Audit and Governance Committee meeting - agenda

Human Fertilisation & Embryology Authority

8 December 2022

HFEA Office, 2nd Floor, 2 Redman Place, London E20 1JQ

10am

Agenda item			Time
1.	Welcome, apologies and declaration of interests		10.00am
2.	Minutes of 4 October 2022 [AGC (08/12/22) DO]	for decision	10.05am
3.	Action log [AGC (08/12/22) MA]	for information	10.10am
4.	Internal audit report [AGC (08/12/22) JC]	for information	10.20am
5.	Progress with current audit recommendations [AGC (08/12/22) MA]	for information	10.40am
6.	External audit planning report on the 2022-23 financial statements audit [AGC (08/12/22) MP/DG]	for information	10.50am
7.	Strategic risk • Risk management strategy [AGC (08/12/22) SQ] • Operational risk register [AGC (08/12/22) SQ] • Strategic risk register [AGC (08/12/22) SQ] • Risk appetite [AGC (08/12/22) SQ] • Proposal for deep dive topics [AGC (08/12/22) RS] • Financial risk on potential income position and government funding [AGC (08/12/22) RS] • Horizon scanning [AGC (08/12/22) RS]	for discussion	11.10am
	Break		12.10pm
8.	Digital projects/PRISM update [AGC (08/12/22) KH]	for information	12.20pm
9.	Resilience, cyber security & business continuity management [AGC (08/12/22) RC]	for comment	12.30pm

10.	Human Resource bi-annual update 2022 **[AGC (08/12/22) YA]**	for comment	12.50pm
11.	Review of AGC effectiveness **[AGC (08/12/22) DO/PR]**	for comment	1.05pm
12.	AGC forward plan **[AGC (08/10/22) MA]**	for decision	1.30pm
13.	Items for noting (verbal update) • Whistle blowing • Gifts and hospitality • Contracts and Procurement • Estate update **[AGC (08/12/22) RS]**	for information	1.35pm
14.	Any other business		1.45pm
15.	Session for members and auditors only		1.50pm
16.	Close		2.00pm
	Lunch		
17.	Training – Interpretation of financial statements		1hour

Next Meeting: Tuesday, 14 March 2023.

Minutes of Audit and Governance Committee meeting 4 October 2022

Details:			
Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science and society		
Agenda item	2		
Meeting date	8 December 2022		
Author	Debbie Okutubo, Governance Manager		
Output:			
For information or decision?	For decision		
Recommendation	Members are asked to confirm the minutes of the Audit and Governance Committee meeting held on 4 October 2022 as a true record of the meeting		
Resource implications			
Implementation date			
Communication(s)			
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes			

Minutes of the Audit and Governance Committee meeting on 4 October 2022 held in person at HFEA Office, 2nd Floor, 2 Redman Place, London, E20 1JQ and via teleconference (Teams)

	In person	Online
Members present	Catharine Seddon - Chair Alex Kafetz Mark McLaughlin Geoffrey Podger	Jason Kasraie
Apologies	Morounke Akingbola, Head of Finance	
External advisers	Mohit Parmar, National Audit Office (NAO) – External Auditor Joanne Charlton, Head of Internal Audit (Internal Auditor)– GIAA	Dean Gibbs, KPMG – Audit lead
Observer		Amy Parsons, Department of Health and Social Care – DHSC
Staff in attendance	Peter Thompson, Chief Executive Richard Sydee, Director of Finance and Resources Rachel Cutting, Director of Compliance and Information Paula Robinson, Head of Planning and Governance Shabbir Qureshi, Risk and Business Manager Debbie Okutubo, Governance Manager	Clare Ettinghausen, Director of Strategy and Corporate Affairs Kevin Hudson, PRISM Programme Manager Martin Cranefield, Head of IT Neil McComb, Head of Information

1. Welcome, apologies and declarations of interest

1.1. The Chair welcomed everyone present online and in person.

1.2. There was an apology from Morounke Akingbola, Head of Finance.

1.3. There were no declarations of interest.

2. Minutes of the meeting held on 28 June 2022

2.1. The minutes of the meeting held on 28 June 2022 were agreed as a true record and could be signed by the Chair.

3. Action log

3.1. The Director of Finance presented this item. Members noted the status of the action log including updates and that some items were agenda items at this meeting.

Action

3.2. Members agreed that future versions of the action log to be updated and all completed items to be tabled for removal from the log.

4. Internal audit report

4.1. An update on the internal audit work undertaken in the period since the start of the new financial year from 1 April 2022 to 23 September 2022 was presented by the Head of Internal Audit. She requested that customer satisfaction questionnaires should be completed and returned as part of the work of the Government Internal Audit Agency (GIAA) to ensure they were meeting the needs of client organisations.

DSPT

4.2. On the Data Security and Protection Toolkit (DSPT), members asked if we would ever be able to achieve the requirements on the toolkit. The Chief Executive responded that we would discuss this with NHS digital and feedback.

4.3. The Director of Finance and Resources commented that we were limited in our resources and there was no longer a lower bar on the requirements of the DSP Toolkit. We were therefore looking to see if we could have a dispensation and also anticipate what the risks could be.

4.4. The Chair commented that the main report on the DSPT from the Internal Audit team suggested significant progress and gave assurance to the committee that we were making progress.

4.5. The DHSC representative commented that they had listened to the HFEA's perspective but they were limited on what they could do. However, they would continue to explore the options available and meet the Executive at the next accountability meeting with an update.

4.6. A member commented that as long as we were confident that IT security was up to date the toolkit was very good but what was more important was ensuring that IT software security was intact.

4.7. Members also commented that if ALBs were being reviewed, the DSP Toolkit might also be reviewed and during those meetings we should seize the opportunity to make the point that we have limited resources to complete the toolkit.

4.8. The Chief Executive commented that we were yet to have a firm date for the ALB review. He also wanted the committee to take assurance from the fact that in the 30 years existence of the HFEA we have had no data loss.

4.9. Members commented that due to the ransomware attacks in the summer, in particular the NHS 111 service, it was very possible that we would have to revisit this issue because IT security was being tightened across the board.

4.10. The Chair commented that AGC members were content to accept the internal audit limited assurance and endorsed the executive's request that small, low risk ALBs be at a different level from NHS trusts.

Staff onboarding

4.11. The Chief Executive commented that this was a helpful report and that the recommendations were noted. Also, that despite not consistently recording the progress of the onboarding of all staff, we know that all new staff are made to feel welcome and carry out the expectation of their roles.

Anti-fraud controls

4.12. The Chair requested that priority be given to implementing the recommendations in this area due to the risk climate around it.

4.13. The Director of Finance and Resources responded that this was the intention and that it was an agenda item. Also, there were other elements in our business which were not financial and that we were looking into these areas to ensure all necessary controls are in place.

Proposed Addition to the Plan – Corporate Governance

4.14. Members asked why this area was on the internal audit plan as it seemed unusual to carry out an audit on Authority member induction.

4.15. The Executives commented that they felt it was important to measure how effective the member induction process was to ensure that Members become effective in post very soon after joining the Authority.

4.16. The Chair commented that there was no longer a presumption that appointees will serve two terms and that, given the importance of decisions that needed to be made at board level, it was important that members started off fully equipped and able to deliver what was expected of them. Other Authority members commented that one term of three years was barely enough time to become experienced in the committee work, and that there were concerns around knowledge management in this area.

4.17. The Internal Auditor commented that it was common in corporate governance audits to look at new member induction as the effectiveness of new members was a critical aspect of effective corporate governance.

4.18. The Chair summarised the discussion and thanked the Internal Auditor for the August Assurance report supplement which she stated was very informative and provided good insight.

Action

4.19. Executive to continue discussions with DHSC and NHS digital to further the argument for certain ALBs being assessed at a different level from that appropriate for NHS trusts and an update brought to the December AGC meeting.

4.20. Annual review of functional standards to be added to the forward plan.

Decision

4.21. Members noted the 2022/2023 progress update and endorsed the changes to the 2022-23 Audit plan.

5. Implementation of recommendations

5.1. The Director of Finance presented this item. It was noted that three audits had been added since the last meeting: Anti-Fraud controls, onboarding and the DSPT. The recommendations from these audits would be addressed during the 2022/23 financial year. There are 50 recommendations in total outstanding as of 12 September 2022 of which 23 were new.

5.2. The Chair commented that there are many pressures on a small number of staff.

5.3. Members commented that the management team needed to look at how some of these recommendations could be implemented. Internal audit made some reasonable suggestions but not how they could be achieved and this needed to be borne in mind as we need to make the best use of our limited resources and ensure that whilst working on the backlog of audit work our statutory work does not suffer.

5.4. The Internal Auditor commented that there are various opportunities for management to communicate any concerns with proposed recommendations when they meet with internal auditors during the audit process. Discussions happen early on and as a management team they can choose to accept the risk.

5.5. Members agreed that management should make the most of the opportunities that are given to them at internal audit meetings.

5.6. The Chief Executive commented that going forward we would engage more with internal audit and come up with a way forward as we do not generally feel that it is good practice to reject recommendations that are somewhat reasonable.

5.7. The Internal Auditor responded that pushing back on recommendations was different from lack of positive engagement during an audit. As the internal audit team, they would still report back to the committee and the discussion held with management would be reflected in the report, highlighting where risk exposure was unlikely to be mitigated.

5.8. The Chair suggested that a way forward might be that the action log be divided into recommendations that are wholly accepted to be delivered and those that following discussion with internal audit we are not equipped to deal with due to limited resources. The Director of Finance and Resources agreed to the suggestion.

5.9. For staff wellbeing and the review of KPIs, members sought reassurance from management that they would be placing priorities on these. The outstanding work on KPIs would be completed alongside the current work on the risk strategy, which was on today's agenda for discussion.

5.10. Following a request from the Internal Auditor, members requested that a process be developed to ensure that recommendations are accurately captured in the tracker.

Actions

5.11. Management to consider future DSPT actions.

5.12. The summary of audit recommendations to record a section of recommendations that are accepted for implementation and another section recording the recommendations that due to limited resources may not be implemented. AGC to scrutinise both sections routinely

Decision

5.13. Members noted the progress with implementing recommendations.

6. External audit report

6.1. The National Audit Office (NAO) External Auditor introduced this item. He commented that following discussion at the June meeting, they delayed completion of the audit as the HFEA received further information from clinics to support the income reported in the financial statements.

6.2. With the additional information they were able to conclude satisfactorily on income and were now working with management to sign off the accounts.

6.3. The KPMG Audit lead commented that they were now satisfied with the low level of unreconciled income and that the risk of a material misstatement was suitably low.

6.4. The KPMG Audit lead then gave an update on audits on ISA 315 and ISA 240 revisions. It was noted that in light of regulatory and technological changes across the audit profession, and to ensure that a consistently high quality efficient and insightful audit was delivered, there would be changes to the work undertaken during the planning of the audit, especially in the consideration given to IT as part of the audit.

6.5. The changes it was noted were primarily driven by the revisions to ISA 315 - Identifying and Assessing the Risk of Material Misstatement, with further changes arising from ISA (UK) 240 - The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements.

6.6. They are effective for audits of financial statements for periods beginning on or after 15th December 2021, which equates to the 2022-23 financial year for UK public sector entities.

6.7. The Director of Finance and Resources commented that in terms of income status we would have further conversations with the auditors on our financial position also that integrity of data submitted remained an area that we will keep an eye on. He thanked the auditors for the work to date.

6.8. Members requested that given that the pressures of the ALB review may conflict with when the audit was planned that the external auditors be flexible around management's availability.

6.9. The Chief Executive thanked all involved and commented that as the Accounting Officer he was comfortable with where the Authority was on billing and estimates. He commented that discretionary spending could be affected by the cost-of-living crisis, we were therefore keeping this under review and will monitor closely any effect on fertility treatments.

6.10. On PRISM, codes had been recorded in a library and in-house staff were now using the library of codes. This meant that the handover notes were proving to be very effective.

Decision

6.11. The committee considered, noted and were content to accept the audit position.

6.12. The committee noted the letter of representation and the certificate and report of the Comptroller and Auditor General to the Houses of Parliament.

7. Strategic risk register and risk management policy

7.1. The Risk and Business Planning Manager presented this item. It was noted that the reviewed Risk Strategy will first be presented at the November Authority meeting, where risk appetite will also be discussed. Following comments from Authority members, the strategy will be presented to AGC in December alongside the new strategic risk register.

7.2. The Head of Planning and Governance gave assurance that the committee's previous comments on the risk strategy and the strategic risk register would be addressed in the next update.

7.3. Members were advised that the new 'Risk strategy' (changed from 'Risk policy') would use both the Orange book principles and audit feedback. Also, that the new Risk strategy would adopt a joined-up approach by ensuring that risk management worked more cohesively with our performance reporting and planning activities, particularly at team level.

7.4. Members commented that it was good to see that continuous improvement had been built into the system and took assurance from the fact that annual and also periodic zero-based reviews of the register would be conducted.

7.5. Members also commented that the Excel sheet was very comprehensive and that the mechanism for teams to share risks was very good.

7.6. On risk champions, members asked if we were resourced to have these. The Risk and Business Planning Manager responded that this was a voluntary additional role taken on by staff. In terms of performing the role there was a time constraint rather than a resource constraint. In terms of training, there was an e-learning module available on Civil Service Learning that staff who were risk champions would be encouraged to do.

7.7. For the 'dip check' of performance indicators, it was noted that specific areas would be looked at, with past data submission accuracy being double checked. Many of the indicators had been reviewed and replaced in recent months, so it had not yet been possible to begin the dip checks, but these would commence by the end of 2022.

7.8. Members were reminded that in terms of our risk appetite, where we positioned ourselves strategically would need to be considered carefully and would always be dependent on assessment of particular contextual risks.

7.9. The Chief Executive commented that our proposals for legislative reform might have a bearing on this but this was as yet unknown.

7.10. The Chair requested that the Authority consider an additional category of risk appetite around communication with stakeholders. This should align well with the new communications strategy which would be presented at the November Authority meeting.

Action

7.11. Executive to consider an additional category of risk appetite around communication with stakeholders.

Decision

7.12. Members noted the strategic risk register and risk review.

8. Horizon scanning & deep dive topics

8.1. The Director of Finance and Resources presented this item. Members were advised that for the December meeting we were looking to bring forward financial risk on potential income position and government funding.

8.2. He also suggested that we wanted to avoid areas and topics that internal audit were looking at for example opening the register (OTR), so as not to duplicate work.

8.3. Also, we might have to avoid scheduling deep dives to the June meeting, since we look at the annual accounts and report.

8.4. The Chair commented that deep dives necessarily incur extra work: it is therefore crucial that they add value and that they be planned to dovetail around internal audit reviews.

8.5. Potential topics for 2023-2024 to include:

- staff retention
- the impact of communication
- the effectiveness of performance management and risk (as this would be a year after the new system has been embedded)

8.6. Potential future risks not yet incorporated into the risk register were highlighted, for example:

- The potential for reduction in fertility services over time
- HFEA's regulatory effectiveness if some or all of our ambition for legislative change fails.
- Increasingly onerous standards of corporate governance reporting materially impacting our ability to put the patient at the heart of all that we do.

Action

8.7. Executive to propose precise topics and timings to AGC in December for deep dives in 2023.

Decision

8.8. Members endorsed the suggested topics.

9. Digital projects/PRISM update

9.1. Members were given an update on PRISM by the Programme Manager. Members were advised that during July and August there were 12 clinics (1 standalone, 8 Mellowood, 3 Meditex) with large billing shortfalls for 2021/22. It could be inferred that the clinics had not properly caught up on submitting their data through PRISM. At the end of August 2022, nine clinics still had data to submit. Most have advised that they will be caught up by December 2022.

9.2. Members sought clarification on the issue with the backport. The Programme Manager responded that three clinics the ARGC group were the last clinics remaining to be deployed in PRISM and that these clinics would require a special 'backport' deployment to ensure that their data in PRISM synchronises with previously submitted data.

9.3. The Chief Executive commented that HFEA built the backport functionality in anticipation of deployment for ARGC but in addition to that, backports would be useful where clinics want to change systems and that St Mary's Hospital, Manchester had requested such a migration and we were in the process of communicating to St Mary's that we will work with them as a pilot for this functionality before commencing work on the ARGC.

9.4. It was noted that PRISM was bedding in and that a new version of General Direction (GD0005) outlining the standards to which clinics must adhere to when entering PRISM had been published.

9.5. The Programme Manager commented that validation errors were now down to 3% but we were still seeing week-on-week variations. We would continue to work to ensure that there was stability as this was essential both for ongoing use of the system and for progressing the verification work on Choose a Fertility Clinic (CaFC).

9.6. Members were informed that the work to assess all remaining legacy data fixes was also still in progress. Due to its complexity, there was only one member of HFEA staff that could undertake this detailed work, and we were not yet sufficiently progressed in this assessment to give a firm date of when the assessment would be complete. A second analyst had been recruited recently to support this work, and therefore, once they had settled in, this could progress faster.

9.7. The Chair requested that at the December AGC meeting we have a best case and a worst-case scenario presented for the data fixes.

9.8. The Chief Executive commented that a status update will be brought to the meeting and that SMT were keeping this under review.

9.9. Members were informed that the development handover from contractors to HFEA in house software developers was completed at the end of June and that there was ongoing work on operational and clinic support for PRISM, testing and PRISM programme management.

Action

9.10. The best case and worst-case scenarios on assessing the legacy data issues to be presented at the December AGC meeting.

Decision

9.11. Members noted the status of PRISM.

10. Resilience & business continuity management

10.1. The Head of IT and Head of Information presented this item.

IT

10.2. The IT infrastructure improvements were explained. It was noted that an email security service, Mimecast, was being evaluated among other services. These offered the ability to send large files to external parties with tight security controls when required on an ad-hoc basis and email phishing training to end users.

10.3. Members asked how this would affect them as they did not have HFEA issued laptops but accessed their emails via Office 365. The Head of IT responded that work had not yet started on

this area and that consideration would be given to this issue, since Authority members did need to access their HFEA emails through Office 365.

10.4. Members were advised that it had been noted that Office 365 was not being backed up. We had since evaluated a specialist third party solution and we will be entering into a contract with the supplier. An update will be brought to the December meeting.

10.5. There was a penetration test carried out on 12 September and no critical risks were identified. There were however some high and medium level risks.

10.6. Members asked what the consequences of these high and medium level risks were. The Head of IT responded that the risks identified were not internet facing systems - for example Epicentre was one of the areas and this was because it was running on an out-of-date system which meant that the stability of the platform is a concern. This is a known risk and planning had started to explore how Epicentre can be replaced.

10.7. Members commented that over the summer there were ransomware attacks on the IT systems of some organisations which meant that we needed to be up to date with our IT security. The Head of IT responded that we would keep up with end user behaviour and remind them how to avoid interacting with potential threats. Members were advised that information security was being prioritised and that it was under constant review.

DSPT

10.8. The Head of Information commented that on the DSPT self-assessment, in 2020/21 the HFEA was in category 2 of the list of organisations who completed the DSPT. This year NHS digital had raised the bar and moved the HFEA into category 1 alongside NHS trusts and Clinical commissioning groups (CCGs).

10.9. To address this, a new Information Governance and Security Steering Group had been set up and will meet for the first time in October to consider the mandatory items and the owners of those items.

10.10. Members commented that the National Data Guardian and the Information Commissioner had both recently been changed and that might be of interest to the Executive when pursuing further discussions about the DSPT.

Decision

10.11. Members noted the infrastructure improvements and the current position on the DSPT, as well as the heavy resource implications.

11. Reserves policy

11.1. The Director of Finance and Resources presented this item. Members were advised that we were yet to resolve the issue of spending our reserves. The Director of Finance and Resources will revisit the issue of the utilisation of reserves with the DHSC during the last half of this business year.

11.2. Members asked why it was so restrictive and not subject to annuity because we keep ‘parking’ the reserves and not using it. The Director of Finance and Resources responded that this could result in a grant-in-aid reduction. It was recognised that we do need some discretion but we will continue to have this conversation with the appropriate people.

11.3. The DHSC representative commented that as sponsors they need to defer to their finance partners but that they noted what the Authority wanted to do.

11.4. The Director of Finance and Resources commented that the reserves we hold were cash reserves and if for any reason we ran out of money, the process was that we approach our sponsor the DHSC.

Decision

11.5. Members noted the Reserves policy position and that there were no proposed changes. Also, that the utilisation of reserves remained an outstanding issue.

12. AGC forward plan

12.1. The Director of Finance and Resources presented this item.

12.2. Deep dive topics to be populated and horizon scanning topics to be populated at each AGC meeting.

Actions

12.3. It was agreed that the deep dive topics discussed in item 8 would be included on the forward plan.

12.4. The training for committee members on the interpretation of financial statements to be added to the March items. The executive to agree with NAO External Auditor what can be offered

12.5. The Risk Management Strategy to be added to the December agenda.

Decision

12.6. Members noted the current position and the requested updates to the forward plan.

13. Fraud Risk Assessment

13.1. The Director of Finance and Resources presented this item. Members were informed that feedback from the recent anti-fraud controls audit was that the fraud risk assessment (FRA) we currently have needs to be reviewed by both the Corporate Management Group (CMG) and the Audit and Governance Committee (AGC) on a regular basis.

13.2. Members were advised that the plan was to broaden the risks beyond income risks.

13.3. The Chair sought clarification about the meaning of a ‘no’ under ‘residual risk not tolerated’. The Director of Finance and Resources responded that it meant the level of control was at an acceptable level.

Decision

13.4. Members endorsed the fraud risk assessment.

14. Legal risks

14.1. The Chief Executive presented this item.

14.2. Members noted the legal risks.

15. Update on goodwill letters

15.1. The Director of Compliance and Information presented this item. It was noted that work had been done by the Head of Information and that there were two options.

Option one

15.2. A company, Iron Mountain had been identified who could scan the documents. However, issues had been identified and the solution was that a dedicated person would be required to file, categorise and scan the documents as they were not in a single place nor in any order. The cost to do this will be approx. £11,000 for Iron Mountain to scan these documents and the dedicated staff would cost £13,000.

Option 2

15.3. Alternatively, we could ask clinics to upload their data into PRISM but this was potentially a reputational risk. There still would be a need to categorise the documents prior to disposal as other communication such as change of address letter could be in the correspondence. There would therefore still be the £13,000 cost.

15.4. Further discussion will take place at SMT level and we will report back to the committee.

16. Items for noting

16.1. Whistle blowing

- Members were advised that there were no whistle blowing incidents.

16.2. Gifts and hospitality

- Members noted that there were no changes to the register of gifts and hospitality.

16.3. Contracts and procurement

- Members noted but there were no contracts or procurements signed off since the last AGC meeting.

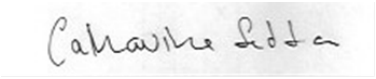
17. Any other business

17.1. Following a discussion, members agreed that meetings should remain as hybrid, therefore all future meetings will be in person to the extent possible, with the option of joining online.

Chair's signature

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

Signature



Chair: Catharine Seddon

Date: 8 December 2022

AGC Action log

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society

Meeting	Audit and Governance Committee		
Agenda item	3		
Meeting date	8 December 2022		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For information		
Recommendation	To note and comment on the updates shown for each item.		
Resource implications	To be updated and reviewed at each AGC		
Implementation date	2022/23 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
Matters Arising from the Audit and Governance Committee – actions from 9 December 2021			
3.14 Pursue suggestions from NAO and GIAA for Board Cyber Security training	Director of Finance and Resources	Mar-22	**Update** – training to be facilitated by NAO at March meeting
5.13 Committee to receive a summary of other ALBs' experiences with DSP Toolkit	Director of Compliance and Information	Mar-22	**Update** – Report on the agenda – Chair requested it is shared with Committee
7.14/15/16 Head of HR to incorporate considerations regarding corporate culture into the proposed action plan and update AGC at October 2022 meeting on progress and effectiveness of the action plan being created from the Staff survey results. The timetable for the roll-out of the action plan to be shared with the Committee	Head of HR	Oct-22	**Update -** This will be given at the October meeting. Action plan shared with AGC **Update** – Action plan tabled at June meeting and includes timetable for each action.
Matters Arising from the Audit and Governance Committee – actions from 15 March 2022			
3.4 Director of Finance and Resources to circulate the summary of ALBs experiences of using the DSP Toolkit with members	Director of Finance and Resources	Mar-22	**Update –** circulated
4.7 In the 2022/23 proposed audit plan, the Board to be included in the ED&I audit	GIAA	Jul-22	**Update –** *check closer to audit date when agreed.*
Matters Arising from the Audit and Governance Committee – actions from 28 June 2022			
3.2 Topics for deep dives to be added to the forward plan	Executives	Oct 22	**Update -** It will be an agenda item at the October AGC meeting

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
5.13 Internal Audit recommendations – Goodwill letters action due date changed to June 2023	Head of Finance	By Oct-22	**Update -** date has been amended see Tracker
5.14 A quotation on the cost of scanning and saving the goodwill letters to be sent to the committee by the December meeting	Head of Information	By Dec-22	**Update –** Total cost including temp staffing and scanning is £30,356.30
5.15 An oral update on goodwill letters	Director of Compliance and Information	Oct-22	**Update –** A brief paper has been submitted to SMT outlining 2 options **1.** Contract Iron Mountain to securely transport the documents, scan them and return digital images of these records for us to bulk upload them to the Register and then securely destroy the paper records. Would involve significant staff time to catalogue and remove unnecessary documents prior to scanning (proposal to recruit temp administration officer). Significant cost to HFEA. **2.** The documents we hold should be copies of originals that reside within clinics. Since we have developed the means by which clinics can send their own images of donor forms to the new Register, we could destroy all the documents we currently hold and produce a report in PRISM that identifies all donor registrations that do not have an image attached. It would then be for the clinics to submit these documents electronically. Reputational risk with sector.
8.21 The Chair to share an example of horizon scanning with the Chief Executive of what some other regulatory bodies do.	AGC Chair	Oct-22	**Update -** The Chair sent the example to the CE – completed**.**
9.7 An update is required outside of the cycle of meetings once the delivery date for OTR through PRISM is known.	Programme Manager	Sep-22	**Update –** We are still undertaking this work and we will advise AGC when the delivery dates are known. Full details on this are in the update paper.

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
11.9 HFEA to meet with GIAA to colleagues regarding DSPT requirements and evidence	Director of Finance and Resources	Mar 2023	**Update –** to be provided at the December meeting
11.10 Chief Executive to meet with the AGC Deputy Chair to discuss DSPT issue.	Chief Executive	Oct 2022	**Update –** to be provided at the December meeting
14.8 The External Auditor and the Director of Finance and Resources to meet to discuss member training.	Director of Finance and Resources	Oct 2022	**Update –** training agreed and to be delivered at December meeting
Matters Arising from the Audit and Governance Committee – actions from 4 October 2022			
4.19 Executive to hold discussion with DHSC and NHS digital for some ALBs to be assessed at a different level on the Data Security and Protection Toolkit (DSPT) and consider future DSPT actions.	Chief Executive	December 2022	**Update –** to be provided at December meeting
5.12 The summary of audit recommendations to record a section of recommendations that are accepted for implementation and another section recording the recommendations that due to limited resources may not be implemented.	Head of Finance	December 2022	**Update –** not complete but will be once reviewed with risk owners.
7.11 Executive to consider an additional category of risk appetite around communication with stakeholders	Director of Strategy and Corporate Affairs	December 2022	**Update** – in progress in new strategic risk register.
8.7. Executive to propose precise topics and timings to AGC in December for deep dives in 2023 and include on the forward plan	Director of Finance	December 2022	**Update –** items to be brought to the December meeting
9.10. The best case and worst-case scenarios on assessing the legacy data	PRISM Programme Manager	December 2022	**Update –** to be provided at December meeting.

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
issues to be presented at the December AGC meeting.			
12.4. The training for committee members on the interpretation of financial statements to be added to the March items. The executive to agree with NAO External Auditor what can be offered.	Director of Finance and Resources and the NAO/KPMG Audit Lead	March 2023	**Update -** this has been added to the forward plan.
12.5. The Risk Management Strategy to be added to the December agenda.	Risk and Business Planning Manager	December 2022	**Update –** papers submitted and to be discussed at December meeting
15.4 Update on goodwill letters to be discussed at SMT and brought back to AGC.	Director of Compliance and Information	Oct 2023	The decision is to proceed with cataloguing the documents and to scan on to the register. Iron Mountain has been contracted. Currently working on job description for temporary staff member to undertake cataloguing and preparation for scanning.

Strategic risk register and risk review

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society
Meeting:	AGC
Agenda item:	7
Meeting date:	8 December 2022
Author:	Shabbir Qureshi, Risk and Business Planning Manager
Annexes	7a –HFEA Risk Strategy, 7b – Operational risk register and Top 3 risks screenshots, 7c – Risk appetite statement, 7d strategic risk register

Output from this paper

For information or decision?	For discussion and decision on risk appetite. For review of new strategic risk register.
Recommendation:	AGC is asked to discuss and agree a risk appetite statement for the HFEA. A draft is attached. AGC is also invited to comment on the revised strategic risk register.
Resource implications:	In budget
Implementation date:	Ongoing
Communication(s):	Feedback from AGC to Authority in January
Organisational risk:	Medium

1. Purpose

1.1. AGC were given an updated timeline for review of the risk policy in June 2022, and this was further updated in October 2022.

1.2. The new risk strategy is attached. This has been approved by CMG in October 2022 and has also been presented at Authority in November 2022.

1.3. A new Operational Risk Register is now in use and teams have commenced migrating previous risk registers into this template. Screenshots of the completed register are attached from some of the teams. This is a work in progress and will be reviewed regularly at CMG.

1.4. A new 'Top 3 risks' document has also been created which is used at CMG. Screenshots of this are also included.

1.5. A new strategic risk register (SRR) template has been created with significant changes from the previous Word document. The previous SRR has been transferred into the new template, which is attached. In migrating our risks across, we have avoided including operational elements of risk that are more appropriately included in teams' operational risk registers. The SRR currently contains ten strategic risks, with 29 sub-risks. The sub-risks can be closed individually.

1.6. The SRR will continue to develop as risks are aligned to both the new business plan and the upcoming work on the new HFEA strategy, and based on feedback. The Authority will receive the SRR at its January 2023 meeting.

1.7. AGC is invited to comment on the new SRR, and in particular on the recommendation from SMT to close our current broad legal risk, and instead to create particular legal risks as and when the need arises in the future.

2. Risk appetite

2.1. Three options for a risk appetite statement were presented to the Authority to discuss. It was agreed that the second option should be used. This will combine some of the categories used in the SRR and produce a statement that covers our position based on risk appetite and tolerance.

2.2. Authority members also asked for the risk appetite statement to be reviewed in a year to decide if the HFEA should move to option 3 which is a more comprehensive statement where a risk appetite is stated for each one of the categories used in the SRR.

2.3. The Authority also asked for the HFEA to consider a balance between a sensible but pragmatic approach against the resource constraints that the HFEA works within. Members did not want to make risk management into an industry; rather make it manageable and then manage it.

3. Recommendation

3.1. AGC is requested to note and comment on the attached risk strategy and associated risk registers.

3.2. AGC is asked to comment on the new SRR, and to respond to SMT's recommendation regarding closure of the current legal risk.

3.3. AGC is asked to discuss and agree on a risk appetite statement following the discussion at Authority on 16 November.

HFEA Risk appetite statement

1. Overview

1.1. The new risk strategy includes a risk appetite and tolerance section which is based on the recommendations from the Orange book.

1.2. The HFEA should have a risk appetite statement which will also need to be incorporated into the new strategy.

2. The options for a risk appetite statement

2.1. Below are possible options to use for developing a risk appetite statement:

Option 1	Option 2	Option 3
Have a single statement of the HFEA's risk appetite.	Combine some of the categories used in the strategic risk register (SRR) / Orange book and produce risk appetite statements that cover our position based on our risk appetite and tolerance.	Create a risk appetite statement for each of the categories currently on the SRR: Commercial, Financial, Governance, Information, Legal, Operational, People, Property, Reputational, Security, Strategy and Technology.
The key advantage of this system is simplicity; however, this approach may not allow enough flexibility in risk approach to be articulated.	This will allow the HFEA to make clear the areas we are more likely to be risk averse and the ones where we would consider a higher tolerance and acceptance of risk. The new risk strategy reflects this option; however not all the categories in the Orange book are directly named.	This is the most comprehensive method and allows for each category to be given a suggested risk tolerance. However, as we further develop the SRR over the coming months, and possibly adapt the categories to better reflect the organisation, this will in turn require updates to the risk appetite statement.

3. Authority feedback

3.1. The above three options for a risk appetite statement were presented to the Authority on 16 November. It was agreed that the second option should be used. This will combine some of the categories used in the SRR and produce a statement that covers our position based on risk appetite and tolerance.

3.2. The Authority also asked for the risk appetite statement to be reviewed in a year to decide if the HFEA should consider moving to option 3 which is a more comprehensive statement where a risk appetite is stated for each one of the categories used in the SRR.

3.3. The Authority also asked for the executive to take a sensible, pragmatic approach considering the resource constraints that the HFEA works within. Members did not want to turn risk management into a cottage industry; rather to make it manageable and then manage it.

4. Draft HFEA risk appetite statement

4.1. The Audit and Governance Committee is responsible for setting and monitoring the HFEA's risk appetite. Risk appetite is defined as 'the HFEA's willingness to accept risk in pursuit of its objectives. An understanding of risk appetite is part of good risk management and should be embedded in the day-to-day activities and culture of the entire organisation.

4.2. The HFEA has a responsible approach to risk management, seeking to recognise and manage exposure to risks. The HFEA is committed to ensuring that no unnecessary or unacceptable risks are taken which might expose the organisation to potential harm or jeopardise the overall achievement of its strategic aims. However, it is recognised that an overly risk-adverse attitude can lead to failure to maximise opportunities or inability to act decisively in the face of changes in the external environment, which can, in itself, be a threat to long-term sustainability.

4.3. The HFEA, therefore, takes a responsible and managed approach to risk, recognising key risks and managing those risks through effective implementation of its risk management strategy and the strategic risk register. This risk appetite statement should be read in conjunction with these documents.

4.4. This risk appetite statement describes the broad parameters within which the HFEA considers its appetite for risk. This is helpful in ensuring that Authority, AGC, the Corporate Managers Group, managers and staff are all aware of those parameters.

4.5. The management of risk is set in the context of the HFEA's strategy and annual business plan and is aimed at ensuring that key risks in relation to the strategy are managed effectively but that the HFEA is also able to assess key opportunities.

4.6. The HFEA's approach is to minimise its exposure to reputational, compliance and regulatory risks, whilst accepting and encouraging an increased degree of risk in pursuit of its strategic aims. In particular, the HFEA is proactive in seeking opportunities to improve patient safety and the quality of care and to support clinical and scientific innovation. Throughout, we strive to put patients first.

4.7. The HFEA recognises that its appetite for risk varies according to the activity undertaken and that the risk taken must be commensurate with the potential reward. Acceptance of risk is subject always to ensuring that potential benefits and risks are fully understood before developments are approved, and that measures to mitigate risk are established.

4.8. **Information, reputational and security risks:**

- It is regarded as critical that the HFEA preserves its high reputation and secures patient information. The HFEA therefore has low appetite for risk in the conduct of activities that affect its reputation or ability to perform its regulatory functions.

4.9. **Legal, governance and financial risks:**

- The HFEA's governance and financial model has a sound financial base in terms of operating costs and there is no appetite for risk in terms of activities that would disrupt this. However, the

HFEA has a moderate appetite for fees risks where we may be able to refine our systems to better reflect the current environment.

- The HFEA operates in a field where legal challenge is likely. This may occur if we take regulatory action which is opposed by the clinic or where we make policy decisions which are contested by pressure groups and others. We accept those risks, because to do otherwise might compromise our regulatory or policy decision making. We mitigate legal risks by having robust arrangements in place to minimise defeat in the courts. Where there is scope for differing interpretations of our legal powers/freedoms, we will consider taking risks where the decision could benefit patients.

4.10. People, operational and commercial risks:

- The HFEA aims to value, support, develop and utilise the full potential of our staff to make the HFEA a stimulating and safe place to work. It places importance on a culture of equality and diversity, dignity and respect, the development of staff, and the health and safety of staff. It has low appetite for any deviation from its standards in these areas.

4.11. Property, strategy and technology:

- The HFEA is prepared to take moderate risks to improve its working environment, balanced by rigorous due diligence and ensuring that the potential benefits and risks are fully understood before developments are agreed and that appropriate measures to mitigate risk are established.

Digital Projects / PRISM Update November 2022

Details about this paper

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time
Meeting:	AGC
Agenda item:	8
Meeting date:	08 December 2022
Author:	Kevin Hudson, PRISM programme manager
Annexes	

Output from this paper

For information or decision?	For information
Recommendation:	To note the plan for delivery of OTR and CaFC through PRISM, the anticipated delivery dates and the mitigations to be enacted to ensure those delivery dates are met.
Resource implications:	
Implementation date:	To deliver OTR through PRISM by the end of July 2023 and to deliver a first CaFC through PRISM between September 2023 (best case) and June 2024 (worst case).
Communication(s):	
Organisational risk:	Medium

1. Introduction and summary

1.1. PRISM went live on 14th September 2021 for 40 direct entry clinics and API deployment was completed by the end of June 2022 for the other 62 clinics. Since then, 291,888 units of activity have been submitted through PRISM from 102 clinics.

1.2. At the AGC meeting on 4th October 2022, we advised on:

- The surge in PRISM activity during summer 2022 as API clinics caught up on their PRISM submission backlogs and the current state of 9 large clinics that had not yet caught up.
- The status of ARGC deployment, the 3 clinics currently not submitting data through PRISM.
- The 'PRISM bedding in phase' that we have communicated to clinics, the level of records that currently cannot be submitted by clinics for technical reasons, and the status of development work on movements and to reduce 'validation variability', concerning which we were observing significant levels of week-on-week variability in the PRISM system.
- Our approach to re-establishing reporting, including a first CaFC through PRISM, led by a full 'bottom-up' assessment of all remaining legacy data issues which is both affecting 100% submission through PRISM and is important for CaFC and OTR delivery.
- The progress with PRISM handover to employed staff, and that our PRISM development and coding risk was now mitigated as a result of our second employed developer now fully up to speed.

1.3. In the meeting on 4th October 2022, AGC requested to be advised at their next meeting of the best and worst cases for CaFC delivery dates.

1.4. Therefore, the purpose of this paper is to update AGC on:

1. The latest status of PRISM submissions, deployment and 'bedding in'.
2. The assumptions we are making for delivering the PRISM completion targets of 'OTR solely through PRISM' and a 'First CaFC through PRISM'.
3. Our detailed plan for delivery of these outcomes, the remaining tasks for data, developers and clinics, and the interdependencies between them.
4. Our anticipated timescales for delivery of OTR and CaFC and the mitigations we will take to ensure we achieve them.
5. The currents status of contracted resources for PRISM.

2. Current PRISM status

Current PRISM activity and error rates

2.1. As of 21st November 2022, 291,888 units of activity has been submitted to PRISM. This is split by clinics using PRISM direct entry and API supply in table 1 below.

Table 1 – Cumulative PRISM activity as of 21st November 2022

		Current Activity		Previously reported activity			
Method of data submission		As of 21st November 2022		As of 19th September 2022		As of 6th June 2022	
	No of Clinics	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate
Direct Entry	42	87,205	1.3%	72,126	1.0%	52,705	0.7%
API - Mellowood	38	127,902	2.9%	105,533	3.4%	60,792	6.6%
API - Meditex	10	28,575	5.2%	26,137	5.3%	15,177	22.3%
API - CARE	12	48,206	7.2%	42,537	6.6%	32,371	12.3%
Total	**102**	**291,888**	**3.3%**	**246,333**	**3.4%**	**161,045**	**7.3%**

2.2. PRISM submission has reached 'steady state' of approximately 5000 units of activity per week. The cumulative error rates are also generally declining or static from previously reporting figures indicating that clinics are successfully addressing the validation errors that PRISM automatically prompts them to correct.

Submission backlogs and 'PRISM bedding in'

2.3. As of the end of August 2022, there were 9 large clinics that were reporting they still had PRISM submission backlogs. These were generally the last API clinics to be deployed by their system supplier. All bar one has indicated they will catch up by the end of December 2022 and we will follow up with those clinics to confirm that catch up has taken place.

2.4. We are continuing to advise clinics that PRISM remains in its bedding in period and that there may be records that clinics cannot submit due to technical reasons. This was clarified in a Chair's Letter issued in April 2022.

2.5. Generally, this is due to issues in their legacy EDI data, and clinics are required to keep a list of records they cannot submit. As previously reported, this is continuing to run at about 1% of activity. For instance, Guys and St Thomas's (Clinic 0102) report that they have 121 records 'on hold awaiting submission' out of a total of 9,072 records submitted.

ARGC deployment

2.6. As previously reported to AGC, our approach for ARGC deployment remains to establish the required API migrations from Meditex with other clinics already established on PRISM (specifically 0067 St Mary's Manchester and API conversations are now also taking place with 0006 Lister who have also recently moved to Meditex). Once this process is fully ironed out, it will be taken to ARGC.

2.7. It remains the expectation that Meditex will release their API migration upgrade at the end of December 2022, after which migrations will be deployed to the pilot clinics according to the documented API migration policy and process that is already published in the HFEA Clinic Portal.

2.8. However, we are not yet at present able to give a date by when we expect ARGC deployment to be completed.

Addressing PRISM validation issues

2.9. We previously reported that across the summer there was significant week-on-week variation in PRISM error rates. Some weeks there would be very high errors and then our data developer would re-validate the records and a large number of these records would fall away.

2.10. Our data developer has done extensive work to scrutinise in detail the individual validation rules in PRISM and how these are interacting with the large volumes of data arriving into PRISM from different sources and at different stages. An additional lesson learned is that testing of validation rules in a test environment is not the same as testing with bulk volumes.

2.11. As a result of this work, since October 2022 PRISM validations have been stable, and we have observed very little week-on-week variation of validation errors. It remains a priority for our developers to introduce an automated re-validation function to guarantee validation stability. This functionality is currently in testing, and it is our plan to deploy this to the live environment by the end of December 2022.

2.12. Given that PRISM is now stable, we are progressing with asking clinics to start to correct backdated validation errors, which is an essential component of CaFC and OTR. We will be commencing the backdating of validation rules, in tranches from 1st December 2022, so as to allow clinics an opportunity to fix historic errors during December when clinic activity is generally quieter.

2.13. We have used the November issue of Clinic Focus to communicate to clinics on this topic, and we will be individually contacting clinics with larger than average errors so to ensure the increase of errors in their PRISM Homepage does not come as a surprise. This is the commencement of a major channel of work for CaFC and OTR and is described in more detail in from 4.13 below.

3. PRISM planning assumptions to deliver OTR and CaFC

3.1. The next three sections of this update concern the plan to complete PRISM in its widest sense: i.e., beyond the introduction of the PRISM data submission system.

Definition of ‘PRISM Completion’

3.2. We have defined the completion of PRISM as:

- Supporting the OTR function to operate solely through PRISM
- Delivering a first CaFC through PRISM

3.3. We have refined our plan to better deliver these objectives, and this is described in detail in this paper. Our previous plan relied heavily on a ‘bottom up’ assessment of remaining fixes to legacy data linkage that are required to ensure 100% accuracy of legacy EDI data in PRISM. However, because of the reliance on just one individual to make this legacy assessment, it is not proving feasible to continue to have this assessment as the overriding critical component on which all parts of PRISM completion are dependent. The reasons for this are described in detail from section 4.2 below.

3.4. Therefore, although a bottom-up plan would be the ideal scenario, it is possible to refine the plan to deliver a parallel approach for data, developers and clinics and introduce mitigations for OTR and CaFC operations if fixing of legacy data issues takes longer than expected.

Our Assumptions to achieve the PRISM completion objectives

3.5. **Assumption 1: We will prioritise OTR.** Given the removal of anonymity which will take effect from late 2023 onwards, we need to ensure the OTR team can operate against the increased demand with most efficiency. We will therefore prioritise data fixes and PRISM development for OTR according to the timetable set by the OTR team for their requirements.

3.6. **Assumption 2: With clinics, we will focus on validations before verifications.** These terms are defined as follows:

- **Validation:** Where PRISM has automatically identified an error with a submitted record and prompts the clinic to correct it. Currently validation rules run from the start of PRISM, but it has always been the intention to backdate these to cover EDI submitted data.
- **Verification:** In EDI the verification process advised clinics of CaFC related errors (through 40+ verification error reports) that they needed to fix 'in bulk' for the CaFC period under measurement. The EDI verification process also presented to clinics a draft version of CaFC outcomes which they could check and confirm.

3.7. Now PRISM validations are stable, we will address backdated validations in tranches, firstly registrations and then cycles. CaFC relevant validations will be backdated to start of the new CaFC period (1st January 2020) and earlier for OTR relevant errors. We will not backdate errors if they don't relate to CaFC or OTR. Clinics will be asked to correct EDI submitted issues in PRISM and may need to be supported if they encounter issues in doing this (see section 4.13 below).

3.8. **Assumption 3: We will assess to what extent 'validated data' is sufficient to run a CaFC.** This will be possible once some of the leading clinics have fixed their backdated errors and will help agree the extent and framework of any subsequent CaFC verification process: specifically, the number of verification reports that might be required, how we build a 'CaFC viewer' for clinics and the length of time given for verification.

3.9. **Assumption 4: Our long-term strategic aim is for CaFCs to be produced without a formal 'clinic verification'.** This may be possible once CaFC is reporting solely from PRISM, if error rates are sufficiently low. This also introduces a risk that any 'verification architecture' that is build for the first CaFC through PRISM may not be required in the longer term.

3.10. The first CaFC through PRISM will cover the treatment dates across a three-year period from January 2020 to December 2022. This ensures continuity of data reporting from previous CaFCs and will be an EDI/PRISM hybrid in terms of source data. Thereafter CaFCs will cover individual calendar years (or possibly shorter in future) and will be based purely on PRISM submitted data.

4. Detailed Plan for the remaining tasks on PRISM

Overall Plan

4.1. The full PRISM completion plans of all remaining tasks for OTR and CaFC is shown in figure 1 overleaf. Please note the ‘swim-lanes’ for data, developers and clinics and the interdependencies between them:

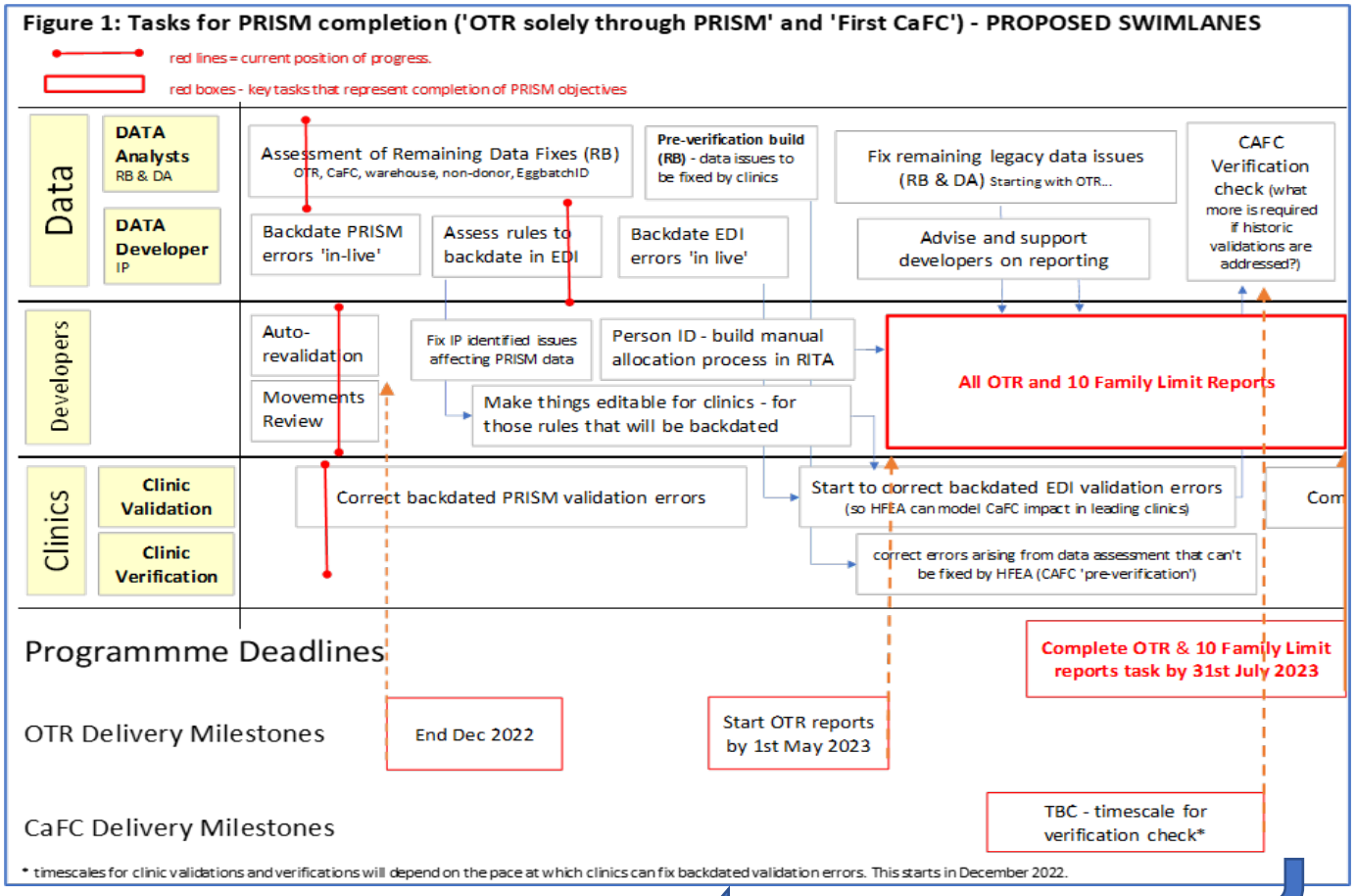
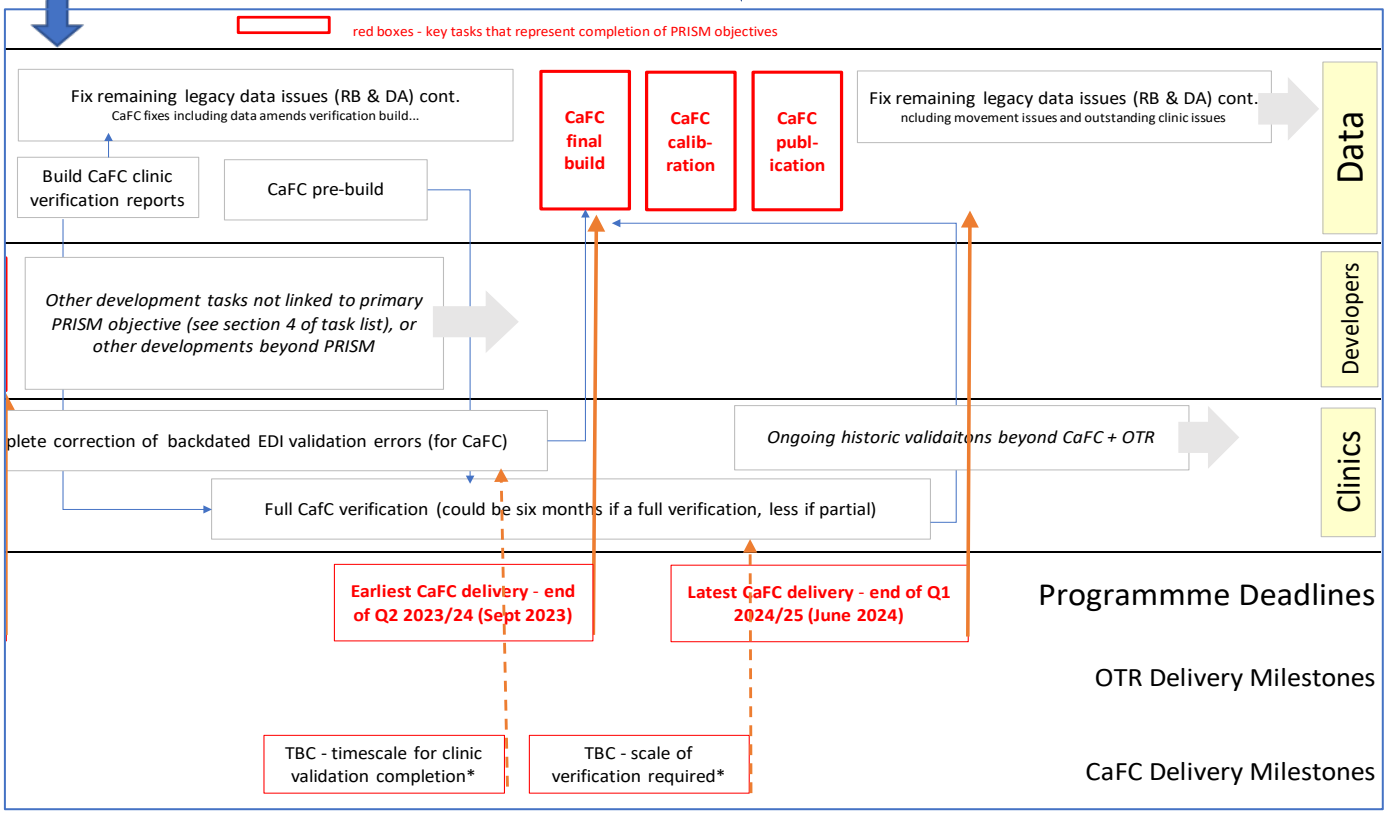


Figure 1: Tasks for PRISM completion ('OTR solely through PRISM' and 'First CaFC') - PROPOSED SWIMLANES
red lines = current position of progress.
red boxes - key tasks that represent completion of PRISM objectives
Data
DATA Analysts RB & DA
DATA Developer IP
Assessment of Remaining Data Fixes (RB) OTR, CaFC, warehouse, non-donor, EggbatchID
Pre-verification build (RB) - data issues to be fixed by clinics
Fix remaining legacy data issues (RB & DA) Starting with OTR...
CAFC Verification check (what more is required if historic validations are addressed?)
Backdate PRISM errors 'in-live'
Assess rules to backdate in EDI
Backdate EDI errors 'in live'
Advise and support developers on reporting
Developers
Auto-revalidation
Movements Review
Fix IP identified issues affecting PRISM data
Person ID - build manual allocation process in RITA
Make things editable for clinics - for those rules that will be backdated
All OTR and 10 Family Limit Reports
Clinics
Clinic Validation
Clinic Verification
Correct backdated PRISM validation errors
Start to correct backdated EDI validation errors (so HFEA can model CaFC impact in leading clinics)
correct errors arising from data assessment that can't be fixed by HFEA (CAFC 'pre-verification')
Programmme Deadlines
Complete OTR & 10 Family Limit reports task by 31st July 2023
OTR Delivery Milestones
End Dec 2022
Start OTR reports by 1st May 2023
CaFC Delivery Milestones
TBC - timescale for verification check*
* timescales for clinic validations and verifications will depend on the pace at which clinics can fix backdated validation errors. This starts in December 2022.


red boxes - key tasks that represent completion of PRISM objectives
Fix remaining legacy data issues (RB & DA) cont.
CaFC fixes including data amends verification build...
CaFC final build
CaFC calib-ration
CaFC publ-ication
Fix remaining legacy data issues (RB & DA) cont.
ncluding movement issues and outstanding clinic issues
Data
Build CaFC clinic verification reports
CaFC pre-build
Other development tasks not linked to primary PRISM objective (see section 4 of task list), or other developments beyond PRISM
Developers
plete correction of backdated EDI validation errors (for CaFC)
Ongoing historic validaitons beyond CaFC + OTR
Clinics
Full CafC verification (could be six months if a full verification, less if partial)
Earliest CaFC delivery - end of Q2 2023/24 (Sept 2023)
Latest CaFC delivery - end of Q1 2024/25 (June 2024)
Programmme Deadlines
OTR Delivery Milestones
TBC - timescale for clinic validation completion*
TBC - scale of verification required*
CaFC Delivery Milestones

Data

4.2. It still remains the aspiration for our data team to make an assessment of all remaining legacy data linkage fixes, but this plan and its mitigations below decouples that requirement from OTR and CaFC delivery.

4.3. In late September 2022 we recruited a second data analyst, and that person has made good progress in their induction on a very complicated topic. They are now working to develop forward frameworks for CaFC under the supervision of our original data analyst who as 25 years' experience of HFEA fertility data. This work will prove very valuable in the later stages of CaFC, and the second analyst is essential for providing resilience for this function.

4.4. However, in relation to the assessment of historic legacy data issues, it remains only our original data analyst who has the experience and knowledge to identify legacy issues, particularly if they relate to EDI. They also currently remain the go-to point for all HFEA ad-hoc data queries. Consequently, there has not been the progress that would have been initially anticipated on the assessment of remaining issues on legacy data linkages.

4.5. When those legacy data issues have been identified, it will be possible for both HFEA data analysts to work on fixing them. Also, the mitigations outlined in section 5 below, mean that there are options if required for truncating the data assessment and for delivering OTR and CaFC even if not all data fixes have been done.

4.6. The main risk of an extended period of time for fixing legacy data linkages lies with an extended PRISM bedding in phase and clinics still having to submit 99% of their records (with 1% on hold) rather than achieve 100% submission.

4.7. In addition, the process of addressing legacy data issues on a topic-by-topic basis (rather than clinic-by-clinic) which is inherent in this plan for delivery of OTR and CaFC may mean that some particular clinic issues may not be fixed until late in the process.

Developers

4.8. We are prioritising the work of HFEA developers to focus on OTR requirements and ensuring the actions of other 'programme swim lanes' are not impeded.

4.9. A key focus of development work for 2023 will be the development of OTR and 10-family-limit reports from PRISM. The full development team will work collectively on this, and three months has been blocked out for this purpose.

4.10. Before then, developers are anticipated to complete their work of movements and auto-revalidation and to address PRISM issues that have identified by the data team, or which might mean clinics are unable to correct historic backdated validation errors.

4.11. Another key requirement both for OTR and 10-familiy-limit is the PRISM 'Person-ID' (previously called HFEAID), the bespoke unique identifier that attempts to recognise unique individual across the sector no matter what clinic they attended. For many months now, an algorithm has been working in the background creating Person IDs for the PRISM database. From 1.6 million records matched, the algorithm has 17,000 records left to process.

4.12. After the algorithm is complete, development work may need to be undertaken to develop processes in RITA to allow register staff to manually match records that the algorithm cannot

match. A detailed assessment of the further requirements for 'Person ID' will be made once the algorithm completes.

Clinics

4.13. As previously mentioned in 3.6 above we are planning to focus clinic activity on addressing backdated CafC related validations before progressing to CaFC verification. We are planning to release backdate errors for clinic correction in tranches, and we are modelling the potential impact of these tranches before they are released to the live environment.

4.14. Because this process could take the longest of any task to complete, it is important to start this as soon as practically possible. We will therefore be releasing approximately 8,500 backdated registration errors to clinics on 1st December 2022 so that these can be addressed by clinics. By itself this will double the number validation errors currently reported in PRISM. It is important to understand that these errors relate to elements of a particular record and may include multiple errors on a single record. They are not 8,500 'missed' cycles.

4.15. On the present modelling there are 16 clinics (out of 102 users) that will have more than 100 backdated errors to address in the first batch that is released. As referenced in 2.13 above, these are clinics we will contact directly. Nevertheless, by releasing errors in bulk-tranches, we are doing so in a way that will be most efficient for clinics to rectify, particularly when they encounter instances where they have multiple errors relating to one record, meaning that they only have to access this record once.

4.16. Beyond this first tranche of registration errors, there will be a far larger number of CaFC related backdated cycle errors that will need to be addressed. In each step we are carefully modelling the number of errors to be released and whether there are any technical issues that will prevent clinics fixing these in PRISM. Some development work may be needed to make some legacy migrated data editable in PRISM.

4.17. We will also need to measure the pace at which clinics are addressing their validation errors and this will help inform the overall delivery timescales for the first CaFC.

4.18. Once the fastest clinics have addressed their errors, our data team will need to break out of their activity for fixing legacy data linkage issues in order to model an early version of CaFC for these clinics and assess to what extent a further verification exercise is needed in addition to clinics having addressed backdated CaFC related validation rules.

4.19. Clearly, if we are able to complete the 1st CaFC without a full verification exercise, or even just with a partial one, then this will have a significant impact on CaFC delivery timescales.

5. Completion timescales and mitigation

OTR delivery timescales

5.1. In order to be ready for the forthcoming OTR changes, the OTR team have advised that they wish to be operating 'solely from PRISM' by the end of September 2023.

5.2. To deliver this we have set a deadline for completion of all OTR and 10 family limit reports of 31st July 2023 and consequently the block of collective development action on OTR will commence on the 1st of May 2023.

5.3. This leaves the time before that date for developers to act on the other requirements outlined in the development swim-lane in figure one, including work on PRISM 'person-ID'. These timescales are considered to be achievable by the developers concerned.

OTR delivery mitigation

5.4. Ideally legacy data fixes for OTR should be completed before development work commences on OTR and 10-family limit reporting on 1st May 2023. To expedite this, there is a mitigation opportunity to assess and fix just OTR legacy data issues instead of assessing all other issues. The programme will keep constant review of whether this mitigation needs to be enacted.

5.5. Further it is a mitigating plan that even if all legacy OTR data fixes are not resolved by the start of development work, then this work will still commence as planned. Even before the legacy OTR fixes are completed, the data being used in PRISM is felt to being of good quality. However, given that all OTR outcomes are checked independently with the clinic concerned, OTR reports can still be used if there is a residual risk with data accuracy arising from any delay to completion of legacy OTR data fixes.

5.6. Given this check at clinics, it is believed that these OTR mitigations and the OTR team has agreed to proceed to moving to working solely through PRISM on that basis.

Timescales for 'best and worst' CaFC delivery

5.7. The timescales for delivering CaFC are very much conditional on the pace at which clinics fix validation errors and whether a full, partial or no verification process is required for the 1st CaFC.

5.8. A best-case scenario is clinics fixing their validation errors during the first half of 2023, then either no or a very minimal verification which would allow the final CAFC to be generated in Q2 2023/34 (i.e., by September 2023, approximately the same time at the OTR team moves to working solely from PRISM).

5.9. A worst-case scenario is that a full clinic verification is required. Given 3 years of data is being covered by this CaFC, a minimum of an additional six months would be likely be needed for the verification and clinics may still request for further extensions. Notwithstanding any extensions given, the final steps of CaFC then would not take place until Q1 2024/25 (i.e., by June 2024).

5.10. This worst case would also mean that there would be a knock-on delay on the 2nd CaFC through PRISM (which would be treatment data for the year ending December 2023), whereas the best-case scenario means that the 2nd CaFC could operate on optimised timescales for that year.

5.11. During Q1 2023/24 (i.e., between April and June 2023), we would expect to have more detailed information on the pace of clinic corrections of validation errors and the data team would have been able to undertake their CaFC verification assessment. At this stage a more accurate assessment of exact CaFC delivery will be able to be made. Given the importance of CaFC to the role of the HFEA in providing impartial information on clinic performance for patients, we will need to develop an accompanying communications plan.

CaFC mitigation and 'calibration'

5.12. Given that CaFC reports at an 'aggregate level' rather than a detailed level, it is not necessarily required for all legacy data issues to be fixed before publishing a CaFC.

5.13. Moreover, the 1st CaFC through PRISM will need to go through a calibration exercise to ensure it is consistent with CaFCs calculated through EDI. This is also a step in the process where it will

be possible to mitigate against other known data issues in the system that might otherwise materially affect clinic CaFC reports.

6. Current status of contacted resource on PRISM

6.1. **The longstanding contracted data developer** currently deals with all matters relating to the underlying PRISM database, PRISM validation and reporting, HFEAID and Person ID, and CAFC verification reports. They also deal with HFEA's billing system and Epicentre. Very close to retirement age, their four-day-a-week contract is currently due to expire in March 2023. However, they have indicated they would be willing to extend for a further year at three-days-a-week from December 2022.

6.2. The 3-month block of development work on OTR reports scheduled to start in May 2023 is also envisaged to serve as a handover of all PRISM reporting functions and would mark the start of an 11-month staged handover of all technical functions covered by this contractor.

6.3. **The contracted PRISM support officer** still remains our operational expert on PRISM and continues to serve as back up support for the Register team in answering clinic queries. They are also essential in working with our developers as a detailed system tester for PRISM developments including both the functions and reports still to be developed. Their contract is currently due to expire at the end of December 2022.

6.4. Unfortunately, they have declined to apply for the vacant testing analyst role. Recruitment for this role is presently on hold. We have also sought and received DHSC contingent labour approval to extend this contract to the end of July 2023, to align with the overall development timescales for OTR delivery.

6.5. **The contracted PRISM programme manager** currently covers on a two-day-a-week basis the ongoing oversight of the overall PRISM plan and PRISM troubleshooting, managing the re-establishment of the data functions through PRISM, prioritisation of PRISM developments and is the managerial interface for current and new API system suppliers and future API migrations. Their contract is currently due to expire at the end of December 2022 though we are keen to agree an extension.

6.6. During December 2022, SMT will agree the ongoing resource requirements for supporting PRISM.

7. AGC recommendations

7.1. AGC is asked to note:

1. The current status with PRISM operations, and that although the system is now stable in terms of validations we are still in a 'bedding in phase' with regards to achieving 100% data submissions (currently running at approx. 99%).
2. The refinement of our plan to mitigate against reliance on detailed data assessments and our assumptions to focus on OTR and clinic validations.

3. The details of our completion plan for ‘OTR solely through PRISM’ and ‘1st CaFC through PRISM’ as described in section 4 and figure 1 (see 4.1 above).
4. That we are confident we can deliver OTR requirements to the timescales required by the OTR team; namely to complete developments by July 2023 and that we have strong mitigations to ensure this succeeds.
5. That we are planning to adopt a ‘validations first’ approach for clinics correcting data in PRISM for CaFC and now PRISM is stable for validations, this process will start from the beginning of December 2022.
6. The best (Q2 2023/4) and worst (Q1 2024/25) dates for delivery of the 1st CaFC through PRISM and that the actual delivery is heavily dependent on the pace of clinics correction validation errors and whether a full, partial or no verification process is required.
7. That we will be able to assess the actual delivery date for the first CaFC through PRISM during Q1 2023/24 – i.e., between April and June 2023.

Resilience, Business Continuity Management and Cyber Security

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time		
Meeting:	AGC		
Agenda item:	9		
Meeting date:	8 December 2022		
Author:	Martin Cranefield, Head of IT and Neil McComb, Head of Information		
For information or decision?	For information		

Recommendation	The Committee is asked to note:
	• Infrastructure improvements
	  • Improvements to IT security that have been implemented and those yet to be completed.
	  • Data Backup review
	  • Infrastructure penetration test
	• Current position on Data Security and Protection Toolkit		

Implementation date	Ongoing		
Communication(s)	Regular, range of mechanisms		
Annexes	7a –HFEA Risk Strategy, 7b – Operational risk register and Top 3 risks screenshots, 7c – Risk appetite statement, 7d strategic risk register		
Organisational risk	☐ Low	☒ Medium	☐ High

1. Introduction and background

1.1. In recent months, AGC has received regular and detailed updates on Resilience, Business Continuity Management and Cyber Security, in line with the strategic risk register.

1.2. This paper provides an update on IT infrastructure and cyber security in a number of areas.

1.3. It also includes an update on our current approach to submitting evidence for next year's Data Security and Protection Toolkit

2. Infrastructure improvements

IT security changes

2.1. As part of the audit and NCSC's recommendations, we were advised to enable DMARC (Domain-based Message Authentication Reporting & Conformance) setting on our domain name hfea.gov.uk to prevent unauthorised email servers on the internet from sending out malicious emails purporting to be from HFEA. We are continuing to monitor and bring in scope legitimate email servers that send emails on behalf of HFEA before we can set our policy to 'quarantine', to ensure all legitimate emails are delivered and not blocked.

2.2. Due to resource constraints, we have not made progress in evaluating an email security service (Mimecast) who offer extensive email security services. Mimecast offers the ability to send large files to external parties with tight security controls when required on an ad-hoc basis. Their service also offers email phishing training to end users by simulating phishing attacks and can identify users which are more prone to fall prey to malicious emails and subsequently target them for further training. We plan to restart evaluation of this service in December.

Data Backup review

2.3. The infrastructure team participated in a workshop with MTI in October, a supplier recommended by NHS Digital to provide independent assessments on data backups. Upon providing an extensive overview of our backup regime and configuration, they have requested a Data Discovery scan of our systems. We are continuing to work with MTI on how best to execute this.

2.4. After extensive evaluation and testing, we have deployed the Office365 backup service with a specialist 3rd party provider called KeepIT, so that all data within Office365 (Emails, OneDrive and SharePoint) are now fully backed up in a non-Microsoft UK datacentre and changes are replicated daily. Microsoft's terms of service states that it is the customer's responsibility to manage and protect their data held within their Office365 environment, with Microsoft being responsible for system availability. Microsoft do not provide a native backup solution for Office365 data, instead guiding customers towards specialist 3rd party providers.

2.5. KeepIT's service does not operate in the public cloud, instead relying on well-known datacentre partners Equinix and Global Connect to provide co-location services which allows KeepIT to run its own service in a resilient environment. This provides further resilience should a public cloud provider like Microsoft suffer a major failure at the datacentre running HFEA's Office365 service.

2.6. KeepIT has been built to be tamper-proof by being an inherently immutable data store; once data is in, it cannot change. In the event that a customer, or an attacker who successfully assumed the identity of an HFEA staff member, deletes a workload from KeepIT, or the entire account, data will remain untouched for a fixed retention period. This additional precaution protects the HFEA from a ransomware attack, or worse, where the attacker would first seek to destroy backups before proceeding to encrypt or destroy the primary data.

2.7. Another reason why we chose KeepIT was because their service protects Microsoft Dynamics data as part of their standard offering. The HFEA has chosen Microsoft Dynamics to power the new OTR IT system, and we are currently in the development phase of this new solution. Having a means to continually protect the data in this new Dynamics deployment will be critical.

2.8. KeepIT's accreditations: ISO/IEC 27001:2013, ISAE 2403-II. They are audited by Deloitte annually.

Infrastructure Penetration Test

2.9. Our supplier conducted the test as scheduled the week of 12th September. We have been working on implementing some fixes to some non-critical vulnerabilities which were identified, to strengthen our infrastructure. Some identified vulnerabilities have been reasonably quick to fix whilst others are more complex, due to the interdependencies.

3. Data Security and Protection Toolkit (DSPT)

Background

3.1. AGC will recall that the Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's ten data security standards. We have completed our submission for 2020/21 and are now preparing for 2022/23.

3.2. This will be our second submission and we expect our experience of last year to proof helpful in this year's performance.

3.3. In 2020/21 the HFEA the HFEA was in category 2 of the list of organisations who completed the DSPT. This year NHS digital have raised the bar and moved the HFEA into category alongside NHS trusts and CCGs.

3.4. This means that there are now 113 mandatory evidence items out of 133 in total to complete. This is over 20 more than last year and will require a significant amount of work for the IG manager and Head of IT.

3.5. In a recent webinar, NHS Digital said that they will increase the work year-on-year as they re-categorise non-mandatory items as mandatory. This may have resourcing implication in the future.

Next steps

3.6. The first IG and Security Steering Group has had to be rescheduled due to staff availability. It will meet on 30/11/2022 and will consider the mandatory items and the owners of those items.

3.7. With the future re-categorisation of non-mandatory requirements in mind we will also consider the non-mandatory items to understand the toolkit standards more holistically. Where new processes need to be planned to meet mandatory requirement it may be possible to create them in a way that meet future requirements.

3.8. We will however still be prioritising the completion of mandatory requirements.

Human Resources bi-annual update 2022

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society
Meeting	AGC
Agenda item	10
Meeting date	8 December 2022
Author	Yvonne Akinmodun, Head of Human Resources

Output from this paper:

For information or decision? For Information

Recommendation	The Committee is asked to note and comment on the: a. Main findings for the report b. Overview of the results from the recent staff survey
Resource implications:	
Implementation date:	
Communication(s):	
Organisational risk	☐ Low ☒ Medium ☐ High

Introduction

1.1. HR papers come to the Audit & Governance Committee twice a year. At the last AGC, we presented key Equality, Diversity and Inclusion (EDI) data. This paper, which represents our second HR report of the year, sets out half year information on key HR metrics within the HFEA.

1.2. We have recently been audited on EDI and are awaiting the final report from the auditors. We will report on this and present the key findings from the audit at the Summer AGC.

2. Staff survey

2.1. The annual all staff survey took place in the autumn of 2022. The headline data from the survey is highlighted in the attached presentation.

2.2. A summary of the survey results has been shared with CMG and staff. We are currently in the process of putting together a staff survey action plan which will be shared with CMG and staff in the new year.

3. Recruitment and Onboarding

Recruitment activities across the organisation continues to either build capacity or to replace roles where staff have left.

Recruitment activities are shown in Table 1 below.

Table 1 – Recruitment Activities

Number of job roles recruited to – March – Oct 2022	Number appointed first time	Advertised more than once
13 new roles appointed	10	3 (2 of which were IT roles which are historically difficult to fill with current salaries)

4. Turnover

According to Civil Service data, in 2022, the median turnover rates across the Civil Service stood at 13.6%, as at March 2022 and 10.7% for voluntary resignations.

The table below illustrates how The HFEA compares to current rates.

Table 2 – Turnover Rates

Turnover Rates	Civil Service	The HFEA
Total Labour Turnover Rate	13.6%	16%
Voluntary Resignation Rate	10.7%	10%

The HFEA's turnover rates are above the Civil Service average. This could be partly attributed to the fact that as a small organisation, opportunities for progression are few compared with that of larger organisations.

There were 11 leavers (approx. 16% of total workforce) within the period. Of this, 7 members of staff (10%) voluntarily resigned. This is in line with voluntary resignation rates within the Civil Service.

The reasons for involuntary resignations are shown below:

1 fixed term contract came to a natural end

1 member of staff retired

2 members of staff were interns who completed their training period

HR continues to work on conducting exit interviews to ensure that we gain greater insights to better understand what more can be done to minimise the number of voluntary resignations.

Based on data received, the reasons for leaving are set out in the table below.

Table 3 – Percentage of Workforce and reasons for Leaving

Reason for leaving	Strategy & Communication	Compliance & Information	Support services (HR, Fin, legal)	Total	% of total workforce
Personal	1	1	1	3	4%
Career progression	3	1		4	6%
Total	**4**	**2**	**1**	**7**	**10%**

The table below shows leavers based on length of service.

Length of service for leavers ranged from between 6 months and over 10 years. Approximately 50% of all resignations had worked for us for less than 2 years and 62.5% of all resignations explicitly cited lack of progression and pay as key factors for leaving.

Wider external analysis indicates that the average point for new staff remaining in role in most organisations is between 2 to 5 years. The table below indicates that the number of leavers for the HFEA who sit within this timeframe is low compared with those leaving within the 6month to 2-year period. It should however be noted that the leavers in the 6 month to 2 year period, includes those on fixed term or training contracts.

Table 4 – Leaver's length of service

Length of Service	Total Number
Less than 6 months	1
6 months - 2 years	3
2 – 5 years	1
5 – 10 years	1
over 10 years	1
Total	**7**

5. Absence

The Office of National Statistics (ONS) report that the COVID-19 pandemic continued to impact on absence rates throughout 2022. This has impacted on absence rates for 'Total days lost' per worker. ONS report a national average of 4.6 days lost per worker. The table below shows the average number of days lost through sickness absence per employee for the public sector and the HFEA.

Table 5 – Absence rates

Absence rates	Days 2022
Public sector average absence rate per employee (Total days lost per worker)	3.6
Average days per employee (from 01/04/22 – 30/09/22) HFEA	2.7

The HFEA's average is significantly below the average for the sector and the absence rate per employee cited in the ONS report.

5.1. Absence Overview

31 Staff were absent for a variety of different reasons with a total of 193 days lost during the period related to general absences. This is a decrease from 265 days from the last period. There were 3 members of staff with more than 10 days absence that contributes to the increase in total days lost – one of those was pregnancy related and one bereavement related.

HR engaged with both managers and staff, in 2 cases making referrals to occupational health where recommendations were implemented.

5.2. General Absences

The reason for absences (not related to COVID-19) were

- Acute medical condition
- Diarrhoea and vomiting
- Mental wellbeing
- Migraine
- Minor illness
- Musculoskeletal Injuries
- Other
- Psychiatric / Stress
- Recurring Medical Condition

5.3. COVID 19 Related Absence

Within the period, April to September, 15 days were recorded as COVID-19 related absences, (13 members of staff). This represents a downward trend in terms of days lost from 20.5 days (2 members of staff) in 2021. The data shows that whilst more people are becoming infected, the effect seems less severe, resulting in one/two days absence per employee compared to the previous period.

6. Recommendations

- The Committee is asked to note and comment on the actions taken to date.

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HFEA Staff Survey 2022 overview

www.hfea.gov.uk

Overview of the survey areas

The survey is split into the following themes:

- Overall experience (engagement) – the extent to which I am committed and enjoy working for the HFEA
- Autonomy
- Enablement
- Reward
- Leadership
- Purpose
- Diversity & Inclusion

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Comparators

Our survey results were compared with other around 200 public sector bodies. Below is a selection of the types of organisations which form comparators

- HSIB (Healthcare safety bereau)
- HTA
- Inland homes
- GPhC – General pharmaceutical council
- Royal college of surgeons
- Francis Crick Institute
- NHS improvement and NHS England
- St John's ambulance
- London School of Hygiene & Tropical Medicine
- Care Fertility
- Welsh Council for Voluntary Action

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Headline Indicators

- Response rate 74% (72% 2021) (Above sector average of 70%)
- Our engagement scores, i.e. the extent to which staff feel happy at work stands at 83% – this is above the average for our public sector comparators of 75% and above last year's score of 80%
- We have a higher percentage of staff, 68% who see themselves remaining with the organisation 2 years from now. Although this is still 1% below the average for the sector of 69% it is slightly higher than the 66% response rate from last year
- Perception of senior management is higher than last year and stands at 66%, compared with 64% last year and is 16% higher than the sector average .
- We have a lower favourable response to the question about having the right tools and resources for the job. 67% agree which is 1% higher than the sector average but 16% lower than our score last year
- Responses on diversity and inclusion are 53% positive which is 14% lower than sector average but 2% higher than our score from last year.

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Top 5 high performing questions against sector average 2022

The following items are the 5 which have the strongest impact on Engagement

Impact	Question	Theme	Response favourability	Survey Overall	Public sector	HFEA Engagement Survey 2021
	Aside from any possible concerns about pay, I enjoy working at HFEA	Reward		0	+1	n/a
	Senior leaders provide a clear vision of the overall direction of HFEA	Leadersh...		0	+24	+7
	People help and support each other here	Enablem...		0	+9	+14
	The culture I experience at HFEA aligns with our values	Purpose		0	n/a	n/a
	Senior leaders make the effort to listen to staff	Leadersh...		0	+16	+9

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5 Low scores compared with the sector norms 2022

Question	Theme	Response favourability	Survey Overall	Public sector	HFEA Engagement Survey 2021
I have the equipment and resources I need to do my work properly	Enablement	67% / 9% / 25%	0	+1	-16
My rewards are linked to my performance and contribution	Reward	16% / 30% / 54%	0	-25	+2
My job makes the best use of the skills and abilities that I have	Autonomy	67% / 18% / 16%	0	-2	-4
I know how well HFEA is doing against its aims	Purpose	56% / 25% / 19%	0	-8	-5
I can comfortably cope with my workload	Autonomy	54% / 21% / 25%	0	-7	-2

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Key themes from the open text responses

Summary responses included:

- Staff like the fact that the organisation offers good work-life balance
- Many felt that relationships within teams is good, with improved cross working relationships.
- Comments suggest that staff believe in the purpose of the organisation and
- ‘my work is making a positive impact on society’
- Some staff expressed concerns about workload
- The lack of opportunities for progression was mentioned by some
- Some expressed concerns diversity, inclusion and fairness of treatment

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Next steps

What will we do next

- Present findings to staff
- Heads to discuss survey results with their teams
- Put together a small group to help pull together an action plan
- Present action plan to CMG and staff prior to implementation
- Monitor and feedback on action plan on a quarterly basis
- Results will be shared on the Hub

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Audit and Governance Committee Forward Plan

Strategic delivery:	☐The best care – effective and ethical care for everyone	☐The right information – to ensure that people can access the right information	☐Shaping the future – to embrace and engage with changes in the law, science and society
Details:			
Meeting	Audit & Governance Committee Forward Plan		
Agenda item	12		
Meeting date	8 December 2022		
Author	Morounke Akingbola, Head of Finance		
Output:			
For information or decision?	Decision		
Recommendation	The Committee is asked to review and make any further suggestions and comments and agree the Forward Plan.		
Resource implications	None		
Implementation date	N/A		
Organisational risk	☒ Low	☐ Medium	☐ High
	Not to have a plan risks incomplete assurance, inadequate coverage or unavailability key officers or information		
Annexes	N/A		

Audit & Governance Committee Forward Plan

AGC items Date:	4 Oct 2022	8 Dec 2022	14 Mar 2023	27 Jun 2023	4 Oct 2023
Following Authority Date:	16 Nov 2022	28 Jan 23	22 Mar 2023	12 July 2023	15 Nov 2023
Meeting 'Theme/s'	Strategy & Corporate Affairs, AGC review	Register and Compliance, Business Continuity	Finance and Resources	Annual Reports, Information Governance , People	Strategy & Corporate Affairs, AGC review
Reporting Officers	Director of Strategy and Corporate Affairs	Director of Compliance and Information	Director of Finance & Resources	Director of Finance & Resources	Director of Strategy and Corporate Affairs
Strategic Risk Register	Yes	Yes	Yes	Yes	Yes
Horizon scanning					
Deep dives		Financial risk on potential income position and government funding	The potential for reduction in fertility services over time		Increasingly onerous standards of corporate governance reporting materially impacting our ability to put the patient at the heart of all that we do
Risk Management Policy[1]	Risk Management Policy/update on review of systems conducted	Risk management strategy			
Digital Programme Update	Yes	Yes		Yes	
Annual Report & Accounts (including Annual Governance Statement)				Yes – For approval	

[1] Policy will have been reviewed by the Executive, including updated appetite statement for Authority approval.

AGC items Date:	4 Oct 2022	8 Dec 2022	14 Mar 2023	27 Jun 2023	4 Oct 2023
External audit (NAO) strategy & work		Audit Planning Report	Interim Feedback	Audit Completion Report	
Information Assurance & Security				Yes, plus SIRO Report	
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes	Yes
Internal Audit	Update	Update	Update	Results, annual opinion approve draft plan	Update
Whistle Blowing, fraud (report of any incidents)	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Public Interest Disclosure (Whistleblowing) policy			Reviewed bi-annually		
Anti-Fraud, Bribery and Corruption policy			Reviewed and presented bi-annually		
Counter-fraud Strategy (CFS), Fraud Risk Assessments (FRA) and progress of Action Plan	Fraud Risk Assessment			CFS; Action plan; FRA	
Contracts & Procurement including SLA management	Update as necessary	Update as necessary	Update as necessary	Update as necessary	Update as necessary
HR, People Planning & Processes		Bi-annual HR report		Bi-annual HR report	
Strategy & Corporate Affairs management					
Regulatory & Register management					
Training		Yes	Yes		

AGC items Date:	4 Oct 2022	8 Dec 2022	14 Mar 2023	27 Jun 2023	4 Oct 2023
		Interpretation of financial statements			
Resilience & Business Continuity Management	Yes	Yes	Yes	Yes	Yes
Finance and Resources management					
Reserves policy	Yes				Yes
Estates	Yes	Yes		Yes	
Review of AGC activities, terms of reference		Yes			
Legal Risks	Yes				Yes
Functional standards					Yes
AGC Forward Plan	Yes	Yes	Yes	Yes	Yes
Session for Members and auditors	Yes	Yes	Yes	Yes	Yes

Suggested training for Committee Members

- Understanding good governance
- Risk Management
- Counter fraud
- External Audit – Knowledge of the role/functions of the external auditor/key reports and assurances.

Suggested deep dive topics as agreed at the 4 October 2022 meeting and not yet slated

- The effectiveness of performance management and risk (as this would be a year after the new system has been embedded).
- Staff retention
- Impact of communication
- HFEA's regulatory effectiveness if some or all of our ambition for legislative change fails.