produce a Governance Statement in place of the Statement on Internal Control in their annual report and accounts for 2011-12 onwards. Guidance on the Governance Statement is set out in the revised Chapter 3 of Managing Public Money (HM Treasury, 2011)

2 *Corporate governance in central government departments: Code of good practice* (HM Treasury, July 2011) provides that Audit Committees should be established and function in accordance with the *Audit Committee Handbook* (HM Treasury, March 2007).

How to use this Checklist

5 To help Audit Committees conclude as to whether they are meeting the Principles highlighted above, we have developed Good Practice Questions to inform the thinking process. These Questions are phrased to identify 'yes', 'no' or 'not applicable' responses.

6 We recognise, though, that organisations and their Audit Committees vary considerably in their size and in the complexity of issues that they deal with. In some circumstances, it may therefore be more appropriate to only use the more important Questions to help inform debate – and we have highlighted these in **bold**.

7 Also, the checklist is not exhaustive, and should the Audit Committee or their organisation feel that they have experience of other good working practice that will make the Committee work more effectively, they should not be deterred from implementing these practices, after consulting with the Board, if appropriate.

NAO Facilitated Workshops

8 To help Audit Committees use this checklist, the National Audit Office, as part of its performance improvement work, offers **Facilitated Workshops** for Audit Committees to help them use a tailored version of this checklist and draw conclusions as to their effectiveness. In this way, the workshop provides an opportunity for individual Audit Committees to work together, away from their normal business, to assess how well they work and establish areas to develop further. The workshop is followed up with an Action Plan that draws from the decisions and actions raised. This Action Plan will be owned by the Audit Committee, and act as the means by which decisions are implemented and reviewed.

9 If you would like the NAO to facilitate a workshop for your Audit Committee, please ask your usual NAO contact or Client Lead.

10 This checklist is also available as a Word document to enable Audit Committees to record their responses electronically.

National Audit Office
November 2009

Section I

Good practice principles for Audit Committees

Principle 1: The role of the Audit Committee

The Audit Committee should support the Board and the Accounting Officer by reviewing the comprehensiveness of assurances in meeting the Board and Accounting Officer's assurance needs, and reviewing the reliability and integrity of these assurances.

Good Practice Questions

	Terms of Reference	**Yes**	**No**	**N/A**
1	Have all executive responsibilities, and making or endorsing of decisions been excluded from the roles and responsibilities of the Audit Committee members?	☒	☐	☐
2	Does the Audit Committee follow up recommendations regarding its effectiveness?	☒	☐	☐
3	**Does the Audit Committee's role include monitoring and reviewing the executive's processes for assessing, reporting and owning business risks and their financial implications?**	☒	☐	☐
4	**Has the role and responsibilities of the Audit Committee been clearly defined and communicated to all Audit Committee members, along with details of how the Committee supports the Board?**	☒	☐	☐
5	**Are the Terms of Reference reviewed at least annually by the Board and the Audit Committee, to ensure that the work of the Audit Committee is aligned with good practice and business needs?**	☒	☐	☐
6	**Do the Terms of Reference include rules for a quorum?**	☒	☐	☐
7	**Does the Audit Committee meet regularly (at least four times a year), and do meetings coincide with key dates in the financial reporting and audit cycle?**	☒	☐	☐

Additional Comments:

Members generally felt happy with the clarity of their role, and the work of the committee.

The Chair noted that the external members brought skills and experience in assurance that benefited the work and decision-making of the committee.

Members expressed concern about proposals to move to three meetings per year, on the basis that it would be harder to stay on top of occurences at the HFEA. In addition, with the extra assurance needed on the IfQ project, the members preferred to retain the fourth meeting for the time being, and revisit the idea in six months.

Conclusions

Do we achieve **Principle 1: The Role of the Audit Committee** – Does the Audit Committee support effectively the Board and the Accounting Officer by reviewing the comprehensiveness of assurances to satisfy their needs, and by reviewing the reliability and integrity of these assurances?

What do we need to do to enhance the Audit Committee?

Actions:

1) Keep with plan to hold four meetings per yer, and re-visit proposal for three meetings per year in six months' time.

2) Ensure an action plan is kept in order to follow up on reviews of effectiveness.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Principle 2: Membership, Independence, Objectivity and Understanding

The Audit Committee should be independent and objective; in addition, each member should have a good understanding of the objectives and priorities of the organisation and of their role as an Audit Committee member.

Good Practice Questions

	Independence	**Yes**	**No**	**N/A**
8	**Is the Chair of the Audit Committee different from the Chair of the Board?**	☒	☐	☐
9	**Are the Audit Committee members either independent non-executive Board members or independent external members, and have they been appointed for an appropriate period of time (e.g. three years)?**	☒	☐	☐
	Relationship with the Executive			
10	**Are the Executive members of the organisation invited to attend Audit Committee meetings, participate in discussions, and provide information to the Audit Committee as and when the Audit Committee deems it necessary?**	☒	☐	☐
	Other Participants			
11	Where appropriate, does a representative from the sponsoring body attend the Audit Committee meetings (e.g. if an Executive Agency, does a member of the Sponsoring Department attend the meeting)?	☒	☐	☐
12	**Does the Accounting Officer, Finance Director, Head of Internal Audit and the External Auditor routinely attend the Audit Committee, or attend at the request of the Audit Committee members?**	☒	☐	☐
13	**Are the numbers attending the Audit Committee meetings sufficient to deal adequately with the agenda, but not too many to blur issues?**	☒	☐	☐
	Conflict of Interest			
14	**Is the first agenda item of every meeting a request for the Audit Committee members to declare any potential conflict of interest with any of the business items on the Audit Committee's agenda?**	☒	☐	☐

Conflict of Interest (continued)		**Yes**	**No**	**N/A**
15	In instances where there is a declaration of interest in any of the agenda business items, are appropriate actions taken, e.g. is the member asked to leave the meeting while the business item is being discussed?	☒	☐	☐
16	In instances where the conflict of interest is likely to last for a long time, has the Audit Committee member been asked to relinquish his or her membership?	☐	☐	☒
17	Are the Audit Committee members required to declare their interest in a register of interests?	☒	☐	☐
Terms of Appointment				
18	**Do all Audit Committee members have a clear understanding of what is expected of them in their role, set out in a letter of appointment, including:**			
	a. their appointment and purpose;	☒	☐	☐
	b. the support and training that they will receive;	☒	☐	☐
	c. the commitment required;	☒	☐	☐
	d. their remuneration;	☒	☐	☐
	e. conflict of interest procedures;	☒	☐	☐
	f. expected conduct;	☒	☐	☐
	g. duration of appointment and how often it may be renewed;	☒	☐	☐
	h. how their individual performance will be appraised, including a clear understanding of what would be regarded as unsatisfactory performance; and	☒	☐	☐
	i. termination conditions?	☒	☐	☐

Additional Comments:

Members noted that the independence of the COmmittee is ensured and enhanced by having two external members, in addition to the Authority members.

The Executive fully supported the committee and members did not feel that there were too few, nor too many, staff in attendance.

Members commented that they would expect to see th Accounting Officer (Chief Executive) more regularly.

Members noted that external attendees were welcome (i.e. NAO, DH, DHIA etc) and this did not in any way inhibit the committee from having frank discussions. It might be that, on occasion, items are discussed without external attendees being present.

Conclusions

Do we achieve **Principle 2: Membership, Independence, Objectivity and Understanding** – Is the Audit Committee suitably independent and objective, and does each member have a good understanding of the objectives, priorities and risks of the organisation, and of their role on the Audit Committee?

What do we need to do to enhance the Audit Committee?

1) Ensure Accounting Officer attends June meeting of the committee every year, as a minimum.

2) Circulate committee minutes to all Authority members once signed off to ensure visibility of work carried out by committee.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Principle 3: Skills

The Audit Committee should collectively possess an appropriate skills mix to perform its functions well.

Good Practice Questions

	Range of Skills	Yes	No	N/A
19	Are there formal assessment criteria for the appointment of the Audit Chair, including attitudes to non-executives, strength of personality, experience of chairing, and time commitment?	☐	☐	☒
20	**Do the assessment criteria of Committee members include, or expect Audit Committee members to acquire as soon as possible after appointment:**			
	a. understanding of the objectives of the organisation and current significant issues for the organisation;	☒	☐	☐
	b. understanding of the organisation's structure, including key relationships such as that with a sponsoring department or major partner;	☒	☐	☐
	c. understanding of the organisation's culture;	☒	☐	☐
	d. understanding of any relevant legislation or other rules governing the organisation; and	☒	☐	☐
	e. broad understanding of the government environment, particularly accountability structures and current major initiatives?	☒	☐	☐
21	**Does the Audit Committee ensure that there are areas of collective understanding, including:**			
	a. accountancy – with at least one member having recent and relevant financial experience;	☒	☐	☐
	b. governance, assurance and risk management;	☒	☐	☐
	c. audit;	☒	☐	☐
	d. technical or specialist issues pertinent to the organisation's business;	☒	☐	☐
	e. experience of managing similar sized organisations;	☒	☐	☐
	f. understanding of the wider environments in which the organisation operates; and	☒	☐	☐
	g. detailed understanding of the government environment and accountability structures?	☒	☐	☐

Additional Skills		**Yes**	**No**	**N/A**
22	**Do the Audit Committee members feel empowered to:**			
	a. co-opt members for a period of less than one year to provide specialist skills that the members do not have to be an effective Committee;	☐	☐	☒
	b. procure specialist advice at reasonable approved expense to the organisation, on an ad-hoc basis to support them in relation to particular pieces of Committee business.	☒	☐	☐
Training and Development				
23	**Is there an induction checklist for new Audit Committee members that details key things that they must do e.g. visits to important business locations, meetings with Board, Risk Manager, Internal Audit and External Auditors?**	☒	☐	☐
24	Do all new members of the Audit Committee attend an induction training course for Audit Committee members run by the National School of Government, or other sector-related organisation?	☐	☒	☐
25	Does the Audit Committee ensure that new members have sufficient knowledge of the business to identify the key risk areas and to challenge both line management and internal and external auditors on critical and sensitive issues?	☐	☒	☐
26	Does the Audit Committee and the Chair make recommendations to the Board on the Committee's and individual members training needs?	☐	☐	☒
27	Does the Audit Committee keep abreast of best practice and developments in corporate governance in central government and more widely?	☒	☐	☐

Additional Comments:

Members felt that they had the right skills mix, being from different backgrounds (lay, financial, audit) but with a shared understanding of the work, culture and ethos of the HFEA. All members are aware of wider government and/or health sector environment.

Additional expert (e.g. legal, clinical, governance) support would be availabile should the committee want it.

The Chair noted that the external members would benefit from observing an Authority meeting and inspection - the Executive would arrange this. The committee further agreed that the members would have an annual appraisal with the Chair.

Conclusions

Do we achieve **Principle 3: Skills** – Does the Audit Committee contain or have at its disposal an appropriate mix of skills to perform its functions well?

What do we need to do to enhance the Audit Committee?

1) Arrange for external members to attend Authority meeting as observers

2) Arrange for external members to observe an inspection.

3) Arrange for members to have an annual appraisal with the Chair, adhering to the Authority member appraisal timescales.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Principle 4: Scope of Work

The scope of the Audit Committee's work should be defined in its Terms of Reference, and encompass all the assurance needs of the Board and Accounting Officer. Within this, the Audit Committee should have particular engagement with the work of Internal Audit, the work of External Auditor, and Financial Reporting issues.

Good Practice Questions

	Relationship with Internal Audit	**Yes**	**No**	**N/A**
28	**Does the Audit Committee consider the independence and effectiveness of Internal Audit?**	☒	☐	☐
29	**Does the Audit Committee consider that the experience, expertise and professional standard of the Internal Audit team are appropriate for the size, complexity, and inherent risk of the organisation?**	☒	☐	☐
30	**Does the Audit Committee consider that the scope of Internal Audit work, the available resources at its disposal, and their access to information and people allow it to address significant risks within the organisation?**	☒	☐	☐
31	**Does the Audit Committee review and approve the Internal Audit plan before they commence any work and make suggestions regarding risk and problem areas that the audit could address in the short and long term?**	☒	☐	☐
32	Does the Audit Committee receive regular progress reports on studies/work undertaken by Internal Audit?	☒	☐	☐
33	**Does the Audit Committee review internal audit reports and management responses to issues raised, and monitor the progress made on Internal Audit's recommendations?**	☒	☐	☐
	Relationship with External Audit			
34	**Where relevant, does the Audit Committee consider the independence, objectivity, and effectiveness of the External Auditors?**	☒	☐	☐
35	Does the Audit Committee periodically obtain the views of the External Auditor on the work and effectiveness of the Audit Committee?	☒	☐	☐

	Relationship with External Audit (continued)	**Yes**	**No**	**N/A**
36	Is the Audit Committee informed by the External Auditors on an annual basis as to their quality control procedures and compliance with applicable UK ethics guidance?	☒	☐	☐
37	**Does the Audit Committee consider the External Auditor's Audit Strategy before they commence work, and make suggestions regarding risk and problem areas the audit could address in the short and long term?**	☒	☐	☐
38	**Do the External Auditors inform the Audit Committee of key developments and issues at key stages of the audit?**	☒	☐	☐
39	Where relevant, does the Audit Committee review the audit fees?	☒	☐	☐
40	**Does the Audit Committee consider the management letter and other relevant reports (e.g. the NAO's Value for Money work), and the management's response, and monitor the progress made on the recommendations?**	☒	☐	☐
	Relationship between Internal Audit and External Auditors			
41	Does the Audit Committee consider whether there are areas where joint working between Internal Audit and the External Auditors would be beneficial?	☒	☐	☐
42	Does the Audit Committee seek confirmation from Internal Audit and the External Auditors on the effectiveness of the relationship?	☒	☐	☐
	Fraud			
43	**Does the Audit Committee consider whether effective anti-fraud and corruption policies and procedures are in place and operating effectively?**	☒	☐	☐
44	Does the Audit Committee consider whether there is a code of conduct and its distribution to employees?	☒	☐	☐
45	Does the Audit Committee consider whether management arrangements for whistle-blowing are satisfactory?	☒	☐	☐

Internal Control		**Yes**	**No**	**N/A**
46	Does the Audit Committee consider whether corporate governance is embedded throughout the organisation, rather than treated as a compliance exercise?	☒	☐	☐
47	Does the Audit Committee consider whether the system of internal reporting gives early warning of control failures and emerging risks?	☒	☐	☐
48	**Does the Audit Committee consider whether the Governance Statement is sufficiently comprehensive and meaningful, and the evidence that underpins it?**	☒	☐	☐
49	**Does the Audit Committee satisfy itself that the system of internal control has operated effectively throughout the reporting period?**	☒	☐	☐
50	Does the Audit Committee consider whether financial control, including the structure of delegations, enables the organisation to achieve its objectives and achieve good value for money?	☒	☐	☐
51	Does the Audit Committee monitor whether the organisation's procedures for identifying and managing business risk have regard for the relevant legislation and regulation?	☒	☐	☐
Financial Reporting				
52	**Does the Audit Committee review the first draft of the annual accounts before the External Auditors start work on them?**	☒	☐	☐
53	**Before the Accounting Officer signs off the Annual Report and Financial Statements, does the Audit Committee consider:**			
	a. that the accounting policies in place comply with relevant requirements, particularly the Treasury's Financial Reporting Manual and Accounts Direction;	☒	☐	☐
	b. that there has been a robust process in preparing the accounts and annual report;	☒	☐	☐

Financial Reporting (continued)		Yes	No	N/A
	c. whether the accounts and annual report have been subjected to sufficient review by management and by the Accounting Officer and/or Board;	☒	☐	☐
	d. that when new or novel accounting treatments arise, whether appropriate advice on accounting treatment has been taken;	☒	☐	☐
	e. whether there is an appropriate anti-fraud policy in place, and whether losses are suitably recorded;	☒	☐	☐
	f. whether suitable processes are in place to ensure accurate financial records are kept;	☒	☐	☐
	g. whether suitable processes are in place to ensure regularity and propriety is achieved; and	☒	☐	☐
	h. whether issues raised by the External Auditors have been given appropriate attention.	☒	☐	☐
54	**Where the accounts have been qualified, does the Audit Committee consider the action taken by the Board to deal with the causes of the qualification?**	☒	☐	☐
55	**Does the Audit Committee satisfy itself that the annual financial statements represent fairly the financial position of the organisation, regardless of the pressures on executive management?**	☒	☐	☐
56	Before the Accounting Officer signs off the Letter of Representation, does the Audit Committee review it and give particular attention to non-standard issues of representation?	☒	☐	☐

Additional Comments:

The committee noted that measures were in place to allow assurance the financial and governance procedures were set and adhered to. It noted that fraud was a low-risk threat in this particular organisation, but was reported at each committee meeting nevertheless.

The relationship between the committee (and its staff) and the external and internal auditors was good, despite recent personnel changes on all fronts. There was regular liaison and all parties felt comfortable having frank conversations.

The committee noted that it assures itself of the corporate governance of the organisation by (among other things) signing off the Annual Governance Statement.

Conclusions

Do we achieve **Principle 4: Scope of Work** – Is the scope of the Audit Committee suitably defined, and does it encompass all the assurance needs of the Board and Accounting Officer?

What do we need to do to enhance the Audit Committee?

1) The committee must have time and space for discussions with Internal Audit only, which could be at the end of a meeting. It was noted that this was unlikely to be necessary, but would be built in to the consideration of agendas in future nevertheless.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Principle 5: Communication

The Audit Committee should ensure it has effective communication with the Board, the Head of Internal Audit, the External Auditor, and other stakeholders.

Good Practice Questions

	Reporting to the Board	**Yes**	**No**	**N/A**
57	Does the Audit Committee send regular reports or provide oral updates to the Board that they review at their meetings?	☒	☐	☐
58	**Does the Audit Committee provide an Annual Report to the Board, timed to support preparation of the Governance Statement?**	☐	☒	☐
59	**Does the Annual Report of the Audit Committee present the Committee's opinion about:**			
	a. the comprehensiveness of assurances in meeting the Board and Accounting Officers needs;	☐	☐	☒
	b. the reliability and integrity of these assurances;	☐	☐	☒
	c. whether the assurance available is sufficient to support the Board and Accounting Officer in their decisions taken and their accountability obligations;	☐	☐	☒
	d. the implication of these assurances for the overall management of risk;	☐	☐	☒
	e. any issues the Audit Committee considers pertinent to the Governance Statement, and any long-term issues the Committee thinks the Board and/or Accounting Officer should give attention to;			
	f. financial reporting for the year;	☐	☐	☒
	g. the quality of both Internal and External Audit and their approach to their responsibilities; and	☐	☐	☒
	h. the Audit Committee's view of its own effectiveness, including advice on ways in which it considers it needs to be strengthened or developed.	☐	☐	☒

Additional Comments:

The members felt that the two-monthly reporting back to the Authority board by the committee Chair worked well. This would be enhanced by the earlier recommendation to circulate the minutes once signed by the Chair. While there was no formal annual report, communication between the Chair of the committee and the Authority was good. A formal annual report would be prepared, timed to go with the Annual Governance Statement.

Members felt less exposed to the workings of the two external licensing appeals committees, and requested that thought be given to improving communication between the Authority/AGC members, and the external committees, both in terms of personnel and their work.

Conclusions

Do we achieve **Principle 5: Communication** – Does the Committee engage effectively with Financial and Performance Reporting issues, and with the work of internal and external audit? And does the Audit Committee communicate effectively with the Accounting Officer, the Board and other stakeholders?

What do we need to do to enhance the Audit Committee?

1) Institute formal annual report to Authority board

2) Give thought to improving communication from external appeals committees to AGC/Authority board, while maintaining independence of those committees.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Section II

The role of the Chair: good practice

The Chair of the Audit Committee has particular responsibility for ensuring that the work of the Audit Committee is effective, that the Committee is appropriately resourced, and that it is maintaining effective communication with stakeholders.

Good Practice Questions

	Agenda Setting	**Yes**	**No**	**N/A**
60	Is the Board Secretary different from the Audit Committee Secretary?	☒	☐	☐
61	Does the Chair of the Audit Committee meet with the Committee Secretary before every meeting to discuss and agree the business for the meeting?	☒	☐	☐
62	Are inputs on Any Other Business formally requested in advance from Committee members and attendees?	☐	☒	☐
63	Are outline agendas planned one year ahead to cover core activities and specific issues on a cyclical basis?	☒	☐	☐
64	Does the agenda exclude executive business, so that there is no overlap with the work of the Board whilst linking to the main elements of the organisation's business?	☒	☐	☐
65	Are the meetings set for a length of time which allows all business to be conducted, yet not so long that the meeting becomes ineffective?	☒	☐	☐
66	Does the Chair encourage full and open discussion and invite questions at the Audit Committee meetings?	☒	☐	☐
	Communication			
67	**Does the Chair of the Audit Committee have open lines of communication with the Board, Head of Internal Audit, and the External Auditors?**	☒	☐	☐
68	Does the Chair encourage all Committee members to have regular interface with the organisation and its activities to help them understand the organisation, its objectives, and business needs and priorities?	☒	☐	☐
69	**Do reports to the Audit Committee communicate relevant information at the right frequency, time, and in a format that is effective?**	☒	☐	☐
70	Does the Audit Committee issue guidelines concerning the format and content of the papers to be presented to the Committee?	☒	☐	☐

	Monitoring Actions	Yes	No	N/A
71	**Does the Chair or the Secretariat ensure that all action points from Committee meetings are appropriately acted upon?**	☒	☐	☐
72	Does the Chair or the Secretariat ensure that members who have missed a meeting are appropriately briefed on the business conducted in their absence?	☒	☐	☐
73	Is a report on matters arising made and minuted at the Audit Committee's next meeting?	☒	☐	☐
	Appraisal	☐	☐	☐
74	Does the Chair ensure that the Committee members are provided with an appropriate appraisal of their performance as a Committee member?	☒	☐	☐
75	Does the Audit Committee Chair seek appraisal of their personal performance from the Accounting Officer or Chair of the Board?	☒	☐	☐
76	**Are Audit Committee meetings well attended, with records of attendance maintained and reviewed annually by the Board?**	☒	☐	☐
	Appointments	☐	☐	☐
77	Is the Chair involved in the appointment of new Committee members, including providing advice on the skills and experience required of the new individual?	☒	☐	☐

Additional Comments:

The Chair recorded her thanks to the members, Executive and external attendees for their support and work on the committeee. The members agreed that the committee was chaired efficiently and effectively.

As previously agreed, the Chair would institute appraisals for the members, in line with the Authority member appraisal timetable.

The Chair would be involved in the decision regarding the expiry of an existing external member's term of office.

Conclusions

Do we meet **Good Practice: the Role of the Chair** – Is the Committee appropriately resourced, work planned in advance as far as possible, and effective communication with stakeholders maintained?

What do we need to do to enhance the Audit Committee?

1) Ensure Chair of committee is involved in decision regarding expiry of existing external member's term of office.

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Section III

Committee support: good practice

The Audit Committee should be provided with appropriate Secretariat support to enable it to be effective. This is more than a minute-taking function – it involves providing proactive support for the work of the Committee, and helping its members to be effective in their role.

Good Practice Questions

	Does the Audit Committee Secretariat:	**Yes**	**No**	**N/A**
78	Commission papers as necessary to support agenda items?	☒	☐	☐
79	Circulate meeting documents to all Committee members, Internal Audit and External Auditors in good time before each meeting, to allow members time to study and understand the information e.g. at least one week before the meeting?	☒	☐	☐
80	Arrange for Executives/senior management to be available as necessary to discuss specific agenda items with the Audit Committee during meetings?	☒	☐	☐
81	**Keep records of meetings and minutes after they have been approved by the Audit Chair and circulate them to Committee members, Head of Internal Audit, External Auditors, Board, and the Accounting Officer on a timely basis e.g. within one week of the meeting?**	☒	☐	☐
82	**Ask for confirmation that the minutes are a true and fair representation of a summary of the business taken by the Audit Committee?**	☒	☐	☐
83	Ensure that the minutes clearly state all agreed actions, the responsible owner, when they will be done by and any advice given from any stakeholders?	☒	☐	☐

Does the Audit Committee Secretariat: (continued)		**Yes**	**No**	**N/A**
84	**Ensure action points are being taken forward between meetings?**	☒	☐	☐
85	Support the Chair in the preparation of Audit Committee reports to the Board?	☒	☐	☐
86	**Arrange the Chair's bilateral meetings with:**			
	a. the Accounting Officer, the Head of Internal Audit, Director of the External Auditors;	☐	☒	☐
	b. the Chair of the Board of sponsored NDPBs.	☐	☒	☐
87	Keep the Chair and members in touch with developments and relevant background information about developments in the organisation?	☒	☐	☐
88	Maintain a record of when members' terms of appointment are due for renewal or termination?	☒	☐	☐
89	Ensure that appropriate appointment processes are initiated when required?	☒	☐	☐

Additional Comments:

The committee felt it was well supported by the Executive, in particular the Secretary to the committee. Organisation is always very efficient, and communication between the Chair and the Secretary and other lead officers works well.

Conclusions

Do we meet **Good Practice: Support for the Committee** – Does the Committee receive appropriate support from its secretariat?

What do we need to do to enhance the Audit Committee?

Where we have carried out the self-assessment before, the audit committee has improved its performance against:

1 ☐ none of the good practice questions.
2 ☐ some of the good practice questions.
3 ☐ most, if not all of the good practice questions.

Where to find out more

The National Audit Office website is
www.nao.org.uk

Links to other websites
www.hm-treasury.gov.uk/audit_committee_handbook.htm
www.hm-treasury.gov.uk/d/mpm_annex3.1.pdf

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Audit and Governance Committee Paper

DRAFT

Paper Title:	**AGC Forward Plan 2014**
Paper Number:	[AGC (10/12/2014) 441]
Meeting Date:	1 October 2014
Agenda Item:	**12**
Author:	Sue Gallone
For information or decision?	Decision
Resource Implications:	None
Implementation	N/A
Communication	N/A
Organisational Risk	Not to have a plan risks incomplete assurance, inadequate coverage or unavailability key officers or information
Recommendation to the Committee:	The Committee is asked to review and make any further suggestions and comments and agree the plan.
Evaluation	Annually, at the review of Committee effectiveness (but the forward plan might be reviewed briefly by the Committee at each meeting)
Annexes	N/A

AGC Forward Plan 2014

Item↓ Date:	**18 Mar 2015**	**10 June 2015**	**7 October 2015**	**9 December 2015**
Following Authority Date:	**7 May 2015**	**16 July 2015**	**11 November 2015**	**14 January 2015**
Meeting 'Theme/s'	**Finance Instructions, Project Management**	**Annual Reports, Information Governance, People**	**Strategy & Corporate Affairs, AGC review**	**Register and Compliance, Business Continuity**
Reporting Officers	**Sue Gallone**	**Peter Thompson**	**Juliet Tizzard**	**Nick Jones**
High Level Risk Register	Yes	Yes	Yes	Yes
Information for Quality (IfQ) Programme	Yes	Yes	Yes	Yes
Annual Report & Accounts (inc Annual Governance Statement)	Plan & review any drafts	Approval		
External audit (NAO) strategy & work	Interim Feedback	Audit Completion Report	Audit Planning Report	Planning Report
Information Assurance & Security		Yes		
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes
Internal Audit	Early Results, approve draft plan	Results, annual opinion	Update	Update
Whistle Blowing, fraud (report of any incidents)	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Contracts & Procurement including SLA management	Update as necessary	Update as necessary	Update as necessary	Update as necessary
HR, People Planning & Processes		Yes		
Strategy & Corporate Affairs management			Yes	
Regulatory &				Yes

Item↓ Date:	**18 Mar 2015**	**10 June 2015**	**7 October 2015**	**9 December 2015**
Register management				
Resilience & Business Continuity Management				Yes
Project Planning & PMO	Yes			
Standing Financial Instructions	Yes			
Reserves policy			Yes	
Review of AGC activities & effectiveness, terms of reference			Yes	
AGC Forward Plan	Yes	Yes	Yes	Yes
Session for Members and auditors	Yes	Yes	Yes	Yes
Other one-off items	1. Representations hearing – lessons learned 2.Shared finance resources 3. Review frequency of AGC meetings			