Audit and Governance Committee meeting - agenda

03 December 2019

Chartered Institute of Arbitrators, Old Library Room (Lower Ground Floor) 12 Bloomsbury Square, London, WC1A 2LP.

Agenda item			Page	Time
1.	Welcome, apologies and declaration of interests			10.00am
2.	Minutes of 8 October 2019 **[AGC (03/12/2019) 698 DO]**	For Decision	3	10.05am
3.	Matters Arising **[AGC (03/12/2019) 699 MA]**	For Information	13	10.10am
4.	Digital Programme Update **[AGC (03/12/2019) 700 DH]**	For Decision	to follow	10.20am
5.	Strategy and Corporate Affairs **[Presentation CE]**	For Information	16	10.50am
6.	Internal Audit Progress report and audit recommendations follow up **[AGC (03/12/2019) 701 TS]**	For Information	21	11.05am
7.	Progress with Audit Recommendations **[AGC (03/12/2019) 702 MA]**	For information	39	11.20am
8.	External Audit – Planning report **[AGC (03/12/2019) 703 JH]**	For Information	48	11.30am
9.	Estates Update **[AGC (03/12/2019) 704 RS]**	For Information	verbal	11.45am
10.	Resilience, Business Continuity Management Cyber Security **[AGC (03/12/2019) 705 DH]**	For Information	to follow	11.50am
11.	Strategic Risk Register **[AGC (03/12/2019) 706 HC]**	For Comment	70	12.05pm
12.	Bi-annual Human Resource report **[AGC (03/12/2019) 707 YA]**	For Information	102	12.15pm

13.	AGC Forward Plan **[AGC (03/12/2019) 708 MA]**	For information	106	12.25pm
14.	Gifts and Hospitality register **[AGC (03/12/2019) 709 MA]**	For Information	109	12.30pm
15.	Reserves Policy **[AGC (03/12/2019) 710 RS]**	For Decision	111	12.35pm
16.	Whistle Blowing and update on Counter Fraud **[AGC (03/12/2019) 711 RS]**	For Information	116	12.40pm
17.	Contracts and Procurement **[Oral MA]**	Verbal update	verbal	12.50pm
18.	Review of Committee effectiveness **[AGC (03/12/2019) 712 DO]**	For discussion [Members only]	separate to members	12.55pm
19.	Any other business			13.15pm
20.	Close (Refreshments & Lunch provided – in the **Garden Meeting room**)			13.25pm
21.	Session for members and auditors only			13.30pm

Next Meeting: 10am Tuesday, 10 March 2020, Chartered Institute of Arbitrators, 12 Bloomsbury Square, London, WC1A 2LP

Audit and Governance

Committee meeting minutes

Strategic delivery:	☐ Safe, ethical, effective treatment	☐ Consistent outcomes and support	☐ Improving standards through intelligence

Details:	
Meeting	Audit and Governance Committee
Agenda item	2
Paper number	AGC (03/12/2019) 698 DO
Meeting date	8 October 2019
Author	Debbie Okutubo, Governance Manager
Output:	
For information or decision?	For decision
Recommendation	Members are asked to confirm the minutes as a true and accurate record of the meeting
Resource implications	
Implementation date	
Communication(s)	
Organisational risk	☒ Low ☐ Medium ☐ High
Annexes	

Audit and Governance Committee meeting minutes

8 October 2019

Chartered Institute of Arbitrators, 12 Bloomsbury Square, WC1A 2LP

Attendees	Present	Anita Bharucha (Chair) Margaret Gilmore Mark McLaughlin Geoffrey Podger
	Apologies	None
	External advisers	Mike Surman, NAO Jill Hearne, NAO Jeremy Nolan, Head of Internal Audit – GIAA Tony Stanley, Audit Manager – GIAA
	Observers	Dafni Moschidou, DHSC Nora Cooke-O'Dowd, Head of Research and Intelligence
	Staff	Peter Thompson, Chief Executive Richard Sydee, Director of Finance and Resources Clare Ettinghausen, Director of Strategy Morounke Akingbola, Head of Finance Dan Howard, Chief Information Officer Paula Robinson, Head of Planning and Governance Helen Crutcher, Risk and Business Planning Manager Debbie Okutubo, Governance Manager

1. Welcome and declarations of Interest

1.1. The Chair welcomed everyone present.

1.2. There were no declarations of Interest.

2. Minutes of the meeting held on 18 June 2019

2.1. Minutes of the meeting held on18 June were agreed as a true record of the meeting subject to Minute 6.2 to read:

"It was explained that grant-in-aid income does not appear alongside other income in the Statement of Comprehensive Net Expenditure but is reflected in the Statement of Changes in Taxpayers' Equity, in line with guidance for accounting for government funding".

Minute 7.2 to read:

"The National Audit Office (NAO) reported that no significant audit findings had been identified in relation to the presumed risk of management override of controls and the risk of fraud in revenue recognition. There were no adjusted misstatements."

3. Matters arising

3.1. The committee noted the progress on actions from previous meetings. Some items were on the agenda and others were planned for the future. The committee noted and agreed items that were removed as completed.

3.2. Members agreed that at meetings where the NAO had presented the Audit Completion Report, the minutes would reflect the management reasons for not adjusting the misstatements, should this be the case.

3.3. The Chief Executive (CE) gave an update on EU exit and commented that we regularly assessed our operational readiness. A green RAG status was reported to the Department of Health and Social Care (DHSC) in August.

3.4. Members asked a question relating to the readiness of clinics. It was noted that we were in correspondence with clinics and nothing had been flagged up as a concern on the continuity of supply of reproductive cells. Contingency plans were in place to support the continued supply of medical devices and clinical consumables used by clinics.

3.5. In response to a question, it was noted that staff had not been pulled away to assist on the EU exit work.

4. Internal audit progress report

4.1. The committee noted the progress on actions from previous meetings. Since the June meeting, the final audit report on capability risks had been issued and was presented to the committee.

4.2. The purpose of the audit was to consider how we were managing specific elements in terms of the strategic risk relating to knowledge and capability.

4.3. Members were advised that the handover procedures when staff were leaving the organisation required strengthening to avoid knowledge and or skills gap and to ensure robust succession planning.

4.4. Members commented that we were a small organisation so there was a limit to the reliance on the Human Resources (HR) team; rather, team managers needed to take responsibility and submit reports to HR as evidence.

4.5. This would improve the situation for when people moved on and knowledge would also be passed on to new postholders.

4.6. A member commented that Standard Operating Procedures (SOP) were being used in some teams and needed to be encouraged throughout the organisation as a way of mitigating risks of inadequate knowledge transfer for both staff and Authority members.

4.7. Another member suggested that there should not be process overload as it could be detrimental and come at the expense of doing the work.

4.8. The Internal Auditor noted that capability was the highest risk on the strategic risk register so it could not be underestimated.

4.9. The executive agreed that it was an area to work on but it was also part of the operating conditions that remained an inherent risk.

Action

4.10. Members recommended that the executive should send a scaled response to the internal audit.

5. Progress with audit recommendations

5.1. The Head of Finance presented this item and stated that there were 21 audit recommendations of which 15 were complete subject to acknowledgement from the Internal Auditors.

5.2. In response to a question, the internal auditors confirmed that they believed that we were moving in the right direction, however, outstanding recommendations from 2018 needed to be treated with some urgency.

5.3. With regard to training, members suggested that in addition to offering and or providing training, competency levels also needed to be tested.

5.4. Members asked what IT security measures were in place and whether the Chair was kept informed when things were not going as planned. The executive responded that it depended on the scale of what went wrong. Also, all staff had been issued with hardware that was fully encrypted and had appropriate security.

5.5. With regard to personal use, it was noted that there was guidance in place for staff although this could be further strengthened with a fact sheet.

Action

5.6. A reminder to be sent to members about IT security.

5.7. Members noted the progress made with audit recommendations.

6. External audit planning work

6.1. The Chair welcomed Mike Surman from the NAO to his first meeting. He gave a brief summary of his portfolio. His colleague, Jill Hearne, then commented on the plans for the financial year. It was noted that these would be presented at the December AGC meeting.

6.2. In response to a question, it was noted that the increase in employer pension contributions to the civil service pension scheme would result in increases to the NAO charge out rates. This meant an increase in audit fees. Jill Hearne stated that this pension change explanation would be brought to the December AGC meeting as part of the NAO's audit planning report.

6.3. As a follow up to an issue raised by the NAO, the Chair agreed that other AGC members be canvassed for alternative dates for the June 2020 meeting to accommodate the NAO's comments about the timings of the AGC meetings coinciding with audit visits and providing an opinion on the accounts.

7. Reserves policy

7.1. The annual review of our reserves position took place and there were no significant changes.

7.2. A prudent assumption was proposed which would ensure a minimum of two months of fixed expenditure was maintained as a cash reserve. The executive suggested that the costs that would need to be met were the non-discretionary spend that would be required to ensure the HFEA could maintain its operations, including (a) salaries (including employer on-costs), (b) the cost of accommodation and (c) sundry costs related to IT contracts, outsourced services and other essential services.

7.3. The minimum level of reserves required more work and close liaison with the DHSC.

7.4. It was confirmed that the policy would be reviewed annually.

7.5. In response to a question it was noted that there had been discussion regarding the level of reserves at a meeting of the Authority.

Action

7.6. The committee requested that the reserves policy be brought back to the December meeting with the exact reserves figure being proposed.

8. Estates update

8.1. The Director of Finance and Resources gave an update to the committee.

8.2. The DHSC was the co-ordinator of the move to Stratford. It was noted that the contract had still not been signed as there were a few elements that needed to be resolved.

8.3. There were five Arms-Length Bodies (ALBs) with various IT needs and cultural differences moving in together and all these needed to be worked out. To aid this transition, new ways of working policies were being developed.

8.4. It was noted that from the staff survey carried out over the move, over 50% of our staff would be negatively impacted. However, there was still the intention to have further conversations with our staff to give them a better understanding of new ways of working and packages available to staff.

8.5. In responding to a question, the Director of Finance and Resources, suggested that there could be staff losses at all levels including senior levels. However, we would align with other ALBs as much as we could.

Action

8.6. Members requested an update at every meeting.

9. The Senior Information Risk Officer's (SIRO) report

9.1. The SIRO annual report to the AGC was presented to the committee.

9.2. It was noted that we had an effective information governance framework in place and that we complied with all relevant regulatory, statutory and organisation information security policies and standards.

9.3. In addition, the Information Governance (IG) Manager position was recently filled, and our retention policy would be finalised by the IG Manager.

9.4. Members noted that there was a need to use our resources effectively especially in the run-up to 2021 and 2023 when those children born after the lifting of donor anonymity in 2005 would start to be eligible to 'Open The Register' and have access to certain information about their donors. This was likely to lead to an increase in information requests.

Action

9.5. Members noted the report.

10. Digital programme update

10.1. An update was given, providing an overview of

- Data migration progress, including the resolution of the EggBatchID issue
- PRISM and API development, including User Acceptance Testing (UAT), preview launch and transitional activities
- Updating Choose a Fertility Clinic (CaFC) performance data on our website
- Communications / engagement and budget review
- Approval to proceed' approach, including the expected metrics, impact, and business consequence
- Detailed timeline, including an outline of the work that would be completed prior to the approval to proceed meeting, the work completed between approval to proceed and launch, and the work that would be completed thereafter
- Risk assessment.

10.2. It was noted that good progress had been made since the last update in August 2019 although PRISM development had not proceeded as quickly as expected because of issues with aspects of code relating to 'gamete sources'.

10.3. Given the above delay, the AGC approval to proceed meeting scheduled for 8 November may need to be postponed and that would be confirmed within two weeks.

10.4. In terms of funding, different scenarios relating to alternative launch dates were being assessed and this project remained a key organisational priority.

10.5. In response to a question, it was noted that there was enough flexibility for existing operational processes, and workarounds would be possible immediately after the go-live phase.

10.6. Regarding 'Choose a Fertility Clinic' (CaFC) the deadline for data sign-off by PRs had been extended during the summer to allow flexibility for clinics and to allow more time for those who had not checked their data.

10.7. In response to a question, it was noted that for the current system the accuracy of data was checked retrospectively once it had been submitted. For the new system, data would be checked at the point of entry using 'validation rules'.

10.8. Members sought clarification regarding gamete sources. The executive responded that there was an issue around the coding for a component of PRISM. The extra work to rectify the issue was expected to take around three weeks. The executive confirmed there was no impact on existing data held within the Register.

10.9. It was emphasised that clinics needed to see the benefits of the system being installed which meant that by the time it was operational it needed to be in good working order. Members commented that the expectations with clinics needed to be managed.

10.10. Members were re-assured that no data was or would be lost, even if linkages were more difficult to establish and we would not go live until we had full assurance over all aspects of PRISM coding.

10.11. In terms of impact, it was stated that the delay to go live was mainly a budgetary concern.

Action

10.12. The committee noted:

- The data migration progress including EggBatchID resolution
- PRISM and API development
- Choose a Fertility Clinic (CaFC) data refresh progress
- Communications, engagement and budget review
- The timeline

10.13. This will be taken to the next Authority meeting following approval.

10.14. The approval to proceed meeting would be managed as a telephone conference call with the committee, Chief Executive, Director of Finance and Resources and the Chief Information Officer.

11. Resilience, business continuity management and cyber security

11.1. In recent months, the committee had received regular and detailed updates on resilience, business continuity management and cyber security, in line with the strategic risk register.

11.2. Members were advised that the implementation of Content Manager, our new electronic document management system (replacing TRIM) had been completed.

11.3. On 3 September there was an IT incident relating to the failure of one of the hard drives in a server at Spring Gardens which resulted in a short-term outage for some IT services. The cause was identified and resolved.

11.4. The telephone and video conference upgrades had taken place and the quality of service had increased substantially in line with the improvements made. The ongoing migration of services to the cloud means the office move to Stratford should be more straightforward than past moves, as there will be minimal server hardware to migrate.

11.5. Committee members were advised that there may be elements relating to the teleconference service outside of the HFEA's control, such as a poor network connection which would impact on service quality.

11.6. Committee members were advised that member guidance on information security would be issued soon by the Chief Information Officer.

Action

11.7. Members noted the report.

12. Legal risks

12.1. There were none to discuss.

13. Strategic risk register

13.1. The Risk and Business Planning Manager presented the strategic risk register.

13.2. There was one high risk around capability. It was noted that this risk and the controls were focused on business as usual capability, rather than capacity, though there were some linkages between capability and capacity. Members asked the executive to consider the extent to which the office move risks would exacerbate this already high risk, and to consider whether any other mitigating controls or contingency actions were possible.

13.3. It was noted that regulatory effectiveness was above tolerance due to the ongoing delays to the release of PRISM and the new register. The executive commented that regular updates on this risk were provided to AGC who had oversight over the final stages of this work.

13.4. In response to a question, it was noted that the risk register would be reviewed when the new strategy was approved.

13.5. Members noted that the executive had discussed legal risk at length and was mindful that the risks in the legal area were not simply about resource diversion, but inherent legal risk was linked to regulatory processes and the risk that the organisation would be challenged on a decision. The executive would reconsider the framing of the legal risk during the process of composing a new strategic risk register for the 2020-2023 strategy.

13.6. Members commented that it was disappointing that legal parenthood remained a risk on the register despite the HFEA's work in helping and encouraging clinics to tackle this.

13.7. They also noted that office relocation was a new risk on the register including its interdependencies. The executive commented that the risk was understood and conversations were occurring at all levels and externally with the DHSC and other ALBs we were moving in with. Members asked the executive to review how risks to the possible benefits of co-location, such as

the opportunity for creating career pathways between organisations and closer working, were reflected in the register.

Action

13.8. Members noted the strategic risk register.

14. Audit and Governance Committee forward plan

14.1. The Head of Finance presented the AGC forward workplan to the committee.

14.2. It was noted that the new Director of Compliance and Information will be attending the next AGC meeting and the Director of Strategy and Corporate Affairs will present her directorate report at the next meeting. The Director of Compliance and Information will present her directorate report at the March 2020 meeting.

14.3. It was agreed that the General Data Protection Regulations (GDPR) could now be removed from the forward plan as the SIRO report has replaced it.

Action

14.4. Members noted the forward plan.

15. Register of gifts and hospitality

15.1. The register of gifts and hospitality which will be a standing agenda item to the committee was presented.

15.2. It was noted that more work needed to be done with staff to get them to declare all gifts offered whether accepted or not.

Action

15.3. Members noted the entries in the register.

16. Whistle blowing and fraud - counter fraud strategy

16.1. The counter fraud strategy setting out what was required over the period 2019 – 2022 was presented to the committee.

16.2. It was noted that the strategy had been previously circulated to AGC members. Members emphasised that staff needed to demonstrate that they had done the training and understood what they had learnt.

16.3. It was also suggested that staff who had done the training should be issued a certificate as proof.

16.4. AGC members and staff present agreed on the importance of an independent note-taker when sensitive meetings take place.

16.5. As part of mitigating against bribery and corruption, it was noted that every three to four years inspector portfolios were re-shuffled.

16.6. Members commented that there was a need to have an approach which was documented and tested for the new Director of Compliance and Information could use. The Internal Auditors commented that this was picked up in the risk assessment, just not included in the report.

16.7. There were no whistle blowing or fraud cases to report on.

Action

16.8. Members noted the updated strategy.

17. Contracts and procurement

17.1. The Head of Finance gave the committee an update on existing contracts. It was noted that since the last meeting the Director of Finance and Resources had signed off the Donor Conceived Register service contract provided by Hewitt Fertility.

Action

17.2. Members noted the update on contracts.

18. Any other business

18.1. For the annual committee effectiveness exercise, it was agreed that the Governance Manager should send the form to members in advance of the 3 December meeting.

18.2. Member training will also be picked up during the session on committee effectiveness.

19. Chair's signature

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

Signature

Name

Anita Bharucha

Date

3 December 2019

Matters arising from previous AGC meetings

Strategic delivery:	☐Safe, ethical, effective treatment	☒Consistent outcomes and support	☐Improving standards through intelligence
Details:			
Meeting	AGC		
Agenda item	3		
Paper number	HFEA (03/12/2019) 699 MA		
Meeting date	3 December 2019		
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	2019/20 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

Numerically:

- 4 items carried over from earlier meetings, 1 ongoing
- 7 items added from October 2018 meeting, 1 ongoing
- 10 items added from June 2019 meeting, 4 ongoing
- 9 Items removed: 4.9 (5 Mar-19), 4.20,5.6,6.6,7.7,7.8,7.9,7.11,13.2 (18 June-19)

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
Matters Arising from the Audit and Governance Committee – actions from 12 June 2018 meeting			
9.10 The Committee to receive monthly updates highlighting any variances and increased risk.	Chief Information Officer	On-going	**Update** - on the three identified risks and issues concerning data migration, additional development work and loss of key staff to be given in the meeting
Matters Arising from the Audit and Governance Committee – actions from 9 October 2018 meeting			
3.8 The Committee Secretary to contact members regarding availability for training after the meeting on 4 December 2018 or 5 March 2019	Committee Secretary	3 Dec-19	**Update** – Training requirements to be ascertained after Members' have discussed committee effectiveness
Matters Arising from the Audit and Governance Committee – actions from 18 June 2019 meeting			
4.7 Committee to be kept updated on the outcome of the meeting with the Cabinet Office – Fraud standards	Director of Finance and Resources	On-going	**Update –** Meeting has not yet taken place as we are waiting for feedback from 2 Sept submission.
10.6 Chief Information Officer to give monthly updates on the progress of the Digital Programme	Chief Information Officer	On-going	**Update –** an item on the agenda
Matters Arising from the Audit and Governance Committee – actions from 8 October 2019 meeting			
4.10 A scaled response to the Risk Management Capability of risks Internal Audit recommendations to be sent by the executive.	Chief Executive Officer	3 Dec-19	**Update -** Responses have not been amended as it was felt they currently reasonably reflect where we are.

5.6 A reminder is to be sent to members about IT security training.	Committee Secretary	17 Dec 19	**Update –** Email sent to Members with guidance as to registering on Civil Service Learning.
7.6 Reserves policy to be re-tabled with amendments to narrative and figures around	Director of Finance and Resources	3 Dec-19	**Update -** Amended policy is an agenda item

Human Fertilisation & Embryology Authority

Strategy and Corporate Affairs update

Clare Ettinghausen
Director of Strategy and Corporate Affairs
3 December 2019

www.hfea.gov.uk

The 'Stratcad' directorate

Planning and Governance
Head: Paula Robinson
- Licensing
- Corporate governance
- Strategic and Business planning
- Risk management
- Programme management
- Performance Monitoring

Research and Intelligence
Head: Nora Cooke O'Dowd
- Information access
- Data analysis
- Intelligence reports
- Data research governance
- FOIs and PQs

Engagement and Communications
Head: Jo Triggs
- Patient information/enquiries
- Internal communications
- Media, campaigns, reports
- Digital and social media
- Communications with clinics
- Stakeholder engagement

Policy
Head: Laura Riley
- Standards and guidance
- Public enquiries
- Stakeholder engagement
- Scientific horizon scanning
- Policy project across and outside organisation

Human Fertilisation & Embryology Authority

Directorate risks: trends

2016 risks

- CaFC litigation
- Vacancies in Governance
- PQ/FoI resilience
- Capacity issues in Comms
- Stakeholder acceptance of website

2017 risks

- Appeal and CaFC litigation
- Staff turnover
- Capacity in Governance
- Comms impact
- Capitalising on data opportunities

2018 risks

- Appeal and CaFC litigation
- Staff turnover/Capacity of key staff
- Comms impact
- Capitalising on data opportunities
- Code implementation - realising changes in Clinic practice

Human Fertilisation & Embryology Authority

Directorate risks: 2019/20

- Staff turnover/impact of office move
- Poor internal comms by leading to miscommunication
- Capacity to achieve strategic objectives and BAU
- Capitalising on data opportunities
- Processing around Register Research Panel requirements
- Capacity of other teams to support our work e.g. IT
- Realising changes in Clinic practice e.g. treatment add-ons
- Matching ambition with resource – having a joined up approach across the organisation
- Core standards and processes being adhered to across the organisation
- Other data providers and our response

Human Fertilisation & Embryology Authority

Human Fertilisation & Embryology Authority

Clare Ettinghausen
clare.ettinghausen@hfea.gov.uk

Strategic risk register

Strategic delivery:	☒ Safe, ethical, effective treatment	☒ Consistent outcomes and support	☒ Improving standards through intelligence

Details:	
Meeting	Audit and Governance Committee
Agenda item	11
Paper number	AGC (03/12/2019) 706 HC
Meeting date	3 December 2019
Author	Helen Crutcher, Risk and Business Planning Manager
Output:	
For information or decision?	For information and comment
Recommendation	AGC is asked to note the latest edition of the risk register, set out in the annex.
Resource implications	In budget.
Implementation date	Strategic risk register and operational risk monitoring: ongoing. SMT review the strategic risk register monthly. AGC reviews the strategic risk register at every meeting. The Authority reviews the strategic risk register periodically (at least twice per year).
Communication(s)	Feedback from AGC will inform the next SMT review in January.
Organisational risk	☐ Low ☒ Medium ☐ High
Annexes	Annex 1: Strategic risk register

1. Latest reviews

1.1. Authority considered the register at its meeting on 13 November and SMT reviewed the register at its meeting on 18 November. SMT reviewed all risks, controls and scores.

1.2. Authority and SMT's comments are summarised in the commentary for each risk and at the end of the register, which is attached at Annex A. The annex also includes a graphical overview of residual risk scores plotted against risk tolerances.

1.3. Two of the six risks are above tolerance.

2. New risk source – member appointments

2.1. As at November, we have a new source of risk relating to member appointments. We currently have two vacancies and, as yet, no agreement on when a recruitment campaign can begin, which is handled centrally by the Department. The Chair's term of office expires at the end of March 2020 and there will be two further vacancies in November. Looking further ahead, another seven members' terms of office expire in 2021. Much will depend on the Government's policy on re-appointment, but the detrimental possible impact on Authority capability and functions is clear.

2.2. Authority and SMT each discussed this risk at their November reviews. As a result of the discussion and in the light of the actions taken by the executive to plan for and mitigate this risk, the Capability risk and its score have been updated. SMT view this risk as above tolerance.

2.3. Given the nature of this risk we would value a discussion with AGC to consider risk handling and also whether this may warrant a separate risk on the strategic register.

3. Recommendation

3.1. AGC is asked to note the above, and to comment on the strategic risk register.

Latest review date – 18/11/2019

Strategic risk register 2019/20

Risk summary: high to low residual risks

Risk area	Strategy link*	Residual risk	Status	Trend**
C1: Capability	Generic risk – whole strategy	**15 – High**	Above tolerance	⇔⇔⇔⇧
RE1: Regulatory effectiveness	Improving standards through intelligence	**9 – Medium**	Above tolerance	⇔⇔⇔⇔
CS1: Cyber security	Generic risk – whole strategy	**9 – Medium**	At tolerance	⇔⇔⇔⇔
FV1: Financial viability	Generic risk – whole strategy	**9 – Medium**	At tolerance	⇔⇔⇔⇔
LC1: Legal challenge	Generic risk – whole strategy	**8 – Medium**	Below tolerance	⇔⇔⇔⇔
ME1: Effective communications	Safe, ethical effective treatment Consistent outcomes and support	**6 – Medium**	At tolerance	⇔⇔⇔⇔
E1: Relocation of HFEA offices in 2020	Generic risk – whole strategy	**6 – Medium**	Below tolerance	⇔⇔⇔⇔

* Strategic objectives 2017-2020:

Safe, ethical effective treatment: Ensure that all clinics provide consistently high quality and safe treatment

Safe, ethical effective treatment: Publish clear information so that patients understand treatments and treatment add-ons and feel prepared

Safe, ethical effective treatment: Engender high quality research and responsible innovation in clinics

Consistent outcomes and support: Improve access to treatment

Consistent outcomes and support: Increase consistency in treatment standards, outcomes, value for money and support for donors and patients

Improving standards through intelligence: use our data and feedback from patients to provide a sharper focus in our regulatory work and improve the information we produce

** This column tracks the four most recent reviews by AGC, SMT or the Authority (eg,⇧⇔⇩⇔).

Recent review points are: AGC 8 October 2019⇨SMT 30 October 2019⇨Authority 13 November 2019⇨SMT 18 November

FV1: There is a risk that the HFEA has insufficient financial resources to fund its regulatory activity and strategic aims.

Inherent risk level:			Residual risk level:		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	4	16– High	**3**	**3**	**9 – Medium**
Tolerance threshold:					**9 - Medium**
Status: **At tolerance**					

Risk area	Risk owner	Links to which strategic objectives?	Trend
Financial viability FV1: Income and expenditure	Richard Sydee, Director of Finance and Resources	Whole strategy	⇔⇔⇔⇔

Commentary
While planning our 2019/20 budget, we took a prudent approach, utilising our predictive model, planning based on 2% growth on the current budget rather than against the recent trend, which was higher. This should ensure that should we see a drop in treatment volumes, the HFEA will be able to meet its financial commitments from its annual receipts. The delays in completing the data migration element of the digital projects has increased costs in 2019/20. In May 2019 the Audit and Governance Committee agreed to secure specialist data migration support to complete this work. This has come out of existing budgets and so has had a knock-on effect on other planned work. To ensure that we do not exceed our control totals with DHSC, at the end of Q2 we have reviewed the emerging situation and reprioritised expenditure in other areas of the organisation. Although at end of Q2 the number of treatments is below our forecast, we are predicting break even against our budget and are monitoring income and expenditure closely.

Causes / sources	Mitigations	Timescale / owner
There is uncertainty about the annual recovery of treatment fee income – this may not cover our annual spending. As at Quarter 2, treatment volumes are down, and fees are also lower than expected as a result.	Heads see quarterly finance figures and would consider what work to deprioritise or reduce should income fall below projected expenditure. We have a model for forecasting treatment fee income and this reduces the risk of significant variance, by utilising historic data and future population projections. We will refresh this model quarterly internally and review at least annually with AGC.	Quarterly, ongoing, with AGC model review at least annually - next review due in December 2019 - Richard Sydee

Our monthly income can vary significantly as: • it is linked directly to level of treatment activity in licensed establishments • we rely on our data submission system to notify us of billable cycles.	Our reserves policy takes account of monthly fluctuations in treatment activity and we have sufficient cash reserves to function normally for a period of two months if there was a steep drop-off in activity. The reserves policy was reviewed by AGC in December 2018. If clinics were not able to submit data and could not be invoiced for more than three months we would invoice them on historic treatment volumes and reconcile this against actual volumes once the submission issue was resolved and data could be submitted.	Ongoing – Richard Sydee In place – Richard Sydee
Annual budget setting process lacks information from directorates on variable/additional activity that will impact on planned spend.	Annual budgets are agreed in detail between Finance and Directorates with all planning assumptions noted. Quarterly meetings with Directorates flag any shortfall or further funding requirements. All project business cases are approved through CMG, so any financial consequences of approving work are discussed.	Quarterly meetings (on-going) – Morounke Akingbola Ongoing – Richard Sydee
Additional funds have been required for the completion of the data migration work and this will constrain HFEA finances and may affect other planned and ad hoc work.	The most cost-effective approach was taken to procure external support to reduce costs and the resulting impact. Ongoing monitoring and reporting against control totals to ensure we do not overspend. Where possible, costs have been covered by the IT budget, reducing the impact on key delivery teams and other strategic deliverables. Second quarter budgets were reviewed at CMG, to allow us to consider the impact and reprioritise as appropriate.	Procurement underway – Richard Sydee Ongoing – Richard Sydee October CMG meeting – Richard Sydee
Inadequate decision-making leads to incorrect financial forecasting and insufficient budget.	Within the finance team there are a series of formalised checks and reviews, including root and branch analyses of financial models and calculations. The organisation plans effectively to ensure enough time and senior resource for assessing core budget assumptions and subsequent decision making.	In place and ongoing - Richard Sydee Quarterly meetings (on-going) – Morounke Akingbola
Project scope creep leads to increases in costs beyond the levels that have been approved.	Finance staff member present at Programme Board. Periodic review of actual and budgeted spend by Digital Projects Board (formerly IfQ) and monthly budget meetings with finance. Any exceptions to tolerances are discussed at Programme Board and escalated to CMG at monthly meetings, or sooner, via SMT, if the impact is significant or time-critical.	Ongoing – Richard Sydee or Morounke Akingbola Monthly (on-going) – Olaide Kazeem

Failure to comply with Treasury and DHSC spending controls and finance policies and guidance may lead to serious reputational risk and a loss of financial autonomy or goodwill for securing future funding.	The oversight and understanding of the finance team ensures that we do not inadvertently break any rules. The team's professional development is ongoing, and this includes engaging and networking with the wider government finance community. All HFEA finance policies and guidance are compliant with wider government rules. Policies are reviewed annually, or before this if required. Internal oversight of expenditure and approvals provides further assurance (see above mitigations).	Continuous - Richard Sydee Annually and as required – Morounke Akingbola
There is uncertainty about the how increases of 6% to the civil service pension employer contributions will be funded next year and the possible impact of this. This may put additional pressure on HFEA financial resources and delivery. In 2019/20 we have funded 2.5% within the HFEA budget with the remainder centrally funded.	Communication with the Department about arrangements to ensure that we understand and can plan for the implications of this as soon as possible.	Ongoing - Richard Sydee
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
DHSC: Legal costs materially exceed annual budget because of unforeseen litigation.	Use of reserves, up to appropriate contingency level available at this point in the financial year. The final contingency for all our financial risks would be to seek additional cash and/or funding from the Department.	Monthly – Morounke Akingbola
DHSC: GIA funding could be reduced due to changes in Government/policy.	A good relationship with DHSC Sponsors, who are well informed about our work and our funding model.	Quarterly accountability meetings (on-going) – Richard Sydee
	Annual budget has been agreed with DHSC Finance team. GIA funding has been provisionally agreed through to 2020.	December/January annually, – Richard Sydee

C1: There is a risk that the HFEA experiences unforeseen knowledge and capability gaps, threatening delivery of the strategy.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
5	4	20 – High	**5**	**3**	**15- High**
Tolerance threshold:					**12 - High**
Status: **Above tolerance.**					

Risk area	**Risk owner**	**Links to which strategic objectives?**	**Trend**
Capability C1: Knowledge and capability	Peter Thompson, Chief Executive	Whole strategy	⇔⇔⇔⇧

Commentary
This risk and the controls are focused on business as usual capability, rather than capacity, though there are obviously some linkages between capability and capacity. For 18/19 turnover was 26.8%. Evidence suggests that the two main drivers of high turnover are the continuing constraints on public sector pay and the relatively few development opportunities in small organisations like the HFEA. In response, we have revised our recruitment strategy using a wider range of national and social media and recruitment agencies to improve the number and quality of applicants. This approach is having some success and we have in recent months attracted several high-quality candidates. We are also taking active steps to improve retention, focussing on things that we can control like learning and development. AGC receive 6-monthly updates on capability risk to consider our ongoing strategies for the handling of these, to allow them to track progress. Looking further ahead, we need to find ways to tackle the issue of development opportunities, to prevent this risk increasing further. An idea we are keen to explore is whether we can build informal links or networks with other public sector or health bodies, to develop clearer career paths between organisations. In November we have two Authority member vacancies which create Board capability gaps. We are managing the impact of these gaps, but in the light of these current issues, SMT reconsidered the risk score in November and agreed to raise the inherent and residual likelihood. We remain in close contact with the department who manage recruitments centrally, although it remains uncertain how swiftly the vacancies will be able to be addressed and this is outside of HFEA control. Looking ahead, the majority of our Board members' terms will end in the next 18 months, so this uncertainty may cause ongoing issues.

Causes / sources	**Mitigations**	**Timescale / owner**

High turnover, sick leave etc., leading to temporary knowledge loss and capability gaps.	Organisational knowledge captured via documentation, handovers and induction notes, and manager engagement. We have developed corporate guidance for all staff for handovers. A checklist for handovers is circulated to managers when staff hand in their notice. This checklist will reduce the risk of variable handover provision.	In place – Yvonne Akinmodun Checklist in use – Yvonne Akinmodun
	Vacancies are addressed speedily, and any needed changes to ways of working or backfill arrangements receive immediate attention. CMG and managers prioritise work appropriately when workload peaks arise. Contingency: In the event of knowledge gaps we would consider alternative resources such as using agency staff if appropriate.	In place – Yvonne Akinmodun In place – Peter Thompson In place – Relevant Director alongside managers
Failure to appoint new or reappoint current Authority members within an appropriate timescale will lead to loss of knowledge and may impact on formal decision making. There are currently two vacancies and two further members' terms of office end in the first quarter of 2020, including the Chair. Looking ahead, this risk may be more significant in the longer term as the current terms of the majority of Authority members will end in the next 18 months.	The recruitment process is run by DHSC and the Chair/CEO are in close contact with the Department to press for an early decision. The Governance team are reviewing recruitment information and member onboarding to ensure that this will be as smooth as possible once it starts. Membership of licensing committees is being actively managed to ensure that formal decision-making can continue unimpeded by vacancies.	Ongoing – Peter Thompson
The Director of Compliance and Information is new in post, there will naturally be a settling in period, meaning that there may be a small continuing resource pressure for a time.	The new postholder has a background in the sector, which will reduce the learning curve and will bring valuable capabilities to the role. A full induction is underway and other staff will be able to support on tasks as required during the induction period.	Underway – Peter Thompson
Poor morale could lead to decreased effectiveness and performance failures.	Communication between managers and staff at regular team and one-to-one meetings allows any morale issues to be identified early and provides an opportunity to determine actions to be taken. The staff intranet enables regular internal communications. Ongoing CMG discussions about wider staff engagement (including surveys) to enable	In place, ongoing – Peter Thompson In place – Jo Triggs

	management responses where there are areas of particular concern. Policies and benefits are in place that support staff to balance work and life (such as the buying and selling of annual leave policy and PerkBox) promoting staff to feel positive about the wider package offered by the HFEA. This may boost good morale.	In Place – Yvonne Akinmodun In place - Peter Thompson
Increased workload either because work takes longer than expected or reactive diversions arise.	Careful planning and prioritisation of both business plan work and business flow through our Committees. Regular oversight by CMG – standing item on planning and resources at monthly meetings.	In place – Paula Robinson
	Oversight of projects by both the monthly Programme Board and CMG meetings, to ensure that projects end through due process (or closed, if necessary). Work is underway to review our interdependencies matrix, which supports the early identification of interdependencies in projects and other work, to allow for effective planning of resources.	In place – Paula Robinson Matrix relaunching 2019/20 – Paula Robinson
	Learning from Agile methodology to ensure we always have a clear 'definition of done' in place, and that we record when products/outputs have met the 'done' criteria and are deemed complete.	Partially in place – further work to be done in 2019/20 - Paula Robinson
	Team-level service delivery planning for the next business year, with active involvement of team members. CMG will continue to review planning and delivery. Requirement for this to be in place for each business year.	In place – Paula Robinson
	Planning and prioritising data submission project delivery, and therefore strategy delivery, within our limited resources.	In place until project ends – Dan Howard
We may not be able to find time to implement the People Plan to maximise organisational capability given our small organisational capacity and ongoing delivery of business as usual.	Small focus groups and all staff awaydays have been utilised to make the most of staff time and involve wider staff in developing proposals. The most recent staff awayday was in July 2019 and we engaged external resources to support work on developing HFEA values and culture.	Ongoing – Yvonne Akinmodun
A number of staff are simultaneously new in post. This carries a higher than normal risk of internal incidents	Recognition that a settling in period where staff are inducted and learn, and teams develop new ways of working is necessary. Formal training and development are provided where required.	Ongoing – Peter Thompson

and timeline slippages while people learn and teams adapt.	Knowledge management via records management and documentation and clear and effective onboarding methods including handover process in place.	In place – Yvonne Akinmodun
The future office move, occurring in 2020, may not meet the needs of staff (for instance location), meaning staff decide to leave sooner than this, leading to a significant spike in turnover, resulting in capability gaps.	See separate E1 risk for full assessment of risk causes and controls.	Early engagement with staff and other organisations underway and ongoing – Richard Sydee
Possible capability benefits of colocation with other organisations, arising out of the office move in 2020, such as the ability to create career pathways and closer working may not be realised.	Active engagement with other organisations early on. We are having wider conversations with other relevant regulators to see what more can be done to create career paths and achieve other benefits of working more closely.	Ongoing – Richard Sydee
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
Government/DHSC The UK leaving the EU may have unexpected operational consequences for the HFEA which divert resource and threaten our ability to deliver our strategic aims.	The department has provided guidance about the impact of a no-deal EU exit on the import of gametes and embryos. We continue to work closely to ensure that we are prepared and can provide detailed guidance to the sector at the earliest opportunity, to limit any impact on patients. We have provided ongoing updates to the sector. Since December 2018, we have run an EU exit project to ensure that we fully consider implications and are able to build enough knowledge and capability to handle the effects of the UK's exit from the EU, as a third country in relation to import and export of gametes. This project includes our role in communicating with the sector on the effects of EU exit, to ensure that clinics are adequately prepared in terms of staffing and access to equipment and materials. We continue to engage with the DHSC and clinics to prepare for Brexit. An internal working group attended by the Senior Responsible Officer (SRO) and recently appointed Deputy SRO meet weekly at this point to highlight any current or new issues and concerns and agree actions accordingly. Authority and AGC are also updated at their meetings.	Communications ongoing – Peter Thompson

CS1: There is a risk that the HFEA has unsuspected system vulnerabilities that could be exploited, jeopardising sensitive information and involving significant cost to resolve.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
5	4	20 – Very high	**3**	**3**	**9 - Medium**
Tolerance threshold:					**9 - Medium**
Status: **At tolerance**					

Risk area	**Risk owner**	**Links to which strategic objectives?**	**Trend**
Cyber security CS1: Security and infrastructure weaknesses	Rachel Cutting Director of Compliance and Information	Whole strategy	⇔⇔⇔⇔

Commentary
We have undertaken cyber security (penetration) testing of the new digital systems such as PRISM and the Register, to ensure that these remain secure. The results have not revealed any significant issues. The third and final test is now underway ahead of go-live and AGC will consider the results of this at a special meeting in December. Go-live has been delayed owing to issues with data migration. Options were considered by AGC in May and revised deployment plans have been developed with delivery of the new system in Spring 2020. The delay poses no increased cyber risk. We continue to assess and review the level of national cyber security risk and take action as necessary to ensure our security controls are robust and are working effectively. A cyber security audit in December 2018 gave us a moderate rating with no significant weaknesses found.

Causes / sources	**Mitigations**	**Timescale / owner**
Insufficient governance or board oversight of cyber security risks (relating to awareness of exposure, capability and resource, independent review and testing, incident preparedness, external linkages to learn from others).	AGC receives reports at each meeting on cyber-security and associated internal audit reports. The Deputy Chair of the Authority is regularly appraised on actual and perceived cyber risks. Recommendations arising from 'moderate' rated internal audit reports on data loss (October 2017) and cyber security (December 2018) have been actioned, with one outstanding recommendation being reported at each AGC meeting. A final report on cyber security will be signed off by AGC before any decision is made to go live with PRISM.	Ongoing regular reporting – Rachel Cutting/ Dan Howard Ongoing – Dan Howard Deployment date of project to be confirmed once ongoing data migration issue resolved – Dan Howard

Changes to the digital estate open up potential attack surfaces or new vulnerabilities. Our relationship with clinics is more digital, and patient identifying information or clinic data could therefore be exposed to attack.	The website and Clinic Portal are secure and we have been assured of this. The focus now is on obtaining similar assurance through penetration testing report to the SIRO in relation to the remaining data submission deliverables (PRISM). The final round of penetration testing is underway and there have been no significant issues found so far.	Penetration testing underway throughout development and ongoing – Peter Thompson/ Dan Howard
There is a risk that IT demand could outstrip supply meaning IT support doesn't meet the business requirements of the organisation and so we cannot identify or resolve problems in a timely fashion. We do not currently have a developer in post.	We continually refine the IT support functional model in line with industry standards (ie, ITIL). We undertook an assessment of our ticketing systems and launched a new system in November 2018. Our vision is to have an internal team working in partnership with a third-party software development provider. In May 2018 we awarded a contract for third-party infrastructure and development support. The service is based on the ITIL framework (IT service standard). Our strategy was to recruit to the in-house software development team following a workload review. The workload review has been completed, however during the delay to PRISM and Data Migration work, the funding for the developer post has been used for this ongoing development. Resourcing for the substantive role will be reviewed in autumn.	Approved per the ongoing business plan – Dan Howard Third-party support arrangement in place – Dan Howard Recruitment to internal development team pending – Dan Howard
Confidentiality breach of Register or other sensitive data by HFEA staff.	Staff are made aware on induction of the legal requirements relating to Register data. All staff have annual compulsory security training to guard against breaches of confidentiality, updated information risk training was completed by staff during April / May 2019. Relevant and current policies to support staff in ensuring high standards of information security. There are secure working arrangements for all staff both in the office and when working at home (end to end data encryption via the internet, hardware encryption) Further to these mitigations, any malicious actions would be a criminal act.	In place – Peter Thompson A review of current IT policies is ongoing – Dan Howard
There is a risk that technical or system weaknesses lead to loss of, or inability to access, sensitive data, including the Register.	Back-ups of the data held in the warehouse in place to minimise the risk of data loss. Regular monitoring takes place to ensure our data backup regime and controls are effective. We are ensuring that a thorough investigation takes place prior, during, and after moving the Register to the Cloud. This involves the use of	In place – Dan Howard The new Register will be deployed once ongoing

	third party experts to design and implement the configuration of new architecture, with security and reliability factors considered. Results of penetration testing have been positive.	data migration issue is resolved in spring 2020 – Dan Howard
Business continuity issue (whether caused by cyber-attack, internal malicious damage to infrastructure or an event affecting access to Spring Gardens).	Business continuity plan and staff site in place. The BCP information cascade system was tested in March 2019 and CMG reviewed the plan and agreed revisions in May. Existing controls are through secure off-site back-ups via third party supplier. A cloud backup environment has been set up to provide a further secure point of recovery for data which would be held by the organisation. The cloud backup environment for the new Register has been successfully tested. Once the final penetration tests are complete we will utilise this functionality as we go live with our new Register and submission system.	BCP in place, regularly tested and reviewed – Rachel Cutting/ Dan Howard Undertaken monthly – Dan Howard System to be completed Spring 2020 – Dan Howard
Cloud-related risks.	Detailed controls set out in 2017 internal audit report on this area. We have in place remote access for users, appropriate security controls, supply chain security measures, appropriate terms and conditions with Microsoft Azure, Microsoft ISO 27018 certification for cloud privacy, GCloud certification compliance by Azure, a permission matrix and password policy, a web configuration limiting the service to 20 requests at any one time, good physical and logical security in Azure, good back-up options for SQL databases on Azure, and other measures.	In place – Dan Howard
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
None. Cyber-security is an 'in-common' risk across the Department and its ALBs.		

LC1: There is a risk that the HFEA is legally challenged given the ethically contested and legally complex issues it regulates.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	5	20 – Very high	**2**	**4**	**8 - Medium**
Tolerance threshold:					**12 - High**
Status: **Below tolerance**					

Risk area	Risk owner	Links to which strategic objectives?	Trend
Legal challenge LC 1: Resource diversion	Peter Thompson, Chief Executive	Safe, ethical effective treatment: Ensure that all clinics provide consistently high quality and safe treatment	⇔⇔⇔⇔

Commentary
We accept that in a contested area of public policy, the HFEA and its decision-making will be legally challenged. Legal challenge poses two key threats: • that resources are substantially diverted • that the HFEA's reputation is negatively impacted by our participation in litigation. These may each affect our ability to regulate effectively and deliver our strategy. Both the likelihood and impact of legal challenge may be reduced, but it cannot be avoided entirely. For these reasons, our tolerance for legal risk is high. We have not had any active legal action since October 2018.

Causes / sources	Mitigations	Timescale / owner
Assisted reproduction is complex and controversial and the Act and regulations are not beyond interpretation. This may result in challenges to the way the HFEA has interpreted and applied the law.	Evidence-based and transparent policy-making and horizon scanning processes. Horizon scanning meetings occur with the Scientific and Clinical Advances Advisory Committee on an annual basis.	In place – Laura Riley with appropriate input from Catherine Drennan
	Through constructive and proactive engagement with third parties, the in-house legal function serves to anticipate issues of this sort and prevent challenges or minimise the impact of them. Where necessary, we can draw on the expertise of an established panel of legal advisors, whose experience across other sectors can be applied to	Ongoing – Catherine Drennan In place – Peter Thompson

	put the HFEA in the best possible position to defend any challenge.	
	Case by case decisions on the strategic handling of contentious issues in order to reduce the risk of challenge or, in the event of challenge, to put the HFEA in the strongest legal position.	In place – Catherine Drennan and Peter Thompson
	We undertake good record keeping, to allow us to identify and access old versions of guidance, and other key documentation, which may be relevant to cases or enquiries and enable us to see how we have historically interpreted the law.	In place – Catherine Drennan
Committee decisions or our decision-making processes may be contested. ie, Licensing appeals and/or JRs.	Panel of legal advisors in place to advise committees on questions of law and to help achieve consistency of decision-making processes. The Head of Legal has put measures in place to ensure consistency of advice between the legal advisors from different firms. These include: • Provision of previous committee papers and minutes to the advisor for the following meeting • Annual workshop • Regular email updates to panel to keep them abreast of any changes.	In place – Peter Thompson Since Spring 2018 and ongoing – Catherine Drennan
	Maintaining, keeping up to date and publishing licensing SOPs, committee decision trees etc. to ensure we take decisions well. Consistent decision making at licence committees supported by effective tools for committees. Standard licensing pack distributed to members/advisers (refreshed in February 2019). Changes made to licensing processes in 2019 to make it more efficient and robust following a 2018 external licensing review.	In place – Paula Robinson
	Well-evidenced recommendations in inspection reports mean that licensing decisions are adequately supported and defensible.	In place – Sharon Fensome-Rimmer
High-profile legal challenges have reputational consequences for the HFEA which risk undermining the robustness of the regulatory regime and affecting strategic delivery.	Close working between legal and communications teams to ensure that the constraints of the law and any HFEA decisions are effectively explained to the press and the public. The default HFEA position is to conduct litigation in a way which is not confrontational, personal or aggressive. We have sought to build constructive relationships with legal representatives who practice in the sector and the tone of engagement	In place – Catherine Drennan, Joanne Triggs In place – Peter Thompson, Catherine Drennan

	with them means that challenge is more likely to be focused on matters of law than on the HFEA.	
	The Compliance team stay in close communication with the Head of Legal to ensure that it is clear if legal involvement is required, to allow for effective planning of work. The Compliance management team monitor the number and complexity of management reviews to ensure that the Head of Legal is only involved as appropriate.	In place – Sharon Fensome Rimmer, Rachel Cutting
Moving to a bolder strategic stance, eg, on add-ons or value for money, could result in claims that we are adversely affecting some clinics' business model or acting beyond our powers. Any changes could be perceived as a threat – not necessarily ultimately resulting in legal action, but still entailing diversion of effort.	Risks considered whenever a new approach or policy is being developed. Business impact target assessments carried out whenever a regulatory change is likely to have a significant cost consequence for clinics. Stakeholder involvement and communications in place to ensure that clinics can feed in views before decisions are taken, and that there is awareness and buy-in in advance of any changes. Major changes are consulted on widely.	In place – Richard Sydee (BIT) / Clare Ettinghausen
The Courts approach matters on a case by case basis and therefore outcomes can't always be predicted. So, the extent of costs and other resource demands resulting from a case can't necessarily be anticipated.	Scenario planning is undertaken with input from legal advisors at the start of any legal challenge. This allows the HFEA to anticipate a range of different potential outcomes and plan resources accordingly.	In place – Peter Thompson
Legal proceedings can be lengthy, and resource draining and divert the in-house legal function (and potentially other colleagues) away from business as usual.	Panel in place, as above, enabling us to outsource some elements of the work.	In place – Peter Thompson
	Internal mechanisms (such as the Corporate Management Group, CMG) in place to reprioritise workload should this become necessary.	In place – Peter Thompson
HFEA process failings could create or contribute to legal challenges, or weaken cases that are otherwise sound	Licensing SOPs are in place and regularly reviewed, committee decision trees in place. Advice sought through a 2018 Licensing review on specific legal points, and the improvements identified have been implemented where possible.	In place – Paula Robinson In place – Paula Robinson
	Up to date compliance and enforcement policy and related procedures to ensure that the Compliance team acts consistently according to agreed processes.	In place but a review is planned following Rachel Cutting settling into post –

		Catherine Drennan
Legal parenthood consent cases are ongoing, and some are the result of more recent failures (the mistakes occurred within the last year). This may give rise to questions about the adequacy of our response when legal parenthood first emerged as a problem in the sector (in 2015).	The Head of Legal continues to keep all new cases under review, highlighting any new or unresolved compliance issues so that the Compliance team can resolve these with the clinic(s).	In progress and ongoing – Catherine Drennan, Sharon Fensome-Rimmer, Rachel Cutting
Storage consent failings at clinics may lead to diversion of legal resource and additional costs for external legal advice. We are aware of endeavours to put some test cases to the courts which may make HFEA involvement more likely.	We took advice from a leading barrister on the possible options for a standard approach for similar cases. Amendments were made to guidance in the Code of Practice dealing with consent to storage and extension of storage, this was launched in January 2019. This guidance will support clinics to be clearer about their statutory responsibilities and thus prevent issues arising in the future. Additional amendments will be made in the 2020 update. Session on storage consent provided at the Annual Conference in June 2019. Storage consent will also be covered in the revision of the PR entry Programme (PREP) in the autumn.	Done in Q1 2018/19 – Catherine Drennan Revised guidance will be provided where appropriate to clinics – Catherine Drennan Underway – Catherine Drennan/ Laura Riley
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
DHSC: HFEA could face unexpected high legal costs or damages which it could not fund.	If this risk was to become an issue then discussion with the Department of Health and Social Care would need to take place regarding possible cover for any extraordinary costs, since it is not possible for the HFEA to insure itself against such an eventuality, and not reasonable for the HFEA's small budget to include a large legal contingency. This is therefore an accepted, rather than mitigated risk. It is also an interdependent risk because DHSC would be involved in resolving it.	In place – Peter Thompson
DHSC: Legislative interdependency.	Our regular communications channels with the Department would ensure we were aware of any planned change at the earliest stage. Joint working arrangements would then be put in place as needed, depending on the scale of the change. If necessary, this would include agreeing any associated implementation budget. The Department are aware of the complexity of our Act and the fact that aspects of it are open to interpretation, sometimes leading to challenge.	In place – Peter Thompson

	Sign-off for key documents such as the Code of Practice in place	

RE1: There is a risk that planned enhancements to our regulatory effectiveness are not realised, in the event that we are unable to make use of our improved data and intelligence to ensure high quality care.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	4	16 - High	**3**	**3**	**9 – Medium**
Tolerance threshold:					**6 - Medium**
Status: **Above tolerance**					

Risk area	**Risk owner**	**Links to which strategic objectives?**	**Trend**
Regulatory effective-ness RE 1: Inability to translate data into quality	Rachel Cutting Director of Compliance & Information	Improving standards through intelligence: use our data and feedback from patients to provide a sharper focus in our regulatory work and improve the information we produce	⇔⇔⇔⇔

Commentary
Data submission work continues although delivery has been delayed as described under risks above. We experienced difficulties with migrating Register data and this has delayed the launch of PRISM and the new Register. Fully developed data migration options went to AGC in May and a plan for deployment was agreed which extended delivery timeframes. These issues obviously cause a delay to accessing improved data and we consequently raised this risk in March 2019. Regular updates on this risk are provided to AGC who have oversight over the final stages of this work.

Causes / sources	**Mitigations**	**Timescale / owner**
IfQ has taken longer than planned, and there will be some ongoing development work needed leading to delays in accessing the benefits.	Data Submission development work is now largely complete although deployment has been delayed while remaining data migration issues are resolved. Oversight and prioritisation of remaining development work will be through the IT development programme board with oversight from AGC.	Deployment date of data submission system planned for Spring 2020– Peter Thompson
Risks associated with data migration to new structure, compromises record accuracy and data integrity.	Migration of the Register is highly complex. IfQ programme groundwork focused on current state of Register. There is substantial high-level oversight including an agreed migration strategy which is being followed. The migration will not go ahead until agreed data quality thresholds are met.	Deployment date Spring 2020 – Peter Thompson/Dan Howard

	AGC will have final sign off on the migration.	
We could later discover a barrier to meeting a new reporting need, or find that an unanticipated level of accuracy is required, involving data or fields which we do not currently focus on or deem critical for accuracy.	IfQ planning work incorporated consideration of fields and reporting needs were agreed. Decisions about the required data quality for each field were 'future proofed' as much as possible, through engagement with stakeholders to anticipate future needs and build these into the design. Further scoping work would occur periodically to review whether any additions were needed. The structure of the new Register makes adding additional fields more straightforward than at present. In 2020/21, we plan to establish a review board to manage any ongoing changes.	In place regular reviews to occur once the Register goes live – Peter Thompson
Risk that existing infrastructure systems – (eg, Register, EDI, network, backups) which will be used to access the improved data and intelligence are unreliable.	Maintenance of desktop, network, backups, etc. core part of IT business as usual delivery. Our IT approach includes some outsourcing of technical second and third line support, to provide greater resilience against unforeseen issues or incidents.	Third-party support contract in place – Dan Howard
Insufficient capability and capacity in the Compliance team to enable them to act promptly in response to the additional data that will be available.	Largely experienced inspection team. The inspection team is now at complement although there will be a bedding in period for newer staff.	In place – Rachel Cutting
Failure to integrate the new data and intelligence systems into Compliance activities due to cultural silos.	Work has been undertaken to bed in systems, such as the patient feedback mechanism, and this is now a part of Compliance business as usual.	Ongoing – Sharon Fensome-Rimmer
Regulatory monitoring may be disrupted if Electronic Patient Record System (EPRS) providers are not able to submit data to the new Register structure until their software has been updated.	Earlier agreements to extend part of 'IfQ' delivery help to address this risk by extending the release date for the data submission project. Plan in place to deal with any inability to supply data. The Compliance management team will manage any centres with EPRS systems who are not ready to provide Register data in the required timeframe. Centres will be expected to use the HFEA's PRISM if they are unable to comply. Early engagement with EPRS providers means the risk of non-compliance is slim.	Ongoing - Rachel Cutting
Data migration efforts are being privileged over data quality leading to an increase in outstanding errors	The Register team uses a triage system to deal with clinic queries systematically, addressing the most critical errors first.	In place – Rachel Cutting
	We undertake an audit programme to check information provision and accuracy.	In place – Rachel Cutting

Excessive demand on systems and over-reliance on a few key expert individuals – request overload – leading to errors. Since July 2019 there has been a significant increase in the numbers of OTR applications.	PQs and FOIs have dedicated expert staff to deal with them although they are very reliant on a small number of individuals. We have systems for checking consistency of answers.	In place – Clare Ettinghausen
	There is a dedicated team for responding to OTRs and all processes are documented to ensure information is provided consistently. Since July 2019, increasing demand on the OTR team has been monitored to understand whether this is an ongoing trend.	In place – Dan Howard
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
None	-	-

ME1: There is a risk that patients and our other stakeholders do not receive the right information and guidance from us.

Inherent risk level:			Residual risk level:		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
3	4	12 High	**2**	**3**	**6 - Medium**
Tolerance threshold:					**6 - Medium**
Status: **At tolerance**					

Risk area	Risk owner	Links to which strategic objectives?	Trend
Effective communications ME1: Messaging, engagement and information provision	Clare Ettinghausen Director of Strategy and Corporate Affairs	Safe, ethical effective treatment: Publish clear information so that patients understand treatments and treatment add-ons and feel prepared Safe, ethical effective treatment: Engender high quality research and responsible innovation in clinics. Consistent outcomes and support: Increase consistency in treatment standards, outcomes, value for money and support for donors and patients.	⇔⇔⇔⇔

Commentary
Authority discussed our communications strategy in January 2019 and agreed that good progress had been made. Communications should be derived from the strategy and aligned with the key organisational objectives. This included the approach to building relationships with political and other stakeholders and developing a wider public affairs approach. Conversations about messaging and engagement are central to early discussion about the new 2020-2023 strategy to ensure that we take a joined-up approach that takes full advantage of our channels and a public affairs approach.

Causes / sources	Mitigations	Timescale / owner
Some of our strategy relies on persuading clinics to do things better. This is harder to put across effectively, or to achieve firm outcomes from.	When there are messages that need to be conveyed to clinics through the inspection team, staff work with the team so that a co-ordinated approach is achieved and messages that go out to the sector through other channels (eg clinic focus) are reinforced. When there are new or important issues or risks that may impact patient safety, alerts are produced collaboratively by the Inspection, Policy and Communications teams.	In place - Sharon Fensome-Rimmer, Laura Riley, and Jo Triggs

Patients and other stakeholders do not receive the correct guidance or information.	Communications strategy in place, including social media and other channels as well as making full use of our new website. Stakeholder meetings with the sector in place to help us to underline key campaign messages. Our publications use HFEA data more fully and makes this more accessible. Policy team ensures guidance is created with appropriate stakeholder engagement and is developed and implemented carefully to ensure it is correct. Ongoing user testing and feedback on information on the website allows us to properly understand user needs. We have internal processes in place which meet The Information Standard (although the assessment and certification scheme is being phased out). New providers are in place for the Donor Conceived Register. The executive facilitated a smooth transition of the service to the new supplier to ensure that effective information and support continued to be in place for donor conceived people.	In place and reviewed periodically (last review Jan 2019) – Jo Triggs Ongoing – Nora Cook-O'Dowd In place – Laura Riley, Jo Triggs In place –Jo Triggs Certification in place – Jo Triggs In place – Dan Howard
We are not able to reach the right people with the right message at the right time.	We have an ongoing partnership with NHS.UK to get information to patients early in their fertility journey and signpost them to HFEA guidance and information. Planning for campaigns and projects includes consideration of communications channels. When developing policies, we ensure that we have strong communication plans in place to reach the appropriate stakeholders. Extended use of social media to get to the right audiences. The communications team analyse the effectiveness of our communications channels at Digital Communications Board meetings, to ensure that they continue to meet our user needs.	In place – Jo Triggs In place and ongoing – Jo Triggs In place - Laura Riley, Jo Triggs In place– Jo Triggs Ongoing – Jo Triggs
Risk that incorrect information is provided in PQs, OTRs or FOIs and this may lead to misinformation and misunderstanding by patients, journalists and others.	PQs and FOIs have dedicated expert staff to manage them and additional staff have been trained to ensure there is not over-reliance on individuals. We have systems for checking consistency of answers and a member of SMT must sign off every PQ response before submission.	In place - Clare Ettinghausen Clare Ettinghausen /SMT - In place

	There is a dedicated OTR team and all responses are checked before they are sent out to applicants to ensure that the information is accurate.	In place - Dan Howard
Some information will be derived from data, so depends on risk above being controlled.	See controls listed in RE1, above.	
There is a risk that we provide inaccurate information and data on our website or elsewhere. Data in CaFC has not been updated for a number of years, due to the continuation of the digital projects. This means that the data provided about success rates on our website is not current.	All staff ensure that public information reflects the latest knowledge held by the organisation. Small working group looking at any minor CaFC issues and CaFC data will be updated in autumn 2019. The Communications team work quickly to amend any factual inaccuracies identified on the website. The Communications publication schedule includes a review of the website, to update relevant statistics when more current information is available.	In place - Nora Cook-O'Dowd, Laura Riley, and Jo Triggs In place – Jo Triggs In place – Jo Triggs
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
NHS.UK: The NHS website and our site contain links to one another which could break	We maintain a relationship with the NHS.UK team to ensure that links are effectively maintained.	In place – Jo Triggs
DHSC: interdependent communication requirements may not be considered	DHSC and HFEA have a framework agreement for public communications to support effective co-operation, co-ordination and collaboration and we adhere to this.	In place – Jo Triggs

E1: There is a risk that the HFEA's office relocation in 2020 leads to disruption to operational activities and delivery of our strategic objectives.

Inherent risk level:			**Residual risk level:**		
Likelihood	Impact	Inherent risk	**Likelihood**	**Impact**	**Residual risk**
4	4	16	**2**	**3**	**6 - medium**
Tolerance threshold:					**8 - medium**
Status: **Below tolerance**					

Risk area	Risk owner	Links to which strategic objectives?	Trend
Estates E1: Relocation of HFEA offices in 2020	Richard Sydee Director of Finance and Resources	Whole strategy.	⇔⇔⇔⇔

Commentary
The Director of Finance and Resources has been involved in discussions with the Department about the office relocation since mid-2018. The physical office build and fit-out is being handled by the British Council and the overall project managing the move of the HFEA and four other organisations is being co-ordinated by the Department of Health and Social Care. An internal project to prepare for the office move is in place to handle the direct impacts of the move on the organisation and ensure that we actively prepare and mitigate associated risks. We have made progress in reviewing working practices and policies and will launch these early in 2020. All cross-ALB working groups have been established and are actively defining requirements and solutions and these are feeding into the HFEA internal project.

Causes / sources	Mitigations	Timescale / owner
The facilities provided in the Stratford office may not fulfil all HFEA requirements and desired benefits, such as ability to host key corporate meetings.	HFEA requirements have been specified up front and feedback given on all proposed designs. Outline plans are in line with HFEA needs and we have staff on the working groups set up to define the detail. If lower-priority requirements are unable to be fulfilled, conversations will take place about alternative arrangements to ensure HFEA delivery is not adversely affected. Some contingency arrangements are in place to handle particular requirements and ensure that costs and access are shared equitably.	Ongoing – Richard Sydee
We may be unable to recruit staff as they do not see the	We have been advertising the move to Stratford in all job adverts, so that applicants are aware. Monitoring of recruitment data to date suggests	From July 2019 –

HFEA as an attractive central London organisation.	that we are not seeing an impact on recruitment, though we will continue to monitor this to enable us to consider whether other mitigations are possible. We will continue to offer desirable staff benefits and policies, such as flexible working, and have begun to evaluate these to ensure that they support staff recruitment and retention. Other civil service and government departments are also being moved out of central London, so this is less likely to impact recruitment of those moving within the public sector.	Yvonne Akinmodun
Stratford may be a less desirable location for some current staff due to: • Increased commuting costs • Increased commuting times • Preference of staff to continue to work in central London for other reasons, leading to lower morale and lower levels of staff retention as staff choose to leave before the move.	Work underway to review the excess fares policy to define the length of time and mechanism to compensate those who will be paying more following the move to Stratford. Efforts continue to understand the impact on individual staff and discuss their concerns with them via staff survey, 1:1s with managers and all staff meetings. These have fed into discussions about flexible working. Conversely, there will be improvements to the commuting times and costs of some staff, which may improve morale for them and balance the overall effect.	Underway, to complete winter2019/20 – Yvonne Akinmodun, Richard Sydee
The Stratford office may cost more than the current office, once all facilities and shared elements are taken into account, leading to opportunity costs. The Finance and procurement strand of the project has been established and detailed costings should be available by Q1 2020/2021.	Costs for Redman Place (the Stratford building) will be allocated on a usage basis which will ensure that we do not pay for more than we need or use. The longer, ten-year lease at Redman Place will provide greater financial stability, allowing us to forecast costs over a longer period and adjust other expenditure, and if necessary fees, accordingly to ensure that our work and running costs are effectively financed. The accommodation at Redman Place should allow us to reduce some other costs, such as the use of external meeting rooms, as we will have access to larger internal conference space not available at Spring Gardens.	Ongoing - Richard Sydee,
The move to a new office will lead to ways of working changes that we may be unprepared for.	Conversations about ways of working are central to the HFEA project. Policies related to ways of working are being agreed and circulated significantly before the move, to ensure that there is time for these to bed in and be accepted ahead of the physical move.	Ongoing - Richard Sydee, Yvonne Akinmodun

	Staff will be involved in their development as appropriate.	
Owing to the different cultures and working practices of the organisations moving, there may be perceived inequity about the policy changes made.	A formal working group is in place including all the organisations who are moving to Stratford with us, to ensure that messaging around ways of working is consistent across organisations, while reflecting the individual cultures and requirements of these. We are looking to ensure transparency, so that staff understand any differences in practice.	Ongoing – Richard Sydee
Current staff may not feel involved in the conversations about the move, leading to a feeling of being 'done to' and lower morale.	Conversations about ways of working to occur throughout the project, to ensure that the project team and HFEA staff are an active part of the discussions and development of relevant policies and have a chance to raise questions. More in depth conversation to occur at the all staff awayday in December 2019. An open approach is being taken to ensure that information is cascaded effectively and staff are able to voice their views and participate. We have a separate area on the intranet where all information is being shared. Staff are visiting the site ahead of time so that they feel prepared.	Ongoing – Richard Sydee
The internal move project may be ineffectively managed, leading to oversights, poor dependency management and ineffective use of resources.	Regular reporting to Programme Board and CMG to ensure that effective project processes and approaches are followed. Assurance will be provided by regular reporting to AGC and Authority. The Director of Finance and Resources is Sponsoring the project meaning it has appropriate senior, strategic guidance. A project manager has been allocated from the IT team to ensure there is resource available for day to day management of project tasks. Other key staff such as HR and representatives from other teams involved in the internal HFEA Project Board.	In place – Richard Sydee
Necessary changes to IT systems and operations may not work effectively, leading to disruption to HFEA delivery.	Early discussions with HFEA and other organisations' IT teams underway to determine IT requirements, allowing more time to resolve these. CMG have agreed the planned migration of infrastructure to the cloud, which will facilitate the move and reduce related risk to IT systems. It will also mean the HFEA should be able to function even if there are IT issues affecting other systems on-site.	Ongoing - Steve Morris, Dan Howard
The physical move may cause short-term disruption to HFEA activities and delivery if necessary resources such as	Careful planning of the move to reduce the likelihood of disruption. We will increase our focus on planning as we move closer to the move date.	Ongoing - Richard Sydee

meeting rooms or physical assets are not available to staff.	Staff would be able to work from home in the short-term if there was disruption to the physical move which would reduce the impact of this. We have reviewed arrangements for remote working and will implement enhanced security arrangements in advance of the move that will allow all staff to access all HFEA systems remotely and securely.	
Risk interdependencies (ALBs / DHSC)	**Control arrangements**	**Owner**
British Council – lead on physical build – may not understand or take HFEA needs into account.	DHSC liaising directly with the British Council and managing this relationship on behalf of the other organisations, with feedback through the DHSC project board, on which the Director of Finance and Resources sits.	In place – Richard Sydee, DHSC
DHSC – Lead on the whole overarching project, entering into contracts on behalf of HFEA and others – HFEA requirements may not be considered/met.	Regular external project meetings attended by the Director of Finance and Resources as HFEA Project Sponsor and other HFEA staff when delegation required.	In place – Richard Sydee
NICE/CQC/HRA/HTA – IT and facilities interdependencies.	Regular DHSC project team meeting involving all regulators. Sub-groups with relevant IT and other staff such as HR. Informal relationship management with other organisations' leads.	In place – Richard Sydee, DHSC

Reviews and revisions

SMT review – November 2019 (18/11/2019)

SMT reviewed all risks controls and scores and made the following detailed points:

- FV1 – SMT discussed the current reduction in treatment fee income and the effect of this on the risk. SMT agreed that we had sufficient levers in place to respond to any ongoing drops. SMT noted that we had not yet had to take any decisions to actively deprioritise work or not undertake recruitment, but we would need to keep a close eye on the situation as it developed.
- C1 – SMT discussed this risk at length, reflecting on the discussion at Authority. Members were concerned about the ongoing uncertainty in relation to member recruitment and the potential significant impact on Board capability in both the immediate longer term due to loss of expertise. Following this discussion, SMT considered and raised the risk score.
- RE1 – SMT discussed the ownership of this risk and agreed that although, as new Director of Compliance and Information, Rachel Cutting was the overall owner of this risk, Peter Thompson would remain the SRO and risk owner in relation to Digital projects risks, owing to the near completion of the work.
- E1 – SMT agreed that the Risk and Business Planning Manager and Director of Finance and Resources would review the risk in the round following a CMG discussion about relevant policies.

Authority review – November 2019 (13/11/2019)

AGC reviewed all risks, controls and scores and made the following points:

- C1 – Authority discussed the impact that the upcoming turnover of members would have the risk in relation to Board capabilities as a result. Members noted that SMT would discuss this when they next review the register, ahead of a further conversation at the next AGC meeting.
- RE1 – Members noted the ongoing impact of the delay to the digital projects on this risk area. The risks in relation to this were being closely monitored and would again be discussed at the next AGC meeting.

SMT review – October 2019 (30/10/2019)

SMT reviewed all risks, controls and scores and made the following detailed points:

- C1 – noted the inclusion of a new risk area about inability to capitalise on collocation opportunities as agreed with AGC in October.
- F1 – considered the reallocation of funds and how this would impact the mitigation of legal resourcing risk. SMT noted that this has been done appropriately for the stage of the year; as there is less of the year remaining there is consequently a reduced chance of being involved in significantly resource intensive legal action within the financial year.

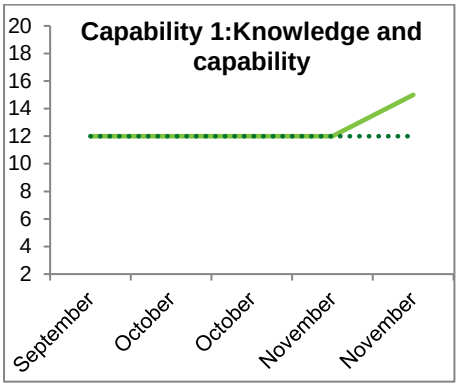
AGC review – October 2019 (08/10/2019)

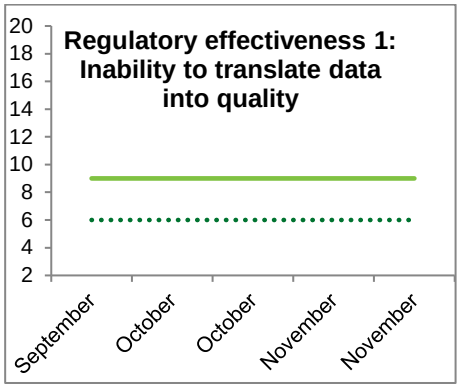
AGC reviewed all risks, controls and scores and made the following points:

- C1 – Members commented on the fact that the office move risks may exacerbate this already high risk and that we therefore needed to consider what other mitigating actions were possible in this shifting situation. This was related to the audit action for the HFEA to consider what contingency actions were possible in relation to the controls for this risk. AGC members commented on the successful appointment of a new Director of Compliance and Information, who would be in post from November.
- LC1 - Members noted that the Executive had discussed legal risk at length and was mindful that the risks in the legal area were not simply about resource diversion, but inherent legal risk was linked to regulatory processes and the risk that the organisation would be challenged on a decision. The Executive would reconsider the framing of the legal risk during the process of composing a new strategic risk register for the 2020-2023 strategy.
- E1 – AGC noted this new risk and asked the Executive to review whether the risk to achieving the benefits of co-location (ie, the opportunity for creating career pathways between organisations and closer working) could be more clearly articulated within the capability risk.

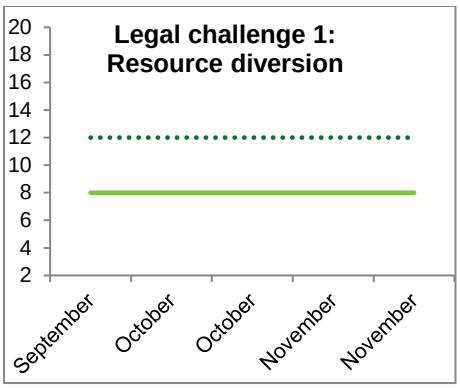
Risk Trends

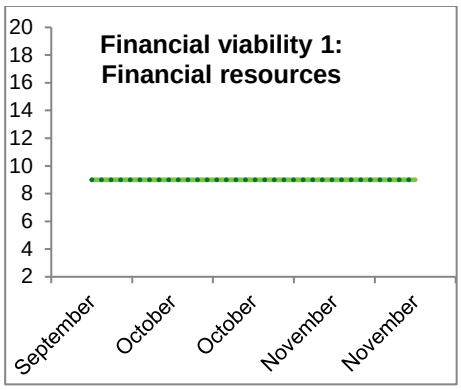
High and above tolerance risks:

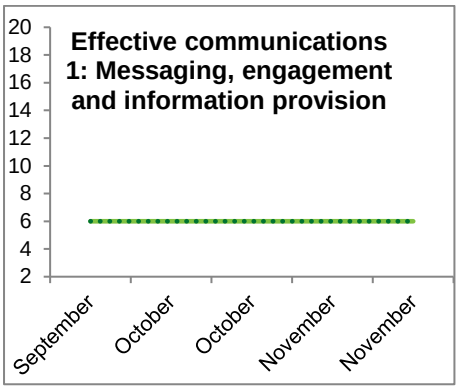


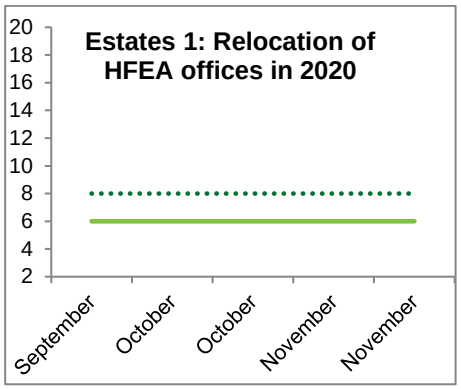


All other risks:









Criteria for inclusion of risks

Whether the risk results in a potentially serious impact on delivery of the HFEA's strategy or purpose.

Whether it is possible for the HFEA to do anything to control the risk (so external risks such as weather events are not included).

Rank

The risk summary is arranged in rank order according to the severity of the current residual risk score.

Risk trend

The risk trend shows whether the threat has increased or decreased recently. The direction of the arrow indicates whether the risk is: Stable ⇔ , Rising ⇧ or Reducing ⇩.

Risk scoring system

We use the five-point rating system when assigning a rating to the likelihood and impact of individual risks:

Likelihood:	1=Very unlikely	2=Unlikely	3=Possible	4=Likely	5=Almost certain
Impact:	1=Insignificant	2=Minor	3=Moderate	4=Major	5=Catastrophic

Risk scoring matrix

Impact	1. Rare (≤10%)	2. Unlikely (11%-33%)	3. Possible (34%-67%)	4. Likely (68%-89%)	5. Almost Certain (≥90%)
5.Very high	5 Medium	10 Medium	15 High	20 Very High	25 Very High
4. High	4 Low	8 Medium	12 High	16 High	20 Very High
3. Medium	3 Low	6 Medium	9 Medium	12 High	15 High
2. Low	2 Very Low	4 Low	6 Medium	8 Medium	10 Medium
1. Very Low	1 Very Low	2 Very Low	3 Low	4 Low	5 Medium
Risk Score = Impact x Likelihood	Likelihood				

Risk appetite and tolerance

Risk appetite and tolerance are two different but related terms. We define risk appetite as the willingness of the HFEA to take risk. As a regulator, our risk appetite will be naturally conservative and for most of our history this has been low. Risk appetite is a general statement of the organisation's overall attitude to risk and is unlike to change, unless the organisation's role or environment changes dramatically.

Risk tolerance on the other hand is the willingness of the HFEA to accept and deal with risk in relation to specific goals or outcomes. Risk tolerance will vary according to the perceived importance of particular risks and the timing (it may be more open to risk at different points in time). The HFEA may be prepared to tolerate comparatively large risks in some areas and little in others. Tolerance thresholds are set for each risk and they are considered with all other aspects of the risk each time the risk register is reviewed

Assessing inherent risk

Inherent risk is usually defined as 'the exposure arising from a specific risk before any action has been taken to manage it'. This can be taken to mean 'if no controls at all are in place'. However, in reality the very existence of an organisational infrastructure and associated general functions, systems and processes introduces some element of control, even if no other mitigating action were ever taken, and even with no particular risks in mind. Therefore, for our estimation of inherent risk to be meaningful, we define inherent risk as:

'the exposure arising from a specific risk before any additional action has been taken to manage it, over and above pre-existing ongoing organisational systems and processes.'

System-wide risk interdependencies

As of April 2017, we explicitly consider whether any HFEA strategic risks or controls have a potential impact for, or interdependency with, the Department or any other ALBs. A distinct section to record any such interdependencies beneath each risk has been added to the risk register, so as to be sure we identify and manage risk interdependencies in collaboration with relevant other bodies, and so that we can report easily and transparently on such interdependencies to DHSC or auditors as required.

Contingency actions

When putting mitigations in place to ensure that the risk stays within the established tolerance threshold, the organisation must achieve balance between the costs and resources involved in limiting the risk, compared to the cost of the risk translating into an issue. In some circumstances it may be possible to have contingency plans in case mitigations fail, or, if a risk goes over tolerance it may be necessary to consider additional controls.

When a risk exceeds its tolerance threshold, or when the risk translates into a live issue, we will discuss and agree further mitigations to be taken in the form of an action plan. This should be done at the relevant managerial level and may be escalated if appropriate.

Human Resources update 2019

Strategic delivery:	☒ Safe, ethical, effective treatment	☒ Consistent outcomes and support	☒ Improving standards through intelligence
Details:	**Human Resources Update Dec 2019**		
Meeting	Audit and Governance Committee		
Agenda item	12		
Paper number	AGC (03/12/2019) 707 YA		
Meeting date	3 December 2019		
Author	Yvonne Akinmodun, Head of Human Resources Peter Thompson, Chief Executive		
Output:			
	For Information		
Recommendation	The Committee is asked to note and comment on the: a. The overview of the HR strategy (section 2) b. Work that is underway to support the forthcoming office move (section 4)		
Organisational risk	☐ Low	☒ Medium	☐ High

1. Introduction

1.1. The staff in any organisation are central to its continued success. That is why we are committed to providing regular updates to the AGC on a range of HR matters. We last discussed HR issues with the AGC in June 2019, where we focussed on organisational capability, notably through the lens of staff turnover and the likely effect of the new pay and grading roll out.

1.2. This paper provides a broad overview of work that has taken place in the last 6 months to help improve employee retention and engagement through the introduction of our new values and behaviours framework and the ongoing preparation to support the move to Strafford in 2020.

2. People strategy

2.1. Work is underway to complete a people strategy which highlights some of the key people priorities over the next 3 years in the light of the Authority's new corporate strategy 2020-2023.

2.2. Our people objectives for 2020 - 2023 include the following:

- Improve leadership capability
- Attract and develop a diverse and high performing workforce
- Build a culture and healthy working environment that promotes collaboration and innovation
- Create an agile workforce that is able to support the delivery of our strategic goals

2.3. Once the strategy has been signed off, we will launch it in the spring to all staff.

3. Staff turnover

3.1. Staff turnover has been higher than we would like for some time. At June AGC, staff turnover was reported to be at an all-time high of 27%. Over the last 6 months turnover has declined to 20%. This is still above our target of no higher than 15%.

3.2. The most common reasons identified in exit interviews for staff wishing to leave the organisation are: pay, lack of progression opportunities and poor relationships with line manager/senior managers.

3.3. The challenge ahead lies in further reducing turnover. To that end we have introduced a new pay and grading system over the summer. This reduces variation and makes it easier for staff to see a clearer line of sight between their current position and the next level.

3.4. We are also looking at ways to increase engagement through cross team collaboration and project working.

3.5. And we have identified some key learning and development we can offer to mid- and junior staff in the form of management development courses with the aim of providing them with some of the necessary skills needed as part of any future leadership role.

3.6. Looking a little further ahead, the impending move to Stratford may also increase turnover, though in a bid to help manage this, all staff recruited to the organisation since November 2018 (about 35% of the workforce), have been made aware of the office move. This issue is explored in more detail in section 4 of this paper.

4. Office move

4.1. In preparation for the forthcoming office move, we conducted a short staff survey in which we sought views on how they felt the move would impact them and what, if anything the organisation could do to alleviate any concerns, they might have around the move. 55 out of our 67 staff

completed the survey. Given the reason for the survey it seems reasonable to assume that those staff that did not have concerns did not complete the survey. The results were as follows:

- 58% of 55 staff (ie. 33) felt they will see either an increase in cost or longer commute times
- Of that 33, just 12% (ie. 4) believe their journey time will increase by longer than an hour
- Of that 33, 35% (ie. 11) believe their journey cost will increase by more than £7.50
- We also asked staff what could be done to reduce the impact of the move. 44 people responded to this question and 45% of those (ie. 19) said that more opportunities to work from home would help.

4.2. The organisation already has comprehensive policies on flexible working and homeworking, where we offer the ability to work from home for up to 2 days per week. We have conducted a review of both and we are broadly in line with, and in some cases more generous than, other ALBs. Our view is that further flexibility would come at the expense of a common organisational culture.

4.3. We are currently reviewing our policy on excess fares with a view to providing those staff most likely to be adversely impacted financially by the move with additional financial support. A final decision has yet to be made, but we are considering meeting excess fares for a period of up to [2/3 years] following the move probably as an upfront payment as a means of retaining staff (if the money is paid upfront it would be conditional on staff remaining with the organisation for a period of time).

4.4. In the new year, HR will be working with CMG members to conduct an impact assessment of the office move on the organisation. The intent behind the assessment is to help identify as early as we can any possible loss of knowledge or skills as a result of staff leaving prior to or shortly after our move to Stratford and to ensure appropriate steps are put in place to mitigate any effect such turnover might have on service delivery.

5. Values and behaviours framework

5.1. In March this year, we began work with all staff on the refresh of our current values and behaviours framework.

5.2. One of the key drivers for change was the Civil Service's decision to abolish its competency framework and replace it with a new framework entitled, 'success profiles'. The new approach places greater emphasis on areas such as employee strengths and positive behaviours

5.3. A small cross section of staff representing all areas of the organisation have worked together to produce a new summary of the values and behaviours which will be shared with all staff at our forthcoming all staff away day.

5.4. Longer term, there will be a roll out of the framework which will become integral to all areas of the employee life cycle starting from the recruitment and induction of new staff through to managing performance and employee development.

5.5. The intention is that the new framework will provide greater clarity at all levels across the organisation on what can be expected from leaders and managers. This will also help improve

staff engagement through a clearly articulated and shared understanding and commitment to the new values and behaviours

6. Recommendations

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

Audit and Governance Committee Forward Plan

Strategic delivery:	☐Safe, ethical, effective treatment	☐Consistent outcomes and support	☒Improving standards through intelligence
Details:			
Meeting	Audit and Governance Committee		
Agenda item	13		
Paper number	AGC (03/12/2019) 708 MA		
Meeting date	03 December 2019		
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:	3 Dec 2019	10 Mar 2020	23 Jun 2020	6 Oct 2020	TBC
Following Authority Date:	29 Jan 2020	18 Mar 2020	2 July 2020	11 Nov 2020	TBC
Meeting 'Theme/s'	Strategy & Corporate Affairs, AGC review	Finance and Resources	Annual Reports, Information Governance, People	Register and Compliance, Business Continuity	Strategy & Corporate Affairs, AGC review
Reporting Officers	Director of Strategy & Corporate Affairs	Director of Finance & Resources	Director of Finance & Resources	Director of Compliance and Information	Director of Strategy & Corporate Affairs
Strategic Risk Register	Yes	Yes	Yes	Yes	Yes
Digital Programme Update	Yes	Yes	Yes	Yes	Yes
Annual Report & Accounts (inc Annual Governance Statement)		Draft Annual Governance Statement	Yes – For approval		
External audit (NAO) strategy & work	Audit Planning Report	Interim Feedback	Audit Completion Report	Audit Planning Report	Audit Planning Report
Information Assurance & Security			Yes plus SIRO Report		
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes	Yes
Internal Audit	Update	Update	Results, annual opinion approve draft plan	Update	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 annually thereafter			

AGC Items Date:	3 Dec 2019	10 Mar 2020	23 Jun 2020	6 Oct 2020	TBC
Anti-Fraud, Bribery and Corruption policy		Reviewed and presented annually thereafter GovS: 013 Counter Fraud			
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		Yes Including bi-annual HR report		Bi-annual HR report
Strategy & Corporate Affairs management	Yes				Yes
Regulatory & Register management		Yes			
Cyber Security Training				Yes	
Resilience & Business Continuity Management	Yes	Yes	Yes	Yes	Yes
Finance and Resources management		Yes			
Reserves policy				Yes	
Estates	Yes	Yes	Yes	Yes	Yes
Review of AGC activities & effectiveness, terms of reference	Yes				Yes
Legal Risks				Yes	
AGC Forward Plan	Yes	Yes	Yes	Yes	Yes
Session for Members and auditors	Yes	Yes	Yes	Yes	Yes

Register of Gifts and Hospitality

Strategic delivery:	X Setting standards	☐ Increasing and informing choice	☐ Demonstrating efficiency economy and value
Details:			
Meeting	AGC		
Agenda item	14		
Paper number	HFEA (03/12/2019) 709 MA		
Meeting date	3 December 2019		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For information		
Recommendation	Attached is the latest Gifts and Hospitality Register. Since the last meeting only one item has been added. Members are asked to note the new item(s).		
Resource implications			
Implementation date	2019/20 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

Register of Gifts / Hospitality Received and Provided/Declined

Version: HFEAG0001
Jan-20

DIVISION / DEPARTMENT: HFEA
FINANCIAL YEAR: 2019/20

	Details of the Gift or Hospitality						Provider Details			Recipient Details	
Type	**Brief Description of Item**	**Reason for Gift or Hospitality**	**Date(s) of provision**	**Value of Item(s)**	**Location where Provided**	**Action on Gifts Received**	**Name of Person or Body**	**Contact Name**	**Relationship to Department**	**Name of Person(s) or Body**	**Contact Name**
Either 'Provision' or 'Receipt'	*Give a brief description of the gift or hospitality recorded*	*Summarize the reason or occasion for the gift or hospitality*	*Give the date(s) on which it was provided or offered*	*Give the known or estimated value - if unknown then state 'unknown' and explain further under the 'Reason for Gift' column.*	*Give the name of the venue or location at which the gift or hospitality was provided*	*For Gifts Received only, specify what happened to the item(s) after it was received*	*Give the name of the individual or organization providing or offering the gift / hospitality*	*Give a contact name if an individual is not specified as the provider - otherwise leave blank*	*Specify the relationship of the provider to the Department (e.g. 'supplier', 'sponsor', etc.) - if the Department is the provider then leave blank*	*Give the name of the individual(s) or organisation receiving the gift / hospitality - if there are multiple recipients, specify each on a separate line*	*Give a contact name if an individual is not specified as the recipient - otherwise leave blank*
Receipt	Lunch invitation	To introduce to Legal Trainers	10/08/2017	£ -	Not known	Lunch accepted	Old Square Chambers	Eleena Misra	Legal Consultancy	HFEA	C Drennan
Receipt	Lunch invitation	Introduce Clients to new lawyers	01/11/2017	£ -	Not known	Lunch accepted	Blackstone Chambers	Catherin Callaghan	Legal Consultancy	HFEA	C Drennan
Receipt	Breakfast invitatoin	Breakfast meeting	08/02/2018	£ -	Not known	Breakfast accepted	Fieldfisher	Mathew Lohn	Legal Consultancy	HFEA	P Thompson
Receipt	Invitation to Silk Party	Informing Clients of a change (to QC)	22/03/2018	£ -	Not known	Invitation accpeted	Blackstone Chambers	Catherin Callaghan	Legal Consultancy	HFEA	C Drennan
Receipt	Lunch provided	Lunch provided prior to a review meeting	24/07/2019	£ 20.00	Not known	Lunch accepted	Alsicent		IT Support supplier	HFEA	D Howard

Reserves policy

Strategic delivery:	X Setting standards	☐ Increasing and informing choice	☐ Demonstrating efficiency economy and value
Details:			
Meeting	Audit and Governance Committee		
Agenda item	15		
Paper number	HFEA (03/12/2019) 710 RS		
Meeting date	3 December 2019		
Author	Richard Sydee, Director of Finance and Facilities		
Output:			
For information or decision?	For information		
Recommendation	The Committee are requested to note the revised rationale for our minimum reserves and approve the amended policy.		
Resource implications			
Implementation date	2019/20 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

Reserves Policy

Introduction

The purpose of this policy is to ensure that both the Executive and Authority of the HFEA are aware of the minimum level at which reserves are maintained and the reasons for doing so. The minimum level of reserves set out in this policy has been agreed with the Department of Health.

Principles

An organisation should maintain enough cash reserves to continue business operations on a day-to-day basis and in the event of unforeseen difficulty and commitments that arise. It is best practice to implement a reserves policy in order to guide key decision-makers.

Reserves Policy

1. The Authority has decided to maintain a reserves policy as this demonstrates:

    - Transparency and accountability to its licence fee payers and the Department of Health
    - Good financial management
    - Justification of the amount it has decided to keep as reserves

2. The following factors have been taken into account in setting this reserves policy:

    - Risks associated with its two main income streams - licence fees and Grant-in-aid - differing from the levels budgeted
    - Likely variations in regulatory and other activity both in the short term and in the future
    - HFEA's known, likely and potential commitments

3. The policy requires reserves to be maintained at least at a level that ensures the HFEA's core operational activities continue on a day-to-day basis and, in a period of unforeseen difficulty, for a suitable period. The level should also provide for potential commitments that arise.

Cashflow

4. To enable sufficient cover for day-to-day operations, a cash flow forecast is prepared at the start of the financial year which takes account of when receipts are expected, and payments are to be made. Most receipts come from treatment fees - invoices are raised monthly and on average take 60 days to be paid. Cash reserves are needed to ensure sufficient working capital is available to make payments when they become due throughout the year.

5. The HFEA experiences negative cashflow (more payments than receipts) in some months but overall there is a net positive position. Based on a review of our cashflows over the last few years we see on average net cash outflows over the last quarter of c£300k, with the range being between £100k and £400k. In order to ensure that there is always a positive cash balance we would wish to maintain a working capital cash balance of £400k, based on our most unfavourable outflow in the last 4 years.

Contingency

6. The certainty and robustness of HFEA's key income streams, the predictability of fixed costs and the relationship with the Department of Health would suggest that HFEA would be unlikely to enter a prolonged period of financial uncertainty that would result in it being unable to meet its financial liabilities.

7. However, it is clearly prudent for an organisation to retain a sufficient level of reserves to ensure it could meet its immediate liabilities should an extraordinary financial incident occur.

8. In arriving at a reserve requirement for unforeseen difficulty we have considered the likely period that the organisation might need to cover and whilst discussions are undertaken to secure the situation, the immediate non-discretionary spend that would have to be met over that period.

9. We believe that a prudent assumption would be to ensure a minimum of two months of fixed expenditure is maintained as a cash reserve; in terms of the costs that would need to be met we consider the following to be non-discretionary spend that would be required to ensure the HFEA could maintain its operations:

    a. salaries (including employer on-costs);

    b. the cost of accommodation.; and,

    c. Sundry costs related to IT contracts, outsourced services and other essential services.

10. These fixed costs would have to be paid in times of unforeseen difficulty, salaries and accommodation costs alone represent 69% of the HFEA's total annual spend.

11. Based on the HFEA's current revenue budget, the combined monthly cost of salaries and accommodation is £407k, accommodation costs have increased since the relocation to Spring Gardens in 2016. A reserve of two months for these two elements would therefore be £814k.

12. A further reserve for other commitments for two months is estimated to be £150k.

Minimum reserves

13. The HFEA's minimum level of reserves will be maintained at a level that enables positive cashflow (£400k), provides £964k for contingency. The minimum level of cash reserves required is therefore £1.4m. These reserves will be in a readily realisable form at all times.

14. Each quarter the level of reserves will be reviewed by the Director of Finance and Resources as part of the HFEA's ongoing monitoring of its cash flow.

15. Each autumn as part of the HFEA's business planning and budget setting process, the required level of reserves for the following financial year will be reassessed.

16. In any assessment or reassessment of its reserves policy the following will be borne in mind.

    - The level, reliability and source of future income streams.
    - Forecasts of future planned expenditure.
    - Any change in future circumstances - needs, opportunities, contingencies, and risks – which are unlikely to be met out of operational income.
    - An identification of the likelihood of such changes in these circumstances and the risk that the HFEA would not able to be able to meet them.

17. HFEA's reserves policy will be reviewed annually by the Audit and Governance Committee.

Document name	Reserves Policy
Original release date	October 2014
Author	Head of Finance
Approved by	CMG
Next review date	September 2020
Total pages	3

Version/revision control

Version	Changes	Updated by	Approved by	Release date
1.0	Created	DoF	AGC	Feb 2015
2.0	Branded/amended	HoF	AGC	Dec 2016
2.1	Cashflow figures amended	HoF	AGC	Oct 2017
2.2	Reviewed	HoF	AGC	Oct 2018
2.3	Reviewed by DoF and amended	HoF	AGC	Dec 2019

Counter-fraud progress report

Strategic delivery:	☒ Safe, ethical, effective treatment	☐ Consistent outcomes and support	☐ Improving standards through intelligence
Details:			
Meeting	Audit and Governance Committee		
Agenda item	16		
Paper number	HFEA (03/12/2019) 711 RS		
Meeting date	03 December 2019		
Author	Richard Sydee, Director of Finance and Resources		
Output:			
For information or decision?	For information		
Recommendation	The Committee are asked to note progress		
Resource implications			
Implementation date	2019/20-21		
Communication(s)			
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes	Annex A: Strategic Action Plan		

1. Introduction

1.1. In June 2019 the HFEA bought to the attention of the committee the Government Functional Standards; Counter Fraud that were introduced in January 2018. The Cabinet Office required that all government organisations submit evidence of their preparedness to meeting these standard by September 2019.

1.2. We submitted all of the required documentation, which included a Risk Assessment, Counter Fraud Strategy (including a high-level Strategic Action plan) and a detailed Action Plan covering a period of 12 months in line with the Cabinet Office deadline.

1.3. To date we have not received feedback from the Cabinet Office as to how close they assess we are to meeting these standards and what gaps, if any, they feel we must fill in order to meet the standards.

1.4. In the absence of direct feedback from the Cabinet Office we have continued to make progress towards completing the actions listed in the Strategic Action plan. The strategic plan and our progress to fate is contained with Annex A.

Annex A - Strategic Action Plan

Strategic Governance							
Ref	**Action**	**Description**	**Core Discipline**	**Owner**	**Due date**	**Update**	**Complete/ Revised target date**
AP1	Roles and responsibilities	Assign accountable individual responsible for delivery of counter-fraud strategy, senior lead for counter-fraud activity	Leadership, Management and Strategy	HoF	June 2019	The Director of Finance and Resources assigned as accountable individual at the Jun-19 AGC meeting. **COMPLETE**	N/a
AP3	Strategy	Detail our arrangements for managing fraud, bribery and corruption.	Leadership, Management and Strategy	DoFR	July 2019, reviewed annually	Strategy completed in August 2019 and was shared with staff via the Hub. **COMPLETE**	N/a
AP2	Action Plan	Develop annual action plan which details the activities needed to manage areas of fraud risk	Prevent	HoF	July 2019 then annually	Annual action plan (AP) updated when actions are complete.	Mar 2020
Inform and involve							
Ref	**Action**	**Description**	**Core**	**Owner**	**Due date**	**Update**	**Revised target date**
AP4	Risk Assessment	Identify and assess HFEA's fraud risk exposure affecting principle activities in order to fully understand changing patterns in fraud and corruption threats and potential harmful consequences to the authority	Leadership, Management and Strategy	HoF	Sep-19 for submission to Cab Office	Risk assessment conducted with CMG input. A review will be carried out in January to ensure risks identified are still valid. **COMPLETE**	N/a
AP5	Training	Actively seek to increase the HFEA's resilience to fraud and corruption through fraud awareness by ensuring that all existing and new	Culture	HoF/HR	July-19	Training for staff who line manage and those that do not have been identified within Civil Service Learning. As at 26/11/19 51% of staff have completed training	Dec-19

		employees in all directorates undertake a fraud and corruption e-learning course					
Prevent and Deter							
Ref	**Action**	**Description**	**Core discipline**	**Owner**	**Due date**	**Update**	**Revised target date**
AP8	Policies	Refresh and promote the HFEA's suite of anti-fraud related policies and procedures to ensure that they continue to be relevant to current guidance.	Leadership, Management and Strategy	DoFR	Annually, each April	A review was recently carried out of the following policies: Anti-Fraud, Bribery and Corruption; Declaration of Interests, Gifts and Hospitality **COMPLETE**	
AP9	Internal Audit	Use of Internal Audit review to identify further weaknesses	Prevent	DoFR	Mar-19	Anti-Fraud controls audit was conducted in March 2019. Recommendation were taken onboard to strengthen process	Follow-up (docs submitted) Nov-19
AP11	Intelligence	Use of information and intelligence from external sources to identify anomalies that may indicate fraud	Prevent	HoF	TBC	This activity has yet to commence. There is a question as to whether this would be cost effective.	TBC

Investigate and sanction							
Ref	**Action**	**Description**	**Core Discipline**	**Owner**	**Due date**	**Update**	**Revised target date**
	Reporting	Produce fraud investigation outcome reports for management which highlight the action taken to investigate the fraud risks, the outcome of investigations e.g. sanction and recommendations to minimise future risk of fraud	Leadership, Management and Strategy	DoFR	AGC meetings (Quarterly)	There have been no incidences recently. A template will be designed that incorporates actions taken and outcomes	2020/21 Business year.
	Recording	System for recording of and progress of cases of fraud to be utilised where practicable	Leadership, Management and Strategy	DoFR		Due to the limited number of cases, we have used the DHSC Anti-Fraud Unit case system and will continue to do so.	N/a
Review and held to account							
Ref	**Action**	**Description**	**Core Discipline**	**Owner**	**Due date**	**Update**	**Revised target date**
ALL	Embedding the standard (GovS 013)	Maintaining staff awareness through consistent sharing of information.	Culture	HoF	On-going	Sharing of updated policies and training courses	Q1 2020/21
AP10	Sharing	Reporting quarterly to Cabinet Office' Consolidated Data Requests	Leadership, Management and Strategy	DoFR	Sep-19	First report to Cabinet Office is not due till February 2020.	Feb-20