Audit and Governance Committee meeting - agenda

27 June 2023

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

10am

Agenda item			Time
1.	Welcome, apologies and declaration of interests		10.00am
2.	Minutes of 14 March 2023 **[AGC (27/06/23) DO]**	for decision	10.05am
3.	Action log **[AGC (27/06/23) MA]**	for information	10.10am
4.	Internal audit results and annual opinion **[AGC (27/06/23) JC]**	for discussion	10.20am
5.	Progress with current audit recommendations **[AGC (27/06/23) MA]**	for information	10.40am
6.	Annual report and accounts (including the annual governance statement) **[AGC (27/06/23) MA]** *-To follow*	for comment	10.50am
7.	External audit completion report **[AGC (27/06/23) MP/DG]** *-To follow*	for comment	11.05am
8.	Strategic risk register/appetite statement **[AGC (27/06/23)SQ]** Updated risk strategy **[AGC (27/06/23)SQ]** Horizon scanning **[AGC (27/06/23)SQ]** *verbal update* Deep dive – other proposed topics**[AGC (27/06/23)MA]** *verbal update*	for discussion	11.20am
9.	Digital projects/PRISM update **[AGC (27/06/23) KH]**	for information	11.45pm
10.	Resilience, cyber security & business continuity management **[AGC (27/06/23) MC/NMc]**	for comment	12.05pm
11.	Information assurance and security (SIRO report) **[AGC (27/06/23) PT]**	for comment	12.20pm
12.	Functional standards **[AGC (27/06/23) MA]** *TBA*	for comment	12.40pm

13.	Human resource update 2023 **[AGC (27/06/23) YA]**	for comment	12.55pm
14.	AGC forward plan **[AGC (27/06/23) MA]**	for decision	1.15pm
15.	Items for noting (verbal update) • Whistle blowing • Gifts and hospitality • Contracts and Procurement **[AGC (27/06/23) MA]**	for information	1.25pm
16.	Any other business		1.30pm
17.	Session for members and auditors only		
18.	Close		
	Lunch		

Next Meeting: Tuesday, 4 October 2023.

Minutes of Audit and Governance Committee meeting 14 March 2023

Details:			
Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science and society		
Agenda item	2		
Meeting date	27 June 2023		
Author	Debbie Okutubo, Governance Manager		
Output:			
For information or decision?	For decision		
Recommendation	Members are asked to confirm the minutes of the Audit and Governance Committee meeting held on 14 March 2023 as a true record of the meeting		
Resource implications			
Implementation date			
Communication(s)			
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes			

Minutes of the Audit and Governance Committee meeting on 14 March 2023 held in person at HFEA Office, 2nd Floor, 2 Redman Place, London E20 1JQ and via teleconference (Teams)

	In person	Online
Members present	Catharine Seddon, Chair Mark McLaughlin	Alex Kafetz, Deputy Chair Jason Kasraie
External Advisers	Mohit Parmar, National Audit Office (NAO) – External Auditor James McGraw, NAO	Dean Gibbs, KPMG – External Audit lead Joanne Charlton, Head of Internal Audit (Internal Auditor) – GIAA Rebecca Jones, Internal Auditor - GIAA
Observers		Amy Parsons, Department of Health and Social Care – (DHSC)
Staff in attendance	Peter Thompson, Chief Executive Clare Ettinghausen, Director of Strategy and Corporate Affairs Morounke Akingbola, Head of Finance Richard Sydee, Director of Finance and Resources Shabbir Qureshi, Risk and Business Planning Manager Debbie Okutubo, Governance Manager	Martin Cranefield, Head of IT Neil McComb, Head of Information

1. Welcome, apologies and declaration of interest

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

1.2. Apologies of absence were received from Steve Pugh, Kevin Hudson and Rachel Cutting.

1.3. Catharine Seddon declared an interest in item 3, in relation to her first term coming to an end in January 2024.

2. Minutes of the meeting held on 8 December 2022

2.1. The minutes of the meeting held on 8 December 2022 were agreed as a true record and could be signed by the Chair.

3. Action Log

3.1. The Head of Finance presented this item. It was agreed that actions 11.9 and 11.10 from 28 June 2022 meeting were complete and could be removed from the action log.

3.2. It was proposed that action 4.19 from the 4 October 2022 meeting be kept open as the Chief Executive and Deputy Chair of the AGC, Alex Kafetz, still wanted to engage with NHS Digital later on in the year.

3.3. Action 5.12 from 4 October 2022 meeting was on the agenda as an item at this meeting and could therefore be closed on the action log. Action 15.4 should be kept as the post was still unfilled.

3.4. From 8 December 2022 meeting, actions 4.10, 5.6, 5.7, 7.15 and 7.21 were agreed as complete and could be removed from the log. Action 9.8 should be closed and action 9.9 be brought back to the June meeting.

3.5. Also from the 8 December 2022 meeting, it was note that actions 10.4 to 11.10 were not yet due. Members agreed that actions 11.11 and 11.13 could be closed.

3.6. The Chair fed back that action 11.15 was discussed with the Authority Chair and it was agreed that it will be kept under consideration, but was not currently a priority, and it was therefore proposed that it be closed.

3.7. Action 5.6 was to be discussed under item 4 on the agenda, the internal audit report. Members noted that the GIAA internal audit tracker was shared with the Head of Finance to ensure that it aligned with the HFEA's tracker and internal documents. As it was an agenda item, it was agreed that it be closed on the action log.

Decision

3.8. Members agreed that future versions of the action log should be updated with all actions from AGC meetings, and all completed actions to be tabled at a meeting for removal from the log.

4. Proposed 2023/24 Internal audit plan & 2022/23 progress update

4.1. The Head of Internal Audit – GIAA presented this item. Members were advised that as at the 28 February 2023, 83% of the audit plan had been delivered to final report stage. The remaining 17% which was in fieldwork stage at the time of issuing of the report was now in the final review stage.

4.2. Members were advised that one of the recommendations made by GIAA as part of the Equality, Diversity & Inclusion (ED&I) review was rejected by the Executive. Four of the medium priority recommendations were still outstanding.

4.3. Members commented that regarding the ED&I recommendation rejected, context was important.

4.4. The Chief Executive responded that the recommendations were difficult to implement given the size of the organisation and that the limited opinion given was in the HFEA's view therefore not justified.

4.5. In response to a question, the Chief Executive commented that the specific rejected recommendation was unlikely to make a substantial difference to culture or recruitment and retention.

4.6. The Internal Auditor maintained her view that the recommendation was proportionate and the approach taken was similar to that in similar sized ALBs. In terms of having champions, it was understood that a similar recommendation was suggested a few years back but there was no take up, which was one of the reasons for the suggested re-introduction. She continued that the HFEA had moved on since then and it was important to recommend this again in order to keep moving the organisation in the right direction.

4.7. The Chief Executive commented that on the ED&I recommendation that was rejected, having a specific EDI objective might be difficult to evidence in all CMG roles, however we would ensure that the corporate management group (CMG) and HR members were assessed against the HFEA values and behaviours. Members asked if staff networks had a view on this recommendation. The Chief Executive commented that it had only been discussed at CMG.

4.8. A Member suggested strategies to move this item forward including an EDI "calendar" with lunchtime talks on diversity issues and not limiting invitations to just the HFEA but across all the arms-length bodies (ALBs) in the building.

4.9. On the issue of corporate governance and new member induction, members commented that they were all offered a clinic visit and that members had to take personal responsibility for doing the training that was an offer.

4.10. The Director of Strategy and Corporate Affairs commented that clinic visits had always been part of our induction process but were temporarily put on hold due to covid. Informal clinic visits for all members had now been planned.

4.11. The Internal Auditor commented that regarding any mandatory training there needed to be a mechanism in place to evidence that members had undertaken that training. On the issue of clinic visits they were aware that this had been reinstated.

4.12. The Chair commented that she found the cross-government department insight report very helpful, in particular noting the common themes, good practice and opportunities therein.

4.13. The Head of the Internal Audit stated that the 2023-2024 proposed internal audit plan had been presented to and agreed by the senior management team (SMT).

4.14. Members commented that they felt that it was a risk-based plan and thorough and were content with the 2023-2024 proposed plan.

Action

4.15. The Executive to consider ED&I strategies to move this item forward including, but not limited to, lunchtime talks on diversity issues which would be open to colleagues from other ALBs in the building.

Decision

4.16. Members noted the progress made against the 2022/23 Internal audit plan and the supplementary GIAA reports.

4.17. Members endorsed the proposed plan for 2023/24.

5. Progress with current audit recommendations

5.1. The Head of Finance presented this item. Members were informed that there had been two new audits since the December 2022 meeting and a total of 13 recommendations had been closed. In addition, the Head of Finance had checked the wording on the summary of recommendations sheet against the recommendation's information provided by Internal Audit to ensure consistency.

5.2. The Chair asked if there were any recommendations where target dates had been missed or target dates not deemed reasonable. The Head of Finance responded that there were two such targets and the owners were in discussion with her about their respective recommendations and target dates.

5.3. The Internal Auditor commented that whilst the organisation may deem a recommendation to be closed, it would not be closed from an audit perspective until sufficient evidence has been provided. She further commented that actions need to be focused on what the risks are and what needs to be done to mitigate those risks.

5.4. The Chair asked if a routine meeting could be convened in advance of the work being carried out between internal audit and the business area on what type of evidence would be expected. The Chief Executive and Head of Finance responded that this was a good idea and will be actioned.

5.5. The Internal Auditor highlighted that this conversation takes place during the close out meeting which occurs at the end of each audit. The internal auditor stressed that audit will highlight what needs to be done not how it should be done but commented that in the management response it should be clear what actions will be put in place to ensure that risks were mitigated.

Action

5.6. Target dates to be reviewed at the time of completing Management Action plans by audit sponsors to ensure they are realistic.

Decision

5.7. Members noted the progress with current audit recommendations.

6. External audit work

6.1. The Audit lead, KPMG, presented this item. He commented that they had carried out the interim audit on our accounts.

6.2. On Income risk, they had seen the forecasted end of year position and understood unreconciled income was expected to be immaterial. It was confirmed that there had been discussions about the PRISM valuation during the interim and that management were undertaking a review of the progress in the achievement of the intended benefits from the system.

6.3. The Director of Finance and Resources commented that regarding the income position, there were only three clinics that had not submitted their data. On the benefits realisation and legacy issues identified, the Chief Executive and the Director of Compliance and Information would work on this to see what still needs to be delivered.

Decision

6.4. Members noted the external audit update.

7. Draft Annual Governance Statement

7.1. The Director of Finance and Resources presented this item. He commented that the statement had been presented in draft in order that the committee may have early sight and comment on any material issues omitted. Also, to provide comment that the Authority may include in the final draft.

7.2. Members commented that the draft statement was comprehensive and well written.

7.3. The External Auditor commented that the conclusion on significant control deficiencies needed a more formal conclusion.

7.4. Members made the following additional points:

- under board activity there should be a re-ordering to reflect our priorities - for instance modernising our regulation should be near the top of the list
- under the AGC heading, we should add routine horizon scanning at each meeting. We might also highlight, after internal audit list, that all recommendations accepted by the senior management team will be implemented in the next year
- under regulatory risk, we should state that our risk assessment tool remains agile in a fast adapting market
- on the OTR risk, add in that the key risk was delay for donor conceived people and donors, (ahead of reputational risk to HFEA)
- on the data security and protection toolkit (DSPT) risk, we should record significant improvement on the previous year and
- on functional standards, we should note that AGC will monitor compliance.

7.5. Members asked who was tasked with whistle blowing arrangements. Members also commented that, wherever possible, we should evidence value for money and a commitment to continuous improvement.

7.6. On the statutory approval committee (SAC) meetings, members asked how attendance would be recorded as members were not expected to attend all meetings. The Chief Executive responded that there is a mechanism in place fairly to reflect that expectation for both members and the SAC Chair.

Decision

7.7. Members noted and commented on the first draft of the annual governance statement.

8. Accounting policies 2022/23

8.1. The Director of Finance and Resources presented this item. Members were advised of amendments and updates to the accounting policies adopted for preparation of the accounts for the financial year 2022/23.

8.2. Members commented that they found the report helpful and the only item that stood out for them were impairments and the fact that this remained a risk.

8.3. In response to a question, the External Auditor confirmed that they had seen the report before it was shared and had no comment.

Decision

8.4. Members noted the accounting policies 2022/23.

9. Strategic risk

Strategic risk register

9.1. The Risk and Business Planning Manager presented this item. Members were reminded that the new strategic risk templates were presented at the December 2022 meeting.

9.2. On the governance risk, it was noted that even though we say it is “at tolerance”, we remain of the view that we need modernised powers as a regulator.

9.3. On information risks, members were advised that the sub-risk of opening the register (OTR) will remain on the register. The Chair commented that she was in support of this as it showed dynamism.

9.4. Following discussion, it was agreed that the legal risk category should be closed.

9.5. Members were advised that the operational risk category related mainly to PRISM and the impact of it on our work.

9.6. On people risks the Chair asked if it was realistic to have a target closure date considering it was not within our purview. The Director of Finance and Resources responded that the view was to close this risk as this was not a live risk at present and that it will be re-activated should the need arise. Following further discussion, it was agreed that this will be left open subject to the response from Ministers on re-appointment of members whose terms of office were ending over the next 12 months.

9.7. On reputational risk, members requested that the Executive should reconsider re-wording, as the primary risk was about our credibility, should future legislative reform not yield positive results. The Director of Strategy and Corporate Affairs suggested that it would be discussed further at the Authority meeting next week.

9.8. On security risk, members noted the risk that the HFEA might face should there be a cyberattack which was a common risk across all ALBs.

9.9. On strategy risk relating to the Public Bodies Review, members were advised that this would be updated as we receive more detail about the scope of the review.

9.10. The Chair commented that the risk register was looking much improved and more dynamic. She requested that the front page in relation to each risk with the management commentary on current risks and views on mitigation, be listed in bullet form.

Actions

9.11. The front page of the strategic risk register with the management commentary on current risks and views on mitigation be listed in bullet form as a cover sheet to the strategic risk register.

Deep dive topics

9.12. Topics that had been chosen previously were discussed and some timelines were agreed:

- Increased reporting of corporate governance standards to be discussed in October 2023
- The effectiveness of performance management and risk (as this would be a year after the new system has been embedded) to be discussed in March 2024
- Staff retention and recruitment as a resource risk – to be discussed after a full year post covid
- Impact and effectiveness of communication
- HFEA's regulatory effectiveness if some or all our ambition for legislative change is not taken forward by the DHSC and
- OTR - what it means for the organisation.

9.13. Members suggested that once the licensing decision and any resultant appeals were concluded, it could be discussed as a deep dive topic.

Decision

9.14. Members noted the deep dive suggestions and proposed dates.

Horizon scanning

9.15. The Risk and Business Planning Manager presented this item and commented that the horizon scanning was run at an operational level and included in the risk register.

9.16. The External Auditor commented that part of what could be assessed were threats facing the organisation.

9.17. The Chair asked if we made sufficient use of data around lived experiences. Following discussion, she requested that the Executive should consider this.

Decision

9.18. Members noted the horizon scanning suggestions.

10. Digital projects/PRISM update

10.1. Members were given an update on PRISM by the Chief Executive in the absence of the PRISM Programme Manager. Members were advised that we are currently on track and making progress for delivery of the OTR.

10.2. On unique person identifiers, members were informed that since PRISM's launch, a new 'Person ID' algorithm has been working through patient records in PRISM to assign unique identifiers to all individuals on the register. Of the 1.6 million records reviewed, there were approximately 6,000 records that the Person ID algorithm could not match.

10.3. This necessitated further work to take place to amend the algorithm better to match the remaining records and then of those that still cannot be matched, to provide 'options' for register team staff to review manually, without any additional work for clinic staff.

10.4. Members were advised of the current work on legacy data issues and that the risk to delivery was our data analysts being distracted by issues that were not in the plan.

10.5. In terms of the assessment of validated data for choose a fertility clinic (CaFC), this assessment was scheduled between May and June 2023 which would allow us understand the level of subsequent CaFC verification activity required after clinics have corrected their validation errors.

10.6. The Head of Information commented that we were working with developers to sketch out what was required for the OTR service.

10.7. The deputy Chair of the AGC stated that as the champion he was updated and given assurance that OTR was on track.

10.8. Members commented that this was a colossal task and were pleased with the improvements made.

10.9. The Committee requested that their appreciation be sent to the PRISM Programme Manager and the entire team for all hard and complex work done to date.

Decision

10.10. Members noted the PRISM status update.

11. Resilience, cyber security & business continuity

Infrastructure improvements

11.1. The Head of IT presented this item. Infrastructure improvements were discussed and members were advised of IT security changes that had taken place.

11.2. The data back-up review and the application penetration testing was also discussed.

Data Security and Protection Toolkit (DSPT)

11.3. The Head of Information presented this part of the report.

11.4. Members were advised that this year NHS Digital had raised the bar and moved the HFEA into the same category as NHS Trusts. This meant that we had 113 mandatory evidence items out of 133 in total to complete.

11.5. It was noted that the new requirements were in the areas of information governance (IG) and information technology (IT).

11.6. The Chair commented that as NHS Digital has advised that mandatory requirements would increase year on year this was a red flag for us and it needed to be escalated.

11.7. The DHSC representative noted the issues and was asked to take this forward on behalf of the HFEA as it seems neither proportionate nor realistic for an organisation of our size to meet all the requirements. It was also noted that for some standards that we do meet, we might not have the evidence to prove it.

11.8. The deputy Chair asked if there were some cyber essentials that we can come up with that will readily satisfy some requirements.

11.9. The Director of Finance and Resources responded that they had been advised by the team in DHSC that it remained mandatory to complete the self-assessment and respond to the requirements as listed.

11.10. The Chair stated that discussions will be held with the deputy Chair of the AGC, Chief Executive and NHS Digital to explain that we do not have the resources to reach full compliance with these requirements. It was noted that the merging of NHS Digital into NHS England might mean that those discussions could not take place for some time.

Action

11.11. The DHSC representative to raise the DSPT issues with the appropriate team within the Department on behalf of the HFEA, noting that we would be unable to meet all the requirements due to the size of the organisation.

11.12. Discussions to be held with the deputy Chair of the AGC, Chief Executive and NHS Digital.

Decision

11.13. Members noted the infrastructure improvements and the current position on the DSPT.

12. Government Functional Standards

12.1. The Director and Finance and Resources presented this item. Members were advised that the Standards were created to promote consistent and coherent ways of working across government departments, and provided a stable basis for assurance, risk management and capability improvement.

12.2. In response to a question, the DHSC representative confirmed they had noted the paper and that the government Functional Standards formed part of the accountability meeting discussions.

12.3. The Internal Auditor commented that there were imminent changes in Functional Standards under the new framework and that the Head of Internal Audit will carry out an assessment in conjunction with the HFEA.

Decision

12.4. Members agreed the proportionate approach in conducting the review of Functional Standards.

13. Counter Fraud Strategy

13.1. The Head of Finance presented this item. Members were reminded that the Counter-fraud Strategy was developed as part of the HFEA's commitment to tackling fraud, bribery and corruption. It was also a key aspect of the Government Functional Standard GovS 013 Counter Fraud and that it would be brought back to the June meeting.

13.2. It was noted that the Strategy had been reviewed and not changed; however, updates were provided against actions detailed in the action plan.

13.3. The HFEA's counter-fraud arrangements are based on the Cabinet Office Government Functional Standard Gov 013 for Counter Fraud. Members were advised that management had agreed all recommendations that came from the Department of Health and Social Care (DHSC) Anti-Fraud Unit (AFU) peer review that was conducted in Q3 (2022/23) apart from those relating to the outcome metrics which did not seem proportionate to an organisation of our size.

13.4. During discussion, it was agreed that the Head of Finance would log what training had been done by whom and when, which would be acceptable to all relevant parties.

Actions

13.5. The Head of Finance to measure what counter fraud training has been completed.

Decision

13.6. Members noted the updated Counter Fraud Strategy.

14. AGC forward plan

14.1. The Head of Finance presented this item.

14.2. During the discussion it was agreed the counter fraud strategy will be brought to the October meeting.

14.3. Also, the accounting policies will be reviewed at the March 2024 meeting as it will be an annual item.

15. Items for noting

15.1. Whistle-blowing

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

15.2. Gifts and Hospitality

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

15.3. Contracts and Procurement

- Members noted that there were no contracts or procurements signed off since the last AGC meeting.
- The Director of Finance and Resources stated that we will need to bring forward a business case on contractors as there were increased controls around procuring this category of staff.
- The Chief Executive stated that Ministers were trying to reduce external spend on consultants as a strategy of growing internal resource, but this had drawbacks as it could lead to delays in particular where projects needed to be accomplished within a short space of time.
- Members commented that HM Treasury put checks and balance in place through IR35.

15.4. Estate update

- There was no update on our estate.

16. Any other business

AGC effectiveness update

16.1. Members were reminded that the Head of Planning and Governance had circulated the actions from the committee effectiveness review that took place in December 2022 and that members who wanted to comment still had the opportunity to do so. On the target dates, it was agreed that all dates seemed plausible.

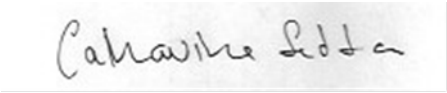
Training for December 2023

16.2. It was noted that the next training session will take place in December 2023 on understanding good governance and that the Director of Finance and Resources was seeking an external provider.

Chair's signature

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

Signature



Chair: Catharine Seddon

Date: 27 June 2023

AGC Action log

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society		
Meeting	Audit and Governance Committee		
Agenda item	3		
Meeting date	27 June 2023		
Author	Morounke Akingbola (Head of Finance)		
Output:			
For information or decision?	For discussion		
Recommendation	To note and comment on the updates shown for each item.		
Resource implications	To be updated and reviewed at each AGC		
Implementation date	2023/24 business year		
Communication(s)			
Organisational risk	☐ Low	X Medium	☐ High

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
Matters Arising from the Audit and Governance Committee – actions from 4 October 2022			
4.19 Executive to hold discussion with DHSC and NHS digital for some ALBs to be assessed at a different level on the Data Security and Protection Toolkit (DSPT) and consider future DSPT actions.	Chief Executive	December 2022	**Update –** due at June meeting
15.4 Update on goodwill letters to be discussed at SMT and brought back to AGC.	Director of Compliance and Information	Oct 2023	**Update** – Process started – good progress being made.
Matters Arising from the Audit and Governance Committee – actions from 8 December 2022			
7.32. Further consideration to be given by the Department to the issue of second terms and staggered terms in future appointments.	DHSC representative	Oct 2023	**Update** – The HFEA Chair and Chief Executive met with DHSC sponsors to discuss the case for re-appointment of members whose first terms finish in 2024. Chair agreed to supply evidence and rationale to sponsors in support of the case for re-appointment of all four members. DHSC Appointments team will signal this intention to Cabinet Office. While second terms are not automatic, a strong case can be made for them to ensure effective delivery of statutory business. **Propose to close**
7.41. Circulate a list of options and the definition of the categories to help hone the appetite and tolerance of risk.	Risk and Business Planning Manager	June 2023	**Update** – on agenda, **propose to close**
9.8. The Director of Finance and Resources commented that a list of DSPT audit of what has been met and what cannot be met will be brought to the March 2023 meeting.	Director of Finance and Resources	March 2023	**Update –** due at June meeting

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
9.9. The Director of Finance and Resources agreed that we will work closely with a similar sized ALBs on their DSPT work and bring this forward.	Director of Finance and Resources	March 2023	**Update –** due at June meeting
10.4. The committee to see the outcome of the analysis on the EDI audit at the next meeting when the HR report will be presented.	Head of Human Resources	June 2023	**Update** – on agenda, **propose to close**
10.5. The Head of HR to capture and include the free text observations from the staff survey in the report.	Head of Human Resources	June 2023	**Update** – on agenda, **propose to close**
11.9. Assurance and assurance mapping to be kept under continuous review and form part of training.	Head of Planning and Governance	Oct 2023	**Not yet due** – Update: A training update is included in the risk paper elsewhere on the agenda – some of our planned training will incorporate elements of risk assurance as relevant. We are also reviewing the latest changes to the Orange book risk framework to see how this references risk mapping. We continue to include consideration of risk assurance in the deep dive items to AGC, and this is a clear element in internal audits as relevant (for example the recent internal audit of our project management processes).
11.10. The Executive to consider risk management near misses as a potential topic for a deep dive.	The Director of Finance and Resources	Oct 2023	**Not yet due**
11.13. As part of continual improvement there should be monitoring of trends in the corporate governance sphere.	Head of Planning & Governance	Oct 2023	**Update** – on October agenda for deep dive.
11.14. The DHSC representative to look into how the AGC Chair can sit on the forum of other ALB ARAC Chairs and discuss the possibility of having associate board members with the department.	DHSC representative	Mar 2023	**Update** -– DHSC representative has now had confirmation that the Department's ARC Chair will extend an invite to both the HFEA and HTA to attend a meeting later this year. I have passed on to Catharine and Alex's contact details. **Propose to close**

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
Matters Arising from the Audit and Governance Committee – actions from 14 March 2023			
4.14 EDI Internal audit – the Executive to consider ED&I strategies to move this item forward including, but not limited to lunchtime talks on diversity issues which would be open to colleagues from other ALBs in the building.	Chief Executive	June 2023	**Oral update due**
5.6 Internal audit recs – meeting to occur between the internal audit team and business areas to discuss and agree on what evidence can be presented to mitigate risks identified	Head of Finance	June 2023	**Oral update**
5.7 Internal audit closure of recommendations target dates to be reviewed	Head of Finance	June 2023	**Oral update**
9.11 Management commentary on the SRR should be listed in bullet form as a cover sheet to the SRR	Risk and Business Planning Manager	June 2023	**Update –** We will do this where possible. As most of the commentary tends to be explanatory/ and or singular in nature, this doesn't always allow bulleting.
11.11 DHSC representative to raise the DSPT issues with the appropriate team in the department on behalf of HFEA, letting them know we will be unable to meet the requirements due to the size of our organisation.	DHSC Sponsor	June 2023	**Update –** The DHSC representative had a meeting this week with the new Head of Cyber Security in National Systems at the Joint Cyber Unit (DHSC/NHSE) where she raised the concerns around the DSPT and HFEA capacity. As part of the new Joint Cyber Unit, they will be establishing a regular forum for cyber leads (to which Head of Information will be invited) in order to facilitate dialogue, better understand the ALB landscape and collaboratively address any concerns. They also have a Cyber Improvement Programme, which is designed to support ALBs meet the requirements of the DSPT and encouraged HFEA to access this. However, they did note that for 21/22 HFEA achieved a 'standards met' rating and had no reason to believe the HFEA would not meet standards again this year. The DHSC representative reiterated that such a rating does not reflect the

ACTION	RESPONSIBILITY	DUE DATE	PROGRESS TO DATE
			wider resourcing implications this may have on other areas for the smaller ALBs. This was noted and the JCU is open to an ongoing discussion on how the HFEA and other smaller organisations can be supported in future. **Propose to close.**
13.5 Counter Fraud Strategy – Head of Finance to measure what training has been completed.	Head of Finance	June 2023	**Update –** due at June meeting
16.2 Training session for members in Dec-23 on understanding good governance. The Director of Finance and Resources to seek an external advisor.	Director of Finance and Resources	June 2023	**Update –** due at June meeting

Digital Projects / PRISM Update June 2023

Details about this paper

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time.
Meeting:	Audit and Governance Committee
Agenda item:	8
Meeting date:	27 June 2023
Author:	Kevin Hudson, PRISM programme manager
Annexes	

Output from this paper

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

1. Introduction and summary

1.1. PRISM went live on 14th September 2021 for 40 direct entry clinics and API deployment was completed by the end of June 2022 for the other 62 clinics. Since then, 420,713 units of activity have been submitted through PRISM.

1.2. At the AGC meeting on 14th March 2023, we advised on:

- The latest progress against the plan for OTR and CaFC through PRISM. At that time the plan was on track for all planning swim-lanes – data, developers and clinics – although the data team had been impacted by work to support the API migration of 0067 St Mary's Manchester which also serves as the pilot for the technical solution to deploy ARGC.
- The work by HFEA developers to deliver OTR requirements in PRISM including establishing Person ID unique identifiers and developing a new reporting engine that will give better outcomes and efficiency for OTR reporting.
- The ongoing work by our data team on addressing legacy data issues and migrating Meditex clinics including the deployment approach for ARGC.
- The progress on clinic readiness for CaFC, including latest error rates and their progress on fixing backdated registration errors, where 71% had been corrected. Backdated cycle errors were being deployed to the sector during March.
- The latest position on resources for PRISM including our appointment of an employed testing analyst and that our contracted resources were currently contracted to June 2023.
- On delivery timescales, we advised in March that:
    - To meet the requirements of the OTR team, we were planning to deliver all OTR and 10 family limit reports from PRISM by the end of July 2023.
    - As requested by AGC, the 'best and worst' for CaFC delivery were a 'best date' of September 2023 or a 'worst date' of June 2024 depending on the level of further 'verification after validation' that was required by clinics (see assumption 3 in paragraph 2.2 below).
    - We would be able to provide a more accurate assessment of CaFC timescales by the end of June 2023.

1.3. In this paper we will update AGC on the latest progress against the detailed plan that was first shared in December 2022, and the latest progress towards delivery of OTR requirements and the first CaFC through PRISM.

1.4. We will also update AGC on our latest assessment of delivery timescales for both OTR reporting and the first CaFC through PRISM.

2. Latest progress against plan for OTR and CaFC through PRISM

2.1. The current progress for OTR and CaFC (as of 9th June 2023) is shown in figure 1 below:

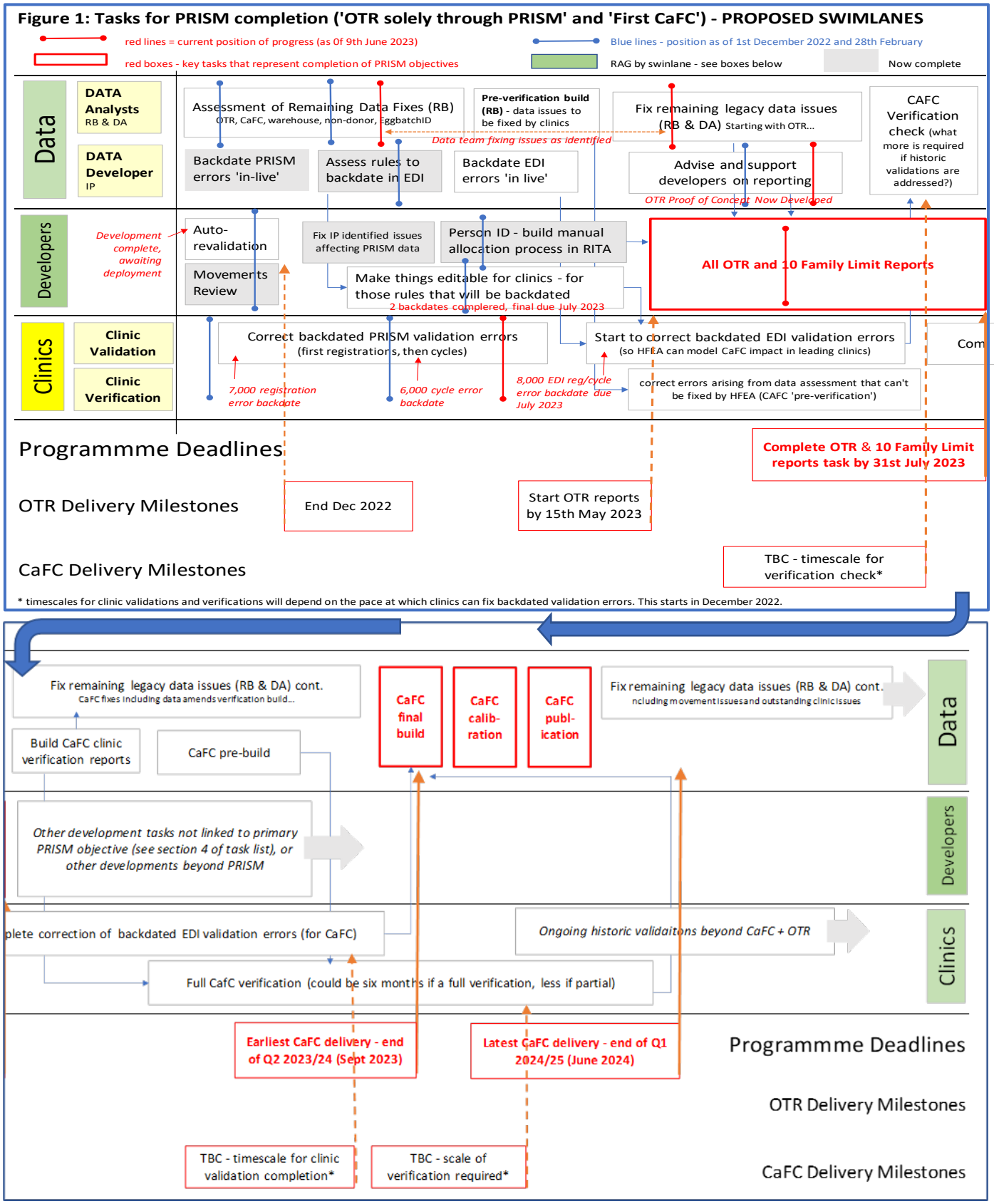


Figure 1: Tasks for PRISM completion ('OTR solely through PRISM' and 'First CaFC') - PROPOSED SWIMLANES
red lines = current position of progress (as 0f 9th June 2023)
red boxes - key tasks that represent completion of PRISM objectives
Blue lines - position as of 1st December 2022 and 28th February
RAG by swinlane - see boxes below
Now complete
Data
DATA Analysts RB & DA
DATA Developer IP
Assessment of Remaining Data Fixes (RB) OTR, CaFC, warehouse, non-donor, EggbatchID
Pre-verification build (RB) - data issues to be fixed by clinics
Fix remaining legacy data issues (RB & DA) Starting with OTR...
CAFC Verification check (what more is required if historic validations are addressed?)
Data team fixing issues as identified
Backdate PRISM errors 'in-live'
Assess rules to backdate in EDI
Backdate EDI errors 'in live'
Advise and support developers on reporting
OTR Proof of Concept Now Developed
Developers
Development complete, awaiting deployment
Auto-revalidation
Fix IP identified issues affecting PRISM data
Person ID - build manual allocation process in RITA
All OTR and 10 Family Limit Reports
Movements Review
Make things editable for clinics - for those rules that will be backdated
2 backdates completed, final due July 2023
Clinics
Clinic Validation
Clinic Verification
Correct backdated PRISM validation errors (first registrations, then cycles)
Start to correct backdated EDI validation errors (so HFEA can model CaFC impact in leading clinics)
Com
7,000 registration error backdate
6,000 cycle error backdate
8,000 EDI reg/cycle error backdate due July 2023
correct errors arising from data assessment that can't be fixed by HFEA (CAFC 'pre-verification')
Programmme Deadlines
Complete OTR & 10 Family Limit reports task by 31st July 2023
OTR Delivery Milestones
End Dec 2022
Start OTR reports by 15th May 2023
CaFC Delivery Milestones
TBC - timescale for verification check*
* timescales for clinic validations and verifications will depend on the pace at which clinics can fix backdated validation errors. This starts in December 2022.
Fix remaining legacy data issues (RB & DA) cont.
CaFC fixes including data amends verification build...
CaFC final build
CaFC calib-ration
CaFC publ-ication
Fix remaining legacy data issues (RB & DA) cont.
ncluding movement issues and outstanding clinic issues
Data
Build CaFC clinic verification reports
CaFC pre-build
Other development tasks not linked to primary PRISM objective (see section 4 of task list), or other developments beyond PRISM
Developers
plete correction of backdated EDI validation errors (for CaFC)
Ongoing historic validaitons beyond CaFC + OTR
Clinics
Full CafC verification (could be six months if a full verification, less if partial)
Earliest CaFC delivery - end of Q2 2023/24 (Sept 2023)
Latest CaFC delivery - end of Q1 2024/25 (June 2024)
Programmme Deadlines
OTR Delivery Milestones
TBC - timescale for clinic validation completion*
TBC - scale of verification required*
CaFC Delivery Milestones

2.2. To recap, as per our report to AGC in November 2022 our plan is based on 4 key assumptions:

1. Given the removal of anonymity from late 2023 onwards, we will prioritise OTR with data and reporting support to ensure they have maximum efficiency.
2. We will focus on clinics fixing validation errors before verification and only on backdated errors relating to OTR or the new CaFC period from 1st January 2020.
3. For CaFC we will assess to what extent 'validated data' is sufficient to run a CaFC which will be possible once leading clinics has fixed their backdated errors.
4. Our long-term strategic aim is for CaFC to be produced without a formal verification, which will be possible once CaFC is reporting solely from PRISM if error rates are sufficiently low.

2.3. The main features of our plan are three distinct planning swim-lanes to deliver OTR and CAFC through PRISM with reference to:

- **Data:** Establish the underlying framework, undertake key reconciliations and correct any arising legacy data issues that will impact either on OTR and CaFC.
- **Developers:** Continue to develop PRISM as required by data and clinics, and to build the OTR and 10 family limit reports according to the stakeholder requirements.
- **Clinics:** To address validation errors in relation to data submitted to HFEA and then, subject to review, to conduct further verification exercises prior to CaFC publication.

2.4. Presently, we are on track on the planning swim-lanes in relation to Data and Developers, but we have downgraded our RAG status on the clinic swim-lane due to the pace of clinic corrections for the cycle error backdate released in March and April. The reasons for this are discussed in more detail in section 5 below (See 5.5 to 5.12 below) as well as the action we are taking to improve clinic error correction rates (See 5.13 to 5.15).

2.5. Nevertheless, we are making very good progress in relation to delivering OTR reporting and are getting good feedback from the OTR team on the developing reporting prototypes. We are confident of hitting the deadline for signed off OTR reports by the end of July 2023. (See 3.7 to 3.13 below)

2.6. Our data team have also completed the Meditex API migration for 0067 St Mary's and we have formally advised ARGC that we are ready to commence their deployment using the same technical solution. (See 4.4 to 4.8 below)

2.7. In relation to CaFC, whilst we have previously advised that we had hoped to advise a more detailed timescale for CaFC by June 2023 (see 1.2 above). However, because of the slower pace of clinic correction, we will not be able to make this detailed assessment until September 2023. (See 4.2 to 4.3 below).

2.8. For CaFC delivery dates, whilst we are not yet able to provide a detailed CaFC assessment, we still think that the previously declared 'best and worst' dates remain approximately correct. We are currently communicating to clinics through Clinic Focus that we expect CaFC publication to be between the 'last quarter of 2023' (slightly after the previous best date of September 2023 advised to AGC in 1.2 above) and the end of 'first half of 2024' (same as worst date of June 2024 as advised to AGC).

2.9. It is our intention to provide clinics with a detailed CaFC timetable after the 'CaFC verification check' in September 2023. (See 5.16 to 5.19 below).

3. Progress on development: delivering OTR requirements

3.1. The development team are making very good progress towards delivering the OTR and 10 family limit reports by the end of July 2023.

3.2. As per our plan in Figure 1 above (see the first large red box), our team started, as scheduled, on 15th May on developing all OTR and 10 Family Limit reports through PRISM.

Development activities prior to commencing on OTR reporting.

3.3. Prior to commencement on OTR reporting, our developers completed work on an upgrade to PRISM that will improve how clinics submit gamete movements. They also completed a number of fixes identified by the data team and developed a Person ID matching system for the Register Team so that they can address the small number of Person ID records that cannot be matched by the automatic algorithm.

3.4. Establishing full matching of Person ID records for donors is an important pre-requisite for 100% accuracy on 10 family limit reporting.

3.5. Our developers have also continued to work on validation rules and ensuring that clinics encounter no issues when asked to correct backdated validation errors. Our developers released tranches of 7000 and 6000 errors in December and March respectively and a further 8000 are due to be released in July.

3.6. These tranches complete the backdated validated errors required for the first CaFC through PRISM although the date of CaFC delivery very much depends on the pace at which clinics correct these errors. This is discussed in more detail in section 5.

Delivery of OTR Reports and reconciliation of OTR data.

3.7. The reporting function historically built into PRISM is quite rudimental. It only allows reporting of simple grids of data, reported only as text which introduces difficulties if the user wishes to apply arithmetical functions to these reports. This is currently how PRISM reports data to clinics.

3.8. For internal uses it was clear that this was not sufficient, particularly with functions with OTR that required a detailed and multi-faceted deep dive into HFEA. Consequently, the PRISM programme researched and then adopted SSRS (SQL Server Reporting Services) to act as the main internal reporting engine for the PRISM database. There is no additional cost for the HFEA if just used internally. SSRS is a Microsoft product and can be integrated with Power BI which is being researched as a presentational business intelligence tool by the HFEA intelligence team.

3.9. During May, technical work was undertaken to integrate SSRS with the technical infrastructure that holds the PRISM database, and then build reporting prototypes from the OTR data extract routines that had been developed in recent months by our contracted data developer.

3.10. On 7th June our developers presented the first prototype of the SSRS PRISM report to the OTR team. It provides a very detailed breakdown of all cycles where a particular donor has been involved and permits drill through to additional PRISM held information relating to those cycles. The feedback from the OTR team was very positive and HFEA developers and OTR staff are now continuing to refine these reports.

3.11. Moreover, whilst our developers have been working to report PRISM data to the OTR team in the way they require, our data analyst has been undertaking a full reconciliation of OTR data held in PRISM. 3,782 reconciliation issues were identified (which is a relatively small number given the size of the PRISM database) of which our data analyst has resolved approximately 3000 issues and he is continuing to work through the remaining 800 issues. OTR does require 100% data accuracy so he will work to fully reconcile this dataset. Nevertheless, this reconciliation is progressing well.

3.12. As well as finalising the reports for OTR, our developers are now focussing on the reports required for 10 Family Limit. We are also working to ensure all the legacy donor information forms (including donor pen portraits for donor conceived individuals) that have been sent into the HFEA over many years, are migrated to be available to the OTR team electronically through PRISM.

3.13. During this phase of work, our employed developers will also be building in time to ensure they fully understand how data has been extracted from PRISM and the routines that have been developed by our contracted data developer, so that this can serve as a parallel handover on this particular aspect of that contractors' works.

4. Progress on data: ensuring legacy accuracy for OTR and CaFC

Current work on legacy data issues

4.1. Our data analyst's work on OTR reconciliation is described in section 3.11 above. This is his main focus of work until that reconciliation is complete. The target for this is the end of July, the same as the overall OTR deadline.

4.2. Thereafter, our analyst will move to other CaFC reconciliations. A key planned piece of work is the 'CaFC verification check' (see figure 1 above), where our analyst will conduct analysis to understand to what extent 'validated' data is sufficient to run a CaFC and therefore what (if any) further clinic verification exercises are required. (See assumption 3 in 2.2 above).

4.3. Also, as mentioned in figure 1 above this check is conditional on 'the pace at which clinics can fix backdated validation errors.' Consequently, as it has taken longer for clinics to fix cycle errors compared to registration errors, this verification check is now scheduled for September after our analyst has completed OTR work and has returned from August summer leave.

4.4. We will reference our actions to improve the rate of clinic correction in section 5 below.

Migrating Meditex clinics (including ARGC)

4.5. Another key aspect of our data analyst's work in the past few months has been supporting Meditex clinics to migrate to API. This is important as it is the technical solution by which ARGC will undertake deployment to PRISM.

4.6. After significant support by the HFEA data analyst on a renumbering exercise, and after detailed testing by our data analyst and Meditex of the HFEA developed bulk data backport (which ensures no submissions are missed or duplicated across an API migration), 0067 St Mary's Manchester successfully went live with an API migration in late May.

4.7. Early signs are that this API migration has progressed well, although there has been an increase in some registration errors on records that that the clinic will need to go back and correct. We will continue to monitor closely submissions from this clinic.

4.8. We previously advised AGC that once this API migration process has been fully ironed out, it would then been taken to ARGC. Rachel Cutting has already had a telephone conversation with the PR of ARGC this topic, and formal letter has now been sent to the PR stating that:

- the technical solution for their deployment is now ready.
- that they should advise to us a point of contact for detailed data submissions in the clinic.
- and to inform Meditex that they wish to undertake and migration and that Meditex should work with the HFEA team on the detail of that deployment.

4.9. We have only just sent this letter and so far, have not yet had a response from ARGC.

5. Progress by clinics: readiness for CaFC

Current PRISM activity

5.1. As of 5th June 2023, 419,414 units of activity has been submitted to PRISM. This is shown, split by clinics using PRISM direct entry and API supply, in table 1 below.

Table 1 – Cumulative PRISM activity as of 20th February 2023

Method of data submission		As of 5th June 2023		As of 20th February 2023		As of 21st November 2022		As of 19th September 2022		As of 6th June 2022	
	No of Clinics	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate	Cumulative PRISM Activity	Cumulative PRISM error rate
Direct Entry	42	120,076	1.6%	104,017	1.7%	87,205	1.3%	72,126	1.0%	52,705	0.7%
API - IDEAS	38	180,307	3.2%	152,881	4.0%	127,902	2.9%	105,533	3.4%	60,792	6.6%
API - Meditex	10	42,171	5.9%	30,384	4.8%	28,575	5.2%	26,137	5.3%	15,177	22.3%
API - CARE	13	76,860	7.4%	64,971	9.1%	48,206	7.2%	42,537	6.6%	32,371	12.3%
Total	**103**	**419,414**	**3.8%**	**352,253**	**4.3%**	**291,888**	**3.3%**	**246,333**	**3.4%**	**161,045**	**7.3%**

5.2. PRISM submissions are continuing at a steady state of approximately 5,000 submissions per week.

Clinic Submission Audits

5.3. Previously during 2022/23, and whilst PRISM was in deployment, we had relied on clinic declarations to advise that they were fully caught up on any submission backlogs arising from PRISM deployment. As of March 2023, all clinics had advised that they had caught up.

5.4. In 2023/24, the HFEA are recommencing direct and on-site clinic submission audits to ensure that all submissions are being sent to the HFEA.

5.5. Neil McComb, the HFEA Head of Information is leading this work and 10 clinics have been identified for audit during this financial year. Those clinics have been selected on the basis of where their current submissions appear at first glance to be less than historically reported activity (although that could be due to a number of commercial or operational reasons) and cover all

different aspects of submission to HFEA through PRISM – direct entry and API routes through IDEAS, Meditex and CARE.

Progress by clinics on correcting backdated validation errors for CaFC and OTR

5.6. In December 2022 and March 2023, after communicating to clinics through Clinic Focus and contacting clinics individually that were due to incur a high number of new errors, we released the first (7000) and second (6000) of three backdated tranches of errors that clinics will require to fix for both OTR and CaFC.

5.7. The first backdated tranche of 7000 errors related to registration errors and we observed that clinics were able to fix these quite quickly. This is generally because clinics need to only look in one place for the error (the PRISM registration record) and that the information needed to correct such errors is generally easily accessible in their own records.

5.8. The second tranche of 6000 errors related to cycle errors and we have observed that clinics are not fixing these at the same pace as they had earlier achieved for registration errors. This is most likely because cycle errors are more complicated to unpick and rectify and therefore the clinic cannot work through as many in the time they have allotted to work on data. Assuming the current rate, we do not expect the sector to fix these errors until August 2023 (see Table 2 below).

5.9. From our weekly activity statistics, we can identify which clinics had an overall net negative reduction of errors in the week. This shows a clinic that is focussing on error reductions. Last week, there were 24 clinics in the sector that had net negative errors and in total they removed 153 errors. Each week there appears a similar number of clinics removing errors and it also appears to be different clinics each week undertaking this activity. The PRISM team have not been able to identify any clinics that are not undertaking error correction, and the Register team are in constant contact with clinics regarding individual issues concerning validation errors.

5.10. Table 2 below shows details about the error backdates that have been undertaken, the approximate rate of error correction and the anticipated dates when these tranches will be fixed.

Table 2 – Details of backdated errors released and estimated completion.

Backdate	Date of Backdate	Description	Backdate Quantity	Approximate 'weekly fix' rate	Approximate weeks to fix backdate	Estimated completion month
Tranche 1	Dec-22	Backdated PRISM registration errors	7,000	500	14	Mar-23
Tranche 2	Mar-23	Backdated PRISM cycle errors	6,000	280	21	Aug-23
Tranche 3	Jul-23	Backdated EDI cycle and reg errors	8,000	tbc	tbc	Oct-Dec23*

** Tranche 3 estimated based on best and worst fixing rates from tranches 1 and 2.*

5.11. The third tranche of errors relates to CAFC data originally submitted in EDI – January 2020 to August 2021. There are approximate 8000 records in this backdate and they consist of both registration and cycle errors. After final developer checks we aim to release this backdate in July and clinics should correct these between October and December 2023.

5.12. The third tranche represents the completion of validation error backdates for CaFC. We have written to clinics in Clinic Focus that we are not intending to backdate errors earlier than January 2020 unless they relate to OTR.

Improving the rate of error correction at clinics

5.13. The underlying clinic environment is one where clinic staff have a limited amount of time within their schedules to address data issues which they often have to juggle with other competing clinical issues. Also, more complicated cycle errors take longer to investigate and fix, and many clinics are also reporting that they do not have sufficient resource. However, despite this, there are a number of immediate actions that we are considering in order to improve the rate of clinic correction of validation errors in PRISM:

- We have been communicating to the CARE group, who have the highest collective error rate (see table 1 above). CARE have identified individuals at a group level with responsibilities for reducing errors, but despite assurances we are not yet seeing real progress.
- Our Head of Information is once again writing to the group leads on this topic and the register team leader will be providing detailed error information to the clinic PRs.
- If these steps fail to bring about an improvement, there is a follow up escalation step we can take. We are keeping this under close review at the weekly programme board meetings.

5.14. In addition, once we have released to clinics the final batch of validation errors in July as described in 5.12 above, we will also be able to adopt additional approaches to speed up error corrections.

- We can set an overall target for the sector for when these errors should be fixed. We cannot do this earlier as it creates confused messaging if we are setting clinic's deadlines for fixing errors if at the same time (or later on) we are also adding new errors for their attention. For clear clinic messaging we need to complete all the backdates first and set a clear task for clinics to complete.
- As part of the final backdate checks we will have detailed counts on a clinic-by-clinic basis for errors across the whole hybrid EDI and PRISM CaFC period. This will then give us a definitive list of clinics that are at risk of taking longer than others to finish their errors which can be prioritised for communication, monitoring and support.

5.15. We will we give a verbal update at the meeting on any changes we have observed on clinic correction rates since this paper.

Estimating CaFC completion dates

5.16. Our plan provides for completing the 'CaFC verification check' (see 4.2 above) once the leading clinics have fixed all error tranches. Given the final tranche will be released in July 2023, this means we should have sufficient data to make the verification check in September 2023 which will provide more detail on exact CaFC publication dates.

5.17. Moreover, given that table 2 suggests a worst-case scenario that all backdated validation errors will be corrected by December 2023, then a worst-case scenario for CaFC of by the end of the first half of 2024 still seems like a sensible estimate.

5.18. Admittedly, the best-case estimate for CaFC in the last quarter of 2023 may be more difficult to achieve and would rely on a faster pace of clinic correction of the third tranche of backdated errors and that the 'CaFC verification check' indicated that no further verification was required (which was always the assumption built into the estimate of the best CaFC date).

5.19. It is our intention to communicate further detail on CaFC dates to clinics after we have conducted the verification check in September 2023. Our preference would then be to give an exact timetable rather than a range of dates.

6. Update on resources on PRISM

Employed resource

6.1. In February 2023 we appointed an employed testing analyst with 20 years testing experience. That individual has commenced well will PRISM and has brought in some very helpful testing frameworks although their direct onboarding on the detailed complexities of PRISM and fertility data continues.

Contracted resource

6.2. We have extended the contract for the PRISM support officer and operational expert in PRISM to the end of September 2023 so that they can complete the handover of detailed PRISM 'know-how' to the employed testing analyst and the register team. The HFEA Head of IT is closely monitoring this transition.

6.3. The contract for the PRISM support manager's contract has also been extended to October 2023 on a two day a week basis, to continue ongoing oversight of the overall PRISM plan and PRISM troubleshooting, managing the re-establishment of data functions through PRISM, prioritisation of PRISM developments, and managing future API migrations including the deployment to ARGC.

6.4. All contract extensions have taken place after an appropriate business case has been approved by DHSC.

6.5. The arrangement for our longstanding contracted data developer remains to retain them at 3 days per week until March 2024. Close to retirement age, this individual deals with all matters relating to the underlying PRISM database, PRISM validation and reporting, HFEAID and Person ID, and CAFC verification reports. They also deal with HFEA's billing system and Epicentre and has just built the extract routines for OTR data.

6.6. As mentioned in 3.13 above, it is part of the current developer workplan for OTR reporting to ensure this time also serves as a handover to employed staff on OTR data sources.

7. AGC recommendations

7.1. AGC are asked to note:

1. The latest position on our plan. That we remain on track for data and developers, but that progress by clinics is slower than previously anticipated. We are actively considering what steps we can take to improve the pace at which clinics correct their errors.
2. That we are making particularly good progress towards delivering the requirements for OTR reporting by the end of July 2023, and that we are now in the latter stages of delivering to the OTR team the efficient reports they need in advance of the removal of donor anonymity in late 2023.

3. That we have completed the Meditex API migration for St Mary's Manchester and have now invited ARGC to deploy to PRISM through this same technical solution.
4. That clinic rectification of cycle errors has been slower that for registration errors, but that error correction is being undertaken by all clinics.
5. This means the date by which we will have sufficient data to make more accurate assessment on CaFC has been deferred from June until September, after which we intend to communicate a detailed CaFC timetable to clinics.

Resilience, Business Continuity Management and Cyber Security

Area(s) of strategy this paper relates to:	The right information – to ensure that people can access the right information at the right time		
Meeting:	AGC		
Agenda item:	10		
Meeting date:	27 June 2023		
Author:	Martin Cranefield, Head of IT and Neil McComb, Head of Information		
For information or decision?	For information		

Recommendation	The Committee is asked to note:
	• Infrastructure improvements
	  • IT security changes
	  • Data backup review
	  • Application & web penetration testing
	• Current position on Data Security and Protection Toolkit		

Implementation date	Ongoing		
Communication(s)	Regular, range of mechanisms		
Annexes			
Organisational risk	☐ Low	☒ Medium	☐ High

1. Introduction and background

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

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

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

2. Infrastructure improvements

IT security changes

2.1. We have successfully implemented Mimecast which is filtering all incoming and outgoing email. Users now have greater visibility of any emails that are held in the secure Mimecast User Portal for further inspection, with the ability to instantly release any genuine emails that have been held. We are currently evaluating the Mimecast Outlook plug-in with a select few users, which will allow users to mark emails as spam/phishing within Outlook to improve the filtering algorithm and ultimately our security position.

2.2. We have made a change to how the Microsoft Authenticator works with our systems for multi-factor authentication (MFA) to include Number Matching. To date when entering an email and password, the user would receive a popup prompt with Approve/Deny. This type of prompt is prone to 'MFA fatigue' should a hacker enter a valid email and password and repeatedly cause the Approve/Deny prompt to appear on a user's phone. There is a risk the user could select 'Approve' to make the message go away, unknowingly authorising access to an intruder. By introducing Number Matching, the user will be asked to enter the 2-digit number on the screen rather than the Approve/Deny. We have started to roll this out across our systems and expect to complete in July.

Data backup review

2.3. On 6th March we received the report from MTI, a supplier recommended by DHSC to provide independent assessments on data backups. We have implemented some 'quick win' changes and are working through the outstanding items highlighted.

Application & Web penetration testing

2.4. We have scheduled the application & web pen test to start week commencing 26th June and will run over the course of a few weeks. Any high-level vulnerabilities found will be highlighted to HFEA IT immediately. Any low to medium, along with other advisories will be disclosed in the final report, which is expected to be received by end of July.

3. Data Security and Protection Toolkit (DSPT)

Background

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

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

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

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

3.5. The Head of Information will give a verbal update on the DSPT and the GIAA audit.

SIRO Report

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society		
Meeting	Audit and Governance Committee		
Agenda item	11		
Meeting date	27 June 2023		
Author	Richard Sydee, Director of Resources		
Output:			
For information or decision?	For information		
Recommendation	N/A		
Resource implications	N/A		
Implementation date	N/A		
Communication(s)	N/A		
Organisational risk	☐ Low	☒ Medium	☐ High
Annexes			

1. Background

1.1. The Senior Information Risk Officer's (SIRO) holds responsibility to manage the strategic information risks that may impinge on our ability to meet corporate objectives, providing oversight and assurance to the Executive and Authority of the HFEA. It is a Cabinet Office (CO) requirement that Boards receive regular assurance about information risk management. This provides for good governance, ensures that the Board is involved in information assurance and forms part the consideration of the Annual Governance Statement (AGS).

1.2. This report is my annual report to the Accounting Officer and AGC.

1.3. The Security Policy Framework (SPF) provides a suitable format for the HFEA's report. ALBs are also asked to assess themselves and report against the 10 Steps to Cyber Security, the guidance issued as part of the Government's Cyber Security strategy. The HFEA has made such an assessment and recorded relevant actions and risks as part of the operational risk register, which is reviewed monthly by the HFEA Management Group.

2. Report

2.1. The HFEA routinely assess the risks to information management across the organisation, through its assessment of the risk of data loss, cyber security and the inclusion of guidance on creating and managing records throughout its Standard Operating Procedures (SOPS) and policies.

2.2. The HFEA has historically held and processed personal data and records and maintained robust controls and security protocols around all data relating to fertility treatments, which it is required to hold under the HFE Act.

2.3. In recent years we have also responded to changes in legislation relating to the broader personal data we hold in relation to our staff, clinic staff and members of the pubic who may have contacted us. We have introduced several changes to our policies and procedures to ensure we comply with the General Data Protection Regulation and the Data Protection Act.

2.4. Throughout the year we undertake scheduled activity to ensure we comply with our policies; this work Is overseen by the HFEA's Information Governance Manager who makes periodic reports to the Corporate Management Group. In particular:

- During the year we have prepared and updated a number of information governance and IT security papers.
- We continue to regularly reviews our Information asset register, ensuring all assets have owners who are reviewing the assets held, there purpose and use. We have protocols to ensure documents that have reached the end of their retention period are reviewed and either deleted or the retention period extended.
- We have updated the information risk training we are using and have made this mandatory across the organisation

2.5. This provides an overview of our approach to RM and specifically the roles and responsibilities of staff across the organisation as well as our approach to record retention and deletion.

2.6. We continue to review our process for assessing our approach to capturing the level of information risk and our tolerance of it. Given the size of the HFEA there is limited resource to provide continuous oversight of this issue, as such our approach is proportionate and looks to embed the consideration of information risks within the broader assessment of organisational risks.

2.7. Our self-assessment against the DSPT for the 2022 submission was one of general compliance with the DSPT mandatory assertions. In terms of the required audit of our evidence, required by the toolkit to be independent of the HFEA and undertaken by our Internal Auditors, this led to an opinion of Limited, and improvement from the last year and one that was noted by GIAA colleagues in their report.

2.8. I am confident that further progress has been made in the HFEA's approach to the DSPT for the June 2023 submission. The number of assertions that our IA colleagues are assessing has both increased and changed from last year, but we have a solid base from which to approach this year's audit and confidence we have moved forward in our assurance position.

2.9. Our internal assessment is that the HFEA will still not meet the requirements of the 2023 mandatory assertions. We are currently working with GIAA colleagues to assess the substance of our evidence for this. We expect to submit our assessment in line with the 30 June 2023 deadline and the AGC will receive the findings from the internal audit review at the October 2023 meeting.

2.10. Overall, we have a low tolerance of risk for information on our Register database, that which falls within the auspices of GDPR and is commercially sensitive or business critical. The focus of our resource will continue to be the secure and compliant storage of these records.

2.11. In terms of the security of our data the HFEA has appropriate cyber security polices in place. AGC regularly receive updates on cyber security and I am assured that the HFEA's approach to cyber security provides significant protection of our information assets and that there is active monitoring of cyber security with appropriate action taken to improve the level of protection against new and emerging cyber threats.

2.12. I have considered the HFEAs compliance with the mandatory requirements set out in the SPF, see Security policy framework - Publications - GOV.UK. The requirements were last updated in July 2014 and focus on eight areas (governance, culture, risk management, information, technology, personnel, physical security, responding to incidents) with three types of consideration for each of those (information, physical and people). The requirements have been applied proportionately and matched to the HFEA's organisational risks. Not all of the areas apply to the HFEA. This is contained at Appendix A to this document.

2.13. In line with the Office of the Government SIRO handbook I have also considered a number of the factors that underpin the management of the HFEA's information risks.

- I believe the HFEA have an effective Information Governance framework in place and that the HFEA complies with all relevant regulatory, statutory and organisation information security policies and standards.
- I am satisfied that the HFEA has introduced and maintains processes to ensure staff are aware of the need for information assurance and the risks affecting corporate information.
- The HFEA has appropriate and proportionate security controls in place relating to records and data and that these are regularly assessed.

2.14. In conclusion I believe the HFEA has progressed in its approach to data, information and records management over the past year and is in a stronger position in terms of its governance in this area as a consequence. As SIRO I believe the HFEA takes issues relating to information risk seriously and has appropriate processes in place to assess and minimise these risks. We will continue to maintain and improve processes over the coming year and ensure we consider how we can maximise the use of our information as a business asset.

Annex A - Assessment of the HFEAs compliance with the Security Policy Framework 2014 (As at 31 March 2023)

	Mandatory Requirement	Compliance	Further actions required
1	Departments and Agencies must establish an appropriate security organisation (suitably staffed and trained) with clear lines of responsibility and accountability at all levels of the organisation. This must include a Board-level lead with authority to influence investment decisions and agree the organisation's overall approach to security.	Director of Resources is SIRO, Chief Information Officer has day to day responsibility of information security.	Ongoing review and refresher training as required.
2	Departments and Agencies must: * Adopt a holistic risk management approach covering all areas of protective security across their organisation. * Develop their own security policies, tailoring the standards and guidelines set out in this framework to the particular business needs, threat profile and risk appetite of their organisation and its delivery partners.	Risks identified as part of routine operational and strategic risk management as well as detailed on the information asset register Policies are in place and reviewed annually.	Ongoing review and development of the information asset register.
3	Departments and Agencies must ensure that all staff are aware of Departmental security policies and understand their personal responsibilities for safeguarding assets and the potential consequences of breaching security rules.	All staff and Authority members are informed of policies and given guidance. Annual training is undertaken by all	Ongoing reminders and awareness raising with staff.

		through Civil Service Learning.	
4	Departments and Agencies must have robust and well tested policies, procedures and management arrangements in place to respond to, investigate and recover from security incidents or other disruptions to core business.	System in place for detecting security breaches and business continuity arrangements in place.	None.
5	Departments and Agencies must have an effective system of assurance in place to satisfy their Accounting Officer / Head of Department and Management Board that the organisation's security arrangements are fit for purpose, that information risks are appropriately managed, and that any significant control weaknesses are explicitly acknowledged and regularly reviewed.	System in place and SIRO reports annually - any weaknesses identified in Governance Statement (none). Response to GDPR and Records management audits during 2018/19 have also been reflected in HFEA processes	None.
6	Departments and Agencies must have an information security policy setting out how they and any delivery partners and suppliers will protect any information assets they hold, store or process (including electronic and paper formats and online services) to prevent unauthorised access, disclosure or loss. The policies and procedures must be regularly reviewed to ensure currency.	Policies and procedures are in place and reviewed annually.	None.
7	Departments and Agencies must ensure that information assets are valued, handled, shared and protected in line with the standards and procedures set out in the Government Security Classifications	The HFEA's assets are all classified OFFICIAL and are appropriately controlled.	None.

	Policy (including any special handling arrangements) and the associated technical guidance supporting this framework.		
8	All ICT systems that handle, store and process HMG classified information or business critical data, or that are interconnected to cross-government networks or services (e.g. the Public Services Network, PSN), must undergo a formal risk assessment to identify and understand relevant technical risks; and must undergo a proportionate accreditation process to ensure that the risks to the confidentiality, integrity and availability of the data, system and/or service are properly managed.	ICT systems are risk assessed as part of the overall operational risk register. IT security was reviewed by Internal Audit in 2017/18	None
9	Departments and Agencies must put in place an appropriate range of technical controls for all ICT systems, proportionate to the value, importance and sensitivity of the information held and the requirements of any interconnected systems.	Patching and firewalls in place. Assurance reports received and reviewed regularly with suppliers. Portable devices and removable media is secured.	None.
10	Departments and Agencies must implement appropriate procedural controls for all ICT (or paper-based) systems or services to prevent unauthorised access and modification, or misuse by authorised users.	Policies and staff induction in place, to clarify proper use and implications of breaches.	None.
11	Departments and Agencies must ensure that the security arrangements among their wider family of delivery partners and third-	Contracts include required conditions and where appropriate third	None.

	party suppliers are appropriate to the information concerned and the level of risk to the parent organisation. This must include appropriate governance and management arrangements to manage risk, monitor compliance and respond effectively to any incidents. Any site where third party suppliers manage assets at SECRET or above must be accredited to List X standards.	parties are given copies of the HFEA's system policies. Changes to arrangements and incident monitoring and results are reviewed at quarterly meetings with suppliers.	
12	Departments and Agencies must have clear policies and processes for reporting, managing and resolving Information Security Breaches and ICT security incidents.	Policies have been revised and are in place.	None.
13	Departments must ensure that personnel security risks are effectively managed by applying rigorous recruitment controls, and a proportionate and robust personnel security regime that determines what other checks (e.g. national security vetting) and ongoing personnel security controls should be applied.	Recruitment and references provide assurance. No vetting in place as very little sensitive data.	None.
14	Departments and Agencies must have in place an appropriate level of ongoing personnel security management, including formal reviews of national security vetting clearances, and arrangements for vetted staff to report changes in circumstances that might be relevant to their suitability to hold a security clearance.	N/a.	
15	Departments must make provision for an internal appeal process for existing employees wishing to challenge National Security Vetting	N/a.	

	decisions and inform Cabinet Office Government Security Secretariat should an individual initiate a legal challenge against a National Security Vetting decision.		
16	Departments and Agencies must undertake regular security risk assessments for all sites in their estate and put in place appropriate physical security controls to prevent, detect and respond to security incidents.	Assessment and sufficient controls provided by building management.	None.
17	Departments and Agencies must implement appropriate internal security controls to ensure that critical, sensitive or classified assets are protected against both surreptitious and forced attack and are only available to those with a genuine “need to know". Physical security measures must be proportionate to the level of threat, integrated with other protective security controls, and applied on the basis of the “defence in depth" principle.	Visitor and entry controls provided by building management. Lockable furniture provided for storage. Clear desk and clear screen requirements reinforced through training, checks and reminders.	None.
18	Departments and Agencies must put in place appropriate physical security controls to prevent unauthorised access to their estate, reduce the vulnerability of establishments to terrorism or other physical attacks, and facilitate a quick and effective response to security incidents. Selected controls must be proportionate to the level of threat, appropriate to the needs of the business and based on the “defence in depth" principle.	Sufficient controls around access and mail provided by building management.	None.

19	Departments and Agencies must ensure that all establishments in their estate put in place effective and well tested arrangements to respond to physical security incidents, including appropriate contingency plans and the ability to immediately implement additional security controls following a rise in the Government Response Level.	Building management provide the lead on incidents. HFEA have contingency plans in place that are reviewed annually, and incident management processes were utilised in 2018 in relation to a power outage	None.
20	Departments and Agencies must be resilient in the face of physical security incidents, including terrorist attacks, applying identified security measures, and implementing incident management contingency arrangements and plans with immediate effect following a change to the Government Response Level.	Building management provide the lead on incidents. HFEA have contingency plans in place that are reviewed annually, and incident management processes were utilised in 2018 in relation to a power outage	

Human Resources update 2023

Details about this paper

Area(s) of strategy this paper relates to:	The best care – effective and ethical care for everyone The right information – to ensure that people can access the right information at the right time Shaping the future – to embrace and engage with changes in the law, science, and society
Meeting:	Audit and Governance Committee
Agenda item	13
Meeting date	27 June 2023
Author	Yvonne Akinmodun, Head of Human Resources
Annexes	Annex 1: EDI report Annex 2: EDI Presentation Annex 3: Staff survey action plan

Output from this paper

For information or decision?	For information
Recommendation:	The Committee is asked to note and comment on the updates on: a. Equality & Diversity b. Staff survey action plan
Resource implications:	
Implementation date:	
Communication(s):	
Organisational risk:	Medium

Introduction

1.1. HR papers come to the Audit & Governance Committee twice a year. At the last AGC, we presented key HR metrics for the Committee's attention. This paper focuses on two issues: Equality, Diversity and Inclusion (EDI) (following the initial discussion at the March AGC of the recommendations from the audit) and actions taken in response to the last staff survey in autumn (the results of which were presented at the AGC in December 2022).

2. Equality and Inclusion

2.1. The EDI audit issued in November 2023. Annex 1 sets out the key findings from the audit. There was a discussion at the March AGC about the stance taken by management in not agreeing to one recommendation. A number of actions and processes that have been put in place following the audit:

- The launch of new EDI page on our intranet
- A refresh of our recruitment page to better highlight our approach in the area of EDI
- The appointment of two members of staff as EDI champions
- The roll out of EDI training for Authority members

2.2. We continue to work in collaboration with other ALBs on EDI matters, sharing information and best practice in this area.

For context, some key EDI data is attached at Annex 2. This data has also been presented to CMG.

3. Staff survey

3.1. The annual all staff survey took place in the autumn of 2022. As noted above, we presented the emerging themes from the survey at the December AGC. At the time of the meeting, we were in the process of putting together a staff survey action plan.

3.2. The action plan is attached as annex 3. The plan was drawn up by an action group led by HR and made up of a cross-section of staff from all areas of the business. The action plan uses a RAG coding system to highlight which actions have been completed, which are in progress and those that cannot be actioned with the reasons why.

3.3. The majority of the areas identified within the plan have been actioned, or responded to in cases where it has not been possible to implement the action sought. One of the primary areas of concern raised by staff relates to our pay and a grading structure. This was the subject of a proposal presented to the Remuneration Committee in May. A business case will also be prepared to share with DHSC and the Secretary of State.

3.4. The action plan has also been shared with CMG and all staff.

4. Recommendations

- The Committee is asked to note and comment on the contents of this report.

Action plan from the staff away day

The actions identified by the various staff action plan groups have been clustered together by staff group. Actions highlighted in green have been completed, actions shown in amber are in progress and those in red are actions we are unable to take forward for the reasons stated.

IT & Finance

You said				Progress to date
What	**Where**	**When**	**How**	Comments
Keep our hybrid teams – accessibility for all	Office/remote	All meetings and events	Create a SOP on tech on remote meetings to promote good practice	Agreed - Hybrid working arrangements of a minimum of one day in the office will remain, unless government policy changes . This does not apply to homeworkers who will still only be required to attend the office when there is a specific requirement for them to do so
Content Manager	N/A	ASAP	Overhaul the IT system including CM/ Epicentre Have a SharePoint system	IT system updates will considered on a case by case basis against competing priorities. Staff can approach us directly with software requirements and this will be reviewed. We recognise that Epicentre is at the end of it lifecycle and we need to consider a replacement as soon as resources allow.
Allowing work from other countries – up to one week a year	Non risk countries within the EU	ASAP	Make a note of how many people are requesting it and how many get approved and how many are denied	Requires further review. However, we will promote the IT & Governance policy on the Hub. Staff to inform line manager and then make a formal request to use laptops aboard to IT& IG for review.
System Resource More licenses/ Access for all the WAP/CM/ ADOBE		ASAP	More licenses/ Access for all the WAP/CM/ ADOBE	Staff can approach us directly with software requirements and this will be reviewed. Some of these licences can be issued depending on IT budget. Staff should start by asking IT to see if it is possible to purchase more licences. With regards to WAP, Finance are currently reviewing the system as we might move to a different platform soon

Second hand Tech purchase scheme			Review if this option is feasible given government spending guidelines	Staff are able to purchase old laptops as long as we can demonstrate value for money We have to be able to demonstrate that we are receiving the equivalent of net proceeds from sale otherwise the difference counts as a benefit in kind by the HMRC and would therefore be taxable

All staff

You said				Progress to date
What	**Where**	**When**	**How**	**Comments**
Share more feedback on achievements	On the hub and in team meetings	ASAP	Teams can be given the opportunity to deliver a show and tell at all staff meetings	Agreed - We can add events as lunch & learn style activities which can also be recorded and posted on the Hub. The communication team are happy to take the lead coordinating the events. We will also look at running some day in the life events at bi-annual all staff meetings
Rotate chairing of all staff meetings	Hybrid	From the new year	Decide who should be the alternative chair. Should it be another member of SMT?	Agreed - This will be a rotating chair within SMT
More in person meetings. More director updates at team meetings	Redman Place	All year round	Teams are able to offer the option for teams to meet in person in addition to the all staff events which take place twice a year	Agreed - The decision on how often and when to meet in person should be decided by each head. Subject to rules relating to home workers attending the office.
Establish a social committee	Hybrid	As soon as agreed	HR to explore with staff if there is an interest	This should be set up as an informal arrangement with a specific channel set up on MS Team, where staff can post social activities
Have a clear space on the Hub for setting our HFEA aims and progress against them	The Hub	As soon as possible	Head of PlanGO to lead	We will explore the possibility of providing quarterly business plan updates on the Hub. We would also encourage staff to attend Authority meetings and read CMG updates where regular updates of note can be found
Allow all staff time to attend (Authority meetings to hear about aims. E.g.	In person or hybrid	Built around workload	Staff can find out dates of Authority meetings which are published on the Hub, which means staff can block out time in diaries schedule in advance,	Agreed – Staff already able to observe Authority meetings, which are organised 12 months ahead. The dates are published on the hub the year before the meetings take place.

Block out inspectors time			make part of culture to regularly attend, discuss/encourage in 1:1s	
Recognising colleagues on PeopleHR	PeopleHR	As needed	On PeopleHR, read out at all staff call, receive notifications, feedback at team meetings/ 1:1s	Agreed - HR can do a reminder in the monthly newsletter
50 min meetings, allow 10 mins for break between call so that we don't have back to back meetings	N/A	As needed	Finish all meetings at 10 to the hour. Have set agendas	Agreed - We will ask staff to support a culture of 50 min meetings wherever possible
Authority meetings Attend Update from Chair	Board and all staff meetings	Annual/ quarterly		Agreed - Updates on Authority meetings already provided at all staff meetings.

Communication

You said				Progress to date
What	**Where**	**When**	**How**	**Comments**
Increase awareness of our website	Events Clinics GP practices Facebook groups social media QR codes Gyms, Influencers	Immediately	Publicise the website through the various mediums shown in the where columns	Working on changes to the website which will improve its visibility in search engines - Looking into the feasibility and suitability of producing hard copy materials for display in various places
Provide a guide on the intranet for staff, in particular new staff to help to make it easier for them to navigate the Hub	On the Hub	ASAP	Provide a guide for all staff to access so that they can use it to navigate the intranet	We welcome the idea and will consider this when time and resources allow

CMG

You said				Progress to date
What	Who	When	How	comments
Ensure vision & strategy resonate /connect with service delivery plans and objectives	Team meetings	Monthly	Link to service delivery plans and cross team.	• We will explore doing values refresh. • HR will run a refresher on values as they relate to PDPS. • We will seek ways of improving social interaction through light touch activities such as desert island disk or favourite Spotify playlist
Building our culture/values into the business plan as a proper place of work we spend time on formalising it	HR to support activities on this if agreed	New business year	Make culture/values a project	• Agreed - plan to run a short workshop on service delivery plans. This might also help in ensuring consistency of format. The plans should also more clearly point towards values such as 'Together as One' and 'Look ahead' as a way of further embedding our values. UPDATE – Spoke with PR – a briefing session is being planned
CMG go to other team meetings – Spend time with other teams	Via Teams and in person	As and when, aim for 2 monthly All year, as and when required	By meeting invite from the team or request by CMG member (Emails) Open invitation and through the inspectors business support team	• Each head to determine with their relevant teams, who they would like to invite to their team meetings as a way of cross sharing of information
Internal secondment	Online/ In person Flexible	Timed around non-critical period. Financial year end Mid point performance year	Discussion with line manager areas of interest, growth, career aspirations. CPD sessions (not always at lunchtime). End of and mid - year Working with 3rd parties, HR to help facilitate process if agreed	• AGREED - as a small organisation we cannot offer extended periods of secondment. However, some areas of the organisations might lend themselves to mini shadowing session of say half a day. Each head to explore if this is something they can implement for their area. • Looking at introducing 'a day in the life' sessions for forthcoming staff away days. Where possible we can

				record the sessions for the hub. We can also ask anyone who might be interested in writing a blog for the hub setting out what a day in the life is like in their area of work

SMT

You said				Progress to date
What	**Where**	**When**	**How**	**Comments**
CMG to become mentors	Same or different organisations	Time has to be agreed and stuck to	Work out what you want out of it. Determine the length of mentoring Needs to be structured. Those volunteering need to be clear on the time commitment	Agreed - all staff now have access to the Whitehall Industry Group (WIG) mentoring platform. Staff can request or become a mentor
Higher pay in line with Civil Service pay bands – including reassessing pay bands	Remotely	ASAP to be implemented by June 2023	Review HFEA fee structure (Income) e.g. Charge new licence enquiries/applications. OTR Inspections	We are in the process of preparing a business case on pay for DHSC and the Secretary of State to sign off
Staff perks such as Gym membership – contribution via salary	Remotely	As soon as possible	Re- evaluate the current package/provider	SMT to review current staff benefits package to see if there is scope to make further improvements
Increasing non- paid incentive for long service e.g, starting from 2 years (Will help increase retention and skills retention)	N/A	Any time, maybe 2023/24	Perkbox? Vouchers? (Poem -Paula) Referral system, Mention at all staff card? Cake	Agreed – an update to the annual leave policy for additional annual leave has been put in place
Increasing non- paid incentive for long service e.g, starting from 2 years	N/A/	October 2023 (start of new leave year)	Update PeopleHR system to accommodate changes to leave policy	HR are updating the annual leave policy to reflect the process for changing long service leave after 5 years of service to one.
Identify activities for fast streamers – engage more free support	Cabinet office fast streamer Team first point of call	April and October (Twice a year)	Ask at each project could this be something for a fast streamer?	Agreed - HFEA has opened opportunities for fast streamers within some teams which includes opportunities for them to work on a range of projects

Birthdays off		From start of new annual leave year	Changes to annual leave policy and on People HR	Government policy does not at present allow ALBs or Government Departments to increase their overall annual leave offerings without it impacting on the overall pay remit provision
Rent deposit loan same as season ticket loan	Policy	As soon as possible, if agreed	Review if this option is feasible given government spending guidelines	We know of no schemes that the employer within government departmentswould permit this type of arrangement

Audit and Governance Committee Forward Plan

Strategic delivery:	☐The best care – effective and ethical care for everyone	**X**The right information – to ensure that people can access the right information	☐Shaping the future – to embrace and engage with changes in the law, science and society

Details:	
Meeting	Audit & Governance Committee Forward Plan
Agenda item	14
Meeting date	14 March 2023
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:	27 Jun 2023	4 Oct 2023	7 Dec 2023	5 Mar 2024
Following Authority Date:	12 July 2023	15 Nov 2023	24 Jan 2024	20 Mar 2024
Strategic Risk Register	Yes	Yes	Yes	Yes
Horizon scanning				
Deep dives		Increasingly onerous standards of corporate governance reporting materially impacting our ability to put the patient at the heart of all that we do		
Risk Management Policy[1]	Updated Risk Strategy/ Appetite statement		Risk management strategy	
Digital Programme Update	Yes	Yes	Yes	
Annual Report & Accounts (including Annual Governance Statement)	Yes – For approval			
External audit (NAO) strategy & work	Audit Completion Report		Audit Planning Report	Interim Feedback
Information Assurance & Security	Yes, plus SIRO Report			
Internal Audit Recommendations Follow-up	Yes	Yes	Yes	Yes
Internal Audit	Results, annual opinion	Update	Update	Update

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

AGC items Date:	27 Jun 2023	4 Oct 2023	7 Dec 2023	5 Mar 2024
	approve draft plan			
Whistle Blowing, fraud (report of any incidents)	Update as necessary	Update as necessary	Update as necessary	Update as necessary
Public Interest Disclosure (Whistleblowing) policy				Yes
Anti-Fraud, Bribery and Corruption policy				Yes
Counter-fraud Strategy (CFS), Fraud Risk Assessments (FRA) and progress of Action Plan		Counter-fraud Strategy (CFS)		
Contracts & Procurement including SLA management	Update as necessary	Update as necessary	Update as necessary	Update as necessary
HR, People Planning & Processes	Bi-annual HR report		Bi-annual HR report	
Training			Yes- see action from Dec 22	
Resilience & Business Continuity Management	Yes	Yes	Yes	Yes
Reserves policy		Yes		
Estates	Yes			
Review of AGC effectiveness and terms of reference		Yes – update from 22/23 effectiveness review and table draft questionnaire for AGC members to complete by December.	Yes – standard review	
Functional standards	Yes	Yes	Yes	Yes

AGC items Date:	27 Jun 2023	4 Oct 2023	7 Dec 2023	5 Mar 2024
AGC Forward Plan	Yes	Yes	Yes	Yes
Session for Members and auditors	Yes	Yes	Yes	Yes

Suggested training for Committee Members

- Understanding good governance – Dec 23 PR to take forward – ideally external (MA to check with HTA provider)
- Risk Management
- Counter fraud
- External Audit – Knowledge of the role/functions of the external auditor/key reports and assurances.

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

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

Suggested deep dive topics as agreed at the 8 December 2022 and revisited at 14 March meeting but yet to be decided when to have them

- OTR - what it means for the organisation
- Retention recruitment- resource risk
- Legal risk and how it will be mitigated
- Public body review – lessons learned?