Human Fertilisation & Embryology Authority

Audit and Governance Committee meeting

Date: 3 April 2025 – 4.00pm to 5.00pm

Venue: Virtual meeting via Teams

Agenda item	Time
1. Welcome, apologies and declarations of interest	4.00pm
2. Review of the capitalisation of PRISM (TS) For decision	4.05pm
3. Close	

Review of the capitalisation of PRISM

Details about this paper

Area(s) of strategy this paper relates to:	The best care/ The right information/ Shaping the future
Meeting:	AGC
Agenda item:	Paper to be taken out of committee to support year end
Paper date:	3 April 2025
Author:	Tom Skrinar
Annexes	A. Investment objectives and main benefits extract from the original OBC B. PRISM clinic activity and error rates from June 2022 to present

Output from this paper

For information or decision?	For decision
Recommendation:	AGC is invited to agree the recommended interim impairment of £93k in 2024/25, with a further review at the end of 2025/26.
Resource implications:	The recommended impairment value will need to be reflected in the 2024/25 Annual Report and Accounts. We do not at this stage believe this impairment will push us into an overspend position in 2024/25, but we will discuss with DHSC Finance Business Partners. Any impairment will impact on the future rate of depreciation, which we will revise for 2025/26.
Implementation date:	2024/25 Annual Report and Accounts
Communication(s):	N/a
Organisational risk:	Low

1. Introduction

1.1. PRISM development began life as part of the IfQ (Information for Quality) Programme. The programme addressed key, pressing issues with our infrastructure, systems and websites that were no longer fit for purpose. The objectives for the IfQ programme were to transform the HFEA's approach to the following:

A. the information we collect – what the dataset should include and why
B. how clinics submit data to us – the system for submitting data and how we check data for publication
C. how the information was held – the structure and resilience of the Register database
D. how we publish information – how success rates should be published on our website and what additional information – such as patient experience information – should be presented.

1.2. The IfQ programme was in three parts: an externally facing element (our website); the transfer of Register data to a new database; and portal for clinics to submit data (PRISM). This review focusses only on PRISM – predominantly B and C above ('how clinics submit data to us'). The IfQ developments for PRISM focussed on improving, standardising and stabilising how our data was collected and stored, so that it could be effectively retrieved and published.

1.3. The PRISM system was launched in September 2021 and roll out to clinics began in January 2022 (the 40 clinics that use the PRISM portal started immediately in September 2021 and the 60 clinics that use a API solution were deployed by their system suppliers over the following 10 months). PRISM has previously been reviewed by AGC as part of a lessons learnt exercise in December 2021, and updates have been provided regularly to AGC since then.

1.4. All clinics are now submitting data via PRISM, whether directly or through third party APIs, but ongoing delays to achieving a steady state of data collection with a small number of clinics has meant that we have had to continue working in a transitional phase, supported by specialist development resources, for longer than initially foreseen. The final element – the update of data for the purpose of Choose a Fertility Clinic (CaFC) should be complete by the end of 2025. This has also delayed our ability to realise the benefits identified in the original IfQ proposal.

1.5. PRISM was capitalised in 2021 as an asset on the HFEA's balance sheet at £885k and was subsequently impaired (in accounting, an impairment is a permanent reduction in the value of an asset) in 2022 by £266k based on an economic analysis / review of costs from 2015/16 to 2020/21. The Net Book Value as at 31 March 2025 is £302k, and NBV will depreciate to zero in July 2028, assuming no changes to the current rate of depreciation (based on the original value and expected ten year useful life; we will review the useful life and the rate of depreciation at this year's year end process irrespective of the outcome of this impairment review).

Table 1: Net book value of PRISM

Action	Value (£k)
Asset capitalised 2021	885
Initial impairment 2022	(266)
Depreciation to 31 March 2025	(307)
Net Book Value as at 31 March 2025	**302**
Current annual depreciation	89

1.6. As per HFEA accounting policy and in discussion with our external auditors, we agreed that a further impairment review at this point would be sensible. This was covered in the recent accounting policies update to AGC as follows:

1.7. *IAS 36 Impairments – management will make a judgement on whether there are any indication of impairment to the carrying amount of PRISM. A benefits realisation review will be undertaken by the team with oversight of PRISM as to whether the benefits as detailed in the original business case have been (or will be) realised. The outcome of which will impact on whether management decides to write down further the value of PRISM which currently sits on the Statement of Finance Positions (SoFP).*

1.8. This paper outlines the current status of the PRISM project and the benefits it is intended to bring, reviews the case for impairment and recommends a decision as to whether the value should be impaired in 2024/25 or not.

2. Current status of the PRISM project

2.1. As noted above, PRISM is now fully functional and all clinics are able to use it, though there are some differences between clinics in how they input data into PRISM and the quality of the data that is received. PRISM went live on 14th September 2021 for 40 direct entry clinics and API deployment was completed by the end of June 2022 for the other 62 clinics that record their data on bespoke internal systems that transfer the data to PRISM via an API. Since then, 830,000 units of activity have been submitted through PRISM. Close monitoring shows that the quality of the data submitted is better and this must reduce both clinics' and the HFEA's need to undertake reviews and corrections (though some outliers still remain, with continued engagement required to improve accuracy for the 14 CARE clinics).

2.2. Although PRISM is up and running and all clinics are using it, some legacy data issues from transferring old data submitted under EDI into the new Register remain to be resolved for us to complete publication of CaFC information. We have an interim CaFC update planned for March/April and a full update planned for summer 2025 and a further full CaFC for treatments in 2024 due by December 2025. However, these two actions will not completely resolve all legacy issues. A retrospective data verification exercise for issues in EDI data before 2021 is due to take place from the start of 2026 (though this is not strictly driven by a 'PRISM issue' – rather, we identified historic data issues in previous EDI submissions through improved analysis via PRISM).

2.3. As the transition work is still ongoing and we have not reached a BAU steady state, it is not yet possible to fully confirm that all benefits identified in the 2014 IFQ business case have been realised. Furthermore, there have been some changes in context since 2014 that impacts on the amount of resource levels required to deliver cash-releasing savings (for example the volume of register enquiries for donor information has increased significantly due to changes in legislation in 2005 that led to the removal of anonymity from 2023 onwards).

2.4. That said, there are a number of very clear benefits from PRISM that show its value. In the context of improving, standardising and stabilising how our data was collected and stored, the improvements we have had as a result have been significant. Perhaps most significantly, PRISM now allows us to have a very effective and accurate Register of treatment activity and outcomes which we can interrogate in new and different ways, providing us with much greater flexibility and responsiveness to changing information needs. The most recent example of this was the automated 10 family limit alerts which started in December 2024, which would not have been possible without a comprehensive database which allows us to automate processes. We

are also able to provide much more nuanced reports for public benefit, for example Fertility Trends[1].

3. Benefits originally identified to be gained by PRISM and current position

3.1. A full overview of benefits expected to accrue to the HFEA can be found at Annex A. This impairment review focusses specifically on those benefits that deliver cash-releasing benefits to the HFEA. These are:

- Item 2: reduce the end-to-end time spent submitting information (and the time spent by HFEA staff solving problems);
- Item 3: reduce the number of current errors in submitted data;
- Item 4: reduce the end-to-end cost of maintaining the Register (a reduction in business-as-usual resource pressures to the Register and IT teams); and
- Item 6: ensure our information business systems are effective, efficient and economical (a reduction in BAU resource pressure to the IT team).

3.2. These benefit categories are reviewed below based on current evidence or on an indication as to whether those benefits will be realised once the PRISM development work has completed and we have moved into BAU management.

3.3. Other benefits that were not originally identified as cash-releasing but are linked to planned system and process changes are as follows:

- Item 1: develop and maintain a clear data dictionary. *This has been achieved. It was agreed in 2018 and is publicly available, providing clarity about what data we collect and on what basis. We use the data dictionary regularly with data researchers and find it very useful in communicating what is currently collected.*
- Item 5: reduce the average time taken to produce internal information for analysis. *We believe this has been achieved, as evidenced by the 10 family limit work outlined above and examples of the range of reports we are now able to publish, as well as identifying historic data issues with IDE submissions.*
- Item 7: make public information more accessible to users and to increase the satisfaction of users. *We believe we are seeing these benefits. The HFEA was the 2024 Winner of the Award for Statistical Excellence in Trustworthiness, Quality and Value by the Office for Statistics Regulation.*
- Item 8: support the Authority's website to publish new and expanded information… improved presentation of clinic information on CaFC. *Information published on the HFEA's website via the dashboard has seen a number of improvements and continues to be developed - https://www.hfea.gov.uk/about-us/hfea-dashboard. We are currently also building on the public HFEA dashboard to provide clinic-level data to support inspections.*

Item 2: To enable clinic users that use the EDI system and Clinic Portal to reduce the end-to-end time spent submitting information, resolving data issues by 20% by 31 March 2017

3.4. Clearly this date has long passed, but a number of improvements have already been gained and we expect a significant improvement for all clinics once legacy issues set out above have been resolved.

[1] Fertility treatment 2022: preliminary trends and figures | HFEA

3.5. PRISM was designed to improve the quality of the data submitted first time by the introduction of validation rules which either prevented the clinic submitting incorrect data in the first place or provided easy visibility of incorrect data for action later, whether by the clinic or the HFEA. Current evidence shows that PRISM has been successful in improving data quality and that, in time, not only should a previously lengthy clinic verification processes be streamlined or eliminated, but also that the time clinics and the HFEA spend on day to day verification and reconciliation should be reduced.

3.6. Current information and metrics on progress can be seen at Annex B, with a clear indication of reduced error rates since June 2022 (ie since API deployment). As error corrections are the major driver of additional time spent by clinics in submitting their data, this shows a clear improvement and time saving.

3.7. Anecdotally we hear from clinics at fortnightly clinic PRISM user group calls that, although there was some initial 'getting used to' PRISM, they would not at all want to go back to EDI (the previous data submission system). The PRISM user interface gets a lot of praise from clinics, and (again anecdotally) we hear that it is easier to use than their API solutions, although API solutions may be more efficient for those clinics that need to send us large amounts of data in bulk.

3.8. We are not able to evidence that the scale of benefit outlined in the original business case has been fully met, as there is no clearly quantifiable methodology to show a 20% reduction in time spent submitting information and resolving data issues by 20%. The overall error rate in March 2025 is less than half of the rate in June 2022, and we expect it to reduce further as we continue to work with outlier clinics on their data accuracy.

3.9. There have clearly been some measurable improvements in error rates, that would reduce time spent resolving data issues, for the majority of clinics since roll-out. We do not have any indications currently that these benefits won't be realised for the remaining outlier clinics once transition is complete. ***Therefore, we do not believe we should impair the value of PRISM on the basis of non-achievement of this benefit at this stage.***

Item 3: To reduce the number of current errors in submitted data from 600 per month to fewer than 200 per month by 31 March 2017

3.10. As of November 2024, 770,960 units of activity have been submitted by all clinics through PRISM (see Annex B for further information). From the standalone clinics in particular we are measuring some very low error rates in PRISM. Compared to an EDI anecdotal average of 10%, the current average PRISM error rate for 'standalone clinics' is 1.2%. The largest standalone submitters are also demonstrating the best quality rates with London Women's Clinic and Guy's and St Thomas's having error rates of 0.2% and 0.4% respectively. This arguably sets the quality standard for the rest of the sector.

3.11. We no longer use absolute monthly error rates as a fair measure of progress, but reduction of error rates from 10% to 1.2% for 'standalone' clinics clearly goes beyond the two thirds reduction in error rates achieved by moving from 600 to 200 errors per month. As previously, some outliers remain, meaning that our average error rate across all clinics is currently at 3.4%. This is about the two thirds improvement we targeted (from an anecdotal average of 10%), and we expect further improvements through continued work with the CARE clinics in particular. We believe that this target has been achieved, and we expect to exceed it once transition has been completed. ***Therefore, we do not believe we should impair the value of PRISM on the basis of non-achievement of this benefit at this stage.***

Item 4: To reduce the end-to-end cost of maintaining the Register by £100,000 per year (cash releasing at least £50,000 per year) by 31 March 2017

3.12. Clearly this is difficult to evidence exactly, due to the length of time that has passed (PRISM was capitalised in 2021) and the changing context. Two HFEA teams, the Opening the Register (OTR) team and the IT team, oversee the maintenance of the register. The table below compares the team current team size that the size of the team at the time of the 2014 business case.

Table 2: Comparison of IT and OTR team sizes between 2014 and 2025

	2014 business case	Current (March 2025)
IT team	• Head of IT • 4 developers • 1 register analyst • 2 business analysts • (also some support from network manager and IT support officer)	• Head of IT • 2.5 FTE developers • 1 register analyst • 1 testing analyst • 1 project lead • (also some support from IT systems manager)
OTR	Register team is 5 members of staff	• Head of Information • 2 Information managers developers • 6 Information officers.

3.13. The OTR team has grown by 80% since the 2014 business case was written, due to a significant increase in requests for information from donors, parents and donor-conceived individuals. The annual rate of enquiries was 242 in 2014 but has increased by a factor of 6 to 1,439 in 2024 due to the removal of anonymity referred to earlier, as well as changing attitudes and increased awareness of rights as donors, parents and Donor-Conceived Individuals. We expect activity to continue growing as the significant growth in the number of donor treatments will mean that more individuals become eligible to access information over time.

3.14. The IT team is currently about the same size that it was when the business case was written. Work is still ongoing and fairly intense at the moment, but we expect some pressure on the team to reduce in 2025 as PRISM transition nears completion. We do not yet have a clear understanding of what our BAU requirements are, but we assume the overall team size will broadly stay the same as currently, due to an increasing workload supporting enquiries.

3.15. Although the OTR team has in fact seen some growth in recent years, we would not have been able to manage the increased intensity of work with current levels of internal resource without the benefits gained from PRISM. ***We do not yet have a clear idea of what our future, steady state resourcing requirements will be, but we do not believe at this stage we should impair the value of PRISM on the basis of non-achievement of this benefit.***

Item 6: To ensure our information business systems are effective, efficient and economical in order to deliver our statutory functions and strategic objectives with 'fit for purpose' technologies supported by sound and resilient processes by 31 March 2017

3.16. This does not really apply to the development of PRISM per se, beyond the length of time taken to deliver PRISM delaying the release IT staff focusing on PRISM to work on broader HFEA IT and data management improvements, including cyber security. That said, beyond ongoing development work, the new system in general is significantly more resilient than previously and

should require less ongoing IT support once we have achieved BAU position, but that is yet to be evidenced.

3.17. The HFEA is currently engaging with an external supplier to replace a significant proportion of our core non-PRISM IT systems. Until this work completes in 2025/26 (possibly 2026/27), we will not be able to make a proper assessment as to whether this broader benefit has been realised. ***We do not believe we should impair the value of PRISM on the basis of non-achievement of this benefit at this stage.***

Conclusion and recommendation

3.18. Due to the ongoing work to finalise transition to PRISM for a relatively small number of outlier clinics that have higher than average error rates (due to not submitting data into PRISM directly), it is not yet possible to say that we have realised the benefits in Items 2 and 3 above, though we think that the general improvements to error rates suggest that, on balance, we have more or less delivered them now and should exceed targets in future - assuming we can realise the same level of improvement for all clinics. We have no reason to believe that those benefits cannot be met, therefore we propose revisiting this at the end of 2025/26.

3.19. Our resource requirements for end to end management of the register, Item 5, has changed to a large extent due to significant growth in the demand for information from the register driven by changes in legislation. We do not believe we would have been able to manage the growth in activity with the current level of internal resource if we had not transitioned to PRISM, and the growth in activity is significantly higher than the growth in the size of the team.

3.20. Item 6, the work being taken forward on Epicentre and Content Manager replacement means that we will not have a clear picture of general IT and tech efficiencies until 2026/27 but expect to have significant improvements in how we manage our IT at that point, with growing potential for efficiencies and productivity gains. We have already gained significant improvements in system resilience through the move to PRISM.

3.21. On the basis of the above, we do not believe there are grounds to undertake a major impairment to the valuation of PRISM on the balance sheet at this stage and feel it would be more timely and appropriate to review this further at a point when we expect PRISM to have been fully rolled out at the end of 2025/26.

3.22. We have shared this paper with KPMG/NAO, who feel that the 'continued difficulties with the system and delays to being able to fully realise its intended functionality is a significant indicator of a possible need for an impairment', and in particular that, with an expected useful life of ten years, three years of rollout leading to delays in functionality suggests an impact on PRISM's book value of roughly that order.

3.23. This is a fair challenge, but due to a lack of detailed information to support setting a value to an impairment on this basis, it is difficult for us to calculate something meaningful – certainly we haven't delivered all of the originally identified benefits over the past three years, but we have delivered a significant proportion of them.

3.24. **A prudent estimate may be to assume that we have delivered 50% of the expected benefits across the three years, which would suggest that a 15% impairment against the value of PRISM on the balance sheet (ie 50% reduction in benefits for 30% of the life of the asset), amounting to a potential interim impairment of £93k (see Table 3 below), with a further review once roll-out is complete at the end of 2025/26. The HFEA executive recommends this approach.**

Table 3: Impairment value at 15% of asset value

Action	Value (£k)
Asset capitalised 2021	885
Initial impairment 2022	(266)
Asset value (before depreciation)	619
Value of impairment at 15% of the asset value	**93**

3.25. **Is AGC content to accept the recommended interim impairment of £93k in 2024/25, with a further review at the end of 2025/26?**

Annex A

Investment objectives and main benefits extract from the original OBC

item	Investment objective	Main benefits criteria for HFEA
1.	• To develop and maintain a clear data dictionary that is consistent with NHS national standards, understood by its users and reflects a balance that reduces the burden of submission whilst meeting the needs of researchers by 31 March 2016	**HFEA** Qualitative • Fewer errors by clinics in submitting data through greater understanding of data to enter • Delivers parts of HFEA strategy (H19, H33) Cash releasing (£s) • None expected
2.	• To enable clinic users that use the EDI system and Clinic Portal to reduce the end-to-end time spent submitting information, resolving data issues by 20% by 31 March 2017	**HFEA** Qualitative • Better quality information • Delivers parts of HFEA strategy (H18, H19, H40, H43) • Greater focus on core value add activities Cash releasing (£s) • Less time spent resolving data issues Noncash releasing (£s) • Less time spent resolving data issues
3.	• To reduce the number of current errors in submitted data from 600 per month to fewer than 200 per month by 31 March 2017	**HFEA** Qualitative • More accurate information • Delivers parts of HFEA strategy (H40, H42 and H43) • Greater focus on core value add activities Cash releasing (£s) • Less time spent correcting information or dealing with clinics Noncash releasing (£s) • Less time spent correcting information or dealing with clinics
4.	• To reduce the end-to-end cost of maintaining the Register by £100,000 per year (cash releasing at least £50,000 per year) by 31 March 2017	**HFEA** Qualitative • More core activities • Better value for money • Delivers parts of HFEA strategy (H17) • Greater focus on core value add activities Cash releasing (£s) • Reduced time spent by HFEA staff Non cash releasing (£s) • Reduced time spent by HFEA staff
5.	• To reduce the average time taken to produce internal information for analysis, FOI, PQs and other information requests for data submitted from the new system	**HFEA** Qualitative • Improved responsiveness from HFEA • Obtain information more quickly • Greater access to information • Greater focus on core value add activities

item	Investment objective	Main benefits criteria for HFEA
	to 3 days in 90% of cases by 31 March 2017	Cash releasing (£s) • N/A Noncash releasing (£s) • Less time spent by staff
6.	• To ensure our information business systems are effective, efficient and economical in order to deliver our statutory functions and strategic objectives with 'fit for purpose' technologies supported by sound and resilient processes by 31 March 2017	**HFEA** Qualitative • More able to undertake core functions • More resilience • Reduced business continuity risks • Delivers parts of HFEA strategy (H19, H42, H43) Cash releasing (£s) • Less time spent supporting systems Noncash releasing (£s) • Less time spent supporting systems • More time on value-add activities
7.	• To make public information more accessible to users and to increase the satisfaction of users as defined by the net promoter score from 0 to 6 by 31 March 2017	**HFEA** Qualitative • Greater capability to meet the HFEA remit about providing information to patients • More authoritative • Improved reputation • Delivers parts of HFEA strategy (H33) Cash releasing (£s) • N/A Noncash releasing (£s) • Fewer telephone calls or emails from people who can't find information on our website
8.	• To ensure the CMS can support the Authority's website to publish new and expanded information (such as the publication of more data to drive up clinic performance) improved presentation of clinic information on CaFC, including user experience scores and a range of new material for patients about treatment options and new scientific developments by March 2016.	**HFEA** Qualitative • More robustness • Ability to schedule items for release and withdrawal • Better information reviewing process • Delivers parts of the HFEA strategy (H3, H9, H10, H14, H27, H29, H30, H32, H33, H34, H36, H37) Cash releasing (£s) • N/A Noncash releasing (£s) • Less time manually releasing information

Annex B

PRISM clinic activity and error rates from June 2022 to present

Method of data submission		As of 3 March 2025		As of 5 February 2024		As of 13 November 2023		As of 5 June 2023		As of 21 November 2022		As of 6th June 2022	
	No of Clinics	PRISM Activity	PRISM error rate	PRISM Activity	PRISM error rate	PRISM Activity	PRISM error rate	PRISM Activity	PRISM error rate	PRISM Activity	PRISM error rate	PRISM Activity	PRISM error rate
Direct Entry	53	246,224	0.7%	165,686	1.6%	152,738	1.5%	120,076	1.6%	87,205	1.3%	52,705	0.7%
API - IDEAS	31	351,053	3.0%	249,012	3.2%	231,163	3.3%	180,307	3.2%	127,902	2.9%	60,792	6.6%
API - Meditex	8	91,618	3.9%	61,078	4.8%	56,301	5.1%	42,171	5.9%	28,575	5.2%	15,177	22.3%
API - CARE	14	151,260	8.6%	98,729	7.1%	92,525	5.9%	76,860	7.4%	48,206	7.2%	32,371	12.3%
Total	**106**	**840,155**	**3.4%**	**574,505**	**3.4%**	**532,727**	**3.4%**	**419,414**	**3.8%**	**291,888**	**3.3%**	**161,045**	**7.3%**